Mental Health, Recovery, and the Community
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Editorial

Mental Health, Recovery, and the Community

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Received 5 February 2013; Accepted 5 February 2013

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1. Introduction

The prevalence of mental health problems is high and causes profound health, social, cultural, and economic problems worldwide [1, 2]. Most psychiatric disorders are characterized by a chronic and complex nature and recurring episodes of acute symptoms. For decades, the treatment of mental health problems was primarily situated in residential services. Criticism of the so-called “total institutions” led to the downsizing or even the total close of institutions in favor of community mental health care [3]. Still, the number of psychiatric beds and hospitalizations remains high in several countries. Moreover, the treatment of mental health problems has traditionally been guided by a cure-oriented approach followed by rehabilitation efforts to reinsert individuals in society after substantial periods of hospitalization.

In reaction against what is perceived to be an overly narrow biomedical model, the recovery movement emphasizes the importance of a client-centred approach, based on individuals’ perceived needs and goal-directed practices that reflect clients’ valued activities [4]. Instead of rehabilitation, in which clients’ role in regaining control over their life is often neglected, recovery focuses on the question how individuals can have more active control over their lives (agency). Recovery has been defined as “a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and roles. It is a way of living a satisfying, hopeful, and contributing life, even with any limitations caused by illness” [5, 6]. It is characterised by a search for the person’s strengths and capacities, satisfying and meaningful social roles, and mobilizing formal and informal support systems. Recovery has begun to have an influence in thinking more broadly about mental health care and how social inclusion can be promoted [4].

Research on recovery among various mental health populations and on effective strategies and interventions to promote recovery is still in its infancy [6]. Empowerment, hope, responsibility, peer support, advocacy, and quality of life have become predominant concepts in the recovery debate but remain poorly understood from a consumer’s perspective. Treatment providers and key workers need to rethink their role as supporters of service users’ personal recovery and require the skills and competences necessary for doing so. On the other hand, service users are considered to be the primary agents of their recovery process and need to employ personal and community resources for living a satisfying life.

In this special issue, we present 11 original papers on the emerging topic of recovery from mental health problems and
the role of community services and support. The contributions concern diverse mental health populations, including people with psychosis or schizophrenia, substance use disorders, offenders with mental disorders, and young adults with posttraumatic stress disorders. We focus on formal as well as informal systems for supporting recovery. Empirical data for this special issue were collected using qualitative as well as quantitative research methods and involve diverse stakeholders, including service users themselves. The papers represent contributions from various continents, illustrating the topicality and international relevance of recovery in the field of mental health care.

Three areas of recovery research can be distinguished in this special issue. The first area addresses the conceptualization of recovery and how professionals, relatives, and society at large can be educated regarding the process of recovery from mental health problems. The second area of papers explores the lived experiences of individuals with mental health difficulties and the personal and community resources they employ to enhance their recovery process. The last area focuses on formal and informal support systems that may stimulate recovery among diverse mental health populations.

2. The Concept of Recovery and Its Spread

Recovery is an increasingly frequently cited term in mental health research, with over 2000 articles included in the Web of Knowledge (Thomson Reuters) mentioning this term in title or abstract during the last 20 years. Although implicitly understood by most stakeholders, conceptual and theoretical inconsistencies are not uncommon and "clinical" and "personal" recovery should be clearly distinguished [6]. The paper by C. Vandekinderen et al. provides a conceptual framework for understanding recovery from a consumer-centered perspective. They distinguish between an individual and social model of recovery: a universal, normative approach of citizenship as opposed to a relational, inclusive approach which enhances hope and belonging and requires alternative support strategies in community mental health care.

Despite the central objective of social inclusion in the recovery discourse, stigmatization of persons with mental health problems has often been reported [7, 8]. It is characterized by a lack of knowledge and false attributions concerning these problems, leading to social exclusion and feelings of guilt and shame. M. Corbière et al. set up a survey among diverse stakeholders in mental health care in Quebec, Canada, to identify strategies to fight prejudices and stigma. The authors argue that disclosure is a crucial factor in the process of destigmatization. Primary strategies to fight stigma identified by mental health care professionals were education and working on recovery and social inclusion, while service users focused on social contacts and person-centered strategies. The effectiveness of an education and training program for changing professionals' knowledge and attitudes about recovery was tested by G. K. M. L. Willyx et al., following a recovery-oriented mental health care reform in The Netherlands. The researchers demonstrated that recovery-oriented training can improve mental health care professionals' attitudes towards recovery, but its effectiveness for increasing knowledge was only temporarily.

3. Lived Experiences of Persons with Mental Health Difficulties

The subjective perspectives of service users and their lived experiences play a pivotal role in the personal recovery movement, but their narratives do not necessarily accord with these of mental health professionals and researchers [6]. These divergent views are illustrated in the paper by M. Lambri et al. who performed a needs assessment among 110 persons with psychosis and their support workers living in diverse supported housing settings in an inner-city area of London. This study underscores the importance of addressing individuals' personal and social needs when implementing support services in the community in order to improve service users' quality of life. Moreover, deinstitutionalization may have unintended and adverse consequences like unemployment, crime, and deprivation (in particular in urban areas), which touches upon recent expert opinions that community treatment is not necessarily of high quality [3] nor better than a hospital admission [2, 9].

The lived experiences of 20 persons with auditory hallucinations in the Chinese administrative region of Hong Kong are explored in a paper by P. Ng et al., who report several personal and informal strategies to cope with hearing voices. The authors stress the importance of understanding these persons' symptoms through education programs for formal and informal caregivers and the need for adapted, culturally sensitive recovery programs for minority groups.

Quality of life is regarded as an important indicator of recovery and subjective wellbeing [10]. F. Morisse et al. assessed dimensions of quality of life and support needs among family members and support workers of persons with intellectual disabilities and cooccurring mental health problems. The authors suggest the existence of generic dimensions of quality of life, although appropriate support strategies are needed for this specific population.

The role of community support and personal and social capital in the recovery process is addressed in several papers, but takes a central position in the paper by S. Vindevogel et al., in which they explore the perspectives of former child soldiers and their peers to identify sources of resilience and agency among young adults in the aftermath of the armed conflict in Uganda. The findings from this qualitative thematic analysis call for the development of community-based support systems to enhance individuals' capacities as well as the communal sociocultural fabric in these war-affected societies.

Recovery cannot be defined as an outcome or state to attain but should rather be seen as a process and a satisfying way to live one's life [6]. The relapsing nature of this process is illustrated in the paper by C. Colman and F. Vander Laenen who explored the concepts of "recovery" and "desistance" in a sample of 40 recovering drug offenders. They highlight the role of human agency and critical turning points in the life
span of “drug addicts” and “criminals”, but emphasize that desistance is hardly attainable without drug abstinence.

4. Formal and Informal Support Systems towards Recovery

The role of formal and informal support systems in promoting recovery is increasingly studied and has been the subject of some recent reviews [11–13]. In this special issue, R. Pratt et al. report on the effectiveness of Wellness Recovery Action Planning (WRAP), a recovery-based self-management approach to improve individuals’ mental health and wellbeing. WRAP is provided in the context of self-help and mutual support groups led by facilitators with lived experiences of mental health difficulties. Based on a qualitative evaluation including interviews and focus groups, the authors found a positive impact of this peer-led intervention, in particular in generating hope and empowering individuals to self-manage their recovery process.

Formal interventions for promoting recovery may include community treatment of offenders with mental health problems. The review by C. Wittouck et al. assesses the impact of drug treatment courts, which divert drug offenders to drug and other types of community treatment instead of sending them to prison, on clinical recovery. Although the findings from this review are indecisive, they provide strong arguments to look beyond substance use and legal outcomes in evaluation studies.

The therapeutic community (TC) for addictions is another example of a formal support system for supporting clinical recovery among drug addicts. Traditionally, TCs have been evaluated from an acute care perspective, whereas a longitudinal or even a career approach is warranted. The review paper by W. Vanderplasschen et al. focuses on the effectiveness of TCs from a recovery-oriented perspective and regards abstinence as a potential resource, but not as a prerequisite, for recovery defined more broadly. This alternative approach sheds new light on the discussion about TC’s effectiveness and proposes a shift in focus from socially desirable outcomes (such as drug abstinence and criminal desistance) to more subjective outcome indicators like family involvement, psychological wellbeing, and engaging in meaningful activities [10].

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References


Review Article

The Impact of Drug Treatment Courts on Recovery: A Systematic Review

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Received 28 October 2012; Accepted 27 December 2012

Academic Editors: R. Apiquian, Y. Bloch, L. L. Lykouras, and W. Pigeon

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Introduction. Earlier reviews regarding the effectiveness of Drug Treatment Courts (DTCs) reported a reduction in reoffending and substance use. Although substance users suffer from other difficulties than drug use and judicial issues, none of these reviews focused on outcomes or effects of DTCs on drug-related life domains, such as social relationships, employment, or health. Therefore, the present paper aims to review the impact of adult DTCs on substance use and drug-related life domains. Method. Primary studies were systematically searched in Web of Knowledge. Observational and controlled evaluation studies of adult DTCs were considered eligible if substance use and/or drug-related life domains were measured. Results. Moderately positive results were found with respect to within-program substance use. Few studies used drug-related life domains as an outcome measure and most of them yielded no effects. Employment and family relations ameliorated when specific interventions were used. Discussion. DTCs yield beneficial outcomes and effects regarding within-program substance use. However, evidence regarding the impact of DTCs on post-program drug and alcohol use and on other drug-related life domains is scarce. These life domains and thus QoL possibly can be improved by DTCs if specifically targeted. Future research is warranted.

1. Introduction

Substance use disorders (SUDs) are important public health problems in Western countries [1, 2] and are often regarded as chronic relapsing disorders [3–6]. The chronicity of SUDs is illustrated by the observation that most substance users cycle repeatedly between abstinence on the one hand and relapses into active substance use on the other hand before reaching the phase of stable recovery. Sometimes stable recovery is never reached [7]. In the past, lifelong abstinence was seen as the only indicator of recovery. In recent years, however, abstinence is seen as just one indicator of recovery. A shift towards a focus on other life domains and quality of life (QoL) as indicators for recovery from SUDs has been initiated [4, 8]. SUDs are typically associated with severe impairments in drug-related life domains such as health, wellbeing, social network, employment, and financial situation [3–6]. Difficulties in these life domains remain for several years after abstinence has been achieved, particularly in the area of employment [4]. Consequently, recovery from SUDs goes beyond abstinence, instead all associated life domains should be considered. Commitment to recovery is related to one’s QoL which in its turn can be enhanced by (re)gaining and maintaining certain desired needs in life (e.g., stable housing, education and work, family, wellbeing, and stable financial situation) [9–11].

Substance users are highly prevalent in the criminal justice system [12, 13] due to substance-related offences (e.g., possession and/or consumption of drugs, driving while intoxicated and theft). Imposing judicial alternatives to imprisonment on substance using offenders contains an opportunity to divert them to community (drug) treatment services. These alternative measures are associated with improvements in drug-related life domains, next to decreases in criminal offending and substance use [14–16]. Generally,
the initiation and maintenance of desistance from (drug-related) crime should be accompanied by improvement in several life domains, such as social network, employment, and housing [17–19].

At court level, Drug Treatment Courts (DTCs) were introduced to divert substance using offenders to (drug) treatment services [20]. Although DTCs differ greatly with respect to, amongst others, inclusion criteria, procedures, treatment services, and treatment providers [21], some key components can be distinguished: (1) alcohol and drug treatment and rehabilitation services are present for participants, (2) a nonadversarial approach and an ongoing judicial interaction with participants, (3) frequent alcohol and drug testing, (4) rewarding or sanctioning according to participants’ compliance, (5) monitoring and evaluation of program goals during multiple court hearings, and (6) partnerships between drug court, public agencies, and community-based organizations [22].

During the past decade, several reviews have been published regarding the impact of DTCs on recidivism and substance use [21, 23–28]. In general, DTCs produce moderately beneficial results regarding recidivism, both during (within-program) [21, 23–28] and after (post-program) [23–25, 27, 28] the DTC program. These favourable outcomes apply for both drug-specific recidivism [25, 27, 28] and overall recidivism [21, 25–28]. However, Wilson and colleagues [28] concluded that DTCs have less impact on non-drug-related offences than on drug-related offences.

With respect to substance use, results are less homogenous. While the majority of reviewers concluded that substance use, as measured by drug tests, is to a certain extent reduced in DTC participants (within-program) [21, 23–25], Wilson and colleagues [28] found a negative effect of DTCs on substance use. In these review studies no information was available regarding post-program urinalysis results, since these tests are only mandatory administered within-program. Only Brown [21] does not explicitly state that the presented results are coming from within-program drug tests.

According to the GAO review [25], data on self-reported substance use within-program are contradictory, and self-reported substance use post-program did not significantly decrease. Mitchell and co-authors [27] also concluded that substance use did not significantly decline, but they did not distinguish drug test results from self-reported substance use nor within-program from post-program results.

None of the above-mentioned systematic reviews reported data on the effects of DTCs on drug-related life domains. Although the National Association of Drug Court Professionals [22, page 7] states that “while primarily concerned with criminal activity and alcohol and other drugs use, the drug court team also needs to consider co-occurring problems such as mental illness, ..., homelessness, basic educational benefits, unemployment ..., spouse and family troubles.”

Obviously, improvement in drug-related life domains plays an important role on the road to recovery and should thus be considered when evaluating DTC outcomes since these aim to reduce substance use and related criminal offending. However, previous reviews have not focused on these drug-related life domains. Therefore, the present paper aims to review the impact of DTCs on substance use and other drug-related life domains.

2. Method

2.1. Inclusion Criteria. Studies on adult DTCs, namely, standard “DTC”, “Family Treatment Drug Court” (FTDC), “Dependency Drug Court” (DDC), “Driving Under Influence Court” (DUI), and “Driving While Intoxicated Court” (DWI) were included. FTDCs (or DDCs) and DUs (or DWIs) are modeled on standard DTCs. The former are aimed at substance abusing parents, the latter at substance abusing drivers (especially drunk drivers). Observational or controlled evaluation studies of DTCs were considered eligible if at least one indicator of substance use and/or drug-related life domains, analogous to the subscales of the Addiction Severity Index (ASI; [29]) (namely, employment, financial situation, housing situation, physical and mental health, family and social relationships, and leisure-time activities), was reported as an outcome measure. No restrictions regarding measurement method or instruments were imposed.

2.2. Search Strategy and Study Selection. Web of Knowledge was consulted twice using the following search terms and Boolean operators up to December 31st, 2011: (1) a general search using drug court AND (evaluation OR effect OR outcome), and (2) a specific search using drug court AND (employment OR work OR income OR financial OR housing OR health OR family OR social OR leisure). The “title only” option was marked and the search was restricted from 1989, since the first DTC was implemented in this year [20].

The general and specific Web of Knowledge searches together generated 576 hits. After removing double hits and screening title and abstract, 61 potentially relevant papers were retrieved for more detailed evaluation. These studies were screened on meeting the inclusion criteria and subsequently 45 studies were excluded after reading the full texts due to irrelevant subject, descriptive nature, a mere focus on recidivism, or secondary analysis of previously published data. Finally, 16 studies met the inclusion criteria, which are [30–45] in the reference list of this paper.

2.3. Data Extraction. Eligible studies were independently screened by two researchers (C. Wittouck and A. Dekkers) using a checklist to extract data on the following variables: (1) author, publication data, and country where the study was conducted, (2) DTC characteristics and procedures, (3) study design and follow-up period, (4) description of intervention and control group (if present), (5) sample size and dropout rate, (6) demographic and substance use characteristics of participants, and (7) outcome variables, measurement instruments, and study findings. Due to the heterogeneity in study methodologies and the variety in data reporting, a narrative review was regarded as most appropriate. The individual study findings were grouped according to outcome measure
and were tabulated in a separate table to facilitate comparison and discussion.

3. Results

3.1. Study Characteristics. Table 1 provides an overview of included studies, according to location of DTC, study design, participant characteristics, and outcome measures.

All but one study ([32], Australia) were conducted in the USA. In half of the studies males were overrepresented (n = 8) [30–32, 34, 35, 38, 39, 42]. In seven studies a larger number of female participants was present [33, 37, 40, 41, 43–45]. The average age of participants is 31.29 years, with a range from 24,37 [35] to 36.4 [45]. The participants are predominantly Caucasian (range 23% to 78%) [32, 43], African American (range 20% to 89%) [30, 34], or Hispanic (range 16.1% to 85.5%) [36, 39].

3.2. Study Quality. Study quality was assessed using the Maryland Scientific Methods Scale (MSMS) [46] and was also based on the quality assessment criteria described in the guidance for undertaking systematic reviews [47].

About half of the included studies (n = 7) were randomized controlled trials (RCT) [30, 34–36, 38, 42, 43]. Three studies used a quasi-experimental design (QED) [33, 41, 44], and two studies a noncontrolled pre-post design (PPD) [32, 45]. All studies, except the study of Brewster [31], specified which data collection tools were used. Often used tools were court files, judicial databases, and interviews. Sample size was mentioned in all studies, and ranged from 30 [42] to 3672 [37]. Ten studies indicated the dropout rate in their research group(s) [30, 32, 34–36, 38–40, 43, 45] with a dropout rate between 1.4% [30] over 28% [34] to 75% [32].

The follow-up period in the 16 included studies differed to a large extent. Some studies carried out a follow-up measurement after a particular time post-admission [36, 38, 41, 45]. Within these studies the follow-up period ranged from four months after baseline [45] up to three years after randomization [34]. In other studies, the outcomes were measured on several follow-up moments, both within- and post-program [30–32, 35, 39, 42, 43]. Some studies only compare post-program outcomes [33, 34, 37, 40, 44].

3.3. Effects on Drug Use, Alcohol Use, and Other Drug-Related Life Domains. In Table 2 the individual study findings are displayed according to study design and outcome measure. Outcome measures were drug use, alcohol use, family and social relationships, employment and income, and mental and physical health. None of the included studies reported on housing situation or leisure-time activities as outcome measures. Five studies using a RCT [35, 36, 38, 42, 43] and one study using a QED [41] were treated as observational studies since they randomized between a standard DTC and an “enhanced” DTC. Some studies only reported on post-program outcomes regarding drug use and family reunification but were still included in the review, since it could be assumed that all participants were drug users at baseline or risked losing parental rights at baseline [33, 34, 37, 40, 44].

Substance use significantly improved over time in almost all studies, regardless of study design. With respect to other drug-related life domains, the difference in results between observational studies and studies using a comparison condition is very obvious. All observational studies, except one [35], conclude that DTC participants improved on all these drug-related life domains from pre- to post-test. These beneficial results were not found by controlled studies. Most of the latter types of studies only found favourable results for DTCs on drug and alcohol use. Only FTDCs found beneficial results regarding family and social relationships.

3.3.1. Effects on Drug Use. In the majority of the included studies (n = 10, participants n = 2390) illicit drug use was an outcome measure. In the Freeman study [32], illicit drug use was measured indirectly by looking into self-reported weekly spending. Weekly spending significantly decreased while weekly legal income did not change significantly, indicating a reduction in drug use over time. In the other studies drug use was measured directly either by urine test results [30, 31, 42] or self-reported data on drug use [34, 38, 45] or both [35, 39, 43].

Self-reported data on drug use showed positive results for DTC participants within-program [35, 43, 45], at discharge [39] and post-program [34, 35, 39, 43]. In addition, DTC participants reported significantly less illicit drug use than drug using offenders diverted to standard adjudication [34] and methamphetamine-dependent outpatients with no drug court supervision [39]. Leukefeld and colleagues [38] found that drug use decreased for all study groups. However, the study’s high upgrading group performed significantly better than the drug court as usual and the low upgrading group. Urine test results also showed beneficial outcomes for DTC participants during the DTC trajectory [39, 42, 43]. Only one study reported on urine test results after a DTC program. Specifically, Dakof and colleagues [43] found that mothers were less likely to provide a positive urine test after the DDC program ended. Deschenes et al. [30] found that about half of DTC participants as well as probationers delivered a positive drug test within-program. Significant differences between these two study groups emerged when type of drugs was considered. Probationers tested significantly more positive for cocaine and heroin, whereas drug court participants were significantly more likely to test positive for marijuana.

Not all studies concluded unanimously positive. Although both DTC study groups in the Marlowe et al. study [35] significantly improved with respect to self-reported drug problems, these results were not mirrored by the urine drug screen results. Positive urine drug screens increased, although not significantly, over time for both conditions. Most of these positive drug tests were related to cannabis use. But then, the vast majority of study participants were cannabis users at baseline. Brewster [31] found that, although the rate of positive drug tests was lower for DTC participants in comparison with probation participants, a comparable amount of participants from both study groups remained drug-free throughout the study period. Possibly, the higher
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<td>Non-randomized comparison group design</td>
<td>DTC ($n = 1,291$ parents and $2,097$ children) versus Standard CPS and ADS Divisions services ($n = 111$ parents and their $173$ children)</td>
<td><strong>DTC:</strong>&lt;br&gt;Mean age 32 years&lt;br&gt;Female (70.4%)&lt;br&gt;Drug of choice: 51.3% methamphetamine, 17.1% alcohol, 17.1% marijuana, 10.1% cocaine, 2.3% heroin&lt;br&gt;Comparison group:&lt;br&gt;Mean age 33.4 years&lt;br&gt;Female (64.9%)&lt;br&gt;Drug of choice: 44.1% methamphetamine, 18.6% alcohol, 20.3% marijuana, 10.2% cocaine, 6.8% heroin</td>
<td>24 mnd PP</td>
<td>Reunification with children</td>
</tr>
<tr>
<td>Study</td>
<td>Location</td>
<td>Study design</td>
<td>Study group(s)</td>
<td>Participant characteristics</td>
<td>Follow-up period</td>
<td>Outcome measures</td>
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<tr>
<td>Leukefeld et al. (2007) [38]</td>
<td>USA</td>
<td>RCT (Pre-test/post-test randomized design)</td>
<td>The enhanced employment intervention (low upgrading ( n = 118 ), high upgrading ( n = 120 )) versus DTC ( n = 239 )</td>
<td><strong>High upgrading group:</strong> Mean age 31.3 years Male (65%) Alcohol and drug use: years of alcohol use in lifetime 6.1, years used marijuana in lifetime 6.7, years used cocaine in lifetime 3.3, years used multiple substances in lifetime 4.5 <strong>Low upgrading group:</strong> Mean age 28.4 years Male (65%) Alcohol and drug use: years of alcohol use in lifetime 6.5, years used marijuana in lifetime 6.7, years used cocaine in lifetime 3.7, years used multiple substances in lifetime 5 <strong>Comparison group:</strong> Mean age 31.3 years Male (64%) Alcohol and drug use: years of alcohol use in lifetime 7, years used marijuana in lifetime 6.9, years used cocaine in lifetime 4, years used multiple substances in lifetime 5.4</td>
<td>BL 12 months after BL</td>
<td>Employment</td>
</tr>
<tr>
<td>Marinelli-Casey et al. (2008) [39]</td>
<td>USA</td>
<td>Non-randomized comparison group design</td>
<td>DTC ( n = 57 ) versus Outpatient treatment under non drug court condition ( n = 230 )</td>
<td>DTC: Mean age 32 years Male (66.7%) Drug use: mean days of MA use in the past month 8.7 <strong>Comparison group:</strong> Mean age 33 years Male (58.7%) Drug use: mean days of MA use in the past month 12.6</td>
<td>BL Weekly IP 6 &amp; 12 months PP</td>
<td>MA-use ASI (psychosocial outcomes) → legal, employment, medical, psychological, family, drug, and alcohol</td>
</tr>
<tr>
<td>Worcel et al. (2008) [40]</td>
<td>USA</td>
<td>Non-randomized comparison group design, matching</td>
<td>FTDC ( n = 301 ) versus Traditional child welfare services ( n = 919 )</td>
<td>No information on age Predominantly female FTDC: Drug of choice: 38% methamphetamine, 18% cocaine, 11% marijuana, 26% alcohol <strong>Comparison group:</strong> Drug of choice: 42% methamphetamine, 13% cocaine, 10% marijuana, 24% alcohol</td>
<td>2 years post child welfare petition</td>
<td>Parent-child reunification</td>
</tr>
</tbody>
</table>
Table 1: Continued.

<table>
<thead>
<tr>
<th>Study</th>
<th>Location</th>
<th>Study design</th>
<th>Study group(s)</th>
<th>Participant characteristics</th>
<th>Follow-up period</th>
<th>Outcome measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dakof et al. (2009)</td>
<td>USA</td>
<td>Quasi-experimental test</td>
<td>Engaging moms program(^4) (n = 43) versus FTDC (n = 37)</td>
<td>Mean age in their 30s Females only Drug use: drug of choice was mainly cocaine or crack</td>
<td>BL 15 months after entering program</td>
<td>Drug court graduation Family reunification</td>
</tr>
<tr>
<td></td>
<td></td>
<td>of 80 consecutive</td>
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<td></td>
<td>enrollments</td>
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<tr>
<td>Marlowe et al. (2009)</td>
<td>USA</td>
<td>RCT</td>
<td>DTC + adaptive interventions (n = 16) versus DTC (n = 14)</td>
<td>Mean age 27.60 years Male (77%) Alcohol and drug use: previous 30 days: use of marijuana (47%), alcohol (43%), opiates (13%) or cocaine/stimulants (6%) and multiple substances (37%)</td>
<td>BL IP 4 months after BL</td>
<td>Drug negative urine specimens</td>
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<tr>
<td>Dakof et al. (2010)</td>
<td>USA</td>
<td>RCT</td>
<td>Engaging Moms program (n = 31) versus FTDC (n = 31)</td>
<td>No information on age Females only Drug use: primarily polydrug users</td>
<td>BL 3, 6, 12, 18 months after intake</td>
<td>Child welfare dispositions SubSTANCE use Mental health Parenting practices Family functioning</td>
</tr>
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<tr>
<td>Burrus et al. (2011)</td>
<td>USA</td>
<td>Quasi-experimental</td>
<td>FTDC (n = 200) versus Traditional child welfare system (n = 200)</td>
<td>No information on age Female (FTCD: 98%, traditional child welfare: 100%) No information on alcohol or drug use</td>
<td>12 month after BL</td>
<td>Treatment (time to treatment, days spend in treatment, completion of at least one treatment episode) Child welfare Child welfare cost savings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>comparison group design</td>
<td></td>
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<tr>
<td>Johnson et al. (2011)</td>
<td>USA</td>
<td>Non-controlled pre post</td>
<td>DTC (n = 261)</td>
<td>Mean age 36.4 years Females only Drug use: cocaine dependence most common SUD diagnosis (45%)</td>
<td>BL FU 4 months post BL</td>
<td>Crack use and days using crack</td>
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<tr>
<td></td>
<td></td>
<td>design</td>
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</tbody>
</table>

1 In this study, there were two comparison groups (“treatment refusal group” and “traditional child welfare”) next to the intervention group (“FTDC”). However, comparison group “treatment refusal” and its results were unclear, therefore this group was not included in this review.
2 Participants were randomly assigned at intake either to attend judicial status hearings on a bi-weekly basis throughout their enrollment in drug court (“bi-weekly condition”), or to be monitored by their treatment case managers who petitioned the court for status hearings as needed in response to serious or repeated infractions (“as needed condition”).
3 Enhanced employment intervention aimed at obtaining, maintaining, and upgrading employment and attending upgrading sessions. The number of upgrading sessions attended by each participant was divided by the total number of possible upgrading sessions that a participant could have attended. The resulting percentages were then split in half, with those below the median in the low upgrading group and those above the median in the high upgrading group.
4 Engaging Moms Program (EMP) was adapted for use in a family drug court context. EMP was designed to help mothers succeed in drug court by helping them comply with all court orders, including attending substance abuse and other intervention programs (e.g., domestic violence counselling, parenting classes, etc.), attending court sessions, remaining drug free, and demonstrating the capacity to parent their children. The only difference between the FTDC and EMP groups was the working relationship between the drug court caseworker and the mothers; all other aspects of the programs, including overall requirements, phases, and sanctions and rewards, were exactly the same.
amount of positive drug tests among probationers can be attributed to drug testing at irregular intervals (e.g. in case of suspicion) of drug use, while testing of DTC participants at regular intervals is standard practice.

3.3.2. Effects on Alcohol Use. Only six studies (participants \( n = 1419 \)) included alcohol use as an outcome measure. Eibner and colleagues [36] focused exclusively on alcohol use since they evaluated a DUI court. All six studies found that DTC participants reported significantly less alcohol use over time. DTC participants as well as outpatients with no DTC supervision, both suffering from methamphetamine dependence, reported significantly less alcohol use over time [39].

3.3.3. Effects on Family and Social Relationships. In ten of the included studies (participants \( n = 6207 \)) family and social relationships were used as an outcome measure. While in some studies social functioning [32], family functioning, and parenting practices [41, 43] of DTC participants significantly improved over time, other studies found no difference regarding family and social relationships [35].

In comparison with non-DTC methamphetamine-dependent outpatients [39] and drug using offenders processed through standard adjudication [34], family and social relations of DTC participants improved significantly.

Slightly more than half (\( n = 6 \), participants \( n = 5512 \)) of these ten studies evaluated FTDC [33, 37, 40, 41, 43, 44]. Dakof and colleagues [41, 43] found that FTDC interventions can positively influence child welfare outcomes. Besides, at follow-up, family reunification was significantly more likely in FTDC cases than in cases processed through traditional child welfare services [37, 40, 44], except in the Ashford study [33]. Children of parents managed by traditional child welfare services were significantly more likely to be allocated to out-of-home-placement [37] and to reach permanency faster [40, 44]. Ashford [33], on the other hand, found that FTDC children reached a permanency decision sooner than children in traditional child welfare services. Furthermore, time to family reunification was significantly longer for children in traditional child welfare services than children in the FTDC group [40]. In addition, Burrus and colleagues [44] found that FTDC children spent less time in nonkinship foster care. Surprisingly, Boles and colleagues [37] also found that DDC participants had a higher re-entry rate to out-of-home care after family reunification than comparison participants. When outcomes of these re-entries were examined, however, it was found that all these comparison children

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**Table 2: Individual study findings according to study design and outcomes measure*.**

<table>
<thead>
<tr>
<th>Drug use</th>
<th>Alcohol use</th>
<th>Family (and social) relationships</th>
<th>Employment</th>
<th>Income</th>
<th>Mental health</th>
<th>Physical health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PPD</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
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<tr>
<td>Johnson et al. (2011) [45]</td>
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<td>#</td>
<td>#</td>
<td>#</td>
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<tr>
<td>Freeman (2003) [32]</td>
<td>+</td>
<td>#</td>
<td>+</td>
<td>#</td>
<td>#</td>
<td>+</td>
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<tr>
<td>Dakof et al. (2010) [43]</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
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<td>+</td>
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<tr>
<td>Dakof et al. (2009) [41]</td>
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<td>#</td>
<td>+</td>
<td>#</td>
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<tr>
<td>Marlowe et al. (2009) [42]</td>
<td>+</td>
<td>#</td>
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<tr>
<td>Leukefeld et al. (2007) [38]</td>
<td>+</td>
<td>+</td>
<td>#</td>
<td>+</td>
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<td>+</td>
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<tr>
<td>Eibner et al. (2006) [36]</td>
<td>+</td>
<td>#</td>
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<tr>
<td>Marlowe et al. (2005) [35]</td>
<td>+ (−)</td>
<td>+</td>
<td>=</td>
<td>=</td>
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</tr>
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</table>

**QED**

| Burrus et al. (2011) [44] | # | # | + | # | # | # | # |
| Worcel et al. (2008) [40] | # | # | + | # | # | # | # |
| Marinelli-casey et al. (2008) [39] | + | = | = | = | = | = | = |
| Boles et al. (2007) [37] | # | # | + | # | # | # | # |
| Ashford (2004) [33] | # | # | = | # | # | # | # |
| Brewster (2001) [31] | = | # | # | # | # | # | # |

**RCT**

| Gottfredson et al. (2005) [34] | + | + | = | = | + | = | = |
| Deschenes et al. (1995) [30] | + | # | # | = | # | # | # |

* A “+” indicates a significant difference in favor of the DTC, a “−” indicates a significant difference in favor of the control group, a “=” indicates no significant difference between the DTC and the control group, and “#” indicates that the outcome variable was not reported.

1 non-controlled pre-post design.

2 randomized controlled trial.

3 quasi-experimental design.
3.3.4. Effects on Employment and Income. About half of the included studies \((n = 7, \text{ participants } n = 2048)\) used employment as an outcome measure, and two of these studies also reported on income. Only two studies found beneficial outcomes for DTC participants regarding employment situation. Dakof and co-authors [43] found that employment problems of mothers in DDC significantly decreased. In their evaluation of an enhanced employment intervention, Leukefeld and colleagues [38] found that high upgrading participants reported significantly more full-time employment, significantly less unemployment, and more days of working when compared to both the no-intervention and the low upgrading group. Participants in the no-intervention group worked significantly more in the past 30 days than those in the low upgrading group. In concordance with the above-mentioned results, participants in the high upgrading group reported more income from a legitimate job in the past year than those in the low upgrading group. The no-intervention group did not differ from either of the upgrading groups.

In the Marlowe et al. [35] study, reported employment problems were not significantly reduced over time for participants from both DTC conditions. Furthermore, employment situation of drug court participants did not differ significantly when compared to non-drug court participants with methamphetamine dependence [39], standard adjudication [34], and probationers [31]. Deschenes and colleagues [30] even concluded that probationers were significantly more likely to be employed than drug court participants. However, during the follow-up period, DTC participants were significantly more likely than probationers to be involved in counselling and outpatient treatment sessions [30]. Although Gottfredson and co-authors [34] did not find a significant difference regarding employment situation between drug court participants and drug offenders processed through traditional adjudication, they did find the former relying on welfare significantly less than the latter, which could be due to a reduction in money spent on drug use since drug use decreased significantly in DTC participants.

3.3.5. Effects on Mental and Physical Health. In only five studies (participants \(n = 757\)) the effects of drug treatment court on mental and physical health was examined. Mental health [32, 43], general health and vitality [32] of DTC participants significantly increased over time, while medical problems [35, 43], bodily pain, and emotional and physical role limits [32] of DTC participants significantly decreased over time. Marlowe and colleagues [35], however, did not find improvement for mental health and Freeman [32] found no improvement regarding physical functioning.

Furthermore, no differences were found regarding mental and physical health between DTC participants and non-DTC methamphetamine-dependent outpatients [39] nor between DCT participants and drug users processed through standard adjudication [34].

4. Discussion

The results of the present paper show that, in general, DTCs appear to produce a decrease of illicit drug use in substance using offenders during a DTC trajectory, which was also found by earlier review studies [21, 23–25]. DTC participants, who did not reach abstinence, often moved away from more harmful substances as heroin to less harmful substances as marijuana [30]. Little information is currently available on the long-term effects of DTCs on illicit drug use. Although long-term self-report data show promising results, information from urinalysis confirming these results is lacking. Alcohol use of DTC participants also decreased. Surprisingly alcohol use was an outcome measure in only half of the included studies, given the well-established link between drug and alcohol use [48–51].

Although the importance of drug-related life domains, for example employment and housing, is recognized in the recovery and desistance literature [9–11, 14, 15, 17–19], only a small amount of DTC evaluation studies focusing on these outcomes were found. The lack of empirical data on the effects of DTCs on drug-related life domains might be explained in two ways. Or DTCs focus predominantly on substance use and drug-related crime which results in a lack of attention to other drug-related life domains. Or DTC research has not yet caught up with the state of the art on recovery, resulting in a lack of focus on these drug-related life domains. Consequently, DTC research should broaden its focus and systematically record information on DTC interventions aimed at these drug-related life domains, and study the short-term and long-term effects of DTCs on these life domains and QoL of DTC participants. Subsequently, evidence-based recommendations can be made in order to improve DTC policy and practice.

As for the studies that do focus on drug-related life domains, observational studies found beneficial results, which were not consistently demonstrated by (randomized) controlled studies. As opposed to standard adult DTCs, FTDCs do appear to positively influence child welfare outcomes (e.g., family reunification) [37, 40, 44]. Next, Leukefeld and colleagues [38] found that DTC participants who received an enhanced employment intervention aimed at obtaining, maintaining, and upgrading employment and attending sufficient sessions, had more beneficial outcomes regarding their work situation (e.g., more full-time employment and less unemployment).

Following the (moderately) positive results of DTCs on substance use, of FTDCs on child welfare outcomes and of the DTC with an enhanced employment intervention on work situation, it can be hypothesized that providing specific interventions for each of the drug-related life domains will beneficially affect these domains. Indeed, considering the chronicity of SUDs and the complexity of associated problems [3–7], one cannot expect that a mere focus on substance use as such will automatically entail improvements in other life domains. Moreover, by offering interventions specifically aimed at improving drug-related life domains, attention is given to outcomes which are reported as desired by drug users themselves. In other words, such interventions start...
from drugs users' own experiences and expectations (e.g., QoL) [52]. After all, the recovery model is a widely used and accepted approach for supporting persons with mental health and/or addiction problems, ultimately aimed at improving QoL [9, 53, 54]. When substance users experience progress in those drug-related life domains they consider important, and subsequently in their QoL, their drug use and criminal offending could be positively influenced.

No information was available regarding the effects of DTCs on housing situation or leisure-time activities, although research shows that moving away from drug-using friends and acquaintances supports the maintenance of abstinence [17] and permanent housing is associated with a reduction in recidivism [14, 15]. In addition, non-substance-related leisure-time activities contribute to a higher QoL [55].

Some limitations of the present paper should be addressed. First, one should be cautious when generalizing the results of the present paper. The restriction of the search strategy to peer reviewed publications could have induced publication bias, since only favorable results are published. Although peer review also guarantees some form of quality control. Mitchell and colleagues [27, p. 69] also found that the results of published and unpublished studies on the effects of DTCs are “roughly similar.” Next, only a small number of individual studies reporting on the effects of DTCs on drug use, alcohol use, and/or drug-related life domains were available. The included studies are also marked with substantial heterogeneity regarding methodology, sample size, and measurement instruments. Comparability of individual study results is further compromised since comparability between DTCs from different jurisdictions is low (e.g., inclusion criteria, procedures, treatment services, and treatment providers) [21]. Evaluations are thus very site-specific, which gives little insight into the overall effectiveness of the system [56]. In fact, a general DTC framework and general DTC theoretical underpinnings are lacking [56, 57]. Generalizability is further limited since beneficial outcomes are more prevalent in DTC graduates than in dropouts [25, 27], and in general about half of DTC participants drop out of the trajectory [21, 23–25]. The dropout rate varied greatly between the included studies, and intent-to-treat analyses were not carried out or were impossible to carry out. In addition, the included studies were almost exclusively USA based. The adoption of USA DTC practices and the generalizability of USA DTC results to other countries, especially European, is problematic because of fundamental differences in the law system. Second, RCTs, which receive the highest score of the Maryland Scientific Methods Scale [46], are rare in evaluating DTC’s effectiveness. In the present review less than half of the 16 included studies used a RCT, and only two of these RCTs randomly assigned participants to DTC or another kind of judicial processing. The observational and quasi-experimental studies do not allow to conclude that the observed beneficial outcomes are attributable to DTCs, since improvement due to confounding factors cannot be ruled out. Finally, to our knowledge, the longest follow-up period in DTC evaluation studies is three years [34]. Empirical data on the long-term effects of DTCs on drug-related life domains and substance use (and criminal offending) is thus lacking since studies with extended follow-up periods are non-existent.

To conclude, although one should consider the abovementioned limitations when generalizing the present paper’s results, some important conclusions should be highlighted. First, through a dominant focus on substance use and criminal offending, DTCs and DTC research possibly suffer from a lack of attention and interest for other drug-related life domains and QoL of substance users. Second, these life domains can be improved as long as they are addressed. Consequently, DTC policy and practice should be adapted according to the recent findings of recovery and desistance research by focusing on improvement in drug-related life domains and by targeting these domains using specific interventions thus improving QoL of substance using offenders. In addition, each DTC trajectory should be tailored to the unique problems a DTC client faces, herewith assuring a more individual approach. As research has shown that great interpersonal variability exists between DTC participants, and that the effectiveness of DTCs differs according to these differences [38, 58, 59]. Finally, it can be expected that a decrease in substance use and criminal offending results from better life circumstances for substance users. Therefore, future research on the effectiveness of DTCs should use a more comprehensive focus and study the short-term and long-term effects of DTCs on drug-related life domains and QoL next to the effects on substance use and criminal offending, which are, after all, socially desirable outcomes [52].

Acknowledgment

This study was supported by a grant from the Belgian Science Policy Office.

References


Research Article

Quality of Life in Persons with Intellectual Disabilities and Mental Health Problems: An Explorative Study

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Received 24 October 2012; Accepted 13 January 2013

Academic Editors: H. P. Kapfhammer, T. Steinert, and A. M. Valenca

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The field of intellectual disability (ID) is strongly influenced by the Quality of Life paradigm (QOL). We aimed at investigating whether or not the QOL paradigm also applies to clients with ID and cooccurring mental health problems. This paper aims at stimulating a debate on this topic, by investigating whether or not QOL domains are universal. Focus groups with natural and professional network members were organized to gather qualitative data, in order to answer two questions: (1) Are the QOL dimensions conceptualized in the model of Schalock et al. applicable for persons with ID and mental health problems? (2) What are indicators relating to the above-mentioned dimensions in relation to persons with ID and mental health problems? The results offer some proof for the assumption that the QOL construct seems to have universal properties. With regard to the second question, the study revealed that the natural and professional network members are challenged to look for the most appropriate support strategies, taking specific indicators of QOL into account. When aspects of empowerment and regulation are used in an integrated manner, the application of the QOL paradigm could lead to positive outcomes concerning self-determination, interdependence, social inclusion, and emotional development.

