THE UNIVERSITY *of York*

NHS CENTRE FOR REVIEWS & DISSEMINATION

SCHOOL OF SOCIOLOGY & SOCIAL POLICY, NOTTINGHAM

Therapeutic Community Effectiveness

A Systematic International Review of Therapeutic Community Treatment for People with Personality Disorders and Mentally Disordered Offenders

CRD REPORT 17

Therapeutic Community Effectiveness: A Systematic International Review of Therapeutic Community Treatment for People with Personality Disorders and Mentally Disordered Offenders

JANINE LEES, NICK MANNING
AND
BARBARA RAWLINGS

School of Sociology and Social Policy, University of Nottingham

© October 1999

© 1999 NHS Centre for Reviews and Dissemination, University of York

ISBN 1 900640 15 5

This report can be ordered from: Publications Office, NHS Centre for Reviews and Dissemination, University of York, York YO10 5DD. Telephone 01904 433648; Facsimile: 01904 433661: email: crdpub@york.ac.uk
Price £12.50

The NHS Centre for Reviews and Dissemination is funded by the NHS Executive and the Health Departments of Scotland, Wales and Northern Ireland; a contribution to the Centre is also made by the University of York. The views expressed in this publication are those of the authors and not necessarily those of the NHS Executive or the Health Departments of Scotland, Wales or Northern Ireland.

Printed by York Publishing Services Ltd.

NHS CENTRE FOR REVIEWS AND DISSEMINATION

The NHS Centre for Reviews and Dissemination (CRD) is a facility commissioned by the NHS Research and Development Division. Its aim is to identify and review the results of good quality health research and to disseminate actively the findings to key decision makers in the NHS and to consumers of health care services. In this way health care professionals and managers can ensure their practice reflects the best available research evidence. The reviews will cover: the effectiveness of care for particular conditions; the effectiveness of health technologies; and evidence on efficient methods of organising and delivering particular types of health care.

Further Information

General Enquiries:	01904 433634
Information Service	01904 433707
Publications:	01904 433648
Fax:	01904 433661
Email:	revdis@york.ac.uk

CRD Reports

1. Which Way Forward for the Care of Critically Ill Children? (1995) £7.50

4. Undertaking Systematic Reviews of Research on Effectiveness. CRD Guidelines for those Carrying Out or Commissioning Reviews (1996) £7.50

5. Ethnicity and Health: Reviews of literature and guidance for purchasers in the Areas of cardiovascular disease, mental health and haemoglobinopathies (1996) £12.50

6. Making Cost-Effectiveness Information Accessible: The NHS Economic Evaluation Database Project. CRD Guidance for Reporting Critical Summaries of Economic Evaluations (1996) £7.50

7. A Pilot Study of 'Informed Choice' Leaflets on Positions in Labour and Routine Ultrasound (1996) £7.50

8. Concentration and Choice in the Provision of Hospital Services (1997)
   Summary Report £6.00
   Part I - Hospital Volume and Quality of Health Outcomes £12.50
   Part II - Volume and the scope of activity and hospital costs £9.50
   Part III - Concentration, patient accessibility and utilisation of services £7.50
   Complete set of reports £30.00

9. Preschool Vision Screening: Results of a Systematic Review (1997) £9.50

10. Systematic Review of Interventions in the Treatment and Prevention of Obesity (1997) £12.50

11. A Systematic Review of the Effectiveness of Interventions for Managing Childhood Nocturnal Enuresis (1997) £12.50

13. Screening for Ovarian Cancer: A Systematic Review (1998) £12.50

14. Women and Secure Psychiatric Services: A Literature Review (1999) £12.50

15. Systematic Review of the International Literature on the Epidemiology of Mentally Disordered Offenders (1999) £12.50

16. Scoping Review of Literature on the Health of Mentally Disordered Offenders (1999) £12.50

AUTHORS AND ACKNOWLEDGEMENTS

Authors

Jan Lees is Research Associate, School of Sociology and Social Policy, University of Nottingham.

Nick Manning is Professor of Sociology and Social Policy, and Head of the School of Sociology and Social Policy, University of Nottingham.

Barbara Rawlings is Honorary Research Fellow, Department of Sociology, University of Manchester.

Acknowledgements

Pre-eminently, Karen George, who undertook all the initial systematic searches for references, and whose contribution was vital for getting this project underway in a thorough and rigorous manner!

Dr Antoine Appeau, Director of Clinique La Chavannerie, generously gave his valuable time to provide contact details of a number of therapeutic communities in France, to comment on the use of terminology in the therapeutic community field in France, and to help the researchers select relevant French-language journals.

Colleagues in the field of languages also contributed much to the international aspects of the Review: Pierre Leizour, who helped in researching French-Canadian use of terminology in the therapeutic community field; and above all Jane Daykin, who provided thoughtful, high-quality translations of important German-language materials, often under pressure of time.

The NHS Centre for Reviews and Dissemination at the University of York.

Nicola, Clare, Alison & Linda for invaluable help, and particularly for producing the format for, and final versions of, the tables, and Amy for photocopying.

Various librarians, especially at the Inter-Library Loan desk, University of Nottingham.

Colleagues in England and overseas, who have gone out of their way to provide us with information and documentation to assist with this review.

Francis Dixon Lodge Therapeutic Community, Leicester, for allowing Janine Lees to undertake some of the work for this review in their time.

High Security Psychiatric Services Commissioning Board for funding us.

The therapeutic communities and Special Hospitals visited and surveyed - they gave freely of their time, which was often considerable, and provided us with a wealth of information and documentation, which has been invaluable.

All the respondents to our mailshots, both in Britain and overseas.

The many commentators from audiences, to whom we have presented papers on our interim results, at the University of Nottingham, the Society for Psychotherapy Research, the Howard League, and the International (Windsor) Conference of the Association of Therapeutic Communities.

Our panel of peer reviewers for their invaluable comments on the draft protocol and draft report:
Professor Trevor Sheldon, Clive Hollin, Pat Edwards, Barbara Hudson, Professor Herschel Prins, Bridget Dolan, A. T. Grounds, David Kennard, Professor John Gunn, Professor Bob Hinshelwood, Phillip Vaughan, Dr. Peter Whewell, Professor Mick Bloor, Professor Conor Duggan, and Dr. Gill McGauley.

CONTENTS

			Page
Authors and acknowledgements			**iii**
Executive summary			**1**
I.	**Main Report**		**11**
	1.	**Introduction**	**11**
	2.	**Objectives**	**14**
	2.1	Research objectives	14
	2.2	Questions addresssed	15
	2.3	Brief summary of work undertaken to retrieve information	16
	3.	**Background**	**17**
	3.1	Therapeutic communities	17
	3.2	Personality disorders	24
	4.	**Methods**	**28**
	4.1	Report on searches	28
	4.2	Selection and cataloguing of articles	34
	4.3	The meta-analysis	40
	4.4	Publication bias – a funnel plot	41
	5.	**Main Findings**	**43**
	5.1.	Descriptive findings	43
	5.2.	Evaluative findings for democratic therapeutic communities	58
	5.3.	Evaluative findings for concept-based therapeutic communities	79
	5.4.	Findings from meta-analysis	86
	6.	**Additional Findings**	**89**
	6.1	Review articles	89
	6.2	Non-secure therapeutic communities for Non-personality disorders	89
	6.3	Non-secure concept-based post-treatment Outcome literature	91

7.	**Discussion: substantive, methodological and definitional issues**	**94**
7.1	Introduction	94
7.2	Diagnosis	94
7.3	Therapeutic communities	95
7.4	Therapeutic communities – specific treatments	98
7.5	Methodological comments	99
7.6	Methodological alternatives	103
8.	**Tables**	**108**
8.1	Democratic	109
8.2	Concept-based	170
9.	**Studies and references**	**184**
9.1	Catalogues of references for all studies reviewed	184
9.2	References	208

THE FOLLOWING SECTIONS, WHICH ARE REFERRED TO IN THE TEXT, ARE AVAILABLE ON REQUEST FROM THE AUTHORS.

II. Main Appendices Glossary

10.1. Additional References
10.2. Search Appendices
10.3. Additional Data
10.4. Additional Descriptive Findings
10.5. Review Articles
10.6. Additional Democratic Findings
10.7. Additional Concept-based Findings
10.9. Odds Ratio Calculations

III. Additional Appendices

11.1. Data extraction sheets
11.2. Survey visits
11.3. Mailshots
11.4. Therapeutic communities from the evaluated literature
11.5. Therapeutic communities from all the retrieved literature
11.6. All other retrieved references
11.7. References not obtained
11.8. Copies of all data extraction sheets
11.9. Copies of all articles data extracted

EXECUTIVE SUMMARY

The structure of the review

This systematic literature review was commissioned by the High Security Psychiatric Services Commissioning Board (HSPSCB), to look at therapeutic communities in psychiatric and other settings, particularly for people with personality disorder. (This review was NOT intended to address issues of defining personality disorder per se.) A therapeutic community is 'a consciously-designed social environment and programme within a residential or day unit in which the social and group process is harnessed with therapeutic intent. In the therapeutic community the community is the primary therapeutic instrument.'(Roberts 1997, p.4)

The original bid call cited Rapoport's (1960) four general principles for defining a democratic therapeutic community, and although this report addresses the various forms of the therapeutic community, the focus of this research review has been on existing literature relating to the democratic therapeutic community, in the tradition of Tom Main and Maxwell Jones, in both psychiatric and other secure settings, and in non-secure psychiatric settings, and on those dealing specifically with people with personality disorders, and mentally disordered offenders.

The call for bids asked specifically for a review of the international literature on the effectiveness of therapeutic communities in such settings, and with such client groups. This review has therefore concentrated on the research literature on effectiveness, and the main part of the report concentrates on post-treatment outcome studies of secure, and non-secure democratic therapeutic communities, for people with personality disorders, and mentally disordered offenders.

Because of their presence in the research literature, we also included hierarchical, or concept-based therapeutic communities. These are usually for substance abusers, in both secure and non-secure settings, both psychiatric and non-psychiatric, although there are considerably more in the USA, Canada, and other parts of the world than in the UK.

In addition to the research literature, the researchers agreed to look at additional ways of finding research literature, and descriptive information about therapeutic communities internationally. This was done by targeting 'grey' literature, and by identifying as many therapeutic communities nationally and internationally as possible. These were subsequently written to, along with known writers, or workers in this field, asking for any published or unpublished research they might have, and, if possible, for information about their therapeutic community, and its principles, organisation and practices. Such a wide trawl also helped to reduce any possible publication bias in favour of positive results.

This work was conducted, in accordance with Centre for Reviews and Dissemination guidelines, in an explicit and structured manner, with clearly stated research objectives, and protocols guiding the work and criteria for describing the relevance and quality of identified research. The results of this literature review are presented in both narrative form and a meta-analysis. This is because the quality of data presented, and

the analyses in the studies retrieved, enabled systematic meta-analysis only in part, while much of the literature was not numerically comparable.

The therapeutic communities

Most secure therapeutic communities admit male offenders only. Some concept-based therapeutic communities in women's prisons in the US are reported in the literature, usually as part of a large study which includes both men and women. Secure therapeutic communities are located mainly within prison and correctional services. Of these, only HMP Grendon, in Buckinghamshire, England, is an entirely therapeutic community prison. Other therapeutic communities comprise small units inside larger mainstream prisons, although some German Social Therapeutic Institutions have been established in separate secure premises outside prisons.

Most democratic prison therapeutic communities specialise in personality disorders and recidivism, whilst concept-based therapeutic communities are directed specifically at substance abuse, which usually refers to drug rather than alcohol use. However, there are overlaps here, since recent studies of concept-based therapeutic communities in the community have suggested that there is a high level of co-morbidity between drug abuse and personality disorder, and between drug abuse and mental illnesses.

The client information for non-secure democratic TCs varies according to the service context, is diverse, and not easily summarised, so is given in detail in the review.

The service contexts described in the research literature on democratic non-secure settings are very varied. Many are located within the NHS, and often at the tertiary level of provision. Abroad, the hospital-based therapeutic communities are described typically as part of a psychiatric hospital.

Non-secure therapeutic communities, such as Henderson Hospital, might typically include psychopaths, sociopaths, personality disorders, and character disorders. For example, in the Henderson Hospital, the majority are young people, with a lower age limit of 18. 87 per cent of residents meet DSM-IV-R criteria for borderline personality disorder, and 95 per cent met criteria for at least one Cluster B Axis II diagnoses.

Treatment is usually voluntary. In secure therapeutic communities inmates are generally selected by staff. In other therapeutic communities selection is by the community, or by staff-patient assessment group. Inmates can leave if they choose to do so, or be expelled from the community for their behaviour.

All units offer a daily or community meeting, democracy or patient participation in decision-making and running the therapeutic community, and a predominance of group activities.

Concept therapeutic communities are organised very differently from democratic therapeutic communities. There is a large body of literature on concept-based therapeutic communities and their outcomes. Although not the main thrust of this report, the relevant in-treatment and post-treatment outcome studies on the effectiveness of secure concept-based therapeutic communities are analysed, while

the non-secure concept-based outcome literature is also summarised. This is provided both for information, and for contrast.

The findings

We began with 8,160 articles and other literature, reduced to 294 broadly covering the relevant area. 181 individual TCs were named in the literature found, in 38 different countries, of which most were in the UK or the USA.

For our core focus on personality disorders/mentally abnormal offenders, there were 52 items on outcome studies of secure democratic TCs, 41 on outcome studies of non-secure TCs, and 20 items on outcome studies of secure concept-based TCs. There were only 10 RCTs of any sort, and 10 cross-institutional or comparative studies, and a further 32 studies using some kind of control. If we take the latter as the minimum level of rigour that is acceptable, then there were in total 52 acceptable studies, all of which are discussed in some detail at some point in the report. Of these 52, 41 relate to democratic type therapeutic communities.

A meta-analysis was set up for the 52 studies with controls. 23 studies were excluded where the outcome criteria were unclear, where the raw numbers were not reported, or where the original sample was not clearly specified before attrition. Where there was a choice of outcome measures and control groups, emphasis was placed on conservative criteria, such as reconviction rates rather than psychological improvements, and on non-treated controls. This reduced the number of studies for the meta-analysis to 29.

The analysis had two stages. Initially the odds-ratios for the individual studies, and 95% confidence intervals, were calculated (Woolf ,1955, discussed in Kahn and Sempos, 1989, pp. 56-57). Subsequently, the odds-ratios were combined to produce a summary odds-ratio for the 29 studies, and subsections of them, also with confidence intervals for the 95% levels (Yusuf, et al, 1985, discussed in Petitti, 1994, pp. 100-102). Several points are worth making about the results. There is strong evidence for the effectiveness of therapeutic community treatment apparent from these studies. The odds-ratio measure used indicates that studies below one have a positive effect, those above one a negative effect, and those on or about one are neutral. However it is vital to consider the confidence intervals for each study, to ascertain that the odds-ratio was unlikely to have happened by chance. This is conventionally expressed through the calculation of the range over which the result would be unlikely to have happened more than 5 times out of a 100 (the 95% confidence interval). 19 of the 29 studies indicated a positive effect, within the 95% level of confidence. The remaining 10 studies all had confidence intervals which straddled the neutral score, of which 8 produced odds ratios above one.

When summary odds-ratios are calculated across all 29 studies, as is the convention with meta-analyses, the strength of this finding is underlined. With a summary odds-ratio of 0.57, and an upper 95% confidence interval of 0.61, this set of studies gives very strong support to the effectiveness of therapeutic community treatment. A check can be made on this by grouping the studies. Odds ratios calculated separately for the RCTs, and for the democratic, concept, and secure types of communities all show strong results, with upper confidence intervals well below one. It is important to note that the RCTs were

scattered across the different types of community. This suggests that there was no one subset of studies that was strongly affecting the overall summary result:

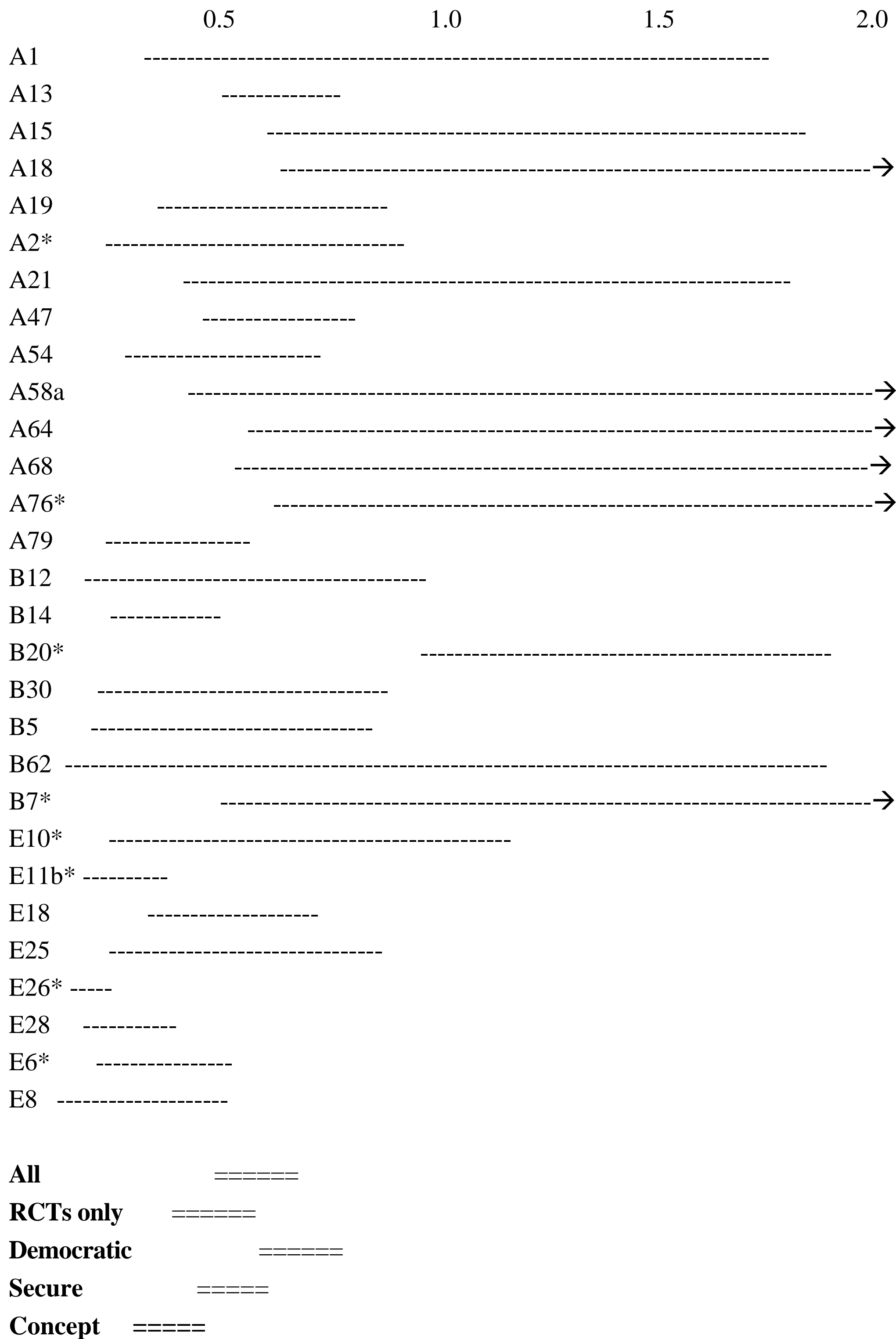
study code	expected 'E'	observed - expected	variance	sample size	odds ratio	confidence interval (95%)
A1	26	-1	6.3	100	0.852	.3885 - 1.868
A13	332.3	-37.3	116.61	2,102	0.725	.604 - .87
A15	152	3	15.42	454	1.222	.736 - 2.03
A18	26.2	3.8	10.99	228	1.409	.782 - 2.54
A19	110	-10	20.68	352	0.614	.397 - .949
A2*	50	-28	17.96	200	0.524	.28 - .98
A21	72.68	-2.68	8.31	173	0.72	.48 - 1.93
A47	320.29	-20.29	58.54	982	0.705	.545 - .913
A54	123.01	-13.01	17.79	340	0.472	.292 - .764
A58a	10.31	0.69	4.6	116	1.163	.466 - 2.9
A64	40.5	2.5	6.86	122	1.446	.679 - 3.08
A68	75.42	1.58	7.96	166	1.219	.612 - 2.43
A76*	59.65	0.35	9.24	173	1.039	.764 - 2.79
A79	76	-19	19.55	312	0.37	.234 - .584
B12	32.63	-4.63	5.43	95	0.412	.171 - .993
B14	261.7	-28.7	29.08	745	0.371	.255 - .539
B20*	85.56	14.44	35.65	828	1.5	1.08 - 2.08
B30	27.24	-6.24	7.71	168	0.451	.224 - .908
B5	121.15	-7.15	8.85	245	0.439	.216 - .89
B62	2.33	-1.83	1.07	30	0.095	.01 - 1.95
B7*	13	2	3.18	50	1.091	.62 - 5.88
E10*	16.06	-5.06	8.358	249	0.52	.248 - 1.19
E11b*	81.41	-26.41	18.79	306	0.23	.142 - .373
E18	133.28	-16.28	24.79	594	0.532	.364 - .779
E25	103.75	-7.75	11.52	233	0.316	.264 - .909
E26*	60.04	-38.04	20.56	483	0.132	.079 - .221
E28	70.82	-40.82	33.83	1,866	0.251	.166 - .379
E6*	86.04	-25.04	23.87	448	0.35	.233 - .526
E8	21.6	-8.6	4.99	298	0.233	.107 - .511
All (29 studies)					**0.567**	**0.524 – 0.614**
RCTs only (*asterisked – 8 studies)					**0.464**	**0.392 - 0.548**
Democratic (As and Bs – 21 studies)					**0.695**	**0.631 – 0.769**
Secure (As and Es – 22 studies)					**0.544**	**0.498 – 0.596**
Concept (Es only – 8 studies)					**0.318**	**0.271 – 0.374**

Full details about these studies, identified by thier code numbers, can be found in the Main Appendix, 10.2.

Conventionally, this meta-analytic data is presented graphically, as follows. An odds-ratio between zero and one indicates some positive effect, around one indicates a neutral effect, and above one indicates a negative

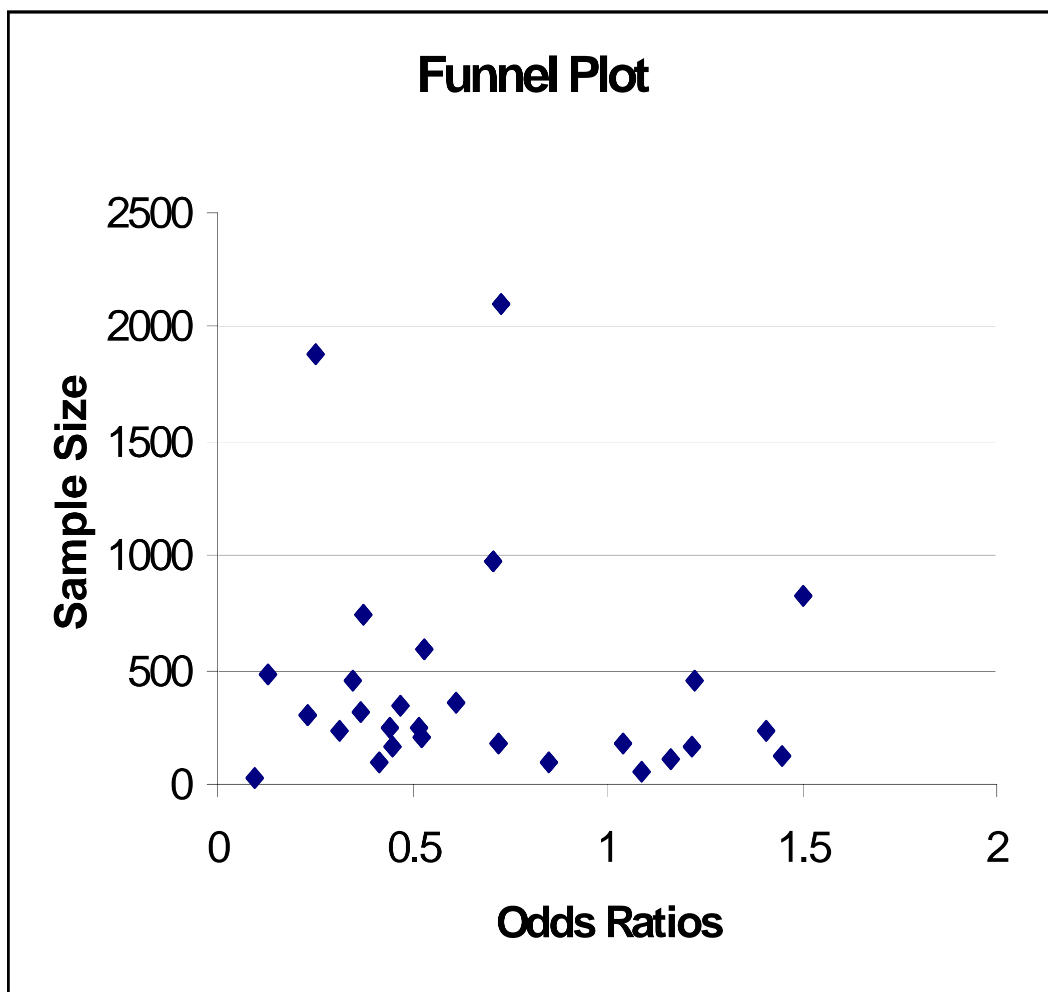
effect. The overall sum, 0.567, is marked with the dotted line:

Odds Ratios



Publication bias - a funnel plot

Considerable efforts have been made to track down unpublished or 'grey' material for this report. In contrast to our expectations, very little turned up. Of concern in meta-analysis is the possibility that publication bias might occur as a result of negative or neutral findings being either not submitted, or not accepted by journals. A check on any publication bias is provided by plotting the meta-analysis odds-ratios against sample size in a 'funnel plot'. The lower the sample size, the higher should be the range of odds ratios reported, giving rise to a typical funnel shaped scattergram. The expectation is that a scattergram would reveal blank spots caused by unpublished findings, or 'lost' studies. The funnel plot for this meta-analysis does not suggest that this is the case:



Methodological issues

Evaluating the effectiveness of therapeutic communities, towards the establishment of which this review has been primarily aimed, depends crucially on a clear understanding of what the therapeutic community is, the setting, whether secure or non-secure, in which it is delivered, and at which patients it is aimed. These elements are all evidently contestable, both within a largely sympathetic literature, and within a smaller, hostile literature.

British Mental Health Law has been ambivalent about psychopaths. Both the 1959 and 1983 Acts separate psychopathy from other conditions, and define it behaviourally, while holding a pessimistic view of treatment interventions. Gunderson,1994, p.12, suggests that 'personality disorder is a diagnosis whose construct (ie its meaning) has grown rapidly and changed dramatically during the past 25 years'. Recent official reports on work in this area have reflected these difficulties. For example the Reed *Report on Psychopathic Disorder,*1994, states that 'the diverse meanings attached to psychopathic disorder often undermined the effectiveness of evaluation of treatment' (p.34). Conceptual expansion makes judgements about research reports difficult, especially if they are more than about fifteen years old.

The definition of therapeutic communities has also been difficult. There are two main types of therapeutic communities: democratic and concept-based/hierarchical. For some writers these are variations on a basically common theme (Sugarman, 1984) - one dealing with deeper intrapsychic change and the other with initial behavioural control; for others they have nothing in common but the name (Glaser, 1983). They have emerged from quite separate origins. In general the intensity, or dosage, of treatment is commonly recognised in the literature by differentiating between therapeutic community approaches and the therapeutic community proper. The former refers to a therapeutic approach across whole hospitals, whereas the latter refers to specialised therapeutic communities dealing with a defined population. In addition, democratic type therapeutic communities developed in prisons or secure settings are inevitably influenced by the requirements of prison regulations concerning security and control.

The methodological issues arising from the studies reviewed are numerous. In the 1994 Cochrane Lecture, McPherson, 1994, pointed out that RCTs are important where there is obvious uncertainty, but that they should not be used where there are ethical problems, a lack of objective outcome measures, resistance from the field, or a reluctance to compare treatments. On these grounds we do not feel that there is any intrinsic reason why RCTs should not be mounted further for therapeutic communities. Why have so few well-designed studies been done? The ideal of an RCT has generated difficulties where it has been attempted. Perhaps the most famous attempt was the Clarke & Cornish, 1972, study undertaken over 25 years ago, but which, in the end, proved impractical, and generated a methodological alternative, the cross-institutional design. Some of the difficulties reported in the literature include treatment complexity, treatment dosage and treatment integrity, population selection, dropouts, effects decay, and diagnostic shift.

On the basis of the positive meta-analysis results, it is suggested that in addition to further RCTs, a more complex cross-institutional study is undertaken, together with further cost-offset studies to complement those few already developed.

Discussion and research recommendations

This systematic international literature review has led us to conclude that therapeutic communities have not produced the amount or quality of research literature that we might have expected, given the length of time they have been in existence, and the quality of staff we know exists and has existed in therapeutic communities. This may be partly due to a lack of emphasis placed on research in the early days of therapeutic community development, and more recently to a lack of resources, in terms of finance, staff and adequate research methodologies, designs and instruments. However, it is clear that since the meta-analysis indicates that existing research is in favour of therapeutic communities, there should be more, and more good quality, and comparative, research on therapeutic communities, in order to confirm the case that therapeutic communities are effective, especially since they are expensive. In addition there is clinical evidence that therapeutic communities produce changes in people's mental health and functioning, but this needs to be further complemented by good quality qualitative and quantitative research studies.

> ***Recommendation one*** There is meta-analytical and clinical evidence that therapeutic communities produce changes in people's mental health and functioning, but this needs to be further complemented by good quality qualitative and quantitative research studies.

There is accumulating evidence, albeit it at a low level of research, of the effectiveness and particular suitability of the therapeutic community model to the treatment of personality disorder, and particularly severe personality disorder. In the absence of conclusive evidence of the effectiveness of any alternative treatment we ought to protect and develop those therapies which can demonstrate some efficacy in treating personality disorder.

> ***Recommendation two*** Further research on the effectiveness of therapeutic communities for personality disorders is warranted.

There is also evidence of the efficacy of therapeutic communities, modified for prison security needs, in managing difficult prisoners, and significantly reducing serious prison discipline incidents after admission, including fire setting, violence, self-harm and absconding. The placement of a therapeutic community within a secure environment however poses some problems. There are often conflicts between the need to maintain security and control (which is regarded as the primary task of prisons) and the provision of therapeutic community treatment, since therapeutic communities ideally devolve major decisions regarding organisation, rules, treatment, sanctions, admission and discharge, to its clients.

> ***Recommendation three*** The development of modified therapeutic communities in prisons in the USA and Germany has grown rapidly. The efficacy of this approach should be considered for a research-based demonstration programme in the UK.

There is evidence that the longer a resident stays in treatment, the better the outcome. Very short stay residents do particularly badly.

> ***Recommendation four*** While a few communities, such as Winterbourne Day Hospital in Reading, are tackling this issue, small research projects should be mounted to identify ways of reducing drop-out rates.

Why have so few well-designed studies been done? The ideal of an RCT has generated difficulties where it has been attempted. Perhaps the most famous attempt was the Clarke & Cornish, 1972, study undertaken over 25 years ago, but which in the end proved impractical, and generated a methodological alternative, the cross-institutional design.

> ***Recommendation five*** A cross institutional design for a study of therapeutic communities 'in the field' should be undertaken.

Concept-based therapeutic community research literature is quite considerable, although of varying quality. However, there is sufficient literature around to warrant a literature review and meta-analysis in its own right.

> ***Recommendation six*** A review of concept-based therapeutic community literature should be commissioned to complement the current review, with a concomitant meta-analysis based on the studies found.

Globally, the modified therapeutic community seems to be surviving, and proliferating best (especially in the USA) in prisons, and for substance abusers; and concept-based therapeutic communities appear to predominate, both in terms of numbers of therapeutic communities, and in amount of literature, and research generated - although again much of it is of variable quality and generalisability. Concept-based therapeutic communities have also exercised themselves much more than democratic therapeutic communities about the reasons and prevention of early drop-outs, or 'splittees'. The health service in the main, and particularly in Britain, seems to have neglected the therapeutic community form of treatment, although there appears to be a resurgence of interest recently.

References

Clarke R.V.G, Cornish D.B. 1972, *The Controlled Trial in Institutional Research - Paradigm or Pitfall for Penal Evaluators*, London, H.M.S.O.

Glaser A.N. Therapeutic Communities and Therapeutic Communities: A personal perspective, *International Journal of Therapeutic Communities*, 1983; 4(2): 150-162.

Gunderson J. Building structure for the borderline construct, *Acta Psychiatrica Scandinavica*, 1994; 89, (Suppl.379): 12-18.

Kahn H.A, Sempos C.T. 1989, *Statistical Methods in Epidemiology*, Oxford, Oxford University Press.

McPherson K.. The best and the enemy of the good: randomised controlled, uncertainty, and the role of patient choice in medical decision making. The Cochrane lecture, *Journal of Epidemiology and Community Health*, 1994; 48: 6-15.

Petitti, D.B. 1994, *Meta-Analysis, Decision Analysis, and Cost-Effectiveness Analysis*, Oxford, Oxford University Press.

Rapoport, R.N. 1960, *Community as Doctor. New Perspectives on a Therapeutic Community*, London, Tavistock Publications.

Reed Report, 1994, Report of the Department of Health and Home Office Working Group on Psychopathic Disorder, D.O.H./H.O., Chair - Dr. John Reed.

Roberts J. How to recognise a Therapeutic Community, *Prison Service Journal*, 1997; 111: 4-7.

Sugarman B. Towards a new, common model of the therapeutic community: Structural components, learning processes and outcomes, *International Journal of Therapeutic Communities*, 1984; 5 (2): 77-98.

1 INTRODUCTION, AND STRUCTURE OF REPORT IN OUTLINE

This systematic literature review was commissioned by the High Security Psychiatric Services Commissioning Board (HSPSCB), as part of their programme for commissioning research and development, to underpin the development of services for those with personality disorder who offend, by identifying a baseline of knowledge.

This review was required to look at therapeutic communities in psychiatric and other secure settings, particularly for people with personality disorder, and also mentally disordered offenders. The original bid call cited Rapoport's, 1960, four general principles for defining a therapeutic community (these will be outlined later in this report). These relate to the 'democratic therapeutic community proper', and although this report will address the various forms of the therapeutic community, the focus of this research review has been on existing literature relating to the democratic therapeutic community, in the tradition of Tom Main and Maxwell Jones, in both psychiatric and other secure settings, and in non-secure psychiatric settings, and on those dealing specifically with people with personality disorders, and mentally disordered offenders.

The call for bids also asked specifically for a review of the international literature on the effectiveness of therapeutic communities in such settings, and with such client groups. This review has therefore concentrated on the research literature on effectiveness, and the main part of the report concentrates on post-treatment outcome studies of secure, and non-secure democratic therapeutic communities, for people with personality disorders, and mentally disordered offenders (Section 5.2.).

In addition, there is also some evaluative literature on in-treatment outcome and these studies for secure and non-secure democratic therapeutic communities are also described in Sections 5.2. Finally, there is also extensiveness outcome literature on democratic therapeutic communities for client groups other than those with personality disorders, and mentally disordered offenders, and this is reviewed briefly in this report (Section 6.).

We feel it is important to take account of the fact that hierarchical, or concept-based therapeutic communities, usually for substance abusers, exist in both secure and non-secure settings, both psychiatric and non-psychiatric, although considerably more in the United States of America, Canada, and other parts of the world than in the United Kingdom. These therapeutic communities are organised very differently from democratic therapeutic communities. There is a large body of literature on concept-based therapeutic communities and their outcomes. Although not the main thrust of this report, the relevant in-treatment and post-treatment outcome studies on the effectiveness of secure concept-based therapeutic communities are analysed in Sections 5.3., while the non-secure concept-based outcome literature is summarised in Section 6. This is provided both for information, and for contrast. This research literature is quite considerable, although of varying quality. However, there is sufficient literature around to warrant a literature review in its own right, and the material we have collected could be used to this end.

The bid call highlighted the fact that therapeutic communities differ in the sense of both overall structure, as well as specific programme content. Identifying these core principles and practices is addressed in three ways in this report.

Firstly, section 3. looks at the overall background and context of therapeutic communities**.** It looks at issues around defining what is a therapeutic community; the types of therapeutic communities; how therapeutic communities philosophies, principles and practice have been modified to fit the needs of particular groups of clients, or the requirements of factors like security; and where therapeutic communities are, and have been, located internationally.

Secondly, this report contains a descriptive section on the therapeutic community, based on a summary of the literature gathered for the research outcome review (Section 5.1.). The original bid call cited the following aims for this literature review:-

i) identify the settings, their regimes and the way in which they defined themselves

ii) the populations of the communities and the regimes should be described with details of the standards, standard monitoring and outcome indicators including in the short, medium and long term

iii) additionally, the catchment area, selection criteria and links with other services should be described as well as the degree to which it is provided as part of an integrated range of services

iv) describe the types of care procedures present in the therapeutic process and identify research evidence about their effectiveness

v) describe what procedures to support the regime are used and identify evidence about their effectiveness

vi) describe, as far as possible, the roles of different disciplines and descriptions of disciplines, as well as the support structures operated, with reference to multi-disciplinary working

Thirdly, these same areas were surveyed in a sample of secure and non-secure democratic therapeutic communities, and the three Special Hospitals - Broadmoor, Rampton and Ashworth, either by visit, or by postal survey. These survey visits are outlined in Additional Appendix 11.2.

In addition to the above, the researchers agreed to look at additional ways of finding research literature, and descriptive information about therapeutic communities internationally, in both secure and non-secure settings. This was done by targeting 'grey' literature, and by identifying as many therapeutic communities nationally and internationally as possible. These were subsequently mailshot, along with known writers, or workers in this field, asking for any published or unpublished research they might have, and, if possible, for information about their therapeutic community, and its principles, organisation and

practices. These methods and findings are summarised in Section 4, and described in Additional Appendix 11.3.

Any additional findings, or relevant material or information is included either in Section 6., or in the Main Appendices.

This work was conducted in an explicit and structured manner, with clearly stated research objectives, and protocols guiding the work and criteria for describing the relevance and quality of identified research. These are described firstly, in Section 4., in the report on searches, and the search appendices (Main Appendix 10.3); and, secondly, in Section 4., in the section on sorting and cataloguing of the research literature, and the reasons for the decisions.

The results of this literature review are presented in narrative form, as well as through a meta-analysis of a sub-section of this literature, in Section 5. An overview of the research literature, together with observations about, and critiques of, the quality of the research literature, and particularly the methodologies used, and recommendations for future research are provided in Section 7.

2 OBJECTIVES AND RESEARCH QUESTIONS

The literature on the nature and effectiveness of therapeutic communities is fairly scattered, both within the UK and abroad . It was also felt likely that significant material is held in the form of unpublished, or 'grey' literature known chiefly to the staff of individual communities, or to networks of communities associated through organisations such as the Association of Therapeutic Communities (and its sister organisation in Holland and elsewhere in Europe), the Planned Environment Therapy Trust, the World Federation of Therapeutic Communities, or the Society for Psychotherapy Research.

The existing state of knowledge in therapeutic communities in psychiatric and other secure settings is patchy. A useful range of material has now accumulated in the *International Journal of Therapeutic Communities*, now *Therapeutic Communities*, since its foundation in 1980. There are also many references to therapeutic communities in related journals in psychiatry and psychology. In addition, for example, the *Index Medicus* has had a therapeutic community section since 1969, as has the SSCI since 1976. Both have reported around 20 papers a year since then (see Manning, 1989 p. 50).

Much of the literature on therapeutic communities has been descriptive of regimes and populations, but the identification of which internal processes are most effective, and the demonstration of effectiveness with standard methodologies has been weak (see Manning, 1979b, for an explanation). Many such studies can be found for example in *the International Journal of Therapeutic Communities/Therapeutic Communities*. The situation for therapeutic communities in secure settings is a little stronger, though by no means good (see Dolan and Coid, 1993, and B.50. Warren and Dolan, 1996, for recent summaries).

2.1 Research Objectives

(i) To review the existing international literature on therapeutic communities in secure and some non-secure settings.

(ii) To identify existing therapeutic communities internationally in secure settings and some non-secure settings, and to obtain information from a sample of these on their practice and research.

(iii) To analyse the material (from published, 'grey' and unpublished sources) for information on treatments, populations, treatment outcomes, monitoring procedures, care procedures, support structures and service integration.

(iv) To evaluate the extent, nature, validity and reliability of the existing research.

(v) To inform policy decisions and further research.

2.2 Questions addressed

A. What literature is available on therapeutic communities?

A.1 How much material is available overall?
A.2 How much is available year by year?
A.3 How much relates to general issues of therapeutic community history/principles/philosophy?
A.4 How much describes specific therapeutic communities?
A.5 How much material is published? Unpublished? Grey?
A.6 How much provides outcome information?

B. What are the range and types of settings that call themselves therapeutic communities?

B.1 Are there differences in therapeutic communities in secure and non-secure settings?
B.2 Are there differences in the range of treatments offered?
B.3 If so, what are the implications of these differences?
B.4 What, if any are the common factors?
B.5 So, what is a therapeutic community?

C. What are the implications of different service contexts? (e.g. prison, NHS, etc.)

C.1 Finance
C.2 Staffing qualities/requirements.
C.3 Requirements to which therapeutic community must conform (officially and unofficially)

D. Who are the clients?

D.1 What are the range and types of client populations?
D.2 How are mentally disordered offenders/personality disorders defined in these studies?
D.3 Are there differences in the client populations between secure and non-secure settings?
D.4 If so, what are the implications of these differences?
D.5 How do clients get referred?
D.6 Why do clients get referred?
D.7 How do clients get selected?
D.8 What is the relationship between selection and admission?

E. How is the therapeutic community sustained?

E.1 What support structures are available?
E.2 What staff training is offered?
E.3 How is the therapeutic community integrated into other services?

F. What types of research studies are there? (e.g. process; cross institutional; client outcomes; environmental)

F.1 How many therapeutic communities are in the studies?
F.2 What types of therapeutic communities are in the studies (e.g.democratic; concept-based etc)
F.3 What treatment factors were measured?

F.3 What environmental factors were measured?
F.4 How is the process studied?
F.5 What numbers of clients were in the studies?
F.6 At what stage of treatment was data collected?
F.7 What outcome measures were used?
F.8 What were the results of these research studies?

G. Overall research findings
G.1 What effectiveness, if any, has been demonstrated by these studies?
G.2 What effectiveness, if any, has been demonstrated for mentally disordered offenders/personality disorders by these studies?
G.3 Are there differences in the research findings for secure and non-secure settings?
G.4 Are there differences for personality disorders/mentally disordered offenders and other client groups in secure settings, and personality disorders/mentally disordered offenders and other client groups in non-secure settings?

H.1 What are the implications for service provision?

J.1 What are the implications for future research?

2.3 Brief summary of work undertaken to retrieve information

For the purposes of this research, we began by checking databases, to locate any other similar reviews extant or in progress. We then designed a list of keywords, to form the bases of our searches, and designed the data extraction manuals, and a protocol for the research work. We conducted electronic database searches for relevant references to the literature; hand-searched relevant journals, and key books, and other reference volumes; we visited key library sites; we mailshot therapeutic communities, and writers and researchers on therapeutic communities, world-wide; we visited or surveyed key therapeutic communities in Britain; and we searched the Internet.

We then retrieved all references that looked relevant. These were then sorted according to our exclusion/inclusion criteria. The remaining references were then sorted into treatment outcome, and non-treatment outcome. All references were then catalogued. We then set aside the core references on in-treatment and post-treatment outcome, and review articles of studies on post-treatment outcome, for democratic therapeutic communities in secure and non-secure settings, and for secure concept-based therapeutic communities. These articles were then data extracted, both for descriptive material on therapeutic communities, based on the data extraction sheets, and for evaluative research findings. The descriptive findings have then been described in narrative form. The outcome research findings are relayed in both narrative and tabular form. The findings have then been summarised, and criticised, and some meta-analysed. Research recommendations have then been made on the basis of these findings.

3 BACKGROUND

3.1 Therapeutic communities

3.1.1. History of Therapeutic Communities

Therapeutic communities inside the secure environments of prisons and special hospitals began in 1962 at Grendon Prison in England (A.9. Genders & Player, 1995) and, following visits by Maxwell Jones to the USA, in the early 1960's in America (E.19. Wexler & Love, 1994). Whilst the first wave of therapeutic communities in the USA was fairly short-lived, Grendon is still operating as a therapeutic community prison. Subsequent therapeutic communities in US prisons have mainly been concept-based (see below). In the UK, the democratic model has become the dominant one, with therapeutic communities being established in several prisons. Some of these have now closed (e.g. Barlinnie Special Unit and the therapeutic community in Glen Parva Young Offenders Institute), but there is still a small but thriving core of secure therapeutic communities, mainly aimed at personality disordered offenders. Some special hospitals in the UK (Ashworth) and Europe (Dr. Henri Van Der Hoeven - A36b. van Emmerik, 1987) also contain democratic therapeutic communities.

The democratic therapeutic community literature refers to Tom Main coining the term 'therapeutic community' in the 1940s, as a result of 'the second Northfield experiment' (Birmingham) (B.12. Dolan, Evans & Wilson, 1992), with soldiers suffering from war neuroses; then going on to develop and facilitate social and group processes within the hospital community, in order to help the men help each other; and finally developing the therapeutic community at Cassel Hospital, London (B.32. Schimmel, 1997, p.120). It also credits Main, along with Maxwell Jones and Stuart Whiteley at the Henderson Hospital, London, with promoting the concepts and practice of therapeutic community treatment and rehabilitation programmes worldwide (B.32. Schimmel, 1997, p.120). Maxwell Jones is also credited with developing the therapeutic community as a widely followed model for the treatment of psychopaths (B.45. Whiteley, 1975, p.164).

Piper, Rosie, Joyce & Azim, 1996, (B.29.) highlight the distinction between the therapeutic community as an atmosphere created in a hospital by a particular approach to patients, and as a radical reorganization of structure within a circumscribed psychiatric treatment. These smaller psychiatric units (generally fewer than 100 patients) were run according to Rapoport's (B.30. Rapoport, 1960, pp.54-64) four principles of democratization, permissiveness, communalism and reality confrontation, which combined to produce a culture of living-learning (see below). There was maximum opportunity for examination and understanding of patients' behaviours in relationship to each other and toward authority figures and institutions. The environment also fostered patients' experimentation with behaviour change. These ideas were pursued through the operation of multiple groups: patient-patient groups, staff member-patient groups, staff member-staff member groups; and the daily community meeting, which all patients and staff members were required to attend. The patients and lay therapists with no training assumed responsibility equal to the trained staff members and psychiatrists. Patients voted on issues such as admission and discharge of patients. The units were, in part, a revolt against the perceived abuse of power by existing

institutions. They were also a radical attempt to shift the responsibility for recovery from the physician-superintendent to the patient. (B.29. Piper, Rosie, Joyce & Azim 1996 pp.14-16).

Denford, Schachter, Temple et al, 1983, (B.10) suggest that the type of therapeutic community typified in Maxwell Jones's work focuses exclusively on group interactions, and is based on the assumption that changing the social milieu may bring about individual change, whereas Main's therapeutic community, as typified by the Cassel Hospital, combines and integrates this therapeutic community work with individual psychotherapy, and emphasises the importance of this in understanding and using the transference which the patient develops to the institution. In the past, this model also used the termination of treatment as an important focus of therapy, a strategy which discouraged routine follow-up (although this practice has been modified recently) (B.10. Denford, Schachter, Temple et al, 1983, p.225).

Schimmel, 1997, (B.32.) describes the period of widespread popularity and influence of the therapeutic community worldwide, and then its decline in importance and relevance and the closure of many units, with particular reference to Australia and New Zealand (B.32. Schimmel, 1997, pp. 120-121). He also suggests that understandings about what constitutes optimal therapeutic community treatment have changed over time (B.32. Schimmel, 1997, p.123). Based on experiences in Holland, Schimmel suggests that there is a trend towards 'shorter duration of stay and a decreasing influence of group-dynamic theorems in favour of psychodynamic and person-oriented diagnostic and therapeutic approaches' (B.32. Schimmel, 1997, p.123). Hafner & Holme, 1996, (B.15) also argue that, although early therapeutic communities were designed to treat a range of psychiatric disorders, their focus shifted progressively toward treating substance abuse disorder, which is now the main emphasis. They add that a few therapeutic communities still treat psychiatric illness in general, and several of these specialise in personality disorders (B.15. Hafner & Holme, 1996, p.461).

Secure concept-based therapeutic communities are mainly to be found in the USA, where the concept-based approach has become dominant. Prison concept-based therapeutic communities began in the 1960's with Asklepieion at Marion Prison, Illinois (A.58. Paddock & Scott, 1973) and others followed. This first wave of prison concept-based therapeutic communities died down in the 1970's, partly because of organisational problems. An influential research review by Martinson in 1974 argued that 'nothing works' in treating criminals, and this marked a down-turn in interest and funding for prison rehabilitation. In 1977, the Stay'n Out prison therapeutic community programme was established on Staten Island, New York, and since then concept-based therapeutic communities for drug-abusers have become widely established in American prisons (E.19. Wexler & Love, 1994). Elsewhere, concept-based therapeutic communities have been established as small units in existing prisons, but not on the same scale as in the USA.

Concept-based therapeutic communities in prisons are modelled on similar therapeutic communities in the community, such as Synanon, in California, which was the original concept-based therapeutic community established by Chuck Dederich in the late 1950's (Yablonsky, 1965). The model was extended and refined by Phoenix House in New York, and copied by many other establishments throughout the USA and Europe. They are usually organised into three stages, or Phases, which are designed firstly to orient new entrants to the hierarchical culture of the therapeutic community and its rules, which are geared

towards drug users learning to behave and feel like non-drug users. Secondly, is a phase involving working in-house, and taking increasing responsibility within the community, and particularly for therapy and confrontation, and the final phase involves re-entry into the community, leading to successful graduation. These concept-based therapeutic communities focus almost exclusively on drug abusers. Most of the concept-based therapeutic communities described in the studies used in this review are based inside mainstream prisons, although the 're-entry' houses, which provide gradual re-integration into the community, are based outside.

(For full findings on the history of therapeutic communities taken from the analysed outcome literature, see Main Appendix 10.5.

3.1.2. Definitions

A wide variety of institutions describe themselves as therapeutic communities, including day hospitals, in-patient settings, secure hospitals and prisons (B.50. Warren & Dolan, 1996, p.206). It is accepted in the field that self-definition is one, but not the sole, criterion for defining a therapeutic community. It is possible, but unlikely, that therapeutic communities exist without being aware of the overall field; it also possible, and perhaps probable, that therapeutic communities claim to exist within the field which others would not accept. What criteria would these others use to identify a therapeutic community?

A starting point is to consider the origins of the term therapeutic community. Manning, 1989 (D.68) (chapter 1) has traced these origins in detail. They came out of a general critique of existing mental hospital provision, and the perceived damaging effects these could have on patients. Even as early as the late eighteenth and early nineteenth century, Pinel in France and Tuke in the UK had argued that there should be a humane 'moral treatment' of the insane. In particular, those social effects that could damage patients in residential care might be turned round and harnessed for their improvement. Two particular streams of work developed in the 1940s in the UK to move this general idea into a specific treatment modality. Tom Main coined the term 'therapeutic community' in the 1940s, as a result of 'the second Northfield experiment' in Birmingham with soldiers suffering from war neuroses. He subsequently developed and facilitated social and group processes within the hospital community, in order to help the men help each other, and finally developed the therapeutic community at Cassel Hospital, London. Maxwell Jones is also credited with developing the therapeutic community in the 1940s, initially as a means of dealing with soldiers experiencing 'effort syndrome', then as a unit funded by the Ministry of Labour for the 'work shy', and ultimately as a widely followed model for the treatment of psychopaths, first at the Belmont Social Rehabilitation Unit, and subsequently the Henderson Hospital at Belmont.

These two origins help to identify some of the variety that has developed in the field: first is the difference between the intensive, small, in-patient therapeutic community 'proper'and therapeutic community 'approaches' to humanising whole hospitals (Clark, 1964). In US terms, the attempt to humanise whole hospitals, and to utilise the general social environment has come to be decribed as 'milieu therapy' (B.32. Schimmel, 1997, p.121), although this can shade into more specific and intensive inpatient units. A second split can also be detected between those, such as Maxwell Jones, who stressed a social model of

environmentally and situationally induced change, and those taking a deeper and more psychodynamic approach to inter-psychic reconstruction (Edelson, 1970).

A further development has been the invention of a second general stream of ‘concept-based or hierachical’ therapeutic communities in the US since the 1950s. These are all of the intensive in-patient type, but have been explicitly targeted at the addictions, and have been organised on an explicitly non-psychodynamic model of closely monitored and highly intrusive social conditioning, designed to get people off drugs and to provide a complete break with their past lifestyle.

Nevertheless there are a number of general points we can make that encompass the general range of therapeutic communities. The therapeutic community is essentially a living-learning situation (B.45. Whiteley, 1975, p.168; B.46. Whiteley, 1990, p.892). This means that patients are totally immersed in the treatment environment, so that all of their daily behaviour, emotional and physical state can be observed, and challenged as appropriate through intensive group experiences. In addition they are encouraged to experiment with alternative ‘corrective emotional experiences’ (B.46. Whiteley, 1990, p.886). Thus Roberts defines the therapeutic community as ‘a consciously-designed social environment and programme within a residential or day unit in which the social and group process is harnessed with therapeutic intent. In the therapeutic community the community is the primary therapeutic instrument.’(Roberts, 1997, p.4)

A widely used cumulative definition of a therapeutic community is:

1. A group of people who live together or meet together regularly and participate together in a range of purposeful tasks - therapeutic, domestic, organisational, educational

... who may have

2. intimate, informal, non-hierarchical relationships and

3. regular and frequent sharing of information between all members of the group.

... it's not yet a therapeutic community, but will begin to be so if there is

4. a shared commitment to the goal of learning from the experience of living and/or working together

... it will be further developed by

5. a shared commitment to open examination and resolution of problems, tensions and conflicts with the group (a culture of enquiry)

... and theoretically informed by

6. bringing a psychodynamic awareness of individual and group process to bear on this examination

... all of which requires

7. A clear set of boundaries concerning time, place and roles within which the above can take place.

(D.22. Kennard, 1994, p.109)

There is also empirical evidence for a consistent difference between therapeutic communities and other programmes. For example, Price and Moos, 1975, undertook a large scale survey of 144 psychiatric treatment programmes, using their Ward Atmosphere Scale to identify differences in terms of social relationships, treatment, and system maintenance. Six types emerged (see Manning, 1989, p.33, Figure 2.1.). From these six types, a clear profile emerged for therapeutic communities: '... this programme cluster strikingly resembles the type of milieu therapy described by Maxwell Jones, 1952, as the 'therapeutic community' in that high patient involvement and a strong therapeutic orientation are emphasised, but little explicit staff control is exercised' (Price and Moos, 1975, p. 184).

3.1.3. Types of therapeutic communities

Underlying the various origins of therapeutic communities and the relative emphasis on socio- or psycho-therapy, the literature coalesces around two basic types of therapeutic community in operation. **Democratic** therapeutic communities, based on the model developed by Maxwell Jones at the Henderson Hospital (Rapoport, 1960) often regard themselves as 'real' therapeutic communities, and their practitioners may reject other organisational forms. However, concept-based therapeutic communities, mainly for substance abusers, which are based on the model developed by Chuck Dederich at Synanon in California (Yablonsky, 1965), thrive particularly in the United States. Indeed world-wide there are many more of the latter in operation. These, too, regard themselves as therapeutic communities, sometimes, but not always, qualifying this with the term '**concept-based**' or 'hierarchical'.

Because of this adoption of the term by both types of therapeutic community, it is not always clear from the studies, which type is being described. Generally however, concept-based therapeutic communities are aimed exclusively at substance abusers, and have structured treatment programmes, whereby clients work their way through a succession of phases, ending with re-entry into the wider community, and 'graduation' from the programme. Democratic therapeutic communities are aimed at a range of mental illnesses, in which substance abuse, if it is present, is considered a symptom rather than the core issue. Though the democratic therapeutic community will generally have a closely structured daily timetable, arranged around a series of different meetings, groups and activities, progress through treatment is less clearly structured and demarcated.

Rapoport's four core treatment values (permissiveness, communalism, democratisation and reality confrontation), developed in his study of the Henderson Hospital (B.30. Rapoport, 1960), are widely used to encapsulate the therapeutic community proper, or democratic, non-hierarchical, as developed by Maxwell Jones (B.50 Warren & Dolan, 1996, p.207). Rapoport gives the following definitions:

permissiveness all members should tolerate from one another a wide degree of behaviour that might be distressing or seem deviant by ordinary standards

communalism there should be tight-knit, intimate sets of relationships, with shared amenities, use of first names, and free communications

democratisation every member of the community (residents and staff) should share equally in the exercise of power in decision making about community affairs

reality confrontation residents should be continually presented with interpretations of their behaviour as it is seen by others, in order to counteract their tendency to distort, deny or withdraw from their difficulties in getting on with others.

(B.30. Rapoport, 1960, pp.54-64)

The model used in the hierarchical concept-based houses or concept-based therapeutic communities was developed in the United States. In these communities, the hierarchy is keener and more authoritarian, and the social organisation is a family surrogate system, with vertically stratified authority, and is more autocracy than democracy. These communities are particularly aimed at substance abusers, the staff members may themselves be ex-addicts and the communities aim to keep each member 'clean' by using very confrontative encounter groups (B.50. Warren & Dolan, 1996, p.207)

There has been some debate about the extent to which the two types might be variations on a common theme, with the possibility of theoretical integration, or two really rather different endeavours, that happen to use a common name. There have been five proposals for considering some integration of the two types. Two are by Maxwell Jones (1979, 1984), doyen of the democratic tradition, published in US addiction journals, normally the province of the concept-based tradition. Three are from authors in the concept-based tradition, including the most prolific research writer in this area, De Leon (1983; also Rubel et al, 1982; Sugarman, 1984), and published in the *International Journal of Therapeutic Communities*, province of the democratic tradition. The arguments are that (a) both types are basically democratic or peer driven, albeit with strong constraints, (b) that concept-based therapeutic communities are widening their client target and becoming very professionalised, and (c) that they are really addressing different stages of a single maturational cycle - concept-based therapeutic communities designed for early containment and behavioural change, and democratic therapeutic communities designed for later intrapsychic reconstruction.

