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Residential treatment for drug use in Europe

Abstract: Today, in most European countries, residential treatment programmes form an important element of the range of treatment and rehabilitation options for drug users. The aim of this paper is to provide a Europe-wide overview of the history and availability of residential drug treatment within wider national drug treatment systems. To help with this, the paper describes the history and availability of residential treatment in Europe and develops a categorisation of the broad range of available models and treatment approaches applied in residential settings. Countries differ in the level of residential treatment provision. Over two-thirds of the 2 500 reported facilities in Europe are concentrated in just six countries, each reporting over 100 facilities. A description is provided of the characteristics of residential treatment (inpatient) clients, as well as discussion of organisational and quality assurance issues relevant to residential treatment and how these matters are dealt with across Europe.

Keywords residential treatment drug use drug treatment systems

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Summary

'Residential treatment' comprises the provision of a range of treatment delivery models or programmes of therapeutic (and other) activities for drug users, within the context of residential accommodation, in either the community or a hospital setting. The main therapeutic approaches used include the 12-step/Minnesota model, therapeutic community and cognitive–behavioural (or other) therapy-based interventions.

In Europe, trends in the development of residential drug treatment closely mirror broader social trends in institutional care. This has included an initial 'psychiatric' phase followed by a more liberal 'social therapy' phase in the second half of the 1970s, involving the family and social environment of drug users; the grass-roots initiatives by self-help groups were followed by a period of professionalisation of therapeutic staff and quality management. The 1970s and 1980s saw an expansion in residential care, followed by a contraction in favour of community-based outpatient treatment; and the objectives of drug treatment changed from a sole focus on abstinence to integrating the reduction of harm. In the history of residential drug treatment, each country retains its own 'story' of the emergence of drug use problems. A large part of the earlier sociopolitical debates reflected national culture and values and determined changes in national health systems and funding streams. However, the HIV/AIDS crisis of the 1980s had a profound impact on the residential treatment response to drug addiction across many European countries, leading to the scaling up of more varied treatment offers within an integrated system of responses to drugs.

Today, in most European countries, residential treatment programmes form an important element of the range of treatment and rehabilitation options for drug users. Countries differ, however, in the level of residential treatment provision. Over two-thirds of the 2 500 reported facilities in Europe are concentrated in just six countries, each reporting over 100 facilities, with Italy reporting the highest number (708 residential facilities). There is also variation in the treatment approaches used to treat drug-using clients in residential settings in Europe today. Although in 15 countries the approach/principles of the therapeutic community were identified as predominant — employed by all or most of the residential programmes in their territory — a combined clinical practice, rather than fidelity to one treatment approach, is widely accepted. Although, historically, residential treatment programmes have been exclusively drug free, current data indicate the growing importance of providing medication to substitute for illicit opioid use.

The best available information source to describe the profile of drug clients entering residential treatment in Europe is the treatment demand indicator (TDI). In the 22 European countries providing data, around 35 000 drug clients entered inpatient treatment in 2011, with those entering inpatient centres representing only around 11 % of all reported drug clients in Europe. This suggests that, on average, around one person commences inpatient treatment for every 10 people starting specialist outpatient treatment. However, substantial inter-country differences exist. Typically, inpatient clients are male and in their early 30s. Compared with outpatient treatment entrants, they live in more disadvantaged social conditions (low education, unstable living conditions and unemployment). Just under half of inpatient clients enter treatment for problems related to primary use of opioids (mainly heroin).

In most European countries, funding for residential treatment is provided by governments, typically in the context of a joint funding arrangement either between different levels of the government or in tandem with health insurance. In a number of countries, drug users make some personal contribution to residential treatment. To aid quality assurance and improved processes in residential treatment, a considerable number of Member States note the existence and use of evidence-based clinical guidelines and service standards.

1. Introduction

Background and aims

Latest estimates suggest that, while almost three-quarters of a million problem opioid users are receiving opioid substitution treatment in Europe, at least a quarter of a million drug users are receiving other forms of treatment, including a range of approaches in residential settings. Most people receiving specialist treatment for drug problems may not need to access residential treatment. Their needs can be met appropriately by community drug treatment services, which have increased in availability and effectiveness over the past decade. However, outpatient treatment and rehabilitation may not always be the most appropriate option, particularly for a select group of drug-dependent clients who need the safety and structure that residential treatment can provide. Hence, residential drug treatment is a sizeable and necessary element in the range of treatment options available to drug users.

While measuring and improving drug treatment provision and outcome in opioid substitution treatment have been high on the research agenda in recent years, the extent and nature of residential treatment has received less research attention. Addressing this information gap is likely to benefit funding

bodies, which need to understand the nature of residential programmes and the extent of services offered in order to make treatment more effective and cost-effective with respect to the range and amount of services offered. Clients and their families too can use such information to gain insights about the nature of treatment and the approaches that may be used — erroneous client expectations about treatment can lead to higher rates of dropout, client perceptions of failure and inefficient use of treatment resources. Although such arguments apply to all forms of treatment, they are particularly relevant to residential treatment because of the high cost of this treatment provision.

There is a wide range of different types of residential treatment, and residential treatment is advancing and currently developing its evidence base. To aid comparison, it is important to establish common factors and models among this variety. Traditionally, residential programmes have been delivered over a number of months, up to a year, to allow successful achievement of treatment goals. In the current unfavourable economic conditions, it is particularly relevant to examine whether and how the pattern of residential treatment provision is changing and how providers are responding to new demands and opportunities — in terms not only of treatment duration, but also of programme content and intensity.

