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

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Addiction and Recovery cluster
OVERVIEW

1. Addiction recovery?!
2. Facts & figures about addiction recovery
3. The role of treatment
4. Natural recovery
5. Some conclusions
1. ADDICTION RECOVERY?!
“Recovery from substance dependence is a voluntarily maintained lifestyle, characterized by sobriety, personal health, and citizenship.”
“The process of recovery from problematic substance use is characterised by voluntarily-sustained control over substance use, which maximises health and wellbeing and participation in the rights, roles and responsibilities of society.”
Anthony (1993) defined recovery as "a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life, even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness."
SOME COMMON ELEMENTS

– Not only about stopping or reducing
– Individual process of change/growth
– Personal choice
– Importance of wellbeing/quality of life
– Meaningful activities
– Social participation
– Social support and the community
– Supportive role of treatment
AT LEAST TWO DIMENSIONS OF RECOVERY
(SLADE ET AL., 2010)

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

– The second involves personal recovery – recovering a life worth living (without necessarily achieving clinical recovery). It is about building a life that is satisfying, fulfilling and enjoyable.
SOME EVEN SUGGEST FOUR DIMENSIONS
(VAN DER STEL, 2013)

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

- Personal recovery as driving force
DO PEOPLE PROCEED SIMILARLY REGARDING THESE RECOVERY DIMENSIONS (CASTELEIN ET AL., 2017)?

METHODS

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

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

Psychotic disorder (99% within schizophrenia spectrum)

- Mean age: 43 year
- Male/female: 67/33%
- Duration of illness: 18 year
PERSONAL RECOVERY: 77%

Personal recovery

Recovered at first measurement (M1)

77% n=1700
90% n=720
93% n=347

Not recovered at first measurement (M1)

23% n=1700
56% n=720
82% n=347

= still recovered
CLINICAL RECOVERY : 50%

Symptomatic recovery

Recovered at the first measurement (M1)

50%  
n=1510

76%  
n=375

87%  
n=122

= still recovered

Not recovered at the first measurement

50%  
n=1510

28%  
n=386

63%  
n=57

= still recovered
FUNCTIONAL RECOVERY: 14%

Functional remission

Recovered at first measurement

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

Not recovered at first measurement

86% still recovered

44%
2. FACTS AND FIGURES ABOUT RECOVERY
The natural course of drug addiction (HSER ET AL. 2000)

The natural history of narcotics addiction among a male sample (N=581).
40 YEARS OF ADDICTION RESEARCH: WHAT DO WE KNOW ABOUT TREATMENT & RECOVERY?
(SCOTT & DENNIS, 2003)

- MOST ADDICTS relapse unless treated early and effectively.
- MOST ADDICTS cycle more than 3 times through periods of untreated addiction, treatment, sobriety, and incarceration
- MOST ADDICTS experience a trajectory for recovery based on genotype (severity of biological addiction)
- MOST ADDICTS improve the odds ratio for remaining sober after one year of sobriety
- MOST ADDICTS achieve self-sustainable recovery (low odds ration for relapse) after 5 years of sobriety
- MOST ADDICTS take over 30 years to achieve 5 years of sobriety.
RECOVERY CLEARLY NOT ONLY ABOUT ABSTINENCE (UKATT, 2005)

Figure 3c: Categorical treatment outcomes from the UK Alcohol Treatment Trial
RECOVERY PREVALENCE (BEST ET AL., 2019)

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

White (2012) reviewed remission rates in a review 415 scientific reports between 1868 and 2011:
- 49.9% of those with a lifetime substance use disorder will eventually achieve stable recovery (increased to 53.9% in studies published since 2000)
- White also argues that between 5.3–15.3% of the adult population of the US are in recovery from a substance use disorder (> 25 million people)
Addiction onset, help seeking, sustained remission (1 year), and relapse risk drops below 15%. Self-initiated cessation attempts can occur in 4-5 years. Treatment episodes/mutual help occur in 8 years. Continuing care/mutual help occur in 5 years. For severely dependent individuals, the course of dependence and achievement of stable recovery can take a long time. (White, 2013)

Opportunity for earlier detection through screening in non-specialty settings like primary care/ED. 60% of individuals with addiction will achieve full sustained remission (White, 2013).
CHIME FRAMEWORK: SUPPORTIVE ELEMENTS FOR PERSONAL RECOVERY

(LEAMY, BIRD, LE BOUTILLIER, WILLIAMS & SLADE, 2011)
RECOVERY CAPITAL (BEST AND LAUDET, 2010)

- Personal Recovery Capital
- Social Recovery Capital
- Collective Recovery Capital
THE ROLE OF RECOVERY CAPITAL

Recovery capital is crucial at different stages of the recovery continuum (Best e.a., 2010; Laudet & White, 2008; Best & Laudet, 2010).