The third general type of therapeutic community and ideology has an older tradition from the field of **education**, and a different client group of children and adolescents. This is a wide field (comprehensively

documented by Bridgeland, 1971), including penal reformatories, learning disability institutions, progressive education, public schools, and, more recently, the general field of maladjusted children and special education. Within this rather loose collection of concerns, there is a line of development which leads from Homer Lane to David Wills and the Planned Environment Therapy Trust (PETT). Lane's principles were expressed through two central structural elements in the Little Commonwealth, to advise on the foundation of which he came to England in 1913. These elements are that, firstly, each member pay their own way through wages earned in work within the community (the Economic Scheme), and secondly, the democratic management of the community by all members in the Citizen's Court. Given Lane's influence over subsequent pioneers such as A. S. Neill, Lane can perhaps be acknowledged as the actual originator of modern therapeutic community practice, despite its apparent re-invention by both Maxwell Jones and Chuck Dederich. Nevertheless, the ideas remained within the education field, and came to be most vigorously expressed by David Wills, while the most systematic expression of his principles has been through PETT. PETT has come to acknowledge the intellectual vigour of writing stemming from the democratic tradition, in a manner reminiscent of the intellectual crossover between the concept-based and democratic streams (e.g. see Vol.3. of Studies in Environmental Therapy, 1979, PETT) (Manning, 1989, pp.38-41).

Clark made an early distinction between the therapeutic community 'proper', in which a specific small ward, unit or hospital is designed explicitly to make the social environment the main therapeutic tool, and the **therapeutic community approach** (Clark, 1965). In the latter case, Main's ideas were applied to a whole hospital, where patients were drawn from a catchment area, with mixed diagnoses, and were referred from G.P.s, and where there were a high number of referrals per year. A similar distinction was drawn by Crocket, 1966, between the general therapeutic community in which individual (including physical) treatments were merely supplement by community and group methods, and the 'psycho-therapeutic community' in which such methods were the exclusive means of treatment. (Manning, 1989, pp.30-32)

Secure therapeutic communities are inevitably modified to suit prison requirements of security and control, so that therapeutic timetables are arranged around prison timetables of work, association, eating and lock-up. Some therapeutic community prisons, which are independent of mainstream prisons, such as MHP Grendon, and some of the German Social Therapeutic Institutions, are able to modify prison timetables and regulations slightly to accommodate therapeutic activities, whereas small therapeutic community units inside mainstream prisons cannot do this. Nevertheless, security and control are overriding features of prison environments, and the placement of a therapeutic community within a secure environment poses some problems for the therapeutic integrity of the therapeutic community regime, in terms of a conflict between control and democracy. At the same time, one of the main positive effects of running a prison therapeutic community is to break down the traditional roles which prisoners and officers create for themselves and each other - enshrined in the terms 'cons' and 'screws'. Prisoners are able to give up the need to impress their peers. (Kennard, 1983, p.58).

3.1.4. Locations world-wide

Initially, we combed **all** the references we had collected, to gain a global overview of the number of therapeutic communities mentioned in the literature. Overall, we found 765 references (i.e. articles) covering 38 countries; of these 409 were for democratic therapeutic communities, and 356 were concept-based. For the literature analysed for the main report, globally we found 294 references/articles. In these we found 181 references to named therapeutic communities, of which 106 were to democratic therapeutic communities, and 75 to concept-based therapeutic communities.

Overall, for this review, most references (i.e. articles) are for the UK and the USA, and most therapeutic communities are in the UK and USA. However, if we look at the types of therapeutic community, while the UK has produced more articles than the USA, and have roughly the same number of therapeutic communities referred to, when we look at concept-based therapeutic communities, and particularly concept-based therapeutic communities in secure settings, the USA dominates the field, in terms of number of articles and number of therapeutic communities referred to. However, the number of concept-based articles are dominated by both a few concept-based therapeutic communities, such as Stay'n Out, and CREST (prison therapeutic communities), and by a few authors, such as De Leon, Wexler, Inciardi, Condelli, etc.

(More extensive details of the above are included in Main Appendix 10.5.).

3.2 Personality disorders

3.2.1. Definitions

The definitions described here are based on the definitions used mainly in the therapeutic community outcome research literature. This is therefore NOT a complete review of the definitions of psychopathy/personality disorder, nor was this the remit of this review. One of the issues for future therapeutic community research, therefore, is to address more accurate and contemporary descriptions of the client groups treated. For a recent discussion of definitions of personality disorder, see Duggan, 1999.

The traditional category used for patients of the type included in this review was **psychopath**. The Mental Health Act definition of **psychopathy** is 'a persistent disorder or disability of mind (whether or not including subnormality of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient and requires or is susceptible to medical treatment' (B.45. Whiteley, 1975, p.159). Whiteley also quotes McCord & McCord's, 1956, definition as 'an antisocial, aggressive, highly impulsive person who feels little or no guilt and who is unable to form lasting bonds of affection with other human beings', and Wootton's, 1959, definition as 'extremely selfish persons and no-one knows what makes them so'.

There is no universally accepted concept of **psychopathic disorder**, nor of what constitutes psychopathic behaviour, so it remains a diffuse and ill-defined disorder of social behaviour, and that, therefore, treatment of so-called psychopaths is also understandably controversial. Whiteley, 1975, p. 159 (B.45.) notes Walker's 1968 view that the diagnosis of psychopathy is no more than a social device to deflect

towards psychiatric treatment an offender against society whom it seems inappropriate to deal with punitively.

More recently, there has been rapid development of the categorisation of **personality disorder**, of which **psychopathy** is a sub-group (anti-social personality disorder, DSM-IV-R - Cluster B sub-type). Piper, Rosie, Joyce & Azim 1996 (B.29.) define **personality disorder** as an enduring, pervasive and inflexible pattern of inner experience and behaviour that results in functional impairments and subjective distress. Its stability of traits and long-term duration, and therefore persistence of diagnosis, suggest that it is not changed easily. Personality disordered patients show poor compliance with treatment and poor treatment outcome. There is little evidence of spontaneous remission for people with personality disorders. Personality disordered patients manifest high co-morbidity within the many Axis II personality disorders (24-76% in the literature). For co-morbid patients, resistance to change not only characterises their personality disorder, but their other disorders as well, and they present a considerable challenge to workers in the mental health field.

It is important to note that there may be cross-cultural differences in definitions of personality disorder and psychopathy, and in understandings of what patients are included in these diagnostic categories, even if the underlying incidence does not vary cross-culturally. For example, Kobal & Zagar, 1994, (B.19.) describes an open forensic unit in Slovenia, and divides **severe personality disorders** into three sub-groups - psychotic patients subject to security measures; those coming from prison in order to have their dissocial behaviour modified, usually after severe suicide attempts; individuals with psychological disorders that are more evident on the social level.

However, Vaglum, Friis, Irion et al, 1990, (B.33.) state that the validity of the DSM-III Axis II eleven categories of personality disorder is unclear (p.161): and the use of the categories `no personality disorder', `other personality disorder' and `severe personality disorder' are heterogeneous, with extensive overlap (p.170).

The fact that many patients with personality disorders also have different Axis I disorders makes it more difficult to validate Axis II disorders, and the difference between Axis I and Axis II disorders, and there is also a lack of validity studies that control for Axis I disorders (B.33. Vaglum, Friis, Irion et al, 1990, p.161). In addition, it may be impossible to discriminate between no personality disorder and other personality disorder patients at admission on the bases of symptom level only (B.33. Vaglum, Friis, Irion et al, 1990, p.171).

Personality disorders occur in 10% of the general population, and their prevalence has been shown to increase with the security of treatment setting, such that they represent 20% of general practice surgery attendees, 30% of psychiatric outpatients and 40% of psychiatric in-patients (B.50 Warren & Dolan, 1996, p.206). In addition, personality disorder as a primary diagnosis represents 8.4% of first psychiatric in-patient admissions in the U.K. and 7.2% of all mental hospital admissions (B.50. Warren & Dolan, 1996, p.206).

A high prevalence of personality disorder has been demonstrated in the prison population, with studies reporting the presence of any personality disorder in 12% of male and 28% of female remand prisoners; 76% of women in Holloway medical unit; and 86% of men in special units for difficult prisoners (B.50. Warren & Dolan, 1996, p.206). The unmet need for treatment in prison populations is indicated in Maden et al's 1994 large cross sectional survey of psychiatric disorder and the treatment needs of over 2000 sentenced prisoners, which estimated that 5% of men and 8% of women imprisoned in Britain were suitable for therapeutic community treatment. These percentages represent some 1920 men and 80 women in the entire sentenced prison population (based on samples of 1:20 and 1:4 respectively (B.50 Warren & Dolan, 1996, p.206).

In addition, people with **severe personality disorders** have usually had notoriously high service usage; they tend to 'suck in' services in a reactive and unproductive way; they often have failed to engage in other forms of therapy; and the severity of their acting out behaviour means they are not contained in out-patient settings; many have a history of repeated contacts with psychiatric, social, forensic, penal and probation services, while evidence suggests that the spontaneous remission of personality disorders is uncommon (B.55. Menzies, Dolan & Norton, 1996). B.50. (Warren & Dolan, 1996) also states that people with personality disorder are often described as 'sucking in services in response to a crisis', and many could be described as 'abusers' of services rather than 'users' (B.50 Warren & Dolan, 1996, p.206).

B.45. (Whiteley, 1975) lists alternative explanations of the aetiology of **psychopathy**: -

1. the physical approach - due to an organic defect, probably innate, of the moral sense;
2. the hereditary approach - hereditary factors, such as mesomorphic build, or chromosomal abnormalities;
3. organic disease of the brain, such as encephalitis, temporal lobe epilepsy, or brain damage in the womb or at birth;
4. the psychodynamic approach - ego strength is weak in relation to the overwhelming id; personality and emotional development is seen as immature; the psychopath is fixated at a proto-phallic level where sex is not yet differentiated, and there is no developed super-ego; the psychopath is egocentric, unable to empathise, sees people only as objects, is manipulative, and unable to delay gratification;
5. the sociological approach - includes the use of the term sociopath, and emphasises pathological social processes, and the behavioural aspects of psychopathy as a defence against breakdown into mental illness; deficiency of role-playing ability; actively seeking to avoid relationships.

The therapeutic community outcome research literature refers little to mentally disordered offenders, per se. However, for the purpose of this review, we have defined mentally disordered offenders as follows: people convicted of criminal offences, who are judged to have a mental illness. Where the offence is judged to have been caused by the disorder, the individual may be directed into psychiatric care. Otherwise the individual, if given a custodial sentence, will go to prison. The literature often distinguishes between mentally disordered offenders and criminals with personality disorders, and this distinction is also found in practice, often on the grounds that whereas mental disorder is thought to be treatable, personality disorder is thought to be fixed. This in itself is debated.

3.2.2. Dual diagnosis/co-morbidity

Numbers of inmates in concept-based therapeutic communities, whose reason for referral is seen to be drug abuse, are also found to have personality disorders. In the USA, such clients have become known as mentally ill chemical abusers or MICAs. Research suggests that MICAs cause special problems for therapeutic communities and that those with the most serious personality disorders are also those who leave early (Sacks et al.,1997).

Wexler 1997 (E.32) reports that 52% of the inmates of Amity in-prison concept-based therapeutic community were also found to have antisocial personality disorder.

4 METHODS

4.1 Report on searches

4.1.1. Introduction

Searches of the Cochrane Library databases failed to locate any similar reviews already undertaken or in progress (see Appendix 10.3.1).

From the outset, the Review team recognised the need for a flexible approach to the literature searches, marrying the basic principles of a 'classic' systematic review with the application of pre-existing specialist knowledge, in a manner sensitive to the topic. In particular, it was accepted that much important material in this field is not very recent, and so a fairly long historical perspective would have to be taken: no fixed start date was initially established, so we were immediately faced with wide variations in date coverage as between databases, journals and other sources of information.

In order to cope with this, and in the light of the scattered and cross-disciplinary nature of the available literature, it was decided to create a framework by undertaking citation searches of a number of books on therapeutic communities, published between 1974 and 1997 (see Appendix 10.3.2 and Section 9. References and Bibliography). Furthermore, the significance of the *International Journal of Therapeutic Communities/Therapeutic Communities* as a focal point and information exchange for the international network of therapeutic communities led to a decision to institute a full hand-search of this journal, including citations.

This preliminary work enabled systematic rankings to be established for the different disciplines in which material might be located (see Appendix 10.3.2. for fuller details). This list of major subject areas was then used to generate lists of: databases to be searched (see Section 4.1.2. below and Appendix 10.3.4; journals to be hand-searched (see Section 4.1.3.1. below and Appendix 10.3.5), and key library sites to be visited (see Section 4.1.3.3. below and Appendix 10.3.6).

In addition, preliminary lists were drawn up for calls for information to: professional organisations; research institutes and other relevant bodies; authors; therapeutic communities (see Appendix 11.3).

Inevitably, electronic databases constitute the main source of information for any systematic review, and therefore searching these formed the bulk of Level One work (see below, section 4.2 for a definition of levels of selection). However, it was also necessary to concentrate a significant part of the project's resources on hand-searching the widest possible range of journals (both English- and foreign-language); on visiting a number of key sites in the UK (both libraries and active therapeutic communities); on UK and international calls for information via direct contacts with individuals and therapeutic communities; and on INTERNET searches.

Each of these sources of information is outlined briefly below (therapeutic community visits being covered in Appendix 11.2.; calls for information in Appendix 11.3), with details of the criteria applied in gathering material, comments on any difficulties encountered, and some conclusions as to the value of each of these sources to the present Review. At this Level, these conclusions are confined to volume and relevance of material found: quality of material is addressed in the Level Two analysis.

A list of keywords (shown in Appendix 10.3.3) was used as the basis for searches in all the different contexts outlined, in the aim of collecting an initial list of candidate texts, as well as a broader range of information to act as a resource base for the Review team and for future researchers.

4.1.2 Electronic database searches

A wide range of databases, covering journal citations, books and similar materials, grey literature, conference proceedings, pamphlets and similar materials, as well as research, both past and present, was considered for inclusion in the Review. However, it was not possible to allocate resources to every potentially useful database, and selection was made on the criterion of subject areas generated by the initial hand-search (see Appendix 10.3.2).

26 databases were selected for **inclusion**:

ASSIA
BIOSIS-PREVIEWS
Boston Spa Conferences
British Humanities Index
CAREDATA
COPAC
CORDIS
Criminal Justice Periodical Index
Dissertation Abstracts
EDINA
EMBASE**
Federal Research in Progress/CRSP
IBSS
ISI - ISTP
ISI - SCI
ISI - SSCI
LILACS
MEDLINE
Mental Health Abstracts
National Criminal Justice Review Service
PASCAL
PsychLIT**
REGARD
SIGLE
Social Science Index
SOCIOFILE (see Note below)

The following databases were **excluded** from the Review because their subject areas did not achieve a ranking on our Subject Areas list (see Appendix 10.3.2).

AMED; CINAHL; DHSS-DATA; ERIC; Healthstar; HELMIS; HSR PROJ; RCN Nurse ROM.

Considerable effort was made to include relevant foreign-language databases in the Review, although it is not always easy to locate or gain access to these. Researchers in the field of bibliometric analysis note the preference of the majority of databases for English-language journals: 'The Institute for Scientific Information's database for the social sciences contained only two German social science journals, whereas

a German database contained 542' (Artus, 1996, cited in Seglen, 1997); and bias towards North American scholarship: 'American scientists, who seem particularly prone to citing each other, dominate databases to such an extent (over half the citations) as to raise both the citation rate and the mean journal impact of American science 30% above the world average...' (Seglen, 1997).

Similarly, the Review team's experience of the therapeutic community field meant we were aware of the possible difficulties faced by researchers in publishing and disseminating important materials. As in many other small fields, they are at a disadvantage (compared with their colleagues in larger fields) in gaining either access to 'high impact' journals or acceptance of specialist journals for indexing by major databases. Therefore, the Review placed a great deal of emphasis on databases that covered any 'grey literature'.

The main list of keywords (Appendix 10.3.3) was used as a basis for devising search strategies and approaches. Appendix 10.3.4 gives all the search strategies used, along with information on the number of references returned, the date of the search, and dates of coverage and search medium for each database.

Database searches were undoubtedly the most fruitful in terms of both relevance and volume of material for the Review. 23 references to research in progress, 379 to past research (including dissertations), and 8,160 book, conference or journal article references were collected for further consideration.

In order to minimise loss of potentially valuable material, collection of references at Level One was intentionally very extensive. Various practical strategies were devised (such as the journal exclusion mentioned above) to avoid duplication of material where possible. However, the view was taken that not all duplication is unnecessary - for example, collection of the same reference with and without an abstract.

The nature of the theme of this Review was such that a lot of duplication during the fairly mechanical Level One searches was preferable to the loss of material for systematic examination by expert researchers at Level Two.

4.1.3. Other sources of information

4.1.3.1. Hand-searches of journals

Resource limitations meant that labour-intensive hand-searches had to be restricted. Given that electronic database searching (without restriction on date coverage) formed the backbone of the Review's approach to information-gathering, it was decided that a historical review of journal materials was beyond either our needs or our remit. The emphasis of journal hand-searches would therefore be to locate recent materials of the following types:

- relevant articles, especially those that might have been mis-titled or mis-described in databases;
- relevant background materials (for example, discussion of evaluating outcomes or cost-effectiveness in psychotherapy or other related treatments);
- individuals or institutions which could be suitable for direct contact (see Appendix 11.3);

- names of major researchers and writers in the therapeutic community field;
- references to research in progress.

In addition, some attempt was made to establish how far therapeutic communities are currently being discussed in journals representing a wide range of disciplines in over 20 countries. This is to some extent predictable (in Germany, 'social therapy' is applied largely in a penal context, so most discussion there takes place in criminology journals): but, in other instances, less so. For example, in some countries such as Norway, leading medical journals occasionally cover topics relating to therapeutic communities. In contrast, although the Netherlands generates probably the largest volume of non-English-language material most relevant to therapeutic community practice, this appears almost entirely in specialist journals.

On this basis, 64 journals were hand-searched. As far as possible, all issues for 1996 and 1997 were reviewed, except for recently established journals or those considered of central importance to the Review, which were searched in complete series. These and any other variations are noted in Appendix 10.3.5 where the journals are listed.

The systematic process of drawing up the list of journals is outlined in Appendices 10.3.2. and 10.3.5., along with the criteria used for exclusion or inclusion of a given journal. Appendix 10.3.5. contains a brief report on each journal searched: these are presented in alphabetical order, but could be sorted according to country or discipline in order to allow further analysis.

The results of these journal searches allowed a tentative revision of the hierarchy of main subject areas in which discussion of therapeutic community issues is taking place (see Appendix 10.3.2.), to the following:

General Psychiatry
Addiction
Hospital Psychiatry
Forensic Psychiatry/Psychology
General Medicine
Criminology/Penology
Medical Psychology
Group Psychotherapy/Group Analysis
General Psychotherapy, Counselling, etc.

The existence was noted of many more journals which either were relevant to the therapeutic community field or should, ideally, be assessed for relevance: resources did not allow the exhaustive study of these. A list and a more detailed explanation are provided in Appendix 7.3.5., as these may be of use or interest to future researchers. However, resources were not the only stumbling-block: both the number of incomplete series and the dearth of foreign-language journals held at institutions in the UK should be noted as barriers to a truly international, comprehensive literature review, as should delays and difficulties in obtaining rarer items through the Inter-Library Loan scheme.

The value of journal hand-searches was negligible in relation to the Review's terms of reference: the volume of text found was small, and its relevance was low, often simply providing a shortcut to obtaining copies of articles that were also located by electronic searching. The main value of searching journals lay in the information it provided about the main researchers - especially institutions - and writers in the field, about active therapeutic communities, and about the broader profile of therapeutic communities in journal coverage.

4.1.3.2. Searches of other relevant publications: reference and compilation volumes

Results of searching the following are included at the end of Appendix 10.3.5.: Addiction Abstracts; Current Research in Britain: Biological Sciences; Current Research in Britain: Social Sciences; Yearbook of Psychiatry and Allied Mental Health.

N.B. National Institute on Drug Abuse (NIDA) Research Monographs were treated as books, since this is how most library catalogues classify them (see Appendix 10.3.6.).

A number of publications were considered for inclusion in the Review: a complete list is given in Appendix 10.3.5. Selection of the above from this list was based on three criteria:

- where no database covering exactly the same or virtually the same material was readily available;
- relevance of the publication to our designated Subject Areas;
- sensible deployment of resources.

As far as the last criterion was concerned, we took a conscious decision to search small series rather than large ones. Reasons for not selecting each publication are given in Appendix 10.3.5.

Although such paper publications are a valuable source of important information, they are now being rapidly superseded by electronic media providing the same material much more quickly. It is recommended that future researchers replace these searches with databases covering the same publications.

4.1.3.3. Visits to key library sites

On the basis of the list of relevant Subject Areas established (see Appendix 10.3.2.), these 5 were selected as key library sites: BMA - to cover General Medicine and Addiction; Tavistock Centre - to cover Psychotherapy, Group Psychotherapy, Group Analysis, Counselling, etc.; Institute of Psychiatry to cover Medical Psychology, Psychiatry (including Hospital and Forensic); Institute of Criminology - to cover Criminology; Prison Service Staff College- to cover Penology.

At each of the key sites, searches were made of the library catalogue using the search terms listed in Appendix 10.3.3., modified according to the terms used in each catalogue. Items identified on the catalogue (books and similar materials, grey literature, conference proceedings, annual reports, research

papers, theses, dissertations, pamphlets and similar materials, audio and video tapes, as well as journal off-prints of previously unrecorded articles) were hand-searched where available and **included** for Level Two examination if they met any of the following criteria:

- dealing with *effectiveness of therapeutic communities* (even where research was not obviously systematic or rigorous)
- giving *statistics* relating to therapeutic communities
- looking at *outcomes of therapeutic communities* (even where research was not obviously systematic or rigorous)
- giving *admission criteria for therapeutic communities*
- dealing with *time spent in therapeutic communities or similar programmes*
- dealing with *types of treatments used in therapeutic communities or similar programmes*.

The results of each visit are reported in Appendix 10.3.6.

Some of the materials located through these searches provided valuable historical and conceptual background to the themes of the Review, and were not revealed by any other means (though subsequent difficulties in actually obtaining items through Inter Library Loans should be noted). Overall, however, the success of these searches in locating material of central importance to the Review was limited. Their value lay more in demonstrating - for the benefit of future researchers as well as the present reviewers - that *specialist libraries are not replete with undiscovered materials on therapeutic community research*: rather, they document the complex historical development of therapeutic communities and give an overview of current therapeutic community practice.

4.1.3.4. Internet searches: World Wide Web

Following NHS Centre for Research and Dissemination recommendations, a search of the World Wide Web was undertaken, starting with a meta-search engine and then going on to review relevant sites offered by each of the search engines suggested. The nature of therapeutic community activities necessitated the use of search terms originating in other languages (rather than literal translations from English). Spanish, German and French terms were selected from keywords on foreign-language databases and from the suggestions of professional colleagues abroad (see Appendix 10.3.3.).

The results of WWW searches are reported in Appendix 10.3.7., along with the criteria used to select materials for collection. Although several hundred sites were visited initially, a final group of 118 relevant sites was selected by a Level One researcher and one of the expert Level Two researchers working together: even this relatively small proportion created files totalling over 1.5 MBytes. The aim was to collect only materials covering extant therapeutic communities, research into therapeutic communities, therapeutic community practice and theory, as well as academic papers on related issues.

The WWW materials collected for the Review give a picture of 'the therapeutic community archipelago' on a number of given days in 1997. They tell us what kind of therapeutic communities exist in which

countries, how therapeutic communities are run and funded, what kind of therapeutic support therapeutic communities aim to provide and to whom, and they discuss many issues of past, current and future therapeutic community practice. To some extent, they form a long-term resource - but not an up-to-date one, nor one that could be easily and systematically updated.

4.1.3.5. Mailshot and survey visits

We also sent out 305 postal requests world-wide, for unpublished work in this area, and related information, to current researchers; authors of relevant articles; interested individuals; a range of government and professional organisations; research institutes and other relevant institutions, and active TCs - all identified through our other search procedures. We received 69 replies, of which one produced unpublished material which we were able to include in the main study. (The results of this mailshot are described in Additional Appendix 11.3.1.)

A small sample (18) of secure and non-secure therapeutic communities, both day and residential were visited, or surveyed by post, for similar relevant material. (Details of the communities targeted are in Additional Appendix 11.2.)

4.2 Selection and cataloguing of articles

We want now to turn to the material we found through our searches, and particularly to the 8,160 book, conference and journal articles references we gathered from our electronic searches, and the other references gleaned from trawling bibliographies in selected journals and books, and other references to outcome literature that came from data extracting the references we already had. *Very little of this turned up as grey literature*, contradicting our expectations.

As the term 'therapeutic community' was only coined in 1946, we conducted our systematic literature searches from 1946 until 1997. As described earlier in this review, we recognise that there were institutions operating along therapeutic community lines before this, in a number of settings, and that therapeutic community ideas have their roots in many related fields. However, for the purposes of this review, we did not search all this literature. For more extensive discussion of the historical roots of therapeutic community ideas, see Manning, 1989 and Kennard, 1998.

4.2.1. Selection criteria

We undertook a sorting of the references retrieved above on the following levels of sorting:-

Level One - the searches produced lists of literature references, many of which will also have abstracts. The lists of titles and abstracts were examined by two of the researchers working independently.

Inclusion criteria were as follows: Outcome studies; Monitoring information; Care procedures; Client information; Information on settings; Information on regimes; Selection criteria; Service integration; Support structures; Learning disabilities. (Material on elders was excluded.)

In addition, judgements were made about the nature of the work, as follows: any short research report or briefing paper was included: any other articles of less than two pages; short idiosyncratic descriptions; and short debates on practice or philosophy were excluded.

Articles which satisfied these inclusion criteria at this stage were collected. We set an upper limit on the number of **articles** to be collected of 300, but we actually netted 294.

Level Two: Scan of articles/books

The 294 articles/books were scanned to ensure that they were of sufficient quality to include in the final report, and/or that they included information which was required by the data extraction sheets. Articles/books which provided research information on the outcome of therapeutic community treatment in secure and non-secure democratic settings for mentally disordered offenders and/or clients with personality disorders were put aside for deeper analysis, as were those for secure concept-based therapeutic communities.

Level Three. The remaining articles/books

These were resorted into in-treatment outcome studies; post-treatment outcome studies; and review articles of post-treatment studies, for both secure and non-secure democratic therapeutic communities, and secure only concept-based therapeutic communities. They were then classified according to the types of methodology and research design used, according to the levels of resolution listed below. These remaining papers were analysed separately from the others, using the data extraction sheets**.** Thus, we included papers on the following topics: Outcome study; Personality disorders; Mentally disordered offenders; Secure/non-secure setting; Democratic therapeutic community; Secure concept-based; Randomised controlled trial; Cross-institutional study; Clients + regime/treatment + outcome.

Level Four: Reading and analysis of remaining qualifying studies

This final level pulled out all studies which describe the in-treatment and post-treatment outcome of democratic therapeutic community treatment in secure and non-secure settings with personality disordered clients and/or mentally disordered offenders, and the in-treatment and post-treatment outcome of concept-based therapeutic community treatment in secure settings. These had already been analysed using the data extraction sheets. The inclusion criteria were as follows: Outcome study; Secure/non-secure democratic setting; Secure concept-based setting; Personality disorders; Mentally disordered offenders.

Note: An additional criteria was that all the articles/books selected should be about therapeutic communities - we used a very loose description here; if the institutions called themselves, or were referred to as, therapeutic communities, or milieu therapy, or in-patient psych

otherapy units, and included a weekly or daily community meeting, group activities, and some form of democratic or client self-government; and offered predominantly group treatment, then the articles/books were retained.

As well as information on the descriptive factors outlined above for our survey of therapeutic communities, we also specifically targeted collecting research information on process studies; individual client case studies; outcome studies of individual clients, outcome studies of populations; review articles of outcome studies; cross-institutional studies; cost-offset studies; and evidence on the effectiveness of therapeutic communities for people with personality disorders, and for mentally disordered offenders.

4.2.2. Principles for Synthesising Data

There were three sorts of data synthesis:

1. How much of which types of research studies is in the material (displayed as tables). This is summarised information, based on the decisions made by the reviewers as to what each section should contain.

2. Narrative synthesis of outcome data. This is a qualitative report on the content of articles. The report also includes information on individual client outcome studies; population outcome studies, their comparability, and their advantages and disadvantages; descriptions of the types of research methodologies used, and their methodological advantages and disadvantages, and validity and reliability; on the effectiveness of therapeutic community treatment for personality disorders, and their effectiveness for mentally disordered offenders; together with a summary of findings.

3. Meta-analysis of studies which contain suitable data.

4.2.3. Sorting of References

4.2.3.1. Discarded or set aside, but retained

Based on the above inclusion/exclusion criteria, 847 items were catalogued, using an alphabetical system (173 were discarded.). As, Bs & Es are the references for the most pertinent research studies, Cs, Ds and Fs contain additional, but relevant, articles, which are also included in this review. All other sections (G-N) contain related references, which are not directly relevant to this review, but are contained in the Additional Appendices, for information.

Ns relate to references to evaluative work on Special Hospitals, about process, in-treatment outcome and post-treatment outcome- 6 were retained; M.A. relates to a wide range of descriptive references about a range of concept-based units - non-secure/drugs/special interest/overseas - 52 were retained. M. relates

again to a wide range of descriptive references about democratic therapeutic communities - non-secure/non special hospitals, and/or innovative/ overseas - 115 were retained.

L. relates to descriptive references on secure settings (prisons, secure units, special hospitals) - 80 were retained. K. relates to references for concept-based units - intake and process studies for secure and non-secure units - 119 were retained (2 were on secure units, and 117 on non-secure). J. relates to references for non-secure democratic therapeutic communities - intake and process studies - 58 were retained. H. relates to secure democratic therapeutic communities- intake and process studies - 12 references were retained. G. relates to non-secure concept-based therapeutic communities - post-treatment outcome - 111 references were retained.

4.2.3.2. Retained for summarising

This reduced our 8,160 items to 294. These were then grouped into categories as follows. All have been reviewed in some way for this review. Categories C, D & F (181) are summarised in Section 6., and are over-viewed in more detail in Additional Appendices 10.6., 10.7. & 10.8.

C = 51 items on non-secure/democratic/non-personality disorders or mentally disordered offenders - post-treatment outcome
D = 69 items on definitional - therapeutic communities/ personality disorders/ methodologies/ reviews etc
F = 61 items on concept-based - definitional/outcome reviews/methodologies/dual diagnosis

4.2.3.3. Retained for analysis

All the remaining articles (113) were retained for further analysis - they constitute the evaluative research literature on secure and non-secure democratic therapeutic communities, and secure concept-based therapeutic communities. These articles include all the post-treatment outcome studies we retrieved, and the in-treatment outcome studies - these were all data extracted, and are described below, and included in the tables. The others are review articles (18), relating to post-treatment outcome, and these were data extracted for descriptive material, and for references that had not already been retrieved through our other searches.

The number of outcome (in-treatment and post-treatment) articles (95) is greater than the final number of studies included, because some articles relate to the same study, but some contain other additional material, so are still retained.

4.2.3.4. Levels of resolution

The in-treatment and post-treatment outcome studies were then categorised according to the level of resolution, or their position on a research methodology hierarchy.

The sort of research undertaken is determined by the level of resolution at which any researcher wishes to examine the therapeutic community. 'Levels of resolution' is a concept borrowed from microscopy, and systems theory (Klir & Valach, 1967, pp.24-27; Kirk & Millard, 1979, 123-125), where, at a low level of resolution, the broad structure of an object can be observed and examined, but the fine detail cannot, whereas at high levels of resolution, detail can be observed, but the general features are lost to view.

At a low level of resolution, the therapeutic community field as a whole, (or e.g., nationally) can be studied. At higher levels of resolution, groups of therapeutic communities can be examined, then individual (or single case) communities, then the finer details of parts of therapeutic communities, such as treatment orientation, staff groups, resident groups, interpersonal interactions, and individual members; and ending with a higher level of resolution, with part-functions of individual, such as intra-psychic processes (see below).

Low level of resolution

International therapeutic community field

National therapeutic community field

Groups of therapeutic communities (including comparisons with other regimes) (e.g. Norwegian network of therapeutic communities)

Individual therapeutic communities

Parts of therapeutic communities, such as treatment orientation, staff groups, resident groups, interpersonal interactions, and individual members

Part-functions of individuals in therapeutic communities, such as intra-psychic processes

High level of resolution

For the purposes of this report, levels of resolution equate quite well with some of the NHS-CRD guidelines for a hierarchy as applied to research methodologies, and the evidence for systematic literature reviews (see below). These levels of resolution will also affect the sort of methodologies, assessment and measuring tools used. For example, if researchers wants to look at the therapeutic community field as a whole, or groups of therapeutic communities, then they need comparative and cross-institutional research designs - using either a number of therapeutic communities, or comparing some therapeutic communities

with other institutions, across a range of dimensions, including process and outcome measure, and with statistical techniques capable of dealing with the amount of information generated.

Research methodologies

Low level of resolution

Well-designed randomised controlled trials (Level **I**)

Other types of trial
- well-designed controlled trial with pseudo-randomisation (Level **II-Ia**)
- well-designed controlled trials with no randomisation (Level **II-Ib**)

Cross-institutional, naturalistic studies

Cohort studies
- well-designed cohort (prospective study) with concurrent controls (Level **II-2a**)
- well-designed cohort (prospective study) with historical controls (Level **II-2b**)
- well-designed cohort (retrospective study) with concurrent controls (Level **II-2c**)

Cohort studies with no controls

Single case studies (of therapeutic communities)

Studies of individuals within one therapeutic community

Individual case studies, using clinical judgements

High level of resolution

We have adapted these levels of resolution here, for the purpose of classifying further the research studies (as opposed to articles) we have data extracted, as follows:-

1. The gold standard of experimental research and the randomised controlled trial technique - post and in treatment = 10

2. Comparative, cross-institutional and cross-treatment design - post and in treatment = 10

3. Single community studies - with control/comparison groups - post and in treatment = 32

4. Single community studies - with no control/comparison groups - post and in treatment = 29

5. Cost-offset studies - in- and post-treatment = 4

4.2.4. Articles/books retained for the systematic literature review

The remaining articles/books (113) left after the implementation of all our inclusion/exclusion criteria were then grouped into categories, as follows:-

A. Treatment outcome studies in secure democratic therapeutic communities for people with personality disorders or mentally disordered offenders = 52
Post-treatment outcome studies = 38
In-treatment outcome studies = 4
Reviews of post-treatment outcome studies = 10

B. Treatment outcome studies in non-secure democratic therapeutic communities for personality disorders = 41
Post-treatment outcome studies = 26
In-treatment outcome studies = 7
Reviews of post-treatment outcome studies = 8

(These two categories form the main basis for our research report.)

This next section is included in our data analysis, because concept-based therapeutic communities are so prevalent in secure settings in America, and have provided extensive research studies. These are described in Section 5.4., and illustrated on the tables.

E. Post-treatment outcome studies in secure concept-based therapeutic communities (we don't know if these include people with personality disorders) = 20

4.3 The meta-analysis

Sufficient studies were found for a meta-analysis to be undertaken. There were 52 studies that reported on the effectiveness of therapeutic communities, and which had used a control group. Relatively few of these were RCTs, the rest using a variety of control groups. Studies were excluded where the outcome criteria were unclear, where the raw numbers were not reported, and where the original sample was not clearly specified before any attrition of the sample over the course of the study. Where there was a choice of outcome measures and control groups, emphasis was placed on conservative criteria, such as reconviction rates rather than psychological improvements, and on non-treated controls. This reduced the number of studies for the meta-analysis to 29.

The analysis had two stages. Initially the odds-ratios for the individual studies, and 95% and 99% confidence intervals, were calculated. This was based on the standard method devised by Woolf (1955, discussed in Kahn and Sempos, 1989, pp. 56-57):

	Treatment	**Control**	**Total**
Fail	a	b	g
Success	c	d	h
Total	e	f	n

OR $= \frac{ad}{bc}$

SE(ln OR) $= \sqrt{(\frac{1}{a} + \frac{1}{b} + \frac{1}{c} + \frac{1}{d})}$

95% CL on ln OR = ln OR ± 1.96(SE)ln OR

95% CL on OR = $e^{(\ln OR \pm 1.96(SE)\ln OR)}$

99% CL on ln OR = ln OR ± 2.58(SE)ln OR

99% CL on OR = $e^{(\ln OR \pm 2.58(SE)\ln OR)}$

Subsequently, the odds-ratios were combined to produce a summary odds-ratio for the 29 studies, and subsections of them, with confidence intervals also for the 95% and 99% levels. The subsections were the RCTs, democratic type therapeutic communities, concept type therapeutic communities, and secure therapeutic communities of either type. This was based on the standard method devised by Peto (Yusuf, et al, 1985, discussed in Petitti, 1994, pp. 100-102):

Expected events, E $= \frac{eg}{n}$

Observed-expected events, O-E = a-E

Variance of O-E $= \frac{Efh}{n(n-1)}$

ln OR(sum) $= \frac{\text{sum(O-E)}}{\text{sum variances}}$

OR(sum) = $e^{\ln OR(sum)}$

CI ln OR (sum) (95%; 99%) = ln OR(sum) ± 1.96$\sqrt{}$(sum variances) (95%);

ln OR(sum) ± 2.58$\sqrt{}$(sum variances) (99%)

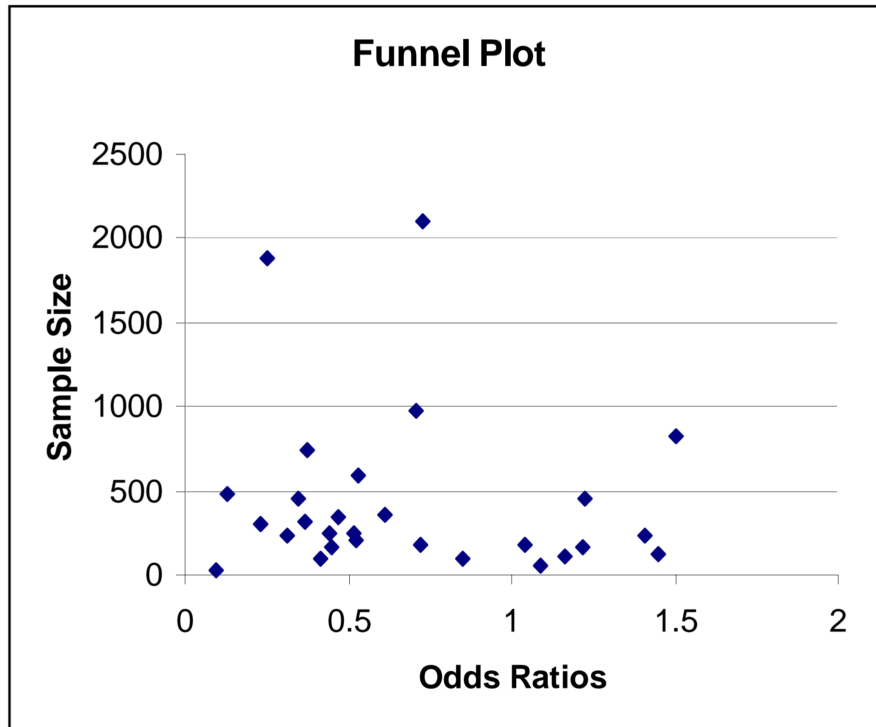
CI OR (sum) (95%; 99%) = $e^{\ln OR(sum) \pm 1.96\sqrt{(\text{sum variances})}\ (95\%)}$; $e^{\ln OR(sum) \pm 1.96\sqrt{(\text{sum variances})}\ (95\%)}$

This two stage analysis produced a standard set of meta-analysis data presented in Section 5.4, and details of the calculations in the Main Appendices, Section 10.9.

4.4 Publication bias - a funnel plot

Considerable efforts have been made to track down unpublished or 'grey' material for this report. In contrast to our expectations, very little turned up. Of concern in meta-analysis is the possibility that publication bias might occur as a result of negative or neutral findings being either not submitted, or not accepted by journals. A check on any publication bias is povided by plotting the meta-analysis odds-ratios against sample size in a 'funnel plot'. The lower the sample size, the higher should be the range of odds ratios reported, giving rise to a typical funnel shaped scattergram. The expectation is that a scattergram would reveal blank spots caused by

unpublished findings, or 'lost' studies. The funnel plot for this meta-analysis does not suggest that this is the case:



5 MAIN FINDINGS

5.1 Descriptive findings from the retained literature

5.1.1. Descriptive findings for secure and non-secure democratic therapeutic communities

The descriptive findings from the evaluative studies were extensive. They are summarised briefly here - the full findings are included in Main Appendix 10.5.

5.1.1.1. History

The findings for the history of both secure and non-secure democratic therapeutic commmunities are already summarised in Section 3. The full findings are in Main appendix 10.5., and therefore are not reproduced here.

5.1.1.2. Descriptions of therapeutic community principles and practices

Secure democratic

Secure democratic therapeutic communities are inevitably modified to suit prison requirements of security and control. Thus therapeutic timetables are arranged around prison timetables of work, association, eating and lock-up. A therapeutic prison, such as Grendon and some of the German Social Therapeutic Institutions, which are independent of mainstream prisons, are able to modify prison timetables and regulations slightly to accommodate therapeutic activities, whereas small therapeutic community units inside mainstream prisons cannot do this. Nevertheless, security and control are overriding features of prison environments, and this is evidenced by the wearing of uniforms by prison officer staff, the carrying of keys, cell and personal searches and other prison activities which are not part of therapeutic community life in non-secure settings.

Non-secure democratic

Whiteley, 1975 (B.45) states that there is no set formula for a therapeutic community regime (p.168).

Schimmel, 1997, (B.32.) describes the basis of the therapeutic community as creating an environment where complex interpersonal and community processes become essential therapeutic factors and are subject to detailed analysis, and considered as a primary medium of treatment (p.121). The therapeutic community also involves patients' participation in these treatment processes (p.121). Schimmel also quotes Maxwell Jones's description of a therapeutic community as ‘distinctive amongst other comparable treatment centres in the way the institution's total resources, both staff and patients, are self-consciously pooled in furthering treatment’, and a healthy therapeutic community as ‘an open system’, being highly facilitative of development and change, and allowing for growth in positive directions (p.121).

Whiteley, 1975, (B.45.) lists the defining characteristics of the social processes of the functioning community as Rapoport's,1960, (B.30) communalism in sharing of tasks, responsibilities and rewards; permissiveness to act in accord with one's feelings without accustomed social inhibitions; democratic decision-making; reality confrontation of the subject with what they are doing in the here and now; as well as social analysis, or Main's 'culture of enquiry' (p.165). Schimmel, 1997, (B.32.) also lists Gunderson's five specific functions that contribute to therapeutic milieu: containment, support, structure, involvement and validation (p.121). Whiteley, 1975, (B.45.) also says the process of treatment in a therapeutic community can be summarised simplistically as Interaction, Exploration, Experimentation (p.891).

Piper, Rosie, Joyce & Azim, 1996, (B.29.) describe the day therapeutic community, as a modified therapeutic community, milieu or environment therapy and partial hospitalisation, and including a physical structure, a social structure, and culture, and psychodynamic group therapy, and large group psychotherapy/community meetings. They suggest that there are three basic principles which are central to effective day treatment - the judicious use of authority; optimal patient-treatment matching; and careful attention to referral sources. They also identify six principles of effective milieu therapy:-

1. it encourages patients to be responsible
2. it engenders mutual respect between staff members and patients
3. it facilitates patients' participation in the treatment of their peers
4. it fosters collaboration with higher order systems
5. it avoids abdication of authority, on the one hand, and abuse of power, on the other, of the designated staff members - in other words, it involves the judicious use of authority
6. its use of the operation of multiple groups at multiple levels throughout the system, which contribute significantly to 'a culture of enquiry'. (pp.18-19).

5.1.1.3. Service contexts

Secure democratic

Secure therapeutic communities are located mainly within prison and correctional services. Of these, only HMP Grendon, in Buckinghamshire, England, is an entirely therapeutic community prison. Other therapeutic communities comprise small units inside larger mainstream prisons, although some German Social Therapeutic Institutions have been established in separate secure premises outside prisons (Lösel, 1997). The Slovenian prison system is largely based on a therapeutic community model (Kriznick, 1996). Some secure psychiatric hospitals also house therapeutic communities for forensic patients (A.17. Ogloff, Wong & Greenwood, 1990; A.19. Rice, Harris & Cormier, 1992; A.36b. van Emmerik, 1987). The therapeutic community at Arnold Lodge Regional Secure Unit in Leicester (A.12. McMurran, Egan & Ahmadi, 1998) was closed in 1997. A new therapeutic community prison is due to open in Marchington, Staffordshire, in 1999. This will be within the private sector and will reportedly consist of a 200-inmate therapeutic community unit attached to a conventional 600 inmate prison.

Non-secure democratic

The service contexts described in the research literature on democratic non-secure settings are very varied. Many are located within the NHS, and often at the tertiary level of provision, for example, the unit studied in B.3. (Chiesa, 1997) & B.4. (Chiesa, Iacoponi & Morris, 1996) is described as a tertiary service, and a referral resource within the NHS, with a national catchment area; B.14. (Dolan, Warren & Norton, 1997) as a tertiary level NHS Hospital; B.43. (Rosser, Birch, Bond et al, 1987) as a hospital funded entirely by the NHS; B.9. (Davies, Campling & Ryan, 1997) as a district service, funded by the local District Health Authority; and B.37. (Miles, 1969) as a large NHS psychiatric hospital for the subnormal.

Abroad, the hospital based therapeutic communities are described as: - part of a metropolitan psychiatric hospital in Australia (B.15. Hafner & Holme, 1996); a public psychiatric hospital in Australia (B.58. Spielman, 1975); a clinic in a private psychiatric hospital in Australia (B.57. Eisen, Blenkhorn, Wendiggensen et al, 1986); an in-patient ward in a University Hospital in America, with a metropolitan and suburban catchment area (B.20. Lehman & Ritzler, 1976); as a Day Hospital in the Psychiatric Department in Ullevål University Hospital, which is the main general hospital in Oslo (B.18. Karterud, Vaglum, Friis et al, 1992 & B.33. Vaglum, Friis, Irion et al, 1990); and a day treatment programme in a university hospital department of psychiatry (B.29. Piper, Rosie, Joyce & Azim, 1996); and finally, a Department of Forensic and Social Psychiatry in a University Hospital in Slovenia (B.19. Kobal & Zagar, 1994).

5.1.1.4. Client information

(Most of the studies discussed in this section relate to adults. One or two relate to adolescents, but are retained both because they refer to the clients as psychopathic, or character or conduct disordered, and contain important research findings.)

Secure democratic

Most secure therapeutic communities admit male offenders only. Some concept-based therapeutic communities in women's prisons in the US are reported in the literature, usually as part of a large study which includes both men and women (E.2. Eisenberg & Fabelo, 1996; E.18. Wexler, Falkin, Lipton & Rosenblum, 1992; E.27. Glider, Mullen, Herbst et al, 1997; E.28. Pelissier, E.33. Field, 1989; E.35. State of New York Department of Correctional Services, 1996). Arnold Lodge Regional Secure Unit admitted men and women. Not all the studies reported the gender of subjects.

All inmates in secure therapeutic communities are offenders, except in one Special Hospital (A.47. van Emmerik, 1987) where some people are held in case they offend. Most democratic prison therapeutic communities specialise in personality disorders and recidivism, whilst concept-based therapeutic communities are directed specifically at substance abuse, which usually refers to drug rather than alcohol use. However, there are overlaps here, since recent studies of concept-based therapeutic communities in the community have suggested that there is a high level of co-morbidity between drug abuse and personality disorder, and between drug abuse and mental illnesses. Indeed, the term MICA has been

recently adopted which stands for Mentally Ill Chemical Abuser (F.42. McLaughlin & Pepper, 1991). The overlap is also evident in admissions to democratic prison therapeutic communities which report a high-level of drug and alcohol abuse amongst inmates. There is little in the literature about specific mental illnesses in inmates except where outcome for the mentally ill is compared with outcomes for the personality disordered (A.17. Ogloff, Wong & Greenwood, 1990; A.19. Rice, Harris & Cormier, 1992).

Non-secure democratic

The client information given varies according to the service context, is diverse, and not easily summarised, so examples are given in this section, but in full detail in Main Appendix 10.5.

For example, for the Cassel Hospital, the clients are described in earlier studies as people with:- previous episodes of functional psychoses, both schizophrenic and manic depressive: chronic severe disturbances and neurotic illnesses, particularly depressive, anxiety and phobic neuroses, often complicated by personality disorders or alcoholism: personality problems or personality disorders, either unspecified or hysterical, with intense hostility, impulsive behaviour, disturbances of identity, transient psychotic experiences, and vacillation between withdrawal and exigency in relationships, and who are borderline as opposed to neurotic: and other minority, organic conditions (B.10. Denford, Schachter, Temple et al, 1983); and as people who typically have proved resistant to other physical and psychotherapeutic approaches (B.43. Rosser, Birch, Bond et al, 1987).

In later studies, Cassel Hospital clients are described as: - adolescents, and families with severe emotional difficulties; adults with severe psychoneurotic conditions; with chronic and severe personality disorders, (Cluster A and B), and some Cluster C (non severe personality disorders): high co-morbidity with Axis I disorders, most commonly with anxiety disorders, phobic conditions, and substance use disorders: and as mostly female, single and unemployed at the time of admission; with severe and multiple symptomatology, chaotic interpersonal relationships, and severely impaired social functioning; with a history of self mutilation and self-destructive behaviour: suicidal feelings and attempts: and previous psychiatric hospitalization, or psychiatric out-patient treatment over the 12 months prior to the Cassel admission (B.3. Chiesa, 1997; B.4. Chiesa, Iacoponi & Morris, 1996).

For the Henderson Hospital, clients are described in earlier studies as:- character disorders; psychopaths; sociopaths; anti-social personalities; young adults with personality disorders, who broadly fall into the diagnostic category of psychopathic disorder; with various degrees of neuroticism: as anxious, emotional, socially isolated, apprehensive and somewhat imaginative; with some awareness of inner emotional disturbance, despite a predominance of acting-out symptoms; and as mostly young people over 18, with histories of drug and alcohol abuse: assault, or self-injury: criminal records: severe depression: suicidal: and severe problems with relationships (B.36. Whiteley, 1970; B.6. Copas & Whiteley, 1976; B.28. Norris, 1983; B.5. Copas, O'Brien, Roberts & Whiteley, 1984).

Later studies of the Henderson Hospital describe clients as:- young adults (17-45); psychopaths, often of a borderline nature; with marked disturbance of emotional and/or social functioning (i.e. personality disorders of a marked to severe degree - 87% of residents met DSM-III-R criteria for borderline personality disorder: 95% met criteria for at least one Cluster B Axis II diagnoses (although formal psychiatric diagnosis beyond personality disorder is rarely referred to (B.46. Whiteley 1990); half with forensic history/criminal convictions: most with previous psychiatric treatment: substance abusers; with self-damaging and suicidal behaviour; with violent and abusive behaviours; as placing high continuing demands on services; and as often refractory to traditional treatments: (B.46. Whiteley, 1990; B.12. Dolan, Evans & Wilson, 1992; B.55. Menzies, Dolan & Norton, 1993; B.14. Dolan, Warren & Norton, 1997).

5.1.1.5. Referral procedures

Secure democratic

There is little specific information about referral procedures in the literature. Discussions with therapeutic community staff indicate that inmates are referred regularly from some prisons and not at all from others, and that this suggests a lack of willingness on the part of some prisons to make referrals. Once a referral is received, the inmate is considered for admission, and if successful, is generally placed on a waiting list. If the inmate is then transferred to the therapeutic community, they are sent on a '1080', which means that if they subsequently leave the therapeutic community they can be sent back to the referring prison.

Non-secure democratic

Not a lot of information is provided in these studies in terms of referral procedures. Referrers and ways of referring vary from setting to setting, and are given in more detail in Main Appendix 10.5.

5.1.1.6. Selection procedures

Secure democratic

As with non-secure therapeutic communities, treatment is usually voluntary. Inmates are generally selected by staff, who make their decisions on the basis of documentation and assessment interviews. Inmates may be consulted at this stage, although they may have less say in the admission of a new member than residents in a non-secure therapeutic community. Inmates can leave if they choose to do so, or be expelled from the community for their behaviour, and transferred back to prison. Whilst treatment is voluntary, it is nevertheless recognised that the alternative is prison, not freedom, and that therefore the choice is limited.

Non-secure democratic

There is more information given on selection procedures, than on referral procedures, but they are quite often idiosyncratic to each unit. Henderson and Cassel are illustrative.

Whiteley, 1970, (B.36.) says that all prospective patients are seen at a group interview; on the basis of this, prospective residents will be selected or not. The selection group consists of staff (psychiatrists, nurses, social workers etc) and elected members from the more senior patients (i.e. those who have been in the unit more than three months). The reasons for refusal are that not all psychopaths and psychiatric categories are suitable for Henderson/intensive therapeutic community treatment and that correct selection is important; also no patient with a definite diagnosis of psychosis, organic mental illness or mental subnormality will be selected. Whiteley adds that the selection group lasts for 2 hours, and assessment is around the following factors:- motivation for change; awareness of own social defects, and the need to do something about them; the capacity for gaining insight, and emotional growth; the particular ability to function in a group therapy setting; and can the therapeutic community at the moment cope with this person. Early leaving is usually decided by discharge votes.

Rosser, Birch, Bond et al,1987, (B.43.) state that for the single adult unit of the Cassel Hospital, the grounds for selection are that patients are too disturbed for outpatient psychotherapy; able to express some feeling and fantasy and to use interpretations for achieving insight; have sufficient ego strength to tolerate intensive analytic treatment; are too old for the adolescent unit; are single or unsuitable for admission to the family unit; that there is no evidence at initial assessment of significant neuropsychiatric disorder; neurotic psychopathology; previous outpatient treatment; and depression. The grounds given for refusal are organic psychopathology. Admission is usually for 9 months to 2 years. (Initially, leaving the Cassel Hospital involved complete separation from the hospital at the end of treatment, with no follow-up, but this has changed more recently, with the development of post-treatment outreach services.)

5.1.1.7. Regime descriptions

Secure democratic

Secure democratic therapeutic communities are based on the original Henderson model (A.9. Genders & Player, 1995; A.37.). Each has a regular, fixed, weekly timetable of meetings and activities. This includes the large group, which is attended by all inmates and some or all staff, and held either daily or every other day. This large group (or community meeting or wing meeting) is a forum where house-keeping matters are discussed and decided, performance within the community is examined and information from other groups and meetings is reported. As with non-secure therapeutic communities, efforts are made to get the inmates to organise and run these meetings, whilst the staff offer help or information when needed. Inmates are assigned to small groups, which may meet daily or less frequently, where the emphasis is more clearly on therapy. These small groups focus particularly on inmates' offences and personal problems as well as behaviour in the therapeutic community. As is usual with the therapeutic community milieu, efforts are directed towards tying current behaviour to referral problems;

throughout the inmate's stay attention is thus focussed on the 'offence-related behaviour' which they display in the community.

A major issue for prison therapeutic communities is the difference between therapeutic community culture and prison culture. Prison culture requires inmates to support each other against staff, not to report illegal behaviour and to be 'hard'. Therapeutic community culture requires inmates to work closely with the staff, to report and confront rule-breaking and to be open and show feelings. It is known to be difficult for inmates to make the switch, particularly since they may end up back in conventional prison or outside in the community, where their therapeutic community activities and behaviours may be remembered.

As with other therapeutic communities, the responsibility for organising and running the community and its affairs is given over to the inmates, although this may be modified in order to comply with prison regulations about security and control.

Non-secure democratic

The regimes described vary, and each have their own particular features. Again, Henderson and Cassel are illustrative.

In B.3. (Chiesa, 1997), the therapeutic community at Cassel Hospital is described as an in-patient psychotherapy unit (IPU); as psychodynamic and socio-therapeutic, with psychosocial treatment, and individual psycho-analytically oriented psychotherapy. Length of stay is usually up to 12/18 months (now called the one-stage programme). There was no out-patient follow-up prior to 1992, and the current research project. The unit has now introduced an additional two-stage programme, since 1993, which involves 6 months in-patient treatment, and then one year of a twice weekly one and a half hour psychotherapy group, together with, in the first six months, psychosocial outreach nursing, and outreach team work. The Cassel Hospital single adult unit has also been described in B.43 (Rosser, Birch, Bond et al, 1987) as an analytically oriented treatment programme.

In B.4. (Chiesa, Iacoponi & Morris, 1996), the same unit is described as an inpatient-treatment unit, and a combination of formal group and individual psychotherapy and experience of living in a therapeutic milieu. Group activities are aimed at fostering ego-strength and the acquisition of social skills. The hospital milieu provides a focus on an understanding of the intrapsychic and interpersonal underpinnings of maladaptive patterns of behaviour, to facilitate the process of resocialisation after discharge from the hospital. The containment given by the hospital milieu is felt to provide safeguards against the risk of suicide often present during treatment of these patients, and it ensures a degree of treatment compliance that is otherwise difficult to obtain in an outpatient setting.

Menzies, Dolan & Norton, 1993, (B.55.), describe Henderson Hospital as a therapeutic community specialising in the treatment of people with severe personality disorders. Dolan, Evans & Wilson, 1992, (B.12.), Dolan, Evans & Wilson, 1992, (B.13.), and Dolan, Warren & Norton, 1997, (B.14.) also describe Henderson Hospital therapeutic community as a specialist psychotherapeutic in-patient treatment, and a national service for severe personality disorder Henderson Hospital regime is an intensive long-term

intervention. Maximum admission is one year.

These last three studies also state that the Henderson Hospital therapeutic community represents a change away from an authoritarian system towards more active participation of the patient in their own treatment - it is the democratic therapeutic community approach. It incorporates a collaborative style of staff behaviour, and avoids the traditional 'medical model', which puts the patient in a passive position. The 'doctor' is the community itself; 'symptoms' are not the focus of therapy; the community concentrates upon the meaning of individuals' feelings or actions, and on their relationships with others. All social interactions are closely examined and commented upon by all. The more active participation of patients in their own treatment, and that of their peers, is central. Treatment involves the conversion of unconscious pathology and pathological behaviours into feelings which can be expressed verbally and handled by interpersonal discussion; a process of expression and containment by personal exchange. All treatment is in a group setting. Responsibility for the day to day running of the therapeutic community is shared among patients and staff, and is collaborative and democratically shared. The community itself is invested with an important decision-making function.

In addition, at Henderson Hospital, there is no psychotropic medication. Treatment is voluntary, and no residents are admitted under Probation Orders with a condition of treatment, or under any section of the Mental Health Act.

Piper, Rosie, Joyce & Azim, 1996, (B.29.) also describe a partial hospitalization/day hospital as: milieu therapy; a modified therapeutic community; time-limited psychodynamic group psychotherapy, for 18 weeks; time-limited group oriented day treatment; and an intensive, dynamic, insight-oriented milieu. The unit was set up in February 1973. The treatment milieu constitutes a physical structure, a social structure and a culture. Treatment is concerned with the optimal recovery of the individual from a mental disorder. Rehabilitation focuses on the individual's psychosocial adaptation to the illness, as well as to the community. It is a three-phase treatment, each phase of 6 weeks. The unit has a sister evening treatment programme.