The aim of this publication is to provide a Europe-wide overview of the history and availability of residential drug treatment within wider national drug treatment systems. To facilitate this, this paper develops a categorisation of the broad range of available models applied in residential settings. Finally, it describes the characteristics of residential treatment clients, as well as presenting and discussing key features of the organisational issues around this type of treatment. This publication is descriptive in nature and does not attempt to consider the effectiveness of residential programmes for drug users. An assessment of the evidence base, with a focus on therapeutic communities, and an evaluation of therapeutic communities' impacts are reviewed and reported elsewhere (EMCDDA, 2014).

Like other parts of the health and social sector, drug treatment systems are under increasing pressure to demonstrate value for money. In this context, this publication builds on the collaboration with the Reitox national focal points to inform discussions about the contribution that residential treatment makes to the drug treatment systems across Europe, as well as acting as a baseline for assessing future changes in the pattern of residential services' design, function and provision.

Scope and coverage

Residential treatment may be defined in a number of different ways. For example, it might be defined as one or more of a broad range of therapeutic interventions provided within the context of residential accommodation, or a definition might require a minimum duration of treatment. For the purposes of this publication, residential treatment programmes are defined as involving therapeutic interventions aimed at long-term change in drug use, usually alongside the other rehabilitative activities, within a residential setting.

It is important to note that residence can occur within a range of settings: community-residential, hospital and prison environments. This publication focuses on treatment facilities in community-residential and hospital settings; drug treatment provision in prison is considered in the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) Selected issue *Prisons and drugs in Europe: the problem and responses* (EMCDDA, 2012a). This publication does not include data and information about supportive residential programmes dedicated to the provision solely of social support (e.g. shelters, supported housing services), although these may have a role in the treatment, care and support of drug users in different stages of their recovery. In some instances, the boundaries may be blurred between some types of supported housing services and residential treatment, as supported accommodation services may have similar treatment aims and may provide a structured daily programme of activities for their residents.

The goals of residential treatment programmes generally are to prevent a return to active drug use, provide individuals with healthy alternatives to drug use and help drug users to understand and address the underlying factors supporting drug use and make healthier decisions (NTA, 2006). Residential programmes thus potentially offer a number of benefits in a coherent package that removes people from their drug-using environment and provides a safe and supportive place to learn the skills conducive to living a sober and rewarding life. However, changing views on addiction as a chronic disorder and emerging theoretical insights that question treatment episodes in closed environments are likely to have an impact and prompt changes in the treatment goals and methods of residential programmes (McLellan et al., 2000).

In this report we distinguish between inpatient detoxification and residential treatment. The main differences are in terms of aims and interventions. Inpatient detoxification provides safe withdrawal from a drug of dependence — not so much a form of treatment but a gateway to treatments that are aimed at long-term change. Residential treatments aim to help individuals to attain control over drug use, achieve recovery from drug problems, improve health and well-being and change lifestyle, including family and social relationships, education, voluntary activities and employment. Key features of such programmes include the provision of individually tailored psychosocial support and a structured programme of

Data sources and definitions used for this report

Data on residential treatment in Europe for this report are primarily sourced from the Reitox national focal points — the EMCDDA's network of national partners in the 28 EU Member States, as well as Turkey and Norway — supplemented by treatment demand data routinely collected by the EMCDDA and reports in the scientific literature.

The sources used to provide the information included were varied and ranged from national statistics through online directories of facilities to expert impression and estimation. The report needs to be read with that caveat in mind.

The 'Residential treatment clients' section draws on the EMCDDA's treatment demand indicator (TDI) database, which covers around 60 % of existing residential units in the reporting countries and does not include data and information on residential units in six countries (Spain, Italy, Portugal, Slovenia, Latvia and Lithuania).

'Residential treatment' is defined as a range of treatment delivery models or programmes of therapeutic and other activities for drug users, including the 12-step/Minnesota model, therapeutic community and cognitive–behavioural (or other) therapy-based interventions, within the context of residential accommodation in the community or hospital setting. This definition excludes (i) programmes providing inpatient detoxification only, (ii) drug treatment provision in prison (reviewed by the EMCDDA, 2012a) and (iii) supportive programmes dedicated to the provision solely of social support (e.g. shelters, supported housing services).

daily activities that residents are required to attend over a planned period of time. There may also be an initial detoxification phase in the programme.

2. Historical perspective of residential treatment for drug users

This section provides an overview of how the activities and organisation of residential drug treatment in Europe have changed during the last half century. That forms a backdrop against which current practice may be considered.

Residential addiction care in Europe at the end of the 1960s

Until the late 1960s, no specific drug-related treatment system existed. Addiction was mainly taken care of by the general health system and in most countries consisted of medico-psychiatric care delivered in inpatient wards of psychiatric hospitals; alcohol users constituted the main client group. Early initiatives in outpatient treatment for people with alcohol problems were reported from the Netherlands (1910), and in the UK ([1]) from the 1920s medical doctors were able to prescribe maintenance with opioids to addicted patients in an outpatient regime. Dedicated addiction facilities such as the 'therapeutic farm', established in 1932 in Alsace as France's first residential facility for the treatment of alcohol dependence, were a rarity.