- **Personal recovery capital**: personal characteristics and skills which can be supportive for recovery, such as specific competences, severity of dependence and style of attribution.

- **Social recovery capital**: includes the social network of the individual and the extent to which the individual experiences support and acceptance from this network.

- **Community recovery capital**: concerns the extent of support that is available within the wider community, such as housing, employment, training, treatment and self-help groups.
3. THE ROLE OF TREATMENT
Prevalence and pathways of recovery from drug and alcohol problems in the United States population: Implications for practice, research, and policy

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Problem resolution
Treatment
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\textbf{ABSTRACT}

\textit{Background:} Alcohol and other drug (AOD) problems confer a global, prodigious burden of disease, disability, and premature mortality. Even so, little is known regarding how, and by what means, individuals successfully resolve AOD problems. Greater knowledge would inform policy and guide service provision.

\textit{Method:} Probability-based survey of US adult population estimating: 1) AOD problem resolution prevalence; 2)
9.1% in recovery of a SUD!

Only 53.9% reported ‘assisted pathways’
Research Paper

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

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Cannabis

\textbf{ABSTRACT}

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

\textbf{Method:} National, probability-based, cross-sectional sample of the US non-institutionalized adult
Table 2
Recovery indices.

<table>
<thead>
<tr>
<th></th>
<th>Primary Problem Substance</th>
<th>OR/d CAN vs. ALC</th>
<th>OR/d CAN vs. OTH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cannabis (12.6%, n = 217)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abstinence from all drugs/alcohol</td>
<td>43.69</td>
<td>0.82</td>
<td>1.05</td>
</tr>
<tr>
<td>Abstinence from problem drugs/alcohol</td>
<td>32.39</td>
<td>2.13*</td>
<td>0.78</td>
</tr>
<tr>
<td>Non-problematic/moderate use of drugs/ alcohol</td>
<td>13.92</td>
<td>0.54</td>
<td>1.54</td>
</tr>
<tr>
<td>Currently self-defined as “in recovery”, %</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric Symptoms, M(SE)</td>
<td>5.53 (0.62)</td>
<td>0.18</td>
<td>−0.03</td>
</tr>
<tr>
<td>Happiness, M(SE)</td>
<td>3.74 (0.10)</td>
<td>0.00</td>
<td>−0.04</td>
</tr>
<tr>
<td>Self-Esteem, M(SE)</td>
<td>3.35 (0.14)</td>
<td>−0.15</td>
<td>−0.04</td>
</tr>
<tr>
<td>Quality of Life (Item mean), M(SE)</td>
<td>3.65 (0.10)</td>
<td>−0.03</td>
<td>0.12</td>
</tr>
<tr>
<td>Recovery Capital, M(SE)</td>
<td>47.70 (1.04)</td>
<td>0.14</td>
<td>0.09</td>
</tr>
</tbody>
</table>

* p < 0.05.
Recovery Indices by Years Since Problem Resolution

Years 0-5

Years 0-2

Quality of Life
Happiness
Recovery Capital
Psychological Distress
Self Esteem

Recovery Index Z-score vs. Years Since AOD Problem Resolved
INFORMAL SUPPORT AND HELP
Importance of ‘connectedness’/belonging + support by social network (family, peers, …)

The network’s involvement and availability is crucial, but not self-evident

– Recovery is a social process

Importance + role of experts by experience

Empowerment + promoting self-care, eg. WRAP

The relational and interactionist dimension of recovery:

– “I am surrounded by people and they really listen to what I say. Sometimes we sit together and laugh with things I like, funny things.” (man, 40 years)
RECOVERY THROUGH THE EYES OF FAMILY MEMBERS (DEKKERS ET AL., 2019)

– Focus groups (n=9) with family members
– Recovery?
  – “Hit rock bottom”
  – Process, but not endless opportunities
  – Identity and/or behaviour change
  – Finding a place to be (me)
ON THE NECESSITY OF RECOVERY-ORIENTED SYSTEMS OF CARE (ROSC) (DAVIDSON & WHITE, 2007)

