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Cultural Reviews
Editorial

Rowdy Yates, Eric Broekaert and Stijn Vandervelde

This issue of the International Journal of Therapeutic Communities focuses upon the work of drug-free therapeutic communities (TCs) for the treatment of addictions. The issue can be seen as falling into four distinct sections.

Firstly, we have included a collection of four short reflective pieces by authors who have been involved in TCs, either at their inception or in their early years. These are not, of course, academic works in the normal sense of the word, but they are important documentary records which add to our understanding of the early development of addiction TCs and which have particular relevance for our understanding of their potential future role in a changing drug policy environment. We have presented these – more or less – in chronological order. Thus, Martien Kooyman describes his growing disillusionment with orthodox drug treatment approaches in The Netherlands during the early 1970s and his establishment of Emiliehoeve, the first addictions TC on mainland Europe. Peter Agulnik and Stephen Wilson then provide a brief outline of the developments which shaped the Ley Community in Oxford and their early attempts at establishing an evidence base for this new and innovative approach. Georges van der Straten reflects on the personal and professional difficulties which had to be overcome in bringing TC methodology to a French-speaking establishment which was generally critical of the method. Finally, Eitan Sela describes a series of similar obstacles and rivalries which he faced more than a decade later in setting up the first addictions TC in Israel.

Secondly, we have selected a further series of papers from the 2005 EWODOR Symposium in Blankenberge. A selection of Blankenberge papers was published in a previous issue of the Journal (Vol. 27, Iss. 1) and these four papers continue the theme of understanding the role of the addiction TC in a changed treatment landscape. Eric Broekaert et al., in a wide-ranging paper, map out the early history of the addiction TC and consider the differences between the American and the European model. Mads Pedersen describes a study

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1 The International Symposium on Substance Abuse Treatment was a joint organisation of the Department of Orthopedagogics (Ghent University, Belgium) and the Ohio Institute for Addiction Studies (Ohio, USA) in close collaboration with the Scottish Addiction Studies group (Department of Applied Social Sciences, University of Stirling, UK), the European Working Group on Drug Oriented Research (EWODOR), the European Federation of Therapeutic Communities (EFTC) and the Association for Alcohol and other Drug Problems (VAD, Belgium). This was one of a series of collaborative EWODOR symposia which commenced in 1983.

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evaluating the experiences of women in TC environments and the potential role of predictive instruments in treatment planning. Gillian Squirrell presents an analysis of the current drugs-crime axis in treatment policy and offers a service-user perspective on the shortcomings of such approaches. Finally, Wouter Vanderplasschen et al. report on a study which examined the experiences of multi-agency service users and the management of their treatment delivery in Belgium.

The third section consists of two papers which present the use of TC methodology in modified form. Peter Vassilev and Teodora Groshkova chart the development of TC Phoenix in Bulgaria and describe their use of cognitive-behavioural therapies within a TC context. Bartomeu Català outlines the approach adopted in Spain in order to integrate the apparently opposing approaches of abstinence-based residential rehabilitation and substitute prescribing in a modified TC.

The fourth and final section is our old friend, the Cultural Review. In this issue, this regular section continues with detailed reviews of two recent publications.

All in all, we are confident that most, if not all, readers will find at least one item in this varied selection which fires their enthusiasm, adds to their understanding or gives them cause to ponder their own practice.
Personal Reflections

Pioneering in the First Drug-Free Therapeutic Community in The Netherlands

Martien Kooyman

ABSTRACT: The author describes in this paper how he, as a doctor prescribing methadone to drug abusers, discovered the existence of drug-free therapeutic communities when he attended a play performed by residents of Daytop Village. With the knowledge that treatment of addiction is possible he started in The Hague in 1972 the drug-free therapeutic community Emiliehoeve. The initial democratic model that proved to be open to manipulation by the residents was replaced by the hierarchical structured model of the American therapeutic communities. In this paper he describes how he learned from consultants from these therapeutic communities and how he struggled with the paraprofessional-professional conflict, with abuse of power and the threat of influences from a sect. Learning from mistakes, changing what did not work and keeping what cannot be changed, the Emiliehoeve therapeutic community grew and became a role model for many programmes in Europe.

On 14 February 1972 the first therapeutic community for addicts was opened in an old farm called Emiliehoeve, which was situated on the premises of a psychiatric hospital in The Hague. I was the psychiatrist in charge and I had invited all persons in The Netherlands who were working with addicts to attend the opening. At the meeting I told them that this community was going to be the first place in The Netherlands where people would be successful in stopping their addiction to drugs. Of course this statement led to some cynical remarks from the sceptical audience. A colleague, Peter Geerlings, who had recently visited a therapeutic community in New York and had attended one encounter group, gave a presentation at this meeting.

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I had heard of a therapeutic community for addicts for the first time only 18 months previously. This was when I attended a performance in a theatre in The Hague called ‘The Concept’ by re-entry residents from the therapeutic community Daytop Village in New York. In the performance they played the history of an addict who comes to Daytop. On stage they showed the intake and even an encounter group. At the end of the performance they left the stage and reached out to the audience, saying: ‘would you love me?’ I felt relieved that I was not sitting in the front row. This play changed my view on addicts. It was the first time that I had seen recovered addicts.

At that time I was in training to become a psychiatrist and was also acting part-time as the medical doctor responsible for a small methadone maintenance programme in The Hague. At that time there was not yet any heroin in The Netherlands. Our clients had used opium, which had been obtained from the Chinese community in Amsterdam, and opiates that had been stolen from pharmacies. We had just introduced urine controls as we suspected that some of our clients were using other drugs. To our surprise we discovered that all of our methadone clients had also been using other drugs.

The performance in ‘The Concept’ had convinced me that treatment and staying clean of drugs was possible. Recently I discovered that attending a performance of ‘The Concept’ also led Ian Christie to start the therapeutic community Alpha House in England in 1970.

The board of the ‘Consultatie Bureau’, the outpatient centre for addiction, was not showing any enthusiasm for my plan to start a therapeutic community. Their advisor, a professor in psychiatry, had convinced them that there was no cure for drug addiction.

However, the director of the psychiatric hospital where I finished my specialisation in psychiatry in December 1971 offered me the possibility to start a therapeutic community in an old farm that had become part of the grounds of the psychiatric hospital after there had been an exchange of land with the city of The Hague.

From the scarcely available literature at the time I concluded that the American TC model looked too much like a military camp and in the first months the Emiliehoeve was set up following the democratic model of Maxwell Jones, which at that time was popular for psychiatric patients. It soon became clear that our residents were not ready to assume the responsibility of functioning in this model.

As their coordinator they voted for the resident who would not put any pressure on them and the groups who were to do the work on the farm were formed on the basis of what they could do the best and who they liked the most. Besides this, the staff were instructed to reinforce all positive behaviour by giving compliments and to ignore self-destructive and anti-social behaviour.

This resulted in the residents continuously testing limits. Because they received no therapeutic restraint the residents became more destructive, not only by breaking glasses but also by throwing a chair through a window. The staff then had no other option than to expel them (Kooymans, 1992).
We later realised that it was not acting out behaviour resulting from anger but from fear due to a lack of control. A radical change in the attitude of the staff started in June of that year. It was the result of the participation of the psychologist of the staff and myself in July 1972 in an encounter marathon group, which lasted 54 hours with only four hours of sleep. This group was led by Denny Yuson, a graduate of Phoenix House New York, who had been the first director of Phoenix House in London. Still full of enthusiasm from this experience we introduced it in the TC in the next week. The residents liked these emotional confrontation groups much more than the dull discussion groups we had used before.

The impact on the TC of the encounter groups was enormous. Everyday life in the TC was confronted and honesty became an important value. In these emotional groups the staff as well as the residents started to confront negative behaviour (1975).

An important moment in that first year of the Emiliehoeve was the recovery of an organ by the residents and staff from the house of a dealer who had previously removed the organ from the farm with the help of some residents and provided them with drugs. On 17 August 1972, the organ was taken from the house of the dealer who was surprised at seeing so many people entering his home and returning the organ on the roof rack of one of the cars with a staff member playing ‘we shall overcome’. Since then, drugs have no longer been used on the premises.

In that same month I had attended two weekend groups led by the American psychiatrist Daniel Casriel. I had read his book on Synanon, So fair a house, and not only discovered in these weekends that he had been one of the founders of Daytop Village but that his therapy groups were very useful in having participants overcome their fear of closeness and their negative self-esteem. When I used these groups (which were later called bonding groups) in my TC, I found out that almost all residents had the attitude that nobody could love them and that they did not even have the right to exist.

Nine months after the encounter group marathon Denny Yuson was appointed as a consultant to the TC. Amongst others, he taught the team the ritual of a verbal reprimand which was called ‘haircut’. The goal was to make the person, who was addressed by three others, aware of his destructive behaviour and to show the relationship to negative behaviour in the past. He did so by giving the staff a haircut and telling them to give some residents a haircut immediately after this.

He also suggested introducing a hierarchical structure in the staff and residents. The staff discussed this for hours. This was a great change at the beginning of the 1970s, the era of democratisation of institutes.

At 3.00am the decision was taken to introduce a hierarchy with coordinators, expeditors, department heads and crew. The positions were now going to be decided by the staff. A person was given a position where he or she had the best possibilities to learn (Kooyman, 1975). At 3.30am the residents were called from their beds and directed to sit in the main stall of the farm without talking or smoking to hear what the staff had to say.
When the job structure was announced and the coordinators and department heads were given a loud applause, the residents were told to meet with their departments and plan the work of the day. To our surprise the residents liked it.

Step by step the philosophy and the tools of the American TCs were introduced in the Emiliehoeve TC. Even the heads of persons that had left the TC, and had used drugs before they were readmitted, were shaven. Although the bald heads may have kept some people from leaving again, it also prevented people from entering as it created associations with a concentration camp. So this method of readmitting was seen as harmful and therefore rejected.

An interesting finding in that period was that, when we increased the places of the TC from the original ten and we had all of the 15 or 17 residents in one encounter together, two or five residents left after a few weeks, reducing our numbers to 11 or 12. This stopped after we had divided the residents in two encounter groups occurring at the same time (Kooyman, 1992).

In the autumn of 1974 I felt secure enough to leave the Emiliehoeve for two months to visit the American TCs. I was greeted at the airport in New York by Msgr William O’Brien who took me to one of Daytop’s TCs, Parksville. When I arrived there, 150 residents were already sitting together waiting for my speech. When I asked the director after the meeting how many staff they had, the answer was: ‘we are lucky, we have seven, as some time ago we only used to have four.’ I then realised that the therapy in the TC is not the input by staff, but the community itself with a clear philosophy of self-help and mutual help, of peer pressure and role models.

Another interesting experience was the meeting I had in Synanon with its founder, Charles Dederich. He was interested to hear that the Emiliehoeve started to be successful after we had introduced the encounter groups, as it was Synanon that had started with these groups, then called games. He said that he had discovered that the confronting of a person in a group was more important than being confronted. On the other hand he regretted that nobody in Synanon confronted him anymore except his wife or his daughter.

Back in The Netherlands I started the drug-free day centre ‘Het Witte Huis’ within the same organisation where I was still the medical director of the methadone programme. The day programme was modelled after the Emiliehoeve TC.

Other workers in the addiction field in The Netherlands became interested in the programme in The Hague. A workshop was organised for them in which they spent a weekend in the Emiliehoeve. They were placed as residents in the different departments, with residents of the TC as department heads and coordinators, in order to experience the TC. On the first day they did not see the staff, as they stayed in their offices, where they could be consulted by the residents. Even the encounter groups were led by the residents. On the next day the staff gave seminars on the philosophy and the therapeutic tools of the TC. After this workshop several TCs were started in The Netherlands, modelled after the Emiliehoeve.
Among them was a TC that was started in the methadone inpatient clinic, Essenlaan in Rotterdam, where recently the fifth patient in the clinic had died of an overdose. The psychiatrist of that clinic, who had given residents a litre of Dutch gin (jenever) as a reward when they had been clean for a week (of course even if they had not been clean, they still got the jenever), had just died. I was asked to replace him. So I added another task to my schedule (I was then also teaching at the Erasmus University in Rotterdam) not knowing that it would take more than two years to find a successor for my position as the Medical Director of the Drug Departments of the Bouman Foundation in Rotterdam.

I made several mistakes in that period: one of them was hiring an ex-resident of Phoenix House London to become the director of the Emiliehoeve TC for a period of nine months. He had left Phoenix House when his director, Denny Yuson, left this programme after a conflict with the medical director. I had not foreseen that he had a paranoid attitude towards professionals and I had to dismiss him a month before the end of his contract as he was abusing his power in relation to the residents, denying them the possibility of confronting him when they made that request and refusing to send them to the re-entry programme because he did not trust the professional leading it. For me, this was a hard thing to do as he had been very good at teaching me the basics of the TC when he had visited the Emiliehoeve as a consultant.

I also made a mistake with the other person who had taught me a lot, Denny Yuson. I had made him director of the training institute for addiction therapists. In the summer before the courses started he went to an ashram in India and came back clothed in orange, wearing a chain with the picture of Baghwan (who later called himself Osho). He promised not to talk of this sect in the courses. However, six months later almost half of his students were wearing orange clothes and the government stopped funding the course.

The best training for professionals who are going to work in TCs is, in my opinion, to be a resident in a TC for several weeks, followed by some weeks assisting the staff while staying in the re-entry house. This, however, has to be in a different TC than the one where they are going to work to avoid role confusion. I once had a psychiatrist in training, who was going to work in the TC where I was the director, as a resident in my own TC. For a long time after this he saw me as his father.

During this time many staff from starting TCs in The Netherlands and also from many other countries in Europe came to the Emiliehoeve to learn the method as residents.

Also staff from many other countries were residents in the Emiliehoeve, and other TCs in The Netherlands were modelled after the Emiliehoeve. They came from Belgium, Germany, Norway, Austria, Switzerland, Sweden and Greece (2001).

In 1980, the 5th World Conference of Therapeutic Communities was organised by the Emiliehoeve. At this conference the World Federation Of Therapeutic Communities was established.

I left the Emiliehoeve programme on the day of its tenth anniversary to become the Director of Treatment of the Jellinek Centre in Amsterdam. I am not
going to write about that period in this paper, nor on my work with traumatised refugees in more recent years. As the chairman of the Friends Association I am still connected with the Emiliehoeve and the other drug-free programmes that have been developed in The Hague.

I am pleased that the book I wrote on the theory and practice of therapeutic communities, in which I could report that the treatment of the Emiliehoeve had been proven successful by research (and that the involvement of parents increased the length of stay of the residents and therefore the success), has been translated into the Spanish, Polish and the Czech languages with several others to come (1993).

Recently I was able to help pioneers in Eastern Europe, with whom I could identify, to learn from my achievements and also from my mistakes.

In September 2006, during the 23rd World Conference of Therapeutic Communities in New York, I saw again the performance of 'The Concept' by the residents of Daytop Village. This time I hugged the performers at the end of the play.

On my way to the airport after the conference I asked the re-entry residents who drove the car which TC they had lived in. They told me they came from the Parksville TC. There were now 210 residents and eight staff.

References

The Early History of the Ley Community – Personal Accounts

Peter Agulnik and Stephen Wilson

Introduction

This paper recounts the origin of the Ley Community in Oxford and summarises research carried out on a cohort of pioneering residents.

History

In the mid-1960s there was a growing awareness throughout the United Kingdom that the prevalence of narcotic addiction, seemingly confined to a small number of relatively socially stable individuals, was changing, and the pattern of street use and its associated crime, long endemic in the cities of the USA, was emerging in Great Britain. The myth that this was mainly a problem of large urban conurbations was also starting to dissolve as studies, such as those undertaken by Arroyave (1972) in Oxford, demonstrated that not only was poly-drug misuse widespread but there was also a significant number of people addicted to heroin. NHS hospitals at that time were organised through Regional and District Authorities. Psychiatric services were managed by local hospital Management Committees. Drug and alcohol services were provided at District level, but both were thought to require specialist input with designated beds to be provided at Regional level. The Oxford Regional Board was responsible for services in Berkshire, Buckinghamshire, Oxfordshire and Northamptonshire. A new Regional Unit was constructed at Littlemore Hospital in Oxford with 33 beds, 11 of which were assigned for people with drug-dependency problems.

Littlemore was the old County Asylum for Oxfordshire. The Warneford Hospital, which had been a private institution, joined with Littlemore with the creation of the NHS. It had a different cultural and therapeutic style with a new professorial unit. Littlemore itself was divided into A and B divisions, reflecting the very different therapeutic approaches provided through the medical leadership. While the B division practised the traditional psychiatry of the time, the A division, under the consultant leadership of Dr Bertram Mandelbrote, was in the forefront of the therapeutic community approach to hospital care, with its emphasis on optimising communal patient responsibility, openness of communic-
ation, and flattening of the hierarchy of authority (Jones, 1955; Rapaport, 1960). It was also committed to open-door policies and the developing of community care in a number of pioneering service modalities. Arbitrarily, it was decided that drug dependency, as opposed to alcoholism, would be the responsibility of the A division.

One author (PA) had come to Oxford in 1969 as Dr Mandelbrote’s Senior Registrar after spending 2½ years as a Senior Resident at Boston State Hospital in Massachusetts. Initial training with Denis Martin at Claybury had resulted in an enthusiasm for the TC approach. Boston State had an excellent psychiatric training programme linked to Tufts and Boston University. Milton Greenblatt, by then State Commissioner for Mental Health, had recently been Physician Superintendent and supported a range of therapeutic community concepts, inspired by Maxwell Jones, into the hospital wards. There were thus clear ideological links between hospital-based therapeutic communities in both countries.

The Ley Clinic, as the new Regional Drug Unit was known, was named after Dr Ley, a former Physician Superintendent at Littlemore. The model of treatment to be followed would use basically the same therapeutic community principles evolved in the Phoenix Unit at Littlemore where Dr Mandelbrote and Dr Ben Pomr yn were joint consultants. Pomryn had earlier spent time with Maxwell Jones at Belmont. The In-Patient Unit at the Ley Clinic was to be drug-free, and prescribing, such as of Methadone, for those who showed no motivation to give up drugs was achieved by consultation to General Practitioners. A similar system was adopted for advice on detoxification.

A small team consisting of a Nursing Officer, a Staff Nurse, an Occupational Therapist and a PA were responsible for the In-Patient Unit during the day. Later, David Kennard joined the team as its first psychologist. The team was under the direction of Dr Mandelbrote who received referrals and, with the staff, interviewed potential admissions at a weekly meeting. The main admission criterion was that the applicant showed evidence of motivation to come off drugs. A day programme was devised, the core of which was the daily ward meeting that all residents and staff attended. The model was one of examining behaviour as revealed by living in the Unit, but with an emphasis on openness and understanding the roots of the dependency through examination of the historical background and current inter-personal tensions.

Alcohol dependents, a largely older group, had an entirely separate programme and used different parts of the building. The opportunities for self-catering and responsibility for the ward environment were extremely limited. The initial months were spent in establishing a therapeutic milieu, and indeed retention of residents seemed encouragingly high. If, in retrospect, this was because many were secretly engaging in illicit drug-taking, this did nothing to blot the enthusiasm of staff who felt progress was being made. Visits were made to Phoenix House in London, recently established with the support of Dr Griffith Edwards and Dr Martin Mitcheson of the Maudsley Hospital as an independent community. Phoenix House followed its namesake in New York, using a self-help concept house model developed by ex-addicts at Synanon. Dr Ian Christie of St James’ Hospital in Portsmouth had also been influenced by the
Synanon-Phoenix House movement, and established Alpha House locally. Nationally, these were the only therapeutic communities for drug addiction in the early 1970s. To get going, Phoenix House imported Denny Yuson, a New York Phoenix graduate, as there were no suitable ex-addict staff in the UK.

It was with this background that PA returned to Boston in 1971. If the main purpose was for renewing his immigration visa, it also became an opportunity to study what was taking place in the United States. He arranged visits to the Boston State Hospital Drug Dependency Unit, Daytop Village, a pioneering therapeutic community in New York, and arranged to attend a weekend staff training course at Phoenix House, New York. These experiences, especially the last one, made a profound impact. The existing programme at Littlemore seemed to pale into insignificance. Rather than a small community with a maximum of 11 residents, here were hundreds, living in a former penal institution on Riker Island, in the East River, just off Manhattan.

The personal exposure to examination by ex-addict staff taking part in the training programme over three intense days was at the same time both ego-shattering and exhilarating. It proved a life-changing experience, also demonstrating that what we were trying to do in Oxford was naïve in the extreme. By chance, Mike Caldwell, an Australian, who was the Senior Administrator of Phoenix House, London at the time, was also a course member. In conversation, PA mentioned that if Mike knew of any ex-addict who had been through the Phoenix House programme and who might be interested in working in Oxford would he please let him know. Just a few months later Mike phoned PA to say that an embarrassing situation had arisen. John McCabe, an ex-addict Phoenix House staff member from New York, had committed an indiscretion with a resident and would be required to resign as Assistant Director. In all other ways his contribution had been satisfactory, and he wondered whether John was the sort of person who could help the Oxford programme.

John came up to Oxford to meet the team. He was open about what had taken place in London and at a personal level we liked him. We agreed to explore whether a post could be created for him with the help of two charitable trusts. This was achieved, and he joined the team as a nursing assistant. Over the course of the next few months, and not without some pain to existing staff members, a transition was made from the traditional to the concept-based type of Community. It soon became apparent that the setting of the Ley Clinic was totally unsuitable for this type of programme, where it was essential to have a sense of independence, separate from the usual trappings of the hospital milieu. The initial plan was to find a place for a day programme, continuing to use the Hospital as a base. The theme of serendipity, which characterised the development of the Ley, was continued when PA off-handedly asked the secretary at the Isis Centre, an innovative NHS counselling facility also established by the A division, whether she knew anybody who would be prepared to put up £10,000 to purchase a school house in the next village to Littlemore, which was coming up for auction. To his surprise, she replied that she had worked as an au pair for a Mr Pye, a local builder, whose firm had a charitable trust, and she would approach him. Further meetings ensued, including those with the local...
alarmed villagers. In the event, the property sold for far more than expected. This turned out to be a godsend as, within a few months, another much more substantial property, which had fallen into disrepair, came onto the market. This offered the prospect of a residential programme for up to 14 people, and the Pye Trustees continued to agree support. At auction, the property, sited in an affluent residential area, was purchased for £25,000.

An independent charitable company, which took on the name The Ley Community (Oxford) Ltd, was created. The composition of the committee was important. The key members were the Deputy and later Director of the local Social Services, the Chief Probation Officer, the Chairman of the Magistrates’ Committee and other senior magistrates, the hospital secretary, AG Palmer, who was the Treasurer of Oxford Group Homes (another of the A division’s Community initiatives), and Bertram Mandelbrote. As the only person with virtually no experience of committees, PA was immediately elected Chair, a post he held for the next 20 years.

By combining the Ley Clinic and the Ley Community into an overall clinical programme, it was possible to retain Health Service revenue funding, whilst at the same time the new charity was able to draw on fresh sources of residential support. With this new structure, it was also possible to employ more ex-addict staff, while maintaining financial viability. John McCabe was appointed the first Director of the Ley Community at Hidsfield House, as the property was called. At that stage, maintaining the consultant-led NHS programme was also useful in establishing the confidence of the Courts which, helped by strong links with the Probation Service, continued to refer potential residents in ever-increasing numbers to the Ley Clinic. The Clinic’s programme linked seamlessly with that of the Ley Community.

By 1979 the pressure on places at Hidsfield was considerable. Again, fortuitously, a more suitable house set in seven acres of land at Yarnton, five miles from Oxford, which had recently been turned down for land development, came onto the market. The house, Sandycroft, was owned by a local medical family, the Livingstones, direct descendents of the African explorer. They took a helpful attitude to the sale and, with the increased value of Hidsfield, only £5,000 was required to secure the purchase. The original loans were paid back.