An alternative, democratic and user-led form of therapeutic environment, therapeutic communities, were introduced in psychiatric hospitals in the UK in the 1940s (Jones, 1953). They represented a shift from individually oriented psychiatric treatments to a group therapy approach with a focus on social interaction, based on a psychological and social perspective of mental illness which had gained ground in psychiatry. These developments also affected the treatment of addiction in psychiatric wards. At the same time, other new approaches, specific to the treatment of addiction, developed, such as the 'Apolinar' residential unit in Prague, which combined medical treatment with collective education and behavioural approaches in the treatment of patients dependent on alcohol, medical opioids, stimulants or inhalants. Another innovative initiative was the 'alternative therapeutic community' set up by Janez Rugelj in Slovenia and based on a treatment method he invented, which entailed an 'open' (outpatient) therapeutic group setting for up to 120 members with different addictions, including gambling and eating disorders, who could join and leave the programme freely. These pioneering units later became models for other specialised residential addiction treatment in their own countries and abroad. In the European countries forming part of the Soviet Union, drug use was not a topic of public discussion during this period.

The creation and expansion of specialised residential treatment facilities for drug addicts (late 1960s until early 1980s)

In the late 1960s and during the 1970s, the spreading use of illicit drugs was reported from a number of countries, including Belgium, Denmark, Germany, France, Italy, the Netherlands, Sweden, Norway and the UK. In 1972 in the Netherlands, fuelled by economic recession and unemployment, heroin use reached epidemic proportions for

([1]) In 1965, prescribing of narcotic drugs was temporarily possible in Sweden.

the first time. By the early 1980s, however, heroin use had markedly increased in several countries, including Germany, Greece, France, Italy, Luxembourg, Spain, Sweden, Norway, Portugal and the UK, and, in Poland and Lithuania, the injecting of opioids extracted from poppy plants had become popular.

Adolescent drug users represented a new type of client in the 1970s and were a challenge for existing addiction services, where psychiatric approaches dominated and which had thus far mainly focused on treating alcohol dependence. In response to this increasing prevalence of drug use, new specialised treatment centres began to emerge and new policies and laws were adopted in European countries, which paved the way to channel public funding into specialised drug treatment facilities. For example, in Germany, addiction was recognised as a disease in 1968 and costs for treatment were, henceforth, to be covered by public insurance funds; in Austria in 1971, the need for health and social interventions was, for the first time, clearly defined in an amendment to the narcotics act; and, in France, the law of 31 December 1970 opened the door to state funding for various new and sometimes experimental treatment initiatives, including therapeutic apartments, foster families and facilities in rural environments, offering 'a way back to healthy living' to drug users.

During the 1970s and 1980s, self-help groups such as Release (UK) and ex-addicts took the lead in developing treatment programmes and centres in several countries. For example, in 1978, Marek Kotanski established the first Monar therapeutic community (TC) in Poland. It became the nucleus of the Monar youth association, which set up another 10 Monar TCs under a funding agreement with the Ministry of Health. Religious-led treatment centres also emerged — mainly in the Catholic countries of the south — as well as the model of hierarchically structured drug-free clinics, following the Alcoholics Anonymous (AA)-inspired TC model of Synanon and other US models (e.g. the first Phoenix house in Europe was opened in London in 1970).

In the course of the 1970s in the UK, the widespread general practitioner-led maintenance prescribing model was replaced by much more controlled prescribing by psychiatrists in specialised regional drug-dependence clinics, based at hospitals. In the early 1980s, residential care was available in 14 drug-free rehabilitation houses, typically located far away from inner-city areas where drug use often concentrated.

In the countries of the Soviet Union, the public image of addicts as offenders dominated and compulsory treatment of drug users was introduced in the 1970s. People diagnosed as dependent had to undergo 60 to 90 days of hospital treatment and were sent to work regime treatment if they did not comply (Latypov, 2011).

Thus, this period saw the establishment of specialised drug treatment facilities and then the rapid expansion of residential drug treatment in the European countries hit by the heroin epidemic. Drug-free TCs initiated by ex-users and their families predated the establishment of public services in many countries and became the 'reference' for residential treatment until AIDS called into question professional practices based solely on abstinence.

Adaptation of the treatment landscape in Europe in response to the HIV/AIDS epidemic and the current situation (mid-1980s until today)

AIDS was first diagnosed in 1981 in the USA and shortly afterwards in Europe. When HIV testing became available in 1985, large numbers of injecting heroin users were found to be infected. As the HIV epidemic swept over much of the European region, it highlighted the need for greater treatment capacity and for a different approach that was able to reach problem heroin users who were not in contact with treatment services. The result was a drastic reshaping and expansion of the drug treatment offer, including outreach work, low-threshold facilities and opioid substitution treatment, delivered to heroin users in the framework of community-based outpatient services.

In the second half of the 1980s, church-led residential programmes were established in several countries where drug treatment did not exist before, such as Hungary in 1986 and Malta in 1989; and, in the 1990s, TCs with a religious orientation were founded in Croatia. Several European countries experienced an increase in the use of illicit drugs only in the course of the 1990s, following the opening of borders after political change (Hungary, the Czech Republic, Slovakia, Bulgaria and Romania) or regaining independence (Estonia, Latvia and Lithuania). In these cases, the establishment of new residential treatment in the 2000s may have benefited to some extent from international training initiatives (e.g. US-led training of 50 Bulgarian professionals), from exchange with European professionals through networks and at conferences and from information about best practice in drug treatment interventions made available online since the late 1990s (EMCDDA website: Exchange on Drug Demand Reduction Action (EDDRA)).