1. Introduction

The field of intellectual disability (ID) is strongly influenced by the Quality of Life paradigm (QOL), from a research, a practice-based, and a policy-oriented perspective [1–5]. This QOL framework supports the equality of persons, which is reflected in concepts such as self-determination, emancipation, inclusion, and empowerment. In daily practice however, in which concepts are translated into tangible actions, professionals are often confronted with difficulties to apply these QOL principles. This seems especially true when working with specific populations, including persons with ID and mental health problems. The application of QOL principles, which should—in ideal conditions—lead to positive outcomes with regard to social participation, independence, and well-being [6], seems to be at risk, as accounts from professionals indicate that empowerment is sometimes replaced by actions solely aimed at “controlling,” “dominating and excluding” clients with ID and cooccurring mental health problems.

This paper aims at stimulating a debate on this topic, by investigating whether or not QOL domains are universal and applicable to people with ID and mental health problems. Although the cooccurrence of mental health problems can be described as an important issue in the field of ID research and practice, there have not been many studies tackling the application of the QOL paradigm in this specific population.

1.1. Quality of Life (QOL). The construct of QOL has been widely applied in the field of ID and implies principles of emancipation and inclusion. Initially, the assessment of QOL was approached from multiple perspectives, resulting in over 1,243 measures reported in the QOL literature by the mid-1990s [7]. The current approach to the measurement of QOL can be characterized by the following:

...
(a) its multidimensional nature involving core domains and indicators;
(b) the use of methodological pluralism that includes the use of subjective and objective measures;
(c) the incorporation of a systems perspective that captures the multiple environments impacting people at the micro-, meso-, and macrosystems levels; and
(d) the increased involvement of persons with ID in the design and implementation processes [5, 8].

In this study, we adopt the following definition of individual-referenced QOL [9]:

“Individual QOL is a multi-dimensional phenomenon composed of core domains that are influenced by personal characteristics and environmental variables. These core domains are the same for all people, although they may vary in relative value and importance. QOL domains are assessed on the basis of culturally sensitive indicators.”

The QOL construct consists of the eight domains that have been validated in a series of cross-cultural studies [6, 10–12]. These eight domains are personal development and self-determination (that reflect a person’s level of independence); interpersonal relations, social inclusion, rights (that reflect a person’s social participation); emotional, physical, and material well-being. The QOL literature does not define a hierarchy amongst those domains nor does it specify cause and effect relations amongst them [8]. QOL indicators are QOL-related perceptions, behaviours and conditions that operationally define each QOL domain.

1.2. Persons with ID and Mental Health Problems: Terminology, Prevalence, and Support Needs. The prevalence of psychiatric disorders in people with ID is higher as compared to the general population [13]. Epidemiological studies estimate the prevalence of behaviour problems and psychiatric disorders amongst individuals with ID at 30–50% [14]. The coexistence and interference of the symptoms of both ID and mental health problems are multiple and complex. This is, for instance, reflected in the lack of an internationally recognized and uniform definition and terminology [14]. Throughout the literature, concepts including “dual diagnosis,” “cooccurring disorders,” “mental health problems,” “mental health needs,” “behavioural problems,” “behavioural disorders,” “conduct disorders,” and “challenging behaviour” are used. In this paper, it was chosen to use the term “mental health problems” in persons with ID. By doing so, we include both “behavioural problems” or “challenging behaviour” [15] as well as psychiatric disorders as defined in currently used manuals, such as the DSM-IV or the ICD-10.

Persons with ID and mental health problems might be amongst the most vulnerable groups of people in our society [13]. Up until now, the medical framework has been very dominant in supporting persons with ID and mental health problems. According to some authors, this is due to the complexity of physical, emotional, and behavioural issues [13, 16]. Under impetus of this tendency, traditional mental health services have focused on establishing special health-care units. Despite the deinstitutionalization movement, community-based services for people with ID and mental health problems are still scarce [17]. This observation could explain why it is more difficult to make the QOL paradigm operational for this population and its care system than for support systems in which concepts as inclusion and participation are more obvious.

1.3. Quality of Life in Persons with ID and Mental Health Problems. Despite a high number of studies on QOL in people with an ID, few empirical studies specifically tackled QOL of people with ID and mental health problems. Yet, the coexistence of ID and mental health problems can have far-reaching effects on the person’s daily functioning and QOL. In this respect, adequate support is a challenge, as Došen and Day [18] argue for an integration of medical, psychotherapeutic, behavioural, cognitive, milieu, and pedagogical treatment methods to enhance QOL. Because of this complexity, the application of the QOL paradigm is not self-evident, although there seems to be consensus about the fact that the same domains are relevant for all persons, including this specific subpopulation. As very few studies exist on QOL for people with an ID and mental health problems, we aimed to explore how the eight-domain QOL construct by Schalock et al. [6] can be operationalized for persons with ID and mental health problems. This leads to the following research questions:

(1) Are the QOL dimensions conceptualized in the model of Schalock et al. [6] applicable for persons with ID and mental health problems?
(2) What are indicators relating to the above-mentioned dimensions in relation to persons with ID and mental health problems?

2. Method

2.1. Participants. The study [19] took place in Flanders, the Dutch-speaking Northern part of Belgium. A partnership amongst three organizations in the support system for people with ID and mental health problems was developed. The Flemish support systems consist of two distinct care systems, which evolved separately: mental health care on the one hand and the care and support system for people with ID on the other hand. Historically, people with ID were supported within mental health care settings (starting from the idea that “intellectual disability” was a mental health problem), but from the 1960s onwards, a separate support system for people with disabilities has emerged. This shift, however, resulted in people with ID and mental health problems frequently falling “between the gaps” [20]. While mental health care stated that “people with disabilities” have to be supported within the care system of people with disabilities, this latter care system claimed that the treatment of people with mental health problems is the responsibility of mental health care [21]. Nowadays, professionals in both systems attempt to collaborate within continuums of care, although both systems still exist in their own right. This study tried to involve
caregivers of both care/support systems. On the one hand, two observation and treatment units for people with ID within mental health care participated in the study. On the other hand, a unit for people with ID and mental health problems within a service center for people with ID was involved.

In these services, participants were selected by purposeful sampling [22] and were contacted by the employees of these organizations. The sample consisted of persons from the natural network (n = 7) and representatives of the professional network (staff members) (n = 10) of people with ID and mental health problems. To achieve a heterogeneous sample of participants, a number of parameters were taken into account: gender, age, place of residence of the client (mental health care or support system for people with ID), type of mental health problems, and level of ID.

2.2 Instruments. Focus groups were organized to gather qualitative data. The first focus group consisted of four mothers, two fathers, and one stepmother, who were all closely involved with their family members with ID. The second focus group consisted of professionals who were employed in the three facilities represented in this research: three staff members of both the psychiatric centers and four of the unit for people with ID and mental health problems within a service centre for people with ID.

The selection of the professional workers/staff was based on age, gender, years of experience (from 1 up to 30 years of experience), and their level of education. The staff members of the psychiatric centers were psychiatric nurses or educational specialists. These of the service centre for people with ID were educational specialists and one social worker.

2.3 Procedure. As a first step, the purpose of the research was explained to the participants, who were also asked to sign an informed consent form. The focus group discussions took about 90 minutes and were led by the second author of this paper, who was assisted by the fourth and fifth authors of this paper. Each focus group was organized twice. In the first focus group participants were asked to brainstorm and reflect on how they consider “Quality of Life” in general and for their family member/client in particular: “which things are important to be able to talk about a quality life for people with ID and mental health problems and for your family member in particular?” In the second focus group, the data from the first focus group were grouped into the eight domains of the QOL construct as developed by Schalock et al. [6] and were conceptualized in indicators, which turn out to be important for the research population.

2.4 Analysis. The four focus groups were audio- and video-taped and were literally transcribed. Two of the authors independently read these transcripts and identified domains/categories and indicators/themes, which guaranteed the interrater reliability. Structuring and clustering the results were primarily based on the QOL construct of Schalock et al. [6]. Statements obtained in the first focus groups were classified in those eight domains (personal development, self-determination, interpersonal relations, social inclusion, rights, emotional well-being, physical well-being, and material well-being). In the second focus groups, the participants were asked to operationalize the indicators corresponding with the eight domains.

3. Results

The first research question investigates whether the QOL dimensions, which are conceptualized in the model of Schalock et al. [6], are applicable for persons with ID and mental health problems. The results show that the participants mentioned aspects of all eight domains (personal development, self-determination, interpersonal relations, social inclusion, rights, emotional well-being, physical well-being, and material well-being) as a response to the general question of the first focus groups. Table 1 reports how frequently professional and natural network members talked about aspects from the eight domains. This reflects which domains received more or less attention.

The domains of “emotional well-being,” “interpersonal relations,” “self-determination,” and “social inclusion” were mentioned most often. “Self-determination” and “interpersonal relations” were more frequently cited by professionals, while “social inclusion,” appeared to be an important domain for families. “Emotional well-being” was mentioned most frequently by both natural and professional network members. Particularly, the domains of “rights” and “physical well-being” received less attention. In addition, compared to “emotional well-being,” “interpersonal relations,” “social inclusion”

<table>
<thead>
<tr>
<th>Domain</th>
<th>Professional workers (PW)</th>
<th>Network members (NM)</th>
<th>Total</th>
<th>Percentage of PW</th>
<th>Percentage of NM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional well-being</td>
<td>19</td>
<td></td>
<td>35</td>
<td>35,2%</td>
<td>64,8%</td>
</tr>
<tr>
<td>Interpersonal relationships</td>
<td>14</td>
<td></td>
<td>10</td>
<td>58,3%</td>
<td>41,7%</td>
</tr>
<tr>
<td>Self-determination</td>
<td>14</td>
<td></td>
<td>7</td>
<td>66,6%</td>
<td>33,4%</td>
</tr>
<tr>
<td>Social inclusion</td>
<td>7</td>
<td></td>
<td>14</td>
<td>33,3%</td>
<td>66,7%</td>
</tr>
<tr>
<td>Material well-being</td>
<td>7</td>
<td></td>
<td>4</td>
<td>63,6%</td>
<td>36,4%</td>
</tr>
<tr>
<td>Personal development</td>
<td>2</td>
<td></td>
<td>7</td>
<td>22,2%</td>
<td>77,8%</td>
</tr>
<tr>
<td>Rights</td>
<td>6</td>
<td></td>
<td>3</td>
<td>66,7%</td>
<td>33,3%</td>
</tr>
<tr>
<td>Physical well-being</td>
<td>1</td>
<td></td>
<td>1</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

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and "self-determination," also "material well-being" and "personal development" were mentioned less often.

The second research question explores which indicators are related to the mentioned domains, specifically in relation to persons with ID and mental health problems. Table 2 shows which indicators were mentioned in relation to a particular domain. The domains that were discussed most extensively ("emotional well-being," "interpersonal relations," "self-determination," and "social inclusion") and their related indicators are further elaborated in the following section.

3.1. Domain Self-Determination

3.1.1. Freedom of Choice. Both natural network and professional staff members indicated that it is important to enable persons with ID and mental health problems to choose as much as possible, albeit to the extent they can handle. In their opinion, offering a limited number of choices seems to be the best option in this respect. Giving too many choices is usually confusing and too abstract, which can lead to stress and anxiety.

"I have already noticed, if you offer a limited number of choices, she will choose. [...] But it has to be limited, otherwise she is not able to manage it anymore." (Member of the social network)

3.1.2. Freedom. Professional network members indicated that the QOL of persons with ID and mental health problems is highly impacted by measures of restricted freedom. Especially in the transition to adulthood, persons suddenly receive more freedom, which may cause problems. Sufficient support and guidance is necessary to support people in coping with this "newly gained" freedom.

"If people's verbal possibilities are sufficient and you talk about freedom profoundly, they actually feel locked up. [...] They go out a lot and do many things, but they rarely go on one's own, which give them a feeling of being locked up and restraint. In our opinion, for certain people, the quality of life is better when they live in such a regimen, but it is not their opinion." (Professional in the care system for people with ID)

3.1.3. Boundary/Limitation. Persons with ID and mental health problems seem to have difficulties with imposing limits on themselves. One of the professional workers defined this behavior as "bottomless." Nutrition, for example, seems sometimes hard to restrain. This may be caused by stress and restlessness on an emotional level. The refuge into food abuse could be seen as compensational behavior of an emotional unbalance. According to the network members, and professional staff, this seems also true for financial matters such as "buying behavior". Therefore, persons with ID and mental health problems directly and indirectly ask to apply external boundaries, which provide safety and structure. Lack of insight into the consequences of their actions may account for this need to external control.

"We also need this [restrictions], but for ourselves, we do this intrinsically, we restrict ourselves and we consider. They [people with ID and mental health problems] do not have those skills and many things are taken over [...]" (Professional in the care system for people with ID)

3.2. Domain Interpersonal Relationships

3.2.1. Social Contact, Social Network. Persons with ID and mental health problems seem to have a great need for social interaction, just like people without ID have. In practice, it is not obvious, however, to build and maintain relationships. The social network of these people is mostly limited to family, professional staff members and fellow clients when residing in support or care services. Network members indicated that they perceived their sons or daughters to be more satisfied with the relationships they have with people of the same intellectual level.

"(…) Because they ask for it. They ask: "Search me a friend!" So those people also know that their world is very small and that they are constantly looking for new contacts. It is frustrating if you do not find those people. And if you meet someone one day it often the case they, who have social disabilities to lose their friends again. Those people

<table>
<thead>
<tr>
<th>Domains</th>
<th>Operationalization by network members and professional workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal development</td>
<td>Education on the personal level, work, self-image</td>
</tr>
<tr>
<td>Self-determination</td>
<td>Independency, freedom of choice, freedom, boundary/limitation</td>
</tr>
<tr>
<td>Interpersonal relations</td>
<td>Social contacts, contact with people with the same intellectual capacities, social network, professional support, partner</td>
</tr>
<tr>
<td>Social inclusion</td>
<td>A normal life, to be accepted by others, going out/trips</td>
</tr>
<tr>
<td>Rights</td>
<td>Tailored care, general rights, privacy, children</td>
</tr>
<tr>
<td>Emotional well-being</td>
<td>Proximity, structure, appreciation, positive attention, confirmation, to be taken seriously, respecting their own pace, rest and overview, watch out for over-demanding (= asking too much)/be careful for overcharge-Affection, sociability, love, medication, nutrition</td>
</tr>
<tr>
<td>Physical well-being</td>
<td>Attention of the physician, coherence between emotional and physical well-being</td>
</tr>
<tr>
<td>Material well-being</td>
<td>Private space for living, more staff, financial and material resources, responsibility for expenses, status</td>
</tr>
</tbody>
</table>
lost interest.” (Professional in the care system for people with ID)

3.2.2. Professional Guidance. According to professional staff members, the relationship between the client and the support worker is an essential aspect of the QOL of persons with ID and mental health problem. An important issue in this respect is the large staff turnover within facilities.

“To me a major quality-killer is the high turnover within facilities, which to me, is a highly underestimated factor.” (Professional in the care system for people with ID)

3.2.3. Relationships. Clients appear to have a strong need for a long-lasting relationship. This can be explained from the desire to live “a normal life”. The accounts of professionals and natural network members underscore that persons with ID and mental health problems want to have a similar life as anyone else. In most cases, however, this is not always possible with important consequences for their QOL.

3.3. Domain Social Inclusion

3.3.1. "A Normal Life". Both caregivers and family members mention that persons with ID and mental health problems very often want to follow the example set forth by people without ID. Many of them long to having a partner, a job, a house, children, and friends.

“Take warning from the standards in society. Everybody marries, everybody get children… And we are just here, we do not have a girlfriend and we could hardly have a beloved because we should be supported in an institution.” (Professional in mental health care)

3.3.2. To Be Accepted by Others. Many persons with ID and mental health problems deal with a low self-image, as a result of, for example, experiences of failing and difficulties encountered in their environment. Family members indicate the importance of having a feeling of acceptance and of “belonging” somewhere. Because persons with ID and mental health problems often “drop out” in social activities, it is important to make sure that people feel included and accepted.

3.4. Domain Emotional Well-Being

3.4.1. Proximity. The proximity of caregivers and family members is important for the emotional well-being of persons with ID and mental health problems. This need could be attributed to the emotional restlessness that persons with ID often experience. Being surrounded by persons on whom to fall back seems to offer the necessary safety and security.

3.4.2. Structure. Family members often emphasized that persons with ID and mental health problems benefit from a structured life. Similar to proximity, structure offers a sense of certainty and predictability. One of the parents stated that structure needs to be fine-tuned with respect to the personal needs of the client.

“Structure which is considered to be “normal,” is not the structure that for instance my daughter needs. When you presents “the normal structure” to them, they try to wriggle, but it do not go “well”. It is very hard to imagine in the structure she needs for me as well (...).” (Natural network member)

3.4.3. Appreciation, Positive Attention, Confirmation, and To Be Taken Seriously. Caregivers and family members experience that the self-image of these people is positively affected when they feel appreciated and found useful by others. One of the mothers communicated the distressing point that people do not listen to her daughter, which results in a declining self-image. Paying attention to the strengths instead of the limitations is an important aspect to improve one’s QOL.

3.4.4. Respecting Their Own Pace. An important issue in the support of people with ID and additional mental health problems is to take into account the pace of the client. Often, people are confronted with too much pressure and too high expectations, which they cannot fulfill.

“She could even not manage the work in the sheltered workplace because of the pressure she experienced. Now she goes to a day care centre. She works on her own tempo. She works with people who accept her and she do not experience pressure. It goes well.” (Natural network member)

A quick accumulation of incidents has to be avoided. People need some time to cope with changes, problems, and incidents; time to get used, to adapt, and to find a way to cope, with or without support of family and/or caregivers.

3.4.5. Peaceful Time and Having an Overview. Chaos is a source of emotional restlessness and behavioral problems. Having an overview of what the day will consist of may support persons with ID and mental health problems.

“In our organization, it is intrinsically united with their problems that they function on an emotional level in which they are still looking for safety which they do not find because they had a "wrong" bond before. Thus emotionally, they struggle for independence which they could never manage. They never experience "peace" or satisfaction…” (Professional in the care system for people with ID)

3.4.6. Watch Out for Overdemanding (=Asking Too Much)/Be Careful for Overcharge. Persons with ID in general and people with additional mental health problems in particular are regularly overdemanded, because of the discrepancy between
the emotional and intellectual level of development. Over-demanding often results in mental health and behavioral problems.

3.4.7. Affection, Sociability, and Love. Persons with ID and mental health problems have a strong need for affection, sociability, love, acceptance, security, and safety.

3.4.8. Medication. The positive effects of medication on the well-being of people may not be underestimated but only in a proportioned and considerate way.

4. Discussion

The aim of this study was twofold. First we wanted to evaluate the relevance of the QOL dimensions as conceptualized in the model of Schalock et al. [6] for persons with ID and mental health problems according to family members and support workers. Second, we wanted to explore specific indicators related to the eight dimensions in relation to persons with ID and mental health problems. We conducted this study based on the eight-domain QOL conceptual model that has both etic (universal) and emic (cultural bound, related to specific life events or circumstances) properties [10].

In regard to the first question, this study confirms the relevance of the eight-domain conceptual QOL model. All domains were quoted spontaneously, which argues for the multidimensionality and universality of the construct. As all domains were reported in the focus groups, the eight-domain conceptual model is a valid model in QOL-assessment for persons with ID and mental health problems. Nevertheless, some domains were more quoted than others. The most common domains reported by professional workers were emotional well-being, interpersonal relationships, and self-determination. The domains reported most by network members were emotional well-being, social inclusion and interpersonal relationships. These results confirm the assumption that QOL may vary in relative value and importance. The relative importance of the domain emotional well-being in persons with ID and mental health problems can be explained by the vulnerability in emotional (and not only intellectual) development. People with ID and mental health problems are at risk because of the discrepancy between cognitive and emotional development [14]. Because the environment of people with ID predominantly addresses the easily perceptible cognitive development instead of the lower and masked emotional development, there is a risk to overestimate and overcharge people with ID.

With regard to the second question, we evaluated how family members and support workers operationalize the different domains for people with ID and mental health problems. This part of the study revealed some interesting and creative responses which gave on the one hand insight in the specificity of this population and on the other hand offered some clues for support strategies. On the level of self-determination family members and support workers argue for own—but limited—choices. Another important observation is that the clear plea for freedom does not conflict with a certain amount of regulation. Furthermore, indicators on interpersonal relationships and social inclusion (social contacts, social network, support, integration, and participation) turn out to be less specific. Finally, the domain on emotional well-being was indicated most. Its interpretation in indicators (e.g., nearness, structure, positive attention, respecting own pace, watching out for over-demanding/overcharge) encourages reflection and needs to be considered as needs in the support plans of those vulnerable clients.

The authors put forward two major implications to the field from the data reported in this paper.

First, the QOL construct has universal properties and is on the level of domains the same for all people. This framework supports the equality of persons, which is reflected by concepts including self-determination, emancipation, inclusion and empowerment.

Second, the presented challenges and difficulties with regard to the QOL of persons with ID and mental health problems clearly illustrate the difficult task natural and professional network members have to fulfill when supporting their family members and clients. The fact that it is not evident to cope with these challenges may lead to a wrong application of QOL principles, albeit with the best intentions. We would like to discuss two potentially harmful consequences that—in our opinion—can be situated on a continuum of extreme control and elimination of all risks on the one hand and a “laisser faire, laisser passer” attitude on the other hand.

The concept of “duty of care” as expressed by many service providers is often used as a rationale for eliminating risks and therefore inhibits a person-centered approach [23]. This leads to a “bounded empowerment” where clients are supported in independence as long as it fits within the boundaries of health and safety [24]. To the authors’ view, an integrative support paradigm offers a framework to consider the concepts of person-centered approach with opportunities for “risk-taking” and “real” empowerment as essential elements of a holistic view on supporting clients with ID and mental health problems [25]. Support staff should reflect on the individual pathology discourse people are put in and the way in which this inhibits opportunities in making choices and having control [24]. Instead of questioning the relevance of the QOL domains in people with ID and mental health problems, it seems important to reflect on what is needed and what is working in the areas of QOL [26].

On the other hand, because of the importance of issues with regard to the social-emotional development, structure, control, and predictability may not be considered as negative “an sich”. On the contrary, these regulating measures may improve one’s QOL. It goes without saying, however, that this may not be used as an excuse to take over all responsibilities of persons with ID and mental health problems.

There are some limitations in this study. First, although this study was the result of a partnership between three organizations, the results of the focus groups cannot be generalized due to the limited sample size. Second, the clients’ perspectives about their own QOL are not reported in this paper. They are part of another study and will be published in the future.
Based on the results of this study, we can conclude that the natural and professional network members are challenged to look for the most appropriate support strategies that lead to an improvement in the QOL of their family members or clients with ID and cooccurring mental health problems. There is, however, a real risk that the QOL principles are not properly applied, which could lead to an elimination of risks and the use of empowerment within very limited contexts on the one hand or a “laisser faire, laisser passer” attitude that lacks the necessary structure and predictability on the other hand. When both aspects of empowerment and control are used in an integrated manner, the application of the QOL paradigm could lead to positive outcomes concerning self-determination, interdependence, social inclusion, and emotional development.

Acknowledgments

The authors would like to thank the participating family/network members of persons with ID and mental health problems and also the professionals who are employed in the three facilities represented in this research.

References


Therapeutic Communities for Addictions: A Review of Their Effectiveness from a Recovery-Oriented Perspective

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Received 28 October 2012; Accepted 9 December 2012

Academic Editors: V. Di Michele, S. M. Dursun, and T. Shioiri

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Therapeutic communities (TCs) for addictions are drug-free environments in which people with addictive problems live together in an organized and structured way to promote change toward recovery and reinsertion in society. Despite a long research tradition in TCs, the evidence base for the effectiveness of TCs is limited according to available reviews. Since most of these studies applied a selective focus, we made a comprehensive systematic review of all controlled studies that compared the effectiveness of TCs for addictions with that of a control condition. The focus of this paper is on recovery, including attention for various life domains and a longitudinal scope. We searched the following databases: ISI Web of Knowledge (WoS), PubMed, and DrugScope. Our search strategy revealed 997 hits. Eventually, 30 publications were selected for this paper, which were based on 16 original studies. Two out of three studies showed significantly better substance use and legal outcomes among TC participants, and five studies found superior employment and psychological functioning. Length of stay in treatment and participation in subsequent aftercare were consistent predictors of recovery status. We conclude that TCs can promote change regarding various outcome categories. Since recovering addicts often cycle between abstinence and relapse, a continuing care approach is advisable, including assessment of multiple and subjective outcome indicators.

1. Introduction

Drug addiction is a complex mental health problem that is often associated with difficulties in various life domains such as unemployment, homelessness, relational conflicts, problems with the courts, and psychiatric comorbidity [1, 2]. While some of these problems certainly evolve from the abuse of substances, many eventual addicts suffer from these problems prior to the onset of their drug use [3]. In both cases, drug addiction has generally been treated as an acute condition during brief episodes of residential care or several months of outpatient treatment, where the primary if not exclusive focus has been on abstinence to the exclusion of other concerns [4]. In contrast, addiction is increasingly regarded as a chronic relapsing disorder where recovery is possible [5], but often the one that requires intensive or even multiple treatment episodes and/or strong personal or community resources. A continuing care approach is needed to initiate and maintain recovery [6, 7]. The recovery movement focuses on individuals’ perceived needs and objectives and sees abstinence as a potential resource, but not as a prerequisite, for recovery [8–10]. A recovery-oriented approach in addiction research implies attention for the evolutions on various life domains and individuals’ subjective...
well being as well as the adoption of a longitudinal perspective to understand the complexity of individuals’ substance use careers and recovery processes [11].

A wide range of treatment and support services are available for persons with alcohol or drug addiction problems: detox programs, drug-free outpatient treatment, methadone maintenance therapy, long-term residential treatment programs, and harm reduction services. Therapeutic communities (TCs) for addictions, also called drug-free or concept TCs, aim at the reinsertion into society of former drug addicts and were one of the first specialized treatment initiatives for individuals with addiction problems, that evolved outside—and often in reaction to—the traditional mental health care. The TC history dates back to Synanon, a self-supporting community of ex-addicts founded in 1958 in Santa Monica (California) [12]. A TC can be defined as “a drug-free environment in which people with addictive problems live together in an organized and structured way to promote change toward a drug-free life in the outside society” [13]. Until the mid-1980s, TCs had a predominant position in most Western addiction treatment systems, but due to the drug and HIV epidemic larger scale harm reduction initiatives (e.g., methadone maintenance, needle exchange programs) became the central focus of most West European drug policies. Despite the long-standing and worldwide availability of TC treatment, TCs were criticized for their drug policies. Despite a long research tradition in TCs [21, 22], the evidence base for the effectiveness of TCs is limited according to the prevailing Cochrane hierarchy of scientific evidence [23]. Available reviews have been biased by a selective focus on some types of TCs or study designs and a predominant focus on drug abstinence. The frequently cited Cochrane review by Smith and colleagues [23] only included randomized trials, while random group allocation appeared to be either not feasible (i.e., significantly higher drop-out among controls) or advisable (i.e., motivation and self-selection are considered to be crucial ingredients of the treatment process) in several studies [24, 25]. Consequently, this meta-analysis included some studies without true randomization and excluded a large number of good quality quasi-experimental studies. A recent review by Malivert and colleagues [26] left out studies on prison TCs, while this type of modified TC has been the most frequently studied TC model during the last decade. Moreover, abstinence and treatment completion were the sole outcome measures in this study. Finally, the meta-analysis by Lees and colleagues [27] can be regarded as outdated, as it does not include any published study since 1999.

Since sound scientific evidence is needed to inform service users, treatment providers, and policy makers about TCs’ potential to promote recovery, the aim of this paper is to review the effectiveness of TCs for addictions, based on a comprehensive systematic review of available randomized and nonrandomized controlled studies. The paper is limited to studies with a controlled design, as these are robust study designs that generate a high level of evidence. Also, nonrandomized studies were included, since the number of randomized studies was very small (n = 5) and true randomization was compromised in several studies. Given the focus on recovery, a range of outcome measures—apart from abstinence—will be evaluated and a long-term outcome perspective will be applied, including an assessment of the influence of afercare or continuing support.

2. Methods

This narrative review focuses on controlled studies (randomized trials as well as quasi-experimental designs) of therapeutic communities for addictions. We opted for a narrative review instead of a meta-analysis, given the heterogeneity of the study methodologies and the variety in data reporting. Studies were eligible if they met the following inclusion criteria.

(i) Intervention: therapeutic communities for the treatment of drug addiction that are long-term hierarchically structured (residential) educational environments, where former drug users live together and work towards recovery, and which are based on self-help and mutual help principles [12, 21].

(ii) Target population: adults addicted to illegal drugs (mostly heroin, cocaine, or amphetamines), often in combination with an addiction to other (legal) substances (e.g., alcohol, prescription drugs). Studies including persons with comorbid psychiatric disorders were eligible, if all study participants had a drug addiction.

(iii) Outcome measures: at least one of the following (nonexhaustive) list of outcome measures was reported: substance use (illicit drug use, alcohol use), length of stay in treatment (retention, treatment completion/drop-out), employment status, criminal involvement, health and well being, family relations, quality of life, treatment status, mortality, and so forth. Objective (describing the actual situation) and
subjective (indicating individuals’ personal perspective) indicators were considered, as well as self-report measures, biological markers, and administrative data.

(iv) Study design: randomized controlled trials and quasi-experimental studies that have compared prospectively residents that followed TC treatment with a control group that was treated in a usual care setting (“treatment as usual”/standard of care) or another type of TC (e.g., shorter program/day TC) or with a control group out of treatment (e.g., in prison/waitlist controls). Studies needed to report findings on TC outcomes separately from these of other types of interventions (e.g., aftercare).

Available reviews and meta-analyses were not included, but all studies selected for the reviews were screened based on the aforementioned inclusion criteria. Studies that did not focus on TC treatment, but on another type of residential care, were excluded from the paper. If several publications concerned the same baseline sample and study design, these publications were regarded as one single study.

2.1. Search Strategy. We searched the following databases: ISI Web of Knowledge (WoS), PubMed, and DrugScope, up to December 31, 2011. There were no language, country, or publication year restrictions. Search strategies were developed for each database, based on the search strategy developed for ISI Web of Knowledge, but were revised accordingly to take into account differences in controlled vocabulary and syntax rules. The key words we searched for were “therapeutic communit*” AND “drug” or “addict” or “dependen” or “substance use” AND “outcome” or evaluation or follow-up or effectiveness.” The reference lists of retrieved studies and of available reviews were checked for relevant studies. In addition, the index of the International Journal of Therapeutic Communities, a specialized peer-reviewed journal on therapeutic communities and other supportive organisations, was screened for relevant publications.

Our search strategy revealed 997 hits, which resulted in a first selection of 185 records, based on title and abstract (see Figure 1). Thorough analysis of these abstracts by two independent reviewers (Mieke Autrique and Wouter Vanderplasschen) led to the selection of 46 studies.

In addition to the database search, conference abstracts of European Federation of Therapeutic Communities (EFTC), World Federation of Therapeutic Communities (WFTC), and European Working Group on Drugs Oriented Research (EWODOR) conferences and the grey literature were scanned for relevant (un)published studies. We made a search of the registry of ongoing clinical trials to identify any ongoing RCTs. In case a publication could not be tracked through the Ghent University online library system, the study authors were contacted for a copy of the original manuscript. Finally, TC experts in various countries as well as the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) national focal points were contacted to retrieve additional (un)published or ongoing studies that have assessed the effectiveness of TCs for addictions.

2.2. Study Selection. In total, 46 controlled studies were identified (28 based on the previously mentioned search strategy and 18 additional titles were selected based on the reference lists of selected studies and available reviews). After reading the full texts of these articles, 16 studies were excluded, because only in-treatment outcomes were reported (n = 1), because the treatment provided was not in line with the TC definition we put forward (n = 1), or because the study design was deemed not a controlled design (n = 8). Four studies were excluded as they concerned secondary analyses of previously published data, usually with a focus on a specific subsample. Two studies did not compare TC treatment with a control intervention but rather compared outcomes related to specific client characteristics.

2.3. Data Extraction and Analysis. Two reviewers (Mieke Autrique and Wouter Vanderplasschen) extracted data on the characteristics and results from the selected studies into a large summary table (cf. Table 1). The following study characteristics were extracted: (1) author, country (state), and year of publication; (2) type of study design and timing of follow-up measurements; (3) inclusion criteria and characteristics of the study participants + attrition rates at follow-up; (4) type of TC (including length of treatment) and type of control condition; and (5) outcome categories: retention and completion rates, substance use outcomes (drug and alcohol use), criminal involvement, employment, and other outcomes like health status, housing situation, and a column including determinants/correlates of abstinence/retention. Findings from studies including multiple follow-up assessments were grouped and numbered accordingly (cf. Table 1). We compared reported outcomes in various categories at all reported follow-up moments post treatment (cf. Table 2.). In this summary table, “+” indicates a significant difference regarding the outcome category in favor of the experimental condition, while “=” indicates a significant difference in favor of the control group. “=” means that no significant between group differences were reported; alternatively text can be rephrased as follows: that no significant differences were reported between the experimental and the control group.

3. Results

Based on our review of controlled studies of TC effectiveness, we identified 30 publications that included a longitudinal evaluation of TCs for addictions and applied a prospective controlled study design (cf. Table 1). These 30 publications are based on—in total—16 original studies, since several articles referred to the same (large) study and/or to various measurements regarding one single study (e.g., the Delaware study (no. 7) by Inciardi and colleagues [28–32]; the Amity prison study (no. 8) by Prendergast and colleagues [33–35]). Thorough methodological screening revealed that only five studies could be regarded as truly randomized (cf. Table 1), since in most studies the random group allocation process was compromised at some point [25, 36] or was not possible/advisable at all [24, 37, 38]. The methodological quality of the studies varied but was often rather poor due to high attrition rates, lack of objective verification of study
Records identified through database searches 
(n = 997)
- WoS: 968
- PubMed: 5 (add. records)
- DrugScope: 24 (add. records)

Records screened based on title and abstract 
(n = 154)
- WoS: 133
- PubMed: 5 (add. records)
- DrugScope: 16 (add. records)

Controlled studies 
Full texts assessed for eligibility 
(n = 46)
- WoS: 24
- PubMed: 2 (add. records)
- DrugScope: 2 (add. records)
- Reference lists: 18

Records excluded 
(n = 139)

Eligible studies 
(n = 30)

Excluded studies (n = 16)
- Not a controlled design: n = 8
- No comparison of two interventions: n = 2
- Only in-treatment outcomes: n = 1
- Intervention ≠ TC treatment: n = 1
- Secondary analysis of previously published data: n = 4

Records added based on search of reference lists 
(n = 31)

Figure 1: Flowchart of the search process and number of studies retained/excluded in each phase.

findings, and a focus on one single study site (cf. Table 1). The oldest controlled studies date back to the beginning of the 1980s [39–41]. The bulk of studies has been carried out/published in the 1990s. All controlled studies have been performed in the United States. Despite a growing research tradition in Europe, Australia, and South America, only observational uncontrolled studies have been carried out on these continents.

The follow-up period in most controlled studies is between 6 and 24 months, and only three studies have followed participants for more than 36 months. Study outcomes may vary according to the follow-up moment [24, 25, 33], but usually the magnitude of the difference(s) between the experimental and control group diminished over time (cf. Table 2). Overall, great within-group reductions in problem severity were observed between baseline and follow-up assessments, in particular regarding drug use, criminal involvement, and employment. The two outcome measures that were assessed in most studies are “substance use” and “criminal involvement.” All included studies reported at least one outcome measure in one of both categories. Eight out of 13 (note that this number is lower than 16, as not all studies reported outcomes concerning all categories) studies reported at least one positive significant difference between
the TC and control group regarding legal outcomes at the one-year follow-up, while 9/14 studies found significantly better substance use outcomes among the TC group at that time (cf. Table 2). All studies included multiple outcome indicators (also within one category), but only one study succeeded to find several significant, positive outcomes regarding most legal outcome measures (i.e., reincarceration rate, days to first illegal activity/incarceration, and length of prison sentence) [34]. Most studies found only one significant between group difference per category (e.g., time to drug relapse), while other outcome indicators within this category did not differ between groups (cf. Table 1). Significantly better outcomes in one category (e.g., substance use, criminal involvement) are not necessarily accompanied by improved outcomes on other domains (e.g., employment, psychological health). Only four studies found significant differences regarding three or more outcome categories [24, 32, 42, 43].

### 3.1. Treatment Retention, Health, and Social Functioning

As opposed to all other outcome categories, TC participants scored worse in comparison with controls on treatment retention/completion. Only two studies showed higher retention rates for the TC group, while three studies found significantly worse completion rates among TC-participants, and six studies found non-significant between group differences, mostly in favor of the control condition (cf. Table 1). Substantial drop-out has been observed in most long-term TC programs, especially in the early phases of treatment [48]. Studies that have compared longer and shorter TC programs usually found lower completion rates in longer and more intensive programs [38, 51].

Five out of six studies that have reported employment outcomes found significantly better employment rates among TC participants. Also, five studies (out of 7) showed superior outcomes on psychological symptoms, as compared with controls. Other outcomes that were studied are risk behavior ($n = 1$) and family and social relations ($n = 2$), which were found to be better in two studies [32, 48].

### 3.2. Substance Use Outcomes

Although TC participants had at some point posttreatment better substance use outcomes than controls in 10 studies, substance use levels varied greatly and overall, between 25% and 55% of the respondents relapsed to drug use after 12 to 18 months. Some studies found very low initial relapse rates (e.g., 4% [38], 9% [42] and 15% [43]), while others found much higher relapse rates (e.g., 53% [34] and 69% [29]). Usually, time to relapse was longer among TC participants [52]. One of the few controlled studies that followed prison TC-participants up to three years after their release found a relapse rate of 77% in the TC and 94% in the control condition [29]. Lower relapse rates were usually associated with longer treatment exposure (length of stay in treatment/retention) [24, 31, 39, 41, 52] and participation in subsequent treatment or aftercare [32, 35]. Treatment drop-out and relapse after treatment were predicted in at least two studies by the severity of substance use at baseline [28, 38].

### 3.3. Legal Outcomes

The majority of studies found a positive impact of TC treatment on diverse legal outcomes, such as recidivism, rearrest, and reincarceration. Recidivism rates (self-reported criminal involvement) of TC participants after one year are usually around 40%–50% [19, 31], as well as rearrest rates [29, 44], although one study reported a rearrest rate of only 17% 18 months after the start of TC treatment [42]. Reincarceration rates 12 to 18 months after release are between 30% and 55% in most studies, although Sacks and colleagues have reported clearly lower rates (19% and 9%, resp.) in two studies [19, 36]. Long-term follow-up measurements of prison TC participants indicate rearrest rates of 63% after three years [29] and 80% after five years [44] and reincarceration rates of over 70% after 5 years [33, 44]. Again, time to reincarceration was lower in the TC group and treatment completion and/or time in treatment predicted absence of recidivism [28, 31, 33, 36, 42, 49]. Treatment completion was found to be associated with (older) age, single (instead of poly) drug dependence and being on parole [42].

### 3.4. Long-Term Outcomes and Outcome Predictors

Six controlled studies have investigated the outcomes of TC participants in comparison with controls beyond a period of 12 to 18 months (cf. Table 2). Five of these studies show significantly better legal outcomes in favor of the TC group, while only three studies could demonstrate significantly lower levels of illegal drug use two years after TC treatment. One of these studies [40] found a higher prevalence of alcohol problems among TC participants at the two-year follow-up, when compared with controls who only followed a short detoxification period.

Several studies have identified correlates of relapse and recidivism after TC treatment. Participation in aftercare [28, 35, 44], posttreatment employment [37], and older age [28, 33] were found to be the most common predictors of abstinence and absence of rearrest (cf. Table 1). The effectiveness of completing treatment was shown in several studies, as TC + aftercare completers had better outcomes than aftercare drop-outs, who had in turn better outcomes than TC completers and TC drop-outs [33, 35]. Martin and colleagues [32] even found no differences between inmates who followed in-prison TC treatment without subsequent aftercare and controls who received usual work release. Relapse to drug use is often associated with reoffending and reincarceration [46].

