Report for

Higher Ground
Drug Rehabilitation Trust

Higher Ground Evaluation

Summary of Findings

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Executive Summary

Higher Ground Drug Rehabilitation Trust (HGDRT) is a registered charitable trust founded in 1984 providing an 18-week residential Therapeutic Community programme to support people who are severely dependent on alcohol and other drugs and who wish to become abstinent. The community is a highly structured drug-free environment with defined boundaries, both behavioural and ethical. While residing at HGDRT programme participants are required to be alcohol and other drug free, they engage in educational and therapeutic processes, and are responsible for their activities of daily living. A strong Māori Whānau programme is provided which most residents, Māori and non-Māori, participate in and find helpful. There is an extensive family education and therapy programme.

Participants are supported prior to and after their period of residence by a community team. Regular attendance at 12-step meetings in the wider community is integral to the programme to support clients to maintain a healthy lifestyle upon programme completion.

Client progress and outcomes in relation to their health and wellbeing are routinely monitored as they progress through treatment. Results from June 2009 to September 2012 including overall 535 residents are outlined in this report. Results show that programme participants are relatively young, the mean age was 35 and 35% were in their twenties. 42% were female. The ethnic mix included 70.5% European, 24% Māori and 4% Pacifica. The majority (74%) gave their highest qualification as secondary. The most common drug of choice was methamphetamine (44%), with others being alcohol (40%), cannabis (10%) opiates (2.4%) and other (3.6%). 35% of participants had legal issues pending. Participants report a history of significant drug use with significant negative impact on their lives, including high levels of physical and mental health problems. Following admission, scores measuring physical and mental health improved markedly.

Nearly half of all residents complete the programme and appear on track towards recovery, comparing well with recent data cited from the UK.[1] Three months after discharge more than 90% of the 162 clients included in follow up data reported that they were drug-free.

Results suggest that residents gain a new understanding of appropriate interpersonal behaviour and an increasing awareness of their own psychological issues. There is evidence of benefit even for those who leave the programme before the end. Residents participating in the Māori Programme found it helpful and, if Māori, they appreciated the opportunity to reconnect with tikanga Māori.

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[1] Hayes, P. (2012). *The Role of Residential Rehab in an Integrated Treatment System*. London: National Treatment Agency for Substance Abuse, NHS.

Introduction

Higher Ground Drug Rehabilitation Trust (HGDRT) was founded in 1984 to provide services to people severely dependent on alcohol and other drugs who wished to become abstinent. Its main activity is the provision of a residential Therapeutic Community programme currently housed at a complex on the Te Atatu peninsula, Auckland (NZ). Participants are required to be alcohol and other drug free, they engage in educational and therapeutic processes, and are responsible for their activities of daily living.

In 2011 Awhina–Research, Waitemata District Health Board was engaged to prepare ongoing evaluative reports on the activities of HGDRT. A final report, in four sections, was submitted in November 2012. This document provides a narrative summary of the findings and places them in the context of international addiction treatment.

Background: Therapeutic Community Context

HGDRT is an example of a therapeutic community (TC); TCs have evolved from two distinct models.[2] In Europe there was a tradition of professionally led residential treatment – schools and borstals run by teachers and mental health services led by psychiatrists. [3]

In California, Synanon founded in 1958 by Charles Dederich, developed out of Alcoholics Anonymous (AA), founded in 1935 in Ohio. Meetings to providing support beyond AA evolved into encounter groups which were found to produce effective change in participants. This paved the way for the development of other TCs in North America for Alcohol and Drug addiction. Abstinence-based TCs have exercised a strong influence on drug treatment, when drug consumption began to increase in the 1980s and resources were limited, the emphasis moved towards community-based services and a harm-reduction approach. Examples of this include the use of methadone as a replacement for opiates, and needle exchanges to reduce HIV infection. There has also been an upsurge in the establishment of an evidence base for the treatment of alcohol and other drug dependency and associated problems.