This is not the place to describe subsequent developments; suffice to say that, with the range of changes within the NHS and overall funding structures, the Ley Community now stands as a totally independent charitable organisation with a National catchment area. The Ley Clinic no longer exists. Ironically, planning consents were subsequently obtained to develop part of the Community’s land, and a land sale enabled new building on the Ley campus, which now comfortably takes 60 residents. The programme, whilst retaining its core concepts, has developed in many other directions beyond the scope of this paper.

For PA, the success of the Ley Community has been a source of continuing pleasure. This is never more apparent than in the graduation ceremonies which mark the achievements of former residents, a high proportion of whom remain drug-free two years after leaving what remains, essentially, a one-year programme of residency.
There is an aesthetic about the buildings and grounds which are a testimony to the achievable. This pleasure is, however, tempered by sadness. John McCabe, who took such a key role in establishing the Community as a concept-based house, failed to maintain his own abstinence from substance misuse. Never returning to narcotic abuse, he did become heavily dependent on alcohol after relinquishing his directorship to take up a place at Balliol College, Oxford. Sadly, his successor, Brian Donellan, an early resident of the initial programme, also succumbed to alcohol dependency. The authors’ own reflections on this are that those of us who supported these pioneers were not sufficiently aware of the immense emotional strain of running such a programme. Changes have been introduced which hopefully go some way in reducing this stress, and staff are more aware of the dangers of alcohol.

Research

I (SW) arrived in Oxford in the autumn of 1973. Like Peter Agulnik I had a background in therapeutic communities, having done my early training in psychiatry at Fulbourn Hospital, Cambridge, at that time under the charismatic leadership of Dr David Clark. Here I met and was also influenced by Dr Junichi Suzuki, a young psychiatrist who had initially travelled from Japan to work closely with Maxwell Jones at Dingleton. My experience at Fulbourn led me to an interest in social aspects of psychiatry and I took a Fellowship with the Social Science Research Council enabling me to study the Sociology of Medicine at Bedford College, London. Here I learnt much from the rigorous research methodologist, George Brown.

I had visited Littlemore Hospital with the newly-formed Association of Therapeutic Communities and realised that it would be a congenial environment to pursue my professional interests. When I needed to move on I applied for a Senior Registrar post in clinical psychiatry at Littlemore but was not appointed – there was a ‘home candidate’. After the interview Dr Mandelbrote, knowing of my recently-acquired expertise in social research methodology, approached me and offered the prospect of a post investigating the work of the Ley Community. I accepted with alacrity. In this way my involvement with the Ley was also serendipitous.

Some psychological data had already been collected by David Kennard but it was in a raw state and no analysis had been attempted. Over the coming years I carried out a comprehensive follow-up study working closely with both David and Bertram. Although the study was retrospective and unrandomised, residents entering the Community and staying for varying periods of time did not differ on a wide range of social and psychological measurements. This meant that our results suggested a causal link between treatment and outcome but were not conclusive. We found evidence that correlated longer duration of residence in the community with an improved outcome. There was a consistent association between longer periods of residence and lower levels of drug use (Wilson, 1978), criminality (Wilson & Mandelbrote, 1978a, 1978b), institutionalisation and unemployment during follow-up. Improvements in reconviction
rates were sustained during a ten year follow-up period (Wilson & Mandelbrote, 1985). We were also able to demonstrate a correlation between improved outcome and psychological extraversion (Kennard & Wilson, 1979). To complete the picture we were able to show that successful residents underwent a measurable psychological change from introversion towards extraversion during their stay in the Community (Wilson & Kennard, 1978) and afterwards obtained employment in a range of occupations (Wilson, 1980).

**Conclusion**

Evidence points to the effectiveness of the Ley Community in promoting psychological change and social rehabilitation in people with drug problems. If serendipity played a part, was its birth and development facilitated by the spirit of an age which really encouraged the social entrepreneur, and which was less bureaucratic, less dominated by issues of risk and, paradoxically for a programme in which hierarchy is so central to its therapeutic programme, much more democratic? Would it be possible today?

**References**


A TC on the Border of Two Cultures

Georges van der Straten

Part I: The ‘Stone Age’ of TCs

From non-directive therapy to a structured psycho-pedagogical approach

In 1974, whilst finishing my studies to become a social worker, I was involved in a trainee assignment in Brussels in a bar run by addicts under treatment with one of the first of the doctors who prescribed methadone for maintenance. At the time, this was still technically illegal. When some patients wished to cease using substances (both legal and illegal), I realised that there was no such thing as a ‘drug-free’ place to receive them and I became interested in ‘therapeutic communities’.

I began taking part in AA groups, I visited ‘De Sleutel’ and ‘De Kiem’ in Flanders, took part in a traineeship with ‘Le Patriarche’ in France and read the literature about Daytop Village TC in New York. This involvement led me to create the first TC for addicts in the French-speaking area of Belgium: ‘Choisis!’ (‘You choose!’). It should be recognised that, at that time, I was on the border between two therapeutic cultures. The Flemish tended towards the Anglo-American ‘TC concept’; that is to say, a hierarchical structure, confrontation between individuals, the requirement to ‘act as if’, and a focus on behaviour. The Belgian-French speakers, meanwhile, were situated in the French sphere of influence using a psychoanalytical reference and based on a post-1968 anti-authoritarian ideology. Consequently, I opted for a version of the TC which bypassed the ‘harsh’ rule-based and confrontational aspects of the Anglo-American TCs.

However, the rehabilitated ex-addicts from these harsher TCs had, in my opinion, a thoroughly credible message in terms of personal change and re-entry into society. For this reason, I put into my team a Flemish ex-addict, Ruud Bruggeman, who had successfully completed the programme at the therapeutic community, De Kiem.

We opened Choisis! in 1978. The team did its best but the residents did not progress. Drugs infiltrated the TC frequently and every two months we had to dismiss several residents. Choisis! operated within the bounds of an inefficient method which didn’t really address the real needs of the residents, and Ruud pointed out to us the weak points of our TC: unclear pedagogical rules, too...
much closeness between staff and residents, lack of psychological pressure on the residents and avoidance of confrontation and educational conflict.

The continuing reoccurrence of these discouraging and humiliating events caused us to re-examine our motivations and approach. Although the therapeutic ideals of Ruud seemed to us to be behaviouristic, we had to admit that, in his own case, they had brought about good results. So, the team decided to alter its approach and test the TC method according to the American ‘TC concept’ for a period of six months. The two main changes were: a) to organise the group of residents into a strong hierarchical structure, with clear pedagogical rules so that residents had a maximum of concrete responsibilities in their own hands, and b) to increase the psychological pressure on the residents so that the intense confrontations and conflicts of encounter groups would provide a means for them to contact, experience and release their pent-up emotions.

Ruud explained to the team – and to the residents – the basic principles of the TC and was appointed team leader, although at that time he had no qualification of any kind. Tangible results appeared very quickly: residents stuck to the new rules, identified with the encounter groups, the group dynamic became positive and drug using or violent behaviour became rare.

_The question is: ‘what do residents need to become well-balanced and autonomous?’_

I began to discover certain specific needs of addicts, and these discoveries confronted me with a fundamental choice: either to undergo a profound personal change in order to become the kind of TC manager that the addicts needed, or to change my profession. I decided to carry on with the concept TC experiment beyond the initial six months, even though I had no theoretical grounds to support our new TC method, and I had to abandon some ideological points of view and patterns which now appeared both inappropriate and, increasingly, ineffective. Observing the practical results obtained in the field, we concluded that we should continue our novel approach.

However, at the same time in France, the image and reputation of TCs was further damaged as a result of an official announcement by the French delegation at the World Federation of Therapeutic Communities (WFTC) congress in New York to the effect that the TC method was authoritarian, sectarian and incompatible with the ethics of French professionals. The French Health Minister, Mme Simone Weil, announced that, as a consequence, France would not accept TCs within its jurisdiction. This principled objection remained in force from 1993 until 2006. These developments compounded the lack of comprehension between the TC Choisis! and the French-speaking mental health community, particularly with respect to adherents of psychoanalytic approaches to addiction treatment, which were particularly dominant at this time and which generally looked unfavourably on the TC approach and its ethical foundation.

Our team, naturally, had a high regard for ethics and was convinced that it was carrying out more than behaviourism, but we were unable to justify this on a theoretical basis since literature on the TC approach was almost non-existent
at that time. Defamatory rumours began to circulate and this created tension for the team. As a result, I decided to undergo an internship as a resident in a TC in order to understand and assimilate the TC experience ‘from the inside’.

I chose to undertake my placement in a TC in The Hague called ‘Het Witte Huis’, modelled after the TC Emiliehoeve. This was the opportunity to meet Martien Kooyman who was at that time in charge of Emiliehoeve. This period was a deeply significant experience for me, which enabled me to gain access to several fundamentals of the TC approach. But, when I came back, the gap of misunderstanding had broadened between myself and a part of my team. As our institution was based on the concept of self-management, this complicated the hierarchical relationships and perpetuated an internal crisis. My attempts to share my new understanding of the TC were ultimately unsuccessful with the majority of the team and I resigned my position there in 1983. Following my departure, Choisis! abandoned the basic principles of the TCs and opted for the French ‘post-cure’ concept. Management errors lead Choisis! to close in 1990.

First lessons taught by experience

- Drug-addicted people have particular therapeutic needs to which the TC responds well. The therapeutic principle of the TC is its psycho-pedagogic approach, the tool of education.
- ‘Behaviour is a language that doesn’t lie’ and close attention has to be given to observation of behaviour. Every instance of lack of respect has to be immediately confronted in order to reinforce self-control of impulses and behaviour, and to teach the residents to avoid acting out. The residents confront each other, and ask each other to control their impulses, and this means that everyone is stimulated to take the floor during group meetings and to express their underlying emotions and needs.
- Every emotion is respected in a TC, even hate or a grudge, and every resident has to be given the opportunity to share his/her emotions in the scope of the encounter group. These groups act as mood and relations regulators, and are a powerful tool for residents to become conscious of their emotional life and needs. One has to make a clear distinction between ‘emotion’ which can never be judged and ‘behaviour’ which has to be considered in terms of respect or danger for others or for oneself.
- Residents should be given a maximum of concrete responsibilities and problems to be solved through the dynamic of the self-help group.
- Hierarchical structure makes a powerful tool enabling the group of residents to take 90% of responsibilities in daily life in an effectively autonomous way and to interact one with others immediately within a perspective of personal growth.
- The staff group has to impose a framework and limits upon the residents, maintaining a climate of psychological stress which is vital for change. They have to be a harmonious team of adults able to tolerate educational conflicts and to model the appropriate use of rewards or sanctions according to the behaviour of the residents.
Ex-addict staff have practical knowledge of this therapy, which is vital for the team as well as for the residents of the TC.

Part II: ‘Trempoline’, a Latin TC

‘Project Man’: the TC concept spelled out in diverse educational approaches

By the time I left Choisis! I was already ‘hooked’ by the challenge of addiction and by the TC approach. While still involved in higher education, I decided, in 1985, to create a new TC named ‘Trempoline’. Dutch friends told me about a TV broadcast concerning families of addicts committed in the Centro Italiano di Solidarietà in Rome (CeIS Roma). So I moved to Rome to discover the CeIS and its ‘Progetto Uomo’ (‘Project Man’).

The staff of CeIS had been trained by Daytop New York and had the same TC roots that I had encountered several years before in Flanders, Sweden and The Netherlands. But what struck me the most was the extraordinary Europeanisation of the ‘TC concept’ through Italian culture. The Welcome phase (which contained 300 participants, no less, in that phase!) was non-residential and the doors were open wide to the city of Rome, the discipline of residents seemed to be warmer and more colourful, and the families were intensively involved through voluntary work. In the mind of Don Mario Picchi (the founder), the ‘TC concept’ was no more a goal in itself but a simple tool based on universal educational values. The numerous CeIS programmes over Italy spelled out the TC concept in an infinite creativity bonded by the perspective of ‘Progetto Uomo’.

The harsh style of the Anglo-American version of TCs took on a baroque and informal tone and this brought a lot of variations and attractive elements to the basic method. ‘Progetto Uomo’ was like a large corpus of knowledge exchange between the TCs of Italy, USA, Spain and Latin America. Finally, I had a model which would correspond more closely to our French-speaking culture. The innovations of ‘Progetto Uomo’ that influenced Trempoline were:

- The ‘corso base’ (basic training in TC approach) of Casa del Sole (the training school of CeIS Rome) where I and my colleagues received basic principles from father figures like Donald and Martha Ottenberg, Lucio Soave and Letizia Pappalardo.
- The Welcome phase as a period of motivation and preparation before admission to the TC itself.
- The principle of ‘parallel family cooperation’ between residents in the TC and their parents as well as the ‘solidarity groups’ for parents.
- The culture of volunteer investment, the proactive and generous attitude leading the institution to pre-empt social needs not yet addressed, thanks to the building blocks of voluntary work, and charitable and public funding.

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2 ASBL Trempoline: http://www.trempoline.be
The mixed composition of the teams: ex-addict staff/conventional professionals.

What is therapeutic in a TC?

A TC is a laboratory where strange things happen. I often wondered: ‘how on earth does it work?’ I can’t explain scientifically why it works, but I can establish some links concerning what makes it possible. Surprisingly, it took me 15 to 20 years to understand links which appear simple, wondering every time how I had taken such a long time to understand such manifest evidence. It works almost mechanically. Insights happen after a long time spent in observation and through enriching exchanges with colleagues. Suddenly you have it and you are struck with the following ‘Eurêka!’

The belief that every drug addict can learn and change is a fundamental lever and every staff member should be convinced about it. This is especially true when the drug user, his family and society have doubts about the possibility of overcoming addiction. A resident will change and learn to trust in his/her own capability, leaning on the faith of the team in his/her potential.

Every resident is the main protagonist of his own therapy and his major partner is the group of residents, not the professionals. Staff members have to keep a strategic position, discrete but strong, in order to guarantee the conditions favourable to the group dynamic that has to nourish the development of the residents.

The TC system has to produce constraints, discomfort, stress and psychological pressure in order to activate motivation for change, to seek new solutions, and to stimulate brain activity and social interactions between residents.

The group of residents can manage autonomously upon receiving simple rules: no special education is required to manage data like ‘when is lunch time?’ or ‘who is my superior?’ or ‘who is under my responsibility?’ etc.

The pedagogical project is inseparable from transmission of models and values like respect, hope, honesty, responsibility, solidarity etc. Concerning values, the behaviour of staff is more important than what they say. The most important task of an educator is to show life skills.

Context plays an essential role in appearance of positive or negative behaviour. The TC is a family-like context where residents can suffer an emotional regression and experience an emotional state, which is characteristic for the early stages of the learning process of life skills (two to 18 years). That is why TCs have to establish a clear and protective framework and strong affective links. They have to refer to the fundamental values of education, to models and to identification roles. In that context, a drug addict who had previously, on ‘the street’, manifested severe and repeated antisocial behaviour, can abandon this behaviour and become sociable. This is strikingly clear during the Welcome phase where, in a comfortable climate and with clear and enforced rules, violence and drugs are the exception.
Welcome phase regroups addicted people who, only a few days earlier, were delinquent in the ‘street’ environment. Clarity and enforcement of rules create a climate of peace and make therapy and personal growth possible.

- There is a logical sequence of steps in the learning process of psychosocial skills. Adult residents follow a similar process to the growth process of children. This growth process is stimulated by the psycho-pedagogic context of the TC which promotes psychological states, and which in turn promote the appropriate skill acquisition.

- The quality of the relational network is the soil for the growth process. Staff and residents are responsible for building a surrounding of good relationships in order to give solid life skills references to each individual. They create a climate of warmth and trust in which residents will root their capacities to change and to be strong in the face of huge obstacles. This awareness is critical during the re-entry phase at the end of the programme, when the residents need to show selectivity in building a healthy new relationship network.

- We learn in the same way as our residents, observing, sharing, confronting our practice and following the examples of our colleagues. The profession of a TC staff member cannot be acquired without seeing colleagues working in the field and without seeing drug-addicted people escaping from drugs through the TC process.

The future for the TC approach in the scope of post-modern culture

During the 1990s, governments opted for quick, large-scale, inexpensive solutions because of the epidemic of HIV/AIDS and because of an association often made between the spread of drug addiction and an increased feeling of insecurity on the part of the general public. TCs seemed increasingly to be reserved for a tiny minority of addicts, and governments made the choice of a medical and public health approach on a large scale, opting for methadone substitution and harm-reduction programmes instead of promoting abstinence. This politically deep change of approach brought certain ‘high threshold’ aspects of TCs to the surface and generated disagreement concerning ‘abstinence’ projects. These differences of view are linked to beliefs about human beings and the social views of politicians and professionals as to the final outcome of these different approaches. There is a deep rift between the values of the TC and the values held within the cultural context. This is also what can make for strength and utility of TCs in the face of the isolation and over-consumption which characterises post-modern society.

TCs are laboratories which have to radiate out and transfer their know-how to other groups (e.g. the modified TCs for people with the dual diagnosis of addiction and mental illness). They have to demonstrate their good cost-benefit ratio, and to establish network relations focusing on the holistic and maximum development of drug-dependent people. The last 20 years have shown that the most advanced countries in matters of social welfare are not necessarily the
most advanced in TC approaches. Countries like Italy, Spain, Greece and Poland have developed large programmes which have become models at the international level.

My learning process has been possible thanks to the openness and welcome of many TC teams over Europe and has been facilitated by my knowledge of foreign languages. In our turn, we want to share what we have received and to facilitate knowledge exchange between TCs. So we have adapted an old tradition of apprenticeship to the professions of TCs and to education in general and we have launched ECEtt (European Companionship in Education, training by travel, www.ecett.eu or www.trempoline.be/en/b3.htm). This is a training service modelled after the French organisation 'Les Compagnons du Devoir', which trains thousands of young apprentices in manual trades who travel from city to city to meet and work with senior experts in their field. This tradition is called, in French, 'compagnonnage' and refers to the old apprenticeship tradition of the 'journeyman'.
The Development of Drug Abuse and Addiction Services in Israel

Eitan Sela

Introduction

The early 1980s were the years in which State entities in Israel became aware of and public attention was drawn to the phenomenon of drug abuse in that country.

Prior to 1967, drug abuse in Israel was almost unknown. After the Six-Day War, thousands of volunteers, from the US and from Europe, streamed into the kibbutzim. These volunteers, mainly students, but also adventurers seeking challenges and thrills, brought with them the use of hashish and LSD, which was common amongst young people in Western countries in those years. For the young population of the kibbutzim, a window was opened to life outside the boundaries of Israel, and a thirst for European culture (which was well known to the majority of the parents of these youngsters) led to the rapid penetration of this lifestyle, including the use of drugs.

In parallel to the meeting of groups and sections of the Israeli population with the drug-use subculture, the Six-Day War created another situation; the encounter with the Arab population. The opening of the borders and the immediate contact with the local people led to an intensified use of hashish, which was typical of the Bedouin population of Sinai, and was also quite common among the Jordanians who lived in the occupied territories west of Jordan.

The encounter with the Arab population, and the accessibility between Israeli Arabs and the Arabs of the occupied territories, led to the growing involvement of Israeli Arabs in the drug trade. The town of Yaffo, adjacent to Tel Aviv, was an important focus of this activity, as were the cities of Ramle and Lod, located between Tel Aviv and Jerusalem. The population in these cities is mixed, consisting of both Jews and Arabs. They are very close to the city of Tel Aviv, where the use of drugs infiltrated and was reinforced in those years after the Six-Day War by the volunteers who came from Europe and the US to Israel.

Trade links, and the ability of the Arab community in Israel to communicate without language barriers with the Arab community in the territories occupied in the Six-Day War, intensified the problem. The enormous economic potential of the drug trade also gave a serious push to this activity, mainly due to the economic distress suffered by the Arab community in Israel.

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therapeutic communities, 28, 1, spring 2007 © The Author(s)
From the end of the 1960s until 1984, the actions taken to deal with the addiction problem were local and ineffective. Until the beginning of the 1980s, only two centres, which mainly dispensed methadone, were operated by the Ministry of Health in Israel. There was one centre in Haifa (in the north), and another in Yaffo (in the centre of the country). In addition, there was a private organisation which also distributed methadone prescriptions for a fee, through which about 2,000 people obtained prescriptions.

The first strategic operation began in 1984, when the Drug Maintenance Treatment Center was set up in the Ministry of Health. I participated in the establishment of this unit, which consisted of the unit director and myself (as national supervisor of the Addictions Unit). The unit’s first actions were to attempt to map out the scope of drug use in Israel. It was our assumption that if we could succeed in convincing the decision makers of the extent of drug usage it would lead to the allocation of the necessary resources. Since we possessed neither the funds nor the means to conduct an appropriate study to establish the extent of the phenomenon, we used speculations and statistical extrapolations to describe it. After a year of work in the Unit, we issued a statement that there were about 30,000 drug addicts and 300,000 occasional users. (Subsequently, this method and these figures were also used by other services, such as the Society for the Prevention of Alcoholism and the like, who wanted to shock the establishment with a dramatic numerical description in order to obtain financial resources. In actual fact, according to the studies conducted later by the Anti-Drug Authority, the numbers of addicts ranged between 15,000 and 18,000.) These (exaggerated) figures cast light on the problem of drug abuse, and exposed it to the media, and subsequently also to the government ministries, who felt obliged to show that they were dealing with the treatment of addicts.

An inter-ministerial committee also commenced activities in those years, examining the scope of drug use, as well as the solutions required to deal with the problem. The committee’s most severe criticism was that there was a lack of cooperation among the various ministries (Ministries of Welfare, Health and Education), and its principal recommendation was that it would be necessary to establish a State authority to deal efficiently with the drugs problem in areas such as prevention, enforcement and treatment.

As an employee of the Ministry of Health in the Addictions Department, I participated in writing a draft bill which led to the establishment of the Israel Anti-Drug Authority. The draft bill dealt with the definition of the structure and functions of the new authority. I can confirm (somewhat cynically), that writing the law generated a rare inter-ministerial cooperation (mainly between the Health and Welfare Ministries), the principal nature of which was to undermine and weaken the powers of the new authority even before it was born, since those directing the services in the ministries saw the future authority as a competing entity. Mainly, they saw it as competing for resources, power and authority.

An ‘important’ question asked in those days was ‘to which ministry would the Anti-Drug Authority belong: to the Ministry of Health or the Ministry of Welfare?’ This question prevented progress in the discussions and therefore it
was proposed that the Authority would be a State entity operating out of the Prime Minister’s office. Since that was the case, the directors of the services in the government ministries decided to deal with the question of the Authority’s powers and functions. The principal question raised was whether the Authority would be an executive entity or merely a coordinator among the ministries. The decision made was that the Authority would be only a coordinating entity among the government ministries. Thus they removed the entity’s power and also, subsequently, its access to resources, even before it was established. But since the Inter-Ministerial Committee had declared the need for the establishment of such a State authority, and since it was an election year and the Prime Minister’s Office wanted to show that it was involved in social activity, it was decided to establish the Authority and it was set up as a coordinating entity. The Anti-Drug Authority was established in 1989, about a year and a half after I had started the first therapeutic community in Israel.

The establishment of the first therapeutic community was not actually the initiative of any government entity in Israel but was due to the initiative, contribution and activity of the late Mrs Aviva Najar, the wife of the Israeli ambassador (Amiel-Emile Najar) who served the State of Israel in many countries (Japan, Belgium, Italy). Mrs Najar had seen the damage caused by the use of drugs all over the world, both as a person with a social and professional awareness (Mrs Najar was a psychologist by profession), and in light of her familiarity with the histories of personal friends in Europe and the US whose sons and daughters had become involved in the use of drugs. The tragic stories she heard led her to decide to take action before it was too late, and to establish the first therapeutic community in Israel.

