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# Editorials

**Rowdy Yates, Eric Broekaert and Barbara Rawlings**

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Advertisement
Over the past two decades there has been an inexorable drift towards substitute prescribing as the treatment of choice for drug addiction in most of the Western world. In part, this has been as a result of the apparent low cost of such treatments coupled with a long-standing, almost atavistic, belief in chemical solutions for all behaviours which appear, at least at first sight, to be inexplicable. However, this tendency has been given added impetus by the failure of abstinence-based treatments – and particularly drug-free therapeutic communities – to understand the need to explain their practice and provide the evidence for its use. Too often, drug-free therapeutic communities have proved insular and reluctant to engage in the wider debate.

But momentous change is coming to the drug treatment field as the misuse of drugs begins to dominate the political agenda and politicians begin to question current practice and wonder whether money might be better spent. Drug-free therapeutic communities have tended to be disadvantaged in previous debates about the direction of drug policy because they have been largely unable to provide strong research evidence of efficacy or value for money. Indeed, they have often found themselves struggling even to explain what a therapeutic community is and how it might differ from other approaches to drug misuse.

In this issue of the journal, we have brought together a collection of papers from EFTC (European Federation of Therapeutic Communities) members, which begin to examine both the evidence base and the problems of definition. Most of these papers were first presented at the 11th EFTC Conference in Ljubljana, in June 2007. In the first paper in this section, Autrique, Vanderplasschen, Broekaert and Sabbe examine the current research landscape and argue for new approaches to data collection and analysis. Paget, Goodman and Wood outline the work of the Community of Communities’ initiative to develop and implement a peer-led review system founded upon an agreed set of quality standards. The following three papers consider the nature of the client group served by therapeutic communities in this field, with Bologa et al. describing the outcomes of an integrated educative system for residents with learning difficulties, Peltonen recounting the development of a family service within a pre-existing community and Yates reporting upon the severity of dependence amongst this client group compared with mainstream drug treatment populations. Finally, Abdollahnejad discusses outcomes in a drug-free therapeutic community in Tehran and includes a compelling series of vignettes where a group of former residents reflect upon the impact on their own lives.
In the second section in this issue, we bring together four papers written by TCA (Therapeutic Communities of America) members. We are indebted to Sushma Taylor and Michael Harle of TCA for commissioning the papers and undertaking the onerous job of first-editing. The papers in this section are largely descriptive and provide a fascinating snapshot of the current work of drug-free therapeutic communities in America and the new directions in which they are going. In the first two papers, Taylor discusses the integration of vocational services into the work of a community and the impact upon the therapeutic programme, whilst Icenhower describes a similar initiative to extend TC methodology to whole families. The subsequent paper by Varma and Williams describes the history and development of a prison TC and its integration with other non-prison treatments. Finally, Davidson describes the operation of a therapeutic community for veterans of the armed forces.

All of the papers in this issue offer new insights upon the work of therapeutic communities and the people they deal with. As the search for better, more robustly-researched treatment interventions begins to define the direction of drug misuse policy, we believe that it is vital that papers such as these begin the task of mapping out exactly what it is we do and how we might be able to do it better.

Rowdy Yates, Eric Broekaert and Barbara Rawlings (editors)
The Drug-Free Therapeutic Community: Findings and Reflections in an Evidence-Based Era

Mieke Autrique, Wouter Vanderplasschen, Eric Broekaert and Bernard Sabbe

ABSTRACT: A growing tendency towards more evidence-based practice can be observed internationally in substance abuse treatment. Recently, a study was conducted on the state of the art and the most important challenges concerning evidence-based practice in Belgian substance abuse treatment. This study revealed that, for treatment providers and practitioners, it is not always clear which conceptions are essential to the evidence-based paradigm and what this means for daily practice. This article discusses what is understood by evidence-based practice and describes the evidence currently available concerning interventions in substance abuse treatment. The evidence for the effectiveness of the drug-free therapeutic community is reviewed, as well as the implications of the evidence-based paradigm for daily practice in therapeutic communities.

* This study was carried out by the University of Antwerp, Ghent University and the Centre de Recherche en Défense Sociale (CRDS) in Tournai, within the context of the 'Research Programme in support of the federal drugs policy document', commissioned and financed by the Belgian Science Policy.

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Evidence-based practice: more than evidence alone

In recent years, evidence-based practice has become an important issue in discussions on the quality of substance abuse treatment. Researchers and policy makers increasingly emphasise the need for the implementation of evidence-based methods and guidelines (Amodeo, Ellis & Samet 2006; Berglund, Thelander & Jonsson 2003; McGovern et al. 2004; Miller et al. 2006; Ravndal 2005; Schippers, Schramade & Walburg 2002). The term ‘evidence-based’ has been derived from ‘evidence-based medicine’ and refers to a movement within medical sciences that originated under the impetus of a large coalition of physicians, researchers, professors and policy makers, to improve the application of evidence resulting from experimental scientific research in clinical practice (Haynes et al. 1996). The basic assumption of evidence-based medicine is that the accelerating evolution of scientific knowledge requires a new way of learning, namely ‘problem-based learning’, in which clinicians develop the habit of looking for the current best answer as efficiently as possible when they are confronted with a clinical question for which they are unsure of the answer (Straus et al. 2005).

Evidence-based medicine is defined as ‘... 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 best research evidence with clinical expertise and patient values’ (Sackett et al. 2000, p.1). In other words, evidence-based practice should be ‘tailor-made’ practice (Autrique 2007). It presumes an integration of three factors: the ‘evidence’, the expertise of the individual practitioner and the values of the individual client. In addition, these factors need to be situated within their societal context, which determines the acceptability of certain interventions (Hannes 2006; Autrique 2007).

‘Evidence’ predominantly refers to clinically-relevant research, especially into the accuracy and precision of diagnostic tests, the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens (Sackett et al. 1996). It is mainly grounded in theoretical models and insights concerning behavioural and environmental influences on the one hand and evaluation studies on the other (Stevens 2006). In the scientific literature, an overwhelming number of outcome studies are available. Different standards are applied for evaluating the effectiveness of interventions, so conceptions of what is ‘evidence-based’ and what is not, are not always consistent.

In medical sciences, a hierarchy, from ‘hard’ to ‘soft’ evidence, is often assigned. RCTs or ‘randomised controlled trials’ are considered to be the ‘gold standard’ and are situated at the top of this hierarchy, followed by experimental and quasi-experimental research, other quantitative research and qualitative research designs. Yet, RCTs are not always feasible or desirable in social sciences. Moreover, even strongly convincing evidence from randomised and controlled circumstances may be inapplicable in real-life situations or inappropriate for individual patients (Sackett et al. 1996). Recently, support for
a wider interpretation of ‘evidence’ and for the integration of quantitative and qualitative research has been growing.

An alternative, complementary approach to the RCT-centred evidence-based practice has been proposed in psychotherapy research: ‘practice-based evidence’ (Lasalvia & Ruggeri 2007). This approach involves gathering good-quality data from routine practice and using large, clinically-representative data sets. It gives a voice to practitioners and service users, recognising that they have first-hand knowledge and experience of what works, what needs to change and how it may change (Lasalvia & Ruggeri 2007). According to its advocates, to gain robust evidence for complex interventions, practice-based evidence is needed, too (Green 2006; Lasalvia & Ruggeri 2007; McDonald & Viehbeck 2007).

It is certainly clear that, while practice may rapidly become out of date when the current best evidence is not taken into account, practice is also at risk of being tyrannised by (evolving) evidence without clinical expertise (Sackett et al. 1996). By ‘individual clinical expertise’ we mean the proficiency and judgement that individual clinicians acquire through clinical experience and practice (Sackett et al. 1996). The evidence-based paradigm should recognise the importance of the therapeutic freedom of clinicians. In evidence-based practice, the available evidence needs to be integrated with clinical expertise to translate scientific research into daily practice, and more specifically to the situation of the individual client (Autrique et al. 2007).

It is important for clinicians to acquire the ability to deal with information resources critically, and to assess the quality of existing and emerging research studies carefully (Cox et al. 2003; Stevens 2006). In substance abuse treatment, for certain clinical questions, no conclusive answers are as yet available in research literature. In this case, evidence-based practice should be translated into ‘reflective practice’, in which practitioners critically reflect on their actions in daily practice, in order to avoid continuing in the same way, simply because they have always done so (Cox et al. 2003). A critical attitude and an open mind are essential, so innovative interventions are not ruled out.

Thirdly, working in an evidence-based fashion also includes taking into account the needs of an individual client or target group. The thoughtful identification and compassionate use of individual clients’ predicaments, rights, and preferences is needed in making clinical decisions about their care (Sackett et al. 1996). The client perspective is accentuated and integrated more and more, for example by involving clients in the development of evidence-based guidelines.

Lastly, what our society considers a problem influences which outcomes are considered to be important and which interventions are preferred, and thus implemented and supported. It is a challenge to select those interventions that are supported by ‘evidence’ – as far as is available – and which are consistent with, or adapted to, specific values, norms and the context in our society (Hannes 2006).
In the present evidence-based era, the position of the drug-free therapeutic community is challenged, since some studies have concluded that evidence for this method is relatively poor (cf. Rigter et al. 2004; Miller et al. 2006). This article aims to discuss some issues related to the tension between and possible integration of the evidence-based paradigm and the drug-free therapeutic community. First, an overview of the evidence for the effectiveness of interventions in substance abuse treatment is presented. Methodological problems in effectiveness research are discussed, with special attention to those problems that are inherent to research in therapeutic communities. Secondly, the evidence for the effectiveness of the therapeutic community is discussed in detail, in relation to their origins and conception of effectiveness. Finally, some recommendations are formulated for the integration of an evidence-based paradigm in present-day therapeutic communities.

Available evidence for the effectiveness of interventions in substance abuse treatment

Various authors have reviewed the effectiveness of interventions in substance abuse treatment, resulting in several reviews that have assessed the level of evidence for the effectiveness of diverse pharmacological and psychosocial interventions (Rigter et al. 2004; Lingford-Hughes, Welch & Nutt 2004; Van Gageldonk, Ketelaars & Van Laar 2006). The most evidence is available for the effectiveness of pharmacological interventions for the treatment of alcohol and opiate abuse. There is also evidence for the effectiveness of specific, brief and behavioural interventions, such as cognitive behavioural therapy (CBT), the community reinforcement approach (CRA), motivational interviewing, contingency management, brief interventions and multidimensional family therapy (Autrique et al. 2007; Rigter et al. 2004). Other interventions, such as acupuncture and compulsory participation in self-help groups, have been proven not to be effective for certain populations. But for the interventions most frequently applied in substance abuse treatment, not much evidence is as yet available (Miller et al. 2006). This appears to be the case for psychoeducation, relapse prevention, social skills training, psychotherapy, case management, counselling and psychodynamic therapy (Van Gageldonk et al. 2006; Autrique et al. 2007). Similarly, for the therapeutic community approach, a complex and comprehensive treatment modality, not much conclusive evidence is available (Van Gageldonk et al. 2006; Autrique et al. 2007).

However, a lack of evidence for a certain intervention or treatment approach does not necessarily imply that this intervention is not effective. Some interventions have not been studied intensively in RCTs or are difficult to evaluate this way, whilst others have attracted much research interest specifically because of the ease with which they can be measured. Thus, specific, brief and behavioural interventions are supported by considerable evidence, since they can be evaluated relatively easily. Moreover, these interventions are often assessed over the short term, which makes the results more favourable than in longer-term evaluations. A shortage of evidence can also be due to the kind of
study that was conducted, such as a comparison of very different interventions, or to an insufficient implementation of the intervention. Sometimes, the experimental and control conditions do not differ significantly from each other (Vanderplasschen 2007). Furthermore, relapse is inherent to substance abuse problems, which may influence treatment outcomes (McLellan 2002).