5.1.1.8. Treatments offered

Secure democratic

Apart from the large and small groups, therapeutic communities mostly offer a range of additional treatments. There are standard prison behavioural programmes for some types of offences and problems. These include SOTP - the Sex Offender Treatment Programme - which certain inmates are required to undertake, and a range of programmes to do with anger management, social skills and addictive behaviour. Some prison therapeutic communities incorporate these programmes into their treatment portfolio; others prefer these to be carried out elsewhere, regarding the community as the treatment. Additionally, many therapeutic communities include creative therapies - especially art therapy and drama therapy.
When considering the range and amount of additional treatments, it is important to consider that there is

inevitably a balance struck between structured and unstructured time. Whilst it is considered useful to spend some time on structured therapeutic activities which promise specific outcomes, it is also considered important for inmates to have unstructured time, so that they can absorb what they have learned, deal with the emotional aspects of therapy and relate to one another in more ordinary ways than is afforded by groups.

Non-secure democratic

All units offer a daily or community meeting, democracy or patient participation in decision-making and running the therapeutic community, and a predominance of group activities - studies were not included in this review unless they met these criteria, so the information presented here describes the treatments offered over and above these treatment factors. Henderson and Cassel are illustrative.

Denford, Schachter, Temple et al, 1983, (B.10.) describe daily community meetings at the Cassel Hospital; community living; assumption of responsibilities in everyday work situations (cooking, cleaning, maintaining furnishing and decorations, practical hospital management); work groups; twice weekly individual psychotherapy; and one weekly meeting with a nurse. The study points out that there is virtually no psychotropic medication used (this is stopped within one week of admission). Rosser, Birch, Bond et al, 1987, (B.43.) describe in addition at the Cassel Hospital a psychoanalytic small group twice weekly; individual psychotherapy with experienced psychotherapists, supervised by a senior psychoanalyst; and individual discussions with their nurses. There is an emphasis on the practical aspects of living together. Anticipatory grieving in preparation for discharge (no follow-up) was regarded as part of therapy. All elements of treatment are totally integrated. Multiple transferences are interpreted.

Whiteley, 1990, (B.46.) describes the treatments offered at Henderson Hospital as analytic groups; formal group therapy; experiential groups; household chores; playing games; and eating meals together. This study suggests that the process of treatment is not confined to the formal group therapy sessions alone; the day is best seen as one on-going group with the staff and patients never out of a therapeutic interaction. The theoretical bases to the treatments offered are object relations; attachment; and living and learning. Whiteley, 1972, (B.35.) and. Whiteley, 1970, (B.36) also enumerate community meetings; small group psychotherapy; work groups - domestic, general maintenance, clerical (administration and research), furniture; visitors group; new members group; selection group; social committee; workshop committee; ward group; and democracy and community jobs, which include 'Top 3' residents - Chair, Vice, Secretary, and sports rep, workshop foreman, librarian, treasurer, shop keeper, catering officer.

Piper, Rosie, Joyce & Azim, 1996, (B.29.) call their day therapeutic community a 'package treatment', operating 5 days a week, 9 - 4, except Fridays when it is until 2.30. There are large daily community meetings, attended by 50 patients, plus large group psychotherapy for one hour a week. Large group psychotherapy is described as a specialised form of community meeting. There is democracy, but with the judicious use of authority - there is a weekly government group, and a daily living seminar. There are a variety of small groups. There are unstructured and insight-oriented small open groups, which meet twice weekly for one and a half hours, and are led by a psychiatrist or non-medical therapist; they are for 7-12 patients, and occur in the 12 weeks of Phase II. There are also structured and skill oriented small

groups, run along the same lines. There is also psychodrama; a projective group; an action group; a personal relations group; a TV group; a life skills group; a re-entry group; a vocational group; a self awareness group; a weekly social outing; a weekly recreation group; and weekly patient evaluation groups; an exercise group; and relaxation training. The unit has a complete group orientation, whether structured or unstructured; skills-oriented or insight-oriented, or treatment or rehabilitation oriented. There is no individual therapy or one-to-one member-patient contacts. There is formal feedback to individual patients in staff and patient groups twice during a patient's stay. The unit also uses behavioural tactics such as contracting, communication and skills training, and other therapies such as family or couple therapy.

5.1.1.9. Monitoring procedures

Secure democratic

Little specific information is provided in the literature about monitoring procedures. Prison therapeutic communities comply with the general monitoring procedures of prisons, and information is kept on admissions, discharges, assaults, serious incidents, positive drug tests etc. This information goes to inform local and national prison statistics, and also provides a means for individual prison therapeutic communities to assess their immediate impact, e.g. reports of lower levels of assaults and serious incidents (A.3. Cooke, 1989).

All inmates have prison files which chart their moves through prison and contain information on offences or achievements whilst in prison, along with statutory reports. These are maintained whilst prisoners are in therapeutic communities, and in addition, notes are kept of behaviour in groups and meetings. Most therapeutic communities have some form of handover report, in which notes are made as and when incidents occur, so that these can be reported to the next shift of staff who are thus kept up-to-date with events.

Non-secure democratic

No information on monitoring procedures was retrieved from the research studies on non-secure democratic therapeutic communities for people with personality disorders.

5.1.1.10. Support structures

Secure democratic

Nothing was found in the literature specifically about support structures for therapeutic communities which are generally described as fairly isolated and vulnerable. This does not mean though that support structures do not exist. In the UK, several therapeutic communities belong to the Association of Therapeutic Communities in Prisons, and members meet to discuss common issues. Concept-based

therapeutic communities are often established as part of larger organisations (e.g. the drug abuse therapeutic community at HMP Holme House is part of Phoenix House England). Gartree Therapeutic Community has a board of outside advisers which meets regularly and HMP Grendon brings in outside consultants and offers support and training to other prison therapeutic communities.

Non-secure democratic

Very little information on support structures was found in the research studies on non-secure democratic therapeutic communities for people with personality disorders. Typically they include a weekly staff meeting, after groups, and clinical supervision.

5.1.1.11. Service integration

Secure democratic

In the UK there is little mention of service integration, except for the difficulties of integrating the therapeutic community with the prison culture. Some of the staff in the therapeutic communities may represent other services, such as probation. Once a prisoner reaches the end of his stay in the therapeutic community, he is either released or returned to mainstream prison. Either way, the therapeutic community has little more officially to do with him.

In the USA, a recent innovation for American prison therapeutic communities has been the establishment of linked therapeutic communities in the community for ex-inmates who leave the prison therapeutic community (E.5. Lockwood & Inciardi, 1994). These act as half-way houses and provide a reference group and a means for inmates to integrate positively with the outside society.

Non-secure democratic

Again, there is no mention in the research studies retrieved of information about service integration.

5.1.1.12. Staff training and selection

Secure democratic

The therapeutic staff of prison therapeutic communities in the UK consists of specially selected and trained prison officers, prison hospital officers and civilians, such as psychologists, doctors and probation officers. Recently there has been a move to recruit NHS nurses, and some of these work in prison therapeutic communities.

In the USA and in other concept-based therapeutic communities, there is usually a mixture of prison staff and ex-addicts, who have been through a therapeutic community programme and now work as staff members.

Non-secure democratic

The information obtained on staffing, and staff training is again limited. Piper, Rosie, Joyce & Azim, 1996, (B.29.) state that the unit has 10 staff - 8 therapists, one full-time and one part-time teacher, a Psychiatrist-Director and secretary, plus staff with nursing, occupational therapy, clinical psychology, and social work backgrounds, and bachelors or masters degrees; on the job training is provided for therapists and teachers; and new staff are trained by day treatment staff members: new staff are selected by the psychiatrist-leader, after a two day interview by the staff members as a group, and by individual staff members: new staff have a probationary period of three months.

Whiteley, 1970, (B.36.) says the Henderson Hospital has 35-40 staff - psychiatrists, social workers, nurses, social therapists, domestic assistants, psychologists, secretaries, work group leaders (one an occupational therapist), and part-time - an attached DRO, Probation Officer, and Chaplain.

5.1.1.13. Financial information

Secure democratic

One study was found which described an attempt to work out the cost-effectiveness of a large drug treatment programme in the USA (A.2. Auerbach, 1977). This programme included therapeutic communities, but also included other treatment approaches. The study was in progress, as the programme had not been running long enough to collect sufficient data.

Non-secure democratic

Very few studies contained financial information about therapeutic communities.

Menzies, Dolan & Norton, 1993, (B.55.) estimated the average daily tariff at Henderson Hospital as £111.00. They also estimated the average daily cost for the general acute psychiatric inpatient beds of four district health authorities and trusts (Thames Region) as £153.20 (range £73 - £242); the average daily cost of close supervision units as £173 (range £111 - £258); the average figure for an assessment and one out-patient appointment with a psychiatrist as £179 (range £86 - £429); and the average figure for a treatment pack (one out-patient appointment, and 8 out-patient episodes) as £586 (range £357 - £1,075); the average daily Day Hospital cost as £71 (range £36 - £123); the average cost of a week in a British adult prison as £386 (range £238 - £744). They also estimated an average length of stay at Henderson Hospital as 7 months x £111, and therefore equal to £23,310 per patient.

Dolan, Warren, Menzies & Norton, 1996, (B.56.) estimated the average annual cost of psychiatric and

prison services (for 24 patients) pre-treatment as £13,966 per patient; and post-treatment as £1,308; with the total cost x 24 as pre-treatment at £335,196, and post-treatment at £31,390. The average cost of this specialist admission was estimated at £23,641 per patient, with a bed tariff for Henderson Hospital of £111.00 per day. They therefore estimated the cumulative annual in-patient costs pre-treatment as £264,438; and post-treatment as £19,462; the cumulative annual outpatient costs - pre-treatment as £36,760, and post-treatment as £11,928; and Prison costs - pre-treatment as £39,968, with post-treatment costs as none.

5.1.1.14. Shortfalls in descriptive information obtained

Secure democratic

Published studies generally provide some information on history, regime description and clients. Unless the studies are specifically about referral and selection procedures, little information is available. In particular, there is little information about how the particular client group in any therapeutic community came to be there. (A.9. Genders & Player, 1995 is a useful exception here). Where therapeutic communities are seen as national resources, it would be helpful to know where their referrals come from, and the grounds on which they are referred and selected. Although monitoring is carried out as part of prison procedure, there is little published information on this. No figures were obtained on costs of running secure therapeutic communities.

Non-secure democratic

While many of the studies give information on the history of therapeutic communities, on their principles and practice, and quite extensive descriptions about regimes, and the treatments offered in therapeutic communities, as well as information about the clients who are selected and admitted, there is much less information on the service contexts of therapeutic communities, on referral procedures, support structures, staff training, and financial information. Also, no information was found on monitoring procedures, or service integration. Obviously, these aspects were not the main focus of this review, but give an indication of what is considered important or relevant to include in studies presenting research findings.

5.1.2. Descriptive findings for secure concept-based descriptive literature

These are mainly to be found in the USA, where the concept-based approach has become dominant. Concept-based therapeutic communities for drug-abusers have become widely-established in American prisons. Elsewhere, concept-based therapeutic communities have been established as small units in existing prisons, but not on the same scale as in the USA. Concept-based therapeutic communities in prisons are modelled on similar therapeutic communities in the community, such as Synanon, in California and have been copied by many other establishments throughout the USA and Europe. These therapeutic communities focus almost exclusively on drug abusers. Most of the therapeutic communities described in the studies are based inside mainstream prisons, although the 're-entry' houses, which provide

gradual re-integration into the community, are based outside. The literature distinguishes two types of concept-based programmes. One is based on the model developed at Synanon and Phoenix House, and exemplified by the Stay'n Out programme and most others. A second type is found in Amity (E.25. Graham & Wexler, 1997), where there is a greater focus on psychodynamic therapy, social education and the development of close relationships.

Concept-based therapeutic communities are organised as classic hierarchies, with ranks of lowest level inmates who communicate upwards through a structure of increasingly more senior inmates, and then staff, and whose instructions come down through the same structure. These therapeutic communities offer a series of treatment stages, which are usually organised into three phases.

Phase 1 is an orientation phase, during which the new entrant is introduced to the culture, concepts and beliefs of the therapeutic community, and to the rules. Some of the rules delimit ordinary behaviour. For example, it is usually forbidden to talk about drugs except in very particular circumstances, and anyone who does so is likely to be 'pulled up', ie., told in a house meeting that they have transgressed the rules and should not do it again. The therapeutic community belief is that inmates can learn new behaviours and attitudes, and particularly, that drug users can learn to behave and feel like non-drug users, and that constant confrontation about their behaviour is the way to achieve this. The therapeutic communities often also have cardinal rules which result in expulsion, such as no drugs, sex or violence, although the absolute nature of these penalties will depend on the individual therapeutic community. Inmates who are expelled are returned to mainstream prison. Therapeutic community residence is voluntary, and inmates who want to leave and return to mainstream prison can do so, although they may be asked to think about it first. All inmates work as part of work teams, which are organised as hierarchies, with workers, foremen and leaders. As far as is possible inside a prison, the work they carry out is real, eg: kitchen crew, maintenance crew, office crew. The hierarchy provides a place for everybody in the therapeutic community (including the staff) and provides opportunities for inmates to be promoted up to positions of considerable responsibility, and to be demoted if it is felt appropriate.

Phase 2 is often the heart of the programme, where inmates who have learnt to use groups and the community, work on their development. It involves working in-house, usually in positions of increasing responsibility, and dealing in therapy groups with the issues which led to drug-taking and crime. Both Phase 1 and Phase 2 revolve around real work, such as cooking, cleaning, maintenance and office duties, and inmates are promoted up through the hierarchy to various work-related positions as they progress. How an individual performs at work, and how an individual feels about work and authority comprise an important part of the treatment. Generally, inmates are required to accept authority and to act as if they are positive and healthy people. The exception to this is during group therapy sessions - encounter group - where they are encouraged to show and deal with their true feelings. (E.32. Wexler, 1997, notes that for some in-prison therapeutic community programmes, there are difficulties in finding real work for inmates to do, since basic housekeeping tasks are largely contracted to outside providers.)

The therapy groups are often modelled on the original encounter groups run by Synanon, and can be heavily confrontative. Like the non-secure therapeutic communities the prison therapeutic communities are seen as self-help organisations, and peer confrontation is seen as one of the most valuable tools of the treatment. Encounter groups generally have strict rules, which try to prevent bullying or inappropriate rescuing, and which try to ensure everyone gets their share of attention. The strength of confrontation tends to vary between therapeutic communities, because it is recognised more and more that whilst drug users are heavily defended, and need powerful techniques to get through to them, they may also have associated personality disorders or be extremely introverted. If confrontation is too direct and constant, it can lead to these inmates leaving early. The literature suggests that, whereas most of the prison therapeutic communities described below are based on this confrontative model, Amity leans towards a slightly more spiritual and educative model. It is not easy though to assess the difference from the literature. Amity is still largely based on the Phoenix House model, and it is still a hierarchical therapeutic community.

Those inmates who complete Phase 2 (which means they will have successfully held the job of a department head within the therapeutic community, and will have been in treatment for usually 9-12 months), move on to Phase 3 or re-entry. This means re-entry into the community, and is a phased progression of moving from full-time residency into work or education in the community. This phase can cause some problems for prison therapeutic communities, since their inmates may be ready for re-entry at an early stage in their sentence, and before their official parole date, and cannot be allowed into the community. Sometimes this means being transferred back to the main prison, which is considered detrimental to their recovery. Sometimes, inmates can be at late stages in their sentence, and once they reach their parole date, have to leave altogether, whichever stage they have reached. However, where the re-entry and parole date can be made to co-incide, the inmate is released into the community, to employment or education. Where possible, inmates are released to a non-secure therapeutic community, so that their re-entry to society can be supervised, and so that he or she can have support to find and keep a job or a place in college. Several studies describe therapeutic community aftercare, and various projects have been established which provide early release for inmates, provided they live in a specially established community therapeutic community on leaving prison.

During the re-entry phase, inmates take on responsibility for education and often therapy for Phase 1 and 2 residents, acting as role models. By the time they finish this Phase 3, they are usually living and working out in the community, but keeping in touch through running or attending groups, attending house meetings, and networking with each other. A successful end to Phase 3 re-entry is usually known as graduation. Usually, graduates are encouraged to keep in touch with the therapeutic community, and with the positive reference they have developed during their time in the therapeutic community. Programme graduates may well return to the therapeutic community as junior staff members, and some end up as permanent staff, even becoming programme directors over time. It is common for concept-based therapeutic communities to recruit ex-addicts, now graduates, as staff members. It is generally believed that ex-drug users are best positioned to help other drug users, because ex-addicts can empathise with the problems - they know the problems and ways of addicts, and can see through the manipulative ploys. Also, graduates can provide encouraging role-models, as their presence is a constant reinforcement to those still in treatment that it is possible to live a drug-free, crime-free, life. This, too, can be a problem

in prisons, as not only are such staff ex-inmates, and thus may be unable to return as staff, but also they often have no officially recognised qualifications (E.32. Wexler, 1997).

Unlike democratic therapeutic communities, concept-based therapeutic communities focus almost exclusively on drug users. Thus, the outcome studies found tend to use relapse and reconviction as the main outcome criteria, although some also look at changes in behaviour and psychological tests scores.

5.2 Evaluative findings from the retained literature for secure and non-secure democratic therapeutic communities

As part of our data extraction of the evaluative literature, we recorded information for individual qualitative case outcome studies, and individual quantitative outcome studies, and for process studies. These findings are all outlined in detail in Main Appendix 10.4. This section contains only the findings relating to in-treatment and post-treatment outcome for secure and non-secure democratic therapeutic communities.

All the studies mentioned below can be found in summarised and tabular form in Section 8. (Tables) below.

5.2.1. In-treatment outcome studies

5.2.1.1. Experimental research/Randomised control trials

Secure democratic

None found

Non-secure democratic

We have only found one experimental, controlled trial for in-treatment outcome.

1. B.37. (Miles, 1969)

Miles' study is of the therapeutic community ward and psychopathic unit at Harperbury Hospital, England, for 'subnormal' male psychopaths, mainly adolescent offenders. The therapeutic community was a new unit, and, after some initial allocations to the new unit, patients were allocated alternately to the therapeutic community group (n=40), and to a non-matched control group (n=20) of similar patients in another ward of the same hospital, who were receiving traditional psychiatric disciplinary treatment. However, the therapeutic community was not separate from the hospital, and so the treatment group experienced not only the therapeutic community, but the total hospital environment, as did the control group. The outcome criterion was increased ability to form satisfactory personal relationships, between admission and one year later in treatment, measured using sociometric observations.

These suggested that during the year, there was a steady if slow improvement in interpersonal relationships in the therapeutic community; that the therapeutic community increased the ability of psychopaths to accept each other more than did traditional hospital treatment; that the empathic ability of at least some of the patients in the therapeutic community increased during treatment, but not for the control group; that patients in the therapeutic community formed reciprocated friendships during treatment, while the control group did not; and the therapeutic community increased the capacity to recognise others feelings towards themselves, whereas the control treatment did not.

5.2.1.2. Cross-institutional/comparative studies

Secure democratic

This section looks at changes which have been identified in inmates between the time of their admission and their departure. Three studies were found in this section, all cross institutional studies which used psychological test scores to identify changes. Two of these (A.53. McCord, 1982 and A.64. (Gunn et al, 1978) were part of larger studies of post-treatment outcome. A.57. (Wenger, 1974) studied a group of 60 mentally ill offenders who were randomly assigned to treatment in a prison therapeutic community, or to conventional drug and observation treatment in a prison psychiatric hospital. He found significant improvements in the psychology and improvements in the behaviour of the therapeutic community group. A.53. (McCord, 1982) matched 35 boys at a secure reform therapeutic community with 35 boys at an authoritarian reform school, and found that whilst the therapeutic community improved some basic personality traits and attitudes, it did not decrease levels of aggression. A.64. (Gunn et al, 1978) found a therapeutic community group at Grendon improved more than an outpatient group at Wormwood Scrubs, becoming less disturbed, acquiring higher self-esteem and becoming more realistic.

Non-secure democratic

Again, we have only found one cross-institutional, comparative in-treatment outcome study.

1. B.28. (Norris, 1983)

This study compares patients at Henderson Hospital, England, with trainees at a detention centre, and residents in voluntary trust communities, and includes matched samples (n=14), and looks at changes in Repertory Construct Grids between admission and discharge. Numbers for the study are reasonable, and attrition rates are lower than for some studies. Findings are complex. The Henderson Hospital sample had graver behaviour problems and were more emotional and anxious than the other two samples, and significantly more of the Henderson Hospital group changed in desired directions. The author claims 60% success rates overall for patients' increased self-esteem; and that 81% of men who stayed 30+ weeks were successful; as were 71% of the men who attended both community meetings and small psychotherapy groups.

5.2.1.3. Single case studies with control/comparison groups

Secure democratic

None found.

Non-secure democratic

We have found three single case studies with control or comparison groups - B.10 (Denford, Schachter, Temple et al, 1983); B.18. (Karterud, Vaglum, Friis et al, 1992); and B.58. (Spielman, 1975)

1. B.10. (Denford, Schachter, Temple et al, 1983). This retrospective study is also related to the prospective study in B.43. (Rosser, Birch, Bond et al, 1987). This is a study of the Cassel Hospital therapeutic community single adult unit for people with severe personality disorders. Numbers are small, but attrition rates are also very small. The group is, however, subdivided into three groups - a drop-out group, and treatment successes and failures, so numbers are tiny. Outcome criterion is clinical improvement between admission and discharge. Factors making for successful outcome are identified, as a potential aid to selection procedures, and a success rate stated of 41.37%.

2. B.18. (Karterud, Vaglum, Friis et al, 1992). This study is also related to B.33. (Vaglum, Friis, Irion et al, 1990 - same study data) & B.26. (Mehlum, Friis, Irion et al, 1991).
This study is of the day hospital therapeutic community at Ullevål University Hospital, in Norway, for decompensated patients with severely disturbed personality disorders. Part of this study is of the therapeutic community social atmosphere and dynamics using the Ward Atmosphere Scale. The outcome study covers changes on a number of clinical dimensions, from admission to discharge. Numbers are reasonable but attrition rates are quite high at each testing stage, and the sample is subdivided by diagnosis, and by length of stay. At discharge, mean symptom scores had dropped for all groups, and symptom reduction was correlated positively with length of stay. However, the group with no personality disorder improved most, followed by the borderline personality group and the 'other' personality group. The study claimed a 58% success rate for patients, in terms of not being on medication at discharge; 95.8% had made no suicide attempts; 96.9% had not been transferred to an acute ward; and 74.33% had fulfilled their treatment. The study then went on to claim that the containing capacity of the day hospital therapeutic community was satisfactory.

3. B.58. (Spielman, 1975)
This study is of the North Ryde Psychiatric Centre, Australia, for severe personality disorders. It is an intensive group psychotherapy treatment programme, run along therapeutic community lines. This study looks at changes in self-esteem, alienation and purpose in life, from admission to discharge. It also relates them to a particular part of the treatment milieu - the closed small psychotherapy groups. Numbers are small, because of an attrition rate of 50%, who did not complete treatment, but early leavers are compared to treatment leavers. No success rates are given, but the study claims that, on discharge, patients show an increase in self-esteem; a decrease in alienation; and an increase in purpose in life.

5.2.1.4. Single case studies with no control/comparison groups

Secure concept-based

Nine studies were found in this section. One of these, A.53. (McCord, 1982) was part of a larger comparative post-treatment outcome study. It is included here because part of the study looked at behaviour change in therapeutic community inmates. Three of the studies are from Grendon (A.9. Genders and Player, 1995; A.14. Miller, 1982; A.16. Newton, 1996) and two from the Barlinnie Special Unit (A.3. Cooke, 1983 and A.60. Cooke, 1997). Populations of all the studies are described as personality disordered, psychopathic, violent or disruptive.

Two studies from Grendon (A.14. Miller, 1982 and A.16. Newton, 1996) used personality questionnaires, the Hostility and Direction of Hostility Questionnaire (HDHQ) and Rotters Locus of Control Scale to assess changes. A.14. (Miller, 1982) found that after treatment inmates had lower hostility, lower criminality and greater internal control whilst A.16. (Newton, 1996) found that all scores changed in the direction of normality, and that greater change was found in men who stayed more than 12 months.

A.53. (McCord, 1982) used tests and observations to find that psychopathic and behaviourally disturbed boys at a reform school therapeutic community improved, whilst boys diagnosed as neurotic or borderline psychotic did not. A.40. (Jones, 1989) at the Wormwood Scrubs Annexe, used Kelly's Construct Grid to establish changes in constructs during treatment, and as part of the research, fed back his research findings to the inmates concerned. He found that the feedback itself led to positive changes. He also found that therapeutic community treatment initially lowered and then raised self-esteem, and used this evidence to argue that very early discharges from the therapeutic community, during a time when self-esteem is lowered, could be particularly harmful. He also found that inmates who arrived at the same time as another did worse, which supports the findings of A.45. (McPherson, 1973) at Grendon.

A.17. (Ogloff et al, 1990) used Hare's Psychopathic Checklist to compare level of psychopathy with length of stay and degree of motivation. Overall, they found that psychopaths had higher attrition rates and spent less time in the programme, a point which is echoed by Jones (1997) in his comments on the Annexe at Wormwood Scrubs. A.17. (Ogloff et al, 1990) also argued that psychopaths showed less motivation and less improvement than non-psychopaths.

Two studies in this section (A.3. Cooke, 1989 and A.60. Cooke, 1997) describe the Barlinnie Special Unit, a small unit set up by the Scottish Prison Service in Barlinnie Prison to contain violent and disruptive prisoners. The A.3. (Cooke, 1989) study provides detailed information on methodology and findings, whilst the A.60 (Cooke, 1997) study, written after the closure of the Barlinnie Special Unit, provides updated figures. Cooke, looked at the number of assaults and serious incidents committed in prisons by the Barlinnie Special Unit population, and on the basis of these figures, calculated the number of assaults and serious incidents which might be expected to occur in the Barlinnie Special Unit. He found that in reality, there were significantly and substantially fewer of these events than would have been predicted, and argues from this that the organisation and administration of a prison regime can greatly contribute to lowering the rate of prison violence.

A.9. (Genders and Player, 1995) carried out an qualitative study of Grendon prison, interviewing inmates and staff, and observing therapeutic and prison activities over an extended period. They used their findings to create a five stage career model of therapeutic attainment, in which each stage described a level of progressive therapeutic maturity. They then used the model to assess the changes brought about by treatment at Grendon, and found that those who stayed the longest (over 18 months) were more likely to achieve therapeutic maturity than others. In an analysis of the characteristics of inmates, they found that those who stayed longest, and thus got furthest, had fewer convictions, higher intelligence and were more self-critical. This study is unusual in that it is qualitative, and the model of progress was derived from qualitative observations and analysis. The career model was later used to inform the Grendon reconviction studies (A.26. Cullen, 1993).

The final study in this section is A.73. (Sandhu, 1970) who looked at a special prison in India which treated 18 psychopaths by mixing them in with 30 ‘well-behaved’ prisoners, in an attempt to create a positive culture of change. Measurement of change was made on the basis of clinical observations. A.73. (Sandhu, 1970) found that 13 cases improved and 5 did not. Like Cooke, he reports a drop in prison violence, with no riots, serious assaults, suicides or escape attempts.

The study of in-treatment behaviour is important for two main reasons. Firstly, it is a way of evidencing treatment effect and divorcing this from reconviction. Reconviction may occur despite treatment effect. Secondly, it examines in-prison behaviour, which in itself can become a serious prison management problem. Studies of behaviour in prison therapeutic communities show that the behaviour of most violent or disruptive inmates improves during treatment.

Non-secure democratic

None found.

5.2.1.5. Cost-offset studies

Secure democratic

None found.

Non-secure democratic

We have only found one in-treatment cost-offset study - B.55. (Menzies, Dolan & Norton, 1993). It is not really a cost-offset study, but provides the groundwork for a later cost-offset study - B.56. Dolan, Warren, Menzies & Norton, 1996), by estimating pre- and in-treatment costs.

1. B.55. (Menzies, Dolan & Norton,1993)
This is a study of the Henderson Hospital, England. It looks at retrospective pre-treatment costs for one year, for a small group of personality disordered patients, in terms of inpatient general psychiatry services; outpatient general psychiatric services; and prison costs. Using earlier post-treatment studies of the Henderson Hospital, which suggest that 41% of treated patients are not reconvicted or readmitted to psychiatric hospital after three years, these authors estimate a potential average saving of £5,981.96 per patient per year, using ECR tariffs and Home Office costs, and a cost-offset of treatment after four years, with a saving thereafter.

5.2.2. Post-treatment outcome studies

5.2.2.1. Experimental research/randomised control trials

Secure democratic

Only two RCTs were found in this section, one from the 1960's (A.76. Cornish and Clarke, 1975) and one from the 1970s (A.2. Auerbach, 1977). A.76. (Cornish and Clarke, 1975) studied 13 - 15 year old boys randomly allocated to a therapeutic community house and to a conventional house in an approved school. A third group of boys, seen as ineligible for therapeutic community treatment and placed elsewhere, was also followed. No significant differences were found in the reconviction rates of the three groups. A.2. (Auerbach, 1977) studied a 'street prison' which was a secure therapeutic community located in an inner city area. Inmates worked though a systematic programme, similar to that provided by concept-based therapeutic communities, eventually being allowed out into the community for work and education. The reconviction study, which included inmates who had been released for between seven weeks and four years, found a significantly lower rate of recidivism for the experimental group. Additionally, it found that the experimental group had a significantly lower incidence of new crimes.

Non-secure democratic

There are four studies included in this section - B.7. (Craft, Stephenson & Granger, 1964); B.20. (Lehman & Ritzler, 1976); B.29. (Piper, Rosie, Joyce & Azim, 1996); & B.3 (Chiesa, 1997). (See RCT tables 1-4).

Not all of these studies meet all the criteria which strictly apply to experimental research and randomised control trials. Not all the programmes were set up as experimental treatments for the purposes of the controlled trials; not all allocations to the different treatments were strictly random; and not all of them have control groups which include either a different treatment or a 'no treatment' option. Some also appear to have run the risk of contamination across treatment variables, and most have quite high attrition rates.

1. B.7. (Craft, Stephenson & Granger, 1964)
This study described a hospital in-patient therapeutic community (based on the Henderson Hospital model) or group psychotherapy unit for male (adolescent) delinquents aged 13-25, with relatively low IQs, at Balderton Hospital, England. Although not a secure unit - the hospital was unlocked, and admission was technically voluntary, the patients who came to the unit were either on probation with a condition of residence, or transferred from Approved Schools for treatment. This unit was not set up specifically for this study, but the study was undertaken not long after the therapeutic community had been implemented as an experimental psychiatric treatment programme.

50 referrals for psychiatric treatment were admitted on a 'strictly alternate basis' (B.7. Craft, Stephenson & Granger, 1964 p.543) to either the group psychotherapy programme, or to another ward offering standard authoritarian training, through a disciplinary programme with individual treatment, and there was no untreated group. This sample was regarded as severely disordered and an extremely maladjusted group. However, 5 referrals who were considered too aggressive, and 10 offenders not requiring psychiatric treatment were not admitted. The expected length of stay for both groups was one year, but in fact varied from less than one month, to a year and a half, and 6 boys were excluded from the final analysis, because they stayed less than three months, and comparisons were not made of the effects of different lengths of stay on outcome. In addition, data was only available for 30 boys on one of the tests.

The group psychotherapy unit was smaller (30-bed) than the authoritarian ward (50-bed), and also received, on average, twice as many nursing hours, and three times as many psychiatrist hours as the authoritarian ward. Also, senior nursing and medical staff in charge of the hospital were common to both treatment wards, and the sample subjects shared common work and occupation therapy programmes, a sheltered workshop and leisure pursuits, and a token economy of 'merit money', which suggests the integrity of the treatment programmes may have been compromised. In addition, the units were only 100 yards apart, and could hear each other!

The authors argue that patients' behaviour after discharge provides the 'obvious' criteria for measuring response to treatment (B.7. Craft, Stephenson & Granger, 1964 p.547), and so this study used outcome criteria of reconvictions; employment record, in terms of proportion of time employed since discharge; and clinical well-being, through two scales - one of clinical recovery, and one of residual neurotic symptoms, such as nail-biting, tics or enuresis; and changes in severity of disorder, as reflected through psychological tests. (Again, this study did not evaluate the possible differential effects of the two treatments on different personality sub-groups.)

The study hypothesis was that boys receiving the therapeutic community treatment would improve to a greater extent than those receiving the traditional authoritarian treatment. There were no significant differences between the two treatment groups on admission. Between admission and discharge (i.e. in-treatment outcome), there were some differences, although the authors acknowledge that overall, the test results are limited. The only statistical difference concerned absconsions, with more boys absconding more often from the authoritarian ward than the group psychotherapy unit. There were also differences in measured intelligence: the group therapy group's scores altered little, but 19 out of 24 boys on the authoritarian ward improved their scores. On the Porteous Maze test, there were no significant changes in

scores by the group therapy group, but a highly significant decrease in scores by those on the authoritarian ward (pp.548-550).

There were differences between the two sample groups at follow-up (this study only includes follow-up results at one year post-discharge). There were significant differences between the two groups in the numbers of offences committed since discharge, with nearly twice as many committed by members of the group psychotherapy group. However, the group therapy boys appeared to have a slightly better employment record, although no statistical difference was found. More than half the group therapy group still needed institutional care, as compared with a quarter of the authoritarian group, a significant difference (B.7. Craft, Stephenson & Granger 1964 p.551).

The authors argue that these 'varying results' suggest that the authoritarian ward provided a more effective treatment of the psychopathic delinquents admitted to Balderton Hospital than the therapeutic community regime. They suggest the most important difference is the just significantly smaller number of offences at follow-up, and that this, taken with the psychological test results and the clinical evaluation, suggest a trend in favour of the authoritarian regime. However, the authors acknowledge that the results in this study do not conclusively show the authoritarian ward to be more effective, but argue that they also do not support the original hypothesis that the therapeutic community regime is any more effective (B.7. Craft, Stephenson & Granger, 1964 p.552). We estimate succes rates of 41% for the therapeutic community unit, and 50% for the authoritarian regime (although the latter was also cheaper to run).

2. B.20. (Lehman & Ritzler, 1976)
This study compares two mixed inpatient psychiatric hospital treatments, one a therapeutic community approach ward, which was designed to teach more effective social skills and provide a better emotional basis for work functioning; and the other a more traditional medically oriented ward, aimed primarily at the elimination or alteration of 'symptoms' - both in the same medical centre in America. This is a post-hoc comparison, in that the therapeutic community ward was not set up experimentally for this study, and some of the data used is retrospective. Also, the distinctions between the two treatments were not as clear as they might have been, with the traditional ward using family therapy, group therapy and insight-oriented approaches, as well as behaviour modification as part of the treatment, and it had twice weekly staff-patient team meetings, where group issues and dynamics were discussed.

Patients were, in theory, randomly admitted to both wards, but this depended on bed supply and demand, and the therapeutic community ward admitted 384 patients per year with an average stay of 21 days, while the more traditional ward admitted 454 patients per year, with an average stay length of 18 days - both very short.

This study hypothesised that the therapeutic community ward would provide an atmosphere with greater involvement, increased patient autonomy, and more practical treatment orientation (as measured by the Community-oriented Program Environment Scale (COPES) - an adaptation of the Ward Atmosphere Scale); would be more satisfactory to its members (patients and staff); and would be more effective, as measured by frequency of discharges against medical advice, and readmission rates.

Approximately 10-20% of the possible sample were not asked to participate because of the severity of their illnesses, so the actual sample used consists of less disturbed patients. Also, there were typical attrition rates for the COPES of between 15 & 30% for staff, and 25 & 55% for patients, but with larger patient response rates for the therapeutic community ward.

The results of the COPES scores showed significant main effects for the wards, and significant interaction effects for wards x COPES categories. The differences were that the therapeutic community ward rated significantly higher on involvement, autonomy, practical orientation, and anger and aggression, but lower on order and organization. There were no differences between patients and staff members in their perceptions of the ward atmospheres. The satisfaction scores (measured by the reciprocal of the mean difference between real and ideal COPES scores) again showed significant main effects for ward and categories, and significant interaction effects for wards x categories, with greater member satisfaction on the therapeutic community ward, and no instance where the medical model ward was more satisfied than the therapeutic community ward.

The therapeutic community ward had a significantly higher readmission rate overall, but had twice the readmission rate for neurotic patients, suggesting that this inpatient treatment approach was not very effective in preventing serious reoccurrence of symptoms following discharge, although the authors point out that this does not necessarily mean the treatment has failed, until other areas of functioning are also taken into account. There were no differences between the wards for overall frequency of discharges against medical advice, but character disorder patients left against medical advice significantly more often on the therapeutic community ward, suggesting an interactional effect between patients' diagnostic categories and treatment approach.

The authors conclude that the more open, free-wheeling atmosphere of the therapeutic community oriented ward may not be a good match for the impulsive, acting-out individual with sociopathic tendencies, and that perhaps patients need a certain base level of social co-operation and concern, for the therapeutic community oriented treatment to be effective. We estimate success rates of 74% for all patients, including character disorders, for the therapeutic community regime, in terms of readmission figures.

The authors' study had originally posed the questions ‘Does the therapeutic community inpatient ward really work?’, to which they conclude that their study appears to provide a qualified ‘yes’ (B.20. Lehman & Ritzler, 1976 p.760).

3. B.29. (Piper, Rosie, Joyce & Azim, 1996)

This study, described as a clinical trial evaluation of treatment efficacy, is of a day treatment programme, also called partial hospitalization, in Canada, run as a modified therapeutic community, offering time-limited (18 weeks) group oriented and milieu therapy to 14-70 year old male and female patients with long-standing personality problems - affective and personality disorders. The study does not compare therapeutic community treatment with other types of treatment, but compares immediate 18 week day therapeutic community treatment, with a ‘control’ group receiving the same treatment, but with a delay condition (waiting list) of 18 weeks. The study also looked more closely at a subsample of 120 patients

(60 matched pairs from each treatment condition). Patients who met the unit exclusion criteria were asked to participate in the study, and were then randomly allocated to one of the two treatments.

Attrition rates were quite high. 5% refused to participate in the study, and another 8.8% were lost in the assessment process. Subsequently, a further 42% of the immediate treatment group were lost to outcome, as were 31.5% of those assigned to the control/delayed treatment condition, so that, out of an original possible sample of 261, 79 completed immediate treatment, and 61 completed the delay period, but only 39 of these completed delayed treatment as well (40.1%). (However, the authors point out that the follow-up patients did not differ significantly from the rest of the sample.)

Outcome was multivariate, and measured in terms of 17 clinical variables, covering the areas of interpersonal functioning (8), psychiatric symptomatology, self-esteem, life satisfaction, and defensive functioning, plus severity of disturbance based on written individual patient treatment objectives (B.29. Piper, Rosie, Joyce & Azim 1996 p.214).

The authors concluded that their 'clinical trial' provided considerable support for the efficacy of the day treatment therapeutic community programme (B.29. Piper, Rosie, Joyce & Azim 1996 p.223), and that there was a strong treatment effect that was maintained at follow-up (at an average of 8 months after therapy was completed). Treated patients improved significantly more than their matched counterparts in the control condition in four of the general content areas studies - interpersonal functioning, symptomatology, life satisfaction and self-esteem, as well as in relation to their individualized goals for treatment: that is, these findings were supported by both between-condition and own-control analyses.

For all variables, improvements associated with treatment were maintained at follow-up, or else demonstrated additional benefit. For all outcome variables, the average treated patient exceeded 76% of the control patients, and 87% for those seven variables deemed to be significant, i.e. the effect sizes of treated patients relative to control patients were of considerable magnitude (.71) (B.29. Piper, Rosie, Joyce & Azim, 1996 p.223). In addition quality of object relations, and psychological mindedness were found to be related significantly and directly to patient success (remaining and benefitting) in the programme, and psychological mindedness was also found to be related directly to the degree to which patients worked in the programme.

4. B.3. (Chiesa, 1997)

This is a study of the psychotherapeutic community at the Cassel Hospital, in England, offering a therapeutic milieu and psycho-social treatment. It is a study of the single adult inpatient psychotherapy unit for people with severe personality disorders, within that hospital. The methodology of the study and some preliminary results are described, because they are of interest to this review, although the research project is still on-going, and final results will not be available until at least next year.

The project is experimental, in that it is a 5-year prospective study, evaluating a newly established treatment programme. It is comparing two different types of therapeutic community treatment - one is a one-stage programme (the traditional Cassel therapeutic community programme) of 12-18 months inpatient therapeutic community treatment; and the new, modified, two stage treatment programme, which involves shorter (6 month) inpatient therapeutic community treatment, followed by an extended out-patient follow-up treatment of one year of twice weekly group analytic therapy and concurrent outreach psychosocial nursing and outreach team work for the first six months. These two treatments will also be compared to another comparison group of similar patients, who are being managed by a general psychiatrist in another region, with no access to therapeutic community treatment. Allocation to the two therapeutic community treatment programmes is not random, but based on geographical considerations - patients referred from within the Greater London area are allocated to the two-stage programme, all others to the longer one-stage inpatient only programme.

The expected final sample was originally 120+. However, the study has already encountered problems with attrition (four years after the implementation of the new programme). Five patients have swapped from the two-stage to the one-stage programme. A significantly higher percentage of one-stage patients have dropped out in the first three months of treatment (although these rates become considerably lower from four to twelve months) than in the two-stage programme. In addition, there has been a significant discrepancy between expected and actual lengths of stay, with a significantly lower rate of attrition for the two-stage programme (mean average length for 12 month programme = 6 months; for 6 month programme = 5.3 months).

The proposed outcome criteria are reduction in treatment costs (expected 40%); improved transition back into society; increase in numbers treated; and a reduction in the waiting list. The study hopes to evaluate the relative effectiveness of the two treatment programmes, and to identify positive and negative prognostic factors.

5.2.2.2. Comparative/cross-institutional/cross-treatment studies

Secure democratic

In theory, all control group studies for secure therapeutic communities should count as cross-institutional studies. Therapeutic community populations are compared with prison populations and thus both groups were receiving some form of treatment. However, a difference was identified between studies which drew control groups from the general prison populations, and those which drew them from one mainstream prison. Those which drew control groups from one specified institution are reported here, whilst the others are reported in 5.2.2.3 as individual therapeutic community/single case studies with control/comparison groups.

Using this criterion, five studies were found.

Three studies found no significant differences between the reconviction rates of therapeutic community inmates and comparison groups - A.15. (Newton, 1971); A.67. (Newton, 1973); A.21 (Sewell & Clark, 1982). A.18. (Rehn, 1979), comparing a German Social Therapeutic Institution with a prison, found that therapeutic community inmates were more likely to offend than the comparison group.

When the figures are broken down into more sensitive gradations, further findings emerge. A.67. (Newton, 1973) notes the positive effect of a long stay in treatment, a finding which is echoed in many other studies. Evidence for a treatment effect is found in A.54. (McCord & Sanchez,1983), a study in which a therapeutic community school was compared to an authoritarian reform school. Ex-therapeutic community boys were at first less likely to re-offend than ex-reform school boys, but after five years, the ex-therapeutic community boys reconviction rates rose sharply, and overtook those of the other group. After extensive analysis, the authors concluded that the initial low re-offending rate was a result of therapeutic community treatment, but that this wore off over time because the boys who came from the therapeutic community were particularly disadvantaged. A high proportion of them were poor and black, and when faced with prejudices and lack of opportunities in society, eventually returned to criminal activities. The reform school boys, who were less disadvantaged as a group exhibited no treatment effect, but had fewer difficulties integrating into society, and so, eventually, began to re-offend less.

A.21. (Sewell & Clark, 1982) found that drug addicts had the highest rate of re-offending, whilst sex offenders had the lowest.

Whilst these cross-institutional studies provide a means of comparing outcomes of treatment, therapeutic communities tend to target difficult and personality disordered offenders, whereas prison wings contain a much broader spectrum of offenders, and prison hospitals contain those who are mentally ill. Thus, it is debatable whether cross-institutional studies in this instance provide a higher quality comparison than control group studies. The difficulties of finding a control group for this type of inmate is discussed below.

Non-secure democratic

We have only found one cross-institutional and/or cross-therapeutic communities study (B.53. Karterud, Pedersen, Friis et al, 1998), and this is still on-going, but again is reported here, because the methodology is of interest

1. B.53. (Karterud, Pedersen, Friis et al, 1998)

This study reports the forming of a Norwegian network of several (currently 5 - one a therapeutic community in a psychiatric hospital department, with 3 preparing to join), psychotherapeutic day hospitals for the treatment of patients with personality disorders, to co-operate in an extensive quality assurance system. The network's quality assurance system is based on formal, signed, contract-based co-operation, and members have to pay an annual fee. The contracts oblige participants to use the same quality assurance system, for which they get a handbook, to receive training and software (free of charge),

and to send their data in anonymous form at regular intervals to a common data base. Treatment is standardised across the network, is based on a variety of group therapy formats, and is for a time-limited period of 18 weeks (like that in B.29. Piper, Rosie, Joyce & Azim, 1996), with a three and a half protracted outpatient phase. Follow-up is for five years.

The authors argue that this system provides benefits to the individual patient, and the individual unit; provides a support system for all the units; and will assist health care planning (B.53. Karterud, Pedersen, Friis et al, 1998 pp.24-25). The strengths of the network, from the research point of view, lie in the larger number of patients, and the similarities and differences between the units. The network units treat around 180 patients a year in the day hospitals, and around 150 additional patients in outpatient group analysis. The differences between the units can be looked upon as a natural experiments (B.53. Karterud, Pedersen, Friis et al, 1998 pp.25-26). Finally, the network is using the Internet, both as a means of communication, and to provide the public with information.

5.2.2.3. Single case studies with control/comparison groups

Secure democratic

Nine studies were found.

An important methodological point here is the difficulty for researchers of finding a matched comparison group for prison therapeutic community populations, since therapeutic community inmates tend to be more disturbed and more likely to be addicted to drugs and alcohol than general prison populations. A.13. (Marshall,1997) used two comparison groups, one drawn from the general prison population and one from the Grendon waiting list. He found that both the treatment group and the waiting list group were different from the general group and at a higher risk of re-offending. On release, the treated group were less likely to be reconvicted than the waiting list group. The methodological arguments in the literature suggest that a waiting list group provides a better comparison than other groups, but that waiting list inmates may well be given treatment of some sort, and so a fair comparison remains elusive.

The therapeutic communities studied admitted a variety of inmates. Some therapeutic communities selected inmates on features of their criminal history such as recidivism (A.1. Angliker et al, 1973; A.63. Briggs, 1972); some because of mental disorder (A.47. van Emmerick, 1987; A.19. Rice et al, 1992) and some simply took offenders (A.68. McMichael, 1974; A.58a. Paddock and Scott ,1973). Four studies looked at inmates in Grendon prison, and described these as personality disordered. Tests and questionnaires administered to inmates in secure therapeutic communities generally show inmates to be more disturbed, more dangerous to themselves and others, have longer psychiatric and criminal histories and to abuse drugs and alcohol more than the general prison population. Consequently, reconviction rates need to be read in this context, since it could be anticipated they would be higher if it were not for therapeutic community intervention (A.13. Marshall, 1997).

Bearing this proviso in mind, several studies found no significant differences between the reconviction rates of therapeutic community inmates and comparison groups. (A.1. Angliker et al, 1973; A.68. McMichael, 1974; A.58a. Paddock and Scott, 1973). Other studies found that therapeutic community inmates were more likely to offend than comparison groups (A.47. van Emmerick, 1987; A.64. Gunn et al, 1978; A.20. Robertson and Gunn, 1987). Other studies found therapeutic community inmates were less likely to reoffend (A.63. Briggs, 1972; A.26. Cullen, 1993; A.13. Marshall, 1997).

When the figures are broken down into more sensitive gradations, further findings emerge. A.26. (Cullen, 1993) compared short stay and long stay inmates at Grendon, and found that long-stay inmates were less likely to be convicted than short-stay inmates. Other writers on therapeutic communities have made this point, but opinion is divided as to why this should occur. Because therapeutic community treatment is voluntary, inmates can decide to leave if they are unable or unwilling to continue. Also, they can be ejected if they do not comply with the behaviour requirements of the community, or do not seem interested in making progress. Thus, there may be a mechanism at work in the therapeutic community which systematically excludes the most difficult of patients, and at the same time systematically retains the least difficult. Thus ,the higher rates of recidivism for short-stay inmates and lower rates for long-stay patients may be a reflection of the selection procedures, and have more to do with the types of inmate who leave or stay than with a treatment effect. However, this remains a matter of speculation: it is thought that the most severely personality disordered offenders do not stay long in therapeutic communities (Jones, 1997; A.17. Ogloff et al., 1990) and that this may account for the finding that short-stay inmates do worst. The problem of finding a truly matched comparison group makes this a difficult question to pursue.

A.63. (Briggs, 1972) reports on a prison therapeutic community which had two distinct organisational phases. At first, the therapeutic community was integrated into Chino Prison. Later however, the therapeutic community was made autonomous, and was able to govern and manage itself. The reconviction rates for this second, autonomous, phase, were improved over those for the first phase, and suggested that prison therapeutic communities work better when kept separate from mainstream prisons.

Some writers have analysed their results in terms of the crimes committed by inmates. A.47. (van Emmerick, 1987) who studied the secure forensic therapeutic community, Dr. Henri Van der Hoeven in Utrecht, found that patients who came in with the most serious offences were the most likely to recidivate.

Non-secure democratic

We have found twelve research studies of individual therapeutic communities, which include some sort of comparison or control group as part of the study. Seven of these relate to one therapeutic community, Henderson Hospital, and will be described together en bloc, and in chronological order (B.30. Rapoport, 1960; B.36. Whiteley, 1970; B.6. Copas & Whiteley, 1976; B.5. Copas, O'Brien, Roberts & Whiteley, 1984; B.12. Dolan, Evans & Wilson, 1992; B.13. Dolan, Evans & Wilson, 1992; B.14. Dolan, Warren & Norton, 1997). The others will be described in the order they appear on tables (individual therapeutic communities with control/comparison groups studies 1-4: (B.26. Mehlum, Friis, Irion et al, 1991; B.43. Rosser, Birch, Bond et al, 1987; B.57. Eisen, Blenkhorn, Wendiggensen et al, 1986; B.59. Gara, Hutchinson & Hafner, 1989; B.62. Tucker, Bauer, Wagner et al, 1987).

1. B.30. (Rapoport, 1960)
This study is actually based on the Belmont Hospital Social Rebilitation Unit, which became the Henderson Hospital. At this stage, its target population were described as working class psychopaths, or patients with long-standing personality disorders. The book reports on two different studies - one conducted by Rosow of all people referred from 1953-1957 (n=1226), and Rapoport's more detailed outcome study of 168 treated patients, split into two series, one cross-sectional, and one consecutive. Rapoport also compared those with stronger and weaker ego strengths, across 5 behavioural defence types; those who improved during treatment and those who did not; and patient profiles at 6 months and one year post-discharge. Attrition rates were high - 58.3% of the outcome sample at the 6 month follow-up, and 61.9% at the one year follow-up, and so numbers at outcome are relatively small. Rapoport concluded that 41% had improved at the one year follow-up, and this number was greater than at the 6 month follow-up. Improvement at follow-up was also significantly related to in-treatment improvement, and those patients with stronger egos made significantly greater gains at follow-up. However, Rapoport also found that 16.6% of the outcome sample were worse at the 6 month follow-up than in their pre-treatment state.

2. B.36. (Whiteley, 1970) and B.6. (Copas & Whiteley, 1976) are related, sequential studies. (B.36. findings are also reported in B.35. Whiteley, Briggs & Turner, 1972.) B.36. (Whiteley, 1970) looked at a sample of 122 consecutive male only discharges from Henderson Hospital, one year and three years after discharge, in terms of reconviction and psychiatric hospital readmission. This sample was compared to a further consecutive group of 50, selected for admission, but who did not arrive. The sample itself was divided for comparison into those with better and poorer outcomes, and according to symptomatology, and whether they had convictions, and compared those with previous convictions only, with those with previous convictions and previous psychiatric hospital admissions. Attrition were again high - 47.6 % at one and three years. Whiteley enumerated a number of factors associated with better outcome, such as the predominance of affective syndrome in the presenting symptomatology of personality disordered patients, and stressed the importance of appropriate selection. He also claimed a success rate overall of 40.1%, but higher for those with previous psychiatric admissions.

3. B.6. (Copas & Whiteley, 1976)
This study and its findings were further developments of B.36. (Whiteley, 1970), to produce a predictive equation for the outcome of therapeutic community treatment at the Henderson Hospital with its particular personality disordered patients, which was to be validated on a further cohort of patients. It was hoped this equation would help improve selection. The predictive equation included six factors, and the outcome criteria were again reconviction and psychiatric hospital readmission - criteria that the authors admit are crude. However, there were no attrition rates once the study started because the authors were only using available government records. The study found that the equation did give a useful differentiation between ‘poor’ and ‘good’ outcome groups. The outcome period was longer - 5 - 6 years, and the authors claimed success rates of 47.1% at 2 - 3 year follow-up, and 40.2% at 5 - 6 year follow-up. One important observation they made was that an early failure is not necessarily a precursor of repeated relapse (B.6. Copas & Whiteley, 1976 p.392).

4. B.5. (Copas, O'Brien, Roberts & Whiteley, 1984). This study included a larger mixed sample (245) of both patients admitted to Henderson Hospital, and those not admitted patients. Patients were classified into a typology of personality disorder, and into successes and failures, and the study then investigated how the various types, and other background characteristics, are related to outcome, again measured as reconviction or psychiatric hospital readmission. Attrition rates are lower than in some studies. The authors claim that therapeutic community treatment is effective with selected individuals, showing the antisocial behaviour associated with personality disorder, and of particular benefit to offenders with only one conviction, who are able to stay in treatment for 6+ months, in order for treatment to be maximally effective (B.5. Copas, O'Brien, Roberts & Whiteley, 1984 p.565). However, they also point out that those who were solely violent to themselves had a particularly poor outcome. Also, the poorest prognosis was for the extrapunitive neurotic personality disordered patient, with or without treatment, but the authors argue that even here, therapeutic community treatment can be effective. Again, the study claims success rates of 41%.

5. B.12. (Dolan, Evans & Wilson, 1992) (This is related to B.13. Dolan, Evans & Wilson, 1992))
This studied changes in neurotic symptomatology at follow-up (average 8 months) for a cohort of Henderson hospital personality disordered patients. They also compared the group who completed the follow-up questionnaire with those who did not, and compared patients staying different lengths of time in treatment (by trichotomisation). Attrition rate was 35%. The authors suggest that the sample has high scores for general symptomatology on admission, but their results show a highly significant reduction in symptomatic distress as measured by the SCL-90 questionnaire, following treatment at Henderson Hospital. Also, the long-stay group (9+ months) tended to show greater improvement than both the short (up to 3 months) and medium (3-9 months) stay groups. The authors state success rates of 55%, in terms of subjects improving reliably; and 32% whose change was also clinically significant. However, 6.5% of patients had deteriorated. The authors also point out that they did not take account of possible intervening life events between discharge and follow-up.

6. B.13. (Dolan, Evans & Wilson, 1992)
This describes the same sample as B.12. (which contains the follow-up results in detail.) This paper looks more closely at predictors of length of stay, and the relationship between improvement in neurotic symptomatology at follow-up, and length of stay in therapeutic community treatment. Attrition rates were 46% for the short and medium length stay groups, and 23% for the long-stay group. The numbers in each group are also relatively small. The findings were:- length of stay is related to gender; is not related to initial neurotic symptomatology; tends to be related to change in symptomatology in the first 3 months of admission; but is not significantly associated with improvement in neurotic symptoms on follow-up - which seems to gainsay the tendency found in B.12.

7. B.14. (Dolan, Warren & Norton, 1997)
This study looked at changes in core personality disorder symptoms, one year after therapeutic community treatment, (or one year after referral if not admitted), for a final sample of 137 patients with severe personality disorder. Attrition rates were 36.5% for completion of the baseline forms, and 58% for baseline sample, who did not complete follow-up forms. The baseline sample were grouped into admitted and not admitted (a sub-sample of this was those ECRs whose funding was refused). At follow-up, all groups showed some decrease in average symptom scores over time. There was a significantly greater reduction in borderline symptom scores in the treated than in the non-admitted group. Changes in borderline symptom scores were significantly positively correlated with length of treatment. There was also a significant difference between the length of stay of admitted patients who showed clinically significant change, and those who did not.

61% of the treated group improved reliably, compared with 37% for the non-admitted group, while 43% of the treated sample showed clinically significant change, compared with 18% of the non-treated group. The authors also state that this change was reliable **and** clinically significant in 42.9% of the treated sample, compared with only 17.9% of the non-admitted group (18.2% of the unfunded ECR group).

8. B.26. (Mehlum, Friis, Irion et al, 1991) (This study is also related to B.18 Karterud, Vaglum, Friis et al, 1992, and B.33. Vaglum, Friis, Irion et al, 1990.)
This is a study of the day unit for personality disorders at Ullevål Hospital, in Norway. The sample was grouped according to type of personality disorder, and these groups related to outcome, at 2 to 5 years after treatment. Attrition rate was relatively low at 24.7% at follow-up. Outcome criteria were multi-dimensional, and findings therefore more complex. The sample as a whole decreased in symptom scores from admission to discharge, and this was maintained at follow-up; there were no statistically significant differences between diagnostic groups; Cluster C personality disorders had both good global outcome, and marked symptom reduction; the borderline personality disorder group had moderate symptom reduction and fair global outcome; the schizotypal personality disorder group had a reduction in symptoms similar to the borderline group, but retained relatively poor global functioning, and were the least socially adjusted, employed and self supporting of all the diagnostic groups. The whole sample received outpatient treatment on average 50% of the follow-up period, and the schizotypal (77.7%) and borderline personality disorder groups had more in-patient treatment in the follow-up period than other groups.

The success rates were 60% for the whole sample in terms of employment; and in terms of global outcome - 60% for the cluster C group and the no personality disorder group, and 20% for the borderline personality disorder group.

9. B.43. (Rosser, Birch, Bond et al, 1987)
This is a study of the single adult unit for people with borderline personality, or personality problems, at the Cassel Hospital psychotherapeutic community in England. For this reason, the sample size is small (28), so that although the attrition rate appears quite low at 17.85%, this reduces the sample to 23. Also, the sample appears to contain more neurotic patients than borderline. The sample was again divided into

groups according to their global outcome ratings - at discharge, and at follow-up, and into drop-outs, and successes and failures, but numbers are then very small.

Outcome criteria were multi-dimensional. The authors concluded that length of treatment positively correlated with outcome. At discharge, it was claimed that 60% of neurotic patients had improved, compared to 10% of other patients. The stated success rate overall at follow-up was 42.85%, but again was much better for neurotic than borderline personality disorder patients. The authors also claimed that some 70% of long-term successes could be identified at admission. In addition, the authors used an estimated lifetime profile of earnings to calculate a net gain for the sample as a whole of £500,000.

