Supporting New Zealand's Therapeutic Community Workforce: An investigation of current needs

A scoping report developed by Matua Raki for the Ministry of Health

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Summary

Therapeutic Communities (TCs) have been operating in New Zealand since the early 1980s to support people to recover from substance use-related problems. In the past ten years with the establishment of Drug Treatment Units (DTUs) that apply a modified TC model in the prison setting, TCs have received increasing prominence. This expansion has led to specific workforce development needs which are the focus for this report prepared by Matua Raki upon request of the Ministry of Health.

Therapeutic Communities in New Zealand employ a 'community as method' approach whose key proponent is George De Leon (De Leon, 2000). Key features of this model are that residents participate and contribute to the running and operation of the community. There is a focus on social, psychological and behavioural dimensions of substance use where the community, through self-help and mutual support, is the principal means for promoting behavioural change (Gowing et al., 2002). In response to meeting the needs of a diversifying client population and changing funding environments, modified TC's have emerged. These tend to run for shorter treatment durations. New Zealand's current addiction related TC's are provided by Care NZ, Higher Ground, Moana House and Odyssey House (Auckland and Christchurch) and are all modified TC's that have been developed to be responsive to the particular population groups they serve. These include adults who experience addiction[1]-related problems, young people, people with coexisting problems[2], Māori, Pacific and prison based populations.

Therapeutic community outcome evaluations, in general, demonstrate they are intensive interventions but have marked reductions in substance use and offending and significant improvements in health and functioning (ALAC, 2010; Gowing et al. 2002). NZ based outcome data reflects international trends with Moana House and Odyssey House Auckland evaluations reporting reductions in substance use and improvements in mental health and other social indicators during and post treatment (ALAC, 2010). Department of Corrections analysis show prisoners who have completed a DTU programme can reduce their reoffending rates by up to a third compared to similar offenders who don't undertake treatment. They also show a 31 percent drop in the severity of re-offending by DTU graduates (Care NZ, 2010). While TC's are an expensive treatment option, they appear to generate savings related to health care and crime in the long term.

The TC uses a very unique therapeutic model and currently there is no TC specific training available in New Zealand. Each TC within New Zealand engages in in-house training for new staff. Training approaches vary and reflect the diversity of New Zealand's TC's but key similarities include a combination of TC theory and exposure to TC practice, supported by mentoring and supervision (clinical and cultural).

As one would expect, all TC representatives interviewed unanimously highlighted the value of having national TC related training. On the job training would still be required to familiarise new staff with contextual differences in application of the model. National training in the TC model would help relieve the perceived burden faced by TCs who are required to teach their new staff all aspects of working in a TC. This training would help support standardisation and quality of

[1] Addiction is a generic term used to include alcohol and other drug (AOD) and problem gambling

[2] TC treatment duration for people with co-existing disorders tends to be longer then for other groups such as youth and prison based populations.

practice and also assist practitioners to gain an understanding of whether the TC is a treatment modality that fits their work style.

There are two main options for TC workforce development that presented during this scoping exercise. These were:

1. The development and delivery of a specific TC qualification

2. Incorporation of TC theory and practice into current addiction qualifications

A combination of these options would also be valuable. While a TC training programme(s) that is able to provide a national qualification or certification recognised by employers would be beneficial, it is also important that all addiction practitioners have an understanding of the TC modality.

Any programme of study or training should focus on;

- Combined theory and practice related modules
- Student immersion in the TC environment
- A strong group work focus
- Involvement of TC graduates
- Responsiveness to cultural diversity-Maori and Pacific
- Consideration of a 'training TC'
- Consideration of providing certification or a TC qualification to those who complete the training
- The continued need tor work based placements

A partnership between a training provider and the New Zealand TCs would need to be formed to establish any training programme(s). Australasian Therapeutic Communities Association (ATCA) and Matua Raki could potentially help to steer the development and progression of this training partnership and programme(s). Engaging ATCA to drive this work could have the added benefit of expanding this programme to encompass an Australasian scope, and pooling of resources.

While only addiction related TCs were included in this scope it is recommended that a further scope be conducted regarding the workforce development needs of other types of TCs in New Zealand, and whether any potential training programme(s) could also be aligned to meet their needs, and therefore potentially expand the demand for training and the pool of the TC competent workforce.

Recommendations: Next Steps

It is recommended that a working group be formed with representatives from the New Zealand TCs (a NZ TC collective), supported by the Ministry of Health, to collectively refine this vision for workforce development with a focus on the following;

- A 'real demand' analysis regarding the number of potential students who would undertake any TC training programme(s) (including staff and students involved in non-addiction related TCs).

- Establishing a reference group to steer developments
- Establishing which option has the strongest support and is most likely to be implemented
- Identifying what resources are required to deliver the preferred option (organisational support, people, training providers, budget).
- Identifying potential training provider partners
- The role of ATCA and Matua Raki

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1. Background and Purpose

Glaser (1981) indicates that the term ‘therapeutic community’ is known to many as a type of residential treatment for psychiatric patients developed by Maxwell Jones in the middle of the twentieth century. It is also applied to a form of non-psychiatrically oriented self-help residential treatment in the addiction field.