Besides these general methodological problems that need to be taken into account, studies evaluating therapeutic communities also have to contend with some more specific complications, such as the complexity of the intervention, the heterogeneity of the research population and a high dropout rate (Lees, Manning & Rawlings 2004). In traditional therapeutic communities with a long-term group programme (two years), only 15–25% of the residents voluntarily complete the programme. Most dropouts occur during the first three months. Another problem is that treatment goals, programme characteristics and outcome measures differ from study to study (APA 2006). Moreover, the term ‘therapeutic community’ has been used extensively (and often with little rigour) to describe specific approaches in a large range of services. One of the consequences of the wide application of this term is that the definition of the TC as a treatment modality for substance abusers, of how it works, and for which clients it is most suited, is unclear (De Leon 1995). Taking these limitations into account, we assess and discuss available studies concerning the effectiveness of therapeutic communities.

‘Evidence’ for the effectiveness of therapeutic communities

The fact that little ‘hard’ evidence is available for the effectiveness of therapeutic communities can be partly explained by some specific methodological problems. However, given the length of time that therapeutic communities have been in existence and the quality of staff-members working in therapeutic communities, they might have been expected to produce a certain level or quality of research literature (Lees, Manning & Rawlings 2004). That not so many good quality studies are yet available may be due to a lack of emphasis placed on research in the early days of therapeutic community development and, more recently, to a lack of resources in terms of finance, staff and adequate research methodologies, designs and instruments. However, these attitudes have changed in recent years and evaluative research has become of primary importance (Lees, Manning & Rawlings 2004).

The first studies on TCs were exclusively carried out in the United States and were conducted with an early generation of substance abusers, mainly opioid addicts. Since the beginning of the 1980s, though, the majority of TC residents have been poly-drug users. New studies were needed to evaluate the effectiveness of the TC for this new generation of substance abusers (De Leon 1995). Moreover, policy makers increasingly demand evidence for the effectiveness and efficiency of therapeutic communities specifically in Europe. Within the European Working group On Drugs Oriented Research (EWODOR), a research tradition originated in Europe in collaboration with the European Federation of Therapeutic Communities (EFTC). Research has shown that ‘time in treatment’
is the most powerful predictor of successful outcomes in TC-treatment, a finding that is parallel with other treatment modalities (Broekaert 2006; APA 2006). Retention in TCs may differ depending on the programme, but consistently predicts outcomes concerning abstinence and criminal involvement. Since dropout rates are highest during the first months of treatment, TCs have introduced different interventions at this stage to maximise retention, such as the use of ‘senior staff’ as well as family and social network support (De Leon et al. 2000; Soyez et al. 2006). According to Broekaert (2006), these findings are supported by comprehensive research on the effectiveness of different treatment modalities in the UK (National Treatment Outcome Research Study – NTORS) and the US (Drug Abuse Treatment Outcome Study – DATOS) (cf. Simpson 2003).

The APA’s ‘Practice guidelines for the treatment of patients with substance use disorders’ (2006) confirm the effectiveness of TCs and specify the target populations for whom they are most likely to be effective. According to these guidelines, it is particularly those individuals with opioid, cocaine or multiple substance use disorders that are most likely to benefit from referral to a long-term residential therapeutic community. These are mainly individuals with a low likelihood of benefiting from outpatient treatment, such as clients with a history of multiple treatment failures or whose profound impairment in social relational skills or ability to attain and sustain employment impede adherence to outpatient treatment. Potential voluntary applicants to a residential therapeutic community should have some understanding of the severity of their substance use disorder and a readiness to change their lifestyle. They should also have a willingness to conform to the structure of the therapeutic community (APA 2006).

Evidence-based guidelines that specifically focus on therapeutic communities are not yet available but, recently, the first edition of the ‘Service Standards for Addiction Therapeutic Communities’ was published (Shah & Paget 2006). These standards originated under the impetus of the Community of Communities, part of the Centre for Quality Improvement at the Royal College of Psychiatrists, UK (see Paget & Goodman elsewhere in this issue), and were developed by various TC experts, practitioners, researchers, managers and residents of TCs in Europe (see Table 1). They are intended to reflect the core elements of current practice in Europe and consist of seven sections; a series of core standards, and standards concerning the physical environment, staff and members, joining and leaving, the therapeutic environment, the treatment programme and external relations. Each standard comprises a general statement and some specific criteria. These criteria are not comprehensive, but are generally given as examples of good practice relating to the standard. The standards represent ideal practice and are thus indicative: it would be unusual if services met every standard (Shah & Paget 2006).
Table 1: Some standards from the ‘Service Standards for Addiction Therapeutic Communities’ (Shah & Paget 2006)

<table>
<thead>
<tr>
<th>Standards for the treatment programme</th>
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<tr>
<td>• The community has a planned therapeutic programme</td>
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<tr>
<td>• There is a structured and consistent daily schedule of group activities</td>
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<tr>
<td>• All client members have a written care plan</td>
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<tr>
<td>• The community prepares members for independent living in the wider community</td>
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<tr>
<td>• The community has an explicitly-structured hierarchy</td>
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<tr>
<td>• There are clearly-defined privileges with a rationale and process for allocating them</td>
</tr>
<tr>
<td>• There are clearly-defined sanctions with a rationale and process for allocating them</td>
</tr>
<tr>
<td>• The community takes responsibility for improving and maintaining client members’ physical health</td>
</tr>
<tr>
<td>• Where client members are offered a methadone treatment programme, there is a written policy</td>
</tr>
</tbody>
</table>

Recently, a methodologically-rigorous Cochrane review was conducted concerning the effectiveness of TCs for drug users (Smith, Gates & Foxcroft 2006). For this review, only RCTs that compared TC treatment with other interventions, no treatment or another TC-model were selected. By doing so, ten reports of, in total, seven RCTs were included. It concerned only studies from the United States.

The review shows that there is little evidence that TCs offer significant benefits as compared to other residential treatment, or that one type of TC is better than another. Prison TCs are probably better than prison on its own or mental health treatment programmes to prevent re-offending post-release for inmates. However, methodological limitations of the included studies may have induced bias, and firm conclusions cannot be drawn (Smith, Gates & Foxcroft 2006).

The way effectiveness is conceived in this type of systematic review differs largely from the TC conception. According to Broekaert (2006), the effectiveness of TC-treatment is situated within a collection of ‘good practices’ directed at improving the quality of life. This originates from a bio-psychosocial approach both to understanding addiction (see Zinberg 1984) and to the resultant treatment modality in which the individual works towards recovery and a drug-free life in a step-by-step process. The objectives of each intervention or component of the system are determined, based on the stage of recovery of the individual (De Leon 1995). This difference in conception illustrates the difficulty in translating the evidence-based paradigm into daily practice in the therapeutic community.
Towards more evidence-based practice in the therapeutic community

The evidence for the effectiveness of the therapeutic community partly consists of studies concerning various interventions that are applied in TCs. In this sense, the evidence base for the effectiveness of therapeutic communities as a whole consists of a combination of evidence-based interventions. In addition, research has also been conducted on the therapeutic community as a comprehensive approach. Some recommendations can be derived from these studies on how treatment in a therapeutic community can be tailored to these findings.

However, as was concluded in previous literature reviews, there are not enough reliable data on therapeutic communities to be sure this treatment modality works, although many positive things have been written about this intervention. It is difficult to determine the position of therapeutic communities in the treatment process of substance abusers. There appears to be little evidence that therapeutic communities offer significant benefits compared to other residential treatments, or that one type of therapeutic community is better than the other. On the other hand, there are indications that TCs produce changes in mental health and functioning, but this needs to be complemented by good quality qualitative and quantitative research studies (Lees, Manning & Rawlings 2004).

Furthermore, TCs should keep pace with contemporary evolutions and challenges. TCs have already elaborated their approach towards specific target groups, such as substance-abusing mothers, so-called ‘dual-diagnosis’ clients, incarcerated substance abusers and adolescents (Morrall, McCaffrey & Ridgeway 2004). TC treatment, methadone programmes and harm reduction initiatives have been integrated in regional networks of care (APA 2006; Broekaert & Vanderplasschen 2003). Brief interventions that use family and social network support have been introduced (Broekaert 2006). Shorter-term programmes (e.g. 3–12 months) and non-residential programmes have been offered for those with less severe social and vocational impairments (APA 2006).

These developments reflect that, in the past, it has become clear for the TC movement that a rigid value system turns into a weakness when it leads to therapeutic fundamentalism (Broekaert 2006). Such an open, critical and reflective attitude is essential to evidence-based practice. However, evidence-based practice does not only mean that comprehensive working methods are supported by evidence and that certain treatment components are dismissed, added or adapted referring to scientific research integrated with clinical expertise. This discussion is also situated at the individual client–practitioner level. It refers to the practitioner who is systematically assessing the client’s situation, providing answers to his/her needs and evaluating if and why a particular treatment did or did not succeed. Staff members in therapeutic communities need to assess their working methods critically and keep up with new developments in the field of substance abuse treatment on a continuous basis. However, some obstacles will almost inevitably be encountered. A great
A deal of time is required to gain access to and acquire the available knowledge. Moreover, the complexity of treatment impedes translation into daily practice; and the available evidence does not always meet current needs.

The existing evidence clearly needs to become more accessible and practitioners in therapeutic communities should be supported to translate research results into daily practice, for example by the development of evidence-based guidelines. More rigorous research is needed, as well as permanent training and education in evidence-based practice, with attention to certain dilemmas, such as taking well-considered decisions when no evidence is available (Cox et al. 2003). Evidence-based practice can also be facilitated by generating more practice-based evidence (Green 2006), for example by creating systematic opportunities for meaningful, focused interaction or exchange between parties that share a desire to improve current practice (McDonald & Viehbeck 2007).

It can be concluded that, in working towards evidence-based practice in therapeutic communities, a constructive debate is needed on this tendency between policy makers, researchers and practitioners. The implications for current practice have to be clarified and efforts need to be made to narrow the gap between policy, research and practice in order to overcome barriers and to integrate different perspectives and conceptions of effectiveness. This way, a higher quality of care in therapeutic communities can be assured.

References


The Development of a Quality Improvement Network for Addiction Therapeutic Communities

Sarah Paget, Paul Goodman and Natalie Wood

ABSTRACT: The Community of Communities is a standards-based Quality Improvement Network for Therapeutic Communities (TCs) based at the Royal College of Psychiatrists’ Centre for Quality Improvement (CCQI). The network was developed in 2002 by the CCQI (previously the College Research Unit, CRU) in partnership with the Association of Therapeutic Communities (ATC) with start-up funding for three years from the National Lottery. This paper describes the background to the development of the Community of Communities’ network and maps out the progress to date. The review system is illustrated by a case study of an English therapeutic community which was part of the network from its inception.

Background

The ATC is an international organisation that represents TCs that hold to the Maxwell Jones’ tradition or what some might call the democratic model of TCs as opposed to the concept-based, now more commonly known as Addiction TCs. They had long been discussing the potential threat to TCs from increasing regulation and the rise of evidence-based practice, especially to those within the NHS. Democratic TCs in the UK needed to develop a more professional profile and to demonstrate rigorous and systematic quality assurance which would be transparent and sympathetic to their ethos and philosophy. The early years of the Community of Communities’ network is well documented (Haigh & Tucker 2004) and it has continued to thrive, becoming self-funding in 2005. At this time C of C had an average membership of 60 TCs in the UK and abroad, with representation from all sectors and client populations.
The Community of Communities' annual cycle

The Community of Communities' approach is based upon an annual cycle of review and self-review. The annual cycle is an iterative process enabling TCs to demonstrate their commitment to service evaluation and providing evidence of quality improvement. The process involves the development of standards for TCs which are then applied through a system of self- and peer-review.

