Phoenix Futures
Ending dependency, transforming lives

THE MANUAL

Staff & Community Members' Manual 2011

Phoenix Futures
Ending dependency, transforming lives

THE MANUAL

Staff & Community Members' Manual 2011

Contents

Introduction

ACKNOWLEDGEMENTS

This manual is intended as a quick, basic primer for staff and community members of Phoenix Futures TC-based services. It is not intended to answer all your questions but to be a guide to where you might look for answers and what the basic principles are. It does not claim to be original. Much of the content has been drawn from the work of Phoenix Futures' own Residential Strategy Group; earlier manuals prepared by Figure 8 Consultancy; and the writings of George De Leon and Rowdy Yates. But it is hoped that all therapeutic community members (paid and unpaid) will use this manual as a starting point for understanding what we do, why we do it and why we believe it works.

The Manual

Welcome

Karen Biggs, CEO Phoenix Futures

Using this Manual

Introduction

This manual has been designed by Phoenix Futures to help both Staff Members and Community Members to understand how the Therapeutic Community works and how to get the most out of it, whatever your role in the Community. The intention here was to write a manual in simple language explaining why we do what we do; how to do it better; and what evidence there is that what we do works and supports change and growth.

Sections

The manual is divided into six separate Sections: origins of the therapeutic community; stages of the programme; therapeutic community principles; group work; additional elements which Phoenix Futures have added to enhance the TC model; and examples of documents and questionnaires used in the TC. Each section represents a core element of TC practice and it is important that you understand how it works and why and how it interacts with other elements to make the whole model that we call the Therapeutic Community. Each section starts with a set of aims. We have listed all the things we hope you can learn by reading and thinking about the section and discussing it with other TC members. To help you test your knowledge, we have also included two separate study areas at the end of each section (one for staff members and the other for community members). These study areas contain a short set of exercises to help you think about what you have read and test out your understanding.

Issues

All six sections are separated into a series of two-page Issues. These are the practices and ideas that go to make up that particular element. So, for instance, the section on TC origins is divided into: a history of therapeutic communities; a description of the development of Phoenix Futures; an explanation of TC philosophy; our views on addiction and recovery; an explanation of our rules & Sanctions; and a discussion about the effectiveness of the model.

Each issue is set out on two facing pages. On the left hand page, one box contains a summary of the issue and explains the thinking and theory behind the practice. This is the Theory box. The Evidence box lists a number of documents (mainly book chapters and journal articles) which have tested the theory and set out to see whether it works and why. All the documents mentioned in the Evidence box are available to Phoenix Futures staff in the Evidence Collection which accompanies this Manual as a compact disc. On the right-hand, facing page, you will find the Practice box. This provides much more detail and explains just how these ideas are put into practice in Phoenix Futures.

Community Members

Anyone who comes to one of Phoenix Futures' services for help in turning their life around becomes a Community Member. Whilst not all Phoenix Futures services are residential Therapeutic Communities, all of them base their practices on the principles that underpinned the original Phoenix Futures Therapeutic Community. Therapeutic communities are different to other types of treatment service because, at their heart, they believe that the users of the service (the Community Members) are an essential part of the solution – both to their own difficulties and to those of other Community Members.

Staff Members

Paid and volunteer staff are also members of the therapeutic community. Of course, they carry more responsibilities than other community members but they are still regarded as part of the community structure and are expected to be positive role models for other community members. Many of these Staff Members will have been through a TC programme themselves and are committed to the model because it has delivered real results for them.

Therapeutic Community Origins

Study Commitment – Staff Members

As a staff member of Phoenix Futures, once you have completed this section, you should be able to:

- understand where TC ideas come from and how they have developed,
- understand the links between TC approaches and other self-help approaches,
- understand the TC view of addiction as a disorder of the whole person & their environment,
- understand the TC emphasis on changes to attitude & environment in recovery,
- understand the basic TC rules and sanctions and what they are there for,
- understand and have a basic knowledge of the evidence on TC effectiveness,
- explain these issues to others, including other Community Members.

Study Commitment – Community Members

As a community member of Phoenix Futures, once you have completed this section, you should be able to:

- understand your place in a historic TC movement,
- understand that you are part of a world-wide family of TCs,
- understand the TC view of addiction as a disorder of the whole person & their environment,
- understand the TC emphasis on changes to attitude & environment in recovery,
- understand the basic TC rules and sanctions and what they are there for,
- feel able to put you trust in this tradition to delivery change for you
- explain these issues to others, including new Community Members.

Therapeutic Communities (TC) History

Theory

Early TC History

The idea of community living to provide support and promote change is not new. In fact, it stretches back at least as far as the Middle Ages. Some writers have argued that it goes back even further to early Christian and other religious communities. The last 150 years have seen a range of experimental communities, particularly communities for young people with difficulties or disabilities. Many of these experiments have been developed as part of the alternative schools movement. Others have been aimed at responding to youth crime: like the early Borstal training units. What they have usually had in common was an element of self-help and community control. That is, these communities have been largely built around the idea that peer support and control are essential to growth and change.

After the Second World War, a number of psychiatrists – initially in the UK – began to experiment with group work and the idea that patients could control some of the direction and pace of their treatment. These were called therapeutic communities and often resulted in the freeing up of locked wards and more outpatient treatment of mental illness.

Drug-free TCs

Synanon, in California was the first drug-free TC and grew out of the experiences of a small group of members of the Santa Monica branch of the Alcoholics Anonymous fellowship. What this group realised was that the younger heroin addicts approaching AA in the 1950s had very little experience of formal work and required a more intensive and more structured setting than AA could offer. They also felt restricted by AA's insistence on "no cross-talking": that the individual's story was theirs and theirs alone. Synanon pioneers argued that there were times when the individual's story needed to be challenged. When it was clear that members were rationalising their behaviour and presenting their past in dishonest ways.

Synanon was established in 1958. Within 10 years, a number of TCs had been established across the US, often using Synanon graduates as senior residents and staff. By the late 1960s, these "second generation" TCs were inspiring a further development of TC services across Europe. The early European TCs deliberately merged the drug-free TC philosophy with the earlier experimental work with young people and mental health patients. European TCs were therefore, more likely to have a mixture of graduate and non-graduate staff, with non-graduate staff usually coming from health service or social work backgrounds.

Therapeutic Communities in the UK appeared at the end of the 1960s when the most common belief amongst drug treatment workers was that recovery was rare and that the best that could be done was to limit the damage that came from a drug-using lifestyle. The idea that drug-users themselves could be part of the solution was met with disbelief at first. In the end, TCs had a huge impact upon the thinking of people in both NHS addiction services and the voluntary addiction treatment sector.

Evidence

Rawlings, B. & Yates, R. (2001) Fallen angel: an introduction. In: B. Rawlings and R. Yates (eds.) *Therapeutic Communities for the Treatment of Drug Users*, London: Jessica Kingsley pp. 9-25.

This book chapter maps out the history of TCs for children & young people; mental health; & addiction. It shows how the drug-free therapeutic community developed in Europe and explains its role in changing how people saw treatment and recovery.

Yates, R. (2003) A brief moment of glory: the impact of the therapeutic community movement on drug treatment systems in the UK, *International Journal of Social Welfare, 12*(3), pp. 239-243.

This journal article covers the establishment of drug-free TCs in the UK and discusses their relations with other addiction treatment providers. The article discusses the how TCs fell out of favour and are now being reassessed as major providers of recovery treatment.

Broekaert,E.,Vandervelde, S., Soyez, V., Yates, R. and Slater, A. (2006) The Third Generation of Therapeutic Communities: the early development of the TCs for addiction in Europe, *European Addiction Research, 12*(1), pp. 2-11.

This journal article charts the growth of the TC movement across Europe and the achievements of the people who pioneered the model in the various European states in the 1970s and 80s.

Practice

Early Children's & Mental Health TCs

One of the earliest TCs for 'maladjusted children' (later they were called 'juvenile deliquents' and 'young offenders') was the *Little Commonwealth* in the South of England. Run by a former woodwork teacher from the *Boys' Republic* in Chicago, the *Little Commonwealth* was divided into 'family' groups with a strict work programme and a token money system. In 1936 David Wills, inspired by this experiment set up the *Hawkspur Camp* where a mixed group of community members built their own community. All of these early children's TCs used a system of self-help, peer support and a structured work programme. Towards the end of the 2nd World War, Maxwell Jones and a small group of radical psychiatrists began to use a similar approach with mental health patients.

Hawkspur – the first hut built

Synanon – early group photo

Synanon

The first therapeutic community for addicts was the brainchild of the ex-alcoholic, Chuck Dederich. Started in an empty beach-front hotel in Santa Monica in 1958, *Synanon* had no professional staff. Those who drew a wage for their work in Synanon were almost all graduates of the programme. *Synanon* was a self-help community with a rigid structure, a daily work programme, role modelling, peer support and a unique safety valve called *The Game. The Game* was a no-holds-barred chance to let off steam, confront other members, vent frustrations and challenge the structure. An early visitor, Carl Rogers, the father of person-centred counselling, was so impressed by *The Game* that he refined it and renamed it the 'encounter group': the name it is most often given in TCs today. In 1963, the New York probation department established *Daytop Village* (drug addicts treated on probation) on Staten Island. Modelled on *Synanon* and managed by a *Synanon* graduate, *Daytop* today is one of the largest and most influential TCs in the world. Five years later, *Phoenix House* was founded by a group of former heroin addicts in Manhattan, New York. *Phoenix House* had a huge impact upon the therapeutic community movement throughout Europe.

TCs in Europe and the UK

In Europe, the drug-free therapeutic community was first established in 1968 at St. James' Hospital, Portsmouth by a junior psychiatrist called Ian Christie, who had visited *Daytop Village*. First called *Pink Villa Huts* and later, *Alpha House*, the community still continues as *Phoenix Futures Hampshire*. The following year, Griffith Edwards, a psychiatrist based at the Maudsley Hospital, London, established the *Featherstone Lodge Project* (later, *Phoenix House*) following a visit and staff exchange with *Phoenix House*, New York. These two communities had a huge impact upon the growth of TCs both in England (*Ley Community, Suffolk House, Inward House* etc.) and in Europe (*Emilihoeve*, the Netherlands; *De Kiem*, Belgium, *Daytop*, Germany; *CeIS Roma*, Italy; *Coolmine*, Ireland etc.). Other therapeutic communities developed independently of this movement, sometimes inspired by the earlier work of Maxwell Jones and R. D. Laing in psychiatry. Some of these independent communities – *Monar*, Poland; *Synanon Haus*, Germany; *Villa Renata*, Italy; *Vallmotorp*, Sweden – adopted much of the ideology of the American-style TC and became, like *Phoenix Futures*, founding members of the European Federation of Therapeutic Communities in 1978.

Phoenix Futures

Theory

The groundbreaking work of Maxwell Jones, Tom Main and others, in the development of so-called ' democratic' therapeutic communities, first at Hollymoor Hospital, Northfield and later at the Henderson Hospital, paved the way for the establishment of drug-free therapeutic communities in the UK. These developments were part of broader changes within psychiatric treatment as a whole. For the previous century, psychiatry had been little more than a specialist branch of the criminal justice system, with psychiatrists providing incarceration and basic remedial treatment for the 'criminally insane'. The impact of the work of Freud, Jung, Klein and others coupled with the availability of new and powerful drugs had led to dramatic changes in post-war psychiatry. Whilst some of these changes were purely about the use of psychoactive drug treatments to facilitate a more humane management of mental illness, others focused upon the ' talking therapies' pioneered by Freud and others, including dynamic psychotherapy, psychoanalysis and group work, whilst still others, such as the experiments with LSD and psychodrama at Powick Hospital (Sandison 1997) were a conscious attempt to marry the two emerging traditions.

Foremost amongst this new radical group of doctors and therapists was the Scottish psychiatrist, R. D. Laing. Laing had already been acclaimed for his experimental work in Scotland with the establishment of his ' rumpus room' in a Glasgow hospital, when in the 1960s, he took the unusual step of moving his patients out of the psychiatric hospital altogether and establishing them in an anarchic therapeutic community – Kingsley Hall – in the east end of London. (This process of moving the TC out of the NHS campus and into the community was a symbolic gesture echoing similar moves by Alpha House, Ley Community and other drug-free TC some ten years later).

Laing and other members of the *Phildelphia Association* he established, both influenced and in turn, were influenced by, patient-led movements such as People not Psychiatry (PNP) and the emerging Italian movement, *Psychiatrica Democratica.* These were movements that brought together mental health patients, radical health workers and social and political activists in a common cause to promote ' community healing' outside the established, hospital-based psychiatric traditions.

So when Griffith Edwards established *Featherstone Lodge Project* in South London, he was following a path laid down by fellow psychiatrists in recent years. The idea of treating people in the community through self-help and group work had already been established and Griffith Edwards had already experimented with a Maxwell Jones – style therapeutic community for alcoholics referred to the Maudsley Hospital. He had been enthused by working alongside TC pioneers like Jones and David Clarke and was deeply impressed by Phoenix House, New York.

Evidence

Yates, R. (2011) Therapeutic communities: can-do attitudes for must-have recovery, *Journal of Groups in Addiction and Recovery, 6*(1),pp. 100-120.

This journal article covers the establishment of drug-free TCs in the UK and discusses the future of TCs within the emerging 'new recovery movement' in 21st Century Britain.

Yates, R. (2003) A brief moment of glory: the impact of the therapeutic community movement on drug treatment systems in the UK, *International Journal of Social Welfare, 12*(3), pp. 239-243.

This journal article covers the establishment of drug-free TCs in the UK and discusses their relations with other addiction treatment providers. The article discusses the how TCs fell out of favour and are now being reassessed as major providers of recovery treatment.

Phoenix Futures (2009) *Our Story: Rebuilding Lives for 40 Years.* London: Phoenix Futures.

This short monograph charts the 40 year history of Phoenix Futures from its birth as *Featherstone Lodge Project*, in South London to the current, UK-wide organisation, a leading UK provider of drug and alcohol services in prison, community and residential settings throughout England and Scotland.

Practice

Featherstone Lodge Project

Phoenix Futures began as *Featherstone Lodge*, a pioneering residential rehabilitation facility based in South London. It was established in 1969 by Professor Griffith Edwards. Griffith Edwards, unhappy with the treatment options the United Kingdom had to offer which were mainly attached to psychiatric wards, was inspired by a visit to *Phoenix House*, New York. *Phoenix House* had been established as a clean house by a group of former heroin addicts in Manhattan. Inspired by *Synanon* and *Daytop Village, Phoenix House* developed a TC model which was largely managed by the residents themselves with minimal support and intervention from professional staff. All the day-to-day paid staff were graduates either of *Phoenix House* or of other sister TCs. In the following years, Griffith Edwards studied the TC methodology, organised staff and resident exchanges and placements and secured the initial funding required. The service was set up as an independent charitable trust with a volunteer management committee. A suitable property was located in Forest Hill, South London and Denny Yuson-Sanchez, was appointed as the first director. Denny was a former New York heroin addict who had graduated from the Phoenix House programme. During the time he was director, *Featherstone Lodge Project* was renamed *Phoenix House*. Denny eventually left the project to move to The Netherlands where he founded the Osho Humaniversity. The Australian psychologist, Mike Caldwell briefly took over the directorship until David Warren-Holland took up post in 1977. David was a former psychiatric charge nurse at St. James' Hospital, Portsmouth and he had, from its beginnings, been the senior staff member for Europe's first TC: *Pink Villa Huts* (later *Alpha House*).

A UK-wide Service

In 1977 David Tomlinson, a graduate of the programme, became director. Under David's directorship, *Phoenix House* expanded dramatically, establishing a further TC in Sheffield in 1984 and in Tyneside the following year.

In the following years, the organisation continued to expand; establishing residential services in Wirral, Birkenhead, Brighton, Bexhill-on-Sea, Glasgow and Sydenham. In 1994, the organisation opened its first in-prison service and in the same year began to offer nonresidential criminal justice services. In 2005, the agency launched its innovative conservation therapy project with *English Nature* (later *Natural England*) and the following year rebranded as *Phoenix Futures*. In 2007, Karen Biggs took over as director and began a process of extensive rebuilding; re-establishing many of the TC principles of the original project, revisiting the methodology and restructuring the organisation so that there was a clear direction and TC philosophy common to all Phoenix Future projects.

UK and Ireland Therapeutic Communities Jamboree at Featherstone Lodge, 1978

The TC View of Addiction

Theory

Early addiction theories concentrated on the relationship between the individual and the substance. These were the biological, disease or allergy models. With the growth of interest in the work of Freud, Jung and others, some theorists like Khantzian and Wurmser began to argue that addiction was a symptom of a 'spoiled' personality. They suggested that drug dependence was the product of early trauma which would result in an addictive personality (characterological models). Still others, like Skinner and Ellis argued that addiction was a learned behaviour which could be unlearned (behaviourist models).

While all of these models had some merit, none of them appeared to explain the complex nature of addiction or the cultural and individual differences noted in treatment. Engels, Zinberg and others argued that addiction was the result of a complex interaction of three different factors: the biological and genetic factors, the social or cultural factors and the personal, individual factors. Zinberg called this the bio-psychosocial model of addiction. The individual's experience of addiction (the 'drug, the set and the setting') is affected by the nature of the substance, the situation in which they find themselves and their personal belief in their own worth and ability. Other experts such as Hester and Sheedy have described this model as the public health model.