Therapeutic Communities (TCs) have been operating in New Zealand since the early 1980s and a number still exist to support recovery from substance use-related problems. Since their inception in New Zealand the number of TC's has expanded, particularly in the past ten years with the recent establishment of Drug Treatment Units (DTUs) which apply the TC model in prison settings. This has placed additional workforce development demands on the providers of TCs. The Ministry of Health requested that Matua Raki develop this report, to help understand the current workforce needs for TCs in New Zealand.

This report was developed in consultation with representatives from New Zealand's addiction related TCs, and by a review of current TC literature. The report examines the following areas as they relate to addiction related TCs:

- TCs and their effectiveness,
- The TC model in the New Zealand context
- Current TC workforce development activity
- Key workforce development priorities.

This report ends by summarising potential options for TC workforce development in New Zealand and offers some suggestion for the next steps in exploring these options further.

2. Therapeutic Communities and effectiveness

Therapeutic Communities are a treatment option with a long history. In its contemporary form two main TC models have emerged. The 'Democratic Model' was developed in Europe in the mid 1940s in hospital psychiatry (De Leon, 2000) where the community was viewed as an instrument for treating mental health issues. Newer clients were educated by those who had been in the programme for longer and differences between staff and service users became less obvious. Physicians moved from a more paternalistic role to a commentator and participant in community life.

The other main stream of therapeutic community formed in America in the mid 1950s and was called the 'Concept-Based Model'. This model stemmed from the Alcohol Anonymous (AA) movement and employed a more regimented, disciplined and hierarchical approach to treat alcohol and other drug related problems, when compared to the democratic model. It focused on community-based residential treatment programmes for people experiencing alcohol and other drug-related problems and it is this model that forms the basis for New Zealand TCs.

Glaser (1981) notes that a feature of both models is that the patients, in collaboration with the staff are engaged in a structured programme and become active participants in their own therapy, that of other patients, and in the general conduct of the entire community. De Leon (2000) identifies ‘therapeutic’ as relating to changing an individual’s lifestyle and identity, while ‘community’ refers to the primary method or approach to achieve the goal of individual change.

The community is used to heal individuals emotionally and to train them in the behaviours, attitudes and values of healthy living.

As part of a comprehensive review of the TC literature Gowing, Cooke, Biven & Watts (2002) searched for a common definition of a TC but instead found many different explanations and no simple accepted version. They settled on the following definition that includes some key features that apply across different settings.

1. *Residents participate in the management and operation of the community.*
2. *The community, through self-help and mutual support, is the principal means for promoting behavioural change.*
3. *There is a focus on social, psychological and behavioural dimensions of substance use, with the use of the community to heal individuals emotionally, and support the development of behaviours, attitudes and values of healthy living.*

(Gowing et al., 2002, p. 10).

TCs are largely designed to treat individuals with severe and complex substance use-related issues. Co-existing issues such as mental health and criminality are also often present requiring a skilled workforce able to work holistically with people who have complex needs. The stages of treatment typically include:

- an induction or early treatment phase where people are assimilated into the TC and learn the basic philosophy;
- a primary treatment phase that provides the therapeutic foundation for the programme where residents work through a structured progression with increasing levels of pro-social attitudes, behaviours and responsibilities; and
- a re-entry phase to assist individuals with integration into the wider community (ALAC, 2010).

Meyers (2008: 21-22) summarises the essential elements of the TCs inherent in the 'community as method' approach as including:

1. The promotion of socially responsible roles by participating in a community.
2. Concerned, responsible feedback on behaviour from peers.
3. Each member's task is to be a positive role model for others.
4. Relationships in the community are used as learning tools: patterns of behaviour that occur in every day life are reflected in these relationships. Self-destructive patterns of feeling, thinking, and behaviour can be studied and modified as they emerge in the community.
5. Collective learning formats: education, working together, meetings, and recreation.
6. Culture and language of change: there is a positive focus on what life can be. This culture is also expressed in celebrations of achievements, traditions, and rituals to enhance community cohesiveness as well as in a belief system, values and philosophy that guide socially responsible living.
7. Structure and systems: daily living in the community is prescribed by job descriptions, chores, sanctions, privileges, rules, routines and procedures, which might be found in any environment that produces socially responsible adults. These are balanced by concern,

affectional bonds, the involvement of others outside the community, and transparent operations to avoid a counter-productive authoritarian culture.

8. The process of feedback within the community is reflected in a similar process between the community and the surrounding society, from neighbours to funding and auditing agencies.
9. Open communication: personal information is openly shared in the community. This is an antidote to the manipulation and secrecy characteristic of people who experience addiction-related problems and or who engage in criminal activity.
10. Individual and community balance: the community exists to serve the individual, but the relationship is reciprocal. The community must have a similar attitude of self- criticism as is expected of the individual. Neither is allowed to become a threat to the other. External auditing and transparency are essential to the health of the community, and it may expel a member who becomes a threat to its integrity and the safety of others.

2.1 Modified Therapeutic Communities

Since their conception TCs have been applied with an expanding range of population groups including young people, people with co-existing problems, prisoners, and the homeless. The TC model has been adapted to fit the needs of these diverse groups. Changes in funding and health care service structures have also resulted in adaption of the model. Different types of TCs have emerged, generally described as 'modified'.