### 3.5. Type of Controls and TC Modalities

Eleven studies have compared TC treatment with some form of usual care (e.g., case management, standard treatment, and probation), and five studies compared one type of TC with another form of TC treatment (modified versus standard TCs, or short versus long TC programs). In the latter case, the longest/most comprehensive TC program was regarded as the experimental condition, while the shorter/least intensive program was seen as the control condition. Only three comparisons of longer and shorter TC programs yielded significantly better substance use outcomes at the first follow-up moment [25, 41, 42], while overall few significant differences were observed in comparison with other TC modalities. Two studies found better employment outcomes compared with lower intensity TC models, and one study found fewer
<table>
<thead>
<tr>
<th>Authors</th>
<th>Study design + measurement(s)</th>
<th>Participants</th>
<th>Intervention + co=mparison group</th>
<th>Retention</th>
<th>Substance use</th>
<th>Outcome measures</th>
<th>Other</th>
<th>Correlates of relapse/abstinence</th>
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<tr>
<td>Sacks et al., 2012 (Colorado, USA) [19]</td>
<td>Prospective controlled study design (partial randomisation, since assignment ratio changed during the study) Outcomes 12 months after TC-entry</td>
<td>127 male offenders with substance use and mental disorders who participated in various types of prison Tx FU: 86.6%</td>
<td>Reentry MTC (n = 71) 6 month program Controls: parole supervision case management (n = 56)</td>
<td>SR drug offences: 37 versus 58%; reincarc. rate: 19 versus 38%; SR crim activity: 39 versus 62%; days till reincarc.: 161 versus 168</td>
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<td>Zhang et al., 2011 (California, USA) [44]</td>
<td>Prospective controlled study design (QES) Outcomes 1 and 5 years after prison release</td>
<td>798 male offenders with documented history of substance abuse FU: 100% (data from official records)</td>
<td>Prison-based TC (n = 395) 18 month program Controls: matched group of untreated inmates in nearby prison (n = 405)</td>
<td>Rearrests: 54.0 versus 47.6% (ns); reincarc.: 54.7 versus 51.9% (ns); days in prison: 79.1 versus 77.4</td>
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<td>Messina et al., 2010 (California, USA) [45]</td>
<td>Prospective randomised controlled study design Outcomes 6 and 12 months after release</td>
<td>115 female offenders with documented history of substance abuse FU: 83% after 6 months FU: 76% after 12 months</td>
<td>Gender-responsive MTC in prison (n = 60) 6 month program Controls: standard prison TC (n = 55) 6 month program</td>
<td>Months in aftercare: 2.6 versus 1.8 MTC group had higher OR (4.60∗) of successful aftercare completion No # regard. alcohol and drug ASI composite scores + self-efficacy No # in (time to) return to custody: 31 versus 45%</td>
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For example, reconviction/rearrest rates ASI scores % reincarcera-
tion For example, % homeless % psychiatric disorders quality of life family relations Which variables were correlated with improved outcomes? Greater reduction in drug use among MTC group∗, when controlling for race, employ. + marital status Return to custody less likely among MTC group, when controlling for race, employ. + living status
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</table>
| (4) Welsh, 2007 (Pennsylvania, USA) [37] | Prospective controlled study design (QES in 5 state prisons) | 708 male inmates admitted to drug Tx in prison FU: 100% (based on official records) | 5 prison TCs (n = 217) Length varied from 9 (n = 1) to 12 (n = 3) and 16 months (n = 1); controls (n = 491): 3 other types of drug Tx (drug education, outpatient Tx, self-help groups) | Lower reincarc. and rearrest rates, respectively 30% and 24% versus 41% and 34% 
Reincarc. and rearrest respectively 1.6* and 1.5* times higher among controls | Higher employ: 39.2 versus 25.9%*** |
| (5) Sullivan et al., 2007 (Colorado, USA) [46] | Prospective randomized controlled study design | 139 male inmates with substance use and other psychiatric disorders FU: 75% (82 versus 69%) | Prison MTC (n = 75) 12 month program Controls: standard mental health Tx in prison (n = 64) | Rates of any substance use: 31 versus 56%***; any illicit drug use: 25 versus 44%*; alcohol intox.: 21 versus 39%* 
Time to relapse: 3.7 versus 2.6 months* | Sign. association between relapse and committing new (non-drug) offences Increased OR for reoffending (4.2*) and reincarc. (5.8*) among persons who relapsed in substance use |
| (5) Sacks et al., 2004 (Colorado, USA) [36] | Prospective controlled study design (no true randomisation, since 51 subjects moved from one condition to another) | 185 male inmates with substance use and other psychiatric disorders FU: 75% (82 versus 69%) | Prison MTC (n = 92) 12 months Controls: standard mental health Tx (n = 93) | Lower reincarc. rates: 9 versus 33%***; no # regarding other criminal outcomes | MTC aftercare participants had superior outcomes regarding rates of reincarc.*, crim. activity* and drug-related crim activity* compared with controls 
Time in Tx predicted absence of reincarc.*** and crim activity*** |
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<th>Employment</th>
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<tr>
<td>(6) Morral et al., 2004 (Los Angeles, USA) [47]</td>
<td>Prospective controlled study design (cases assigned by probation) Outcomes 12 months after start TC program</td>
<td>449 adolescent probationers with substance abuse problems</td>
<td>MTC in prison (Phoenix Academy) (n = 175) 9 month program Controls (n = 274): alternative probation disposition (res. group homes)</td>
<td>No ≠ in program retention</td>
<td>Improved substance use outcomes on substance problem index*, density index*, and involvement scale*</td>
<td>Greater, nonsign. declines on various measures of crm involvement</td>
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<td>Greater reduction of somatic** and anxiety* symptoms</td>
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<td>(7) Inciardi et al., 2004 (Delaware, USA) [28]</td>
<td>Prospective controlled study design (group assignment by correctional staff) Outcomes 42 and 60 months after baseline</td>
<td>690 male inmates with substance abuse problems, eligible for work release</td>
<td>Work-release (transitional) TC (n = 472) 6 month program Controls: standard work release, without Tx (n = 218)</td>
<td>TC participation strongest predictor of drug-free status after 42 (OR 4.49**) and 60 months (OR 3.54***)</td>
<td>TC participation strongest predictor of absence of rearrest after 42 (OR 1.71**) and 60 months (OR 1.61*)</td>
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<td>Older age predicted drug-free** and no rearrest status**, while frequency of prior drug use predicted relapse** after 48 months No previous Tx experience predicted relapse after 60 months, while older age* and being female* predicted no rearrest TC completion associated with no rearrest and being drug free after 42 and 60 months, with superior outcomes for persons who attended additional aftercare</td>
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| (7) Martin et al., 1999 (Delaware, USA) [29]  
Prospective controlled study design (partial randomization, since KEY program autom. followed by CREST)  
Outcomes 6, 18, and 42 months after baseline (i.e., 1 and 3 years after TC period)  
428 inmates with drug abuse problems  
FU: approx. 80% | Transitional TC (CREST) ($n = 157$)  
6 month program Controls: prison TC (KEY) ($n = 38$)  
12 month program Prison TC + transitional TC ($n = 68$)  
Regular work release ($n = 165$) | 18 month outcomes | Retention, Substance use, Crim activity, Employment | 31% drug-free versus 16%* in work-release group (versus 47% in KEY + CREST group) | While greater exposure to TC Tx led to better outcomes after 1 year, at 3 years after discharge no ≠ were found between various TC modalities CREST drop-outs as likely to be rearrested as work-release group, but CREST completers++ + CREST-completers who followed subsequent aftercare+++ were least likely to be arrested CREST drop-outs more likely to be drug free than work-release group++, but CREST completers+++ + CREST-completers who followed subsequent aftercare+++ even more likely to be drug free |
| (7) Lockwood et al., 1997 (Delaware, USA) [30]  
Prospective controlled study design  
Outcomes 6 months post-release  
483 inmates with history of substance abuse  
FU: approx. 80% | Transitional TC (CREST) ($n = 193$)  
6 month program Controls: prison TC (KEY) ($n = 44$)  
12 month program Prison TC + transitional TC ($n = 34$)  
Regular work release ($n = 212$) | 42 month outcomes | OR for being drug free 8.2 times higher in CREST-group++, 7.4 times in KEY-group++, and 6.7 times in KEY-CREST group+ compared with work release group+ 23% drug-free versus 6%* in work-release group | 37% not rearrested versus 30% in work-release group after 42 months |

* | ** | +++ | ++ | + |
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<tr>
<td>(7) Nielsen et al., 1996 (Delaware, USA) [31]</td>
<td>Prospective controlled study design (QES) Outcomes after 6 and 18 months</td>
<td>689 inmates with history of substance abuse FU: 77% versus 72.6% after 6 months, FU: 58.5 versus 36.7% after 18 months</td>
<td>Transitional TC (CREST) (n = 248) 6 month program Controls: conventional work release (n = 441)</td>
<td>Sign. lower relapse after 6 (16.2 versus 62.2)*** and 18 months (51.7 versus 79%)***</td>
<td>Age, race, and gender do not affect outcomes, but length of time in program reduced relapse and recidivism rates (ns) Program completion associated with fewer relapse*** after 6 and fewer recidivism after 6*** and 18 months*</td>
</tr>
<tr>
<td>(7) Martin et al., 1995 (Delaware, USA) [32]</td>
<td>Prospective controlled study design (QES) Outcomes 6 months after release</td>
<td>483 inmates with history of substance abuse FU: approx. 80%</td>
<td>Transitional TC (CREST) (n = 176) 6 month program Controls: prison TC graduates (KEY) (n = 43) Prison TC + transitional TC (n = 32) Regular work release (n = 206)</td>
<td>Probability of being drug free the highest among CREST (0.84)*** and KEY + CREST group (0.94)***</td>
<td>No # between TC only and work release group on any of the outcome measures Longer time in (subsequent) Tx the best predictor of drug-free*** and arrest-free” status after Tx, as well as participation in a longer TC program</td>
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<td>(8) Prendergast et al., 2004 (California, USA) [33]</td>
<td>Prospective randomized controlled study design Outcomes 5 years after release</td>
<td>715 male inmates with substance abuse problems FU: 81.2%</td>
<td>Amity prison TC (n = 425) 9–12 month program Controls: no Tx condition (waitlist) (n = 290) Months receiving Tx post-release: 4.6 versus 1.7***</td>
<td>Heavy drug use past year: 24.9 versus 22.6%</td>
<td>Reincarcerated within 5 years: 75.7 versus 83.4%* Days to reincarc: 809 versus 634*** Stable job in past year: 54.8 versus 52.3% Psychologic distress: 31.8 versus 44.6</td>
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<td>(8) Prendergast et al., 2003 (California, USA) [34]</td>
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<td>715 male inmates with substance abuse problems</td>
<td>Amity prison TC (n = 425) 9–12 month program Controls: no Tx condition (waitlist) (n = 290)</td>
<td>Longer time to first drug use: 77 versus 31 days*** No ≠ in pos. drug tests (52.9 versus 61%)</td>
<td>Participation in Tx associated with more days to reincarc. Aftercare completers had the lowest reincarc rate + the longest time to first illegal activity and to reincarceration and fewer days in prison. Prison TC drop-outs had the shortest time to SR drug use (32 days), followed by TC completers (62 days), aftercare dropouts (91 days), and aftercare completers (184 days) + more pos. drug tests</td>
</tr>
<tr>
<td>(8) Wexler et al., 1999 (California, USA) [35]</td>
<td>Prospective randomized controlled study design</td>
<td>715 male inmates who volunteered for TC treatment in prison</td>
<td>Amity prison TC (n = 425) 8–12 month program Controls: no Tx condition (waitlist) (n = 290)</td>
<td>Lower reincarc rates after 12 (33.9 versus 49.7%)*** and 24 months (43.3 versus 67.1%)**** More days to reincarc after 12 (192 versus 172*) months OR for reincarc sign lower: 0.52*** after 12 and 0.63** after 24 months</td>
<td>Reincarc. rates sign lower after 12 and 24 months among TC+ aftercare completers, as opposed to persons who dropped out previously. Aftercare completion positively related to time to reincarc. + the strongest predictor of positive outcomes</td>
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<td>Greenwood et al., 2001 (San Francisco, USA) [25]</td>
<td>Prospective controlled study design (only partial randomisation, since sign. drop-out among controls before Tx start) Outcomes 6, 12, and 18 months after admission</td>
<td>261 substance abusers seeking treatment at Walden House FU: 82.4% at 6 months FU: 82.7% at 12 months FU: 82.7% at 18 months</td>
<td>Residential TC (n = 147) 12 month program Controls: day TC program (same TC, but returned home at the end of the day) (n = 114)</td>
<td>Time in program: 109.8 versus 102.7 days</td>
<td>Total abstinence after 6 (62.6 versus 47%), 12 (47.9 versus 49%) and 18 months (50.4 versus 55.2%) OR for relapse at 6 months = 3.06*, not sign. at 12 and 18 months</td>
</tr>
<tr>
<td>Guydish et al. 1999 (San Francisco, USA) [48]</td>
<td>Prospective controlled study design (only partial randomisation, since sign. drop-out among controls before Tx start) Outcomes 6, 12, and 18 months</td>
<td>188 substance abusers seeking treatment at Walden House who participated in all 3 FU-interviews</td>
<td>Residential TC (n = 99) 12 month program Controls: day TC program (same TC, but returned home at the end of the day) (n = 89)</td>
<td>No ≠ in time to drop-out (119.7 versus 108.1 days) 12 month retention in day TC: 17% versus 9%</td>
<td>Lower SCL scores at 6 <em><em><em>, 12</em>, and 18 months, lower BDI scores after 12 months</em>, higher social support scores at 18 months; lower social problem severity (ASI)</em></td>
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<tr>
<td>Guydish et al. 1998 (San Francisco, USA) [49]</td>
<td>Prospective controlled study design (only partial randomisation) Outcomes at 6 months</td>
<td>261 substance abusers starting treatment at Walden House FU: 82.4% at 6 months</td>
<td>Residential TC (n = 114) 12 month program Controls: day TC 12 month program (n = 147)</td>
<td>Tx adherence after 6 months: 29 versus 34% in day TC; Time in Tx: 109.8 versus 102.7 days</td>
<td>Lower ABI severity scores for social* and psychological problems**</td>
</tr>
</tbody>
</table>
Table 1: Continued.

<table>
<thead>
<tr>
<th>Authors</th>
<th>Study design + measurement(s)</th>
<th>Participants</th>
<th>Intervention + comparison group</th>
<th>Retention</th>
<th>Substance use</th>
<th>Crim activity</th>
<th>Employment</th>
<th>Other</th>
<th>Correlates of relapse/abstinence</th>
</tr>
</thead>
<tbody>
<tr>
<td>(10) Nemes et al. 1999 (Washington, USA) [42]</td>
<td>Prospective, randomised controlled study design Outcomes 18 months after admission</td>
<td>412 substance users seeking Tx at a central intake unit FU: 93%</td>
<td>Standard TC (n = 194) 12 month program (10 months inpatient, 2 outpatient) Controls: abbreviated TC (n = 218): 12 month program (6 month inpatient, 6 month outpatient + extra services)</td>
<td>Completion rates: 33 versus 38% (ns), and similar time in Tx (8.2 versus 8.6 months)</td>
<td>Lower SR heroin use: 9 versus 15%*</td>
<td>Lower rearrest rates: 17 versus 26%** + longer time to arrest (9.4 versus 6.9 months)*</td>
<td>Employment rate higher in standard TC: 72 versus 56%**</td>
<td></td>
<td>Lower heroin and cocaine use levels + lower rearrest rates among treatment completers versus noncompleters Positive cocaine tests were associated with premature Tx drop-out Treatment completion was predicted by age, single heroin dependence, and parole status</td>
</tr>
<tr>
<td>(11) De Leon et al, 2000 (New York, USA) [24]</td>
<td>Prospective controlled study design (QES: sequential group assignment) Outcomes 12 and on average 24 months after baseline</td>
<td>342 homeless mentally ill substance abusers FU: 68% at 12 months FU: 82% at latest FU</td>
<td>MTC1 for homeless persons (n = 183) 12 month program MTC2: lower intensity, flexible program (n = 93) 12 month program Controls: treatment as usual (n = 66)</td>
<td>12 months</td>
<td>MTC2 had less alcohol intox* + fewer illegal drug use** + used less substances** than TAU No # between MTC1 or MTC2 and TAU MTC1*** and MTC2*** more likely to be employed than TAU MTC1** and MTC2*** more likely to be employed than TAU MTC2 had less symptoms of depression*** and anxiety* than TAU</td>
<td>No # between MTC1 or MTC2 and TAU regard. HIV risk behavior and psychological dysfunctions</td>
<td></td>
<td>MTC2 improved more on several outcomes measures than MTC1 MTC completers scored sign better than MTC drop-outs and TAU</td>
<td></td>
</tr>
</tbody>
</table>
### Table 1: Continued.

<table>
<thead>
<tr>
<th>Authors</th>
<th>Study design + measurement(s)</th>
<th>Participants</th>
<th>Intervention + comparison group</th>
<th>Outcome measures</th>
<th>Correlates of relapse/abstinence</th>
</tr>
</thead>
<tbody>
<tr>
<td>(11) French et al., 1999 (New York, USA) [50]</td>
<td>Prospective controlled study design (QES: sequential group assignment) Outcomes at last FU-point (on average 24 months after baseline)</td>
<td>342 homeless mentally ill substance abusers FU: 82%</td>
<td>MTC for homeless persons (n = 228) 12 month program Controls: treatment as usual (n = 53)</td>
<td>No ≠ regard, substance use outcomes</td>
<td>Fewer criminal activity** Better employm. outcomes (ns) Lower scores on BDI*, no ≠ regard. other psychological symptoms or risk behavior</td>
</tr>
<tr>
<td>(12) Nuttbrock et al., 1998 (New York, USA) [38]</td>
<td>Prospective controlled study design (QES, as allocation based on availability + client preference) Outcomes 12 months after start Tx</td>
<td>290 homeless men with major mental disorder and history of substance abuse FU: not reported</td>
<td>Modified TC (n = 169) 18 month program Controls: 2 homeless community residences (n = 121) 18 month program</td>
<td>43% stayed 6 months in TC (versus 55%); 25% stayed 12 months (versus 37%)</td>
<td>Time to drug use not ≠ between TCs and than MTC Stronger effect of long TC versus short TC and MTCs regarding legal problems</td>
</tr>
<tr>
<td>(13) McCusker et al., 1997 (New England, USA) [51]</td>
<td>Prospective controlled study design (no real randomisation, since ≠ interventions at both study sites) Outcomes 3 months after discharge and 18 months after admission</td>
<td>539 drug abusers entering residential Tx at 2 sites FU: 86% after 18 months</td>
<td>Traditional TC program (6 (n = 86) and 12 month alternative (n = 75)) Controls: MTC program (relapse prevention) 3 (n = 192) and 6 month (n = 186) alternatives</td>
<td>Time to drug use not ≠ between TCs and than MTC Stronger effect of long TC versus short TC and MTCs regarding legal problems</td>
<td>Effect of TC on employm. stronger than in MTC*</td>
</tr>
</tbody>
</table>

*Significant at the 0.05 level.
**Significant at the 0.01 level.
<table>
<thead>
<tr>
<th>Authors</th>
<th>Study design + measurement(s)</th>
<th>Participants</th>
<th>Intervention + comparison group</th>
<th>Retention</th>
<th>Outcome measures</th>
<th>Correlates of relapse/abstinence</th>
</tr>
</thead>
<tbody>
<tr>
<td>(13) McCusker et al., 1996 (Massachusetts, USA) [52]</td>
<td>Prospective randomized controlled study design</td>
<td>444 drug abusers entering one residential Tx facility</td>
<td>Long MTC (n = 221) 6 month program Controls: short MTC (n = 223) 3 month program</td>
<td>Program completion: 30% versus 56% in short TC program</td>
<td>Relapse to drug use in first week after leaving Tx: 33% versus 70%* No group ≠ in heroin or cocaine use</td>
<td>Greater improvement in levels of depression among persons staying &gt;80 days in TC*** Length of stay in TC** + program completion pos. associated with levels of precontemplation Persons staying &gt;80 days in TC had lower drug use***</td>
</tr>
<tr>
<td>(13) McCusker et al., 1995 (New England, USA) [53]</td>
<td>Prospective controlled study design</td>
<td>628 drug abusers entering residential Tx at 2 sites</td>
<td>Traditional TC program (6 (n = 97) and 12 month (n = 87) alternative) Controls: MTC 3 (n = 223) and 6 month program (n = 221) 40 day retention: respectively, 70, 85, 73, and 72%; Tx completion: respectively, 33, 21, 56, 30% (ns ≠ in 4 groups)</td>
<td>Relapse: 50% in TC versus 44% in MTC No ≠ in number of days of drug use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(14) Hartmann et al. 1997 (Missouri, USA) [43]</td>
<td>Controlled study design (QES, self-selection for exp. intervention)</td>
<td>286 male offenders with a history of substance abuse No information on FU-rate</td>
<td>Prison TC graduates (n = 161) No information on program length Controls: comparison group of eligible persons who did not attend prison TC (n = 125)</td>
<td>No substance abuse: 67.4 versus 62% (ns) No arrest: 85.4 versus 72%** Reincarc.: 16.4 versus 27.6*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(15) Bale et al., 1984 (California, USA) [39]</td>
<td>Prospective controlled study design (only partial randomization due to substantial drop-out after group allocation)</td>
<td>363 male veterans addicted to heroin entering withdrawal Tx</td>
<td>3 TCs (n = 181): standard TC (n = 25) + two MTCs (n = 77 and n = 79) 6 month programs Controls: 5-day withdrawal Tx (n = 166)</td>
<td>Mean TIP longer in TC 1 (10.4 weeks) and TC3 (11.5 weeks)* than in TC2 (6.0 weeks)</td>
<td>No heroin use: 40, 48.1, and 35.4% versus 33.3% of controls; No other illegal drug use: 40, 41.6, and 53.3%* versus 39.3% of controls More alcohol problems: 40, 47.3* and 30.8% versus 22.4% of controls No conviction: 44%, 32.5 and 59.5%** versus 31.3% of controls Employed/attending school: 48%, 46.8 and 51.9%** versus 34% of controls Mortality: 1.7% in TCs versus 6.6% among controls</td>
<td></td>
</tr>
</tbody>
</table>

(*) = p < 0.05 ** = p < 0.01 *** = p < 0.001
<table>
<thead>
<tr>
<th>Authors</th>
<th>Study design + measurement(s)</th>
<th>Participants</th>
<th>Intervention + comparison group</th>
<th>Outcome measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>(15) Bale et al., 1980 (California, USA)</td>
<td>Prospective controlled study design (as treated analyses)</td>
<td>Outcomes after 1 year</td>
<td>Veterans staying long (≥50 days) ((n = 75)) or short in TC program (&lt;50 days) ((n = 75)) Controls: MMT ((n = 59)); detox only ((n = 224)); detox + other Tx ((n = 112))</td>
<td>Retention: 1-year retention rate: &lt;5% in TC versus 74.5% in MMT Recent heroin use + any illicit drug use lower in long TC subjects (37.3 and 29.3) than in detox only-group (65.5 and 46.9)%; but not than MMT group (46.6 and 38.6%)</td>
</tr>
<tr>
<td>(29) Coombs, 1981 (California, USA)</td>
<td>Prospective controlled study design (group allocation by self-selection)</td>
<td>Outcomes 11–18 months after leaving TC</td>
<td>Long-term TC ((n = 77)) Controls: short-term TC ((n = 130)) 3 month program</td>
<td>Program completion: 63.6 versus 74.6% Total abstinence: 4.3 versus 0% Return to heroin use: 28.6 versus 53%</td>
</tr>
</tbody>
</table>

TC: therapeutic community; MTC: modified therapeutic community; SR: self-reported; QES: quasi-experimental study; Tx: treatment; TIP: time in program; BDI: Beck Depression Inventory; ASI: Addiction Severity Index; level of significance: * \(P < 0.05\); ** \(P < 0.01\); *** \(P < 0.001\).
### Table 2: Summary of the findings from the selected studies (n = 16).

<table>
<thead>
<tr>
<th>Reference number of the study/studies</th>
<th>Type of TC</th>
<th>Comparison condition</th>
<th>Followup length</th>
<th>Outcome measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Sacks et al., 2012 [19]</td>
<td>Prison</td>
<td>TAU</td>
<td>1 year</td>
<td>+</td>
</tr>
<tr>
<td>(2) Zhang et al., 2011 [44]</td>
<td>Prison</td>
<td>TAU</td>
<td>1 year</td>
<td>=</td>
</tr>
<tr>
<td>(3) Messina et al., 2010 [45]</td>
<td>Prison</td>
<td>Other TC</td>
<td>1 year</td>
<td>+</td>
</tr>
<tr>
<td>(4) Welsh, 2007 [37]</td>
<td>Prison</td>
<td>TAU</td>
<td>2 years</td>
<td>=</td>
</tr>
<tr>
<td>(5) Sullivan et al., 2007 [46]</td>
<td>Prison</td>
<td>TAU</td>
<td>1 year</td>
<td>+</td>
</tr>
<tr>
<td>(6) Morral et al., 2004 [47]</td>
<td>Prison</td>
<td>TAU</td>
<td>1 year</td>
<td>=</td>
</tr>
<tr>
<td>(7) Inciardi et al., 2004 [28]</td>
<td>Prison</td>
<td>TAU</td>
<td>6 months</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 year</td>
<td>+</td>
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<tr>
<td></td>
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<td></td>
<td>3 years</td>
<td>+</td>
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<td></td>
<td>3 years 6 months</td>
<td>+</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>5 years</td>
<td>+</td>
</tr>
<tr>
<td>(8) Prendergast et al., 2004 [33]</td>
<td>Prison</td>
<td>TAU</td>
<td>1 year</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2 years</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5 years</td>
<td>=</td>
</tr>
<tr>
<td>(9) Greenwood et al., 2001 [25]</td>
<td>Community-based</td>
<td>Other TC</td>
<td>6 months</td>
<td>=</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 year</td>
<td>+</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>1 year 6 months</td>
<td>+</td>
</tr>
<tr>
<td>(10) Nemes et al., 1999 [42]</td>
<td>Community-based</td>
<td>Other TC</td>
<td>1 year</td>
<td>=</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 year 6 months</td>
<td>+</td>
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<td></td>
<td>2 years</td>
<td>=</td>
</tr>
<tr>
<td>(12) Nuttbrook et al., 1998 [38]</td>
<td>Community-based</td>
<td>TAU</td>
<td>1 year</td>
<td>=</td>
</tr>
<tr>
<td>(13) McCusker et al., 1997 [51]</td>
<td>Community-based</td>
<td>Other TC</td>
<td>6 months</td>
<td>=</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 year</td>
<td>=</td>
</tr>
<tr>
<td>(14) Hartmann et al., 1997 [43]</td>
<td>Prison</td>
<td>TAU</td>
<td>6 months</td>
<td>=</td>
</tr>
<tr>
<td>(15) Bale et al., 1984 [39]</td>
<td>Community-based</td>
<td>TAU</td>
<td>1 year</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2 years</td>
<td>+ (illicit)</td>
</tr>
<tr>
<td>(16) Coombs et al., 1981 [41]</td>
<td>Community-based</td>
<td>Other TC</td>
<td>1 year</td>
<td>=</td>
</tr>
</tbody>
</table>

TC: Therapeutic Community, Other TC: Other TC modality, TAU: Treatment As Usual.
psychological symptoms and relational problems among the higher intensity treatment group. Some studies have included multiple control conditions [29], but usually significant differences were only observed when the most intensive intervention was compared with the least intensive treatment condition.

Most controlled studies of TC effectiveness have focused on TCs in prison settings \((n = 9)\) that prepare inmates for reintegration in society, while seven studies concerned TCs in the community. Whereas a substantial number of residents enter community TCs under legal pressure, TC treatment in prison can be regarded as a different context given the compulsory custody and conditional release term and privileges. Substance use outcomes in community TCs were significantly better than those among controls in five (out of 6) studies, while legal outcomes were found to be superior in three (out of 4) studies of community TCs. On the other hand, only in four (out of 7) studies of prison TCs, the experimental group scored significantly better than the control group, and only one study could demonstrate this difference beyond the one-year follow-up assessment [28]. Six (out of 9) prison TC studies found significantly better legal outcomes among TC participants. Three studies could demonstrate these gains after two years, and two studies found these benefits maintained up to five years after prison TC treatment [28, 33].

4. Discussion

4.1. Main Findings. This narrative review was based on 16 studies that have evaluated the effectiveness of TCs as compared with other viable interventions regarding various indicators related with recovery: substance use, criminal involvement, employment, psychological well being, and family and social relations. Based on the study findings, we can conclude that there is some evidence for the effectiveness of therapeutic community treatment. Almost two out of three studies have shown significantly better substance use and legal outcomes at the first follow-up moment after treatment among persons who stayed in a TC as compared with controls. Five studies found superior employment outcomes among TC participants, while another five studies showed significantly fewer psychological problems in the experimental group. Only four studies have reported significantly better differential outcomes in at least three outcome categories. This does not mean that TC participants do not improve equally on all life domains, but these outcomes often remained unreported or the observed progress did not differ significantly from that among the control group. Several reviews [22, 26, 27, 54] have addressed the question whether TCs generate better outcomes than other interventions, often leading to conflicting and not really convincing conclusions. Although several studies included in this paper showed improved differential outcomes \([28, 33, 38, 39, 42, 50]\), these findings were observed among varying populations in diverse settings, and few studies have succeeded to replicate the findings from other studies in exactly the same conditions. Moreover, some studies \([25, 42, 45]\) have compared modified TCs with standard TCs that were not specifically adapted to address the needs of special target groups. In general, such comparisons of one type of (modified) TC with a less intensive (standard) TC model did not demonstrate much between group differences, given the strong similarities between both treatment conditions. Consequently, the main question is not whether one type of TC is better than another intervention/type of TC, but rather which persons benefit most from (what type of) TC treatment at what point in the recovery process [22]. Also, uncontrolled treatment outcome studies have repeatedly shown fairly similar effects of various types of residential treatment \([55, 56]\) and when compared with outpatient methadone treatment \([40, 57, 58]\), demonstrating that—from a longitudinal perspective—no single intervention is superior to another. Not the differential effectiveness of TCs, but rather individuals’ assets and community resources and their personal needs and goals will determine whether TC treatment is indicated on the road to recovery.

4.2. Towards a Recovery Perspective on TC Treatment. While looking beyond abstinence and desistance is warranted from a recovery perspective [8], six of the selected controlled studies did not report other than substance use and legal outcomes. Stable recovery in opiate addicts has been primarily associated with social participation and having meaningful activities and purposes in life, rather than with drug abstinence or controlled drug use [59]. Focus groups with drug users regarding their perceived quality of life revealed few specific but mostly generic aspects of QoL like well being, social inclusion, and human rights [60]. Still, a predominant focus on objective socially desirable outcome measures (e.g., work, alcohol and drug use, and recidivism) prevails in addiction research, while more subjective outcome indicators like emotional well being, quality of life, or job satisfaction have largely been disregarded [61]. Such a broad perspective is also needed in TC research, as it allows a more accurate evaluation of individuals’ personal growth and well being after TC treatment. Up to now, recovery has primarily been measured based on abstinence rates after TC treatment, while abstinence is not a synonym of nor a prerequisite for recovery [8]. Total abstinence—as required during and expected after TC treatment—appears not to be self-evident, not even after a lengthy treatment episode in a TC and subsequent continuing care. TC participants typically improve on most life domains during the first months of treatment and are usually able to maintain this status until they leave treatment [26, 48]. However, once individuals leave the TC, success rates tend to drop quickly, especially during the first month(s) after treatment. A recent review of longitudinal (mostly uncontrolled) TC studies showed that 21% to 100% relapsed into drug use six months to six years after leaving treatment [26]. We found substantial relapse rates (25%–70%) 12 to 18 months after leaving treatment, which indicate that 30% to 75% of the studied TC sample did not relapse within one year after TC treatment. Although the definition of “relapse” varied largely between studies (e.g., any substance use, illicit drug use, regular use, and last month use), relapse can be addressed in at least two different ways, depending whether one starts from an acute
or a continuing care perspective. The former approach sees relapse as a failure as treated individuals did not succeed to abstain from drug use after intensive treatment. The latter perspective acknowledges the chronic relapsing nature of drug addiction and assumes that relapse is part and parcel of the recovery process and should rather be considered as a learning moment to keep the precarious balance between abstinence and relapse [62]. Factors that may contribute to recovery are longer length of stay in the TC (retention) and participation in subsequent aftercare, since both variables have been consistently identified as predictors of improved substance use outcomes [23, 26]. Surprisingly, treatment completion was not found to be a predictor of abstinence, but it was associated with reduced recidivism rates in several studies of prison TCs [33, 36].

Treatment in TCs for addictions takes time, usually around 6 to 12 months, which heightens the possibility that residents leave prematurely [27]. Retention in (longer term) TCs is typically lower than in shorter term programs [42, 51, 55], but in general TC residents who stayed longer in treatment had significantly better outcomes than persons who dropped out early. This has led to concerns with enhancing retention through the involvement of the family and social network and the use of senior staff [63] and with promoting initial engagement through motivational interviewing, contingency management, and induction interventions [64–66]. An alternative promising way of looking at retention may be to see it as the sum of treatment episodes in different services and the accumulation of associated treatment experiences instead of defining retention as a single uninterrupted stay in one treatment program [67]. Reentry in the community appears to be a critical point after TC treatment, if not prepared adequately (e.g., by providing aftercare) or if drug users go back to their old neighborhoods [68]. Some type of continuing support is warranted after TC treatment not only to prevent relapse, but also to link with employment/training and to engage in community-based activities. Moreover, treatment discharge should be dealt with in a flexible and individualized way, since some persons will need to be further supported or to reenter the community if they are doing poorly.

The recovery movement starts from a longitudinal approach to addiction and other mental health problems [69], but few controlled studies have assessed TC outcomes beyond a two-year follow-up period. Available studies suggest that—despite a fading effect of TC treatment over time—recidivism rates continued to be significantly better than those of controls in three studies of prison TCs [28, 33, 37], while findings regarding substance use outcomes indicated fewer between group differences. The three-year follow-up outcomes of the Delaware prison study showed a 94% relapse rate among the usual care group (traditional work release) compared with a 77% relapse rate in the prison aftercare TC group [29]. These figures do not only illustrate the relapsing nature of addiction problems, but also point at the relatively poor effectiveness of treatment programs. Although robust study designs including substantial follow-up periods that are able to retain most respondents in the analyses are needed, one may not overestimate the lasting effects of one single (prolonged) treatment episode. Recovery is considered to be a lengthy process, and continuing care is needed to maintain recovery that has been initiated during, for example, TC treatment. Some studies have shown that the provision of aftercare was as or even more effective than initial TC treatment [29, 70], and the combination of TC treatment and subsequent aftercare has generated the best results [33, 71].

Finally, the study findings show that TC treatment has generated beneficial outcomes in diverse treatment settings and may have particularly strong effects among severely addicted individuals like incarcerated, homeless, and mentally ill drug addicts [22, 36, 37, 46]. Therefore, treatment in TCs should be considered as a specific intervention, reserved for drug addicts with multiple and severe problems. Although outpatient methadone maintenance therapy is the mainstream addiction treatment worldwide, therapeutic communities for addictions can be regarded as a valuable alternative for persons who do not do well in outpatient treatment due to the lack of structure and supports in the community and the fact that they live in neighborhoods that are pervasively affected by drug abuse [68]. TCs can be supportive places where clients can learn some of the internal control and refusal skills conducive to stable recovery. Motivation, social support and coping with stress without using substances appear to be key factors in successful recovery [72].

4.3. Limitations of the Paper. First, most selected studies were published in peer reviewed journals. Although the restriction of peer-review guarantees some form of quality control, it may have induced a selection bias as the likelihood of retrieving non-English language articles was limited in this way. Only results that were reported in the published papers could be included, while it was often unclear whether the nonreporting of some specific outcomes (e.g., recidivism, alcohol use) meant that this information was not collected, not analyzed, or did not yield significant findings. Second, substantial heterogeneity has been observed between the included studies, not only regarding program and setting characteristics, but also regarding sample characteristics and outcome measures. Despite the common "community as method" principle [18], TCs for addictions consist of various practices and programs with varying treatment length. Standard and modified TC programs have been evaluated in this paper, as well as TCs in prison settings and aftercare TCs. This heterogeneity should be taken into account when interpreting the study outcomes. Although the underlying elements may be fairly similar across TC programs, the dosage of the program and fidelity to the concept may have varied considerably [22, 27]. Also, types of controls varied across studies from waitlist controls to interventions that differed only slightly from the experimental group (e.g., residential/longer versus day/shorter TC programs). Another limitation is the use of varying outcome measures and instruments across studies, which further hampers the replication and generalization of the findings. Third, this systematic review was not restricted to randomized trials, although the Cochrane collaboration and other proponents...
of the evidence-based paradigm regard this type of study design as the gold standard for the evaluation of evidence of effectiveness [73]. Given the difficulties to apply this design to long-term and comprehensive multi-interventions like TCs and the low number of randomized controlled trials on the effectiveness of TCs, a comprehensive review of randomized and nonrandomized controlled studies was deemed to be of surplus value in comparison with available reviews, still generating an acceptable level of evidence [68]. Treatment drop-outs may further compromise the validity of the reported results. Several studies only included substance users who stayed for a substantial period in the TC or who completed treatment but made no intent-to-treat analysis of everyone who started TC treatment (cf. Table 1). Finally, this is a narrative review of controlled studies that does not allow to weigh the findings from different studies or to estimate effect sizes. A meta-analysis was not possible at this point, given the substantial heterogeneity between programs and the diverse outcome categories and measures that were reported in the selected studies.

5. Conclusion

Therapeutic communities for addictions can be regarded as recovery-oriented programs that produce change regarding substance use, legal, employment, and psychological well-being outcomes among drug addicts with severe and multiple problems. Despite various methodological constraints, TCs appeared to generate significantly better outcomes in comparison with other viable interventions in two out of three studies. TC programs have usually been evaluated from an acute care perspective with a primary focus on abstinence and recidivism, while a continuing care approach including multiple and more subjective outcome indicators is necessary from a recovery perspective. If residents stay long enough in treatment and participate in subsequent aftercare, TCs can play an important role on the way to recovery. Abstinence may be just one resource to promote employment or enhance personal well being which can in turn contribute to recovering addicts’ participation in community-based activities and their social inclusion.

Acknowledgments

This study was supported by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (Contract code: CT.11.IBS.057). The authors would like to thank Dr. Teodora Groshkova for her support with this comprehensive review of the outcome literature on TCs for addictions. They are further grateful to Ilse Goethals and Mieke Autrique for their preparatory work for this literature review.

References


Research Article

Experience of Wellness Recovery Action Planning in Self-Help and Mutual Support Groups for People with Lived Experience of Mental Health Difficulties

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Received 27 September 2012; Accepted 3 December 2012

Academic Editors: E. Broekaert, R. C. Rapp, and W. Vanderplasschen

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The main aim of this research was to assess the relevance and impact of wellness recovery action planning (WRAP) as a tool for self-management and wellness planning by individuals with mental health problems from pre-existing and newly formed groups, where the possibilities for continued mutual support in the development of WRAPs could be explored. Interviews and focus groups were conducted and pre-post recovery outcome measures completed (Recovery Assessment Scale and Warwick Edinburgh Mental Well Being Scale). 21 WRAP group participants took part in the research. The WRAP approach, used in groups and delivered by trained facilitators who could also share their lived experience, was very relevant and appeared to have a positive impact on many of the participants. The impact on participants varied from learning more about recovery and developing improved self-awareness to integrating a WRAP approach into daily life. The apparent positive impact of WRAP delivered in the context of mutual support groups indicates that it should be given serious consideration as a unique and worthwhile option for improving mental health.

WRAP groups could make a significant contribution to the range of self-management options that are available for improving mental health and well-being.

1. Introduction

1.1. Self-Help and Recovery. There has been a growing commitment to a recovery approach in mental health in the recent years in many countries [1]. This has been particularly evident in Scotland, and the Scottish Recovery Network has supported a wide range of recovery-promoting activities [2–6]. Alongside this interest in recovery, there has been an increasing emphasis on self-help, self-management, and mutual support as important options in the range of therapeutic encounters that people seek to address mental health concerns [7–13]. Self-help and self-management approaches to mental health vary in their approaches but offer a potentially consistent way to explore key concepts of recovery, particularly those of personal responsibility, education, hope, self-advocacy and support, through patient self-directed interventions.

There are a range of self-management approaches available for people to enhance well-being, from guided self-help, such as computerized CBT [14, 15], mindfulness [16], and bibliotherapy [17, 18]. However many self-help or self-management interventions are professionally developed resources, which may focus on education and personal responsibility but have the potential to be promote adherence with professional-led views on mental health, rather than encouraging patient-led perspectives. Some approaches, such as the recovery workbook approaches [19–21], draw on partnerships between lay people and professionals to offer self-management strategies. Self-management approaches that have been developed by nonprofessionals, or people with lived experience, also exist, such as peer support [5]. One more formalized version of self-management that emerges from the experience of lay people is wellness recovery action planning, or WRAP. WRAP was developed in the USA by
a user of mental health services, Mary Ellen Copeland, and as such is a nonprofessionally developed recovery approach based on self-management approach to improve mental health and well-being [22].

1.2. Wellness Recovery Action Planning (WRAP). WRAP explores key values of recovery, such as hope, personal responsibility, education, self-advocacy, and support, and provides a structured process for developing individualized WRAP plans [22]. These individualized WRAPs serve to document triggers for difficult feelings or behaviors, encourage the identification of tools that contribute to well-being, propose ways to self-monitor, help develop action plans for managing wellness, and can be plans that are shared with others should that be necessary in times of illness or crisis [23]. The focus of self-management resonates closely with the recovery approach, particularly in relation to empowering people to manage their own health and conditions.

WRAP is reported in the research to be perceived positively by those who have used it. The findings from the research on WRAP that have been conducted tend to elicit very positive feedback from those that attend a WRAP group [24–26]. WRAP has also been reported as being particularly useful for the identification of triggers for negative mental health [26, 27] and for developing daily strategies for wellness [25–27]. Studies have also demonstrated an increase in expressing hope for recovery, taking responsibility, having a support system in place, managing medications, and developing a crisis plan [27]. Of those studies that were conducted in group settings, there appeared to be much positive feedback about the role of mutual support [24, 26].

WRAP has also been shown to have a positive impact on mental health outcomes. Two studies with much larger sample sizes found that following the use of WRAP, there were significant decreases in global symptom severity, a statistically significant decrease in symptoms, and a significant increase in the scores for recovery [23, 28]. A sample of 58 consumers undertaking WRAP groups showed a reduction in psychiatric symptoms and an increase in hopefulness in comparison with those who did not receive WRAP [29]. A randomized study in Ohio, which randomized 519 participants, showed reduction in anxiety and depression and an improvement in Recovery Assessment Scale scores [30]. Two further studies also indicated that participants described changing behaviors to support wellness [24, 27], and reported an improvement in quality of life [26].

The benefits of WRAP extend to how individuals might also interact with others around them, such as carers or professionals. Research that focused on self-reports showed that participants reported an increase in more positive thinking [26], greater confidence in talking to doctors about their needs [25, 26], and improved ability to seek and get support from family, professionals, and others in the WRAP group [26, 31]. There was an increased knowledge of recovery, and this appeared to have a very empowering and inspirational impact on participants [32]. These benefits of better engaging with others have important implications for self-management, showing the potential benefits of successful self-management leading to fostering better patient-led care and planning.

WRAP has been used in a number of settings and cultures, such as with Chinese mental health consumers in New Zealand [26] Somali women in England [33], and Black and minority ethnic women in Glasgow [24]. These studies have reported positive experiences for participants of WRAP although there was some indication that the WRAP approach could be better adapted to be more culturally appropriate to different groups. The participants in one study included people with lived experience of mental health problems, practitioners, and carers, illustrating the potential usefulness of WRAP to be conducted in mixed groups [32].