A recent summary of outcomes has been published from the United Kingdom based on the records of 4,166 people who were in residential rehabilitation; follow-up rates were high and a majority of centres contributed data.[4] It showed that, of people admitted to residential rehabilitation: 30% overcame their addiction and became abstinent; 10% dropped-out; the remaining 60% sought further community support

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[2] De Leon, G. (2000). *The Therapeutic Community Theory, Model and Method.* New York: Springer Publishing.

[3] An example was the Northfield Hospital in 1942; also Wilfred Bion from the Tavistock Clinic ran a hospital based residential programme to rehabilitate and return men to the army.

[4] Hayes, P. (2012). *The Role of Residential Rehab in an Integrated Treatment System.* London: National Treatment Agency for Substance Abuse, NHS.

and, of these, a further 20% overcame the addiction, 20% were still in the system and 10% dropped out. Across providers the rate of success varied from 20% to 60%.

The Programme

HGDRT was founded to follow the abstinence-based TC model. The community is a highly structured drug-free environment with defined boundaries, both behavioural and ethical. This creates strong barriers to drug use and cohesive community relationships essential to the rehabilitation of the severely drug dependent. It also offers the essential tools to live drug-free. Key features of the programme include: input from community members themselves and input from professional staff. The community can impose consequences as well as advancement of status and privileges as part of the recovery and growth process. Being part of something greater than oneself is an especially important factor in facilitating positive growth. Many community members have little or no experience of living a supported and ordered life; few will have had, or have taken, the opportunity to explore their own behavioural and psychological processes.

Integral to the programme is introduction to and regular attendance at 12-step meetings in the wider community. This is essential for the maintenance of a healthy lifestyle upon completion of the programme. In addition, staff members are trained therapists who work from evidence-based therapy approaches in group, individual and family formats. These include cognitive-behavioural therapy (CBT), dialectical-behaviour therapy (DBT), motivational-interviewing (MI), psycho-education, relapse prevention and family/whanau therapy. There is an extensive family education and therapy programme. The programme is also culturally responsive, for example, HGDRT has a Māori programme which uses Māori symbolism and rituals to explore issues related to addiction.

The residential programme duration is up to 18 weeks. Prior to this the pre-admission community team provide assessment, support and group work to develop readiness for the intensive residential component of the programme. Continuing care is provided after graduation from the programme consisting of group and individual therapies, and supportive accommodation whilst they re-adjust to life in the community.

HGDRT is a non-profit organisation registered as a charitable trust.

Evaluation

HGDRT introduced a system of client monitoring in 2009, using standard tests to assess the clients' health and wellbeing as they progressed through the programme. This information has been used since to contribute to programme reviews with the aim of improving efficacy and consumer satisfaction. Annual reports of programme functioning according to the dimensions measured are made available to staff and other interested parties. In addition, a more in-depth analysis of programme elements was conducted using both quantitative and qualitative research methods. The following is a summary of the findings.

Methodology

Quantitative - A log is kept of the clients' demographic data, their legal status and drug of choice, as well as the duration of their stay and type of discharge. In addition the monitoring programme includes ten assessment tools most of which are administered on four occasions - on admission, at six and twelve weeks, and on discharge. They are repeated at each of four three-monthly post-discharge follow-up contacts, finishing at 12 months. Each tool uses multiple questions and some cover more than one topic. In the analysis, indices were calculated covering 15 discrete areas.

Data analysed covered the period from June 2009 to September 2012 and includes 535 residents. Most analyses were confined to the 475 participants admitted by May, 2012, as these had completed the programme by the end of August 2012.

For each index, mean values were calculated for all residents and for sub-groups distinguished by demographic (age, gender, ethnicity) and problem characteristics (drug of choice, legal status and type of discharge). Comparisons are made across the programme using data **only from those who completed all questionnaires.** Comparisons are made across the follow-up period using data only from those who were followed for the full 12 months. These indices are presented under the following headings: history of drug use; physical and psychological health; behavioural issues; and social and spiritual functioning.

