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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>
</tr>
<tr>
<td>• All client members have a written care plan</td>
</tr>
<tr>
<td>• The community prepares members for independent living in the wider community</td>
</tr>
<tr>
<td>• The community has an explicitly-structured hierarchy</td>
</tr>
<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 (Morral, 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
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