1.3. WRAP in Scotland. The Scottish Recovery Network supported four organizations throughout Scotland to train people with lived experience of mental health problems as WRAP facilitators, who would go on to run WRAP groups in their own organisations for people who were having mental health difficulties. Each organization identified two facilitators who were given advanced level training as WRAP facilitators and who then went on to deliver WRAP groups. This research followed the delivery of WRAP for the first two groups (often also described as courses or as training) undertaken by the newly trained facilitators. WRAP can be delivered in a variety of formats, but for this intervention, all were delivered in groups. During the first and second deliveries of WRAP, two of these organisations convened the WRAP training over two days whereas the other two organisations spread the WRAP training over 4 days. Both groups who conducted the training over 4 days ran the sessions a week apart over 4 weeks. One group that ran two sessions did so a week apart for both the first and second deliveries of training, and the other ran the first training delivery one week apart and the second delivery on two consecutive days over a weekend.

The main aim of this research was to assess the relevance and impact of wellness recovery action planning (WRAP) as a tool for self-management and wellness planning by individuals with mental health problems in mutual support group settings.

The specific objectives of the research we report on here are as follows.

(1) An assessment of the extent to which participants who received training benefited in terms of recovery and wellness and the extent to which they used their own WRAP to help them do so.

(2) An examination of the role of self-help and mutual support groups in supporting recovery and wellness planning.

In this paper we report on the aims as they relate to the groups’ participants. Data describing the experience of the facilitators has been reported elsewhere [34].
2. Methods

The experience of those taking part in the WRAP training groups was explored in different ways, through focus groups, individual face-to-face interviews, by collecting pre-post test outcome measures, and by the use of session-by-session evaluation forms. Qualitative data was only collected on a sample of participants taking part in the first round of WRAP training, and quantitative data was collected in both rounds of delivering WRAP training.

The participants who took part in the first WRAP training sessions were invited to attend a focus group at the end of their training. Four focus groups with group participants were conducted in each of the 4 sites between December 2009 and February 2010. In total, 21 people participated in the focus groups. Group participants were also asked to complete brief session-by-session evaluation forms although these were mostly used by the facilitators themselves to gauge the usefulness of their individual training sessions and/or topics covered in the groups, and those are not reported on here.

Follow-up individual face-to-face interviews were conducted with 11 people who took part in the baseline participant focus groups. Participants across all four focus groups, from the four different organizations, were interviewed. These interviews were conducted 3-4 months after the baseline focus group had taken place, in order to explore their experience of developing their own WRAP and whether participants were still using the WRAP approach.

The use of scales that measure outcomes has increasingly been used to establish the effectiveness of self-management approaches in mental health. This project used two different outcome measures: one that focuses on recovery, the Recovery Assessment Scale, and one that focuses on well-being, the Warwick-Edinburgh Mental Well-being Scale (WEMWBS). Participants completed the short version of RAS and WEMWBS before and after their WRAP training, and these have been used to show any improvements in different outcome measures, and by the use of session-by-session evaluation forms. The quantitative data was only collected on a sample of participants taking part in the first round of WRAP training, and quantitative data was collected in both rounds of delivering WRAP training.

2.1. Analysis. All focus group and interview data were recorded, transcribed, and analyzed in NVivo8 (QSR). A thematic analysis was conducted, following the principles of the social constructivist version of grounded theory [35]. Themes and subthemes were identified and organized as they emerged from the data. Emerging themes were discussed and reviewed regularly by the research team to ensure reliability and validity of the qualitative analysis. The quantitative outcome data were analyzed using Excel; due to the relatively small sample size basic frequencies and means were calculated only. Pre- and postscores of RAS and WEMWBS were compiled and reported.

2.2. Ethics. The ethical subcommittee of the Scottish Centre for Social Research’s parent organization, the National Centre for Social Research, reviewed the study and gave it ethical clearance in July 2009. No National Health Service sites were included in this research and as such an ethical opinion was not required from the NHS.

3. Findings

First we describe the qualitative findings from the WRAP group participants, and then we describe the recovery and well-being measures collected.

3.1. Group Participants Experience. Many of the participants described attending the WRAP group as a process to learn about themselves and reflect on the various aspects of their mental health. The benefit of going through that process of reflection was viewed as having the potential to increase self-awareness and acceptance. One of the key benefits for many participants was learning about a recovery approach. For many participants this was a new and different way of looking at their lives, which was transformative for some. Here we describe the reported benefits of WRAP; the impact of the group setting, the levels of integration of WRAP into daily life, and the challenges encountered.

3.1.1. Perceived Benefits of WRAP. The consensus was that there were lasting benefits from undertaking WRAP. These included being able to challenge your own behaviors, identifying alternative responses, and evaluating what constitutes a priority. Participants reported a reduction in anxiety, a reduction in panic attacks, and an increased identification of their own triggers for poor mental health and the benefits of identifying wellness-promoting activities. The sense of achievement was evident from being able to find different, useful approaches to dealing with stressful situations. One participant said that she had put her Christmas tree up for the first time in three years and attributed this action to having undertaken the WRAP course. Seeing strategies written out offered confidence and, as participants described they could check back on their own ideas and get clear feedback or reinforcement from their WRAP. These strategies were ones that were tailor made, by the participants, for the participants. This led to a sense of ownership of the WRAP plan.

Um...it's for me, I think it's mine, its nobody else's and I wrote it, I think...that's how I see me. And I think that's probably how a lot of other people see me so it's not something that somebody else has wrote and I need to follow it. It's just mine I think. Yeah. (Follow-up interview)

3.1.2. Group Setting. Some respondents reflected that they felt undertaking WRAP in a group, compared with undertaking WRAP one to one, would be more supportive, less intense, and had the potential to offer mutuality and the ability to learn together. Participants described a range of benefits to this, including increased confidence, challenging stigma, increased self-esteem, and a feeling that they were
not alone. Participants valued having the opportunity to both offer and receive support.

Well I feel...I mean I don't talk to strangers about my condition. It's like I live a secret life, like nobody knows I've got this condition, but when I come here I can talk to people that...that understand what I've been through and stuff, you know?, and they might come up with suggestions about maybe medicine they've been on. You know? You just pick up different ideas. (Focus group)

Many of the participants had experienced a range of interventions, and some reflected that the collective setting was much more interactive for participants, and that was seen to increase the likelihood of engaging with the approach.

Whereas on a one-to-one, for a start you'd be embarrassed to ask any questions. You'd just go, "Oh, right you are. Thanks very much", you know?...and you would...you wouldn't want to sort of, say, "Well, look. I don't really understand that". But it was so easy, so everything that anyone has said here, the (facilitators), the charts where all our thoughts went up. (Focus group)

3.1.3. Integration of WRAP into Daily Life. The vast majority of the participants, both in the focus groups and the follow-up interviews, had drawn on WRAP in their daily lives. In the follow-up interviews, the majority had used their WRAPs and intended to continue to do so. The ways in which participants integrated WRAP into their lives varied at times, and the many different ways in which people utilised their WRAP and the related activities and resultant benefits can be broadly characterised as having drawn on the concept and ideas, engaging in the WRAP process itself, integrating the WRAP into daily life, and fully integrating WRAP into activities and outlook. Table 1 describes this in further detail.

Not all participants went on to develop their own WRAP. Some comments suggested that undertaking a WRAP was challenging, and actively using the components contained within it required a certain level of commitment and motivation. Some felt that they were not in the right place in their life or feeling well enough to explore the WRAP process further. However, many reflected that the process of systematically working through a process of self-awareness was very helpful, even if they did not develop a WRAP as such. This process alone appeared to offer useful insights into one's own experience of living with a mental illness.

Almost all of the participants reported that they were drawing on WRAP in their daily lives. For some it provided an element of security, a comforting feeling that there was a way to look at mental health, and tools to draw on that would support recovery. Ultimately, a few participants felt that their WRAP had so significantly influenced their well-being that it had started to become an intuitive way of thinking.

And I feel that um...in the WRAP training it's almost along those lines of quite fundamental in...um...it's almost a seismic shift in thinking.

3.1.4. Challenges. One challenge was that crisis planning aspect could be quite difficult for participants to complete, both because respondents thought that they had either not experienced a genuine "crisis" or because of the sensitivities of thinking back to a time of crisis. Where participants had experienced a crisis that resulted in admission to a health care facility, this part of WRAP was seen as being vital at communicating the individual's wishes to friends, family, and health care staff.

I wonder if an acceptance of the fact that sometimes your lie will be in crisis, and that knowing that there's another side storm. You come out the storm. (Focus group)

3.2. Recovery Measures for Group Participants. Table 2 shows the scores from the groups of participants for each of the four participating organisations. This shows that RAS scores increased in all groups, and WEMWBS scores in all but one group, after the respondents had completed their WRAP training. This suggests that the participants had more positive views in relation to their own sense of recovery and well-being having been trained in WRAP. However, these results must be treated with caution as the numbers who completed the forms were relatively small and the pre- and post-WRAP training questionnaires were not completed by the same number of people. Any differences between pre- and post-WRAP training scores might, therefore, be due to the low sample size and also that people with higher scores may be more likely to complete the post-WRAP training questionnaires. However, these results do support the very positive views expressed by group participants in the main qualitative phase of the study. Note that the Recovery Assessment Scale ranges between 20 and 100; 20 = very low mood/pessimistic about future and 100 = very optimistic/positive, and WEMWBS ranges between 14 and 70; 14 = very negative views and 70 = very positive views.

4. Discussion

This research found that the WRAP approach used in groups and delivered by trained facilitators who could also share their lived experience was very relevant and appeared to have a positive impact on many of the participants. The
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Table 1: Levels of integration of WRAP into daily life.

<table>
<thead>
<tr>
<th>Level of integration</th>
<th>Activities</th>
<th>Example</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>The concept and ideas</td>
<td>(i) WRAP training as an introduction to the concept of recovery. (ii) Thinking about recovery in relation to own experience of mental illness and mental well-being. (iii) Increased awareness of self and challenging stigma.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&quot;I always vow never to go back up there (acute inpatient ward), but I end up being back there, and I think I actually have to try and take the control more into my own hands, and I think obviously WRAP is one way that I can take back that control, and... so it is definitely something that I will get round to doing, because I'm determined that the only way I can feel better is... with mental illness... is definitely you really need to take the control because there is no... there's no answers.&quot; (Follow up interview)</td>
</tr>
<tr>
<td></td>
<td>The WRAP process itself</td>
<td>(i) Process of self-reflection and benefits of mutual support environment. (ii) Mostly using the WRAP itself in the group meetings only. (iii) Increased insight into own mental well-being, including identification of triggers and wellness strategies.</td>
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<tr>
<td></td>
<td></td>
<td>&quot;I think that the only person can do it is yourself. I think it's got to be in... from the inside out. I don't see how it can be done from the outside in. D'you understand what I mean?&quot; (Focus group)</td>
</tr>
<tr>
<td></td>
<td>Integrating WRAP into daily life</td>
<td>(i) Continuing to refer to WRAP and using it in daily activities. (ii) Drawing on the learning of WRAP to self-monitor behaviour and thinking. (iii) Using WRAP to guide changes in behaviour to promote well-being.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&quot;I found it really useful for...like...like if I am...very stressed or whatever, I find it very good. Because when I refer to it, it sort of cheers me up because I think to myself oh well I don't want to end up in hospital again, I want to keep myself well and I refer to it as like I have got to focus on everyday and get up in the morning, and listen to music, do things that make me feel good. So I look at it in a positive light.&quot; (Follow up interview)</td>
</tr>
<tr>
<td></td>
<td>Fully integrated WRAP</td>
<td>(i) Using WRAP regularly. (ii) WRAP becoming integrated to a point where it feels it becomes an intuitive way of looking at your life. (iii) Telling others about WRAP as a concept. Sharing own WRAP with others.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&quot;But for me, it's given me. it's given me a better understanding of my own mental health and my mental health state. But no only that, it's given me confidence in myself, you know... you know, that I've gained throughout the group and the Support Workers. The... there is light at the end o' the tunnel. But it's also given that same confidence to my family because they've had the benefit from the WRAP as well. It's not just me that's, you know, that's getting the benefit from it. My family's getting that as well because they can see the difference. It's like, you know, my eldest daughter said, &quot;My dad's back&quot;, and that's how she explains it.&quot; (Focus group)</td>
</tr>
</tbody>
</table>

Table 2: Groups one and two participant responses to scales pre- and post-WRAP training.

<table>
<thead>
<tr>
<th>Participants</th>
<th>Recovery assessment scale</th>
<th>WEMWBS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-WRAP</td>
<td>Post-WRAP</td>
</tr>
<tr>
<td>Site 1 group 1</td>
<td>64.6 (n = 9; 51–74)*</td>
<td>76.4 (n = 7; 61–96)</td>
</tr>
<tr>
<td>Site 1 group 2</td>
<td>67.5 (n = 8; 39–82)</td>
<td>70.0 (n = 6; 38–92)</td>
</tr>
<tr>
<td>Site 2 group 1</td>
<td>62.3 (n = 3; 56–72)</td>
<td>74.0 (n = 4; 62–87)</td>
</tr>
<tr>
<td>Site 2 group 2</td>
<td>59.8 (n = 4; 56–62)</td>
<td>Not available</td>
</tr>
<tr>
<td>Site 3 group 1</td>
<td>83.1 (n = 8; 74–99)</td>
<td>87.3 (n = 7; 79–100)</td>
</tr>
<tr>
<td>Site 3 group 2</td>
<td>67.9 (n = 7; 51–92)</td>
<td>75.4 (n = 5; 60–94)</td>
</tr>
<tr>
<td>Site 4 group 1</td>
<td>83.5 (n = 2; 75–92)</td>
<td>92.5 (n = 2; 89–96)</td>
</tr>
<tr>
<td>Site 4 group 2</td>
<td>73.3 (n = 7; 46–89)</td>
<td>82.1 (n = 7; 69–99)</td>
</tr>
</tbody>
</table>

Note to tables: *Mean score presented for all participants combined; range of responses included in brackets. Only one RAS questionnaire was returned following the second group for site 2 WRAP training group. These data are not included in the table as it cannot represent the scores of the whole group. Only one WEMWERS questionnaire was returned following the second group of site 2 WRAP training group. These data are not included in the table as it cannot represent the scores of the whole group.
group-based format and facilitators offering mutual support through sharing their lived experience with group members appeared to be important aspects of the impact of this approach.

The level of impact varied among the participants, and ranged from increased awareness gained from the concept and ideas of recovery, increased self-awareness, integrating WRAP tools and self-management into daily life, and fully integrating it into their thinking about well-being. All of these levels of impact offered substantial benefits for participants even if participants did not go on to complete their own written version of their WRAP. This is an important point to note in ongoing work researching WRAP completed WRAP plans may not be an indicator of how much the intervention might impact participants.

Most participants had not come across the concept of recovery before this experience and found that this offered a useful, and for some, powerful new perspective on their experience. Participants described feeling they could take ownership over their well-being and were able to challenge stigma to the point where they could talk about their experiences, sometimes for the first time. As put by one participant, WRAP offers a reminder of what you are like when you are well, and that offered hope and uncovered strategies for overcoming challenges when encountering an episode of illness. These findings are consistent with the growing literature on the positive benefits of undertaking WRAP [23, 24, 26, 27]. Additionally, in this research the impact also appeared to have been sustained over time (as illustrated by the 3–4 month follow-up interviews), although it would be worthwhile to gauge this sustainability over a longer follow-up period in the future.

The group setting appeared to provide optimal conditions for the delivery of WRAP. The provision of mutual support appeared to enhance the recovery-oriented principles of WRAP. Mutuality offered a supportive, caring environment, and it was viewed as being particularly positive that facilitators were also able to share their experiences. The group aspect of the WRAP intervention itself was clearly an important factor to the success of the WRAP groups, and research on other group recovery orientated approaches based in group settings have also demonstrated positive benefits for participants [19–21]. It would appear, though, that WRAP does require some local modifications for different contexts.

There are limitations that should be considered in relation to this research. It may have been the case that the individuals taking part in the study were a fairly self-selecting group, both in terms of participating in the interviews and in the intervention itself. The WRAP program and evaluation only focused on four organizations, and it is possible that other organizations and groups would not have had such a favorable response to WRAP. As the sample size of the study was relatively small, the limited quantitative results should be viewed with some caution, even if they tended to support the positive perceptions elicited during the qualitative research phase. Similarly, whilst there were attempts to collect control group data in this research, and RAS and WEMWBS scales were distributed to those attending self-help groups not using the WRAP approach, there were insufficient returns to include as a comparison. Future research should consider including control group data. Although there was very little indication of negative impact, the potential for a negative impact should continue to be monitored in future work.

The apparent positive impact of WRAP delivered in the context of mutual support groups indicates that it should be given serious consideration as a unique and worthwhile option for improving mental health. WRAP groups could make a significant contribution to improving mental health and well-being, and further research that established and compared its effectiveness with other modalities may be worthwhile. WRAP is a self-management tool that is underpinned by mutuality and empathy, not by a professionally-applied treatment or therapy, and therefore offers a unique alternative to professionally-driven approaches, yet with much consistency with the patient-led emphasis of self-management. The results of the research indicate that WRAP has the potential to offer a unique and useful approach that could play an important role in the development of interventions for improving mental health.

Funding

This research was funded by the Scottish Recovery Network.

References


Research Article

Informal and Formal Supports for Former Child Soldiers in Northern Uganda

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Received 28 September 2012; Accepted 17 December 2012

Academic Editors: A. Fiorillo, L. Tait, and M. J. Zvolensky

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This study aimed to evaluate the potential contribution of informal community initiatives and formal interventions in support of former child soldiers’ resilience in the wake of armed conflict. Using a cross-sectional survey design, a stratified random sample of 330 formerly recruited and 677 nonrecruited young people was consulted about their perspective on desirable support for former child soldiers provided by close support figures, communities, humanitarian organizations, and governments. Data analysis occurred by conducting qualitative thematic analysis and statistical chi-square analysis to explore clusters, similarities, and variations in reported support across the different “agents,” hereby comparing the perspectives of formerly recruited and non-recruited participants. The results indicated that formerly recruited and non-recruited participants had comparable perspectives that call for the contribution of various informal and formal support systems to former child soldiers’ human capacities and the communal sociocultural fabric of war-affected societies. This highlights the importance of community-based, collective, and comprehensive support of formerly recruited young people and their surroundings in the aftermath of armed conflict.

1. Introduction

Contemporary warfare increasingly inflicts military strategies on civilians and sometimes particularly victimizes children (minor 18s) [1]. Among the more notorious and devastating war strategies is the recruitment of children by armed groups and forces. It is estimated that currently about a quarter of a million children are conscripted and militarily engaged in armed conflicts worldwide [2]. Such child soldiering experiences typically involve persistent and intense exposure to war-related adversity, which constitutes a severe threat to the mental health of these children [3, 4]. As a consequence, substantial psychological distress has consistently been assessed in former child soldiers [5–8]. Additionally, child soldiering also inflicts harm on the physical, social, educational, and economic aspects of their lives and therefore creates multiple challenges [9–11]. This potentially degrades former child soldiers’ capacities upon return from the armed group or armed force and may lead to considerable loss of “human capital,” which refers to the resources endowed to individuals [12]. However, the impact of child soldiering reaches far beyond the individual level. Targeting civilians as a war-strategy profoundly disrupts familial networks, social cohesion, civic services, and therefore destabilizes the entire social ecology of affected communities. The “social ecology” refers to the social context in which individuals develop and that offers the social capital that they can use in responding to encountered challenges [12]. War strategies targeting civilians also erode traditional practices, mores and values and defy human rights in the
affected community, thereby rupturing the “cultural capital,” that is, the resources emanating from cultural and moral frameworks [12–16]. These multiple and intersecting ways in which child soldiering impinges on the psychosocial well-being of formerly recruited young people bring along implications for their transition from military to civilian life and for desirable support in the aftermath of the child soldiering episode [17–20].

These implications have been incorporated into the Psychosocial Working Group (PWG)’s conceptual framework for psychosocial intervention in complex emergencies [12]. This framework forms an integration of resource-based approaches (e.g., conservation of resources theory [21, 22]) and social ecological approaches to child development (e.g., ecological systems theory [23]). The PWG theoretical framework delineates how people and communities at large deal with potential or actual loss of human, social and cultural capital in complex emergencies. When facing loss of such resources, people strive to maximize gain and to minimize loss in order to obtain and preserve resources that help in dealing with chronic and acute challenges [21, 22]. As such, formerly recruited young people may seek to reactively repair the damage caused by child soldiering and to proactively protect their resources against the possible cascading demands that are associated with its aftermath. Through the use of such resources, many former child soldiers are able to maintain or regain well-being despite the unpromising circumstances, in a process which is termed “resilience” [24]. Hereto, they actively engage to gain support for the extant resources and create new, supplementary resources [25]. Additionally, when confronted with an adversity such as armed conflict, affected communities tend to strengthen their informal support systems and to actively engage in self-help processes to address the challenges in their situation [12, 26]. In this process, a myriad of resources is employed and socially exchanged to counter the inflicted harm and to proactively bolster one another’s well-being [21, 22]. Thus, agents in the environment are mediating the individual’s access to supplementary resources in the collective resource pool. This points to the important intersections between individual and collective processes in response to the potential or actual demands associated with child soldiering and war at large. These indigenous sources and processes of support that communities use to enable well-being of their members is referred to as “community resilience” [12, 27, 28]. It is expected that by virtue of community resilience and the presence of these indigenous resources, the majority of former child soldiers is able to maintain or regain well-being [28].

All this raises questions concerning the role that formal support systems, such as governmental agencies and nongovernmental organizations, must fulfill and the necessity and complementarity of their services in conjunction with those already provided by informal support systems. The initiation of formal support in (post-)conflict settings often follows the assumption that the informal support systems have insufficient resources or engage insufficiently in resource exchange processes to deal with the formidable harm inflicted on them [12, 20]. By doing so, programmatic responses risk disregarding the remarkable resourcefulness and resilience of war-affected individuals and their communities [12, 20]. While there is a consensus that the availability of indigenous resources and supportive responses is far from antithetical to the need for professional interventions [28], different perspectives exist on the desirable focus areas, methods of operation and position to take when intervening in war-affected areas. This study aims at addressing this issue through consulting former child soldiers’ perspective on what different agents could ideally do to support them in the aftermath of their child soldiering experience. It is expected that what is proposed as desirable support covers a broad range of domains and is accounted for by different “agents” that are either informally or formally involved. Since resilience is largely dependent on the response of the environment and the extent to which agents in this environment invest and exchange resources [12, 29], it is also important to know whether the environment acknowledges and endorses the agents’ supportive role towards former child soldiers. As an initial attempt to explore the views of close support figures, this study examined the perspectives of former child soldiers’ age mates with regard to what different agents should do to support formerly recruited young people. Since former child soldiers frequently were found to be stigmatized [5, 30–32], the hypothesis seemed plausible that their age mates tended to think that formerly recruited youths themselves are to blame for their situation, which therefore they should resolve on their own with little support from environmental agents.

2. Methods
This study is part of a larger mixed-method research project conducted between October and December 2010 in the Lira district of northern Uganda. This area is currently in transition after two decades of a complex armed conflict in which the Lord’s Resistance Army (LRA) forcibly recruited thousands of minors as child soldiers [5]. The aim of the research was to assess challenges and resources in the transition of formerly recruited young people, whereby this study specifically aimed to enhance the understanding of how different agents can contribute to this transition and eventually to well-being in the wake of child soldiering. Hereto, the study took a contextually grounded, participatory approach that was approved by the Ethical Committee of the Faculty of Psychology and Educational Sciences of Ghent University.

2.1. Participants. To create a stratified random sample, the District Education Office’s overview of schools in Lira district was used to select six secondary schools and for each school two adjacent villages in urban, periurban, and rural areas. The age range of 12–25 years was determined to include youth that were at the time of the LRA insurgency most likely to be among the young people that the LRA targeted for recruitment. In the villages, the out-of-school youth in
this age bracket was invited to participate. In the schools, the students of classes Senior 2 and 3 of the O-level were considered to be the best age-match, given that in the lower level a diversity of ages was represented and that the higher level showed a considerable frequency of drop-outs. This resulted in a sample of 1008 Ugandan youths, of whom about a third had formerly been recruited by the LRA (one participant did not disclose his status).

2.2. Procedure. In cooperation with community leaders and school principals, a plenary meeting was organized in each village and school to disperse information necessary to make an informed decision on participating in this study. This information mainly included the purpose and procedure of the study, the possibilities and consequences of refusal or withdrawal from the study, and the availability of psychosocial support during or subsequently to the study. The written informed assent or consent was obtained from all participants. Collecting consent of legal guardians of minors was hindered by them living separately and often far apart. The participants did not receive any compensation for their participation in this study.

A cross-sectional survey questionnaire with mainly open-ended questions was administered. This questionnaire firstly consisted of sociodemographics of the participants, including age, gender, district and location of residence, occupation, religion, household composition, and former child soldiering experiences. Secondly, it contained open-ended questions on what different agents could do to support formerly recruited young people in their transition from military to civilian life. The questions were carefully designed by the bicultural research team to ensure inclusion of the most relevant informal and formal agents (i.e., themselves, family, friends, community, organizations, government) and ease of understanding (e.g., What can they themselves do? What can their family do?). “Family” referred to the nuclear and extended family members; “friends” consisted of intimate friends, age mates and classmates; “community” referred to the people who are linked by social ties and the geographical location, including neighbors, social groups and local cultural, religious and political leaders; “organizations” included charitable, non-governmental and United Nations agencies; and “government” referred to national and international government bodies. Rules were made concerning how to communicate and translate this additional information, which was orally disseminated to the participants.

The in-school participants and out-of-school participants with sufficient literacy skills individually administered a written version of the questionnaire in English (the official language of education), while the researcher and a trained bilingual research assistant remained available. For out-of-school participants with limited literacy skills, the questionnaire was in interview format administered orally by the researcher and simultaneously translated on-site into Lango (the native language of the region) by trained bilingual research assistants. These interviews took place individually in a confidential setting.

2.3. Data Analysis. The answers were analyzed and divided into meaning units, whereby those that were conceptually identical were merged and each unique meaning unit received a different numerical code. This procedure resulted in composite lists of the reported unique items per agent. The analysis of these items was based on the Psychosocial Working Group (PWG)’s conceptual framework for psychosocial intervention in complex emergencies, which incorporates an integration of the original conceptual framework discerning the main domains of resources (i.e., human capacities, social ecology, culture and values) [12] and empirical elaboration of this framework defining key subdomains of resources in northern Uganda [33]. The thematic analysis was done by two blinded researchers to minimize errors in categorization. Using the software application for qualitative data-analysis Nvivo, the items were thematically analyzed and categorized according to the conceptual framework. Subsequently, cluster analysis by coding similarity was performed to visualize patterns in coded items across the agents, in order to determine the similarity of item allocation over the different agents. Jaccard similarity coefficient was calculated. Further statistical analyses were conducted in SPSS 20. Descriptive statistics were used to represent the sociodemographic characteristics of the sample and the allocation of the categorized items over the resource (sub-)domains for each agent. Chi square analysis of the data allowed to explore similarities and variations in reported resources across the different domains and agents, comparing between formerly recruited and non-recruited participants. The significance level was set at 0.01, to reduce the chance of Type I-error but still allow exploratory testing.

3. Results

The subsample of 330 formerly recruited participants comprised 201 (60.91%) males and 129 (39.09%) females, with an average age of 17.04 (sd = 2.31, range = 12–25) years. The median duration of their recruitment in the LRA was 348.50 (m = 564.79, sd = 752.74, range = 1–6570) days.

The greater part of them had escaped (n = 242, 74.46%) on average 5.57 (sd = 1.88, range = 1–10) years ago. A majority of 225 (68.2%) participants originated from Lira district, others resided here for familial, economic, or educational reasons. Most of them lived in a rural (n = 155, 47.26%) or periurban (n = 118, 35.98%) village, while the minority lived in town (n = 37, 11.28%) or in a camp (n = 18, 5.49%). Most participants were attending school (n = 235, 71.21%). Of the out-of-school participants, the greater part engaged in farming activities (n = 46, 48.42%) or declared to have no occupation (n = 33, 34.74%). The subsample of 677 non-recruited participants consisted of 346 (51.18%) males and 331 (48.89%) females, with the average age of 16.54 (sd = 1.91, range = 12–24) years. They either lived in the same village or attended the same class as the formerly recruited participants in this study.

The cluster dendogram (Figure 1) shows a split between the items of formerly recruited individuals and the items of other agents. Among the other agents, the items of friends...
and family were closest related and so were those of the government and community \((J = 1.00)\). The items allocated to organizations were situated in between the items of family and friends on the one hand and the items of community and government on the other hand. However, the similarity metric shows that there was high similarity between the sample sets of all agents (range \(0.80–1.00)\).

Table 1 and Figure 2 represent the allocation of support items per agent and per resource domain. Most items reported by formerly recruited participants pertained to support for “human capacities”, in which “knowledge and skills”, “livelihood”, and “mental health” resources were most prevailing. The reported number of items pertaining to “human capacities” was quite high for all agents, but the highest number was reported for family and friends. Another large number of items referred to support for the “social ecology”, including “social support”, “social services and infrastructure”, and “social connectedness” as the most common subdomains. Support to the “social ecology” was mostly assigned to the government, organizations and the community and the least to formerly recruited young people. The third resource domain consisted of “culture and values”, in which, respectively, “human rights”, “religious values”, and “cultural practices” were to be supported mainly by formerly recruited youths, their families and friends. The least frequently occurring items were reported for “political” and “economic” resources in the “periphery”, which were mainly assigned to governments and organizations.

This table and figure also show that formerly recruited adolescents were primarily recommended to strengthen their own “human capacity”, by developing their “knowledge and skills”, adhering to “religious beliefs”, applying “mental health” strategies, and strengthening their “livelihood”. To a lesser extent, they were also expected to contribute to the “culture and values” and the “social ecology” of their environment. The table and figure further seem to indicate that support expected from families, friends and communities diminished steadily from resources in “human capacities” to the “periphery”. Families’ largest contribution lies in the support of “human capacities”—specifically their children’s “knowledge and skills”, “livelihood”, and “physical health”—and in the provision and promotion of “social support”. Friends were mainly expected to contribute to “human capacities” by supporting the “knowledge and skills” and “mental health” of their friends, and also to the “social ecology” by facilitating their “social connectedness” and delivering “social support”. The community’s assignments were equally divided over the three core domains, and were more specifically oriented to support the “knowledge and skills” and “livelihood” of formerly recruited young people, as well as “social support” and “human rights” issues in the community. The support functions assigned to organizations and the government mainly pertained to the “human capacities” and “social ecology” domains, but then diminished markedly for “culture and values” and the “periphery”. Organizations were reported to make the largest contributions to “human capacities” by supporting the “livelihood”, “mental health”, and “knowledge and skills” of formerly recruited young people, and also to the “social ecology” by initiating “social services and infrastructure” and promoting “social support”. The government’s responsibilities were mostly defined in relation to the “social ecology”, including the initiation of “social services and infrastructure” as well as “law and order”, and in relation to the “human capacities”, mainly the “knowledge and skills” and “livelihood” of formerly recruited youth. Table 2 gives an illustration of the most frequently reported items for all agents in each resource domain.

Table 1 and Figure 2 further depict the comparison between formerly recruited and non-recruited youth, showing seemingly similar patterns for both comparison groups. A few significant differences appeared. Firstly, families’ support to “mental health” resources was esteemed higher by non-recruited participants. Secondly, non-recruited participants reported less support from friends for “human rights” resources. Thirdly, this group reported a lower contribution of organizations to “human capacities” in general and to “social support” resources. Fourthly, communities were less supposed to support “culture and values”, and particularly “cultural practices”. Lastly, they expected governments to deliver more support to formally recruited youth’s “livelihood”, but less support to “social services and infrastructure” and to “human rights” issues.

4. Discussion

This study examined formerly recruited young people’s perspectives on the potential contributions that diverse informal and formal support systems can make to their well-being in the wake of child soldiering. The results revealed that formerly recruited young people call for support on a variety of resource domains to which both informal and formal agents can make significant contributions. Required supports seemingly diminished from resources endowed to individuals to resources in the periphery. A plausible explanation is that those challenges and resources that are most directly related to one’s well-being are often considered salient and therefore are more reported \([21, 22]\). Hence, the largest part of the recommendations refer to support for human capacities and more particularly for the former child soldiers’ knowledge and skills, livelihood and mental health. When interpreting these most recommended types of support against the backdrop of the most pertinent challenges identified in our previous study \([31]\), interesting parallels appear between the urge for support in “knowledge and skills” and “livelihood” resources to meet “training and skills-related” and “economic” challenges, and between support for “mental health” resources to meet “emotional”
| Table 1: Proportion (n (%)) of formerly recruited (n = 330) and non-recruited (n = 677) youth’s answers per resource domain and agent. |
|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|
|                     | Recruited n (%)     | Non-recruited n (%) | Recruited n (%)     | Non-recruited n (%) | Recruited n (%)     | Non-recruited n (%) | Recruited n (%)     | Non-recruited n (%) | Recruited n (%)     | Non-recruited n (%) |
|                     | χ²                   |                     | χ²                   |                     | χ²                   |                     | χ²                   |                     | χ²                   |                     |
| Human capacities    | 243 (73.64)          | 539 (79.62)         | 4.57 (87.27)         | 571 (84.34)         | 1.52 (83.94)         | 558 (86.85)         | 0.36 (71.82)         | 420 (62.04)         | 9.36 ** (69.09)     | 486 (71.79)          |
| Mental health       | 97 (29.39)           | 249 (36.78)         | 5.37 (15.76)         | 163 (24.08)         | 9.14 ** (31.82)      | 35.60 (35.60)       | 1.41 (104.205)       | 5 (13.33)           | 0.16 (21.35)        | 74 (6.36)           |
| Physical health     | 7 (2.12)             | 15 (2.22)           | 0.01 (29.09)         | 17 (25.55)          | 1.42 (6.67)          | 8.57 (4.43)         | 1.10 (21.30)         | 7 (19.27)           | 1.72 (21.71)        | 42 (10.93)           |
| Knowledge & skills  | 133 (40.30)          | 284 (41.95)         | 0.25 (60.00)         | 398 (58.79)         | 0.14 (50.91)         | 47.12 (62.04)       | 1.28 (26.06)         | 203 (20.38)         | 4.13 (39.39)        | 250 (36.93)          |
| Livelihoods         | 69 (20.91)           | 111 (16.64)         | 3.08 (43.33)         | 271 (40.03)         | 1.00 (23.03)         | 23.19 (33.23)       | 0.00 (39.70)         | 157 (33.23)         | 4.05 (33.33)        | 223 (38.85)          |
| Personal values     | 32 (9.70)            | 68 (10.04)          | 0.30 (9.09)          | 34 (5.02)           | 6.17 (6.97)          | 6.50 (4.73)         | 0.08 (5.15)          | 44 (2.42)           | 0.09 (3.25)         | 2 (0.00)            |
| Social ecology      | 116 (35.15)          | 249 (36.78)         | 0.26 (46.67)         | 344 (50.81)         | 1.53 (54.24)         | 61.00 (62.63)       | 4.19 (68.79)         | 424 (62.63)         | 3.68 (61.21)        | 402 (58.98)          |
| Social connectedness| 54 (15.11)           | 151 (22.30)         | 4.83 (12.12)         | 97 (14.33)          | 0.92 (33.03)         | 38.70 (8.42)        | 3.07 (8.48)          | 26 (12.17)          | 0.00 (35.63)        | 272 (71.34)          |
| Social support      | 56 (16.97)           | 79 (11.67)          | 5.37 (34.85)         | 215 (31.76)         | 0.96 (27.58)         | 32.20 (21.58)       | 2.23 (22.42)         | 74 (13.15)          | 14.08 *** (33.64)   | 25.85 (11.75)        |
| Social service &   | 25 (7.58)            | 41 (6.06)           | 0.84 (4.55)          | 61 (9.01)           | 6.34 (3.03)          | 1.03 (49.70)        | 5.33 (47.86)         | 25.64 (18.61)       | 0.30 (17.88)        | 32 (4.17)           |
| infrastructure      | 0 (0.00)             | 1 (0.15)            | 0.49 (2.42)          | 24 (3.55)           | 0.91 (1.52)          | 3.69 (5.15)         | 1.18 (6.36)          | 25.32 (5.61)        | 0.46 (7.58)         | 38 (1.46)           |
| Safety              | 0 (0.00)             | 1 (0.15)            | 0.49 (2.42)          | 24 (3.55)           | 0.91 (1.52)          | 3.69 (5.15)         | 1.18 (6.36)          | 25.32 (5.61)        | 0.46 (7.58)         | 38 (1.46)           |
| Law & order         | 7 (2.12)             | 13 (1.92)           | 0.05 (0.31)          | 15 (0.15)           | 0.27 (0.00)          | 0.74 (2.84)         | 2.45 (7.26)          | 3.94 (7.16)         | 0.06 (26.67)        | 177 (26.14)          |
| Culture & values    | 127 (38.48)          | 272 (40.18)         | 0.27 (24.55)         | 176 (26.00)         | 0.25 (31.21)         | 29.69 (9.60)        | 0.24 (10.00)         | 63 (9.60)           | 0.04 (32.72)        | 180 (23.63)          |
| Cultural practices  | 38 (11.51)           | 67 (9.90)           | 0.62 (2.73)          | 16 (2.36)           | 0.12 (8.48)          | 8.71 (7.27)         | 0.02 (0.30)          | 1 (0.00)            | 2.05 (11.21)        | 36 (5.32)           |
| Religious beliefs   | 99 (29.66)           | 226 (33.38)         | 1.16 (6.36)          | 64 (9.45)           | 2.74 (10.61)         | 13.44 (21.21)       | 1.63 (4.43)          | 91 (34.86)          | 1.90 (21.64)        | 123 (15.75)          |
| Human rights        | 5 (1.52)             | 5 (0.74)            | 1.36 (16.36)         | 104 (15.36)         | 0.17 (15.76)         | 9.04 (8.79)         | 6.90 ** (9.31)       | 103 (9.31)          | 0.07 (20.91)        | 140 (16.40)          |
|                     | 1 (0.30)             | 2 (0.60)            | 0.00 (0.30)          | 0.30 (0.00)         | 0.98 (0.30)          | 0.00 (0.00)         | 2.05 (0.30)          | 0.05 (0.30)         | 0.05 (0.00)         | 0.05 (0.00)         |
|                     | 1 (0.30)             | 2 (0.60)            | 0.00 (0.30)          | 0.30 (0.00)         | 1.98 (0.30)          | 0.00 (0.00)         | 2.05 (0.30)          | 0.05 (0.00)         | 0.05 (0.00)         | 0.05 (0.00)         |

**p ≤ .01; ***p ≤ .001.
Table 2: Formerly recruited youth's most frequently reported items for each agent and resource domain.

<table>
<thead>
<tr>
<th>Human Capital (n, %)</th>
<th>Social ecology (n, %)</th>
<th>Culture and values (n, %)</th>
<th>Periphery (n, %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>to do agricultural activities (KS) (49, 14.85)</td>
<td>to take their problem to organizations and ask for support (SSI) (18, 5.46)</td>
<td>to pray to God (RB) (57, 17.27)</td>
<td>to work hard for the development of the country (EC) (1, 0.30)</td>
</tr>
<tr>
<td>to start or continue studying (KS) (42, 12.75) to forget about the past (MH) (32, 9.70)</td>
<td>to organize themselves in a self-help group (SS) (13, 3.94) to join a youth club or organization (SC) (11, 3.33)</td>
<td>to always put God first (RB) (25, 7.58) to behave respectful to others (CP) (15, 4.55)</td>
<td>/</td>
</tr>
<tr>
<td>to support them in education and training (KS) (149, 45.15)</td>
<td>to give them parental care (SS) (50, 15.15)</td>
<td>to avoid segregating them from the other children in the family (HR) (22, 6.67)</td>
<td>/</td>
</tr>
<tr>
<td>to provide them basic requirements (L) (76, 23.03) to feed them properly with balanced diet (PH) (68, 20.61)</td>
<td>to show love to them (SS) (38, 11.52) to stay close to them (SC) (15, 4.55)</td>
<td>to avoid mistreating them (HR) (11, 3.33) to avoid isolating them from others (HR) (7, 2.12)</td>
<td>/</td>
</tr>
<tr>
<td>to give them advice (KS) (99, 30.00)</td>
<td>to stay close to them (SC) (54, 16.36)</td>
<td>to avoid insulting them (HR) (25, 7.58)</td>
<td>/</td>
</tr>
<tr>
<td>to counsel them (MH) (30, 9.09) to share their properties with them (L) (29, 8.79)</td>
<td>to show love to them (SS) (38, 11.52)</td>
<td>to do storytelling with them (CP) (17, 5.15)</td>
<td>/</td>
</tr>
<tr>
<td>to support them in education and training (KS) (203, 61.52)</td>
<td>to organize free medical care (SSI) (30, 9.09)</td>
<td>to advocate for these children's rights (HR) (5, 1.52)</td>
<td>to settle peace in the area (PC) (3, 0.91)</td>
</tr>
<tr>
<td>to provide them basic requirements (L) (60, 18.18) to give them scholastic materials (L) (59, 17.88)</td>
<td>to organize care for the most vulnerable and needy (SSI) (16, 4.85)</td>
<td>to talk to them in a good, friendly way (HR) (1, 0.30)</td>
<td>to encourage and facilitate peace talks with the rebels (PC) (2, 0.61)</td>
</tr>
<tr>
<td>to support them in education and training (KS) (74, 22.42)</td>
<td>to care for them as their children (SS) (24, 7.27)</td>
<td>to treat them equally to other members of the community (HR) (29, 8.79)</td>
<td>to monitor country-level political affairs (PC) (1, 0.30)</td>
</tr>
<tr>
<td>to make sure they are fed properly (PH) (52, 15.76) to give them clothes and shoes (L) (34, 10.30)</td>
<td>to show love to them (SS) (17, 5.15) to welcome them back when they return (SC) (16, 4.85)</td>
<td>to introduce them to community norms (CP) (15, 4.55) to avoid insulting them (HR) (12, 3.64)</td>
<td>to work hard for the development of the country (EC) (2, 0.61)</td>
</tr>
<tr>
<td>to support them in education and training (KS) (106, 32.12) to provide them basic requirements (L) (42, 12.73) to give them food and water (PH) (37, 11.21)</td>
<td>to organize affordable or free education (SSI) (48, 14.55)</td>
<td>to make sure their rights are not abused (HR) (6, 1.82)</td>
<td>to build peace and stability in the country (PC) (27, 8.18)</td>
</tr>
<tr>
<td>MH: mental health; PH: physical health; KS: knowledge and skills; L: livelihoods; SC: social connectedness; SS: social support; SSI: social service and infrastructure; CP: cultural practices; RB: religious beliefs; HR: human rights; EC: economic climate; PC: political climate.</td>
<td>to build schools (SSI) (29, 8.79)</td>
<td>to support them equally to other citizen (HR) (5, 1.52)</td>
<td>to create job opportunities (EC) (16, 4.85)</td>
</tr>
<tr>
<td>to give free medical care (SSI) (26, 7.88)</td>
<td>to provide free medical care (SSI) (12, 3.64)</td>
<td>to control if they are taken back to school (HR) (4, 1.21)</td>
<td>to organize peace talks with the rebels (PC) (9, 2.73)</td>
</tr>
</tbody>
</table>
challenges. In the wake of armed conflict, formerly recruited young people may particularly face challenges related to the mental health consequences of their augmented exposure to war-related adversity and to the educational and economic impact of child soldiering [5, 7, 34]. This might explain their high demand for support in these domains and shows that there is a considerable need for specific individualized support to strengthen young people whose human capital has been threatened or affected and who consequently may experience substantial distress in the aftermath of child soldiering [1]. According to the participants of this study, such support can largely be provided by support figures among their kith and kin, but to a considerable extent also by the community-based, humanitarian, and governmental support structures.