The issues arising during the self- and peer-review process are fed back into local reports which are presented to member TCs with an expectation that action will be taken to address any development needs that have been identified. Members of the network meet at the annual forum where key issues and selected findings are presented and discussed and where decisions can be made and voted upon. Finally, the annual report presents the aggregated data from the review cycle which enables members to benchmark their performance. It also identifies overall areas of achievement and areas for improvement for TCs locally, nationally and internationally.

TC or not TC: that is the question

The Service Standards for Therapeutic Communities, now in their 5th edition (2006), were initially a generic set of statements about TC practice. They assumed no particular client group, sector or approach and indeed included statements about having 'play materials' (Standards 1.5, 2002), recognising TCs for children and young people and not just the adult population. As the standards have developed, they have become increasingly more relevant in defining the parameters of what it is to be a TC. Standards review and revision is a key point of the annual cycle and, as the majority of members were from TCs based within the NHS or social care sector in the UK, populated by adults with mental health problems or offending behaviour, the standards more accurately reflected these environments and client groups. As a result a number of TCs did not sign up to the network or withdrew, as they recognised that the standards were not always appropriate for their needs. In addition there was an increasing need for sector-specific standards with the new commissioning agenda, threatening the existence of many communities, especially in the NHS; there was also a need for the work to dovetail with more rigid audit structures in some sectors, specifically within the prison service.

It was becoming increasingly clear that the differences between TCs were as numerous as their similarities and that 'one size would not fit all'. The Community of Communities needed to further develop the network to accommodate the needs of all TCs. Over the first few years the Community of Communities worked in partnership with HM Prisons to develop a joint-review, an audit process for prison TCs (2005), and with the Department of Health to develop standards to support the commissioning of TCs in the NHS (2005). Whilst these initiatives were significant, they still centred on the needs of TCs working with adults with mental health or offending behaviour problems and that there were significant numbers of TCs which required new standards and
networks of their own. To this end the Community of Communities and the CRU set about applying for further funding from the National Lottery for phase 2 of the programme of work, three new networks for: Addiction TCs; TCs for Children and Young People; and Communities working with people with learning disabilities.

The two main TC traditions have had a difficult relationship over the past 40 years. Even now there are discussions, even arguments, about how they should be differentiated. In this paper the terms ‘Democratic TC’ and ‘Addiction TC’ have been used but this is not ideal and new and more accurate terminology may emerge as the relationship develops. The TCs have begun to realise perhaps that they have more in common than that which sets them apart and the implication that Addiction TCs are not democratic is clearly erroneous and even insulting. However, it is true that the hierarchical structures that exist within Addiction TCs are normally discouraged within Democratic TCs and it is one point where the models diverge and where the Service Standards for Therapeutic Communities did not quite capture what it is to be an Addiction TC.

**A question of fidelity**

The desire for Democratic TCs and Addiction TCs to work more closely together spurred a number of collaborative initiatives. One of the most significant was the recruitment of George De Leon and Eric Broekaert (and, later, of Rowdy Yates) to the editorial board of the journal *Therapeutic Communities* and the invitation to begin forging closer links between the ATC and the European Federation of Therapeutic Communities (EFTC) at the ATC Windsor Conference 2004. It was there that Anthony Slater and Rowdy Yates outlined the standards that the EFTC had developed and that their members sign up to on joining the federation. The idea that these might be expanded upon and developed into a network of communities focused on developing the TC model and ensuring consistency, quality improvement and commitment to best practice was exciting to all present.

It has often been commented that the TC approach has largely been an oral tradition, passed on from members to members and, whilst this culture is rich, it can become diluted and ineffective as time passes, especially if no-one is manning the boundaries. During the Windsor Conference in 2004, George De Leon talked about the way in which TCs can become estranged from their original approach and how the need to maintain ‘fidelity to the model’ prompted him to write the definitive manual for TC practice, *Community as Method* (2001). Whilst it is important that TCs remain organic and responsive to their environments and members’ needs, the structures and processes need to provide consistent and firm boundaries within which the culture can thrive and be allowed to grow and develop. It is within the context of these discussions that the EFTC nominated Rowdy Yates to chair an independent expert panel which would support the application for funding to the National Lottery. This bid was successful and the Community of Addiction Therapeutic Communities was born in March 2006.
A question of need

In researching the need for the network, it was clear that, whilst individual TCs or organisations are preoccupied with ensuring they deliver the best and most effective service that they can and one that is faithful to an agreed model, the growing view in health and social care in the UK is that TCs are unfashionable and out of line with modern approaches to the treatment of substance misuse. In particular, residential care is seen as a prohibitively expensive option and community-based interventions are more attractive and affordable. TCs struggle to promote their approach in a world where short-term, individualistic treatment approaches take centre stage and where increasing statutory regulation and emphasis on standardised external quality control mechanisms add to their difficulties in maintaining the TC identity. Many UK TCs actually stopped using the term [therapeutic community] in order to gain referrals, adding to increasing isolation from each other and from other providers in the field. It was generally agreed that Addiction TCs would benefit from becoming part of a network that provided an inclusive and peer-led evaluation process tailored to their needs with opportunities for shared learning and exchange of ideas (Yates 2005).

Case study [PG]

The experience of the Ley Community - members of the Community of Communities for five years

What attracted the Ley Community to sign up for the Quality Network when it was first formed? There were two factors at play at the time. There was considerable pressure on residential treatment facilities to demonstrate their effectiveness in what was becoming an ever-increasing competitive treatment market, dominated in the UK by substitute prescribing. The Government was (and continues to be) fixated by targets, and funding agencies have been required to increase the numbers placed in treatment, with the inevitable temptation to place more people in short programmes rather than fewer in longer ones; hence the need to demonstrate that long programmes, such as ours, provide value for money and meet defined quality standards. The other initiative that influenced our decision to join was the British Prison Services’ requirement that all programmes delivered within prisons needed to be fully accredited through their rigorous accreditation process: a challenge that we were at the time taking the Ley Community’s prison-based programme through.

Membership of the Community of Communities’ Quality Network provided an opportunity to benchmark our programme against an agreed set of criteria. It allowed our community to undertake a self-review against the standards, and then host a peer-review from another community to add a sense of distance and objectivity into the review process. Out of this exercise, the strengths of our
community would be identified, areas for improvement pinpointed, and an Action Plan put in place.

In addition, membership of the Network provided a wonderful vehicle for breaking out of the isolation that I believe we often felt as a community. We knew that our programme was 'different' from other British residential treatment programmes, and we liked to think that what we did was better and superior to elsewhere. The general climate in which treatment facilities operated was one of competition rather than collaboration or cooperation, underlined by the competitive tendering process for new contracts. This fostered a culture of isolation and suspicion about what other treatment services were offering, and a bunker mentality that had the impact of closing our minds to the fact that we could do anything better than we currently did. I would describe this state as one of arrogant defensiveness; hardly a healthy place for a therapeutic community to grow and develop.

So what was our experience of membership of the Quality Network in the early years, and why was it not 'plain sailing'? I think in part it was due to my inability to appreciate the full potential of the process. It has only been during the last two years that I have involved the whole community in the exercise. Previously, I had delegated to a small group of staff and residents the task of completing the self-review exercise, and there was no ownership within the wider community to the scoring. The failure to involve the whole community in the self-review was not unique to the Ley Community: I have undertaken a number of peer-reviews where the self-review had been completed by one member of staff – and, in the worst case scenario, that member of staff was absent when the peer-review took place! It has become clear to me that to make the most of involvement in the 'Quality Network', the participation of the whole community is essential.

Perhaps even more pertinent, the initial 'Quality Network' was made up predominantly of democratic TCs working with a significantly different client group. Our early peer-reviews were disappointing. The visiting review teams were often small, and did not necessarily appreciate the different nature of our treatment regime. In particular, I questioned the principle of including 'service users' as members of the review team after a couple of peer reviews, when the service users who visited failed to contribute to any of the formal discussions. The result was that our staff and residents began to question the value of the visits, and whether it was justifiable to forego the normal routine for an exercise that appeared to be of limited value. It is perhaps not surprising that as a result the lengthy reports that followed the peer-reviews were given little attention: they were neither copied nor circulated.

On completion of the third cycle, I had reached the conclusion that we should withdraw from the Quality Network. In part, funding for membership had changed and, whereas for the first few years I had been able to lead reviews and draft local reports in lieu of paying for membership, we would now need to pay the full fee – and this concentrated my mind as to whether membership provided value for money. It was only after a lengthy conversation with Sarah Paget that we agreed to remain; this was mainly based on the plan to
set up a new network specifically for addiction TCs. In addition, Coolmine TC from Dublin had joined the Quality Network, and we were able to arrange to ‘pair up’ for the review process, with our staff going to Coolmine and their staff coming to the Ley Community. This proved to be a much more productive process, with staff staying overnight and learning much more about each other’s community than could be achieved on a formal day visit’s programme. Unbeknown to me at the time, these visits provided a template for the new network and the peer-review visits that would follow.

**A community for Addiction Therapeutic Communities**

In the first year, ten communities were involved in piloting the standards and review methods.

*Service Standards for Addiction Therapeutic Communities*

The Service Standards provide the foundations for the annual cycle and the basis for self- and peer-reviews. They are organised into seven overarching sections. These are Core Standards (standards identified as being central to being a TC), Physical Environment, Staff, Joining and Leaving, Therapeutic Environment, Treatment Programme and External Relations. The standards focus on the structures and processes that exist within the TCs as opposed to measuring outcomes, the principle being that positive outcomes come from adhering to an agreed method. The development of the standards is documented elsewhere (Shah & Paget 2006) but it is important to emphasise that they provide statements of the central elements of Addiction TC practice as agreed by experts in the field and through consultation with TC staff and residents. These standards will be reviewed and revised annually, ensuring they remain relevant to our members and reflect existing methods. It is this ‘dynamic and iterative nature of the standards [that] is a fundamental tenet of the approach of the Community of Communities’ (Haigh & Tucker 2004).

**Self-reviews**

Each TC receives a workbook which contains a selection of standards from the *Service Standards for Addiction Therapeutic Communities*. The review workbook is used to stimulate discussion and enables TCs to score their TC’s performance against individual standards and comment on areas of achievement and areas for improvement. The TC is expected to engage all members in this process, which allows everyone to become familiar with the standards and prepare for the peer-review.
Peer-reviews

The peer-reviews involve members visiting one another’s services, further exploring the self-review scores and comments, exchanging ideas about improving services and learning from each other. The process is not an inspection but an opportunity for members to engage with others in open and honest enquiry about what they do well and what they would like to improve. The process is intended to reflect the nature of TCs and therefore emphasises the quality of the relationships and the opportunities for learning and change. On completion of the peer-review visit, the visiting team return the completed workbooks to the Community of Communities’ team.

Local reports

Completed workbooks are transferred to a local report which documents the findings and discussions generated at self- and peer-review and highlights areas of achievement and for improvement. The report includes quantitative data (i.e. the scores awarded by the TC at self-review and by the peer-review team), and qualitative data (i.e. the comments and record of discussion). Each local report includes a summary of the areas of achievement and areas for improvement, which enables TCs to quickly see where they are doing well and where they need to create action plans to address problem areas.