Basic assumptions:
1. Recovery looks different for different individuals
2. ROSC matches with where an individual is in their recovery process, with appropriate interventions and resources
3. Recovery is a process along a continuum
4. Peer support, family support and involvement, and spirituality as core components
RECOVERY-ORIENTED SYSTEMS OF CARE (ROSC)

1. Early identification and engagement;
2. Use of role modeling;
3. Increase motivation for change;
4. Offer education;
5. Provide effective treatments and interventions;
6. Provide opportunities for individuals to occupy valued roles;
7. Connection between individuals and the larger recovery community;
8. Provide post-treatment monitoring and recovery coaching;
9. Offer meaningful recovery support services (e.g. supported housing, supported employment, supported education)
10. Offer legal advocacy
ONE STEP BEYOND: BUILDING RECOVERY READY COMMUNITIES (ASHFORD ET AL., 2019)
4. RECOVERY PATHWAYS (REC-PATH)
RECOVERY PATHWAYS IN THE UK, THE NETHERLANDS AND BELGIUM
Welcome to the Life in Recovery survey.

We are glad you have found us. Here you can share your recovery experience.

Just click on the button next to your preferred language and fill in the questionnaire.

English language version

Begin survey

Vlaamse versie

Start de enquête

Nederlandse versie

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

Life in Recovery Survey N=722
STAGES OF RECOVERY (LIFE IN RECOVERY SURVEY, 2018)

- < 1 year: n=187
- 1-5 years: n=290
- > 5 years: n=305
HOUSING, CRIME & OCCUPATIONAL SITUATION BY RECOVERY STAGE

Differences between recovery stages

- Problems with housing:
  - < 1 year: 14, p < 0.01
  - 1-5 year: 6, p < 0.01
  - > 5 year: 2

- Crime:
  - < 1 year: 27, p < 0.01
  - 1-5 year: 12, p < 0.01
  - > 5 year: 6

- Occupation situation:
  - < 1 year: 54, p < 0.001
  - 1-5 year: 82, p < 0.001
  - > 5 year: 88

GHENT UNIVERSITY
SUBSTANCE USE BY RECOVERY STAGE

Differences in substance use

- **ALCOHOL**
  - < 1 jaar: 25
  - 1-5 jaar: 19
  - > 5 jaar: 25

- **HARD DRUGS**
  - < 1 jaar: 17
  - 1-5 jaar: 8 (p < 0.05)
  - > 5 jaar: 5

- **CANNABIS**
  - < 1 jaar: 17
  - 1-5 jaar: 9 (p < 0.05)
  - > 5 jaar: 9

- **ABSTINENT VAN ALCOHOL, DRUGS EN OPIAATVERVANGERS**
  - < 1 jaar: 63
  - 1-5 jaar: 73
  - > 5 jaar: 70

Legend:
- Blue: < 1 jaar
- Orange: 1-5 jaar
- Gray: > 5 jaar

Note: Differences in substance use are statistically significant at the p < 0.05 level.
LIFE IN ACTIVE ADDICTION VS IN RECOVERY

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

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

Figure 7: Stable housing in active addiction and in recovery

Figure 8: Steady employment in active addiction and recovery
## COMBINATIONS OF TREATMENT & SUPPORT (EVER)

<table>
<thead>
<tr>
<th>Treatment / Mechanisms of behaviour change</th>
<th>N</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natural / none</td>
<td>17</td>
<td>4.6</td>
</tr>
<tr>
<td>Mutual aid only</td>
<td>20</td>
<td>5.4</td>
</tr>
<tr>
<td>Outpatient only</td>
<td>19</td>
<td>5.2</td>
</tr>
<tr>
<td>Residential only</td>
<td>21</td>
<td>5.7</td>
</tr>
<tr>
<td>Outpatient + Residential only</td>
<td>58</td>
<td>15.8</td>
</tr>
<tr>
<td>Mutual aid + Outpatient only</td>
<td>33</td>
<td>9.0</td>
</tr>
<tr>
<td>Mutual aid + Residential only</td>
<td>49</td>
<td>13.4</td>
</tr>
<tr>
<td>Mutual aid + Outpatient + Residential</td>
<td>150</td>
<td>40.9</td>
</tr>
</tbody>
</table>

OSB: Baseline assessment (n=367)
5. NATURAL RECOVERY
“I was extremely embarrassed during that period. I still am. I didn’t want anyone to find out about it. I wanted to overcome my addiction on my own and I succeeded. Although I imagine that for many people this is incredibly difficult and almost impossible.”