In addition, there is a great deal of recommendations that represent nonspecific and communal support, given that these pertain to the social and cultural fabric. The need for support of the social ecology might be explained by the fact that the impact of war is in part influenced by the extent to which social networks, public facilities, and customary practices are affected and hence limited in their supportive capacities [1, 19]. To offset the loss of social capital, social connectedness may reduce alienation and install a sense of belonging in the aftermath of child soldiering [35, 36]. Further, social support has consistently been associated with better psychosocial well-being and stronger resilience of formerly recruited youth, for it strengthens people’s capacities to deal with challenges [37, 38]. Social services and infrastructure related to education, healthcare, and development among others are indispensable for human welfare. It should be noted that the limited reports with regard to safety and law and order may have been biased by the current, relatively stable and peaceful post-conflict status of northern Uganda, whereas this in the midst of conflicts is rather a primary concern and important duty to protect young people’s well-being [39]. All this shows that support in the aftermath of war should work on the reconstruction of the social fabric and on the development of social capacities to support members who are in need of particular support [1, 40]. According to the participants, such support can in the first place be provided by formal support structures such as governments and organizations, but also considerably by communities, friends, and families who are at the heart of the social environment.

Support for culture and values was less reported, though still requires considerable attention from informal and formal agents. Support in this domain should mainly be oriented to human rights issues and cultural practices. During and following warfare, grave abuses may occur that defy basic human rights, and formerly recruited young people may in particular experience subjugation and discrimination, which possibly explains their need for support in this area [12]. War also often erodes the culture that unites people and constructs a shared identity, and that forms the framework for cultural-specific manifestations of challenges and responses to it [1, 19]. Support for cultural practices and values therefore is important to reinstall communal life and stimulate cooperative, indigenous responses to encountered challenges. Informal support systems fulfill an important role in reconnecting formerly recruited youth to contextually-appropriate ways of meaning-making and living, grounded in cultural, ideological, and spiritual frameworks [19]. Formal support systems should in their efforts build upon these informal and culturally grounded approaches [1, 19, 20, 40].

Influences of the broader context are still relevant to the formerly recruited youth, albeit apparently to a lesser extent. These peripheral factors are mainly considered to be an issue of the government that bears a duty with regard to the economic and political climate of the country. The latter should be supported by organizations [41]. The emphasis on the three core domains of resources confirms the importance of support that covers the broad range of human, social and cultural capital. It also indicates that former child soldiers’ trajectories to resilience are ideally scaffolded by human, social, and cultural resources [12, 19, 20].

In addition, the study explored similarities and differences between the perception of formerly recruited and non-recruited participants concerning the contribution that
The high similarity of items across informal and formal agents indicates that all agents are supposed to work toward similar goals and largely must support the same resource domains. This recommends collaborative initiatives, whereby local informal support systems within the community report to formal agents about the resources at their disposal and about their ongoing initiatives to deliver the required support. Formal support systems may in turn strengthen the local capacities by revitalizing, augmenting or formalizing the support offered by communities [19, 20, 35, 40]. Such community-based initiatives in support of former child soldiers may create an environment that fosters resource engagement and exchange, and eventually resilience of former child soldiers [44].

With regard to the role to fulfill by formal support systems, this implies that the locus of support should be communal rather than solely individual, and that their interventions should target affected communities [12]. The orientation of support to individual human resources and collective social-cultural resources indicates that specific interventions for formerly recruited youth should not be singled out, yet be integrated into wider support systems. Additionally, former child soldiers’ request for support on various resource domains indicates that they do not necessarily need a singular nor an utmost specialized kind of support. This implies that supports for former child soldiers should be part of a comprehensive, multilevel initiative that operates on the individual, social and cultural dimensions of life [1, 40, 41, 45].

These findings should be interpreted in the light of the methodological limitations of this study. To begin with, when asked to share perspectives on desirable support, people are likely to favor direct needs satisfaction to compensate direct resource loss [21, 22]. As a consequence, it is possible that certain types of support have been underestimated and therefore were not reported, yet they could make a valuable contribution in a rather indirect manner or in the longer term. Thus, the motivation for direct needs satisfaction might have biased the participants’ responses. Moreover, the hypothetical question on what might be done to support formerly recruited young people may inadvertently have raised the expectation of actually acquiring the requested support. This implies the possibility that the participants exaggerated their recommendations for informal and formal support systems, while neglecting their extant resources in hopes of emphasizing the much needed additional support [46]. Moreover, the difference in written and oral administration of the questionnaire might have generated an inadvertent bias in the data collection. Another constraint is related to the limited perspectives included in this study, given that only the non-recruited age mates were heard as representatives of the different informal and formal agents. In order to evaluate whether former child soldiers’ requests for support can rely on social backing and are feasible, a thorough examination of the perspectives and resources of all different agents should occur. This could facilitate a better estimation of the extent to which formerly recruited young people’s needs can be satisfied or are frustrated by environmental support systems, which is an important determinant of well-being [47].

Acknowledgments

This study was supported by the Service Peace Building of the Federal Public Service Foreign Affairs, Foreign Trade and Development Cooperation. The authors wish to acknowledge the invaluable help of the dedicated research assistants as well as the cooperative principals and LC1 chairpersons who have facilitated this research considerably. Sincere gratitude and appreciation go in particular to the participants of this study.

References


Research Article

“Recovery Came First”: Desistance versus Recovery in the Criminal Careers of Drug-Using Offenders

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Received 28 October 2012; Accepted 28 November 2012

Academic Editors: E. Broekaert, R. C. Rapp, and W. Vanderplasschen

The aim of our paper is to gain insight in the desistance process of drug-using offenders. We explore the components of change in the desistance process of drug-using offenders by using the cognitive transformation theory of Giordano et al. as a theoretical framework. The desistance process of drug-using offenders entails a two-fold process: desistance of criminal offending and recovery. The results however indicate that desistance is subordinate to recovery because of the fact that drug-using offenders especially see themselves as drug users and not as “criminals.” Their first goal was to start recovery from drug use. They were convinced that recovery from drug use would lead them to a stop in their offending. In the discussion, we explore the implications of this result for further research.

1. Introduction

Since the early 1990s, the interest in criminal careers has been increasingly reflected in the criminological research. Although there is a longstanding tradition of criminal career studies (onset and duration), the study of desistance from crime (the end of a criminal career) is a more recent research area. Some scholars define desistance as a termination point [1, 2], albeit most scholars prefer to see desistance as a dynamic and gradual process because several turning points can occur during the criminal career [3, 4]. When a person experiences life events such as finding a job or getting married, their social capital can increase through entering into those new social bonds [5]. These life events can then be considered as turning points away from crime.

Different theories explain desistance from crime. A key-theory on desistance is the age-graded informal social control (AGISC) theory of Sampson and Laub [5]; a dynamic model to explain the development of the criminal career. The AGISC-theory states that individual changes occur because of the development of social bonds. Social bonds can be considered as stakes in conformity and they act as a reason to stop offending [5, 6]. Social bonds are a dynamic characteristic since the strength of the social bonds can vary over time and can change depending on the age of the individual, making it an age-graded informal social control theory [7–9]. Furthermore, Sampson and Laub acknowledge the importance of human agency as a central element in understanding crime over the life course. They see individuals as active agents, engaged in transformative action oriented towards their future self (e.g., as a “desaster from crime” or as a “family men”). They have the choice and individual will to give up crime.

Maruna [4, 10–12] elaborates on agency in his “narrative perspective.” According to Maruna [4], desistance occurs when the intrinsic motivation to change (inner change agent) is present [4, 13–15]. To desist from crime, (ex-)offenders need to develop a prosocial identity for themselves. Maruna makes a specific distinction between a condemnation script (story of the persisters) and a redemption script (story of desasters) [4, 16].

Next to Maruna, Giordano and her colleagues focus on agency and in particular on the role of the actor in the change process. In their cognitive transformation theory, they introduce the concept of cognitive shifts as part of the desistance process [17]. Based on the theory of symbolic interaction, they stress that human agency requires choice and power. In this context hooks for change, that is, turning
points, can serve as a catalyst for change. Giordano et al. indicate that the desistance process consists of four steps. The first step is an openness to change; the offenders need to realize that change is necessary and desirable. This requires reflection and reassessment. Second comes the exposure to the hook for change, the opportunity to change. The third step is an insight in the conventional “replacement self,” the possibility to see themselves in the new role. The fourth and final step is the transformation away from criminal behaviour and the consideration that the former behaviour is negative [2]. The first and second steps focus on openness and willingness to change and the necessity to answer to the opportunities to change. The third and fourth steps are related to the development of a new conventional identity. Individuals need to have the ability to recognize and to show their openness for that hook. This however requires agency: the desire, the ability, and the access to change [18].

The desistance research has regularly developed theoretical insights and empirically studied the role of life events, such as marriage [5, 19] and employment [20, 21] as important elements of social control in desistance [22, 23]. However, life course theories have overall left agency out of the theoretical picture [24] and most longitudinal data sets do not provide the researcher with the opportunity to empirically study the role of human agency [24].

Nevertheless, human agency is an important element in the desistance process. For some offenders, life events like marriage and having a job have a positive influence on desistance, while the same life events do not appear to have the same influence on others. However, there is no clarity about which factors play a role in which circumstances. Agency could have a mediating effect on the objective factors that have an influence on desistance. Hence, the motivation of the offender to change and the attitude of the offender towards those social bonds are also crucial.

The aim of our paper is to get insight in the desistance process of drug using offenders by using the cognitive transformation theory of Giordano et al. as a theoretical framework. Firstly the cognitive transformation theory is a widely known and empirically tested theory [25, 26]. Secondly, in this study, we want to further explore the readiness for change and investigate how the desistance process of drug-using offenders works. After all, Giordano et al. refer themselves to the group of drug-using offenders in explaining the first type of cognitive transformation, namely, exposure “The most fundamental (step), is a shift in the actor’s basic openness to change. The importance of this readiness for change has been discussed extensively in various treatment literatures, especially those dealing with addictions” [17, page 1000].

To this end, this study has one central question: what are the components of change in the desistance process of drug-using offenders?

2. Method

The current study is part of an ongoing Ph.D. study on turning points in the criminal careers of drug-using offenders. Unraveling the contributing elements in the recovery and desistance processes and the way in which they have influenced each other calls for a qualitative research. Only in such a design can the subjective experiences of drug users be put at the centre of the study in order to increase insight into the “how” and “why” of desistance [4, 27]. The research design comprised of semistructured interviews in which implicit meanings and reflections can be taken up with the respondents [28]. The questionnaire was based on the questionnaire used in the study of Byrne and Trew [14], complemented with the questionnaires of the studies of Rönkä et al. [29] and Laub and Sampson [3].

The current study is aimed at desisting drug-using offenders. In order to find individuals who had been strongly involved both in offending and in drug use, the study makes use of gatekeepers in order to identify suitable research subjects. After all, this population can be considered as a hidden population. Gatekeepers were sought in treatment services and in social work services (so-called “street corner services”) rather than in prison staff, because the former are more suited for identifying desisting drug users. The gatekeepers were contacted in 13 different cities in Flanders in order to secure adequate territorial coverage. Gatekeepers identified and established the contact with 35 respondents, after which snowball sampling was used to come into contact with 5 additional respondents [30]. The snowball sampling was limited because most respondents broke contact with a former drug-using context.

After the snowball sampling, we conducted a critical case sampling to decide on the inclusion of the respondents for the interviews. The criteria for whether or not to be included depended on the assessment of the gatekeepers and the self-reports with regard to drug use, offending, and desistance. With regard to the use of illicit drugs, previous use “on a regular base” was required. To determine which use constituted “regular use,” the definition of Nelles et al. [31] was used, stipulating that drug use is regular when it happens “at least three times a week for 1 year” [31]. With regard to offending, our criteria were that the respondents had to have committed at least five offences (property, violent, sexual, or consensual crimes) during a period of five years. A minimum of five offences is required in order to select those exoffenders who previously had “criminal careers” and to exclude first and/or occasional offenders. In order to be able to study their desistance process, this process needed to have started one year before the inclusion in the research project.

In total, 40 desisters were interviewed, 32 of them male and 8 female. They had desisted from offending for a period of, on average, 28 months. The respondents had used several types of drugs and had committed several offences.

The interviews lasted between one and three hours. Their anonymity and confidentiality were guaranteed. Respondents were informed about the project, first briefly by the gatekeeper, later on in detail by the researcher. All respondents signed an informed consent (describing the research theme, their (confidentiality) rights and a contact address for further information). The interviews were recorded, after the consent of the respondent had been obtained. Afterwards transcripts were made and processed using specific software for qualitative analysis (NVivo) using a codebook. We used
the four phases of the cognitive transformation theory as the basis for this codebook and the further analysis.

3. Results

3.1. Recovery rather than Desistance. The respondents were asked how their desistance processes had evolved, both with regard to drug use and to offending. Starting from the four phases desistance process, described by Giordano, we notice that the desistance and recovery process of drug-using offenders is complex.

For some of the respondents, their offending was limited to selling drugs, without this being dealing at a large scale. Rather they sold drugs to their friends, with no other goal than to obtain some extra money for their personal drug use. Mostly, they never earned a lot of money with it, so for them desistance from offending was easy and a logical result of their drug use desistance, although there could be a lag between the desistance from drug use and the desistance from dealing.

I was dealing drugs. But it was not dealing, dealing. It was for my own use and as a favour for my friends. Our “gang” that was fun. I did not earn a lot of money with it, so for me it was easy to stop doing it. (Male, 38, desisted for 1 year)

A significant group of the respondents committed offences in order to have enough money to sustain their own drug use. Their offences were property offences and could be denominated as the so-called acquisitive offences. In these cases, offending only started after the drug use and could be considered a consequence thereof. Because of this, we see that the respondents consider their desistance from offending to be subordinate to their drug use desistance. Their first goal was to stop using drugs. Because both offending and the use of drugs were related to each other, they were convinced that desistance from drug use would lead to a stop in their offending.

I stole to have money for food and also a bit for drugs. I stopped offending because it was not necessary anymore because I did not have to buy drugs anymore. (Female, 37, desisted for 9 months)

For me, stop using drugs and committing offences were related. But to stop using was the most important thing. Because I knew: “if I stop using, then I do not have to offend anymore.” (Male, 39, desisted for 1 year)

A minority of the respondents was involved in offending in a way which was not strictly related to their drug use. They had had several contacts with the police and with judicial authorities. Unlike the previously mentioned persons, these respondents experienced desistance from offending as a conscious process. They grew to see their involvement in offending as being at odds with their new responsibilities and life styles. They wanted to avoid going to prison, not so much because they fear prison in itself but rather because a stay in prison would jeopardize their lives as a partner or as a parent.

You have a certain responsibility now. Why don’t you want to commit offences anymore? Because you don’t want to leave your partner behind on her own. I am not afraid of prison, but I would be afraid of leaving her on her own. It frightens me more than prison. I chose consciously not to commit offences ever again. I had already stopped offending when I stopped using drugs. I don’t think that they had a very strong influence on one another. It was the sense of responsibility that made the “click”. (Male, 38, desisted for 4 years)

To conclude, most of our respondents (four out of five) consider their desistance from offending to be subordinate to their drug use “desistance” (so recovery). Their first goal was starting to recover from drug use. They were convinced that recovery from drug use would lead them to a stop in their offending. After all, as seen in the literature, commitment to recovery is related to one’s quality of life which in turn can be enhanced by (re)gaining and maintaining certain desired needs in life (e.g., stable housing, education and work, family, well-being, stable financial situation) [32, 33]. In the interviews, they could not answer the question how their desistance process from offending developed. For them, desistance from offending is not a conscious process of making the choice for change, but rather a consequence of their new life style, namely, a drug-free life. As a consequence, for the analysis of the key concepts of Giordano’s cognitive theory, we focus on the recovery from drug use rather than on desistance from crime in the remainder of the section.

3.2. Openness to Change. Several respondents indicated that at a particular time in their lives they “reformed,” they made a change which they describe as a “click.” They found the motivation to change their life. For most respondents the exact cause of that motivation is difficult to identify. They cannot explain what the trigger was to make the decision to stop using drugs. They can only say that they wanted to change themselves and their lives.

It couldn’t last anymore, it was not livable. Waking up, against my will, never fully awake, working, money. Never enough money because you have spend too much on partying. You feel dirty… ultimately, it had been enough. (Male, 25, desisted for 2 years)

Some of these respondents did refer to a specific cause for their openness to change, when they explicitly mention the “aging”-argument described in desistance literature [34].

A lot of things happen during your drug-using career. At a certain moment it cannot go on anymore and then you have two choices: continue what you are doing until you die or say to yourself “I am already 55, I do not want to die when I am 56.” (Male, 55, desisted for more than 20 years)
Most respondents came to the decision to change after evaluating their life course and realizing the need to change. They indicated that they wanted to have a future, that they did not want to remain an outsider and wanted to become an active member in society. For some respondents, this assessment process was concluded after several months, for others this assessment process took years. For most respondents in this group, this reflection started after a difficult period in their life of heavy drug use and drug-related crime. For others, the reflection process started when they experienced the weakening of social bonds, that is, periods when social bonds were at stake or already lost.

I started shoplifting, I lost my job, I lost my girlfriend, I lost my parents. I had nobody. So I’ve said to myself: I have to stop. Otherwise, I would have killed myself. (Male, 34, desisted for 2 years)

3.3. Exposure. A key issue in recovery, according to the respondents, is that recovery should be motivated by internal rather than by external reasons, such as the presence of external social bonds. Most respondents place the entire responsibility for recovery on themselves. To them, it is clear that the real turning point with regard to their drug use should be situated in their own decision to stop using, arising from their own motivation. According to the respondents, drug use is intrinsically personal and motivated by the self. Because drug use is so attached to personal—selfish—motivations, recovery should be as well.

However, this does not imply that external factors do not play some role in this process. External factors such as family, relationships, or death of peers can trigger the internal motivation or can provide the added value to make the decision to stop using drugs. Another person or a change in social bonds made respondents realize that change was necessary. Most of the respondents mentioned family and new or changing relationships. Especially starting a new romantic relationship or becoming a parent have been denominated as the most important external factors which led to an internal motivation. In some cases, this immediately led to desistance. In other cases, several years passed before these personal ties led to change, for example, when the relationship was in danger or when they would lose custody of their child. At these moments, they realized what they could lose. Besides family and personal relationships, a large group of respondents mentioned the influence of treatment. Some respondents mentioned difficult periods such as the death of a relative or friend. This period often made the respondents think about their lives. Such strong impacts and emotions made them also push through when they were at risk of a relapse. Finally, a few respondents mentioned the influence of the criminal justice system.

In treatment I got structure. I knew that I needed that, therefore I also did my best. Without treatment, I could not have done it. It took me a long time to tell myself that it could not go on like that… I went to treatment for my girlfriend… In treatment I did everything to get her back, but it’s not because of her that I stopped. I stopped not only for her, but also for me. She is the cherry on top… Of course she stimulated me, but it was not enough… I can’t stop for somebody else… (Male, 25, desisted for 2 years)

Openness to change and exposure to change seem to go hand in hand. Most respondents indicated that it was their decision to stop using and that external factors are of secondary importance. With regard to “hooks for change,” it is important that the individual recognizes the hook and considers it as a chance to desist from their deviant behavior. This process demands a level of active involvement and the energy to grab the chance to change. Where openness can stand alone and lead to recovery, exposure requires the openness to change. When the respondent does not realize that change is necessary, they could not stay abstinent. Some respondents compared their current recovery process with previous ones, in which they had stopped using for somebody else (e.g., partner, parents…). In their previous attempts, this external motivation for change was not sufficiently bent towards an internal motivation, which led to relapses. It was only after these periods of relapse that they had found a personal motivator for change, which ultimately led to their recovery. This means that external social bonds need to be accompanied by openness to change (the internal motivation).

My mother used to say that I should stop using for her. But that never worked. I think that when you are doing it for somebody else, that it does not work. You should want it for yourself. When you are doing it for somebody else… at these moments when you are using drugs or ready to use drugs, you do not think about somebody else, you think about yourself. That is why I am doing this for me. You can try to stop for somebody else, but sooner or later you start again, that is what the past has shown me. Now that I am doing this for me, it finally lasts. (Male, 19, desisted for 6 months)

3.4. Insight in the Conventional “Replacement Self.” Most of the respondents indicated that they wanted to change because they wanted to be themselves again. Like mentioned before, they felt like they became someone else during their drug using period, especially when their drug use was combined with offending—the latter being contrary to their personality (which was also found by Maruna [4] in the redemption script). When recovered, they wanted to have a new role as a father, as a partner, or a nondrug user. The respondents made plans for the future, they realise they wanted to make something out of their lives.

At forty, I want a house, a job, be somebody in life. I am willing to give it all up to achieve my goal. I do not go out anymore, I have stopped smoking and I am even a sportsman now. First the baseline, the foundations and then the rest… You just have to realize you have to take it step by step… Just continue and fight. (Male, 38, desisted for 2 years)
Often they compare their situation with that of others, mostly nondrug using people. They regretted they not yet achieved the same things as people in their age group have. But at the same time, it motivates them to make something out of their lives. They assessed what they had achieved and still wanted to achieve on different life domains. The most important life domain for them was family; they wanted to be a good mother/father to their children. Secondly, the development of a stable relationship with their partner was frequently mentioned. Finally, finding a (different) job was also considered to be an important goal. They wanted to develop meaningful relationships (with their children, with a partner), they want to be a good parent, and they wanted a satisfying job. Often, they had lost everything (custody, their job) and the moment they decided to recover, they wanted to regain these lost social bonds and start fighting for it.

I could no longer carry on like that, it had to end... I had no life... I started comparing myself to my sister; university, married... and what had I achieved in my life? I was jealous of people who had done something with their lives, who took care of their children, worked and owned a house. And now I want the same. (Female, 28, desisted for 3 years)

3.5. Transformation. Looking back on their past and present behaviour, respondents realize that they were “someone else.” This is particularly the case for respondents who combined drug use with acquisitive crimes. Almost all respondents look at their lives differently and have another goal expectation compared to the period in which they still use drugs or commit crimes. Their image of themselves and their personality also changed. When they used drugs, and committed crimes, they were someone else; they feel that their behaviour was contradiciting their personality. Looking back at their past behaviour they label themselves as a “junk,” although at that time they did not realize that they were having problems with drug use. Interestingly, none of the respondents labeled themselves as former offenders.

I never realized it was so bad. I had a job. If you asked me: what is a junk? I thought: it is somebody who lies in the gutter, without work and with a needle in his arm. I never was like that, but still I was a junk. The image I had of a junk was something completely different than me, but still I was one. (Male, 25, desisted for 2 years)

As mentioned in the former phase (replacement self), the respondents see themselves in their new role before they are actually transformed. Since they are very realistic about their future, taking into account that a former drug user should never consider him/herself to be completely “recovered;” therefore, they do not call themselves recovered persons successfully reached the end of the recovery process, but rather recovering persons, indicating they consider recovery as an ongoing process.

Yes, it is always difficult. Both physically and mentally. Every day I am tempted. I won’t say “I’m clean and this is for the rest of my life”. It’s like alcoholics. I am clean today, but we’ll see about tomorrow... For now I am ok. You have to live from day to day, especially with heroin. (Male, 38, desisted for 1 year)

Although former drug-using offenders are oriented towards the future, they are still to some extent contemplating their past because it is a very important aspect of their recovery process. They consider their past as a kind of life experience, a period that made them think about the direction of their lives and made them want to focus on other goals.

I have lost a lot of money and I hurt a lot of people who loved me without even realizing because I was so tangled up in the drug scene... I know that you should look ahead and not backwards, but it will always be a part of my luggage. (Male, 34, desisted for 2 years)

The respondents also indicate that they continue to fight a labeling process. During their drug using period, they were somebody else: a junk, a criminal. Now that they are recovering, they become themselves again, “the clean person.” A difficult obstacle however is that society needs to accept them as a clean person (again) and needs to accept the new roles they are willing to take. This is not always evident. Therefore, some respondents want to move to another city where they can make a fresh start.

I've changed for myself. I want to be part of a group of clean people. I don't want to be the outsider... the user...the junk... Although they still look and point at me “Look there, a junk!” That label will last forever... until my death. (Male, 37, desisted for 4 years)

3.6. Behavioural Change. Entering new social environments and (re)establishing social bonds, as well as avoiding or breaking contact with previous networks, is denominated an important element in desistance. To sustain recovery from drug use, most respondents identified that they had to break with a drug-using partner or drug-using friends. They prefer to start a quest for (drug-free) bonds who could support them in a life free of drug use, and consequently, of crime.

I left it behind me. I broke up contact with everyone (former friends). Otherwise, they would say: Come on X., it would not do you any harm. That's the reason I don't want to see them again. (Female, 41, desisted for 13 years)

4. Discussion

4.1. The Cognitive Transformation Theory Is Applicable to Drug Using Offenders. The population of drug-using offenders is of special interest for the study of desistance.
because of the influence of drug use on the development and continuation of criminal behaviour [35], since this population commits a substantial number of offenses [36] and since recidivism rates are high amongst this population. Thus, drug-using offenders have a bigger chance to develop a long lasting criminal career [37]. From our interviews with desisting drug-using offenders, it became clear that the cognitive transformation theory and its different phases are applicable to our research group. Like Giordano and colleagues mention in their cognitive transformation theory [17], it is especially the first phase, openness, and readiness to change that is characteristic for drug-using offenders. Intrinsic motivation is a key factor in the recovery process [38, 39]. Besides that openness, drug-using offenders need the opportunity to change. Their hooks for change are mostly relationships, family, and treatment related. It became clear though that most of our respondents are stuck in the third phase, before the identity change (fourth phase). They consider their past behaviour as negative, they want to become themselves again, and they want to show their new role to society. But most of the respondents do not believe that a real transformation is possible since drug addiction is a long lasting problem and since society is still labeling them as such. In fact, they are quite realistic about their success rate, distinguishing them from other groups of offenders. Where other types of disasters make ambitious plans for the future (as became clear from the redemption script described by [4]), drug-using offenders take into account the possibility of personal relapse and societal rejection. They are always alert for situations or people who can tempt them to start using again. This type of ambivalence is widely recognized in desistance literature and is thought to be common in the first stages of change [40].

4.2. Desistance Is Subordinate to Recovery. From research, it has become clear that the link between drug use and crime is not straightforward [41]. Researchers have been interested in establishing what came first: drug use or crime. Because of the intertwined relationship between drug use and crime, it is not obvious to distinguish both processes. There are not a lot of studies on the specific desistance process of drug-using offenders. This small amount of studies uses in most cases desistance (from crime) and recovery (from drugs) as synonyms [42, 43]. This study aimed to gain insight in the desistance process of drug-using offenders. We started from the desistance perspective and explored whether a general desistance theory is also applicable to drug-using offenders (it was however not our aim to test this theory). However, during the study respondents indicated that “to them” recovery is more important than desistance. In most cases the respondents indicate that desistance is a result of recovery. However, this does not imply that their goal is abstinence. 15 respondents were still using drugs in the year preceding the interview. Despite their drug use, these respondents identified themselves as desasters; for instance, they were former regular heroin users but since that period they switched to regular cannabis use. We did include these respondents in our study when they identified themselves as desisting persons. In the past, lifelong abstinence was seen as the only indicator of recovery. In recent years, however, abstinence is seen as just one indicator of recovery and not the only or ultimate goal; significant reductions in drug use are also seen as important indicators [44].

4.3. The Transtheoretical Theory as an Extension of the Cognitive Transformation Theory. Recovery and desistance are two research traditions originated from a different context, developed parallel to each other, and seldom interconnected. Recovery originated from the mental health discipline; desistance originated from the criminal career tradition and it is predominantly criminological focused. However, theories on recovery and desistance have important similar characteristics. Recovery and desistance are both transformational processes and not linear but dynamic and gradual processes. People in the process of recovery and desistance are active agents. These processes require human agency which in its turn demands individual choice and power. The major difference between recovery and desistance is that has to do with the final “goal” of change. Regarding recovery, the people themselves define what recovery entails. White has described this goal for people living with psychiatric and/or addiction disorders as “to eliminate or manage their symptoms, increase their capacity to participate in valued relationships and roles, and embrace purpose and meaning in their lives, in other words, experience recovery” [45]. In desistance, however, the focus is mainly on socially desirable outcomes (e.g., no illegal drug use, no criminal offences, employment) and less on client-reported outcomes and starting from clients’ own expectations and experiences (e.g., quality of life) [46]. As active agents, the respondents in our study challenge some of the socially desirable outcome indicators of change, in particular of no drug use. Following the drug users’ perspective, when tackling drug-related crime, it is as important to tackle the drug using problem and related problems on other life domains, besides the criminal problem. After all, in most cases, when controlling the drug problem, the criminal career will be positively influenced.

We are thus convinced that these two traditions can learn from each other and that evidence of one tradition can extend knowledge of the other. An illustration of this is the transtheoretical theory of Prochaska [47].

4.4. Structural Constraints. We already mentioned the evolution in criminological theories. Hirschi rephrased the question of “why do offenders commit crime” into “why do they not commit crimes,” which led him to explore social bonds and focus less on motivation. The present scholars however acknowledge and emphasise the role of the individual actor. This theoretical shift can be situated within a cultural shift. In the modernization process, our society became more individualistic. At macrolevel, individuals act more independently. Some social norms do not exist anymore or became more liquid [48]. More responsibility is given to the individual and less attention is given to his/her social bonds. In this study, we found the same state of mind. Most of the respondents place the entire responsibility for
recovery on themselves. For them, it is clear that the real turning point with regard to their drug use should be situated in their own decision to stop using, with self-motivation as a starting point. According to the respondents, drug use is intrinsically personal and motivated by the self. Because drug use is so attached to personal and selfish motivations, recovery should be as well.

In this context, some authors represent the symbolic interaction theory as a perspective that works well for describing individual behaviours, but not the society/group behaviours [49, 50]. Giordano et al. recognise this criticism in their cognitive transformation theory [17]. Intrinsic motivation is important but not sufficient to abstain. The (immediate) social world plays an important role in this regard. It is not because you WANT to change that you will SUCCEED. Structural constraints/barriers for instance the stigma of former drug users or the lack of job opportunities for former prisoners play a significant role [51]. Our respondents noticed these broader social forces by describing the difficulty of living with the label "ex-drug-using-offender."

Based on our results with desisting drug using offenders, we formulate two recommendations for future desistance research.

Firstly, in most desistance studies, drug use is not studied as a separate element in the desistance process. Drug use is mostly considered as a risk factor in the desistance process of crime [52]. Less desistance studies are focused on the factor of drugs as an inherent factor of the desistance process and the (inter-)relationship between recovery and desistance. This paper however illustrates the importance to see the drug using part as a crucial part in the desistance process. Like mentioned several times, our respondents see themselves as drug users, not as criminals. Future studies on desistance need to emphasise the factor of drug use and consider it as a separate factor instead of a part of antisocial behaviour. This is particularly relevant since research established that 70% of repeated offenders are regular users [36] and 14% of registered crime (property, sexual, and violent crimes) is drug related [53].

Second, when looking at desistance, it is important to look, next to the official reports registering offending, to the perception of the offender/desister itself. If this study was based on official data, more than a half of the respondents could not have been considered as "desasters." More than 60% of the respondents were still using cannabis at the time of the interviews but they had recovered from heroin use. They do not consider cannabis use as "drug use" as they do not consider dealing, in the form of social supply as a "criminal act" [54]. This also refers to the earlier mentioned state of ambivalence (referring to the fourth phase of the TTM). Although they considered themselves as nondrug users or noncriminal, they could still have had arrest records or convictions relating to their cannabis use or dealing. So, when studying desistance and its underlying processes, it is recommended to include a qualitative study on the perceptions of (former) offenders, next to the study of official police data since the former will add to the insight into the complexity of the desistance process.

To conclude we stress one important study limitation linked to our sampling method. The sample size of this study was limited. Gatekeepers identified and established contact with 35 respondents, after which snowball sampling was used to come into contact with 5 additional respondents [30]. The snowball sampling was limited because most respondents broke contact with a former drug-using context. Furthermore, our sample consisted especially of men instead of women (ratio 32:8), but this is a reflection of reality: more men than women are involved in crime and drug use [55, 56] as well as in drug treatment [57, 58]. Therefore, the results of this qualitative study should be interpreted with caution, as the findings might not be transferrable to the total group of drug-using offenders.

References

[14] C. Byrne and K. Trew, "Pathways through crime: the development of crime and desistance in the accounts of men and


Research Article

Mental Health Recovery: Evaluation of a Recovery-Oriented Training Program

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Received 27 October 2012; Accepted 24 November 2012

Academic Editors: S. Pearce, W. Vanderplasschen, and S. Vandevelde

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Aim. This study investigates the effectiveness of a recovery-oriented training program on knowledge and attitudes of mental health care professionals towards recovery of people with serious mental illness. Methods. Using data from a longitudinal study of recovery, changes in knowledge and attitudes of 210 mental health care professionals towards recovery were explored using the Recovery Attitude Questionnaire and the Recovery Knowledge Inventory. The study uses a two-group multiple intervention interrupted time-series design which is a variant of the stepped-wedge trial design. A total of six measurements occasions took place. Results. This study shows that professionals’ attitudes towards recovery from mental illness can improve with training. After two intensive recovery-oriented training sessions, mental health care professionals have a more positive attitude towards recovery in clinical practice. Conclusion. A recovery-oriented training program can change attitudes of mental health care professionals towards recovery of serious mental illness.

1. Introduction

With growing interest in the concept of recovery of patients with severe mental illness, the role of the mental healthcare system is receiving increasing attention. The National Consensus Statement on Mental Health Recovery defined recovery as “a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life with the limitations of the illness, in a community of his or her choice while striving to achieve his or her full potential” [1]. Recovery in this sense is focused on personal growth, hope and autonomy [2], and learning to live with the negative consequences of the disease [3]. Recovery, in this way, is based on the client’s perspective [4, 5]. It is seen as a continuing process of change [6] which is not illness focused. The main issue is how treatment can facilitate the recovery process of patients with long-term psychiatric problems, and how the relationship with the mental health consumer might impede or facilitate recovery [7–10]. Professionals can contribute to the recovery process [11–15] and are able to facilitate a recovery-promoting environment for people with serious mental disorders (e.g., [16]). However, for successful implementation of a recovery approach, mental health care professionals need to change or adapt their attitudes towards this new vision of recovery.

To change the traditional mental health care system to a more recovery-oriented one, many organisations train their professionals in the recovery concept. However, lack of knowledge and skills, organisational barriers (such as poor leadership), a change-averse culture, insufficient collegial support, and bureaucratic constraints may hinder the dissemination and implementation of innovative approaches...
A supportive factor for effective implementation is the use of understandable language, which promotes a more positive attitude towards the topic and increases perceived behavioural control over the implementation [18, 19]. Hence, to implement a more recovery-oriented care system, it is important to focus on the professional’s belief in and understanding of recovery, and the ability to promote patient recovery [10, 11]. Moreover, professionals who have to assimilate a new recovery vision into their routine practice need to master a set of core competencies [20]. These competencies include effective communication, fostering hope, appropriate self-disclosure, and a mutual respectful partnership in treatment. Working in partnership, identifying individual needs and strengths [21], and responsible risk-taking are also capabilities that strengthen a new way of working with people with severe mental illnesses. Unfortunately, much of the evidence available today is of a narrative nature, whereas to validate a new recovery approach more empirical-based data are required [22].

Therefore, this study investigates the effectiveness of a recovery-oriented training program implemented in the Netherlands. To explore changes in knowledge and attitudes of mental health care professionals, a variant of the stepped-wedge trial design [23, 24] was used.

2. Methods

2.1. Procedure. All mental healthcare workers of the department “Impact” (the department for long-term mentally ill people in Breda/Etten-Leur) were asked to participate in an educational program about recovery. All participants were verbally informed by their managers; they received an information flyer about the program, and gave informed consent before the study started. The educational program was mandatory for all professionals. Parallel with the educational program an evaluation study was conducted to assess the effects of the educational program. The management team explicitly encouraged participation in the evaluation study.

Prior to the start, the regional Medical Ethics Approval Committee for Mental Health Care Institutions (METIGG) was approached. According to the Medical Research Involving Human Subjects Act (WMO), ethical approval was not required.

2.2. The Training Program. In order to implement the new recovery vision and to achieve a culture change within the mental health organisation located in Breda, a recovery-oriented care project was developed by three major mental health care organisations: that is, two rehabilitation organisations (Rehabilitation ’92 [25] and STORM rehabilitation [26]) and one peer-support organisation (HEE [27]). The “Recovery and recovery-oriented care” project was developed especially for the mental healthcare network “Impact” where people with chronic psychiatric disorders, for example psychotic disorders, are treated. Inpatients and outpatient’s settings are involved. The main goal of the project was to create and promote a new culture towards recovery from serious mental illness: how can treatment promote the recovery process of patients with long-term psychiatric problems and does the relationship with the mental health professional facilitate recovery [13, 14, 21]?

The educational program was given in two separate intensive training sessions, one in 2008 and a second one in 2009. The training program was developed for all professionals who are in close contact with the mental health care patients, like there are psychologists, psychiatrists, secretaries, managers, and nurses. The training program consisted out of two modules given in a two-day session every six months. The first module was focused on the basics of recovery-oriented care in order to familiarise the professional with the concept of recovery. The second module was focused on the recovery-oriented attitude of the professional. Both courses were presented by an expert by experience from a peer support centre and a professional rehabilitation teacher. A more extensive description of the development of the training program is given in Boevink et al. [28].

The participants were randomly selected and eighteen groups were formed with 10–16 professionals per group. The first module “Basics of recovery and recovery-oriented care” (intervention A) was given in the first half of 2008. The second module (intervention B) was given in spring and summer of 2009. This seminar was focused on attitude towards recovery and the way the professional is able to stimulate and facilitate recovery within the client. An overview of the training seminars (experimental conditions) with the different measurement occasions and the corresponding response rates is given in Figure 1. Both seminars were given in close cooperation with an expert by experience from the peer-support organisation.

2.3. Sample of Professionals. The sample of professionals was recruited at Impact. All 270 professionals were invited to participate in this longitudinal study. Of these, 210 agreed to participate: their average age was 43.3 (range 20–60) years and 74% was female. Their mean period of employment in the mental healthcare sector was 13.2 years and their mean period of experience dealing specifically with long-term psychiatric disabilities was 11.3 years. The sample of professionals consisted of psychiatrists, psychologists, psychiatric nurses, day-activity workers, care assistants, and other professionals in close contact with clients. Two subsamples were formed which each consisted out of nine groups of 10 to 16, randomly selected, professionals. The aim of the educational program was to induce a culture change towards recovery in the entire organization. This was the rationale to include (additional) staff members, such as managers and secretaries, working in different settings. Table 1 presents an overview of the demographic characteristics of the study group.

Note. Parallel with the measurement occasions for professionals, data were collected of 142 mental health consumers for which the Mental Health Recovery Measure (MHRM; [29]) and the Recovery Promoting Relationship Scale (RPRS; [30]) were used. These data will not be used in this study.
2.4. Instruments. In this study, the Dutch versions of the Recovery Knowledge Inventory (RKI; [31]) and the Recovery Attitude Questionnaire (RAQ; [32]) were used. Both instruments are self-report questionnaires for professionals. The original questionnaires were translated into Dutch using a backward-forward translation procedure [33]. Details of the translation procedure and the psychometric properties of the Dutch scales are provided in Wilrycx et al. [34].

2.4.1. Recovery Knowledge Inventory (RKI). The RKI was used to assess the professionals’ general knowledge about recovery over time. The Dutch version of the RKI consists of 14 items and focuses on “Knowledge of recovery”. Cronbach’s alpha for this total scale was 0.80.

2.4.2. Recovery Attitudes Questionnaire (RAQ). The RAQ was used to assess the professionals’ feelings and attitudes
Table 1: Demographic characteristics of the study group (n = 210).