Initial results

A simple analysis of the quantitative data for the ten pilot TCs provided a complex and varied picture. The data, representing the percentage of ‘met’ standards indicated that the TCs collectively performed well in each section (see Figure 1). TCs performed best in Therapeutic Environment (90%) and Treatment Programme (86%) and least well in Physical Environment (75%) and Staff (67%). However, individual TCs had widely differing strengths and weaknesses. For example, one TC which scored particularly poorly in standards relating to Staff (38%) excelled in the Core Standards (94%), whereas another scored poorly on Core Standards (50%) but did very well in the Staff section (88%). Whilst it is not possible to draw any definitive inferences from such a small sample, it does enable us to have a first glimpse at how TCs perform against the new standards and demonstrates the value of the peer-review. Since all of the therapeutic communities involved in this initial pilot reported differing profiles, the opportunities for inter-community learning and support were significant. For full details of the results see the Community of Communities’ National Report for Addiction TCs 2007-2008.
Conclusion

The Community of Addiction Therapeutic Communities is up and running, the standards are published and the team is busy recruiting members to the network. Addiction TCs have been isolated for a number of years and many may well have diverged from their original model. The first results of the pilot demonstrate that those who have chosen to be involved at this stage do have a strong identity and do well in key areas. However, the results, whilst in no way conclusive, show that they do vary in performance and struggle with different issues, the reasons for which may become clearer over time. This does illustrate the potential strength of the network, with members strong in some areas supporting and advising those who are weaker but who in turn have something to offer in other areas. Moreover, there is almost certainly an added benefit – that of improving fraternal relations between addiction TCs and reducing their feelings of isolation.

The final word: The Ley Community [PG]

I think that it is helpful to emphasise the significance of visits within the Addiction TC network. Over the last five years, the Ley Community has developed relationships with a number of other Addiction TCs, which we believe has been to our mutual benefit. The relationship with Coolmine continues outside the Community of Communities’ context. We have had a number of staff exchange placements to and from Phoenix Bulgaria; earlier this year we had staff from an Addiction TC in Israel on placement at the Ley for two weeks; and a visit to Phoenix Haga in Norway in 2006 was instrumental in changes that we subsequently made to our programme. I believe that the new network provides a wonderful opportunity for extending this process of learning from each other – and to do so in a spirit of cooperation rather than competition.
It has already become apparent from the first year’s experience of the addiction network that relationships between TCs will change through participation in the process. The Ley Community’s relationship with Phoenix Futures following peer-review visits has started to blossom. There can be no doubt that we feel far less isolated, and have much to offer each other in a market place where we remain a very small part of the treatment sector.

There is something very wonderful about the fact that Addiction TCs have blossomed all round the World. Wherever you visit an Addiction TC, it is recognisable, whatever the country and whatever the culture. This is clearly something to celebrate. We must build on visits and training placements between our TCs. I would encourage the peer-review to become something added on to a longer visit, particularly in view of the distances that people will need to travel for the reviews. It is certainly evident that peer-review teams have gained a much better perspective on the community they are visiting when they have been able to stay the night and spend informal time with staff and residents outside the formal business of the peer-review. As is so often the case, much learning takes place over dinner and subsequent late night discussions!

References


Royal College of Psychiatrists’ Research Unit (2002) *Community of Communities – Service Standards for Therapeutic Communities*. London: Royal College of Psychiatrists’ Research Unit.


Treatment Programme Changes for Residents with Long-Standing Learning Difficulties

Liana Gerber Bologa, Detlev Bähr and Gustavo Torres Díaz-Guerra

ABSTRACT: Long-standing learning difficulties may have a medical, psychological, or social origin and may lead to difficulties within the therapy process and during the re-entry phase. Our multi-disciplinary therapy concept addresses all three origins of learning difficulties. This paper considers the socio-pedagogic elements of the therapy programme aimed at the correction of this problem. The attention of the therapists concentrates on the aspect 'learn to learn'. For clients that have demonstrated in their biography special difficulties in learning, programme changes, including formal and informal learning approaches under medical and psychological guidance, were included. The elected mix of methods led to spectacular recoveries as demonstrated by the case presentations and emphasised the relationship between the learning style, motivation and result on the one hand and the healing process on the other. The results suggest that long-standing difficulties can efficiently be treated parallel to addiction problems.

Introduction

Therapy programmes that aim at the development of an addiction-free personality, capable of social reinsertion at the professional, private and societal levels are often confronted with the problem presented by clients with no profession, who exhibit long-standing learning difficulties and thus find themselves unable to follow the therapy programme satisfactorily and achieve the desired re-entry outcomes. Though long-standing learning difficulties may have medical, psychological or social origin, the practical correction of these conditions requires modification of the therapy programme in line with evidence produced by modern pedagogical studies.

As a therapeutic community is obviously not a formal educational unit, the first question raised concerns the design of the pedagogic work within the
framework of the treatment programme. Here we must consider the concept of informal learning, which is one of the most important recent discoveries in the field of education (Wittwer & Kirchhof 2003). The discovery of the fact that informal learning contributes in a proportion of up to 90% to our knowledge (Staud & Kley 2001) underlines the importance of this learning form. Informal learning has a conscious and an unconscious component (Laur-Ernest 2000). This second aspect becomes effective when the learning effect becomes transparent through retrospective biographical reflection (Gudjons, Pieper & Wagener 1999; Schäffter 1998). Kirchhof and Kreimeyer (2003; Overwien 1999) show that the voluntary aspect of informal learning is one of its most important traits.

Learning (independent of its formal or informal form) aims at the acquisition of different competences (Arnold & Schüssler 2001). The understanding of the content of each competence is very important for the process of informal learning. The authors describe in one level professional competence (professional knowledge), self-competence (autonomy, efficiency, persistence, motivation, curiosity, personal goals, interest, attention, concentration, no alternative behaviour) and social competence (conflict, contact and team abilities); and in another level emotional (empathy, self-perception and expression), communicative (verbal and non-verbal abilities), and methodical (knowledge acquisition, organisation, integration and control) competences.

A very important competence, which deserves special attention, is the competence of adapting to changes (Wittwer 2001a; Wittwer 2001b). Wittwer points out that nowadays a working person has to be prepared to undertake, during their professional life, several changes in task, working place, enterprise or profession itself. This emphasises the importance of practical handling (Becker & Rother 1998) and of ability to cope with very practical aspects of life (Johnson 1998; Kotter & Rathgeber 2005). It has been suggested that high individual competences act as a stabilising factor in the case of social changes (Borutta, Münchhausen & Wittwer 2003).

Informal learning can fulfil four important functions (Wittwer 2003a): it can aid discovery of individual competences; help acquire professional knowledge rapidly; help find a compromise between societal changes and the personal professional trajectory; and aid application in practical situations to formally acquire knowledge. Moreover, a very important role of informal learning is given by its orientation power. Through the informal education intervention itself, the individual gains an opportunity to learn experientially through trial and error and to focus, within professional education, on their own resources rather than their deficiencies (Wittwer 2003a). While the embedding of experience into the long-lasting memory takes place within a psychologically-coached biography work process, the prospective planning of a professional future is envisaged within pedagogically-structured orientation sessions, in which the dialogue between the therapist and the client enables the latter to achieve a perspective change (Herbartz 1997).

The persistence, or the long-lasting effect of learning, seems to correlate with the coherence and the systematic structure of the teaching input (Dohmen
1997; Overwien 2003), with its emotional (Ciompi 1999) and experiential (Brinkmann 2003a) content; and with the inclusion of the individual biographical element (Wittwer 2003b) as well as with the ability to transfer the theoretical knowledge into practice.

Contrary to informal learning, formal learning means a goal-oriented, planned learning, which takes place in a special education unit (e.g. school) or in another system that allows the candidate to obtain an official diploma (Straka 2000; Laur-Ernst 2000) and makes the candidates more competitive while seeking a position.

This brief literature review shows that the concept of informal learning includes unconscious and self-reflective components, orientation possibilities, the learning-by-doing principle and learning in a social environment. It is interesting to observe that the therapy of addict persons is similarly based on unconscious and self-reflective components, orientation possibilities, the learning-by-doing principle and learning in a social environment. This observation lends strength to the contention that a therapeutic community is an ideal place for introducing learning structures. However there appear to be no publications in which the above-mentioned theories of learning were studied within a therapeutic setting.

The present paper presents the programme changes that were considered in order to cover the needs of the clients presenting multiple, long-standing learning difficulties as the main cause of an unsuccessful reintegration.

**Method**

**Setting**

The programme change addressing clients with long-standing learning difficulties was undertaken in the Fuente Alamo Therapeutic Community, which is open to men and women and offers 15 long-term (15–24 months) treatment places. Whilst the therapeutic community with its own internal life and traditions appears as an important healing force (De Leon 1997), specific interventions given by professional staff 24 hours/7 days are meant to facilitate the recovery process. There is a multidisciplinary staff offering a complete therapeutic programme in the following fields: medicine, nursery, psychology, pedagogy/teaching, music, arts, sports, dance and social training. The aim of the therapeutic programme is the development of an addiction-free personality, capable of complete reintegration on the professional, private and social level.

**Population**

The treatment population (n=90) over a period of eight years (May 1999–May 2007) consisted of men (78%) and women (28%) over 18 years of age. Many had no profession, had a broken education or were dissatisfied with their professional position. In order to decide about the best treatment methods, a
psychological characterisation of the population was undertaken with regard to the presence or absence of the following features: self-reflection, self-esteem, conflict ability, ability to cope with failure, impulse control, capability to delay pleasure, cause of drug consumption (stress or seeking pleasure). The particular traits of those individuals that exhibited special learning difficulties were registered and a 'robot portrait' was constructed.

**Pedagogical approach**

This was designed in order to compensate for deficiencies exhibited by clients with learning difficulties and consisted of a mixture of informal and formal learning. According to the psychological characteristics and to the typical portrait of clients with learning difficulties, it was indicated that all participants had to develop the necessary competence in order to cope with a variety of life situations and that the learning process has to be designed for overcoming the learning difficulties of the participants.

The therapy 'department' charged with this part of the programme was the educational team. Its main goal was to let participants discover learning as a major source of personal satisfaction. This was done through two approaches: in the first, participants learned how to learn and developed different skills independent of content; in the second, the content of learning had a central position (participants learned something particular, e.g. languages, music, arts, schools). These approaches were applied by using a mixture of informal and formal teaching. Preferences by the choice of learning modalities were registered.

**Informal learning**

Informal learning is defined as learning that takes place outside of a specific educational institution and does not result in an award of any kind. It emphasises the development of competences such as personal learning competence (autonomy, efficiency, endurance, will, motivation, curiosity, interest, concentration, organisation, integration, learning methods, etc.) and social competence (contact, empathy, verbal and non-verbal expression and communication, conflict and team abilities, etc.). In accordance with the studies of Ciompi (1999) and of Brinkmann (2003a) the pedagogical construction of special rooms for acquiring non-verbal learning experience through musical, artistic and corporal expression and of rooms for acquiring recordable emotional states received special attention. Informal learning was also used as an important orientation method regarding the choice of the formal learning.

Evaluations regarding the efficiency of these elements were carried out. All clients were involved in informal learning.
**Half-formal learning**

Half-formal learning describes informal learning that was carried out in order to pass admission examinations in a formal education system.

The basic programme that was used as a frame for the informal learning consisted of a daily, a weekly and a yearly rhythm.

The daily programme consisted of seven therapy hours of 50 minutes each, a one hour lunch break and 1½ hours of therapeutic community meeting. The weekly programme consisted of two equal days (Monday/Thursday; Tuesday/Friday); one sports/group dynamic day (Wednesday); one cleaning/art expression day (Saturday) and one free day (Sunday). The yearly programme consists of one-week repetitive activities: three excursions in natural parks (April, June, September), two self-confidence/communication seminars (March and November), one olive harvest project (December) and one creative seminar of two weeks in (August).

**Formal learning**

Formal learning is defined as acquisition of professional skills in a formal education institution (e.g. school) and puts the accent on the final attainment of a diploma. Only clients finding themselves in their second therapy year participated in formal learning. The weekly and the yearly programmes of clients embedded in a formal educational system were similar to those that participated solely in informal learning. Their daily programme, however, contained less non-verbal experiential sessions and therapeutic community meetings. In contrast, it contained classes outside of the therapeutic community and additional tuition sessions. Evaluation of successful graduation in a formal learning system and the main traits and attitudes of successful students was evaluated. Two short case presentations vividly illustrate the power of such an intervention.