- Emma, 26, had problems with speed and cocaine (LiR survey) -
### Table 2
Recovery pathway choices of U.S. adults who endorsed “used to have a problem with drugs or alcohol, but no longer do” (9.1% (SE =0.28)).

<table>
<thead>
<tr>
<th>Pathway</th>
<th>weighted%</th>
<th>SE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Used support</td>
<td>53.9</td>
<td>1.60</td>
</tr>
<tr>
<td>Professionally assisted recovery support (aka formal treatment) (any)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient addiction treatment</td>
<td>16.8</td>
<td>1.21</td>
</tr>
<tr>
<td>Inpatient or residential treatment</td>
<td>15.0</td>
<td>1.08</td>
</tr>
<tr>
<td>Alcohol/drug detoxification services</td>
<td>9.1</td>
<td>0.91</td>
</tr>
<tr>
<td>Anti-relapse/craving medication use (any)</td>
<td>8.6</td>
<td>0.93</td>
</tr>
<tr>
<td>Recovery support services</td>
<td>21.8</td>
<td>1.40</td>
</tr>
<tr>
<td>Mutual-help groups</td>
<td>45.1</td>
<td>1.60</td>
</tr>
</tbody>
</table>

46.1% in unassisted/natural recovery

NATURAL RECOVERY

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

- Research mainly focused on:
  - smoking cessation
  - Prevalence

- Need for in-depth understanding of the phenomenon

- Complement to treatment-focused studies
6. SOME CONCLUSIONS
– Emerging recovery research in Europe, emphasizing:
  – Individuals’ unique recovery journeys
  – clear country/regional differences
  – role of ≠ treatment mechanisms
  – importance of informal network and ongoing support

– Natural recovery may not be underestimated, but appears to be rather uncommon in Europe
  – Area of further interest
Funding acknowledgement:

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CONTACT & ADDITIONAL INFORMATION

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

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

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


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

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Dept. of Special Needs Education
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OVERVIEW

– History and development of TCs
– TCs and the evidence-base
– TCs in an era of community-based care: supporting addiction recovery
  – Recovery an quality of life
– Conclusion
HISTORY AND DEVELOPMENT OF TCS
HISTORY AND DEVELOPMENT OF TCS

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

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

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

– However, renewed interest in TCs due to emerging recovery movement, international expansion of TCs and the evidence that the cycle of addiction can be broken
THERAPEUTIC COMMUNITIES (TCS) FOR ADDICTIONS: A DEFINITION

- “A drug-free environment in which people with addictive problems live together in an organized and structured way to promote change toward a drug-free life in the outside society” (Broekaert, Kooymans, & Ottenberg, 1998, p. 595)
Table 1: Overview of the number of TCs per country, their capacity and (estimated) number of clients per year (2011), as well as an estimation of the average number of clients per TC/country and the estimated number of treated clients per available bed/year

<table>
<thead>
<tr>
<th>Country</th>
<th>Number of TCs</th>
<th>Total capacity</th>
<th>Number of clients per year</th>
<th>Average number of clients per TC</th>
<th>Number of treated clients/bd per year</th>
<th>Number of TCs/100 000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>9</td>
<td>269</td>
<td>599</td>
<td>30</td>
<td>2.23</td>
<td>0.107</td>
</tr>
<tr>
<td>Belgium</td>
<td>8</td>
<td>204</td>
<td>357</td>
<td>25</td>
<td>1.75</td>
<td>0.073</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>3</td>
<td>60</td>
<td>140</td>
<td>20</td>
<td>2.33</td>
<td>0.040</td>
</tr>
<tr>
<td>Croatia</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
<tr>
<td>Cyprus</td>
<td>1</td>
<td>50</td>
<td>86</td>
<td>50</td>
<td>1.72</td>
<td>0.125</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>10</td>
<td>169</td>
<td>394</td>
<td>16</td>
<td>2.46</td>
<td>0.095</td>
</tr>
<tr>
<td>Denmark</td>
<td>1</td>
<td>15</td>
<td>41</td>
<td>15</td>
<td>2.73</td>
<td>0.018</td>
</tr>
<tr>
<td>Estonia</td>
<td>1</td>
<td>26</td>
<td>82</td>
<td>26</td>
<td>3.15</td>
<td>0.074</td>
</tr>
<tr>
<td>Finland</td>
<td>4</td>
<td>58</td>
<td>264</td>
<td>14</td>
<td>4.55</td>
<td>0.074</td>
</tr>
<tr>
<td>France</td>
<td>11</td>
<td>380</td>
<td>n.a.</td>
<td>34</td>
<td>n.a.</td>
<td>0.017</td>
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<td>Germany</td>
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<td>851</td>
<td>45</td>
<td>1.87</td>
<td>0.016</td>
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Total               | 1,223         | 8,449.5        |                           |                                  |                                       | 0.16                  