The US study of treatment programmes, the Drug Abuse Reporting Program (DARP) (Simpson & Sells 1983), divided TCs into three categories:

- traditional **TCs**, having the goal of total resocialisation, one to three years duration, treatment includes high demands, confrontation and sanctions;
- **modified TCs**, where the goal is developing practical skills, six to eight months duration, moderate treatment demands and sanctions;
- **short-term TCs**, with the goal of providing survival skills to clients and facilitating re-establishment of family relationships, three to six months duration with treatment demands being moderate to high.

New Zealand's TCs have shifted over the last ten years and tend to utilise a modified TC model. It is important to note that while modified TCs for youth and prison populations often use a shorter treatment period, service users in modified TCs to treat co-existing problems tend to engage for a longer duration - up to 18 months for those with multiple complexities.

2.2 The Effectiveness of Therapeutic Communities

Both the Gowing et al. (2002) and Moana House Evaluation (ALAC, 2010) provide extensive reviews of the TC literature. The later summarises these findings as follows:

> *Taking into account methodological issues, therapeutic community outcome evaluations, in general, demonstrate marked reductions in substance use and offending and significant improvements in health and functioning. However, sufficient retention in treatment (a minimum of three or more months) coupled with adequate provision of services, client participation and active engagement in the programme and treatment progress is required for positive outcomes*.
> (ALAC, 2010, p.ix)

General conclusions based on outcomes across multiple follow-up studies in different contexts and across varying time periods indicate that:

- overall levels of substance use are reduced with TC treatment up to two years post-discharge;
- there is a degree of recovery at least similar to and possibly exceeding methadone treatment;
- studies also show a consistent correlation between TC treatment and improvements in mental health such as recovery from depression or reductions in suicidality (Hubbard et al., 1984; Ravndal & Vaglum, 1994).
- less data is available on criminal behaviour but evidence indicates TC treatments can lead to reductions in criminal activity. For example a study by Hiller et al. (1999) found that 30% of parolees completing an in-prison TC and aftercare TC treatment were rearrested for a new offence, compared to 42% of the untreated matched parolees.

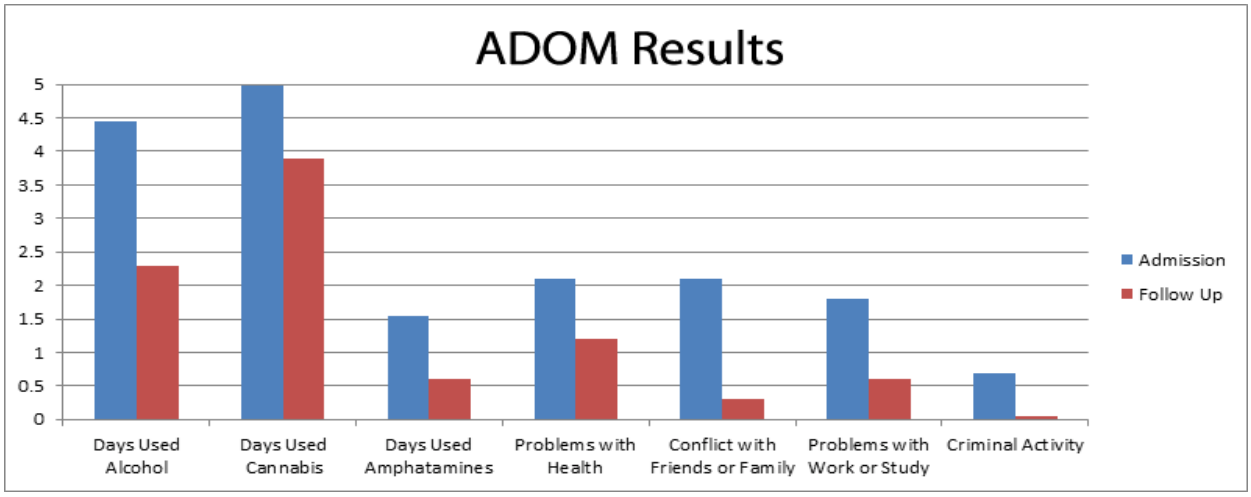
New Zealand is seeing similar reductions in recidivism through TC treatment, particularly in the TC based DTUs. Department of Corrections (2010) analysis show prisoners who have completed one of Care NZ's DTU programmes can reduce their reoffending rates by up to a third compared to similar offenders who don't undertake any treatment.

Their analysis also suggests a reduction in the severity of re-offending by graduates of the DTU programme. The Department of Corrections (2010) report that impacts on recidivism resulting from the DTU programme are equivalent to best-practice achievements internationally in correctional rehabilitation. In addition, Māori offenders achieved particularly good outcomes through DTU participation as well as in the Māori focus Units which in many ways are similar in intent to a therapeutic community (Department of Corrections, 2010).

During treatment Odyssey House Auckland also collect measures on; progress in the TC, mood, craving to use substances, and client satisfaction. During treatment clients report being significantly less depressed, having less craving to use substances, and high satisfaction with treatment. These findings support international literature showing that a length of stay in a TC of over 3 months has a lasting effect on the clients behaviour and substance use (Gowing et al. 2002). In 2011 Odyssey House Auckland had an average length of stay for all services of over 6 months.