One day, Mrs Najar appeared in the office and a conversation developed on the issue of methods of treating addicts. I brought to this conversation my difficult experiences from the attitude of the medical professions and the scornful and humiliating attitude of psychiatrists to the addict population. In that period, in parallel with my work in the Addictions Department of the Ministry of Health, I was working in the psychiatric department of the Ministry of Health, which operated within the central prison of the Prison Service. In this period the psychiatric establishment rejected the addict population and, in fact, avoided treating them in ambulatory psychiatric frameworks, arguing that these people were suffering from personality disturbances and therefore could not be treated.

The only involvement of the psychiatric establishment was to provide detoxification treatment in a psychiatric hospital located near Tel Aviv, where a maximum of eight beds was allocated in those years and where those who were hospitalised were addicts upon whom the courts had enforced hospitalisation. The impression was that not only was the addict forced by the court but also that the psychiatric therapeutic framework was forced to treat the addict population which it did not want to see on its premises.

Due to the psychiatrists’ attitude at that time, opportunities for detoxification and rehabilitation were withheld from addicts who sought assistance and help, and therefore many of those requiring assistance travelled to Europe to
obtain it from therapeutic communities which were then operating in Spain and France.

The first therapeutic community in Israel was established with the help of contributions collected by Mrs Najar among her friends in the US and Europe. The Community's initial operating budget came mostly from contributions. The government ministries also participated: the Ministry of Health gave 25% of the budget and the Welfare Ministry 25%.

Mrs Najar died suddenly about one week before the opening of the therapeutic community of which she had dreamed and the establishment of which she had initiated. The Society I established, the purpose of which is to promote and establish therapeutic communities for drug abuse, is named after her.

For a year and a half the therapeutic community continued to operate on the basis of such private donations from individual sponsors. This first therapeutic community contained only 20 beds. It commenced operations in a region close to Jerusalem. About 18 months after the start of these activities, the Anti-Drug Authority was established and with their help I located another place. Thus, about a year and a half after I had set up the first therapeutic community in Israel, I embarked upon the establishment of the second one, located in the centre of the country, about 20 kms north of Tel Aviv. This second community, Ilanot, was started in 1989, with the help of the graduates of the first community, who agreed to participate in this pioneering effort.

In 1993, in response to the request of a candidate for treatment, the mother of a two-month-old child, I decided to activate the programme of the unit for the treatment of addicted mothers and their children. The unit operated on the site of the Ilanot therapeutic community in the Sharon region. In 2004, the new building was inaugurated, named the Therapeutic Center for Addicted Mothers and their Children, designed to hold 20 mothers and up to 40 children, which I established with contributed funds.

Today, the Society treats about 160 adult patients – women and men – in its communities and hostels. They are aged between 18 and 50, and the unit for the treatment of addicted mothers and their children, although having full facilities, is presently only partly occupied, holding 10 mothers and 12 children.

The dynamics of the development of the services in Israel

The concept of the therapeutic community has accelerated since the first one was established. At present, a total of five such communities have been set up (four in the Jewish sector and one for the Israeli Arab population), operating in the format of therapeutic communities. Over time, additional services have been developed within the private sector, which have adopted the name 'therapeutic community' as they sensed that it was 'familiar', although their operation is not based on the philosophy and understanding of the ideas of the therapeutic community.

1 Now the Har-Tov Community, although formerly this community was called Beit Or, which became the name of the Society with the addition of the name of Mrs Aviva Najar.
The establishment of the new frameworks brings me to the issue of the policy of development of frameworks for the treatment of addicts. Upon the establishment of the Anti-Drug Authority, it adopted the deployment programme of therapeutic frameworks dictated by the Ministry of Health. In parallel, the Authority notified donors that it would be prepared to undertake to pay the Society for treating the community’s residents.

From the moment of its establishment, the Authority wanted to be an executive authority, although it was defined as a coordinating entity. This was made possible since the government ministries did not have the resources required to operate the new therapeutic framework that was established.

As soon as it was established, in a desire to prove its effectiveness, the Anti-Drug Authority undertook to finance the accommodation of the residents of the first Community that was set up, and also financed the cost of treatment for the residents of the new therapeutic community, Ilanot, which was in the construction stages. At the same time, the Authority indicated its determination to establish an additional therapeutic community in the north of the country. This actually concluded the State’s initiative concerning involvement in the establishment of therapeutic and other units. Since 1990 the State has neither initiated nor established on its own initiative any new framework for treating addicts.

The Ministry of Welfare, regardless of the development of the therapeutic communities, commenced developing services in municipal units as part of the welfare services. The Ministry of Welfare considered itself to be conducting a treatment policy parallel to and, to a certain extent, in competition with the therapeutic services that had been set up prior to that time. These day-care units were defined as dealing with detoxification, therapy and rehabilitation. When they first started, doctors attached to these units were mainly expected to develop physical detoxification protocols in what were called ‘home detoxification’ programmes. For this purpose, the social worker would see to locating the candidate and would prepare him and his other family members for the physical detoxification process. The doctor would go to the addict’s home from time to time, would conduct clinical tests and would examine the patient’s response to the medications prescribed for him.

These units were set up in about 50 towns. Over the years, due to many problems (cases of death from the consumption of drugs in addition to prescribed medications), the concept was altered, and physical detoxification now takes place only in specially-adapted hospitalisation units. Physical detoxification is also performed in therapeutic communities, the majority of which have the appropriate manpower to complete this stage.

**Public and private social effects on the development of therapeutic services for addicts in Israel**

Since 1990 we have seen that most of the initiative to develop these frameworks comes from social organisations such as non-profit societies (NGOs or charities). These organisations operate in the spirit of the period typical of
Israel in recent years. The State of Israel is engaged in massive privatisation and its involvement in the fields of welfare and health is diminishing.

Other therapeutic communities, in addition to the three in the establishment of which the State was involved (to a certain extent), were established over the years under the auspices of various societies. One community was founded by a society identified with a political social movement. Two additional communities were established by private voluntary organisations – one by a voluntary organisation in the Arab sector, and another by a totally private voluntary organisation.

At first, these organisations received no government assistance, and the patients were required to finance their stay in the communities by themselves. Over time, the members of these voluntary organisations set up a social political lobby, which exerted pressure on the decision makers in the Anti-Drug Authority. This pressure led to the allocation of more resources to finance hospital beds.

One of the most significant developments of recent years is the establishment of addict treatment centres by private organisations and/or persons. These organisations in fact now determine the character of the services available in Israel. Many private centres have been set up in recent years by ‘clean’ former addicts for whom the centre they have founded is a source of income due to their ability to recruit patients. Since many of these (former) patients were involved in their environment for years and they know many other addicts, they succeed in surviving by recruiting the next generation under the original declaration, mainly for the purpose of physical detoxification. In fact, this population utilises these centres as proof to the court that they intend to make a change in their lifestyle. The patients stay at the centres for only a short while, no more than one month. Payment is covered by the addict him/herself (although, in practice, it is actually the family which almost always pays these fees). In certain cases, following the patient’s stay at one of these centres, he/she is transferred to the well-known and professional therapeutic communities.

**Special characteristics of the treatment services**

In recent years we have witnessed a new fashion in the field of treatment of addicts in Israel. Attempts have been made to adapt specific therapy frameworks to special groups – and sometimes subgroups. The basic theoretical assumption behind this approach is that there is a great number of differences between the various patients, and therefore the treatment must be adapted in accordance with the various characteristics. The differences may be demographic, such as family status, age, extract and culture, emotional characteristics, gender, etc. The basic assumption is that not every treatment will be suitable for every addict, and the treatment must be designed in accordance with the particular person’s needs.

Based on this concept, the various therapeutic communities endeavoured to formulate different identities and to adopt for themselves therapeutic characteristics distinct from the traditional community format. Some of them adopted
the individual therapy (psychotherapy) format as a principal component of the treatment, their basic assumption being that the addict population usually suffers from emotional 'malfunction' and, therefore, for the purpose of individual improvement, emotional treatment must be offered. In contrast with these centres, other communities emphasised the socialisation process and the addict's adaptation to the social environment, while building up trust and reinforcing interpersonal processes and social skills. Another centre places emphasis on accepting the population characterised by dual-diagnosis, with the majority of their patients usually suffering from a psychiatric problem coupled with drug abuse.

The issue of gender is also greatly emphasised and recently a centre has been opened intended for women only. The basic assumption here is that women cannot deal with their problems and cannot feel secure enough to discuss their past in a masculine environment. In contrast with that approach, in the original therapeutic community, the concept is that separation of this kind is artificial and that the therapeutic environment must be as similar as possible to the natural environment in which the patients lived in the past and in which they will live in the future. Therefore, integrated treatment for women and men is preferable, and where necessary special women's (as well as men's) groups, and any other intervention, can be organised.

Other treatment centres provide therapy for different lengths of time. Compared with the therapeutic communities, which offer treatment periods of a year and more, two centres have been established providing therapy for periods of between six and eight months. This shortening of the treatment period often constitutes a marketing gimmick, since many addicts want the treatment to be short and not particularly demanding.

Even in the types of treatment which emphasise only the medical approach, we see attempts at creating types and sub-types. In Israel, a number of methadone clinics have been operating since the beginning of the 1990s. Recently, new centres have been set up based on the use of Subutex. These are physically separate from the methadone centres and are operated by special staff teams.

From the point of view of the addict, who has to select the most appropriate treatment, his decisions and his choice of the type of intervention and character of the clinic do not testify to a rational decision based on mature and real deliberation concerning the character and type of treatment. To the best of my experience, the addict is looking for an 'easy life', for a treatment that will be as short as possible, requiring a minimum of energy. Many times an addict begins treatment only in order to calm his family and to stop the personal, family, social and legal pressure he is under. For this reason many will consider the therapeutic communities as a last resort, since it is a treatment that is too serious, too long and particularly promises results that are too good.
Description of work relationships among the therapeutic services

The work relationships among the treatment clinics are derived from the reciprocity between the various government ministries (Ministries of Health and Welfare, Anti-Narcotic Authority) who operate their own centres. For a long time there was no cooperation between the various government ministries and, moreover, the only relationship between them was competitive. There were no working relationships or contacts among the various therapeutic organisations either. The physical detoxification centres, funded by the Ministry of Health, operated independently, with no contact with the continuation treatment frameworks except in very few cases. Nor did the Ministry of Health’s methadone treatment clinics show any cooperation with optional alternative therapeutic frameworks.

The physical detoxification centres keep the patient for periods of between three weeks and one month, although physical detoxification takes no more than one week. After the first week these centres conduct emotional therapy groups and they also hold individual meetings with specially-trained people in the field of emotional health. Many patients consider this a total treatment process, and therefore the great majority do not continue with any further therapeutic programmes.

The physical detoxification frameworks do not initiate onward referrals unless representatives of the various therapeutic communities come on their own initiative to the hospitalisation units to market their facilities to potential candidates. Sometimes, representatives from a number of therapeutic communities arrive on the same day at the physical detoxification unit and compete for the same population segment.

The therapeutic clinics run by the Ministry of Welfare in the municipalities operate completely separately from any other framework. This can also be seen from an analysis of the referrals to the therapeutic communities from these centres. The clinics are ambulatory units to which applicants come for individual sessions. The treatment given there to individuals, and sometimes to groups, is normally weekly.

The referrals from these centres are occasional and random.

The main reasons for the separation and non-cooperation between the various organisations are as follows.

1. The various centres do not operate under a single operating entity. Accordingly, each one wants to view the target population as if it were under its auspices.

2. The main criterion for maintaining the centres is based on the number of patients they actually have. For this reason each centre tends to keep its patients for itself, and it refrains from transferring them to other frameworks, due to its need for survival. We have seen that, at the methadone clinics, a person can be treated for 10-15 years with no change in his state of addiction or quality of function. Often, the message given to methadone
patients is that addiction is a chronic condition of which they will never be cured, so they have to see themselves as if they were diabetics who require their daily dose of insulin. Sadly, there are other, similar messages which discourage patients from attempting to change their condition.

A similar situation can also be seen in the Ministry of Welfare’s ambulatory clinics. Here, there are usually very few patients, and the staff hold on to them since the clinic’s existence and survival depends on their presence. Indeed, many of these centres were closed down due to the small number of patients. There were situations which I witnessed where a centre held on to a patient for a number of years on the pretext of providing emotional therapy, while the patient continued, throughout the five years he was in contact with the centre, to use the drugs with no evidence of any change in his function.

The situation as described above means that the patient does not receive the treatment he deserves. The centre ostensibly cooperates with the patient but the aim is not always, truly, change, recovery and cessation of use. The question often arises in my mind as to who is at centre stage – the patient or the clinic?

The solutions to this situation depend on a number of principal points:

1. Clear definition of every therapeutic entity operating in the field, with reference to fields of responsibility, definition of authorities and clear intervention boundaries.

2. Finding ways to improve cooperation among the various ministries, on the understanding that there is no ‘Ministry of Health patient’ as against a ‘Ministry of Welfare patient’, but that there is a person who needs assistance, and his/her needs must be seen as a whole, and s/he should not be offered a certain type of treatment as part of an attempt to ‘reinforce’ the therapeutic system s/he happens to encounter.

3. The third possible solution is to establish an umbrella organisation, which will provide the entire range of services in the region for which it is responsible, thus preventing organisational discord, and no conflict of interest and/or existential anxieties will be created concerning the referral of a patient from one system to another according to the patient’s needs. Cooperation among all treatment entities will be made possible by setting up a steering committee with powers conferred by all ministerial entities, and operative action will be taken only after an orderly decision-making process by the committee, which will monitor the execution of such decisions.

4. A multi-annual programme to be written by the steering committee, which will consist of a structural rationale with details of the components of the therapy based on patients’ actual needs, and not on pressures and whims.

All these solutions depend in great measure on clear leadership which will dare to warn of any problems and to propose solutions different from those presently prevailing, and which will have the backing of the political leadership in order to execute these changes.
Transatlantic Dialectics: 
A Study on Similarities and Dissimilarities 
in Approaches to Substance Abuse Problems 
in the United States and Europe

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ABSTRACT: Similarities as well as differences can be observed between Europe and the United States regarding the organisation of substance abuse prevention, treatment and policy. These issues were addressed during the EWODOR Symposium, which took place in Blankenberge (Belgium) in September 2005. This paper describes the complex, underlying social and ideological background to this transatlantic comparison from a historical perspective, focusing on the changing roles and positions of TCs in Europe and the United States. A number of themes are discussed here, e.g. the origins of TCs; the increasing importance of treatment evaluation and evidence-based research; the introduction of methadone as a therapeutic means; and harm reduction initiatives. In their conclusions, the authors refer to an evolution that is taking place on both sides of the Atlantic towards comprehensive or integrated treatment systems, whereby harm reduction practitioners collaborate in mutual understanding with therapeutic communities and other drug-free treatment modalities.
Introduction

The European Working Group on Drug Oriented Research (EWODOR) has a long tradition of organising expert meetings to provide a forum within which researchers in the field of drug and alcohol treatment, prevention and policy can share research experiences, compare methods and results, and subject their work to peer examination. The symposium in 2005 (Blankenberge, Belgium) was a ‘Transatlantic Forum’, gathering practitioners, researchers and policy-makers from several European countries and US states. The objective of this symposium was to study a broad spectrum of differences and similarities in substance abuse approaches between Europe and the United States. Based on the development and evolution of the drug-free therapeutic community and current challenges to it, this paper aims to introduce the complex, underlying social and ideological background to this transatlantic comparison from a historical perspective.

1. Early development

Starting in the 1950s, several Western countries were confronted with the phenomenon of young people using heroin, amphetamines, LSD and cannabis as a new kind of hedonism (Kooyman, 1993). Soon, it appeared that these individuals were indulging themselves beyond normative limits. Severe social control and penalisation of possession and trade of these drugs followed, as well as the insistence on abstinence from any use of illicit drugs (Tucker, 1999).

The establishment of specialised treatment services for substance abusers goes back to the observation that this population has specific needs, which were often not adequately provided for in existing (mental) health care agencies (Vanderplasschen, De Bourdeaudhuij & Van Oost, 2002). The drug-free therapeutic community (hereafter TC) can be regarded as one of the first institutional reactions to the growing drug problems. Based on self-help principles and the experiences of Chuck Dederich and his followers in Synanon, Daytop Village was established in 1964 as the first drug-free TC for drug addicts in the United States (Broekaert, Vanderplasschen, Temmerman, Ottenberg & Kaplan, 2000).

1.1 European TC predecessors

In Europe, the precursors of therapeutic education and therapeutic communities were the new school movement and pioneering work with maladjusted children before the Second World War (Bridgeland, 1971). Then, during the war, the 1943 Northfield Experiments with neurotic soldiers (Harrison, 2000) and the ‘Transatlantic Forum’ took place 19-21 September 2005 in Blankenberge (Belgium), jointly organised by the Department of Orthopedagogics (Ghent University, Belgium) and the Ohio Institute for Addiction Studies (Ohio, US), in close collaboration with the Scottish Addictions Studies group (Department of Applied Social Sciences, University of Stirling, UK), the European Federation of Therapeutic Communities (EFTC) and the Association for Alcohol and other Drug Problems (VAD, Belgium).
Maxwell Jones’ democratisation of the psychiatric hospital (Jones, 1957) posed important challenges for psychiatric services. Psychoanalysis and social learning inspired the birth of milieu therapy and the therapeutic community (Broekaert et al., 2000). Jewish phenomenological educationalists and psychologists such as K. Lewin, K. Goldstein and C. Bühler, who had escaped from the Nazis, fled to the United States and there laid the basis for existentialist and humanistic psychology (Missiak, 1973).

### 1.2 American TC origins

During the 1960s, humanistic psychologists such as C. Rogers and especially A. Maslow directly influenced Chuck Dederich (Janzen, 2001), who founded Synanon, the cradle of the drug-free TC (Yablonsky, 1965). The quick and dramatic expansion of the TC should be understood in the light of a long American tradition of prohibition and temperance. Through its affiliation with Alcoholics Anonymous (Dick, 1996), Synanon built upon the legacy of the evangelically-inspired ‘Oxford Group movement’ of Dr Buchman (Garfield, 1978; Lean, 1985). Its existentialist and humanist ‘philosophy’ and ‘value system’ (Soyez & Broekaert, 2005) perfectly matched the aspirations and ideals of the pioneers that shaped the American State. In line with American traditions, behaviourism played a prominent role in the American drug-free TC (Bratter, Fossbender, Pennachia & Rubel, 1985), while the influence of psychoanalysis was relatively modest.

### 1.3 First methadone experiments

Starting in the 1960s, methadone was introduced experimentally in the United States as a medical substitute for heroin. It was originally synthesised in Germany, but further developed as a therapeutic tool in the United States by the doctors Marie Nyswander and Vincent Dole (Dole & Nyswander, 1974). The use of methadone inhibited withdrawal symptoms, cravings and feelings of euphoria, and enabled addicts to return to a normal lifestyle (Inciardi, 1999). From the outset, this practice had to contend with strong reactions. Its opponents considered methadone a street drug like any other that was often used in combination with other substances and led to severe withdrawal symptoms (Acampora & Stern, 1994).

The therapeutic use of methadone was also questioned in most European countries, where abolition and temperance went together with a traditional medical approach using classical neuroleptic medication for the detoxification of ‘addicted’ people. There were some exceptions: in Britain, any general practitioner was permitted to prescribe heroin, though this led to an enormous increase in the number of addicted people and, in 1969, prescription was restricted to licensed doctors working within a network of newly-established specialist clinics (Yates, 2002). A limited number of experiments with the controlled administration of narcotics was also set up in Sweden.
1.4 The golden TC seventies

During the 1970s, the American drug-free TC expanded all over the States and spread to Europe and other continents. It further optimised its methodology for changing addicts’ behaviour and value system through self-help, structured community life and the open expression of emotions. The TC-method strived for an integration of its ‘graduates’ into society and promoted a healthy lifestyle. It was a clear product of the ‘American Dream’ and represented its values and philosophy.

When it penetrated the European treatment system at the end of the 1960s, it faced an antiquated mental health care system, unable to cope with the problem of addiction. However, a group of well-trained idealistic professionals was eager to start up TCs in several European countries (Broekaert, Vandevelde, Soyez, Yates & Slater, 2006). They were acquainted mostly with the work of Maxwell Jones and, as a result of the May 1968 revolution, took a keen interest in the work of anti-psychiatrists such as Laing (1960), Szasz (1970) and Cooper (1967). They succeeded in establishing TCs all over Western and Southern Europe (e.g. The Netherlands, Belgium, Sweden, Germany, Italy and Spain).

2. Evolution

2.1 The end of TC hegemony

With the start of the AIDS epidemic in the 1980s, the drug-free TC lost its leading position in favour of methadone treatment and, later, harm reduction. This was a gradual process, which varied from one country to another. North and Central Europe had to cut down on expenses for treatment as the number of substance abusers had increased and care was mostly in the hands of professionals. In Sweden, TCs were almost all closed down. In the UK, despite a dramatic expansion of provision, funded by the central government in the early 1980s, most TCs gradually abandoned much of their fundamental methodology or, in some cases, ceased to exist at all. In Belgium and Norway they flourished. In Denmark and France they had never had real success. Dropout rates from treatment were too high and the number of positive outcomes was considered too low. In Southern Europe, on the other hand, volunteers contributed to a situation which was generally more stable, although treatment standards were often questionable. TCs also suffered from negative experiences with ‘charismatic’ leaders.

TCs tried to fight back by expanding their treatment offer to special target groups, such as mothers with young children, prisoners, the homeless, children and adolescents, and dually-diagnosed clients. In the United States, TCs were less vulnerable. Their survival was the result of the employment of ex-addicts, staff members with lower wages, a more conservative ideology and a better use of scientific research results.
2.2 Repression

Following the heroin and cocaine epidemics sketched out briefly above, and related problems (such as the spread of HIV/AIDS) in the 1970s and 1980s, stringent anti-drug laws were passed, focusing primarily on legal enforcement and punishment (Lang & Belenko, 2000). Although existing rehabilitation and treatment services (both abstinence-oriented and harm-reduction initiatives) continued to operate, a shift towards a more repressive approach was evident, as manifested in the American War on Drugs (Auerhahn, 2004) and policies of penalisation across much of Europe (EMCDDA, 2002). These (more) repressive policies went hand in hand with an increasing lack of interest in rehabilitation and treatment efforts for (often drug-involved) offenders, an attitude which started in the mid-1970s under the influence of the ‘nothing-works-for-rehabilitating-offenders idea’ (Martinson, 1974).

2.3 Harm-reduction initiatives

In the 1990s, a drug legislation debate began in both Europe and the United States (Inciardi, 1999). Harm reduction approaches such as methadone treatment, information on safer injection techniques, free heroin distribution, needle exchange and drug consumption rooms gradually became available in several European countries and have even become the prevailing approach to substance use and misuse in some countries. Harm reduction is considered as a spectrum of practical strategies that reduce the negative consequences of drug use, incorporating safer use, managed use and abstinence (Harm Reduction Coalition, 2006). These strategies meet drug users ‘where they’re at’ and address the conditions of use along with the use itself. Because harm reduction demands that interventions and policies designed to serve drug users reflect specific individual and community needs, it has no universal definition nor formula for implementing it. Some core principles, however, may be identified: acceptance of drug use as an omnipresent phenomenon whose harmful effects should be minimised rather than ignored or condemned; a view of drug use as a complex, multi-faceted phenomenon encompassing a continuum of behaviours from severe dependence to total abstinence; recognition of the quality of individual and community life and wellbeing as criteria for successful interventions; non-coercive provision of services and resources to people who use drugs and the communities in which they live; giving drug users a real voice in the creation of programmes and policies designed to serve them; recognition of drug users themselves as the primary agents of reduction in the damage caused by their drug use; the empowerment of drug users so that they can share information and support each other in strategies which meet their actual conditions of use (Harm Reduction Coalition, 2006). However, despite increasing acceptance within the addiction field, the harm reduction movement’s principles still seem to be in conflict with the wider majority’s vision and ideology.
2.4 New management

A new management style with a clear focus on quality of care and professionalisation has taken over from education and psychotherapeutic treatment (Broekaert & Vanderplasschen, 2003). While a neo-liberal and free-market system prevails in both the United States and Europe, the former gives the privatisation of care a more prominent position and, since the federal Health Maintenance Organization's (HMO) subsidies were discontinued in the 1980s, for-profit HMOs have quickly captured the market (Zimmerman, 1999). In Europe, the social security system is to a larger extent subsidised by the State, and services sometimes even belong to the public sector. Nevertheless, in Europe as well as in the US, substance abuse treatment is increasingly divided into clear-cut functions and modalities, which are interconnected and coordinated by alternative treatment and management approaches such as case management, integrated treatment systems and networking (Broekaert & Vanderplasschen, 2003).

