A. It is expected that the first day of the master-class will target the following aspects related to **therapeutic communities**:

1. Definition and the concept of therapeutic community.

According to NIDA (National Institute on Drug Abuse) the therapeutic community (TC) has existed for about 40 years. In general, TCs are “drug-free residential settings that use a hierarchical model with treatment stages that reflect increased levels of personal and social responsibility”[1]. TCs are one part of the complex set of services referred to as “treatment services”.

In the UK a therapeutic community is described as “a drug-free environment in which people with addictive problems live together in an organised and structured way to promote change towards a drug-free life in the outside society”[2].

The EMCDDA (Europan Monitoring Centre for Drugs and Drug Addiction) agrees with this definition. The repeating aspect of a therapeutic community across the spectrum seems to be “a drug-free” setting, a form of structured treatment where the user spends weeks or months outside is current circumstances. Traditional TCs offer different types of support (one-to-one counseling, group therapy and support groups), some vocational training and include an element of the users helping each other – self support approach.

Although the modern European view on the treatment process tents to see the TC process more focused on the person as whole than only on the drugs dependency. And the programme is based on BPS[3] model of work.

The main aims in such therapy are focused on:

1. **development of once personality**
2. **behavioural issues**
3. **personal ethics and personal “higher values” or “spirituality” if you want**
4. **life/social and survival skills as well as building capacity of competing on a job market**

Obviously there are TCs there focused on a specific target group such as women only TC, underage only, specific ethnic oriented TC etc.

Some TCs are recognised as offering methadone and other substitution treatment (e.g. Holland). The EMCDDA accepts these centres as effective and functioning TCs too.

Two essential principles of a TC are: the community in itself is a change agent and the efficacy of self-help.

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[1] NIDA, 2008 definition

[2]

[3] Bio-Psycho-Social model

There are different streams in TCs. The UK Department of Health in 1997 divided TCs in three major themes to be supported by the Government.

1. Twelve-steps based – also known as the Minnesota Model
2. Psychotherapeutic – counselling based, psychodynamic, therapeutic based.
3. Religious based TCs

The model more commonly used and proven to be considerably successful in Europe is model number two. This is a comprehensive model that uses a holistic approach that incorporates in its programme issues that include educative, psychotherapeutic and self-support aspects.

2. Structure of the programs that work as a therapeutic community and the way of its operation (programme governance, service policies, etc.).

TCs are physically designed to emphasise the experience of community within the residence. Newcomers are immersed in the community and must fully participate in it. It is expected that in doing so, their identification with and ties to their previous drug-using life will lessen and they will learn and assimilate new pro-social attitudes, behaviours, and responsibilities.

It is essential to remember that the approach, setting, programme and therapeutic school that a TC decides to follow is very much determined by its target group. For example the TC that treats female drug users only will need to look into issues such as eating disorders and other gender-specific matters, which will not become so relevant if the target user group is underage.

When determining what type of TC programmes to include under "one roof" it is also important to look at whether the target group include Hep C or HIV positive individuals to incorporate adequate treatment (including medical), counselling and therapy into it. Issues such as bereavement, bear to death experiences,

Risk assessment has to be included in the initial process of accepting a client in the TC around certain areas to determine the indication to access the TC. Mental health issues are one of the major issues to be considered. There might be a special TCs concerned with specific target group such as dual diagnoses or co morbid issues such as psychoses. ***The training of a risk assessment should be part of regular update of staff knowledge.***

The characteristics of the target group will determine the staff needed in both the TC and the aftercare programs. An important aspect is whether or not clients with mental health issues are going to be treated. Recent research reflects that as much as 50% of drug users have some form of mental health disorder, therefore the likelihood of these forming part of our target group is very high. Most main stream modern TCs would work with some clients with mental health problems such as border line personalities but would refer clients diagnosed with schizophrenia to specialised clinics or TCs. Though, it is advisable to have among the mainstream TCs staff with a clinical psychologist, and the regular cooperation with an external psychiatrist.

Although the residential capacity of TCs can vary widely, there are some smaller communities of 15 clients and very large ones (mainly in the US) that can accommodate as many as 80 clients. Smaller TCs are more typical of Europe. TCs are located in various settings, often determined by need, funding sources, and community tolerance. Some, for example, are situated on the grounds of former camps, near small villages or in suburban houses. In the UK it is not uncommon for TCs to be located within the cities. In the US there is an average of one therapist for every 11 residents in treatment. In European TCs the average is higher, with one therapist for an average of 8-10 clients. Many TCs count with counselling staff who had themselves successfully completed drug abuse treatment programs and who join the team after receiving the adequate training (in these cases it is essential to build the professional identity of these staff members so that they might not work only from their own personal experience).