**Results**

**Treatment population**

No cases of typical learning disorders (such as F81: dyslexia, dyscalculia; or F70: cognitive disorders) were observed in this population. Three clients had previously been diagnosed with F90: A.D. hyperkinetic syndrome; of these, only one wished to participate in the special programme addressing learning difficulties.

It was found that neurotic developments, especially those that mirrored a distortional self-image, were the main cause of learning difficulties. In their turn, these difficulties produced a large palette of side effects such as behavioural disorders, personality changes and false compensation through
addiction. The percentage of these traits in the treatment population appears in Figure 1.

**Figure 1: Frequency of some personal traits exhibited by clients with learning difficulties**

<table>
<thead>
<tr>
<th>Trait</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>low self-reflection</td>
<td>75%</td>
</tr>
<tr>
<td>low self-esteem</td>
<td>64%</td>
</tr>
<tr>
<td>low conflict ability</td>
<td>62%</td>
</tr>
<tr>
<td>fear of failure</td>
<td>52%</td>
</tr>
<tr>
<td>low impulse control</td>
<td>60%</td>
</tr>
<tr>
<td>low pleasure-delay</td>
<td>53%</td>
</tr>
<tr>
<td>drugs for stress</td>
<td>70%</td>
</tr>
<tr>
<td>drugs for pleasure</td>
<td>66%</td>
</tr>
</tbody>
</table>

A typical portrait of the student with learning difficulties

In addition to the personal traits listed above, clients who wished to overcome their learning difficulties exhibited the following common characteristics: the father was an unreachable ideal; the fear of disappointment was enormous; self-confidence and self-esteem were non-existent; concentration and memory were low; they lacked orientation; they wanted to learn; they exhibited different degrees of addiction to cannabis, benzodiazepines, hard drugs and alcohol. Clients suffering under these conditions expressed their feelings plastically in art therapy sessions. Figure 2, ‘The chosen one’, indicates that ‘to be chosen’ does not mean for these people a distinction, but a huge fear produced by unbearable expectation and feelings of loneliness. Figure 3, ‘Self-portrait’ (same artist), illustrates the insecurity, ambivalence, fear and disdain with which these clients regard their own personality and the constant twisting of their thoughts (expressed here as tornados) around this problem.
Preferences by the choice of learning modalities

Most people, with learning difficulties because of neurotic developments of their personality, wished to escape this condition and requested special learning help. Figure 4 shows that out of the 90 persons who were treated in our therapeutic community during the past eight years, almost half chose to participate in some formal education forum. These ranged from attainment of high school examination diplomas to the attainment of professional formation diplomas (e.g. nursery nurse) to language proficiency certificates.

Clients received orientation with regard to their choice through special counselling sessions, through the complex programme that explored their resources, through special tuition that reinforced their talents, or through
practice in the desired field. Figure 5 shows that counselling was a very effective method of orientation, unlike practice, which had a poor orientation effect. Interestingly enough, in several cases it served to lead the client to decide against the field that had been subjectively, initially viewed as appropriate.

Figure 5: Professional orientation by special pedagogic interventions of informal learning

![Bar chart showing percentages of counselling, programme, tuition, and practice](chart.png)

Non-verbal learning experience

These learning experience sessions were introduced in the programme with the purpose of enhancing expression, confidence, joy, communication skills, courage, curiosity, cooperation and ‘belonging-together’ feelings. In 77% of cases, they showed themselves to be an important factor in helping clients achieve a positive self-image, which resulted in an improved learning capacity.

Figure 6: Importance of non-verbal learning experience session for improving overall learning capacity

![Pie chart showing 77% important and 23% not important](chart.png)
Contribution of recordable emotional states

Recordable emotional states were achieved especially within the frame of the yearly cycle. These consisted of adventure situations which occurred within excursions (adventure situation), occasional concerts (recordable success experience), and group dynamic exercises. Results show that the emotional learning through adventure experience was accessible to the largest population.
From the 90 clients who were admitted into our therapeutic community between May 1999 and May 2007, 42 exhibited different degrees of learning difficulties and wished to participate in formal education programmes in parallel to the therapy. All these participants had in the past been incapable of finishing their studies or their professional formation. Out of these, 90% successfully graduated in the formal programme elected. This unusual high success rate indicates the helpfulness of the mixture between the formal and the informal learning that we propose.
Case history E.M.

This 24-year-old man was admitted in July 2002. He had a history of incomplete high school studies, was on a disability pension because of an AD-hyperkinetic syndrome, had low concentration, no patience, no self-concentration, no self-confidence and was addicted to a number of drugs. For 2½ years he was engaged in a programme of intensive self-confidence and personal competence training in foreign languages, music, sports and cookery lessons. He gained self-confidence, concentration and motivation, succeeded in obtaining a language proficiency certificate and successfully passed his admission examination to a high school for adult persons. Today (July 2007) he has completed high school, is finishing his high school examination diploma and is fully abstinent.

Case history M.L.

This 23-year old woman was admitted in April 2000. She had a history of incomplete high school studies, was not able to learn because of a tremendous fear of failure, and was addicted to cannabis, alcohol and cocaine. During the following 18 months, she developed her personal competence within an intensive teaching programme in sports before enrolling in the final year of a formal high school for adults which she undertook in parallel with her therapy until Autumn 2002, when she successfully passed her high school examination diploma. At present she is studying marketing design in a university.

Some features exhibited by successful clients

It was observed that clients who were especially successful exhibited some common behavioural and personal traits. These were: self-control, awareness, active attitude, social sensibility and an ambition to succeed.

Clients clearly expressed these features and this mental attitude in art therapy sessions. Thus, client M.L. (an example of a successful case history) depicted ‘having fun’ as a boat without a skipper on lazy waters and ‘being reasonable’ as a skipper who was conducting his boat attentively through the waves. The same client depicted ‘my free time’ as herself in the middle of a lot of activities, whilst client M.G., who shortly after the end of the therapy broke up her studies as a nurse because of a problematic relationship, painted a beautiful but quiet and empty landscape. With the subject ‘feeling good’, M.L. depicted a social situation and, with the subject ‘my goal’, she expressed clearly that her goal was to succeed.
Figure 13: Art therapy, ‘having fun’ (M.L.)

Figure 14: Art therapy, ‘being reasonable’ (M.L.)

Figure 15: Art therapy, ‘my free time’ (M.L.)

Figure 16: Art therapy, ‘my free time’ (M.G.)

Figure 17: Art therapy, ‘feeling good’ (M.L.)

Figure 18: Art therapy, ‘my goal’ (M.L.)
Discussion

Treatment programme changes for residents with long-standing learning difficulties were implemented through introducing personal, tailored, informal and formal learning structures which were in accordance with the learning theories found in the literature. Results show that the envisaged changes of the socio-pedagogic therapy programme can lead to the correction of this problem.

It was found that the success of the learning process was greatly influenced by the intervention of the student himself/herself and depended upon the degree of self-control exercised. This observation confirms previous studies by other authors, which underline the role of the pupil in all learning processes (Zimmerman 1986, 1994; Schiersmann & Strauss 2003; Overwien 2003; Leutner & Leopold 2003). Our clients expressed awareness of these matters behaviourally, verbally and plastically in the art therapy sessions (Figures 14 & 15). Successful students understood that lack of control could eventually be connected with a divertissement situation, but not with daily tasks (Figure 13). Those who envisaged their free-time passively (Figure 16) showed a less successful outcome.

However, in this process, the supportive role of the social environment appeared to be crucially important, since a too critical attitude of the individual himself/herself with regard to the discrepancy between his/her ideal state and the reality bore the risk of overwhelming the pupil and could negatively influence motivation and learning strategies. This risk has also been described by other authors (Zimmerman & Martinez-Pons 1990). The awareness of the pupils with regard to the importance of the supportive role of the social environment and of the clarity of their goals (Figures 14 & 18) was mirrored in art therapy paintings (Figures 15 & 17).

Emotional learning experiences, as described by Brinkmann (2003b), were part of the treatment programme, were very much appreciated by the participants, and led to the acquisition of personal and social skills which were an important factor in overcoming the self-image problems usually exhibited by students with long-standing learning difficulties as a main disturbance source.

It was interesting to observe that this programme change, consisting of a mixture of formal learning with emotionally-accentuated informal learning, gave excellent results with regard to the percentage of students able to overcome their learning difficulties and finish their studies. Further, successful students who were satisfied with their results and achieved a better self-image exhibited fewer problems with their addiction.

Conclusion

Programme changes that consisted of a mixture of formal learning in parallel with the therapy and of pedagogically-conducted, emotionally-accentuated informal learning which occurs within the therapeutic community led to personality changes of the participants that resulted in the correction of their learning difficulties. This study suggests that a therapeutic community is an
ideal place for correcting the long-term learning difficulties of the participants and can be treated alongside their addiction problems.

References


Integration of Family Treatment into the Mikkeli Community

Kaarina Peltonen

In Finland there are strong traditions of developing theories and methods about therapeutic communities, dating back to the late 1960s. The Mikkeli Community was founded in 1998. The purpose was to develop a therapeutic community for drug abusers, which would be of as high a quality as possible, with scientific research integrated into its activities (Hännikäinen-Uutela 2004).

Family treatment started in the Mikkeli Community in Autumn 2005. One of the most important aims was to integrate family treatment into the functioning of the whole community, so that clients in family treatment would be responsible also for the wellbeing and progress of the other clients.

From the families’ point of view, the goal of family treatment is that, after treatment, the family is able to offer children a safe environment to grow up in, and is able to manage everyday life, solve problems and seek help when needed.

The principles of family treatment in the Mikkeli community are as follows.

1. The safety of the family is guaranteed.
2. The needs of children are answered.
3. Parenthood is strengthened.
4. The everyday life of the family is supported.

Starting family treatment in the Mikkeli Community met with some initial resistance. Some of the staff and the clients at the time were afraid that the arrival of the families would ruin the well-functioning community. It was feared that children would bring restlessness, families would fail to participate in the work of the community, that they would operate to a different set of rules and that the staff would divide between the family workers and the others. The worst fears were that family treatment would bring with it such a relaxation of the rules and blurring of the accepted practices and norms, that it would ultimately lead to the breaking up of the community and thus, recovery would become impossible for the existing clients. The less serious concerns were around the issues of whether the parents would have enough time to participate in the addiction treatment whilst simultaneously taking care of their children and whether the families would integrate into the whole community or remain apart to form a community of their own.

A separate building with three family apartments was renovated for the purpose of the family treatment. However, the first family arrived with so little

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warning that the family apartments had not yet been furnished. The first family, therefore, had to be located in one of the general accommodation rooms.

This first family taught us a simple, but important lesson: parents in the family treatment initiative will join the community naturally if they live among the other clients for the first few weeks. This practice was followed with the subsequent families and it was found that integration into the life of the community happened just as quickly and effectively as it generally did with those coming to treatment alone. Thus far, mothers and fathers have learned the practices and rules of the community well and have participated both in the common tasks and in their own addiction treatment, after the day care of the children has been organised.

There has been one exception to these developing arrangements for the first weeks’ accommodation. A family with a father, mother, a three-year-old and a two-month-old baby, who cried at night, moved straight to a family apartment. With this family, it was clearly observed that they integrated with the wider community less fully and, for much of their time, became occupied with attempts to form their own social group, which was not open for everybody in the community. Moreover, the weaker integration into the community of this one family seemed to have the effect of undermining the community orientation of other families already in treatment who began to withdraw from the community.

