Background, current state and future of therapeutic communities for addictions in Europe[1]

von **Wouter Vanderplasschen**
und **Stijn Vandevelde**

The therapeutic community (TC) is one of the longest standing modalities for the treatment of drug addiction, dating back to Synanon, a community of ex-addicts in California.

The Synanon model quickly spread across the United States and gave rise to the first 'concept' TCs for drug addicts (e.g. Daytop Village, Phoenix House, Odyssey House) (Goethals et al., 2011). These drug-free, peer-led environments adopted Synanon's hierarchical structure and therapeutic techniques and set a three-stage treatment model (detoxification/induction, treatment, reintegration). 'Drug-free' or 'concept' TCs, later called TCs for addictions (De Leon and Ziegenfuss, 1986), have been defined as «drug-free environments in which people with addictive problems live together in an organised and structured way to promote change towards a drug-free life in the outside society" (Broekaert et al., 1993, p. 55). Not all residential treatment programmes are TCs and not all TCs are organised and delivered in a residential setting (Broekaert et al., 1999). Moreover, not all programmes self-identified as TC programmes employ the same theory, model or method.

The TC is essentially a living and learning setting, which means that residents are totally immersed in the treatment environment, so that all of their daily behaviour and their emotional and physical state can be observed and challenged as appropriate through intensive group experiences (Vanderplasschen et al., 2014). In addition, they are encouraged to experiment with alternative behaviours and corrective emotional experiences. Thus, the TC can be regarded as «a consciously-designed social environment and programme within a residential or day unit, in which the social and group process is harnessed with therapeutic intent" (Roberts, 1997, p. 4). Or like George De Leon, one of the main proponents of the international TC movement, asserts: «In the TC, the community is the primary therapeutic instrument." (De Leon, 2000, p. 93). The concept of 'community as method' or the «purposive use of the peer community to facilitate social and psychological change in individuals" is central to the TC treatment practice (De Leon, 1997, p. 5). Residents, in collaboration with staff, become active participants in their own therapy and that of other residents (Glaser, 1981).

From the 1960s and 1970s onwards, TCs were developed in Europe, e.g., in the United Kingdom (Phoenix House), Italy (e.g. CeIS), Germany (e.g. Daytop Germany), Switzerland (e.g. Aebi Hus), and Belgium. Later, TCs were founded in Spain, Norway, Greece, Austria and some east European countries (e.g. Poland and the Czech Republic) after the fall of the Iron Curtain. Its development took place in a period characterised by increased availability of heroin and other illicit substances and lack of effective treatment responses. The heroin epidemic in the mid-1980s resulted in a rapid spread of infectious diseases, mainly HIV/AIDS, and a dramatic growth in the number of drug-related deaths. Around this time, TCs started to lose their dominant position in treating drug users as several countries, including the UK, Netherlands and Switzerland, embraced the harm reduction approach for reducing the negative health and social consequences of drug use (Hedrich et al., 2008). TCs also faced other challenges, such as financial cutbacks as a result of the economic crisis, questions about high dropout and relapse rates and changing drug policies primarily aimed at reducing drug-related harm. Problems with charismatic leadership in TCs in some countries (e.g. 'Le Patriarche' (France), Vallmotorp (Sweden)) and the switch from self-funded, independent organisations to mainstream services that are funded and controlled by the government led to the closure of some TCs and their replacement with smaller communities run by professionals instead of ex-addicts (Vanderplasschen et al., 2014). Changing views on addiction as a chronic, relapsing disorder and increasing criticism on the benefits of lengthy treatment in closed residential settings by scientists, client advocates and service users have further challenged the development of TCs in several countries. Finally, the evidence-based paradigm that applies the randomised controlled trial (RCT) as 'gold standard' for evaluating interventions has questioned the efficacy of TCs, as TCs scored low in an (outdated) meta-analysis of case management (Smith et al., 2006) and in comparative 'evidence-based' rankings (Broekaert et al., 2010). Yet, several systematic reviews have demonstrated the effectiveness of TCs, in particular regarding substance use and criminal justice outcomes, mediated by length of stay in treatment (retention) and subsequent aftercare participation (De Leon, 2010; Vanderplasschen et al., 2013).

