DRUG & ALCOHOL FINDINGS *Review abstract*

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Doing time on a TC: how effective are drug-free therapeutic communities in prison? A review of the literature.

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Evidence gathered over the last decade affirms the greater effectiveness of therapeutic communities in prison versus other treatment models, and highlights improved recidivism and drug use outcomes when the prison regimen is reinforced by community aftercare on release.

SUMMARY Therapeutic communities are community-led, living and learning environments designed to promote social, psychological and behavioural change. In the context of addressing substance use problems they tend to involve an intensive (24 hours a day, seven days a week), structured programme which entails residents living together and being encouraged to confront and un-learn addiction-related and anti-social patterns and behaviours. A defining feature of therapeutic communities is the use of the community itself as an agent of change.

Evaluation of early therapeutic communities was widespread, varied in design, and produced significant findings in favour of the therapeutic communities as an effective and cost-effective treatment option for people with substance use problems. Despite further evidence being added in support of therapeutic communities, some still dispute their success, highlighting ambiguous outcomes and methodological flaws in study design. Researchers have pinpointed the lack of randomised controlled trials as a reason why the effectiveness of therapeutic communities has yet to be proven.

The featured paper considered evidence relevant to the effectiveness of prison-based therapeutic communities that treat offenders with substance use problems, focusing on contemporary studies (2007–2017).

The author found that there was support for the current efficacy of therapeutic communities over other prison-based treatment for people with substance use problems (1 2 3 4 5 6 7 8). Further findings highlighted the importance of offering in-prison therapeutic community treatment in conjunction with a community aftercare intervention – a combination which produces the best results in terms of reducing recidivism and relapse to drug use than other substance use programmes for prisoners.

Two studies found that negative outcomes were associated with therapeutic communities, and found that drug relapse findings were, at times, tenuous. One study also mirrored early findings of a diminishing treatment effect over time.

A brief history of therapeutic communities

The first residential therapeutic community for people with drug and alcohol problems opened in the US in 1958, and propelled a movement for community living and providing support through self-help and group work.

The idea that drug users themselves could be part of the solution took hold, and ten years later the first residential therapeutic community opened up in the UK and the approach quickly became an established treatment model.

In the 1970s, America saw the advent of therapeutic communities in criminal justice settings including prisons. However, introducing a treatment model where personal exploration, self-disclosure, and individual growth and responsibility were deeply encouraged and situating this in an establishment based around punishment, sanctions, and security was not without challenges. Despite this, early research suggested that the transition was successful.

A single paper stood out as being the most robust trial conducted on prison-based therapeutic communities. It found that those who participated in therapeutic community treatment and aftercare had significantly reduced reoffending rates in comparison to all other groups. Perhaps surprisingly, those who participated in therapeutic community treatment alone actually fared worse than any other comparison group in the study. While this evaluation did not meet the gold-standard criteria of a randomised controlled trial, researchers made considerable efforts to create a stringent and robust evaluation that appeared to adequately address the research question:

- The study had an extremely large-sample size of over 4,000 participants and carefully matched participant groups.
- Authors were able to evidence fidelity to the therapeutic community model and aimed to assess

therapeutic community treatment with and without aftercare.
• Detailed descriptions were provided of the rigorous statistical testing employed and at over six years, the evaluation had the longest follow-up yet in a therapeutic community trial.

FINDINGS COMMENTARY The most robust study identified by the featured review was set in a dedicated drug-treatment facility based on a therapeutic community model in Illinois (United States). The study found that those who participated in the therapeutic community and accessed aftercare had significantly reduced reoffending rates compared to other groups, while therapeutic community participation alone was relatively ineffective. Although aftercare may have been a significant factor in people's trajectories after leaving prison, key differences in the characteristics of people in the therapeutic community versus therapeutic community plus aftercare groups may have also influenced their outcomes. While everyone in the therapeutic community was required to participate in community-based drug treatment programmes, only half accessed aftercare or found a form of aftercare available – potentially reflecting the level of resources, motivation, and social capital they had, which with or without aftercare may have affected their success. For example, people who returned to rural areas of Illinois were less likely to participate in aftercare programming than those from urban areas; and when they did, they were less likely to complete the aftercare programme successfully.

A 2012 review of therapeutic communities, which included services in prison or offered as an alternative to prison, was unable to draw a firm conclusion in respect of their lasting impacts, firmly concluding only that while residents stay, they use substances less often than before they entered. This in itself is a worthwhile achievement, but one considerably diluted by the review's finding that typically stays are short because residents quickly leave. This too seemed the major limitation on the effectiveness of English residential rehabilitation services in an audit of the progress of residents in 2010–11. Reporting on that audit, England's National Treatment Agency for Substance Misuse stressed that residential rehabilitation works in concert with non-residential services, typically taking its residents after they have been prepared by other services, which also continue the treatment of many residents after they leave. Based on the 2012 review, internationally it may also be the case that for many residential rehabilitation is not the end of a treatment and addiction career but an episode within it, making it difficult to isolate the contribution of the residential element in the treatment journey.

A rare randomised trial, analysed in the Effectiveness Bank, attempted not just to establish the effectiveness of a US prison therapeutic community relative to outpatient treatment, but also what types of prisoners may differentially benefit from these modalities. Over a three-year post-release follow-up period no extra reduction in reimprisonment was found from the intensive option. The same finding emerged among prisoners at the highest risk of re-offending, confounding expectations that the more intensive treatment would be particularly suitable for these offenders. The setting for the study was the Chester men's prison in Pennsylvania in the US, a facility dedicated to problem drug users. To be admitted, prisoners had to have severe drug-related problems approximating to dependence, 18–34 months left to serve, and no serious mental health problems. In the community's favour was that prisoners who by the end of treatment were relatively low in anger and hostility had on average responded better to the therapeutic community than to outpatient counselling. Without pre-treatment measures, we cannot know whether this means it is best (all else being equal) to allocate prisoners who *start* this way to a therapeutic community, or whether the inmates who *ended up* relatively calm after 12 months of intensive therapy and intensively interacting with staff and other residents were those who adjusted best to this more challenging regimen.

Of the above study, the featured paper said:

> *"Outcomes reported were that [therapeutic community] participants experienced higher recidivism rates than their matched comparisons. On closer inspection, outcomes appeared vague and somewhat variable with some analysis producing no differences between the groups or small non-significant differences as well as the described findings negating the [therapeutic community] condition. The authors superficially acknowledge that they were unable to assess the fidelity and quality of the aftercare services provided in this study and it is unclear as to whether any participants accessed any aftercare at all and if they did what this was. This is a significant limitation in this study that perhaps reduces the robustness of the trial and potentially provides an explanation behind the unexpected results."*

The degree that the study was dismissed does not seem warranted. Reimprisonment was not a "vague" outcome and the aftercare was equalised between the different groups: "Graduates of both programs were required to complete a mandatory, 6-month community aftercare program offered by a private treatment provider contracted with the [Department of Corrections]." Overall the therapeutic community performed less well, which may suggest that unless a high level of uptake in effective aftercare can be ensured, alternatives to prison therapeutic communities are preferable.

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