2.5 Treatment evaluation

The evolutions discussed above have, at least partly, been informed by the increasing importance and impact of research into substance abuse treatment. This process was initiated in North America by a number of large-scale longitudinal treatment outcome studies funded by the National Institute on Drug Abuse (NIDA). The major studies were DARP (Drug Abuse Reporting Programme, 1969-1972), TOPS (Treatment Outcome Prospective Study, 1979-1981) and DATOS (Drug Abuse Treatment Outcome Study, 1991-1993). All three aimed to improve scientific knowledge of the effectiveness of substance abuse treatment on the one hand, and of drug use and drug treatment careers on the other hand (Gossop, 2004). In these studies treatment effectiveness was examined for various treatment modalities, including long-term drug-free residential programmes or TCs. Length of time in residential treatment has been identified as one of the most important predictors of positive treatment outcomes (Gossop, 2004).

In line with evolutions in the US, prospective longitudinal cohort studies at national level have also been set up in Europe: the UK’s National Treatment Outcome Research Study (NTORS) is the best known, but similar studies have also been conducted in Sweden (SWEDATE), and more recently in Norway and Scotland (Gossop, 2004).

3. New tendencies

3.1 European experiments and American restraints

In some European countries, such as Switzerland, The Netherlands and Germany, controlled heroin distribution has even become accepted politically.
The Swiss experiment that started in 1994 for refractory opiate addicts as a last resort of treatment has shown positive results concerning physical and mental health problems, social integration including reduction of criminal behaviour, and reduction in use of illicit drugs (Gschwend, 2003). Based on the evaluation of the Dutch heroin experiment, it was concluded that supervised co-prescription of heroin and methadone was more effective than treatment with methadone alone (=standard methadone maintenance treatment) in reducing the physical, mental, social and legal problems of treatment-resistant heroin addicts (Blanken et al., 2005). Controlled heroin distribution is regarded as a valuable addition to the existing offer of substance abuse services and is therefore continued in all major Dutch cities.

It is paradoxical that the United States, once the pioneer with methadone treatment, now lags behind many European countries. As Inciardi reports: ‘[t]he 115,000 Americans receiving methadone today represent only a small increase over the number of 20 years ago’ (Inciardi, 1999:163). In many places in the United States, no needle exchange programmes or over-the-counter sales of injection equipment as an HIV prevention measure are available. Methadone maintenance treatment programmes are not available in nearly one-fifth of the country (Harm Reduction Coalition, 2006). Existing services are endangered by the trend towards privatisation and managed care. The American federal government spends approximately two-thirds of its drug intervention dollars on incarceration and prosecution and only one-third on drug education, prevention, research and treatment combined.

The reasons for this situation can be found not only in the restrictions of state and federal laws, but also in the conservative reactions of people who don’t want to have treatment centres in their neighbourhood – the so-called NIMBY (‘Not In My Back Yard’) syndrome (Dear, 1992).

3.2 Alternatives to repression

In many European countries, the repression of non-problematic substance abuse, mostly involving cannabis, is no longer regarded as the only means with which to deal with drug problems. This evolution is underpinned by the implementation of extra-judicial alternative measures for substance abusers within the drug policies of several countries in the European Union (EMCDDA, 2001). Moreover, the correction-based therapeutic community experienced an expansion in the 1990s (Vandevelde et al., 2004), especially in the United States, stimulated by the positive outcomes which were demonstrated by several studies in (American) prison-based TCs and associated after-care programmes (cf. Inciardi et al., 1997; Knight et al., 1999; Wexler et al., 1999). Harm-reduction approaches among prison populations, including needle exchange programmes (Dolan et al., 2003) and substitution treatment (Dolan et al., 2005), have also been investigated and positive results, such as decreases in mortality, lower re-incarceration rates and fewer infections of blood-borne diseases (e.g. hepatitis C) have been demonstrated.
Other promising ‘treatment-oriented’, as opposed to ‘repression-based’ approaches have recently been developed. One of these is drug courts, which originated in the United States in 1989 (Cooper, 2003), where these modalities are well-developed. Several studies have already examined their positive functioning and results (Belenko, 1998, 2001; Eley et al., 2000; Logan et al., 2000), such as reductions in recidivism and cost savings as a result of reduced prison/jail use (Eley et al., 2002). Based on the positive American results, drug courts have also recently been set up in some European countries, including England and Scotland (Eley et al., 2002).

3.3 Evidence-based research

Research methods themselves have also undergone important changes as the evaluation of treatment systems gradually became guided by an evidence-based perspective. As a result, phenomenological qualitative research has been pushed aside into a secondary position.

In the US, NIDA has begun funding Clinical Trials Networks, with the objective of conducting studies of the therapeutic effect of behavioural, pharmacological, and integrated behavioural and pharmacological treatment interventions in rigorous, multi-site clinical trials to determine efficacy across a broad range of community-based treatment settings and diverse patient populations. In the meantime, the Substance Abuse and Mental Health Services Administration (SAMHSA) has conducted cross-site prevention and treatment evaluations and identified ten National Outcome Measures (NOMs). These embody meaningful, real-life outcomes for people who are striving to attain and sustain recovery, build resilience, and work, learn, live, and participate fully in their communities.

In addition, between 1996 and 1999, the European Commission, within the framework of the BIOMED Fourth Framework Programme, invested one of the largest single grants in European history into a study aiming to improve substance abuse treatment. This IPTRP project (Improving Psychiatric Treatment in Residential Programmes) involved a network of 26 TCs spread over 13 European countries.

Both in Europe and the United States, TCs have attempted to meet the challenges of developing evidence-based practice and adapting to new management approaches, and have opened their doors to university-based research. In their attempt to underpin their functioning with this evidence-based research, they have drawn closer to more traditionally scientifically-oriented medical and harm-reduction approaches. In addition to quantitative research, TCs have also introduced more qualitative research methods aimed at understanding, evaluating and improving action (Broekaert et al., 2002).

Conclusion

In Europe, as well as in the United States, an evolution towards comprehensive or integrated treatment systems, whereby harm reduction approaches collabor-
ate in mutual understanding with therapeutic communities and other drug-free treatment modalities, is taking place (Denning & Little, 2004). Such integration requires a real dialogue between the harm-reduction movement, which advocates to a certain degree for the legalisation of drugs, and the drug-free ideology, which stands for temperance (McKeganey, 2005). Both in Europe and in the States, the evolution towards the alternative use and combination of various treatment systems is co-determined by tendencies in prevailing ideologies.

In Europe, the existentialists – as the leading force behind the student revolutions of the 1960s – incorporated the Marxist (Hegelian) ideology on social injustice for the working classes. Later, existentialism was criticised by post-modern philosophers, who not only radically questioned the position of self-realisation in the here and now of a given world by arguing that the 'subject' is always determined by language (structuralism) (Lacan, 1977) but, in the footsteps of Foucault (1973), also expanded the grip of language on everyday life to history and politics (post-structuralism) (Best & Kellner, 1991). This perspective argues that a free-market system will also be tempered by these determining structures.

In the United States, 'American values' accepted post-modernist thinking in terms of 'social constructivism', in which emotional learning competes with intellectual skills and people create an open-hearted responsiveness and in which the promotion of the successful individual remains an ideal that is best possible in a free economic system. This absolute priority given to freedom implies less social security and a sharp accent on efficacy. But, even if the individual fails and becomes a chronic abuser, he remains a 'full' person who has to strive for ideals such as temperance and recovery.

While the TC could easily cope with new concepts such as 'inclusion of the powerless', 'collaboration between equal partners', 'emancipation and self-advocacy', or 'feminism and the end of colonialism', it was much harder for it to accept the accent on the individual rights of the citizen, such as substance use, above the Christian values of recovery and abstinence. Harm Reduction, on the other hand, more easily fits into the global picture of post-modern times. It respects the individual to a far-reaching degree for his consumer needs, the subject is determined by his global health condition and social situation, and its treatment methodology is well-controlled by science and evidence-based practices. However, whatever the differences in ideologies and treatment systems, collaboration and fine tuning of the approaches are in the interest of all involved and can be the basis for new transformations and further integration.

References


Women in Residential Drug-free Treatment: How to Use a Bottom-up Strategy and a Prediction of Completion Instrument to Prevent Early Dropout

Mads Uffe Pedersen

ABSTRACT: In Denmark women in drug-free residential treatment have proved to have significantly more psychosocial problems and a significantly higher dropout rate from treatment than men. The question is raised whether or not it is adequate to treat all the women with the same method, this method being an evidence-based one. It is suggested that instead we have to implement strategies that make it possible to identify different target groups with different needs and different risks of leaving treatment before planned. This strategy is defined as a bottom-up strategy. A prediction of completion instrument identifying such a specific target group of women is presented and the rationale behind such an instrument is discussed. It is concluded that it certainly is possible to develop a prediction of completion scale with a very strong prediction power and that such an instrument with advantage could be developed at a local level.

1. Evidence-based treatment and the question about top-down and bottom-up strategies

Evidence-based treatment can be divided into two elements, the evidence-based method and evidence-based practice. Unfortunately these two elements are often mixed even though they do not necessarily have much to do with each other.

Evidence-based methods

Evidence-based methods means treatment methods which have proved to be more effective than 'standard' treatment/support (or no treatment/support) in at least one meta-analysis of randomised controlled trials (RCTs) and second best in at least one RCT.
In Denmark there has been a lot of focus on the overall method (or programme) under which the clients are treated. The methods/programmes most commonly used in Danish residential treatment settings are: 12-step treatment; cognitive-behavioural therapy (different combinations); motivational interviewing; Gestalt/experience-oriented therapy; interpersonal/psychodynamic therapy; systemic-oriented therapy; different relapse prevention methods (most common is Gorsky Relapse Prevention); and different kinds of therapeutic communities which for the most part may be considered as a framework within which one or more of the above methods is used. Other methods which have attracted interest are contingency management and multi-systemic treatment, and there has also been an increased focus on different kinds of family therapeutic methods.

Several of these methods/programmes have proved to be effective in RCTs. This applies to cognitive-behavioral therapy, including behavioral couples therapy (Carroll et al., 1994; Azrin et al., 1994; Kelley et al., 2002; Winters et al., 2002; Brown et al., 2002), contingency management (Higgins et al., 1994; Griffith et al., 2000), methadone treatment (Carroll et al., 2001; Carroll & Onken, 2005), multi-systemic treatment (Curtis et al., 2004), motivational interviewing (Dunn et al., 2001; Secades-Villa et al., 2004) and family therapy (Stanton & Shadish, 1997). Systemic-oriented psychotherapy, not least in relation to family therapy and multi-systematic methods, can be considered as evidence-based methods.

Finally, 12-step treatment can also be considered as an evidence-based method, not least (and perhaps only) when 12-step group treatment is combined with individual 12-step counselling (see Crits-Christoph et al., 1999; Weiss et al., 2005). Several other reviews conclude that the 12-step method is an effective form of treatment (Siqueland et al., 1999; Stoffel et al., 2004).

The psychodynamic method is more debatable, even though some elements in the method can be effective (Crits-Cristoph & Connolly, 1999). Several studies have shown that the supportive-expressive method (which can be considered as a variant of the psychodynamic method) is just as effective as other methods (Najavits & Weiss, 1994).

There is very little new research into the use of Gestalt therapy with drug addicts. There is an older meta-analysis from 1994 which shows that Gestalt therapy is just as effective as other forms of therapy (Bretz et al., 1994), but this does not involve treatment of addicts. Certain older studies, however, indicate that Gestalt therapy can be effective in the treatment of drug abusers (see Freidman & Glickman, 1986).

It can hardly be stated that any of the methods/programmes currently being used in Denmark are ineffective per se. Yet perhaps it can be claimed that some methods are more effective than others for particular clients, in certain settings, in combination with other methods etc. In addition the competence of the counsellor in the methods/programmes used is without any doubt of critical importance.

It is one thing that a method/programme has generally shown itself to be more effective than standard treatment/support in American RCTs. It is quite
another as to whether the method is equally effective in Denmark, in completely different settings, conducted by a therapist with a different educational background and client groups quite different from those who participated in the experiments and so on. In addition, there is a great lack of evidence-based methods for particular populations in particular settings (for example, pregnant women in groups, group treatment of men diagnosed with antisocial personality disorder and young people in day treatment for abuse of central stimulating substances). Research has only yet reached such a specific level to a limited extent, which also means that, for example, cognitive-behavioural therapy (CBT) cannot simply be considered as an evidence-based method for everyone.

Evidence-based practice

The fact that we cannot just transfer evidence-based treatment methods and automatically expect them to be effective, leads the discussion further to the matter of evidence-based practice. Like the definition of evidence-based methods, that of evidence-based practice has been taken from medical research. The definition of evidence-based practice given by Webb (2001) is, for example, largely the same as Sackett et al.’s definition of evidence-based medicine. Sackett’s definition is:

Evidence based medicine is the conscientious explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available clinical evidence from systematic research. (Sackett et al., 1996)

Conscientious, explicit and judicious can be interpreted relatively widely, where the most stringent interpretation would be the use of manual and direct documentation, while a looser interpretation would also include qualified knowledge and the qualified assessment of an experienced practitioner.

‘Current best evidence …’ should be understood as the best currently available research and evidence-based knowledge, which covers far more than methods which have shown themselves effective in RCTs. ‘Evidence-based practice’ also includes the application of knowledge through proper diagnosis/identification of target groups, proper cross-sectional studies, proper follow-up studies etc.

Using an evidence-based practice strategy, it can be completely pointless to expose everyone to the same method without considering whether the treatment may be counter-indicated for certain groups – even though the method can be elevated to being an evidence-based method. Claiming that an evidence-based method/programme is effective for all substance-using clients would in an evidence-based practice perspective be a naïve top-down strategy which forces the clients into a particular form and allows absolutely no room for individuality or particular problems. It is the method/programme which is right and the client who is wrong. If the client does not benefit from the method/pro-
gramme, then there is something wrong with him or her, not with the method/programme.

Evidence-based practice can thus be seen as a bottom-up strategy with focus on the clients' specific needs in contrast to a narrow method and programme perspective, which can be seen as a top-down strategy (see Sheldon, 2001).

It has often been said that evidence-based practice is used as a rationalisation for reducing treatment costs. This is a total misunderstanding. Evidence-based practice is on the contrary an individual responsible and competent identification of a problem and the best available method to approach it. Such a strategy cannot be used as a tool for an economical rationalisation (see Sackett et al., 1996).

Evidence-based practice in Denmark

One problem with the Danish drug abuse treatment is that 'current best evidence' is often solely defined as the treatment method/programme being used (such as 12-step treatment, cognitive behavioural therapy etc). Qualities, such as: identification of specific needs or specific target groups; specific intervention offered to specific needs; intensity, coordination and systematisation of treatment; monitoring/documentation used as a clinical tool; training of the staff/practical competencies; working environment etc, are often included only sporadically or not at all. All these are elements of treatment which have proved to have a decisive importance for a 'good' treatment (for example, McLellan et al., 1988; Luborsky et al., 1985; McCaul & Svikis, 1991; Luborsky et al., 1997; Prendergast et al., 2000; Najavits et al., 2000). Including the above 'evidence-based practice factors' (of course in combination with the method/programme) will be treated in the following as a bottom-up strategy, whereas only working on the basis of one overall method/programme which has to suit everyone will be treated as a top-down strategy.

The bottom-up strategy also includes a recognition that substance abuse often occurs in close relation with various physical, psychological and social problems which require quite different interventions than those offered by the methods or programmes in question.

2. The project

Implementing the above bottom-up strategy into practice is the basic idea behind this project. The objective is to implement a computer-based prediction tool that identifies specific groups of drug-using women at special risk of discontinuing treatment. These groups have different needs and need different intervention.

In the first phase of the project the prediction instrument has been developed. This article will primarily be focusing on this phase. The next phase of the project is to define specific intervention to the specific risk groups. These specific interventions will leave space for different treatment methods. However, the question is not whether they have to offer specific evidence-based
methods to specific groups of women but more a question of intensity, individual versus group, the dynamic between women and men at the residential treatment centre, specific needs of the women etc. The third and final phase of the project is to implement the prediction tool and specific intervention strategy offered to the special groups at risk in 5-6 residential treatment centres. Another 5-6 residential treatment centres with a similar group of clients, using comparable methods/programmes and staff with comparable educational backgrounds will serve as the control group. These two last phases do not fall under the aim of this article.

The registration system behind the project

In recent years, through the monitoring system DanRIS (Danish Registration and Information System) we have been able to document that Danish women in residential treatment for substance dependence have been more socially and psychologically stressed than men and that the drug-dependent women drop out of treatment more frequently.

DanRIS has existed since 2001. It was inspired by the American DENS system (Drug Evaluation Network Study; see Carisse et al., 1999) and the Swedish DOK system (DOCumentations system; see Jenner & Segraeus, 2005). Initially, DanRIS operated as a monitoring system to which residential centres which treated drug-dependent persons could voluntarily sign up. From January 2005 signing up to DanRIS became compulsory for all residential centres treating drug-dependent persons in Denmark. This means that it is now a prerequisite for residential treatment centres which wish to have clients from the public sector treatment system referred. Table 1 shows the information obtained.

The variables used above are updated every 2-3 months via the Internet (www.danris.dk). The counsellors themselves update the information about treatment, staff and organisation on the Internet. The information about the clients is provided by the clients themselves through a questionnaire (self-report). A number of control mechanisms has been introduced. For example, is the number of admitted clients cross-checked with the reports from the counties who have made referrals to the residential institutions?

Table 1: Variables in DanRIS

<table>
<thead>
<tr>
<th>Clients</th>
<th>Treatment</th>
<th>Staff</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background - Education - Housing conditions - Income - Children - Ethnicity - Living arrangements</td>
<td>Days in treatment - Completion of programme - Client-counsellor ratio - Treatment methods - Educational activities</td>
<td>Number - Seniority - Sex - Average age - Administration vs counsellors</td>
<td>Prices (different phases) - Capacity (number of beds) vs occupied beds - EuropASl response rate</td>
</tr>
</tbody>
</table>
3. Women in drug-free residential treatment

Table 2 shows the difference in problem severity between men and women.

Table 2: Completion of treatment programme and EuropASI composite scores for men and women in residential drug-free treatment

<table>
<thead>
<tr>
<th></th>
<th>Women n=565</th>
<th>Men n=1733</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion of programme</td>
<td>42.3%</td>
<td>48.2%</td>
<td>0.01</td>
</tr>
<tr>
<td>Days in treatment</td>
<td>119</td>
<td>151</td>
<td>NS</td>
</tr>
</tbody>
</table>

Composite score

<table>
<thead>
<tr>
<th></th>
<th>Women n=565</th>
<th>Men n=1733</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs</td>
<td>0.46</td>
<td>0.47</td>
<td>NS</td>
</tr>
<tr>
<td>Alcohol</td>
<td>0.18</td>
<td>0.22</td>
<td>0.003</td>
</tr>
<tr>
<td>Legal</td>
<td>0.21</td>
<td>0.28</td>
<td>0.000001</td>
</tr>
<tr>
<td>Economy</td>
<td>0.90</td>
<td>0.87</td>
<td>0.01</td>
</tr>
<tr>
<td>Family</td>
<td>0.41</td>
<td>0.34</td>
<td>0.000001</td>
</tr>
<tr>
<td>Other network</td>
<td>0.35</td>
<td>0.31</td>
<td>0.006</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>0.49</td>
<td>0.43</td>
<td>0.000008</td>
</tr>
</tbody>
</table>

The higher the score the more severe the problems (range 0-1)

The table shows the severity of problems and short-term outcome for 2,298 dependent women and men admitted and discharged from residential treatment in 2003-2004 who have responded to the EuropASI composite questions (84% of the admitted clients completed the EuropASI questionnaire).
As can be seen, women leave the treatment before planned significantly more often than men (42% versus 48%). In addition, women are significantly more challenged than men in the areas of Family and Other network, Economy and Psychiatric. Men, on the other hand, are greatly more challenged by the factors Alcohol and Legal. Some examples:

- 37% of women say that it is very important for them to get help to solve family problems; this applies to 28% of men
- 58% of women experienced anxiety symptoms before admission, whereas the figure for men is 49%
- 42% of women contemplated suicide in the month before admission, whereas the figure for men is 33%
- 13% of women earned income in the month before admission, whereas the figure for men is 18%

This difference has been stable over the last couple of years.

These gender differences are by no means exceptional. The same phenomenon has been reported by Grella et al. (2005), Cook et al. (2005), Zilberman et al. (2003), Brienza & Stein (2002), Brady & Randall (1999), and Davis & DiNitto (1996). On the other hand there has been nothing in the research which shows that women respond less well to treatment, not least in regard to achieving a long-term effect (measured as a reduction in substance use).

Perhaps the higher dropout rate of Danish women in residential drug-free treatment is not because they are less responsive, but on the contrary because of the inability of the institutions to adapt to the special needs of women and to create an environment which makes the women wish to stay. For example, there are many centres where only 1-2 women are admitted alongside 11-12 men, and where there are very few options specifically for women (such as women's groups or individual counselling).

The above specific problems for women in residential drug-free treatment indicate that the treatment centres are in high need of a new way of thinking. This project is one way to illuminate and maybe even do something about this problem.

4. The development of a prediction tool for women in drug-free treatment

The aim of this project was initially to develop a prediction tool which could identify women at special risk of dropping out of treatment. It quickly became apparent during the development process that a) women and men cannot use the same prediction scale and that b) it was not possible to develop a prediction scale which worked for all residential treatment centres. For example, it is no problem to develop a scale which can predict early dropout for all 565 women included in the project. But when the women are divided into centres the prediction force of the scale is not strong enough for about half the centres while it is even stronger to predict dropout for the other centres.
In addition, the scale had to be constructed on the basis of dynamic variables instead of fixed variables. These two categories of variables can be defined as follows: a) dynamic predictors can be changed within a shorter timeframe (e.g. drug-use in the last 30 days, motivation, stress, working alliance, illegal activities in the last 30 days/all EuropASI composite score); b) fixed variables cannot be changed at all (e.g. age of first use, sex, family background) or they can be changed within a longer timeframe (e.g. years in prison, personality disorder). The reason for developing a prediction tool solely or mainly on the basis of dynamic variables is principally of an ethical nature. Referral authorities, for example, could use a prediction tool only based on fixed variables to assess who should be referred to residential drug-free treatment. A substance misuser not referred to residential treatment on the basis of such a prediction score will thus never have the opportunity to enter drug-free residential treatment because he cannot change his prediction score (because it is based on fixed variables alone). This is unethical and perhaps also irrational – a lot of substance misusers can improve in many different ways and complete the drug-free programme despite their background and different negative fixed predictors.

The 565 women and the DanRIS client data constituted the basis for identifying the prediction variables. The women were admitted to 23 residential treatment centres which a) had women admitted to treatment in both 2003 and 2004 and b) had submitted data to DanRIS for the whole of 2003 and 2004.

A total of 19 variables correlated significantly with women’s completion of the programme (Correlation, p.level <.01). The 19 variables are tabulated below.