This bio-psychosocial or public health model is central to TC theory and practice. The TC views drug dependence as a disorder of the whole person. It is a sign that something is badly wrong with how the person feels about themselves and the others around them and with the environment they exist in. Full recovery will need changes made to all of these elements and the TC is structured to provide a healing and learning setting in which new behaviours can develop and new skills can be learned.

Chuck Dederich famously remarked that Synanon, "*...is not a drug treatment programme. It's a school where people learn to live right. Stopping using is just a side effect.*" This view captures much of what TCs still believe today. That some aspects of addiction are behaviours. That new behaviours can be learned and used to replace bad behaviours. But also that some behaviours have their roots in the individual's deep-seated unhappiness with how they are and how their life has been. These are problems which need to be confronted on an emotional (not a cognitive) level: the heart not the head.

For this reason, the TC uses the community itself as the agent of change. By shaping the structure of the community so that it is both safe and often, challenging, the TC can provide a setting in which good behaviour can be learned and emotional difficulties can be experienced, discussed and resolved.

Evidence

Hester, R. & Seehy, N. (1990) The grand unification theory of alcohol abuse: it's time to stop fighting each other and start working together. In: R. Engs (ed.) *Controversies in the Addictions Field, Dubuque*: Kendal-Hunt, pp. 2-9.

This short chapter lists and describes the major models of addiction and calls for the use of a public health or biopsychosocial model of addiction.

Kumpfer, K., Trunnell, E. & Whiteside, H. (1990) The biopsychosocial model: application to the addictions field. In: R. Engs (ed.) *Controversies in the Addictions Field*, Dubuque: Kendal-Hunt, pp. 55-67.

This chapter explains the public health or biopsychosocial model of addiction in detail and discusses its practical application in the field.

Kooyman, M. (1992) *The therapeutic community for addicts: intimacy, parent involvement and treatment outcome*, Lisse: Swets & Zeitlinger. (see Chapter 2, pp. 20 – 31)

This chapter examines theories of addiction from a TC perspective and shows how the TC can respond to the issues posed by the more complex models.

Practice

The Drug

Some individuals entering a TC will already have stopped using drugs and/or alcohol. For those that haven't, a period of physical withdrawal will be needed. Once the community member is physically withdrawn ('clean') they will usually continue to experience cravings for their substance – or substances – of choice. These cravings can be very intense but will lessen over time. Group and individual work can be used within the TC to help the community member understand that periods of craving can be resisted and that they will eventually disappear. In addition, the TC environment, with it's intensive daily programme of work, group work and social activities is designed to fill much of the available time and reduce the amount of time spent in individual contemplation: certainly in the early phases.

But addiction does not exist in a vacuum. Some individuals will probably have a physical predisposition to dependence and will need to learn how to control their involvement with mood-altering activity and be aware of the risks they will continue to run. This is not to suggest that recovery is not possible or that addiction is incurable. It is simply a recognition that recovery is a very long journey for most people and although the risk of relapse will reduce – and may even disappear entirely – over time, it is a risk that needs to be guarded against. Most drug users will also experience other mental health and physical or functional difficulties such as personality disorders, depression, dyslexia, dyspraxia, post-traumatic stress disorder etc. Again, the TC needs to allow its members the space and opportunity to explore and understand these difficulties and to develop ways of containing and managing them.

The Set

Most people entering a drug-free TC will have very low self-esteem. Many will have experienced suicidal thoughts and some may have actually attempted suicide. The TC provides a safe and supportive environment in which members can begin to reassess how they feel about themselves and receive positive feedback from their peers about how they are seen by others around them. Group work can help to challenge behaviour that peers find irritating or innappropriate and these lessons can be learned and used to change behaviour. Initially this will be a deliberately constructed response ('acting as if') but TC outcome research and research in other clinical settings has shown that over time, these behaviours are internalised and become instinctive. The peer support system – which is built into the heart of TC practice – is critical here in helping the individual to reshape their identity and reassess their feelings about themselves and their value to others. Experience has show that people who have successfully recovered through a TC programme have tended to maintain strong supportive relationships with their former peers long after they have left the programme. Building strong supportive relationships is an essential component in long-term recovery and TC practice is constructed in such a way as to nurture such relationships as a starting point for the development of 'recovery capital'.

The Setting

Most people entering a drug-free TC will have come from an environment where dishonesty and deceit is common; where social deprivation is largely accepted; where poor education is seen as normal; and where drugs and drug dependence are regarded as a permanent feature of the landscape. TC practice offers an opportunity to encourage members to care for and about each other and to be honest with each other in all their dealings. A TC can also explore educational and employment diff iculties and begin to repair relations with members of the individual's social circle – including family and friends

-who are in a position to offer long-term support. Above all, the TC offers an intensive environment where drugs are not simply accepted and where other ways of coping and of feeling good can be explored and built upon.

TC Philosophy

Theory

George De Leon, the first Research Director at Phoenix House New York and a respected authority on TC methods, has coined the term community as method to describe the basis of the TC approach. Community is at the heart of the TC approach. The idea here is to use the community as a tool to teach the individual member both how to change and how to change others around them.

TCs are guided by a perspective consisting of four interrelated views of: the substance disorder, the person, recovery and 'right living'. Substance abuse is a disorder of the whole person. Recovery is a self-help process of incremental learning toward a stable change in behaviour, attitudes and values of right living, that are associated with maintaining abstinence. There are 14 essential elements of the TC:

- Community separateness
- Community environment
- Community activities
- Staff as community members
- Peers as role models
- A structured day
- Stages of the programme and phases of treatment
- Work as therapy and education
- Instruction and repetition of TC concepts
- Peer community ('encounter') groups
- Awareness training
- Emotional growth training
- Planned duration of treatment
- Continuation of recovery after programme completion

Residents of a TC spend much of their time engaged in structured therapeutic group work, one-to-one keywork, developing practical skills and interests, and (at later stages) in education and training. The aim of the treatment process is to develop self-worth, personal responsibility and life and social skills with the goal of achieving long-term abstinence and reintegrating into the community and into employment.

The hierarchy of the community is demonstrated through individual job functions and is designed to look like work in the real world. Progression up the hierarchy of job functions is much like the movement up the occupational ladder in the real world. The hierarchy and the daily work programme are used to provide community members with goals and targets and tangible rewards for improved attitude and behaviour.

Groups are used to reinforce positive behaviour and challenge negative behaviour. Movement through the stages is facilitated by group work, modelling from senior residents, key-work sessions focussing on individual issues, and through work opportunities. The ultimate goal of the hierarchy within the TC is personal growth, with job functions teaching positive attitudes and values.

Evidence

Warren-Holland, D. (2006) Some reflections of a decade of experiences in British and American concept house therapeutic communities, 1967 to 1977: *a personal experience*, *International Journal of Therapeutic Communities*, 27 (1), pp. 13-29.

This journal article by a former *Phoenix House* director is a description of the structure and concepts of the drug-free TC. The article describes the operation of the early TCs and some practices are no longer used but the principles of peer support and recovery are still valid.

De Leon, G. (2001) Therapeutic communities for substance abuse: developments in North America. In: B. Rawlings and R. Yates (eds.) *Therapeutic Communities for the Treatment of Drug Users*, London: Jessica Kingsley, pp. 79-104.

Broekaert, E. (2001) Therapeutic communities for drug users: description and overview. In: B. Rawlings and R. Yates (eds.) *Therapeutic Communities for the Treatment of Drug Users*, London: Jessica Kingsley, pp. 29-42.

Two book chapters by two authors who are well known and respected within the TC movement. Both chapters describe the founding principles of the drug-free TCs and their modification over the past 40 years both in Europe and the USA.

Practice

Community as Method

The term community as method is often heard in TCs, and refers to the TC treatment approach. Unlike other treatment models, in the TC it is the community itself that brings about change within individuals. Although the TC has similarities with the wider community, in that it has work, leisure, rules, boundaries etc., its purpose differs in that the main objective of the community is to bring about change in individuals in both attitudes and behaviour. Community as method means teaching community members to use life within the community to learn about themselves and bring about personal change. The TC places demands on its members to participate, to behave appropriately, to respect the standards and rules. Being a member of a TC means that as well as conforming to these expectations, members are required to monitor, observe and feedback where others are not. So, both residents and staff are continually observing and assessing each individual's behaviour, attitudes and personal change.

Everything that happens in a TC is designed to bring about change in community members and allow them to learn, or re-learn, how to function in an alternative lifestyle to the one they have been involved in previously. Residents are part of the TC, 24 hours a day, 7 days a week, and are observed in everything they do: work, leisure, peer interactions, group participation etc. In a member's early stages in the TC, it is through these observations that a picture is drawn up of the behaviours and attitudes which need to be changed or modified. As they progress, it is through the community that change begins to take place; positive examples are set by role models, while negative behaviour is challenged, and recognised change rewarded.

Philosophy

The programme philosophy is a fundamental cultural ingredient in all TCs. Phoenix Futures has developed its own philosophy which distinguishes its unique character and culture. The philosophy is recited by the whole community every day at the morning meeting, keeping it alive and signifying its powerful role in the recovery of past members, and offering hope to current ones:

We are here because there is no refuge, finally, from ourselves. Until we have confronted ourselves in the eyes and hearts of others, we are running. Until we suffer them to share our secrets, we have no safety from them. Afraid to be known, we can know neither ourselves nor others, and will be alone. Where else but in our common ground can we find such a mirror? Here, together, we can appear clearly to ourselves not as a giant of our dreams nor a dwarf of our fears, but as a person, part of a whole with a share in its purpose. In this ground, we can take root and grow, not alone, anymore, as in death, but alive to ourselves and others.

Life Stories

As members progress through the TC, they will inevitably share stories of their lives, time in the TC, in other treatment interventions and how they have changed. Through this sharing of stories, newer residents begin to understand the role of the community in their own change process. The telling of the life story helps to bind the teller to the community and to individuals in it. It is through this sense of belonging that bonds begin to form and support networks are built up. By listeners feeding back their positive reactions to the teller's story and through the recognition that others have experienced similar situations, the individual member begins to develop strong bonds with others in the community and gains a sense of common purpose.

TC Rules and Sanctions

Theory

The TC demands that members are drug-free on arrival and remain drug and alcohol-free throughout the programme. Members are expected to treat each other with respect and be aware of how other members are behaving.

The TC has strict moral codes and rules that need to be smoothly and safely. They are also designed to create an appropriate environment in which members can feel safe and able to learn and change. Most TC members learn, very quickly that displaying anti-social attitudes and feelings within the TC will not be productive for them. Individuals are expected to adopt pro-social attitudes in order to become fully integrated into the therapeutic community – to *act as if*.

Respect for authority figures is demanded by the hierarchical structure of the TC, and pro-social attitudes are modelled by more senior residents. This reinforces the message to the newer residents that there are benefits to developing pro-social attitudes and feelings. Anti-social attitudes are not reinforced at any point during the TC programme. Anti-social attitudes and feelings, if expressed, are challenged by the community (by other members and staff) in a variety of ways.

The routines, structure and order of the TC regime require individuals to delay gratification, and learn that achieving their long-term goals will take time, patience and consistent positive behaviour. This demands that residents become less impulsive. Although daily duties may feel dull and repetitive, it is this routine that develops in the member the skills required for long-term recovery. Members will receive positive feedback from other residents and staff when they behave less impulsively and this will further reinforce their behaviour.

Evidence

Warren-Holland, D. (2011) Some reflections of a decade of experiences in British and American concept house therapeutic communities, 1967 to 1977: a personal experience, *International Journal of Therapeutic Communities*, 27 (1), pp. 13-29.

This journal article by a former *Phoenix House* director is a description of the structure and concepts of the drug-free TC. The article describes the operation of the early TCs and some practices are no longer used but the principles of peer support and recovery are still valid.

De Leon, G. (2001) Therapeutic communities for substance abuse: developments in North America. In: B. Rawlings and R. Yates (eds.) *Therapeutic Communities for the Treatment of Drug Users*, London: Jessica Kingsley, pp. 79-104.

This book chapter charts the developments in TC practice in North America and explains the use of the rules and principles to engender positive, pro-social behaviour.

Yates, R. (2011) *Act as if and other great ideas: concepts in a concept-based TC*, Stirling: University of Stirling (unpublished MS.).

A short descriptive article outlining some of the major concepts used in drug-free therapeutic communities and the meanings behind them.

Practice

As with all communities, the TC must have rules which are followed. Like any community, in order for the Therapeutic Community to be effective, there must be clear rules of conduct. In a TC, rules and regulations protect the community and also allow members to better manage their lives. It is important that every member is aware of the rules which they must follow and this should be covered with them on assessment and reinforced during the Welcome House stage (or during recruitment/induction for staff members), as well as the TC having signs displaying the rules in appropriate places, e.g. group rules in the group rooms etc. The TC rules apply to all TC members paid staff and volunteer members are expected to follow these rules at any time they are in the community or in the wider community on TC business.

There are two general sets of community rules in the TC:

- Main Rules.
- House Rules.

Main Rules

Main rules are considered to be absolute and breaking them may result in very serious consequences, up to and including the possibility of being asked to leave the TC. They help provide a safe environment and ensure everyone is treated as equals. The Main Rules are:

- No drugs or alcohol (this includes giving a positive drug test or failing to supply a urine sample for a drug test or providing a sample that is 'too dilute')
- No threats or acts of physical violence
- No carrying of weapons and no use of weapons
- No discrimination

The breaking of the Main Rules in the TC is a serious violation as these are the key rules which keep the community safe and they should be taken and treated seriously. However, every case is dealt with on merit and fully investigated before action is taken.

House Rules

These rules govern how members interact with other community members and how daily life in the TC is organised: TC members (both staff and community members) agree to:

- accept authority whether from staff or through the resident management structure
- tell the truth
- avoid swearing
- fully take part in – and commit to – the community
- avoid racial, ethnic, or sexual slurs or insults.
- respect each other's and the TC's property
- follow programme confidentiality guidelines
- not take part in any criminal activity or damage to property
- not take part in any sexual activity or any other exclusive relationship
- avoid gambling
- be punctual and show that they can be good time managers
- avoid smoking in undesignated areas or during programme activity times.
- respectfully receive awareness or concerns offered by other members.

House rules are concerned with work performance, how members address other community members, how they give feedback and how they look after the safety, security and environmental interests of the TC and its members. House rules address behaviours that can be tolerated within narrow limits and provide a fair and equal structure for the community to follow. It is important that both staff and community members read and understand the rules. They are there to help community members learn the value of boundaries, to help change previous chaotic behaviours and to ensure equal treatment.

TC Effectiveness

Theory

For many years, the randomized controlled trial (RCT) has been viewed as the gold standard of evidence. Whilst it is true that there is a compelling attraction to the apparent simplicity of the RCT in measuring and evaluating interventions (add this element, or medication and things get better; take it away or fail to add it and things get worse or at best, stay the same), the truth is, that some interventions, like TCs, are so complex and involve so many interacting components, that isolating a single element and identifying it as the "what works" factor simply misses the point.

At its best, the TC represents a careful balancing of a series of interventions which, *in themselves*, have been tried and tested for many years. Whilst much of the evidence regarding the effectiveness of TCs is in outcome studies and not RCTs, the sheer number of these studies and the striking similarity of their findings provide a compelling argument of TC effectiveness.

For over 40 years, the drug-free TC has been studied and evaluated. Most of this evidence suggests that drug-free TCs have a profound and long-lasting impact upon those members who complete treatment. A number of studies show that even those who fail to complete treatment see improvements in a variety of areas including drug and alcohol use, self-esteem, employment, health care needs and offending.

TCs have often been criticized for a perceived high dropout rate; particularly within the first months of treatment. But this is not just a problem for TCs. Drop-out rates for a number of treatment interventions (diabetes, hypertension, asthma etc.) is poor and in most studies, only half complete treatment. Even in methadone treatment programmes drop-outs are a serious problem. Some studies have found that almost two-thirds drop out within the first 12 months, with one-third dropping out in the first 12 weeks.

This is not to suggest that retention is not important. There is clear evidence that the longer the community member remains within a TC treatment programme, the better his/her chances are of recovery. So retention – and working to improve retention – is a real concern for therapeutic communities; as it is for all drug treatment services. But early drop-out should not be confused with ineffective treatment. Therapeutic communities are effective for those who remain in treatment long enough for treatment to work.

Nor is this necessarily a very expensive treatment. Although some studies have suggested that TCs cost far more than other treatments, this is generally because the studies have failed to really compare like with like or considered the long term costs of full recovery against continued medication and support. Where these factors are taken into account TCs look like real value for money.

Evidence

De Leon, G. (2010) Is the therapeutic community an evidence-based treatment? What the evidence says, *International Journal of Therapeutic Communities*, 32(2), pp. 104-128.

Journal article by George De Leon, former Research Director at *Phoenix House* New York and head of the Center for Therapeutic Community Research, summarises the evidence on TC effectiveness.

Wexler, H. & Prendergast, M. (2010) Therapeutic communities in United States prisons, *International Journal of Therapeutic Communities*, 32(2), pp. 157-175.