10. B.57. (Eisen, Blenkhorn, Wendiggensen et al, 1986)
This study is of a modified therapeutic community at the Melbourne Clinic Psychotherapy Unit, in Australia, for people with long-standing personality disorders (93% of those admitted have severe personality disorders). The sample was 76, but attrition rates were 51.2%, and in fact only 18.42% (18) had completed treatment at the end of the study. The sample was further subdivided into admitted and not admitted, and by length of stay, and by diagnosis. The study claimed that avoidant and dependent personality disordered patients showed less retention of symptoms following treatment, whereas borderline, narcissistic, histrionic and schizotypal personality disorders showed retention of higher symptom scores (but numbers are small). 46.16% (18) of patients were regarded as successfully independent, that is, were able to undertake full or part-time work, home duties or study at follow-up. Only 10.26% of those admitted were symptomless at follow-up.

11. B.59. (Gara, Hutchinson & Hafner, 1989)
This study is of the Willows therapeutic community in Australia. It is of interest, because its target population are patients with personality disorders and substance abuse, but it is a democratic, not a concept-based, therapeutic community. The sample was grouped and compared according to patients' attitudes to the treatment regime. Attrition rates are high - 51.5% of the sample were not traceable, and a further 36.1% were non-responders, so the final sample at follow-up was 32. The sample demonstrated increased coping with everyday life; increased level of satisfaction with employment and social-leisure activities, and improvement in their main problems at follow-up. Success rates claimed were 50.9% for increased number of close relationships, and 56.9% for better quality close relationships.

12. B.62. (Tucker, Bauer, Wagner et al, 1987)
This study is of a specialised long-term in-patient psychiatric unit for patients with ‘borderline conditions’ in America. However, the sample of 40 inpatients are described as severe personality disorders. The sample was subdivided according to different durations of stay. Attrition rates were 19.5% at one year, and 35.5% at the two year follow-up, again leaving numbers quite small. The group as a whole had fewer rehospitalisations, one and two years after discharge, than for equivalent periods of time before admission, and patients were more likely to be in continuous outpatient psychotherapy both one and two years after discharge - which can be regarded as a success for this patient group. Patients also improved clinically and in global functioning, and reported improved relationships and interpersonal networks. Those who stayed longest had greater severity of illness at admission, and showed greater change in global functioning at follow-up.

5.2.2.4. Single case studies without control/comparison groups

Secure democratic

Nine studies were found. Whilst these were single case studies, in that they studied patients or inmates in one institution, several studies provided a comparative element between a study group and another group. Thus:

(i) A.12. (McMurran et al, 1998) studying a therapeutic community in a Regional Secure Unit, compared outcomes for patients admitted for assessment only, and patients admitted for assessment and then kept on for treatment. They found no significant differences between the reconviction rates of the two groups, but a reduction in crime in both groups.

(ii) A.47. (van Emmerick, 1987) studying the Dr.Henri van der Hoeven clinic in Utrecht, compared patients released into the community with patients transferred somewhere else first, and found that those released directly from the hospital were less likely to be reconvicted and less likely to have drug and alcohol problems. This finding was echoed by A.37b. (Grendon Psychology Unit,1996) and by A.26. (Cullen, 1993) in his study of Grendon (see 3.4.3.3.).

(iii) Several studies noted that the longer an inmate stayed in therapy the less likely they were to be reconvicted. A.40. (Jones, 1988) in a study of the Annexe in Wormwood Scrubs found that those who stayed more than 26 months did best; A.43. (George, 1971) found a better outcome for men who stayed more than twelve months in treatment at Grendon,

(iv) Whilst several writers argue that patients leave treatment early because of individual psychological reasons (eg: Jones 1997), A.12. (McMurran et al, 1998) found no significant differences between a group which stayed less than six months and a group which stayed longer. A.45. (McPherson, 1973) following A.43. (George, 1971) focussed on an organisational reason for length of stay - the number of new patients admitted together. He noted that therapists prefer to take new inmates separately so that they do not form anti-therapeutic relationships with other newcomers, and are more influenced by the established therapeutic community culture. He found that men admitted to Grendon on their own, rather than at the same time as other new men, were likely to stay longer, and thus ultimately be less likely to recidivate.

Research in this category also looked at a variety of personal and psychological traits, and related these to reconviction. A.43. (George, 1971) found that more positive outcomes could be expected for Grendon men who were older, married, and had few previous convictions, whilst (Jones 1988) at the Wormwood Scrubs Annexe found that extra-punitiveness was related to reconviction. A.67. (Newton, 1973), focussing on treatment effect, found that inmates whose hostility scores became significantly lower during treatment were less likely to recidivate.

Overall then, whilst the studies in this category did not compare treated inmates to inmates treated elsewhere, they nevertheless generated comparisons within the groups studied. Findings suggest that inmates who stay longer do better, but information on why some people leave early and some stay is inconclusive. Length of stay may be related to individual characteristics or to local therapeutic community dynamics. Studies also showed that inmates released into the outside community did better than those transferred back to mainstream prison. However, there are unresolved questions attached to this finding, too. Most of these studies have looked at prison therapeutic communities where inmates are admitted towards the end of their sentence, and, if treatment goes according to plan, these inmates stay in treatment and are released into the community on their release date. Inmates who leave treatment early are transferred back to mainstream prison; therefore, as a group, they are all treatment drop-outs or rejects. It may be this feature which affects the likelihood of their being reconvicted, rather than the effect of experiencing mainstream prison after the therapeutic community. One prison therapeutic community in the UK which has a different policy is the Gartree Therapeutic Community, where inmates are admitted towards the beginning of their life sentence, which means that all of them will be transferred before release. Further research with this group may help to establish the effect of transfer after a successful therapeutic community career.

Non-secure democratic

We found four single case studies of post-treatment outcome, which did not include control or comparison groups - B.2. (Carson, 1973); B.19. (Kobal & Žagar ,1994); B.15. (Hafner & Holme, 1996); and B.8. (Davidson, 1976).

1. B.2. (Carson, 1973)

This is a fairly simplistic outcome study of a therapeutic community for anti-social adolescents in Canada. The sample size was fairly small, and attrition rates were high - 48.9%. The length of follow-up was not stated. While 55.56% of the adolescents were employed or at school at follow-up, and 62% reported improved relationships with their parents, 28.88% had been in court since discharge, and 82.88% said they had committed offences which could have brought them to court if they had been caught, and the success rate of 71.12% non-offenders at discharge has to be considered in the light of this.

2. B.19. (Kobal & Žagar, 1994)

This study is retrospective, and is not a rigorous outcome study, It contains mainly descriptive facts and figures, and has no data about the samples referred to, or the overall time span, etc. However, it is included here, because it is of interest to this review. It is about forensic patients - psychotic offenders, and some prisoners and people with socially accentuated psychiatric disorders - in Slovenia, and is non-secure, open ward, even though many of the patients are subject to security restrictions. The outcome criteria are therefore whether or not patients have been discharged, which is unusual for this patient group - the authors say the discharge of offenders from comparable institutions is relatively rare - and whether or not they have committed socially dangerous offences post-discharge. Readmissions are not regarded as failure. The authors claim 100% success rates for patients being discharged - of the initial number of 127 offenders subject to security measures, none are still in the institution; and for psychotic patients committing further socially dangerous offences since discharge.

3. B.15 (Hafner & Holme, 1996) (This study is of the same therapeutic community as B.59. Gara, Hutchinson & Hafner, 1989.)
The sample size in this study is again quite small, and attrition rates cumulatively high. 82.9% of the sample were not readmitted to psychiatric hospital at follow-up, although 6.25% had been admitted for the first time. There was an overall and statistically significant reduction in psychological symptoms that occurred after an average of 64 days in the community; by 3 month follow-up, symptom levels had fallen by 45% since admission. Patients continued to improve after discharge.

4. B.8. (Davidson, 1976)
Elliott House is a Home Office Probation Hostel therapeutic community for persistent male offenders. Again, this is not a rigorous outcome study, and little detail is given. Sample numbers are relatively small, and no attrition rates are given, nor are the parameters of the follow-up period, and the outcome criterion is crude. However, the author claims that 78% of residents competed twelve months in treatment without returning to prison; and 69% completed a further twelve months after leaving Elliott House, without returning to prison.

5.2.2.5. Cost offset studies

Secure democratic

None found

Non-secure democratic

We have found three post-treatment cost-offset studies - B.4. (Chiesa, Iacoponi & Morris, 1996); B.9. (Davies, Campling & Ryan, 1997); and B.56. (Dolan, Warren, Menzies & Norton, 1996). Unfortunately, they do not all measure exactly the same service usages, so findings are not directly comparable.

1. B.4. (Chiesa, Iacoponi & Morris, 1996)
This study relates to the Cassel Hospital. It looked at two groups of patients, one pre-treatment and one post-treatment, in terms of their use of inpatient and outpatient psychiatric services; outpatient psychotherapy services; and inpatient medical and surgical services. Numbers are small - initially, 26 in each group, because attrition rates were high - 10% from the pre-treatment group, and 50% for the post-treatment group. The authors found a significant decrease in the use of these services, particularly in terms of psychiatric readmissions, and also in the use of psychotropic medication, and of cigarette and alcohol consumption, and an increased employment rate for the post-treatment group. The authors estimated an annual cost-offset or saving, over all three sets of services, of £7,423 per patient.

2. B.9. (Davies, Campling & Ryan, 1997)

This study of Francis Dixon Lodge, in England, looked at pre-treatment and post-treatment inpatient general psychiatric admissions only for Leicestershire patients admitted to the Lodge, and for ECR patients admitted. Numbers are again small, but attrition rates are lower, largely due the the fact that the Lodge takes mainly local patients, who are more easily traced. The authors recorded usage for three years pre-treatment, but particularly look at costs for the year before, which represents 54% of the three year total, and the year after treatment, although further follow-up is planned. The cost-offset for Leicester patients was £2,579; for ECR patients £8,575; and the total £3,074.

3. B.56. (Dolan, Warren, Menzies & Norton, 1996)

This study looks at pre- and post-treatment usage of inpatient general psychiatric services; outpatient general psychiatric services, and prison costs. Numbers are very small - 24. Costs are calculated using Home Office and ECR data - which reflects the Henderson Hospital's national catchment funding (although the authors do not confirm that all 24 patients are ECR funded), but, as can be seen from the above study (B.9. Davies, Campling & Ryan, 1997), is much higher than for those using local therapeutic communities, so is not generalisable beyond Henderson Hospital, and ECRs. The authors found an overall average cost offset of £12,658.59 per patient.

5.3 Evaluative findings from the retained secure concept-based outcome literature.

This section covers the concept-based therapeutic communities, which are almost always used for treating drug abusers. Although there are concept-based therapeutic communities in Europe and the UK, these are mostly based in the community, and have little published literature. In contrast, the USA has developed a number of concept-based therapeutic communities housed in prisons, and has published a considerable amount of outcome research on these.

5.3.1. Post-treatment outcome studies

5.3.1.1. Experimental research/randomised control trials and tables

Four studies were found in this section, all relating to CREST, a secure therapeutic community work release centre set up by the University of Delaware to provide therapeutic community prison aftercare and to provide the setting for the RCT. This research is all part of a large research demonstration project funded initially with two grants from NIDA (National Institute on Drug Abuse) and later with a follow on grant. Because the studies compared slightly different groups, they will be described separately here.

E.11b. (Nielsen et al, 1996) randomly assigned eligible inmates to CREST, or to a conventional work release programme. At 6 and 18 months after admission, both groups were interviewed, to ascertain criminal involvement, and blood and urine samples were taken, to ascertain drug use. They found that therapeutic community work release was effective in reducing recidivism and drug use, and that length of time in the programme improved outcome.

E.10. (Martin et al, 1995) studied the KEY in-prison therapeutic community (part of Delaware Prison) and the CREST work release centre (part of Delaware University). CREST had been set up not just as an autonomous work release centre, but also to provide continuing therapeutic community treatment for drug abusers who left the KEY. E.10. (Martin et al, 1995) compared four groups: those who had been through the Key programme only, those who had been through the CREST programme only, those who had been through both KEY and CREST and a comparison group who had been through none of these, but were eligible to do so. Whilst the CREST only group and the comparison group were randomly assigned, the others were not. Virtually all KEY inmates went on to CREST as a matter of course; the KEY only group was a historical one which comprised inmates who went through KEY before CREST existed. Thus the study can only partially be considered an RCT. At 6 month follow-up, using self-reports and urinalysis, the KEY-CREST group showed improved recidivism and relapse rates over the other three groups. Of the four groups, the comparison group had the worst outcome, followed by KEY only, CREST only and KEY-CREST, in ascending order.

A similar, slightly more recent, study, E.26. (Lockwood et al, compared groups which were allocated in the same way as the E.10. (Martin et al, 1995) study, and came to the same conclusions, i.e., that the comparison group had the worst outcome in terms of relapse and recidivism, followed by KEY only, CREST only and KEY-CREST. Again, urinalysis and self-report were employed to establish this. E.26. (Lockwood et al, 1997) provide the additional finding that the treated groups were more likely to use drugs than to get arrested. They suggest that this indicates some treatment-effect decay.

The final study in this section is E.6. (Inciardi et al, 1997) who compared four groups. These were allocated in the same way as in the E.10. (Martin et al, 1995) and the E.26. (Lockwood et al, 1997) studies above, except that by the time E.6. (Inciardi et al, 1997) began their research, a new in-prison therapeutic community for women - WCI Village - had been established at the local women's prison, and some of these women were now arriving at CREST work release centre. Thus the groups comprised KEY only (WCI Village had not been operating long enough to include its members in the prison-therapeutic community only group), KEY/WCI Village + CREST, CREST only, and a comparison group. Once again, the CREST only and comparison groups were randomly allocated, the others were not. Interviews and urine tests at 6 and 18 month follow-up showed only no significant differences between the KEY group and the comparison group, but greatly improved recidivism and relapse rates for the KEY/WCI Village + CREST group.

Overall, all four studies found much improved results for the groups which went through both an in-prison therapeutic community and the work-release therapeutic community. This supports a claim made fairly often in the literature that, without good aftercare - preferably therapeutic community aftercare, the effect of therapeutic community treatment in prison does not last, and that good aftercare is needed for ex-therapeutic community inmates to reintegrate properly with the outside community. CREST operates as a therapeutic community, and so provides an aftercare organisation with which ex-inmates are familiar, and provides help with reintegration, by supporting inmates in their search for employment and education.

This study is also one of the very few therapeutic community research projects set up as a randomised control trial. However, as noted above, only two groups in each study were truly random. Moreover, all four studies are unusual, in that they rely on self-report to establish recidivism, and do not triangulate these with official criminal records.

5.3.1.2. Cross-institutional/comparative studies

One study was found. E.18. (Wexler et al, 1992) looked at rearrests, and time until rearrest, for inmates released from the Stay'n Out therapeutic community, which operates programmes for male and female inmates in the New York State correctional system. Stay'n Out was established in 1977, and is the longest-running, concept-based prison therapeutic community in the USA. E.18. (Wexler et al, 1992) compared outcomes for therapeutic community inmates with three groups: milieu therapy, counselling and no treatment. (The authors define milieu therapy as less structured, less regimented and less hierarchical than the therapeutic community, which suggests that the milieu therapy they studied may have been modelled more on the democratic therapeutic community. However, there is not enought information in the paper to make this clear.) Using parole records and treatment records, they found that the hierarchical therapeutic community was the most effective means of reducing recidivism for both men and women, and that the longer an inmate spent in the programme the greater the success rate.

5.3.1.3. Single case studies with control/comparison groups

Five studies were found in this category.

E.25. (Graham and Wexler, 1997), looked at Amity, a therapeutic community in Donovan Prison, San Diego. Three groups were studied: Amity 'completers', who were released straight into the community; Amity completers who chose to move on to Vista, a community-based therapeutic community; and a control group, which did not enter treatment. Arrest records at eleven month follow-up showed that, whereas the control group were rearrested about as often as parolees generally, there were significant improvements for Amity completers, and much greater improvements for the Amity + Vista completers (only 4.3% rearrests). Since these last were people who had chosen to go to Vista on leaving prison, and then had stayed there to complete the programme, they represent a self-selected group of highly motivated inmates, and as is usual with outcome research on therapeutic communities, it is difficult to disentangle the treatment effect and the effect of individual commitment. The authors note that whilst their findings support findings from the Stay'n Out therapeutic community (E.18. Wexler et al, 1995) and from the KEY - CREST studies (E.6. Inciardi et al, 1997; E.26. Lockwood et al, 1997; E.10. Martin et al, 1995), their conclusions remain tentative, awaiting a more comprehensive analysis of the data.

Two of the studies look at the IPTCs (In Prison Therapeutic Communities) in Texas. The Texas drug treatment programme was set up extremely quickly in 1992, and many difficulties were experienced in staffing and running the IPTCs and the community therapeutic communities to which inmates were sent on release from prison. Resources were promised, which were not delivered because of budget problems, and eventually the programme was slimmed down to smaller proportions. However, a number of IPTCs

were established through this programme. E.2. (Eisenberg and Fabelo, 1996) compared the recidivism and employment rates of men and women who had been through the therapeutic community programmes at Kyle and Gatesville Prisons, with outcomes for inmates who were eligible for treatment but who had not been selected. They found that recidivism was lower and employment significantly higher for inmates who had been through the IPTC and then gone on to spend time in the non-secure therapeutic community and received counselling. The IPTC on its own had no impact on either recidivism or employment.

E.8. (Knight et al, 1997) studied the Kyle IPTC programme, and compared completers (those who had been through the therapeutic community in prison and in the community) with non-completers (those who had been through the prison therapeutic community but dropped out of the subsequent community therapeutic community) and a comparison group of inmates eligible but not selected for treatment. E.8. (Knight et al, 1997) found at six-month follow-up that drop-outs did slightly better than the comparison group, and that completers did significantly better in terms of arrests, self-reported crimes, drug use and employment.

E.28. - a study from the US Bureau of Prisons (1998) examined DAP (the Drug Abuse Treatment Program), which provides modified in-prison therapeutic community for drug abusers followed by transitional therapeutic community treatment for inmates released from prison and up to three years of monitoring. Using crime records and information from probation officers, the report found that inmates who completed DAP treatment used significantly less drugs and were significantly less likely to be arrested than a comparison group of inmates eligible for treatment but not given it. The report also gives information on the numbers of inmates who dropped out of the programme before completion, but these are not counted in the final outcome figures.

The final study in this section is of CASAT, the Comprehensive Alcohol and Substance Abuse Treatment Program (E.35. New York State Correctional Services, 1996). The study examined seven 200-bed facilities, which were organised into three phases of treatment: prison, community and aftercare. Treatment completers were compared to three other groups: Phase 1 failures, Phase 2 failures and 'all releases'. The authors used a technique they call 'survival analysis', which is an attempt to control for the different lengths of time people have been released out into the community, so that treatment outcomes can be meaningfully compared. This is an analytic technique which determines the cumulative rate of return to custody. It is based on the number of cases remaining in the community (and therefore 'at risk',) and relates these to the number of months since release. The authors provide return-to-custody figures for all four groups at 12, 18, 24 and 30 months after release, and show that whilst all the groups have cumulatively more members being rearrested, the treatment completer group has significantly fewer.

Overall, the concept-based prison therapeutic communities provide outcome figures which suggest that the treatment is effective for people who complete the programme. In particular, those who go through a prison therapeutic community and then move onto a non-secure therapeutic community on release, and graduate from that therapeutic community, do well. This may be because the non-secure therapeutic communities focus heavily on gradually integrating their residents into the community, by helping them to find employment and education. Additionally, graduates of concept-based programmes are strongly encouraged to remain close to the therapeutic community core, to attend groups and often to become staff

members themselves in non-secure therapeutic community programmes. Thus, they are provided with a new, positive reference group in the community, which condemns the use of drugs and offers support to those tempted to relapse.

All the studies note that the longer the time spent in the programs (TIP effect) the better the outcome. It is sometimes assumed that this can be interpreted to mean that greater exposure to the programme produces more positive change. However, a note of caution should be sounded here, as the difference in outcome could be a result of the gradual dropping out of those individuals less motivated to change. Concept-based therapeutic communities traditionally have high drop-out rates, especially in the first few months. This is because (i) residents are admitted only on a voluntary basis, (ii) they have generous admission criteria and (iii) they tend to have strict behaviour rules, which makes it more likely that individuals will be expelled. Thus the TIP effect could be as much a result of keeping on only the most promising individuals as a result of treatment.

Although the outcomes are encouraging, they could be criticised on statistical grounds. Firstly, the comparison groups used are not necessarily similar to the treatment groups. Several of the studies use 'eligible' inmates as comparisons, with no information about how the inmates are deemed eligible, or whether they would be willing to enter a therapeutic community given the opportunity. Thus, the comparisons may differ from the treated groups in terms of initial motivation. Secondly, the figures given either compare drop-outs and graduates (two groups which differ in motivation and commitment) or compare the comparison group with drop-outs and graduates. This second method can obscure the fact that the less promising inmates have dropped out of the treatment cohort, whilst they are still included in the comparison group. A basic comparison between the entire treatment cohort and the entire comparison cohort is rarely made. It should be added here that this comparative procedure is not limited to the concept-based research, but occurs in the democratic therapeutic community research as well. It is mentioned here because the concept-based research has a characteristic methodology which is repeated, with slight variations, in all the different studies.

5.3.1.4. Single case studies with no control/comparison groups

Four studies were found in this section. Although these studies did not have comparison groups, two of them (E.33. Field et al, 1989 and E.31. Swartz et al, 1996) compared outcomes for long-stay and short-stay clients. E.31. (Swartz et al, 1996) conducted a retrospective study of IMPACT (Integrated Multiphase Program of Assessment and Comprehensive Treatment) in Cook County Jail, Chicago, examining the treatment records and criminal records of 1991-92 clients. They found that, at upwards of one year after release from prison, the shortest-stay group were most likely to be rearrested, and that the rate of re-arrest decreased with increasing lengths of stay in IMPACT. The group least likely to be rearrested comprised inmates who had gone through the IMPACT programme and then gone on to drug treatment in the community. E.33. (Field et al, 1989) studied inmates from the Cornerstone Progam in Oregon State Hospital, Salem, who were discharged between 1983 and 1985. Tracking them for three years after leaving prison, the authors found that those who completed the in-prison programme, and then went on to complete six months of aftercare/transitional services whilst on parole did best. In their conclusions they argue that the Cornerstone Program has a positive effect on decreasing criminality.

They say that addicted offenders who receive little or no treatment show an increasing pattern of criminal activity and compare this with the finding that, whilst many successfully treated addicted recidivist offenders continue to be involved in criminal activities, their involvement is reduced.

E.13. (Sweet et al, (1977) examined inmates from the Drug Offender Rehabilitation (DOR) programme in Memphis, Tennessee, a modified therapeutic community with behaviour therapy. Their criteria for successful outcome was successful completion of the aftercare programme. This programme comprised drug testing, group counselling and required participants to remain in education or employment. They describe the total recovery rate of 57% (successful aftercare completers) as exceptional, and add that the four year success rate was over 50%.

Finally, E.27. (Glider et al, 1997) studied two cohorts of inmates treated by the Amity programme at Pima County Jail. The authors administered a number psychosocial tests on admission and discharge, and again six months after discharge. They found that positive changes occurred on scales for depression, anxiety and self-concept and that these were maintained after release. They found that recidivism rates at 6 and 30 months were considerably lower than rates for the general prison population, and conclude that the therapeutic community is an effective model for treating drug abuse within prisons. In particular they note that a very significant majority of the participants continued in treatment after release from the programme.

In summary, the findings of the four studies support the effectiveness of in-prison therapeutic community programmes for drug abusing offenders, and the studies which compare long and short-stay groups support the general finding that those who stay longer in treatment do better. Support is also offered for aftercare programmes.

5.3.1.5. Cost offset studies

None found.

5.3.2. In-treatment outcome studies

5.3.2.1. Experimental research/randomised control trials

None found.

5.3.2.2. Cross-institutional/comparative studies

None found.

5.3.2.3. Single case studies with control/comparison groups

None found.

5.3.2.4. Single case studies with no control/comparison groups

Two studies were found which offered evidence for this section. Both were cited above and both used psychosocial tests to ascertain change. E.27. (Glider et al, 1997) in the study of Amity at Pima County Jail, found significant positive changes between admission and discharge on the Beck Depression Inventory (BDI), the Shortened Manifest Anxiety Scale (SMAS) and the Tennessee Self-Concept Scale. E.13. (Sweet et al, 1997) administered the Eysenck Personality Inventory (EPI) and found that length of time spent in the programme seemed to produce no significant differences in the amount of change on EPI measures. What did produce a significant difference was appointment to a junior staff position, a standard feature of aftercare. Appointees showed heightened anxiety and neuroticism, possibly because of the increased responsibility, and lower scores on the lie scale.

5.3.2.5. Cost offset studies

E.35, the CASAT study by the State of New York Department of Correctional Services (1996), includes a preliminary model for ascertaining cost savings that may be attributed to the operation of the CASAT programme. The basic assumption of the model was that no CASAT inmate would have been approved for temporary release programme participation without participation in the CASAT programme. Thus the major savings calculated are the difference between the cost of temporary release, and the greater cost of full-time incarceration. Whilst the in-prison therapeutic community treatment is more costly than general confinement, the earlier date of temporary release makes the CASAT programme cheaper to run overall. Overall the authors estimated that approximately $153 million in cost savings to the Correctional Department has resulted from the operation of the CASAT programme from its initiation in 1990 to the end of year 1996. The model is base solely on 'hotel' costs, and does not estimate other possible savings, such as lower costs of reincarceration or lower costs of crime and unemployment.

5.3.2.6. Summary

In summary, in-treatment outcome is an under-researched area for secure concept-based therapeutic communities. However, the two studies cited suggest that therapeutic community treatment facilitates some positive psychological changes.

5.3.3. Overall summary for in-treatment and post-treatment secure concept-based

A total of twelve published studies were found in this section. Of these, four examined KEY and CREST; two examined an Amity therapeutic community and two examined the Texas IPTCs. Thus, the published studies provided information on a total of seven therapeutic community programmes. It may be useful to note that an additional fifteen published studies were found which did centrally describe an outcome study, but which referred to these outcome studies in reviews and discussion articles. Thus, certain

therapeutic communities (such as Amity, Stay'n Out and CREST) have a high publication profile. Two unpublished outcome studies were also found in this section, E.28. (Bureau of Prisons, 1998) and E.35. (New York Correctional State Services, 1996). These differed from the published studies in that they covered larger numbers of drug treatment therapeutic communities, and aggregated the figures provided by the prison monitoring procedures. The published studies tend to focus in more depth on one therapeutic community, and to introduce their own research technologies, rather than use existing information.

5.4 Findings from meta-analysis

There were only 10 RCTs of any sort, and 10 cross-institutional or comparative studies, and a further 32 studies using some kind of control. If we take the latter as the minimum level of rigour that is acceptable, then there were in total 52 acceptable studies, all of which are discussed in some detail at some point in the report. Of these 52, 41 relate to democratic type therapeutic communities.

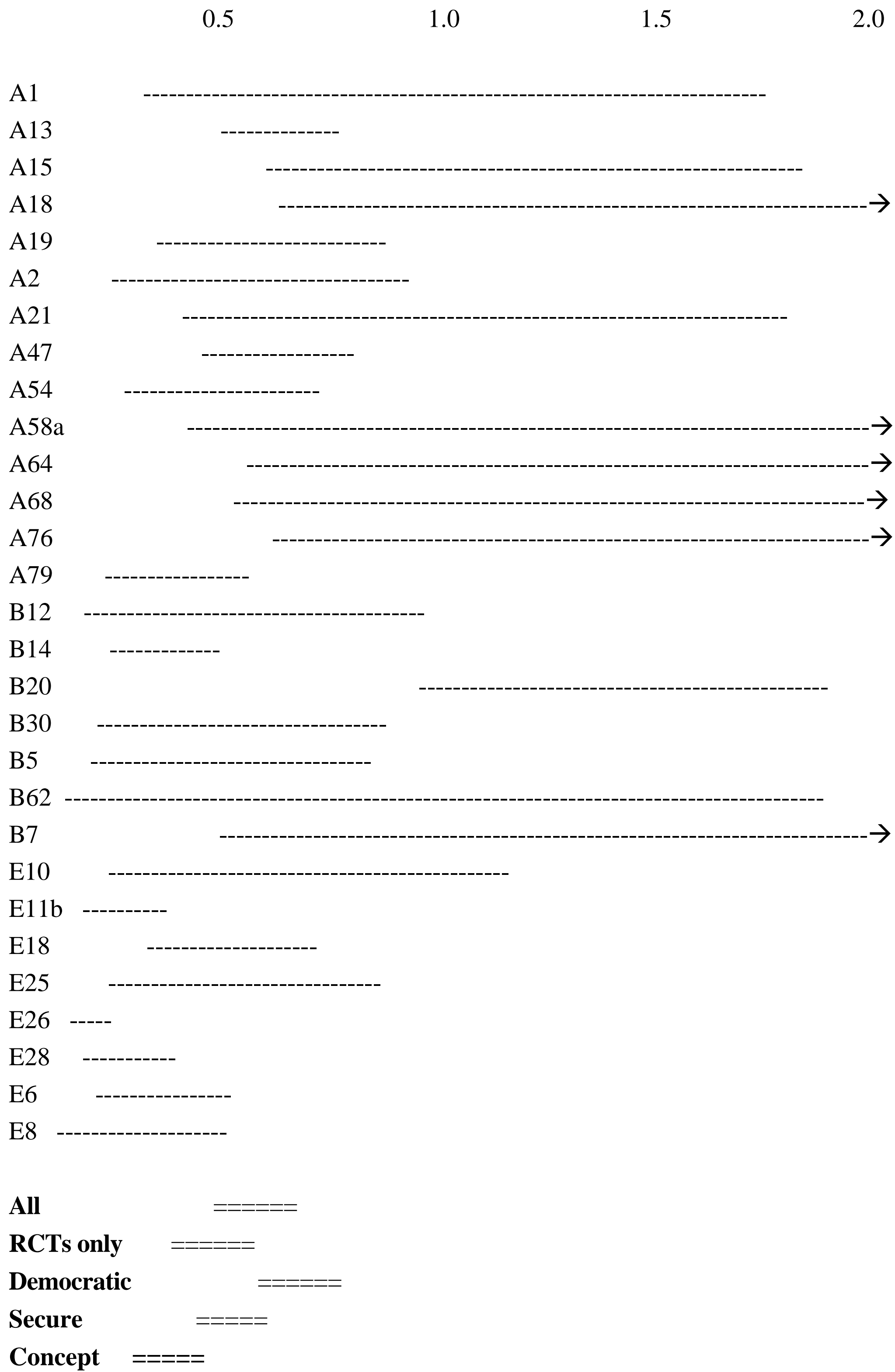
A meta-analysis was set up for the 52 studies with controls. 23 studies were excluded where the outcome criteria were unclear, where the raw numbers were not reported, or where the original sample was not clearly specified before attrition. Where there was a choice of outcome measures and control groups, emphasis was placed on conservative criteria, such as reconviction rates rather than psychological improvements, and on non-treated controls. This reduced the number of studies for the meta-analysis to 29.

The analysis had two stages. Initially the odds-ratios for the individual studies, and 95% confidence intervals, were calculated. Subsequently, the odds-ratios were combined to produce a summary odds-ratio for the 29 studies, and subsections of them, also with confidence intervals for the 95% levels. More details on this method are presented in Section 4.3, and details of the calculations in the Main Appendices, Section 10.9.

study code	expected 'E'	observed - expected	variance	sample size	odds ratio	confidence interval (95%)
A1	26	-1	6.3	100	0.852	.3885 - 1.868
A13	332.3	-37.3	116.61	2,102	0.725	.604 - .87
A15	152	3	15.42	454	1.222	.736 - 2.03
A18	26.2	3.8	10.99	228	1.409	.782 - 2.54
A19	110	-10	20.68	352	0.614	.397 - .949
A2*	50	-28	17.96	200	0.524	.28 - .98
A21	72.68	-2.68	8.31	173	0.72	.48 - 1.93
A47	320.29	-20.29	58.54	982	0.705	.545 - .913
A54	123.01	-13.01	17.79	340	0.472	.292 - .764
A58a	10.31	0.69	4.6	116	1.163	.466 - 2.9
A64	40.5	2.5	6.86	122	1.446	.679 - 3.08
A68	75.42	1.58	7.96	166	1.219	.612 - 2.43
A76*	59.65	0.35	9.24	173	1.039	.764 - 2.79
A79	76	-19	19.55	312	0.37	.234 - .584
B12	32.63	-4.63	5.43	95	0.412	.171 - .993
B14	261.7	-28.7	29.08	745	0.371	.255 - .539
B20*	85.56	14.44	35.65	828	1.5	1.08 - 2.08
B30	27.24	-6.24	7.71	168	0.451	.224 - .908
B5	121.15	-7.15	8.85	245	0.439	.216 - .89
B62	2.33	-1.83	1.07	30	0.095	.01 - 1.95
B7*	13	2	3.18	50	1.091	.62 - 5.88
E10*	16.06	-5.06	8.358	249	0.52	.248 - 1.19
E11b*	81.41	-26.41	18.79	306	0.23	.142 - .373
E18	133.28	-16.28	24.79	594	0.532	.364 - .779
E25	103.75	-7.75	11.52	233	0.316	.264 - .909
E26*	60.04	-38.04	20.56	483	0.132	.079 - .221
E28	70.82	-40.82	33.83	1,866	0.251	.166 - .379
E6*	86.04	-25.04	23.87	448	0.35	.233 - .526
E8	21.6	-8.6	4.99	298	0.233	.107 - .511
All (29 studies)					**0.567**	**0.524 – 0.614**
RCTs only (*asterisked – 8 studies)					**0.464**	**0.392 - 0.548**
Democratic (As and Bs – 21 studies)					**0.695**	**0.631 – 0.769**
Secure (As and Es – 22 studies)					**0.544**	**0.498 – 0.596**
Concept (Es only – 8 studies)					**0.318**	**0.271 – 0.374**

Conventionally, this meta-analytic data is presented graphically, as follows. An odds-ratio between zero and one indicates some positive effect, around one indicates a neutral effect, and above one indicates a negative effect. The overall sum, 0.567, is marked with the dotted line:

Odds Ratios



6 ADDITIONAL FINDINGS

The studies reviewed for the sections below are only summarised in very brief detail. Although they contain useful and interesting information, they did not provide any additional findings, or methodological definitions or ideas that were not accessed through the other literature reviewed. The details of these studies are to be found in Main Appendices 10.6, 10.7. & 10.8.

6.1 Review articles

Secure democratic

None reviewed

Non-secure democratic

8 studies were retrieved for this review - B.11a. (Dolan & Coid, 1993); B.11b. (Dolan & Coid 1998); B.32. (Schimmel, 1997); B.45. (Whiteley, 1975); B.46. (Whiteley, 1990); B.49. (Dolan, 1993); B.50. (Warren & Dolan, 1996); and B.54. (Dolan, 1997). Any relevant references to outcome studies which did not otherwise come up in our systematic review were included. Full details of these review articles are in Main Appendix 10.6.

Concept-based

10 review articles were found - F.22. (Smart, 1976); F.44. (Sheffet et al, 1973); F.23. (Sugarman, 1974); F.17. (Platt & Husband, 1990); F.36. (De Leon, 1984); F.12. (Gerstein, 1994); F.11. (Gerstein, 1992); F.2. (Anglin & Hser, 1992); F.1. (Anglin et al, 1996); F.27. (McLellan et al, 1992). Some contained and comments on outcome studies, and therapeutic community effectiveness. Full details are contained in Main Appendix 10.6.

6.2 Non-secure democratic therapeutic communities for non-personality disorders – post- and in-treatment outcome studies - (Cs)

The studies summarised here were all retrieved through our databases, but were not systematically targeted per se, and so are not a full review of the area. The studies are not about therapeutic communities for personality disorders, but for other forms of mental illness, mainly psychosis and schizophrenia. Overall, the findings are mixed, some positive, some finding no advantage for therapeutic community treatment over other treatments, but often with therapeutic community treatment being more expensive, and some negative findings.

We retrieved three experimental or randomised control trial studies - two relating to the same institution (C.43. Mosher, 1991; C.44. Mosher & Menn, 1977; C.71. Williams, 1992). We retrieved references to 19 cross-institutional or cross-treatment studies (C.1. Alanen, Rakkolainen, Rasimus et al, 1985; C.41. &

C.42. both May 1976; C.52. Salonkangas, 1986; C.40. Mariotto, 1978; C.34. Lehman, Strauss, Ritzler et al, 1982; C.2. Austin, Liberman, King & DeRisi, 1976; C.63. Vaitl, Bender, Hubmann et al, 1989; and 11 studies related to one project, the Dutch Follow-up Project Psychotherapeutic Communities - C.26. Koning & Wagenborg, 1988; C.27. Koning & Wagenborg, 1988; C.28. Koster, 1986; C.29. Koster & Wagenborg, 1986; C.30. Koster & Wagenborg, 1988; C.59. Tremonti & Koning, 1986; C.60. Tremonti & Koning, 1987; C.61. Tremonti & Koning, 1988; C.66. Wagenborg, 1986; C.67. Wagenborg, 1988; and C.68. Wagenborg, Hesselink, Tremonti & Koning, 1988. This project reports perhaps the largest-scale comparative follow-up (up to 5 years) evaluation of inpatient psychotherapy/therapeutic communities.)

We found 18 single case studies with comparison groups. 5 were from Finland, relating to the effectiveness of a modified therapeutic community for different samples of acute psychiatric patients with severe psychopathology (C.21. Isohanni & Hirvenoja, 1989; C.22. Isohanni & Nieminen, 1989; C.23. Isohanni, Nieminen & Isohanni, 1997; C.45. Nieminen, Isohanni & Winblad, 1994; and C.46. Nieminen, Makikyro & Isohanni, 1996.) 2 relate to Soteria Berne in Switzerland (C.8. Ciompi, Dauwalder, Maier et al, 1992; C.9. Ciompi, Kupper, Dauwalder et al, 1993). 2 further studies relate to Littlemore Hospital, England (C.36. Mandelbrote & Trick, 1970; C.79. Kennard, Clemmey & Mandelbrote, 1977). A further 3 papers relate to Kromeriz, in Czechoslovakia (C.3. Beran, 1993; C.7. Brezinova-Brziakova & Kratochvil, 1989; and C.31. Kratochvil & Dubska-Papiasvili, 1977). One study relates to a therapeutic community in a hospital department in Yugoslavia (C.25. Kecmanovic, Ceric & Trograncic, 1975); one to an adolescent unit in Australia (C.47. Nurcombe, Owen & Beran, 1973); one to a partial hospitalization programme in America (C.58. Thompson, 1985); one to a residential programme in Belgium (C.78. Verhaest, Pierloot & Bostjin, 1982); and one to the Marlborough Hospital, England (C.82. Evison & Trauer, 1983).

We also found 9 individual therapeutic community case studies without control/comparison groups. One relates to maladjusted adolescent boys (C.33. Lampen & Neill, 1985). The other 8 studies relate to psychiatric patients. One is about Fraser House, in Australia (C.11. Clark, 1968); one a hospital therapeutic community in America (C.12. Cluxton, 1966); one a day hospital in Sweden (C.15. Ekman, Rosengren & Cronholm, 1981); one to an in-patient unit in Sweden (C.16. Forsberg & Starrin, 1996); one in Czechoslovakia (C.32. Kratochvil, Liskova & Machu, 1983); one to a modified hospital therapeutic community for black patients in South Africa (C.50 Pillay, Du Plessis, Vawda & Pollock, 1994); one of a day hospital workshop in London (C.57. Stevens, 1973); and another of a hospital in America (C.72. Wright & Kogut, 1972).

We retrieved only one reference to a review article (C.18. Gunderson, 1980), which looked at various units offering intensive milieu therapy for non-chronic schizophrenia patients, and attempted to identify the therapeutic ingredients of the treatment milieu. Further details of all these studies are contained in Main Appendix 10.7.

6.3 Non-secure concept-based post-treatment outcome literature – Fs

A large body of literature was found relating to non-secure concept-based therapeutic communities. Most of these come from the USA. These therapeutic communities treat substance abusers exclusively, although recent writings have stressed the comorbidity of drug abuse and various types of mental illness and psychopathology. There are some studies of therapeutic communities which have been modified to accommodate mentally ill clients. About half of the papers cover issues which are not centrally related to the focus of this review, such as modifications to therapeutic communities for different types of clients, histories, overviews and programme descriptions. The other half are of interest here however. These include papers on psychopathology and mental illness in treatment, outcome studies and cost benefit analyses. These are mentioned briefly below, and are summarised in Main Appendix 10.8.

The following studies relate to psychopathology and mental illness, and substance abuse in concept-based therapeutic communities, or MICAs (mentally ill chemical abusers, whose primary problem is a mental disorder); CAMIs (whose primary problem is chemical abuse, although they also have a severe psychological or psychopathic disorder) and CAs (chemical abusers, whose primary problem is chemical abuse, although they exhibit Axis II borderline or anti-social personality disorders and/or mild pathological signs). DeLeon notes that generally concept-based therapeutic communities tend to exclude MICAs and choose to treat CAMIs & CAs; the best outcome seems to be for CAs. (F.50. Jainchilli, De Leon & Pinkham 1986; F.6. De Leon, 1989). 2 other papers look at the treatment of MICAs in concept-based therapeutic communities. One paper uses clinical observations to classify drug addicts into 4 types (F.28 Cancrini et al, 1985).

In addition, 2 outcome studies on concept-based therapeutic community treatment of personality disorders and drug abuse were found (F.41. Lennings, 1990; F.56. Clerici & Carta, 1996). Overall, there have been few studies which look specifically at outcomes for personality disordered clients in concept-based therapeutic communities. Baseline statistics demonstrate that there are high levels of personality disorder among drug users treated in concept-based therapeutic communities, which suggests that outcome studies which do not look specifically at personality disorders may nevertheless contain useful information on this topic.

Two studies look at psychological status and retention (F.44. Sheffet et al, 1973; F.32. Lewis & Ross, 1994). Concept-based therapeutic communities, like democratic ones, have high drop-out rates, particularly in the first few months. One argument is that personality disordered clients are more likely than others to drop out of treatment at an early stage. This would tend to depress the outcome figures for personality disordered clients, since it would reduce the amount and intensity of treatment. However, other studies have found that initial psychological scores are not predictors of retention or treatment outcome.

There are several outcome studies which have been carried out for these concept-based therapeutic communities, to assess their effectiveness and to find predictors for success. In general, the predictors studies relate to individual characteristics of clients rather than features of the programme, although there have been attempts to construct methodologies for evaluating treatment processes (F.38. DeLeon, 1995;

F.34. Holland, 1983; F.6. DeLeon, 1989; F.14. Kooyman, 1993). Overall, the general findings are that the best predictors of outcome are the length of time spent in the programme and previous criminal history.

The outcome studies reviewed here only form part of those retrieved, as those which relate explicitly to personality disorder and mental illness are reviewed elsewhere in this review. Relatively few outcome studies in this section were retrieved, since non-secure concept-based therapeutic communities were not specifically targeted by our research procedures. The review articles, summarised earlier, point to the existent of many other outcome studies in this area.

Finally, 2 studies of cost-offset or cost-benefit were found (F.33 Griffin, 1983 & F.11. Gerstein, 1992). The latter found that overall therapeutic communities were cost-beneficial compared to prisons, less cost-beneficial than methadone maintenance, cost-effective insofar as they reduced crime costs and unemployment costs, and paid for themselves by simply keeping street crime off the street.

In conclusion, there is a great deal of literature on non-secure concept-based therapeutic communities. In general they are viewed as an effective way of treating drug users, although there are criticisms that too much attention is paid to outcomes for graduates, and too little to outcomes for programme drop-outs. In recent years, programmes have been modified to accommodate different clients groups, in particular mentally ill chemical abusers. Studies of client characteristics suggest that admissions overwhelmingly display comorbidity with other symptoms, in particular personality disorder, and that the client group therefore should be regarded as dually diagnosed.

Current writing is concerned not just with whether or not therapeutic communities work, but who they work for and which parts of the programmes and processes work most effectively. The most recent writings by DeLeon (F.58. DeLeon, 1994 and F.38. DeLeon, 1995) at the Centre for Therapeutic Community Research in America, present detailed models of programme characteristics, processes, treatments and clients, in an attempt to develop a model of change which can be used to refine outcome research and improve effectiveness of treatment.

It should be pointed out that the studies retrieved cover a span of about thirty years, and that during that time, concept-based therapeutic communities have changed, gradually developing from fairly marginal self-help organisations run by a few radical professional and ex-addicts, to mainstream state-funded organisations run by a much more professionalised mixed group of therapeutic community graduates and professional medical, social and mental health staff. This practice development has been mirrored and supported by research development, in particular De Leon's studies of Phoenix House in New York.

It is clear from the literature that most of the concept-based therapeutic community research is American, and that large research programmes studying multiple drug treatment organisations have been funded and carried out in the USA, using major state funding. There is little to match this research output outside the USA. Recently however, two major projects have been initiated, but are not yet due to report. NTORS (National Treatment Outcome Research Study) is a prospective longitudinal cohort study which is monitoring the progress of 1,110 clients who entered treatment in four different types of drug programme in the UK between March and July 1995. This is based at the Maudsley Hospital in London. The IPTRP

(Improving Psychiatric Treatment in Residential Programmes) is a project funded through the BIOMED II programme of the European Commission and has partners in 9 universities and 33 residential treatment centres across Europe. The UK partner is the Scottish Drugs Training Project at the University of Stirling. The study aims to standardise psychiatric protocols for relapse prevention, and to provide information on the extent of comorbidity or dual diagnosis amongst substance abusers. The final phase of this project will be an outcome study. Neither NTORS or IPTRP will focus explicitly on therapeutic communities, but like some of the large American studies, therapeutic communities will be one of the major treatments included.

7 DISCUSSION: SUBSTANTIVE, METHODOLOGICAL AND DEFINITIONAL ISSUES

7.1 Introduction

Research was an important part of the early therapeutic community innovations (Manning 1976; 1979a). However, early therapeutic communities tended to prefer descriptive, qualitative and participant observation types of research, as more in keeping with the philosophy and practice of the therapeutic community. They were often suspicious of quantitative research, and reducing people to numbers, and particularly unhappy about the ethics of techniques, such as random allocation, and control groups, which also run counter to therapeutic community selection processes. This meant that there was little quantitative or evaluative research undertaken until the 1970s, when there began to be more interest generally in the professionalisation of therapeutic communities, which involved their alliance more with medicine and psychotherapy. There were also increasing threats to therapeutic communities' survival and funding. The 1980s was a period of mixed fortunes for the therapeutic community, with many therapeutic communities closing - e.g. Paddington & Marlborough Day therapeutic communities. More recently, therapeutic communities seem to be experiencing a revived interest in their treatment methods (Reed 1992; Dolan & Coid 1993; Cox 1997). At the same time, there has been an increase in both the quantity and quality of research work undertaken on therapeutic communities, together with a recognition of the need for research to prove both treatment and cost effectiveness, in response to external pressure. (Manning has charted and explained these fluctuations and tensions in the relationship between therapeutic communities and research (Manning 1979b).

In this section some methodological considerations will be addressed. The initial focus will be on issues of definition. In order to evaluate treatment effectiveness, some indication of the clarity of definition about the disorder to be treated and the treatment intervention employed is essential. In this case, there are considerable uncertainties on both counts, which have given rise to methodological disagreement. We will begin with definitions of the disorder, then consider the treatment, and the interaction or 'fit' between them, before coming on to methodological debates that have arisen in this area.

7.2 Diagnosis

Patients diagnosed as psychopaths, or more recently personality disorder, are the main category of disorder in this field. D.2. (Barbour-McMullen et al 1988) summarises two types of psychopathy: the North American DSM-III tradition, represented also in the Hare Psychopathy checklist, characterised in terms of antisocial behaviour; and the European tradition, characterised in terms of personality deviation in two dimensions of impulsiveness and social withdrawal. The US definition, which stresses poor early parenting, and consequent immaturity as the cause, has come to dominate work in this field.

British Mental Health Law has been ambivalent about psychopaths. Both the 1959 and 1983 Acts separate psychopathy from other conditions, and define it behaviourally, while holding a pessimistic view of treatment interventions. For example, it appears to be unrelated to decisions differentiating those patients deemed treatable from those not treatable in a study of a special hospital by (D.8. Collins 1991). An early

paper, D.5. (Blackburn 1983 p. 32), comments that ‘The inadequacies of clinical classification, then, render most of the treatment research on 'psychopaths' worthless’. One consequence has been a rapid elaboration of the concept. D.32. (Whiteley 1995) and B.36. (Whiteley 1970), for example, following the classic work of Henderson (1939), has consistently differentiated three types, separating the inadequate and aggressive types from the creative type, and suggesting that the latter are most likely to respond to treatment. This has now been followed by a rapidly expanding classification, not of psychopathies, but of personality disorders, of which psychopathy is seen as a sub-type.

For example, in the DSM III/IV manuals, where a special axis, axis II, is devoted to the personality disorders, there are eleven different types of personality disorder identified, one of which is the classic anti-social type most strongly associated with psychopathy (D.65. Stone, 1993). D.36. (Norton and Hinshelwood 1996) suggests, in reviewing treatment for severe personality disorders that this is ‘an imprecise but useful clinical term’ (D.36. Norton & Hinshelwood 1996 p. 723). However D.10. (DeJong et al 1993) question the utility of the detailed categorisation of personality disorders in hospitalised patients.

One area of particular interest to evaluating therapeutic communities, and much debated in the recent literature, is that of borderline personality disorders (BPDs). D.15. (Higgitt and Fonagy 1992) discuss seven different types of borderline personality disorder, and suggest that this group are characterised by (i) symptom variability within the group, and over time for individual patients, and (ii) impairment of social relationships. The official DSM-IV definition is ‘a pervasive pattern of instability of interpersonal relationships, self-image, affects and control over impulses’ (D.35. Gunderson 1994 p.17). Gunderson describes how there have been three distinct phases of conceptualisation during which ‘ borderline personality disorder is a diagnosis whose construct (ie its meaning) has grown rapidly and changed dramatically during the past 25 years.’ (D.35. Gunderson 1994 p.12).

Recent official reports on work in this area have reflected these difficulties. For example D.46. (Reed Report on Psychopathic Disorder 1994) states that ‘the diverse meanings attached to psychopathic disorder often undermined the effectivenes of evaluation of treatment’ (D.46. Dept. of Health and Home Office 1994 p.34).

Conceptual expansion of this rapidity makes judgements about research reports difficult, especially if they are more than about fifteen years old. The terms, and their meanings, used to classify, describe and diagnose patients have changed so extensively that any studies of the impact of treatments on these patients may be difficult to compare or compile.

7.3 Therapeutic communities

The definition of therapeutic communities has also been difficult. There are two main types of therapeutic communities: democratic and concept-based/hierachical. For some writers these are variations on a basically common theme ((D.29. Sugarman 1984) - one dealing with deeper intrapsychic change and the other with initial behavioural control; for others they have nothing in common but the name (D.41. Glaser 1983). They have emerged from quite separate origins. Democratic therapeutic communities arose partly

from the observation that, since the social environment of custodial mental hospitals could severely damage patients, then they might also be turned around to benefit them too. Combined with psychological and social theories about the interaction between personality and environment, democratic therapeutic communities developed in the UK through the influential proselytising of a few key founding innovators. Concept-based therapeutic communities however are an American innovation designed to deal exclusively with problems of addiction. Again the product of zealous innovators, they have expanded rapidly to encompass a truly world-wide self-help movement.

We can summarise the definition of therapeutic communities in terms of three factors. All need to be present for us to identify a therapeutic community. First is a set of values about treatment, or a specific therapeutic culture. These were famously summarised by the social anthropologist Rapoport (B.30. Rapoport 1960 pp.54-64) in terms of the four themes: democratisation, permissiveness, communalism, and reality confrontation. These are themes that are still widely used and measured in questionnaires (D.7. Clarke 1994; D.68. Manning, 1989). However, these themes have been reworked, and added to recently, as: agency; containment; communication; involvement; and attachment (Haigh, 1999, p.257). Second is the therapeutic programme used, particularly the use of therapeutic groups, including regular community groups which include all members. The amount of time in groups has also been used in systematic measures of therapeutic communities (Crockett, et al, 1978). Third is the self-definition of the community, or at least its staff, as a therapeutic community.

Clearly there might be considerable variation within these parameters. A very widely used measure that combines measures of the relationships in a community, its treatment, and the way in which the community system is sustained, is the work of Moos (1997), and in particular his development of the 'ward atmosphere scale' as a measure of the environmental factors constituting the therapeutic community treatment intervention. This gives a twelve dimension picture of any therapeutic community, rather than a single dimension of 'pure' therapeutic community intensity or 'dosage': *relationships* - involvement, support, spontaneity; *treatment* - autonomy, practicality, personal problem orientation, anger/aggression levels; *system maintenance* - order and organisation, programme clarity, staff control.

In general the intensity, or dosage, of treatment is commonly recognised in the literature by differentiating between therapeutic community approaches and the therapeutic community proper. The former refers to a therapeutic approach across whole hospitals, whereas the latter refers to specialised therapeutic communities dealing with a defined population (see next section).

Democratic type therapeutic communities developed in prisons or secure settings are inevitably influenced by the purity of the treatment. Because of the requirements of prison regulations concerning security and control, Rapoport's four principles have been modified. Cullen (1997) outlines how the modifications have been made at Grendon. Instead of full democracy, inmates have the power to make or influence certain decisions but not those that would compromise security. Instead of full permissiveness, deviant behaviour is not tolerated, but it is addressed by the community or small group, and fed into the therapeutic process (in prison it would be simply punished). According to Cullen, the principle of communalism, which covers individual and collective responsibility for managing the therapeutic community, survives relatively intact. Confrontation is often done in a much more directive way than that

described by Rapoport, in order to prevent men from minimalising their offences and to help them appreciate the real perspective of their victims.

The difficulties of establishing a fully democratic and self-governing organisation inside a prison is partly documented by A.57. (Wenger 1974). He notes that in a prison hospital therapeutic community on Rikers Island, New York, the inmates were encouraged to establish self-governing systems and define rules of behaviour via inmates' committees. However this resulted in rumours of sexual assault, theft and beatings by committee members, who ran their committee through strength and criminal reputation. The example shows how conventional inmate culture might be able to flourish in a therapeutic community setting unless some modifications are made to ensure that staff maintain control (a step which is in principle antithetical to the therapeutic community philosophy). The problems with Rikers Island were solved by closing the therapeutic community down, and starting again with a modified regime. The Barlinnie Special Unit in Scotland was closed because a working party found that the staff had relinquished control to the inmates, and that this had led to the deterioration of the therapeutic regime (A.48. Scottish Prison Service 1994).

Modified regimes however continue to operate inside prisons. Modifications vary. Therapeutic communities in prisons such as Grendon, Wormwood Scrubs and Gartree, which base their regimes on the principles set out above, value large groups and collective responsibility, and see the community as a whole, rather than the staff, as the main therapeutic agent. Indeed, this use of the community, and the peer pressure it comprises, is often seen as the hallmark of the therapeutic community. Other prison therapeutic communities do not feature this communalism so clearly. For example, the Social Therapeutic Institutions of Germany are based on a more individualistic, psychotherapeutic model, and feature behavioural programmes, education and rehabilitation. Whilst they require that the inmate acknowledges and confronts their offence, there is emphasis on reparation as well as on psychological change (A.62. Lösel & Egg 1997).

Rawlings (1998) argues that therapeutic communities in prisons are required constantly to work to maintain their survival, since the principles on which they are based are virtually the opposite of prison principles. Whilst more modification might endear the therapeutic community to the prison, it would move the therapeutic community away from the therapeutic regime originally intended. On the the hand, too little regard to prison principles might result in isolation and ultimate closure. E.32. (Wexler 1997), who writes about the more hierachical and structured concept-based therapeutic communities for drug users, argues that these therapeutic communities can fit very well into prisons, provided therapeutic community personnel regard themselves as guests of the correctional system.

Whether therapeutic communities are a continuing treatment option has been intensively debated. For some writers the period of expansion, fuelled through an idealistic desire to revolutionise the psychiatric hospital, was over in the 1970s, to be followed by a steady decline as community care developed (D.38. Ploeger 1980, for Germany; D.37. Vaglum et al 1982, for Norway; D.40. Miller 1992, for the UK - 'the therapeutic community has passed its sell-by date', p.127). Others however have noted that the decline is illusory. It may actually be the consequence of the disappearance of controversy as therapeutic communities in fact grow in number and acceptability, as D.56. (Clark and Walker 1984) show for

Australia, and which they interpret as the result of its wide tacit acceptance. In fact, therapeutic community practitioners have more recently focussed their therapeutic claims on specific targets, with more carefully designed programmes: therapeutic communities proper for personality disorders, therapeutic communities in prisons, and therapeutic communities for the addictions. This development, to which we now turn, has been characterised by D.68. (Manning 1989), as a shift from social movement to scientific innovation.

7.4 Therapeutic communities and specific treatments

In recent years therapeutic communities, or modified versions of it, have come to be concentrated on specific populations, for economic and theoretical reasons, as well as a result of lengthy clinical experience and some modest research data. There are three such areas: personality disorder, the addictions and prison settings.

Personality disorder, as we have noted, has developed rapidly in nosological terms in recent years. The dominant US approach, epitomised in DSM III and IV, defines personality disorder as a behavioural condition whereby impulsive antisocial actions, and poor social relationships, are seen as arising from immaturity through poor early parenting, and which can be substantially ameliorated through intense residential therapeutic experiences in a therapeutic community - a ‘crash course in living’ which will provide the opportunity for rapid and permanent maturation. Doyal, in the Reed Report (D.46. Dept. of Health & Home Office 1994), argues cogently on theoretical grounds that the key features of personality disorder, the failure to sustain moral reciprocity and the resultant atrophy of long-term social relationships, are (a) necessarily treatable (since the ability to manipulate depends on understanding that reciprocal obligation is an essential feature of social life) and (b) particularly suited to therapeutic community treatment, as the site for reinserting such reciprocity as a basic feature of a patient's mode of life. D.33. (Whiteley 1994), D.36. (Norton and Hinshelwood 1996), and D.15. (Higgitt and Fonagy 1992) - in a widely cited review of the use of psychotherapy for personality disorders, make similar arguments. D.68. (Manning 1989 chapter 3) develops a sustained argument from social theorists such as Giddens, Harre, Seve, Lacan, and Gramsci to argue that the difficulties that such patients exhibit are ideally suited to therapeutic community treatment.

Comparative empirical studies, for example, D.48. (Karterud 1988), also indicate that therapeutic communities are not good for short term emergency or catchment area cases, nor long-term psychotic patients, but have produced the best results for personality disorders. There is also widespread clinical support for the use of therapeutic communities for personality disorders: ‘there is a great deal of clinical evidence to support the value of therapeutic communities’ (D.15. Higgitt and Fonagy 1992 p.36).

For those where this has manifested itself in addiction, concept-based therapeutic communities have proved effective at breaking the addiction, and developing alternative ways of life. As addiction has spread to be a world wide problem, so have these therapeutic communities, which number now many thousands in dozens of countries.