This episode of withdrawal and isolation happened at a time when the family treatment initiative had existed in the Mikkeli Community for little less than a year and where there were for the first time three families in treatment at the same time. In my view, the issues of practical accommodation resulting in this particular moving straight into a family apartment were only partly responsible for the subsequent period of separation and tension. It was clear too, that the staff at that time were also conflicted about this development and this attitude impacted on the resident community and their feelings and attitudes.

The solution adopted was to begin separate community meetings for the family treatment clients. These meetings developed and agreed proposals, which were then taken forward to the meetings of the entire community. Attention was also given to having adults in family treatment as members of the ‘responsible group’ of the client community. The ‘responsible group’ is a group of clients which has been in the community for a longer time and which is responsible for the activities of the community when the staff are not present. With these changes, the feeling of togetherness between family treatment and the rest of the community improved somewhat. However, a clearer integration into the community was achieved only with families arriving for treatment later.

It is important to monitor regularly the position of the family treatment section within the wider community to ensure that it remains a part of that community. Where appropriate or necessary, there may be a need to adjust the dynamics of the community to ensure a healthy feeling of community ‘oneness’. Clearly, for this to be successful, the entire staff needs to continuously take responsibility for the realisation of the community’s feelings and practices.
The family treatment has changed the atmosphere and the look of the community. The families have brought to the community more softness, flexibility and tolerance. There is also more noise, surprising situations and toys here and there. After the initial confusion, the common opinion has been that families have brought more liveliness to the community – and that this has been a good thing.

It seems that, while family treatment has influenced the look and feel of the community, the community spirit has influenced the parenting of those in treatment. In the Mikkeli Community, each individual’s responsibility for the wellbeing and progress of other clients is emphasised from the very beginning of the treatment. The structure and the forms of the activities are designed to underpin and support this culture of caring. This kind of culture strengthens the feeling of responsibility and the care of the parents for their own children. Caring for others also reduces the self-centeredness caused by substance abuse and helps the parents to see themselves and their families as a part of the wider community, and society at large.

Children whose parents have a history of drug and alcohol abuse are often traumatised in many ways. In family treatment, the children’s situation is much improved simply by the family life becoming regular and safe. Within the community, the parents are encouraged to create a stable, positive routine for the everyday life of the family and to give attention to interaction with the children. Early interaction has been supported with small children, and pregnant mothers have been helped to keep the baby in their mind in order to encourage good interaction from the moment the baby is born.

It has been observed in the pre-school children of those families coming to treatment, that they often suffer from symptomatic behaviour evidenced by a feeling of insecurity and a lack of boundaries. In these cases, the regularising and calming of their everyday life also helps a great deal; but, in addition to this, children are provided with regular opportunities to work through their experiences by drawing or playing, with a member of staff.

Children are in day care and therefore form a small community of their own. In the evening and at weekends, the children are together with their parents and often participate in the activities of the whole community. The other clients of the community sometimes take care of the children when the parents are in self-help groups. There are over 20 members in the community and, especially for a shy child, this number of people may initially be quite intimidating. However, experience thus far indicates that a well-functioning community gives children peace, safety and clear limits. For a child who has experienced growing up in a drug world, it is immensely reassuring to find themselves within an environment where all the surrounding adults are sober and behave in a predictable way.

The parents in family treatment take part in the work of the community and in the community forums, group sessions, individual discussions and therapy – exactly like all the other clients. However, there are special arrangements for the very young babies, and the mothers mostly look after these babies independently. In the evenings and at weekends the other clients carry out
written tasks related to the rehabilitation. The parents also have these tasks, but in addition they will need to have time to interact with their children and to establish everyday routines at home. Many of the adults in family treatment have to make an effort to strengthen their own parenthood. As a result, there is often less time for their own rehabilitation, and overall treatment time often needs to be longer than if the same client had been undergoing individual treatment. On the other hand, research suggests that parenthood is a strong motivation for change (Meier, Donmall & McElduff 2004; Brudenell 2004; Ruismiemi 2006). In addition, the experience from the Mikkeli Community shows that those in family treatment generally evidence a strong commitment.

Family rehabilitation has also changed the status and duties of those undergoing individual treatment. Each client looks after the children in turn, and the clients also have to give various kinds of temporary assistance to the families. The responsibility of everyone for the safety and welfare of the children has been emphasised.

The presence of the children in the community has given those in individual treatment the opportunity to develop the most sensitive sides of their nature: to give care and look after small children. Overall, childcare skills have developed and the sense of responsibility has increased. In addition, it seems that the presence of families in the community makes it easier for those clients who have children in the care of the social or welfare services to start developing positive relationships with their own children. The difficult issues related to the clients’ own childhood are also brought to the surface more easily.

Family treatment has now been established in the Mikkeli Community for almost two years. The worst fears have not been realised: the community hasn’t fallen apart, and the rehabilitation progresses. Family treatment has not separated from the main entity to form its own community and there is no antagonism between the staff members depending on whether they work with the families or not. The parents in family treatment work both in the community and to aid their own rehabilitation – just like everyone else. The community has easily survived the noise and the breadcrumbs under tables that the children have brought with them. The community is not the same as it was, but the changes are seen as positive. Big challenges remain. However, we are more than ready to take on those challenges!

References


Different Strokes for Different Folks: Results of a Small Study Comparing Characteristics of a Therapeutic Community Population with a Community Drug Project Population

Rowdy Yates

ABSTRACT: This paper reports the findings of a small study undertaken in Scotland and England. The Maudsley Addiction Profile (MAP) and Lucid Adult Dyslexia Screening (LADS) were used to interview a small sample of 50 drug treatment service users. Half of the sample were residing in a therapeutic community (TC), whilst the other half were attending a community drug project and, almost exclusively, were receiving long-term prescriptions for methadone. Whilst the main intention of the study was to explore the prevalence of dyslexia amongst treatment-seeking populations, this paper examines the differences found between the users of the two treatment types. The TC population was significantly more likely to have been injecting prior to treatment, was using a more extensive range of drugs and was more likely to report psychological health problems, including suicidal ideation. The paper examines whether current UK policy on residential treatment is responsible for these differences and what these findings might mean for both treatment delivery and estimating the cost-benefits of treatment interventions.

Introduction

Three main instruments were used in this study in order to collect the necessary data. The level and severity of dyslexia was tested through the use of a computerised adaptive test called LADS (Lucid Adult Dyslexia Screening). The nature and extent of the dependent behaviour was tested using the Maudsley Addiction Profile (MAP). Finally, a small sub-sample of ten individuals were interviewed using a short interview schedule specifically designed for this study. Analysis of both the LADS screening and the interviews and any correlation with the MAPs outcomes will be reported upon at a later stage and this paper is...
intended simply to report upon and discuss the different character profiles found within the two treatment populations.

The purpose of this paper is to report upon the results of the MAP data insofar as these data suggest differences in severity of dependence and associated issues between the two sub-populations. The dyslexia-related findings of the wider study are to be presented in a subsequent paper and are not discussed here.

Methodology and instruments

The Maudsley Addiction Profile is designed as a brief, interviewer-administered questionnaire for dependence assessment, treatment outcome and general research application (Marsden et al. 1998). The questionnaire was originally designed as a response to a UK-wide call for standardised models of outcome measuring in the addictions field (Task Force to Review Services for Drug Misusers 1996) and was subsequently refined for use as the core instrument in the major study: National Treatment Outcome Research Study (NTORS) (Gossop et al. 2003).

The MAP, like a number of other similar treatment-oriented substance-misuse screening instruments, measures problems in four domains recognised within the treatment literature to impact upon successful intervention outcome: substance use, health-risk behaviour, physical and psychological health and personal/social functioning (Ardila & Bateman 1995).

The substance use section of the MAP records both frequency and intensity of the use of a range of commonly used/misused substances over a recall period of 30 days. The recall period is a compromise between the commonly used seven days, which often fails to adequately record episodic or intermittent (binge) misuse, and longer periods of six months or a year, which pose problems of accuracy in respondent recall. Frequency is recorded over the 30-day period with the use of ‘prompt cards’ whilst intensity is assessed through verbatim reports of typical daily consumption. In scoring the MAP, these verbatim reports are converted into standardised units. Route of administration is recorded as oral, intranasal, inhalation and injection.

The health risk behaviour domain records frequency of injection, together with self-reported evidence of sharing of injecting equipment (including paraphernalia such as spoons, filters etc.). In addition, respondents are asked to recall frequency of unprotected sexual activity within the 30-day recall period, together with an estimate of number of sexual partners.

The physical health domain comprises a series of questions adapted from Darke et al.'s more extensive Opiate Treatment Index (1991, 1992). Each symptom is recorded on a five-point Likert-type scale measuring frequency during the recall period. Psychological health is similarly recorded using questions derived from the anxiety and depression sub-scales of the British Symptom Inventory (BSI) (Derogatis 1975).

Finally, the personal/social functioning domain examines client activity within the 30-day recall period in respect of relationship conflict, employment
and criminal activity. The level of conflict with sexual partners, relatives and friends is measured in a similar way to the relevant domain in the Addiction Severity Index (McLellan et al. 1992) except that, in the MAP, respondents are also asked to recollect frequency of contact. Employment and criminal activity is similarly measured in terms of frequency and intensity with respondents questioned about a series of crimes commonly associated with substance misuse.

Completed MAPs can be scored in each domain to provide an overall level of dependence measure which is comparable across treatment populations and primary drug types (both alcohol and drug misusers).

The study comprised a series of interrelated stages:

1. Literature search
2. Leaflet and interview schedule design
3. Piloting of the chosen instruments
4. Recruitment of the required sample
5. Collection of the data
6. Feedback to individuals and agencies
7. Data analysis

In addition, an initial on-line survey of the views of drug treatment professionals regarding the prevalence of dyslexia amongst their caseloads and their impression of its relevance to the treatment process was undertaken. This provided an early indication that a study of the type envisaged would be of value.

The consent form was written in simple everyday language and substantial sections took the form of comic-style cartoons. Both the consent form and the MAP were subsequently tested with a small group of drug users in the Fife area for readability and comprehensibility. In the event, this pilot group (five current drug treatment service users) became quite enthusiastic about the project and requested a further session. No members of the pilot group were included within the final sample of 50 individuals.

A range of drug treatment services were contacted to request access. Given Kirk and Reid’s (2001) recent study of dyslexic offenders in a Scottish custodial establishment, no agencies were approached where referral is overtly coercive, such as Drug Courts, Drug Treatment and Testing Order Projects etc. Thus, although some of the eventual sample were indeed attending court-mandated treatment, the majority were not and were therefore primarily a cohort of drug misusers rather than offenders.

Both residential and non-residential agencies were contacted and the final sample comprised 25 attenders of non-residential treatment services and 25 residents from two residential rehabilitation agencies. Both the residential agencies were ‘concept-based’ therapeutic communities (see Yates et al. 2006).

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1 Although these stages were largely chronological, there was, inevitably, a significant amount of overlap. The literature search, for instance, continued throughout the study period.
Fieldwork was completed in May and June 2006 and data were subsequently analysed by hand. Transcripts of interviews were also analysed manually. In two cases, responses were judged to be identifiable and the clients involved were re-contacted and permission sought to use specific quotations within the final report. In both cases, permission was given without hesitation.

**Limitations of the process**

There are several limitations to this study, not least the relatively small sample size. However, a good deal of effort went into ensuring that the sample was representative of the wider drug treatment population, with one notable exception: no female respondents were included within the final sample. The decision to exclude female substance misusers was taken at a relatively early stage in the study since the literature estimates male to female ratios of between 4:1 and 3.3:1 (and, in terms of the wider study, similar estimates are offered for relative prevalence of dyslexia). It was therefore felt that, within a sample of 50, the data collected from female respondents would be unlikely to achieve statistical significance.