Journal article mapping the effectiveness of in-prison TCs (particularly when they are linked to TC-related after-care services.

Yates, R. (2010) Recovery we can afford: an analysis of a sample of comparative, cost-based studies, *International Journal of Therapeutic Communities*, 32(2), pp. 145-156.

Critically examines a sample of cost studies and argues that they do not tell the whole story and that the difference in costs is generally overestimated.

Freestone, M. & Goodman, P. (2009) Mental health and engagement outcomes for a UK addiction TC: the Ley Community, *International Journal of Therapeutic Communities*, 30(1), pp. 35-42.

Journal article exploring outcome data for a group of drug users undertaking treatment in a TC. Notes a strong link between length of stay and successful outcome.

Practice

Overview

Most studies of TC effectiveness have been field trials measuring outcomes over a period of time up to 12 years. The majority of these studies show quite striking similarities in findings. Whilst there is an argument that findings of this type are not as convincing as randomised trials; that there are problems with the samples studied because they had self-selected a TC treatment; or that not all TCs have the same operational structures, the sheer number of these studies provide a strong argument.

Most studies show that TCs are effective in changing behaviour, reducing drug use and anti-social behaviour; and improving social reintegration. Most also show that the longer the individual stays in treatment, the better the outcome.

George De Leon of the Center for Therapeutic Community Research (CTCR) at the Natioinal Development and Research Institutes has conducted research on TC effectiveness for many years and analysed the findings of other studies. Their findings are summarised here.

Strength of Association

CTCR estimates that most TC studies show improved outcomes. Between 40% and 60% of drop-outs had improved in a range of measures one year after treatment. Of those who completed TC programmes, around 90% showed improvements.

Dose response relationship

These findings relate to the relationship between time in the TC treatment programme and improved functioning outcomes. In almost all studies, there was a strong relationship between the length of time in treatment and better outcomes. Programme completers did consistently better than drop-outs.

Consistency

In most TC outcome studies, the resulting improvements were remarkably similar. The similarity of these findings across different geographical areas, different timescales and populations and different treatment structures adds weight to the belief that TCs achieve positive change.

In-treatment Effects

A number of studies in both the US and Australia have suggested that the dramatic reductions in drug-use, health service utilisation and offending during treatment are, in themselves evidence of some sort of treatment impact. Some studies have calculated that these reductions during treatment actually made TC treatment cost-effective even if no long term benefits occured.

Existing Knowledge

The TC approach contains a number of essential elements which have been studied in other contexts and have proved their value. Most TC research studies have shown that the use of these elements within a TC setting are equally effective.

While there is much more to be done to improve the evidence base, there can be little doubt that TC treatments work. The urgent task now is to study *how* they work so that the approach can be adjusted to improve outcomes. In particular, TCs need to encourage staff to explore ways of improving drop-out rates and programme completion. But this is not simply about length of time in treatment. A number of studies show that positive engagement with the treatment system also improves outcome. In TCs, treatment engagement is usually measured in terms of position within the hierarchy. Much more needs to be done to make sure that members are positively rewarded for their engagement in their own recovery and that initiatives like the Welcome House are supported and provided with appropriate resources to succeed. In De Kiem, a TC in Belgium, the establishment of a Welcome House dramatically increased retention.

Study Area

Please use the study areas below to check your learning so far

Study Area – Staff Members

To complete this section please:

Exercise One

- divide a blank sheet of paper into three columns marked 'Drug', 'Set' and 'Setting'. In each column write down what you understand by this term and give an example of how the TC can help in making changes to this issue.
- discuss your notes with a colleague or group of colleagues or supervisor.

Excercise Two

- on another blank sheet of paper write down five arguments which show that TC is an effective means of delivering recovery
- explain your arguments to a colleague or group of colleagues or supervisor. Are they convinced? Do they have similar arguments?

Study Area – Community Members

To complete this section please:

Exercise One

- divide a blank sheet of paper into three columns marked 'Drug', 'Set' and 'Setting'. In each column write down what you understand by this term and give an example of how this issue has affected you in the past.
- discuss your notes with a peer or your buddy. How do you think you can change this issue? What can the community do to help?

Excercise Two

- on another blank sheet of paper write down three ways in which the TC has helped you change
- discuss these changes with a peer or your buddy. Would another treatment have worked with them?

TC Stages

Study Commitment – Staff Members

As a staff member of Phoenix Futures, once you have completed this section, you should be able to:

- understand the different stages of treatment and their purpose
- understand the difference between the one-to-one emphasis in the Welcome House and the peer-led emphasis in the TC proper
- understand the concept of Community as Method
- understand the use of stages and the structure as targets and goals for individual community members
- understand what community members need to do to show that they are ready to move on to a further stage
- explain these issues to community members who question them

Study Commitment – Community Members

- As a community member of Phoenix Futures, once you have completed this section, you should be able to:
- understand why you are in the stage that you are in
- understand where you are in the structure and why
- understand what you need to do to move to the next stage
- understand how you can move to another position in the structure and what will be expected of you
- understand how the community works for you and how you are expected to work for the community
- explain these issues to new community members who may be confused by them

Welcome House

Theory

Stepping Stone

The Welcome House initiative is a new development within *Phoenix Futures* intended to replace earlier induction phases and provide a more systematic 'stepping-stones' approach to new community members. At the moment, the idea is is in the experimental phase and it is expected that some elements may be changed or added to as practice shows the need for alterations or adjustments to be made. In this, it is no different to other aspects of the programme which is continually being reviewed and adjusted to respond to changes in the environment and new findings in addiction science.

The idea is based upon the practice of *De Kiem*, a long-standing TC in Gent, Belgium. *De Kiem* established their welcome house system in 1997 as a way of improving their retention and completion rates and to provide a 'safety-net' for residents who were either contemplating leaving against advice or had been asked to leave the main TC programme. In the *De Kiem* model, the welcome house is in a separate building and is staffed by its own specialist team.

As the idea is put into practice across *Phoenix Futures*, some of these aspects will need to be adapted to suit our particular circumstances. A short video presentation of the *De Kiem* welcome house system has been made by *Phoenix Futures* and is available online at: **http://vimeo.com/18531256** or in the disc version of the ***Evidence Collection***.

This is a new departure for Phoenix Futures and the theoretical basis for it is largely untested. However, we do know that the establishment of a welcome house system in De Kiem had a huge impact on their retention rates. Before setting up the system, only 20% of people entering their TC actually completed the programme. In 2009 that had increased to 60%.

Easing In

The new Welcome House stage has two clear purposes. It is intended to provide new members with a more welcoming, less intense introduction to TC life. More attention is given in this phase to supporting the individual and encouraging change. Welcome House members interact with the main TC in a more limited way and are provided with more individual support and more detailed explanations of why the TC works in the way that it does.

Re-Focus

The new Welcome House stage also provides the basis for a further new development called Re-Focus. Re-Focus offers a temporary safety net to members who are struggling for one reason or another in the main TC programme. The idea is that residents who would previously have left against advice or perhaps been asked to leave because of a breach of rules or unacceptable behaviour can instead be transferred to a more individualised programme which uses many of the Welcome House elements. Thus for a limited time, some residents may be offered a period of reflection which might include attendance of some Welcome House activities and groups.

Evidence

De Leon, G. (1991) Retention in drug-free therapeutic communities. In R. W. Pickens, C. G. Leukefeld and C. R. Schuster (eds.) *Improving Drug Treatment (NIDA Research Monograph 106).* Rockville, MD: National Institute on Drug Abuse.

This is a short chapter in a NIDA monograph that reports on retention rates in American drug-free TCs and maps improvements in this area.

Lewis, B. F. and Ross, R. (1994). Retention in therapeutic communities: challenges for the nineties. In F. M. Timms, G. De Leon, and N. Jainchill (eds.), *Therapeutic Community: Advances in Research and Application (NIDA Research Monograph Series* (p. 99). Rockville MD: National Institute on Drug Abuse.

This is a short chapter in a NIDA monograph that looks at what sort of clients leave treatment against advice and what TC service providers might be able to do about it.

NTA (2005) *Retaining Clients in Drug Treatment: A Guide for Providers and Commissioners* London: National Treatment Agency for Substance Misuse

Official generalised advice for drug treatment services in England. Explains why retention and engagement is important and suggests ways that services might improve it.

Practice

Set Apart

The intention of the Welcome House stage is to create a separate area of the TC where activity is less intense and more reflective. This should provide a more welcoming (and less frightening) introduction to the TC for new or returning community members. For TC residents who might otherwise have left against advice ('split') or been asked to leave, the Welcome House can also provide space to think things through – a 're-focus' period.

The goal is to increase the numbers of people coming into the community and the numbers staying and completing the programme. We know that our TC programmes work but we want them to work for more people.

New Community Members

New community members will normally be expected to remain within the Welcome House phase of the programme for a minimum of 4 weeks (and a maximum of 8). Members in the Welcome House stage will interact with the main TC programme at certain times of the day; such as, morning meetings, evening activities etc. They will not be assigned to specific work departments but these will be explained to them and they will be expected to keep their own area in a clean and tidy condition. In the same way, they will not take part in encounter groups but they will be told how they work and what they are for. Towards the end of their time in the Welcome House phase they may be expected to observe an encounter group or try a practice one with their immediate peers. Throughout this stage, the emphasis is upon them being the most important members of the community with a far higher level of support and encouragement. There will not be a specific staff team but all staff will be given training to adapt their practice to this less intensive phase of the programme. The Welcome House also provides an opportunity for prospective members to complete a detoxification if this is required and full assessment will be completed before they move to the TC proper.

Buddies

Every new community member entering the Welcome House phase will be assigned a suitable buddy. This will be a senior community member who will have received specific training to undertake this role. Buddies will be expected to be there to greet the new member on arrival, to explain the rules and operation of the community and share sleeping quarters with them. Buddies will liaise with their new member's keyworker and mentor them throughout their time in this phase. Keyworking – and meetings with keyworkers and other staff – will be more frequent than would be expected within the main TC programme.

Re-focus

The final, crucial aim of the Welcome House is to act as a 'safety net' for people in the main programme who are at risk of leaving early. In this Re-Focus period, residents who are struggling may be offered more one-to-one input and may be asked to attend some Welcome House activities. It is hoped that this will:

- providing a 'breathing space'
- providing increased individual intervention with staff members
- providing a less confrontative environment in which to reflect

Re-focusing should never be used as a punishment and is normally for no more than 7 days. Welcome House achievement markers and measures are set out in Examples 1 (page 58).

Primary Stage

Theory

The Primary Stage is the heart of the TC. The objective within this stage is to create an environment which is both ordered and therapeutic in content. The structure of this stage (as with the Senior Stage) provides realistic, visible opportunities for goal-setting and achievement.

TC structure has evolved and developed over its 50 years of practice, but the theory which provides the framework remains largely unchanged. The way in which the community is run within this stage is built upon the TC view of addiction, the need for order and measured or measureable change and the TC view of the community member as the instrument of his/her own recovery. This is the hallmark of the TC approach to growth and change which sees addiction as a disorder of the whole person and change as something which needs to happen to all aspects of the member's life.

The structured day within this stage is designed to create order in a life which has previously been chaotic and opportunistic. This sense of order, clarity and regularity provides a foundation upon which change can be built. Added to this, the hierarchy of community members - with each member assigned a place which reflects their status within the community and their ability to accept responsibility - creates an opportunity both to hold out the promise of real rewards for improved behaviour and a real-life pressure to complete tasks on time and to a high standard.

The creation of an environment where there are clear expectations around behaviour and task completion and where the pace of life is often intense and expectations high, is intended to provide a learning situation where community members can learn to stick with a task; not to 'act out' in response to criticism; to gain a real sense of achievement in 'a job well done' - a job which benefits the community member and the community s/he is part of.

Promotion up the hierarchy (and sometimes demotion for poor performance or bad behaviour) gives each community member an opportunity to celebrate change and achievement; to experiment with increasing responsibility; and to test out their new, 'unspoiled identity' in a safe and supportive setting.

The theory behind the creation of a learning environment where stages of change are clearly marked and where goals are set and achieved in a logical, progressive way, is not unique to the TC and has been shown to have value in many other treatment settings. In AA/NA fellowships, for instance, the 12 steps, which members are expected to move through, ask them to undertake increasingly demanding tasks to cement their recovery. Numerous studies have shown that those who engage with treatment and leave with a positive sense of achievement have the best outcomes.

Evidence

Broekaert, E. (2001) Therapeutic communities for drug users: description and overview. In: B.Rawlings and R. Yates (eds.) ***Therapeutic Communities for the Treatment of Drug Users,*** **London: Jessica Kingsley, pp. 29-42.**

This book chapter outlines the structure of the TC and the theory which lays behind the structure and operation.

De Leon, G. (1994). The therapeutic community: toward a general theory and model. In F. M. Timms, G. De Leon, and N. Jainchill (eds.), ***Therapeutic Community: Advances in Research and Application (NIDA Research Monograph Series*** **(p. 16). Rockville MD: National Institute on Drug Abuse.**

This chapter in a NIDA monograph looks the basic principles that underpin TC practice and how they are normally operationalised.

White, W., Kurtz, E. & Sanders, M. (2006) ***Recovery Management*****, Chicago, IL: Gt. Lakes Addiction Technology Transfer Center.**

A monograph on recovery history and evidence with practical advice for structuring recoveryoriented programmes, centres and communities.

Yates, R. (2011) ***Act as if and other great ideas: concepts in a conceptbased TC*****, Stirling: University of Stirling (unpublished MS.).**

A short descriptive article outlining some of the major concepts used in drug-free therapeutic communities and the meanings behind them.

Practice

Purpose

The aim of the Primary Stage is to provide a safe and therapeutic setting for the community member to begin the process of change and to learn to care for themselves and others.

The Primary Stage lasts for a minimum of 10 weeks – a maximum of 20 weeks and is the core of the programme and the point at which the treatment process begins to emphasise the values of right living and skills for independent decision making.

Community as Method

The goal of the Primary Stage is to encourage the community member to use the community as a tool for change – not only change for the individual but for the whole community. This is at the heart of De Leon's concept of *Community as Method*. Through structured groups and peer group sessions, each community member begins to focus on self-discipline, self-awareness and an acceptance of their individual problem areas. Problems with behaviour, social skills, attitude etc. are addressed by the whole community and in individual sessions. These difficulties are identified through the daily programme of work and group interaction and are worked through with an emphasis on each individual accepting responsibility for their own behaviour.

Relapse prevention sessions are delivered throughout the Primary Stage as part of the structured sessions, peer support, encounters and seminars which all members attend. During this stage, members also start to develop pro-social values and positive attitudes and behaviours and, through their community work, gain a positive work ethic. Members are given the opportunity to earn positions of increased responsibility by showing greater involvement in the programme and through working on themselves. There are a variety of processes involved within the Primary Stage. For example, all community members are expected to increasingly engage in monitoring and challenging their own and other members' behaviour through the use of pull-ups and to actively take part in the encounter process. Keywork continues throughout this phase, but with less frequency and intensity than during the Welcome House stage. Instead, the community itself becomes the main tool for encouraging and internalising change.

Act as If

It is during the Primary Stage that the TC concept, *Act as If* becomes central to the development of members' new identity. This is one of the behaviourist elements of TC practice and is based on extensive research showing that new behaviours can replace old, destructive ones if they are practiced over a period of time and are rewarded. The full detail of the concept is: *"act as if, be as if, be!"*. That is, if members are prepared to supress their natural responses (to fear, irritation, humiliation) and to instead act in a responsible and attentive fashion, then the newly learned behaviour eventually becomes the natural response. Primary Stage achievement markers and measures are set out in *Examples 2* (page 60).

Senior Stage

Theory

Role Modelling

As with many other recovery-focused interventions, the TC places a strong emphasis on the power of peer support and mentoring.

Senior members (and members in the Re-entry Stage) are expected to take on a leadership role in the community and to act as a role-model for more junior members.

There is a strong evidence base for the value of such role-modelling in recovery. Not only do senior members offer more junior members direction and encouragement; the research suggests that they themselves gain real therapeutic benefit from reinforcing the recovery journeys of others. The TC concept: *"You can't keep it if you don't give it away"* is a powerful reminder that the process maintaining recovery can be improved through positive involvement in the recovery of others.

Meeting the Real World Again

During the senior phase of their programme, members begin to interact with the world outside the TC. This will often be through voluntary work or education.

Senior members are encouraged to try out the skills and the new identity they have gained through their treatment in 'real world' settings.

Again, there is strong evidence for the value of allowing recovering users limited freedom to test out their newfound strength whilst they are still able to fall back on the support of the community when they find this difficult.

Exit Strategy

At this stage in their treatment programme, senior members will begin to plan for life outside the TC. This may require rebuilding relationships with family and friends, although this process will have been going on since their arrival. Individual treatment plans may be required for specific problems and difficulties.

Evidence

De Leon, G. (1994). The therapeutic community: toward a general theory and model. In F. M. Timms, G. De Leon, and N. Jainchill (eds.), *Therapeutic Community: Advances in Research and Application (NIDA Research Monograph Series* (p. 16). Rockville MD: National Institute on Drug Abuse.