Today's drug treatment systems in Europe are characterised by a broad and diversified range of providers and interventions. The provision of outpatient treatment, in particular, has increased considerably since the beginning of the 2000s, encompassing a range of services. Residential treatment facilities in most countries form a small but essential part of the overall treatment response to drug use in national drug systems. The best indication currently available of the share of treatment provided through residential

treatment at the European level is the share of treatment demands collected through the EMCDDA treatment demand indicator (TDI) and this will be explored in the context of an overview of residential treatment clients (Section 4).

3. Extent and nature of residential treatment

This section addresses issues related to the availability of treatment in residential settings in Europe and its place in drug treatment systems today. This is followed by a description of residential treatments along two dimensions: (i) therapeutic approach and (ii) treatment components. Finally, this section outlines the provision of residential treatment for specific client groups, highlighting examples of implementation and good practice and what is known about what works.

The aim is to give an indication of the availability and degree of variability across Europe, in terms of the:

- number of facilities (national availability);
- therapeutic models employed;
- typical planned treatment duration.

Availability of treatment facilities in Europe

This review identified 2 500 residential treatment facilities providing services for drug users (Table 1). Italy, Germany, Sweden, Spain, the UK and Ireland reported over 100 facilities each and between them accounted for over two-thirds of all reported facilities in Europe. These facilities are divided into two broad groups based on the setting — community-residential or hospital — for service delivery:

1. Community-residential facilities — residential facilities within the community for the treatment of clients with drug-use problems.
2. Hospital-based facilities — providing beds for the treatment of clients with drug-use problems in a hospital environment. These can be either stand-alone facilities used for nothing but treatment of clients with drug-use problems or wards within psychiatric or general medical facilities that are theoretically available for drug users but in practice could be and are occupied by general or medical psychiatric clients.

Community-residential facilities form the larger group (*n* = 2 330), with 17 countries reporting all of their residential facilities to be of this variety, and 170 hospital-based ones exist across Europe.

Twelve countries reported the existence of residential facilities in both the community and hospital environments. In four countries, hospital-based residential facilities make up the bigger share of available residential treatment facilities — just over half in Belgium and Ireland and three-quarters in Bulgaria and Latvia.

TABLE 1

Number of residential facilities in community and hospital environment (2011, unless otherwise noted)

Country	Community-residential facilities	Hospital-based facilities	Total
Belgium	14	17	31
Bulgaria	5	15	20
Czech Republic	18	15	33
Denmark	31	0	31
Germany	320	0	320
Estonia	8	0	8
Ireland	41	67	108
Greece	11	1	12
Spain	207	1	208
France	44	0	44
Croatia	30	0	30
Italy	708	0	708
Cyprus	2	1	3
Latvia	1	3	4
Lithuania	25	0	25
Luxembourg	1	1	2
Hungary	14	0	14
Malta	7	0	7
Netherlands	80	0	80
Austria	24	0	24
Poland	79	0	79
Portugal	68	0	68
Romania	9	3	12
Slovenia	7	0	7
Slovakia	33	0	33
Finland	75	n/a	75
Sweden	311	0	311
UK	120	18	138
Turkey	n/a	n/a	n/a
Norway	37	28	65
Total	2 330	170	2 500

Notes:
Czech Republic: reported ranges are, for community residential facilities, n = 15–20 and, for hospital-based facilities, n = 13–17, of which the means (n = 18 and n = 15 respectively) are used to calculate the total number of residential facilities.
Netherlands: 80 residential treatment facilities are treatment units (i.e. parts of big addiction treatment centres). Each of these centres has a number of different units spread over the region in which they are operating.
Ireland: 2010 data. The figures present numbers of facilities reporting to the National Drug Treatment Reporting System; not all units in the country report to the system. In addition, these figures include inpatient services, which provide detoxification only and/or treat only problem alcohol use.
France: 2013 data.
Finland: 2010 data; estimate based on the Register of Institutions in Social Welfare and Health Care; hospital data could not be accessed, as hospitals are analysed as single entities and are not analysed by specialisation.
Luxembourg: hospital-based facility operational only since 2012.
n/a: not available.

However, care is needed in interpreting these data. For example, the facilities can vary considerably in size, as do the populations that they serve and the prevalence of drug problems in the different countries. The completeness of the information may also vary; for example, in Ireland, the information covers only those facilities that report to the National Drug Treatment Reporting System and, in Finland, hospital information was not available.

Therapeutic approaches used in residential facilities in Europe

Residential treatment programmes aim to foster recovery beyond detoxification and stabilisation, focusing on health, personal and social functioning and enhanced quality of life. These programmes, however, can differ markedly, as they can be based on a number of different *therapeutic approaches* (or philosophies) and employ a range of different *treatment components (or interventions)*.

Therapeutic approaches relate to the programme's theoretical underpinnings, ethos and method of delivering programme interventions. Based on key characteristics of individual residential programmes, the following main distinct types of residential treatment can be identified: 12-step/Minnesota model, therapeutic community approach and psychotherapy-based, using either CBT or other models.

However, treatment programmes often involve combinations of goals and activity components that are determined by programme directors and staff beliefs about effective drug treatment, staff training and experience, and the types of clients in the programme. Staff may adhere to one or two primary approaches, or they may be eclectic and combine multiple orientations and approaches.