Qualitative - Over 2012, open ended interviews were conducted with: the Programme Director; the Clinical Manager; six Case Managers and a Psychologist; three Supervisors and a Consumer Representative. Seven residents were interviewed on admission; follow-up interviews were conducted fortnightly until the residents either completed the programme or left. Three additional senior residents were identified and interviewed fortnightly until they left. A separate qualitative evaluation of the Whanau programme was undertaken by a Māori Doctoral student.

Findings: Quantitative Measures of Residents' Status

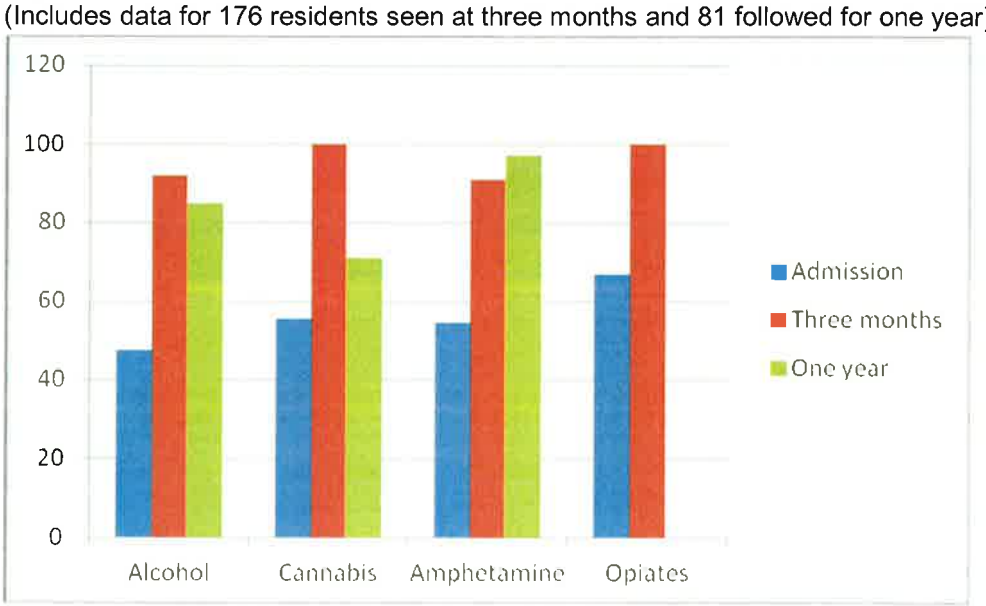
The Residents - The mean age of residents was 35 (and 35% were in their twenties) and 42% were female. Most gave their ethnicity as European (70.5%), while 24% were Māori and 4% Pacifica. The majority (74%) gave their highest qualification as secondary. The most common drug of choice was methamphetamine (44%), closely followed by alcohol (40%); the remainder (16%) included cannabis (10%) opiates (2.4%) and other (3.6%). A significant minority (35%) had some legal issues pending (most commonly residents were on bail).

History of Drug Use - At first contact, those who subsequently entered the programme reported a history of addiction which often had had significant negative effects on their relationships, social and work life, and physical health. All participants gave accounts of major personal and social damage related to drugs.

They were required to be drug free at admission and while waiting for a place attended several interviews and group sessions to support them to become drug-free. As a result, 41% had not used any drugs for 30 days prior to admission and they remained drug free while in the house. Data are provided for 475 residents who were assessed using the Alcohol and Drug Outcome Measure (ADOM) adopted in October 2011.

Among the 162 people followed-up for three months, 92% had been drug free after discharge. Comparing the percentage who were drug free for 30 days prior to admission and for the 30 days after discharge by drug of choice the figures were: alcohol free 48% increased to 92%; cannabis 56% increased to 100%; and amphetamines 54% increased to 91% (see Figure 1). Among the 81 people followed-up for one year, 90% had been drug free for 30 days.