In addition, the therapeutic community has coincidentally the capacity to contain in a humane and efficient manner those who are prone to violent and disruptive behaviour. The ability of therapeutic communities to contain difficult patients has been commonly observed, and, in some respects, the use of large community groups by articulate staff is a mechanism of social control, in which the principle of physical observation by staff on the basis of Bentham's pantopicon is replaced by mutual community observation - with overtones of totalitarianism. Whatever the morality of this, D.49. (Natarajan and Falkin 1997) argue that therapeutic communities in prison are an effective means of surveillance, and reduce costs by reducing violence and difficult behaviour.

7.5 Methodological comments

Although painstaking, and occasionally tedious, systematic literature reviews like this provide very useful information on treatment interventions where there is clinical uncertainty, such as is the case for therapeutic communities, and they are respected as a research tool, particularly within the NHS.

The methodological issues arising from the studies reviewed are numerous. In the 1994 Cochrane Lecture, McPherson, (1994) pointed out that RCTs are important where there is obvious uncertainty, but that they should not be used where there are ethical problems, a lack of objective outcome measures, resistance from the field, or a reluctance to compare treatments. On these grounds we do not feel that there is any intrinsic reason why RCTs should not be mounted further for therapeutic communities. However RCTs are very difficult to run for therapeutic communities:

- There are great difficulties in randomly allocating residents to treatment programmes, and keeping the experiment uncontaminated. Most of the RCTs found were only partially successful in this. The practical difficulties involved in random controlled studies mean that such approaches may be unlikely in this area.

- Outcome measures were often very crude, such as reconviction or readmission, or very idiosyncratic to particular institutions. This makes the generalisability of findings difficult.

- Almost all studies have high attrition rates, typically of around one third or more. Although we have been careful to check and exclude doubtful studies from our meta-analysis, where studies with comparisons or controls do not include the whole sample, this might considerably affect the results reported.

- The literature suggests a great range of structures and practices that are covered by the umbrella term therapeutic community, and this makes it very difficult to ensure treatment integrity when comparing therapeutic communities.

- It is difficult to allow for, or take account of, factors which intervene between discharge and follow-up.

These difficulties have been taken up more recently by Seligman, in relation to psychotherapy research. He distinguishes between the **efficacy** study, as epitomised by the randomised control trial, and the **effectivenesss** study – 'how patients fare under the actual conditions of treatment in the field'. Seligman expresses his disillusion with the 'gold standard' of the efficacy study (expensive in time and money) as 'the only, or even the best way of finding out what treatment actually works in the field' , and concludes that 'deciding whether one treatment, under highly controlled conditions, works better than another treatment or a control group is a different question from deciding what works in the field' (Seligman, 1995 pp.1-2).

Seligman suggests that some treatments are 'too cumbersome for the efficacy study paradigm' (Seligman, 1995 p.3), particularly long-term therapies, especially if there is no fixed, or variable, duration; where the therapy is self-correcting; where patients have multiple problems or psychiatric diagnoses; and where improvement is concerned with the general functioning of patients, as well as improvements in disorders, or specific presenting symptoms. He also suggests that random assignment 'may turn out to be worse than useless for the investigation of the actual treatment of mental illness in the field'. (Seligman, 1995 p.13) What Seligman suggests instead is naturalistic surveys of large numbers of people who have gone through any particular treatment, with multivariate measures of effectiveness, using sophisticated correlational methods. (Seligman, 1995 pp.4-5).

In addition, Evans et al (1996) have offered a more sophisticated critique, particularly of the statistical shortfalls, of experimental and observational methods - here in relation to forensic psychotherapy. They argue that selecting from the complexity of therapy for research purposes must diminish it; that experimental research in the field is never as 'clean' as it is in laboratory conditions; that even very strong associations between variables still allow for many different explanations for that association; and that many other variables which were not controlled or manipulated could explain the association found between the variables studied (Evans et al, 1996 p.517).

However, Evans et al's most important arguments relate to sample size and statistical significance, and the need for very large, 'sometimes logistically impossible' sample sizes of people, to have even 'a good chance' of detecting a realistic significant effect for treatment (here psychotherapy) (Evans et al, 1996 pp.523-524). Seligman also asked what degree of statistical significance is clinical significance, and how large an effect size is meaningful (Seligman, 1995 p.8).

The therapeutic field is notable for strong clinical support, but poor research based evidence (D.17. Holman, 1996: 'studies of therapeutic communities are few' p.65.) Writers in this field are quite familiar with the ideal - what should be done (for example, D.26. Paul, 1967 is widely cited), and would like nothing more than to be able to prove to the satisfaction of sceptics and health purchasers that this treatment works. It is another thing to achieve this ideal. Definitional ambiguities, and programme complexity have generated considerable methodological debate about the way to undertake evaluation in this field. The key problems are that the treatment itself is multi-dimensional, the dosage strength is

difficult to determine, the programme controls its own intake, there are steady dropouts from the programme, observed effects decay over time, and the target patient population has been steadily refined and re-classified. However, poor research does not necessarily mean poor treatment results, as has frequently been concluded by critics of the therapeutic community.

Why have so few well-designed studies been done? The ideal of an RCT has generated difficulties where it has been attempted. Perhaps the most famous attempt was the Clarke & Cornish, 1972 (D.55.) study undertaken over 25 years ago, but which, in the end, proved impractical, and generated a methodological alternative, the cross-institutional design, discussed in the next section. Some of the difficulties reported in the literature are summarised here:

Treatment complexity

First is the issue of treatment complexity, and the problem of identifying exactly what the therapeutic community treatment is that is being evaluated. As outlined in Section 3., therapeutic communities come in at least two types. Within these types, there are variations in the treatment values involved, the programme structure, time spent in groups, and the self-identity of the community as a therapeutic community. Evans 1994 (D.12) points out that any experimental research design needs a clearly specified programme, but in reality, as Berg, 1979 (D.3.) argues, therapeutic communities are very difficult to replicate for evaluative purposes. Paul, 1967 (D.26.) provides the classic statement of the need for no-treatment controls and randomisation if at all possible, but makes the point that patient and treatment characteristics vary, as do follow-up times. Other writers covering these points in much the same way include Pilgrim, 1997 (D.57.), Einstein, 1981 (D.11.), and Hine et al, 1982 (D.66.). The Report undertaken for the Council of Europe by Clarke and Sinclair, 1974 (D.50.) argues this case in detail.

Dosage and integrity

A further point is that, even if there is some confidence that the treatment has been identified clearly, it is difficult to know how to measure the dosage (other than time-in-treatment - see below), since not only do programme timetables vary, but also the quality of staff and the administrative context of the therapeutic community. A particular division is frequently made in the literature between the therapeutic community proper and the therapeutic community approach, although there is little specific attempt made to identify these differences consistently (but see D.30. Warren, 1994, who suggests that some contradictory findings may have been caused by confusion between these types). Moreover, since one of the criteria identified above for the definition of a therapeutic community is that of self-identity, there is a difficulty over treatment integrity - how do we know that the self-identity of a particular programme is not erroneous? Or what happens when therapeutic communities, as they have been known to do, go through periods of disruption, or sluggishness? At what point is the treatment itself compromised? This is a point raised in connection with the Clarke & Cornish, 1972 (D.55.) study of Kingswood - it was not clear how ‘pure’ the therapeutic community house was, and thus how representative of a therapeutic community treatment modality.

Population selection

The randomisation of patients to treatment required in experimental models may involve ethical difficulties, and these are often raised tangentially in the literature. It does not seem to us that these are in principle insurmountable, and they will not be addressed in this review. However there other much more significant practical difficulties discussed at greater length. Patients accepted for therapeutic community treatment are normally both self-selected (in terms of application to join) and community-selected (in terms of the whole community, not just staff or consultants). This means there is no independent decision that can guarantee referral and acceptance, and consequently randomisation is difficult to set up and sustain. Candy et al, 1972 (D.67.), for example, set up a feasibility study of using an RCT to study psychotherapy, but found that it was impractical, in that referrers and staff compromised randomisation through non-random selection effects.

Higgitt and Fonagy, 1992 (D.15.) suggest that personality disorders are particularly unlikely to allow themselves to be randomised, or at least those that do will be selective. Staff may also be reluctant to support randomisation, or be tempted to undermine it in practice. The consequence is that a carefully designed RCT can become undermined to the point of failure. The Clarke & Cornish, 1972 (D.55.) study of Kingswood is one of the best known failures in this respect, because referrers stopped referring within the system. Staff influenced each other across the programmes included as experimental and controls, and undermined the randomisation process. It proved difficult to control the Hawthorne effect. The authors concluded that 'the controlled trial would seem to have a more limited function in penal research than has sometimes been ascribed to it in the past and certainly much more limited than it has in medicine. In the view of the writers it is particularly unlikely that its widespread use at present would significantly advance knowledge about institutional treatment in ways that could not be otherwise achieved' (D.55. Clarke & Cornish, 1972 p.21). The recommendation is for studies of larger number of institutions and their natural variation (see below).

Dropouts

Treatment in therapeutic communities takes time - typically around six to nine months. This heightens the possibility that patients will leave prematurely. In fact, dropouts from therapeutic community treatments are commonplace. Dropouts from research studies are also a difficulty. The US literature on addiction therapeutic communities contains numerous articles (discussed elsewhere in this report) on such 'splittees'. In treatment terms, there is a clear association with in-treatment improvement and length of stay (D.54. Nieminen, 1996), and hence a concern, almost an obsession, with retaining patients in the programme. In research, as we have mentioned, sustaining comparable dosage is an essential pre-requisite for evaluation, which is seriously compromised by dropouts.

Effects decay

Even if the patients are randomised, and treatment is successfully delivered and measured, there remains the problem of the point at which improvement should be measured. On the one hand in penal research, it has been possible to follow up failures over quite long periods of time through the use of criminal records,

for example, for five years or more. On the other hand, many studies have been content to look at change while still in treatment, at the end of treatment, or at a year post-treatment. Clearly, given the likely effects of post-treatment experiences and effects, sustained effects over long periods even if smaller, may be more convincing than larger effects early on which are not sustained. Early home office research, where longer post-treatment effects could be monitored, was particularly concerned about the extent to which post-treatment environmental effects could swamp treatment gains (D.44. Dunlop, 1974; D.50. Clarke and Sinclair, 1974; D.62 Clarke and Cornish, 1978). The solution to this problem was fairly obviously felt to be the measurement of intermediate change during and soon after treatment, and the use of cross-institutional designs (see below) to capture changes during treatment.

Prison-based research has in a sense suffered from the opportunities that prison records offer for long-term follow-up, since the effect of any intervention is likely to decay over long periods of time. Any consistently positive effect over long periods would be remarkable. For prison research, this led in the 1970s to an assumption of therapeutic pessimism, famously expressed in the dictum that 'nothing works' (Martinson, 1974). However, the accumulation of dozens of studies since then has, through meta-analysis (see below), shown that even over long periods a consistent effect of a ten per cent reduction in recidivism compared to controls has been achieved in German social-therapeutic prisons and American correctional facilities for juveniles (D.64. Lösel, 1995).

Diagnostic shift

The discussion above of the rapid development of the diagnostic classification of personality disorders, combined with the widespread agreement that therapeutic communities are inappropriate for schizophrenics and other psychotic patients, and their rapid spread throughout the US and other countries to deal with the addictions, and to a lesser extent in prisons, means that the population on which therapeutic communities have been targeted has changed very substantially since the early post-war years. This is a further source of difficulty for evaluative designs, and particularly for the accumulation of sufficient studies to enable meta-analysis to be undertaken (D.34. Beach, 1989).

7.6 Methodological alternatives

There are two strategies recommended in the literature for dealing with these accumulated difficulties, apart from the admonition to 'try harder!'.

Meta-analysis

In the prison and addiction fields, there are a considerable number of smaller follow up studies. One alternative is to collect these studies together and conduct a meta-analysis. The best known attempt to do this is reported a series of publications by Lösel and his associates, (D.63. Lösel & Koferl, 1989, D.51. Lösel, 1993, D.52. Lösel, 1995, D.21. Lösel, 1997 (unpublished)). Lösel 1995 (D.64.) is a representative analysis. In all these studies, he reiterates the points already reported in many other references in this section that issues of treatment integrity, diagnosis, drop out, and so on make RCTs of doubtful use. In reaction to the pervasive view 20 years ago, that 'nothing works' in terms of prison therapy interventions

(Martinson, 1974), Lösel presents a meta-analysis of 19 German studies of effects of social-therapeutic prisons, plus 12 meta-analyses of many US prison programmes for juvenile delinquents. All effects are found to be positive, but small (generally about a 10 per cent reduction in recidivism). Within this range of studies, the ‘cognitive-social learning approach’ is the most successful type. Lösel concludes that ‘For the critics of the treatment approach, it should be easier to achieve consensus on the fact that certain forms of intervention under certain circumstances lead to substantial increases in effect sizes beyond the 10 percentage points’ (D.64. Lösel, 1995 p. 33). On this basis he suggests a list of 20 factors associated with ‘what works’, including a clear conceptualisation of the programme, clear identification of the offender's needs, and supportive post-treatment social and family networks.

In the light of this set of papers by Lösel, the first systematic meta-analysis of the effectiveness of therapeutic communties to have been undertaken is presented in this report. A meta-analysis was set up for the 52 studies with controls. 23 studies were excluded where the outcome criteria were unclear, where the raw numbers were not reported, or where the original sample was not clearly specified before attrition. Where there was a choice of outcome measures and control groups, emphasis was placed on conservative criteria, such as reconviction rates rather than psychological improvements, and on non-treated controls. This reduced the number of studies for the meta-analysis to 29.

The analysis had two stages. Initially the odds-ratios for the individual studies, and 95% confidence intervals, were calculated (Woolf ,1955, discussed in Kahn and Sempos, 1989, pp. 56-57). Subsequently, the odds-ratios were combined to produce a summary odds-ratio for the 29 studies, and subsections of them, also with confidence intervals for the 95% levels (Yusuf, et al, 1985, discussed in Petitti, 1994, pp. 100-102). Several points are worth making about the results. There is strong evidence for the effectiveness of therapeutic community treatment apparent from these studies. The odds-ratio measure used indicates that studies below one have a positive effect, those above one a negative effect, and those on or about one are neutral. However it is vital to consider the confidence intervals for each study, to ascertain that the odds-ratio was unlikely to have happened by chance. This is conventionally expressed through the calculation of the range over which the result would be unlikely to have happened more than 5 times out of a 100 (the 95% confidence interval). 19 of the 29 studies indicated a positive effect, within the 95% level of confidence. The remaining 10 studies all had confidence intervals which straddled the neutral score, of which 8 produced odds ratios above one.

When summary odds-ratios are calculated across all 29 studies, as is the convention with meta-analyses, the strength of this finding is underlined. With a summary odds-ratio of 0.57, and an upper 95% confidence interval of 0.61, this set of studies gives very strong support to the effectiveness of therapeutic community treatment. A check can be made on this by grouping the studies. Odds ratios calculated separately for the RCTs, and for the democratic, concept, and secure types of communities all show strong results, with upper confidence intervals well below one. It is important to note that the RCTs were scattered across the different types of community. This suggests that there was no one subset of studies that was strongly affecting the overall summary result.

Turning to the variation between these different groups of studies, it is clear that the studies of concept-based therapeutic communities indicate the most effective treatments, with democratic types showing slightly less. This pattern might be due to several causes. First might be the date of the study (all the concept studies have appeared since 1993). Second might be the nature of the patients (concept therapeutic communities deal exclusively with the addictions). Third might be the type of therapeutic regime itself. Clearly some useful outcome is indicated by the meta-analysis, and further research would be useful for identifying the factors which are effective. RCTs by themselves cannot do this for the reasons discussed earlier, but one means of doing this is to adopt a cross-institutional design.

Cross institutional design

This was the solution recommended by the Home Office research team that tackled the Kingswood trial. If the treatment, patient disorder, and post-treatment effects, are all sources of experimental uncertainty, the alternative is to study a range of therapeutic community treatment interventions in their existing natural state, including normal variation between them. In this way, different aspects of the 'black box' can be unravelled, and can be related to patient change during and after treatment. For example, Bergland et al, 1991 (D.4.) analysed 21 addiction programmes, grouped into 5 types, in the SWEDATE project. Variations in programme type were related to outcome, in terms of the per cent who remained drug free at follow-up. Clarke and Cornish, 1978 (D.62.), after the collapse of the Kingswood RCT, reported good effect on behaviour in-treatment, despite no positive effect on long-term recidivism, and concluded therefore that a cross-institutional design looking at in-treatment would be useful. The same argument is elaborated in Cornish, 1987 (D.9.), Dunlop, 1974 (D.44.), and Dunlop, 1975 (D.53.).

Manning and Lees, 1985 (D.42.) and Manning, 1989 (D.68.) designed a study in the light of these recommendations and report a cross-institutional design looking at six therapeutic communities in Australia. Using structural equations to model the variations in treatment components, they were able to account for 58.24% of the outcome variance from in-treatment variables (D.68. Manning, 1989 p.180). There are, as yet, no other published attempts to use this design to evaluate therapeutic communities. This is partly due to the research costs involved.

The cross-institutional design can be both interpretative and exploratory, and can also include survey investigation in the design, both to facilitate exploration, and provide a basis for interpretation.

Interpretative research is perhaps best symbolised by the school of ethnography. It emphasises relying for explanation on the interpretations people themselves put on the reasons lying behind their actions. It also emphasises naturalistic observation of phenomena in the field, and seeks insights into social behaviour from data collected in a way which is as unadulterated as possible by the procedures and preconceptions of the researchers. An excellent example of this type of research is Bloor et al's sociological collection of 'ethnographies of therapeutic work in eight different therapeutic communities' (Bloor et al, 1988 p.1.) They argued that all comparative studies are relevant to the issue of evaluation, and pointed out that only a few existing studies of therapeutic communities dealt with more than one community. On the basis of their qualitative data, Bloor et al divided their therapeutic communities into two types - those using mainly reality confrontation, and those using instrumental intervention; and identified six principles of

therapeutic work -reflexive, interpretative, interventionist, dominating, selective, and subject to habituation. (Bloor et al, 1988 p.11)

Other past examples of cross-institutional studies, which compare therapeutic communities to other types of treatment regimes are Street, Vinter & Perrow's (1966) comparison of therapeutic community regimes with other forms of treatment regime for delinquent adolescents; Whiteley, Briggs & Turner (1972), who described the principles and practice, and some small-scale research studies undertaken in two therapeutic communities - Henderson Hospital, and Chino Prison in California, and a rehabilitative community-based hostel for ex-offenders, which was not a therapeutic community; Almond's (1974) study of healing communities, which included therapeutic communities; and Shenker's (1986) study of 'intentional communities' - therapeutic communities, kibbutzim, and Hutterite colonies.

More recently these cross-institutional, comparative designs have been adapted to be evaluative as well, sometimes by including methods used in randomised controlled trials, to make the results both interpretative and quantitative. This is done through the use of both qualitative and quantitative measures, and through the use of techniques such as prediction, partial correlation and other statistical techniques, i.e. the relative risks distributed in the populations of each setting are standardised, so that differences between predicted and observed outcomes will indicate the relative effectiveness of different institutions. In addition, measures of various aspects of the treatment process, or analyses of the treatment regime, are correlated with measures of effectiveness. Dunlop has suggested that the advantage of such a design is that it is capable of identifying small differences in regime effectiveness, and that, rather than using an artificial experimental situation, it can 'use, explore and, thus, help to explain the natural situation of the regime.' (Dunlop, 1975 p.23) Dunlop also suggests that, because the method depends on correlating scores which have been assigned to each setting, eight is probably the minimum number of therapeutic communities, for which the method is feasible (Dunlop, 1975 p.23, while Manning suggests it is necessary to look at perhaps 20 or more (Manning, 1979b p.306).

This method of research is also not without its problems. In the past, it has still been assumed that treatments can be broken down into separately identifiable classes or units, but this involves regarding individual units or treatment regimes as molar, single variables, rather than molecular, multiple variables, and loses the subtleties of complexity. Secondly, there is the problem that correlations between measures of treatment process and measures of effects do not prove causation. Clarke & Sinclair pointed out that correlations are easier to interpret when there is a clearly causal dependent and independent variation and the direction of causality is only one way, but this condition is not fulfilled, for example, in a therapeutic community, where staff influence residents, and vice versa. (Clarke & Sinclair, 1973 p.50). In addition, cross-institutional methods of research, like experimental methods, have sought to demonstrate and compare the gross effects of particular treatments, without making systematic attempts to describe the treatments, or to understand or explain how any results of treatment might be brought about and how any beneficial gross treatment effects could be replicated (Clarke & Sinclair, 1973 p.30).

A more recent, and particularly useful example of this methodology, is that proposed by Moos, which attempts to address some of these issues. Moos has been working for some years on ways of characterising treatment environments in more sophisticated ways, in order to be able to relate these to

treatment outcomes (Finney & Moos, 1984; Moos & Burnett, 1996). Initially, Moos did this through the Ward Atmosphere Scale (Moos, 1997), and later through the Multiphasic Environmental Assessment Procedure (Moos, 1980; Moos & Lemke, 1996). The WAS and its variants (e.g. COPES) have been used in therapeutic communities - occasionally in Britain (e.g. Verhaest, Pierloot & Janssens, 1982; Moffet, 1984; Bell, 1983 & 1985; Vollmer & Henrich, 1985; Karterud, Vaglum, Friis et al, 1992; Moffet & Flagg, 1993; Eklund & Hansson, 1996; Smith, Gross & Roberts, 1996). MEAP has been used in a number of treatment settings in the USA, mainly for substance abuse programmes, but also psychiatric settings (Moos, 1997), and was used by Lees & Manning in their study of Richmond Fellowship houses in Australia (Lees & Manning, 1985; Manning, 1989). It has been little used in Britain, despite its potential usefulness for comparative, evaluative research.

MEAP evaluates the physical and social environments of treatment settings, and enables description, monitoring and comparison of such settings. It describes objective characteristics of the setting, such as the aggregate personal and social characteristics of residents and staff, the physical design of the setting, the programme's policies and services, and the quality of the programme's social climate. Through path-analytic structural equation causal modelling, the data can be used to plot the direct and indirect effects of these key aspects of the treatment process and setting, in relation to resident outcome, both in-treatment and post-treatment (Cronkite & Moos, 1978; Moos & Lemke, 1996; Moos, 1997). This provides a means of evaluating the effectiveness of treatment regimes (Moos and Lemke 1996; Moos, 1997; Manning, 1989). Moos has now moved on to look at more sophisticated ways of measuring in-treatment outcomes, such as satisfaction and participation (Moos & King, 1997; see also Rogers, Wood & McCarthy, 1993 for an evaluation of community meeting participation as an indicator of treatment progress.)

Cost offset

There were only four studies found. This is a new area of development for therapeutic community research, stimulated by the relatively high cost of this treatment. These studies show clearly that the cost of treatment is offset quickly by subsequent savings on future service use. Given the strong evidence from the meta-analysis for the efficacy of therapeutic communities, further cost-offset studies are warranted.

8 TABLES

8.1 Democratic

A: In treatment outcome – RCT Democratic non-secure TCs

Table 1: Description of institutions covered by outcome studies

Study	Pub. date	Institution	Approx. op. dates of inst.	Target population	Description of treatment regime
B37 Miles, A.E.	1969	TC Ward, Harperbury Hospital, England	Not stated	“Subnormals” Male psychopaths mostly adolescent offenders	Therapeutic community Psychopathic unit

Table 2: Subjects in outcome studies

Study	Pub. date	Institution	Diagnostic criteria	Sample characteristics			
				Age	Gen.	Num.	Additional information
B37 Miles, A.E	1969	TC Ward Harperbury Hospital England	Psychopath	14-27	Male	40	Persistent anti-social behaviour. IQ’s 66-112 58% Had parents in social classes IV&V 82.8% had been engaged in stealing, breaking, & entering, & larceny Great majority had been committed by the courts because of offences

Table 3: Methodology of outcome studies

Study	Pub. date	Institution	Period of study	Control com. group	Treatments compared	Instruments used	Test admin. times	Post-treatment follow-up	Outcome criteria	Attrition rates
B37 Miles, A.E	1969	TC Ward, Harperbury Hospital England	1 year	(1) Control group (20) not matched (2) TC group (40) (3)After initial allocations to new TC ward, alternate locations to control & TC ward	(1) Traditional psychiatric ward treatment for “subnormal” (2) TC treatment	(1) Interviews (2) Continuous observations (3) sociometry	(1) Within 2 months of admission (2) After one year	None	Development of inter personal relationships	None stated

Table 4: Findings of outcome studies

Study	Pub. date	Institution	Psychological/behavioural findings	Recidivism/re-admission/relapse	Success rate stated %
B37 Miles A.E	1969	TC Ward Harperbury Hospital England	(1) Observations during the year showed steady if slow improvement in psychopaths interpersonal relationships in the TC, & NO such improvement in the control group. (2) TC increased the ability of psychopaths to accept each other more than did traditional hospital treatment for control group. (3) Observations suggested that the empathic ability of at least some of the patients in the TC increased during treatment but did not in control group. (4) Patient in the TC formed reciprocated friendships during treatment, while control group did not (5) TC helped patients increase their capability to recognise others feelings towards themselves, control treatment did not.	None stated	None stated

B: In-treatment outcome, cross-institutional studies. Democratic secure TC's

Table 1: Description of institutions covered by outcome studies

Study	Pub. date	Institution	Approx. op. dates of inst.	Target population	Description of treatment regime
A53 McCord, W.M.	1982	Wiltwyck School	1950-	Delinquents & psychopaths	Secure therapeutic community reform school
A64 Gunn, J et al	1978	Grendon	1962-	Personality disordered offenders	TC Prison

Table 2: Subjects in outcome studies

Study	Pub. date	Institutuion	Diagnostic	Sample characteristics			
				Age	**Gen.**	**Num.**	**Additional Information**
A53 McCord, W.M.	1982	Wiltwyck	Current pupils	9-13	male	35	
A64 Gunn J. et al	1978	Grendon	Admissions June 1971-May 1972 & released by May 1973	21+	male	107	

Table 3: Methodology of outcome studies

Study	Pub. date	Institution	Period of research study	Control/com. group	Treatments compared	Instruments used	Test admin. dates	Post-treatment follow-up	Outcome criteria	Attrition rates
A53 McCord, W.M.	1982	Wiltwyck School	1952	35 matched boys from Lyman School	TC / authoritarian reform school	Adult-child Interaction test, word association, tests on values authoritarianism & prejudice & projective personality test	Administered once	No	Differences on test scores	
A64 Gunn J, et al	1978	Grendon	1971-73	Group from Wormwood Scrubs	TC prison with infrequent psychotherapy	MMPI * AC * AP * Case histories Crime histories	Arrival 3 months 9 months 15 months leaving	No	Differences on test scores	

*MMPI – Minnesota Multiphasic Personality Inventory
*AC- Attitude to Crime Scale
*Attitude to Psychiatry Scale

Table 4: Findings of outcome studies

Study	Pub. date	Institutions	Psychological/behavioural findings	Recidivism/re-admission/relapse	Success rate stated %
A53 McCord, W.M.	1982	Wiltwyck School	Wiltwyck improved some basic personality traits & attitudes. Aggression did not decrease		
A64 Gunn J, et al	1978	Grendon	Psychiatric disturbance dropped in TC group from 37%-18% of population Rise in self-esteem, lower unrealistic expectations of psychiatrist. TC group were different from Scrubs group & changed more, & more positively		

B: In treatment outcome-cross institutional studies, democratic non-secure TC's

Table 1: Description of institutions covered by outcome studies

Study	Pub. date	Institution	Approx. op. dates of inst.	Target population	Description of treatment regime
B28, Norris, M	1983	Henderson Hospital, England	Not stated (But 50+ years)	Psychopaths, sociopaths and anti-social personalities, often regarded as unamenable to treatment	Therapeutic community

Table 2: Subjects in outcome studies

Study	Pub. date	Institution	Diagnostic	Sample characteristics			
				Age	Gen.	Num.	Additional information
B28, Norris, M	1983	Henderson Hospital, England	Psychopathy	Mean 24	Male (70) Female (33)	139/103/91	c.33% aged 21, or under: 1 over 35 95.15% (98) single, divorced or separated Included in sample if stayed 1+ months and completed at least two grids 60%- history of drug abuse, including alcohol 33%- History of assault or self-injury 72%-Criminal record

Table 3: Methodology of outcome studies

Study	Pub. date	Institution	Period of study	Control/com. group	Treatments compared	Instruments used	Test admin. times	Post-treatment follow-up	Outcome criteria	Attrition rates
B28, Norris, M	1983	Henderson Hospital, England	1977-1981	(1) Trainees at a detention centre (2) 130 young residents in voluntary Trust Communities (3) Henderson Hospital patients (4) matched samples (Henderson 14)	Detention Centre Voluntary Trust Communities TC	Repertory Grids	(1) on Arrival (2) 3-monthly intervals (3) Discharge	None	(1) Changes in desired direction/ benefit (2) Changes in self percept (3) Aspirations concerning rule breaking (4) Aspirations concerning	26% (36) –non-responders at start of study 11.5% (12) non-responders to 2nd grid

									independence	

Table 4: Findings of outcome studies

Study	Pub. date	Institution	Psychological/bevioural findings	Recidivsm/re-admission/ relapse	Success rate stated %
			(1) Trend for length of stay to be associated with age (2) Henderson patients graver behaviour problems than other samples (3) Significantly more Henderson patients changed in desired directions than in previous studies (4) Overall, majority of Henderson patients improved (5) 50% of men who benefited had parents in managerial, Professional or white-collar occupations (6) Henderson patients more emotional and more anxious than other 2 samples (7) Percentage of those benefiting was higher amongst those staying longer (8) Higher percentages of Henderson patients changing to self-percepts as rule- abiding and independent than other 2 samples (9) 71% of men attending Community meeting and small Psychotherapy Group benefited	None stated	(1) 60% increased in self-esteem (2) 81% of men staying 30+ weeks (3) 71% of men attending groups

C: In treatment outcome - single case, control/comparison group studies. Democratic secure TC's

Table 1: Description of institutions covered by outcome studies

Study	Pub. date	Institution	Approx. op. dates of inst.	Target population	Description of treatment regime
A57 Wenger, R.T.	1974	Rikers Island	1960's	Mentally ill offenders	A democratic TC inside a prison hospital 30 beds
A69 Beard	1980	Institutional pre-release programme	1970's	Adult offenders	Concept-based TC for general offenders inside a large prison

Table 2: Subjects in outcome studies

Study	Pub. date	Institution	Diagnostic	Sample characteristics			
				Age	**Gen.**	**Num.**	**Additional information**
A57 Wenger, R.T.	1974	Rikers Island	TC inmates	adult	male	30	Part of a group of 60 MDO's alternately allocated to TC & to control group
A69 Beard	1980	Institutional pre-release programme	Adult offenders	21+	male	84	

Table 3: Methodology of outcome studies

Study	Pub. date	Institution	Period of research	Control/com. group	Treatments compared	Instruments used	Test admin. times	Post-treatment follow-up	Outcome criteria	Attrition rates
A57 Wenger, R.T.	1974	Rikers Island	Early 1970's	30-MDO's	TC prison hospital	PEF * and observation	On admission 90 days	No	Change on test scales	
A69 Beard	1980	Institutional pre-release programme	1970's	Randomly allocated	TC/prison	*CIES *481 CET *WSDI & measures of work and behaviour	Pre and post one month in treatment	No	Change on test scales	

*PEF – Psychiatric Evaluation form, CIES - Correctional Institutional Environment Scale, 481CET - Counselling Evaluation Tst, WSDI - Wahler Self-description Inventory

Table 4: Findings of outcome studies

Study	Pub. date	Institution	Psychological/behavioural findings	Recidivsm/re-admission/ relapse	Success rate stated %
A 57 Wenger, R.T.	1974	Rikers Island	TC significantly improved total pathology, disorganisation, subjective distress, withdrawal, grandiosity & externalisation. Improved anti-social behaviour		
A69 Beard	1980	Institutional pre-release programme	Significant changes on psycho-social scales for treatment group only. No change in self-reported problems, feelings about self or behaviour		

C: In treatment outcome single case control/ comparison group studies, democratic non-secure TCs

Table 1: Description of institutions covered by outcome studies

Study	**Pub. date**	**Institution**	**Approx. op. dates of inst.**	**Target population**	**Description of treatment regime**
B.10 Denford, J, Schachter, J & Temple, N. et al	1983	Cassel Hospital, England	Not stated (But 50+ Years)	People with severe personality disorders	A Psychotherapeutic Community (single Adult Unit only of TC)
B.18 Karterud, S, Vaglum, P, Friis, S et al (see also B33*)	1992	Day Hospital, Ullevål University Hospital Norway	1981	Decompensated patients with severely disturbed personality disorder	Day Hospital Therapeutic Community Proper
B.58 Spielman, R.	1975	North Ryde Psychiatric Centre, Australia	Not stated	Severe personality disorder	Therapeutic Community lines Intensive Group Psychotherapy treatment program

* Vaglum, P, Friis, S, Irion, T, et al, 1990 - same study data.

Table 2: Subjects in outcome studies

Study	Pub. date	Institution	Sample characteristics				
				Age	**Gen.**	**Num**	**Additional information**
B.10 Denford, J, Schachter, J, Temple, N et al	1983	Cassel Hospital, England	Severe personality disorders (43% borderline or psychotic)	Mean=27	Male (10) Female (18)	28	Histories of failed treatments chronically and intractably disturbed. 70% - 1 or more previous Psychiatric admissions and physical treatments - tendency to depend on drugs and alcohol
B.18 Karterud, S,Vaglum, S, Friis, S. et al	1992	Day Hospital, Ullevål University Hospital, Norway	51.54%(50) cluster A & B personality disorders((DSM-III R) 76% (74) Axis II DSM-III.R	Mean 35.7	Male (28) Female (69)	97	Consecutive admissions. 57% single, separated or divorced. 66% low ranking occupation 46% hospitalised previously(61% of Schizotypal & borderline patients; 27% of cluster PPS and Axis I disorder only) 54% of borderline personality disorder patients (n=34) had alcohol abuse problem 23% - major depression
B58 Spielman, R	1975	North Ryde Psychiatric Centre, Australia	Severe personality disorder	Not stated	Not stated	76/38	Not stated

Table 3: Methodology of outcome studies

Study	Pub. date	Institution	Period of research	Control/com. group	Treatments compared	Instruments used	Test admin. times	Post-treatment follow-up	Outcome criteria	Attrition rates
B10 Denford, J, Schachter J, Temple, N et al	1983	Cassell Hospital England	Sept 1976 & Dec 1977	(1) Drop-out group (n=8) (2) Treatment Failures (n=8) (3) Treatment success (n=12)	TC only	Clinical assessment	(1) Admission (2) Triage 1 month into treatment (3) Discharge	None	Clinical improvement	3.44 (1) at start of study
B18 Karterud, S Vaglum, S Friis, S et al	1992	Day Hospital Ullevål University Hospital Norway	1982-1985	(1) Borderline personality disorder (n=34) (2) Schizotypal personality Disorder(spd) (n=13) (3) Other personality disorder (opd) (n=27) (4) No personality disorder (nopd) (n=23) (5) Length of stay & drop-outs	TC only	(1) Ward atmosphere scale (2) Symptom checklist 90 (GS1) (3) Health sickness rating scale	(1) Was one month after admission (2) SCL 90 –1st & last weeks of stay (3) Admission & discharge	None	(1) Symptom levels. (2) Psychosocial functioning (3) Frequency of suicidal attempts (4) Drop out rate (5) Number of psychotic breakdowns (6) Level of medication (7) Need for Assistance from co-operating acute ward	38% for SPD & BPD patients 31.93% (31) by 3 months 24.74 % (24) by 3-6 months 36.02% by 6-12 months

Table 3: cont'd

B58 Spielman, R	1975	North Ryde Psychiatric Centre Australia	Not stated	(1) Early learners (2) Treatment completers	Closed psychotherapy group in TC treat-ment	(1) Question-naire with 3 scales (a) Self-esteem (b) Alienation (c) Purpose in life(PIL) (2) Clinical assessment	(1) Admission (2) Discharge	None	(1) Improved self-esteem (2) Less alienation (3) More purpose in life	50% (36) Did not complete treatment.

Table 4: Findings of outcome studies

Study	Pub. date	Institution	Psychological/behavioural findings	Recidivism/Re-admission/relapse	Success rate stated %
B.10 Denford, J, Schachter, J, Temple, N et al	1983	Cassel Hospital, England	(1) Successful group differed from failures & dropouts at admission- in estimated intelligence, diagnosis, & rating of sexual adjustment and depression (2) At triage – no differences in groups except successful group judged to have deteriorated in sexual adjustment (3) At discharge successful group rated as having better social relationships: making better use of individual group sessions in terms of verbal capacity, emotional expression, and quality of relationships: making better use of the community: planning more effectively for discharge: grieving more appropriately at pending departure: more highly motivated for change: better prognosis		41.37% (12)

Table 4: cont'd

B.18 Karterud, S, Vaglum, S, Friis, S etal	1992	Day Hospital, Ulleval University Hospital, Norway	(1) At discharge, mean symptom score(GSI) had dropped for all groups (2) NOPD group improved most on GSI as discharge, followed by BPD or OPD (3) Different diagnostic groups differed considerably on HSRS score on admission (4) Change in mean HSRS score at discharge, due mainly to improvement in NOPD & OPD patients, SPD patients did not change and BPD patients showed very modest change (5) NOPD patients improved significantly more than both SPD or BPD patients on HSRS (6) OPD patients improved significantly more than SPD patients on HSRS (7) Patients treated 6+ months had highest GSI level (8) Patients discharged before 3 months had lowest GSI level (9) Symptom reduction correlated positively to length of stay (10) Length of stay was clearly related to symptom levels at admission	(1) 60% received medication during stay (2) 2 suicide attempts (1BPD: SPD) (3) 4 transfers to adult ward (2SPD: 2OPD) (4) 25.77% (25) discharged irregularly	58% -Not on medication at discharge 95.88% - no suicide attempt 96.9% - not transferred to adult ward 74.33% (72) fulfilled treatment
B.58 Spielman, R.	1975	North Ryde Psychiatric Centre, Australia	(1) No significant difference in questionnaire results at admission between group who leave and group who complete the contracted time (2) On discharge, patients show an increase in self esteem; a decrease in alienation and increase in Purpose In life (3) Clinical assessments suggest improvement of self-image and self respect; increased ability to adopt leadership roles within the community; increased understanding of their own (patients) behaviour ; appearance of positive plans towards future employment and relationships	None stated	None stated

D: In treatment outcome - single case, no control/comparison group studies – Democratic secure TC's

Table 1: Description of institutions covered by outcome studies

Study	Pub. date	Institution	Approx. op. dates of inst.	Target population	Description of treatment regime
A3 Cooke	1989	Barlinnie	1973-	Violent and disruptive prisoners	Small TC unit inside prison. Very long stay.
A9 Genders & Player	1995	Grendon	1962-	Personality disordered offenders motivated to change	TC prison, in 4 TC wings. Democratic. Modified for prison setting. Maximum stay 18+ months
A14 Miller	1982	Grendon	1962-		
A16 Newton	1996	Grendon	1962-		
A17 Ogloff et al	1990	Prairies Regional Psychiatric Centre	1980-	Personality disordered offenders	Democratic TC in a forensic psychiatric hospital. 24 beds
A50 Jones	1989	The Annexe Wormwood Scrubs	1973-	Addicts & personality Disordered Offenders	TC inside a prison
A53 McCord, W.M	1982	Wiltwyck School	1950-	Delinquents & psychopaths	Secure therapeutic community reform school
A60 Cooke	1997	Barlinnie Special Unit	1973-1995	Violent & disruptive prisoners	TC unit inside prison
A73 Sandhu	1970	Hissar, Punjab, India	1962-4	Psychopathic offenders	TC unit inside a special prison. 18 psychopaths & 30 "well-behaved" prisoners to provide positive reference group.

Table 2: Subjects in outcome studies

Study	Pub. date	Institution	Diagnostic	Sample characteristics			
				Age	Gen.	Num	Additional information
A.3 Cooke	1989	Barlinnie	All inmates 1973-1986		Male	25	
A.9 Genders & Player	1995	Grendon	All in therapy at time of study	21+	Male	282 (inter-views in total)	Number of subjects interviewed is less than 282, as some were interviewed more than once. Also interviewed staff.
A.14 Miller	1982	Grendon	All for whom test/retest data available	21+	Male	83	
A.16 Newton	1996	Grendon	Men who left 1994-1995	21+	Male	99	
A.17 Ogloff et al	1990	Prairies Regional Psychiatric Centre	Patients & ex-patients		Male	80	
A.50 Jones	1989	The Annexe, Wormwood Scrubs	Inmates in TC		Male	22	
A.53 McCord	1982	Wiltwyck School	Population of school in 1954	9-13	Male	107	
A.60 Cooke	1997	Barlinnie Special Unit	All inmates 1973-1995	Adult	Male	36	
A.73 Sandhu	1970	Hissar, India	All psychopathic admissions	Adult	Male	18	

Table 3: Methodology of outcome studies

Study	Pub. date	Institution	Period	Control/com. group	Treatments compared	Instruments used	Test admin dates	In treatment outcome	Outcome criteria	Attrition rates
A.3 Cooke	1989	Barlinnie	1973-1986	No		Hare psychopathy scale Prison records			Number of serious incidents & assaults	
A.9 Genders & Player	1995	Grendon	1987-1989	No		Participant observation & qualitative interviews	At beginning during & end of therapy & after transfer/release		Therapeutic maturity	N/A
A.14 Miller	1982	Grendon		No		HDHQ * EPI ** Locus of control	Admission & 6 months		Change on psychological test results	None
A.16 Newton	1996	Grendon	1994-95	No		EPQ*** HDHQ Rotter****	Admission & discharge		Change on psychological test results	50%
A.17 Ogloff	1990	Prairies R.P.C	1980's	No		Hare's psychopathy Checklist			Compared psychopathy ratings with length of stay & degrees of motivation	
A.50 Jones	1989	The Annexe Wormwood Scrubs	1980's	No		Kelly's Rep Construct Grid & self Esteem questionnaire	Tested twice-12 week interval		Change in constructs	
A.53 McCord	1982	Wiltwyck School	1954-55	No		Adult-child Interaction Test, Values Questionnaire & observation	Once	No	Improvement in behaviour & attitudes	

Table 3: cont'd

A.60 Cooke	1997	Barlinnie Special Unit	1973-95	No		Prison records		No	Compared number of assaults & serious incidents	
A.13 Sandhu	1970	Hissar	1962-64	No		Clinical observations		No	Improvement in general attitude	

* Hostility and Direction of Hostility Questionnaire
** Eysenck Personality Inventory
*** EPQ – Eysenck Personality Questionnaire
**** Rotter Internal –External Locus of Control Scale

Table 4: Findings of outcome studies

Study	Pub. date	Institution	Psychological/behavioural findings	Recidivism/re-admission/relapse	Success rate stated %
A.3 Cooke	1989	Barlinnie	20% psychopathic, 52% psychopathic traits Significantly & substantially fewer assaults & serious incidents		
A.9 Genders & Player	1995	Grendon	Those who stay longer (18+ months) more likely to complete therapeutic development Those who stay longer have fewer convictions, higher intelligence & more self-critical		
A.14 Miller	1982	Grendon	Lower hostility) Lower criminality) on retest Greater internal control)		
A.16 Newton	1996	Grendon	All scores changed in direction of 'normality' Extraversion, neuroticism & criminality changed significantly Progressive treatment effect: >12 months stay: 20% change <12 months: 66% change		
A.17 Ogloff	1990	Prairies	Psychopaths show less clinicalimprovement, less motivation, higher attritition rates & less time in program		

Table 4: cont'd

A.50 Jones	1989	Annexe, Wormwood Scrubs	Feedback of constructs led to positive change. Treatment initially lowers, then raises, self esteem Arrival with another dilutes treatment effect		
A.53 McCord	1982	Wiltwyck School	Psychopathic & behaviourally disturbed boys improved Neurotic & borderline psychotic did not		
A.60 Cooke	1997	Barlinnie Special Unit	Before BSU: prisoners committed total of 181 assaults & 174 serious incidents. Therefore predicted rate on BS: 131 assaults & 102 serious incidents Actual rate: 2 assaults & 11 serious incidents		
A.13 Sandhu	1970	Hissar	Improvement in 13 cases. Little or no improvement in 5. No riots, serious assaults suicides or escape attempts		

E: In-treatment cost offset studies

Table 5: Methodology of cost- offset studies in-treatment, democratic, non-secure TCs Error! Bookmark not defined.

Study	**Pub. date**	**Institution**	**Period of research study**	**Control/com. group**	**Which pre-treatment costs measured**	**Which in-treatment costs measured**	**Which post-treatment costs measured**	**Attrition rates %**
B55, Menzies, D, Dolan,B.M. & Norton, K	1993	Henderson Hospital, England	1 year retrospective from May 1992- 1 year prior to admission for 29 consecutive admissions		(1) In-patients general psychiatry services (2) Out patient general Psychiatry services (3) Prison costs	Average stay at Henderson	None	13.79%(5) did not complete 3rd form

Table 6: Findings from cost- offset studies, in-treatment, democratic, non-secure TCs

Study	**Pub. date**	**Instituion**	**Pre-treatment annual cost**	**Treatment annual cost**	**Post-treatment annual cost**	**Com. with other treatment cost**	**Annual cost-ofset/savings calculated**
B55, Menzies, Dolan, B M & Norton, K	1993	Henderson Hospital, England	Health & Prison services combined - £14,590 per patient	Not annual but for average 7 month stay - £23,310 per patient	None	None	Estimated £5,981.96 per patient

A: Post treatment outcome- RCT, democratic Secure TC's

Table 1: Description of institutions covered by outcome studies

Study	**Pub. date**	**Institution**	**Approx. op dates of inst.**	**Target population**	**Description of treatment regime**
A2 Auerbach	1977	Youth Crime Control Project "Street Prison"	1970	Young Offenders, not convicted of murder or rape	5 phase programme, progressing from residential treatment, to unsupervised parole. Community meetings, team meetings (inmates & staff assigned to small teams) family groups, couples groups, education vocational training & placement. Minimum security facility in Washington vice area, to provide maximum realism. 2 years for all 5 phases. Concept –style treatment for general offenders
A76 Cornish & Clarke	1975	Kingswood Training School, Bristol, England	1964	Young Offenders aged 13-15	House in approved school run as a democratic TC. Social Therapy in large and small groups. Some activities (eg education) shared with boys & staff in the rest of the approved school

Table 2: Subjects in outcome studies

Study	Pub. date	Institution	Diagnostic	Sample characteristics			
				Age	Gen.	Num.	Additional information
A.2 Auerbach	1977	Youth Crime Control Project "Street Prison"	Young offenders not convicted of murder or rape	Oldest	Male	100	IQ 75+. By chance all subjects were black
A.76 Cornish & Clarke	1975	Kingswood Training School, Bristol, England	Young offenders sentenced to Kingswood & deemed eligible for TC treatment	13-15	Male	86	

Table 3: Methodology of outcome studies

Study	Pub. date	Institution	Period of research study	Control/com. group	Treatments compared	Instruments used	Test admin. times	Post-treatment follow-up	Outcome criteria	Attrition rates %
A.2 Auerbach	1977	Youth Crime Control Project "Street Prison"	mid 1970's	100	TC and Youth Prison	Shostrum's Personal Orientation Inventory Jesness Inventory	On arrival and on getting parole	yes	Recidivism	
A.76 Cornish & Clarke	1975	Kingswood Training School Bristol	1965-1973	87 (randomly allocated) 107 (not considered eligible for TC)	TC approved school TC & approved school	Official criminal records	2 year follow-up	yes	recidivism	

Table 4: Findings of outcome studies

Study	Pub. date	Institution	Psychological/behavioural findings	Recidivism/re-admission/relapse	Success rate stated %
A.2 Auerbach	1977	Youth Crime Control Project "Street Prison"	No significant differences between the 2 groups	21.9% recidivism YCCP 34.8% recidivism controls	88.1%
A.76 Cornish & Clarke	1975	Kingswood Training School Bristol		70% reconvicted (TC) 69% reconvicted (comparative group) 68% reconvicted (ineligible group)	30%

A: Post-treatment outcome - RCTs, democratic non-secure TCs

Table 1: Description of institutions covered by outcome studies

Study	Pub. date	Institution	Approx. op. dates of inst.	Target population	Description of treatment regime
B7 Craft,.M Stevenson, G & Granger,G (see also B63 Craft, M 1966- Same Study data	1964	Group Psychotherapy Unit, Balderton Hospital, Newark, Notts, England	1958 – (Now defunct)	Male Delinquents Aged 13-25, referred for psychiatric treatment, on probation with condition of residence or transferred from approved school + IQ of 59+	Ward with intensive group psychotherapy programme, with considerable self-government. Generally followed programme offered by Henderson Hospital. 30 beds
B20 Lehman, A & Ritzler, B.	1976	TC Ward, University of Rochester Medical Center, New York, USA	Not known	Male & Female Psychiatric in-patients	Psychiatric ward with TC approach to treatment -A TC in "statu nascendi"

Table 1: cont'd

B29 Piper, W.E, Rosie, J. S, Joyce, A.S. & Azim, H.F.A	1996	Edmonton Day Treatment Program, Canada	Feb 1973	14-70 year old patients referred to University Hospital, Dept of Psychiatry, with long-standing personality problems. For patients not currently psychotic, or in need of 24 hour hospitalisation, & not severely intellectually impaired.	Partial hospitalisation (=Day Hospital Treatment) Time-limited (18 weeks) group oriented. Modified TC TC is a type of Milieu Therapy
B3 Chiesa, M	1997	Cassel Hospital, Ham Common, England	Not stated (but 50+ years as TC)	Adult patients, adolescents & families with severe emotional difficulties	In-patients psychotherapy unit (IPU) Psycho-social treatment Therapeutic Milieu TC

Table 2: Subjects in outcome studies

Study	Pub. date	Institution	Diagnostic	Sample characteristics			
				Age	**Gen.**	**Num.**	**Additional information**
B7 Craft, M, Stephenson, G & Granger, C	1964	Group Psychotherapy Unit, Balderton Hospital, Newark, Notts, England	Male Delinquents referred for psychiatric treatment	13-25	Male	50	IQ 59+
B20 Lehman, A & Ritzler, B	1976	TC Ward, University of Rochester Medical Center, New York, USA	Neurotic patients, character disorder patients & psychotics	Not stated	Male & Female	385	10 – 20% of patients not asked to participate in study because of the severity of their illness – therefore sample consists of less disturbed patients
B29 Piper, W.E., Rosie, J.S., Joyce, A.S. & Azim, H.F.A	1996	Edmonton Day Treatment Program, Canada	Affective & personality disorders (Axis II PDs) (=60% of sample)	14-70	Male & Female	248	95% (of 261 possible) agreed to participate 79 completed immediate treatment 61 completed delay period (39 of these completed treatment): 120 – matched pairs of 60 – completed immediate and delay conditions

Table 2: cont'd

B3 Chiesa, M	1997	Cassel Hospital, England	Cluster A & B of DSM –III – R Cluster C - DSM III – R High Co-morbidity with Axis I Disorders – anxiety, phobic & substance use Severe personality disorders	18-50	Male & Female	Expected final sample – 120+	IQs 90+; good command of English; All patients selected will have Axis II diagnosis of personality disorder in the Dramatic cluster. Excluded: - -diagnosis of schizophrenia - 2 year hospital i/p treatment previously - current substance addiction - organic brain damage - physical illness - current criminal proceedings for - violent crime

Table 3: Methodology of outcome studies

Study	Pub. date	Institution	Period of research study	Control/com. group	Treatments compared	Instruments used	Test admin. times	Post-treatment follow-up	Outcome criteria	Attrition rates %
B7 Craft, M, Stephenson, G & Granger, C	1964	Group Psycho-therapy Unit, Balderton Hospital, Newark, Notts, England	1959-1961	25+25 (random allocation)	TC, and authoritarian disciplinary programme with individual treatment (both had form of token economy) (Senior Medical staff common to both)	MMPI Porteous Maze test – Stott's Social Adjustment Guides WAIS Follow-up questionnaire	Just after admission & discharge	3 years	Re-conviction Re-admission employment clinical well-being	Before 3 mths TC – 16% (4:25) Authoritarian Regime – 8% (2:25) + 4% (1) of EACH group at follow up
B20 Lehman, A & Ritzler, B	1976	TC Ward, University of Rochester Medical Center, New York, USA	Not stated	(1) 385 (TC) + 443 on medical model ward (random allocation on depending on bed space) (2)Diagnosis x 4 groups	TC + medically oriented treatment ward – range of therapies	COPES	Once only	1 year	Frequency of discharges AMA Re-admission rates	See outcome + (1)10-20% too ill to participate (2) COPES - 15-30% of STAFF - 25-55% of PATIENTS

Table 3: cont'd

B29 Piper, W.E, Rosie, J.S, Joyce, A,S & Azim, H.F.A	1996	Edmonton Day Treatment Program, Canada	Jan 1989 – Dec 1990	Random allocation	Immediate 18 week day TC + 18 week delay before treatment	Independent clinical assessments of personality & outcome. Diagnostic interview schedule- IIIA. Social adjustment scale interview – modified. Interpersonal behaviour scale. The people in your life questionnaire. Interpersonal dependency scale. Attachment questionnaire SCL-90. Mood survey. Rosenberg self-esteem scale. Defensive style questionnaire. COPES. Psychological mindedness assessment procedure	Before & after treatment and delay period + at follow-up	Average of 8 months after completing treatment	17 outcome variables – areas of: interpersonal functioning; Psychiatric symptomatology; Self-esteem; Life satisfaction; Defensive functioning; Severity of disturbance	5% (13) refused to participate 8% (22) during assessment 42% (58 out of 137) assigned to immediate treatment 31.5% (28 out of 89) assigned to control/ delayed condition = 46% overall (121 out of 261) to allocation + 50.9% (133 out of 261) to completion of both treatments

Table 3: cont'd

B3 Chiesa, M	1997	Cassel Hospital, England	1993 + 5 years	2 treated and 1 not-treated groups	1-stage group – 12-18 month in-patient TC treatment only + Modified 2-stage treatment programme – 6 months in-patient TC + 1 year x twice weekly group analytic therapy + 1st 6 months concurrent outreach nursing + outreach teamwork + management by general psychiatrist in another region with no access to TC.	SCID I & II Cassel baseline questionnaire. Client service receipt interview. SCL – 90 Social adjustment scale. Global adjustment scale. Community adjustment questionnaire. Adult attachment interview.	Baseline + 6 months into treatment + discharge from treatment + follow-up	1 year	Reduction in treatment costs. Improved transition back into society. Increase in numbers treated. Reduction of waiting list	Significantly higher % of 1-stage patients drop out in first 3 months. Significant discrepancy between expected and actual lengths of stay. Significantly lower rate of attrition for 2-stage programme.

Table 4: Findings of outcome studies

Study	Pub. date	Institution	Psychological/behavioural findings	Recidivism/re-admisstion/relapse	Success rate stated %
B7 Craft, M, Stephenson, G & Granger, C	1964	Group Psychotherapy Unit, Balderton Hospital, Newark, Notts, England	TC did slightly but significantly worse overall TC slightly better (but not significantly) employment record 25% authoritarian : 50% TC still needed institutional care	58.7% recidivism – TC 45.8% recidivism – authoritarian regime 50% re-admission – TC 25% re-admission – authoritarian	41.3% 50%
B20 Lehman, A & Ritzler, B	1976	TC Ward, University of Rochester Medical Center, New York, USA	TC Ward – Greater patient satisfaction than on traditional medical model ward	Re-admission Rates: TC Ward Medical Model Ward All patients 26% 19% Character Disorder 26% 20% Discharges AMA Overall 7% 5% Character Disorder 13% 5%	 74% 74% 93% 87%
B29 Piper, W.E, Rosie, D.S, Joyce, A,S & Azim, H.F.A	1996	Edmonton Day Treatment Program, Canada	Strong treatment effect – maintained at follow-up Treated patients – significant improvement in areas of interpersonal functioning, symptomatology, life satisfaction and self-esteem – reduction in severity of disturbance Quality of object relations, and psychological mindedness – related significantly to patient success Treated patients – significantly greater improvement than control patients on 7 of 17 outcome variables Significantly greater improvement during treatment than during delay period for 3 of 17 outcome variables. Little evidence of spontaneous remission during control period.		Average effect size for all 17 outcome variables = .71 (i.e. average treated patient exceeded 76% of control patients).
B3 Chiesa, M	1997	Cassel Hospital, England	Study ongoing	- findings not yet available	

B: Post treatment outcome, cross-institutional studies – democratic secure TC's

Table 1: Description of institutions covered by outcome studies

Study	**Pub. date**	**Institution**	**Approx. op. dates of inst.**	**Target population**	**Description of treatment regime**
A15. Newton	1971	Grendon, England	1962-	Personality disordered offenders	TC prison in 4 TC wings. Democratic, modified for prison settings. Maximum stay, 18+ months
A.18 Rehn	1979	Bergedorf Social Therapeutic Institution and Moritz-Leipmann Haus	1969-1972	Offenders – no sex offenders at MLH	"Reality oriented social training" SAB-34 bed's MLH – 30 – 35 beds. Work experience
A54 McCord & Sanchez	1983	Wiltwyck School	1950	Delinquents & psychopathic boys	Therapeutic community reform school
A67 Newton	1973	Grendon	1962	Personality disordered offenders TC prison	TC prison
A21 Sewell & Clarke (see also A.27, Clarke & Glatt, 1985 - same study & data)	1982	The Annexe, Wormwood Scrubs	1973	Addictions & sex offenders	TC unit within a prison

Table 2: Subjects in outcome studies

Study	**Pub. date**	**Institution**	**Diagnostic**	**Sample characteristics**			
				Age	**Gen.**	**Num.**	**Additional information**
A.15 Newton	1971	Grendon, England	All released. 1964-6	21+	Male	377	
A.18 Rehn	1979	Bergedorf & Moritz-Leipman-Haus	Released offenders		Male	61	
A.54 McCord & Sanchez	1983	Wiltwyck School	Residents admitted 1952-1955	9-13	Male	175	
A.67 Newton	1973	Grendon	All released 1967-8	Adults	Male	176	
A.21 Sewell & Clarke	1982	The Annexe, Wormwood Scrubs	All admitted 1977-79	21+	Male	127	

Table 3: Methodology of outcome studies

Study	Pub. date	Institution	Period of research study	Control/com. group	Treatments compared	Instruments used	Test admin. times	Post-treatment follow-up	Outcome criteria	Attrition rates
A.15 Newton	1971	Grendon	1964-6	77+	Grendon TC/ Psychiatric treatment at Wormwood Scrubs	Official Records		Yes	Re-conviction at 12 months	
A.18 Rehn	1979	Bergedorf & Mc Haus	1970's	167	Social Therapy & Fuhlsbüttel Prison	Prison files Criminal Records		Yes	Re-conviction	
A.54 McCord & Sanhez	1983	Wiltwyck School	1980	165 boy's from Lyman School	TC reform school	Interview treatment records & crime health records	25 year follow-up	Yes	Re-conviction & psychiatric relapse	
A.67 Newton	1973	Grendon	1967-71	176 men from Oxford Prison	TC /prison	Re-conviction data	1 & 2 years		Re-convicted	
A.21 Sewell & Clarke	1982	The Annexe, Wormwood Scrubs	1977-1982	(1) 100 men on 'C' wing (2) 46 outpatients in the prison	TC/outpatients/ prison	Re-conviction data/personal & criminal histories	1 & 2 years	Yes	Re-conviction	

EPI - Eysench Personality Inventory. HDHQ - Hostility & Direction of Hostility Questionnaire.