Odyssey House Auckland provided recent outcome data for this report which is presented in Table 1 below. Similar to international evidence, the graph shows reductions in substance use and health problems, improvements in social relationships and employment for service users who have graduated from the programme and are now receiving aftercare.

Table 1: Odyssey House Auckland client outcomes (ADOM results) on admission to treatment and at follow up during aftercare



The Moana House evaluation (2010) provides further New Zealand based evidence for the effectiveness of TCs. Findings indicated good motivation to engage in treatment, with residents showing high levels of responsibility. The programme showed a positive impact on the dimensions of wairua, hinengaro, tinana, and whānau as measured by the outcome measurement tool Hua Oranga. In addition, mental health functioning was improved for the men who stayed in the programme for longer periods of time. Moana House has achieved good retention rates (77% beyond one month, 45% beyond three months) and these rates were even better for the most recent group of residents included in the study (89% and 67% respectively).

2.3 The Role of ATCA and the TC Standards

The Australasian Therapeutic Communities Association (ATCA) was formed in 1986 to bring together TCs across Australia and New Zealand to support and promote the TC as a method of treatment for addiction related problems. ATCAs key functions are related to professional development and the maintenance of the fidelity of the TC model.

Gowing, Cooke, Biven & Watts (2002) were commissioned by ATCA to review the essential elements of the TCs developed in the USA, for the Australasian context. Responses to the 'Survey of Essential Elements Questionnaire' (SEEQ), a review of published literature and views of individuals with experience working in Australian and New Zealand TC's were combined for this review. The essential elements identified fall under three main categories, with related subcategories:

- TC Ethos (reflects the nature of the TC environment that provides a background context to intervention)
- Aspects of programme delivery (reflecting the components of intervention experienced by residents of TCs)
- Quality assurance (more routine aspects that are important to ensuring that TCs operate in accordance with current health care standards)

ATCA has recently developed of a set of standards that identify and describe good TC practice. These standards were informed by the earlier work of Gowing et al. (2002) and cover eight key areas:

1. Appropriate and timely service provision
2. Leadership and management principles
3. Consumer participation
4. Strategic human resource management
5. Informational management and appropriate use/evaluation of data
6. Occupational health and safety
7. Health and safety risk management; and
8. Continuous improvement.

Odyssey House Auckland has been the first New Zealand TC to complete the process to be accredited in the ATCA Therapeutic Community standards. The plan is for all New Zealand ATCA members to be accredited in the standards by early 2013. These standards should be linked to national workforce development activity, to achieve consistency in practice.

3. Therapeutic Communities in New Zealand

A number of therapeutic communities continue to operate in New Zealand for substance use related problems but not all are members of the Australasian Therapeutic Association (ATCA). TCs include:

Care NZ. Since 1997, Care NZ has in conjunction with the Department of Corrections established Drug Treatment Units (DTUs). The programmes use the TC model within one women's and seven men's prisons in both the North and South Islands. Programmes are either 3 or 6 months in length and the TC model is modified where necessary to fit the compliance and containment requirements of the Department of Corrections. The re-entry stage is also modified to reflect the population group, where clients will often return to prison post treatment requiring a strong internal handover process to other services operating within the prison. Care NZ also makes use of family inclusive practice to support after care. Care NZ employs 102.5 FTES in its DTU facilities.

Higher Ground Drug Rehabilitation Trust. Established in Auckland in 1984 to provide treatment for people with 'severe substance dependence'. This TC provides an 18 week residential programme modeled on 12 Step recovery principles with a strong therapeutic process. Higher Ground has an aftercare support house and provides aftercare services which include group therapy and individual counseling. It also has a Māori programme component and a family and whānau therapy programme. Higher Ground employs approximately 25 FTE's.

Odyssey House Trust Inc. Odyssey House in Auckland opened its first TC facility in 1981. It now offers a diverse range of programmes and services operating from eight treatment centres in Auckland City, Manukau City, and Whangarei. These include an adult and young adult residential programme, a family residential programme (inclusive of children aged less than 12 years), a youth residential programme, a programme for people with co-existing problems,

transitional houses and a mobile community programme that provides assistance to people who have had previous contact with Odyssey House.

The average length of stay at Odyssey is between six and eight months, people in the co-existing programme tend to have a longer average stay of approximately fourteen months. Odyssey also runs a 3.5 month TC program within a prison setting for people with extensive criminal backgrounds. Odyssey House Trust Inc. employs 115 FTES.

Odyssey House Trust Christchurch. Odyssey House Trust Christchurch offers a TC programme comprising mixed gender youth residential and day programmes and a residential programme for adult men. This programme caters for up to 22 men and is of up to 15 months duration. A transitional house is available to men transitioning from the residential programme to independent living. Odyssey House Trust Christchurch employs 22 FTES.

Moana House is a 17 bed residential therapeutic community for recidivist offenders in Dunedin. It was set up in 1984 and in its current form was opened in October 1987. With a strong tikanga emphasis, Moana House has developed a unique bicultural programme of four stages, each more difficult than the previous and with no set time spent in each. Moana House's work participation programme takes place in the wider community where residents work in a paid or unpaid capacity. Average length of stay is 7 to 8 months. The programme is highly used by Māori and increasingly by Pacific men. As a consequence Moana House has developed a Pacific programme in liaison with the Pacific community. Moana House also operates an NZQA Registered and Accredited Training Institute currently delivering a Level 6 Applied Addiction Diploma. While this is open to everyone it does provide a pathway for previous programme users to enter training - an important aspect of the TC model. Moana House employs 13.5 FTE's and usually has one intern funded from an alternative source.