Therapeutic approaches may be delivered one to one and/or in group format. Typically, these interventions are specific to the tasks and challenges faced at each stage of the treatment process and enable staff members to use suitable stepwise approaches in developing and using treatment protocols.

What are the main therapeutic approaches that guide residential services provision?

The main therapeutic approaches found in residential treatment programmes in Europe are based on:

- therapeutic community principles — in a programme using therapeutic community principles, the pillars of the therapeutic process are self-help and mutual self-help; clients and staff live together in an organised and structured way that promotes change and makes possible a drug-free life in society;
- 12-step/Minnesota model — in a programme with a 12-step orientation, group sessions focus primarily on encouraging clients to accept that drug dependence is a disease;
- psychotherapy, using:
  - cognitive–behavioural therapy (CBT) — in a programme with a CBT orientation, group sessions emphasise helping residents to identify situations in which there is a risk of relapse and to learn appropriate coping responses; or
  - other psychotherapeutic models, for example psychodynamic, gestalt, family-oriented.

However, some residential treatment programmes use a mixture of approaches.

Therapeutic community approach

The therapeutic community (TC) approach has many features in common with 12-step treatments. Both approaches focus on abstinence as the overriding goal of treatment and see recovery from addiction as requiring a restructuring of thinking, personality and lifestyle in addition to giving up drug-taking behaviour. The key distinction of the TC approach is the use of the community itself as a fundamental change agent ('community as a method') (De Leon, 2000).

Two of the defining features of the 'community as method' are a community environment with a range of structured activities where both staff members and residents are expected to attend community meetings and share activities; and the notion of peers as role models who give the right example by living according to the TC's philosophy and value system. At first, residents are completely isolated from their former life and are not permitted to have visitors, letters or telephone calls. Daily life within the community is very structured and with little opportunity for doing anything alone. This forces interaction with other residents and permits constant scrutiny of their behaviour by their peers. Residents who show personal growth in terms of honesty and self-awareness move up in the hierarchy, assuming greater responsibilities and increased privileges, so that senior residents become models for new residents.

A recent systematic review (EMCDDA, 2014) of the evidence for the TC approach — the most widely applied approach in residential settings in Europe — found that studies conducted in North America suggest that therapeutic communities are at least as effective for the treatment of addiction as other (residential or community) interventions in terms of lowering

drug and alcohol use and recidivism rates. These findings, however, are predominantly based on imprisoned drug users; similar evidence for the effectiveness of community residential treatment using the TC approach has yet to be developed. The same review found that European studies on therapeutic communities show improvements on a number of outcomes (e.g. drug use, recidivism, quality of life, health) measured at different time points after treatment. However, because of the observational nature of the studies conducted in Europe and the related methodological limitations, the possible conclusions that can be drawn remain tentative.

12-step/Minnesota model

Both 12-step and Minnesota model programmes owe their origins to the influence of Alcoholics Anonymous (AA), which views addiction as a disease. The two types of treatment have a number of features in common, although Minnesota-type treatment is typically delivered by professionals and is less reliant on self-help components than 12-step treatment. Both types of programmes generally provide a highly structured and relatively short (three to six weeks) package of residential treatment involving an intensive programme of daily lectures and group meetings designed to implement a treatment plan based upon the 12 steps. This usually involves an initial therapeutic rehabilitation phase, in which residents work with therapists individually and in groups to analyse their personality and their patterns of behaviour. Much of the focus of this initial phase is around dealing with the issues that led the individual into active addiction. This is followed by therapeutic work centred on 'starting on the path to a new life', which, while maintaining a clear therapeutic philosophy and approach, is very much about developing the key skills needed for a new life.

Two systematic reviews of the evidence on the effectiveness of residential programmes indicated the effectiveness of treatment programmes based on a 12-step/Minnesota model (or a mixed 12-step/CBT model) in reducing drug use and associated problems among adolescents (Elliott et al., 2005) and people with dual diagnoses (Brunette et al., 2004).

Cognitive–behavioural therapy

Cognitive–behavioural therapy is a general therapeutic approach that seeks to modify negative or self-defeating thoughts and behaviours. CBT uses the resident's thinking errors (cognitive distortions) as the basis for identifying activities to promote behavioural change. The principle is to find out which modifiable behaviours and beliefs are maintaining drug use and to decide what change is wanted and how this change can be achieved. Thus, before therapy can be initiated, a behavioural and/or cognitive analysis is carried out so that the current behaviours and ways of thinking are understood, goals are identified and the ways of achieving these goals are defined. According to the individual analysis, the resident's programme may be narrow, focusing only on the problem of drug use, or broad, encompassing a range of related problems and dealing with various aspects of the individual's behaviour and belief system.

There is a 'family' or collection of cognitive–behavioural approaches rather than a single cognitive–behavioural method. This includes motivational interviewing (MI) (Miller and Rollnick, 1991, 2002), aimed at enhancing an individual's motivation to change by exploring and resolving ambivalence and helping the resident to clarify goals and commit to continuing change; relapse prevention (Marlatt and Gordon, 1985), aimed at developing the resident's ability to recognise cues and to intervene in the relapse process so that lapses occur less frequently and with less severity; and behaviour modification (Skinner, 1953; Bandura, 1969), focused on arranging contingencies of positive reinforcement to develop and maintain appropriate patterns of behaviour.