This is a short chapter in a NIDA monograph that looks the basic principles that underpin TC practice and how they are normally operationalised.

Warren-Holland, D. (2006) Some reflections of a decade of experiences in British and American concept house therapeutic communities, 1967 to 1977: a personal experience, *International Journal of Therapeutic Communities*, 27 (1), pp. 13-29.

This journal article is a description of the structure and concepts of the drugfree TC. The article describes the operation of the early TCs and some practices are no longer used but the principles of peer support and recovery are still valid.

Dawson, W. & Zandvoort, A. (2010). The therapeutic community as a method of intervention. In R. Yates and M. Malloch (eds.), *Tackling Addiction: Pathways to Recovery* (pp. 96-105) London: Jessica Kingsley.

This is a short chapter in a book on recovery that looks at life in a therapeutic community and the pressures on senior residents.

Practice

The Senior Stage is the time in treatment when the senior member begins to use the growth that has occurred in previous stages for the benefit of other community members and in interaction with the 'real world'. Within the service, senior members take on a leadership role, and begin to deal with the issues that face them in the external environment.

Description

This is the stage when the senior member begins to demonstrate abilities to deal with the realities of the outside world. Specific activities during this phase may include:

- fully integrating vocational and/or educational activities into his/her daily routine
- taking part in individual interventions designed to address particular problems
- taking a leadership role in the therapeutic environment and the life of the TC
- working with staff and peers to resolve outstanding family issues
- attending special groups for psychosexual issues
- involvement in external counselling for acute or chronic mental health issues
- taking an active role in his/her treatment and pre-discharge planning.

Anticipated outcomes

There are several specific outcomes that demonstrate that a senior member has successfully completed this phase of treatment. On completion of the Senior Stage, a member should be able to demonstrate an ability to:

- set an example for fellow community members
- successfully manage senior status in the social structure of the community
- handle increased personal freedom
- be a role model in accepting of the programme philosophy and methods
- show a general adaptability to job changes
- acceptance of staff as rational authorities
- contain and resolve negative thoughts and emotions
- demonstrate improved self-esteem based on status and progress
- accept full responsibility for his/her actions and decisions
- assist staff in confronting peers
- succeed in educational and/or vocational activities in the outside environment.

The Senior Stage stage will normally last between a minimum of 8 weeks and a maximum of 22 weeks. Achievement markers and measures are set out in *Examples 3* (page 62).

Phoenix Futures Sheffield Residential Service

Re-entry Stage

Theory

Re-entry is the last phase of treatment after the client completes the Senior Stage. During Re-entry, the senior member formally addresses the process of adapting to life outside the protective shell of the Phoenix Futures community they have been attending.

During early re-entry, some clients may continue to live in and/or participate in some services within the treatment setting. The goal of Re-entry is to end the individual's dependence on Phoenix Futures as the primary point of learning and to increase involvement in the outside world.

Senior members in the Re-entry Stage will normally be in college, training, or part-time job placement. They will be actively working to resolve family issues. Ideally reentry and re-settlement should take place near the home area where the clients will eventually live, though this is sometimes impractical logistically and financially.

While in the re-entry stage of treatment, clients are expected to participate in aftercare activities suited to their needs. The focus of this phase should revolve around skills and behaviours necessary for drug-free daily living and independent functioning in society.

In some Phoenix Futures services, clients in the Reentry Stage may volunteer to assist staff with specific tasks as role models and/or mentors for earlier-stage clients. Completion of re-entry marks the end of direct treatment services.

The evidence base for the value of TC-oriented after-care or re-entry is very strong. For instance, an American study of re-imprisonment of drug-using offenders with mental health problems completing a modified TC programme in San Carlos Correctional Facility, found that 16% of the TC population were re-imprisoned compared to 33% of the control group one year after release. But for those prisoners who attended a TC-oriented aftercare re-entry programme, the re-imprisonment rate dropped to 5%. Similar findings were reported for the impact of modified TC plus after-care services for homeless mentally ill drug users.

In a study of the TC programme provided by Amity Foundation in Donovan Prison, one year after return to custody rates were 39% for TC programme completers but 8% for prisoners who had both completed the TC programme and entered Amity's after-care TC facility.

Almost all TC studies show that TC completers - those who complete the *whole* TC programe and go on to complete a programme of controlled re-entry into society - do significantly better than those who simply complete the main treatment phase.

Evidence

Sacks, S. & Sacks, J. (2010) Research on effectiveness of the modified therapeutic community for Persons with co-occurring substance use and mental disorders, *International Journal of Therapeutic Communities*, 31 (2), pp. 176-211.

This journal article reports on a series of outcome studies of modified TCs for people with dual diagnosis.

Wexler, H. & Prendergast, M. L. (2010) Therapeutic communities in US prisons: effectiveness & challenges, *International Journal of Therapeutic Communities*, 31 (2), pp. 176-211.

This journal article reports on a series of outcome studies of in-prison TCs with and without after-care or re entry.

Condelli, W. S. & Hubbard, R. L. (1994). Client outcomes in therapeutic communities. In F. M. Timms, G. De Leon, & N. Jainchill (eds.), *Therapeutic Community: Advances in Research and Application (NIDA Research Monograph Series* (p. 16). Rockville MD: National Institute on Drug Abuse.

This is a short chapter in a NIDA monograph that summarises the evidence base on TC outcomes

Practice

Staff Skills

Dealing with clients who are in the aftercare and/or re-entry phases, requires a very different approach to that used in the main programme. These community members are out in the wider society for most of their time and are largely free to behave and act as they choose. To approach them with the same attitudes and sense of responsibility would not work. Staff working with these very late stage community members need more individualised and focused ways of interacting. And community members at this stage in their treatment are expected to me more capable of using their own skills and knowledge to resolve issues or confront their difficulties. Every completing member's needs, assets, and challenges will be different and need very focused interventions from their support staff.

Outcomes

Outcomes for successful re-entry could be measured in several ways, including current drug/alcohol use, housing consistency, health improvement, educational attainment, etc.

One of the most important measures for long term success will be vocational status.Successful engagement with education and/or employment is probably the greatest predictor of long-term drug-free recovery. Some re-entry measures regarding vocation might include:

- entry into and/or completion of an educational or training programme
- temporary or permanent job
- earning level and/or level of benefits
- employment evaluations, promotions, raises
- duration of employment
- job satisfaction
- return to education to pursue long-term vocational goals

Regardless of the particular focus, re-entry is something that should be a part of the planning process from early in treatment ("Begin with the end in mind").

Relapse

The risk of relapse remains high for many years after treatment. Relapse prevention work begins early in the treatment process with all community members. But for members in the Re-entry Stage, staff will need to be actively working to reinforce the message that there is a huge difference between a lapse and a relapse and that one certainly does not have to lead directly to the other.

Graduation

All residents have a formal graduation following the completion of their programme (either at the end of the residential programme or following completion of the re-entry programme). Friends and family are invited to the graduation celebration and a rolled up graduation certificate is presented as recognition of achievement and commitment. Graduation days are at regular intervals and include individuals graduating in that period.

My Recovery Day

Once a year *My Recovery Day* celebrates one year on from graduation; those who graduated from the programme and remained abstinent for 12 months from departure will be formally invited to celebrate this milestone. *Phoenix Futures* recognises that lapse can be part of recovery. So, where an ex-resident has lapsed, which has not resulted in the regular use of drugs and/or alcohol, this does not prevent them from being invited and attending My Recovery Day.

Study Area

Please use the study areas below to check your learning so far

Study Area - Staff Members

To complete this section please:

Exercise One

- choose two of the four Stages of treatment and list what community members should be learning in each of these two stages and what staff members should be doing to make sure that happens.
- discuss your two lists with a colleague or group of colleagues or supervisor. Try to use these lists to discuss current community members to see whether they show if those members are ready to move on or not

Excercise Two

- Write a short - one paragraph - explanation or description of *Community as Method* in your own words
- read your description to a group of colleagues. Are they convinced? Do they have questions about the approach that you haven't explained?

Study Area - Community Members

To complete this section please:

Exercise One

- Write a short - one paragraph - explanation or description of *Community as Method* in your own words.
- discuss your two lists with a peer, group of peers or keyworker. Does what you have written make sense? Have you missed out any important parts of the idea?

Excercise Two

- Take one of the 10 concepts (see: *Act as If and other Great Ideas in the Evidence Collection disc*) and write a short description of the concept and what it means to you and to the community.
- Prepare and present a seminar on the concept you have chosen (this can be either for your own peers or for Welcome House members.

TC Principles

Study Commitment – Staff Members

As a staff member of Phoenix Futures, once you have completed this section, you should be able to:

- understand your role and responsibilities in the community
- understand how the structure works to help members form recovering identities
- understand the TC as a learning environment
- understand the purpose of role changes and know when they are approporiate
- explain the rules and sanctions and their role in the learning process
- explain the structure and how it works

Study Commitment – Community Members

As a community member of Phoenix Futures, once you have completed this section, you should be able to:

- understand your role and responsibilities in the community
- understand how the structure works to help you form recovering identities
- understand the TC as a learning environment
- understand the purpose of role changes and how you can progress
- explain the rules and sanctions and their role in the learning process to junior members who are confused by them
- explain the structure and how it works to junior members who are confused by it

On the Floor (Daily Routine & Structure)

Theory

A Therapeutic Environment

TCs are traditionally built around the concept of total immersion in a therapeutic environment where every waking part of the day is designed to allow the individual member to use the community to learn new ways of living and behaving both for themselves and for other community members.

So whilst the busy daily work programme serves the purpose of keeping members occupied and preventing negative reflection, it is also a key element of the treatment process. Working 'on the floor' is *not* simply to provide something to do between treatment episodes like groups, counselling, seminars etc. It is actually a deliberately constructed environment which is an integral part of the treatment and change process.

The hierarchical structure of the daily work departments allows each member to see how far they have progressed in their own treatment and to set new goals (to be an Assistant Department Head, to be a House Manager etc.).

Progress

The speed with which an individual moves through the programme will depend on their needs and progress through prescribed markers of achievement (see Examples 1-3 (pages 58-62). In-built care plan reviews make sure that residents progress at an appropriate pace. Care plan reviews, at a minimum, take place every 12 weeks (NTA guidance) and include care co-ordinators and families; more regular reviews of goals will be set between the keyworker and resident, as needed. It will be agreed at set reviews whether a phase needs to be shortened or extended, the programme can be extended to suit the individual's needs, stage-by-stage, up to a maximum programme length of 12 months. Where a resident's stay is governed by the length of funding, funders will be informed of what the programme will cover. Where a residents funding is less than 3 months, a resident will receive the Welcome House and Primary Stages only.

Aims

The purpose of the daily routine then, is to teach the member to operate within a structured community within which there are opportunities to learn self-discipline, responsibility and concern for other community members.

The overall structure can be adjusted according to the needs of each individual member. The learning aims are:

- to practice *right living*
- to learn to delay reward and deal with frustration
- to set achievable goals & reach them
- to become a working part of the whole
- to provide a role model for other more junior members

Evidence

Broekaert, E. (2001) Therapeutic communities for drug users: description and overview. In: B. Rawlings and R. Yates (eds.) *Therapeutic Communities for the Treatment of Drug Users*, London: Jessica Kingsley, pp. 29-42.

This book chapter outlines the structure of the classic TC and the theory which lays behind the structure and operation.

De Leon, G. (1994). The therapeutic community: toward a general theory and model. In F. M. Timms, G. De Leon, and N. Jainchill (eds.), *Therapeutic Community: Advances in Research and Application (NIDA Research Monograph Series* (p. 16). Rockville MD: National Institute on Drug Abuse.

This is a short chapter in a NIDA monograph that looks the basic principles that underpin TC practice and how they are normally operationalised.

Warren-Holland, D. (2006) Some reflections of a decade of experiences in British and American concept house therapeutic communities, 1967 to 1977: a personal experience, *International Journal of Therapeutic Communities*, 27 (1), pp. 13-29.

This journal article is a description of the structure and concepts of the drug-free TC. The article describes the operation of the early TCs and some practices are no longer used but the principles of peer support the purpose of the structure and recovery goals are still valid.

Practice

Structure Boards

It is important that members are aware where and how they fit into the structure; this is done via a 'structure board' (see below). This is usually a large rectangular board, which displays the structure of the TC much like any organisational chart in the wider community. The board should always be sited in an accessible and visible area (normally the main reception area) where it can readily be viewed by all members. Members should be listed by name, the role they play and phase they are in. Colours can be used to distinguish between phases, departments etc. As well as being an aid to managing the TC, structure boards are used to strengthen members' perceptions of being part of a community and to provide a visual picture of mobility through the programme.

Another board should also be maintained, displaying staff on duty, a timetable for the day, appointments, new residents coming into the TC etc. The timetable allows members to give structure to their day and know their role in the community at any given time. This also assists in the management of the community in relation to members being pulled-up for not attending sessions etc. It also informs them of the roles of staff, if they are available to be seen, if anyone new is joining the TC and other news for the day.

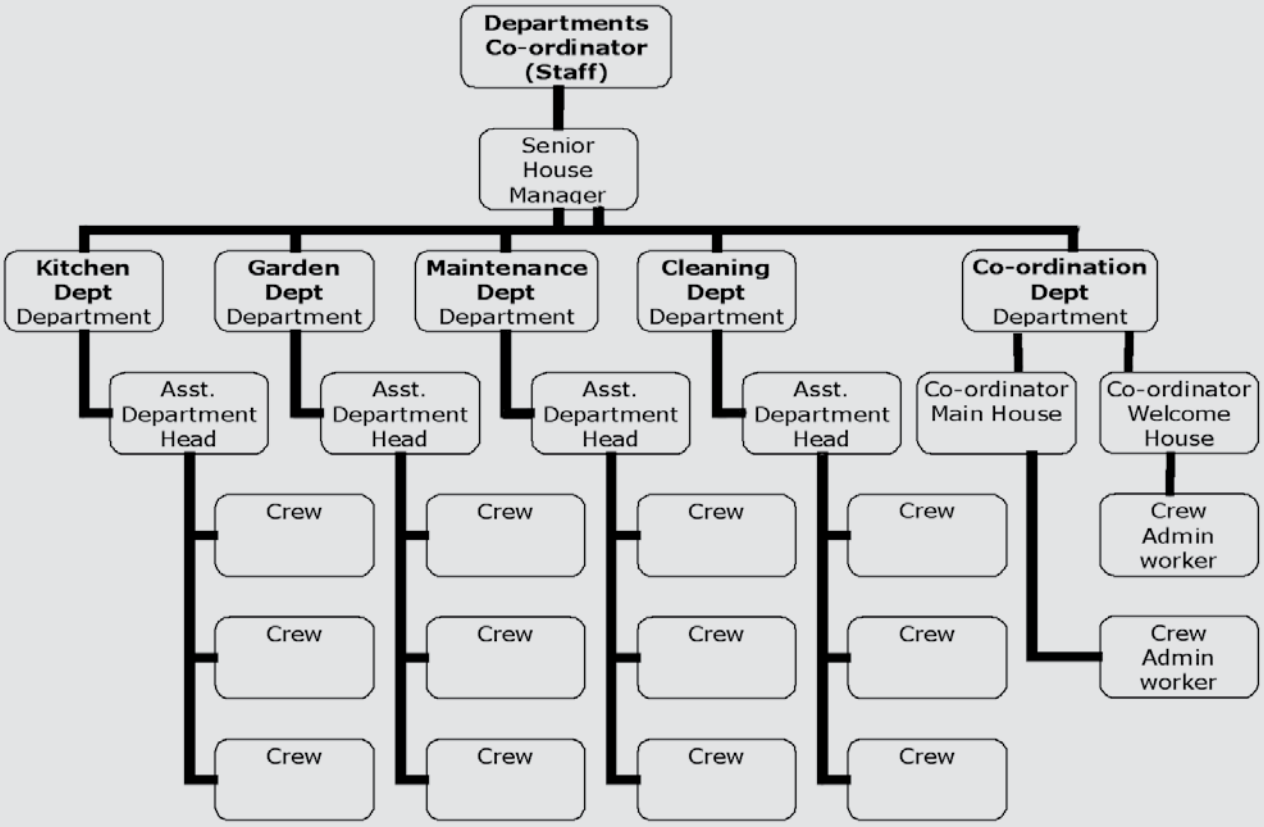

Diagram of a possible structure board (structures may differ slightly from community to community)

A Learning Environment

As many members will have had no structure to their lives previously, the structure exposes them to situations where they have to deal with issues such as time keeping, accountability, dealing with authority, carrying out tasks, giving direction etc. These situations, in turn, can show up problems with attitude, emotions and behaviours, which can be addressed through interactions with staff and peers. As bad behaviours and habits are challenged, constructive advice and examples (from the actions and behaviours of other members) are provided to make sure that new – more appropriate – ways of thinking and coping strategies are learned.

On the Floor (Rules)

Theory

George De Leon, a recognised authority on the working of therapeutic communities notes,

"Authority is formally and explicitly defined by community position and job function, and informally by community status. Staff members possess both formal and informal authority, while residents have little formal but considerable informal authority."

Staff make decisions based on rational authority, meaning that they are grounded in the TC perspectives to

protect the community and enhance personal growth. Staff are the primary decision makers in areas such as job changes and disciplinary matters.