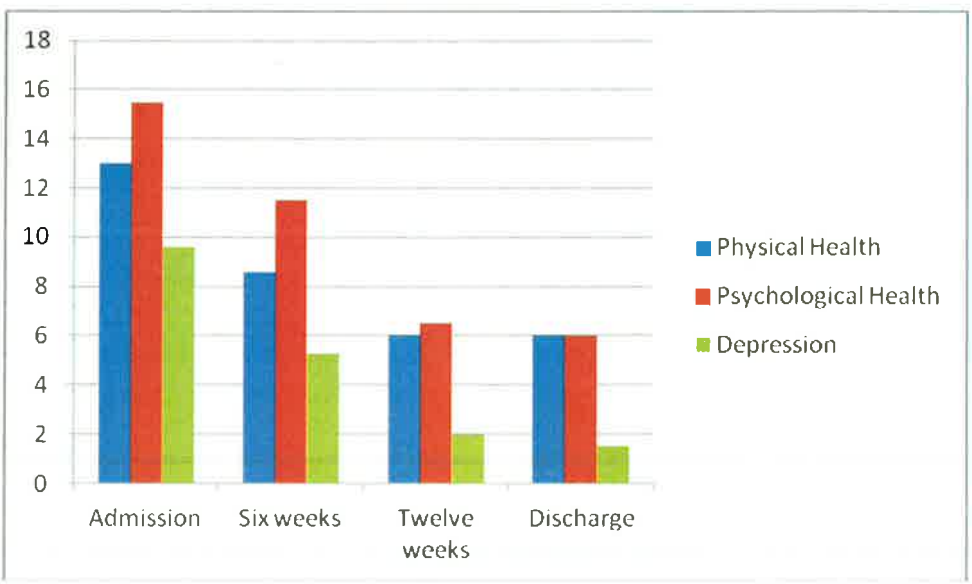
Figure1. Percentage Drug Free - Admission; Three Months; and One Year.
(Includes data for 176 residents seen at three months and 81 followed for one year).



Physical and Mental Health - In the early stages of monitoring, the Maudsley Addiction Profile (MAP) and the Beck Depression Inventory (BDI) were used; the MAP included an index of physical and mental health. From October 2011 the Depression, Anxiety and Stress Scale (DASS) and the Post-traumatic Stress Disorder Scale (PTSD) were used; use of the MAP for physical health was continued.

Physical health - Residents reported a significant level of physical ill-health on admission; physical health improved during and after the programme. The MAP, with a maximum score of 48, showed a mean score of 13.1 with a highest score of 48. The mean score decreased progressively over the first twelve weeks of the programme to a value of six and this level was maintained at discharge (see Figure 2) and over follow-up. A separate questionnaire relating to eating disorders was used on admission and showed that 5% of residents had a score of more than 20 – a score indicative of a clinically significant eating disorder.

Figure 2. Comparison of Indices of Physical and Psychological Health and and Depression from Admission to Discharge (includes data for 161 people).