Traditional TCs used to cover a programme that lasted 18 months and included a 3 stage process. The TCs today programs are usually shorter from 3 – 9 months period. For example the mainstream UK services supported from the public budget are maximum 6 months period.

Example of 3 stages programme

Stage 1. Induction and early treatment typically occurs during the first 30 days to assimilate the individual into the TC. The new resident learns TC policies and procedures; establishes trust with staff and other residents; initiates an assisted personal self-assessment; begins to understand the nature of drugs life style/drugs dependency; and should begin to commit to the "recovery" process.

Stage 2. Primary treatment often uses a structured model of progression through increasing levels of prosocial attitudes, behaviours, and responsibilities. The TC may use interventions to change the individual's attitudes, perceptions, and behaviours related to drug use and to address the social, educational, vocational, familial, and psychological needs of the individual.

Stage 3. Re-entry is intended to facilitate the individual's separation from the TC and successful transition to the larger society. At this stage the client is prepared to move onto the next stage of treatment, after-care and might move to a post-residential aftercare service.

Modern TCs have different approaches and programmes. Today treatment is looked at as "resocialisation process and personal development", not looking only at the drugs problem itself but at changing the life style, at helping the individual to come back to society, it is not a medical approach that looks at detoxification and abstinence. It is more the treatment of a chaotic life style, looking at co morbid issues, etc.

Cranstoun Drug Services, a UK leading organisation providing services for drug users, runs a modern and comprehensive programme in their TCs. The client begins with a one-month detoxification which is done inside the TC itself, this is followed by a 6-month residential stay (the TC is inside the city), this is followed by aftercare. The programme in their TCs begin with a 6-week induction stage, once that stage has been completed by the client, he becomes a senior resident that receives individually prepared programme. Before he/she leaves the TC, at the later weeks of the stay, he/she begins to receive skills aimed at gaining employment.

This approach makes the TC member an active actor in his/her rehabilitation process.

The daily life in a therapeutic community varies but it is always well organised and regimented. A typical day beings at 7 a.m. and ends at 11 p.m. and includes morning and evening community meetings, job assignments, groups, seminars, scheduled personal time, recreation, and individual counselling. As employment is considered an important element of successful participation in society, work is a distinctive component of the TC model.

The range of therapeutic tools used in a TC are the following:

- **Therapeutic meetings** (both on an individual and group basis) use a variety of therapeutic approaches to address significant life problems.
- **Community meetings** (e.g., morning, daily house, and general meetings) review the goals, procedures, and functioning of the TC.
- **Vocational and educational activities** occur in group sessions and provide work, communication, and interpersonal skills training.
- **Community management activities** (e.g., privileges, disciplinary sanctions, security, and surveillance) maintain the physical and psychological safety of the environment and ensure that resident life is orderly and productive.

3. Examples of protocols and/or international best practices in this field.

At the 11th European Conference on Rehabilitation and Drug Policy organised by the EMCDDA and the European Federation of Therapeutic Communities (EFTC) in June 2007 a set of very practical standards and best practices was developed that covers all aspects of setting up and running a therapeutic community. They form the basic requirements of being a TC.

A brief summary is provided below (although the full set of standards will be available to the course attendees). They are divided into:

- **Core Standards**
  - The therapeutic community has a clear set of boundaries, limits or rules which are understood by all members
  - The whole community meets regularly, all members work alongside each other on day to day tasks and share social time together including meals
  - Community members take a variety of roles and levels of responsibility
  - All community members can discuss any aspects of life within the community

- All community members regularly examine their attitudes and feelings towards each other and share responsibility for each other
- All community members create an emotionally safe environment for the work of the community

– **Physical Environment**

- The internal and external physical environment is comfortable and welcoming, clean and well maintained
- The therapeutic community has the necessary environmental facilities, resources and rooms for community meetings, preparing meals, for dining, recreation, confidential counseling, etc.
- Community members are involved in maintaining the physical environment and keeping it safe

– **Staff**

- There are enough staff members for the community to operate effectively with at least one senior community member, including during the therapeutic programme
- Some community members might be involved in directing the therapeutic process, they must receive regular clinical supervision froma suitably trained person
- There are regular meetings for all staff to reflect on their experience of the work
- There is a daily handover process and staff debriefing following community, therapeutic and group meetings as well as critical incidents
- Staff members are adequately trained, their training needs are assessed regularly and there is an adequate budget for training
- Staff receive training appropriate to their role in the therapeutic community