Although, as De Leon highlights, residents have no formal authority, through the levels of the structure and hierarchy they carry informal authority in other ways. For example, Department Heads are expected to train, supervise and manage other residents in their work departments, as well as monitor behaviour and confront negative elements, and report back to staff.

As with the programme structure, the communication pathways for the TC can also be shown as a pyramid with information being passed from the top down to the lowest level, e.g. from the staff members and the Senior House Manager to the crew members and vice versa. The flow of information should always follow ordered steps, regardless of which way it is being passed.

Residents are expected to manage themselves to ensure they are on time for activities within the routine, such as group sessions, meetings, seminars etc. as well as planning for free time and weekends. Failure to be on time leads to consequences. For example, members may be required to prepare and present a seminar on the importance of being on time, aimed at teaching time management and awareness. On other occasions, members who perform their work poorly, *act out* or in other ways display bad behaviour, will be given a verbal or written *pull-up*. Positive pull-ups can also be used to reward positive change or good behaviour. These rules and sanctions are important both for the smooth running and safety of the TC environment and also as learning exercises for members to build their new identities for recovery.

There has been some debate about the value of confrontation and TCs are no longer the harsh and rigid regimes they were some years ago. But it remains the case that many former addicts in long-term recovery will invariably point to occasions when the have been challenged over their actions and behaviours as significant points in their recovery journey. Challenge should always be non-threatening; include constructive criticism and advice; and provide the possibility for the member involved to learn from the challenge and change.

Evidence

De Leon, G. (1994). The therapeutic community: toward a general theory and model. In F. M. Timms, G. De Leon, and N. Jainchill (eds.), *Therapeutic Community: Advances in Research and Application (NIDA Research Monograph Series* (p. 16). Rockville MD: National Institute on Drug Abuse.

This is a short chapter in a NIDA monograph that looks the basic principles that underpin TC practice and how they are normally operationalised.

Warren-Holland, D. (2006) Some reflections of a decade of experiences in British and American concept house therapeutic communities, 1967 to 1977: a personal experience, *International Journal of Therapeutic Communities,* 27 (1), pp. 13-29.

This journal article is a description of the structure and concepts of the drugfree TC. The article describes the operation of the early TCs and some practices are no longer used but the principles of peer support the purpose of the structure and recovery goals are still valid.

Substance Abuse and Mental Health Services Administration (2006) *Therapeutic Community Curriculum: Trainers' Manual.* Rockville, MD: SAMHSA (Module 6).

Description of a training session for TC staff on peer relationships within a traditional TC.

Practice

Communication

Throughout the programme, community members are taught to use the appropriate channels of communication. This will usually mean that junior members will communicate with staff and senior community members via the structure. It is important that this system is followed closely. Many new members will have been used to having their needs and requests met by professional staff; often at very short notice. The desire for immediate reward is very much a hallmark of addictive behaviour and new behaviours need to be learned. Community members by-passing the structure in this way will normally be warned not to do so in future. These warnings should always be delivered via the appropriate channel of communication in order to reinforce the message and support the power of the structure.

Pull-ups and Encounters

The confrontation system in the TC should never be used as punishment. It is designed to be a learning experience for residents whose behaviour is being pointed out to them by the raising of awareness. There are a number of ways of pointing out behaviour in the TC, but the most common are:

- The verbal pull-up
- The written pull-up (see sample pull-up note in *Examples 4* (page 64)
- An encounter (see the next section on Groups)

Confronting and challenging of behaviour within the TC may be informal and spontaneous (verbal pull-up) or more formal, planned interventions (written pull-ups, encounters). Verbal pull-ups are the most common form of corrective (or pointing out) behaviour in the TC and are a basic and effective way of letting peers know their behaviour is unacceptable. They are given 'on the spot' from one peer to another and are usually reminders of a lapse in behaviour. There is no outcome or sanction attached to this type of pull-up. Residents giving the pull-up are expected to be polite and courteous when issuing the pull-up, and those receiving it are required to listen without commenting, assume that it is valid, thank the individual for pointing out the behaviour, and quickly correct it.

Everyone within the TC, both community and staff members, are responsible for delivering pull-ups. Verbal pull-ups might be given for lapses in awareness, such as a lack of punctuality, not saying 'please' or 'thank you', leaving items out of place, not saying 'excuse me', not carrying out a task quickly enough, etc. Written pull-ups are used when a behaviour is seen to be more serious; where verbal pull-ups have been given previously or where a House Rule has been broken. It is important to remember that the TC should be using both positive and negative pull-ups. So on many occasions, members will be given a positive pull-up to reward good behaviour or performance: *Catch people doing something good!*

Phoenix Futures Wirral Residential Service

On the Floor (Changes)

Theory

Changes to the structure – or, more properly, to the position of people within the structure – are decided at a weekly Clinical Meeting attended by staff members and senior residents.

The general principle is that members are assigned to positions within the structure for one of two reasons. Firstly, they may be promoted (or demoted) as part of a learning exercise which matches their treatment needs at that time. This will be decided in light of their care planning reviews and their day-to-day behaviour. Secondly, there may be occasions when the smooth running of the TC requires that residents with particular skills be moved to particular places in the structure. In such cases, the needs of the whole community overides the treatment needs of the individual.

All changes, for whatever reason, must be carefully considered and discussed at length. The Clinical Meeting must make sure that both the impact on other community members and upon the community as a whole are considered in detail before a decision is made.

Once made, whether the new position has been applied for or not, the decision is first raised in private with the individual(s) concerned and the reasons for the decision are clearly set out to him/her.

Changes in the structure are then announced at the Evening Meeting and those promoted are congratulated by the community and given detailed feedback on the reasons for the decision. This public endorsement serves the purpose of clarifying for the whole community why the structure is changing and why it looks as it does. It also reinforces the community's understanding that position within the structure is important and reflects individual progress.

Again, the evidence base for this sort of goal-setting is very strong and echoes treatment and supports structures in many other recovery-oriented interventions.

Evidence

Broekaert, E. (2001) Therapeutic communities for drug users: description and overview. In: B. Rawlings and R. Yates (eds.) ***Therapeutic Communities for the Treatment of Drug Users,*** **London: Jessica Kingsley, pp. 29-42.**

This book chapter outlines the structure of the classic TC and the theory which lays behind the structure and operation.

De Leon, G. (1994). The therapeutic community: toward a general theory and model. In F. M. Timms, G. De Leon, and N. Jainchill (eds.), ***Therapeutic Community: Advances in Research and Application (NIDA Research Monograph Series*** **(p. 16). Rockville MD: National Institute on Drug Abuse.**

This is a short chapter in a NIDA monograph that looks the basic principles that underpin TC practice and how they are normally operationalised.

Best, D., Rome, A., Hanning, K., White, W., Gossop, M., Taylor, A. & Perkins, A. (2010) ***Research for Recovery: A Review of the Drugs Evidence Base.*** **Edinburgh: Scottish Govt.**

An extensive review of the evidence base for long-term recovery. Many sections highlight the importance of peer support and goal setting.

Practice

Community members should be encouraged to think about their personal growth in relation to job moves and this should be discussed in keywork sessions. There is a clear process for job changes in the TC, which is informed by the care planning process and by members' day-to-day behaviour and formally decided by the Clinical Meeting.

All new residents entering the TC will be allocated to a crew position within a work department by the House Manager. Normally, this will be decided at the Clinical Meeting or confirmed by that meeting as soon as possible afterwards. The decision is dependent on the size of the various departments and not on treatment needs at this point. Once a resident has been part of the TC for a period of 1 month, they are able to begin to progress through the structure. This month's period is to allow them to settle into the programme and begin to learn about what is expected of them. It is also to allow their peers, the staff and their Key-Worker to get to know them a little before looking at treatment need.

Community members may apply for a job change using a job application form which, once completed, they pass up through their structure, e.g. to the Assistant Department Head, who then passes it to the Department Head, who passes it to the Senior House Manager/House Manager, then to the appropriate staff member.

Jobs are allocated on a weekly basis at a meeting of staff and Department Heads known as the Clinical Meeting. In this meeting, all applications are read out and discussed, as well as the individuals' current progress, e.g. how they are behaving within the programme, their attitudes, behaviour etc. Keyworkers are informed of any of their members who have applied for a job change prior to the Clinical Meeting taking place, enabling them to have input into the process.

Community members may be given job changes without applying to move or be given a job which is different to the one they have applied for, if their keyworker or the people at the Clinical Meeting feel this would benefit them.

For example:

- Jim applies for a change in job from crew member on the Cleaning Crew to crew member on the Garden Party. However, his keyworker knows he has had difficulty in giving and taking direction and so feels a move to an Assistant Department Head position would benefit him in this.
- Simon is the Assistant Department Head of the Cleaning Crew and is finding this job very easy and is 'hiding' in it, so he has not applied for any job change. The people at the Clinical Meeting feel he would benefit from taking on more responsibility; therefore, they give him a position as Department Head of the Garden Party.
- Jim then moves into the Assistant Department Head position in the Cleaning Crew.
- Job changes are announced at the Evening Meeting, where residents receive their new positions and feedback from their applications.
- For example, Simon receives feedback that he has been doing a good job as assistant and, therefore, the clinical meeting attendees felt it was time for him to progress and take on more responsibility. Jim receives feedback that he has been unsuccessful in his application to move from the Cleaning Crew to the Garden Crew. Instead, he will move to a position as Assistant Department Head of the Cleaning Crew. He is told that this is because the clinical meeting attendees felt he would benefit from taking on more responsibility within his programme.

On the Floor (Roles & Management)

Theory

The daily work programme provides skills training as well as the strengthening of individual's association and attachment with the community. It is also designed to 'mirror' work in the wider community, with movement through the hierarchy much like progression up the occupational ladder.

Work roles range from crew members at the lowest level of the hierarchal structure, to the Senior House Manager who holds the highest level of job role outside the staff member group. New residents join the community at the crew level and begin to work their way through the 'occupational ladder' as they move through their work roles.

However, what differs from the 'real world' is that residents do not earn more money the more responsible their role becomes, as in the TC, the work role itself is considered a privilege since the resident has an opportunity to serve the community, to learn specific skills, and to use work for therapeutic growth and personal change. Payment for this is considered to undermine the therapeutic process.

The key to understanding how the work programme and the hierarchical structure work as a therapeutic tool, lies in understanding that the system is as much about learning to give orders as it is about taking them. TC members learn and practice their new identities by taking on additional responsibilities and showing leadership. A number of studies have shown that recovered addicts function better in their communities and enjoy a higher quality of life than the general population average. This concept is often described as: *better than well.*

This surprising finding seems to result from the fact that in order to recover from addiction, individuals need to work much harder than the non-addict population on their feelings about themselves, their relationships with those around them and their capacity to give.

So managing and leading within the house structure at various levels allows members to learn to offer leadership and constructive criticism; to take decisions for reasons other than personal benefit; and to co-operate as part of a wider team. The personal benefit from these learning experiences is a gradual increase in self-belief and selfconfidence. These developments have a direct relationship to the fundamental TC concept: *"You can't keep it if you don't give it away"*.

So roles with increasing responsibility should, in almost all circumstances, be assigned as learning experiences unless there is a wider need for the smooth running of the whole community.

Evidence

Best, D., Rome, A., Hanning, K., White, W., Gossop, M., Taylor, A. & Perkins, A. (2010) ***Research for Recovery: A Review of the Drugs Evidence Base.*** **Edinburgh: Scottish Govt.**

An extensive review of the evidence base for long-term recovery. Many sections highlight the importance of peer support and goal setting.

White, W., Kurtz, E. & Sanders, M. (2006) ***Recovery Management,*** **Chicago, IL: Gt. Lakes Addiction Technology Transfer Center.**

Short monograph outlining recovery history and evidence with practical advice for structuring recovery-oriented programmes, centres and communities.

Warren-Holland, D. (2006) Some reflections of a decade of experiences in British and American concept house therapeutic communities, 1967 to 1977: a personal experience, ***International Journal of Therapeutic Communities,*** **27 (1), pp. 13-29.**

This journal article by a former Phoenix House director is a description of the structure and concepts of the drug-free TC. The article describes the operation of the early TCs and some practices are no longer used but the principles of peer support and recovery are still valid.

Practice

Senior House Manager

The Senior House Manager holds the highest and most responsible position within the hierarchy and will have the general oversight of the community as a whole. Given this position, s/he is expected to act as a role model at all times. They are responsible for ensuring all work is completed; rooms are set for groups; groups start on time; planning for encounters; and running meetings etc. All community and work issues pass through the Senior House Manager before going to staff. The majority of day-to-day decisions in relation to the management of the work departments, up to the Senior House Manager, will be managed without having to be passed to staff. The Senior House Manager should be the only resident with 'open' access to staff keeping the lines of communication clear.

Expeditor

The Expeditor has a 'roving role' within the community and act as the 'eyes and ears' of the community structure. The Expeditor has a particular responsibility for the links between the Welcome House and the main TC community. They reinforce the community rules by issuing pull-ups and also via their input to the Senior House Manager/House Manager and Department Heads on decisions relating to the resident hierarchy. Expeditors have a degree of informal authority as they are a visible position within the community and responsible for reporting everything which happens within it.

House Manager

The House Manager is there to assist the Senior House Manager in the daily running of the community. However, they are also there to provide cover when the Senior House Manager has to be absent from their role, for example, due to attendance at a group or keywork session.

Department Heads

Department Heads usually make up a number of positions within the work hierarchy, depending on the number of work areas (or 'crews') there are and directly supervise other residents. These residents head up the work department, taking overall responsibility for the completion and standards of the work of their assistants and crews. It is their responsibility to ensure all tasks related to their area are completed and to a high standard, as well as liaising with the Senior House Manager regarding difficulties, residents who are causing concern, matters to pass to staff etc.

Assistant Department Heads

Again the Assistant Department Heads are there to assist the Department Heads in the

running of their departments and to provide cover during absence. Work departments with

large crews or high workloads (for example, a cleaning crew) may require there to be two assistants to ensure adequate cover is available.

Crew members will usually be 'directly managed' by the assistants who will allocate and check work, following liaison with the Department Head.

Crew Members

Crew Members form the largest part of the work roles within the community and have little responsibility other than for the work they do. They are allocated tasks which are then checked off and have to make no decisions in relation to the department they work in. However, they are expected to take personal responsibility for their allocated tasks and complete them to a high standard and the best of their ability. Feedback (both positive and negative) should be available on a continual basis and crew members should be encouraged to progress.

Study Area

Please use the study areas below to check your learning so far

Study Area - Staff Members

To complete this section please:

Exercise One

- From memory, draw the structure of your own community.
- Check your diagram against the structure board. Did you get the complete structure set down correctly?

Excercise Two

- Write down a pull-up or sanction you have recently administered or sanctioned
- Explain how the community member involved could use this as a learning experience? Is that what happened? If not, what went wrong and how might you make sure it didn't go wrong next time?

Study Area - Community Members

To complete this section please:

Exercise One

- From memory, draw the structure of your own community.
- Check your diagram against the structure board. Did you get the complete structure set down correctly?

Excercise Two

- Write down a brief description of your current position in the community and a list of your responsibilities
- How did you get to this position? Why were you given it? Where were you before? What will you need to do to progress further and what position would you like to be awarded next? Why?

TC Groups

Study Commitment -Staff Members

As a staff member of Phoenix Futures, once you have completed this section, you should be able to:

- understand how the various groups counter-balance the structure
- understand how to run a group yourself
- understand how to assist a senior community member facilitate a group without intervening
- understand how to judge when it is appropriate to intervene
- explain how groups work and how they can be used to help members grow in maturity and be more self-aware

Study Commitment -Community Members

As a community member of Phoenix Futures, once you have completed this section, you should be able to:

- understand how the various groups counter-balance the structure
- understand how to contribute to a group in a meaningful way
- understand how to run a group yourself
- understand why confrontation may help you to be more self-aware
- explain how groups work and explain their uses to junior members who may not understand them or may feel frightened or hurt by them

Groups (Rules & Roles)

Theory

The main dynamic of the TC is the group. TCs use various types of meetings and groups including: morning meetings, house meetings, TC Orientation groups, behavioural groups, seminars, teaching/education (learning) groups, peer encounters and evaluations relapse prevention etc.

The first group work intervention was said to have been in 1905 by Joseph Pratt. And there is a consensus amongst historians of psychotherapy that group psychotherapy literature formally began in 1906, with the publication of Pratt's *The Home Sanatorium: Treatment of Consumption* His classes brought together patients with tuberculosis who took it in turns to present themselves to their fellow members and tell how they had successfully struggled with their illness. Participation in the group mobilised group support, aroused hope and corrected misinformation. In an article published in 1922 in the Hospital Social Services Quarterly, Pratt acknowledged that this development was - initially at least - inspired by entirely practical objectives.

" I originally brought the patients together as a group simply with the idea that it would save my time. It was planned as a labour saving device. I did not have the time to instruct or encourage the patients individually. Advice, encouragement or admonition given to one I hoped would be heeded by all."