Note:

*a* = 2010 data; *b* = 2009 data; *c* = 2008 data; n.a. = not available
TC MODEL UNDER PRESSURE IN SEVERAL EU-COUNTRIES

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

- Situation varies substantially across Europe:
  - eg. North vs. South and East Europe
  - Modified TCs for specific populations, shorter term programs, smaller scale units + prison TCs
TCS AND THE EVIDENCE-BASE
EVIDENCE FOR EFFECTIVENESS?

- TCs have been widely evaluated
  - Early (and later) studies underscored the strong relationship between TIP and success
    - Abstinence rates: 85-90% among graduates vs. 25-40% among early drop-outs (Holland, 1983)

- Relatively few controlled studies regarding TC effectiveness
  - Poor applicability of controlled study designs in TC environments
    - Lack of adequate control conditions
    - High attrition rates
    - Reciprocal influence of resident and TC environment
  - Controlled studies mainly from US

- Numerous (uncontrolled) field effectiveness studies from Europe and Australia/NZ and recently from Brazil, Iran, China, Korea, Philippines, Kyrgyzstan, ...
AVAILABLE REVIEWS

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

- Leading to rather divergent conclusions:
  - ≠ scope, objectives, selection criteria, analytic methods
  - Few studies retained in all reviews
29 controlled studies on TC treatment (8 RCTs)

- Democratic TCs, as well as concept TCs (1/4)
- Strong positive effect of TCs compared with control interventions
- Substantial study heterogeneity
- Addiction TC outcomes significantly more effective than democratic TCs (! More severely disturbed population, personality disorders)
Therapeutic communities for substance related disorder (Review)

Smith LA, Gates S, Foxcroft D

7 RCTs of drug-free TCs, compared with varying control conditions (day TC, community residence, short TC program, ...)

- Focus on substance use and retention
- Few evidence that TCs offer significant benefits compared with other types of residential Tx or other types of TCs
- Poor evidence due to lack of studies + its methodological limitations (high attrition rates, drop-out from Tx)

OUTDATED !!!
– Critical evaluation of the assertion that TC effectiveness is not proven (Smith et al., 2006)
– Non-exhaustive review of North American literature on addiction TCs
– Consistent evidence of TC effectiveness
  – numerous field effectiveness studies
  – controlled studies: better outcomes
  – meta-analyses: 4 found small to moderate effect sizes, 2 found insufficient evidence
  – cost-benefit analyses: in favor of TC treatment, in particular reduced costs associated with criminality and gains in employment
– most TCs routinely use evidence-based interventions like MI, CBT, …
Systematic review of 12 follow-up studies of TC effectiveness during and after Tx (studies on prison TCs excluded)

- Tx completion: 9-56%, program cessation most often after 15-30 days
- Decrease in substance use during follow-up, still 21-100% used or relapsed
- 20-33% re-entered Tx
- Large differences between studies in Tx duration + length of follow-up period
- Tx completion and retention identified as robust predictors of abstinence
Review Article

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

Wouter Vanderplasschen,1 Kathy Colpaert,1 Mieke Autrique,1 Richard Charles Rapp,2 Steve Pearce,3 Eric Broekaert,4 and Stijn Vandevelde4

– Systematic review of 16 controlled studies
– Traditional + modified TCs, in prison and community settings
– Retention + participation in aftercare robust predictors of TC outcomes, although drop-out higher than in most comparison conditions
– In majority of studies, TC group had better substance use and legal outcomes than comparison condition
– TCs can promote change regarding various outcome indicators, but continuing care approach needed
Table 3.6: Overview of the review results