– **Joining and Leaving**

- Community members provide written material about the community which is informative for prospective client members, referrers and other relevant professionals
- There is a clear and written procedure for joining the community which is understood by all new members
- All new client members agree and sign a contract upon arrival setting a list of
- fundamental rules and consequences
- All client members are properly assessed for their therapeutic needs

  - There is a written procedure for leaving the community, which includes those clients who leave prematurely
  - Community members are welcomed back to the TC after leaving to an event that celebrates their drug-free life

- **Therapeutic Environment**
  - Community members treat one another with respect at all times
  - The therapeutic community promotes a culture of openness
  - The therapeutic community has a written complaints procedure known and understood by all members
  - Community members are involved in the day-to-day running of the community
  - The community maintains a drug-free environment, with the exception of prescribed drugs

- **Treatment Programme**
  - The community has a planned therapeutic programme
  - Each stage of the programme has clearly defined written goals, activities and expectations
  - There is a structured and consistent daily schedule of group activities including work, therapeutic groups, activities and informal time
  - All client members have a written care plan which is agreed with the client and subject to regular reviews
  - The community prepares members for independent living in the wider community by offering when possible appropriate educational and vocational training
  - There are clearly defined privileges and clearly defined sanctions with a rationale and process for allocating them e.g. status advancement, more desirable living space
  - The community takes responsibility for improving and maintaining client members' physical health
  - Where client members are offered a methadone treatment programme, there is a written policy

- **External Relations**

- The therapeutic community contributes to effective multidisciplinary and multi-agency working, between health, education, probation services, social services and voluntary organisations

The National Institute on Drug Abuse (NIDA) compiled in 1999 a booklet containing principles of effective treatment and identified 13 best practices that have been widely adopted by many TCs and other service providers in the US as well as in Europe. They are the following:

1. There is no single treatment that is appropriate for everyone
2. Treatment needs to be readily available and accessible
3. Effective treatment addresses the multiple needs of the individual, the drug use and any associated medical, psychological, social, vocational, and legal problems.
4. An individual's treatment and services plan must be assessed continually and modified.
5. Remaining in treatment for an adequate period of time is critical for treatment effectiveness (according to research a minimum of 3 months is needed to identify improvement).
6. Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction.
7. Medications are an important element of treatment for many patients.
8. Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.
9. Detoxification by itself does little to change long-term drug use.
10. Treatment does not need to be voluntary to be effective.
11. Possible drug use during treatment is not allowed and must be monitored continuously.
12. Treatment programs should assess for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases.
13. Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.

4. Indicators to measure the effectiveness of this intervention. Monitoring of the rehabilitation process.

European focal points that prepare annual national reports on the drug situation in all the countries of the European Union follow a set of five general key indicators in order to measure the effectiveness of drug treatment services, drug trends and assess the drug situation of a given country.

These are as follows:

- General Population Surveys (GPS) – Data from general and school population drug surveys provides basic information to help to understand patterns of use, risk perceptions, social and health correlates, and consequences of use of illicit drugs and other psychoactive substances. Extent and pattern of drug abuse among the general population.

- Problem Drug Use (PDU) - Problem drug use is defined as 'injecting drug use or long-duration/regular use of opiates, cocaine and/or amphetamines'. Prevalence of problem drug abuse.

- Treatment Demand Indicator (TDI) – Demand for treatment among drug users.

- Drug Related Deaths and Mortality (DRD) - The aim of this indicator is to obtain statistics on the number and characteristics of people who die as a consequence of drug use.

- Drug Related Infectious Diseases (DRID) - This key indicator collects data on drug-related infectious diseases, particularly among injecting drug users

5. Evaluation of the effectiveness of the program, methods of measurement and monitoring of the dynamic of the patients' status.

6. Estimated financial costs of therapeutic communities (personnel, operations, facilities, etc).

http://www.podaneruce.cz/en/programs/other-centers/therapeutic-community-podcestny-mlyn.html

B. It is expected that the second day of the master-class will target **after-care/social adaptation approaches.**

1. Definition and the concept of the after-care/social adaptation approaches, their organizational, operational and financial aspects.

Aftercare is support that is planned for when clients leave structured treatment. The aim is to maintain the positive developments clients have made in their treatment, and help them return to normal life. Examples include help with housing, education, employment, general health care and relapse prevention.