However, Pratt, quickly saw the wider potential for this style of work and by 1922 was recommending the use of

group treatment for a whole range of medical patients including undernourished children, diabetic and cardiac patients and obesity patients. In 1930 he established a clinic in Boston for the treatment of psychosomatic (emotionally triggered) illnesses and subsequent writings took a sharp turn toward treating the emotional causes of physical and psychological disorders.

Many other leading psychiatrists and psychoanalysists developed these ideas further and Trigant Burrows, a young Freudian analyst appears to have experimented with an early form of encounter group at the Lifwynn Camp in the early 1950s.

But, it was *The Game,* developed at Synanon in the late 1950s, that was the inspiration for much of the later expansion of TC practice. Carl Rogers, the father of person-centred counselling, renamed *The Game,* the encounter group.

In modern TCs, the encounter group remains a central element of the overall TC process. Research shows that this is an extremely powerful tool which requires skill and insight from the facilitator to make sure that it is used for the positive benefit of its members. The basic principles which apply to the correct running of an encounter group – apply to all groups within the TC.

Evidence

De Leon, G. (1994). The therapeutic community: toward a general theory and model. In F. M. Timms, G. De Leon, and N. Jainchill (eds.), *Therapeutic Community: Advances in Research and Application (NIDA Research Monograph Series* (p. 16). Rockville MD: National Institute on Drug Abuse.

This is a short chapter in a NIDA monograph that looks the basic principles that underpin TC practice and how they are normally operationalised.

White, W. et al. (2005) *Ethical Guidelines for the Delivery of Peer-based Recovery Support Services.* Philadelphia: Philadelphia Department of Behavioral Health & Mental Retardation Services.

This short paper is neither about group work or TCs but it does provide sound advice & food for thought for managing peer-led work.

Toseland, R. W. & Rivas, R. F. (2005) *An Introduction to Group Work Practice: Fifth Edition (Chapter 3).* London: Pearson Education.

Sample online chapter from a classic book on group work, group work ethics & good practices.

Phoenix Futures (2011) *Residential Project: Programme and Timetables.* London: Phoenix Futures.

Internal Phoenix Futures document giving detailed instruction on group work, timetabling etc.

Practice

Structured Group Planning and Delivery

Structured groups are delivered by staff and a senior member or graduate. All available community members are expected to attend these groups as required. Groups and other structured meetings cover a wide variety of subjects aimed at raising awareness and allowing members scope for discussions, role play, skills practice, etc.

Planning for the week's sessions -and allocation of individual members to particular groups

-should take place towards the end of the week for the week coming by the staff and senior resident members. In planning for the sessions, these will take into consideration issues arising from the community from the past week by consulting the Handover Book, facilitators' session debriefings (which highlight individuals of concern), as well as matters arising from team meetings and supervision sessions.

In planning for the delivery of sessions, facilitators must use session plans to highlight any creative elements they wish to include in the delivery of the session. They can include additional discussions, role plays, visual aids, ice breakers and so on. Facilitators are encouraged to be creative with their sessions to enhance delivery. However, all of the information must have been covered and the session's aims, objectives and key learning points met.

Group Rules

Meetings and groups in the TC have a variety of rules to ensure the safety of the community, respect for individuals and what is being said, and to keep order and control. The following are the rules relating to structured groups and sessions, relapse prevention sessions, peer support groups, etc.

- Always be on time
- Do not make any explicit or implicit threats
- Do not verbally attack, or call anyone names (either individual or collective verbal attacks)
- No name-calling, labelling or references to race, ethnicity, culture, gender, sexual preference or family members
- Do not come to the aid of a confronted member, by interrupting the encounter, or explaining, rationalising or otherwise defending the member
- Do not leave the room or engage in side conversations
- Use language that expresses your true feelings
- Be completely honest and show responsible concern for all members of the group
- No eating, drinking or smoking for the duration of the group
- Do not walk around (except when the layout of the seating is being rearranged)

Phoenix Futures Hampshire Residential Service

Encounter Groups (Preparation)

Theory

The most significant form of group process used within the TC is that of the encounter group. Although encounter (and similarly structured resolution groups) are used in other addiction treatment interventions, they are regarded as the hallmark element of TC practice. The basic encounter group is peer-led (with a staff member acting as the overseeing facilitator), and generally consists of between 12 and 15 residents. The group meets at least twice a week for approximately 2 hours. The general purpose of the encounter group is to change negative patterns of behaviour, thoughts and feelings. The specific goal of each encounter, however, is limited to heightening the individual's awareness of specific attitudes or behaviour patterns that should be modified.

Much of the work of an encounter group will be pre-determined. That is, the topics for resolution and the individuals involved will have been identified before the meeting starts.

Much of this content will come from *written pull-ups* or *encounter slips* posted by various members of the community in the Pull-up Box.

Encounter groups can be volatile, emotional experiences and careful planning is essential. All encounter slips should be carefully considered and discussed before the group starts and facilitators should make themselves aware of the issues and make sure that supports will be in place. This may involve increasing the number of facilitators in a group or seating a more senior member next to the subject of the encounter. Experienced facilitators should be able to gauge what time will be required and ensure that the number of issues to be dealt with fits the time available.

Timing is important. An experienced facilitator will always ensure that each issue has been resolved before moving on to the next and that there is enough time at the end for group members to receive support and reassurance.

Phoenix Futures Tyneside Residential Service

Evidence

De Leon, G. (1994). The therapeutic community: toward a general theory and model. In F. M. Timms, G. De Leon, and N. Jainchill (eds.), *Therapeutic Community: Advances in Research and Application (NIDA Research Monograph Series* (p. 16). Rockville MD: National Institute on Drug Abuse.

This is a short chapter in a NIDA monograph that looks the basic principles that underpin TC practice and how they are normally operationalised.

White, W. et al. (2005) *Ethical Guidelines for the Delivery of Peer-based Recovery Support Services.* Philadelphia: Philadelphia Department of Behavioral Health & Mental Retardation Services.

This short paper is neither about group work or TCs but it does provide sound advice & food for thought for managing peer-led work.

Toseland, R. W. & Rivas, R. F. (2005) *An Introduction to Group Work Practice: Fifth Edition (Chapter 3).* London: Pearson Education.

Sample online chapter from a classic book on group work, group work ethics & good practices.

Phoenix Futures (2011) *Residential Project: Programme and Timetables.* London: Phoenix Futures.

Internal document giving detailed instruction on group work, timetabling etc.

Practice

Planning

A community member will request an opportunity to encounter another member by putting an encounter slip in the Pull-up Box.

ENCOUNTER SLIP

Resident bringing the encounter .....

Who the encounter is for .....

Date .....

Reason for the encounter: .....

Example Encounter Slip

Encounter groups should be carefully planned by staff in order to be successful and allow everyone to be heard. All slips should be reviewed during planning, and where possible/necessary (due to time limitations), grouped by range and type of issue, who the encounters are aimed at, or from, desired outcomes etc.

For example: slips have been 'dropped' by various members regarding Tony Smith for his *'negative attitude towards the community', 'not taking his recovery seriously'* and *'disrespecting his peers'.* The essence of these issues is similar in that Tony is seen to have a negative attitude in a number of situations, and a number of his peers want to point this out to him. Also, the desired outcome is to raise his awareness of his attitude and to secure a commitment to change. Therefore, all of the slips would be grouped so that they could be addressed in the same encounter session, making the message to Tony more powerful and ensuring everyone is dealt with during the session.

An encounter should include between 12 and 15 members, or the whole of the community in a small TC. The make-up of the group will usually be 3 members to be encountered, the 3 members who put in encounter slips, 2 senior members, the facilitator, 3-5 other community members and a staff member (or two if it is felt the subject matter or tension within the group may require this). The group should reflect the issues (as highlighted above) but also be balanced in terms of time in the programme, age, gender, ethnicity etc., as well as ensuring the participation is not such that one individual will be 'rat packed', or ganged up on. Facilitators should make sure that during the course of each member's programme, they are exposed to the encounter group on a variety of occasions (sometimes as the person being encountered, sometimes because they are encountering someone and other occasions, as an allocated 'other' member of the group).

Seating

Chairs should be arranged in a circle (with no empty seats). This is so that everyone participating in the encounter feels equal, that everyone can be seen and communicate with each other without obstruction, and no one person can feel threatened by the physical presence of other members. Members who are confronting each other should be facing within the circle to enhance the impact of the encounter. So it is important that seating arrangements are agreed within the planning process. The Facilitator should ensure that attendance and seating arrangements do not allow for groups of members from the same area, ethnic background, cliques etc. to be grouped together. Members representing peer strength and members who have been in the TC for more than 6 months should be seated next to the person being confronted. As the group progresses, seating may be changed according to the issues. Staff and senior members, who are part of the facilitation, should be seated as part of the circle and so that they have a good open view of the participants. This will normally take the form of a triangle within the circle (where three staff/members are involved), or sitting directly opposite each other (where two are involved).

Encounter Group (Operation & Stages)

Theory

Role of the Facilitator

Facilitators will normally be a senior community member or, occasionally, a graduate. They should always remain neutral within the encounter and not offer too much help to those who are being confronted. However, their role is to protect the group members from being abused, picked on, ganged up on or unfairly treated in any way. If a facilitator wishes to encounter another resident, or they are to be encountered themselves, they should not act as the facilitator for that session.

Facilitators should ensure that they are aware of timing so that everyone is able to be heard and that no one issue is laboured over for too long. The allocated time of ninety minutes should be kept to as closely as possible. Although there are essentially 4 elements or stages to the encounter, the process should flow, forming a smooth discussion of the issues, feelings and outcomes of the encounter.

Role of the Staff Member

Staff members of the community who sit in on encounter and other groups will normally be non-participators. Their role is to supervise the preparation and selection of members; observe the process and members' reactions and behaviours; obtain feedback from other staff members and/or senior members to make sure their observations are correct; and to decide whether and when emergency intervention is required.

Encounter Group Impasse

At times, the encounter may reach impasse (stalemate) and it is the facilitators' (staff or members) job to guide the group through this. The group can reach impasse for a number of reasons, for example, non-acceptance of the validity of the encounter, poor planning, lack of facilitation skills, the facilitator personally relating to the issues of confrontation etc.

Impasse can be recognised when the group appears confused about the issues being raised, are bored, hostile, frustrated, lacking in participation, resistant etc. and the facilitator must use words or phrases which can be directed at individuals or the group as a whole to attempt to break the impasse or offer clarification on what is being said to end the confusion.

In such situations, they may legitimately interrupt aggressively, or present hostile attacks. These interventions are designed to redirect the group back to the issues when they are veering off track etc. However, throughout the process they must maintain the integrity of the encounter process. Encounter groups are powerful tools for change but they must be used with respect. Facilitators must make sure that they are aware at all times of the group dynamics and be careful to allow sufficient time at the end for reassuring any members left bruised by the encounter.

Evidence

De Leon, G. (1994). The therapeutic community: toward a general theory and model. In F. M. Timms, G. De Leon, and N. Jainchill (eds.), *Therapeutic Community: Advances in Research and Application (NIDA Research Monograph Series* (p. 16). Rockville MD: National Institute on Drug Abuse.

This is a short chapter in a NIDA monograph that looks the basic principles that underpin TC practice and how they are normally operationalised.

White, W. et al. (2005) *Ethical Guidelines for the Delivery of Peer-based Recovery Support Services.* Philadelphia: Philadelphia Department of Behavioral Health & Mental Retardation Services.

This short paper is neither about group work or TCs but it does provide sound advice & food for thought for managing peer-led work.

Toseland, R. W. & Rivas, R. F. (2005) *An Introduction to Group Work Practice: Fifth Edition (Chapter 3).* London: Pearson Education.

Sample online chapter from a classic book on group work, group work ethics & good practices.

Phoenix Futures (2011) *Residential Project: Programme and Timetables.* London: Phoenix Futures.

Internal document giving detailed instruction on group work, timetabling etc.

Practice

The Facilitator officially 'opens' the encounter by saying *'The encounter is now open.'* Only once the encounter is officially opened can the encounter be discussed and brought forward. There are four main stages or phases to the encounter process (confrontation, conversation, closure and social):

Confrontation – The main purpose of this phase is to confront to the individual in question. Any member may be confronted about any aspect of their behaviour or attitudes. The facilitator will ask the member who wrote a slip to state his or her observations and experiences of the confronted member's attitudes and behaviour. The focus of the material must be on current or recent behaviour and attitudes and how these affect others. The facilitator will then ask another group member (who has witnessed the behaviour and attitude of the member being encountered) to 'second' the slip encounter. Other encounter group members may provide additional observations. This enables a 'picture' to be drawn of the individual's behaviour, for them to focus on. This ensures that the member who is being challenged is aware of what they are being challenged for. If an individual is to change their behaviour, it is important that they are aware of what the inappropriate behaviour is and why it is inappropriate. Provocative tools may be used to focus on the issues and to evoke the feelings of the person being confronted. The member being confronted is expected to listen and respond to his or her peers' comments only when the whole confrontation has been heard. The confrontation phase is over when the resident acknowledges and accepts the group's reaction to his or her behaviour.

Conversation – Encounter group members encourage the member being confronted to focus on the behaviour or attitude being discussed. This involves the member having a *'right of reply'*, either taking on board and accepting the criticism, or making justifications for their behaviour if they do not accept the initial confrontation. Encounter group members encourage the member to talk about his or her feelings. Encounter group members may use evocative tools to deepen the resident's understanding of the problem. The conversation phase is over when the resident displays an understanding of the confrontation. He or she will: label his or her feelings; state his or her self-defeating pattern of behaviour or attitude; and/or ask for help in making personal changes. If the individual does not accept the confrontation, the group encourages the individual to focus on the behaviour and attitudes of the encounter topic and not on other issues or problems. They will be urged by the group to relate honestly, by talking about their own thoughts and feelings.

Closure – When the person who is being encountered demonstrates a level of understanding and acceptance of the confrontation, they will ask for help concerning personal change. The group will then offer support to the individual. This can be in the form of feedback and suggestions for making changes in the confronted behaviour or attitude. The group member is then encouraged to make a 'commitment to change' to the group. However, if the member does not accept the confrontation, the other members of the group may decide on an appropriate commitment for that resident. An important feature of the commitment is that it must be appropriate to the behaviours or attitudes the resident has been confronted about. For example, someone who has been repeatedly late for the morning meeting may be told to give a seminar on the importance of punctuality. The encounter ends with the group members giving positive messages to the individual who was encountered. Once the group has offered support to the individual, the encounter is formally closed by the facilitator. After this closure, the issue should not be discussed again.

Social – It is important for the entire TC to participate in 30 minutes of socialising (snacks should be provided) to continue the closure phase of supporting, affirming and encouraging residents to change their behaviours and attitudes. It is a time for the residents to socialise away from the formal encounter format and reaffirm bonds and support. There should be no discussion about the encounter which has just taken place, other than to give expressions of support, for example: *"I know what you're going through; I've been there too."* Senior peer role models should ensure that they reach out to residents who may be upset about their experience and make sure that they report back any continuing concerns.

Peer Groups & Other Meetings

Theory

There are several types of group work undertaken at Phoenix Futures services in addition to Encounter Groups. Most follows the same basic rules and principles of constructive engagement; respect, punctuality and non-aggresive behaviour.

They may be led by staff, or by peers. There are groups focused on the effective running of the community (whether residential or day services) and its daily tasks (Morning Meetings Evening Meetings and other community meetings), and those focused on client change (Peer Groups, Relapse Prevention Groups, General Meetings etc.). Some are process-oriented. That is, they have a focused topic for conversation, but do not have a pre-determined agenda or outcome. Others deal with particular clients and their behaviours or with certain topics that arise in the community and need attention, or are in a rotating list of topics to be covered as and when.

Groups may be therapeutic, educational or a combination of both. All Phoenix Futures groups should begin with an explicit statement of the Ground Rules, the purpose of the group, and a description of objectives. An aim of most therapeutic group activities is to encourage self-disclosure. As a result, personal and emotional safety is essential if such groups are to be successful.

Most Phoenix Futures programmes have different schedules of groups for clients at different stages (e.g. Welcome House, Primary Stage, Senior Stage and Re-entry), in addition to groups for other segments of the user population in the service. Some services choose to run groups every day (often 2 or 3 groups per day) while others have core group work days, with perhaps a formal group (as opposed to a peer group) at other times. There is room for variation between and among the Phoenix Futures service sites and types, but the basic guidelines should be maintained for all groups.

Groups are used to develop a feeling of belonging amongst members and are important in fostering positive peer support attitudes across the community. There is a huge body of evidence showing that the more individuals engage with a treatment process, the more likely they are to stay with it and the better the outcomes will be. Groups and meetings should be carefully monitored by staff or senior community members to make sure no-one is being 'left out'.

Evidence

De Leon, G. (1994). The therapeutic community: toward a general theory and model. In F. M. Timms, G. De Leon, and N. Jainchill (eds.), *Therapeutic Community: Advances in Research and Application (NIDA Research Monograph Series* (p. 16). Rockville MD: National Institute on Drug Abuse.

This is a short chapter in a NIDA monograph that looks the basic principles that underpin TC practice and how they are normally operationalised.

White, W. et al. (2005) *Ethical Guidelines for the Delivery of Peer-based Recovery Support Services.* Philadelphia: Philadelphia Department of Behavioral Health & Mental Retardation Services.