There were, additionally, some minor difficulties in administering the MAP, which is normally intended for use at initial assessment and for outcome monitoring thereafter. In the majority of cases, respondents’ drug/alcohol use had been modified by their contact with their respective treatment service. This was particularly the case with the residential cohort, where almost all respondents were drug-free. Respondents were therefore asked to recall the 30-day period immediately prior to their current treatment episode. Clients who indicated either that they had difficulty in recalling this period or that they had been in treatment for eight weeks or longer were interviewed as normal but excluded from the final sample. In fact, most respondents claimed to have very good recollection of the recall period and this was particularly true of the residential cohort.

Respondents who were clearly intoxicated at the time of interview, or who reported being on medication above certain daily limits, were neither tested nor interviewed. Typically, this included a small number of respondents in non-residential treatment services receiving a prescription of methadone above 70 millilitres per day. This was not an issue with respondents in residential treatment settings who were either drug and/or alcohol free or on low, detoxification levels of medication at the time of interview. Finally, one individual was of a minority ethnic background. He described himself as ‘Scottish Asian’ and appeared to have no difficulty with English language. Indeed, he had been born in Scotland and regarded Urdu as ‘just the language I have to use at home’.

All respondents were asked before commencement of the test whether they wished their results to be communicated to the relevant keyworker. All but two agreed to this procedure. These two requested that they received their results individually. In both cases, a further appointment was agreed later in that same day, at which they were given a detailed appraisal of their results. The delay
was felt to be appropriate since it was important for the administrator to be confident about the test results and to have a clear view of the implications and the appropriate action to be recommended in each case.

Consent forms were coded numerically, with the same code used on the MAP questionnaire and all other data collected. A further code indicated the respondent’s ‘handedness’ since some studies have indicated a tendency towards higher prevalence of dyslexia amongst left-handed males (Snowling 2000; Owen et al. 1971; Tonnessen et al. 1993).

Results from the MAP interviews

Of the 50 individuals assessed with the Maudsley Addiction Profile, the majority (94%) were using more than one substance. All were using at least one substance – overwhelmingly either heroin or alcohol – on a daily basis. The amounts consumed were generally very high.

Daily (and even regular) users of alcohol were typically consuming between eight and 60 units per day. Heroin users were using between 0.5 and 3.5 grams per day, whilst those who noted that they were also smoking cannabis – and cannabis was generally described by this group as a secondary drug of choice – would typically smoke between five and 15 joints per day. Seventy-two per cent were using one of the benzodiazapine drugs (usually either diazepam or nitrazepam) in addition to their primary drug of choice; typically between 50 and 150 milligrams per day. Those using either cocaine hydrochloride or crack cocaine (68%) were smoking, inhaling or, in some cases, injecting between 0.5 and 3.0 grams per day.

Many respondents were using methadone mixture either via prescription or purchased illicitly on the streets. No distinction was made in this study between prescribed and illicit medications since the intention was to understand overall consumption figures prior to the current treatment episode. Sixty-four per cent were using methadone in a variety of combinations. Almost all were using methadone mixture orally, although two respondents were using physeptone (injectable methadone), which had been stolen from a pharmacy. Of the rest, around half were using prescribed methadone often ‘topped up’ with illicit methadone. The remainder were purchasing black-market methadone to supplement their heroin supply.

Only four respondents reported use of amphetamine and, in all four cases, the reported usage was below five days in the 30-day recall period. As a result, amphetamine has not been individually recorded below.

\(^{2}\) The current UK Government recommendation of safe limits for adult males is 3–4 units per day to a maximum of 21 units per week.

\(^{3}\) The amount of cannabis in a single rolled cigarette (joint or spliff) is understandably subject to huge variation but each joint is likely to contain at least 0.5 grams.

\(^{4}\) A single rock of crack cocaine has been assumed to contain the equivalent of 0.5 grams.
Figure 1: Consumption of alcohol by units per day (n=50)

Figure 2: Consumption of heroin by grams per day (n=50)
Other heavily-used substances, notably cocaine, benzodiazepines and cannabis, showed a similar profile of consumption.

Although there was little or no discernable difference between the residential and the non-residential cohorts in terms of the types of drugs consumed and the frequencies of consumption, those interviewed in residential settings were significantly more likely to have been using by injection (80%) than those interviewed in non-residential agencies (36%). The residential cohort also reported a wider use of substances over the recall period.
Total number of drug use incidents is measured in MAP by calibrating the number of drugs used multiplied by the number of days used in each type. Thus an individual reporting that they had used heroin and diazepam on a daily basis over the 30-day recall period plus alcohol on every other day would score 75 ([2 x 30] + [1 x 15] = 75).

Since the MAP measures for eight drugs identified as problematic with space to add a theoretically unlimited list of other drugs not identified, technically there is no limit to the number of drugs/days which could be reported. However, in practice, the majority of other drugs reported within the ‘Other’ category, could successfully be assigned to one of the named drugs (thus both lofexidine and subutex were classified with methadone, and ecstasy was classified as amphetamine). Moreover, those reporting use of cocaine, overwhelmingly used both cocaine hydrochloride powder and crack cocaine (generally according to which version was available on that particular day) and these two were therefore elided in the final calculations.

Thus, the overall range was judged to be from 0–240 (8 drug types x 30 possible days). This range was further sub-divided into moderate and high-risk consumption categories, with 120 drugs/days as the division point. Thirty-eight respondents (76%) were moderate risk (range: 26–120) and 12 (24%) were high risk (range: 122–219).

When separated into residential and non-residential categories, once again, those in residential treatment were more likely to be in the high-risk consumption category than their non-residential equivalents. Twice as many individuals in the residential cohort were high-risk consumers when compared to their counterparts. Moreover, the range within the high-risk category for the residential cohort was somewhat higher overall at 135–219 with an average score of 162. The non-residential cohort, by contrast, reported a range of 122–162 with an average score of 143.
The disparity in drug consumption intensity would appear to show that drug users presenting to residential treatment are likely to be more heavily dependent and living more chaotic lifestyles. This in itself is not entirely surprising since many local authorities have a policy of only referring for residential treatment when community-based options have failed.

Health risk behaviour was relatively low across the whole cohort. Few had had more than one sexual partner within the 30-day period and 19 (36%) had had no sexual partner at all during that time. Of the 29 (58%) who had been injecting, 15 reported sharing injection equipment, with twice as many sharers in the residential cohort (10:66%) as there were in the non-residential one (5:33%).

Both physical and psychological health is measured by the MAP in a ten-question matrix which allows overall scoring in a range from 0–40. As with drugs use incidence, these scores were divided evenly into ‘moderate’ and ‘high’ incidence of health problems. Twenty respondents (40%) reported high incidence of health problems.

The physical health problems most commonly reported were stomach pains, tremors and joint pains: symptoms which might generally be expected amongst
a sample of drug users, the majority of whom were reliant upon an intermittent supply of tolerance-creating drugs with the consequent risk of regular experience of withdrawal symptoms.

There was, though, little discernable difference between the residential and non-residential cohorts in reporting incidence, with approximately half of the high-incidence reports coming from each sub-group.

**Figure 8:** MAP physical health indices in medium- and high-risk categories by treatment type (n=50)

![Pie charts showing medium and high incidence categories by treatment type](chart)

With psychological health, however, the picture looked significantly different. Thirty-five respondents (70%) reported high incidence of psychological difficulties including panic attacks, depression and suicidal ideation.

**Figure 9:** MAP psychological health indices in medium- and high-risk incidence categories (n=50)

![Bar chart showing incidence categories by treatment type](chart)

There were significant differences too, between the two sub-groups. Of those reporting high incidence of psychological distress, the majority (60%) were from the residential cohort.
In terms of both social conflict and criminal activity, scores ranged from 0 to 100 and 0 to 692 respectively. In neither domain were there significant differences between the two sub-groups. Those reporting low scores for social conflict often noted that they had no contact with partners, relatives and/or friends and, therefore, limited opportunity for conflict of the kind described.

A surprising number (10: 20%) reported that they had committed no crimes other than possession of controlled drugs during the recall period. Those who reported committing crimes on a daily basis (28: 56%) were generally shoplifting or dealing in drugs. Drug dealing accounted for some 92% of criminal activity in those committing more than 200 crimes in the recall period. In part, this is because those actively involved in selling controlled drugs as part of their strategy to support their own individual habits, might typically commit between 20 and 50 such offences each day. Unemployment was the norm across the whole sample with only two reporting any days paid work in the recall period. Of those two, one had worked for 15 of the 30 days within the ‘black’ economy, as a mini-cab driver whilst the other had worked for two days as a window-cleaner.

Summary

This was a necessarily small, unfunded study in an area where there is no substantive body of literature against which to compare data outcomes. However, it does appear possible to draw some tentative conclusions from the data available.

There were clear differences between the residential and non-residential sub-groups which are likely to have resulted, at least in part, from current British drug policy, which generally reserves the (apparently) more expensive option of residential rehabilitation for those individuals who have demonstrated an inability (often, after a significant number of failed treatment episodes in community settings) to cease or moderate their misuse of drugs without the

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1 Throughout this study, the term ‘controlled drugs’ relates specifically to those drugs listed within the Misuse of Drugs Act 1971. This terminology remains consistent, regardless of whether the drugs in question were legally prescribed or obtained illicitly through diverse sources.
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highly structured and intensively supportive environment offered by residential treatment settings.

Differences between these two populations are important given the current emphasis, in UK drug policy, on comparative treatment outcomes and the consequent 'value for money' of various types of treatment episode (Roberts, Bewley-Taylor & Trace 2006; Healthcare Commission/NTA 2006). A number of large-scale treatment outcome studies, including NTORS, DARP, TOPS and DATOS have consistently shown a strong correlation between the severity of dependence and reduced retention, compliance and, thus, overall treatment outcomes.

If drug-free therapeutic communities (and, indeed, other residential rehabilitative facilities) are routinely responding to the needs of a treatment-seeking population which is significantly more damaged than that seen by comparable community-based agencies, then this must inevitably impact upon respective treatment outcomes. Simple comparative, cost-benefit analyses which assume a homogeneous population across a number of treatment modalities may be quite misleading and, specifically, may seriously underestimate the impact of treatment episodes within a therapeutic community.

Results from this small study appear to indicate that there may be value in further investigation into the characteristics of treatment populations presenting to the various treatment modalities made available within the UK. If residential treatment services are seeing drug users whose needs are more complex and whose prognosis is less favourable than in other services, then this factor would need to be taken account of in any calculation of comparative treatment episode cost.

References


NTORS: National Treatment Outcome Research Study. DARP: the Drug Abuse Reporting Programme. TOPS: Treatment Outcome Prospective Study. DATOS: Drug Abuse Treatment Outcome Study (see: Gossop 2005).


Follow-Up Evaluation of Tehran Therapeutic Community

Mohammad Reza Abdollahnejad

ABSTRACT: This paper describes a research project which set out to evaluate the effectiveness of treatment in Tehran Therapeutic Community. The Addiction Severity Index (ASI) was used to collect and assess information on six domains of the subjects’ lives.

This survey was conducted over a three-year period between 2003 and 2005. A total of 43 recovered subjects, all male, who had completed their treatment in the Therapeutic Community, were evaluated.

Findings indicate that the mean scores relating to drug and alcohol use, quality of social/family relationship, psychiatric status and medical status have reduced between the pre-test phase and the post-test phase, i.e. improvements were found in all these domains. Scores for legal status show no change in the three phases of pre-treatment, post-treatment, and follow-up. Scores for employment status show a reduction in the three phases demonstrating an improvement in this domain both in the pre-test-post-test phase and in the follow-up phase.