The two main tasks of aftercare are, firstly to separate the individual from institutional dependence gained in the rehabilitation stage, and, secondly to prepare the person for when they are again alone and have to "walk on their own two feet". This is maintained by two major focuses

- rebuilding a positive and supportive social structure and
- maintaining the rules of the relapse prevention - Transtheoretical Model

Cycle of Change Stages
Applied to ADP interventions

"The Transtheoretical Model" (Cycle of Change process) created by two American psychologists Joseph Prochaska and Richard Diclemente also informs the programme development. This model has been used successfully to facilitate behaviour change to help people stop smoking tobacco, reduce substance use, gambling etc.

The programme intervenes at all stages of the Cycle of Change, beginning with motivational enhancement and affirming all 'helpful behaviour' throughout. The sessions progress to more intensive and personal rehearsal of strategies for relapse prevention and management. The acquisition of other "life skills" such as decision making, problem solving and communication skills is part of this process.

There are (though) different types of aftercare programmes. The after care programme usually are both residential and out patient once.

In the US and some European countries some so called "rehab programmes" offer what is called a "work exchange". This is the best option for those who need an intensive aftercare solution. Once the individual has completely finished the rehabilitation program, they are eligible to apply to stay longer, anywhere from one to six months. During this time they work various jobs throughout the rehab centre and are supportive to patients in other phases of the program. They will receive free room and board and be paid a normal salary.

Another type of aftercare program is "sober living housing" or "halfway houses". Many drug rehab centres offer transitional housing, where upon completion of the treatment program the

individual goes to live in a setting with other ex-users. This is a great option for them to start fresh in new environment with the support of other addicts. They are required to find work and pay rent, usually inexpensive, and attend therapy and follow up meetings.

When the person has been discharged from treatment and goes onto the aftercare process, it requires support as a means to prevent relapse. A key aspect of the work with an aftercare client is to do work (either on a one-to-one basis or on a group set up) that focuses not only on self-awareness but also on how to recreate the social structure and rebuild relationships (family, friends). This is a key point in the successful survival without drugs life style.

In order to help a client to remain drugs life style-free, aftercare services need to have a well-planned intervention strategy that includes:

- Drug-related support, such as relapse prevention (motivational cycle as mentioned above), support groups and individual support as well as access to users groups (e.g. Narcotics Anonymous)
- Non-drug related support, such as access to education and training, support for advisory services, helping develop social networks and employment and housing support.

Major aspect of an after care programme is what is often called a key work. Key work in the after care programme is mainly based on an individual planning. The individual plan is determined together with the client and sets the aims where the client wants to be after a decided period of the programme. It is also a very good tool for a feed back evaluation. The individual plan usually includes:

- Housing
- Family and other important (social network) relations
- Legal situation if needed so
- Getting on the job market
- Personal development
- Working with a free time
- Learning skills (studies etc.)

Aftercare facilities do not have staff 24 hours (as it is the case in TCs) and the process is not so closely monitored but it is still usual to do a random urine tests as well as other risk assessment procedures.

Most of the procedures, house rules and philosophies of the residential after care programmes are going to be the same or similar to the TC.

When recruiting staff for an aftercare facility (or a TC) it is essential to consider the characteristics of the target group and to ensure that staff has the adequate training. For aftercare it will be necessary to count in the staff team with social workers, nurses, psychotherapists, and somebody with pedagogical experience.

2. Examples of protocols and/or international best practices in this field.

The best practices developed by NIDA are also applicable to aftercare services and should be taken into consideration when developing effective programmes.

On a more specific level it can be highlighted the aspects and implications that aftercare services, programmes and interventions should look into as a form of best practices.

Aftercare needs to cover the following areas:

- Medical aftercare – Hepatitis and HIV/AIDS testing, GP registration, oral healthcare and general healthcare
- Physical and emotional aftercare – nutrition, sport, peer support, developing healthy relationships, living without drugs, complementary theories (to reduce anxiety levels and improve energy)
- Social aftercare – community integration, family issues, gaining life skills, housing and education, re-learning social aspects of living
- Economic aftercare – welfare rights, benefits advice, debt and financial advice, training and employment support, gain the right to earn his or her own money
- Psychological aftercare – counselling, one-to-one support and therapy, gaining coping mechanisms, understanding drug use, relapse prevention, motivational interventions

3. Indicators to measure the effectiveness of these interventions. After-care process monitoring.

4. Evaluation of the effectiveness of after-care programs. Methods of measurement and monitoring the dynamic of the patients' status.

4. **Estimated financial costs of after-care programs**

Web side – example of our programme

http://www.podaneruce.cz/en/programs/other-centers/after-care-center-jamtata.html