<table>
<thead>
<tr>
<th>Table 3: 19 variables predicting dropout of treatment (DanRIS)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age when admitted (semi-fixed variable)</strong></td>
</tr>
<tr>
<td>Last 30 days</td>
</tr>
<tr>
<td>- Heroin</td>
</tr>
<tr>
<td>- Methadone</td>
</tr>
<tr>
<td>- Sedatives/tranquiliser</td>
</tr>
<tr>
<td>- Cannabis</td>
</tr>
<tr>
<td>- More than one drug</td>
</tr>
<tr>
<td>- Awaiting charge/sentence</td>
</tr>
<tr>
<td>- Illegal activities</td>
</tr>
<tr>
<td>- Legal problems</td>
</tr>
<tr>
<td>Calculation</td>
</tr>
<tr>
<td>=Age/60</td>
</tr>
<tr>
<td>=Days/30</td>
</tr>
<tr>
<td>=Days/30</td>
</tr>
<tr>
<td>=Days/30</td>
</tr>
<tr>
<td>=Days/30</td>
</tr>
<tr>
<td>=Score/4</td>
</tr>
<tr>
<td>Need help (rated 1-4)**</td>
</tr>
<tr>
<td>- Need help legal problems</td>
</tr>
<tr>
<td>- Need help psychiatric problems</td>
</tr>
<tr>
<td>Calculation</td>
</tr>
<tr>
<td>=Score/4</td>
</tr>
<tr>
<td>0=yes, 1=no</td>
</tr>
<tr>
<td>Problem with concentration</td>
</tr>
<tr>
<td>- Violent behaviour</td>
</tr>
<tr>
<td>- Contemplate suicide</td>
</tr>
<tr>
<td>Calculation</td>
</tr>
<tr>
<td>Score 0 or 1</td>
</tr>
<tr>
<td>Score 0 or 1</td>
</tr>
<tr>
<td>Score 0 or 1</td>
</tr>
</tbody>
</table>
**Table 4: 565 women divided into five groups on the basis of the prediction score**

<table>
<thead>
<tr>
<th>Score</th>
<th>n</th>
<th>Completion of programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>group 1 &gt;=0&lt;2</td>
<td>21</td>
<td>4%</td>
</tr>
<tr>
<td>group 2 &gt;=2&lt;6</td>
<td>117</td>
<td>29%</td>
</tr>
<tr>
<td>group 3 &gt;=6&lt;10</td>
<td>197</td>
<td>40%</td>
</tr>
<tr>
<td>group 4 &gt;=10&lt;14</td>
<td>180</td>
<td>52%</td>
</tr>
<tr>
<td>group 5 &gt;=14</td>
<td>50</td>
<td>64%</td>
</tr>
</tbody>
</table>

Group 1 consisted of 21 women of whom only 4% completed the treatment as planned. Group 5 consisted of 50 women of whom 64% completed the treatment as planned.

Table 4 includes all the centres meeting the above-mentioned criteria. As already mentioned, PPC19 was not applicable to all residential treatment centres. PPC10 worked optimally at 11 residential centres, whereas it was of questionable use at 12 residential centres. These two categories of centres are shown in Table 5.

As Table 5 shows, the prediction power is quite weak for 12 treatment centres and very strong for 11 centres. This could of course be due to the clients admitted at the two categories of institutions being very different. As shown in Table 6, this seems not to be the case.
Table 5: PPC applicability to the two categories of residential institutions

<table>
<thead>
<tr>
<th>Group</th>
<th>n</th>
<th>Completion of programme</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>PPC19 does not work</td>
<td>PPC19 works</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>12 treatment centres</td>
<td>11 treatment centres</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 1</td>
<td>5</td>
<td>20%</td>
<td>0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 2</td>
<td>53</td>
<td>42%</td>
<td>19%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 3</td>
<td>84</td>
<td>40%</td>
<td>40%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 4</td>
<td>80</td>
<td>41%</td>
<td>60%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 5</td>
<td>45</td>
<td>45%</td>
<td>77%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>242</td>
<td>41%</td>
<td>43%</td>
<td>323</td>
<td></td>
</tr>
</tbody>
</table>

Table 6: The difference between clients admitted at institutions where PPC10 works and where it does not

<table>
<thead>
<tr>
<th></th>
<th>PPC19 does not work</th>
<th>PPC19 works</th>
<th>p.value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion of programme</td>
<td>41%</td>
<td>43%</td>
<td>NS</td>
</tr>
<tr>
<td>Days in treatment</td>
<td>129</td>
<td>112</td>
<td>NS</td>
</tr>
<tr>
<td>Age admission/years</td>
<td>30.8</td>
<td>31.2</td>
<td>NS</td>
</tr>
<tr>
<td>Drugs composite score</td>
<td>0.44</td>
<td>0.47</td>
<td>NS</td>
</tr>
<tr>
<td>Alcohol</td>
<td>0.22</td>
<td>0.14</td>
<td>0.0003</td>
</tr>
<tr>
<td>Legal</td>
<td>0.20</td>
<td>0.23</td>
<td>NS</td>
</tr>
<tr>
<td>Economy</td>
<td>0.90</td>
<td>0.91</td>
<td>NS</td>
</tr>
<tr>
<td>Family</td>
<td>0.42</td>
<td>0.40</td>
<td>NS</td>
</tr>
<tr>
<td>Other network</td>
<td>0.36</td>
<td>0.34</td>
<td>NS</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>0.50</td>
<td>0.48</td>
<td>NS</td>
</tr>
<tr>
<td>Medical</td>
<td>0.40</td>
<td>0.39</td>
<td>NS</td>
</tr>
</tbody>
</table>

As can be seen, the only factor where the clients from the two categories of treatment centre differ is that of Alcohol, and this factor has not previously shown itself to influence the percentage of completion. Nor do the two categories of centres differ in regard to the percentage of completion or the length of admission.

Then the reason that PPC19 doesn’t work at 12 centres cannot be explained by different clients or different courses. Maybe the differences in applicability could be explained by other factors, such as the treatment programmes, counsellor characteristics etc. The programmes could be divided into TC programmes, Minnesota programmes and Social Educational programmes. A) PPC19 does not work: 4 TC, 2 Minnesota and 6 Social Educational programmes.
B) PPC19 does work: 6 TC, 1 Minnesota and 4 Social Educational programmes. Even though more TC centres are included in the ‘PPC19 does work’ group, this could not be the explanation of why PPC19 is not applicable to all the treatment centres. Regarding the staff members, the mean age of the counsellors was the same and the distribution by sex was the same; but, more interestingly, it was found that the counsellors from the ‘PPC19 does work’ group could furnish proof of having received some kind of psychotherapeutic training (could show a diploma) significantly more often than the counsellors from the ‘PPC19 does not work’ group.

In the project, PPC19 will therefore only include the 11 centres where the PPC19 scale works. The 11 centres will randomly be assigned to an experimental group and a control group. PPC19 will be supplied to the experimental group, including supervision and a proposal to specific intervention to the specific risk groups. The control group will later receive PPC19, supervision etc.

Discussion

These results from the first phase of this project raise among others the question as to how far it is appropriate to implement a particular standard (such as a specific method or a specific assessment instrument) within a wide range of institutions. Such an ‘over-generalisation’ immediately seems to be debatable and is in fact not in accordance with the bottom-up understanding which claims that one specific programme, one method (or one prediction scale) etc. cannot suit everyone. We have to take different needs and different treatment conditions into consideration and these conditions differ in some degree from setting to setting. Why, then, develop such prediction-scales, could someone maybe argue. The answer must be ‘because, without matching specific needs to different treatment conditions and without a forward-looking treatment plan for each client, the treatment is mainly based on personally well-intentioned here and now/trial and error estimations and such kind of estimation has a very limited prediction value’ (Serota et al., 1995).

In this first phase of the project we will offer the treatment centres a prediction instrument we know works. But later we will help them to further develop and update the instrument so it suits the specific treatment centre. Then, the final aim of this study is to help the centres develop their own prediction scale which in fact must be updated every one or two years. We can then talk about local documentation (or bottom-up documentation), which in this project is built upon a standardised questionnaire that can be used in national surveys.

Recognising that documentation very often is regarded as an irritating time-consumer which gives no meaning to the clinical practice, the PPC19 could give some meaning to the counsellors. This is maybe a naïve hope, but nevertheless the ultimate objective of this project.
References


Seeking Desistance in the Community: Drug Users’ Experience of the Criminal Justice System

Gillian Squirrell

ABSTRACT: This paper focuses on policy developments within the UK criminal justice system and its links with treatment in working with substance-using offenders. The paper focuses on a dynamic area. Policy developments to improve access to treatment and to develop treatment opportunities are to be praised. Yet there are tensions where policies mandate treatment and mandate it to serve a criminal justice rather than public health agenda. Tensions are experienced by drug agencies as they try to work to criminal justice-funded agendas. There are risks of further excluding drug users who are drawn into a net-widening of the criminal justice system and who are subject to initiatives and policy change for which the evidence base often lags behind the speed of change.

The paper begins to unpick some complex issues and invites the reader to listen to some commentary on current practice and suggested policy changes offered by substance users and ex-users.

Introduction

This paper explores drug policy in the UK and its increasing blending of criminal justice with drug treatment. It offers some analysis of current trends in policy. It also offers some data from life stories collected from individual users and ex-users who have experienced treatment as part of their involvement with the criminal justice system. Some were still engaged in treatment in jail and within the community; others had completed treatment programmes and their sentences, and were continuing with their recovery. The paper juxtaposes their voices against policy developments.

The paper is in three parts. The first reviews some current developments in drug policy as it relates to the criminal justice system. The second presents the voices of the users and ex-users; and the third explores some of their suggestions for improvements for managing drug misuse and offending.
The crime-drugs nexus: 
Policy and practice developments and issues

This section offers a brief overview of current policy developments in Britain. These have been described by Shapiro as a ‘complex matrix of activity ... grown up in a very short space of time’ (Shapiro, 2004:1). The Labour Government is committed to understanding much crime as drug-driven. It targets more problematic users coming into contact with the criminal justice system as a means to crime reduction. The 2002 Drugs Strategy Update argued that these users were responsible for 99% of the social and economic costs of drug misuse, amounting to between £10 and £18 billion per year.

Coming to office in 1997, the Government committed itself to being ‘tough on crime and tough on the causes of crime’, a political position riven with tensions: not least because many perpetrators of crime are victims of crime (Charman & Savage, 2002). Many drug users are criminalised by our drug laws and, once stigmatised and marginalised as criminals, often have few options other than committing further criminal acts.

Further tension lies in the fact that ‘legal punishment appears to have very little impact on drug use’ (Loxley, 2005a:241; see also Manski et al., 2001; Lenton, 2005). Drug use, it seems, is beyond rational choice theory on which deterrence theory is based.

Some commentators on legal and punitive responses to drug use note the ‘merging of the health and justice approaches to dealing with drug misusers lies in the fact that the criminal justice system has been spectacularly unsuccessful at preventing drug driven offenders from re-offending’ (Quinn & Barton, 2000). This merging has far-reaching consequences, which are explored below. It should be noted that emphasis on managing offenders into treatment is a response to the National Treatment Outcomes Research Study (1997), which found that every £1 spent on treatment saved £3 within the criminal justice system.

Some issues arising from current policy

This section offers a flavour of some issues which may arise from current policy, such as the increased association of drug users with crime, the potential for net-widening and for difficulties in the mandated partnerships between health services and the criminal justice system.

The criminalisation of drug misusers

Targeting the drugs-crime nexus has featured in policy since 1995. The 1998 Second Drugs Strategy emphasised the importance of breaking ‘once and for all’...
the vicious cycle of drugs and crime which wrecks lives and threatens communities’ (Tackling Drugs, 1998:2). The 2002 Updated Drugs Strategy, the Government’s more fine-tuned thinking, underscored the drugs-crime nexus. It was described as ‘the biggest single scourge affecting individuals, families and communities.’ The emotive language in some policy documents nods towards enslavement theories of drugs (Bean & Wilkinson, 1988). Drugs were said to:

... turn law abiding citizens into thieves, including from their own parents and wider family. The use of drugs contributes substantially to the volume of crime as users attempt to raise the money to pay dealers ... otherwise decent people become dealers in pyramid selling ... so that they themselves can fund their own addiction.

Management of volume crime through treatment is summarised by the National Treatment Agency (NTA):

[the growing understanding of the link between heroin and crack/cocaine use and acquisitive crime allied with emerging evidence of the effectiveness of drug treatment has resulted in the rapid expansion of criminal justice based initiatives.]

(NTA, 2004:5)

Some commentators on the post-1998 strategy have been concerned at the myriad of routes for offenders to take into treatment and the degree of ‘encouragement’ or coercion being used. Some of the more negative consequences of these drugs strategies are explored below.

Net-widening and marginalisation

Net-widening means more people are drawn into the criminal justice system, deeper into social marginalisation, and are often given greater sentences. This may result from the punitive approach to managing offending drug users through incarceration, an irony when New Labour’s policy is to tackle social exclusion. Yet ‘crime policy wrapped in the tough on crime agenda facilitates the exclusion of large numbers of offenders from the community through incarceration’ (Charman & Savage, 2002:222).

Fear of possible punishment may have public and individual health consequences as some users make ‘rapid and unsafe use of drugs because of the fear of apprehension’ (Loxley, 2005:241). Concerns about the health and compromised health of drug users can lead to their further marginalisation from mainstream society.

The rapid roll out of initiatives, often without a clear evidence base as to their impact, may lead people who ‘fail’ in the treatment they are offered to experience more severe sentences. Spooner et al. (2001) suggest there is a range of variables which can impact on a person’s success in treatment, not all of which will be related to an individual’s motivation or willingness to comply with an intervention. Thus punishment for ‘failing’ may be misapplied.
Labelling

Policy and political statements linking problematic drug use to offending may serve to deter some people from voluntarily seeking help; often 'women and minority groups' (Barton, 1999a), and young people who may not want to be stigmatised as 'junkies' and criminals and who fear the consequences of being so labelled.

Labelling impacts on problematic users: they may absorb and play to the deviant labels they are given (Becker, 1963), receding further into marginalised lifestyles and into marginalised groups, where they find acceptance and support for their deviant identities (see, for example, Taylor, 1993).

Treatment interventions may need to target helping people to make changes to their personal identity constructs. Marginalised lifestyles may have led to some people developing roles and gaining a status within a deviant community, which they are not likely to be able to replicate within mainstream communities (see, for example, Dunlap et al., 1994, 1996; Taylor, 1993; Carnwath & Smith, 2002). This shades into the concept of 'side bets' where people become so attached to the additional benefits and opportunities of any role they play that they find it hard to relinquish such roles (Becker, 1963).

Users' identities may also be so damaged because they 'accept the blanket condemnations, and may come to believe that they will never be able to contribute anything to society' (Lenton, 1998:22). Again such self-esteem and identity issues may need to be explored in treatment.

The pace of change and Government commitments

Government's heavy investments of finance and its reputation in reducing crime through creating more treatment interventions initiated through the criminal justice system may 'be a double-edged sword' because it is 'partnered by too close and overanxious scrutiny and frenetic changes in systems as government chases the goal of achieving a quick win' (Baker, 2004:56). In looking for proof that policies designed to defeat the crime-drugs nexus work, there are unintended negative social consequences. These include developing a two-tier treatment system 'where those in the criminal justice system are fast tracked into services' (Baker, 2004:55; Barton, 1999a). Political enthusiasm runs 'ahead of the evidence base' (Baker, 2004:55) and so initiatives are rolled out before there are sufficient impact assessments. The pace of change, lack of evidence and political persistence may lead to confusion, less accountability and greater dominance of the criminal justice over treatment objectives.

Coercion

Drawing on evidence from the USA that 'addicts entering programmes following coercion from the criminal justice system perform in much the same manner as those who volunteer for treatment' (Barton, 1999a), there has been an increasing emphasis on directing offenders to treatment. The 1998 Crime and Disorder Act allowed for coercion of offenders into treatment, with the proviso they be willing to engage. However, as Barton (1999a) notes, there is often little
sense of choice if the options are between treatment and a sentence. The 2005 Drugs Act has gone further and mandates assessments on apprehension and suspicion of drug use by an offender. This may undermine the potential shown by Arrest Referral Schemes for the development of an early therapeutic relationship between offender and a drugs worker offering assessment and referrals.

The evidence base for the effectiveness of forced treatment is limited and ambiguous (Anglin & Hser, 1992; Marlowe et al., 1996). Gossop (2005) suggested the nature of mandated treatment should be better understood so evidence for coercive treatment could be more thoroughly evaluated. For example, much evidence of successful coercive treatment in the States is based on community-based methadone substitution, a very different treatment from that of expecting offenders to engage in abstinence-based programmes, either in the community or residential programmes.

It is argued that forcing offenders into treatment captures them when they are unwilling (Anglin & Hser, 1992) and that once in treatment they have to stay (Barton, 1999a) and this will lead to cooperation and success. However, there is a high dropout rate from treatment (see Audit Commission Report, 2004) and offenders may prefer to complete a sentence rather than treatment (Bur, 1987; Anglin & Hser, 1992). Poor or incomplete treatment is problematic. It may affect users’ perceptions of the efficacy of treatment, their capabilities to sustain and succeed in treatment and so affect their subsequent motivations to enter treatment.

Mandated partnerships

Barton (1999a) argues that forced partnerships are often unequal and difficult arrangements, with drug treatment and health provision becoming subservient to the criminal justice system and the goal of community safety. In this partnership the professional culture and ethics of health and welfare based agencies may be at risk. For example, such agencies may become ‘conduits of information from the patient to the court’, and be forced to break client confidentiality. Some health professionals may not want to break confidentiality if it jeopardises treatment goals, leads to a breach of the offender’s licence, a greater sentence or the termination of treatment (Barton, Quinn & Barton, 2000). Health professionals may have a very different concept of engagement with services and of success than criminal justice professionals. This role of information conduit can also ‘disrupt the flow of information from patient to treatment provider’ with the patient withholding information, which then adversely affects the clinical intervention (Green, 1999).

The power to determine who receives treatment, and what treatment, may become a legal rather than a clinical decision (Barton, 1999a; 1999b).

Despite such reservations, the policy agenda is set. The following pages explore service users’ experiences of their treatment, which were generated through the criminal justice system, and offer some of their observations for improving services and options.
The voices of experience

The following discussion has been developed from data collected as part of a wider research project, employing narrative and life story approaches to explore desistance from offending and criminality, which is being undertaken by the author. The respondents who have contributed to this paper were interviewed between May and September 2005; they knew of the focus of this paper and were happy to be anonymously cited. The data are taken from a data pool of 33 people interviewed in this period. Most were in the community, engaged in treatment or following treatment principles in community-based dry accommodation. Four were in jail. They were aged between 23 and 46. All but three were men. The group commented on initiatives they had directly experienced such as:

- drug treatment and testing orders
- drugs awareness programmes within community and within jails
- therapeutic community in jail
- being part of the prolific offenders scheme with drug testing and reporting arrangements
- being in residential treatment paid for by probation services
- arrest referral schemes.

There are several themes emerging from the data. These include poor provision of services; the large part played by chance; feelings of being devalued as an individual; and limited follow-through and community support. Those with problematic alcohol use commented on feeling highly let down by the system.

Poor provision and being devalued

Many users felt devalued as a result of their contacts with the criminal justice system and treatment providers. This theme is explored under several headings.

Limited help in the community

Those seeking help within the community found it limited. They felt betrayed by the systems which were supposed to help them.

I felt let down by the system, worthless and shaken, another rejection. They can't do anything for you. It's easier if you've offended. It's too long for referrals, 12 weeks. When you ask for help you're serious and you want it now, in a week. People do feel suicidal and desperate. After 12 weeks, it changed, you've taken more drugs, have been rejected and aren't ready any more. (Alex, mid-30s)

Others described community-based care as falling short of meeting people's individual needs. Quite simply, there seemed to be insufficient treatment opportunities available.
Ain’t no help out there really. They might do acupuncture, but all they’re good for is a clean needle. They give you a booklet ... they don’t phone round for you. I always feel let down. A lot of people feel let down; people try to deal with it themselves. That’s the one place for the whole of Bristol, for somewhere the size of Bristol with its problems. (Chris, mid-30s)

_Poor programme leadership, content and delivery_

Many who went onto programmes had a number of criticisms. Some found the same programme was run in both jail and community and there was no differentiation in content despite differences in the context. Many accessing such programmes were concerned about repeating the same programme content. For, they asked, if it did not work the first time, why would it help a second or third time?

Same course in prison and community, same content. I’d do the drugs programme, it was two minutes from me mum’s house, rather than go to jail. I was on the swerve. (Merrick, mid-20s)

Respondents spoke of staff running programmes, knowing that the participants were insincere, but being without interest in challenging this. One young man said participants would ‘sit there talk a load of rubbish, how much you want to stay drug free, and you’ve already worked out about going shopping for drugs at the end of the day.’

Another spoke of the ways the participants were stealing from the programme provider in order to buy drugs. He did not think that the course leaders could be unaware of this.

On the day programme they’d choose people to do the cooking and they’d give you £10 for the food. We’d work out ways to keep the £10 for drugs and smoke the drugs after the group. (Jason, mid-20s)

Many respondents felt that people referred into programmes were not serious about them: this also included themselves.

I’d go on the courses because it would stop my mum nagging at me. I don’t want to go and I realise I don’t, but just because she’s nagging at me. Twelve weeks and she thinks I’m trying and really I haven’t stopped at all. Then when I do ‘relapse’ she thinks that I’ve tried. (Merrick, mid-20s)

Aside from side-stepping custodial sentences by joining community-based programmes, some offenders in jail were also thought to have pragmatic motivations.

There were a lot of different reasons for doing it. Security re-classification, wanting to get parole; it was accredited, it made a big difference. (Terry early-30s, in jail)
People sign up for courses because it looks good and because they’re locked up and it’s a special little treat. You go upstairs to do the course, get gym every day, you’re out of your cell and you get paid for it. Some haven’t got any money and they get money for doing the drugs course. (Jon, late-20s)

This made it hard for people who really wanted to be successful.

The STAR programme was really good. I did it with my co-d [co-defendant]. We supported each other through it. (Robbie, mid-20s)

Respondents thought the programmes were not taken seriously by the authorities commissioning them, nor by the personnel engaged in their delivery. One respondent commented:

[Programmes are mainly just to make prison and probation look good. There’s no motivation for a prisoner or a free man to go to the PASRO, ETS [Enhanced Thinking Skills]. They’re really shallow: it’s going just for the sake of it. (Warren, early-30s)

Another said he had taken:

PASRO, short duration drugs awareness courses and relapse prevention courses. They don’t work. It’s people talking to me. A prison officer’s in the chair and he’s telling you and he’s had three days’ training. They don’t want to do it. They’re just doing it and that’s it. (Terry early-30s, in jail)

[You need to] have people taking the programmes who really know. The prison officers don’t know anything. They just tell you what they are supposed to say. (Warren, early-30s)

Not being safe

The venues used for community-based programmes were often known to dealers. This made it unsafe for those who really wanted to use the opportunity to change. They, like those who did not have such motivations, were quickly approached by dealers at the end of sessions.

Doing a DTTO in my area wasn’t clever really. Ninety per cent were using in our area. Dealers would come up to you after the programme; they’d be parked round the corner. You could see the cars out of the window and you’d be in the sessions saying you wanted to stop, and just thinking about getting round the corner. (Merrick, mid-20s)

In some prisons the lack of space meant that beds in drug-free and therapeutic units where reportedly used for prisoners on normal location, thereby exposing those working on their drug problems to risks of relapse. Similarly the lack of space within drug-free wings meant that prisoners would often be released into normal location at the close of intense drug programmes and be
without support, open to temptation and to risk of overdose as a result of having been drug-free for a period of time.

_Falling through the gaps_

A number of respondents thought there was a lack of help even though they were caught in the criminal justice system. This was often the case for those on short sentences or who were moved between jails.