<table>
<thead>
<tr>
<th></th>
<th>N/mean</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>157</td>
<td>74</td>
</tr>
<tr>
<td>Mean age in years (SD)</td>
<td>43.3 (10.8)</td>
<td></td>
</tr>
<tr>
<td>Mean working history, in years (SD)</td>
<td>13.2 (10.2)</td>
<td></td>
</tr>
<tr>
<td>Mean working history within chronic care, in years (SD)</td>
<td>11.3 (9.5)</td>
<td></td>
</tr>
<tr>
<td>Working discipline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatrist/psychologists</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Psychiatric nurse</td>
<td>117</td>
<td>56</td>
</tr>
<tr>
<td>Occupational therapist</td>
<td>32</td>
<td>15</td>
</tr>
<tr>
<td>Placement supporter</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>Case manager</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Care assistant</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>General staff members of Impact*</td>
<td>24</td>
<td>12</td>
</tr>
<tr>
<td>Setting of employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical intensive care</td>
<td>39</td>
<td>19</td>
</tr>
<tr>
<td>Crisis intervention team</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Sheltered and protected care</td>
<td>65</td>
<td>31</td>
</tr>
<tr>
<td>Ambulatory care</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>Day-activity centre</td>
<td>42</td>
<td>20</td>
</tr>
<tr>
<td>Impact general*</td>
<td>26</td>
<td>12</td>
</tr>
<tr>
<td>Information not available</td>
<td>20</td>
<td>10</td>
</tr>
</tbody>
</table>

*The Impact general group includes managers, secretaries, administrative employees, and a priest.

towards recovery. The Dutch version of the RAQ consists of 5 items and focuses on “Attitudes towards recovery”. Cronbach’s alpha for the total scale was 0.61.

Correlation between the RAQ and the RKI scale scores was 0.20 (P = 0.004); this is a significant but low enough correlation to demonstrate that both scales measure different constructs and each instrument has sufficient discriminant validity.

Both instruments were send by mail after each intervention, and participants were asked to complete and return these questionnaires within two weeks.

2.5. Study Design. In this study, a two-group multiple intervention interrupted time-series design was used which is a variant of the stepped-wedge trial design. The stepped-wedge trial design [23, 35, 36] is a repeated-measures design in which the sample is randomly divided into several subsamples which are observed at all time points but differ with respect to the moment at which the experimental intervention is implemented. At the first measurement occasion, all subsamples are observed prior to the intervention. The moment at which the intervention is systematically implemented varies across the subsamples, but at the end of the study all subsamples are observed after the intervention.

For the present study, the basic stepped-wedge design first was modified because two different interventions (represented by the symbols A and B; see Table 2) were implemented at different times. Intervention B always followed after intervention A. Another modification of the basic design concerned the number of subsamples that could be formed. Although in the present study six measurement occasions were planned, only two subsamples could be formed because of the way the educational program was organised. The training sessions were delivered in two sessions over two years. Table 2 shows when the two interventions were implemented in each subsample.

At the first time point (0 = baseline measurement), both subsamples were observed before implementation of either A or B. The first subsample was then observed twice after implementation of A, and three times after implementation of B. The second subsample was observed twice before intervention A, twice after intervention A, and finally twice after intervention B. In both subsamples, a total of six measurement occasions (1–5 = follow up measurements) were planned. At the end of the study, all participants had received both interventions. The time point 5 was observed one year after the time point 4. Since assignment of the subjects to the subsamples was carried out randomly, no systematic differences were expected to exist between the two subsamples.

2.6. Statistical Analyses. The differences between the means of the RKI and the RAQ before and after intervention were tested using a random intercept multilevel regression model with time periods nested within individuals. This model is described in a linear structural equation model and its parameters are estimated by means of AMOS. This software package allows full information maximum likelihood estimation of a model without discarding any observed score in the sample. The analysis of the data was based on the following model. Let i represent a participant in anyone of the subsample c = 1 or c = 2, let t denote measurement occasion and y_{cit} the observed score on a dependent variable for participant i in subsample c at occasion t. Then, the following decomposition of the individual scores was postulated:

\[ y_{cit} = \mu_{cit} + v_{it} + \epsilon_{cit}. \] (1)

In this expression, \( \mu_{cit} \) represents the population mean for subsample c at measurement occasion t. The term \( v_{it} \) is an individual random effect that is included in the model for capturing systematic differences between subjects in the general response level. Finally, the quantities \( \epsilon_{cit} \) are the individual error terms. All random effects are assumed to be mutually independent. Due to the design of the stepped wedge trial design, some of the subsample means \( \mu_{cit} \) are constrained to be equal (see Table 2).

In Table 2, the symbols O_1 and O_2 represent the observations before the implementation of intervention A in both subsamples; the symbols A_1 and A_2 represent the observations after the implementation of intervention A but before implementation of B in both subsamples; finally, the symbols B_1 and B_2 represent the observations after implementing B.

The first hypothesis, that is whether there are no systematic differences between the means of the two subsamples,
resulted in the joint test of three subhypotheses, $\mu_{O1} = \mu_{O2}$, $\mu_A = \mu_B$, and $\mu_B = \mu_B$. When this first hypothesis cannot be rejected, the number of means to be estimated is further reduced and only three different means remain to be estimated (second hypothesis): $\mu_A$ representing the mean before any of the interventions, $\mu_A$ representing the mean after implementing A but before implementing B and, finally $\mu_B$ representing the mean after implementing B. This second hypothesis tested the following subhypotheses: whether intervention A has an effect, that is, $\mu_A = \mu_O$, whether intervention B has an effect that is, $\mu_B = \mu_O$, and, whether the effects of B and A are equal, that is, $\mu_B = \mu_A$. In the model, the effects of intervention A and B are estimated by the differences $\mu_A - \mu_O$ and $\mu_B - \mu_O$, respectively.

Both hypotheses mentioned above were tested by different linear structural equation models in AMOS. The significance of the models was tested by means of conditional likelihood ratio tests which under the null hypothesis follow chi-square distributions with their degree of freedoms equal to the number of constraints imposed on the model parameters. This requires two consecutive models to be tested: in one model without imposing the constraints on the subsample means implied by the hypothesis being tested, and one in which these constraints are explicitly imposed. Because the two models are nested, the conditional chi-square test is obtained by subtracting the chi-square values of the two analyses [37].

3. Results

3.1. Results for the RLI. For the RLI, the null hypothesis that there were no systematic differences between the means of the two subsamples could not be rejected with a $\chi^2 = 1.641$ with 3 degrees of freedom ($P = 0.650$). The sample estimates of the three means (represented by $M_O$ = mean before intervention A, $M_A$ = mean after intervention A but before intervention B, and $M_B$ = mean after intervention B, resp.) to be estimated under the reduced model and their standard errors are

(i) $M_O = 3.027 (0.021)$,
(ii) $M_A = 3.113 (0.019)$, and
(iii) $M_B = 3.066 (0.022)$.

Intervention A has a significant effect since the null hypothesis $\mu_A = \mu_O$ has to be rejected with a $\chi^2 = 17.888$ with 1 degree of freedom ($P = 0.000$). However, the null hypothesis $\mu_B = \mu_O$ cannot be rejected ($\chi^2 = 2.939$, df = 1, $P = 0.086$), and intervention B fails to have an effect. Moreover, since the hypothesis $\mu_B = \mu_A$ is also rejected ($\chi^2 = 5.783$, df = 2, $P = 0.016$), the mean after intervention B drops back to the initial level. Intervention B then seems to annihilate the positive effect of intervention A.

3.2. Results for the RAQ. For the RAQ, the null hypothesis that there were no systematic differences between the means of the two subsamples could not be rejected with a $\chi^2 = 0.890$ with 3 degrees of freedom ($P = 0.828$). The estimates of the three means to be estimated under the reduced model and their standard errors are

(i) $M_O = 3.008 (0.029)$,
(ii) $M_A = 3.100 (0.031)$, and
(iii) $M_B = 3.176 (0.028)$.

Intervention A has a significant effect since the null hypothesis $\mu_A = \mu_O$ has to be rejected with a $\chi^2 = 8.097$ with 1 degree of freedom ($P = 0.004$). Also the null hypothesis $\mu_B = \mu_O$ has to be rejected ($\chi^2 = 29.603$, df = 1, $P = 0.000$), indicating that intervention B has an effect. Finally, also the hypothesis $\mu_B = \mu_A$ is rejected ($\chi^2 = 5.783$, df = 2, $P = 0.016$), and intervention B is seen to have a larger effect than intervention A.

4. Discussion

This study evaluated a recovery training program for professionals in the Netherlands. Specifically, the changes in knowledge and attitudes of mental health care professionals towards recovery of mentally ill patients were investigated using a modified stepped-wedge trial design. The results suggest that over the total course of the training program, expected changes were found in attitudes towards recovery. Similar findings were reported by Crowe et al. [12], and Cleary and Dowling [11], who found that mental health professionals had more favourable beliefs and more positive attitudes related to recovery during the course of the training program. One explanation for the positive results in the present study might be the way the intervention was given. The trainer was an expert by experience, who reflected on the quality of treatment received in the past thereby generating self-reflection. According to Bandura [38] self-reflection can result in a change of attitudes. Because the professional undergoing training was confronted with reports of maltreatment stories, the educational program had an emotional as well as a learning impact. Secondly, the use of understandable/appropriate language might contribute to the positive effect and the perceived behavioural control over the implementation.
Positive results were also found for the change in knowledge after intervention A on knowledge about recovery. However, intervention B (that focused mainly on attitude) had a negative effect on knowledge rather than the expected positive cumulative result. This negative result towards knowledge of recovery might be explained as follows. First, the program developers and the department managers did not investigate the professionals’ readiness to change. Before educating or training people, it is important that professionals are motivated to learn [39, 40]. Second, the lack of rehearsal of knowledge about recovery during intervention A might be responsible for the negative results after intervention B. Studies show that rehearsal is crucial for the implementation of information and is essential for the integration of new knowledge in long-term memory [41–43]. Third, the relatively high age of the professionals might play a role in this poor result, since younger and less experienced people are generally more eager to learn [16]. Forth, because the course was mandatory the extrinsic motivation to change might have been greater than the intrinsic motivation to learn [40]. Finally, as we now know from the recently developed Refocus model [44], the implementation of recovery is much more complex than how it was offered in the training program for professionals discussed in this study. The training program was based on just one part of the Refocus implementation model, namely, staff values, knowledge and partnership and lacked specific training at the work place.

4.1. Limitation and Strengths. This study has a number of limitations. First, the original stepped-wedge trial design needed a modification because of the way the training program was organised. Epidemiological studies using this design have generally explored the long-term effect of just one intervention [44–46], whereas in the present study, the effects of two interventions over a two-year period were examined. Second, there are no reference data for comparison purposes. Reference data of epidemiological studies are available, but data from psychosocial studies using this two-group multiple intervention interrupted time-series design are lacking. Third, the multiple measurement occasions made the research vulnerable; because six measurements took place this made it difficult to maintain the cooperation/motivation of the professionals.

The specific strength of this study is that it has many advantages: it enables to investigate the stepwise implementation of new ideas over time, in a practical situation that does not permit to deliver the intervention simultaneously to all participants [20]. Because of the stepwise implementation of the new recovery concept, professionals could maintain their routine practice. Another strong point is that subjects were randomly assigned to one of the two subsamples defined in the modified stepped-wedge trial design. The fact that no systematic differences were found between the two subsamples demonstrated that the randomization was successful. Finally, the modified stepped-wedge trial design is a within-subject design, which makes the inclusion of a “no intervention” control group less urgent.

5. Conclusion

The study shows that staff knowledge and attitudes regarding recovery from mental illness can improve with training. Mental health care workers have more positive attitudes towards recovery in clinical practice after completing the two training sessions. Furthermore, the modification of the stepped-wedge trial design—which resulted in a two-group multiple intervention interrupted time-series design—has proved to be a useful and promising design to investigate different groups of subjects within behavioural science. More research is needed about the use and the advantages of this specific design within behavioural science. More follow-up research is necessary to investigate how to stabilize changes in attitudes of professionals over time and to evaluate the effectiveness of the recovery-oriented training programs within the mental care.

Conflict of Interests

The authors declare that there is no conflict of interests.

Acknowledgments

The authors are very grateful to Kees van Aart (GGz Breburg) for the facilitation of this study and they thank all the professionals for their willingness to participate in the numerous assessments.

References

[1] Substance Abuse and Mental Health Service Administration (SAMSHA), National Consensus Statement on Mental Health Recovery, Department of Mental Health and Human Service, United States, 2004.


Review Article

Rediscovering Recovery: Reconceptualizing Underlying Assumptions of Citizenship and Interrelated Notions of Care and Support

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Received 25 October 2012; Accepted 29 November 2012

Academic Editors: S. Pearce, W. Vanderplasschen, and S. Vandevelde

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Over the last few decades, research, policy, and practice in the field of mental health care and a complementary variety of social work and social service delivery have internationally concentrated on recovery as a promising concept. In this paper, a conceptual distinction is made between an individual approach and a social approach to recovery, and underlying assumptions of citizenship and interrelated notions and features of care and support are identified. It is argued that the conditionality of the individual approach to recovery refers to a conceptualization of citizenship as normative, based on the existence of a norm that operates in every domain of our society. We argue that these assumptions place a burden of self-governance on citizens with mental health problems and risk producing people with mental health problems as non-recyclable citizens. The social approach to recovery embraces a different conceptualization of citizenship as relational and inclusive and embodies the myriad ways in which the belonging of people with mental health problems can be constructed in practice. As such, we hope to enable social services and professionals in the field to balance their role in the provision of care and support to service users with mental health problems.

1. Introduction

In the field of (mental) health care and a complementary variety of social work and social service delivery, the emergence of new understandings and paradigms of care and support for people with mental health problems has been observed over the last few decades [1–4]. Since the mid-1980s, research, policy, and practice have internationally concentrated on recovery as an inspiring concept [1, 5–10]. The recovery paradigm was considered to be a promising and innovative framework [6, 11] that justified the deinstitutionalization of residential services over the last few decades [12, 13] and has enabled an increasing emphasis on developing community-based services in different Western welfare states [13–19]. This development has been associated with the emergence of new ideas about citizenship, focusing on the right of people with mental health problems to live on equal terms in mainstream society and promoting social inclusion in the community [4]. As discussed by Peck et al. [20, page 442], these ideas have challenged both traditional service structures and the authority of the “professional narrative about the nature of, and responses to, mental distress.”

Quite recently it has been argued, however, that there is an urgent need for conceptual clarity about what constitutes recovery-oriented practice [9, 21], since “key knowledge gaps have been identified as the need for clarity about the underpinning philosophy of recovery” [21, page 449]. In many Western countries, the ambiguity of the emerging concept of recovery in mental health has “created major dilemmas about how to develop adequate (…) community-based services in the context of recurring financial underfunding” [19, page 426]. The central issue implies how mental health systems and services can support the recovery process [1, 2]. In this paper, based on a comprehensive review of the recovery literature and recent empirical research [22–25], a conceptual distinction is made between an individual approach and a social approach to recovery. First, we will outline the scope of the recovery paradigm. Second, underlying assumptions
of citizenship and interrelated notions and features of care and support are identified in each of these approaches to recovery. As Slade [2, page 703] recently asserted, the domain of promoting citizenship among individuals in recovery “has been the least investigated, and yet, plausibly, it is the most influential. Improving social inclusion and community integration requires clinicians (and social service professions) to pay more attention to supporting the person to make connections and to the creation of inclusive communities.”

2. The Scope of the Recovery Paradigm

The recovery movement grew in the realms of the self-help and deinstitutionalization movement in the 1960s and 1970s, when ideas about promoting a life in the community and providing adequate care and support were increasingly developing a broad social base [5, 26, 27]. Since the mid-1980s, an impressive body of knowledge about mental health recovery has been generated from the perspectives and experiences of service users, family members, and mental health and social work professionals [21, 28–34]. The recovery paradigm rejects the assumption that being diagnosed with—even chronic—mental health problems is inevitably considered a tragic catastrophe and the cause of becoming a social outcast [35], and an attempt is made to “reach beyond our storehouse of writings that describe psychiatric disorder as a catastrophic life event” [33, page 335]. Although there are many perceptions and definitions of recovery, William Anthony, Director of the Boston Center for Psychiatric Rehabilitation, introduces a cornerstone definition of mental health recovery, identifying recovery as “a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life, even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness” [5, page 27]. As an approach that constitutes a branch of the comprehensive family of strengths-based perspectives [36], the key themes and ingredients in the academic literature base, including published first-person recovery narrative accounts, can be identified as embracing strengths rather than weaknesses, hope rather than despair, and engagement and active participation in life rather than withdrawal and isolation [2, 6, 21, 31, 33]. At first glance, the recovery discourse explains recovery in terms of a journey of hope [31], consisting of a lifelong, individual process in which the individual takes back control, gets on with his/her life [37], and (re)integrates into the social world [38]. In a nutshell, recovery is crafted onto empowering service users with mental health problems to stimulate their personal growth and responsibility [35].

In what follows, we focus on different conceptual notions of recovery and on the complicated issues and dilemmas that are emerging concerning the ways in which care and support can be provided by professionals [13, 19], as it is stated that social service professionals play a pivotal role in supporting service users with mental health problems in their recovery [1, 2, 17]. In the extensive body of recovery literature, we identify and distinguish an individual and a social approach to recovery. In our conceptual analysis, these different conceptualizations of recovery intrinsically construct different notions of citizenship and imply disabling as well as enabling features of care and support offered by professionals in social service delivery. In the individual approach to recovery, an underlying notion of normative citizenship is persistently at work, implying a residual perspective on care and support services. In the social approach to recovery, an underlying notion of relational and inclusive citizenship is uncovered, enabling a structural perspective on care and support services.

3. An Individual Approach to Recovery

In both theory and practice, stressing the service user’s responsibility appears to be a central component in the empowering process of recovery [39]. According to Deegan [31, page 2], for example, recovery involves enabling people with mental health problems to “regain control over their lives, and (…) be responsible for their own individual journey of recovery.” Recently, mental health experts formulated a working definition of recovery as a person-driven process: “self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals. Individuals optimize their autonomy and independence to the greatest extent possible by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience. In so doing, they are empowered and provided the resources to make informed decisions, initiate recovery, build on their strengths, and gain or regain control over their lives” [40]. The majority of recovery-oriented researchers and practitioners emphasize that recovery involves a resurgence of a coherent sense of self and of personal responsibility for one’s own state of being in the process of social reintegration [41, 42]. In that vein, the work of recovery-oriented professionals revolves around a logic of empowerment to stimulate personal growth [43]. Craig [44, page 126] formulates the recovery-oriented task of the services as “a matter of doing as much as possible to empower the individual. The aim is to have consumers assume more and more responsibility for themselves. Their particular responsibilities include developing goals, working with providers and others—for example, family and friends—to make plans for reaching these goals, taking on decision-making tasks, and engaging in self-care. In addition, responsibility is a factor in making choices and taking risks; full empowerment requires that consumers live with the consequences of their choices.” As Jacobson and Greenley [38, page 483] state, “empowerment emerges from inside one’s self—although it may be facilitated by external conditions.”

In the most favorable and far-reaching view, the individual approach to recovery suggests that people with mental health problems individually have to take “personal responsibility through self-management, being responsible for your own well-being” [1, page 268]. As Slade [2, page 703] asserts, “the central shift in a recovery-oriented system, therefore, involves seeing an individual not as a patient—someone who is fundamentally different and therefore needs
treatment before getting on with life—but as a person whose efforts to live the most fulfilling life possible are fundamentally similar to those of people without mental illness.” Nevertheless, although the recovery paradigm is heretical within the dominant biomedical model [33, 39], “the fashionable concept of ‘recovery’ can be a two-edged sword” (Hopton, [12, pp. 65-66]). As Hopton [12, pp. 65-66] argues aptly, “on one level, it represents a step away from the once prevalent idea that (…) only compliance to medication will prevent a relapse. On the other hand, (sometimes) it also seems to have medical overtones.” In clinical conceptualizations, for example, it is stated that recovery implies that it is possible to regain control of one’s life, to reintegrate socially and become independent [41], and to “return to a normal or healthy state, free of the symptoms of illness, (…) being able to work, to go to college, to live in ordinary housing, have an active recreational life and find friendship and romance” [44, page 125, our italics]. This clinical and diagnostic emphasis on difference and intrapsychic deficits that should be overcome by the individual who is engaging in self-care and expected to recover from an illness and regaining a coherent sense of self is a long-standing criticism of the mental health system. These insights inherently refer to underlying assumptions of citizenship.

3.1. Normative Citizenship. There are substantial objections to the idea of individual responsibility “as part of the quest for the model citizen” [45, page 72]. The recovery paradigm can be sharply criticized because of the socially constructed norm of the self-managing, self-sufficient, and independent consumer–citizen who is fully responsible for his/her own choices [24]. A conceptualization of citizenship as normative implies that citizenship is perceived as a status and an achievement [46], mainly based on a norm of active and “good” citizenship that is imposed on individuals and persistently at work in both discourse and practice [23]. In this normative notion of citizenship that promotes “projects of the self” [47], people with mental health problems are expected to become self-sufficient and productive citizens within the scope of self-responsibility, as the responsibility for leading a fulfilling life is individualized [48]. As such, “citizenship becomes conditional on individuals (…) citizens have no rights but responsibilities, and rights shift into social obligations” [23, page 100]. As Rose [49, page 230] observed, “individuals are to become, as it were, entrepreneurs of themselves, shaping their own lives through the choices they make among the forms of life available to them.” The recovery paradigm can be understood against this background, cultivating a project of self-development and self-improvement [47] and enabling societies to make “technologies of opportunity and self-government in the hopes of activating a vital, entrepreneurial and enterprising spirit among (their) subjects” operational [50, page 92].

It becomes particularly tricky when this ideology of individual choice and opportunity denies the fact that some citizens have few available choices and resources [46], while at the same time implying that so-called ‘responsible citizens’ make reasonable choices and, therefore, ‘bad choices’ result from the wilfulness of irresponsible people” [51]. Recovery implies “a danger of running too close to contemporary neoliberal notions of self-help and self-responsibility and glossing over the structural inequalities that hamper personal and social development” [52, page 10]. This logic masks the restricted role of the advanced liberal welfare state [53] in guaranteeing the right to an existence in human dignity, and in pursuing social justice. Although the notion of ideal citizens as choice-making, self-directing, and self-governing subjects in the advanced liberal welfare state is based on individual autonomy and self-responsibility, it lies equally well at the heart of disciplinary control [54, 55]. As Goodley [45, pp. 72-73] argues aptly, a strange paradox emerges for disabled people, including people with mental health problems: “while they are cast as the dependent other, when they do attempt to gain a foothold on the ladder of individualism then they are expected to demonstrate extra-special, hyper-individual forms of being in order to maintain their place (…) being more normal than normal people. (…) And if disabled people fail, then a host of professionals lie in wait to aid and (re)habilitate their journey towards self-containment.” This underlying dynamic refers to the ways in which the provision of care and support is coined by professionals and social services.

3.2. Residual Perspective on Care and Support. The recovery paradigm clearly requires a reconceptualization of how social services are (re)organized and delivered [1, 2]. In our view, however, the individual approach to recovery leads easily to residual practices, implying that professionals are expected to empower people with mental health problems in becoming autonomous and self-sufficient citizens, without providing the proper care and support and resources to create fulfilling lives on a structural base. It has been widely observed that minority, marginal, disabled, and chronically ill people might already bear heavy caring responsibilities, but that they also have the fewest social resources and might not be the best risk managers [47]. As citizens, people with mental health problems have the right to be offered care and support, but they do not always fit the support models that make an appeal to the service user’s responsibility, “whereby everything would be controlled to the point of self-sustenance, without the need for intervention” [56, page 241]. If the delivery of social services is based on a logic of self-responsibility and self-management of service users with mental health problems, social service professionals might be treading on a tightrope, since they are charged with “motivating and cajoling service users towards projects of autonomy and self-development, while controlling the deviant and destructive aspects of resistance strategies (crime, drugs, benefit fraud, self-harm, mental illness)” [47, page 10]. Social service professionals’ preoccupation with empowerment and individual responsibility of service users with mental health problems has been criticized for downplaying and devaluing the provision of care and support [3, 45]. In that light, Rose [53] refers to the privatization of risk, which concerns people who do not, and cannot, live up to the expectations of becoming self-responsible in managing their mental health and other social problems, which creates “a division of
the population into those who are capable of managing risk and those whose riskiness requires management under what might be called a tutelary relationship, a division that might be expressed as one between the ‘civilized’ and the ‘marginalized’” [57]. As soon as individual citizens cannot prove that they are able to participate in the societal game as self-governing entrepreneurs, they become the objects of intensified surveillance, control, and disciplinary practices [13, 19, 51, 58]. The tendency to transform the responsibility for social risks into a problem of “self-care” inherently contributes to the individualization, decontextualization, and depoliticization of social problems [59].

In that vein, the notion of the ideal citizen marginalizes “competing conceptions of the citizen-subject” [60, page 291] and constructs and transforms some citizens gradually into members of a residual category of nonrecyclable and nondeserving citizens who become waste products in society [61]. Clarke [51, page 453] introduces the conception of the abandoned citizen, which unveils “the dynamics of activation, empowerment and responsibilization as rhetorical, masking the real dynamic of abandonment” of residual social practices, in which chiefly an economic rationality is brought to bear on social problems [48]. This residual approach turns social policy into an instrument for rationing services into risk assessment rather than furnishing better care and support, due to scarce resources that are covered under the veil of autonomy, choice, and empowerment [47]. Following this line of thought, the conception of self-managing citizens is a means of reducing costs and pressures on social service systems, as they become “expert patients” and create mutual self-help, take on managing their own lifestyles and well-being, and require less direct attention from residential (and more expensive) services since they learn to embrace the spirit of “do-it-yourself” [51]. The focus lies on the definition of prestructured criteria for access to care and support, and only those “worthy” of care—those who are willing to learn to play the game of self-responsibility—are allowed into the system. Such a vision of humanity threatens to individualize social life, changing individuals rather than society, and fails to support people in their social contexts. From Clarke’s [51, page 453] point of view, this version of “responsibility appears as a smokescreen behind which the state is systematically divesting its responsibilities,” including dismantling social services and particularly residential services that are subsidized by the state. Hence, the focus of recovery lies on the characteristics of people with mental health problems, rather than on the policy and organization of the support system [62].

4. A Social Approach to Recovery

In the extensive body of recovery literature, rather infrequently a social approach to recovery is identified that covers different connotations [2, 8, 10, 63–66]. In embracing the social nature of recovery, of crucial importance is the finding that recovery processes cannot be forced into a cookbook full of recipes for everyone to follow, since recovery often consists of a turbulent process of ups and downs, given the heterogeneous situations of people with mental health problems, implying that “the manifestation and course of their mental illness are unique to them and often non-linear” [11, page 887]. As Ridgway [33, page 339] asserts, “recovery is not linear, the journey is not made up of a specific succession of stages or accomplishments, and it does not follow a straight course. Instead, recovery is an evolving process, one that sometimes spirals back upon itself, and may result in a frustrating return to active disorder.” In that light, Whitwell [63, page 621] refers to the myth of recovery, meaning “being restored to your former state (…) as a state of a person, as the end state following a period of illness.” As an exploration of the experiences of people with mental health problems shows that people are conscious of their impaired life position, describing “unemployment, divorce, housing problems, lack of money and social isolation” [63, page 622], a conceptual shift implies moving into a nuanced and social understanding of recovery. Also, Tew et al. [10, page 444, our italics] have recently revealed that recovery “emphasises rebuilding a worthwhile life, irrespective of whether or not one may continue to have particular distress experiences—and central to this can be reclaiming valued social roles. (…) Recovery may involve a journey both of personal change and of social (re)engagement—which highlights the importance of creating accepting and enabling social environments within which recovery may be supported.” Secker et al. [64, page 410, our italics] describe a reconceptualization of recovery that is “viewed as establishing a dynamic and meaningful life with an impairment (…), the process of recovery involves the reintroduction of the individual into a socially accepting and acceptable environment.” According to Slade [2, page 703], this social approach to recovery can be summarized as “recovery begins when you find someone or something to relate to. The job of the system is to support the relationship (…), maintaining an organizational commitment to recovery, and promoting citizenship among individuals in recovery.” In our view, these insights refer to the necessity to consider notions and interpretations of citizenship in these social practices as relational and inclusive.

4.1. Relational and Inclusive Citizenship. In reality, our societies are often characterized by the dynamics of social exclusion and marginalization [67]. The experience of people with mental health problems of not being recognized as citizens is frequently identified [21, 30–34] and refers to the discrepancy between their formal citizenship (embodied as an entitlement and a status) and their de facto citizenship (constructed through the experience of being a member of a particular community and society in practice) [46]. Lawy and Biesta [68, page 43] refer to a notion of citizenship articulated as relational and inclusive that does not presume that people move through a prespecified trajectory into their citizenship status/achievement as “good” and contributing citizens, yet “it is inclusive rather than exclusive because it assumes that everyone in society (…) are citizens who simply move through citizenship-as-practice, from the cradle to the grave.” Pols [69] introduced the concept of relational citizenship, which differs radically from normative citizenship, as it “develops in the relationship between people, embedded in a set of relational questions, interests and concerns”
Winance [70] observes that, in practices of citizenship, normalization processes are challenged from the position of an alignment to work on the norm, the societal norm gets problematized on a collective level. In that vein, inclusive citizenship implies that “the main components of citizenship—membership and belonging, the rights and obligations that flow from that membership, and equality of status—(...) should all apply to all citizens equally” [71, page 4]. In this perspective, citizenship is shaped through relations where norms have to be renegotiated, performed, refreshed, and reestablished in each situation [23]. As such, rights and responsibilities are actualized and constantly renegotiated through (inter)actions in which contradiction and temporary consensus are vital elements [72]. In this frame of reference, the value of care and support depends on the ongoing engagement of professionals in shaping the relationship between the citizen with mental health problems and everyday society as the terrain of interactions with other people, based on an assumption of interdependency and joint responsibility which is redefined in every situation [73].

4.2. Structural Perspective on Care and Support. According to Beresford and Croft [16], an alliance between service users with mental health problems and professionals is likely to be the most productive way forward for securing the interests of both. Here the question of what care and support mean for people with mental health problems in everyday life plays a pivotal role and requires a continuous dialogue between the client and the professional [23]. Borg and Davidson [73, page 139] stress that supporting people with mental health problems to exercise all of the rights and responsibilities involved in citizenship is the key implication for practice, as “living conditions, income, employment/unemployment, and social interactions outside of treatment settings are central to processes of recovery and cannot be seen as lying outside of the scope of clinical or rehabilitative practice.” In that vein, responsibility might be approached as the ability to respond [74], based on the recognition of the fundamental elements of community in which every citizen should have the opportunity to participate: housing, education, income, and work [75].

However, we also want to address implications at the level of social service provision. In a structural perspective on support services, the focus shifts from prestructured criteria of access to the criteria of qualitative social support [76, 77]. These criteria question the ways in which organizations are structured and function in relation to the demands of clients and problems as well as in relation to those clients and problems that remain off the picture in a residual perspective because they do not manage to become self-sufficient citizens. According to this theoretical frame of reference, five interrelated features need to be constructed as leverages for (more) equality and quality, defined as availability, accessibility, affordability, usefulness, and comprehensibility [72].

(i) Availability refers to the existence of a supply and to the fact that social services can also be called upon for matters that do not necessarily relate directly to the assessed problem.

(ii) Accessibility refers to the (lack of) thresholds when care is needed, for instance an inadequate knowledge of the supply.

(iii) Affordability refers to financial and other costs that the client may encounter, for instance giving up one's privacy or the negative social and psychological consequences of an intervention.

(iv) Usefulness refers to the extent to which the client experiences the care as supportive; is the help attuned to the demand, the skills, and the language of the client?

(v) Comprehensibility refers to the extent to which clients are aware of the reasons for the intervention and the way in which the problem should be approached.

This implies that the welfare state should develop a differentiated supply of social services that offers all its citizens, in a diversity of situations, the scope to develop their full potential from a structural perspective on care and support [72].

5. Conclusion

The concept of recovery can be interpreted against the background of the processes of change in social service systems in many developed countries since the mid-1980s. In this paper, we aimed to explore the pitfalls and the opportunities of the recovery paradigm in relation to these changing service organizations, based on underlying notions of citizenship of people with mental health problems. On the one hand, an individual approach to recovery is identified, undergirded by a neoliberal and normative conception of citizenship, which conceives citizenship as circumscribing the domain of the active entrepreneurial spirit [51]. Those service users with mental health problems who are provided with care and support are committed to act as responsible and reasonably enterprising citizens. In this conception of normative citizenship, these issues are seen as natural, uncontested, and incontestable, and they risk to range people out as nonrecyclable and abandoned citizens [61]. On the other hand, we reclaim a social approach to recovery that implies a conception of relational and inclusive citizenship [22, 23, 70, 71]. This conceptualization of citizenship offers new perspectives for both people with mental health problems and social service professionals, since the debate continues about the actualization of citizenship, about the conditions in which people are expected to lead a dignified life in the community, and about the care and support needed. A high-quality supply of social services that is made usable for all its citizens needs to be provided by the welfare state [72].
References


Research Article

Recovering from Hallucinations: A Qualitative Study of Coping with Voices Hearing of People with Schizophrenia in Hong Kong

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Received 23 September 2012; Accepted 24 November 2012

Academic Editors: W. Vanderplasschen and S. Vandevelde

Auditory hallucination is a positive symptom of schizophrenia and has significant impacts on the lives of individuals. People with auditory hallucination require considerable assistance from mental health professionals. Apart from medications, they may apply different lay methods to cope with their voice hearing. Results from qualitative interviews showed that people with schizophrenia in the Chinese sociocultural context of Hong Kong were coping with auditory hallucination in different ways, including (a) changing social contacts, (b) manipulating the voices, and (c) changing perception and meaning towards the voices. Implications for recovery from psychiatric illness of individuals with auditory hallucinations are discussed.

1. Introduction

Schizophrenia is a major mental illness in contemporary society which affects about 1% of the world population [1]. People in an acute episode of schizophrenia are characterized by the positive symptom of auditory hallucinations or voice hearing. The voices, particularly those with negative and critical connotations, would directly or indirectly affect their emotional, economic, occupational, and social functioning. In Hong Kong, while psychiatric medication is the primary treatment, there are no specialized services for Chinese patients with the problem of hearing voices. With the influence of traditional Chinese cultural beliefs, they may worship gods, drink “amulet tea,” or adopt methods associated with folk religions or customary lay practices in trying to cope passively or actively with the voices. As there has been no previous study on the hearing of voices by Chinese people with schizophrenia, this paper examines their coping strategies with an emphasis on how they adopt lay practices within the sociocultural context of Hong Kong.

2. Schizophrenia in the Chinese Sociocultural Context

Schizophrenia is a group of disorders which severely disrupts the memory, visual and auditory perceptions, problem-solving, social, and cognitive abilities of the persons affected [2, 3]. In a study of people with schizophrenia in Beijing, China, it was found that the general lifetime prevalence of the illness was 0.49% and 0.44% for men and 0.55% for women [4]. There is no comprehensive study on the lifetime prevalence of schizophrenia in Hong Kong. However, a 15-year outcome study of 100 people with schizophrenia found that about 10% had committed suicide though about 50% had experienced improved symptomatic outcomes [5, 6]. There has been very little research on voice hearing of people with schizophrenia in different environments and cultures. In Chinese culture, the traditional beliefs of Chinese medicine, which emphasize the balance of yin and yang and proper proportions of five elements, including wood, fire, earth, metal, and water, have considerable influence on people’s perception of health and mental health [7]. Imbalance between yin and yang and among the five elements will result in illness or psychopathology [8, 9]. There is not a distinct mental disorder called schizophrenia according to traditional Chinese medicine, and mental illness is broadly divided into two categories, namely, “Kuang”—psychosis with excitation and “dian”—psychosis without excitation or epilepsy [10, 11].

In addition to traditional Chinese medicine beliefs, spirit possession and retribution for sinful deeds are other commonly held folk beliefs related to the etiology and treatment of madness by lay persons in Chinese societies,
such as Hong Kong [7, 12], Taiwan [13], and Singapore [14]. Chinese mental patients often attribute their problems to possession, to a charm cast on them, or to having stepped on a spirit or a "dirty thing" accidentally. Chinese people also have the folk religious belief of retribution for sin in the form of a bad spirit that would invade the body and inflict madness when misdeeds and human transgression, such as family conflict, occurred [7].

Confucian thought is another traditional belief that shapes Chinese people's experience of mental health problems. Mental illness was regarded as a punishment for violating the Confucian norms governing interpersonal relations, especially filial piety [15], and ancestors could become malevolent spirits to haunt their descendants who had violated Confucian teachings [7].

3. Coping with Auditory Hallucinations

Although individuals with schizophrenia were often thought to be passive victims of auditory hallucinations [16], researches have identified the difference between the coping strategies of the "copers" and the "non-copers" [17–19]. The "copers" could manage well and feel themselves to be stronger than the auditory hallucinations. They could experience the voices as positive and could experience fewer comments from them. The "non-copers," on the other hand, experienced the voices as negative and aggressive. The "copers" were found to engage more often in selective listening, such as listening only to the positive voices, and were more able to ignore them, while the "non-copers" more often tried to utilize distraction techniques. In general, changes in social contacts and manipulating the level of sensory stimulation were the two basic coping strategies identified for the "copers" [19–21].

Changes in social contacts included increased social contacts and engaging in social conversations. There were two processes underlying this coping strategy. First, engaging in a conversation with others acts as a form of distraction that might help persons experiencing hallucinations to keep their minds focused and their attention distracted from the contents thereof [21, 22]. Second, engaging in conversation through verbalization on hallucinations could serve as a protective factor for psychological dysfunctioning [23]. As auditory hallucinations are often accompanied by subvocalization [24], concurrent verbalization helps suppress the subvocal speech and to reduce the severity of hallucinations [25]. Increasing social contacts therefore served a dual purpose, that is, (a) distracting oneself from the content of distressing hallucinations and (b) disrupting the subvocal activity concomitant with hearing voices. Although an increase in social contacts was frequently reported, some patients might actually withdraw from social contacts in order to cope with their hallucinations [19]. This was particularly true for patients with relatives highly expressive of their emotions when contacts with the latter were sources of their stress.

Manipulating the levels of sensory stimulation was accomplished by minimizing sensory input, such as by closing the eyes or putting plugs in the ears, or by increasing other sensory stimulations [20, 21], such as listening to loud, stimulating music [19, 20, 26, 27]. Decreases in internal auditory hallucinations, such as threatening and critical comments, with increased external auditory stimulations through the use of a portable cassette player, have proven to be a popular form of coping strategy for people who hear voices [25, 28, 29]. The meaning of the stimuli, such as meaningful sound, music, and interesting excerpts of speech, was important in helping to reduce the frequency of auditory hallucinations [26].

In addition to the change in social contacts and manipulating the levels of sensory stimulation, developing a meaning of the voices was another significant means to cope with voice hearing. Apart from reducing ambiguities, developing a meaning of the voices would reduce likelihood of error in the attribution of the source of one's perceptions. Thus, listening to music with a meaningful pattern of sounds, preferably at a high volume, would help to reduce hallucinatory activity and the feeling of powerlessness of patients [29, 30].

Perhaps the most important foundation of these coping strategies is based on the conceptualization of the individuals as active goal-directed agents who can influence the course of their voice-hearing problem. Thus, in focusing our view on the strength rather than on the problem and its symptomatology of the individuals, this study attempts to get a more complete picture of the course and coping strategies of voice-hearing problems of Chinese people in Hong Kong.

4. Method

4.1. Participants and Procedure. The objective of this paper was to examine the coping strategies on auditory hallucinations, of Chinese people with schizophrenia in Hong Kong. As the coping with the problem of hearing voices is subject to the hearers’ own interpretations, a qualitative research method therefore was adopted to facilitate the participants’ ability to describe the phenomena of the voices in fine detail and in their own terms. The qualitative approach was used to gain a deep understanding of the complex subjective experiences people afflicted with the problems [31]. With respect to sample size, McCracken suggested that eight respondents would be sufficient for many qualitative projects [32] while Creswell thought that ten subjects in a study represented a reasonable size [33]. In view of the qualitative and exploratory nature of investigating the subjective experience of the voice hearers, purposive sampling was employed to select participants who met the criteria for the study. The inclusion criteria for the participants included the following: (a) that they had received a definite diagnosis of schizophrenia, (b) that they were 18 years of age or above, (c) that they had had the illness for more than 6 months, (d) that they has been clinically stable for at least 1 month prior to assessment (clinical stability is operationally defined as absence of exacerbation of illness requiring an increase in drug dosage by 50% or more), and (e) that they had reported the presence of auditory hallucinations. The exclusion criteria included (a) patients with diagnosis of organic brain syndromes, substance abuse, subnormal intelligence, and (b) those having difficulty in verbal communication.
The participants were recruited through nongovernmental organizations (NGOs) providing services for people with mental illness in Hong Kong. Invitation letters and a brief research proposal were sent to the directors of five NGOs for ethics review and approval. Finally, two NGOs gave positive responses to the invitations. With the assistance of the social workers of the two NGOs, individuals who met the inclusion criteria were invited for interviews with their consent. Altogether 20 participants from these two NGOs were recruited for the study.

4.2. Data Collection. This study was based on in-depth interviews with 20 schizophrenia patients with auditory hallucinations. Before interviewing the participants, pilot interviews with reference to “Interview with a Person who Hears Voices” [34] were conducted with two Chinese adults with schizophrenia. The results of these pilot interviews were of help in developing a semistructured interview guide which included 4 areas of inquiry, including (a) general characteristics of the voice hearers, (b) content of the voices and attitudes about the voices, (c) impacts of the voices on the hearers, and (d) coping strategies with voice hearing. The draft interview guide was developed with reference to pre-study interviews with social workers working with people with voice hearing and clients with voice-hearing problems in 2 NGOs and was sent to social workers of the NGOs for comments. The interviews took place in the interview rooms of the two NGOs on a face-to-face basis. To prevent overly long interviews and to avoid overtaxing the subjects, the in-depth interviews were broken into two to three shorter sessions, each lasting normally for 45 minutes to an hour.