Regarding the 12 subjects interviewed for the case studies, the study shows that relationships with employers, colleagues and family had improved, and that there were positive changes in employment status, level of offending, psychiatric status, drug and alcohol use and physical health. A brief statement is included from each of the 12 interviewed subjects on their views about the effects of the treatment.

Introduction

Nowadays we observe a noticeable increase in the various therapeutic approaches with regards to substance abuse treatment. Different agencies apply different techniques depending on their understanding of and attitude towards the substance abuser and substance abuse. The question of which of these approaches is the most effective has been fundamental to debates among policy makers, therapists, researchers, and the public of many societies. This
question has led to researchers carrying out evaluations of the effectiveness of the different approaches and techniques around the globe. Such research suggests that effective approaches include methadone maintenance treatment (MMT), therapeutic communities (TCs), and outpatient drug-free treatment (Hubbard 1992; Institute of Medicine 1990; Tims, Fletcher & Hubbard 1991). These all have favourable outcomes for male opiate addicts with a decline in criminal behaviour resulting in arrests or incarceration after treatment. They also show employment levels six months after treatment to be substantially higher than pre-treatment levels. This paper is concerned with the evaluation of therapeutic community treatment, as this has been widely implemented, in response to the demand for more treatment options for offenders (De Leon et al. 2000).

Much evaluative research has already been conducted on TCs. One study was carried out in the Proyecto Hombre ('Project Mankind') in Asturias, Spain, in a long-term follow-up (ranging from 73 days to eight years) with a sample of 249 subjects. The results obtained by those completing the treatment (194 subjects) were compared with pre-treatment results and with those of the group that dropped out (55). The measurements used were relapses in illegal drugs, alcohol consumption, changes in family situation, educational level, employment, criminal involvement, and state of health. Findings support the effectiveness of the treatment in all measures and the validity of self-reported items (Fernández-Hermida et al. 2002).

Further, in another five-year follow-up evaluation by De Leon, Wexler and Jainchill (1982) from 1970 to 1975 on 75 subjects who had completed their period of treatment in a therapeutic community it was concluded that the success rate was more than 75% on indices such as productive activity, criminal behaviour, and the use of drugs.

The present paper describes a research project which set out to evaluate the effectiveness of treatment in Tehran Therapeutic Community. The Addiction Severity Index (ASI) was used to collect and assess information on six domains of the subjects’ lives.

Drug abuse and treatment in Iran

It is thought that the existence of opium in Iran dates back to the 8th century A.D. as a remnant of the Persian Empire. Opium was brought by the Arabs when they conquered Iran and has been used in some parts of Iran ever since. In the 19th century poppy seeds began to be planted and harvested in Iran and this continued until the 1950s, when the first primary prohibitory regulation on planting and consumption of opium was constituted (Atasheen 2002).

The original drug abuse treatment centres in Iran date back to 1961. At that time medical methods were the main focus and little attention was paid to the psychological aspects of treatment. After 1980, further developments in substance abuse treatment occurred, and psychological concerns began to be emphasised more than those of biology. In the past two decades other approaches such as the ‘twelve-step group’ approach started to emerge in Iran,
and Narcotics Anonymous (NA) groups in Iran turned out to be among the biggest in the world. As a result, other medical and non-medical methods began to be practised in Iran. These included methadone maintenance, the twelve-step group approach, miscellaneous medical therapies and the therapeutic community approach, amongst others.

The therapeutic community approach is regarded as a modern approach which has become widespread since the year 2000. Since then, close to 20 therapeutic communities have been established in Iran. Both specialists and substance abusers themselves have displayed a great deal of interest in the therapeutic community approach.

Therapeutic communities in Iran are under the supervision of the State Welfare Organization (responsible for health, health education, rehabilitation and social support in Iran) and nearly all major provinces in Iran have a therapeutic community centre. These communities are centrally organised and managed. All centres are drug-free therapeutic communities and are organised through a hierarchy of authority. Like TCs elsewhere in the world, each has several work departments including a cooking department, an expeditor department, a gardening department, a cleaning department, and a cultural/media department. All newcomers to therapeutic communities are sent to the cleaning department as the first step and are subsequently shifted to other departments and promoted through the hierarchy depending on their performance. Each client stays in the therapeutic community for six months, during which time they work through and complete the three main phases of treatment known as orientation, treatment, and re-entry.

**Tehran (Hejrat) Therapeutic Community**

In Tehran Therapeutic Community various treatment programmes and groups are provided. They include training classes and group therapies including encounter groups, cognitive behaviour therapy (CBT) groups, music therapy groups, family training classes, family therapy groups and vocational counselling.

The daily schedule in Tehran Therapeutic Community starts at 06:30 a.m. with body exercise, serving breakfast, and morning prayers. At 08:00 a.m. the morning meeting starts, covering such subject areas as expressing personal and group feelings, motto of the day and reading the news of the day, including items of political, social, and sports news. After the morning meeting, training classes start and later on job functioning and group therapy follow. At midday, the clients have their lunch and take a rest. Afternoon activities include training classes, sports, and reading books.

In Tehran TC there are rules about using drugs, aggressive behaviour and sexual relationships. If a client breaks one of these rules the matter is discussed in a special TC meeting, and a decision on disciplinary action is reached. The meeting will take the frequency and severity of the offence into account when reaching a decision. For instance, if the client uses drugs outside the TC for the first time, he will probably be downgraded to an inferior
position and department. If the client uses drugs inside the TC and does it several times, he will be discharged from the TC.

**Methodology**

This survey was conducted over a three-year period between 2003 and 2005. A total of 43 recovered subjects, all male, who had completed their treatment in the Therapeutic Community, were evaluated. All participants had completed the therapeutic community programme of six months’ duration. Prior to handing out any questionnaire or conducting any interview with clients, they were assured that the information they supplied would be used for research purposes only and that strict confidentiality would be observed.

In Tehran TC, the majority of the clients are opium addicts. However, this does not necessarily indicate that there are no alcohol-dependent people in Iranian society. It may be that, because alcohol is heavily prohibited in Iranian society both from a social and a religious point of view, there is less official information on its use. As far as marijuana consumption is concerned, the abusers do not become resident in the TC, nor are they referred as outpatients to the TC, as it is generally believed that this substance does not cause dependency.

<table>
<thead>
<tr>
<th>Total admitted</th>
<th>Graduated</th>
<th>Dropped out</th>
<th>Death among graduated clients</th>
<th>Uncompleted forms</th>
<th>Clients who moved to new places</th>
</tr>
</thead>
<tbody>
<tr>
<td>140</td>
<td>53</td>
<td>87</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>

As shown in Table 1, a total number of 140 clients were admitted to Tehran TC between 2003 and 2005, out of which 53 managed to graduate. Thus, 87 clients did not manage to complete the six-month period due to voluntary cancellation or discharge. On the other hand, out of the 53 graduates, two died of overdose and heart deficiencies, three refused to answer the family-related and medicine-related questions, and five were unavailable due to moving to new places without prior notification to Tehran TC. Hence, we conducted the research on a total number of 43 clients.

Demographic information on these 43 clients on entry to treatment was as follows.
<table>
<thead>
<tr>
<th>Table 2: Jail sentence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jail sentence</td>
</tr>
<tr>
<td>Percentage</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 3: Type of employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
</tr>
<tr>
<td>Percentage</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 4: Educational status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational status</td>
</tr>
<tr>
<td>Percentage</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 5: Legal status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal status</td>
</tr>
<tr>
<td>Percentage</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 6: Marital status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital status</td>
</tr>
<tr>
<td>Percentage</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 7: Consumption style</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumption style</td>
</tr>
<tr>
<td>Percentage</td>
</tr>
</tbody>
</table>

In the following tables, the term ‘poly drug use’ refers to clients who are dependent on two or more different types of drugs.
Table 8: Type of drugs

<table>
<thead>
<tr>
<th>Type of drug</th>
<th>Heroin</th>
<th>Opium</th>
<th>Marijuana</th>
<th>Alcohol</th>
<th>Poly drug use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>25</td>
<td>25</td>
<td>0</td>
<td>0</td>
<td>50</td>
</tr>
</tbody>
</table>

Measurements were based on the Addiction Severity Index (ASI) (McClellan et al. 1992). This was administered by trained psychologists and therapists through the use of interviews and covered six ‘life domains’: medical status, psychiatric status, legal status, employment status, substance use (drug and alcohol), family (marital) status/social relationships. The ASI was administered at three stages: pre-treatment (before therapeutic community treatment), post-treatment (after six months’ residence in the therapeutic community), and follow-up (three years after graduation from the therapeutic community). Additionally, qualitative ‘case studies’ were obtained from 12 subjects who had completed their treatment and had graduated three or more years earlier. For this part of the research, questions related to the six life domains in the ASI schedule were posed to the graduates and their families.

The demographic make-up of the 12 case-study graduates on entry to treatment was as follows.

Table 9: Type of drug

<table>
<thead>
<tr>
<th>Type of drug</th>
<th>Poly drug use</th>
<th>Alcohol</th>
<th>Marijuana</th>
<th>Opium</th>
<th>Heroin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 10: Marital status

<table>
<thead>
<tr>
<th>Marital status</th>
<th>Single</th>
<th>Married</th>
<th>Separated</th>
<th>Widower</th>
<th>Divorced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>6</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 11: History of drug abuse

<table>
<thead>
<tr>
<th>History of drug abuse</th>
<th>3 to 6 years</th>
<th>6 to 9 years</th>
<th>9 to 12 years</th>
<th>12 to 15 years</th>
<th>15 to 18 years</th>
<th>Over 18 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>
### Table 12: Age range

<table>
<thead>
<tr>
<th>Age range</th>
<th>25–30</th>
<th>30–35</th>
<th>35–40</th>
<th>40–45</th>
<th>45–50</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>2</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

### Table 13: Jail sentence

<table>
<thead>
<tr>
<th>Jail sentence</th>
<th>0 to 3 years</th>
<th>3 to 6 years</th>
<th>6 to 9 years</th>
<th>More than 9 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

### Table 14: Type of employment

<table>
<thead>
<tr>
<th>Employment</th>
<th>Self-employed</th>
<th>Labourer</th>
<th>Jobless</th>
<th>Clerk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>6</td>
</tr>
</tbody>
</table>

### Table 15: Educational status

<table>
<thead>
<tr>
<th>Educational status</th>
<th>Under High School diploma</th>
<th>High School diploma degree</th>
<th>University degree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>7</td>
<td>4</td>
<td>1</td>
</tr>
</tbody>
</table>

### Table 16: Legal status

<table>
<thead>
<tr>
<th>Legal status</th>
<th>Drug smuggling</th>
<th>Theft</th>
<th>Violence</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

### Table 17: Consumption style

<table>
<thead>
<tr>
<th>Consumption style</th>
<th>Smoking</th>
<th>Oral</th>
<th>Intravenous injection</th>
<th>Sniffing</th>
<th>Poly consumption style</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>
The findings from the three stages of the ASI study are presented below. They indicate that the mean scores relating to drug and alcohol use, quality of social/family relationship, psychiatric status and medical status have reduced between the pre-test phase and the post-test phase, i.e., improvements were found in all these domains. However, the mean score remained unchanged in the follow-up phase. In other words, it appears that the mean continues at the new lower level in the follow-up phase but improvement here does not increase. Scores for legal status show no change in the three phases of pre-test, post-test, and follow-up. The data for this domain showed that one resident moved from a forensic to a non-forensic status during the study. Scores for employment status show reduction in the three phases demonstrating an improvement in this domain both in the pre-test-post-test phase and in the follow-up phase.

Figure 1: Change in drug and alcohol use at admission, post-treatment and follow-up
Figure 2: Change in medical status at admission, post-treatment and follow-up

Figure 3: Change in employment status at admission, post-treatment and follow-up