> Sentenced for six months, do three and move a couple of times b cat to a c cat and then it’s too short to do a course. Saw Resettlement a couple of times; they said they’d get back to me. They’re useless. The first couple of times it happened, they build up your hopes and you walk out of the door with nothing. You have to do a couple of years [to get help]. (Richard, mid-30s)

> Others quite simply attracted no attention. There were several comments about the limited diagnosis of alcohol problems.7

> The only thing they offered was a cell and a cooked breakfast in the morning. Even they [the police] said, ‘You’re a different man in the morning.’ (Alan early-40s)

> Some users with more extreme needs, such as dual diagnosis, got overlooked. One user described how she spent time in jail between the hospital and the punishment block. She was sent to both because of her behaviour, the product of her mental health disorder, but her drug problems were not addressed and she felt her case was not sufficiently managed as she moved into the community.

> After a 4½-year sentence and being on the hospital wing or punishment block for most of it I was released onto the streets from the hospital wing with nowhere to go. My CPN when I was out wanted me to sue prison health. I was really ill; they should have hospitalised me. (Joanne, late-30s)

_Limited follow-up_

Several respondents spoke of having had good treatment experiences but felt that they were let down on completion of treatment. This took several forms and sometimes had highly deleterious consequences for the individual. One woman, having completed a period within a prison-based therapeutic community, stated:

> [i]n the TC rehab six months working on yourself, taking responsibility. I was climbing the ladder. Did really well then released back into the system with 1½ years to go. Not released to a drug-free wing, so I picked up and then lost my chance of parole. My daughter started using then. (Angel, late-30s)

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7 This concern highlights the needs for assessments to be made by knowledgeable and skilled people.
Others found poor support in the prison. Some created their own by isolating themselves or mixing with very few other prisoners. Some tried to remain on drug-free or therapeutic wings, working for programmes or doing domestic duties in order to stay in drug-free locations. Often times of transition to other jails were dangerous, when prisoners could not find support against drug use in new jails.

There was a massive drug problem, a big heroin problem. On the course I felt fairly safe and secure, not mixing with users. I was transferred and I just stayed with my co-d. We did gym every day and just kept away from the others.

(Robbie, mid-20s)

Many spoke of the difficulties in negotiating a drug-free course through jail and many thought that prison staff were not always helpful. One commented:

[j]prison officers’ attitudes towards users are bad. You get a lot of stick off screws for doing something about it [your drug problem]. If you do something then you show up as a drug user, so they think they can take the piss out of you. Get a lot of attitude off prison officers, some help off them too.

(Warren, mid-30s)

A problem which frequently emerged through the data was a perceived lack of support with resettlement.

Got a two-year sentence, used to go to AA and getting on OK in prison. There was no follow-up help when I got out. Straight back on the booze again, nowhere to live, no-one to help me through. I went back with the ex. She’s a user, straight back to it. Self-harmed and got into trouble.

(Alan, early-40s)

In the last 18 months [of his sentence] I realised that I didn’t want to use. But I came out and nothing had changed. On the first day I smoked weed and within three, I was smoking class A drugs.

(Alex, late-30s)

Got sent to a bail hostel in Bluechurch. Hated it. More like an organised squat for users. That was just before Christmas. There was a fight and I got thrown downstairs. I left to go to my girlfriend’s [house to stay]. I got breeched and was back in the cells for Christmas.

(Jason, mid-20s)

Likewise, some who had succeeded on community-based courses found no follow-through.

[I] did ASRO last year on probation, 10 weeks, two hours, twice a week. It was good, made sense, what drink does to you and your triggers. Once it stopped I drank again. Boredom. The hostel was dingy, no light, grimy. Just got drink and sat in my chair watching TV. Depressed and bored and on anti-depressants.

(Alan, early-40s)
Chance

There were a number of respondents who attributed their access to treatment as a chance happening. While this made some respondents feel they were lucky, it is not an equitable principle on which to organise provision.

I started going to AA in prison: only went first of all to get out of cell, then got right into it.  
(Jackson, late-30s)

The judge said it's your last chance. Eighteen months DTTO and a drug programme. It really hit me that I didn't want it. Done programmes before and hadn't lasted two weeks [drug free] on the programme. Back in prison for five weeks with CARATs, trying to find a residential place. Then the judge said, 18 months DTTO and eight months residential; it was just luck.  
(Merrick, mid-20s)

The CARAT worker'd known me from before in HMP Bluechurch. Just luck. She did everything; made all the phone calls; she got me here [a dry house]. It was luck.  
(Jason, mid-20s)

Community support

For those interviewees who had negotiated the criminal justice system and treatment programmes there were problems as they tried to find places in the community. Overwhelmingly there were issues about the lack of accommodation and especially accommodation that would support their recovery: 'there's a need for more sound accommodation. Not many places are dry. Most of the time they get you accommodation, but it's not dry.'

Within the community there was little to hold them in place beyond AA and NA meetings. For those for whom the 'rooms' and 'shares' were not a congenial way to add structure and purpose to their lives there were few alternatives. Many relied on voluntary sector projects to signpost them to training opportunities or to provide mentors. However, not all such programmes were geared to the needs of people in recovery.

A number of interviewees were thinking about working in the treatment industry. Motivations varied, but for some it was thought to be a way for them to access some support to stay on track and a chance to work in a vocational area where there would be acceptance of their pasts.

Progression

Many interviewees were thinking about or had become engaged in working with other users and offenders. Some seemed to think that it was the only viable career option which they had, something for which they were experienced and for which their experience made them feel qualified. Many thought other job opportunities would be closed to them or they found starting at the bottom an unattractive option. A few respondents were volunteering and working in users’ fora.
I’m part of the UFO [users’ forum] and the BME that the council’s setting up for black minority users. I’m vice chair and they’re putting me on a course.  
(Merrick, early-20s)

Many thought they could achieve for others what some of the professionals in treatment had not managed to do for them.

A lot of the counsellors didn’t do a lot for me. Some lady – she just had a different view of things to me. I came out of there generally depressed. She had a view that people were on drugs because of some sort of trauma as a child. For me it was because I was bored, my mates and my area. I’d go to counselling and she’d ask me if my dad used and if he was afraid of relapse. They were always looking for deep issues; it couldn’t just be because of boredom, my friends and my area.  
(Robbie, mid-20s)

She was just reading from a book. She hasn’t got a clue. I’m the one on drugs and she’s trying to tell me.  
(Terry, mid-30s)

There was a range of motivations for entering treatment as a career. Some wanted to help save another or to be able to generate respect within their chosen community. The literature on life courses explains the desire to put back into society as the ‘generativity script’ (see, for example, Maruna, 2001). For those whose lives have been marked in some way, putting something back is also a way to make a life that has gone wrong come right again. It allows the person to prove that, although temporarily they did bad things, they have returned to being the good person that originally they were. So they are able to improve their self-image.

In part, thinking about this work was because it was ‘all they could do’ on the one hand, coupled with ‘I’m qualified by experience to do this’ on the other. Many thought that they did not need such training and to take qualifications because they had had experience and knew where service users would be coming from. However, there are dangers for the industry in having an under-developed workforce (Mills et al., 2003), qualified mainly by experience. There are also ethical issues in basing so much practice on the personal basis of ‘it worked for me’. There are projects working in the arena of resettlement but, like the issue of accommodation, employment and encouraging employers to open the doors to people with offending and substance misusing pasts continue as unresolved challenges.

Reflections

This paper has explored some elements in the changing landscape of the criminal justice system, its interface with drug treatment practice and the mandated nature of some treatment. The paper has offered some experiences of people with backgrounds in drug and alcohol use and the criminal justice system. These people are crucial stakeholders or customers of the systems of treatment and the criminal justice system. The majority of the respondents
were, at the time of the interviews, interested in and committed to their recovery from addiction and to following an abstinence-based lifestyle. Their observations were therefore grounded against this backcloth of interest.

The first part of the paper explored the shift of treatment from an agenda driven more by public health concerns to one driven by criminal justice concerns. It looked at the increasing imperative being placed on the criminal justice systems to manage more problematic users into treatment in order to impact upon volume and acquisitive crimes, which are attributed to these users.

Currently research evidence does not completely support the argument that coercion into treatment through the criminal justice system will have a positive impact on people’s desistance from substance use. In part, people’s motivation will be affected by a range of factors, and coerciveness as exercised by the criminal justice system may not have a positive impact on seeing people through treatment. This will be an interesting area to explore as elements of the Drug Act 2005 are implemented.

The respondents highlighted a number of areas of concern based on their experiences. Some suggested that accessing treatment through a self-referral route was hard and that involvement with the criminal justice system had to prefigure getting a referral. This they thought should be addressed.

It should be easier to access detox and treatment. The wait is immense, three months in most cases. You’ve got to go and do something until three months later. So much changes in three months because it’s a reckless life. You get a lot more angry and damaged. Then you’re not inclined to put the effort in.

However, having got caught within the criminal justice system, respondents felt that there were areas where improvements could be made. They wanted more help available for the asking in jail. Several respondents had experiences of ‘pushing for it [help] for myself,’ having help through sheer chance, or receiving no or patchy help. Overall they felt that ‘there should be more work on drugs in jail.’

Officers and their attitudes were also an area of concern, some respondents feeling that they received limited help from officers and some that they were the brunt of less than helpful comments and attitudes. ‘More work with the officers; there’s more talk with them, they know the residents.’ Certainly there were issues raised about the nature of the through-care within prison and the ways in which drug-free accommodation was used and drug-free prisoners were allocated.

Just as there should be more work in jail, so there should be assistance to move into the community and supportive work after release.

There should be rehabs in jails. Someone should be with you in jail and move with you to the outside. You should be housed and there should be structure.

Post-release was a time of heightened risk, possibly immediate risk. Prisoners have a discharge grant and, without clear support, ‘by 10 in the morning
you’re blathered. It’s easy to fall down the hole.’ Housing and the availability of supportive agencies were seen to be key in helping to sustain drug-free life after release. Accommodation especially featured on the list of necessities to support post-release life: ‘more halfway houses, like this, with courses and structure.’ People needed ongoing support. ‘Centres to go to every day,’ ‘Someone to talk to about problems, who could advise you and point you in the right direction.’

For offenders with alcohol dependence problems there were glaring gaps within the criminal justice system, from community, through the criminal justice system and back into the community. The 2006 Alcohol Strategy may help to manage such gaps.

While some respondents found that the treatment they accessed through the criminal justice system worked, many of these accounts still included wasted years and false starts. Addiction may be a chronic relapsing condition, but there seems to be a number of gaps in the system, which may support if not prompt opportunities for relapsing.

Longer-term support to access employment beyond the drug and alcohol treatment industries was also an area which could be addressed. Entry to an employment arena to help manage a damaged identity or because it seemed to be a way to gain support seem unnecessary restrictions on people’s freedom of development.

These life stories have covered many years of using and offending, but most have included accounts of current and developing initiatives. Often these have been found wanting by these particular consumers of criminal justice-based initiatives. Their stories are perhaps supportive of commentary by researchers such as Baker (2004) and Loxley (2005b), who find initiatives were ‘rolled out before results of the pilots were known and have proved to be expensive and (to date) have shown only a modest success rate both in terms of treatment and crime reduction outcomes’ (Baker, 2004:55). These voices of experience deserve an airing in the consideration of the developments of the next phases of drug strategies.

References


Gillian Squirrell

Marlowe, D. et al. (1996) Assessment of coercive and non-coercive pressures to enter drug abuse treatment, Drug and Alcohol Dependence, 42, 77-84.
Dealing with Multiple and Frequent Service Utilisation in Substance Abuse Treatment: Experiences with Coordination of Care in Residential Substance Abuse Agencies in the Region of Ghent, Belgium

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ABSTRACT: Frequent and multiple service utilisation is a well-known problem in residential substance abuse treatment and traditional agencies have proven to be relatively ineffective for this population. Given the lack of cooperation between treatment agencies, two alternative interventions that aim to improve coordination and continuity of care were implemented: structural inter-agency care coordination and intensive case management. Based on interviews with case managers and care coordinators and 20 clients who participated in one of both conditions, we explored how the persons directly involved themselves experienced these interventions.

Intensive case management was very much appreciated by clients, especially the comprehensive and client-oriented approach, while care coordinators – rather than clients – identified various advantages of inter-agency care coordination. We conclude that both interventions may be – for specific purposes – important additions to the existing residential agencies, if they are well integrated in a comprehensive network of services and if some pre-requisites concerning implementation are addressed.
1. Introduction

1.1 Frequent and multiple service utilisation

Frequent and multiple service utilisation is a well-known problem at emergency wards, crisis and detoxification centres and other residential services (Okin et al., 2000; Thornquist et al., 2002; Witbeck et al., 2000). Among other reasons, this phenomenon is due to the growing complexity of health problems and systems of care (Willenbring, 1996). Frequent service utilisation has been associated with substance abuse, homelessness, unemployment, social exclusion, lack of insurance entitlement, medical and psychological problems, suicidal behaviour and increased mortality rates (Keene et al., 2000; Langdon et al., 2001; Okin et al., 2000; Witbeck et al., 2000). Despite much anecdotal evidence about persons who repeatedly use the same agencies or a range of different agencies, relatively little empirical information is available about these so-called ‘revolving door’ or ‘shared’ clients (Keene et al., 2001; Kertesz et al., 2003; McCarty et al., 2000).

Treatment of and service delivery to this specific population has been described by care-givers as challenging and frustrating due to a lack of adequate strategies and interventions to deal with these clients (Vanderplasschen et al., 2002). Overall, traditional agencies have proven to be relatively ineffective for this population, resulting in clients receiving episodic, non-continuous and inadequate care (Cox et al., 1998; Okin et al., 2000; Thornquist et al., 2002). Since these clients make disproportionate use of available services and resources, various interventions have been implemented to better meet these persons’ needs and to improve treatment outcomes. If comprehensive and ongoing support is available, beneficial outcomes concerning service utilisation, treatment retention and clients’ functioning have been observed (Braucht et al., 1995; Cox et al., 1998). For example, intensive case management has been applied successfully among frequent service users to reduce the use of expensive inpatient services, to promote participation in community-based services, and to stabilise clients’ functioning (Okin et al., 2000; Thornquist et al., 2002; Witbeck et al., 2000).

1.2. Organisation of treatment and service utilisation in the region around Ghent

Due to historical reasons (i.e. the establishment of the first drug-free therapeutic communities (De Kiem & De Sleutel) and some other specialised treatment initiatives for drug abusers) and the lack of direction and programming on behalf of the government, the region around Ghent is characterised by an extended and differentiated (but uncoordinated) network of treatment agencies. This region counts relatively many residential services, e.g. therapeutic communities (n=3), specific wards in psychiatric hospitals (n=4), and crisis/detoxification centres (n=3). Given this multitude of treatment services and given
clients’ multiple and complex problems and various treatment episodes, coordination and continuity of care will be important indicators of quality of care (de Weert-van Oene & Schrijvers, 1992; Vanderplasschen et al., 2002). During various studies we have focused on different aspects of coordination and continuity of care and on methods and interventions to improve both aspects of quality of care (Vanderplasschen, 2004; 2006). These studies – including the study reported in the results and discussion section – have been approved by the Ethical Committee of the Faculty of Psychology and Educational Sciences of Ghent University and by the national Commission for the Protection of Persons’ Privacy.

First, we explored aspects of coordination and continuity of care based on interviews with key informants from the drug treatment system and on a study of client files (Vanderplasschen et al., 2002). No systematic and/or formalised coordination and continuity of care was observed in any of the (residential) treatment agencies in this region. Some key informants indicated a trend towards more cooperation, coordination and communication between services, but these were scarce and merely ‘ad hoc’ initiatives. Overall, a lack of objective, systematic, and joint thought and action characterised this field. This could be derived from cooperation and communication that was based on personal choice and benevolence, divergent intake procedures, the lack of a common and standardised registration system, and referrals that were determined almost exclusively by subjective factors (Vanderplasschen et al., 1999). Moreover, indicators of continuity of care were nearly totally absent. This appeared from the lack of treatment planning, monitoring of the treatment process and follow-up of clients, care-givers’ reluctance to interfere in clients’ situations after a treatment episode as other services may be involved, and few strategies to deal with so-called ‘revolving door clients’. Finally, several key informants stressed the necessity of enhancing coordination of care at client and structural level, and – to a lesser extent – of providing more continuous services (Vanderplasschen et al., 2002).

Similar observations arose from focus groups that we have organised with clients who had contacted these treatment agencies (Vanderplasschen & De Wilde, 2002). Clients’ personal stories illustrated the necessity of more individualised and comprehensive treatment, adapted services in various stages of their addiction career, involvement of stabilised or recovered drug users in treatment services, better accessibility of services, and more information about and participation in the treatment process.

During two consecutive utilisation studies, we analysed the nature and extent of multiple service utilisation in specialised substance abuse agencies in the region of Ghent (Vanderplasschen et al., 2001a; Vanderplasschen et al., 2003). The first study showed that one quarter (27%) of all treatment demands concerned clients that asked twice or more for treatment during the eight-month registration period (Vanderplasschen et al., 2001a). Further analyses revealed that almost 20% of the clients had been registered twice (12%) or more (7.5%), and that 15% of all clients had been registered in at least two different agencies. During the second study (six-month registration period), we identified
1,500 unique clients in 18 different treatment agencies, of whom 19.1% had had at least two intake assessments during the registration period (Colpaert et al., in press; Vanderplasschen et al., 2003). The percentage of substance abusers that had started treatment in three or more agencies within the six- and eight-month registration period was estimated to be 2.9% and 4%, respectively (Vanderplasschen et al., 2001a; Vanderplasschen et al., 2003). Although these cases do not represent a numerically large group of substance abusers (n<50), this subgroup was involved in 9.9% and 14% of all registrations during the respective registration periods.

Finally, we set up a small-scale study among substance abusers with multiple and complex problems (n=24) in therapeutic communities and other (residential) treatment agencies in order to improve coordination and continuity of care (Vanderplasschen et al., 2001b). This study revealed that intensive case management contributed significantly to participation and retention in treatment and indirectly to the reduction and stabilisation of substance use and legal, employment, and family problems. According to the case managers, this intervention led to increased coordination and communication between all agencies involved and was best suited for clients with multiple problems and/or in contact with multiple services (Vanderplasschen et al., 2001b).

1.3 Towards more coordination and continuity of care

These empirical findings concerning the organisation of treatment and aspects of quality of care revealed a lack of cooperation and communication between treatment agencies. Moreover, it appeared that case management can be a valuable addition to the existing offer of services (Vanderplasschen et al., 2001b; 2004b). Following these observations, two interventions that aim to provide coordination and continuity of care for multiple and frequent service users were developed in the region of Ghent: structural inter-agency care coordination and intensive case management. The first intervention includes tri-weekly meetings of care givers from specialised treatment agencies (e.g. five detoxification and/or crisis units, three outpatient centres, one shelter for homeless persons) to discuss and monitor admissions and referrals of and services delivered to shared clients. Therapeutic communities and other long-term residential programmes are not directly involved in these care coordination meetings, but they are represented by their detoxification unit or induction team, as admissions are always assessed in these services. Each time some 30 clients are discussed who are currently in contact with at least two of the treatment agencies involved, resulting in a common strategy/solution to deal with these persons’ situations.

Intensive case management is characterised by a comprehensive, individualised and continuous approach, assertive outreach and provision of direct services by one single case manager (Vanderplasschen et al., 2004b; SAMHSA, 1998). Case managers support clients' functioning in the community and their appropriate use of helping resources and attempt to improve coordination and communication between services. Based on a thorough assessment of clients'
situations, case managers develop or amend an individualised treatment plan that outlines specific activities intended to move clients towards desired goals (Moxley, 1989). They link clients with the services they need, coordinate the interventions provided by different agencies and monitor the treatment process. Case managers further advocate for their clients when services are not readily available, e.g. in case of waiting lists or legal or housing problems. Assertive outreach means that case managers meet with clients in their own living environment (e.g. at home, at work, at a treatment agency, in prison); also, unexpectedly. Case managers ensure that clients receive the services specified in the treatment plan and keep track of compliance and progress towards specified goals (monitoring) (SAMHSA, 1998).

Both interventions should fit into an evolution towards the integration of treatment services for various mental health populations (including substance abusers) in Belgium, which is encouraged by federal and regional authorities (Vanderplasschen et al., 2004a; Broekaert & Vanderplasschen, 2003). An integrated treatment system refers to all treatment programmes – consisting of various modules – organised by a network of agencies that represents all necessary treatment services for a certain target group (i.e. substance abusers) and guarantees continuous and individualised care (Nassen, 1999). In each region, a care coordinator has been appointed to stimulate cooperation and coordination in the field of substance abuse treatment and to facilitate the establishment of an integrated treatment system. In addition, a formal steering network representing all treatment agencies was established in the region of Ghent, in order to optimise the organisation of existing services, to meet the treatment needs of specific target groups more adequately and to discuss the development of new initiatives and services.

1.4 Aims of the study

We assumed that both interventions (inter-agency care coordination and intensive case management) would decrease multiple service utilisation and lead to more individualised and continuous care. Because case management is an intensive and specialised intervention, additional improvement was expected concerning clients’ situations, treatment participation and retention, quality of life, and satisfaction with the intervention received.

A randomised and controlled study was set up to answer these research questions. In this paper, we discuss some preliminary findings of this ongoing study, based on six-month follow-up interviews with case managers/care coordinators and the first 20 clients who participated in the case management and care coordination group (September 2003–September 2004). We focus on the results of interviews with clients and case managers, since we want to explore how the persons directly involved experience this innovative intervention themselves. Clients’ views are often ignored in treatment evaluation, although these may provide invaluable information for tailoring services to clients’ needs, which has been positively associated with treatment outcomes (Brun & Rapp, 2001; Hser et al., 1999; Drumm et al., 2004).
2. Methods

The sample of this study consisted of multiple and frequent service users in need of comprehensive care because of the complexity of their situation and whose case was discussed at an inter-agency care coordination meeting between September 2003 and September 2004. Formal eligibility criteria were: substance dependence for more than two years according to DSM IV criteria (APA, 1996), problems in at least three life domains of the Addiction Severity Index (McLellan et al., 1992), a minimum of three previous treatment episodes and recent contacts with two or more specialised centres for substance abuse treatment. In order to be eligible, clients had to give informed consent for participation and could not be followed by another case management programme. Clients who followed or planned to start long-term residential treatment or who had a place of residence outside the region of Ghent could not be included. Both of these categories were excluded because the previous study had shown that the former situation led to less intensive contacts with and limited authority of the case manager, while the latter scenario was not practical, inefficient and time-consuming (Vanderplasschen et al., 2001b).

All eligible persons were randomly assigned to the case management or control condition (care coordination). Due to the small number of case managers (two FTE) and the low caseload, data collection was spread over a three-year period in order to collect data with sufficient statistical power (n≥200). In this paper, we solely focus on the data from the first 20 clients that participated in the case management and care coordination condition.

Several data sources (e.g. EuropASI (Broekaert et al., 2002), Symptom Check List 90-Revised (SCL-90-R) (Derogatis & Cleary, 1977), TCU Motivation for Treatment (MfT) scales (De Weert-van Oene et al., 2002), semi-structured interviews with clients and case managers/care coordinators, case managers’ logbooks) were used to monitor clients’ situations and quality of life at baseline and follow-up interviews after six, 12 and 24 months. Case managers were consulted regularly about their activities, the evolution of clients’ situations and their contacts with services. Client interviews focused on service utilisation, treatment participation and satisfaction with the services received. Clients were further interviewed about their subjective perception of their situations, their level of functioning on various ASI life domains and what they liked and disliked about the intervention.

Given the initially small sample size and the focus on clients’ and on case managers’/care coordinators’ perspectives concerning both interventions, we only report qualitative data in this paper. The qualitative interviews were coded and analysed based on a hierarchical coding structure, using the software package WinMAX 98 Pro for text analysis (Kuckartz, 1998). From the comparison of coded text-segments, several important themes emerged, which are discussed below.
3. Results

All but one of the case-managed clients evaluated this intervention ‘positively’ (n=11) or ‘very positively’ (n=8). Nearly all clients (n=16) stressed that they appreciated the close and confidential relationship with their case manager and the fact that they were able to arrange quite a few things for them (e.g. accommodation, paid work). They emphasised that the case manager had helped them to link with appropriate services and to stabilise their situation (n=10). Overall, case-managed clients (n=11) were happy with the comprehensive and client-oriented approach, with the fact that they were involved themselves in the treatment process, and that they could decide what to focus on. Clients (n=7) were appreciative of the fact that the case manager supported them in achieving their goals and that they could always rely on the case manager when they needed to.