Table 4: Findings of outcome studies

Study	Pub. date	Institution	Psychological/behavioural findings	Recidivism/re-admisstion/relapse	Success rate stated %
A.15 Newton	1971	Grendon		41% Grendon re-convicted 36% Wormwood Scrubs re-convicted	
A.18 Rehn	1979	Bergedorf & M-L Haus		40.8% Fulsbüttel re-convicted 50% Treatment group re-convicted	
A.54 McCord & Sanchez	1983	Wiltwyck School	Wiltwyck had high treatment effect initially but poor social conditions led to boys eventually re-offending	Lyman graduates recidivism higher at first than decreased; Wiltwych lower at first then increased	Wiltwych 62.8% & Lyman 77.5% recidivated
A.67 Newton	1973	Grendon		Grendon men re-convicted about as often as controls. Long stay Grendon men had low re-conviction rate.	
A.21 Sewell & Clarke	1982	The Annexe, Wormwood Scrubs	Annexe men significantly more previous convictions, drug use & psychiatric histories	At two years: 50% 'C' wing reconvicted 63% outpatients reconvicted 55% Annexe reconvicted	

B: Post treatment outcome, cross-institutional studies, democratic non-secure TCs

Table 1: Description of institutions covered by outcome studies

Study	Pub. date	Institution	Approx. op. dates of inst.	Target population	Description of treatment regime
B53 Karterud, S. Pederson, G, Friis, S, et al	1998	Norwegian Network of Psychotherapeutic Day Hospitals	1993 -	Personality disorders	Psychotherapeutic Day Hospital treatment x 5 units Group Therapy 18 – week time-limited treatment

Table 2: Subjects in outcome studies

Study	Pub. date	Institution	Diagnostics	Sample characteristics			
				Age	Gen.	Num.	Additional information
B53 Karterud, S. Pederson, G, Friis, S, et al	1998	Norwegian Network of Psychotherapeutic Day Hospitals	Personality disorders	Not stated	Not stated	180+ 150+ p.a.	None given

B: Post treatment outcome, cross-institutional studies, democratic non-secure TCs

Table 3: Methodology of outcome studies

Study	Pub. date	Institution	Period of research study	Control/com. group	Treatments compared	Instruments used	Test admin. times	Post-treatment follow-up	Outcome criteria	Attrition rates
B53 Karterud, S. Pederson, G, Friis, S, et al	1998	Norwegian Network of Psycho-therapeutic Day Hospitals	1993 – ongoing	5 day hospitals to be compared + TC day patients and group analytic out-patients	5 psycho-therapeutic Day Hospitals +Day patients treatment and out-patient group analytic treatment	SCL – 90R 11 P-C SAS – SR Social history schemes M.I.N.I SCID – 2 GAF WAS Evaluation question-naire	Intake 6 weeks (WAS only) Discharge/ termination follow-up	1 year + 5 years	Clinical improvement	20-25% (estimated)

Table 4: Findings of outcome studies

Study	Pub. date	Institution	Psychological/behavioural findings	Recidivism/re-admission/relapse	Success rate stated %
B53 Karterud, S. Pederson, G, Friis, S, et al	1998	Norwegian Network of Psychotherapeutic Day Hospitals	Study on-going	Findings not yet available	On-going- but 90% suggested to date

C: Post-treatment outcome, single case control/comparison group studies - democratic secure TC's

Table 1: Description of institutions covered by outcome studies

Study	Pub. date	Institutuon	Approx. op. dates of inst.	Target population	Description of treatment regime
A1 Angliker et.al.	1973	Clinton Prison U.S.A.	1966	Recidivists-not certifiably insane	TC inside maximum security prison. 6-18 month stay. 50 beds
A13. Marshall	1997	Grendon Prison, England	1962-	Personality disordered offenders	TC Prison in 4 TC wings. Democratic, modified for prison setting. Maximum stay 18+ months
A19 Rice et.al.	1992	Penetanguishene	1965-1978	Violent & mentally offenders	TC Compulsory admission. No option to leave except through improvement. 2+ years program. 150 patients on 4 wards
A20 Robertson and Gunn	1987	Grendon	1962	Personality disordered offenders	TC Prison
A.47 Emmerick	1987	Dr Henri van der Hoeven Clinic	1955-	Mentally disordered offenders	TC in high security hospital
A58a Paddock and Scott	1973	Asklepieion Community	1969-	Volunteer inmates	TC in Martin Prison, Illinios USA. Encounter groups and transactional analysis
A63 Briggs	1972	Chino, California	1960's	Recidivists	TC unit inside prison
A64 Gunn et al	1978	Grendon	1962-	Personality disordered offenders	TC prison
A.68 McMichael	1974	Loaningdale School Scotland	1965-	Delinquent boys	TC reform school 40 beds
A79 Hodges	1971	Patuxent, New York State	1955 -	Mentally disordered offenders & personality disordered offenders	Concept-based therapeutic community for offenders

Table 2: Subjects in outcome studies

Study	Pub. date	Institution	Diagnostic	Sample characteristics			
				Age	Gen.	Num.	Additional information
A.1 Angliker et.al.	1973	Clinton Prison, USA	First 50 admitted	25-35	male	50	
A.13 Marshall	1997	Grendon, England	All admitted 1984-9 & released for 4 years	21+	male	702	
A.19 Rice et al	1992	Penetanguishene	Had spent at least 2 years in program	adult	male	176	
A.20 Robertson and Gunn	1987	Grendon	Same sample as Gunn et al 1978	21+	male	61	
A.47 Emmerick	1987	Dr Henri van der Hoeven Clinic	Discharges 1974-1979			589	
A.58a Paddock & Scott	1973	Asklepieion Community	All treated inmates 1969-72	Adult	male	52	
A.63 Briggs	1972	Chino	All inmates treated	Mainly adults under 25	male	No information	Of a group of eligibles, 2/3 randomly assigned to TC, 1/3 to prison
A.64 Gunn et al	1978	Grendon	Adult admissions from June 1971-May 1972 released by May 1973	adult	male	61	
A.68 McMichael	1974	Loaningdale School	All released 1963-8	13-16	male	117	50 of main sample selected for interviews
A79 Hodges	1971	Patuxent	All paroled, 1955 - 1966	adult	male	156	

Table 3: Methodology of outcome studies

Study	Pub. date	Institution	Period of research study	Control/com. group	Treatments compared	Instruments used	Test admin. times	Post-treatment follow-up	Outcome criteria	Attrition rates
A.1 Angliker et al	1973	Clinton Prison USA	1966-72	50 eligible but not admitted – in prisons throughout New York State	TC/prison	Prison files interviews and postal questionnaires	Average 43 months follow-up	Yes	Re-conviction	Control group 18% Treatment group 0
A.13 Marshall	1997	Grendon	1984-1989	Waiting list group (N=142) General prison group N=1,400	TC /prison	Criminal records & Prison records	4 year follow-up	Yes	Re-conviction	
A.19 Rice et al	1992	Penetanguishene	1968-1978	Matched from forensic assessment cases	TC/prison	Prison files and criminal records	Mean 10.5 years follow-up	Yes	Re-conviction	
A.20 Robertson & Gunn	1987	Grendon	1971-72 & 1980's	61 matched	TC/prison	Criminal Health Records	10 year follow-up	Yes	Re-conviction	
A.47 Emmerick	1987	Dr Henri van der Hoeven Clinic	1974-9	393 long term prisoners	TC/prison	Criminal records	3-8 years	Yes	Re-conviction	
A.58a Paddock & Scott	1973	Asklepieion Community	1972	64 inmates randomly selected from prison	TC/prison	Prison treatment files, post release dates	1-4 year follow-up	Yes	Family life employment re-incarnation	
A.63 Briggs	1972	Chino	1960's	1/3 of eligible group	TC/prison	Parole records, treatments records	1 year follow-up	Yes	Re-conviction	
A.64 Gunn et al	1978	Grendon	1971-73	61 matched from Home Office Parole Index	TC/prison	Criminal records	2 year follow-up	Yes	Re-conviction	

Table 3: cont'd

A.68 McMichael	1974	Loaning dale School	1963-1971	49	TC/approved school	Re-conviction rates & interviews	3 year follow-up	Yes	Re-conviction	
A79 Hodges	1971	Patuxent	1955 - 1966	(1) 156 prison (2) 198 released by court	TC/prison treated/ partially treated	Criminal records	3+ years	Yes	Re-conviction	

Table 4: Findings of outcome studies

Study	Pub. date	Institution	Psychological/behavioural findings	Recidivism/re-admission/relapse	Success rate stated %
A.1 Angliker et al	1973	Clinton Prison, USA		Rates of recidivism comparable, but TC group convicted of lesser crimes, whilst control group convicted of similar or more serious crimes than before.	50% TC 54% reconvicted 46% control reconvicted
A.13 Marshall	1997	Grendon	Grendon has been selecting inmates with a higher risk of re-conviction than the general prison population	Treated group significantly less likely to re-offend than other groups	Treated group 58% reconvicted Waiting list group 66% reconvicted General prison group 50% reconvicted
A.19 Rice et al	1992	Penetanguishene		Psychopaths had higher levels of failure & violent crimes than matched comparisons, non-psychopaths had lower levels	Overall recidivism All treated-57% All untreated-68% Treated psychopaths 89% Untreated psychopaths 81%

Table 4: cont'd

A.20 Robertson & Gunn	1987	Grendon	Frequency of court appearances associated with vagrancy, alcohol, low intelligence, self-esteem & motivation	Grendon men perform worse – but authors highly critical of re-conviction as a valid means of evaluating TC treatment	92% Grendon re-convicted 85% control re-convicted
A.47 Emmerick	1987	Dr Henri van der Hoeven		Control group had higher recidivism, especially for more serious offences	60% control re-convicted 51% treated re-convicted
A.58a Paddock & Scott	1973	Asklepieion Community	Better quality & longer treatment related to employment stability. Some treatment better than none	No significant differences in re-incarceration	20.7 treated re-convicted 19.2 control re-convicted
A.63 Briggs	1972	Chino	No outcome difference found for time in treatment	Statistically significant improvements obtained during second phase of programme, when TC was autonomous from Prison	21% treated recidivated 21% control recidivated
A.64 Gunn et al	1978	Grendon		More Grendon men recidivated, but case studies led authors to have reservations about re-conviction as a valid criterion of TC success	70% Grendon re-convicted 62% controls re-convicted
A.68 McMichael	1974	Loaningdale School	Study looked mainly at after-care & family interaction. Found that after-care was inadequate & unsettled families quickly reversed therapeutic gains.	No significant differences between TC group & control	66% treated re-convicted 61% control re-convicted
A79 Hodges	1971	Patuxent		Untreated and partially treated had higher rate of re-conviction, & more serious offences than treated	Treated 32% reconvicted P. treated 56% reconvicted Untreated 61% reconvicted

C: Post-treatment outcome, single case, control/comparison group studies, democratic non-secure TCs

Table 1: Description of institutions covered by outcome studies

Study	Pub. date	Institution	Approx. op. dates of inst.	Target population	Description of treatment regime
B12 Dolan, B.M, Evans, C, & Wilson, J.	1992	Henderson Hospital, England	Not stated (but 50+ years)	17-45 years old Young adults – marked disturbance of emotional and/or social functioning (i.e. personality disorders of marked to severe degree)	Intensive, long-term TC treatment for personality disordered patients
B13 Dolan, B.M, Evans, C, & Wilson, J. (related to B12)	1992	Henderson Hospital, England	Not stated (but 50+ years)	As above	As above
B14 Dolan, B, Warren, F & Norton, K	1997	Henderson Hospital, England	Not stated (but 50+ years)	Severe personality disorders	National specialist (Tertiary level) in-patient unit for severe personality disorders which employs a democratic TC approach. Specialist in-patient psychotherapy
B26 Mehlum, L, Friis, S Irion, T. et al	1991	Day Unit Psychiatric Dept. B, Ullevål University, Oslo Norway	1981- Present	Personality disorders	Day Unit specialising in long-term treatment of PDs Psychodynamic psychotherapy – individually and in groups
B43 Rosser, R.M, Birch, S, & Bond, H. et al	1987	Cassel Hospital England	Not stated (but 50+ years as TC)	Chronically and severely disturbed neurotic patients, who have typically proved resistant to other physical and psychotherapeutic approaches	Analytically oriented. Therapeutic community for single adult, adolescent and family units.
B57 Eisen, P. Blenkhorn, J & Wendiggensen, P, et al	1986	The Melbourne Clinic Psychotherapy Unit, Australia	April 1983 ?	Age 16+. Long-standing PDs, who had mostly experienced long-term and continuing difficulties despite considerable prior treatment. Serious, long-standing, and disabling mental disorders	Specialised in-patient psychotherapy unit. Intensive treatment. Modified TC, based on functional decision-making with a clear delineation of levels of authority, rather than on fuller democratisation.

Table 1: cont'd

B36 Whiteley, J.S (See also B35 Whiteley, J, Briggs, D, and Turner, M - same study data)	1970	Henderson Hospital, England	Not stated (but 50+ years)	Psychopaths, sociopaths, personality disorder or character disorder	Very intensive therapeutic community. In-patient treatment of young people of both sexes who are psychopaths Highly differentiated dynamic and stressful TC.
B6 Copas, J.B & Whiteley, J.S	1976	Henderson Hospital, England	Not stated (but 50+ years)	Young adults with personality disorders who, broadly, fall into the diagnostic category of psychopathic disorder	Therapeutic community treatment
B5 Copas, J.B, O'Brien, M, Roberts, J. & Whiteley, J.S	1984	Henderson Hospital, England	Not stated (but 50+ years)	Psychopathic or personality disorder	Therapeutic community method of treatment
B30 Rapoport, R.N	1960	Belmont Hospital Social Rehabilitation Unit – now Henderson Hospital	April 1947	Patients with long-standing personality disorders: working class psychopaths	Therapeutic community
B59 Gara, A, Hutchinson, V. & Hafner, R.J.	1989	The Willows, Australia	1984 - ?	People with substance abuse and personality disorders	Therapeutic community 10 - bed unit
B62 Tucker, L, Bauer, S.F & Wagner, S et al	1987	In-patient psychiatric unit, Westchester Division, New York Hospital, USA		Borderline patients	Specialised long-term in-patient psychiatric unit Milieu

Table 2: Subjects in outcome studies

Study	Pub. date	Institution	Diagnostic	Sample characteristics			
				Age	Gen.	Num.	Additional information
B12 Dolan, BM, Evans, C, & Wilson, J.	1992	Henderson Hospital, England	Personality disorder with co-existing neurotic symptomology – mainly cluster B, Axis II of DSM – III R and borderline personality disorder	17-44	Mixed	95/62 (62 = 33 women and 29 men)	C 50% have forensic history Majority have had previous psychiatric treatment
B13 Dolan, BM, Evans, C, & Wilson, J.	1992	Henderson Hospital, England	As above	17-44	Mixed 51 men 44 women	95/62	As above
B14 Dolan, B, Warren, F & Norton, K	1997	Henderson Hospital, England	DSM – III R Personality disorders – most prevalent (80%) borderline and paranoid personality disorder	Not stated	Not stated	598/ 380/ 137	None given
B26 Mehlum, L, Friis, S Irion, T. et al	1991	Day Unit Psychiatric Dept. B, Ullevål University Hospital, Oslo, Norway	DSM – III R Personality disorder – borderline and schizotypal PD and cluster C, other and no PD	Mean Age – 35	Mixed	97 (69 women and 29 men)	Average length of stay 5.5 months Consecutive admissions
B43 Rosser, R.M, Birch, S, & Bond, H. et al	1987	Cassel Hospital, England	Borderline personality/ personality problems			28	Consecutive admissions. Had received other in-patient or out-patient psychiatric treatment prior to referral. Former psychiatric illness. Chronic, incapacitated, dependent, isolated, intelligent.
B57 Eisen, P. Blenkhorn, J & Wendiggensen P et al	1986	The Melbourne Clinic Psychotherapy Unit, Australia	Severe personality disorder (93% of those admitted)	21-35 (82%)	Male & Female	76 (groups A & B – 80% female	All those referred for assessment – April 1983-December 1984
B36 Whiteley, J.S	1970	Henderson Hospital, England	Psychopaths – 3 syndromes – affective; thought disorder; action	18+	Males only	122	Consecutive male discharges. Most had previous histories of convictions, and/or psychiatric hospital admissions. Anxious, emotional, socially isolated, apprehensive, somewhat imaginative.

Table 2: cont'd

B6 Copas, J.B & Whiteley, J.S	1976	Henderson Hospital, England	Psychopathic disorder	Not stated	Males only	(1) Initial series 104 (out of 122) (2) Valida-tion series – 87	Initial series – see Whiteley 1970 (B36) Validation series – consecutive male admissions
B5 Copas, J.B, O'Brien, M. Roberts, J & Whiteley, J.S	1984	Henderson Hospital, England	Psychopathic, personality disorder, sociopath, etc. plus neurotic; extra-punitive neurotic; intropunitive psychopath; psychopath	17-39	Male (169) & Female (76)	245 (194 admitted and 51 not admitted)	All referrals from September 1969 and February 1971. 72% unmarried; 10% divorced/separated 18% married Females showed greater incidence of delinquency than males. Substantial numbers overall had previous convictions. High proportion had previous psychiatric admissions.
B30 Rapoport, R.N	1960	Belmont Hospital Social Rehabilitation Unit – now Henderson Hospital, England	Personality disorders (81%) Neurotics (8%) Psychotics (9%) Indeterminate (2%)	Under 20 (10%) 20-29 (50%) 30-39 (28%) over 40 (10%) over 50 (2%)	122 male 46 female	(1) 1226 (2) 168 (84+84) (3) 70 (4) 64	(1) All referrals 1953-1955 (3) Treated patients – Series I – 84 - total in-patients on chosen day – Series II – 84 – consecutive admissions in period immediately after chosen day 63% single, 27% married, 10% divorced/separated. 37% criminal convictions 40% rated as totally incapacitated 43% intermittent work problems. 34% chronic work problems 27% socially isolated: 31% history of unstable relationships Social Class – 9% Class II; 51% Class III; 15% Class IV; 20% Class V. Outcome sample at 6 months Outcome sample at 1 year

Table 2: cont'd

B59 Gara, A. Hutchinson, V. & Hafner, R.J.	1989	The Willows, Australia	DSM – III – 3 – dysthymic disorder 2 – major depressive episode 8 – substance abuse disorder 3 - anxiety disorder - anorexia nervosa 1 – obsessive – compulsive disorder. 1 – schizophreniform disorder 3– paranoid personality disorder 4 – anti-social PD 5 – BPD 1 – Narcissistic PD	20-45	Male 10 Women 22	103/ 51/32	19 single; 6 married; 7 divorced/separated
B62 Tucker, L, Bauer, S.F, Wagner, S et al	1987	In-patient Psychiatric Unit, Westchester Division, New York Hospital, USA	Primary personality disorders (Axis II, DSM – III); Borderline PD	14-45	Male 28 Female 34	62/40	Respondents: (1) 32% (13) Stayed 12 mths; 30% (12) 6-11 mths; 38% (15) less than 6 mths (2) 73% (29) Single (3) 50%+ - self-harm (4) 33% (13) - two or more hospitalisations during 2 years before admission

C: Post treatment outcome, single case, control/comparison group studies, democratic non-secure TCs

Table 3: Methodology of outcome studies

Study	Pub. date	Institution	Period of research study	Control/com. group	Treatments compared	Instruments used	Test admin. times	Post-treatment follow-up	Outcome criteria	Attrition rates
B12 Dolan, B,M, Evans, C, & Wilson, J.	1992	Henderson Hospital, England	Jan 1985 – Dec 1988	95 Admitted -62 who completed follow-up questionnaire compared to 33 who did not + short/med/long-term stay groups compared	In-patient TC Treatment + lengths of stay by trichotomisation	SCL – 90R (+GSI)	Pre-assessment for admissions and follow-up	Average 8.2 months	Overall reduction in symptomatic psychological distress	35% did not complete post-discharge questionnaire
B13 Dolan, B.M, Evans, C. & Wilson, J	1992	Henderson Hospital, England	Jan 1985- Jan 1989	32% (30) in short stay (up to 3 months) group; + 32% (30) in medium stay (6-9 months) group; + 36% (35) in long-stay (9 months +) group	TC Treatment + Different durations of admission + simple duration of stay	SLC 90R (+GSI)	Pre-assess-ment for admission 3, 6, 9+ 12 months in-treatment + follow-up	6 months	As above	Excluded those staying less than 3 weeks. Non-response at discharge; Long-stay 23% Medium-stay 46% Short-stay 46%
B14 Dolan, B, Warren, F & Norton, K.	1997	Henderson Hospital, England	Sept 1990 – Nov 1994	Those admitted and those not admitted for treatment	In-patient TC treatment + not admitted + not admitted because funding refused by local purchasing authority (= 32.8%)	Borderline syndrome index (BSI) + Personality diagnostic questionnaire (PDQ-R)	On referral and follow-up	1 year (after referral if not admitted or after discharge)	Changes on core personality disorder features	36.5% did not complete baseline forms (23% (52) of admitted patients + 45% (66) of non-admitted) 58% of baseline sample (221) did not complete follow-up forms (45.6% of admitted and 46.8% of non-admitted)

Table 3: cont'd

B26 Mehlum, L, Friis, S, Irion, T et al	1991	Day Unit, Psychiatric Dept. B, Ullevål University Hospital, Oslo, Norway	1982-1985 & 1986-1988 (follow-up)	(1) BPD (no concomitant STP) = 29 (2) STP (with or without concomitant BPD) = 9 (3) Cluster C PD (but not BPD or STP) = 16 (4) Other PDs = 9 (5) No PD = 17 (i.e. Axis I only)	Day TC only	(1) Health sickness rating scale (2) Social adjustment scale (3) SCL – 90 (+ global symptom index) (4) Social activity scale (5) Independence evaluations of 29 audio-taped follow-up interviews (randomly selected (out of 73) (6)SCID (as follow-up)	Admissions and follow-up	Average of 3 years (2-5 years)	Global symptom level Overall level of mental health Social adjustment Rehospitalisation rates Use of out-patients psychiatric treatment Use of psycho-tropic drugs Suicide rate	24.7% (24) at follow-up – incomplete set of data

Table 3: cont'd

B43 Rosser, R.M, Birch, S, Bond, H. et al	1987	Cassel Hospital, England	1976-1984	Divided into groups according to global outcome ratings at discharge (Part I); and follow-up (Part II). Part I (to discharge) (1) drop-out group (2) more successful (3) failures/less successful Part II (follow up) (1) Successes early and late (4) Failures + by diagnosis	In-patient TC only	(1) Clinical assessment ratings and blind ratings (2) General health questionnaire (3) Present state examination (4) WAIS (5) Montgomery Asbery depression rating score (6) Leeds score of depression and anxiety (7) Health-sickness rating scale (8) Interviews (taped)	Admissions: Triage (one month after admission): Discharge: 5-year follow-up	5 years	(1) Clinical improvements (2) Less dependence on the (3) Health Service (4) Improved economic productivity	17.85% (5)

Table 3: cont'd

Study	Pub. date	Institution	Period of research study	Control/com. group	Treatments compared	Instruments used	Test admin. times	Post-treatment follow-up	Outcome criteria	Attrition rates
B57 Eisen, P, Blenk-horn, J, Wendiggensen, P et al	1986	The Melbourne Clinic Psycho-therapy Unit, Australia	April 1983-1985	(1) admitted: stayed 1 month+ (2) admitted: stayed less than 1 month = 7 (3) Assessed: not accepted for admission (4) Assessed: accepted for admission – patient refused = by diagnosis	In-patient TC Treatment + different durations of stay + not admitted	(1) Direct clinical information* (* by one staff member) (2) Secondary clinical data		3-9 months	(1) Clinical improve-ments* (* diag-nosis and symptoms) (2) Self-destructive behaviour (less) (3) Utilisation of medication (less) (4) Capacity to work and live inde-pendently	39.34% not admitted (=30) + 9.2% by one month (=7) + 2.6% by 8 weeks (=2) =51.2% (39) 18.42% (14) had completed treatment at end of study

Table 3: cont'd

Study	Pub. date	Institution	Period of research study	Control/com. group	Treatments compared	Instruments used	Test admin. times	Post-treatment follow-up	Outcome criteria	Attrition rates
B36 Whiteley J.S.	1970	Henderson Hospital, England	November 1964 until late October 1965	(1) Further consecutive group of 50, selected for admission, but D.N.A. (2) Group with better outcome (3) Group with poorer outcome (4) 3 groups according to sympto-matology: affective; thought disorder: action syndromes. (5) Those with convictions/no convictions (6) Those with previous convictions and psychotropic admissions and those with previous convictions only.	In-patient TC only + Not admitted	Interviews and social history data	Admission 1 year 2-3 years	1 year and 3 years	(1) Re-conviction (2) Psychiatric Hospital Re-admission	1 year – 47.6% 3 years – 47.6%
B6 Copas, J.B & Whiteley, J.S	1976	Henderson Hospital, England	1966-1968	(1) Initial series (see Whiteley 1970 (B36)). (2) Validation series. (3) Successes & failures.	In-patient TC only	Social history data	Admission 2-3 years (5-6 years).	2-3 years (5-6 years)	(1) Re-conviction (2) Psychiatric Hospital Re-admission.	None (because used criminal records and DSS information only).

Table 3: cont'd

B5 Copas, J.B, O'Brien, M, Roberts, J. & Whiteley J.S	1984	Henderson Hospital, England	September 1969 – February 1971 + follow-up	(1) admitted (194), & not admitted (51). (2) Successes (64) and failures (83)	In-patient TC only + not admitted	(1) Hostility and direction of hostility questionnaire. (2) S-R. Inventory of Anxiousness (3) Ego-identity scale (4) Eysenck personality inventory lie scale	Referral	3 years & 5 years (from assessment, or discharge).	(1) Recon-viction. (2) Psychia-tric Hospital Re-admission	(1) 20.8% not admitted (n=51) (2) 24.2% of admitted not psychologically tested (19.1 of original sample) (n=247). (3) c70% of all those referred and not admitted not psychologically tested (6.1% of original sample (n=36). None for re-conviction and Re-admission figures.
B30 Rapoport, R.N.	1960	Belmont Social Rehabilitation Unit – now Henderson Hospital, England	1953-1957	(1) Those with stronger and weaker ego-strengths and 5 behavioural defence types. (2) Those who improved dur-ing treatment and those who did not. (3) Profiles at 6 months and 1 year post-discharge.	In-patient TC only	Clinical assessment interview	Discharge; 6 months follow-up; 1 year follow-up	6 months and 1 year	Clinical and functional improvement in overall condition	(1) 58.3% of outcome sample at 6 months follow-up. (2) 61.9% of outcome sample at 1 year follow-up.

Table 3: cont'd

B59 Gara, A, Hutchinson, V, & Hafner, R.J.	1989	The Willows, Australia	1985-1986	Strong and weak attitudes to treatment regime.	In-patient TC + different attitudes to treatment regime.	(1) Crown Crisp Experiential Index. (2) Hostility and direction of hostility questionnaire.	Follow-up only	Mean duration 18 months	(1) Improved personal relation-ships. (2) Coping with every-day life. (3) Satis-faction with employ-ment and social/ leisure activities. (4) Overall improve-ment.	(1) 51.5% (n=52) not traceable. (2) 36.1% (n+19)non responders
B62 Tucker, L., Bauer, S.F., Wagner, S. et al.	1987	In-patient Psychiatric Unit, Westchester Division, New York Hospital, USA.	3 years	Extended (12 months); Intermediate (6-11 months); Short-term (0-5 months) lengths of stay.	In-patient Milieu (TC) + Different durations of stay	(1) Clinical interview and independent rating. (2) Global assessment scale.	Admiss-ions 1 year follow-up. 2 year follow-up.	1 & 2 years	(1) Rehosp-italisation (2) Suicide or self-destructive behaviour or feelings (3) Impro-ved relation-ships and inter-personal networks. (4) Use of outpatient psycho-therapy rather than psychiatric hospital Re-admission	19.5% (n=32) – non responders at 1 year follow-up. 35.5% (n=22) - non responders at 2nd year follow-up.

Table 4: Findings of outcome studies

Study	Pub. date	Institution	Psychological/behavioural findings	Recidivism/re-admission/relapse	Success rate stated %
B12 Dolan, B.M, Evans, C. & Wilson, J.	1992	Henderson Hospital, England	(1) Significant decrease in distress caused by symptoms following treatment, as measured by SCL – 9OR. (2) Long-stay group (9 months +) tended to show greater improvement both short (up to 3 months) and medium (3-9 months) stay groups	Not measured	55% (of 62) had improved reliably – of these, 32% showed clinically significant change 6.5% (of 62) had deteriorated. Estimated 33% (of 95) showed improvement.
B13 Dolan, B.M, Evans, C. & Wilson, J.	1992	Henderson Hospital, England	(1) As above + (2) Length of stay – (a) is related to gender (more women stayed 9 months+). (b) is not related to initial neurotic symptomatology. (c) tends to be related to change in symptomatology in first 3 months of admission. (d) is not significantly associated with improvement in neurotic symptoms on follow-up.	Not measured	As above
B14 Dolan, B, Warren, F & Norton, K.	1997	Henderson Hospital, England	(1) At follow-up, all groups showed some decrease in average symptom scores over time. (2) Significantly greater reduction in symptoms of personality disorder psychopathology in treated sample than in non-treated groups. (3) Change in BSI score found to be positively correlated with length of stay in treatment. (4) Also significant difference between length of stay of admitted patients who showed clinically significant change and those who did not..	Not measured	61% of treated group improved reliably (compared with 37% for non-treated) 43% of treated sample showed clinically significant change (compared with 18% of non-treated).

Table 4: cont'd

B26 Mehlum, L, Friis, S, Irion, T et al	1991	Day Unit, Psychiatric Dept B. Ullevål University Hospital, Oslo, Norway	(1) Sample as whole decreased in symptom score from admission to discharge – maintained at follow-up (2) No statistically significant differences between diagnostic groups. (3) BPD Group – Moderate symptom reduction of fair global outcome. (4) STP – Similar reduction in symptoms, but retained relatively poor global functioning. (5) Cluster C PDs – both global outcome and marked symptom reduction. (6) STP – Least socially adjusted, employed and self supporting of all groups.	(1) STP and BPD – More in-patient treatments in follow-up period than other groups (77.7% of STP). (2) Whole sample received OP treatments on average 50% of follow-up period.	(1) GSI – a) BPD 70% b) CLC & NOPD – 60%. (2) Employment – 60% of sample. (3) 1% (1) suicide rate. (Other figures not given).
B43 Rosser, R.M, Birch, S, Bond, H et al.	1987	Cassel Hospital, England	(1) Length of treatment positively correlated with outcome. (2) At discharge 60% of neurotic, 10% of other patients improved. (3) Using estimated lifetime profile of earnings – net gain for sample as whole £500,000.	Not stated	42.85% (12) overall but much better for neurotic than BPD patients.
B57 Eisen, P, Blenkhorn, J, Wendiggensen P et al.	1986	The Melbourne Clinic Psychotherapy Unit, Australia	(1) Borderline, narcissistic, histrionic and schizotypal PDs showed retention of higher symptom scores. (2) Avoidant and dependent PDs – less retention of symptoms. (3) 18 patients able to undertake full or part-time work, home duties or study.	Not stated	10.26% (4 out of 39 admitted) – symptomless at follow-up. 46.16% (18 of 39 admitted) – independent.

Table 4: cont'd

B36 Whiteley, J.S.	1970	Henderson Hospital, England	Better outcome associated with:- (1) Better school attainment and IQ. (2) More occupational achievement (3) Marriage. (4) Age. (5) Predominance of affective syndrome in presenting symptomatology. Poorer outcome associated with:- (1) Previous criminal history. (2) Institutional care during childhood.	59.0% (n=70) relapsed in 2 year follow-up period in terms of re-conviction or further psychiatric hospital admission. 1 suicide.	40.1% (n=49) overall 43.6% (n=58) of those with previous convictions. 57.55% (n=58) of those with previous psychiatric hospital admissions.
B6 Copas, J.B. & Whiteley, J.S.	1970	Henderson Hospital, England	None other stated	***Initial Study:-*** 44 free of re-conviction and psychiatric hospital Re-admission on at 2-3 years. ***Validation Study:-*** (a) 41 free of re-conviction and psychiatric hospital Re-admission at 2-3 years. (b) 35 free at 5-6 years.	Initial Series – 42.3% (at 2-3 year follow-up). Validation series – 47.1% (at 2-3 year follow-up). 40.2% (at 5-6 year follow-up).
B5 Copas, J.B, O'Brien, M, Roberts, J & Whiteley, J.S.	1984	Henderson Hospital, England	(1) TC treatment is effective with selected individuals showing the anti-social behaviour associated with such disorder. (2) TC treatment is of particular benefit to offenders with one conviction who stay in treatment 6 months+. (3) Poorest prognosis – the extra punitive neurotic, with or without treatment, but even here, TL treatment can be effective. (4) Those who were solely violent to themselves had particularly poor outcome.	(1) 41% no re-convictions or psychiatric Re-admission at 3 years. (2) 36% at 5 year follow-up.	41% at 3 years for admitted group (23% for non-admitted). 36% at 5 years (19% for non-admitted group).

Table 4: cont'd

B30 Rapoport, R.N.	1960	Belmont Social Rehabilitation Unit – now Henderson Hospital, England	(1) Greater number of people improved at end of 1 year follow-up than after first 6 months. (2) Follow-up condition is significantly related to improvement in the unit. (3) Patients with stronger egos made significantly greater gains in follow-up than those with weaker egos, (twice the improvement). (4) Behavourial defence types. (a) conformists and illness group did relatively well – aggressives – poor outcome (b) aggressives – higher rate of improvement during treatment (c) passive modes, (illness and withdrawal) no better at follow-up. (5) Positive relationship between marital status and improvement, especially for men. (6) The more severe the disorder, the less resilience in follow-up gains. (7) Greatest change occurs in the moderately incapacitated group. (8) 52% of those staying 7+ months improved at 1 year follow-up (33% of all others).	16.6% (11) of outcome sample worse at 6 month follow-up than pre-treatment stage.	(1) 61% (43) improved at discharge. (2) 31% (21) improved at 6 months follow-up. (3) 41% (26) improved at 1 year follow-up.
B59 Gara, A, Hutchinson, V. & Hafner, R.J.	1989	The Willows, Australia	(1) 26 – increased number of close relationships. (2) 29 – better quality of close relationships. (3) Increased coping with everyday life. (4) Increased level of satisfaction with employment and social/leisure activities. (5) Improvement in main problems. (6) 24 – no mental illness (self-report). (7) Those with strong positive attitude to treatment regime improved significantly more than those with weak positive attitude. (8) Those with strong, positive attitude to treatment scored significantly lower on intropunitiveness and had significantly more social-interpersonal view.	(1) 5 – decreased number of close relationships. (2) 2 – worse quality of close relationships.	50.9% (n=26) – more close relationships. 56.9% (n=29) – better quality close relationships. 47% (no mental illness). Others not stated.

Table 4: cont'd

B62 Tucker, L, Bauer, S.F, Wagner, S et al.	1987	In-patient Psychiatric Unit, Westchester Division, New York Hospital, USA.	(1) At follow-up fewer patients reported suicidal or self-destructive feelings. (2) Marked decline in reported suicidal or self-destructive behaviour. (3) Most patients had close relationships, visited friends more frequently, and valued relationships with family members more positively. (4) GAS ratings reflect positive change over time, which continued from 1 year to 2 year follow-up. (5) Extended stay group had less rehospitalisation. (6) Extended stay group had greater severity of illness on admission, and greater change on GAS scores from admission to 1 year and 2 years follow-up.	(1) Fewer rehospitalisations 1 and 2 years after discharge than for equivalent periods of time before admission. (2) Less suicidal and self-destructive behaviour and feelings 1 and 2 years after discharge than for equivalent period of time before admission	(1) 92.5% (2) 75%

D: Post treatment outcome, single case, no control/comparative group studies, democratic Secure TC's

Table 1: Description of institutions covered by outcome studies

Study	**Pub. date**	**Institution**	**Approx. op. dates of inst.**	**Target population**	**Description of treatment regime**
A3 Cooke	1989	Barlinnie Special Unit (BSU)	1973	Violent & Disruptive Prisoners	Small TC unit inside prison. Very long stay
A12 McMurran et al	In press 1998	Cairngorm Ward, Arnold Lodge, RSU England	1987-1997	Personality disordered offenders detained under Mental Health Act	TC inside secure setting. 8 beds. Patients admitted for assessment or treatment
A26 Cullen	1993	Grendon	1967-	Personality disordered offenders	TC prison
A36b Emmerick	1987	Dr Henri van der Hoeven Clinic, Netherlands	1955-	Offenders assigned to psychiatric treatment by courts	TC in high security psychiatric hospital

Table 1: cont'd

A37b Grendon Psychology Unit	1966	Grendon	1962	Personality disordered offenders	TC prison
A40 Jones	1988	The Annexe Wormwood Scrubs	1973-	Addicts & personality disordered offenders	TC unit inside a prison
A43 George	1971	Grendon	1962	Personality disordered offenders	TC prison
A45 McPherson	1973	Grendon	1962	Personality disordered offenders	TC prison
A.55 Sanchez	1986	Wiltwyck School	1950-	Delinquent & psychopathic boys	Therapeutic community reform school
A67 Newton	1973	Grendon	1962-	Personality disordered offenders	TC prison

Table 2: Subjects in outcome studies

Study	**Pub. date**	**Institution**	**Diagnostic**	**Sample characteristcs**			
				Age	**Gen.**	**Num.**	**Additional information**
A.3 Cooke	1989	BSU	All in-mates 1973-1986		Male	25	
A.12 McMurran et al	1998	Cairngorm Ward, Arnold Lodge RSU, England	All patients admitted since opening	Mean age 26.9	Male & female	53	
A.26 Cullen	1993	Grendon	Discharges 1984-8	21+	Male	214	Only those discharged who could have completed two years "at risk".
A.36b Emmerick	1987	Dr Henri van der Hoeven Clinic	Ex patients 1955-1977			331	
A.37b Grendon Psychology Unit	1966	Grendon	Discharges July – Dec 1964	21+	Male	61	
A.40 Jones	1988	The Annexe, Wormwood Scrubs	Discharges 1983-4	20-69	male	122	
A.43 George	1971	Grendon	Discharges 1967-68	18+	male	265	

Table 2: cont'd

A.45 McPherson	1973	Grendon	'B' Wing discharges 1967-69	18+	male	110	
A.55 Sanchez	1986	Wiltwyck School	Sample used before (McCord & Sanchez 1983)	9-13	male	165	
A.67 Newton	1973	Grendon	Men released	adult	male	211	

Table 3: Methodology of outcome studies

Study	Pub. date	Institution	Period of research study	Control/ com. group	Treatments compared	Instruments used	Test admin. times	Post-treatment follow-up	Outcome criteria	Attrition rates
A3 Cooke	1989	BSU	1973-1986	No		Prison records		In prison post treatment follow-up Post release follow-up	No. of serious assaults & incidents Re-conviction	
A.12 McMurran et al	In press 1998	Arnold Lodge RSU England	1987-96	No	Assessed and treated/ Assessed only	Clinical files Home Office Records		Yes	Re-conviction	
A.26 Cullen	1993	Grendon	1984-8	No	Short stay/ long stay	Clinical files. Re-conviction records	2 year follow-up	Yes	Re-conviction	
A.36b Emmerick	1987	Dr Henri van der Hoeven	1955-77	No	Patients released into community/ patients transferred elsewhere first	Interviews treatment records & court records	3-25 year follow up	Yes	Re-conviction	
A.37b Grendon Psychology Unit	1966	Grendon	1964	No		Unstructured interviews		Yes	Seven categories derived from data	

Table 3: cont'd

Study	Pub. date	Institution	Period of research study	Control/com. group	Treatments compared	Instruments used	Test admin. times	Post-treatment follow-up	Outcome criteria	Attrition rates
A.40 Jones	1988	The Annexe Worm Wood Scrubs	1983-4	No		HDHQ* conviction & treatment records	2 year follow-up		Re-conviction	
A.43 George	1971	Grendon	1967-68	No		Criminal records & treatment records	2 years follow-up	Yes	Re-conviction	
A.45 McPherson	1973	Grendon	1967-9	No		Re-conviction records & treatment records	2-4 years	Yes	Re-conviction	
A.55 Sanchez	1986	Wiltwyck School	1952-5 (follow-up)	No		Treatment files	25 year follow-up	Yes	Re-conviction	
A.67 Newton	1973	Grendon	1967-9	No		HDHQ*	Admission & release	Yes	Re-conviction	

* Hostility & direction of hostility questionnaire

Table 4: Findings of outcome studies

Study	Pub. date	Institution	Psychological/behavioural findings	Recidivism/re-admission/relapse	Success rate stated %
A.3 Cooke	1989	BSU		Post-treatment in-prison: significantly & substantially fewer assaults & serious incidents Post release: fewer re-convicted than predicted	26 serious incidents & 73 assaults predicted after transfer 17 serious incidents & 10 assaults occurred. 8.31 re-convicted predicted 4 actually re-convicted
A.12 McMurran et al	In press 1998	Arnold Lodge RSU	No significant differences between a group staying less than 6 groups & a group staying longer, on background or criminal history	Both short stay (>6 months) & long stay (<6 months) show reduction in crime. No significant differences between the two groups	
A.26 Cullen	1993	Grendon		Long stay group less likely to be re-convicted. Re-convictions for Grendon lower than average re-convictions	33.2% re-convicted within 2 years (42-47% of all adults males are re-convicted)
A.36b Emmerick	1987	Dr Henri van der Hoeven Clinic		Patient released less likely to be re-convicted & have better health, higher self-esteem, less drug and alcohol problems	70% of those transferred to other institutions and 31% of those released directly from clinic recidivated
A.37b Grendon Psychology Unit	1966	Grendon	40% settled or improved 3% unsettled but not re-convicted	Those re-convicted more likely to be transferred from Grendon prior to release.	34% re-convicted
A.40 Jones	1988	The Annexe Wormwood Scrubs	Extra-punitive trait related to re-conviction	Marked decrease in re-conviction rates 26 months +	54.8% personality disorders re-convicted 76.25% addicts re-convicted
A.43 George	1971	Grendon	Better outcome for men who are older, married, few previous convictions	Better outcome for 12+ months in treatment	57% re-convicted
A.45 McPherson	1973	Grendon		Men who are admitted alone more likely to stay than when admitted with another. Men who stay longer are less likely to be re-convicted	50% re-convicted -42% long stay 58% short stay (13 months cut-off)
A.55 Sanchez	1986	Wiltwyck School	Anti-social Personalities-short stay more likely to recidivate Over 4 years 1 month least likely to recidivate		58% re-arrested
A.67 Newton	1973	Grendon	Total hostility scores tended to become significantly lower during treatment for men who were not subsequently re-convicted.	Grendon men rearrested about as often as Oxford counterparts	No information

D: Post Treatment outcome, single case, no control/ comparison group studies, democratic non-secure TC's

Table 1: Description of institutions covered by outcome studies

Study	Pub. date	Institution	Approx. op. dates of inst.	Target population	Description of treatment regime
B2. Carson, W.M	1973	Hamilton Wesley House, Canada	January 1970-?	Anti-Social Adolescents	Therapeutic Community
B19 Kobal, M & Žagar, D	1994	Department of Forensic & Social Psychiatry, Slovenia	August 1967	Psychotic offenders: some prisoners & people with socially accentuated psychiatric disorders	Therapeutic Community open forensic ward. A therapeutic, rehabilitative and environment orientated TC.
B15 Hafner, R.J. & Holme, G	1996	The Willows, Australia	Non Stated	Not stated (although implies personality disorders)	Therapeutic Community
B8 Davidson, G.P	1976	Elliott House, England	May 1970-?	Persistent Offenders	Therapeutic Community Home Office Probation Hostel

Table 2: Subjects in outcome studies

Study	Pub. date	Institution	Diagnostics	Sample characteristics			
				Age	**Gen.**	**Num.**	**Additional information**
B2 Carson, W.M.	1973	Hamilton Wesley House, Canada	None Given	Average age 17 ½ years	Male & female	88/45	(1) Some of the most disruptive young people who are not legally confined to an institution. (2) Low relative maturity poor, adaptive behaviour & school attendance. Under-achievement, drug experimentation & deviant social relations: highly manipulative behaviour: violence: self destructive behaviour. (3) 53.3% had been in court (juvenile or adult) prior to admission.
B19 Kobal, M. & Žagar, D.	1994	Dept of Forensic & Social Psychiatry, Slovenia	Psychoses & personality disorders	Not stated	Not stated	103 127	All admissions & discharges from 1992-1993 All offenders subject to security measure
B 15 Hafner R.J. & Holme, G	1996	The Willows, Australia	DSM-III-R Axis II usually borderline personality disordered (n=34) + AXIS I – substance Abuse most common (n=34)	20-53	Male-25 Female-25	59/48	All clients admitted to the community May 1991-May 1993 & who stayed more than seven days. 52.1% (25)-previous admissions to psychiatric hospital 6.25% (3) employed at admissions 66.6% (32) single: 12.5% (6) marked: 20% (10) divorced /seperated
B8 Davidson, G.P	1976	Elliott House, England		21-30	Male	(1) 60 (2) 42	

D: Post-treatment outcome, single case, no control/ comparison group studies, democratic non-secure TC's

Table 3: Methodology of outcome studies

Study	**Pub. date**	**Institution**	**Period of research study**	**Control/com group**	**Treatments compared**	**Instruments used**	**Test admin. times**	**Post-treatment follow-up**	**Outcome criteria**	**Attrition rates**
B2. Carson, W.M	1973	Hamlton Wesley House, Canada	January 1970-June 1971 + follow-up	None	Residential TC only	Interviews	Follow-up	Time not stated	(1) Improved relationships with parents, employers & neighbours (2) Court appearances	48.9% non responder
B19 Kobal, M. & Žagar, D	1994	Dept of Forensic & Social Psychiatry Slovenia	1992-1993	None	In patient TC only	None	None	Time not stated	(1) Discharge (2) Committal of socially dangerous offenders	None stated
B15 Hafner,R J. & Holme, G	1996	The Willows, Australia	May 1991- & May 1993	None	In patient TC only	(1) Brief symptom inventory (2) Hostility & direction of hostility questionnaire (3) Clients evaluation questionnaire	(1) Week after admission (2) Within 2 weeks of discharge (3) 3 months after discharge	(1) 2 weeks (2) 3 months (3) (12 months for re-conviction/ Re-admission to psychiatric hospital	(1) Re-conviction (2) Psychiatric hospital Re-admission (3) clinical improvement	(1) 18.66(n=9) non responders at start of study (2) 33.3% (n=16) at 2 week follow-up (3) 39.5% (n=19) at 3 month follow-up
B8 Davidson	1976	Elliott House, England	Not stated (but suggests May 1970-April 1974)	None	Residential TC only	None	None	Time - not stated	(1) 12+ months at Elliott House without Re-admission to prison (2) Completion of further 12 months after discharge without Re-admission to prison	Not stated

Table 4: Findings of outcome studies

Study	Pub. date	Institution	Psychological/behavioural findings	Recidivism/re-admisstion/relapse	Success rate stated %
B2 Carson, W.M	1973	Hamilton Wesley House, Canada	(1) 62% reported improved relationships with parents (2) 78.37% of parents reported an improvement (3) 55.56% employed or at school (4) 65.83% claimed changed/ opposed attitude to drug use.	(1) 28.88% - In court since discharge (2) 82.88% - Committed offences which could have brought them to court.	71.12% (n=32) Non offenders (but 53.33% only had been in court before treatment)
B19 Kobal, M & Žagar, D	1994	Dept of Forensic & social psychiatry Slovenia	None stated	None stated although re-admissions clearly not regarded as failure	(1) 100% for discharge (rare for comparable institutions in Slovenia) (2) 100% for psychotic patients committing suitably dangerous offences
B15 Hafner, R.J & Holme, G	1996	The Willows, Australia	(1) Client ratings of severity of main residual mental health problem fell significantly at discharge, & although slightly increased at follow-up, was still significantly below the mean admission rating (2) Ratings for main inter-personal problem also fell (3) BSI scores decreased on all symptom scales (4) There were similar decreases on the HDHQ, with particular reduction on extra-punitiveness	27.1% (n=13) admitted to psychiatric hospital (6.25% (n=3) for first time	(1) 82.9% - not admitted to psychiatric hospitals (2) 45% reduction in psychological symptoms by 3 months follow-up
B8. Davidson, G.P	1976	Elliott House, England	None stated	18% returned to prison from Elliott House (of all past & present residents)	(1) 78% (n=46) returned to prison from Elliott House for 12+ months (2) 69% (n=29) completed further 12 months after discharge without returning to prison

E: Post-treatment cost offset studies

Table 5: Methodology of cost offset Studies – post-treatment, democratic non-secure TC's

Study	Pub. date	Institution	Period of research study	Control/com. group	Which pre-treatment costs measured	Which in-treatment costs measured	Which post-treatment costs measured	Attrition rates %
B4 Chiesa, M, Iacoponi E, & Morris, M	1996	Cassel Hospital, England	(a) June 1993-May 1994 (b) May 1991-Dec 1992	(a) Pre-treatment group (26) consecutive admissions (b) Post treatment Group (26)- received inpatient treatment at Cassel discharged for at least one year. (c) High and low service users	(1) Utilization of out patient /inpatient medical services. (2) Utilization of laboratory investigations (3) Inpatient & outpatient psychiatry (4) Visits to GP's (5) Use of social work/community psychiatry nursing services (6) Cigarettes & alcohol consumption (7) Levels of employment	Not stated	(1) Inpatient & outpatient psychiatry (2) Outpatient psychotherapy (3) In patient medical & surgical	(a) 10% -non-responders (b) 50% (26)-non-responders
B9 Davies, S, Campling P & Ryan, K	1997	Francis Dixon Lodge, England	1 January 1993-31Dec 1995+3 years Prior + post discharge to 30 June 1997	(1) Leicestershire Patients (2) ECR's	In patient general psychiatric admissions	Total cost & average cost per patient per group	In patient general psychiatric admissions	(1) 1.88% at start (n=1) (2) 11.1% at discharge (n=5)
B56 Dolan, B.M, Warren, F.M Menzies, D & Norton, K	1996	Henderson Hospital, England	May 1992 (+ 1 year pre-admission) + 1 year post discharge		(1) In patient general psychiatric services (2) Out patient general psychiatric services (3) Prison costs	Overall daily costs	(1) Inpatient general psychiatric services (2) Outpatient general psychiatric services (3) Prisons costs	17.24% at start of study (n=5)

Table 6: Findings from cost-offset studies – post treatment, democratic non-secure TC's

Study	Pub. date	Institution	Pre-treatment annual cost	Treatment annual cost	Post-treatment annual cost	Com. with other treatment costs	Annual cost-offset/savings calculated
B4. Chiesa, M Iacoponi, E & Morris, M	1996	Cassel Hospital, England	(1) In patient psychiatric services- total average cost per patient - £5,522 (2) Out patient Psychiatric services (3) Out patients psychotherapy (4) Inpatient medical and surgical	Not stated	(1) £34 per patient	None	(1) £5,488 per patient in year post discharge (2) £640 per patient (3) £737 per patient (4) £558 per patient Total £7,423 per patient
B9 Davies, S. Campling, P & Ryan, K	1997	Francis Dixon Lodge, England	(1) Leicestershire patients- £3,910 per patient (2) ECRs -£9,499 per patient (3) Total per patient £4,301	(1) Total costs Per patient, per admission £23,765 (2) £34,910	(1) £1,331 (2) £924 (3) £1,227		(1) £2,579 (2) £8,575 (3) £3,074
B56 Dolan, B.M Warren, F.M. Menzies, D & Norton, K	1996	Henderson Hospital, England	(1) In patient general psychiatric services-per patient average. £11,018.25 (2) Out patient general psychiatric services-per patient average. £1,532.92 (3) Prison costs per patient average- £1,415.34 (4) Total annual cost per patient average. £13,966	(1) Average per patient £40,515 (2) Average cost per treatment episode £25,641	(1) In patient general psychiatric services =£810.92 (2) Out patient general psychiatric services =£497 (3) Prison costs- £0 (4) Total - £1,308		(1) £10,207.33 (2) £1,035.92 (3) £1,415.34 (4) TOTAL = £12,658.59

8.2 Concept-based

A: Post – Treatment Outcome, RCT, concept secure TC's

Table 1: Description of institutions covered by outcome studies

Study	Pub. date	Institutuon	Approx. op. dates of inst.	Target population	Description of treatment regime
E6 Inciardi et al	1997	WCI Village KEY-CREST	1990	Drug involved offenders	KEY – in prison TC (men) WCI Village – in prison TC (women) CREST - TC work release centre, in community
E10 Martin et al	1995	KEY- CREST	1990	Drug involved offenders	KEY – in prison TC CREST – work release TC
E11b Nielson et al	1996	CREST	1990	Drug involved paroled offenders	CREST – work release TC
E26 Lockwood et al	1997	KEY - CREST	KEY 1988 CREST 1990	Drug involved offenders	KEY – In prison TC CREST – Work release TC

Table 2: Subjects in outcome studies

Study	Pub. date	Institution	Diagnostic	Sample characteristics			
				Age	Gen.	Num.	Additional information
E.6 Inciardi et al	1997	WCI Village KEY CREST	Randomly assigned (as much as possible)	Mean age 30.8	Male & female	264	In 4 groups: KEY only; KEY/WCI+CREST; CREST only; and comparison
E.10 Martin et al	1995	KEY CREST	Randomly assigned	Mean 29.6	Male	457	457 altogether in 4 groups KEY, KEY-CREST, CREST, comparison
E.11b Nielson et al	1996	CREST	Ex-CREST work release	18+	Male & Female	248	
E.26 Lockwood et al	1997	KEY/CREST	EX KEY & CREST clients	30.6	Male	271	3 groups – KEY only, CREST only, KEY + CREST.

Table 3: Methodology of outcome studies

Study	Pub. date	Institution	Period of research study	Control/com. group	Treatments compared	Instruments used	Test admin. times	Post-treatment follow-up	Outcome criteria	Attrition rates %
E.6 Inciardi et al	1997	WCI Village KEY CREST	1990-97	184 eligible but randomly assigned elsewhere	TC/prison and conventional work release	Interviews & urine tests	6 monthly & 18 monthly follow-up	Yes	Re-conviction relapse	
E.10 Martin et al	1995	KEY-CREST	1990-95	Eligible but randomly assigned elsewhere	TC/prison & conventional work release	Interviews & blood & urine tests	6 months	Yes	Re-conviction relapse	
E.11b Nielson et al	1996	CREST	1990-96	Eligible but randomly assigned to other work release programs	TC/conventional work release program	Interviews & blood & urine samples	6 & 18 months	Yes	Recidivism & relapse	
E.26 Lockwood et al	1997	KEY & CREST	1990-97	212 eligible but randomly assigned elsewhere	TC/prison & conventional work release program	Self-report & urine test	6 months	Yes	Arrest & relapse	

Table 4: Findings of outome studies

Study	Pub. date	Institution	Psychological/behavioural findings	Recidivism/re-admission/relapse	Success rate stated %
E.6 Inciardi et al	1997	WCI Village, KEY, CREST		KEY & CREST show much improved recidivism & relapse rates	Arrest free at 18 months Comparison 46% KEY only 43% CREST only 57% Key & CREST 77%Drug free at 18 months Comparison 16% KEY 22% CREST 31% KEY & CREST 47%
E.10 Martin et al	1995	KEY - CREST		KEY-CREST show improved recidivism & relape rates	Arrest free at 18 months KEY 54% CREST 84% KEY-CREST94% Comparison 38% Drug free at 6 months KEY 74% CREST 86% KEY-CREST 97% Comparison 60%
E.11b Nielson et al	1996	CREST		TC work release is effective in reducing recidivism & drug use Length of time in program has positive effect on relapse & recidivism	Arrest free at 18 months CREST 61.8 Comparison 27% Drug free at 18 months CREST 48.3**%** Comparison 21%

Table 4: cont'd

E.26 Lockwood et al	1997	KEY/CREST		Treatment groups do better Clients more likely to use drugs than get arrested.	Arrest free at 6 months KEY 71.4% CREST 87.5% KEY/CREST 92.3% Comparison 59.6 % Drug free at 6 months KEY 45.7% CREST 76.4% KEY/CREST 84.6% Comparison 36.8%

B: Post–treatment Outcome, cross-institutional, concept secure TC's

Table 1: Description of institutions covered by outcome studies

Study	Pub. date	Institution	Approx. op. dates of inst.	Target population	Description of treatment regime
E.18 Wexler et al	1992	Stay'n Out	1977	Drug involved offenders	In prison therapeutic communities

Table 2: Subjects in outcome studies

Study	Pub. date	Institution	Diagnostic	Sample characteristics			
				Age	Gen.	Num.	Additional information
E.18 Wexler et al	1992	Stay'n out	Clients who left 1977-84	(mean) 29.8 30.1	Male Female	435 247	

Table 3: Methodology of outcome studies

Study	Pub. date	Institution	Period of research study	Control/com. group	Treatments compared	Instruments used	Test admin. times	Post-treatment follow-up	Outcome criteria	Attrition rates
E.18 Wexler et al	1992	Stay'n Out	1977-84	3 Male groups 2 Female groups	Male-milieu, counselling, no treatment/TC Female-counselling, no treatment/ TC	Parole records, treatment records			Re-arrest time until re-arrest	

Table 4: Findings of outome studies

Study	Pub. date	Institution	Psychological/behavioural findings	Recidivism/re-admission/relapse	Success rate stated %
E.18 Wexler et al	1992	Stay'n Out		TC more effective than other groups in reducing recidivism Longer time in program leads to greater success after release	Males lowest re-arrest rate :26.9% (TC) Highest :40.9% (no treatment) Females Lowest: 17.8% (TC) Highest : 29.2% (counselling)

C: Post – Treatment outcome, single case, control/comparison group studies, concept secure TC's

Table 1: Description of institutions covered by outcome studies

Study	**Pub. date**	**Institution**	**Approx. op. dates of inst.**	**Target population**	**Description of treatment regime**
E2 Eisenberg and Fabelo	1996	Kyle and Gatesville in prison TC's, Texas	1992-	Substance abusing offenders	Concept-based. Kyle :500 beds, Gatesville 96 beds 9 months IPTC (in-prison TC) program, followed by 1-3 months in community residence & 3-12 months counselling
E8 Knight et al	1997	Kyle IPTC	1992	Substance abusing offenders	Kyle as above
E25 Graham & Wexler	1997	Amity & Vista VISTA San Diego	1987	Substance abusing offenders	Amity – in prison TC Vista – post- release TC
E28 Bureau of Prisons U.S.	1998	DAP (Drug Abuse Treatment Programme)	1988	Drug abusing offenders	Modified TC 9-12 months – in – prison TC followed by halfway house outside
E.35 New York State Correction Services	1996	CASAT- Comprehensive Alcohol & Substance Abuse Treatment Program	1990-	Drug abusing offenders	Serves in prison TC's Phase 1 – secure; Phase 2 – community TC Phase 3 – Aftercare

Table 2: Subjects in outcome studies

Study	Pub. date	Institution	Diagnostic	Sample characteristics			
				Age	**Gen.**	**Num.**	**Additional information**
E.2 Eisenberg & Fabelo	1996	Kyle & Gatesville, Texas	Inmates released for one year	26-35	Male & female	672	
E.8 Knight et al	1997	Kyle IPTC	IPTC Graduates	?	male	222	Two groups – TC completes – N=145 TC non completes-N=77
E25 Graham & Wexler	1997	Amity & Vista	Ex-residents	31 31	male	108 23	Amity Vista
E.28 Bureau of prisons	1998	DAP	Discharge up till Dec 1995	18+	Male & female	799	719 male, 180 female
E.35 New York Sate Correction Studies	1998	CASAT	All who entered phase III	Average 35	Male & female	3,067	

Table 3: Methodology of outcome studies

Study	Pub. date	Institution	Period of research study	Control/com. group	Treatments compared	Instruments used	Test admin. times	Post-treatment follow-up	Outcome criteria	Attrition rates
E.2 Eisenberg & Fabelo	1996	Kyle & Gatehead	1993	395 – eligible for program but not selected	TC/prison	ASI* interviews treatment files offence data re-convictions	1 year follow-up	Yes	Re-conviction & employment	
E.8 Knight et al	1997	Kyle IPTC	1994-97	76 eligible but not entering treatment	TC/prison	Prison files, interview, Hair sample analysis	6 month	Yes	Criminal involvement drug use	
E25 Graham & Wexler	1997	Amity & Vista	1990-93	75	TC/prison	Self report tests Criminal records	6 month follow-up	Yes	Re-arrest	
E.28 Bureau of prisons	1998	DAP	1995-98	967 eligible but not treated	TC/prison	Crime records, probation officers	6 months	Yes	Re-arrest drug use	
E.35 New York State Correction Services	1996	CASAT	1990-96	72,322 men 4,646 women (all releases) 1883 Phase 1 failures 2377 Phase II failures	TC/prison & long stay/short stay	Crime records	12-30	Yes	Re-arrest	

* Addiction Severity Index

Table 4: Findings of outome studies

Study	Pub. date	Institution	Psychologica/ behavioural findings	Recidivism/re-admission/relapse	Success rate stated %
E.2 Eisenberg & Fabelo	1996	Kyle and Gateshead		Completion of in-prison phase only had no impact on recidivism. Completion did. Completers had significantly higher employment.	Completers 7% re-conviction Not completed 19% Comparison 19% Completers 81% employed Not completed 57% employed Comparison 53% employed
E.8 Knight et al	1997	Kyle IPTC		Kyle graduates did significantly better than non-completers, who did better than comparison group on arrests, crimes, drug use & employment	Involvement in crime Graduates 6% Non-completers 23% Comparison 21% Drug use Graduates 35% Non-completers 47% Comparison 55%
E25 Graham & Wexler	1997	Amity & Vista		Significant improvement re-arrest rates for Amity & Vista completers	Rearrest Control 76% Amity 61.1% Amity+Vista 4.3%
E.28 Bureau of Prisons	1998	DAP		DAP's make significant difference in lives of inmates after release	Drug use Treatment 20.56% Comparisons 36.7% Arrest Treatment 3.3% Comparisons 12.1%
E.35 New York State Correctional Services	1996	CASAT		Phase III graduates do best.	All releases 25.5 rearrested at 2 years Phase III graduates 18% rearrested at 2 yearsPhase I & II failures 32.25 rearrested at 2 years.