TCs in Europe today

Although essentially inspired by the US TCs, European TCs clearly have their own identity; there was strong opposition to the hard learning techniques such as wearing signs and shaving hair — the so-called haircuts — and the extremely

[1] This contribution is based on Vanderplasschen, W., Vandevelde, S. & Broekaert, E. (2014). Therapeutic Communities for Addictions in Europe: Evidence, current practices and future challenges (EMCDDA Insights Series). Luxembourg: Publications Office of the European Union.

harsh confrontations in encounter groups (Goethals et al., 2011). The American behaviouristic approach was complemented by European educational theories, psychoanalytical thinking, social learning, involvement of trained professionals (instead of recovered ex-addicts serving as staff members) and more family-oriented approaches (Broekaert et al. 2006). TCs from various European countries collaborate in the European Federation of Therapeutic Communities (EFTC; http://www.eftc-europe.com/) and emphasize the importance of TC standards and quality control.

Over the last 50 years, TCs have evolved from the standard, long-term, generic treatment model to modified and shortened models (modified TCs) that are better tailored to the needs of specific groups of drug users, e.g. women with children, detainees and individuals suffering from other psychiatric disorders (Goethals et al., 2011). According to several sources the availability of TC programmes has decreased in several European countries, such as the Netherlands, Sweden, Switzerland and the United Kingdom (Broekaert and Vanderplasschen, 2003), mainly due to the relatively high cost of long-term treatment. However, there are also national and cultural factors at play, as different countries have shaped unique drug treatment provision landscapes and therefore given different degrees of prominence to TC treatment. In order to estimate the extent of TC treatment in Europe, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) commissioned a study on current evidence and TC practices in Europe in 2012 (see Vanderplasschen et al., 2014). In total, we identified over 1 200 TC programmes throughout Europe; only in Turkey and Croatia the TC was not applied as a treatment method. Two-thirds of the identified programmes were reported from Italy (n = 798), with the Italian experts describing most of these programmes as small, family-type structures with a capacity of four to six residents, but adhering to international TC guidelines and standards. Outside Italy, we identified just over 400 facilities providing TC treatment. While the number of TC programmes is low in one in three countries (<5), it seems to be a well-established treatment modality in the south of Europe (e.g. Greece, Spain, Italy, Portugal) and in some East European countries (e.g. Lithuania, Hungary, Poland). Countries like Austria, Belgium and the Czech Republic report around 10 TCs, or about 1 TC programme per one million inhabitants.

Key informants from these countries reported sustainability issues in terms of public funding for TCs, resulting in the shutdown of some TCs in Norway and the UK, reductions in treatment duration (e.g. Czech Republic, Spain, Finland) and the number of beds per unit (e.g. Latvia, Sweden). France is a clear exception in this sense, as TCs for addictions have recently been re-established. The capacity of TC programmes varies greatly, but is usually between 15 and 25 residents. The number of treatment slots per unit is clearly higher In some countries (e.g. Cyprus, France, Poland, the United Kingdom). Overall, the number of places for drug addicts in TC programmes in Europe was estimated to be over 15 000 beds (Vanderplasschen et al., 2014).

The estimated number of TC residents per year in each country is indicative of the turnover and average treatment duration. In most countries, TC programmes last between 6 and 12 months and the number of residents (persons retained in the TC for at least one night) per year is twice the available capacity. In some countries, this rate is considerably higher (e.g. Poland, Finland), due to the high turnover and/or short length of (some) TC programmes. The low resident turnover in other countries (e.g. Austria, Belgium, Ireland) may be explained by high retention rates and adequate induction strategies to prepare drug addicts for TC treatment.

Future of the TC

The effectiveness of TCs has been and will be further questioned. Longitudinal studies and systematic reviews are needed to document the (cost-)effectiveness of these long-term interventions (Vanderplasschen et al., 2013). The future of TCs is likely to depend on how well these programmes continue to target areas where they can make the most impact and achieve the most good at adequate costs. This means continuing the implementation of modified TC programmes for particularly vulnerable populations, such as homeless persons or those with co-existing disorders, as well as establishing TCs in prison settings. While positive outcomes from prison-based TCs have been reported in the US literature, these findings may not be directly translated into the European context.

Despite the strained relation between abstinence-oriented and harm reduction programmes previously, today TCs, psychiatric services, substitution and harm reduction initiatives are increasingly becoming better attuned to each other. In fact, they serve the same clients and methadone maintained persons can access residential TC treatment. While maintenance treatment has proven its effectiveness with respect to health conditions, quality of life and use of illicit drugs, TCs can look to the long-term perspectives of reintegration, social inclusion and abstinence.

