Therapeutic Communities: Australian experience

Lynne Magor-Blatch
John Howard

ATCA

Historical foundations

- The roots of the contemporary therapeutic community lie in the self-help movement and mutual-aid fellowship (Broekaert, Vandervelde, Soyez, Yates & Slater, 2006; DeLeon, 1997; Rawlings & Yates, 2001)
- Continuation of a long history of recovery groups.
- Interest and support of the medical fraternity and academics, in the UK and other parts of Europe in early years.
- TC practice merged with social psychiatry through the innovative practice of Jones, Laing, Clarke, Mandlebrote, Christie and others (Rawlings & Yates; Yates, 2010).
- TCs and residential treatment also met with suspicion and rejection by many in mainstream medical addiction treatment.

Evolution of the Therapeutic Community

- The idea of the TC recurs throughout history in different incarnations
- Communities that teach, heal and support appear in spiritual, temperance, mental health and other contexts
- In contemporary form – 2 major variants – social psychiatry (UK) & community-based residential treatment (USA)

Evolution of the TC - UK

- TCs in psychiatric hospitals pioneered by Maxwell Jones (mid-1940s) and others in UK
- Maxwell Jones founded a community to provide structure and content for therapeutic change in the lives of individuals with long-standing mental disorders
- Treated difficult psychiatric cases considered beyond treatment, such as “chronic failures” and “troublemakers”
- Based his approach on the theory that a healthy group life would make healthy individuals

Evolution of the TC – UK

- Considered all relationships to be potentially therapeutic
- Placed high value on communication
- Believed that productive work was an essential component of treatment
- Successfully resocialised patients into the outside community
- 1946: British Medical Journal - Tom Main coined the phrase Therapeutic Community to describe a place “organised as a community in which all are expected to contribute to the shared goals of creating a social organisation with healing properties” (Rapaport, 1960).
- Earliest UK TCs – Alpha House (1969), The Ley Community (1972)

- TCs in UK appeared about 15 years earlier than TCs for addictions in USA, pioneered by Charles (Chuck) Dederich
- Synanon model developed from self-help meetings held in Dederich’s home as AA meetings not comfortable with drug users attending
  - Based on the notion of self responsibility
  - No acknowledgement of post-treatment phase
  - Drug-abuser understood as a character-disordered individual who couldn’t sustain prosocial lifestyle in mainstream society
  - Also recruited people who were not drug dependent
  - By 1978 Synanon transformed into alternate lifestyle community

- American TCs largely staffed in the early days by “ex-addict” (recovered, other professional) staff
- UK model, growing out of psychiatric hospitals, largely staffed by professionals (nurses, psychologists, psychiatrists)
- In late ’60s and early ’70s the concepts of the self help tradition merged with the use of professional practices and staffing in UK began to include people who had been through programs and US programs started to include professionally trained staff

The Australian Beginnings...

- Therapeutic Communities for the treatment of alcohol and other drugs misuse have been in operation overseas since the 1940s and in Australia since 1972.
- The therapeutic community movement was formalised in Australia in 1985 during the Premier’s Conference, held in Melbourne, Victoria. This was the forerunner of the National Campaign Against Drug Abuse (NCADA).
- Many of the Australian programs had their beginnings in the 1930s and 1940s, developing into therapeutic communities as understanding of the model has grown.

Therapeutic communities have operated in Australia since the mid to late 1970s (Carr-Gregg, 1984).