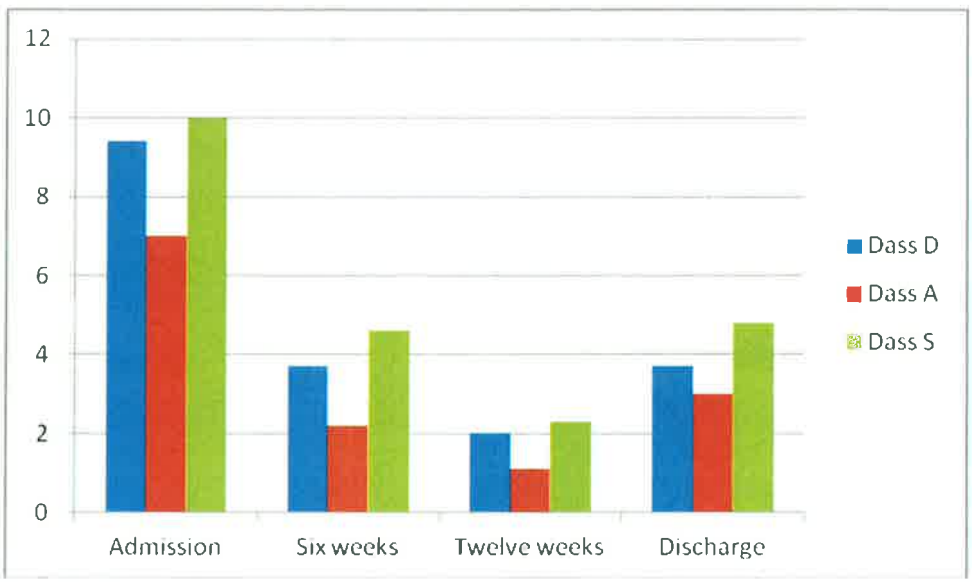


Psychological health - Residents also reported a significant level of psychological ill health on admission. The MAP, with a maximum score of 40, showed a mean score of 15.8 with a highest score of 40. The mean score decreased progressively over the first 12 weeks in the programme to a value of six and this improvement was maintained at discharge and over follow-up. The scores on depression showed that 55% of residents had evidence of moderate to severe depression; this also improved over the programme (see Figure 2).

DASS scores may be divided into three areas – depression, anxiety and stress. On admission, the mean depression score for the whole group was 8.4; up to nine is considered normal and 73 (41%) participants fell above this value. The mean anxiety score was 6.4; up to seven is considered normal and 67 (38%) participants fell above this value. The mean stress score was 10.1; up to 14 is considered normal and 38 (22%) fell above this value. The mean total score was 24.9. Figure 3 shows the mean

score for each component from admission to discharge for the 49 people for whom discharge scores were available. For each index there was a marked improvement following admission; this was maintained at twelve weeks but there was a small rebound at discharge.

Figure 3. Comparison of Mean Scores on Depression (DASS D), Anxiety (DASS A) and Stress (DASS S) across the programme.



For the PTSD scale, the mean score on admission was 46 where a score of 44 or more is indicative of PTSD; 56% exceeded this score. Scores at discharge were available on 43 residents; for this sub-group, the mean score was 43 on admission and 31 on discharge, indicating an improvement.

The Canadian Problem Gambling Inventory was administered on admission; 17% of residents had a score said to be indicative of problem gambling.

Social Functioning - On admission residents were asked about relations with partners, relatives and friends. They were asked how often contact had occurred, if it was positive and how often there was conflict. Over the 30 days prior to admission, 61% of residents had had contact with a partner, 94% had had contact with a relative and 87% had had contact with a friend.

The percentage of days on which there was conflict diminished quickly and dramatically over the programme. During follow-up, the percentage with contact with partners, relatives and friends remained stable.

A series of questions addressed issues related to work and illegal activities. Eleven percent had been working in the four weeks prior to admission and 12% admitted criminal activity. Over the follow-up period, for those contacted, the percentage working gradually increased to reach 55% at 12 months and only 2.5% admitted criminal activity.

Acknowledgement of a Higher Power - In keeping with the twelve-step philosophy, HGDRT acknowledges the importance of a Higher Power in the resolution of personal problems and residents were asked about their sense of this influence in their lives. On admission, the mean score suggested a position between "neutral" and "believe." During the programme there was a modest increase to a mean score to representing "believe," which was maintained at the end of follow-up.

Satisfaction with the programme - A Satisfaction Questionnaire is completed by residents at six weeks and on discharge; it indicated a mean level equivalent to "satisfied," with very little change in overall satisfaction over time.