One systematic review of the evidence on the effectiveness of residential programmes indicated that treatment programmes based on a CBT model (or a mixed 12-step/CBT model) can be effective in reducing drug use and associated problems among people with dual diagnoses (Brunette et al., 2004).

Combined approaches

Combined approaches, sometimes called integrative or eclectic approaches, combine two or more therapies to maximise a person's progress. Sometimes, staff at residential programmes would have a primary orientation, such as CBT, but supplement it with techniques from family therapy, giving an eclectic identity to the residential programme. Combined approaches have a broader theoretical base and may be more sophisticated than approaches using a single theory. They offer greater flexibility in treatment — individual needs are potentially better matched to treatment when more options are available. However, the lack of a defined therapeutic approach may result in the loss of theoretical background and identity, thereby rendering the programme less amenable to evaluation and its nature less understandable to clients, their families and funding bodies.

Distribution of different therapeutic approaches in Europe

Although all the above types of therapeutic approach can be found within European residential treatment facilities, identifying the specific categorisation that applies to each facility is difficult. For instance, in the majority of countries,

FIGURE 1

Therapeutic approaches applied in residential facilities in Europe

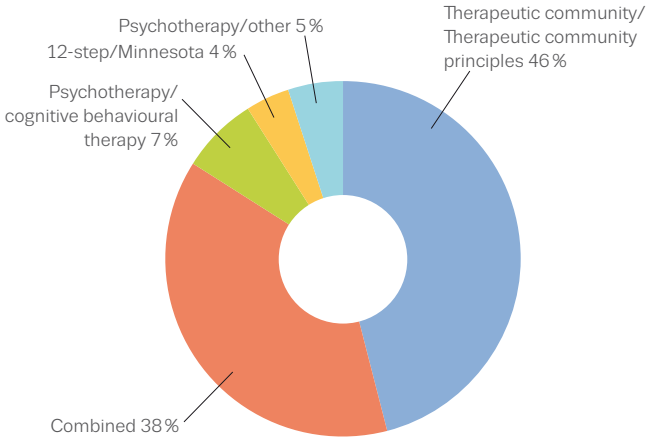
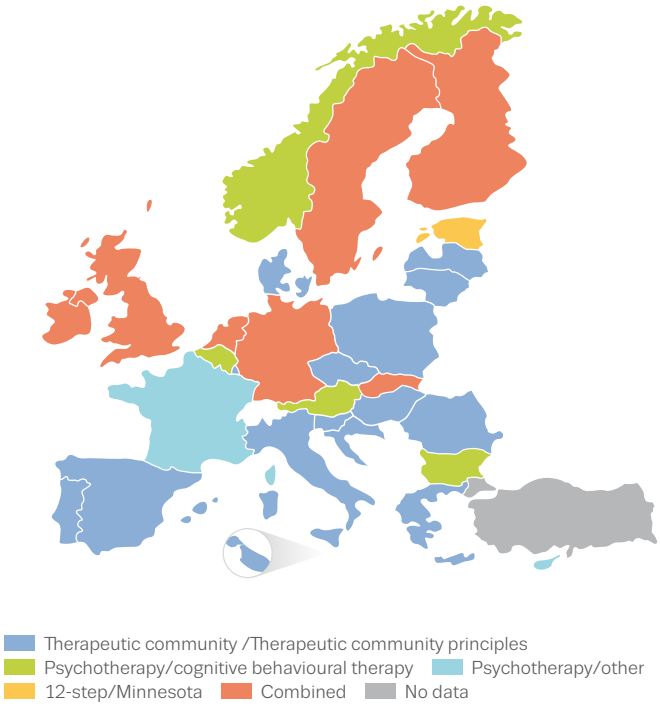


FIGURE 2

Predominant therapeutic approaches in residential facilities as a percentage of the total number of residential facilities



many of the residential facilities state that they use a number of different programmes and neither offer any indication of their primary or predominant approach nor indicate if the programme that would be used depends on the individual presenting for treatment.

Furthermore, there is substantial variation among countries in the capacity to classify residential treatment facilities and, at the national level, a range of approaches may be adopted to gather information that helps to associate facilities with a predominant therapeutic approach. In Denmark, indicators such as the number of employees trained in a certain treatment approach or school of psychotherapy were used to guide the classification of residential facilities; in Hungary, national associations and relevant therapy institutes were approached to access relevant information and to determine the correct assignment of residential facilities to one of the above categories.

For each country, the total numbers of residential facilities that do and do not provide information on their predominant treatment approach were established. The latter were grouped and marked as having a 'combination of approaches'.

Overall, of the 2 500 reported residential facilities, 46 % (1 160) followed therapeutic community principles. The philosophy of the remaining facilities could be described as 'combined' (38 %; *n* = 942), CBT-based (7 %; *n* = 163), based on some other psychotherapy approach (5 %; *n* = 131) or 12-step/Minnesota type (4 %; *n* = 104) (Figure 1).

There was some variation between countries in the therapeutic approaches used by residential facilities (Appendix 1).