Australian beginnings

- We Help Ourselves (WHOs) in NSW, 1972
- The Buttery, NSW, 1975
- ADPACT (now ADFACT) established in Canberra 1976, Karralika TC established in 1978
- Odyssey House established in Australia & New Zealand, 1977
- Killara House (Vic/NSW), 1978-1979
- Cyrenian House WA, 1981
- 1986 - The beginning of the ATCA as an Association to support and promote TCs

Australasian Therapeutic Communities Association (ATCA)

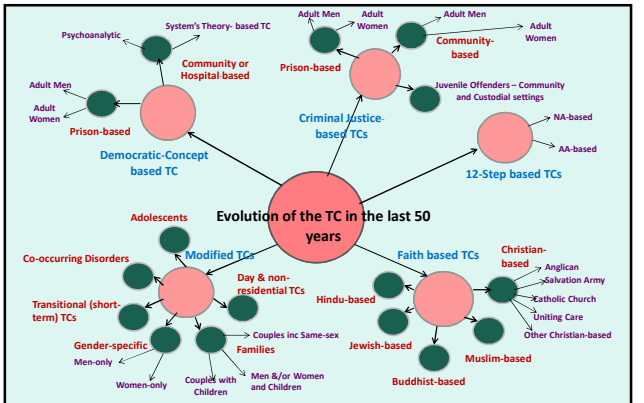
- Established in 1986
- Currently represents 38 members operating 63 TCs in Australia and New Zealand.
- 12 prison-based TCs – 9 of these in NZ.
- In 2010-2011, admitted 9,129 residents – 1,704 in custodial TC settings.
- Programs working with families admitted 223 children along with their parents.
- TCs worked with 23,386 people in outpatient, education and support services.
- Total of 32,738 residents and clients in the past year.

Therapeutic Community Model

- Provides a combination of therapeutic involvements between residents and staff and among residents (especially senior and junior residents) through living in a caring and challenging community as the principal means to encourage change and personal development
- Provides a multidimensional treatment involving therapy, education, values and skills development
- The common theme to all TCs is one of self-help and the notion that residents play an integral, active role in their own therapy and in the therapy of other residents

Therapeutic Community Model

- Social-cognition approach, comprising attitudinal, normative and behavioural control components
- Process involves five main areas of primary treatment:
  - socialisation in terms of developing attitudes and values of a mainstream, prosocial lifestyle;
  - psychological improvement, in terms of heightened insight, self-esteem and self-efficacy;
  - recognition of triggers to substance use;
  - the development of self-efficacy through new coping skills; and
  - the development of supportive networks



- TCs can vary in size from 8 to 100 or more residents.
- They may be in community or correctional settings, and residents or participants can be:
  - adolescents or adults,
  - males or females only,
  - mixed genders,
  - parents, either singles or couples, who bring their children with them into the service.
- TCs employ more than 1,000 staff and treat over 9,000 people annually in residential services and more than 24,000 in outclient programs.
- Provide critical services such as detoxification units, family support programs, child care facilities, exit housing & outreach services.

Indicators of the TC Model's Evolution Into Mainstream Human Services

- A mix of professionals
- Evaluation research
- Program and staff competence standards
- Professional associations
- Common components
- Adaptations to new settings and special populations

Features common to TCs

- TCs use a holistic approach that goes beyond the single-level approach of traditional psychiatry or medication alone.
- The community that is created affects the recovery of the individual.
- Residents actively participate in the community and engage in work that allows them to return to society.
- Communication and relationships among all members of the community aid in the recovery process.

TC Models are divided into three sub-categories

Traditional TCs
•a goal of total resocialisation
•one to three years in duration
•treatment that includes high demands, confrontation and sanctions

Modified TCs
•a goal of developing practical skills,
•six to eight months duration
•treatment that includes moderate demands and sanctions

Short-term TCs
•a goal of providing skills to allow the client to survive in society and re-establish family relationships
•three to six months duration
•treatment demands that are moderate to high

Research into TCs

- The TC studied and evaluated for over 40 years.
- Majority of evidence points to the fact that for those who complete treatment, there is a profound impact on both drug using and lifestyle behaviours.
- Also importantly, there is ample evidence of long term benefit even for those who do not complete treatment, but who undertake a period of rehabilitation, even if they are not 'graduates'.