The TC movement has become reconciled to approaches that advocate the introduction of shorter programmes and outreach and community-based interventions. For example, the length of the residential treatment phase has been reduced in most countries to around 9 to 12 months or less. A growing emphasis on expenditure containment is likely to contribute to further reductions in the planned duration of TC treatment, as well as a number of other possible changes to the TC model and the way it is practised. This includes an emphasis on the role of volunteers and self-help elements at the expense of 'professional' staff members. The ways in which the quantity and, more importantly, the quality of the TC intervention are negotiated will determine its future role in addiction treatment.

Governmental control and adherence to standards such as the standards and ethics code formulated by the World Federation of TCs (WFTC) provide a general framework for TC professionals. For accreditation purposes and continued quality control, however, more detailed standards are necessary and the set of 'Service Standards for Addiction Therapeutic Communities' developed by the Community of Communities (CofC, 2012a, b) is an encouraging example. Although quality control in TCs in most countries is limited to staffing issues, TCs themselves appear to be open to more in-depth and comprehensive assessment and accreditation of their services.

In conclusion, TC programmes for the rehabilitation of drug users are established in many European countries and play an important role as part of national addiction treatment systems. There is some evidence for the effectiveness of TCs in terms of reduced substance use and criminal activity, at least

→ Seite 31

→ Seite 7

in the US and a culture of TC research is being developed in Europe. It is vital to maintain this type of treatment to support recovery of drug addicts, in particular for individuals with long-lasting and complex problems.

References

Broekaert, E. (2006). What future for the Therapeutic Community in the field of addiction? A view from Europe. Addiction, 101, 1677-1678.

Broekaert, E., Autrique, M., Vanderplasschen, W. & Colpaert, K. (2010) The human prerogative. Questions on the integration of evidence-based, existential and social critical paradigms of care in substance abuse treatment. Psychiatric Quarterly, 81(3), 227-238.

Broekaert, E., Kooyman, M. & Ottenberg, D. (1993). What cannot be changed in a therapeutic community? Orthopedagogische Reeks Gent 2, 51-62.

Broekaert, E., Raes, V., Kaplan, C.D. & Coletti, M. (1999). The design and effectiveness of therapeutic community research in Europe: An overview. European Addiction Research, 5, 21-35.

Broekaert, E. & Vanderplasschen, W. (2003). Towards the integration of treatment systems for substance abusers: Report on the Second International Symposium on Substance Abuse Treatment and Special Target Groups. Journal of Psychoactive Drugs, 35(2), 237-245.

Broekaert, E., Vandevelde, S., Soyez, V., Yates, R., Slater, A. (2006). The third generation of therapeutic communities: The early development of the TC for addictions in Europe. European Addiction Research, 12, (1), 1-11.

Community of Communities (CofC) (2012a). Our values and standards. Retrieved from: http://www.rcpsych.ac.uk/quality/qualityandaccreditation/therapeuticcommunities/communityofcommunities/ourvaluesandstandards.aspx.

De Leon, G. (1997). Community as method. Therapeutic communities for special populations and special settings. Westport, C.T.: Greenwood Publishing Group, Inc.

De Leon, G. (2000). The therapeutic community. Theory, model and method. New York: Springer.

De Leon, G. (2010). Is the Therapeutic Community an Evidence-based Treatment? What the Evidence Says. International Journal of Therapeutic Communities, 31(2), 104-128.

De Leon, G. & Ziegenfuss, J. (1986). Therapeutic communities for addictions: Readings in theory, research and practice. Springfield, IL: Charles C. Thomas.

Glaser, F.B. (1981). The origins of drug-free therapeutic communities. Addiction, 76(1), 13-25.

Goethals, I., Soyez, V., Melnick, G., De Leon, G. & Broekaert, E. (2011). Essential elements of treatment: A comparative study between European and American therapeutic communities for addiction. Substance Use & Misuse, 46, 1023-1031.

Hedrich, D., Pirona, A. & Wiessing, L. (2008). From margin to mainstream: The evolution of harm reduction responses to problem drug use in Europe. Drugs: Education, Prevention and Policy, 15(6), 503-517.

Kennard, D. (1994). The future revisited: New frontiers for therapeutic communities. Therapeutic Communities, 15(2), 97-102.

Roberts, J. (1997). How to recognise a therapeutic community. Prison Service Journal, 111, 4-7.