The TC approach or its principles represent the predominant treatment approach applied in all or most residential facilities in 15 countries. CBT is applied in most residential facilities in Belgium, Bulgaria, Austria and Norway. Most facilities in France and Cyprus identify themselves with other psychotherapy approaches such as psychoanalysis and family therapy, whereas 12-step-oriented facilities prevail in Estonia. Although residential facilities in most countries can be associated with a predominant therapeutic approach, a combination of approaches is used in most residential facilities in Germany, Ireland, the Netherlands, Slovakia, Finland, Sweden and the UK. Figure 2 shows the reported predominant therapeutic approach in residential facilities in Member States as a percentage of the total number of all residential facilities in the country.

Planned treatment duration in residential programmes

Treatment duration has been shown to be related to improved outcomes in a number of studies (see Box 'Duration of treatment') and a minimum threshold of three months for treatment impact has been identified. The residential programmes identified in this study can be categorised according to their reported planned treatment durations, as short-term (planned stay of three months or less) and longer-term (planned stay of more than three months). The planned treatment duration for the majority of programmes is over the threshold of three months, but some are shorter. The duration varies according to the therapeutic approach adopted.

Three-quarters of residential programmes following the 12-step approach or applying some form of psychotherapy have a planned treatment duration of three months or more. Additionally, the majority of TCs and programmes applying TC principles (93 %) are longer-term. Where programmes provide facilities for on-site medically assisted detoxification (using methadone or buprenorphine), the length of the detoxification phase typically does not exceed 28 days.

Residential treatment is typically medium to long in duration, with the actual length varying according to individual requirements. However, it was reported that recent years have seen a decrease in the planned length of time in residential treatment in some European countries, through the evolution of treatment but also in response to financial pressures. Whereas some countries, such as Estonia, report no change to planned residential treatment duration, others (e.g. Latvia, Denmark, Germany, the UK) continue to see shortening of planned residential treatment programmes. In Denmark, most notably, planned courses of treatment of one to two years are rarely seen, if at all, according to national treatment experts. In an era of spending cuts, planned residential treatments typically last less than 24 weeks, and are most often offered for 12 weeks.

However, individuals may drop out of treatment before it is completed, and this may be a more common reason for treatment duration being below the minimum threshold. The length of stay is shaped by both programme characteristics, such as therapist caseload size and the balance between therapy, demand for domestic duties and 'programme-free' time (Meier and Best, 2006), and individual client features, such as motivation for change and treatment readiness (Meier et al., 2005).

Promising practices in enhancing engagement and retention include:

- the use of motivational interviewing (e.g. Carroll et al., 2006);
- using more senior staff to induct new residents into treatment (e.g. De Leon et al., 2000);
- increasing the focus on the therapeutic relationship in staff training and supervision (e.g. Meier et al., 2006).

Although the application of the above means a more resource-intensive approach, it is linked with earlier client engagement in the treatment process, which, in turn, is linked to better retention and improved outcomes (Simpson, 2004).

Duration of treatment: 'minimum retention thresholds'

The length of time in treatment has been found to be related to favourable post-treatment outcomes in studies of residential and outpatient settings and with clients dependent on opiates or cocaine (e.g. Gossop et al., 2000; Moos et al., 2000).

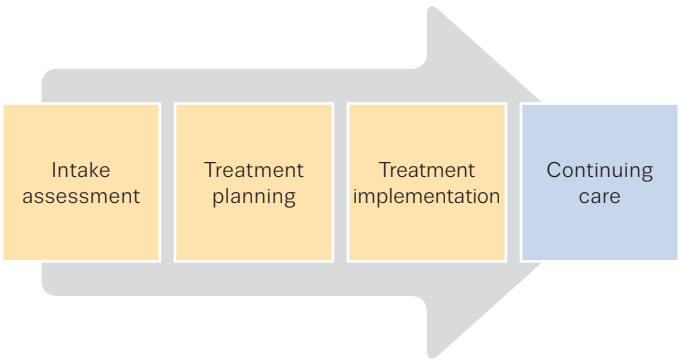
Treatment outcomes tend to improve as retention increases from three months up to 12 to 24 months or more (Simpson, 1997; Simpson et al., 1999). Such findings have been used to support the concept of 'minimum retention thresholds' for effective opiate treatment, often defined as 90 days for residential treatment (Simpson, 1981). Other studies have found a more linear relationship between the time spent in treatment and improved outcomes, with a stronger relationship between treatment duration and improvement for long-term residential treatment (Moos and Moos, 2003; Zhang et al., 2003). Clients from the UK's National Treatment Outcome Research Study (NTORS) residential programmes who remained in treatment for longer periods of time achieved better one-year outcomes than those who left earlier, in terms of abstinence from opiates and stimulants, reduced injecting and reduced criminal behaviour (Gossop et al., 2000). The effect of time in treatment is confirmed after controlling for the influence of other potential predictive factors.

4. Treatment elements in residential programmes

Having provided an overview of the therapeutic approaches used within residential programmes in Europe, this section will consider the different elements or phases of the treatment process. Treatment elements are the specific change techniques or services that can be offered at different points within each treatment approach to achieve certain goals and meet individual clients' needs. The categorisation of these components is not standardised and the terminology differs across countries and facilities in Europe. Nonetheless, the principal elements include stages such as intake assessment, treatment planning, treatment implementation and continuing care, sometimes called aftercare (Figure 3), as well as specific therapeutic (psychotherapy and pharmacotherapy) and social reintegration (e.g. education, vocational skills training, volunteering opportunities) interventions, which may be used at different times over the course of the residential treatment programme.