Currently the New Zealand TC workforce comprises of approximately 278 professionals spanning a wide variety of roles[3] including nurses, AOD workers, psychologists, counsellors, psychotherapists, social workers, occupational therapists, support workers, administrators, researchers and management.

3.1 Current Therapeutic Community Training Approaches

Currently there is no TC specific training available in New Zealand. Yet, the TC is a very unique model that TC staff should be trained in, in order to operate at the top of scope in this milieu. Consequentially each TC within New Zealand engages in extensive in-house training for new staff. Training approaches vary and reflect the diversity of New Zealand's TCs but key similarities are apparent in that training combines TC theory and practice and is supported by mentoring and clinical/cultural supervision. Following is a brief summary of the training processes used by each TC:

3.1.1 Odyssey House Auckland

Training at Odyssey House varies across units but generally a one week immersion process is employed for new staff, who focus on observing the way the TC works in their first week. This observation is supported with reading to understand the TC theory. New staff are paired with an experienced staff member who becomes their mentor. During early stages in the new role the mentorship continues to be an important vehicle for training. Clinical supervision is also used.

[3] This TC workforce figure is an estimate and does not include private service providers.

Ongoing training is provided to staff including four core modules covering the Treaty of Waitangi, non violent crisis intervention, Pacific competencies and first aid.

Jackie Long, Specialist Services Manager for Odyssey House, highlights that a one week immersion process is not ideal as staff generally need longer to understand the TC model of working. Odyssey have completed a review of their training processes and recommend that:

- a comprehensive training manual be provided including relevant resources that describe the TC model and its application at Odyssey House and a clear description of staff positions and roles;
- all new staff members be given at least a week long practical training relative to their role before they assume their responsibilities;
- clinical supervisors be involved in the orientation of new staff members as well as providing on-going support and feedback to current staff members.

3.1.2 Care NZ

Induction is a joint process for both Care NZ and the Department of Corrections. This induction includes an immersive component and uses an apprentice learning style where a novice or some one with no TC experience will be assigned to an experienced TC practitioner who guides them parallel to the induction pathway. While training approaches may vary across DTU's for the first 4 weeks new staff will generally participate in the TC's daily programme as an observer. This practical experience is supplemented by TC theory sessions with a senior staff member. This period of observation helps inform their performance and development plan and is linked to clinical supervision.

Despite this investment in internal training staff turnover can still be quite high (approximately 10 to 30% per year). Graham Thorne, National Performance Manager-Quality and Service, with Care NZ notes that there is a high staff turnover during the first year due to lack of appropriate skills and experience for the role. 'I think that a lot of the turn over issues we are facing could be resolved if we had ways to up-skill and prepare people prior to them starting in the role'.

Graham also highlights another limitation of their in house training:

> *Because of the nature of the apprenticeship model with senior peer support and clinical supervision, while it allows a lot of intense participation, the model is vulnerable to the specific people who are available on site locally which is different across TCs. This is a strategic weakness. I would prefer there to be more conformity and consistency in the training we give staff, and as an industry. There needs to be something in the sector that norms what we are and how we do it*.

To assist in maintaining quality standards Care NZ's national consistency project has been developed to identify the core pillars of effective practice within its prison based drug treatment units. These compliment the ATCA TC standards. Staff are trained to apply these pillars in their practice and an induction pack is being developed to support new staff to consistently apply these indicators.

3.1.3 Moana House

Moana House carefully selects staff who possess skills, knowledge and values that can be adapted to work within the Moana House TC model. New staff complete an extensive orientation programme that introduces them to Moana House's polices and procedures and

ways of working. Training is tailored for individual staff members who work alongside an experienced staff member for up to three months. Initially they have an observer role and are involved in staff debriefing after group work and other interventions. There are a range of supervision opportunities such as fortnightly group clinical supervision with an external clinical psychologist, internal group supervision for newer staff, individual professional supervision and cultural supervision.

In addition Moana House have developed a six session 'Stepping In' programme, with accompanying work book, for new staff entering the TC. The addiction work based placement programme, currently administered by Te Rau Matatini has also been successfully applied in this context. To further develop their workforce Moana House would like to see more use of work based placements and internship programmes which provide a good fit with the experiential TC training model. They would also like to see the development of nationally recognised qualification, similar to the 'Stepping In' course, where people are equipped with the key knowledge and experience to work in a TC or residential setting.

The Moana House evaluation (ALAC, 20120: p. xii) concludes with recommendations that are relevant to the current report:

- The call for a strong national commitment to TC treatment as a viable and effective alternative to prison for individuals with significant substance use and offending issues;
- The maintenance of a distinctive TC programme identity by ensuring fidelity of the model, such as that proposed by De Leon (2000);
- That a cost effectiveness study to identify the actual costs and benefits associated with New Zealand TC programmes for individuals with high and complex treatment needs would allow for quantification of their benefit and assist in setting funding priorities;
- Workforce implications of any expansion in TC provision should be considered, as well as the extent to which the current TC workforce is adequately supported and trained;
- That a national network or body of New Zealand TC programmes be established along the lines of the National Association of Opioid Treatment Providers.