<table>
<thead>
<tr>
<th>Reference number of the study/studies</th>
<th>Type of TC</th>
<th>Comparison condition</th>
<th>Follow-up length</th>
<th>Outcome measures</th>
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<td></td>
<td></td>
<td></td>
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<td>Retention</td>
</tr>
<tr>
<td>1. Prison</td>
<td>TAU</td>
<td>1 year</td>
<td></td>
<td>+</td>
</tr>
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<td>TAU</td>
<td>1 year</td>
<td></td>
<td>=</td>
</tr>
<tr>
<td>3. Prison</td>
<td>Other TC</td>
<td>1 year</td>
<td></td>
<td>+</td>
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<td>TAU</td>
<td>2 years</td>
<td></td>
<td>=</td>
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<td>5. Prison</td>
<td>TAU</td>
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<td>+</td>
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<td>TAU</td>
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<td></td>
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<td>TAU</td>
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<td></td>
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</tr>
<tr>
<td></td>
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<td></td>
<td>+</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 years</td>
<td></td>
<td>+</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 years 6 months</td>
<td></td>
<td>+</td>
</tr>
<tr>
<td></td>
<td></td>
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<td>+</td>
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<td>TAU</td>
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<td></td>
<td>+</td>
</tr>
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<td></td>
<td></td>
<td>2 years</td>
<td></td>
<td>+</td>
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<tr>
<td></td>
<td></td>
<td>5 years</td>
<td></td>
<td>+</td>
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</tr>
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<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>1 year 6 months</td>
<td></td>
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Abbreviations: TC=Therapeutic Community, Other TC=Other TC modality, TAU=Treatment As Usual
Varying follow-up period (mostly 6-12 months, exc. >36 months)
- Between group differences diminished over time
- ‘Substance use’ and ‘legal involvement’ most frequently assessed
  - 10/14 studies: ++ substance use outcomes
  - 9/13 studies: ++ legal outcomes
- Multiple outcome indicators used:
  - seldom ≥ 2 significant outcomes in one category (cf. Prendergast, 2003)
  - Improvement in one category not necessarily associated with improvement on other domains
WHAT TO CONCLUDE FROM ‘THE EVIDENCE’?

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

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

– Lack of convincing evidence ≠ evidence of ineffectiveness

– Need for comprehensive a review/meta-analysis of TC studies, taking into account setting, population, program/follow-up length, …
TCS IN AN ERA OF COMMUNITY-BASED CARE: SUPPORTING ADDICTION RECOVERY
“Recovery from substance dependence is a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship.” (Betty Ford Institute, 2007)

“A deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life, even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness.” (Anthony, 1993, p. 527)
DIFFERENT TYPES OF RECOVERY (SLADE ET AL., 2010)

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

- Clinical vs. personal recovery
- Abstinence vs. Quality of Life!
CHIME FRAMEWORK FOR PERSONAL RECOVERY (LEAMY, BIRD, LE BOUTILLIER, WILLIAMS & SLADE, 2011)
IMPORTANCE OF AFTERCARE AND CONTINUING CARE FOR PROMOTING RECOVERY

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

Link with employment, new social networks and community-based support
QUALITY OF LIFE AND RECOVERY:

“Individuals’ perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns.” (The WHOQOL Group, 1998, p. 551)
NOT A FOCUS IN MOST TC-STUDIES

– Despite numerous TC-studies, few have focused on QoL or well-being
– Focus on ‘hard’/socially desirable outcomes
– Often regarded as an ‘umbrella term’
– Scoping review of longitudinal studies of TC treatment and QoL:
  – N<15
  – Large heterogeneity
  – Mental health, wellbeing and QoL seldom reported
  – QoL recently used as outcome measure in TC studies on differential effectiveness
PATHWAYS THROUGH TREATMENT: A MIXED-METHODS LONGITUDINAL OUTCOMES STUDY OF COOLMINE THERAPEUTIC COMMUNITY

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

Figure 7: Self-perceived quality of life over 24 months: Mean scores
“Post-treatment improvements in quality of life were reported by all participants. Establishing a routine, maintaining a household, moving away from full-time recovery-focused activities, (re)connecting with family, (re)building relationships with their children were all cited as sources of fulfilment, joy and self-esteem. Overall, participants aspired towards what they described as ordinary or everyday things, such as family contact, a home, children, a pet or the means to travel. The sense of hope extended beyond the material world to a more abstract, overarching sense of optimism that emerged from the narratives of drug-free participants.”
ROUTINE MONITORING OF QUALITY OF LIFE AFTER TC TREATMENT IN DE KIEM (BE)

- Exploratory study of QoL during and after TC treatment
- Baseline assessment + after 3, 6, 12, 24 and 60 months
- Computerised assessment using the MANS (Priebe et al., 1999)
  - Including objective as well as subjective indicators
  - Measured on a 7-point Likert scale
  - 5-10 minutes
CONCLUSION
THE ROLE OF TCS IN A NETWORK OF DRUG SERVICES?

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

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

DEPARTMENT OF SPECIAL NEEDS EDUCATION
ADDITION & RECOVERY CLUSTER

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