Research into TCs

- One factor repeatedly associated with better treatment outcome is longer period of treatment (Hubbard et al, 1997; Gossop et al, 1999; Flynn et al, 2003; Hubbard et al, 1989; Simpson et al, 1997).
- What is also important is cause of program separation – ie graduation or successful completion of program stages shown to be important – independent of program length and retention rate per se (Toumbourou & Hamilton, 1993).
- Therefore, retention needs to be seen in the context of intended treatment length.

Outcome studies

- Retention of at least 3mths shown to have better outcome in US studies (Simpson, 1997).
- UK studies show better outcome amongst those who stayed 90 days or more as well as those who stayed 28 days or more in shorter programs (>3mths) (Gossop et al, 1999).

Short vs. Longer term programs at 24mths

- No difference between short or longer-term programs in either current heroin abstinence (72% vs. 70%) or daily use (10% vs. 13%).
- No significant difference between males and females in proportions who were heroin abstinent at 24mths (69% vs. 74%), or who were daily heroin users (12% vs. 12%).
- The large decline in heroin use marked at 3mth follow-up, and overall proportion reporting current heroin abstinence remained constant at each subsequent follow-up point.
- Of those who had been heroin abstinent at 12mth interview, 84% reported heroin abstinence at 24mth (Simpson, 1997).

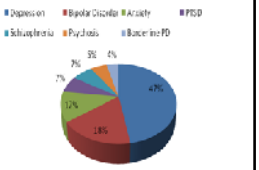
TC treatment

Similar dropout rates to other medical conditions, such as diabetes, asthma and hypertension (around 50%).

Substance use disorders require similar long-term treatment to other medical conditions, and will also suffer from similar drop-out rates (McLellan, O'Brien & Kleber, 2000; O'Brien & McLellan, 1996; White, 2006).

TCs at the forefront of providing services to clients with co-occurring/co-existing disorders with 50%-80% of TC clients having a co-occurring disorder.

Historical Diagnoses: Salvation Army Therapeutic Communities



TC populations

- Evidence suggests that TCs attract clients with complex behaviours and problems.
- Australian 2006-07 National Minimum Data Set shows alcohol most common principal drug of concern reported by clients entering residential treatment (44% of episodes), followed by amphetamines (22%), cannabis (21%) and heroin (9%) (AIHW, 2008).
- ATOS study found mean length of heroin use 9.2 (SD 7.0, range <1-31) yrs. TC residents in sample (n=100) had used mean of 9.6 (SD 1.4, range 5-11) drug classes in their lives (Darke et al, 2006).

Efficacy of the model

- Effectiveness of the TC model has been shown in positive outcomes for drug use, criminality and employment in single-site (De Leon, 1987, 1989; De Leon & Rosenthal, 1989) and multi-site studies employing pre-post designs (Hubbard, Craddock, Flynn, Anderson & Etheridge, 1997).
- Their efficacy is supported by evidence based research in Australia (ATOS, 2002; Eassop et al, 2000; Guydish, 1999; Toumborou et al, 1994) and in the US through the Drug Abuse Treatment Outcome Study (DATOS).
- This study showed major reductions in all types of drug use (66% reduction in cocaine and heroin, 50% in weekly or frequent use of alcohol and cannabis, Hubbard et al, 1997).

Darke, Williamson, Ross & Teesson, 2006

- Australian study to determine levels of sustained heroin abstinence, current drug use, and drug-related problems of residential rehabilitation (RR) admissions 24 months after entering treatment.
- Longitudinal cohort study of 100 heroin users admitted to short-term (1 month) or long-term (3-6 months or longer) RR.
- 18% successfully graduated, 47% self-discharged, and 30% were discharged.
- Postindex treatment exposure was widespread (82%), with additional RR the most common treatment.