D: Post – Treatment outcome, single case, no control/comparison group studies, concept secure TC's

Table 1: Description of institutions covered by outcome studies

Study	Pub. date	Institution	Approx. op. dates of inst.	Target population	Description of treatment regime
E13 Sweet et al	1977	DOR* Memphis Tennessee	1973-	Drug abusing offenders	TC with behaviour management
E27 Glider et al	1997	Amity	1987-	Drug abusing offenders	In-prison TC
E31 Swartz et al	1996	IMPACT	1991-	Drug abusing offenders	In-prison TC
E.33 Field et al	1989	Cornerstone	1983-1985	Drug abusing offenders	In prison TC + 6 months aftercare

* DOR – Drug offender Rehabilitation Programme

Table 2: Subjects in outcome studies

Study	Pub. date	Institution	Diagnostic	Sample characteristics			
				Age	**Gen.**	**Num.**	**Additional information**
E.13 Sweet et al	1977	DOR Memphis	Graduates of in-house phase			254	
E.27 Glider et al	1997	Amity	Admissions 11/87-6/94	Mean 28	Male & female	410 207	Cohort 1 – admissions 11/87-12/90 Cohort 2 – admissions 6/92-6/94
E.31 Swartz et al	1996	IMPACT	Clients Jan 91- Aug 92	Mean 28.6	Male	453	
E.33 Field	1989	Cornerstone	Discharges 1983-5	18+	Male & female	220	Mostly male

Table 3: Methodology of outcome studies

Study	Pub. date	Institution	Period of study research	Control/com. group	Treatments compared	Insturments used	Test admin. times	Post-treatment follow-up	Outcome criteria	Attrition rates
E.13 Sweet	1977	DOR Memphis	1973-	No					Successful completion of aftercare	
E.27 Glider et al	1977	Amity	1987-	No		ASI TSC BDI SMAS CMRS*	Admission & 6 month follow-up		Arrest psychological change	
E.31 Swartz et al	1996	IMPACT	1991-96	No	Short stay/long stay	Criminal records & treatment records	1+ years		Drug use re-arrest	
E.33 Field	1989	Cornerstone	1983-88	No	Short stay/long stay	Crime records	36 months		Recidivism	

* ASI – Addiction Severity Index, BDI – Beck Depression Inventory
TSC – Tennessee Self-Concept Scale SMAS – Shortened Manifest Anxiety Scale CMRS – Circumstances, Motivation, Readiness & Suitability for Treatment Scale

Table 4: Findings of outome studies

Study	Pub. date	Institution	Psychological/behavioural findings	Recidivism/re-admission/relapse	Success rate stated %
E.13 Sweet	1977	DOR Memphis		57% successfully completed after-care program	At 2 years: 40% relapse At 4 years: 50% relapse
E.27 Glider et al	1997	Amity	Significant improvements on BDI & TSC & SMAS at discharge, and maintained at 6 month follow-up	Cohort 1 - 18.5% recidivism at 6 months 35% at 30 months Cohort 2 – 20.5% recidivism at 6 months	
E.31 Swartz et al	1996	IMPACT		Most effective: 90-150 days in IMPACT followed by community treatment Least effective: 1-30 days in IMPACT & no community treatment	51% re-arrested 69% of 1-30 day treatment group 45% of 151 + days treatment group
E.33 Field	1989	Cornerstone		Graduates have similar pre-treatment records to others, but are significantly less likely to re-offend after treatment.	Graduates – 26% convictions 0-6 months, 76% convictions

D: In-treatment outcome, single case, no control/comparison group studies, concept secure TC's

Table 1: Description of institutions covered by outcome studies

Study	Pub. date	Institution	Approx. op. dates of inst.	Target populations	Description of treatment regime
E13 Sweet et al	1977	DOR (Drug offenders Rehab. Program), Memphis, Tennessee	1973-	Drug abusing offenders	TC with behaviour management. In house phase followed by after-care.
E27 Glider et al	1997	Amity, Pima, USA	1987	Drug abusing offenders	In-prison TC

Table 2: Subjects in outcome studies

Study	Pub. date	Institution	Diagnostic	Sample characteristics			
				Age	Gen.	Num.	Additional information
E.13 Sweet	1977	DOR Memphis Tennessee	Current DOR Clients			16	Divided into 3 groups 0-7 weeks (N=6) 14-21 weeks (N=5) & 28-64 weeks (N=5)
E27 Glider et al	1997	Amity, Pima, USA	Admissions 11/87 - 6/94	Mean 28	Male & Female	410 207	Cohort 1 admissions 11/87 - 12/90 Cohort 2 admissions 6/92 - 6/94

Table 3: Methodology of outcome studies

Study	Pub. date	Institution	Period of research study	Control/com. group	Treatments compared	Instruments used	Test admin. times	Post-treatment follow-up	Outcome criteria	Attrition rates
E.13 Sweet	1977	DOR Memphis	1973-7	No		EPI	Once		Differences for long stay/ short stay groups	
E27 Glider et al	1997	Amity, Pima, USA	1987	No	ASI* TSC* BDI* SMAS* CMRS*		On admission & prior to release		Test score changes	

Table 4: Findings of outome studies

Study	Pub. date	Institution	Psychological/behavioural finding	Recidivism/re-admisstion/ relapse	Success rate stated %
E.13 Sweet	1977	DOR Memphis	No changes for short/medium/long stay groups. Significant improvements in lie scale, realism & extraversion, and increased neuroticism, for more responsible positions in hierarchy.		
E27 Glider et al	1997	Amity, Pima, USA	Significant positive changes on depression, anxiety and self-concept		

ASI* - Addiction Severity Index TSC* - Tennessee Self Concept Scale BDI* - Beck Depression Inventory
SMAS* - Shortened Manifest Anxiety Scale CMRS* - Circumstance, Motivation, Readiness & Suitability for Treatment Scale

9 CATALOGUE OF REFERENCES FOR ALL STUDIES REVIEWED

A = SECURE DEMOCRATIC + PDs OUTCOME STUDIES – POST- & IN-TREATMENT, AND REVIEWS

A.1. ANGLIKER, C.C.J., CORMIER, B.M., BOULANGER, P. & MALAMUD, B., 1973, A THERAPEUTIC COMMUNITY FOR PERSISTENT OFFENDERS. AN EVALUATION AND FOLLOW-UP STUDY ON THE FIRST FIFTY CASES, CANADIAN PSYCHIATRIC ASSOCIATION JOURNAL, 18, 4, 289-295

A.2. AUERBACH, A. W., 1977, THE ROLE OF THE THERAPEUTIC COMMUNITY "STREET PRISON" IN THE REHABILITATION OF YOUTHFUL OFFENDERS, PH.D. DISSERTATION, GEORGE WASHINGTON UNIVERSITY

A.3. COOKE, D. J., 1989, CONTAINING VIOLENT PRISONERS: AN ANALYSIS OF THE BARLINNIE SPECIAL UNIT, BRITISH JOURNAL OF CRIMINOLOGY, 29, 2, 129-143

A.8. FINK, L., DERBY, W.N. & MARTIN, J. P., 1969, PSYCHIATRY'S NEW ROLE IN CORRECTIONS, AMERICAN JOURNAL OF PSYCHIATRY, 126, 124-128

A.9. GENDERS, E. & PLAYER, E., 1995, GRENDON. A STUDY OF A THERAPEUTIC PRISON, OXFORD, CLARENDON PRESS

A.11. HARRIS, G., RICE, M. & CORMIER, C., 1994, PSYCHOPATHS: IS THE THERAPEUTIC COMMUNITY THERAPEUTIC?, THERAPEUTIC COMMUNITIES, 15, 4, 283-299

A.12. McMURRAN, M., EGAN, V. & AHMADI, S., 1998 (FORTHCOMING), A RETROSPECTIVE EVALUATION OF A THERAPEUTIC COMMUNITY FOR MENTALLY DISORDERED OFFENDERS, JOURNAL OF FORENSIC PSYCHIATRY

A.13. MARSHALL, P., 1997, A RECONVICTION STUDY OF HMP GRENDON THERAPEUTIC COMMUNITY, RESEARCH FINDINGS NO. 53, LONDON, HOME OFFICE RESEARCH AND STATISTICS DIRECTORATE

A.15. NEWTON, M., 1971, RECONVICTION AFTER TREATMENT AT GRENDON. CP REPORT, SERIES B, NO.1, LONDON, OFFICE OF CHIEF PSYCHOLOGIST, PRISON DEPARTMENT, HOME OFFICE

A.18. REHN, G., 1979, RUCKFALL NACH SOZIALTHERAPIE. VERGLEICHENDE UNTERSUCHUNG AUS DREI HAMBURGER JUSTIZVOLLZUGSANSTALTEN (RE-OFFENDING AFTER SOCIAL THERAPY. COMPARATIVE INVESTIGATIONS CARRIED OUT IN THREE PENITENTIARY CENTRES (PRISONS) IN HAMBURG), MONATSSCHRIFT FUR KRIMINOLOGIE UND STRAFRECHTSREFORM, 62, 357-365

A.19. RICE, M.E., HARRIS, G.T. & CORMIER, C.A., 1992, AN EVALUATION OF A MAXIMUM SECURITY THERAPEUTIC COMMUNITY FOR PSYCHOPATHS AND OTHER MENTALLY DISORDERED OFFENDERS, LAW AND HUMAN BEHAVIOUR, 16, 4, 399-412

A.20. ROBERTSON, G. & GUNN, J., 1987, A TEN YEAR FOLLOW-UP OF MEN DISCHARGED FROM GRENDON PRISON, BRITISH JOURNAL OF PSYCHIATRY, 151, 674-678

A.21. SEWELL, R. V. & CLARKE, C. R., 1982, AN EVALUATION STUDY OF THE ANNEXE - A THERAPEUTIC COMMUNITY IN WORMWOOD SCRUBS PRISON, UNPUBLISHED REPORT, HOME OFFICE

A.26. CULLEN, E., 1993, THE GRENDON RECONVICTION STUDY, PART I, PRISON SERVICE JOURNAL, 90, 35-37

A.27. CLARKE, C.R. & GLATT, M.M., 1985, WORMWOOD SCRUBS ANNEXE - A THERAPEUTIC COMMUNITY WITHIN A PRISON: DISCUSSION PAPER, JOURNAL OF THE ROYAL SOCIETY OF MEDICINE, 78, 8, 656-662

A.29. COOKE, D.J., THE BARLINNIE SPECIAL UNIT, PRISON SERVICE JOURNAL, 75, 12-17

A.36b. VAN EMMERIK, J., 1987, DETENTION AT THE GOVERNMENT'S PLEASURE: A FOLLOW-UP STUDY OF PATIENTS RELEASED FROM THE DR. HENRI VAN DER HOEVEN CLINIC, IN BRAND-KOOLEN, M.J.M., (ED), STUDIES ON THE DUTCH PRISON SYSTEM, AMSTELVEEN, THE NETHERLANDS, KUGLER PUBLICATIONS, CH.9, 117-136

A.37a. CORMIER, B.M., 1975, THE WATCHER AND THE WATCHED, MONTREAL, QUEBEC, CANADA & PLATTSBURG, NY., TUNDRA BOOKS

A.37b. GRENDON PSYCHOLOGY UNIT, 1966, A PILOT STUDY OF THE SUBSEQUENT PROGRESS OF FORMER GRENDON INMATES DISCHARGED JULY-DEC 1964, GRENDON PSYCHOLOGY UNIT REPORTS, SERIES C, C/23, LONDON, DIRECTORATE OF PSYCHOLOGICAL SERVICES, HOME OFFICE

A.40. JONES, L.F., 1988, THE HOSPITAL ANNEXE: A PRELIMINARY EVALUATION REPORT, DIRECTORATE OF PSYCHOLOGICAL SERVICES, SERIES II, NO.164, LONDON, DPS., HOME OFFICE

A.43. GEORGE, R., 1971, GRENDON FOLLOW-UP 1967-68, GRENDON PSYCHOLOGY UNIT, SERIES A, REPORT NO. 47

A.45. MCPHERSON, R.H., 1973, WING STABILITY AND SUCCESS RATE. HMP GRENDON, UNPUBLISHED DOCUMENT

A.47. VAN EMMERIK, J., 1987, RECIDIVISM AMONG MENTALLY DISORDERED OFFENDERS DETAINED AT THE GOVERNMENT'S PLEASURE (TBR). A REPORT OF A FOLLOW-UP STUDY OF PATIENTS DISCHARGED BETWEEN 1974 AND 1979, IN BRAND-KOOLEN, M.J.M., 1987, STUDIES ON THE DUTCH PRISON SYSTEM, AMSTELVEEN, KUGLER, CH.X, 137-150

A.50. JONES, L., 1990, THE USE OF A REPERTORY GRID AS A TOOL FOR THE EVALUATION OF A THERAPEUTIC COMMUNITY, M.SC. IN APPLIED CRIMINOLOGICAL PSYCHOLOGY DISSERTATION, BIRKBECK COLLEGE, UNIVERSITY OF LONDON

A.52. CORMIER, B.M. & ANGLIKER, C.C.J., 1972, A THERAPEUTIC COMMUNITY FOR PERSISTENT OFFENDERS, IN SAGARIN, E. & MACNAMARA, D. E. J., (EDS.), CORRECTIONS, PROBLEMS OF PUNISHMENT & REHABILITATION, NEW YORK, PRAEGER PUBLISHERS, 96-105

A.53. MCCORD, W.M., 1982, THE PSYCHOPATH AND MILIEU THERAPY: A LONGITUDINAL STUDY, NEW YORK, ACADEMIC PRESS

A.54. MCCORD, W. & SANCHEZ, J., 1983, THE TREATMENT OF DEVIANT CHILDREN: A TWENTY-FIVE YEAR FOLLOW-UP STUDY, CRIME & DELINQUENCY, 29, 2, 238-253

A.55. SANCHEZ, J., 1986, THE USE OF MILIEU THERAPY IN TREATING THE ANTISOCIAL PERSONALITY, RESIDENTIAL TREATMENT FOR CHILDREN AND YOUTH, 4, 1, 25-38

A.56. MCCORD, W., 1985, THE EFFECTIVENESS OF MILIEU THERAPY WITH PSYCHOPATHS, MILIEU THERAPY, 4, 1, 29-40

A.57. WENGER, R.T., 1974, AN EXAMINATION OF THE EFFECTS OF TREATMENT IN A THERAPEUTIC COMMUNITY VERSUS THE CUSTODIAL PSYCHIATRIC APPROACH IN A PENAL SYSTEM (PH.D. DISSERTATION), BROOKLYN CENTER, LONG ISLAND UNIVERSITY

A.58a. PADDOCK, A.L., III. & SCOTT, R.J., 1973, EVALUATION OF THE INCREMENTAL EFFECTIVENESS OF THE ASKLEPION COMMUNITY ON POST-INCARCERATION ADJUSTMENT OF CONVICTED FELONS, BAKERSFIELD, CA., CALIFORNIA STATE COLLEGE

A.63. BRIGGS, D., 1972, RESEARCH AND EVALUATION, APPENDIX TO CHAPTER SIX, IN WHITELEY, S., BRIGGS, D. & TURNER, M., DEALING WITH DEVIANTS, PART II, CHINO, CALIFORNIA, LONDON, THE HOGARTH PRESS, 165-171

A.64. GUNN, J., ROBERTSON, G. & DELL, S., 1978, PSYCHIATRIC ASPECTS OF IMPRISONMENT, LONDON, ACADEMIC PRESS

A.67. NEWTON, M., 1973, PROGRESS OF FOLLOW-UP STUDIES AND COMPARISON WITH NON-PATIENTS CARRIED OUT AT HMP OXFORD, GRENDON PSYCHOLOGY UNIT REPORT, SERIES A, A/15

A.68. MCMICHAEL, P., 1974, AFTER-CARE, FAMILY RELATIONSHIPS AND RECONVICTION IN A SCOTTISH APPROVED SCHOOL, BRITISH JOURNAL OF CRIMINOLOGY, 14, 3, 236-247

A.73. SANDHU, H.S., 1970, THERAPY WITH VIOLENT PSYCHOPATHS IN AN INDIAN PRISON COMMUNITY, INTERNATIONAL JOURNAL OF OFFENDER THERAPIES, 14, 138-144

A.76. CORNISH, D.B. & CLARKE, R.V.G., 1975, RESIDENTIAL TREATMENT AND ITS EFFECTS ON DELINQUENCY, LONDON, H.M.S.O. (TO BE READ IN CONJUNCTION WITH: CLARKE, R.V.G. & CORNISH, D.B., 1972, THE CONTROLLED TRIAL IN INSTITUTIONAL RESEARCH - PARADIGM OR PITFALL FOR PENAL EVALUATORS, LONDON, H.M.S.O. - D.55.)

A.79. HODGES, E. F., 1971, CRIME PREVENTION BY THE INDETERMINATE SENTENCE LAW, AMERICAN JOURNAL OF PSYCHIATRY, 128, 3, 291-295

SECURE - DEMOCRATIC - IN-TREATMENT OUTCOME

A.14. MILLER, Q., 1982, PRELIMINARY CONSIDERATION OF PSYCHOLOGICAL TEST/RETEST SCORES AND THEIR BEARING ON CRIMINAL RECONVICTION, GRENDON PSYCHOLOGY UNIT SERIES D, REPORT D13

A.16. NEWTON, M., 1996, OUTCOME OF TREATMENT AT GRENDON: CHANGES IN PERSONALITY (EPQ), HOSTILITY (HDHQ) AND LOCUS OF CONTROL (UNPUBLISHED RESEARCH REPORT)

A.17. OGLOFF, J.R.P., WONG, S. & GREENWOOD, A., 1990, TREATING CRIMINAL PSYCHOPATHS IN A THERAPEUTIC COMMUNITY PROGRAM, BEHAVIORAL SCIENCES AND THE LAW, 8, 181-190

A.69. BEARD, J.A., 1980, THE EFFECTS OF A STRUCTURED SMALL TREATMENT UNIT ON THE PERCEPTIONS, PERSONALITY, AND BEHAVIOR OF ADULT MALE INMATES, PH.D. THESIS, THE PENNSYLVANIA STATE UNIVERSITY

REVIEWS ONLY - SECURE - DEMOCRATIC - POST-TREATMENT OUTCOME

A.4. CULLEN, E., 1994, GRENDON: THE THERAPEUTIC PRISON THAT WORKS, THERAPEUTIC COMMUNITIES, 15, 4, 301-311

A.10. GRAY, W. J., 1973, THE THERAPEUTIC COMMUNITY AND EVALUATION OF RESULTS, INTERNATIONAL JOURNAL OF CRIMINOLOGY AND PENOLOGY, 1, 4, 327-334

A.22. SHIREMAN, C.H., MANN, K. B., LARSEN, C. & YOUNG, T., 1972, FINDINGS FROM EXPERIMENTS IN TREATMENT IN THE CORRECTIONAL INSTITUTION, SOCIAL SERVICE REVIEW, 46, 1, 38-5

A.34. SIDLEY, N.T., 1974, THE EVALUATION OF PRISON TREATMENT AND PREVENTIVE DETENTION PROGRAMS: SOME PROBLEMS FACED BY THE PATUXENT INSTITUTION, BULLETIN OF THE AMERICAN ACADEMY OF PSYCHIATRY & THE LAW, 2,2, 73-95

A.35a. COOKE, D.J., 1991, VIOLENCE IN PRISONS: THE INFLUENCE OF REGIME FACTORS, THE HOWARD JOURNAL OF CRIMINAL JUSTICE, 30, 95-109

A.48. SCOTTISH PRISON SERVICE, 1994, SMALL UNITS IN THE SCOTTISH PRISON SERVICE. THE REPORT OF THE WORKING PARTY OF THE BARLINNIE SPECIAL UNIT, EDINBURGH, SCOTTISH PRISON SERVICE

A.59. CULLEN, E., 1997, CAN A PRISON BE A THERAPEUTIC COMMUNITY? THE GRENDON TEMPLATE, IN CULLEN, E., JONES, L. & WOODWARD, R., (EDS.), THERAPEUTIC COMMUNITIES FOR OFFENDERS, CHICHESTER, JOHN WILEY & SONS, CH. 4, 75-99

A.60. COOKE, D.J., 1977, THE BARLINNIE SPECIAL UNIT: THE RISE AND FALL OF A THERAPEUTIC EXPERIMENT, IN CULLEN, E., JONES, L. & WOODWARD, (EDS.), THERAPEUTIC COMMUNITIES FOR OFFENDERS, CHICHESTER, JOHN WILEY & SONS, CH. 5, 101-120

A.61. JONES, L., 1997, DEVELOPING MODELS FOR MANAGING TREATMENT INTEGRITY AND EFFICACY IN A PRISON-BASED TC: THE MAX GLATT CENTRE, IN CULLEN, E., JONES, L. & WOODWARD, R., (EDS.), THERAPEUTIC COMMUNITIES FOR OFFENDERS, CHICHESTER, JOHN WILEY & SONS, CH. 6, 121-157

A.62. LOSEL, F. & EGG, R., 1977, SOCIAL-THERAPEUTIC INSTITUTIONS IN GERMANY: DESCRIPTION AND EVALUATION, IN CULLEN, E., JONES, L. & WOODWARD, (EDS.), THERAPEUTIC COMMUNITIES FOR OFFENDERS, CHICHESTER, JOHN WILEY & SONS, CH. 8, 181-203

B = NON-SECURE DEMOCRATIC + PDs OUTCOME - POST- & IN-TREATMENT AND REVIEWS

B.2. CARSON, W.M., 1973, A CANADIAN THERAPEUTIC COMMUNITY FOR DISRUPTIVE YOUTHS, INTERNATIONAL JOURNAL OF OFFENDER THERAPY AND COMPARATIVE CRIMINOLOGY, 17, 3, 268-284

B.3. CHIESA, M., 1997, A COMBINED IN-PATIENT/OUT-PATIENT PROGRAMME FOR SEVERE PERSONALITY DISORDERS, THERAPEUTIC COMMUNITIES, 18, 4, 297-309

B.4. CHIESA, M., IACOPONI, E. & MORRIS, M., 1996, CHANGES IN HEALTH SERVICE UTILIZATION BY PATIENTS WITH SEVERE PERSONALITY DISORDERS DEFORE AND AFTER INPATIENT PSYCHOSOCIAL TREATMENT, BRITISH JOURNAL OF PSYCHOTHERAPY, 12, 4, 501-512

B.5. COPAS, J.B., O'BRIEN, M., ROBERTS, J. & WHITELEY, J.S., 1984, TREATMENT OUTCOME IN PERSONALITY DISORDER: THE EFFECT OF SOCIAL, PSYCHOLOGICAL AND BEHAVIOURAL VARIABLES, PERSONALITY AND INDIVIDUAL DIFFERENCES, 5, 5, 565-573

B.6. COPAS, J.B. & WHITELEY, J.S., 1976, PREDICTING SUCCESS IN THE TREATMENT OF PSYCHOPATHS, BRITISH JOURNAL OF PSYCHIATRY, 129, 388-392

B.7. CRAFT, M., STEPHENSON, G. & GRANGER, C., 1964, A CONTROLLED TRIAL OF AUTHORITARIAN AND SELF-GOVERNING REGIMES WITH ADOLESCENT PSYCHOPATHS, AMERICAN JOURNAL OF ORTHOPSYCHIATRY, 34, 543-554

B.8. DAVIDSON, G.P., 1976, A BRITISH THERAPEUTIC COMMUNITY FOR THE PERSISTENT OFFENDER, INTERNATIONAL JOURNAL OF OFFENDER THERAPY AND COMPARATIVE CRIMINOLOGY, 20, 1, 77-81

B.9. DAVIES, S., CAMPLING, P. & RYAN, K., 1997, DOES EVERY DISTRICT NEED A THERAPEUTIC COMMUNITY, UNPUBLISHED PAPER, FRANCIS DIXON LODGE, GIPSY LANE, LEICESTER

B.12. DOLAN, B.M., EVANS, C. & WILSON, J., 1992, THERAPEUTIC COMMUNITY TREATMENT FOR PERSONALITY DISORDERED ADULTS: CHANGES IN NEUROTIC SYMPTOMATOLOGY ON FOLLOW-UP, INTERNATIONAL JOURNAL OF SOCIAL PSYCHIATRY, 38, 4, 243-250

B.13. DOLAN, B.M., EVANS, C. & WILSON, J., 1992, NEUROTIC SYMPTOMATOLOGY AND LENGTH OF STAY IN A THERAPEUTIC COMMUNITY, 13, 3, 171-177

B.14. DOLAN, B., WARREN, F. & NORTON, K., 1997, CHANGE IN BORDERLINE SYMPTOMS ONE YEAR AFTER THERAPEUTIC COMMUNITY TREATMENT FOR SEVERE PERSONALITY DISORDER, BRITISH JOURNAL OF PSYCHIATRY, 171, 274-279

B.15. HAFNER, R.J. & HOLME, G., 1996, THE INFLUENCE OF A THERAPEUTIC COMMUNITY ON PSYCHIATRIC DISORDER, JOURNAL OF CLINICAL PSYCHOLOGY, 52, 4, 461-468

B.19. KOBAL, M. & ZAGAR, D., 1994, AN OPEN FORENSIC PSYCHIATRY WARD ORGANISED AS A THERAPEUTIC COMMUNITY, THERAPEUTIC COMMUNITIES, 15, 4, 265-272

B.20. LEHMAN, A. & RITZLER, B., 1976, THE THERAPEUTIC COMMUNITY INPATIENT WARD: DOES IT REALLY WORK?, COMPREHENSIVE PSYCHIATRY, 17, 6, 755-761

B.26. MEHLUM, L., FRIIS, S., IRION, T., JOHNS, S., KARTERUD, S., VAGLUM, P. & VAGLUM, S., 1991, PERSONALITY DISORDERS 2-5 YEARS AFTER TREATMENT: A PROSPECTIVE FOLLOW-UP STUDY, ACTA PSYCHIATRICA SCANDINAVICA, 84, 1, 72-77 (SEE ALSO B.18 & B.33 - RELATED IN-TREATMENT STUDIES)

B.29. PIPER, W.E., ROSIE, J.S., JOYCE, A.S. & AZIM, H.F.A., 1996, TIME-LIMITED DAY TREATMENT FOR PERSONALITY DISORDERS. INTEGRATION OF RESEARCH AND PRACTICE IN A GROUP PROGRAM, WASHINGTON, DC., AMERICAN PSYCHOLOGICAL ASSOCIATION

B.30. RAPOPORT, R.N., 1960, COMMUNITY AS DOCTOR. NEW PERSPECTIVES ON A THERAPEUTIC COMMUNITY, LONDON, TAVISTOCK PUBLICATIONS

B.35. WHITELEY, S., 1972, EXPERIENCES IN THE THERAPEUTIC COMMUNITY: THE RESULTS OF TREATMENT, IN WHITELEY, S., BRIGGS, D. & TURNER, M., DEALING WITH DEVIANTS, LONDON, HOGARTH PRESS, CH.3, 53-72

B.36. WHITELEY, J.S., 1970, THE RESPONSE OF PSYCHOPATHS TO A THERAPEUTIC COMMUNITY, BRITISH JOURNAL OF PSYCHIATRY, 116, 517-529

B.43. ROSSER, R.M., BIRCH, S., BOND, H., DENFORD, J. & SCHACHTER, J., 1987, FIVE-YEAR FOLLOW UP OF PATIENTS TREATED WITH INPATIENT PSYCHOTHERAPY AT THE CASSEL HOSPITAL FOR NERVOUS DISEASES, JOURNAL OF THE ROYAL SOCIETY OF MEDICINE, 80, 9, 549-555 (SEE ALSO B.10 - RELATED IN-TREATMENT OUTCOME STUDY)

B.53. KARTERUD, S., PEDERSEN, G., FRIIS, S., URNES, O., IRION, T., BRABAND, J., FALKUM, L.R. & LEIRVAG, H., 1998, THE NORWEGIAN NETWORK OF PSYCHOTHERAPEUTIC DAY HOSPITALS, THERAPEUTIC COMMUNITIES, 19, 1, 15-28

B.56. DOLAN, B.M., WARREN, F.M., MENZIES, D. & NORTON, K., 1996, COST-OFFSET FOLLOWING SPECIALIST TREATMENT OF SEVERE PERSONALITY DISORDERS, PSYCHIATRIC BULLETIN, 20, 413-417

B.57. EISEN, P., BLENKHORN, J., WENDIGGENSEN, P., ENTWISTLE, L., SHAW, N., BUSHBY, R. & CANN, S., 1986, THE MELBOURNE CLINIC PSYCHOTHERAPY UNIT: CLINICAL OUTCOME OVER THE FIRST 21 MONTHS, INTERNATIONAL JOURNAL OF THERAPEUTIC COMMUNITIES, 7, 3, 211-223

B.59. GARA, A., HUTCHINSON, V. & HAFNER, R.J., 1989, RESIDENTS' EVALUATION OF A THERAPEUTIC COMMUNITY, AUSTRALIAN CLINICAL REVIEW, 8, 211-216

B.62. TUCKER, L., BAUER, S. F., WAGNER, S., HARLAM, D. & SHER, I., 1987, LONG-TERM HOSPITAL TREATMENT OF BORDERLINE PATIENTS: A DESCRIPTIVE OUTCOME STUDY, AMERICAN JOURNAL OF PSYCHIATRY, 144, 11, 1443-1448

B.63. CRAFT, M., 1966, METHODS OF CARE. II. THE BALDERTON PSYCHOPATHIC UNIT, IN CRAFT, M., (ED.), PSYCHOPATHIC DISORDERS AND THEIR ASSESSMENT, OXFORD, PERGAMON PRESS

NON-SECURE - DEMOCRATIC - IN-TREATMENT OUTCOME

B.10. DENFORD, J., SCHACHTER, J., TEMPLE, N., KIND, P. & ROSSER, R., 1983, SELECTION AND OUTCOME IN IN-PATIENT PSYCHOTHERAPY, BRITISH JOURNAL OF MEDICAL PSYCHOLOGY, 56, 225-243 (SEE ALSO B.43 - RELATED POST-TREATMENT STUDY)

B.18. KARTERUD, S., VAGLUM, S., FRIIS, S., IRION, T., JOHNS, S. & VAGLUM, P., 1992, DAY HOSPITAL THERAPEUTIC COMMUNITY TREATMENT FOR PATIENTS WITH PERSONALITY DISORDERS. AN EMPIRICAL EVALUATION OF THE CONTAINMENT FUNCTION, THE JOURNAL OF NERVOUS AND MENTAL DISEASE, 180, 4, 238-243 (SEE ALSO B.26. & B.33. - RELATED IN- AND POST-TREATMENT STUDIES)

B.28. NORRIS, M., 1983, CHANGES IN PATIENTS DURING TREATMENT AT THE HENDERSON HOSPITAL THERAPEUTIC COMMUNITY DURING 1977-1981, BRITISH JOURNAL OF MEDICAL PSYCHOLOGY, 56, 2, 135-143

B.33. VAGLUM, P., FRIIS, S., IRION, T., JOHNS, S., KARTERUD, S., LARSEN, F. & VAGLUM, S., 1990, TREATMENT RESPONSE OF SEVERE AND NONSEVERE PERSONALITY DISORDERS IN A THERAPEUTIC COMMUNITY DAY UNIT, JOURNAL OF PERSONALITY DISORDERS, 4, 2, 161-172 (SEE ALSO B.18. & B.26. - RELATED IN- AND POST-TREATMENT OUTCOME STUDIES)

B.37. MILES, A.E., 1969, THE EFFECTS OF A THERAPEUTIC COMMUNITY ON THE INTERPERSONAL RELATIONSHIPS OF A GROUP OF PSYCHOPATHS, BRITISH JOURNAL OF CRIMINOLOGY, 9, 22-38

B.58. SPIELMAN, R., 1975, A NEW APPLICATION OF CLOSED GROUP PSYCHOTHERAPY IN A PUBLIC PSYCHIATRIC HOSPITAL, 9, 3, 193-199

B.55. MENZIES, D., DOLAN, F.M. & NORTON, K., 1993, ARE SHORT TERM SAVINGS WORTH LONG TERM COSTS? FUNDING TREATMENT FOR PERSONALITY DISORDERS, PSYCHIATRIC BULLETIN, 17, 517-519

REVIEWS ONLY - NON-SECURE - DEMOCRATIC - POST-TREATMENT OUTCOME

B.11a. DOLAN, B. & COID, J., 1993, THERAPEUTIC COMMUNITY APPROACHES, IN DOLAN, B. & COID, J., PSYCHOPATHIC AND ANTISOCIAL PERSONALITY DISORDERS. TREATMENT AND RESEARCH ISSUES, LONDON, GASKELL, CH.8, 146-180

B.11b. DOLAN, B. & COID, J., 1993, HOSPITAL ADMISSION AND `MILIEU' THERAPY, IN DOLAN, B. & COID, J., PSYCHOPATHIC AND ANTISOCIAL PERSONALITY DISORDERS. TREATMENT AND RESEARCH ISSUES, LONDON, GASKELL, CH. 9, 181-205

B.32. SCHIMMEL, P., 1997, SWIMMING AGAINST THE TIDE? A REVIEW OF THE THERAPEUTIC COMMUNITY, AUSTRALIAN AND NEW ZEALAND JOURNAL OF PSYCHIATRY, 31, 1, 120-127

B.45. WHITELEY, J.S., 1975, THE PSYCHOPATH AND HIS TREATMENT, BRITISH JOURNAL OF PSYCHIATRY, SPEC. NO.9, 159-169

B.46. WHITELEY, J. S., 1990, THE CURATIVE FACTORS IN THE THERAPEUTIC COMMUNITY, IN. STEFANIS, C.N., RABAVILAS, A.D. & SOLDATOS, C.R. (EDS), PSYCHIATRY: A WORLD PERSPECTIVE, VOL 3, PHARMACOTHERAPIES; PSYCHOTHERAPIES; OTHER THERAPIES, NEW YORK, ELSEVIER SCIENCE PUBLICATIONS, B.V., CH.159, 886-895

B.49. DOLAN, B., 1993, OUTCOME OF DAY HOSPITAL TREATMENT FOR PATIENTS WITH PERSONALITY DISORDER. THERAPEUTIC COMMUNITIES RESEARCH COLUMN, THERAPEUTIC COMMUNITIES, 14, 2, 135-138

B.50. WARREN, F. & DOLAN, B., 1996, TREATING THE "UNTREATABLE": THERAPEUTIC COMMUNITIES FOR PERSONALITY DISORDERS, THERAPEUTIC COMMUNITIES, 17, 3, 205-216

B.54. DOLAN, B., 1997, A COMMUNITY BASED TC: THE HENDERSON HOSPITAL, IN CULLEN, E., JONES, L. & WOODWARD, R., (EDS.), THERAPEUTIC COMMUNITIES FOR OFFENDERS, CHICHESTER, JOHN WILEY & SONS, CH. 3, 47-74

C - NON-SECURE - DEMOCRATIC - NON-PDS/MDOS - POST-TREATMENT OUTCOME

C.1. ALANEN, Y. ET AL, 1985, PSYCHOTHERAPEUTICALLY ORIENTED TREATMENT OF SCHIZOPHRENIA: RESULTS OF 5-YEAR FOLLOW-UP. WORLD PSYCHIATRIC ASSOCIATION REGIONAL SYMPOSIUM: NEW PERSPECTIVES IN PSYCHIATRIC RESEARCH, ACTA PSYCHIATRICA SCANDINAVICA, 71, 319, 31-49

C.2. AUSTIN, N.K., LIBERMAN, R.P., KING, L.W. & DeRISI, W.J., 1976, A COMPARATIVE EVALUATION OF TWO DAY HOSPITALS. GOAL ATTAINMENT SCALING OF BEHAVIOUR VS MILIEU THERAPY, JOURNAL OF NERVOUS AND MENTAL DISEASE, 163, 4, 253-262

C.3. BERAN, J., 1993, PRISPEVEK KE SLEDOVAVI EFEKTU LECBY SKUPINOVOU PSYCHOTERAPII/ A CONTRIBUTION TO THE FOLLOW UP OF THE EFFECTS OF GROUP THERAPY TREATMENT, CESKO-SLOVENSKA PSYCHIATRIE, 89, 3, 166-172

C.7. BREZINOVA-BRZIAKOVA, J. & KRATOCHVIL, S., 1989, CALSI VYSLEDKY SESTITYDENNI LECBY NEUROZ V TERAPEUTICKE KOMUNITE/ FURTHER RESULTS OF SIX-WEEK THERAPY OF NEUROSES IN A THERAPEUTIC COMMUNITY, CESKOSLOVENKSA PSYCHIATRIE, 85, 5, 328-333

C.8. CIOMPI, L., DAUWALDER, H.-P., MAIER, C., AEBI, E., TRUTSCH, K., KUPPER, Z. & RUTISHAUSER, C., 1992, THE PILOT PROJECT "SOTERIA BERNE": CLINICAL EXPERIENCES AND RESULTS, BRITISH JOURNAL OF PSYCHIATRY, 16, SUPPL.18, 145-153

C.9. CIOMPI, L., KUPPER, Z., DAUWALDER, J.P., HUBSCHMID, T., TRUTSCH, K. & RUTISHAUSER, C., 1993, DAS PILOTPROJECT `SOTERIA BERNE' ZUR BEHANDLUNG AKUT SCHIZOPHRENER.II. ERGEBNISSE EINER VERGLEICHENDEN PROSPEKTIVEN VERLAUFSSTUDIE UBER 2 JAHRE/THE PILOT PROJECT "SOTERIA BERNE" FOR THE TREATMENT OF ACUTE SCHIZOPHRENICS. II. RESULTS OF A COMPARATIVE PROSPECTIVE STUDY OVER 2 YEARS, NERVENARZT, 64, 7, 440-450

C.11. CLARK, A.W., 1968, THE PERSONALITY AND SOCIAL NETWORK ADJUSTMENT SCALE: ITS USE IN THE EVALUATION OF TREATMENT IN A THERAPEUTIC COMMUNITY, HUMAN RELATIONS, 21, 1, 85-95

C.12. CLUXTON, J.F., 1966, THERAPEUTIC COMMUNITY-ORIENTED PSYCHIATRIC INPATIENT UNIT. FOLLOW-UP STUDY OF FIRST FIVE HUNDRED PATIENTS TREATED, JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, 53, 10, 945-947

C.15. EKMAN, G., ROSENGREN, C. & CRONHOLM, B., 1981, MILJOTERAPI SOM BEHANDLINGSALTERNATIV VID EN DAGAVDELNING FOR PSYKIATRISK REHABILITERING/MILIEU THERAPY AS AN ALTERNATIVE TREATMENT IN A DAYTIME DEPARTMENT FOR PSYCHIATRIC REHABILITATION, NORDISK PSYKIATRISK TIDSSKRIFT, 35, 1, 23-31

C.16. FORSBERG, E. & STARRIN, B., 1996, THE MILLHILL. A STUDY OF DISCHARGED PATIENTS' EXPERIENCES OF CARE AT A THERAPEUTIC COMMUNITY IN SWEDEN, SCANDINAVIAN JOURNAL OF SOCIAL WELFARE, 5, 2-11

C.18. GUNDERSON, J.G., 1980, A REEVALUATION OF MILIEU THERAPY FOR NONCHRONIC SCHIZOPHRENIC PATIENTS, SCHIZOPHRENIA BULLETIN, 6, 1, 64-69

C.21. ISOHANNI, M. & HIRVENOJA, R., 1989, VILKA FAKTORER FORUTSAGER VARDRESULTATET PA EN MILJOTERAPEUTISKT INRIKTAD VARDAVDELNING?/WHICH FACTORS PREDICT TREATMENT OUTCOME IN A THERAPEUTIC COMMUNITY?, NORDIC SYMPOSIUM ON RESEARCH ON AND PSYCHOTHERAPY OF PSYCHOSES, NORDISK PSYKIATRISK TIDSSKRIFT, 43, 1, 87-91

C.22. ISOHANNI, M. & NIEMINEN, P., 1989, PREDICTING IMMEDIATE OUTCOME ON A CLOSED PSYCHIATRIC WARD FUNCTIONING AS A THERAPEUTIC COMMUNITY, PSYCHIATRIA FENNICA, 2O, 13-23

C.23. ISOHANNI, I, NIEMINEN, P. & ISOHANNI, M., 1997, THE RELATIONSHIP BETWEEN PATIENTS' EDUCATIONAL LEVEL AND THERAPEUTIC PROCESS IN AN ACUTE PATIENT THERAPEUTIC COMMUNITY, EUROPEAN PSYCHIATRY, 12, 3, 130-135

C.25. KECMANOVIC, D., CERIC, I. & TROGRANCIC, Z., 1975, INFLUENCE OF THE THERAPEUTIC COMMUNITY ON THE RESOCIALIZATION OF PSYCHIATRIC PATIENTS, SOCIJALNA PSIHIJATRIJA, 5, 2, 221-230

C.26. KONING, R.F. & WAGENBORG, J.E.A., 1988, PSYCHOTHERAPEUTIC COMMUNITIES FOLLOW-UP PROJECT (10), TIJDSCHRIFT VOOR PSYCHIATRIE, 30, 10, 658-678

C.27. KONING, R.F. & WAGENBORG, J.E.A., 1988, IT WAS WORTHWHILE, WASN'T IT? RETROSPECTIVE REFLECTIONS ON THE FOLLOW-UP PROJECT ON PSYCHOTHERAPEUTIC COMMUNITIES, INTERNATIONAL JOURNAL OF THERAPEUTIC COMMUNITIES, 9, 3, 205-221

C.28. KOSTER, A.M., 1986, THE FOLLOW-UP PROJECT PSYCHOTHERAPEUTIC COMMUNITIES (7): CONSUMER-SATISFACTION, TIJDSCHRIFT VOOR PSYCHIATRIE, 28, 8, 555-570 + 572

C.29. KOSTER, A.M. & WAGENBORG, J.E., 1986, HET FOLLOW-UP PROJECT PSYCHOTHERAPEUTISCHE GEMEENSCHAPPEN (8): EIND GOED, AL GOED? OFWEL, HOE GAAT HET MET EX-PATIENTEN TOT EN MET VIJF JAAR NA HUN ONTSLAG UNIT DE PTG?/THE FOLLOW-UP PROJECT PSYCHOTHERAPEUTIC COMMUNITIES: VIII. ALL IS WELL THAT ENDS WELL?, TIJDSCHRIFT VOOR PSYCHIATRIE, 28, 9, 632-644

C.30. KOSTER, A.M. & WAGENBORG, J.E.A., 1988, THE FOLLOW-UP PROJECT ON PSYCHOTHERAPEUTIC COMMUNITIES: A COLLECTION OF MEASURES OF CHANGE, INTERNATIONAL JOURNAL OF THERAPEUTIC COMMUNITIES, 9, 3, 163-176

C.31. KRATOCHVIL, S. & DUBIAS-PAPIASVILI, E., 1977, RESULTS OF SIX WEEK TREATMENT OF NEUROSES IN A THERAPEUTIC COMMUNITY, CESKOSLOVENSKA PSYCHIATRIE, 73, 2, 104-109

C.32. KRATOCHVIL, S., LISKOVA, M. & MACHU, V., 1983, RESULTATE DER THERAPEUTISCHEN GEMEINSCHAFT FUR NEUROTIKER/RESULTS WITH THE THERAPEUTIC COMMUNITY FOR NEUROTIC PATIENTS, PSYCHIATRIE, NEUROLOGIE UND MEDIZINISCHE PSYCHOLOGIE, 35, 1, 10-15

C.33. LAMPEN, J. & NEILL, T., 1985, "A BUCKET OF COLD WATER". A FOLLOW-UP STUDY IN A RESIDENTIAL SPECIAL SCHOOL, JOURNAL OF ADOLESCENCE, 8, 3, 271-287

C.34. LEHMAN, A.F., STRAUSS, J.S., RITZLER, B.A., KOKES, R.F., HARDER, D.W. & GIFT, T.E., 1982, FIRST-ADMISSION PSYCHIATRIC WARD MILIEU: TREATMENT PROCESS AND OUTCOME, ARCHIVES OF GENERAL PSYCHIATRY, 39, 11, 1293-1298

C.36. MANDELBROTE, B.M. & TRICK, K.L.K., 1970, SOCIAL AND CLINICAL FACTORS IN THE OUTCOME OF SCHIZOPHRENIA, ACTA PSYCHIATRICA SCANDINAVICA, 46, 1, 24-34

C.40. MARIOTTO, M.J., 1978, INTERACTION OF PERSON AND SITUATION EFFECTS FOR CHRONIC MENTAL PATIENTS: A TWO-YEAR FOLLOW-UP, JOURNAL OF ABNORMAL PSYCHOLOGY, 87, 6, 676-679

C.41. MAY, P.R., TUMA, H. & DIXON, W.J., 1976, SCHIZOPHRENIA: A FOLLOW-UP STUDY OF RESULTS OF TREATMENT: I. DESIGN AND OTHER PROBLEMS, ARCHIVES OF GENERAL PSYCHIATRY, 33, 4, 474-478

C.42. MAY, P.R. ET AL, 1976, SCHIZOPHRENIA: A FOLLOW-UP STUDY OF RESULTS OF TREATMENT: II. HOSPITAL STAY OVER TWO TO FIVE YEARS, ARCHIVES OF GENERAL PSYCHIATRY, 33, 4, 481-486

C.43. MOSHER, L.R., 1991, SOTERIA. A THERAPEUTIC COMMUNITY FOR PSYCHOTIC PERSONS, INTERNATIONAL JOURNAL OF THERAPEUTIC COMMUNITIES, 12, 1, 53-67

C.44. MOSHER, L.R. & MENN, A.Z., 1977, SOTERIA HOUSE: ONE YEAR OUCOME DATA (PROCEEDINGS), PSYCHOPHARMAC0LOGY BULLETIN, 13, 2, 46-48

C.45. NIEMINEN, P., ISOHANNI, M. & WINBLAD, I., 1994, LENGTH OF HOSPITALIZATION IN AN ACUTE PATIENTS' THERAPEUTIC COMMUNITY WARD, ACTA PSYCHIATRICA SCANDINAVICA, 90, 6, 466-472

C.46. NIEMINEN, P., MAKIKYRO, T. & ISOHANNI, M., 1996, FACTORS PREDICTING SECOND ADMISSION TO AN ACUTE PATIENTS' THERAPEUTIC COMMUNITY, NORDIC JOURNAL OF PSYCHIATRY, 50, 2, 133-141

C.47. NURCOMBE , B., OWNE, S. & BERAN, R., 1973, PSYCHOTHERAPY WITH ADOLESCENT PATIENTS. THE FIRST THREE YEARS OF THE PRINCE HENRY HOSPITAL ADOLESCENT UNIT, MEDICAL JOURNAL OF AUSTRALIA, 1, 13, 625-629

C.49. PAPOUCHIS, N., 1972, AN EVALUATIVE STUDY OF A THERAPEUTIC COMMUNITY APPROACH TO TREATMENT, PH.D. THESIS, CITY UNIVERSITY OF NEW YORK

C.50. PILLAY, A.L., DU PLESSIS, W.F., VAWDA, N.B.M. & POLLOCK, L.R., 1994, DEMOGRAPHIC AND READMISSION DATA IN A THERAPEUTIC COMMUNITY FOR BLACK PSYCHIATRIC PATIENTS IN SOUTH AFRICA, AUSTRALIAN & NEW ZEALAND JOURNAL OF PSYCHIATRY, 28, 4, 684-688

C.52. SALOKANGAS, R., 1986, PSYCHOSOCIAL OUTCOME IN SCHIZOPHRENIA AND PSYCHOTHERAPEUTIC ORIENTATION, ACTA PSYCHIATRICA SCANDINAVICA, 74, 5, 497-506

C.57. STEVENS, B.C., 1973, EVALUATION OF REHABILITATION FOR PSYCHOTIC PATIENTS IN THE COMMUNITY, ACTA PSYCHIATRICA SCANDINAVICA, 49, 2, 169-180

C.58. THOMPSON, C.M., 1985, CHARACTERISTICS ASSOCIATED WITH OUTCOME IN A COMMUNITY MENTAL HEALTH PARTIAL HOSPITALIZATION PROGRAM, COMMUNITY MENTAL HEALTH JOURNAL, 21, 3, 179-188

C.59. TREMONTI, G.W. & KONING, R.F., 1986, THE FOLLOW-UP PROJECT PSYCHOTHERAPEUTIC COMMUNITIES (5): THE PREDICTABILITY OF READMISSION; AN INVESTIGATION INTO THE VALIDITY OF THE `NIEUWKOOP QUESTIONNAIRE', TIJDSCHRIFT VOOR PSYCHIATRIE, 28, 2, 123-134

C.60. TREMONTI, G.W. & KONING, R.F., 1987, HET FOLLOW-UP PROJECT PSYCHOTHERAPEUTISCHE GEMEENSCHAPPEN (9): OPZOEK NAAR VERGELIJKINGSMATERIAAL/THE FOLLOW-UP PROJECT PSYCHOTHERAPEUTIC COMMUNITIES. IX. IN SEARCH OF A COMPARISON, TIJDSCHRIFT VOOR PSYCHIATRIE, 29, 7, 452-463

C.61. TREMONTI, G.W. & KONING, R.G., PTC OUTCOME IN A GRAND PRIX CONTEST: IN SEARCH OF A COMPARISON, INTERNATIONAL JOURNAL OF THERAPEUTIC COMMUNITIES, 9, 3, 193-203

C.63. VAITL, P., BENDER, W., HUBMANN, W., HUMMEL, C., KRONER, A. & KRONER, M., 1989, VOLLSTATIONARE VERSUS HALBSTATIONARE PSYCHIATRISCHE ANSCHLUSSBEHANDLUNG - EINE VERGLEICHENDE RETROSPEKTIVE STUDIE/FULL INPATIENT VERSUS PARTIAL INPATIENT PSYCHIATRIC AFTER-CARE - A COMPARATIVE RETROSPECTIVE STUDY, PSYCHIATRISCHE PRAXIS, 16, 6, 214-217

C.66. WAGENBORG, J.E.A., 1986, THE FOLLOW-UP PROJECT PSYCHOTHERAPEUTIC COMMUNITIES (6): DO CLIENTS MEET THE EXPECTATIONS OF EXPERTS?, TIJDSCHRIFT VOOR PSYCHIATRIE, 28, 3, 188-198

C.67. WAGENBORG, J.E.A., 1988, THE GOOD, THE BAD AND THE UGLY: OUTCOMES OF RESIDENTIAL PSYCHOTHERAPY, INTERNATIONAL JOURNAL OF THERAPEUTIC COMMUNITIES, 9, 3, 177-191

C.68. WAGENBORG, J.E.A., TREMONTI, G.W., HESSELINK, A.J. & KONING, R.F., 1988, THE FOLLOW-UP PROJECT ON PSYCHOTHERAPEUTIC COMMUNITIES: DESIGN AND PRELIMINARY RESULTS, INTERNATIONAL JOURNAL OF THERAPEUTIC COMMUNITIES, 9, 3, 129-152

C.71. WILLIAMS, G.H., 1992, EFFICACY OF BEHAVIORAL AND MILIEU GROUP THERAPIES FOR TRAINING PSYCHIATRIC INPATIENTS IN PROSOCIAL BEHAVIOURS AS A FUNCTION OF SOCIAL SKILLS, PH.D. THESIS, THE UNIVERSITY OF CONNECTICUT

C.72. WRIGHT, L.A. & KOGUT, R.S., 1972, A RESOCIALIZATION PROGRAM FOR THE TREATMENT OF CHRONIC HOSPITALIZED SCHIZOPHRENIC PATIENTS, DISEASES OF THE NERVOUS SYSTEM, 33, 9, 614-616

C.78. VERHAEST, S., PIERLOOT, R. & BOSTJIN, C., 1982, PATIENT VARIABLES INFLUENCING OUTCOME IN A RESIDENTIAL PSYCHOTHERAPY PROGRAMME, INTERNATIONAL JOURNAL OF THERAPEUTIC COMMUNITIES, 3, 1, 15-23

C.79. KENNARD, D., CLEMMEY, R. & MANDELBROTE, B., 1977, ASPECTS OF OUTCOME IN A THERAPEUTIC COMMUNITY SETTING. HOW PATIENTS ARE SEEN BY THEMSELVES AND OTHERS, BRITISH JOURNAL OF PSYCHIATRY, 130, 475-480

C.82. EVISON, M. & TRAUER, T., 1983, AN EVALUATION OF OUTPATIENT GROUP PSYCHOTHERAPY AND THERAPEUTIC COMMUNITY TREATMENT, INTERNATIONAL JOURNAL OF THERAPEUTIC COMMUNITIES, 4, 2, 118-131

C.83. NIEMINEN, P., 1996, THERAPEUTIC COMMUNITY RESEARCH AND STATISTICAL DATA ANALYSIS, ACTA UNIVERSITATIS OULUENSIS MEDICA, D360, OULU, UNIVERSITY OF OULU PRINTING CENTER

D - DEFINITIONAL - TCS, PDS, METHODOLOGIES, REVIEWS, ETC

D.1. ASHWORTH, P., 1993, PARTICIPANT AGREEMENT IN THE JUSTIFICATION OF QUALITATIVE FINDINGS, JOURNAL OF PHENOMENOLOGICAL PSYCHOLOGY, 24, 1, 3-16

D.2. BARBOUR-MCMULLEN, J., COID, J. & HOWARD, R., THE PSYCHOMETRIC IDENTIFICATION OF PSYCHOPATHY IN MENTALLY ABNORMAL OFFENDERS, PERSONALITY AND INDIVIDUAL DIFFERENCES, 9, 4, 817-823

D.3. BERG, W.E., 1979, THE EVALUATION OF TREATMENT IN THERAPEUTIC COMMUNITIES: PROBLEMS OF DESIGN AND IMPLEMENTATION, EVALUATION AND PROGRAM PLANNING, 2, 1, 41-48

D.4. BERGLUND, G.W., BERGMARK, A., BJORLING, B., GRONBLADH, L., LINDBERG, S., OSCARSSON, L., OLSSON, B., SEGRAEUS, V. & STENSMO, C., 1991, THE SWEDATE PROJECT: INTERACTION BETWEEN TREATMENT, CLIENT BACKGROUND AND OUTCOME IN A ONE-YEAR FOLLOW-UP, JOURNAL OF SUBSTANCE ABUSE TREATMENT, 8, 3, 161-169

D.5. BLACKBURN, R., 1983, ARE PERSONALITY DISORDERS TREATABLE, ISSUES IN CIMINOLOGY AND LEGAL PSYCHOLOGY, 4, 23-26

D.6. BURNS, J.L., 1976, THE EVALUATION OF RESEARCH DATA AND THE ORIENTATION OF RESULTS PAPERS: A COMMENTARY ON "RESIDENTIAL TREATMENT AND ITS EFFECTS ON DELINQUENCY", COMMUNITY HOME SCHOOLS GAZETTE, 70, 9, 411-416