Clients from the care coordination group were less positive about this intervention, since most of them (n=12) were undecided about its value (‘not satisfied, not unsatisfied’). Still, the number of clients that evaluated care coordination negatively was low (n=3). Clients (n=7) appreciated that clear arrangements were made between care-givers from different agencies, leading to smoother transitions in their treatment process. However, clients themselves were not (or only minimally) consulted about the further steps to take in this process. Some clients (n=5) said they liked in particular that they didn’t have to tell their story over and over again. They appreciated that the current treatment episode built further on arrangements and achievements from previous treatment episodes. After all, most persons (n=14) stated they could not observe many differences between the care coordination condition and the services they received before. If available, they expressed that they would welcome more individualised support from a case manager.

Both groups of clients utilised various services (e.g. substance abuse, medical, employment, social services) during the first six months that the intervention was started up. It appeared that the case management group had more contacts with services (four to five contacts) than the care coordination group (two to three contacts). While contacts of the care coordination group mainly concerned substance abuse treatment agencies, case-managed clients had in addition more contacts with ancillary services (e.g. housing and employment services, child care). More clients from the case management group engaged for long-term residential treatment, while clients from the care coordination group were rather retrieved in outpatient and short-term residential treatment agencies.

Care coordinators reported improved deliberation, coordination, and communication preceding and initially following clients’ intake/admission, but further follow-up and monitoring of clients appeared to be hardly feasible. In addition, case managers found that this intervention contributed to more individualised and continuous care. Attrition in the case management group was minimal, as only one client was no longer in touch with his case manager after six months.
Most case-managed clients thought their drug (n=14) and employment problems (n=11) had improved, while fewer persons found their situation had changed in other life domains. According to the case managers, the global situation of 11 clients had improved after six months, while the situation of five persons was stabilised. In three cases the situation remained unchanged and one person’s situation deteriorated completely. Case managers observed positive effects where it concerned drug use (n=13), physical health (n=12), and employment (n=11), while adverse outcomes were noted concerning clients’ judicial status (n=7).

Among the care coordination group clients’ functioning had improved to a lesser extent after six months, since only eight persons found their alcohol and/or drug problems were less severe. Moreover, clients’ situations in other life domains seemed to be less affected. The care coordinators involved judged that the global situation of seven clients had improved six months later, the situation of five persons was stabilised, and eight cases remained unchanged. Most positive outcomes concerned clients’ alcohol and drug use status (n=9) and their physical health (n=8).

4. Discussion and conclusion

From this qualitative analysis, it appears that case management is viewed as an effective and valuable intervention by the persons directly involved (clients and case managers). Based on findings from the literature (Cox et al., 1998; Rapp et al., 1998; Vanderplasschen et al., 2004b), it may be expected that the quantitative study will demonstrate that this intervention is (relatively) effective for linking clients to treatment and ancillary services and for reducing drug, housing and employment problems. According to case managers’ logs, these were the main domains/activities on which case managers focused. Also, care coordination generated some positive outcomes, which were mainly recognised by care coordinators rather than by clients. Overall, case-managed clients were satisfied with the support provided, e.g. the confidential relationship, comprehensive and client-oriented approach, and longitudinal scope (cf. Brun & Rapp, 2001). According to the case managers, this intervention contributed substantially to the coordination of care and the provision of the right services at the right time. The benefits of care coordination should rather be situated at the level of improved deliberation, coordination and communication concerning the treatment process.

Clients’ and case managers’ ratings show that intensive case management may help to improve drug and employment problems and to link multiple and frequent service users with the services they need (Braucht et al., 1995; Stahler et al., 1995; Cox et al., 1998; Drake et al., 1998; Rapp et al., 1998; Okin et al., 2000). The effects of care coordination are mainly limited to temporarily attuning the interventions from different agencies. In case intensive and continuous monitoring is indicated, case management seems to be more appropriate. Therefore, a clear link and referral options should be available between both
conditions, in order that those with minor and temporary problems and those with more chronic problems can be allocated to the right condition.

4.1 Prerequisites for successful coordination of care

These preliminary results support our basic assumptions and illustrate the improvements made concerning the coordination of care in (residential) substance abuse agencies in the region of Ghent. Since we started in 1997 to work towards more collaboration and cooperation in the field of substance abuse treatment, which aspects have been identified as important gains and prerequisites for success?

Implementation of case management

The introduction of case management contributed to enhanced participation and retention in residential treatment (e.g. in therapeutic communities) and to increased utilisation of ancillary services (Vanderplasschen et al., 2001b). Substance abusers monitored by a case manager rather entered and continued long-term residential programmes, illustrating the role of the case manager in motivation and advocacy (Brun & Rapp, 2001). During the residential treatment episode the contribution of the case manager was limited, but became very important once reintegration into society was prepared. Moreover, case management played a role in reducing the number of crisis situations and short-term hospitalisations and in improving quality of life among case-managed individuals. Finally, the comprehensive approach resulted in contacts with various types of (ancillary) services that are coordinated and monitored by one single person.

Deliberate conceptualisation and robust implementation of case management have been identified as powerful determinants of successful outcomes (Jerrell & Ridgely, 1999; Perl & Jacobs, 1992). Based on our experiences and contacts with projects in the United States and The Netherlands, we withheld six key questions that need to be addressed before implementing case management (Vanderplasschen et al., 2004b).

1) Which problems will be addressed with this intervention and what are the objectives and target group?
2) What is the position of case management in the system of services and how will cooperation and coordination between services be enhanced?
3) What model of case management and which of its crucial features will be utilised?
4) Which qualifications and skills are required and which support will be provided for the case managers?
5) How will the project be financed and how will its continuity be guaranteed?
6) Which standards will be used to evaluate the intervention?
Unfortunately, the implementation of case management has also been accompanied by some difficulties. Due to the focus on clients with multiple and complex problems, case managers’ time investment was high and their caseload relatively low. Since case management was implemented as an independent service provided by the network of treatment agencies, not all agencies were eager to refer clients to this new service or only referred their ‘most problematic cases’. Consequently, case managers needed to do a lot of direct interventions, hardly realised long-term planning, dealt with a caseload with little turnover and had an increased risk of burnout (Yates & Gilman, 1990; Wolf et al., 2002). Finally, the continuity of the project remains uncertain as the continuation of the project is decided on a yearly basis.

To counter the above-mentioned financial issues (partial), pooling of human and financial resources by various treatment agencies seems a good alternative, as it will allow the continuation of this project over time despite high costs and a limited caseload (Vanderplasschen et al., 2004a). As the project addresses substance abusers who often fall through the cracks of the treatment system, it is important to continue these efforts, but at the same time to try to link them more quickly with usual care and ancillary services. In addition, this system of pooling resources may strengthen the involvement of the participating agencies in and increase the likelihood of referral to the case management project. To address the problems concerning planning, lack of turnover and burnout, we plan to implement a strengths-based model of case management, in which clients’ strengths and resources, client-oriented planning, self-direction and emancipation, and the use of informal help networks are central issues (Brun & Rapp, 2001). This intervention is not only very much appreciated by clients and case managers, but also some evidence of its effectiveness has been demonstrated (Vanderplasschen et al., 2007). Consequently, the implementation of strengths-based case management – and of case management in general – meets the call for more evidence-based practice in Belgian and international substance abuse treatment (Amodeo et al., 2006; Broekaert et al., 2002).

The integration of treatment agencies into a network of services

Success of case management largely depends on its integration in a comprehensive network of services (Graham et al., 1995; Ashery, 1996; Wolf et al., 2002). If this intervention is not exquisitely sensitive to potential system-related barriers such as waiting lists, inconsistent diagnoses, opposing views, and lack of housing and transportation, it risks being just one more of the fragmented pieces of the system of services. Therefore, case management was implemented as one of the crucial components of an integrated treatment system to monitor and coordinate the trajectories that clients follow (Drake et al., 1998; Vanderplasschen et al., 2004a). Such a functional and client-centred – rather than institution-based – organisation of substance abuse treatment includes more guarantees for offering clients the type of treatment they need at a certain moment.
Implementation of an integrated treatment system is recognised as a long-term process that is preceded by the development of a common language and approach, the theoretical conceptualisation of what this integrated system should entail, and an inventory of available and needed services, based on clients’ treatment needs (Vanderplasschen et al., 2004a). Monitoring and evaluating will be necessary to assess if this alternative organisation of treatment services allows the realisation of the postulated goals (e.g. comprehensive and continuous care, efficiency of service delivery, increased transparency and flexibility, and client satisfaction) (de Weert-van Oene & Schrijvers, 1992; Wolf, 1995).

Respect for the treatment philosophy and approach of all partners in the network has been identified as a crucial prerequisite for establishing an integrated treatment system (Broekaert & Vanderplasschen, 2003). A win-win situation should be created in order to convince all partners to participate in such a network, e.g. by making clear arrangements concerning time-out, differentiation of treatment services. This system change should be implemented and extended gradually; for instance, based on functional cooperation concerning certain aspects of care such as crisis care, reintegration, or treatment of dually-diagnosed individuals. A neutral and independent coordinator at regional level is needed to facilitate this changing process. Other decisive factors that we have observed were the (partial) reimbursement of agencies for staff members participating in coordination meetings and scientific research to objectify and evaluate the alternative organisation of services. Finally, the biggest challenge that we still face is the transformation of the present-day subsidising system, since our ‘fee for services’ system stimulates competition rather than cooperation between treatment agencies.

The organisation of care coordination meetings

Besides the implementation of case management and the establishment of an integrated treatment system, the care coordination meetings with care givers from various treatment agencies have been an excellent tool to foster collaboration between the agencies involved and their staff members. As these meetings are held alternately in another treatment agency, care givers can learn more about the intake procedures and treatment regimens of these agencies and also learn to know their colleagues from other agencies better. In addition, mutual staff exchanges have been organised with the same intention. These care coordination meetings have contributed to improved cooperation between agencies and to better attuned services at the time various agencies are involved. One of the challenges for the future is to involve clients more in this process of care coordination and to strengthen the legal basis of these inter-agency and interdisciplinary meetings, since professional secrecy and privacy regulations may hinder such exchange of information. A clear framework needs to be created, based on clients’ informed consent, in order to have a solid basis to communicate ‘need to know’ information in clients’ interest.
4.2 Conclusion

Based on our experiences in the region of Ghent, we propose a dual strategy to improve coordination of care in (residential) substance abuse agencies. On the one hand, a comprehensive framework (e.g. an integrated treatment system) is necessary to enhance cooperation between treatment agencies, to guarantee accessibility and availability of services, to avoid double work and to be able to meet substance abusers’ divergent treatment needs. On the other hand, specific interventions may be needed to help those with (long-term) problems on several life-domains and in need of various services. Intensive case management is such an intervention that contributes to increased treatment participation and retention, more individualised and continuous care and adequate linking with substance abuse and ancillary services. Although its direct impact on clients’ functioning should not be overestimated, clients themselves think of it as a valuable addition to existing services. Inter-agency care coordination is regarded as a complementary intervention since it helps care givers to attune the interventions by different treatment services. In case intensive monitoring and continuous care are needed, case management will probably be a better alternative.

Acknowledgements

We would like to thank the Province of East-Flanders [Provincie Oost-Vlaanderen], the Regional Board on Mental Health Care [PopovGGZ], the City of Ghent [Stad Gent], and the Medical-Social Care Center (Ghent) [Medisch-sociaal Opvangcentrum voor druggebruikers van de Stad Gent] for their financial and logistic support.

References


Application of Cognitive-Behavioural Therapy in a Therapeutic Community for Drug-Dependent Individuals

Peter Vassilev and Teodora Groshkova

ABSTRACT: This paper describes the establishment of TC Phoenix in Bulgaria. The paper describes the process of founding and developing a classic hierarchical TC and the contribution of this initiative to the TC movement. The authors, in addition, elaborate their introduction of cognitive-behavioural therapeutic techniques and examine the ways in which the two models can be adjusted to complement each other.

Introduction

The period 1990–2000 saw an epidemic spread of drug misuse in Bulgaria. According to expert estimations made by the Ministry of Health, the number of people misusing heroin in 2000 was between 20,000 and 30,000. The figures for cocaine and cannabis were 5,000–10,000 and 80,000–110,000, respectively. Regular amphetamine users were said to be between 10,000 and 15,000. The misuse of heroin in Bulgaria became a real and significant public health issue. The rate of intravenous users infected with hepatitis C dramatically increased, reaching 70% in 2001. The epidemic spread of drug misuse has led to increased demands on the national health system. The number of drug misusing clients in residential or inpatient treatment increased more than six times during the period 1990–1999. In this context, a major priority for national drug policy was the development of a national programme for prevention, treatment and rehabilitation of drug dependence (2001–2005) and a national strategy for combating drugs (2003–2008). A concrete action plan was also required and developed. With regard to rehabilitation, a set of
Regulations was issued by the Ministry of Health in 2000 setting rules for the establishment and conduct of rehabilitation programmes.

**Theoretical framework**

The Therapeutic Community (TC) is both a model and a treatment approach for people with substance abuse and related problems (De Leon, 2000). The TC model comprises specific elements that include structured community living to integrate work, education, treatment and other activities in a therapeutic milieu that occurs 24 hours a day, seven days a week. Within the TC structure, residents are taught the tools to learn how to hold each other accountable at all times – in groups, at work, or during leisure activities. The 24/7 milieu reflects the need to change the whole person and their lifestyle, and the depth of the change requires ongoing, constant attention and work.

The primary approach to treatment is ‘community-as-method’. Residents live together in a drug-free environment, organised and structured in order to promote changes in attitudes, perceptions, and behaviours associated with drug use and to make possible a drug-free life in the outside society. In addition to the importance of the community as a primary agent of change, a second fundamental TC principle is ‘self-help’. Self-help implies that residents are the main contributors to the change process. ‘Mutual self-help’ means that individuals also assume partial responsibility for the recovery of their peers – an important aspect of an individual’s own treatment.

TC Phoenix programmes have a solid grounding in the existing professional literature that describes the TC theory and treatment model. Programme activities are logically linked to the theoretical foundation of addictive behaviours change. The treatment fully integrates TC procedures (clinical groups, community meetings, vocational and educational activities, and community and management activities) and cognitive-behavioural (cognitive case formulation and relapse prevention) procedures.

**Historical background and overall structure of TC Phoenix**

TC Phoenix was established by Dr Peter Vassilev and his team in 2001. It started with a group of four residents, which gradually increased to eight. Since the beginning of 2002, the TC has been working with its full capacity – a case-load of 30 residents. Step by step, it was thus possible to develop the hierarchy, expectations, values and culture of the TC.

In 2002 TC Phoenix became a member of the Association of Therapeutic Communities (ATC) and was involved in the Royal College of Psychiatrists’ research project ‘Community of Communities, A Quality Network of Therapeutic Communities’. In 2003, the TC became a full member of the European Federation of Therapeutic Communities (EFTC). In May 2003, close collaboration was established with Ley Community, Oxford, UK in terms of training, exchange of residents and traineeships for clinical staff. As of the present moment, eight people from TC Phoenix, Bulgaria (six staff members and three residents) have
undergone practical training at the Ley Community. In September 2003 Anthony Slater, President of EFTC, made a work visit to TC Phoenix. The same year contact was established with TC Phoenix Haga, Norway, KETHEA, Greece and Trempoline, Belgium. This provided opportunities for improved ongoing staff training and integration of the experience of European colleagues. For example, in 2003 two people (one staff member and one resident) from Phoenix, Bulgaria went through the one-month training of rehabilitation at Phoenix Haga.

The programme of TC Phoenix is highly structured, with clear rules, hierarchy, and daily regimen, balancing work, therapy and recreational activities. The length of the programme is 14 months, divided into four stages: Orientation, Primary treatment, Re-entry and Resocialisation. The primary, distinct, yet overlapping categories of activity at Phoenix are as follows: behaviour shaping, emotional growth, intellectual development, vocational skills training and medical management. The Resocialisation programme was started at the beginning of 2003. Following a successful application for funding during the period 2003–2004, the programme was financially supported by the UK Department for International Development (DFID).

**Staff selection and qualifications**

TC Phoenix staff are qualified and committed to the programme. Many of them have had prior professional experience working with drug-dependent individuals. Staff consist of one psychiatrist working at the Admission centre, seven psychologists (BSc and MSc in Clinical Psychology), two social workers, a psychiatric nurse, and four ex-residents working as volunteers. Two of the staff members are licensed cognitive-behavioural therapists. All of the staff have undergone specialised training in the therapeutic community model.

The TC is staffed at all times (including evenings and weekends). While the responsibility of carrying forth the community is placed on residents and the TC is ultimately reliant on residents’ internalisation of the concepts learned and the desire to change, they are a group of individuals who have long histories of poor decision making and poor impulse control. To effect the cognitive and behavioural changes necessary in many aspects of their lives, a broad plan of staff coverage is effectively in place.

**Therapeutic approach and interventions**

*Community as method.* The therapeutic approach consists of the group and its rules, the culture and expectations. The educational process is a built-up system stimulating positive behaviour and giving a negative response to unacceptable behaviour from the residents. It provides goals and meaning for moving up in the hierarchy of the programme. Each move upward brings more opportunities for learning.

An important aspect of the programme is the *individual treatment plans*, including residents’ main problem areas, treatment goals and an outline as to how problems will be resolved within the therapeutic milieu. At programme
entry, each resident is allocated a referent – a staff member who is completely engaged with the individual treatment plan of the resident. They both work together on developing the treatment plan, following it whilst the resident remains in the programme as well as preparing them for entering the programme for Resocialisation. The referent also serves as a main source of support for the resident when it comes to developing the cognitive formulation as well as coping with difficulties in the therapeutic process.

**Common themes of recovery at therapeutic community Phoenix**

At a minimum, residents in the beginning of the programme learn how to overcome the strong cravings common in early recovery and how to identify and avoid the triggers that can prompt dropout and subsequent relapse. They accomplish the challenging task of learning to identify the cycle of thoughts, emotions, and behaviours that act as triggers, and develop coping strategies. This task is undertaken during a period which is frequently emotionally turbulent. Painful feelings associated with acknowledging the harm one may have done to others, or suffered at the hands of others, can be particularly strong, especially when powerful cravings are present, and the person in recovery needs to develop new strategies to cope with these powerful feelings, as well.

Cognitive restructuring, social skills training, and participation in the therapeutic community rituals and groups are some of the strategies and techniques for learning new behaviours. Other key components in sustaining recovery are learning to identify personal stressors; developing a personal approach to stress management, self-care and self-efficacy; and practising these skills through the everyday community tasks and activities.

Other important tasks are: addressing powerful feelings of grief, loss, shame and guilt about the past; and facing one’s fears and apprehensions about the future. When these feelings are not dealt with, they can linger, adversely affecting relationships and self-esteem, as well as hampering the ability to accomplish the tasks of daily community life and develop or regain a sense of competence. A strong sense of competence helps to facilitate the development of effective cognitive processes and increases performance in a variety of areas of life.

Another important task that is addressed in most individual treatment plans is that of developing a healthy sense of autonomy in order to establish and maintain personal boundaries and to establish healthy relationships. Learning to resolve the tension between the desire for closeness and establishing appropriate distance is necessary to preserving personal relationships and establishing and maintaining new ones.

As recovery continues to progress, priorities often shift to achieving important but less urgent goals. This change in focus may come about naturally, as confidence in one’s ability to sustain recovery grows. Educational or career development goals may emerge, as well as a desire to address unresolved family issues.
The task of building a network of social support is perhaps the most challenging part of continuous recovery work. At the centre of the web is the person, whose own sense of self-worth may be fragile and who may be overwhelmed by demands to reprocess – and sometimes reconfigure – the internal dynamics related to his or her most important relationships. He or she may have many social skills and healthy relationships to fall back upon, or may have few. As one moves out from the centre to family and other intimate relationships, peers, and the larger community, he or she will find many resources that support recovery. At the same time, the individual will encounter others that undermine recovery, and will be put to the task of distinguishing between them and deciding which fit comfortably with his or her newly recovering self.

Reconnecting with – and sometimes disconnecting from – friends, acquaintances, and colleagues are important goals during Resocialisation. Making decisions about reconnecting and coming to terms with necessary separations constitute challenges because bonds of love and deep human needs are often involved. For the same reasons, cultivating strong and healthy new relationships is rewarding and contributes to a recovery that endures. One mark of mature recovery is completion of these processes.

Some residents need to learn new skills to survive in the larger society. They need help in becoming employable, finding work, assuming the role of employee, finding suitable housing, and even acquiring basic skills such as learning how to prepare a meal. Many need to learn, or re-learn, how to socialise without alcohol or other drugs as a social lubricant. Some are challenged to develop a healthy sexual life that is not intimately connected to drug use.

Liberated from their dependence, residents often return to school to complete their education and go on to pursue more advanced education and other professional goals. Others become interested in simply expanding their personal knowledge. Many take up expected family roles – son or daughter, spouse or partner, parent or grandparent – that they formerly ignored. Some do this within their pre-recovery family structures, while others do so within new family arrangements or in other constructions of interpersonal relationships.

Success at an expanding array of life tasks and the assumption of new or enhanced roles in the community – as they are identified and defined by the person in recovery over time – both derive from and contribute to sustained recovery. Those without emotional and financial resources or social supports and skills to accomplish new or enhanced tasks and roles need a great deal of support from others to achieve their goals.

Cognitive-behavioural therapy (CBT)

From a cognitive-behavioural perspective, individuals begin to use drugs as compensatory strategies associated with maladaptive beliefs. An important advantage of a CBT intervention is that the psychological, emotional and behavioural issues implicated in the factors leading to substance misuse can be described, or ‘formulated’, thus informing an intervention (Persons, 1989).
Residents and their referents work together to identify and understand problems in terms of the relationship between thoughts, feelings and behaviour. The approach focuses on difficulties in the here and now, and relies on the referent and resident developing a shared view of the individual’s problem. This then leads to identification of individualised, time-limited goals and strategies which are integrated in the individual treatment plan; they are achievable through a resident’s active participation in the daily community activities and are continually monitored and evaluated. The approach is inherently empowering in nature, the outcome being to focus on specific psychological and practical skills, such as reflecting on and exploring the meaning attributed to events and situations that occur in the community and re-evaluation of those meanings. It is aimed at enabling the resident to tackle their problems by harnessing their own resources. The acquisition and utilisation of such skills is seen as the main goal, and the active component in promoting change with an emphasis on putting what has been learned into everyday practice. Thus, the overall aim is for the individual resident to attribute improvement in their problems to their own efforts, with the assistance of the peer group, and in collaboration with staff members.

As part of their treatment, residents at Phoenix develop and present an individual formulation – a description of the problem within the CBT framework. The cognitive formulation integrates information about a resident’s early development, schemas, stimulus situations, emotions and maladaptive behaviours. This link between the cognitive and developmental profiles is based on the cognitive-developmental model of substance abuse (Beck et al., 1993). The main purpose of the cognitive case conceptualisation is raising awareness about an individual’s dysfunctional mechanism. A final point in the process of development of the conceptualisation at Phoenix is an established procedure: each resident presents in front of the whole community their hypothesis for the development of problem substance use.

All activities and interpersonal and social interactions at Phoenix are considered important opportunities to facilitate residents’ individual change. Treatment methods include clinical groups (encounter group, static group, goal group, personal growth, relapse prevention group, and groups by similarity) to address significant life problems and specific issues, community meetings (morning, daily house, and general meetings and seminars) to review the goals, procedures, and functioning of the TC, vocational and educational activities to provide work, communication, and interpersonal skills training, and community and clinical management activities (systems of privileges and behavioural sanctions, learning experience, house ban, and daily house runs) to maintain the physical and psychological safety of the environment and ensure that resident life is orderly and productive.