Length of stay - The programme is designed to last 126 days but there was a steady attrition of residents during the programme with the mean duration of residency being 77 days. Residents could be discharged in three ways. Almost half (45%) graduated with staff approval; this was almost always at the planned end of the residency and the mean length of stay was 118 days. Almost a third (32.5%) left against staff advice; this group had a mean stay 38 days. Almost a fifth (19%) left at staff request; they had a mean stay of 54 days. Of those who completed the programme, 51% entered follow-up and 30% were able to be followed for the full year.

Differences across sub-groups of residents - There were some differences between the sub-groups of residents. Women had fewer legal problems and were more likely to indicate that alcohol was their drug of choice. They reported more health problems both physical and psychological. They had more contact with people outside the programme but also reported more conflict. Women spent fewer days in the programme and were more likely to leave against staff advice.

Māori and Pacifica people were more likely to have legal problems and, on average, stayed in the programme longer. Younger people and cannabis users were likely to leave earlier. Those with legal issues stayed longer and were **less** likely to report physical or mental problems (including PTSD).

In summary - those admitted to the programme report a history of significant drug use with significant negative impact on their lives; they also report a high level of physical and mental health problems. The scores on the PTSD instrument are particularly high. Following admission scores measuring physical and mental health problems improve markedly and this improvement is maintained among those who remain in follow-up. Three months after discharge more than 90% of residents were drug-free.

Findings: Qualitative Reports on the Programme

Introduction - The pre-admission team assesses applicants and determines who would benefit from admission. They help those accepted with practical problems and refer others to alternate sources of care.

When people join the community their day is filled with activities which include house meetings, process groups and individual activities such as writing up their goals and meeting with their case managers. Evenings are occupied with twelve step meetings.

The Māori programme welcomes residents with a powhiri and explores addiction using Māori concepts and symbolism; residents also visit Marae. The majority of residents, both Māori and non-Māori participate.

The atmosphere in the house is one of mutual respect and personal safety. Community members have the opportunity to live in a well ordered environment and to explore the issues that face them as they move into a new culture – a culture of recovery.

Residents' experience of the programme - In the qualitative interviews new residents reported that they found the first few days stressful but soon they began to appreciate the structured and predictable life within the community and enjoyed respite from the stress of their habitual lives. To begin with some had difficulty with learning and following the complex rules and constant exposure to other people.

Residents also noted the conflict between needing to undertake psychological work and fear of self-exposure. As their stay continued, residents reported that they began to identify key personal issues. Initially, problem behaviours were revealed; subsequently, historical causes were discovered. In many cases old traumas and current conflicts were able to be worked through.

Residents participating in the Māori Programme found it helpful and, if Māori, they appreciated the opportunity to reconnect with tikanga Māori.

Staff Experience - Case managers reportedly found the work rewarding. Strong support from peers and management was noted. The Clinical Manager oversaw the management of the house and the work of the case managers, and was responsible for balancing competing responses and differing approaches to clients. For all staff there was a strong sense of common purpose in working to improve the lives of residents.

Summary

Overall, the results reported show a positive response both during the programme and into follow-up for residents, all of whom presented with a combination of serious dependency problems and significant physical and mental health issues.

All residents have an opportunity to experience an ordered and supportive environment which often contrasts with dysfunctional past experiences. The results suggest that residents gain a new understanding of appropriate interpersonal behaviour and an increasing awareness of their own psychological issues. There is evidence of benefit even for those who leave the programme before the end. Those who embrace the culture of recovery enter a new, more functional and supportive period of their lives. The Māori programme, of value to all, additionally helps Māori residents reconnect with their culture.

On admission, residents reported a history of high levels of drug use that had significantly interfered with their lives. Residents remain free of alcohol and other drugs during the programme and, the great majority of those in the outreach programme remain abstinent. That nearly half the residents complete the programme and appear on track towards recovery, compares well with the data cited from the UK. Measures of physical and psychological symptoms improve during the programme and are maintained during continuing-care. The percentage of residents who are gainfully employed increases progressively after discharge. The level of conflict with partners, relatives and friends decreases during the programme and this improvement is maintained during after-care.