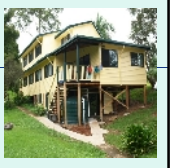
Outcome studies

- At 24 months, 71% were heroin abstinent over the month preceding interview, and 18% reported heroin abstinence over the entire follow-up period.
- Large declines in levels of recent needle borrowing, crime, psychopathology, and improvements in global and injection-related health.
- Independent predictors of continuous heroin abstinence were being female and successful graduation from the index program. These were independently associated with abstinence, whereas having had post-treatment MT exposure was related to reduced odds of abstinence.
- The study confirms the effectiveness of RR and highlights the impact of program graduation.

Outcome studies

- Despite poor clinical presentations, Australian, US and UK studies show good outcomes for TC treatment.
- Gossop et al (1999) in UK based National Treatment Outcome Study (NTOS) reported ½ TC clients abstinent from heroin in period immediately preceding 12mth follow-up, as were 70% of those from Australian study (Darke et al, 2006).

Changing face(s) of TCs



The Buttery, NSW

- In 2013, TCs provide a range of services –
  - Residential programs – for adults, family groups, women with children, young people
  - Non-residential Day Programs
  - Methadone to Abstinence (MTAR) and Pharmacotherapy Stabilisation (RTOD)
  - Harm Minimisation – inc NSPs and Supervised Injecting
  - Short, medium and long-term programs, some 6 – 8 wks

Kuitpo, SA

Odyssey House, Victoria

Changing face(s) of TCs

Kuitpo, SA

- In 2013, TCs provide a range of services –
  - Outpatient and community-based services – gambling, detoxification, education, early childhood development, housing, vocational training, medical services

Salvation Army Recovery Services, Qld

Mirikai, Qld: Banjara Medical Centre

Karralika, ACT: Certificate II Hospitality training at TaFE

Changing face(s) of TCs

- TCs provide programs for special populations: Comorbidity, Indigenous, Families
- In 2011, there were 38 ATCA members in Australia & New Zealand operating 63 TCs – 12 of which were in prisons
- During this time there were more than 9,000 admissions to TC treatment – with 1,700 of these in prison settings
- More than 200 children entered the TC with their parent
- TCs provided non-residential services to more than 23,000 people

Odyssey House, Auckland, NZ

Namatjira Haven, NSW

Cost benefits of TC treatment

- ATCA 2001 study undertaken on single day across member agencies to ascertain costs of respondents' drug use to the community in preceding year.
- Costs calculated against medical, legal and welfare services, utilising formula calculated by Ernst and Young (1996).
- Respondents (n=345) estimated daily use of drugs in 12 mths prior at $302.03 or approx. $110,242.00 per person per year.
- Yearly total for whole cohort (345) $46,742,608.00 (Pitts & Yates, 2010).
- Further costs include crime costs (estimated cost of burglaries and other crimes to support drug use), law enforcement, health and welfare costs.

Cost benefits of TC treatment

Cost Centre	Overall cost per annum
Drug purchasing (crime costs)	$46,742,608.00
Enforcement and Court costs	$10,302,500.00
Healthcare costs	$1,211,952.00
Welfare Benefits	$4,510,272.00
Total	$62,767,332.00

Pitts & Yates, 2010

- Even based on the estimated treatment cost of $98.00 per day (Darke et al, 2006) the overall cost of treatment for the 345 people in this study for one year would be $12,340,650.00.
- Therefore TC treatment for this cohort would provide a savings of $50,426,682.00 over a 12mth period – or $146,164.30 per person per annum. This is a savings of $400.00 per person per DAY!