This short paper is neither about group work or TCs but it does provide sound advice & food for thought for managing peer-led work.

Toseland, R. W. & Rivas, R. F. (2005) *An Introduction to Group Work Practice: Fifth Edition (Chapter 3).* London: Pearson Education.

Sample online chapter from a classic book on group work, group work ethics & good practices.

Phoenix Futures (2011) *Residential Project: Programme and Timetables.* London: Phoenix Futures.

Internal document giving detailed instruction on group work, timetabling etc.

Practice

Peer groups

Peer groups are scheduled to run a minimum of twice per week, with one of these sessions at the weekend. Peer support groups are run by the members and the purpose of the group is for discussion on a range of topics decided by the group, and as a means of supporting each other. Residents should be able to openly discuss their feelings, fears and treatment, and seek to gain support from other peers in areas where they need help. The facilitator, who should have received facilitation training from the staff, should feedback the key points of the session to staff once the group has closed, so that staff are aware of what has been discussed and particular individuals of concern.

Morning Meeting

The Morning Meeting is vital in the TC as it may be the only time that the community is together as a whole group. It is run every morning after breakfast, but prior to any work departments or TC activities taking place and is usually chaired by the Senior House Manager. The meeting lasts for a minimum of 30 minutes and all members are expected to attend; it is everyone's own responsibility to ensure they are there on time. Additionally, all available staff in the TC that day will also attend. Attendance at the meeting is checked by the House Manager through a crew check. The Morning Meeting gives the opportunity to say 'Good Morning' to each other, as well as to start the day in a positive and light-hearted manner. It is an 'uplifting' meeting, with elements of fun as well as announcements etc. The Morning Meeting is designed to get people awake, alert and ready for the day ahead. It should set the tone for the day and start the community off on a positive note. It is designed to motivate individuals to understand what is happening in the TC on that day in a positive way. It also strengthens the sense of community.

A key element of the Morning Meeting is that the whole community read out together the TC philosophy (see p. 8), to enhance the community spirit and act as a further enhancement of the TC ethos. Morning Meetings encourage individuals to develop confidence, self-belief and teamwork skills, by way of 'entertainments' and involvement in these. Each morning, someone is asked to provide a 'Thought of the Day', which will be written on the 'Thought of the Day Board' for all of the community to see throughout the rest of the day.

The meeting is also an opportunity for everyone in the community to be made aware of who is doing what on that day; i.e. which members of staff are running groups and the floor and so on. Groups and meetings to be held that day are announced, along with any other activities, such as gym sessions etc.

Evening Meeting

The Evening Meeting is different to the Morning Meeting in that it is the 'business' meeting for the community. It runs 7 days a week and lasts between 15 and 30 minutes. As with the Morning Meeting, it is usually the Senior House Manager who runs the meeting and everyone is expected to attend. Business for the Evening Meeting will normally include announcements of changes to the structure; announcements of any pull-ups and sanctions; and any community-wide pull-ups that may be required.

Other Meetings

General Meetings – occasionally, staff will call a General Meeting. These meetings are ad hoc and are usually called when something is going wrong which affects the whole community. All community members must attend these meetings.

Department Meetings – generally these are business meetings to decide the allocation of tasks and the order of priority etc. within the workload of a particular crew. Occasionally, meetings will be called by the Senior House Manager/House Manager or Department Head when there are problems which are affecting the work of the crew.

Department Heads Meeting – a weekly meeting to give Department Heads an opportunity to discuss any issues arising in their crew with their fellow crew leaders.

Clinical Meeting – a weekly meeting of staff, Senior House Manager, House Manager and Department Heads to discuss job allocations and any changes required to the structure.

Seminars

Theory

Many authorities on TC methods (Eric Broekaert, Harry Wexler, George De Leon, David Deitch) have argued that the therapeutic community is much more like a school than a treatment service. Chuck Dederich, the founder of Synanon, famously said that Synanon: *"...is not a drug treatment programme. It's a school where people learn to live right. Stopping using is just a side effect."*

So therapeutic communities have always put great store by their involvement in a learning process for all members. Mostly, these formal learning experiences will be in organised seminars.

Seminars may take different forms. A member may have been instructed to prepare a seminar on a particular topic as the outcome of a pull-up. Some seminars will involve staff or senior members providing detailed instruction on some aspect of TC practice. On other occasions, external speakers may be invited to speak to members on a wide range of topics and issues. On some occasions, community members themselves may have indicated that they would like to present a seminar on a topic; either because the topic interests them or because they want to 'test themselves out'.

All of these learning sessions are regarded as valuable opportunities for members to grow both in confidence and understanding.

50 years of research shows that people rarely recover or succeed in treatment settings they do not understand so it is important that members have a clear grasp of what the various concepts mean, why we do the things we do and what we believe about their purpose.

Evidence

De Leon, G. (1994). The therapeutic community: toward a general theory and model. In F. M. Timms, G. De Leon, and N. Jainchill (eds.), *Therapeutic Community: Advances in Research and Application (NIDA Research Monograph Series* (p. 16). Rockville MD: National Institute on Drug Abuse.

This is a short chapter in a NIDA monograph that looks the basic principles that underpin TC practice and how they are normally operationalised.

Phoenix Futures (2011) *Residential Project: Programme and Timetables.* London: Phoenix Futures.

Internal document giving detailed instruction on group work, timetabling etc.

Wexler, H. & Prendergast, M. (2010) Therapeutic communities in United States prisons, *International Journal of Therapeutic Communities*, 32(2), pp. 157-175.

Journal article mapping the effectiveness of in-prison TCs (particularly when they are linked to TC-related after-care services). Argues that TCs should be seen as special schools and not medical treatment.

Practice

Seminars are normally scheduled to run at least twice each week. They last for a minimum of one hour and are usually given by community members themselves. Occasionally though, a guest speaker may be brought in. All members should attend, as well as all available staff.

Seminars presented by community members (not staff) are seen as important learning opportunities both for the community itself and for the individual presenting. Typically, substance misusers have poor schooling histories, difficulty in remaining focused for any period of time, low self-esteem and feelings of inferiority etc. The seminar helps to address these deficits. For those delivering a seminar, the process is aimed at directly building self-esteem by their delivery of a 'talk' on a particular subject for which they have prepared. For those listening, the aim is to train their focus of attention and learning skills.

Seminars can be delivered for a wide range of reasons. For example, they may be given as a therapeutic intervention where a resident is seen to be withdrawing from the community or needing enhancement in their affiliation with the TC teachings. They may be the outcome of a sanction or commitment from an encounter, or be because the member has expressly asked to deliver a seminar for personal growth or to assist the community.

There are a number of different types of seminars, including:

- **Concept:** A concept such as "honesty is the best policy" is presented and analysed by the community. Topics can be suggested by staff or members and should be appropriate to the needs and interests of the community.
- **TC Concepts:** A group exercise can be conducted based upon one of the concepts of a Therapeutic Community. This promotes understanding and development of the concept of 'right living'.
- **A Pro & Con Debate:** A current issue such as "relocation on departure from reentry" or "legal highs" is offered and the group is divided into two to debate pros and cons. This helps members to think through issues, to listen to others views, to challenge one another's viewpoint, and to appreciate the bigger picture rather than acting on impulse and having set ways of thinking.
- **Recovery:** A treatment progression story. A graduate or other senior member or guest may present a description of their particular recovery journey.
- **Guest Speaker:** An outside speaker may be invited to address the TC on a topic of relevance and interest to community members.

Phoenix Futures Brighton Family Residential Service

Study Area

Please use the study areas below to check your learning so far

Study Area - Staff Members

To complete this section please:

Exercise One

- Reflect on a group you were part of where you had to intervene or where the facilitator had to resolve an impasse
- Discuss the incident with a fellow staff member or supervisor. Could the situation have been handled differently?
- List the things you learned from this incident.

Study Area - Community Members

To complete this section please:

Exercise One

- Prepare a seminar on the differences between an encounter group and a peer group
- What are the major differences? What things are the same? What can members learn from them?
- you can present this either to a TC meeting or to a Welcome House seminar

Additional Elements

Study Commitment -Staff Members

As a staff member of Phoenix Futures, once you have completed this section, you should be able to:

- understand how individual interventions can complement the TC model
- understand how to maintain a balance between one-to-one interventions and *community as method*
- understand the general principles of CBT and RPT
- complete the four diagnostic instruments appropriately and accurately
- explain how CBT and RPT work to community members

Study Commitment -Community Members

As a community member of Phoenix Futures, once you have completed this section, you should be able to:

- understand how individual interventions can complement the TC model
- understand how to use these interventions for your own growth and learning
- understand how you can contribute to your own care planning process
- explain how CBT and RPT work to junior community members

Key-working

Theory

Every Phoenix Futures service provides keywork sessions for its clients and allocates each member a named keyworker within the first days of starting at the service.

Ultimately, of course, therapeutic communities are a group work and peer support service. However, in many of Phoenix Furutres non-residential services, the opportunities for peer interaction are often more limited. Day service community members may need more one-to-one time with staff. Generally speaking, keywork focuses on the practical and support needs of clients during treatment, while individual counselling focuses on therapeutic needs.

Keywork sessions are an opportunity to provide motivational support to clients in achieving the specific goals set out in their Care Plan. These could be personal development (or treatment) goals, but they might just as easily focus on outside practical issues such as pending legal, housing, health or benefit issues.

Every member in Phoenix Futures services should be clear about what achievement goals they have for completing the stages of their treatment process. These markers should be clearly set out in the Care Plan and reviewed on a regular basis.

Most Phoenix Futures staff use Cognitive Behavioural Therapy (CBT). CBT theory together with Motivation Interviewing and Brief Therapy techniques to underpin their approach to the counselling aspect of key-working.

It is not so much the specific theory that underlies the approach in the keyworking session that matters, as that those techniques and approaches that are used are known to and understood by other members of the staff community so that each community member is sure of getting the best possible contiuation of care should their keyworker have to be changed at some point during their treatment.

Care plans should reflect these essential items:

- Withdrawal potential
- Biomedical conditions and status
- Emotional and behavioural issues and complications
- Treatment acceptance and resistance
- Relapse potential
- Educational/vocational issues
- Family Issues
- Recovery environment

It is vital that staff and community members understand the purpose of the care planning system and that there is a balance between individual interventions and *community as method* in their particular service.

Evidence

National Institute on Drug Abuse (2000) ***Approaches to Drug Abuse Counselling.*** **Rockville, MD: NIDA.**

A collection of papers outlining a variety of approaches to one-to-one work with drug users.

National Treatment Agency (2006) ***Models of Care for the Treatment of Adult Drug Users: Update 2006.*** **London: NTA.**

Official guidance for English drug treatment services.

National Treatment Agency (2006) ***Models of Care for Alcohol Misusers (MoCAM).*** **London: NTA.**

Official guidance for English alcohol treatment services.

National Treatment Agency (2006) ***Care Planning Practice Guide.*** **London: NTA.**

Official guidance for English addiction treatment agencies providing advice and guidance on care planning.

Scottish Govt. (2006) ***National Quality Standards for Substance Misuse Services.*** **Edinburgh: Scottish Govt..**

Scottish guidance document on setting up service user involvement systems and standards.

Practice

The essential aspects of keywork and care planning are:

Frequency – All Phoenix Futures services should provide keywork sessions at least fortnightly, though these can be more frequent if needed by the client. There are different keywork programme arrangements for people in the Welcome House stage (where keyworking sessions are weekly: see p. 5). Where a hierarchical structure exists within a community, it is expected that individual members will follow the correct channels of communication in requesting any additional keyworking sessions. All keywork sessions should be aimed at moving clients through their specific goals as defined in the Care Plan.

Other Individual Sessions – There is some diversity across Phoenix Futures sites on the particular approach to informal individual time between staff and community members. Some services encourage informal ad-hoc contact whilst others see it as undermining the *community as method* ethos. Clearly, a balance needs to be struck which suits the circumstances of the service and meets the needs of its community members.

Planning and preparation – Keyworking staff should ensure that they receive handover reports from other relevant staff and community members (either in written or verbal form) before beginning each new session. Each session should be written up, and added to client files. In this way, the Care Plan becomes a continual and 'live' document.

Supervision – All keywork staff should have at least monthly supervisory sessions.

Life Stories & Other Tools – Keyworkers will use a variety of tools to assist them in making their keywork sessions as relevant and therapeutic as possible for each member. Clients will often use diaries or journals which can be discussed at each session reviewing progress and reflecting on feelings over the previous days.

Several projects used the Life Story (drawing on Park's Inner Child Theory) as a key element of the programme, both as a therapeutic process and as a mark of being ready to move to the next stage. Some clients produce a mini Life Story at the end of the Welcome House stage, prior to the full Life Story some 2 months later. Members will be given time and appropriate support to work on their Life Story. During this time they may sometimes be excused from many of the programme's groups, work and/or activities. It is important that these special arrangements are understood and respected by the community.

In some services, members may be rewarded for their Life Story by further concessions. Again, these will be made clear to the rest of the community through the appropriate meeting. In some cases, once the Life Story is complete, members may be encouraged to produce art work, in any media they chose, to portray their new beliefs and self perceptions as identified through the Life Story process.

Cognitive Behavioural Therapy

Theory

Cognitive Behavioural Coping Skills Therapy (CBT) has been included in Phoenix Futures' approach to treatment and recovery not as an alternative to *community as method*, but as an enhancement of it.

The version of CBT used within Phoenix Futures has also been designed for use in groups. The key difference is that CBT is normally designed to help clients who are currently dependent and are struggling to become abstinent. So, it may often be the case that a client who successfully completes a CBT programme can then, if they wish, go on to take part in an TC programme and build on their progress. In addition, CBT approaches are extensively used within Phoenix Futures residential services as an additional element for residents.

The goal of CBT is to help clients gain control over their use of substances so that they can better recognise, manage or avoid, and cope with their old tendencies to use drugs. CBT is based on social learning theory and argues that drug dependence is, to a great extent, a complex interaction between modelling, classical, and operant conditioning. That is, it is a learned behaviour that can be unlearned.

Before CBT begins, staff should conduct a personal assessment of each member's personal profile of psychological, physical and environmental aspects of drug taking. All staff engaged in CBT need to be able to gather information from a client to answer the following questions:

- What is the member's drug taking history and profile or pattern of use and periods (if any) of abstinence?
- What are the specific situations that precede the member taking drugs?
- What were the member's thoughts and emotions before, during and after drug taking?
- What, if any, were the strategies and actions the member used to limit how much of a particular substance was taking?
- Where are the likely intervention points to help the member deal with these drug taking situations?

CBT has two related objectives:

- *To describe the 'social ecology' of drug taking:* Specific behavioural psychological techniques (based on conditioning theory) are used to help the member develop new strategies and coping skills to avoid using or using less riskily or harmfully, and
- *To improve personal and social functioning:* Techniques are also used to help the member develop a set of basic and more advanced skills that will help them to cope with urges to use and avoid falling into common drug taking situations.

Evidence

National Institute on Drug Abuse (2000) ***Approaches to Drug Abuse Counselling.*** **Rockville, MD: NIDA.**

A collection of papers outlining a variety of approaches to one-to-one work with drug users.

Carroll, K. (1998) *A Cognitive Behavioral Approach: Treating Cocaine Addiction.* **Rockville, MD: NIDA.**

Detailed manual on CBT approaches to substance use from the National Institute on Drug Abuse.

Webb, C., Scudder, M., Kaminer, Y. & Kadden, R. (2002) ***The Motivational Enhancement Therapy & Cognitive Behavioral Therapy Supplement: 7 Sessions of Cognitive Behavioral Therapy for Adolescent Cannabis Users.*** **Rockville, MD: SAMHSA.**

American CBT manual intended for use with young cannabis users but useful in a broader context.

McCaul, M. & Svikis, D. (1991). Improving Client Compliance in Outpatient Treatment: Counselor-Targeted Interventions. In R. W. Pickens, C. Leukefeld, and C. Schuster (eds.), ***Improving Drug Abuse Treatment (NIDA Research Monograph Series 106*** **(pp. 204-217). Rockville MD: National Institute on Drug Abuse.**

Mostly about retention in outpatient settings but this chapter has interesting things to say about improving the therapeutic alliance.

Practice

CBT is based on two central activities, Functional Analysis and Skills Training.

Functional analysis

A functional analysis is an exercise in recall in which the group facilitator asks the member to remember their situation, mood, beliefs and expectations before, during and after the last time they used drugs. This is an important part of the CBT process. It helps to identify high-risk situations and the specific reasons they are using each drug they are taking. The functional analysis is usually a good way of bringing these reasons to the surface. Common drug use reasons include using to cope with stress or trauma, using to escape from relationship difficulties, etc. When done properly, this is a free-flowing discussion which the facilitator records later in a structured record of the group.

Skills Training

Phoenix Futures group leaders should explain and discuss the CBT model with each member. They should outline its roots in social learning theory and classical conditioning theory. The example of Pavlov's experiments with salivating dogs triggered by a ringing bell, is a good way of explaining craving and helping members to establish urge control. Group leaders will also describe the concept of extinction -noting that urges pass after a period if not acted upon and remind members that Pavlov's experiments showed how behaviour will be extinguished over time.