The process of change begins when negative behaviours are blocked by the programme rules. As a result, intense feelings of anger, pain, fear, and frustration surface. Once these emotions are expressed and validated by the groups, the true therapeutic work can begin. Groups offer residents the opportunity to identify their feelings and thoughts, what behaviours have and have
not been helpful, the coping strategies that have interfered with incorporating new behaviours and, finally, an opportunity to plan new roles and behavioural tasks that are rehearsed within the TC milieu. As much as possible, the feedback that each resident receives comes from other residents, for this emphasises an empowerment that also supports other residents’ sense of self-efficacy, and personal responsibility for their treatment.

Moving through the programme includes further practice of cognitive-behavioural therapy. Self-awareness is built through developing of the case conceptualisation, which links personality with drug use. Participation in relapse prevention (RP) groups, based on the cognitive-behavioural model for RP (Marlatt & Gordon, 1985) provides additional learning and practice of new skills through role-play work and application of skills in present-day situations. Some of the components, such as assertiveness training or cognitive restructuring, teach coping methods for specific types of situations: managing negative emotions, interpersonal conflicts etc. Others, like leisure education, assist the residents in developing more global strategies to manage stress and develop a balanced lifestyle. A final element in the process of change is overcoming of behavioural deficit, determined by suppressed fears from childhood.

Conclusion

Our informal clinical observations suggest that application of cognitive-behavioural procedures within the TC milieu has potential advantages over each approach singly. For example, the 24/7 nature of the TC milieu provides an excellent environment for intensive modelling and practising of cognitive-behavioural skills based on a constant feedback loop from the peer residents group. Similarly, the cognitive-behavioural skills present a practical format for social interactions and problem-solving that facilitates the day-to-day running of the TC.

The factors that we consider critical for early engagement of a new resident in the programme are: the maturity of the group – whether it demonstrates an open attitude towards a new member; the degree of behavioural change and personal growth of senior residents; and the efficacy of socialisation of the new resident in the TC model. In addition, essential in the process of change are the explicit expectations for personal growth, which are set up criteria for the transition from one hierarchical level to another; these expectations are inherent to every element in the therapeutic milieu (the messages of staff members, community procedures, and rituals).

References

Ten Years of the Therapeutic Community,
Casa Oberta (Open House)

Bartomeu Català

ABSTRACT: This paper describes the origins of a distinct client population of the TC Casa Oberta, which was established by Projecte Home Balears in June 1996. This organisation is a publicly-owned entity belonging to the Gobierno Insular of Mallorca. The TC has a number of characteristics that make it quite distinctive. In the first place, it is a harm reduction TC, since it admits not only users who are treated with methadone or users with a dual pathology, but also users wishing for a drug-free treatment. What makes Casa Oberta different from other substitute-prescribing maintenance programmes is the fact that in this TC we propose to go further than just the harm reduction; offering the possibility of following a personal growth programme within the atmosphere of a Therapeutic Community. This type of community unites the two therapeutic approaches: the one of the drug-free TC together with the harm reduction programmes based on substitutes maintenance.

Introduction

Casa Oberta was established because, in the mid-1990s, we found that we had a residual population that did not take advantage of the treatment provided by the TCs and that this population was serviced largely by methadone maintenance programmes. These programmes help to reduce harm but, being very limited therapeutically, they maintain the problem although it is controlled. Using these programmes, heroin consumption could be controlled and also the risk of transmission of diseases through intravenous consumption was reduced. Other problems such as those of law and order and medical health improved, but the realities told us that consumption of other drugs remained or even increased.

The challenge was to be able to offer to these people the possibility of obtaining a personal autonomy and a social reintegration, beyond the fact of their continuation or not in the methadone maintenance programme, and having also the possibility of access to other programmes with higher exigency.

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therapeutic communities, 28, 1, spring 2007
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Methadone permitted these users to access this type of treatment since it gave them a first point of stability, and the TC with its personal growth programme gave them resources to face a decrease of the methadone that can reach zero. The decrease was not an objective, but it was and is a consequence of the personal growth programme.

These users access Casa Oberta (managed by a private entity as Proyecto Hombre) through the relevant public services. The conjugation of the public with the private permits us to add the advantage of the universal treatment which is the other advantage of a personalised, long-lasting treatment. Networking is becoming a reality, each one contributing with their proper treatment, creating a continuum in the attention.

Profile of the users

Over the past ten years 340 persons have attended. The following data provide a profile of the characteristics of these users during this decade, giving a more detailed understanding of the services offered at this Community.

Most attendees are men (86%) with an average age of 33 years. With regard to the physical condition of the users of the TC, the percentage of people having sometimes been infected by hepatitis or by HIV has gradually diminished. During the first years these infection rates were measured at 91% and 46% respectively. More recently, these rates have dropped to 55% and 25%. The majority (72%), nevertheless, have some kind of physical or mental problem which requires treatment, sometimes lifelong.

Generally (89%) they are poly-consumers, with their principal drug of choice generally being heroin and/or cocaine. Most prefer the intravenous injection of these drugs. During the first years, the vast majority of clients administered drugs in this way. Lately, however, the intravenous consumption route has been significantly reduced, although this appears to be a relatively unstable health gain and within the past year there has been an increase again to a rate of 88%. This development coincides with a tendency for the client profile to increasingly include older drug consumers with a longer case history of consumption and who began early with parental injection. Contrary to popular conception, intravenous consumption is still significant, even if it is true that the consumption habits are changing and people are now smoking heroin; a practice which was rarely seen in the Balearic Islands when we started the Projecte Home Programs.

The average age of initiation into drug use is around 14 years, starting normally with alcohol and cannabis. When they enter the TC the average history of consumption is around 14 years of cannabis and 11 years of heroin and cocaine. Thus, Casa Oberta caters mainly for long-term consumers with an important range of negative consequences derived from this lengthy history of misuse.

The users of Casa Oberta throughout these ten years can also be characterised by the important deficits in their social structure. In general, they report few social supports when they commence treatment. After so many years of addiction and numerous unsuccessful attempts at recovery, they have lost on
the way the family and the friends they had. However, in many cases (as time goes by and the users are recovering), many of them re-institute contact with family relations and family members start to involve themselves in the treatment. In Projecte Home we work alongside the families and these interventions are seen as very much a part of the treatment objectives, so this re-establishment of the family relations is not surprising. It is also the case, though, that some 10% to 20% of our treatment population have a brother, father or mother with alcohol, drug or psychiatric problems, so we are facing a complex family situation that makes it difficult in many cases to stabilise the support to our users.

Another important aspect of the profile of the people attending during these ten years is the offending history of many of them. The percentage of users having been imprisoned for drug consumption or related crimes has been oscillating between 25% and 60%.

Equally remarkable is the level of dual diagnosis or psychiatric comorbidity amongst those attending the TC during this period. From the outset, the presence of people with mental health problems, primarily or secondarily related to the addiction problem, has been significant. The percentage has always been around 50%; at least one in two present a psychiatric pathology susceptible to treatment.

**Comparison between three different programmes**

The profiles of this cohort were compared to those of regular users of other programmes to afford a more complete picture of the population treated at Casa Oberta. (All figures relate to treatment populations in treatment during 2005.)

**Medical issues**

The percentage of users of Casa Oberta with physical diseases associated with drug consumption was far higher than was the case for those using the Traditional Programmes (this classification refers to the classic TC of Proyecto Hombre Traditional Program, which includes the Reception Center, TC and Re-insertion Center) and for Horabaixa (an ambulatory evening programme, with minimal structure for people presenting with cocaine misuse problems):

<table>
<thead>
<tr>
<th></th>
<th>CASA OBERTA</th>
<th>TRADITIONAL</th>
<th>HORABAIXA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis</td>
<td>67%</td>
<td>32%</td>
<td>10%</td>
</tr>
<tr>
<td>HIV</td>
<td>33.3%</td>
<td>11%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Other chronic</td>
<td>68%</td>
<td>40%</td>
<td>22.5%</td>
</tr>
<tr>
<td>Mental diseases</td>
<td>55%</td>
<td>30%</td>
<td>20%</td>
</tr>
</tbody>
</table>
In all the cases, the users of Casa Oberta are those who represent the highest percentage of diseases.

**Drug consumption area**

With respect to the beginning of consumption, as we already commented, the age is around 14 years. In the Traditional Program this age is about 15 years, and in Horabaixa 16 years. In this respect, the differences in the age are not significant. However, when we consider the individual histories of consumption, the differences appear quite stark. Table 2 shows the average time of consumption before presenting for the current treatment episode.

<table>
<thead>
<tr>
<th></th>
<th>CASA OBERTA</th>
<th>TRADITIONAL</th>
<th>HORABAIXA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis</td>
<td>13</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>Alcohol</td>
<td>10</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Cocaine</td>
<td>6</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Heroin</td>
<td>12</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>Injection as habitual way</td>
<td>89%</td>
<td>35%</td>
<td>8%</td>
</tr>
</tbody>
</table>

The data relating to cocaine consumption is of relatively short duration compared to other drugs. This is mainly due to the fact that in recent years those presenting for treatment generally reported heroin as their first-choice drug with cocaine reported mainly as a secondary drug, often mixed with heroin and not regarded (by them) as their drug of habituation. However that may be and whatever the future may hold in respect of that drug, the average time of consumption of heroin - at 12 years on average - indicates a remarkably long history of heroin consumption.

Cocaine is the principal consumed substance of the Traditional Programs’ users and of the ones of Horabaixa (respectively 60% and 79%), whereas at Casa Oberta heroin is the principal substance in 85% of the cases.

**Legal history**

There are also significant differences in the legal data between the users of Casa Oberta and the ones of the other two programmes.

<table>
<thead>
<tr>
<th></th>
<th>CASA OBERTA</th>
<th>TRADITIONAL</th>
<th>HORABAIXA</th>
</tr>
</thead>
<tbody>
<tr>
<td>With criminal records</td>
<td>55.6%</td>
<td>21.3%</td>
<td>15%</td>
</tr>
<tr>
<td>Has been imprisoned</td>
<td>44.4%</td>
<td>20.6%</td>
<td>5.6%</td>
</tr>
</tbody>
</table>
Almost half of the users of Casa Oberta have been convicted and imprisoned at some point, as opposed to 20.6% at the Traditional Program and 5.6% at Horabaixa. There are also significant differences related to the possession of a criminal record: over 55% at Casa Oberta as opposed to 21.3% and 15% at the Traditional Program and Horabaixa, respectively.

**Family facts**

With regard to the differences with other programmes, the most significant difference in family and relationship data is that only 33% lived together with their boy- or girlfriend while this percentage for the Traditional Program and for Horabaixa were respectively 41% and 51%. Difficulties within the family structure are exemplified by the fact that, among the users of Casa Oberta, one in four has a brother or sister with alcohol or drug problems, whilst this figure is reduced to one in ten in the other two programmes.

**Summarising**

In conclusion, the TC Casa Oberta has allowed us to respond to a quite distinct population of drug consumers with a poorly structured personal profile and with many areas of their lives seriously affected by this consumption. Many of the people who have entered this TC have achieved total social re-integration (30%), and in other cases (55%) it has served as a bridge for them to access other specialised services (to other programmes of Projecte Home or of the network, or to other mental health services) to attain the objective of a life without drugs and an optimal quality of life.

**How we work**

In order to achieve this, we establish different objectives with increasing exigency as the programme progresses, so that the users during the first part of their process become stable on the physical and mental level, for them to update with their personal matters and to begin to become aware of the small changes. Thus, the objectives of the first part of the treatment are as follows:

- to develop self-control and respect the norms and the atmosphere at the TC
- to resolve their judicial situation
- to improve their health situation
- to acquire basic sanitary habits: daily personal hygiene, order personal objects, clean up the environment
- to develop an acceptance that they are themselves responsible for their own health, for acquiring habits of healthy life and for correctly following the guidelines of their particular treatment plan.

Once they have achieved these first structured habits, they start to work on aspects of their consumption and the acquisition of skills for the maintaining of
a life away from drugs. Therefore, the objectives during the second and the third phases are as follows:

- to recognise and accept their own resources and their personal difficulties in different areas: behavioural, emotional and cognitive
- to recognise that they themselves are responsible for their legal issues
- to restore the family relationship if this has been interrupted
- to initiate a family relationship based on the here and now
- to become aware of the family reality and their role in the family, before and now
- to consolidate a clear and satisfactory family relationship
- to initiate social relations with their companions in the TC
- to acquire and use the basic social skills
- to acquire basic abilities of conversation
- to become aware of their personal, relational difficulties
- to deepen their relationships with their TC companions
- to learn to behave assertively
- to reconstruct a positive social network
- to reach a consensus on the common therapeutic work between the therapists and the professionals of the referral centres
- to coordinate specific actions with each user.

Each day our work confirms to us that this is worthwhile and that while we are alive we have hope. We know that this is not easy, but it is not impossible either.
This book is about the work of the Cassel Hospital, an NHS therapeutic community, which provides a crisis intervention service for adults, adolescents and families experiencing severe emotional difficulties, and caught in cycles of abusive behaviour. The eight chapters provide detailed and valuable insights into this work. The hospital is organised into three therapeutic units, including the 'children’s centre'. Psychotherapeutic and psychoanalytically-informed work is used within daily living to meet the needs of the referred individuals and families. Patients come together to share the daily running of the whole community, which includes developing responsibility for creating appropriate child care routines, cooking, budgeting and attending community meetings alongside the nursing staff.

Having initially accepted to be sent and review this book, I was reminded of a visit of observation I made to the Cassel some 15 years ago, when I spent time in the family unit, then situated in a prefabricated wing, connected to the main building by a wooden corridor. My hazy memory is of coming away with a sense of depression, I think subliminally evoked by the apparent apathy of mothers to engage in a lively way with their young children. In those days I was less equipped to digest and reflect on my emotional response, but nonetheless I was put in touch with the painful reality of the work.

I visited the hospital in May this year and was shown the new family accommodation and the superbly designed children’s centre. It was light, bright, homely and felt genuinely child-centred. The physical environment reminded me of the re-development work at the Mulberry Bush School, where we work with a similar population of children.
Throughout the book examples of ‘collaborative therapeutic care’ for severely emotionally troubled patients is shown to be held by the close working relationship between therapists and nursing staff, and how the hospital structures ‘frame’ and provide containment for this demanding work. The importance of reflective spaces (‘strains meetings’) for staff to digest their complex emotional experience was also touched on.

It was not hard to see the need for such structures, the detailed descriptions of clinical work with abusing parents and abused children put me in touch again with feelings of despair, and the emotional ‘weight’ of the task. If not for the existence of the Cassel, I was left wondering how these people would get the help they so desperately needed, as their family and community networks are so dislocated and abusive, and their disturbance so destructive and entrenched.

After reading some of the moving accounts of successful outcomes: children being rehabilitated with previously abusive parents, I was left with more hopeful feelings. In parallel to my own work experience, I was put in touch with how impossible it might be to think, never mind work with such issues, outside of a meaningful organisational frame.

The text moved between detailed descriptions of psychotherapy sessions, to more general overviews of the day-to-day work. It would be of value to anyone with an interest in social work, therapy, education and therapeutic environments.

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The Freud Wars – An Introduction to the Philosophy of Psychoanalysis

By Lavinia Gomez

Published by Routledge, 2005, pp.210

This is an interesting and in some ways original book. Yet, despite the author’s suggestion to the contrary, those without a background in philosophy may not find it easy.

The book is divided into two parts. The first is entitled: ‘How can psychoanalytic thinking be justified?’ Here the author considers what kind of beast psychoanalysis is and outlines two rather different ways in which psychoanalysis is generally understood: namely, either as a science or as a form of...
Gomez then concludes part one by proposing an original alternative to these two descriptions, while maintaining that this solution is a reflection of Freud’s own position. Her solution is to bring together the scientific or physical approach with the hermeneutic or mental explanation, under the unifying concept of the soul rather than seeing the two traditional categories in contradiction.

In part two of the book, the author re-publishes three texts which she considers seminal and which form the basis for the discussion in part one. They are the ‘Critique of Psychoanalysis’ by Adolf Grünbaum (2002) and ‘Freud’s Permanent Revolution’ by Thomas Nagel (1994) both of which form the basis for the author’s discussion about whether it is valid to describe psychoanalysis as a science, and ‘The Scientistic Self-Misunderstanding of Metapsychology’ by Jürgen Habermas (1971), which forms the basis for the author’s discussion of whether psychoanalysis is better described as a form of hermeneutics.

The title ‘The Freud Wars’ refers to an academic debate conducted in the mid-1990s between Frederick Crews and the philosopher Thomas Nagel, about whether psychoanalysis can really be thought of as a science. The reason why Gomez reprints the text by Grünbaum is that this text is cited by Crews as his primary source. And it is more in response to Grünbaum than Crews that Nagel made his counterattack.

The subtitle, ‘an introduction to the philosophy of psychoanalysis’ would better be expressed as an introduction to the – often covert – philosophical foundations which underpin psychoanalysis. This may seem hair-splitting, but the argument of the book rests on the understanding not that psychoanalysis is a philosophy, but rather that philosophical assumptions not only informed Freud’s original conception but also inform all subsequent readings of psychoanalysis.

Gomez assembles the two arguments well. That is the argument in favour and against reading psychoanalysis as a science, and that in favour of reading psychoanalysis as a form of hermeneutics. She then presents her own argument: namely, that it is not necessary to see this question as one of either/or. Here she relies largely on Strawson’s concept of personhood, and of particulars. It is an holistic vision in which body and mind are united and made dependent on the notion of intentionality. This, she suggests, comes close not only to Nagel’s concept of dual-aspect theory but was also present in Freud’s notion of the psychical as pertaining not to mind, nor to body, but to persons … [thus] a psychophysical theoretical approach which extends beyond the person is not unthinkable. The seed from which it could develop is contained within the unarticulated sense of a unitary reality which is assumed in practical living and registered in the depths of the psyche. To that extent, psychoanalysis can be endorsed as a theoretical development of a previously untheorized reality, in which the ground of unity between the mental and physical worlds can almost be envisaged (p.102).
There are some things to be said in favour of this book. Principally, the author assembles three key texts concerning the nature of psychoanalytic discourse, and comments on them. But it also has three serious deficiencies.

Firstly, as the book’s ambitious subtitle suggests, its author assumes throughout that her discussion concerns the philosophy behind psychoanalytic thinking. However, her philosophical review is extremely deficient and in fact boils down to a discussion of what is broadly a Cartesian view, mediated through Popper and Grünbaum, and the hermeneutics of Habermas. The contribution from other thinkers is much more limited. Socrates, Plato, Brentano, Leibniz, Nietzsche, Ricoeur, Schopenhauer and Hume all get just one mention, while Popper and Strawson receive more attention. Notably absent is any mention of Lacan’s engagement with philosophy; of the thought of Hegel, Heidegger, Levinas, of Wittgenstein or of Derrida.

Secondly, Gomez discusses hermeneutics only in reference to Habermas, as if he is its main or indeed only proponent. But the importance of psychoanalysis for Habermas is principally as a way of demonstrating how combining natural and scientific methods within critical theory can bring about an emancipatory science. Gadamer and Ricoeur, both of whom have a more significant position in the development of hermeneutic philosophy, would have been arguably a far richer source for an hermeneutic exploration of psychoanalytic theory than the ideology critique of Habermas.

Thirdly, Gomez implies that there is only one psychoanalysis. But in fact there are many. Yet it is only in the Grünbaum text that we find reference to Kohut and other post-Freudian psychoanalysis. Gomez herself seems to fail to take into account the variety of psychoanalytic theory or show any real appreciation of the relevance, for her theme, of the divergence between object relations, ego psychology or Lacanianism.

The grave shortcomings of this book lie fundamentally perhaps with its author’s familiarity with logical positivism (e.g. Popper) at the expense of a very limited understanding of the hermeneutic tradition and the lack of attention she gives to phenomenology. This is coupled with a simplistic reading of Freud that takes too little account of his interpreters. This having been said, the book gives an interesting account of a recent debate within psychoanalysis and assembles three texts worthy of attention. But, more importantly, the author presents in Chapter 5 an eloquent and original argument of her own which should inspire debate among those interested in thinking philosophically about psychoanalysis.
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The journal publishes academic papers, case studies, empirical research and opinion. The journal is interested in publishing papers that critically and creatively engage with ideas drawn from a range of discourses: the therapeutic community movement and other related professional practice, psychoanalysis, art, literature, poetry, music, architecture, culture, education, philosophy, religion and environmental studies. It will be of value to those who work in health services, social services, voluntary and charitable organisations, and for all professionals involved with staff teams, service users and experts by experience in therapeutic communities, therapeutic environments and supportive organisations.

**General Guidelines**

Original contributions that fall within the scope of the journal are welcomed, including articles on current issues, practice, theory and research (academic papers), case studies of particular communities or organisational environments, and personal contributions arising from the experience of the writer. The Editorial Collective uses different criteria to assess contributions in these categories, and the following guidelines are provided. It will assist us in assessing papers if authors indicate which guidelines they have followed. Final articles for publication should be typed in double spacing and submitted as an email attachment to Lorna Viik (journal.editor@therapeuticcommunities.org.uk). All articles are submitted for peer review by anonymous assessors drawn from the Editorial Collective, the International Editorial Advisory Group, and a panel of assessors. Authors will receive acknowledgement of their submissions.

**Note:** For authors submitting an article where English is a second language, it is recommended that the article be proofread by a fluent interpreter prior to sending, in order that intended meanings can be checked in the translated article.

**Academic Papers**

These can include reports of original research, papers developing original links between theory and practice, review articles and critiques of current practice. The normal conventions of academic papers should be observed, with a brief abstract (up to 150 words), followed by a review of the relevant literature, statement of the problem, method, findings, discussion and conclusion. References should follow the style of the Journal. Academic papers should normally not exceed 5,000 words excluding references.

**Case Studies from Practitioners**

These describe examples of practice, innovation, action research or evaluation in the practitioner’s own unit. They should include: a brief description of the setting, of the piece of work undertaken and the reasons for doing it; a clear account of the process and findings with relevant data in easy to read tables or graphics; a brief conclusion with discussion of the findings and their implications for practice within the unit and perhaps more widely. A small number of relevant references may be included, following the style of the Journal, but no literature review is needed. Case studies should normally not exceed 2,500 words.

**Commentary/Response**

The journal would welcome short papers (up to 2,000 words), which address topical issues. These issues may arise from recent themes or views addressed within the papers in the journal. They may describe an event or situation involving the writer, occurring at the individual, group or organisational level. Contributions from experienced practitioners as well as from authors with relevant experience to appear alongside personal contributions. They may describe an event or situation involving the writer, occurring at the individual, group or organisational level. Contributions from experienced practitioners as well as from authors with relevant experience to appear alongside personal contributions. They may describe an event or situation involving the writer, occurring at the individual, group or organisational level. Contributions from experienced practitioners as well as from authors with relevant experience.

**Letters**

Letters should normally not exceed 2,500 words. With the author’s permission comments may be sought from practitioners with relevant experience to appear alongside personal contributions.

**Website**

If you inform us to the contrary, after three months papers will be posted on the ATC website at www.therapeuticcommunities.org.
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28, 1, spring 2007

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Women in residential drug-free treatment: How to use a bottom-up strategy and a prediction of completion instrument to prevent early dropout
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Dealing with multiple and frequent service utilisation in substance abuse treatment: Experiences with coordination of care in residential substance abuse agencies in the region of Ghent, Belgium
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Application of cognitive-behavioural therapy in a therapeutic community for drug-dependent individuals
Peter Vassilev and Teodora Groshkova

Ten years of the therapeutic community, Casa Oberta (Open House)
Bartomeu Català

Cultural Reviews

therapeutic communities is the international journal of the Association of Therapeutic Communities, UK and is sponsored by Nottinghamshire Healthcare NHS Trust