3.1.4 Higher Ground's Apprenticeship Model

We end up training our own staff because it is virtually impossible to find a training system that works for staff. Johnny Dow, Director, Higher Ground.

Higher Ground employ an apprenticeship training model where they select approximately 6 to 7 students from a variety of disciplines, for example psychotherapy, AOD counselling and social work. These students complete a training programme where they spend one to two days per week for up to two years within the TC. This is a voluntary learning experience that students engage in to acquire practical skills that complement their tertiary study. These are unpaid places; however some students have received funding for these positions through the addiction work-based placement programme. Higher Ground staff have tended to be recruited from this group of students.

> *Generally if you bring people in from the outside they are totally overwhelmed, they have no idea what a TC is like. It's quite a different environment to a straight residential or outpatient treatment unit. It's fairly intense; they have to learn how the systems work. So we find its best that they come on as a student so they can be part of groups, they can see what's going on and they can get supervision so they understand the model we use.* Johnny Dow, Director, Higher Ground.

The training programme is largely based on shadowing staff members to learn how things are done. A pathways document supports the induction and training process for students and new staff, it provides a detailed overview of Higher Ground's policies and processes. Students and staff receive regular supervision. Higher Ground also run internal training on co-existing problems for example a psychologist delivers six education sessions during the year on mental health and personality disorders to assist staff to manage the complex issues presented by some clients.

Higher Ground's training method is meeting their workforce needs. Students enjoy the programme and are keen to be recruited into paid positions when vacancies occur. Additional training opportunities however would be welcomed by Higher Ground. Training in group work, working with families and further co-existing problems training relevant to the TC environment were noted to be particularly desirable.

4. Workforce development needs for Therapeutic Communities

All addiction related residential programmes and TCs in New Zealand have comprehensive on the job training approaches by necessity. Some people who apply for roles in a TC have residential programme experience but do not have experience working in a TC environment. At Care NZ it was reported that '*of 104 applicants we had 5 people with TC experience. We have to hire people with no experience, because otherwise we are not hiring anybody*.' Graham Thorne, Care NZ.

Training new staff is resource intensive work, particularly for the large TC organisations such as Care NZ and Odyssey House.

All TC representatives interviewed for this report were unanimous in highlighting the value of having a national TC related training to accompany in house training for people who are interested in pursuing a career working in TCs and/or have been employed by a TC and need to learn how the model works. Such a training programme would provide consistency and national training standards. Each TC environment is unique and internal training to understand how the model is contextually applied will still be required.

Interviewees indentified the need for the following:

4.1 A national qualification in Therapeutic Community

There are currently no training opportunities specific to TCs available in New Zealand outside of the on-the-job training TCs provide to new staff and the apprenticeship programme provided by Higher Ground. Interviewees highlighted the value of developing a TC related curriculum that could also be embedded in current addiction qualifications as well as provide stand alone certification for people wanting to specialise in TCs. There is also a need to investigate the workforce development requirements of non-addiction TCs and whether these could be incorporated into any TC training programme(s) that may be developed, thereby increasing the real demand for such a programme(s) and potentially expanding the pool of the TC competent workforce.

While each New Zealand TC has modified its approach to best serve its population group, the core principles and structure of the 'community as method' model apply across all TCs.

> *There is a significant amount of cohesion and similarity in the sector - community as method is the common ground. A national training module would not only build closer ties in an already very unified movement and school of thought for TCs in NZ but also build the consistency in the workforce that you want*. Graham Thorne, Care NZ

4.2 Potential to modifying existing addiction qualifications training

It was seen as particularly valuable for the addiction workforce to be introduced to the TC treatment model during their training, both to raise their awareness of this career path and to equip them with understanding of this treatment method when they enter the addiction workforce.

Graham Thorne from Care NZ further explains the value of including TC training in AOD and mental health training:

> *Each year on average 1000 of the 9000[4] people sentenced to New Zealand prisons will go through the Drug Treatment Units which use the TC model. Too often these people end up working with clinicians who are completely unaware of the tools and assets the client has acquired. Six months in a TC is a lot of therapeutic work but it needs to be supported. In many cases because we do not have the TC immersive experience or even just a theoretical component that is wide enough to be incorporated through the AOD sector, we are handing over large amounts of clients without handing over the language of their recovery*.

TC specific training modules or papers could be developed in already established addiction qualification programmes to cover the theory and practice relevant to TC's These modules could potentially provide stand alone learning, but would also be part of the over all addiction qualification or combined to form part of any national TC qualification (if one was to be offered). Currently there is little in the way of TC theory or practice taught in current addiction qualifications and while general training workshops and short courses are also available for addiction and mental health practitioners, this material is not usually contextualised to the TC model.

4.3 Applied training; blending immersion with theory and practice

International evidence confirms that effective training for TCs needs to combine theory and practice with immersion in the TC environment.

> *TCs are dynamic places and the culture is hard to teach in a classroom, it is community as method so you need to see a community operating*. Tim Harding, CEO,Care NZ.