Many people with drug problems have very predictable patterns of behaviour. CBT aims to help the member 'unlearn' ingrained patterns of behaviour that are related to drug taking and replace these with healthier behaviours that do not focus on drugs as the only way of coping. The approach recognises that:

- Some members have substantial problems with coping and may never have developed strategies that do not involve drugs.
- For others, a history of drug taking means that the healthy skills 'repertoire' they once had has become compromised by drug taking and masked.
- Although the individual may have acquired effective strategies at one time, these skills may have decayed through repeated reliance on substance use as a primary means of coping.
- The negative consequences of drug taking, such as depressed and anxious mood, may further bury coping behaviours because the individual has based their whole lifestyle on drugs.

Specific CBT interventions

The core technique in CBT is skills training which is designed to help the member unlearn current harmful patterns of behaviour and replace this with new, healthy patterns. In Phoenix Futures programmes, CBT skills training focuses on an abstinence goal by:

- Assessing the member's concerns about stopping
- Discussing immediate concerns and problems the member is focusing on
- Modelling new behaviours through role play exercises
- Searching for alternative non-drug related activities ('reinforcers')
- Looking in depth at both the long and short term consequences of cocaine and other substance abuse.

This is employed as a strategy to build or reinforce the member's resolve to reduce or cease substance use. Not using drugs when feelings of craving occur (extinguishing the behaviour through urge control) is another aspect of CBT. These craving management skills are based on:

Distraction – alternative activities the member can do when experiencing craving
Talking about craving – simply talking about craving with someone can be helpful
Self-talk – being conciously aware of craving messages and countering them with 'self-talk'
Going with the craving – using imagery to view craving as something which will pass
Recalling Negative Consequences – recalling negative consequences they have experienced

Relapse Prevention Treatment

Theory

Relapse Prevention Treatment (RPT) shares many of the same theoretical origins as Cognitive Behavioural Therapy. Both are drawn from a behaviourist or social learning tradition which argues that drug-taking behaviours are essentially learned behaviours which can be unlearned or replaced with more positiv, healthy behaviours.

RPT approaches addiction as a chronic relapsing condition, making the prevention of relapse one of the critical elements of effective treatment for alcohol and other drug misuse. Studies have shown that 54 % of all alcohol and other drug abuse patients can be expected to relapse, and that 61 % of that number will have multiple relapse episodes.

It is not unusual for addicts to relapse within one month following treatment, and research suggests that as many as 47% may relapse within the first year after treatment.

Although relapse is a symptom of addiction, it is preventable. A key factor in preventing relapse is improved social adjustment. This aspect of relapse prevention echoes the work of many in the recovery movement who have argued that a long-term view of recovery requires interventions which improve the three main factors at play in addictive behaviour -the drug the set and the setting (see pp. 5 & 6).

Relapse prevention methodologies are critical to the success of therapeutic community treatment. It is important for the successful community member to understand and address the process of relapse, along with information about recognising its 'warning signs' or triggers and the elements of relapse prevention treatment methodologies.

As with the use of CBT, before RPT is used it is important that a clear inventory is taken of the drug users specific issues:

- Are there specific situations that serve as triggers for relapse?
- Were the causes of a lapse the same as those that caused a total relapse? (and if not -how are they different?)
- How did the client think about the events before and after lapses and relapses?
- Where are the likely intervention points to help the client deal with high-risk situations?

As with CBT, there is a strong evidence base for the use of RPT. However, it is important to recognise that Phoenix Futures attracts a high percentage of clients who are chaotic and severely damaged. Many will have significant cognitive impairment which may limit their ability to make full use of these approaches.

Evidence

Larimer, M., Palmer, R. & Marlatt, A. (1999) Relapse prevention: an overview of Marlatt's cognitive-behavioral model, *Alcohol Research and Health,* 23 (2), pp. 151-160.

Detailed review of Relapse Prevention Treatment and its outcomes.

Slattery, J., Chick, J., Cochrane, M., Craig, J., Godfrey, C., Macpherson, K. & Parrott, S. (2002) *Health Technology Assessment of Prevention of Relapse in Alcohol Dependence.* Edinburgh: NHS Scotland.

A brief summary of the technique written by the originator (Marlatt) for the Behavioral Health Recovery Management Project.

Marlatt, A., Parks, G. & Witkiewitz, K. (2002) *Clinical Guidlines for Implementing Relapse Prevention Therapy.* Seattle: University of Washington.

Extensive review of alcohol use & misuse in Scotland, retention in treatment and the issue of relapse and relapse prevention.

Best, D., Rome, A., Hanning, K., White, W., Gossop, M., Taylor, A. & Perkins, A. (2010) *Research for Recovery: A Review of the Drugs Evidence Base.* Edinburgh: Scottish Govt.

An extensive review of the evidence base for long-term recovery. Many sections highlight the importance of peer support and goal setting.

Practice

Assessment

The purpose of an extensive and detailed RPT assessment is to establish where the community member stands against a catalogue of high-risk factors for relapse. These are not a sentence to life-long addiction but a warning list of dangers to be aware of. All community members should be encouraged to understand that these risks will not remain the same but that most will fade over time.

Personal/ Environmental Risk Factors

- *Coping with negative emotional states* – frustration, anger, fear, anxiety, tension, depression, loneliness, sadness, boredom, worry, grief and loss.
- *Coping with negative physical-physiological states* – craving and withdrawal symptoms that led to use before. Also coping with pain, illness and fatigue that have not been associated with prior substance use.
- *Enhancement of positive emotional states* – use of substances to increase feelings of pleasure, joy, freedom, celebration, etc.
- *Testing personal control* – use of substances to test out ability to engage in controlled or moderate use or to test willpower.
- *Giving in to temptations or urges* – substance use in response to temptations, or craving in the presence or absence of substance cues (drugs, drugs paraphernalia, other users)

Interpersonal/ Social Risk Factors

- *Coping with interpersonal conflict* – interpersonal relationships and coping with problems arising from arguments, disagreements, fights, jealousy, hassles etc. Coping with anxiety, fear, tension, worry, and concerns associated with other people.
- Social pressure – influences of another individual or group of individuals who exert direct or indirect social pressure to use.
- *Enhancement of positive emotional states* – use of substances in a primarily interpersonal situation to increase feelings of pleasure, celebration, sexual excitement, freedom, etc.

Specific and Global RPT Intervention Strategies

Both group based sessions and individual counselling may use some or all of the following techniques and strategies:

Specific RPT interventions

- Assessing motivation for change
- Using a decision matrix (balance sheet of pros and cons for change)
- History of drug taking and relapse susceptibility
- Coping with high risk situations and enhancing self-efficacy
- Problem solving and relapse management rehearsal
- Stress management
- Coping with lapses and
- Dealing with the Abstinence Violation Effect

Global RPT interventions

- Increasing lifestyle balance
- Increasing awareness of relapse warning signs
- Analysing relapse 'road maps' (high risk situations and choices)
- Coping with desire for indulgence
- Coping with urges and craving and
- Coping with rationalisations and denial

Diagnostic & Assessment Instruments

Theory

The measurements carried out in all Phoenix Futures service have two main purposes:

Assessment for Selection Purposes

The aim of this part of the assessment process is to assess the extent to which each prospective community member is experiencing a given set of problems, in order to make sure we select those who will benefit most from our services. These measures are usually administered before the individual is accepted into our services. Assessment processes look at both the suitability and eligibility of individuals for that particular service against a clear set of criteria.

Assessment for Evaluation Purposes

Phoenix Futures regard evaluation as an important aspect of all its drug treatment programmes. It not only determines the short-term impact of programmes but will also help to inform the development and improvement of programmes.

In line with this view, the organisation is committed to routinely using the following validated and standardised assessment and/or evaluation instruments in all our services:

- The Addiction Severity Index (ASI-X version)
- The Circumstances, Motivation and Readiness Scale (CMRS)
- The Outcomes Star questionnaire
- The Treatment Outcomes Profile (TOP)

Training is available throughout the organisation for all staff who are required to administer any or all of these four instruments. Copies of the instruments and any guides are included in the Evidence Collection.

Evidence

Makela, K. (2004) Studies of the reliability and validity of the Addiction Severity Index, *Addiction*, 99, p. 398-410.

This journal article reviews the literature on the European version of the Addiction Severity Index.

Fanzese, R. (2005) *A Review of the Reliability and Validity of the Addiction Severity Index.* Omaha, NK: Orion Healthcare Technology.

A mainly American sources review of the literature on the European version of the Addiction Severity Index.

MacKeith, J., Burns, S. & Graham, K. (2008) *The Outcomes Star: User Guide.* London: Homeless Link.

Official guide to using the Outcome Star questionnaire – second edition.

National Treatment Agency (2007) *The Treatment Outcomes Profile (TOP): A Guide for Keyworkers.* London: NTA.

Official guide for to using the TOP – mandatory in services in England.

National Treatment Agency (2007) *The Treatment Outcomes Profile (TOP): An Implementation Guide for Managers.* London: NTA.

Official guide for to implementing the TOP in services -mandatory in services in England.

Practice

Addiction Severity Index

The ASI-X (an updated and slightly expanded version of the EuropASI -Addiction Severity Index) is used as the primary assessment and evaluation tool for Phoenix Futures Residential programmes. The Addiction Severity Index is a relatively brief (45-60 minutes), semi-structured interview designed to provide important information about aspects of a client's life, which may contribute to their substance abuse disorder. It can be used for either clinical and/or research purposes. The interview covers seven life domains:

- Medical History
- Employment/Support History
- Alcohol History
- Drug History
- Legal History
- Family and Social Relationships
- Psychological History

Circumstances, Motivation & Readiness Scale

The Circumstances, Motivation and Readiness Scale (CMRS) for Substance Abuse Treatment Questionnaire is an 18-item self-administered questionnaire. The CMRS is designed to measure motivation and readiness for treatment and to predict retention in treatment among abusers of illicit drugs. The instrument consists of four factor derived scales: Circumstances (external influences to enter or remain in treatment); Circumstances (internal influences to leave treatment); Motivation (internal recognition of the need to change); and Readiness for treatment. The instrument is based on recovery theory which stresses the impact of both external and internal motivation on the readiness for treatment.

The Outcomes Star questionnaire

The Outcomes Star questionnaire was originally developed for services working with the homeless community as a way of estimating whether the individual client was ready to move on to a more demanding form of accommodation (for instance from a hostel into supported housing). Effectively, what is being measured with this questionnaire is any increases in recovery capital. That is, has the individual community member increased their self-esteem; managed to exercise more control over their impulses; established a supportive social structure around themselves? So, although the questionnaire was designed for a quite different client group, it does work well within the structured setting of Phoenix Futures community services.

Treatment Outcomes Profile

The Treatment Outcomes Profile (TOP) was developed by the National Treatment Agency for Substance Misuse (NTA) in order to monitor outcomes from a range of different substance use services.

At a minimum, services in England are expected to use the TOP on initial assessment and discharge. In practice, like the Outcomes Star, it can be used to track progress throughout the treatment programme.

Study Area

Please use the study areas below to check your learning so far

Study Area - Staff Members

To complete this section please:

Exercise One

- On a blank sheet of paper, list the seven domains of the ASI-X
- Discuss your list with a group of colleagues and explain how each domain might be affected by treatment within a TC setting.
- Were they convinced? Did they have other suggestions that made sense?

Excercise Two

- Reflect on a recent keyworker session you ran.
- What happened? Do you think the community member found it helpful? What do you think you might have done better?
- Discuss your thinking with colleagues or a supervisor. What advice were they able to offer? Would it have helped at the time?

Study Area - Community Members

To complete this section please:

Exercise One

- Immediately after your next keywork session, make a brief note of what happened.
- Try to write down as accurately as you can what happened and what was said. Were there things your keyworker said that you found helpful? Were there things you thought were unhelpful or that you didn't understand?
- Discuss your experience with your peer group before your next keywork session
- At your next keywork session, ask to review the previous session.

Examples

Example 1: Welcome House Markers

Phoenix Futures
Ending dependency, transforming lives

Welcome House	Markers of achievement	Measures of achievement
(min 4 weeks; max 8 weeks) • Provides a warm welcome • Introduces the TC approach • Acts as a period of adjustment • Prevents early or premature departures	• Has understood the purpose of the TC, its philosophy and expectations. • Established some trusting relationships with staff and/or recovering peers. • Completes an assessment of self, circumstances and needs. • Begins to understand the nature of the addictive disorder and the demands of recovery. • Makes a tentative commitment to the recovery process. • Has a firm commitment to remain through the primary stage of the programme. • Completed detox (if appropriate)	• Completion of all required groups and set assignments. • Monitor of progress against care plan goals agreed with worker and Care Manager, measured by Outcomes Star. • Completion of care planned goals. • Completion with Therapeutic worker of comprehensive psychosocial assessment and initial / individual care plans. • Develop Relapse Prevention and Harm Minimisation Plan. • Tasters of departments. • Preparation for Life Story (in 1-2-1).

Example 2: Primary Stage Markers

Phoenix Futures
Ending dependency, transforming lives

Welcome House	Markers of achievement	Measures of achievement
(min 12 weeks; max 22 weeks)	*Primary Phase 1* • Identifies oneself as a community member • *Acts As If* – understands and complies with the programme, participating fully in daily activities • Displays a practical knowledge of the TC • Participation in the community increases • Displays limited personal disclosure in groups and in one-to-one sessions • Group and communication skills are not fully acquired • Carries out allocated house duties	*Primary Phase 1* • Completion of all required groups and set assignments. • Completion and presentation of life story (in 1st or 2nd week).
	Primary Phase 2 • Sets an example for other community members • Greater personal freedom • Key attitudes reflect acceptance of the programme. • Personal growth evident in adaptability to job changes, acceptance of staff as rational authorities, and ability to contain negative thoughts and emotions. • Self-awareness is manifest in identification of characteristic images. • Reveals a higher and more stable levels of self-esteem • Carries out allocated house duties	*Primary Phase 2* • Completion and presentation of comprehensive Relapse Prevention and Harm Minimisation Plan. • Monitor of progress against care plan goals agreed with worker and Care Manager, measured by Outcomes Star. • Attendance at Primary Stage Care Plan review and interview. • To have demonstrated role modelling, buddying and involvement in encounters as needed. • Work in departments.

Example 3: Senior Stage Markers

Phoenix Futures
Ending dependency, transforming lives

Welcome House	Markers of achievement	Measures of achievement
• **(min 10 weeks; max 18 weeks)**	*Senior Phase 1 (5 weeks)* • Elevated status in the social structure evident in privileges and house functions. • Established role model in the programme; provides leadership in the community • Accepts full responsibility for his/her behaviour, problems and solutions • Carries out allocated house duties	*Senior Phase 1* • Completion of all required groups and set assignments. • Co-facilitating groups, both peer support groups and Welcome House/Primary groups • To have demonstrated role modelling, buddying and involvement in encounters as needed • Work in departments • Completion and presentation of comprehensive Senior Phase 1 Portfolio, including: – Autobiography; – "How I see myself" essay; – "How others see me" essay; – Strengths & weaknesses; – Long & short term goals; – Significant events; – "What have I learned so far?".
	Senior Phase 2 (5 weeks) • Reveals elevated self-esteem based on status and progress through programme duration • Acquired group and communication skills and is expected to assist facilitators in group process • Carries out allocated house duties	*Senior Phase 2* • Monitor of progress against care plan goals agreed with worker and Care Manager, measured by Outcomes Star. • Completion of care plan/ re-entry plan groups • Preparing exit plans and developing links with external agencies and providers • To have demonstrated role modelling, buddying and involvement in encounters as needed • Attendance at Senior Stage Care Plan review and interview. • Work in departments.

Example 4: Pull-up Slips

Phoenix Futures
Ending dependency, transforming lives

Written Pull-Up Slip

To: James Smith
From: Dan Brown
Date: June 14th

Reason: You are constantly late for work every day, leaving other crew members to start the work for you. You are always the first to go on tea break or pack up at the end of the day. This is disrespectful to your peers and me as your Dep. Head and shows lack of concern, motivation and commitment to the TC and the community.

Suggested Sanction: Apologise to your peers on the work crew. Be on time for work in future. Get the cleaning materials out for the whole of the crew for one week and pack up at the end of the day.

Checked by staff: David Lindy **Date:** June 14th
Sanction valid? Yes

TC Primary Stage Feedback Form

Name..... **Date**.....

Please give us your opinions of the Primary Stage.

1. How useful has this stage been in helping you address your drug use?

Not at all useful ☐ *Not particularly useful* ☐ *Not sure* ☐ *Quite useful* ☐ *Very useful* ☐

Please state why

2. Where there specific issues you wanted addressed during this stage? *No* ☐ *Yes* ☐

If yes, what were the issues?

Were the issues addressed?

3. Were there any groups you found helpful? *No* ☐ *Yes* ☐

If yes, what were the groups?

In what way were they helpful?

4. Were there any groups you found unhelpful? *No* ☐ *Yes* ☐

If yes, what were the groups?

In what way were they unhelpful?

5. Do you think you had the right number of keywork sessions in this stage? *No* ☐ *Yes* ☐

Please add any other comments about the primary phase.

Example Feedback Form (Forms differ according to the Stage achieved)