D.7. CLARKE, L., 1994, AN EXAMINATION OF THERAPEUTIC PRINCIPLES AND PRACTICE IN TWO FORENSIC UNITS, JOURNAL OF PSYCHIATRIC & MENTAL HEALTH NURSING, 1, 2, 99-107

D.8. COLLINS, P., 1991, THE TREATABILITY OF PSYCHOPATHS, JOURNAL OF FORENSIC PSYCHIATRY, 2, 103-110

D.9. CORNISH, D.B., 1987, EVALUATING RESIDENTIAL TREATMENTS FOR DELINQUENTS: A CAUTIONARY TALE, IN HURRELMANN, K., KAUFMANN, F-X. & LOSEL, F. (EDS), SOCIAL INTERVENTION: POTENTIAL AND CONSTRAINTS. PREVENTION AND INTERVENTION IN CHILDHOOD AND ADOLESCENCE 1. CH.20. 333-345, BERLIN/NEW YORK, WALTER DE GRUYTER

D.10. DeJONG, C.A., VAN DEN BRINK, W., HARTEVELD, F.M. & VAN DER WIELEN, E.G., 1993, PERSONALITY DISORDERS IN ALCOHOLICS AND DRUG ADDICTS, COMPREHENSIVE PSYCHIATRY, 34, 2, 87-94

D.11. EINSTEIN, S., 1981, UNDERSTANDING DRUG USER TREATMENT EVALUATION: SOME UNRESOLVED ISSUES, INTERNATIONAL JOURNAL OF THE ADDICTIONS, 16, 3, 381-400

D.12. EVANS, C., 1994, TC METHODS WITHIN THE PENAL SYSTEM: IS RESEARCH ON POSSIBLE SELECTION VARIABLES AS SIMPLE AS IT SOUNDS? OR SHOULD IT BE SIMPLER?, THERAPEUTIC COMMUNITIES, 15, 4, 319-324

D.13. EVANS, C., CARLYLE, J. & DOLAN, B., 1996, FORENSIC PSYCHOTHERAPY RESEARCH, IN COX, M. & CORDESS, C. (EDS), FORENSIC PSYCHOTHERAPY, CH.11.30, 509-542, LONDON, JESSICA KINGSLEY

D.14. HALLEBONE, E.L., 1992, USE OF TYPOLOGIES FOR `MEASURING' SELF-IDENTITY CHANGE: METHODOLOGICAL ISSUES IN LONGITUDINAL QUALITATIVE RESEARCH, QUALITY AND QUANTITY, 26, 1-17

D.15. HIGGITT, A. & FONAGY, P., 1992, PSYCHOTHERAPY IN BORDERLINE AND NARCISSISTIC PERSONALITY DISORDER, BRITISH JOURNAL OF PSYCHIATRY, 161, 23-43

D.16. HOBBY, E.E., 1972, THE PSYCHOPATHIC CODE AND THE THERAPEUTIC COMMUNITY, HOSPITAL AND COMMUNITY PSYCHIATRY, 23, 1, 41-43

D.17. HOLMAN, C., 1996, A TWENTY YEAR PROGRAMME OF RESEARCH ON TREATMENT VARIABLES, THERAPEUTIC COMMUNITIES, 17, 1, 63-65

D.18. ISOHANNI, M. & NIEMINEN, P., 1996, A TWENTY-YEAR-PROGRAMME OF RESEARCH ON TREATMENT (MAINLY) AND VARIABLES (ALSO): A RESPONSE TO HOLMAN, THERAPEUTIC COMMUNITIES, 17, 3, 217-220

D.19. JONES, M., 1984, WHY TWO THERAPEUTIC COMMUNITIES, JOURNAL OF PSYCHOACTIVE DRUGS, 16, 1, 23-26

D.20. KIGER, R.S., 1967, TREATING THE PSYCHOPATHIC PATIENT IN A THERAPEUTIC COMMUNITY, HOSPITAL AND COMMUNITY PSYCHIATRY, 18, 7, 15-20

D.21. LOSEL, F., c1997, HAS THE CONCEPT OF TREATMENT FAILED? AN EMPIRICAL REVIEW, UNPUBLISHED PAPER, UNIVERSITY OF ERLANGEN-NURNBERG

D.22. KENNARD, D., 1994, THE FUTURE REVISITED: NEW FRONTIERS FOR THERAPEUTIC COMMUNITIES, THERAPEUTIC COMMUNITIES, 15, 2, 107-113

D.23. NIEMINEN, P., 1995, STATISTICAL CONTENT OF PUBLISHED THERAPEUTIC COMMUNITY RESEARCH, THERAPEUTIC COMMUNITIES, 16, 4, 239-250

D.24. NIEMINEN, P. & ISOHANNI, M., 1997, THE USE OF BIBLIOMETRIC DATA IN EVALUATING RESEARCH ON THERAPEUTIC COMMUNITY FOR ADDICTIONS AND IN PSYCHIATRY, SUBSTANCE USE & MISUSE, 32, 5, 555-570

D.25. NORTON, K., 1996, THE PERSONALITY-DISORDERED FORENSIC PATIENT AND THE THERAPEUTIC COMMUNITY, IN COX. M. & CORDESS, C. (EDS), FORENSIC PSYCHOTHERAPY: CRIME, PSYCHODYNAMICS AND THE OFFENDER PATIENT, VOL.2: MAINLY PRACTICE, CH.11-23, 401-421, LONDON, JESSICA KINGSLEY

D.26. PAUL, G.L., 1967, STRATEGY OF OUTCOME RESEARCH IN PSYCHOTHERAPY, JOURNAL OF CONSULTING PSYCHOLOGY, 31, 2, 109-118

D.27. PIKOFF, H.B., 1996, TREATMENT EFFECTIVENESS HANDBOOK: A REFERENCE GUIDE TO THE KEY RESEARCH REVIEWS IN MENTAL HEALTH AND SUBSTANCE ABUSE, BUFFALO, NY, STATE U NEW YORK

D.28. ROBERTS, J., 1997, HOW TO RECOGNISE A THERAPEUTIC COMMUNITY, PRISON SERVICE JOURNAL, 111, 4-7

D.29. SUGARMAN, B., 1984, TOWARDS A NEW, COMMON MODEL OF THE THERAPEUTIC COMMUNITY: STRUCTURAL COMPONENTS, LEARNING PROCESSES AND OUTCOMES, INTERNATIONAL JOURNAL OF THERAPEUTIC COMMUNITIES, 5, 2, 77-98

D.30. WARREN, F., 1994, WHAT DO WE MEAN BY A `THERAPEUTIC COMMUNITY' FOR OFFENDERS? COMMENTARY ON PAPERS BY HARRIS ET AL AND CULLEN, THERAPEUTIC COMMUNITIES, 15, 4, 312-318

D.31. WILSON, S., 1978, EVALUATING THERAPEUTIC COMMUNITIES: WHAT WE KNOW AND WHAT WE WANT TO KNOW, PAPER PRESENTED AT THE 3RD WORLD CONFERENCE OF THERAPEUTIC COMMUNITIES, ROME, ITALY, SEPTEMBER

D.32. WHITELEY, S., 1995, THE EFFECTIVENESS OF THERAPEUTIC COMMUNITIES, CORRESPONDENCE, THERAPEUTIC COMMUNITIES, 16, 2, 146-147
HARRIS, G.T. & RICE, M.E., 1995, REPLY TO WHITELEY, CORRESPONDENCE, THERAPEUTIC COMMUNITIES, 16, 2, 147-149

D.33. WHITELEY, J.S., 1994, ATTACHMENT, LOSS AND THE SPACE BETWEEN: PERSONALITY DISORDER IN THE THERAPEUTIC COMMUNITY, 18TH S.H. FOULKES ANNUAL LECTURE, GROUP ANALYSIS, 27, 4, 359-387

D.34. BEACH, K., 1989, THROUGH THE DODO BIRD TO THERAPEUTIC FACTORS, EDITORIAL, INTERNATIONAL JOURNAL OF THERAPEUTIC COMMUNITIES, 10, 2,

75-79

D.35. GUNDERSON, J.G., 1994, BUILDING STRUCTURE FOR THE BORDERLINE CONSTRUCT, ACTA PSYCHIATRICA SCANDINAVICA, 89, (SUPPL.379), 12-18

D.36. NORTON, K. & HINSHELWOOD, R., 1996, SEVERE PERSONALITY DISORDER. TREATMENT ISSUES AND SELECTION FOR IN-PATIENT PSYCHOTHERAPY, BRITISH JOURNAL OF PSYCHIATRY, 168, 723-731

D.37. VAGLUM, P., FRIIS, S., JORSTAD, J., KARTERUD, S. & LORENTZEN, S., 1982, FROM A PANACEA TO A SPECIAL TREATMENT METHOD:, INTERNATIONAL JOURNAL OF THERAPEUTIC COMMUNITIES, 3, 1, 24-32

D.38. PLOEGER, A., 1980, THE THERAPEUTIC COMMUNITY IN THE FEDERAL REPUBLIC OF GERMANY IN THE PAST, AT PRESENT AND IN THE FUTURE, INTERNATIONAL JOURNAL OF THERAPEUTIC COMMUNITIES, 1, 2, 75-79

D.39. MOOS, R.H. & BURNETT, E.B., 1996, SOCIAL CONTEXT AND PSYCHOLOGICAL ADAPTATION, THERAPEUTIC COMMUNITIES, 17, 3, 167-172

D.40. MILLER, E., 1992, "THE THERAPEUTIC COMMUNITY APPROACH" - DOES IT EXIST?, THERAPEUTIC COMMUNITIES, 13, 2, 127-129
PULLEN, G., 1992, A RESPONSE TO ERIC MILLER, THERAPEUTIC COMMUNITIES, 13, 2, 129-130

D.41. GLASER, A.N., 1983, THERAPEUTIC COMMUNITIES AND THERAPEUTIC COMMUNITIES: A PERSONAL PERSPECTIVE, INTERNATIONAL JOURNAL OF THERAPEUTIC COMMUNITIES, 4, 2, 150-162

D.42. MANNING, N. & LEES, J., 1985, AUSTRALIAN COMMUNITY CARE: A STUDY OF THE RICHMOND FELLOWSHIP, CANTERBURY, UNIVERSITY OF KENT

D.43. NIEMINEN, P., 1996, TYPE OF EMPIRICAL RESEARCH REPORTS AS AN EXPLANATORY FACTOR IN CITATION PERFORMANCE OF PSYCHIATRIC RESEARCH, SCIENTOMETRICS, 35, 3, 309-320

D.44. DUNLOP, A.B., 1974, THE APPROVED SCHOOL EXPERIENCE. AN ACCOUNT OF BOYS' EXPERIENCES OF TRAINING UNDER DIFFERING REGIMES, WITH AN ATTEMPT TO EVALUATE THE EFFECTIVENESS OF THAT TRAINING, LONDON, H.M.S.O

D.45. DEPARTMENT OF HEALTH & HOME OFFICE, 1992, REVIEW OF HEALTH AND SOCIAL SERVICES FOR MENTALLY DISORDERED OFFENDERS AND OTHERS REQUIRING SIMILAR SERVICES, CMN 2088, LONDON, H.M.S.O

D.46. DEPARTMENT OF HEALTH & HOME OFFICE, 1994, REPORT OF THE DEPARTMENT OF HEALTH & HOME OFFICE WORKING GROUP ON PSYCHOPATHIC DISORDER, (REED REPORT), LONDON, H.M.S.O

D.47. KNOBLOCH, F., 1990, THERAPEUTIC COMMUNITY AND INDIVIDUAL PSYCHOTHERAPY IN THE INTEGRATED PSYCHOTHERAPY SYSTEM, IN STEFANIS, C.N., RABAVILAS, A.D. & SOLDATOS, C.R., 1990, PSYCHIATRY: A WORLD PERSPECTIVE, VOL.3. PHARMACOTHERAPIES; PSYCHOTHERAPIES; OTHER THERAPIES, NEW YORK, ELSEVIER SCIENCE PUBLICATIONS, 881-885

D.48. KARTERUD, S., 1988, WHAT ARE THE PREREQUISITES AND INDICATIONS OF THE THERAPEUTIC COMMUNITY PROPER - A COMPARATIVE STUDY, ACTA PSYCHIATRICA SCANDINAVICA, 77, 6, 658-669

D.49. NATARAJAN, M. & FALKIN, G.P., 1997, CAN CORRECTIONS OPERATE THERAPEUTIC COMMUNITIES FOR INMATES? THE IMPACT OF THE SOCIAL ENVIRONMENT OF JAILS, JOURNAL OF CORRECTIONAL HEALTH CARE, 4, 1, 19-36

D.50. CLARKE, R.V.G. & SINCLAIR, I., 1974, TOWARDS MORE EFFECTIVE TREATMENT EVALUATION, IN EUROPEAN COMMITTEE ON CRIME PROBLEMS, (ED.), COLLECTED STUDIES IN CRIMINOLOGICAL RESEARCH, VOL. XII., METHODS OF EVALUATION AND PLANNING IN THE FIELD OF CRIME, STRASBOURG, COUNCIL OF EUROPE, 53-87

D.51. LOSEL, F., 1993, THE EFFECTIVENESS OF TREATMENT IN INSTITUTIONAL AND COMMUNITY SETTINGS, CRIMINAL BEHAVIOUR AND MENTAL HEALTH, 3, 416-437

D.52. LOSEL, F., 1995, THE EFFICACY OF CORRECTIONAL TREATMENT: A REVIEW AND SYNTHESIS OF META-EVALUATIONS, IN MCGUIRE, J., (ED.), WHAT WORKS: REDUCING REOFFENDING - GUIDELINES FROM RESEARCH AND PRACTICE, CHICHESTER, JOHN WILEY & SONS

D.53. DUNLOP, A.B., 1975, EXPERIENCE OF RESIDENTIAL TREATMENT AND ITS EFFECTIVENESS, HOME OFFICE RESEARCH UNIT RESEARCH BULLETIN, AUTUMN, NO.2., 22-26, LONDON, HOME OFFICE

D.54. NIEMINEN, P., 1996, THERAPEUTIC COMMUNITY RESEARCH AND STATISTICAL DATA ANALYSIS, ACTA UNIVERSITATIS OULENSIS MEDICA, D360, OULU, UNIVERSITY OF OULU PRINTING PRESS

D.55. CLARKE, R.V.G. & CORNISH, D.B., 1972, THE CONTROLLED TRIAL IN INSTITUTIONAL RESEARCH - PARADIGM OR PITFALL FOR PENAL EVALUATORS, LONDON, H.M.S.O.

D.56. CLARK, A.W. & WALKER, R.M., 1984, THE CONTINUING INFLUENCE OF THE THERAPEUTIC COMMUNITY CONCEPT, INTERNATIONAL JOURNAL OF THERAPEUTIC COMMUNITIES, 5, 3, 140-156

D.57. PILGRIM, D., 1997, SOME REFLECTIONS ON `QUALITY' AND `MENTAL HEALTH', JOURNAL OF MENTAL HEALTH, 6, 6, 567-576

D.58. KERNBERG, O.F., 1982, ADVANTAGES AND LIABILITIES OF THE THERAPEUTIC COMMUNITY, IN PINES, M., THE INDIVIDUAL AND THE GROUP: BOUNDARIES AND INTERRELATIONS, VOL. 1., 543-565

D.59. MORSTYN, R., 1993, SOME FALLACIES OF STATISTICAL INFERENCES ABOUT PSYCHOTHERAPY, AUSTRALIAN AND NEW ZEALAND JOURNAL OF PSYCHIATRY, 27, 101-107

D.60. VAGLUM, S & VAGLUM, P., 1985, BORDERLINE AND OTHER MENTAL DISORDERS IN ALCOHOLIC FEMALE PSYCHIATRIC PATIENTS: A CASE CONTROL STUDY, PSYCHOPATHOLOGY, 18, 50-60

D.61. LEVINSON, A., THE STRUGGLE TO KEEP A CULTURE OF ENQUIRY ALIVE AT THE CASSEL HOSPITAL, 1996, THERAPEUTIC COMMUNITIES, 17, 1, 47-56

D.62. CLARKE, R.V. & CORNISH, D.B., 1978, THE EFFECTIVENESS OF RESIDENTIAL TREATMENT FOR DELINQUENTS, BOOK SUPPLEMENT TO THE JOURNAL OF CHILD PSYCHOLOGY & PSYCHIATRY, 1, 143-159

D.63. LOSEL, F. & KOFERL, P., 1989, EVALUATION RESEARCH ON CORRECTIONAL TREATMENT IN WEST GERMANY, IN WEGENER, H., LOSEL, F. & HAISCH, J., (EDS.), CRIMINAL BEHAVIOUR AND THE JUSTICE SYSTEM: PSYCHOLOGICAL PERSPECTIVES, NEW YORK, SPRINGER, 334-355

D.64. LOSEL, F., 1995, INCREASING CONSENSUS IN THE EVALUATION OF OFFENDER REHABILITATION? LESSONS FROM RECENT RESEARCH SYNTHESES, PSYCHOLOGY, CRIME & LAW, 2, 19-39

D.65. STONE, M.H., 1993, LONG-TERM OUTCOME IN PERSONALITY DISORDERS, BRITISH JOURNAL OF PSYCHIATRY, 162, 299-313

D.66. HINE, F. R., WERMAN, D. S. & SIMPSON, D. M., 1982, EFFECTIVENESS OF PSYCHOTHERAPY: PROBLEMS OF RESEARCH ON COMPLEX PHENOMENA, AMERICAN JOURNAL OF PSYCHIATRY, 139, 2, 204-208

D.67. CANDY, J., BALFOUR, F. H. G., CAWLEY, R. H., HILDEBRAND, H. P., MALAN, D. H., MARKS, I. M. & WILSON, J., 1972, A FEASIBILITY STUDY FOR A CONTROLLED TRIAL OF FORMAL PSYCHOTHERAPY, PSYCHOLOGICAL MEDICINE, 2, 345-362

D.68. MANNING, N.P., 1989, THE THERAPEUTIC COMMUNITY MOVEMENT: CHARISMA AND ROUTINISATION, LONDON, ROUTLEDGE

D.69. KENNARD, D., 1978, IDENTIFYING DIMENSIONS OF PERCEIVED PATIENT CHANGE: SOME PROBLEMS IN THE USE OF FACTOR ANALYSIS, BRITISH JOURNAL OF MEDICAL PSYCHOLOGY, 51, 1, 41-52

E - SECURE - CONCEPT OUTCOME - POST- & IN-TREATMENT OUTCOME - DK IF PDS

E.2. EISENBERG, M. & FABELO, T., 1996, EVALUATION OF THE TEXAS CORRECTIONAL SUBSTANCE ABUSE TREATMENT INITIATIVE: THE IMPACT OF POLICY RESEARCH, CRIME & DELINQUENCY, 42, 2, 296-308

E.5. INCIARDI, J.A. & LOCKWOOD, D., 1994, WHEN WORLDS COLLIDE: ESTABLISHING CREST OUTREACH CENTER, IN FLETCHER, B.W., INCIARDI, J.A. & HORTON, A.M., (EDS), 1994, DRUG ABUSE TREATMENT. THE IMPLEMENTATION OF INNOVATIVE APPROACHES., CONTRIBUTIONS IN CRIMINOLOGY AND PENOLOGY, NO.45, WESTPORT, CT., GREENWOOD PRESS

E.6. INCIARDI, J.A., MARTIN, S.S., BUTZIN, C.A., HOOPER, R.M. & HARRISON, L.D., 1997, AN EFFECTIVE MODEL OF PRISON-BASED TREATMENT FOR DRUG-

INVOLVED OFFENDERS, JOURNAL OF DRUG ISSUES, 27, 2, 261-278

E.7. INCIARDI, J.A. & SURRATT, H.L., 1996, LES COMMUNAUTES THERAPEUTIQUES EN MILIEU CARCERAL/THERAPEUTIC COMMUNITIES IN THE PRISON ENVIRONMENT, CRIMINOLOGIE, XXIX, 1, 71-83

E.8. KNIGHT, K., SIMPSON, D.D., CHATHAM, L.R. & CAMACHO, L.M., 1997, AN ASSESSMENT OF PRISON-BASED DRUG TREATMENT: TEXAS' IN-PRISON THERAPEUTIC COMMUNITY PROGRAM, JOURNAL OF OFFENDER REHABILITATION, 24, 3/4, 75-100

E.10. MARTIN, S.S., BUTZIN, C.A. & INCIARDI, J.A., 1995, ASSESSMENT OF A MULTISTAGE THERAPEUTIC COMMUNITY FOR DRUG-INVOLVED OFFENDERS, JOURNAL OF PSYCHOACTIVE DRUGS, 27, 1, 109-116

E.11b. NIELSEN, A.L., SCARPITTI, F.R. & INCIARDI, J.A., 1996, INTEGRATING THE THERAPEUTIC COMMUNITY AND WORK RELEASE FOR DRUG-INVOLVED OFFENDERS: THE CREST PROGRAM, JOURNAL OF SUBSTANCE ABUSE TREATMENT, 13, 4, 349-358

E.13. SWEET, R.S., LITTLE, G.L., WOOD, R.W. & HARRISON, H.D., 1977, A DRUG OFFENDER REHABILITATION PROGRAM: RECOVERY RATES, PERSONALITY VARIABLES, AND MAINTENANCE FACTORS, QUARTERLY JOURNAL OF CORRECTIONS, 1, 1, 13-27

E.16. WEXLER, H.K., 1996, EVALUATION OF PRISON SUBSTANCE ABUSE TREATMENT PROGRAMS: OUTCOME STUDIES AND METHODOLOGY, IN EARLY, D.E., (ED), 1996, DRUG TREATMENT: PRISON-BASED STRATEGIES FOR CHANGE, WESTPORT, CT., PRAEGER

E.17. WEXLER, H.K., FALKIN, G.P. & LIPTON, D.S., 1990, OUTCOME EVALUATION OF A PRISON THERAPEUTIC COMMUNITY FOR SUBSTANCE ABUSE TREATMENT, CRIMINAL JUSTICE AND BEHAVIOR, 17, 1, 71-92

E.18. WEXLER, H.K., FALKIN, G.P., LIPTON, D.S. & ROSENBLUM, A.B., 1992, OUTCOME EVALUATION OF A PRISON THERAPEUTIC COMMUNITY FOR SUBSTANCE ABUSE TREATMENT, NIDA RESEARCH MONOGRAPH, ISSUE 118, 156-175

E.19. WEXLER, H.K. & LOVE, C.T., 1994, THERAPEUTIC COMMUNITIES IN PRISON, NIDA RESEARCH MONOGRAPH, ISSUE 144, 181-208

E.25. GRAHAM, W.F. & WEXLER, H.K., 1997, THE AMITY THERAPEUTIC COMMUNITY PROGRAM AT DONOVAN PRISON: PROGRAM DESCRIPTION AND APPROACH, IN DE LEON, G., (ED), 1997, COMMUNITY AS METHOD. THERAPEUTIC COMMUNITIES FOR SPECIAL POPULATIONS AND SPECIAL SETTINGS, WESTPORT, CT., PRAEGER, CH.5, 69-86

E.26. LOCKWOOD, D., INCIARDI, J.A., BUTZIN, C.A. & HOOPER, R.M., 1997, THE THERAPEUTIC COMMUNITY CONTINUUM IN CORRECTIONS, IN DE LEON, G., (ED), COMMUNITY AS METHOD. THERAPEUTIC COMMUNITIES FOR SPECIAL POPULATIONS AND SPECIAL SETTINGS, WESTPORT, CT., PRAEGER, CH.6, 87-96

E.27. GLIDER, P., MULLEN, R., HERBST, D., DAVIS, C. & FLEISHMAN, B., 1997, SUBSTANCE ABUSE TREATMENT IN A JAIL SETTING: A THERAPEUTIC COMMUNITY MODEL, IN DE LEON, G., (ED), COMMUNITY AS METHOD. THERAPEUTIC COMMUNITIES FOR SPECIAL POPULATIONS AND SPECIAL SETTINGS, WESTPORT, CT., PRAEGER, CH.7., 97-112

E.28. PELISSIER, B., 1998, TRIAD TREATMENT EVALUATION SIX-MONTH REPORT EXECUTIVE SUMMARY, http://www.bop.gov.

E.31. SWARTZ, J.A., LURIGIO, A.J. & SLOMKA, S.A., 1996, THE IMPACT OF IMPACT: AN ASSESSMENT OF THE EFFECTIVENESS OF A JAIL-BASED TREATMENT PROGRAM, CRIME & DELINQUENCY, 42, 4, 553-573

E.32. WEXLER, H., 1977, THERAPEUTIC COMMUNITIES IN AMERICAN PRISONS, IN CULLEN, E., JONES, L. & WOODWARD, (EDS.), THERAPEUTIC COMMUNITIES FOR OFFENDERS, CHICHESTER, JOHN WILEY & SONS, CH. 7, 161-179

E.33. FIELD, G., 1989, THE EFFECTS OF INTENSIVE TREATMENT ON REDUCING THE CRIMINAL RECIDIVISM OF ADDICTED OFFENDERS, FEDERAL PROBATION, 53, 10, 51-56

E.35. STATE OF NEW YORK DEPARTMENT OF CORRECTIONAL SERVICES, 1996, THE COMPREHENSIVE ALCOHOL AND SUBSTANCE ABUSE TREATMENT PROGRAM. AS OF JUNE 30, 1996, NEW YORK, STATE OF NEW YORK DEPARTMENT OF CORRECTIONAL SERVICES

F - CONCEPT - DEFINITIONAL - OUTCOME REVIEWS - METHODOLOGIES - DUAL DIAGNOSIS - BA

F.1. ANGLIN, D., CARDOZO, A., DI MENZA, S., DE LEON, G., GAWIN, G., HAVASSEY, B., HEAPS, M., HOFFMAN, N., HUBBARD, R., INCIARDI, J., MCBRIDE, D., MCLELLAN, T., MCCLOUD, A., MILLER, N. & SIMPSON, D., 1996, TREATMENT PROTOCOL EFFECTIVENESS STUDY, JOURNAL OF SUBSTANCE ABUSE TREATMENT, 13, 4, 297-319

F.2. ANGLIN, M.D. & HSER, Y-I, 1992, DRUG ABUSE TREATMENT, IN WATSON, R.R., (ED), 1992, DRUG ABUSE TREATMENT, TOTOWA, N.J., HUMANA PRESS, CH.1., 1-36

F.3. BALE, R.M., 1979, OUTCOME RESEARCH IN THERAPEUTIC COMMUNITIES FOR DRUG ABUSERS: A CRITICAL REVIEW 1963-1975, INTERNATIONAL JOURNAL OF THE ADDICTIONS, 14, 8, 1053-1074

F.4. BARR, H.L., 1977, THE PROBLEM OF EVALUATING THE EFFECTIVENESS OF THERAPEUTIC COMMUNITIES, ADDICTION THERAPIST, 2, 1, 38-40

F.5. CRITS-CRISTOPH, P. & SIQUELAND, L., 1996, PSYCHOSOCIAL TREATMENT FOR DRUG ABUSE, ARCHIVES OF GENERAL PSYCHIATRY, 53, 8, 749-756

F.6. DE LEON, G., 1989, PSYCHOPATHOLOGY AND SUBSTANCE ABUSE: WHAT IT BEING LEARNED FROM RESEARCH IN THERAPEUTIC COMMUNITIES, JOURNAL OF PSYCHOACTIVE DRUGS, 21, 2, 177-188

F.7. DE LEON, G., 1990-1991, AFTERCARE IN THERAPEUTIC COMMUNITIES, INTERNATIONAL JOURNAL OF THE ADDICTIONS, 25, 9A-10A, 1225-1238

F.8. DE LEON, G., 1993, MODIFIED THERAPEUTIC COMMUNITIES FOR DUAL DISORDERS, IN SOLOMON, J., ZIMBERG, S. & SHOLLAR, E., (EDS), 1993, DUAL DIAGNOSIS: EVALUATION, TREATMENT, TRAINING, AND PROGRAM DEVELOPMENT, NEW YORK, PLENUM

F.9. DE LEON, G., 1995, RESIDENTIAL THERAPEUTIC COMMUNITIES IN THE MAINSTREAM: DIVERSITY AND ISSUES, JOURNAL OF PSYCHOACTIVE DRUGS, 27, 1, 3-15

F.10. DE LEON, G., INCIARDI, J.A. & MARTIN, S.S., 1995, RESIDENTIAL DRUG ABUSE TREATMENT RESEARCH: ARE CONVENTIONAL CONTROL DESIGNS APPROPRIATE FOR ASSESSING TREATMENT EFFECTIVENESS?, JOURNAL OF PSYCHOACTIVE DRUGS, 27, 1, 85-91

F.11. GERSTEIN, D.R., 1992, THE EFFECTIVENESS OF DRUG TREATMENT, IN O'BRIEN, C.P. & JAFFE, J.H., 1992, ADDICTIVE STATES. RESEARCH PUBLICATIONS: ASSOCIATION FOR RESEARCH IN NERVOUS AND MENTAL DISEASE, VOL.70, NEW YORK, RAVEN PRESS, CH.15, 253-282

F.12. GERSTEIN, D.R., 1994, OUTCOME RESEARCH: DRUG ABUSE, IN GALANTER, M. & KLEBER, H.D., 1994, THE AMERICAN PSYCHIATRIC PRESS TEXTBOOK OF SUBSTANCE ABUSE TREATMENT, WASHINGTON, DC., AMERICAN PSYCHIATRIC PRESS, INC., CH.5, 45-64

F.13. HEIT, D.S., 1993, THERAPEUTIC COMMUNITIES FOR DRUG ABUSE: THE CONTEMPORARY SCENE IN THE U.S.A., THERAPEUTIC COMMUNITIES, 14, 3, 151-163

F.14. KOOYMAN, M., 1993, THE THERAPEUTIC COMMUNITY FOR ADDICTS: INTIMACY, PARENT INVOLVEMENT, AND TREATMENT SUCCESS, AMSTERDAM, SWETS & ZEITLINGER

F.15. KUFNER, H., 1995, BEHANDLUNGSFAKTOREN BEI ALKOHOL UN DROGENABHANGIGEN/TREATMENT FACTORS FOR ALCOHOL AND DRUG ADDICTS, ZEITSCHRIFT FUR KLINISCHE PSYCHOLOGIE, 24, 2, 170-183

F.16. O'BRIEN, W.B. & HALPERN, S., 1989, THE THERAPEUTIC COMMUNITY IN RETROSPECT AND PROSPECT, IN EINSTEIN, S., (ED), 1989, DRUG AND ALCOHOL USE. ISSUES AND FACTORS, NEW YORK, PLENUM, 295-302

F.17. PLATT, J.J., HUSBAND, S.D. & TAUBE, D., 1990-1991, MAJOR PSYCHOTHERAPEUTIC MODALITIES FOR HEROIN ADDICTION: A BRIEF OVERVIEW, INTERNATIONAL JOURNAL OF THE ADDICTIONS, 25, (12A), 1453-1477

F.18. ROSENTHAL, M.S., 1984, THERAPEUTIC COMMUNITIES: A TREATMENT ALTERNATIVE FOR MANY BUT NOT ALL, JOURNAL OF SUBSTANCE ABUSE TREATMENT, 1, 1, 55-58

F.19. ROSS, R.R. & CARLESSO, M.L., 1991, LA EFICACIA DE LOS PROGRAMAS DE REHABILITATION DE LAS DROGAS PARA DELINCUENTES/THE EFFICACY OF DRUG REHABILITATION PROGRAMS FOR OFFENDERS, DELINCUENCIA, 3, (1-2), 35-94

F.20. SENAY, E., 1983, "TREATMENT CHARACTERISTICS ASSOCIATED WITH OUTCOME". CRITIQUE, NIDA TREATMENT RESEARCH MONOGRAPHS, NO.83 - 1281, 565-572

F.21. SIMPSON, D.D. & SELLS, S.B., 1982, EFFECTIVENESS OF TREATMENT FOR DRUG ABUSE: AN OVERVIEW OF THE DARP RESEARCH PROGRAM, ADVANCES IN ALCOHOL AND SUBSTANCE ABUSE, 2, 1, 7-29

F.22. SMART, R.G., 1976, OUTCOME STUDIES OF THERAPEUTIC COMMUNITY AND HALFWAY HOUSE TREATMENT FOR ADDICTS, INTERNATIONAL JOURNAL OF THE ADDICTIONS, 11, 1, 143-159

F.23. SUGARMAN, B., 1974, EVALUATING DRUG TREATMENT PROGRAMS: A REVIEW AND CRITIQUE OF SOME STUDIES ON PROGRAMS OF THE CONCEPT HOUSE TYPE, DRUG FORUM, 3, 2, 149-153

F.24. TIMS, F.M., JAINCHILL, N. & DE LEON, G., 1994, THERAPEUTIC COMMUNITIES AND TREATMENT RESEARCH, NIDA RESEARCH MONOGRAPH, ISSUE 44, 1-15

F.25. DE LEON, G., 1989, THE THERAPEUTIC COMMUNITY APPROACH TO REHABILITATION: PERSPECTIVE AND A STUDY OF EFFECTIVENESS, IN EINSTEIN, S., (ED), 1989, DRUG AND ALCOHOL USE: ISSUES AND FACTORS, NEW YORK, PLENUM

F.26. DE LEON, G., 1994, THERAPEUTIC COMMUNITIES, IN GALANTER, M. & KLEBER, H.D., (EDS), 1994, THE AMERICAN PSYCHIATRIC PRESS TEXT BOOK OF SUBSTANCE ABUSE TREATMENT, WASHINGTON, DC., AMERICAN PSYCHIATRIC PRESS, INC.

F.27. MCLELLAN, A.T., O'BRIEN, C.P., METZGER, D., ALTERMAN, A.I., CORNISH, J. & URSCHEL, H., 1992, HOW EFFECTIVE IS SUBSTANCE ABUSE TREATMENT - COMPARED TO WHAT?, IN O'BRIEN, C.P. & JAFFE, J.J., 1992, ADDICTIVE STATES. RESEARCH PUBLICATIONS: ASSOCIATION FOR RESEARCH IN NERVOUS AND MENTAL DISEASE. VOL.70, NEW YORK, RAVEN PRESS

F.28. CANCRINI, L., CONSTANTINI, D. & MAZZONI, S., 1985, DRUG ADDICTION AMONG YOUNG PEOPLE: A STUDY OF TYPOLOGY AND ITS RELEVANCE TO TREATMENT PROGRAMMES, BULLETIN ON NARCOTICS, XXXVII, 2-3, 125-133

F.29. MANN, R.D. & WINGARD, J., 1981, A CROSS-CULTURAL FIELD STUDY OF DRUG REHABILITATION METHODOLOGIES IN SWEDEN AND THE UNITED STATES, JOURNAL OF DRUG EDUCATION, 11, 3, 245-260

F.30. BIASE, D.V. & SULLIVAN, A.P., 1986, EMERGING CROSS-CULTURAL THERAPEUTIC COMMUNITY RESEARCH, JOURNAL OF PSYCHOACTIVE DRUGS, 18, 3, 199-201

F.31. TIMS, F.M., DE LEON, G. & JAINCHILL, N., 1994, THERAPEUTIC COMMUNITY RESEARCH AND PRACTICE: RECOMMENDATIONS, NIDA RESEARCH MONOGRAPH, ISSUE 144, 280-286

F.32. LEWIS, B.F. & ROSS, R., 1994, RETENTION IN THERAPEUTIC COMMUNITIES: CHALLENGE FOR THE NINETIES, NIDA RESEARCH MONOGRAPH, ISSUE 144, 99-116

F.33. GRIFFIN, K.S., 1983, THE THERAPEUTIC COMMUNITY: AN EXPLORATORY COST BENEFIT ANALYSIS, INTERNATIONAL JOURNAL OF THERAPEUTIC COMMUNITIES, 4, 4, 276-284

F.34. HOLLAND, S., 1983, EVALUATING COMMUNITY-BASED TREATMENT PROGRAMMES: A MODEL FOR STRENGTHENING INFERENCES ABOUT EFFECTIVENESS, INTERNATIONAL JOURNAL OF THERAPEUTIC COMMUNITIES, 4, 4, 285-306

F.35. ROUSE, J.J., 1991, EVALUATION RESEARCH ON PRISON-BASED DRUG TREATMENT PROGRAMS AND SOME POLICY IMPLICATIONS, INTERNATIONAL JOURNAL OF THE ADDICTIONS, 26, 1, 29-44

F.36. DE LEON, G., 1984, PROGAM-BASED EVALUATION RESEARCH IN THERAPEUTIC COMMUNITIES, NIDA RESEARCH MONOGRAPH, 51, 69-87

F.37. DE LEON, G., 1988, LEGAL PRESSURE IN THERAPEUTIC COMMUNITIES, JOURNAL OF DRUG ISSUES, 18, 625-640

F.38. DE LEON, G., 1995, THERAPEUTIC COMMUNITIES FOR ADDICTIONS: A THEORETICAL FRAMEWORK, INTERNATIONAL JOURNAL OF THE ADDICTIONS, 30, 12, 1603-1645

F.39. INCIARDI, J.A., LOCKWOOD, D. & MARTIN, S.S., 1994, THERAPEUTIC COMMUNITIES IN CORRECTIONS AND WORK RELEASE: SOME CLINICAL AND POLICY CONSIDERATIONS, NIDA RESEARCH MONOGRAPH 144, 259-167

F.40. JAFFE, J.H., 1984, EVALUATING DRUG ABUSE TREATMENT: A COMMENT ON THE STATE OF THE ART, NIDA RESEARCH MONOGRAPH, 51, 13-28

F.41. LENNINGS, C.J., 1991, DRUG DEPENDENCE AND PERSONALITY DISORDER: ITS RELATIONSHIP TO THE TREATMENT OF DRUG DEPENDENCE, DRUG & ALCOHOL DEPENDENCE, 27, 3, 209-212

F.42. MCLAUGHLIN, P. & PEPPER, B., 1991, MODIFYING THE THERAPEUTIC COMMUNITY FOR THE MENTALLY ILL SUBSTANCE ABUSER, NEW DIRECTIONS FOR MENTAL HEALTH SERVICES, 50, 85-93

F.43. REED, T., OUTCOME RESEARCH ON TREATMENT AND ON THE DRUG ABUSER: AN EXPLORATION, INTERNATIONAL JOURNAL OF THE ADDICTIONS, 13, 1, 149-171

F.44. SHEFFET, A., HICKEY, R.F., LAVENHAR, M.A., WOLFSON, E.A., DUVAL, H., MILLMAN, D. & LOURIA, D.B., 1973, A MODEL FOR DRUG ABUSE TREATMENT PROGRAM EVALUATION, PREVENTIVE MEDICINE, 2, 4, 510-523

F.45. SORENSEN, J.L., DEITCH, D.S. & ACAMPORA, S., 1984, TREATMENT COLLABORATION OF METHADONE MAINTENANCE PROGRAMS AND THERAPEUTIC COMMUNITIES, AMERICAN JOURNAL OF DRUG & ALCOHOL ABUSE, 10, 3, 347-359

F.46. VAILLANT, G.E., 1974, OUTCOME RESEARCH IN NARCOTIC ADDICTION - PROBLEMS AND PERSPECTIVES, AMERICAN JOURNAL OF DRUG & ALCOHOL ABUSE, 1, 1, 25-36

F.47. DE JONG, C.A., VAN DEN BRINK, W., HARTEVELD, F.M. & VAN DER WIELEN, E.G., 1993, PERSONALITY DISORDERS IN ALCOHOLICS AND DRUG ADDICTS, COMPREHENSIVE PSYCHIATRY, 34, 2, 87-94

F.48. RAHAV, M., RIVERA, J.J., COLLINS, J., NG-MAK, D., STURZ, E.L., STUENING, E.L., PEPPER, B., LINK, B.G. & GROSS, B., 1994, BRINGING EXPERIMENTAL RESEARCH DESIGNS INTO EXISTING TREATMENT PROGRAMS: THE CASE OF COMMUNITY-BASED TREATMENT OF THE DUALLY DIAGNOSED, IN FLETCHER, B.W., INCIARDI, J.A. & HORTON, A.M., (EDS), 1994, DRUG ABUSE TREATMENT. THE IMPLEMENTATION OF INNOVATIVE APPROACHES, WESTPORT, CT., GREENWOOD PRESS, CH.6., 79-93

F.49. DE LEON, G., STAINES, G.L., SACKS, S., HILTON, R. & BRADY, R., 1994, MODIFIED THERAPEUTIC COMMUNITY METHODS IN METHADONE MAINTENANCE (PASSAGES): PROBLEMS AND ISSUES, IN FLETCHER, B.W., INCIARDI, J.A. & HORTON, A.M., (EDS), 1994, DRUG ABUSE TREATMENT. THE IMPLEMENTATION OF INNOVATIVE APPROACHES, WESTPORT, CT., GREENWOOD PRESS, CH. 10, 147-160

F.50. JAINCHILL, N., DE LEON, G. & PINKHAM, L., 1986, PSYCHIATRIC DIAGNOSES AMONG SUBSTANCE ABUSERS IN THERAPEUTIC COMMUNITY TREATMENT, JOURNAL OF PSYCHOACTIVE DRUGS, 1986, 18, 3, 209-213

F.51. NEBELKOPF, A., 1986, THE THERAPEUTIC COMMUNITY AND HUMAN SERVICES IN THE 1980'S, JOURNAL OF PSYCHOACTIVE DRUGS, 18, 3, 283-286

F.52. DE LEON, G., 1994, RESIDENTIAL THERAPEUTIC COMMUNITIES IN THE MAINSTREAM: DIVERSITY AND ISSUES, JOURNAL OF PSYCHOACTIVE DRUGS, 27, 1, 3-15

F.53. MULLEN, R., 1996, THERAPEUTIC COMMUNITIES IN PRISONS: DEALING WITH TOXIC WASTE, IN EARLY, K.E., (ED), 1996, DRUG TREATMENT BEHIND BARS: PRISON-BASED STRATEGIES FOR CHANGE, WESTPORT, CT., PRAEGER, CH.4, 45-64

F.54. INCIARDI, J.A., 1996, THE THERAPEUTIC COMMUNITY: AN EFFECTIVE MODEL FOR CORRECTIONS-BASED DRUG ABUSE TREATMENT, IN EARLY, K.E., (ED), DRUG TREATMENT BEHIND BARS: PRISON-BASED STRATEGIES FOR CHANGE, WESTPORT, CT., PRAEGER, CH.5, 65-74

F.55. SINGER, S.F., 1996, ESSENTIAL ELEMENTS OF THE EFFECTIVE THERAPEUTIC COMMUNITY IN THE CORRECTIONAL INSTITUTION: A DIRECTOR'S PERSPECTIVE, IN EARLY, K.E., (ED), DRUG TREATMENT BEHIND BARS: PRISON-BASED STRATEGIES FOR CHANGE, WESTPORT, CT., PRAEGER, CH.6, 75-88

F.56. CLERICI, M. & CARTA, I., 1996, PERSONALITY DISORDERS AMONG PSYCHOACTIVE SUBSTANCE USERS: DIAGNOSTIC AND PSYCHODYNAMIC ISSUES, EUROPEAN ADDICTION RESEARCH, 2, 3, 147-155

F.57. COMAS, A.D., GARCIA, M.E. & ROLDAN, I.G., 1996, POLITICAS SOBRE DROGAS A PARTIR DE LOS RESULTADOS DE UN ESTUDIO LONGITUDINE RETROSPECTIVE DE ADICTOS A LA HEROINA (1982-1992)/DRUG POLICIES CONSIDERATIONS COMING FROM A RETROSPECTIVE LONGITUDINAL STUDY ON HEROIN ADDICTS, ADICCIONES, 8, 1, 75-89

F.58. DE LEON, G., 1994, THE THERAPEUTIC COMMUNITY: TOWARD A GENERAL THEORY AND MODEL, IN TIMS, F.M., DE LEON, G. & JAINCHILL, N., (EDS), THERAPEUTIC COMMUNITY: ADVANCES IN RESEARCH AND APPLICATION, NIDA RESEARCH MONOGRAPH, 144, ROCKVILLE, MD., US DEPARTMENT OF HEALTH AND HUMAN SERVICES, 16-53

F.59. THERAPEUTIC COMMUNITIES OF AMERICA, 1994, PARADIGMS PAST, PRESENT AND FUTURE, PROCEEDINGS OF THE THERAPEUTIC COMMUNITIES OF AMERICA 1992 PLANNING CONFERENCE, WASHINGTON, DC., THERAPEUTIC COMMUNITIES OF AMERICA

F.60. PELISSIER, B., 1998, ALTERNATIVE SOLUTIONS TO THE PROBLEM OF SELECTION BIAS IN AN ANALYSIS OF FEDERAL RESIDENTIAL DRUG TREATMENT PROGRAMS, UNPUBLISHED REPORT, FEDERAL BUREAU OF PRISONS, CANADA

F.61. WEXLER, H.K., WILLIAMS, R.A., EARLY, K.E. & TROTMAN, C.D., 1996, PRISON TREATMENT FOR SUBSTANCE ABUSERS: STAY'N OUT REVISITED, IN EARLY, K.E., (ED.), DRUG TREATMENT BEHIND BARS: PRISON BASED STRATEGIES FOR CHANGE, WESTPORT, CT., PRAEGER

10 REFERENCES

Almond R. (1974). *The Healing Community*, New York, Jason Aronson.

Artus H.M (1996). Science indicators derived from databases, *Scientometrics*, *37,*297-311.

Bell M.D. (1983). The Perceived Social Environment of a Therapeutic Community for Drug Abusers, *International Journal of Therapeutic Communities*, 4, 4, 262-270.

Bell M.D. (1985). Three Therapeutic Communities for Drug Abusers: Differences in Treatment Environments, *International Journal of Addictions*, 20, 10, 1523-1532.

Bloor M, McKeganey N, Fonkert J.D. (1988). *One Foot in Eden: a sociological study of the range of therapeutic community practice*, London, Routledge.

Clark D.H. (1964). *Administrative Therapy*, London, Tavistock.

Clark D.H (1965). The therapeutic community concept. Practice and future, *British Journal of Psychiatry*, 3, 947-954.

Clarke R.V.G, Sinclair I. (1973). *Towards more effective evaluation*, Strasbourg, Council of Europe.

Cox J.L. (1997). *Contemporary Community Psychiatry: Where is the Therapy?* Paper presented as Maxwell Jones Memorial Lecture, 27 June, Regent's College, London.

Crocket R, Kirk J, Manning N, Millard D.W. (1978). Community Time Structure, *Bulletin of the Association of Therapeutic Communities*, 25, 12-17.

Cronkite R.C, Moos R.H. (1978). Evaluating Alcoholism Treatment Programs: An Integrated Approach, *Journal of Consulting and Clinical Psychology*, 46, 5, 1105-1119.

Cullen E. (1997). Can a Prison be a Therapeutic Community?, In Cullen, E., Jones, L. & Woodward (Eds.), *Therapeutic Communities for Offenders*, Chichester, Wiley, 75-99.

Cullen E, Jones L, Woodward R. (1997). *Therapeutic Communities for Offenders*, Chichester, John Wiley & Sons Ltd.

De Leon G. (1983). The next therapeutic community: autocracy and other notes toward integrating old and new therapeutic communities, *International Journal of Therapeutic Communities*, 4, 4, 249-261.

Dolan B, (Ed.). (1996). *Perspectives on Henderson Hospital*, Sutton, Henderson Hospital.

Dolan B, Coid J. (1993). *Psychopathic and Anti-Social Personality Disorders - treatment and research issues*, London, Gaskell.

Duggan C. (1998). *Personality Disorder - What Role for the Mental Health Services?* Draft chapter.

Dunlop A.B. (1975). Experience of residential treatment and its effectiveness. Home Office Research Unit Bulletin, Autumn, 2, 22-26, London, H.M.S.O.

Edelson M. (1970). *Sociotherapy and Psychotherapy*, Chicago, University of Chicago Press.

Eklund M, Hansson L. (1996). The ward atmosphere of a psychiatric day care unit on the basis of occupational therapy: Characteristics and development during a 5-year period, *Nordic Journal of Psychiatry*, 50, 2, 117-125.

Evans C, Carlyle J, Dolan B. (1996). Forensic Psychotherapy Research, In Cox, M. & Cordess, C., (Eds.), *Forensic Psychotherapy*, Vol. II, London, Jessica Kingsley, Ch. 11.30, 509-542.

Finney J.W, Moos R.H. (1984). Environmental Assessment and Evaluation Research: Examples from Mental Health and Substance Abuse Programs, *Evaluation and Program Planning*, 7, 151-167.

Gabbard G.O. (1988). A contemporary perspective on psychoanalytically informed hospital treatment, *Hospital and Community Psychiatry*, 39, 12, 1291-1295.

Genders E, Player E. (1995). *Grendon: a study of a therapeutic prison*, Oxford, Clarendon Press.

Gunn J, Robertson G, Dell S, Way C. (1978). *Psychiatric Aspects of Imprisonment*, London, Academic Press.

Haigh R. (1999). The Quintessence of a Therapeutic Environment, Five Universal Qualities, in Campling, P. & Haigh, R., (Eds.), *Therapeutic Communities. Past, Present and Future*, London, Jessica Kingsley.

Henderson D.K. (1939). *Psychopathic States*, New York, Norton.

Hinshelwood R.D, Manning N, (Eds). (1979). *Therapeutic Communities. Reflections and Progress*, London, Routledge and Kegan Paul.

Jadad A R. (1998). Rating health information on the Internet: navigating to knowledge or to Babel? *JAMA* 279, 8, 611-4.

Jones L. (1997). Developing Models for Managing Treatment Integrity and Efficacy in a Prison Based Therapeutic Community: The Max Glatt Centre, In Cullen, E., Jones, L. & Woodward, R., (Eds.), *Therapeutic Communities for Offenders*, Chichester, Wiley, 121-157.

Jones M. (1952). *Social Psychiatry*, London, Tavistock.

Jones M. (1953) The therapeutic community: A new treatment method in psychiatry, New York, Basic Books.

Jones M. (1979). Therapeutic communities, old and new, *American Journal of Drug and Alcohol Abuse*, 6, 2, 137-149.

Jones M. (1984). Why Two Therapeutic Communities, *Journal of Psychoactive Drugs*, 16, 1, 23-26.

Karterud S, Vaglum S, Friis S, Irion,T, Johns S, Vaglum P. (1992). Day hospital therapeutic community treatment for patients with personality disorders. An empirical evaluation of the containment function, *Journal of Nervous and Mental Disease*, 180, 4, 238-243.

Kennard D. (1994). The Future Revisited: New Frontiers for Therapeutic Communities, *Therapeutic Communities*, 15, 2, 107-113.

Kennard D, Roberts J. (1983). An Introduction to Therapeutic Communities, International Library of Group Psychotherapy and Group Process, London, Routledge and Kegan Paul.

Kennard D. (1998). *An Introduction to Therapeutic Communities*, London, Jessica Kingsley.

Kernberg O. (1982). Advantages and liabilities of the therapeutic community, in Pines, M., (Ed.), *The individual and the group*, New York, Plenum Press.

Kernberg O. (1984). *Severe personality disorders: psychotherapeutic strategies*, New Haven, Yale University Press.

Koeningsberg H.W. (1984). Indications for hospitalization in the treatment of borderline patients, *Psychiatric Quarterly*, 56, 247-258.

Kirk J.D, Millard D.W. (1979). Personal growth in the residential community, In Hinshelwood, R. D. & Manning, N., (Eds.), *Therapeutic Communities: Reflections and Progress*, London, Routledge & Kegan Paul.

Klir G.J, Valach M. (1967). *Cybernetic Modelling*, London, Iliffe.

Kriznik L. (1996). Co-operation between social organisations and prisons in the rehabilitation of prisoners in the Republic of Slovenia. Paper presented at the International Conference on "The Role of Social Organisations in the Rehabilitation of Prisoners", Pecs, Hungary, 5-7 September 1996.

Lees J, Manning N. (1985). *Australian Community Care*: a study of the Richmond Fellowship, Canterbury, University of Kent.

McCord W.M, McCord J. (1956). *Psychopathy and Delinquency*, New York, Grune & Stratton.

McPherson K. (1994). The best and the enemy of the good: randomised controlled, uncertainty, and assessing the role of patient choice in medical decision making. The Cochrane lecture, *Journal of Epidemiology and Community Health*, 48, 6-15.

Maden A, Swinton M, Gunn J (1994). Therapeutic Community Treatment: A Survey of Unmet Need Among Sentenced Prisoners, *International Journal of Therapeutic Communities*, 15, 4, 229-236.

Main T.F. (1946). The Hospital as a Therapeutic Institution, *Bulletin of the Menninger Clinic*, 10, 66-70.

Main T. (1977). The concept of the therapeutic community, variations and vicissitudes, *Group Analysis*, 10, 2-16.

Manning N. (1976). Values and practice in the therapeutic community, *Human Relations*, 29, 2, 125-138.

Manning N. (1976a). The politics of survival: the role of research in the therapeutic community. In Hinshelwood, R. D. & Manning, N., (Eds.), *Therapeutic Communities: Reflections and Progress*, London, Routledge & Kegan Paul.

Manning N. (1976b). Evaluating the therapeutic community, In Hinshelwood, R. D. & Manning, N., (Eds.), *Therapeutic Communities: Reflections and Progress*, London, Routledge & Kegan Paul.

Manning N. (1989). *The Therapeutic Community Movement*: Charisma and Routinization. International Library of Group Psychotherapy and Group Process, London, Routledge and Kegan Paul.

Margo G.M, Manning J.M. (1989). The current literature on inpatient psychotherapy, *Hospital and Community Psychiatry*, 49, 9, 909-915.

Martinson R. (1974). What Works? questions and answers about prison reform, *Public Interest*, 35, 22-45.

Moffet L.A. (1984). Assessing the Social System of a Therapeutic Community: Interpersonal Orientations, Social Climate and Norms, *International Journal of Therapeutic Communities*, 5, 2, 110-119.

Moffet L.A, Flagg C. (1993). Real and Ideal Social Climate Perceptions of Residents, Staff, and Visitors in a Therapeutic Community for Substance-Dependent Patients, *Therapeutic Communities*, 14, 2, 103-118.

Moos R.H. (1997). *Evaluating Treatment Environments*. The Quality of Psychiatric and Substance Abuse Programs, (2nd. Ed.), New Brunswick, Transaction.

Moos R.H, Burnett E.B. (1996). Social context and psychological adaptation*, Therapeutic Communities*, 17, 3, 167-172.

Moos R.H, King M.J. (1997). Participation in community residential treatment and substance abuse patients outcomes at discharge, *Journal of Substance Abuse Treatment*, 14, 1, 71-80.

Moos R.H, Lemke S. (1996). *Evaluating Residential Facilities. The Multiphasic Environmental Assessment Procedure*, Thousand Oaks, Sage.

Nieminen P. (1995). Statistical content of published therapeutic community research, *Therapeutic Communities*, 16, 4, 239.

O'Brien M. (1976). The diagnosis of psychopathy - *A study of some characteristics in personality and behaviour of psychopaths referred for treatment to a therapeutic community*, Unpublished Ph.D. Thesis, University of London.

Price R.H, Moos R.H. (1975). Towards a taxonomy of inpatient treatment environments, *Journal of Abnormal Psychology*, 84, 3, 181-188.

Rapoport R.N. (1960). *Community as Doctor. New Perspectives on A Therapeutic Community*, London, Tavistock Publications.

Rawlings B. (1998). *Maintaining Regime Integrity in a Secure Environment*, paper presented at the Annual Conference of the Association of Therapeutic Communities, Cumberland Lodge, Windsor, September 1998, (in Therapeutic Communities - forthcoming).

Reed J. (1992). *Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services*, London, Department of Health and Home Office.

Reed Report. (1994). Report of the Department of Health and Home Office Working Group on Psychopathic Disorder. DoH/Home Office, Chair - Dr. John Reed.

Roberts J. (1997). How to Recognise a Therapeutic Community, *Prison Service Journal*, 111, 4-7.

Rogers J.H, Wood K.A, McCarthy S.M. (1993). Community meeting participation as an indicator of treatment progress: the crisis stabilization unit, *Therapeutic Communities*, 14, 3 165-178.

Rubel J.G, Baker K.G, Bratten T.E, Hartwig-Thomson L, Smirnoff A.M. (1982). The role of structure in the professional model and the self-help concept of the therapeutic community: different strokes for

different folks, *International Journal of Therapeutic Communities*, 3, 4, 218-232.

Sacks S, Sacks J, De Leon G, Bernhardt A.I, Staines G.L. (1997). Modified therapeutic community for mentally ill chemical "abusers": background; influences; program description; preliminary findings, *Substance Use and Misuse*, 32, 9, 1217-1259.

Seglen P.O. (1997). Why the impact factor of journals should not be used for evaluating research, *BMJ* 314, 498-502.

Seligman M.E.P. (1995). The Effectiveness of Psychotherapy, *American Psychologist*, December, 50, 12, 965-974.

Shenker B. (1986). *Intentional Communities. Ideology and Alienation in Communal Societies*, London, Routledge & Kegan Paul.

Smith J, Gross C, Roberts J. (1996). The evolution of a therapeutic environment for patients with long-term mental illness as measured by the Ward Atmosphere Scale, *Journal of Mental Health*, 5, 4, 349-360.

Street D, Vinter R.D, Perrow C. (1966). *Organisation for Treatment. A Comparative Study of Institutions for Delinquents*, New York, Free Press.

Sugarman B. (1984). Towards a new, common model of the therapeutic community: Structural components, learning processes and outcomes, *International Journal of Therapeutic Communities*, 5, 2, 77-98.

Tucker L, Bauer S.F, Wagner S, Harlam D, Sher I. (1987). Long-term hospital treatment of borderline patients: A descriptive outcome study, *American Journal of Psychiatry*, 144, 11,1443-1448.

Verhaest S, Pierloot R, Janssen G. (1982). Comparative Assessment of Two Different Types of Therapeutic Communities, *International Journal of Social Psychiatry*, 28, 1, 46-52.

Vollmer H, Henrich G. (1985). Ward atmosphere in a therapeutic community for the treatment of opiate addicts, *Suchtgefahren*, 31, 2, 133-145.

Walker N, et al. (1968). *Cropwood Conference on Psychopathic Offenders*, (Ed. West, D. J.), Cambridge, Institute of Criminology.

Warren F. (1994). What Do We Mean by a Therapeutic Community for Offenders? *Therapeutic Communities*, 15, 4, 312-318.

Warren F, Dolan B. (1996). 'Treating the "untreatable": therapeutic communities for personality disorders', *Therapeutic Communities* 17, 3, 205-216.

Whiteley S, Briggs D, Turner M. (1972). *Dealing with Deviants*, London, The Hogarth Press.

Woodward R. (1997). Selection and Training of Staff for the Therapeutic Role in the Prison Setting, In Cullen, E., Jones, L. & Woodward, R., (Eds.), *Therapeutic Communities for Offenders*, Chichester, Wiley, 221-252.

Wootton B.F. (1959). *Social Science and Social Pathology*, London, Allen & Unwin.

Yablonsky L. (1965). *The Tunnel Back*, MacMillan, New York.