> *All the theory in the world won't prepare you to work in a community... the community can challenge you on your behaviour. This can rock professionals initially - its not an easy programme, you need to have good self awareness*. Jackie Long, Odyssey House.

[4] 9000 is an approximate estimate for the number of sentenced prisoners in New Zealand's prisons currently. At March 2011 New Zealand's prison population was 8755 (see www.corrections.govt.nz/about-us/facts_and_statistics/prisons/march_2014.html).

The basic tenants of the TC community as method approach are well defined and could quite easily be developed into key theoretical modules. These modules could be supported by peer based practice through simulation, role modelling, video taping and reflection. This training would need to also include an immersive experience where students spend considerable time in TCs observing all aspects of the programme's structure. A cornerstone of workforce development for TCs is TC practice.

4.4 The importance of group work

Community as method necessitates far more group work and less individual counselling compared to most other treatment models. However most clinicians who apply for roles in TCs have experience working individually with clients and lack good clinical skills in group work.

> *The challenge is that most of the larger providers of AOD training have virtually nothing, or very limited training, on group work. In addition clinical training tends to be individually focused*. Graham Thorne, Care NZ.

Having a structured standardised module with focus on theory, practice and skill development in group work that would sit inside existing training or as a stand alone module for TC practitioners, would be of benefit for the TC workforce.

4.5 Developing internships and placements

The addiction work-based placement programme administered by Te Rau Matatini is a three to twelve month supportive work-based programme aiming to contribute to growing the number of people currently working in addiction treatment environments. Higher Ground and Moana House have acted as host organisations for the work-based placement recruits who are paid a salary while engaged in the placement. The work-based placements have proven to be a useful workforce development initiative for these TCs as the placement model is a good compliment to the apprentice based learning style required to gain competence in the community as method model.

More internships coupled with a national qualification recognised by Dapaanz would be an excellent combination. Claire Aitken, Programme Director, Moana House.

4.6 Scope for a Training Therapeutic Community

A ‘training TC’ concept was presented, particularly by Care NZ, as an innovative way to develop people's capability to work in a TC within a safe environment, where the TC model would be kept as pure as possible.

> *I would love to see the TC training model in action, we would invest in that. Even De Leon is wanting to see this happen and he would bring in the National Development Research Institute based in New York to support the set up because this would be a world first*. Tim Harding, CEO, Care NZ.

Without consistent exposure to the TC theory and practice, it can be hard for services to maintain the purity of the TC model. People bring their own training and experiences into the TC environment often diluting the ‘community as method’ model. Care NZ have introduced the National Consistency Project to address this, similarly the ATCA standards and accreditation process will assist with maintaining fidelity to the ‘community as method’ model. The ‘training TC would operate in a similar way to a teaching hospital, where special care is taken to keep the

model pure so all staff learn consistent practices. After initial training staff can periodically return to the Training TC to refresh their knowledge and skills.

> *De Leon would be keen to support the set up of this model in New Zealand as he sees this training method as the best way to achieve fidelity to the model.* Tim Harding, Care NZ.

Care NZ would like to see a 'training TC' set up in a prison setting as there are some important and dynamic differences that occur in this context which need to be experienced. Therefore a second 'training TC' would need to be considered in a community based setting to provide people with the range of TC experience reflective of the New Zealand environment.

4.7. TC Graduates: A crucial workforce

It is important to acknowledge the vital role people with lived experience of addiction have within the TC workforce. Their understanding of the TC recovery journey can not be emulated by any training programme. TC graduates will also be key contributors to development of training curriculum for the TC workforce. They need to be actively involved in TC training, both through contributing curriculum content based on their intimate knowledge of the TC recovery pathway and by completing this training so they acquire the clinical understanding to enter the TC as staff members.

> *De Leon and others have clearly stated that the best people to work in the TC model of Community as Method are graduates of that model as they have the best understanding. This is something "professionals" struggle with which demonstrates why it gets diluted.* Tim Harding, Care NZ.

4.8 Needs of Māori and Pacific people

The original 'community as method' approach did not take into account cultural diversity. New Zealand's TCs have needed to modify their approach to fit the New Zealand population. It would be important to include these methods in any training so students begin to understand how the TC approach can work most effectively for people from different cultures, especially Māori and Pacific people. Moana House in particular has invested considerable effort to design their program to fit their multicultural client group.

> *If the model is applied strictly then it can be quite authoritarian and shaming if left with no real controls. This is certainly not mana enhancing practice.* Claire Aitken, Programme Director, Moana House.

Staff need to be willing to hear a critique of their TC model from a cultural perspective and be prepared to address the issues which may emerge. This takes more then having a cultural consultant or embedding cultural exercises such as singing waiata. It requires an authentic cultural partnership and openness to change amongst all staff, particularly those in leadership roles.

> *What we discovered was in the very early days, 1988-89, many Māori began to use our service but were not staying. They did not say anything or complain but we noticed it and began to address it in conjunction with local runaka. We now have around 70% or more who are Māori because when you provide something that is attractive it will be used.* Claire Aitken, Moana House.

Changes to the Moana House programme have helped cross the cultural divide by ensuring the programme has a framework of practice which actually names and addresses cultural difference. At Moana House this framework of practice is Heke Tikanga which sits over the TC Model. Recently Moana House has employed a number of Pacific staff and created a Pacific group in a move towards incorporating Pacific models within the TC. With these changes they are now attracting more Pacific men to the programme.