Prison-based Therapeutic Communities

- Prison-based TC programs may vary in their design but most have a set of core commonalities that define them in a general sense.
- These often include :
  - separation from the general prison population
  - highly structured and hierarchical group environment OR UK democratic model where roles are shared and allocated – perhaps on weekly basis
  - a safe and secure environment where participants feel comfortable opening up emotionally and expressing their feelings

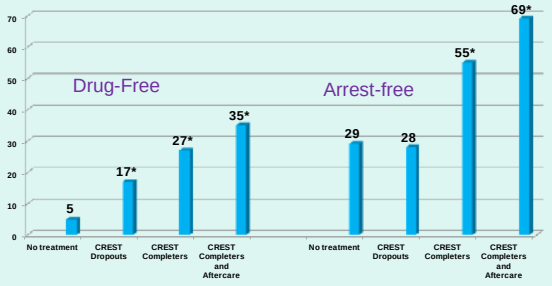
Prison-based Therapeutic Communities

- ✓ Strong research evidence in US and UK, and growing research evidence in New Zealand.
- ✓ Based on 30 years of research, starting with the "Stay 'n Out" Study in US, prison drug abuse treatment has overwhelming utilized the TC model.
- ✓ In 1991, a NIDA-funded evaluation of the Amity TC at R.J. Donovan prison in California replicated the Stay'n Out findings, and demonstrated the additive effects of aftercare TC treatment in the community.
- ✓ Early 1990s, the CREST project in Delaware demonstrated the efficacy of a new TC work release model and an evaluation conducted by Texas Christian University (TCU) produced similar findings.

Prison-based Therapeutic Communities

- In UK, a Campbell systematic review concluded that, for all types of prison drug programs, TCs have strongest evidence for successfully reducing drug relapse and recidivism (Mitchell, Wilson & Mackenzie, 2006).
- Outcomes improve with increased time, and are further enhanced when community aftercare is included.
- CBT also found to have promising results – once again this can be combined with TC treatment, further supported by 12-step fellowships.
- Concluded that TCs have the strongest international evidence base, with UK studies indicating same positive impact of treatment as found in other countries.

Value of Aftercare to enhance treatment gains



*p< 05 from Comparison Martin, Butzin, Saum & Inciardi (1999), The Prison Journal

Treatment as turning point

- Laub & Sampson (2004) study of delinquent adolescents through to 70 years of age.
- Change occurred where relationships were successful and employment was stable.
- Confirms value and need to address psychosocial issues which surround delinquent behaviour.
- Hallmark of therapeutic community treatment.
- Treatment can be a turning point, particularly if it provides the window for change and the resources to sustain and support recovery in a real-life situation, are available.

Desistance predictors

- Stress concept of Adult Growth.
- Recognises that while substance use is a chronic and relapsing condition, it is not a life sentence.
- There is the concept of 'turning points' or 'windows of opportunity' which are psychological and social – not biochemical – and desistance predictors.
- Desistance, the opposite of persistence, simply means 'quitting' – stopping use. Desistance is a process which takes place over time.

What finally enabled participants to give up?

	Not at all	A little	Quite a lot	A lot
Physical health problems	19.6%	42.4%	15.2%	22.8%
Psychological health problems	23.4%	18.1%	22.3%	36.2%
Criminal justice	30.4%	26.1%	19.6%	23.9%
Family pressures	36.0%	24.7%	21.3%	18.0%
Work opportunities	76.55	9.4%	9.4%	4.7%
Support from partner	72.6%	15.55	6.0%	6.0%
Help from friends	37.9%	28.7%	14.9%	18.4%
Tired of lifestyle	6.3%	4.2%	13.55	76.0%

Best et al, 2008

What enabled people to maintain abstinence?

	Not at all	A little	Quite a lot	A lot
Support from partner	45.2%	20.0%	12.9%	21.9%
Support from friends	14.5%	21.1%	16.9%	47.6%
Moving away from drug using friends	16.1%	5.0%	18.0%	60.9%
Having a job	31.2%	17.8%	18.5%	32.5%
Having reasonable accommodation	10.3%	17.6%	26.1%	46.1%
Religious or spiritual beliefs	22.3%	11.4%	16.3%	50.0%

Best et al, 2008

TCs as turning points

- Only formal treatment service noted by this group as providing help to become abstinent was residential rehabilitation (16.9%).
- In addition, mutual-aid groups were cited by 29.3% as a key factor in achieving abstinence and by 41.6% as a key factor in staying completely abstinent.
- These responses also fit with the fact that residential services, and particularly therapeutic communities, see their role as a unique treatment episode which 'kick-starts' the recovery process, most often working in concert with the mutual-aid fellowships to assist the person to maintain and sustain their recovery.