Smith, L.A., Gates, S. & Foxcroft, D. (2006). Therapeutic communities for substance related disorder. Cochrane database of systematic reviews, 1: DOI: 10.1002/14651858.CD005338.

Vanderplasschen, W., Colpaert, K., Autrique, M., Rapp, R.C., Pearce, S., Broekaert, E. & Vandevelde, S. (2013). Therapeutic communities for addictions: a review of their effectiveness from a recovery-oriented perspective. The Scientific World Journal, 2013, Article ID 427817.

Vanderplasschen, W., Vandevelde, S. & Broekaert, E. (2014). Therapeutic Communities for Addictions in Europe: Evidence, current practices and future challenges (EMCDDA Insights Series). Luxembourg: Publications Office of the European Union.

Wouter Vanderplasschen (PhD)
is associate professor at the Department of Special Needs Education (Orthopedagogiek) of Ghent University (Belgium). He is a senior researcher in the field of addictions, recovery and mental health. His main research interests are substance abuse, case management, therapeutic communities, vulnerable groups, and evaluation of interventions.

→ Seite 19

Peergroup in Bezug auf Medienkonsum. Einen bedeutenden Faktor stellen darüber hinaus intrafamiliäre Konflikte dar (vgl. Wölfling et al. 2013). Da viele Computerspiele ihre Schwierigkeit an das Können der Spielenden anpassen und die volle Aufmerksamkeit der Spielenden fordern, können sie dabei helfen, unangenehme Empfindungen in den Hintergrund zu rücken. So kann exzessives Spielen auch ein wichtiger Hinweis auf zugrunde liegende familiäre Konflikte sein. In diesem Sinne wäre ein suchtartiges Computerspielverhalten eher als dysfunktionale und vermeidende Copingstrategie denn als eigenständiges Krankheitsbild zu verstehen.

Bewertung

Das Familiensystem ist sowohl bei der Prävention als auch bei der Behandlung suchtartigen Spielverhaltens einzelner Mitglieder ein zentrales Element. Eltern, die ein Problembewusstsein haben und selbstständig aktiv werden, finden Anlaufstellen sowohl im beraterischen (z. B. www.fachstelle-enter.at, www.bupp.at, www.saferinternet.at) als auch im therapeutischen Kontext (z. B. www.ambulanz.sfu.ac.at, www.api.or.at). Schwieriger ist es natürlich, Familien zu erreichen, die Helfersystemen kritisch gegenüberstehen und freiwillige Angebote nicht in Anspruch nehmen. Sinnvoll wäre hier, indirekt über MultiplikatorInnen zu wirken und LehrerInnen sowie Fachkräfte in der Kinder- und Jugendhilfe auf spezifisch medienpädagogische Aufgabenstellungen hin zu schulen.

Grundsätzlich halte ich es für eine gesamtgesellschaftliche und somit politische Aufgabe, auf Phänomene exzessiven Computerspielens und den Stellenwert, den das Medium vor allem bei einer jüngeren Zielgruppe einnimmt, adäquat im Sinne von Präventionsmaßnahmen zu reagieren. Bis dies geschieht, sind Familien mit diesem Thema auf sich allein und auf eine vor allem außerhalb Wiens sehr dünn gesäte Beratungs- und Therapielandschaft gestellt.

Literatur

Gee, J. (2010): What Videogames have to teach us about learning and literacy. Palgrave Macmillan, New York.

Kammerl, R. et al. (2012): EXIF – Exzessive Internetnutzung in Familien. Studie im Auftrag des BMFSFJ, Berlin.

Petry, J. (2016): Computersüchtig? Pathologischer PC/Internetgebrauch als neues Störungsbild. In: Archiv für Wissenschaft und Praxis der sozialen Arbeit, Heft 1/2016.

Puhm, A./Strizek, J. (2016): Problematische Nutzung von digitalen Spielen: Forschungsbericht. Gesundheit Österreich, Wien.

Wölfling, K. et al. (2013): Computerspiel- und Internetsucht. Ein kognitiv-behaviorales Behandlungsmanual, Kohlhammer, Stuttgart.

Markus Meschik, MA
ist Sozialpädagoge und leitet die Fachstelle für digitale Spiele »Enter« in Graz. Er ist Gutachter und Experte für die »BUPP« des Bundesministeriums für Frauen, Familien und Jugend und dissertiert zum Thema Sucht bei digitalen Spielen an der Karl-Franzens Universität Graz.