4.3. Data Analysis. With the consent of the participants, the interviews were digitally recorded. With the assistance from a student research helper, a verbatim transcript of each interview was prepared in Chinese so as to faithfully record the original form of expression of the participants and allow cross-referencing during the process of analysis. Observations, reflections and remarks concerning the codes were noted, sorted, and sifted in order to identify similar points, phrases, patterns, themes, relationships, sequences, or differences between different groups of data. Finally, common themes or patterns, commonalities, and differences in the participants’ experiences in voice hearing were identified.

5. Results

5.1. Profiles of the Participants. There were 12 men and 8 women, ranging in age from 22 to 55, who participated in the study. The mean age of the males was 44.1 years, and that of the females was 27 years. All the participants were living in half-way houses and were receiving comprehensive social security assistance (CSSA). Most participants were unmarried. Five were working in sheltered workshops, and five in day activity centres; 10 were unemployed (see Table 1). All participants were receiving psychiatric follow-up treatment and were currently on psychiatric medications. Nine of them had had the first onset of illness before they were 17 years old. Most had been ill for over 20 years. All had a history of hospitalization or admission to mental hospitals.

5.2. Coping with Auditory Hallucinations. While the impacts of auditory hallucinations might affect different people in different degrees, there are variations of the adoption of strategies to cope with the voices of the hearers. In this study, participants had expressed different coping experiences in their adjustment toward hearing voices.

5.3. Changing Social Contacts through Ignoring and Justifying Voice Hearing with Lay Practices. Many participants were trying to ignore the strange new social experience particular at the early stage of voice hearing. The voices were so frightening, and the experience was so unfamiliar that they might retreat to their nut shell so as to reduce confusion. Ten participants of this study were admitted to mental hospitals as a result of the confusion caused by auditory hallucinations. They described the onset of the auditory hallucinations as being quite sudden, startling, and anxiety-provoking. Participant Alfred, for example, was admitted to a mental hospital as he was frightened by the voices:

I was so frightened by the voices in my head. A doctor in the hospital explained to me that the voices I heard were auditory hallucinations… While in hospital and under medication, my voice hearing decreased… I believed that my brain was sick and that the voices were being released by my sick brain.

Some participants were accompanied by family to seek medical treatment as Participant Catherine related:

I was frightened by the voices and lost my temper with others. I tried to ignore the voices but
Table 1: Profile of research participants.

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<th>Sociodemographic characteristics</th>
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<td>Male</td>
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</tr>
<tr>
<td>Female</td>
<td>8</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>20–29</td>
<td>1</td>
</tr>
<tr>
<td>30–39</td>
<td>8</td>
</tr>
<tr>
<td>40–49</td>
<td>10</td>
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<tr>
<td>50–55</td>
<td>1</td>
</tr>
<tr>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>8</td>
</tr>
<tr>
<td>Secondary</td>
<td>10</td>
</tr>
<tr>
<td>Postsecondary</td>
<td>2</td>
</tr>
<tr>
<td>Employment</td>
<td></td>
</tr>
<tr>
<td>Sheltered workshop</td>
<td>5</td>
</tr>
<tr>
<td>Day activity centre</td>
<td>5</td>
</tr>
<tr>
<td>Unemployed</td>
<td>10</td>
</tr>
<tr>
<td>Living situation</td>
<td></td>
</tr>
<tr>
<td>Living with family</td>
<td>14</td>
</tr>
<tr>
<td>Living with spouse</td>
<td>2</td>
</tr>
<tr>
<td>Half-way house</td>
<td>4</td>
</tr>
</tbody>
</table>

could not do so... My mother got me a medical appointment and then I was admitted to a mental hospital.

Apart from medical treatment, some participants and their family members believed that their voice hearing was related to folk religion and thought that worshipping gods in a temple could help cure the illness. Participant David remarked:

My mother and I believed that the voices came from ghosts and made me confused. I went to meet a medium master who told me that the voices were induced by evil spirits. He suggested that I worshipped Chinese gods on the Mainland and took the amulet tea prescribed by the temples... The voices went away for a short time but returned after a month. I was then brought by my brother to seek medical treatment... I have been taking drugs for over ten years. However, I still feel confused about the causes of my voice-hearing in terms of spirits and mental illness.

Many participants had tried different methods to deal with their voices but in vain. Take participant Gilbert, for example, who had tried a variety of strategies to cope with the voice hearing, but the strategies were not effective:

I ignored the voices but in vain. I committed crimes after following the instruction of the voices. Then I was admitted to the hospital. I took medication in the hospital but I still listened to voices. I also tried to worship a Taoist god and the Buddha as well as my deceased paternal grandmother in different temples. However, all my efforts ended in failure.

Many people with voice hearing experienced fear and confusion at the beginning of the illness. Their emotion, interwoven with folk beliefs, affected their help-seeking behaviour. Despite their efforts to deal with the problems, such as worshipping gods or drinking amulet tea, many people with auditory hallucinations ended up in hospital treatment.

5.4. Manipulating and Regulating the Voices. Once the patients were able to deal with the basic problem of fear of voice hearing because it prompted concern as to whether they could feel safe and secure, they began to lock horns with the task of trying to find ways to cope with the voices. Learning to regulate the voices appeared to be a useful coping strategy for many participants. However, this could last for months or years for some hearers. In this study, some participants developed effective coping strategies, such as regulating the voices, or entering into willingness to dialogue with them by listening to them selectively. Many participants were able to reorganize their voices and became willing to comply with psychiatric treatment. In this study, all participants had received psychiatric treatment for several years. Compliance to drug treatment was conducive to good coping with voice hearing, as Participant Alfred observed:

Before psychiatric treatment, I always looked for a source of my voices, such as people nearby, staff of a telephone network company, computers or other "spying devices", and I never thought of mental illness... I had more insight into the voice hearing and learnt after the treatment that the voices were due to my mental illness. I considered drug treatment the most effective way to stop the voices and I complied with drug treatment.

As a result of their side effects, psychiatric medications were often the last resort for dealing with voice hearing after the participants had struggled with the voices for some years. A number of the participants had tried their own folk or layman strategies to cope with auditory hallucinations themselves. The common layman strategies of the participants are shown in Table 2. Sometimes they found the strategies effective and sometimes they did not, as Participant Alfred reiterated, stating that he found his techniques of coping with the voice ineffective:

I have tried to ignore the voices, ask the voices to go away, set the boundaries with the voices, and use distraction, such as engaging myself in other activities. They don't seem to work well... I give two scores for jotting down the content of the voices and covering my head with a blanket, and I give 5 as the highest score for paying attention to what the voices said to me.

Although the coping strategies might not work for one person, there are no "supposed to's" in the process that lead
Table 2: Coping strategies adopted by the participants.

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ignoring the voices</td>
<td>Alfred, Bobo, Catherine, David, Fred, Henry, Gilbert, Ada, Betty, Ben</td>
</tr>
<tr>
<td>Asking the voices to go away</td>
<td>Alfred, Carol, Daisy, Joe</td>
</tr>
<tr>
<td>Scolding or arguing with the voices</td>
<td>Bobo, Catherine, David, Ivan, Eva, Carol, Ben</td>
</tr>
<tr>
<td>Setting boundaries for the voices</td>
<td>Alfred, Catherine, David, Fred, Flora, Edmond, Ken, Joe</td>
</tr>
<tr>
<td>Distracting the voices through engaging in other activities, such as listening to music, singing, and reading</td>
<td>Alfred, Bobo, Catherine, Fred, Gilbert, Ivan, Daisy, Flora, Edmond</td>
</tr>
<tr>
<td>Jotting down the content of the voices</td>
<td>Alfred, Ken, Joe</td>
</tr>
<tr>
<td>Relaxing</td>
<td>Alfred, Gilbert, Jason</td>
</tr>
<tr>
<td>Selectively listening to the voices</td>
<td>Alfred, Catherine, Joe</td>
</tr>
<tr>
<td>Sharing the voices with family members/friends/professionals</td>
<td>Henry, Gilbert, Ken</td>
</tr>
<tr>
<td>Accepting the existence of the voices</td>
<td>Bo, Joe</td>
</tr>
<tr>
<td>Others: decreasing meat intake</td>
<td>Jason, Edmond</td>
</tr>
</tbody>
</table>

us to assume that the same would happen to other persons. Participant Bobo said:

> I ignored the voices or tried not to listen to them but it was just one time out of two that I found these strategies useful. I then tried to scold the voices in my head, and sang to them about four times a week, and this turned out to be the most effective method... I could not reject the voices but gradually accepted their existence though I did not like them.

There were also other strategies, such as going to bed, reading books, listening to songs, going to the library, trying to relax, and talking with family members; however, they were found not to be very effective in coping with the voices most of the time, as Participant David noted:

> I ignored the voices when I was not interested in them... I found it more effective if I sometimes argued with the voices. I was happy when I won through my sound argument and the voices would stop at times... I also set boundaries with the voices so that the voice identities only giggled to themselves instead of speaking to me... I consider my active reaction to the voices was the most effective way to deal with them.

In general, people with voice hearing in the organizing phase have developed different layman strategies to cope with the voices. These strategies, effective or not, could be divided into two categories, namely, (a) passive and avoidance strategies and (b) assertive and interactive ones. As a strategy might be effective for one person and not for another, it is important for the voice hearers to get to know more about their own strategies and expand their repertoire thereof over time.

5.5. Changing Perception and Meaning toward the Voices. Another important way that participants influenced the course of their voice hearing was through a shift in perception and meaning which could lead to alternation of their help seeking behaviors. An important aspect of this shift appeared to be the development of a balance or compromise between the voices and themselves. With the new meaning towards the voices, they might consider the voices as a part of themselves and of their lives and could feel more in control of the voices. There is a growing ability to accept the voices as inevitable and to trust the professionals and receive help and treatment from them, as made clear by Participant Alfred:

> I did not share my voice hearing experience with others as I believed that others did not know about my (mental) illness and would look down on me. I would only talk about my voice hearing to those understood my illness... Now, I can take the initiative to tell my psychiatrist about my voices though I would not share with my friends who are ignorant about my illness.

There is also a growing awareness of the significance of the impacts of the voices and of finding ways to solve problems in daily life that are linked to voice hearing. They had the confidence to talk about their voices, particularly with professionals, such as psychiatrists and social workers. Participant Catherine put it this way:

> I felt more relaxed and happy after sharing my voices with the psychiatrist and social worker... I got more insight about my voices from them and I was more confident of managing the voices... The social worker explained to me that the voices were hallucinations and encouraged me to communicate with my family members, friends, and advised me to find something to occupy myself during the day. I found such support and supportive communication to be effective in managing my problems.

With the insight, Catherine began to accept her voices and to see professionals as persons she could trust and from whom she could receive proper treatment. As the acceptance of the voices gave the hearers a certain measure of autonomy in reacting to and dealing with them, they were better able...
to evaluate their relationships with the voices and to solve problems related to them on a reality basis.

6. Discussion

In Hong Kong, schizophrenia has constituted a long-recognized mental disorder and accounted for the largest number of persons receiving psychiatric recovery services [35, 36]. As auditory hallucination is a major psychotic symptom of schizophrenia, it has salient impacts on the lives of the sufferers. The experiences shared by the participants in this study highlighted the day-to-day struggles of persons with auditory hallucinations in the Chinese cultural context of Hong Kong. Results from this study showed that not only did the participants struggle with the voices, but they also had to bear the negative consequences in isolation. In general, the voice hearers were psychologically burdened, prone to odd behavior, financially disadvantaged as a result of poor employability, and socially isolated from family members and friends. They suffered great emotional strain with limited social support.

Hearing voices that no one else can hear can be disturbing and frightening for the hearers and for those around them. Family members and friends may have difficulty in accepting that the persons they care about are experiencing voice-hearing problems. No one really knew why people had auditory hallucinations. However, the participants in this study made use of some effective lay coping strategies, including (a) changing social contacts through ignoring and justifying the voices, (b) manipulating and regulating the voices, and (c) changing perception and meaning towards the voices. Moreover, the effectiveness of the strategies was related to the respective individuals’ characteristics and might vary according to different phases of the problems. The results of this study have provided an initial understanding of coping strategies of people with auditory hallucinations in Hong Kong.

6.1. Limitations of the Study. Each research method has its limitations and strengths. The great strength of the qualitative method used in this study is the rich abundance of data on the subjective experiences of the participants obtained from in-depth interviews. However, in spite of the potential advantages of qualitative methods, there are situations that could undermine the validity of the study. Most pertinent in this regard is the fact that its qualitative nature meant that only 20 participants were interviewed. A small sample is unlikely to be representative of the population of the voice hearers in Hong Kong. Thus, the findings of this study cannot provide the basis for conclusions supported by statistical analysis, as with quantitative methods.

Because of the impact of schizophrenia, the side-effects of drugs and perceived secrets of the voices, some participants might not be totally open to disclosing their hallucinations. Understandably, it was not easy for some of them to disclose freely the private contents of their hallucinations in the interviews. Owing to the nature of their illness, the answers given by some voice hearers were short and not necessarily relevant to the study. Again, the researcher had to rely on some follow-up questions in the interviews. It is therefore possible that some participants might not have been able to tell their story in their own terms, and this might well have affected the effectiveness of the study.

7. Implications for Practice

For many people with auditory hallucinations, coping with the voices could be a nightmare. In this study, we found that many Chinese people with schizophrenia were coping with the voices by adopting layman strategies. The findings from this study have generated insight and directions for social services to help people with auditory hallucinations. These include (a) developing a respectful attitude toward voice-hearing experiences, (b) developing culturally sensitive interventions for voice hearing, (c) formulating a specialized treatment programme for voice hearers, (d) enhancing the training for mental health professionals working with voice hearers, and (e) providing family education for family members of the voice hearers.

7.1. A Respectful Attitude toward Voice Hearing Experiences. In this study, we found that the voices were, to a significant extent, meaningful to the hearers, a fact that might have been disregarded by the professionals working with them, such as psychiatrists and social workers. The professionals should have a respectful attitude toward the hearers’ voice hearing experiences. The voices themselves might contain a considerable fund of information about the individuals’ unresolved feelings and conflicts. More in-depth understanding about the voice experience would help achieve insight into hearers’ problems and direction of intervention from their perspectives. Professionals should not simply use a preconceived frame of reference or medical jargon to negate the hearers’ voice experiences. In dealing with the subjective voice experiences of the hearers, they have to be patient so as to develop a relationship of trust with the hearers. With the establishment of such rapport, they become able to encourage the hearers to talk freely about their experiences in therapy sessions. It was found that even in such research interviews, a respectful attitude toward their voice experiences proved helpful to hearers in obtaining some insight into their voice experiences.

7.2. Culturally Sensitive Interventions. Auditory hallucinations are not totally meaningless, and they cannot be understood in a social vacuum. Understanding the social and cultural contexts is important for constructing, defining, and interpreting the reality that people with mental illness perceive and how they interpret their auditory hallucinations [37]. To be effective in helping people with voice hearing in coping with their auditory hallucinations, the interventions must build up a comprehensive understanding of community sanctions and social values as well as the life circumstances of the hearers. Thus, mental health professionals have to equip themselves with sensitivity toward indigenous heritages and social practices so as to prevent stereotypical or “supposed to” assessments and treatment. An indigenous
culturally sensitive approach is needed for better therapeutic relationships and understanding of the hearers [38].

7.3. Specialized Programmes for Voice Hearers. Although psychiatric medication is still the primary treatment for auditory hallucinations, voice-hearing problem of many hearers persists. Helping the hearers to accept the voices on a basis of coexistence is a helpful way to defuse their unwanted internal sources of distress. In Hong Kong there is no specialized treatment programme to help voice hearers to cope with auditory hallucinations [39–41]. However, as there are more people with schizophrenia living in the community, there is a need for specialized programme to help them cope with auditory hallucinations so that they can adjust to community living.

7.4. Training for Professionals Working with People with Auditory Hallucinations. There are a significant proportion of people with schizophrenia who suffer from auditory hallucinations. However, there has been a general lack of direction in respect of casework, group therapy, self-help groups, family education, and community networks for rendering specific interventions for people with auditory hallucinations. Psychiatric recovery in Hong Kong generally stress medical care, and there is no systematic individual and self-help group service for the voice hearers. As basic mental health training does not cover work with psychiatric patients in depth, not to mention those with auditory hallucinations, there is a need to enhance the training of mental health professionals so that they are equipped with knowledge to help hearers cope with auditory hallucinations. With the implementation of community care policy, professionals, such as psychologists, psychiatric nurses, and psychiatric social workers at different settings have encountered more clients living in the community who face mental health problems, in particular auditory hallucinations. Continuing education programmes for effective practice or intervention with people with auditory hallucinations should be provided so that professionals can bring more knowledge and skills to bear in psychiatric assessment of auditory hallucinations, in particular with regard to their propensity toward self-harm or violence, and in developing interventions with the clients.

7.5. Family Education for Family Caregivers of Voice Hearers. For many Chinese patients with schizophrenia, family members are still their primary caregivers. As a result of the illness, voice hearers may not trust their families enough to share their voices with them. Many family caregivers suffer great emotional strain as they have to tolerate delusions, hallucinations, and accusations from the patients. Many are frustrated with the loneliness and helplessness involved in providing care to their sick family members, as well as in encountering discriminatory attitudes from the community at large. Family education is therefore needed so that the family caregivers may be equipped with knowledge about the prognosis of schizophrenia and become better able to cope with the impacts of the problem of auditory hallucinations. With such knowledge and skills, family caregivers can play a key role in the recovery of the voice hearers. This is an exploratory study on auditory hallucinations of people in Hong Kong; its results suggest that comprehensive research to study the needs of family caregivers of people with schizophrenia in Hong Kong is warranted.

References


Research Article

Quality of Life and Unmet Need in People with Psychosis in the London Borough of Haringey, UK

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Received 26 August 2012; Accepted 26 September 2012

Academic Editors: W. Vanderplasschen and S. Vandevelde

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Objectives. Deinstitutionalization of long-term psychiatric patients produced various community-based residential care facilities. However, inner-city areas have many patients with severe mental illness (SMI) as well as deprivation, unemployment, and crime. This makes meeting their community needs complex. We undertook a needs assessment of service provision and consonance between service users’ evaluation of need and by care workers.

Design. Cross-sectional study with random sample of SMI service users in four housing settings: rehabilitation units; high-supported; medium-supported; low-supported housing.

Setting. London Borough of Haringey.

Outcome Measures. 110 SMI service users and 110 keyworkers were interviewed, using Camberwell Assessment of Need; SF-36; Lancashire Quality-of-Life profile; demographic and clinical information.

Results. People in “low-support” and “high-support” housing had similar symptom scores, though low support had significantly lower quality of life. Quality of life was positively predicted by self-reported mental-health score and negatively predicted by unmet-need score in whole sample and in medium-support residents. Residents’ and care-workers’ assessments of need differed considerably.

Conclusions. Although patients’ housing needs were broadly met, those in low-supported housing fared least well. Attendance to self-reported mental health and unmet social needs to quality of life underpins planning of residential services for those with SMI. Social and personal needs of people in supported housing may be underestimated and overlooked; service providers need to prioritise these if concept of “recovery” is to advance.

1. Introduction

1.1. Background. An important theme to emerge over the last two decades since the move away from institutional care and towards community mental health care services has been the recognition of the importance of a needs-led approach towards care provision for the individual with severe mental illness (SMI). Housing and socioeconomic care needs form the central thrust to this approach, acting as stabilising forces to establish a daily routine and address life issues. However, due to low income, stigma, difficulties in daily functioning inherent to SMI, and fluctuations in symptoms, people with SMI find it difficult to compete for better-quality housing and often live in substandard accommodation that is physically inadequate, crowded, noisy, and located in noisy neighbourhoods [1].

This suggests a fundamental mismatch in meeting the needs of those with SMI. A prospective needs study across six European countries of those with schizophrenia found that one in four patients had needs that were not adequately met by the mental health service in their region [2]. It also found a systematic relationship between the availability of community-based mental health care and the need status of its cohort: the fewer outpatient and rehabilitation services available, the more unmet needs there were.

1.2. Housing and Well-Being. Planned housing support is central to a mental health promotion strategy, helping to reduce the incidence and prevalence of mental illness and unnecessarily long stays in hospital settings; it also makes good fiscal sense. The shift away from a response to homelessness that focuses on providing emergency services
to one that emphasizes prevention can, if implemented effectively, save money, according to a Toronto-based report [3]. Prevention means stopping people from becoming homeless in the first place. An example of this is improving discharge planning and transitional housing (and supports) for people leaving hospital. By providing supports to someone who would otherwise become homeless the life-time savings to the system are considerable.

The provision of affordable, decent-quality, adequately supportive accommodation is a major factor in helping people recover from mental illness and decreasing the risk of depression, hospitalisation, suicide, family break-up [4, 5]. However, a recent systematic review of studies examining the effect of housing need on health, quality of life, and healthcare use for those with SMI reported that there is a dearth of evidence of housing solutions for those with SMI in precarious or unsupported housing [6].

The deinstitutionalization of long-term psychiatric patients has led to the creation of a wide variety of community-based residential care facilities. In designing such residences, “a balance must be sought between providing structure and protection on the one hand and fulfilling the aims of normalization and community integration on the other” [7]. This tension in mental health care has been highlighted and underpinned by a growing interest in recovery models, empowerment, and social inclusion [8, 9].

1.3. Supported Housing. Supported housing may be provided by private and voluntary sectors, the statutory sector, housing associations and charitable organisations. Briefly, models of supported accommodation include communal group homes and hostels with onsite support workers; therapeutic communities; independent living supported housing schemes for people with mental health problems through self-contained accommodation located in one building or site, with onsite support workers during office hours; independent tenancies in general needs housing with outreach workers or floating support visits regularly.

Evidence suggests high levels of satisfaction with supported housing amongst patients and relatives compared to hospital environments [10], an improvement in social functioning, a dramatic reduction in hospital admissions, higher levels of social networks, and a reduced level of the negative symptoms of schizophrenia. There is also a decrease in the rates of subsequent homelessness, other psychiatric symptoms [11], and overall cost [12]. This, however, may be at the risk of increasing dependence on professionals and prolonging exclusion from the community [13].

Some patients, moreover, have concerns regarding the stigma and restrictiveness of such high levels of supported accommodation, including boredom and having poor access to leisure and recreational facilities. Similarly, community living does not always equate with increased patients’ social networks. There have also been reports in bias in the selection of patients for placements leaving the most disturbed individuals in hospital environments [4].

1.4. Need in Haringey. According to the 2001 census Haringey has a population of over 216,000, ranking it the 50th most dense district in the United Kingdom. However, it is considered that the census may have underestimated the population of the borough. There is a clear divide between the affluent west of the borough, which include the wards of Highgate, Muswell Hill, Crouch End, and Alexandra, and the east of the borough which has considerable levels of deprivation: 40% of residents live in wards that are amongst the 10% most deprived in the UK. These include White Hart Lane, Northumberland Park, Noel Park, Bruce Grove, Tottenham Hale, Tottenham Green, Haringey, and Hornsey (index of deprivation score is 50.3–66.4 and depicts most deprived quintile). With the strengths of its multicultural environment, the borough representing over 50% of its population from ethnic minorities, there are also challenges that the community face. Associated with the levels of deprivation are high rates of long-term unemployment, mental and physical ill-health, substance misuse, crime, asylum seekers, and large numbers of homeless households. Many of these households live in insecure temporary housing thus making efforts from the local authority and allied service agencies to promote social inclusion and cohesion more complex.

Haringey exhibits a high level of SMI in its population. An inpatient census was carried out by BEH MHT in August 2004 and identified that the most frequent diagnosis of those admitted was schizophrenia (35%). When all the psychotic disorders were grouped (schizoaffective disorder, psychosis, bipolar disorder, and schizophrenia), this accounted for 55% of those admitted.

The mental illness needs index [14] records need for specialist mental health services for SMI. It incorporates population characteristics, which contribute to variation in hospital admissions, indicators of deprivation, long-term illness, and disability, and the numbers of people living in a hostel/lodging house. A score of more than 1.0 represents a greater need for mental health services. The model suggests that the need for mental health services in Haringey is 1.16, similar to the London average of 1.15. Some wards in Haringey, namely, Seven Sisters, Noel Park, Bruce Grove, and Northumberland Park, however, have a greater need for mental health services with scores ranging from 2.01–2.33, which is twice the national average.

1.5. Need, Functioning, and Quality of Life. When evaluating needs and the policy of deinstitutionalization by comparing hospitalized and community residents, extensive research has shown the importance of a combined evaluation of functioning, clinical status, individual needs assessments, and quality of life to inform service provision.

A broad definition of quality of life is “adequate resources, fulfilment of social roles in multiple life domains, satisfaction with life in various domains, and general life satisfaction [15].” People with SMI report key problem areas that affected their quality of life were: a lack of personal achievement, lack of job, difficulty in forming and maintaining relationships, loneliness, health problems (both mental and physical), lack of leisure activities, personal safety, and looking after themselves. More often than not, individuals with SMI generally display lower levels of
educational, financial, and vocational achievement than the general population.

Identifying unmet needs can provide information for gaps in services and implications for improvement. Evidence from Slade and colleagues [16] and the UK700 Group [17] showed that meeting unmet need was important because the number of unmet needs was related to reduced health and ongoing health-related expenses. Also, Slade and colleagues [18] observed that as needs increase, quality of life decreases and that unmet needs have more influence on quality of life than met needs.

Quantifying functioning and identifying need at a local level for people with SMI will enable providers and patients to access a range of different forms of supported accommodation, through which patients may move according to needs as well as by choice, at different times in their lives or stage of their illness.

1.6. Haringey SP Programme. The Haringey “Supporting People” (SP) programme provides 377 units of housing-related support (HRS) for people with mental health problems in the borough. The level of HRS offered varies from very low levels of provision to very intensive services. Although the Local Authority administers the programme, decisions on commissioning and strategy are made by a partnership including the Local Authority, the Primary Care Trust and Probation.

This study was exploratory in nature and sought to collect information from a random sample of those with SMI residing in different housing types in Haringey. Demographic and clinical data was collected in order to form a profile of residents in different housing, as well as to measure their degree of met and unmet need. We aimed to examine differences between the self-assessed needs of residents and those determined by their caseworkers. Additionally, we sought to determine which variables (if any) predicted quality of life, irrespective of housing type.

2. Methods

2.1. Participants. 110 participants with severe mental illness (SMI), and 110 keyworkers were interviewed. Inclusion criteria were (1) a lower age limit of 16 years, with no upper age limit; (2) a primary diagnosis of SMI; defined as a clinical diagnosis of schizophrenia, bipolar disorder, or other psychosis made by the psychiatrist in-charge; (3) to be resident in the Rehabilitation Units at St Ann’s Hospital, high-support-accommodation (24 hr staffing including waking night staff), medium-support accommodation (staff available during the whole day or visiting regularly), or low support accommodation (peripatetic staff and/or an alarm or on-call system) within the London Borough of Haringey. Accommodation grading was based on the information provided by the local authority (LA) on the housing providers’ service provision. This was subsequently grouped according to the GLA reports criteria [19]. Participants with a primary diagnosis of substance misuse or an organic condition were excluded.

2.2. Procedure. Housing providers in Haringey were identified through the LA database. The aim was to include a representative sample covering residential care to low level supported housing, with a minimum of a third from each of the residences/providers. A sample of participants was identified through the LA database and local patient register for potential inclusion. The approach was fully compliant with the Data Protection Act. A random sample of those who were interested was selected from the database for the purposes of the needs-assessment interview. Of those individuals who refused or were ineligible, the next person on the list was chosen.

The interview process involved validated survey methods using face-to-face interviews at the individual’s own home unless they requested otherwise, at a time convenient to the participants and following the safety guidelines for researchers. Participants received £10 expenses for their involvement. Individual keyworkers were interviewed separately to complete the test battery. Data was triangulated by gathering additional information from the participants’ keyworker and medical and other case notes. All participants completed a written informed consent form. Verbal consent was obtained from keyworkers.

2.3. Measures. All participants were evaluated using the following validated instruments.

2.3.1. The 36-Item Short Form (SF-36) [20]. It was constructed to survey health status in the Medical Outcomes Study. It is a generic measure, which can be interviewer or self-administered, and assesses eight health concepts (physical functioning; physical role; bodily pain; general health; vitality; social functioning; emotional role; mental health). The scores range from 0–100, with a higher score indicating a greater level of functioning.

2.3.2. Camberwell Assessment of Need Research (CAN-R) [21]. The instrument assesses needs for care and help over the last month in 22 health and social domains. Separate assessments can be recorded from the perspectives of the service user and staff. CAN-R has four sections for each of the 22 domains assessed: existence of a need; informal help; help from formal services; user satisfaction with help. Based on responses, a “need rating” is made for the last month within each domain by means of a three-point scale. The number of met and unmet needs may be scored per domain. An overall total need score can also be summed.

2.3.3. Lancashire Quality of Life Profile [22]. This is an interviewer-administered questionnaire based on Lehman’s work and retains eight of Lehman’s domains (health and self-concept, social relations; law/safety; living situation; leisure/participation; family; work; and finances; religion). Objective ratings are made from direct questioning about participant’s lives, while subjective well-being is measured by asking participants to rate their satisfaction with each separate life domain on a seven-point Likert scale.
2.3.4. Brief Psychiatric Rating Scale: Expanded Version 4.0 [23]. This is an interviewer-based instrument and rates the severity of psychiatric symptoms on a scale of one to seven (not present to extremely severe) in 24 domains. Information is also gathered via behavioural observation, medical case notes, and from keyworker. The BPRS contains four symptom clusters that tend to cooccur.

2.3.5. WHO Life Chart. This consisted of health-related information gathered from medical notes charting the past two years [24].

2.4. Statistical Analysis. Basic descriptive statistics of the sociodemographic and clinical were calculated for the whole sample and for all four groups of supported accommodation residents. These data were also examined in relation to assessment of need as determined by participant’s scores on the SF-36, the CAN-R, and Lancashire Quality of Life Profile domain scores and overall scores.

Next, regression analysis was used to model the effect of need upon quality of life, therefore, the primary exposure was “need”, and the primary outcome was “quality of life”. The following list of a priori variables was compiled by the Research Group (with expertise in the field), and considered for confounding: age, gender, ethnicity, BPRS score, SF-subscore, medication, suicidality, and hospital admissions. Prior to analysis, variables were checked for normality of distribution. If they were not normally distributed, they were collapsed into categories to make maximal use of the information. Those confounders found to be significantly correlated with either the primary exposure or primary outcome, were then entered into each regression analysis. Analysis was performed for the whole sample and by housing group, separately.

3. Results

The demographic and clinical data of the participant sample is shown in Table 1. The sample’s mean age was 41.6 years and the majority were male (77.3%), single (79.1%), of African-Caribbean ethnicity, and diagnosed with schizophrenia (81.8%). The greatest proportion interviewed resided in “medium-supported” housing (staff was available and visited but not permanently on site). Total psychiatric symptom score measured on the Brief Psychiatric Rating Scale (BPRS) was ten points higher in rehabilitation than on the SF-36, the CAN-R, and Lancashire Quality of Life Profile domain scores (see Table 2). Need scores perceived by participants and their keyworkers measured using the CAN are shown in Table 3, above. There was significant dissonance in all-need scores between participant and keyworker in all housing settings apart from accommodation. More met needs were reported by keyworkers than by participants in all settings, except in low-supported housing. The met-need score tended to increase from low-supported accommodation through rehabilitation settings; however, the unmet-need score varied far less across housing types.

Quality of life (QoL) scores are reported in Table 4. Overall, differences were minimal. Participants in high-supported accommodation had the greatest total QoL score as well as the greatest number of highest scores, whereas the total QoL score was lowest in low-supported residents.

Table 5 shows the results of multiple regression with quality of life as the outcome; only significant exposure variable was included in the final models. Model one was performed for the entire sample. It showed that a greater Lancashire quality of life score was predicted by lower user-determined unmet needs ($b = −2.20$) and greater SF-36 mental scores ($b = 0.029$). Model two was performed for the largest subsample of participants: those in medium-supported housing. Model one’s findings were replicated: quality of life was predicted by lower user-determined unmet needs ($b = −0.27$) and greater SF-36 mental score ($b = 0.016$).

4. Discussion

4.1. Summary of Findings. This was a cross-sectional study of a random sample of people with psychosis residing in various types of housing within the London Borough of Haringey. The main findings were as follows: the largest ethnic group was of African-Caribbean origin and the largest housing group resided in medium-supported accommodation (where trained staff were available during the day or visited regularly). Those interviewed in the rehabilitation units, who received the greatest level of trained support, also exhibited the greatest observer-rated psychiatric symptom scores but scored themselves least for symptoms.

In community residences, those in low-support accommodation provided lower scores than those in high-support housing for the various domains of social functioning measured by the SF-36, despite similar levels of psychopathology in both environments. This was also reflected in quality of life scores, which were commensurate with level of support provided.

Within the needs assessment, the magnitude of unmet need was less than that for met need, and this did not vary across housing type. Finally, self-reported mental health and unmet need were the only significant variables to predict quality of life score in regression analyses of the sample as a whole and those in medium-support housing alone.

4.2. Limitations of the Study. This was a cross-sectional study, which makes it difficult to infer causality between variables that are associated with each other; a prospective study would make aetiological inferences easier. Although the study sample was selected in a random manner, there
Table 1: Demographic and clinical data, by housing type (n = 110).

<table>
<thead>
<tr>
<th>Participant characteristic</th>
<th>Low support (inpatient)</th>
<th>Medium support</th>
<th>High support (peripatetic staff and/ or alarm/on-call)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Male</td>
<td>10 (83.3)</td>
<td>24 (80.0)</td>
<td>41 (78.8)</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>2 (16.7)</td>
<td>6 (20.0)</td>
<td>11 (21.2)</td>
</tr>
<tr>
<td>Ethnicity grouped</td>
<td>African Caribbean</td>
<td>7 (58.3)</td>
<td>17 (56.7)</td>
<td>29 (55.7)</td>
</tr>
<tr>
<td></td>
<td>White British</td>
<td>3 (25)</td>
<td>6 (20)</td>
<td>11 (21)</td>
</tr>
<tr>
<td></td>
<td>European</td>
<td>1 (8.3)</td>
<td>4 (13.3)</td>
<td>10 (19.2)</td>
</tr>
<tr>
<td></td>
<td>South Asian</td>
<td>—</td>
<td>—</td>
<td>2 (3.8)</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>6 (54.5)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Time in residence</td>
<td>0–12 months</td>
<td>4 (36.4)</td>
<td>1 (4.5)</td>
<td>5 (9.1)</td>
</tr>
<tr>
<td></td>
<td>13–28.5 months</td>
<td>1 (9.1)</td>
<td>1 (4.5)</td>
<td>2 (3.7)</td>
</tr>
<tr>
<td></td>
<td>&gt; 29 months</td>
<td>3 (27.3)</td>
<td>3 (13.6)</td>
<td>4 (7.5)</td>
</tr>
<tr>
<td></td>
<td>Ethnicity grouped</td>
<td>Female</td>
<td>9 (75.0)</td>
<td>21 (77.8)</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>3 (25.0)</td>
<td>6 (22.2)</td>
<td>10 (22.2)</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>12 (108.3)</td>
<td>27 (100)</td>
<td>50 (100)</td>
</tr>
<tr>
<td></td>
<td>Implicit support</td>
<td>1 (100)</td>
<td>4 (100)</td>
<td>7 (100)</td>
</tr>
<tr>
<td></td>
<td>Explicit support</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>3 (100)</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>1 (100)</td>
<td>4 (100)</td>
<td>7 (100)</td>
</tr>
</tbody>
</table>

*Note:* The table provides a summary of demographic and clinical data, categorized by housing type. The data includes age group, gender, ethnicity, time in residence, and implicit/explicit support. The table also includes BPRS scores for various dimensions.
Table 2: Comparison of mean self-reported health scores (SF-36), across housing type.

<table>
<thead>
<tr>
<th>SF-36 summary scores</th>
<th>Rehab settings</th>
<th>High-support accommodation</th>
<th>Medium-support accommodation</th>
<th>Low-support accommodation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical functioning</td>
<td>66.3</td>
<td>82</td>
<td>81.5</td>
<td>76.6</td>
</tr>
<tr>
<td>Role limitations due to physical problems</td>
<td>59.1</td>
<td>75</td>
<td>76.9</td>
<td>68.8</td>
</tr>
<tr>
<td>Role limitations due to emotional problems</td>
<td>61.1</td>
<td>73.3</td>
<td>59.6</td>
<td>56.3</td>
</tr>
<tr>
<td>Bodily pain</td>
<td>74</td>
<td>75.1</td>
<td>68.3</td>
<td>67.2</td>
</tr>
<tr>
<td>General health</td>
<td>64.7</td>
<td>65.5</td>
<td>59.3</td>
<td>56.3</td>
</tr>
<tr>
<td>Vitality</td>
<td>55.5</td>
<td>59.6</td>
<td>51.5</td>
<td>47.2</td>
</tr>
<tr>
<td>Social Functioning</td>
<td>82.5</td>
<td>97.4</td>
<td>89</td>
<td>79.3</td>
</tr>
<tr>
<td>Mental health</td>
<td>74.8</td>
<td>71.4</td>
<td>63.3</td>
<td>60.5</td>
</tr>
</tbody>
</table>

Table 3: Comparison of the mean total needs, met and unmet needs in all housing types (Wilcoxon-matched pairs signed-rank test).

<table>
<thead>
<tr>
<th>CAN Score</th>
<th>Keyworker Mean (S.D.)</th>
<th>Participant Mean (S.D.)</th>
<th>Difference</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehab</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All needs</td>
<td>10.6 (2.0)</td>
<td>9.7 (2.0)</td>
<td>0.9</td>
<td>0.44</td>
</tr>
<tr>
<td>Met needs</td>
<td>8.8 (1.5)</td>
<td>7.5 (1.4)</td>
<td>1.3</td>
<td>0.05</td>
</tr>
<tr>
<td>Unmet needs</td>
<td>1.8 (1.1)</td>
<td>2.2 (1.9)</td>
<td>0.5</td>
<td>0.60</td>
</tr>
<tr>
<td>High support</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All needs</td>
<td>9.1 (2.5)</td>
<td>7.8 (2.2)</td>
<td>1.3</td>
<td>0.006</td>
</tr>
<tr>
<td>Met needs</td>
<td>7.3 (2.1)</td>
<td>6.7 (2.0)</td>
<td>0.6</td>
<td>0.07</td>
</tr>
<tr>
<td>Unmet needs</td>
<td>1.8 (1.6)</td>
<td>1.1 (1.2)</td>
<td>0.7</td>
<td>0.70</td>
</tr>
<tr>
<td>Medium support</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All needs</td>
<td>8.2 (3.2)</td>
<td>7.3 (2.7)</td>
<td>0.9</td>
<td>0.07</td>
</tr>
<tr>
<td>Met needs</td>
<td>6.8 (2.7)</td>
<td>5.8 (2.3)</td>
<td>1.0</td>
<td>0.02</td>
</tr>
<tr>
<td>Unmet needs</td>
<td>1.6 (1.6)</td>
<td>1.5 (1.5)</td>
<td>0.1</td>
<td>0.80</td>
</tr>
<tr>
<td>Low support</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All needs</td>
<td>5.9 (3.1)</td>
<td>6.5 (2.9)</td>
<td>0.6</td>
<td>0.006</td>
</tr>
<tr>
<td>Met needs</td>
<td>4.4 (1.6)</td>
<td>4.8 (2.4)</td>
<td>0.4</td>
<td>0.2</td>
</tr>
<tr>
<td>Unmet needs</td>
<td>1.6 (1.9)</td>
<td>1.7 (1.1)</td>
<td>0.1</td>
<td>0.7</td>
</tr>
</tbody>
</table>

may have been a systematic bias in those that agreed to be interviewed. However, the number that refused to participate was minimal which limits this possibility. Finally, the smaller subsamples in rehabilitation, high- and low-support housing may have limited precision and masked any significant effects in the regression analyses. However, the overall housing profile of those interviewed is likely to reflect the real-life population where most people on the Haringey register with SMI are in medium-support housing.

4.3. Implications. Need scores tended to be greater when estimated by keyworkers rather than the participants themselves. This is reflected in other research findings [25] and may represent a degree of concern by service users not to overstate their perceived needs to figures in authority in case it led to overly restrictive accommodation interventions. This larger estimation of need by keyworkers may also represent a deliberate way of ensuring that the users’ needs are adequately met, thereby reflecting a general concern that resources available to clients are limited and in demand.

We found that the magnitude of unmet need was less than for met need, irrespective of housing type, implying the relatively successful and important function of residential facilities for those with SMI. This may be a global and time-independent finding as it has been replicated in a recent Indian study using the CAN of patients with SMI living in a halfway home in Bangalore [26].

Those in high-support accommodation tended to show higher social function scores and self-perceived quality of life scores than those in low-support housing. Another UK study found that patients who moved from more independent living to a group home showed both a reduction in psychiatric symptom scores and concomitant improvement in their quality of life scores [27]. Baker and Douglas in the USA noted that a move from housing that was appropriate to need to more inappropriate housing led to deterioration in quality of life of those with SMI [28]. It is important to note...
Table 4: Lancashire quality of life scores across housing type.