TCs as turning points

- Of particular importance are psychological factors – belief systems, self-esteem and coping skills – deriving from or combined with the support of rehabilitation or mutual-aid which, it would seem, can act as a significant turning point in the addiction career and act as a catalyst for abstinence.
- Most importantly, both these forms of assistance provide ongoing support in the recovery journey.
- Importantly, in Australia there is a recognition of the need, contained in the 2011 Review of NMDS, for halfway/transitional and aftercare funding to prevent discharge into homelessness and a corresponding belief in continuity of care and comprehensive health and recovery services.

"The TC process is one of social learning and social development. A basic tenet of the TC is that substance use is a complex condition combining social, psychological, behavioural and physiological dimensions. It is a symptom of underlying social, psychological and/or behavioural issues which need to be addressed if recovery is to occur"

(Gowing, Cooke, Biven & Watts, 2002).

Quality Framework

- TCs were one of the first organisations to establish a systematic process to assess the efficacy of its model using the Community Health Accreditation and Standards Project (CHASP).
- The ATCA supports the development of a quality framework for AOD services and notes that Objective 2 under Actions in "Demand" Reduction in the Consultation Draft of NDS states:
  - Develop planning models for treatment services that anticipate needs, and develop and implement quality frameworks for treatment services.
- The ATCA has worked with the Australian Government in the development and implementation of the Australasian Alcohol and other Drug Therapeutic Communities Standards and Support Package (2009), to form part of an overarching national quality framework.

Quality Framework

- Sine 2009, the ATCA Standards have been trialled and further refined, and have now been applied to 14 peer reviews – including 2 prison-based programs (ACT and Auckland).
- At the commencement of 2013, they were submitted to JAS-ANZ for certification.
- When approved, they will be come available to Certifying Accreditation Bodies (CABs) to be utilised under licence from ATCA as part of an organisation's accreditation process.
- Designed in 2 tiers – Residential Rehabilitation and TC.

The future...

- Currently 40 members – 18 Organisational members (1 TC + community-based services), 7 Group members (27 TCs – prison & community), 9 Provisional members (16 TCs, 12 in prison-settings), 6 Affiliate members (individual and organisational). Total of 63 TCs.
- Funding provided to support the Secretariat to June 2015.
- ATCA committed to working with governments and the sector to support the Quality Framework for AOD services, both within the sector and broadly across sectors (ie agencies that provide AOD services but are funded from other sources).

Our purpose

- To advance the Therapeutic Communities Model in Australasia
- To promote community awareness of the Therapeutic Communities Model of treatment in Australasia
- To ensure consistency in approach through the application of the ATCA Essential Elements in practice
- To encourage capacity building in Therapeutic Communities through a variety of peer support and professional development opportunities
- To advocate for recognition and funding for Therapeutic Communities in Australasia
- To encourage and support ongoing research into the Therapeutic Communities Model
- To support and network with organisations and individuals interested in, or aspiring to become members of the ATCA

Reconciliation Vision

The ATCA has always acknowledged the need to ensure that our services are both accessible and appropriate for Aboriginal and Torres Strait Island peoples and those with culturally and Linguistically Diverse (CaLD) backgrounds. Cultural security is about ensuring that the delivery of health services is such that no one person is afforded a less favourable outcome simply because she or he holds a different cultural outlook.

The ATCA is committed to applying this principle in practice across all aspects of organisational governance and planning, service delivery and all relationships with individuals and organisations. We aim to further develop positive relationships and ways of working that will contribute to improving the health and wellbeing and dignity of all Australasians.