Since the development of Pasifika mental health and addiction services in the 1990s the Pacific community has been calling for a Pacific Therapeutic Community. This call culminated in the *Pacific Therapeutic Communities Scope for the MOH* that was produced in June 2010 by a national group of Pacific practitioners, led by Tupu, the Pacific Mental Health and Addiction Services, Waitemata District Health Board. This scoping document cited the low utilisation of Auckland TCs by Pacific people and low retention rates.

> *Our counsellors were finding it hard to get continuity of care for the Pacific people attending the current TC's, they were either dropping out early or not even turning up for the treatment.* Pulotu Bruce Levi, Service Manager, Tupu.

Pulotu Bruce Levi suggested this low rate of use was because the current TCs were not familiar enough for Pacific people to keep them in the treatment for at least the three months required to see change. In addition, Pacific people often have very strong ties and obligations to family which can make it difficult for them to attend treatment in residence. To be effective for Pacific people family inclusive work needs to feature strongly within the TC approach.

> *Spirituality is also a point of difference for Pacific people, it's like breathing for our people and if that's not reflected in the TC structure then it will be very hard to be effective*. Pulotu Bruce Levi, Service Manager, Tupu.

Current TCs use Pacific competencies and have, or are developing, Pacific programmes to be responsive to Pasifika clients. However these supplementary activities are not a substitute for a Pacific TC which can be built on Pasifika models of wellness, led by Pacific people, and which hold a strong family focus.

4.9 The ATCA as a vehicle for workforce development

Jackie Long, New Zealand representative on the ATCA, reports that Australia are experiencing similar challenges for training new staff and there is scope to work collectively to develop a solution. '*ATCA is a likely vehicle for TCs to unify to form workforce development solutions'*. Graham Thorne, Care NZ.

> *Feedback from our members and people attending the related conferences include an overwhelming call for the ATCA to provide a curriculum for workforce development and sustained support to foster an appropriately skilled workforce in the sector. Currently the professional qualifications and experiences of staff in the AOD workforce are diverse. They include psychologists, nurses, and social workers, all of whom bring a dynamic perspective but whose education and training is varied with very little focus on AOD issues and residential treatment in particular*. (ATCA April, 2010 report, p. 13)

Currently ATCA are focused on accrediting all TC members in the ATCA quality standards. This will include developing subsets of standards for co-existing problems and prison settings. These standards form a strong foundation for an Australasian training programme that reflects the

essential elements of the community as method TC model. ATCA now sees it has a role to play in providing a curriculum that will ensure a standard of training (both theoretical and practical) that will not only maintain the integrity of the TC model but will ensure a standard of service delivery across the AOD and co-existing residential treatment sector. ATCA have also developed a workforce development plan in response to member feedback that includes:

1. establishing a training department within ATCA that will oversee the professional development of TC management and staff.
2. the implementation of training packages that will facilitate professional development in the sector - online and face to face modules.
3. the development of centres of excellence providing structured practical experience linked to theoretical learning - criteria for centres of excellent will be developed from the National Quality Standards. These centres will cover different population groups and practical and theoretical training will be available for indigenous communities.

This training will not be restricted to ATCA members but will be offered across the addiction sector with special emphasis on remote and indigenous services.

This ATCA direction, currently planned for Australian implementation, closely aligns with the workforce development directions expressed by representatives of the New Zealand TCs interviewed for this report. New Zealand and Australian ATCA members could potentially combine thinking and resources to develop this plan to meet the needs of both countries.

Conclusions

New Zealand addiction related TC's are unified in their call for specific training in the TC model to augment in-house training particular to their context and population group. Participants in this scope believe that this training will help relieve the burden currently faced by TCs who are required to teach their new staff all aspects of working in a TC on-the-job. The 'real demand' from students or practitioners who would undertake such training however is still unknown.

There are two main options to help meet the workforce development needs identified by the addiction related TCs involved in this scope. These are:

1. The development and delivery of a specific TC qualification

2. Incorporation of TC theory and practice into current addiction qualifications

A combination of these options would also be valuable. While a TC training programme(s) that is able to provide a national qualification or certification recognised by employers would be beneficial, it is also important that all addiction practitioners have an understanding of the TC modality.

Any programme of study or training should focus on;

- Combined theory and practice related modules
- Student immersion in the TC environment
- A strong group work focus
- Involvement of TC graduates
- Responsiveness to cultural diversity-Maori and Pacific

- Consideration of a 'training TC'
- Consideration of providing certification or a TC qualification to those who complete the training
- The continued need tor work based placements

Recommendations: Next Steps

It is recommended that a working group be formed with representatives from the New Zealand TCs (a NZ TC collective), supported by the Ministry of Health, to collectively refine this vision for workforce development with a focus on the following as they relate to the two options identified above;

- A 'real demand' analysis regarding the number of potential students or practitioners who would undertake any TC training programme(s) (including staff and students involved in non-addiction related TCs).
- Establishing a reference group to steer developments
- Establishing which option has the strongest support and is most likely to be implemented
- Identifying what resources are required to deliver the preferred option (organisational support, people, training providers, budget).
- Identifying potential training provider partners
- The role of ATCA and Matua Raki

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