<table>
<thead>
<tr>
<th>Housing type</th>
<th>Mean</th>
<th>Std deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehab (inpatient)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LQoL general well-being score</td>
<td>3.91</td>
<td>1.83</td>
</tr>
<tr>
<td>LQoL mean education score</td>
<td>4.40</td>
<td>1.26</td>
</tr>
<tr>
<td>LQoL leisure score</td>
<td>4.64</td>
<td>1.65</td>
</tr>
<tr>
<td>LQoL religion score</td>
<td>4.90</td>
<td>0.74</td>
</tr>
<tr>
<td>LQoL finances score</td>
<td>3.96</td>
<td>1.47</td>
</tr>
<tr>
<td>LQoL living situation</td>
<td>3.94</td>
<td>1.25</td>
</tr>
<tr>
<td>LQoL legal and safety score</td>
<td>5.55</td>
<td>2.24</td>
</tr>
<tr>
<td>LQoL family relations score</td>
<td>4.88</td>
<td>1.52</td>
</tr>
<tr>
<td>LQoL social relation score</td>
<td>4.50</td>
<td>1.35</td>
</tr>
<tr>
<td>LQoL health score</td>
<td>4.75</td>
<td>1.23</td>
</tr>
<tr>
<td>LQoL total score</td>
<td>4.59</td>
<td>0.65</td>
</tr>
<tr>
<td>High-support 24 hr staffing inc. waking night staff. res.</td>
<td>4.86</td>
<td>1.30</td>
</tr>
<tr>
<td>LQoL mean education score</td>
<td>4.24</td>
<td>1.64</td>
</tr>
<tr>
<td>LQoL leisure score</td>
<td>5.21</td>
<td>1.06</td>
</tr>
<tr>
<td>LQoL religion score</td>
<td>5.15</td>
<td>0.69</td>
</tr>
<tr>
<td>LQoL finances score</td>
<td>4.70</td>
<td>1.06</td>
</tr>
<tr>
<td>LQoL living situation</td>
<td>4.87</td>
<td>1.05</td>
</tr>
<tr>
<td>LQoL legal and safety score</td>
<td>5.22</td>
<td>1.09</td>
</tr>
<tr>
<td>LQoL family relations score</td>
<td>4.97</td>
<td>1.36</td>
</tr>
<tr>
<td>LQoL social relation score</td>
<td>4.92</td>
<td>1.03</td>
</tr>
<tr>
<td>LQoL health score</td>
<td>4.94</td>
<td>0.99</td>
</tr>
<tr>
<td>LQoL total score</td>
<td>4.90</td>
<td>0.56</td>
</tr>
<tr>
<td>Med-support staff available during whole day/visit reg. (SP)</td>
<td>4.70</td>
<td>1.22</td>
</tr>
<tr>
<td>LQoL mean education score</td>
<td>3.88</td>
<td>1.38</td>
</tr>
<tr>
<td>LQoL leisure score</td>
<td>5.07</td>
<td>0.88</td>
</tr>
<tr>
<td>LQoL religion score</td>
<td>4.87</td>
<td>1.05</td>
</tr>
<tr>
<td>LQoL finances score</td>
<td>4.44</td>
<td>1.16</td>
</tr>
<tr>
<td>LQoL living situation</td>
<td>4.79</td>
<td>0.91</td>
</tr>
<tr>
<td>LQoL legal and safety score</td>
<td>4.82</td>
<td>1.01</td>
</tr>
<tr>
<td>LQoL family relations score</td>
<td>4.84</td>
<td>1.49</td>
</tr>
<tr>
<td>LQoL social relation score</td>
<td>4.81</td>
<td>0.85</td>
</tr>
<tr>
<td>LQoL health score</td>
<td>4.74</td>
<td>0.91</td>
</tr>
<tr>
<td>LQoL total score</td>
<td>4.68</td>
<td>0.58</td>
</tr>
<tr>
<td>Low-support peripatetic staff and/or alarm/on-call (SP)</td>
<td>4.72</td>
<td>1.90</td>
</tr>
<tr>
<td>LQoL mean education score</td>
<td>4.03</td>
<td>1.34</td>
</tr>
<tr>
<td>LQoL leisure score</td>
<td>4.60</td>
<td>1.09</td>
</tr>
<tr>
<td>LQoL religion score</td>
<td>4.17</td>
<td>1.11</td>
</tr>
<tr>
<td>LQoL finances score</td>
<td>4.16</td>
<td>1.50</td>
</tr>
<tr>
<td>LQoL living situation</td>
<td>4.74</td>
<td>1.19</td>
</tr>
<tr>
<td>LQoL legal and safety score</td>
<td>4.88</td>
<td>1.36</td>
</tr>
<tr>
<td>LQoL family relations score</td>
<td>4.59</td>
<td>1.67</td>
</tr>
<tr>
<td>LQoL social relation score</td>
<td>4.91</td>
<td>0.97</td>
</tr>
<tr>
<td>LQoL health score</td>
<td>4.75</td>
<td>1.07</td>
</tr>
<tr>
<td>LQoL total score</td>
<td>4.57</td>
<td>0.87</td>
</tr>
</tbody>
</table>
that only trends in scores were found rather than significant differences: a Canadian study revealed no differences in mean quality of life scores between those with SMI in supportive housing and those in basic “board-and-care” homes [29]. Nevertheless, these trends may have become more significant with a larger sample size.

Our regression analyses demonstrated that self-reported mental health score was positively predicted, and unmet-need score was negatively predicted quality of life. Lasalvia and colleagues also found that self-reported psychological distress rather than BPRS score predicted subjective quality of life [30]. In terms of need, the same-led research group reported upon a four-year cohort study which found that an improvement in clinical conditions, and a reduction in unmet-need predicted a lower follow-up quality of life, suggesting self-perceived social needs rather than reduction in psychopathology-improved quality of life in those with SMI [27]. Additionally, a cross-sectional multicentred Nordic study of 418 schizophrenics found that more unmet needs were associated with a poorer quality of life, accounting for 6% out of 41% of the explained variance in quality of life at regression [31]. This highlights the importance to attend to (and hopefully improve) the subjective experience of illness and distress as well as addressing the social needs of those with SMI.

4.4. Conclusions and Future Research. The needs assessment of this sample found the mean unmet-need scores to be lower than met needs suggesting that needs are being broadly met for those with SMI in Haringey. However, those in low-support housing seemed impaired and distressed by the relative lack of input they received, reflected in their lower social-functioning and quality of life scores.

The lack of variation in need scores across housing types may suggest that the apportioning of housing may be more arbitrary than previously believed. An interesting study would be to follow up those with SMI in low-support housing and see if their perceived disadvantage is reflected in increased hospital admission.

Another important point was that observer-rated psychiatric symptom score did not determine quality of life, although self-reported psychopathology and social need did. The aetiological significance could be underscored by a prospective study in Haringey, as performed by Lasalvia’s group in Italy [32]. If this were the case, it could steer the emphasis of community services for those with SMI more toward relieving the individual’s subjective experience of distress.

Finally, that needs are often not being met should not be lost in this study’s findings. It may reflect a global problem of inadequately meeting the needs of those with mental illness in general, as has been seen at the population level in Europe [33]. It may also indicate that needs are interdependent, with the failure to meet a need in one domain, having a detrimental effect on need in other areas. A recent study by colleagues in Buffalo, New York highlighted the problem of the unmet need of social connectedness of patients with SMI [34]. This acted as an obstacle to the global goal of recovery—patients returning to or achieving meaningful social roles, relationships, and membership in their communities; it also indicated that needs may be “cantilevered,” rather than hierarchical, with each essential to the other and to overall functioning and well-being. Finally, another population survey of Swedish mental health burden found that those most likely to have an unmet need were males, socially isolated, and had educationally underachieved [35]—descriptive factors that often describe those suffering with severe and enduring mental illness, irrespective of geographical origin.

If we are to enable those with SMI in their process of recovery and reintegration, helping in the fulfilment of need should be paramount.

Ethical Approval

The ethical approval was received from Barnet, Enfield, and Haringey Local Research Ethics Committee.

Conflict of Interests

The authors declare that they have no conflict of interests.

Authors’ Contribution

M. Lambri wrote the proposal, sought ethical approval, collected and analysed the data, and authored and edited
the paper. All other authors contributed to the methodology, analysis and commented on drafts of the paper.

Acknowledgment

A fund was received from Barnet, Enfield and Haringey Mental Health and Social Care NHS Trust.

References


Research Article

Strategies to Fight Stigma toward People with Mental Disorders: Perspectives from Different Stakeholders

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Received 6 August 2012; Accepted 13 September 2012

Academic Editors: E. Broekaert, R. C. Rapp, W. Vanderplasschen, and S. Vandevelde

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This study aims to provide a more complete and exhaustive perspective on the whole range of potential strategies to fight stigma by considering the perspectives of different stakeholders. Delegates to a Canadian conference were invited to participate in a survey that focused on stigma, from which the responses to the following question were analyzed: tell us briefly what you do to reduce prejudice and stigma toward people with a diagnosis of mental disorder? From 253 participants, 15 categories of strategies to fight stigma were identified from the verbatim (e.g., sharing/encouraging disclosure). These categories fell under six main themes: education, contact, protestation, person centered, working on recovery and social inclusion, and reflexive consciousness. The occurrence of these themes was different among stakeholders (clinical, organizational, and experiential knowledge). For example, people with mental disorders (experiential knowledge) often mentioned contact and person centered strategies, while mental health professionals (clinical knowledge) preferred education and working on recovery and social inclusion strategies. The results from this study highlight the need to pay more attention to the concept of disclosure of mental disorders in the process for de-stigmatization. Future studies are needed to assess the impact of the emerging strategies to fight stigma in the community.

1. Introduction

Much has been written about stigma and how it applies to people with severe mental illness [1–3]. Stigma is a complex term defined as a visible or invisible attribute, deeply discrediting, that disqualifies its bearer from full social acceptance, often resulting in several forms of discrimination [4]. Today, stigma is described as “a severe social disapproval due to believed or actual individual characteristics, beliefs or behaviors that are against norms, be they economic, political, cultural or social” [5, p. 10]. It is characterized by a lack of knowledge about mental health, fear, prejudgment, and discrimination. In its most advanced forms, stigma leads to exclusion of the person from several spheres of social functioning and it causes feelings of guilt, shame, inferiority, and a wish for concealment [6].

Stigma toward people with mental disorders is a complex issue with the capacity to affect all facets of a person’s life, such as the opportunity to find housing and employment, enter higher education, obtain insurance, and get fair treatment in the criminal justice or child welfare systems [7, 8]. Thus, stigma robs people with mental illness of particularly important life opportunities vital to achieving life goals, obtaining competitive employment, and living independently in a safe and comfortable home [9].

Stigmatization toward people with mental disorders stems from different stakeholders in the community and can be expressed differently, considering these perspectives,
sometimes resulting in self-stigmatization. Evans and Repper [10] reported that the general tendency for employers and mental health professionals is to underestimate the capacities and skills of people with mental illness: these behaviors, to a certain extent, can be experienced as discriminating. Lack of interest in the person's background and needs and exclusion of relatives from treatment planning have also been mentioned as professionals' stigmatizing attitudes toward people with mental illness [11, 12]. It has also been argued that mental health professionals can sometimes hold the same public stigmatizing attitudes toward mentally ill individuals as well as very pessimistic views of their chances of recovery [8]. Stigmatizing attitudes have also been observed among students from many segments of medical and psychological services [13]. An additional issue is that some people with mental illness endorse stigmatizing attitudes about psychiatric disability, starting to believe that he/she deserves treatment and acceptance associated with severe mental illnesses [14]. Thus, self-stigma leads people with mental illness and their families to adopt attitudes of self-loathing and self-blame, resulting in a sense of helplessness and hopelessness [8].

More than 40 negative consequences of stigma have been reported in the literature [15, 16]. While the damaging impact of stigma is mainly confined to the stigmatized individual, public stigma also impacts their families and close friends, who can experience high levels of shame and embarrassment [17]. This is what has been called the "courtesy of stigma," meaning the result of being related to a person with a stigma [4, 11, 18]. In general, everyone who comes into close contact with the mentally ill, such as mental health support groups and even mental health professionals [4, 13, 19, 20], suffers from their own type of public stigma. For example, a psychiatrist's authority has been considered inferior to other medical experts, so patients often ignore their advice and, therefore, they frequently appear ineffective [21].

In sum, stigma can severely and negatively impact mentally ill individuals, their families, and service providers in a number of ways. Due to stigma's devastating effects, studies worldwide have recently aimed to raise awareness and understanding about the most effective strategies to combat stigma and discrimination. Little is known about how to combat stigmatizing attitudes toward people with mental illness and the ingredients for successful antistigma activities [18, 22]. The literature identifies three general approaches for countering stigmatizing attitudes and discriminating behavior associated with mental illness. These are education, contact, and protest [23, 24]. Although each of these stigma-reducing approaches has some degree of validity on the surface, they are not uniformly effective [25].

The first strategy to fight stigma originates from the belief that stigma is related to poor factual knowledge about mental illness and seeks to inform the general public and health professionals by replacing inaccurate stereotypes and false assumptions of mental illness with facts and accurate conceptions about the illness [24, 26]. The limitations of this kind of intervention are that many stereotypes are resilient to change [27], and it has been argued that education modifies literacy and, sometimes, attitudes, but rarely behavior [18].

The second strategy aims to change negative attitudes toward the mentally ill through direct interactions with affected persons. Direct and face-to-face interactions are examples of contact interventions [28]. Contact appears to be the most promising strategy for reducing stigma [27], especially when contact is one-on-one: when people are seen as having equal status and when people are working together in a cooperative rather than competitive manner [29–31]. However, reducing stigma through contact is time-consuming and may not be cost efficient [32]. Also, the efficacy of this strategy seems to depend on the context and the nature of the contact.

The third strategy works on conveying messages to report and to believe reported negative and inaccurate representations of mental illness. Advocacy activities, educational support groups, and patient empowerment groups are examples of interventions within the protest strategy. This kind of strategy is usually effective in diminishing negative attitudes about mental illness but it fails to promote more positive attitudes supported by facts. Also, a rebound effect may occur and can be observed in the stigmatizing beliefs of the public [24, 27], meaning that protest does not necessarily change people's prejudice about mental illness.

The challenge of combating stigma is still prominent in the mental health field and much more needs are to be done. The fight against stigma is a complex endeavor, with multifaceted implications, and must be examined from multiple perspectives (e.g., mentally ill individuals, their families, and healthcare professionals) to increase knowledge and experience about the best strategies for antistigma campaigns. Until now, few studies focusing on the perspective of those having mental illness, relatives or mental health practitioners, have been published and there is a paucity of research using everyday life settings for examining strategies to fight stigma. Most efforts have focused on directly improving community attitudes even though it seems relevant that antistigma programs would also address patients and their relatives. Studies conducted in this manner reported few suggestions, which were mainly concerned with improving information on mental health issues for the public [12, 19].

The main objective of this study is to provide an exhaustive perspective on the whole range of strategies to fight stigma used by different stakeholders, such as mentally ill individuals, their families, mental health professionals, and other people working in mental health organizations. The intent is to focus on everyday and practical strategies that can, ideally, be applied across various settings, such as health, community, workplace, and school. More particularly, specific objectives aim to (1) produce emerging strategies to fight stigma that consider the perspectives of different stakeholders groups; (2) compare the occurrence of different types of strategies to fight stigma according to different types of knowledge: organizational (i.e., directors, managers, or coordinators working in the field of mental
health), clinical (i.e., mental health professionals and/or clinicians), and experiential knowledge (i.e., users of mental health services).

2. Methodology

2.1. Procedure. In November 2010, the Quebec Association for Psychosocial Rehabilitation (AQRP) held its fifteenth conference entitled: “Overcoming Stigma, a Collective Challenge!”. This event brought together over 800 delegates from the public and community sectors of mental health (people who use mental health services, professionals, researchers, managers, etc.). The main objective of this event was to promote collective reflection on the consequences of stigmatization or destigmatization toward people with a mental disorder. As part of this conference, another objective was to enable understanding and familiarization of approaches, actions, resources, and strategies to overcome stigma and promote destigmatization.

At the beginning of the event, the conference delegates were invited to participate in a survey that focused on stigma (see below for a description). The survey invitation was delivered by direct contact: located in strategic areas and at appropriate times (mainly on the first day, during registration and breaks); volunteers invited delegates to a room reserved for data collection. The survey could be answered online (online survey created with SurveyMonkey) or on paper. The survey was approved by the ethics committee of the Université de Sherbrooke.

2.2. Survey Description. The questionnaire was developed by a subgroup of the scientific committee of the fifteenth conference of the AQRP. The survey was composed, in part, of a series of questions (Likert scale) from an existing questionnaire. (The questionnaire is found in an ongoing project: Study of Factors Influencing Return-to-Work of People with Depression in (2009) by M. Corbière, M. J. Durand, M. F. Coutu, L. St-Arnaud, T. Lecomte. The project is funded by CIHR and IRSST.) Other questions (open) were inspired by the literature on the subject [23]. Three groups of strategies obtained were grouped into six major themes as “reframing words” by one author and as “defending references” by the other. These differences were discussed until a consensus was reached.

The results presented in this paper relate to one open-ended question of the survey, that is, the strategies used by respondents to reduce prejudice and stigma toward people with a diagnosis of mental disorder. The question was worded as follows: tell us briefly what you do to reduce prejudice and stigma toward people with a diagnosis of mental disorder.

2.3. Participants. Every conference delegate was eligible to participate in the study. Of the 801 delegates, 315 agreed to answer the questionnaire. (Please note that it is not possible to establish a precise response rate because the conference was held on 3 days (November 8-9-10, 2010) and data collection was done at the beginning of the conference, at which time not all delegates were present.) A total of 277 people answered the question specific to this paper: 121 (44%) were clinicians/professionals and 74 (27%) were users of mental health services. The other types of respondents each comprised 10% or less of the participants: managers (10%), coordinators (8%), professors-researchers/research professionals/teachers (3%), parents/friends (3%), students (1%), and other (4%). Our sample included 183 women (71%). Considering the whole sample, 168 respondents (62%) held a university degree, nearly a quarter (24%) had a college degree, and (14%) had a high school diploma or less. The age groups of the respondents included 154 (56%) people between 35 and 54, with the remaining respondents either under 35 (21%) or over 54 (23%).

2.4. Data Analyses. The authors (M. Corbière and E. Samson) read the verbatim to get a general idea of the strategies mentioned by the respondents. After independently identifying categories of the strategies observed in the verbatim, the authors, together, established a final list of 15 categories of strategies, which excluded nonrelevant or incomprehensible references. The process of establishing categories reduced the number of selected respondents to 253. Because the verbatim was generally simple and straightforward, the strategies mentioned by the respondents were easy to conceptualize. From this common list, the authors conducted categorization of all verbatim independently, then compared the category or categories(s) awarded by each of them to each transcript. The concordance rate for the categories between the authors was high, approximately 92%. Disagreements between the two authors were mainly about categories of strategies that were close in content. For example, “I refuse to speak against people that have a mental disorder” was categorized as “reframing words” by one author and as “defending rights” by the other. These differences were discussed until a consensus was reached.

To distinguish whether the strategies used to fight social stigma differed between the respondents, the 15 categories of strategies obtained were grouped into six major themes inspired by the literature on the subject [23]. Three groups of respondents were also created, according to their type of knowledge: clinical, experiential, and organizational. Respondents matching the clinical knowledge profile were professionals and/or clinicians (n = 115) working with people with a mental disorder. People with an experiential knowledge profile were those who, in the survey, identified themselves as users of mental health services (n = 61); finally, those who worked in the field of mental health as directors/managers (n = 24) or coordinators (n = 22) fit the organizational knowledge profile. Since the percentage of other respondents (e.g., professors-researchers/research professionals/teachers (n = 8), parents/friends (n = 7), students (n = 2) was very low (lower than 4% each category), they were not considered for analyses. In the end, respondents with a profile that corresponded to the three targeted types of knowledge (n = 222) were included in comparison analyses. Figure 1 presents the number of retained respondents according to the different steps of the analysis.
3. Results

3.1. Part 1. As mentioned above, a first analysis of the results obtained from the 253 respondents whose entries to the question “Tell us briefly what you do to reduce prejudice and stigma toward people with a diagnosis of mental disorder” produced several strategies that were grouped into 15 categories. Table 1 shows the occurrence of each category. (The occurrence of each category is the result of dividing the number of respondents who gave a response associated with the category by the total number of respondents to the 15 categories (253). A given respondent may cite more than one strategy.)

We observed that the strategies used addressed not only the general population, but also the people directly concerned by the illness (AQRP conference delegates), which explains the particular nature of strategies used to fight stigma. Indeed, the strategies mentioned in this study can be viewed from three different perspectives depending on who the action targeted: the general population (e.g., educating/teaching); the person with a diagnosis (e.g., working on social inclusion); or the respondent himself (e.g., doing introspective work).

The most commonly mentioned type of strategy, Educating/teaching (42%), is a strategy directed at the general population. It aims to inform people and to correct misconceptions with facts.

I downplay what presents itself and make people aware of what is mental health. I take this opportunity to explain what it can mean to the person, demystify what is happening and bring the person to understand what is happening. (Coordinator)

A third of the respondents (32%) also mentioned strategies calling for normalizing. In most cases, normalizing was observed as a strategy directed at the person with a diagnosis. This meant treating or considering this individual the same as any other person, looking at that person the same way as anyone else, without any distinction related to the diagnosis, nor to a specific behaviour or opinion.

I act normal, I treat them like whole people and I ignore the illness. (Clinician/professional)

Having the same attitude, the same look as I have for others. (Clinician/professional)

In some cases, Normalizing was a strategy directed at the general population. People with a mental disorder were then presented to others as people who have the right to be different people. The notion of demystification was also present in this category.

I often tell people that mental health is very much like physical health [...] for me, treating mental health is the same as treating physical health, a good doctor with a good treatment, good will to want to recover. You can live in the community like everyone else. (User of mental health services)

These two strategies, Educating/teaching and Normalizing were the two main strategies mentioned by all respondents. Two other strategies also emerged: Working on Recovery (19%) and Working on social inclusion (15%).

I work as an occupational therapist in mental health among people with a diagnosis of mental disorder. I accompany them, help them realize their life plan based on their strengths and own difficulties. (Clinician/professional)

As a specialized mental health educator, it is part of my work to reduce prejudice by doing the most possible integration into the community with people with a mental health problem. (Clinician/professional)

These two strategies were directed at the person with a diagnosis. To work on recovery involved supporting, assisting, and encouraging the person. It was about believing in the person, building on his or her strengths and possibilities, rather than taking charge. The respondents identified these attitudes and behaviors as ways to reduce prejudice and stigma. The second strategy, Working on social inclusion, referred to promoting the integration of the person with a mental disorder in the community, for example, in terms of social activities, education, or employment.

Sharing/encouraging disclosure were strategies directed at the general population and were used by about one in ten respondents (9%). This meant, for people with a diagnosis, disclosing their condition in appropriate circumstances or more formally sharing their story with the public. For people working with individuals with a diagnosis, it meant allowing them to share their story.
Table 1: Categories of strategies used to reduce prejudice and stigma.

<table>
<thead>
<tr>
<th>Categories</th>
<th>All (n = 253)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
</tr>
<tr>
<td>Educating/teaching</td>
<td></td>
</tr>
<tr>
<td>I try to make people around me aware of prejudice whenever I get the chance by explaining what mental health problems are. (Clinician/professional)</td>
<td>42%</td>
</tr>
<tr>
<td>Normalizing</td>
<td></td>
</tr>
<tr>
<td>I think that people who receive a diagnosis are like everyone else and they shouldn’t be treated differently. (Clinician/professional)</td>
<td>32%</td>
</tr>
<tr>
<td>Working on recovery</td>
<td></td>
</tr>
<tr>
<td>I help them to keep faith [...], I work with their strengths and their potentialities. I think with them, rather than taking charge of them or trying to save them. (Coordinator)</td>
<td>19%</td>
</tr>
<tr>
<td>Working on social inclusion</td>
<td></td>
</tr>
<tr>
<td>I work with mental health clients, I help them to “mingle” in society through various activities. (Clinician/professional)</td>
<td>15%</td>
</tr>
<tr>
<td>Listening/caring</td>
<td></td>
</tr>
<tr>
<td>… listening to them, welcoming them. (User of mental health services)</td>
<td></td>
</tr>
<tr>
<td>I place importance on what the person with the diagnosis thinks and expresses. (Coordinator)</td>
<td>11%</td>
</tr>
<tr>
<td>Sharing/encouraging disclosure</td>
<td></td>
</tr>
<tr>
<td>I share my story of mental illness. (User of mental health services)</td>
<td></td>
</tr>
<tr>
<td>Encouraging and supporting people with mental illness to disclose and share their experiences. (Director/manager)</td>
<td>9%</td>
</tr>
<tr>
<td>Accepting/respecting</td>
<td></td>
</tr>
<tr>
<td>I try not to judge these people. (User of mental health services)</td>
<td></td>
</tr>
<tr>
<td>Respecting their point of view, opinions on their needs and services received. (Clinician/professional)</td>
<td>8%</td>
</tr>
<tr>
<td>Reframing words</td>
<td></td>
</tr>
<tr>
<td>I insist that they not be called fools during meetings with others. (Clinician/professional)</td>
<td>7%</td>
</tr>
<tr>
<td>Giving successful examples</td>
<td></td>
</tr>
<tr>
<td>This can be done by showing specific examples of people who have come out of the hospital and were able to live a normal life, like anyone else. (Clinician/professional)</td>
<td>7%</td>
</tr>
<tr>
<td>Doing introspective work</td>
<td></td>
</tr>
<tr>
<td>You have to be willing to address these issues, to confront yourself, with respect to people with disabilities, to let go of ideas or imagination linked to ignorance. (Clinician/professional)</td>
<td>6%</td>
</tr>
<tr>
<td>Meeting/coming close to</td>
<td></td>
</tr>
<tr>
<td>I am close to people with mental health problems and these people are my friends. (Parent/friend)</td>
<td>3%</td>
</tr>
<tr>
<td>Defending rights</td>
<td></td>
</tr>
<tr>
<td>I campaign for the defence of mental health rights. (User of mental health services)</td>
<td>3%</td>
</tr>
<tr>
<td>Acting on an organizational level</td>
<td></td>
</tr>
<tr>
<td>I am creating new recovery programs, representation at the health agency … (Clinician/professional)</td>
<td>2%</td>
</tr>
<tr>
<td>Being natural</td>
<td></td>
</tr>
<tr>
<td>I stay natural with everyone. (User of mental health services)</td>
<td>2%</td>
</tr>
<tr>
<td>Paying attention to language</td>
<td></td>
</tr>
<tr>
<td>I remove inadequate vocabulary: - user; services user. Person first! (Clinician/professional)</td>
<td>1%</td>
</tr>
</tbody>
</table>
I tell my story. (User of mental health services)

I disclose my illness to my employers despite prejudices. (User of mental health services)

Have people share their story in front of certain audiences. (Coordinator)

Other categories of strategies are listed in Table 1, three of which will be discussed here: listening/caring (11%), accepting/respecting (8%), and meeting/coming close to (3%). These three categories of strategies were directed at the person with a diagnosis. It was interesting that the more the category of strategies involved a significant degree of proximity between the respondent and the person with a diagnosis, the less it was mentioned. Thus, while 11% of respondents mentioned that they listen, welcome, and take an interest in the person, and that 8% say they respect, accept, and do not judge the person, only 3% mention meeting, coming close to the person, and making the person a friend, a spouse.

In addition, two other strategies deserve our attention despite their low incidence: doing introspective work (6%) and being natural (2%) were two self-directed categories of strategies. Doing introspective work involved focusing on personal prejudices, ignorance, and working to reduce self-stigmatization.

I learn to better understand their reality, to correct my perceptions. (Clinician/professional)

I don’t stigmatise myself. (User of mental health services)

Conversely, the person with a mental disorder may also choose simply to act naturally (Being natural), without publicly disclosing his or her diagnosis. At first glance, this strategy may seem to contradict the notion of sharing. However, the person living with a diagnosis who is acting, day-to-day, like everyone else, without reference to diagnosis, symptoms, or treatments, for example, normalizes mental illness for those she/he meets. For example, the following is the verbatim of a respondent who identified herself as a user of mental health services:

I live with a diagnosis of mental disorder with being myself. Therefore I become a living model, and since it is not written on my forehead, my mental disorder is part of me and I do not think it is a nuisance. I do not feel compelled to tell everyone. To counter the prejudice and stigma, I chose to act like a person without distinction. (User of mental health services)

3.2. Part II. To determine if the nature of the strategies used varied among types of respondents, the authors placed the respondents into three groups according to their type of knowledge: clinical (n = 115), experiential (n = 61), and organizational (n = 46), as defined above. In addition, the 15 categories of strategies identified initially were grouped under six main themes: education, contact, protestation, person centered, working on recovery and social inclusion, and Reflective consciousness, as presented in Table 2.

The themes Education, Contact, and Protestation were inspired by the literature on the subject and they refer to three proven strategies to fight stigma [23, 33]. The theme Education aims to reduce stigma by providing accurate information about mental disorders. The strategies within this theme rest on the assumption that a better understanding of mental disorders will cause people to reduce their prejudices and act in a nondiscriminatory manner toward individuals who live or has lived with a mental disorder [34]. The theme Contact promotes positive interpersonal interactions between a person who has or has lived with a mental disorder (who disclosed his/her condition) and a member of the public; living libraries are an example of the application of this strategy [35, 36]. (Organized in a public place, the living libraries allow the public to “borrow” time (30 min) from a person who has or had a mental disorder and have a conversation with her.) The theme Protestation addresses inappropriate or negative representations of mental illness used by the public or media by denouncing them. Some authors include the strategies used by organizations for the defense of rights in the strategies of protestation [37], while others see them as a separate strategy [22].

In the context of this study, the theme Education includes strategies from the following categories: Educating/teaching, giving successful examples, acting on an organizational level and paying attention to language. Contact refers to the strategies that correspond to the categories Sharing/encouraging disclosure and Meeting/coming close to. Protestation is the theme for defending rights and re-framing words.

In addition to these three themes of strategies directly inspired by the scientific literature, this study, which was aimed at people related to the mental health field, has identified three additional major themes of strategies: person centered, working on recovery and social inclusion and reflective consciousness. The theme Person centered implies treating the person with a mental disorder diagnosis as any other person (as seen above), but also accepting, respecting, listening to, and caring for the person. This last theme means to act without discrimination against a person with a mental disorder, to welcome that person like anyone else; it is to have speech and values that place the individual as a whole person, beyond diagnosis. The theme Working on recovery and social inclusion implies the idea of supporting and encouraging the person, believing in him/her, building on his/her strengths and possibilities, and fostering his/her integration into the community. The theme of Reflective consciousness refers to Doing introspective work and Being natural. The strategies related to this theme imply a return to oneself. Based on these six broad themes of strategies to fight stigma, Figure 2 highlights the percentages of the three groups of people according to their type of knowledge: experiential, organizational, and clinical.

Figure 2 shows some important distinctions in the strategies used by the three groups of respondents in the study. People with experiential knowledge were easily distinguished from the other two groups. First, they were less likely to have
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Table 2: Themes and corresponding categories of strategies.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Categories of strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>Educating/teaching</td>
</tr>
<tr>
<td></td>
<td>Giving successful examples</td>
</tr>
<tr>
<td></td>
<td>Acting on an organizational level</td>
</tr>
<tr>
<td></td>
<td>Paying attention to language</td>
</tr>
<tr>
<td>Contact</td>
<td>Sharing/encouraging disclosure</td>
</tr>
<tr>
<td></td>
<td>Meeting/coming close to</td>
</tr>
<tr>
<td>Protestation</td>
<td>Defending rights</td>
</tr>
<tr>
<td></td>
<td>Reframing words</td>
</tr>
<tr>
<td>Person centered</td>
<td>Normalizing</td>
</tr>
<tr>
<td></td>
<td>Accepting/respecting</td>
</tr>
<tr>
<td></td>
<td>Listening/caring</td>
</tr>
<tr>
<td>Working on recovery and</td>
<td>Working on recovery</td>
</tr>
<tr>
<td>social inclusion</td>
<td>Working on social inclusion</td>
</tr>
<tr>
<td>Reflexive consciousness</td>
<td>Doing introspective work</td>
</tr>
<tr>
<td></td>
<td>Being natural</td>
</tr>
</tbody>
</table>

| Figure 2: Types of strategies (themes) according to the respondents’ type of knowledge. |

mentioned a strategy related to the theme *Education* (30% versus 55% and 52% for those with clinical knowledge and organizational knowledge, resp.). Second, they were more likely to have mentioned strategies related to the theme of *Contact* (30% versus 4% for those with a clinical profile or organizational). People with *clinical* knowledge mentioned strategies like *Working on recovery and social inclusion* more often than those with *organizational* knowledge and *experiential* knowledge (43% versus 26% and 16%, resp.). In addition, the theme of *Person centered* was a strategy widely used by the three groups studied: nearly half (between 42% and 49%) mentioned it. Strategies grouped under the themes of *Protestation* and *Reflexive consciousness* were less cited by these three groups (between 5% and 20%). Figure 2 shows that, compared to the other two groups, the experiential knowledge group tended to mention more strategies in connection with the theme *Reflexive consciousness* (15% versus 5% and 7%).

4. Discussion

The objective of this study was to describe the strategies used by different stakeholders to fight social stigma toward people with a mental disorder. This study is interesting on two levels. First, it was specifically aimed at people connected to mental disorders (e.g., people with a mental disorder, mental health professionals). Second, the strategies identified were, with few exceptions, strategies used individually and spontaneously in everyday life, while studies from the specialized literature almost always report strategies used in structured programs or initiatives [38–41].

From the Canadian conference delegates who answered the question *Tell us briefly what you do to reduce prejudice and stigma toward people with a diagnosis of mental disorder*, the study identified 15 categories of strategies to fight stigma (e.g., *Reframing words, Working on recovery*). These results underline the creativity of diverse groups of people implementing various strategies to fight social stigma on a daily basis. To our knowledge, few studies have provided these types of results, and this illustrates the importance of consulting different stakeholders to capture the richness and range of opportunities. Indeed, we identified particular categories of strategies rarely cited, such as those relating to *Being natural* or *Doing introspective work*, which display the importance of introspective work for the individual in fighting stigma.

To compare the different stakeholders based on their knowledge—that is, *experiential* (users of mental health services), *organizational* (directors, managers, or coordinators working in the field of mental health), and *clinical* (mental health professionals and/or clinicians)—the 15 previous categories were grouped into six broad themes: *Education, Protestation, Contact, Person centered, Working on recovery and social inclusion, and Reflexive consciousness*. As noted in the introduction, the first three themes, *Education, Protestation*, and *Contact*, were inspired by the literature on the subject; they refer to three widely recognized strategies to fight stigma [22, 33]. *Education* strategies are very popular because they are readily available to the public, in the case of campaigns, or transferred from one organization to another, in the case of more or less long-term education and awareness programs [23, 39]. *Protestation* strategies aim to reduce stigma by denouncing inaccurate messages. The concepts of testimony and disclosure are also very present in the literature on mental illness stigma. We refer here to the strategy of *Contact* that encourages interactions between a person with a mental disorder and a member of the general public [27].

The other three major themes that emerged from this study were the strategies of *Person centered, Working on recovery and social inclusion, and Reflexive consciousness*. Strategies within the theme *Person centered*, used in large proportion (50%) by all types of respondents, are similar to an approach described by Davidson [42] which states that one way to
fight stigma toward people living with a mental disorder is to modify the elements that contribute to identifying them, through the eyes of the general population, as people with a mental disorder. The strategies grouped under the general theme Working on recovery and social inclusion refer to the psychosocial movement of rehabilitation in psychiatry linked with the (re)construction of personal identity [42, 43]. The concept of recovery is based on the hopefulness of a better life, both inside and outside the network of mental health. These new avenues for the recovery of the individual share the concerns and values of current psychiatric rehabilitation [44]. Reflective consciousness strategies are reminiscent of the principles from the reflective approach (or reflection). Reflective consciousness is generally defined as a process by which a person reflects and attempts to restructure one's experience and/or knowledge and, consequently, to deal with attitudes and behaviours as objects of observation—in this case toward the social stigma against people with a mental disorder.

The three major themes of the literature-inspired strategies to fight stigma can have both positive and negative results. While Education can help to change attitudes, the magnitude and duration of these changes may be limited [23]. Stuart [34] also emphasized that it is very likely that massive public education campaigns may be weak or ineffective as a contributor to changes in attitudes and behaviors. It has been generally observed that although Protestation strategies may remove certain media messages detrimental to people with a mental disorder at the individual level, they can also cause a “rebound” effect, reinforcing the behaviour we wish to eliminate. People targeted by the protest may have the opposite of the intended reaction because nobody likes to be told what to do, say, or think [23, 45]. It has been observed that when the general population interacts with a person with a mental disorder as part of an antistigma program, Contact strategy may result in significant improvements in attitude. Moreover, changes in attitudes resulting from these contacts are maintained through time and are related to changes in behavior [2]. The results obtained in this study show that a much higher proportion of respondents with experiential knowledge (those who live or have lived with a mental disorder) use Contact strategies to fight against stigma than do respondents with clinical or organizational knowledge. Those with clinical or organizational knowledge can be distinguished from those with experiential knowledge by the former’s use of Education strategies. Note that the Contact strategy implicitly involves the concept of disclosure. According to Corrigan and O’Shaughnessy [23], a way to massively increase the power of contact is to encourage people with mental disabilities to disclose their experience. Those who actually do disclose their experience can contribute significantly to fighting stigma. However, some disadvantages can be associated with disclosure: social avoidance by people who know and discrimination in employment or housing. Thus, it is hardly surprising that a few respondents with clinical or organizational knowledge have cited encouraging disclosure as a strategy they use to reduce stigma, given the disadvantages their clients could encounter.

Strategies within the theme Person centered create physical or relational environments that enable a person to begin the process of reconstruction of citizenship identity through the development of interconnectedness capacities, therefore gradually becoming an integral part of society [46]. This theme is intimately linked to the theme of Working on recovery and social inclusion. Thus, it is no surprise that people with clinical knowledge make significant use of both Person centered and Working on recovery and social inclusion in similar proportions (42-43%) since their work is based on social inclusion and recovery of people with mental disorders, as well as to help them attain full citizenship [47]. Conversely, adopting Doing introspective work or Being natural strategies, from the general theme of Reflective consciousness, allows better development of self-knowledge and, therefore, helps the individual to adopt behaviours and attitudes that are closer to social inclusion or even destigmatization.

Based on the results of this study, the theme Contact has emerged as an important strategy for people with a mental disorder diagnosis. Given that the literature emphasizes its efficiency to combat social stigma, it is important to better understand the phenomenon of disclosure because it is a key element in the fight against stigma. Several interesting questions arise: what is the experience of people who have disclosed their mental condition? What advantages and disadvantages have they experienced? what are the reasons why some people are not afraid to disclose their condition? Are there beneficial conditions that allow or promote disclosure (e.g., security acquired in housing, employment, social network)? Some of these questions are already answered in the literature. For example, some studies show that disclosure in the workplace has the advantage of ridding the individual of the stress inherent in hiding one’s mental disorder, among others, and creates the possibility of requesting work accommodations [48, 49]. Disadvantages can include being at risk of being treated differently and reducing professional opportunities [49]. During the development of programs to fight stigma using a Contact strategy, it is important to be well informed about and to consider the factors surrounding disclosure in order to fully support people who decide to disclose their mental disorder. This knowledge is also important for staff working with people with a mental disorder to help them better support those who voluntarily wish to disclose their mental disorder. Currently, the stigma of mental illness is a major barrier to disclosure: according to the Quebec Ministry of Health and Social Services, 42% of people struggling with a mental health problem have not told their family for fear of being judged [50]. Moreover, according to a Canadian Medical Association report [51], only half of Canadians would tell their friends or colleagues if a family member was diagnosed with mental illness (50%), compared to a wide majority that would speak of a cancer diagnosis (72%) or diabetes (68%) in the family. Disclosure (or testimony) and stigma are highly correlated: the more people with mental disorders willingly talk about their condition, the less mental illness will be stigmatized and the more people with a mental disorder will be inclined to disclose their condition.
Some of the published literature notes the importance of working with health professionals to reduce the stigma faced by people with a mental disorder when they receive services [52]. The strategies adopted here by people with 
clinical knowledge can certainly serve as clues to guide these professionals in their contacts with people with a mental disorder. This refers to Person centered and Working on recovery and social inclusion. By paying attention to the whole person, beyond the diagnosis and symptoms, as implied by a recovery-based approach, a health care professional could avoid falling into the trap of diagnostic overshadowing, which has adverse consequences for people with a mental disorder. Thornicroft [35] explains that because of their diagnosis, people with mental illness are less likely to receive adequate health care from the health professionals than people who do not have this type of disease: examinations are less thorough, treatments are less complete, and the service offer for these people is diminished.

This study has some limitations. First, it identifies strategies to fight stigma used by various groups of people connected to mental disorders but it does not assess the effectiveness of these strategies. If the strategies of Education, Protestation, and Contact are well documented in relation to their effectiveness in fighting stigma, those that emerged in this study would benefit from being evaluated, including strategies of Person centered and Working on recovery and social inclusion, as well as Reflexive consciousness.

It is also important to note that this study used a sample of individuals concerned with the subject, who, by their presence at the conference, were immersed in an environment where stigma against people with a mental disorder was clearly denounced (recall the title of the symposium: Overcoming Stigma, a Collective Challenge!). This limit may also be an asset: highly aware of and sensitive to the topic, respondents were probably better able to identify the strategies they personally use to combat the social stigma against those with a diagnosis of mental disorder.

In conclusion, this study aimed to provide a thorough and exhaustive perspective on the whole range of strategies to fight stigma used by different stakeholders. Several categories of strategies emerged from the verbatim, which were organized into six main themes: Education, Contact, Protestation, Person centered, Working on recovery and social inclusion, and Reflexive consciousness. Some strategies were used more often than others by specific stakeholders. Furthermore, the notion of disclosure of mental disorders emerged as a key factor for fighting stigma. Future studies will allow us to assess the impact of these strategies on various settings, such as health, community, workplace, and school.

**Conflict of Interests**

The authors declare that there is no conflict of interests.

**Acknowledgments**

The authors would specifically like to thank the conference delegates who took part in this study, as well as Diane Harvey, Claude Charbonneau, Rosalie Bérubé, Karine Genest, and the research assistants who helped along the way. These results were in part presented during the last day of the 15th conference entitled “Overcoming Stigma, a Collective Challenge!” in order to provide a feedback to participants.

**References**