While outlining all treatment elements, this paper focuses greater attention on two of them: pharmacotherapy in

FIGURE 3
Treatment elements: activities



residential treatment programmes and continuing care. These areas are undergoing considerable change and development, yet are largely unexplored within the EMCDDA publications to date.

Intake assessment

The intake assessment typically includes a number of areas (e.g. drug use, physical and mental health, family and social support) evaluated upon entry into a residential treatment programme. It is a way of gathering information about the individual in order to better treat them and engaging in a process that enables understanding of their readiness for change, problem and resource areas. In addition, the basic information can be augmented by some objective measurement. It is essential for treatment planning that the collected information from assessment be organised in a way that helps to establish a treatment plan.

Treatment planning

Treatment plans span from intake assessment to continuing care planning and onward referral. They coordinate the range of interventions and supports (e.g. legal, educational, employment services) provided to an individual client. In essence, these documents typically outline what is expected of the client and what the programme will provide in return. They are formulated by the client and the residential treatment programme staff and are used to monitor and document treatment goals and accomplishments. Typically the treatment plan recognises that treatment may occur in different settings (residential as well as outpatient) over time and reinforces long-term participation of the patient across settings.

Implementing treatment

Detoxification

Detoxification is a medically supervised intervention to resolve withdrawal symptoms associated with chronic drug use, and is sometimes a prerequisite for initiating long-term abstinence-based residential treatment.

In most Member States, residential facilities provide on-site detoxification — from opiates, benzodiazepines and alcohol — and, in many cases, medicines are used during detoxification.

Evidence from the UK indicates significantly better outcomes when inpatient detoxification is followed up with residential treatment. Ghodse et al. (2002) reported significantly lower rates of relapse in clients completing detoxification when it was immediately followed by residential rehabilitation treatment than when this was not available. Therefore, there are grounds for assuming that the provision of detoxification and rehabilitation within the same treatment context would reduce the likelihood of treatment dropout between services.

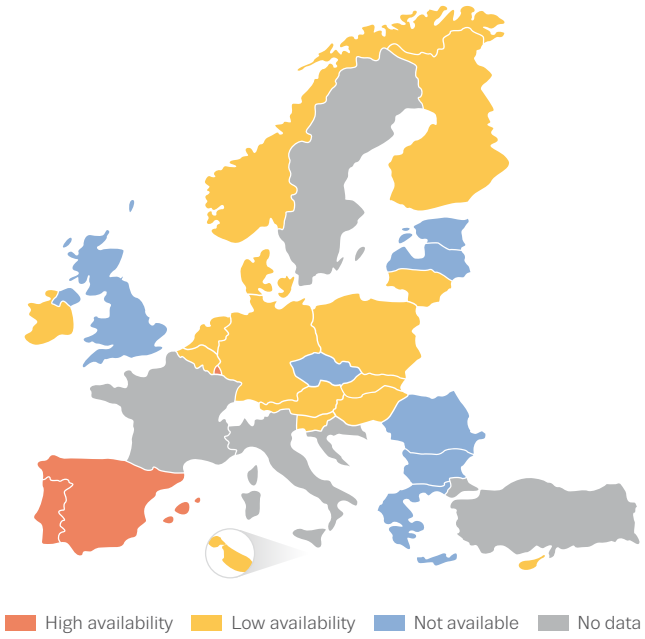
In the UK, Meier et al. (2007), based on a national sample of 87 residential treatment facilities, established that over one-third (39 %) offer medically assisted detoxification within their treatment programmes. Although there were no differences in treatment philosophies, residential treatment in facilities that offered detoxification were typically of shorter duration and reported offering more group work than residential treatment services that did not offer detoxification.

Opioids for substitution treatment

Substitution treatment refers to the treatment of drug dependence by prescription of a substitute drug with the goal of reducing or eliminating the use of a particular substance, or of reducing harm and negative social consequences. For this analysis, data were available for 25 countries. Of these, just under three-quarters (n = 18) report some availability of integrated pharmacological (opioid substitution) residential programmes, in which residents receive opioid substitution treatment for their heroin addiction and follow a structured therapeutic programme. Within the 18 countries reporting residential facilities that provide integrated opioid substitution treatment (OST), just over half (n = 10) indicated qualitatively the level of availability (acceptance) of this treatment within residential programmes; a further eight countries supplied quantitative data on the facilities offering continuation of OST to residents.

FIGURE 4

Availability of integrated opioid substitution within residential programmes in Europe, 2011



The 18 countries in this analysis were subdivided into those with high availability of OST within residential treatment (e.g. Spain, Portugal, Luxembourg), where more than half of the residential treatment facilities in the country offer an integrated opioid substitution programme in a residential setting, and those with low availability (rare acceptance) (e.g. Hungary, Austria, Slovenia, Poland, Ireland, Malta), where fewer than half of the residential facilities admit clients who continue to receive prescribed opioids during their residential stay (Figure 4).

In the eight countries for which numerical data are available, the residential treatment facilities that are reported to offer integrated OST vary considerably (ranging from one in Poland to nearly all facilities in Spain).

Thus, although opioid substitution services are on offer to opioid-dependent clients in residential programmes in a number of European countries, the access to these services and the consequent uptake vary considerably. Because, traditionally, residential programmes, notably therapeutic communities and 12-step-based programmes, have had unfavourable views about substitution treatment and concerns that the use of substitution medicines by residents would pose a threat to the programme, valid questions arise about the consequences of treating clients in OST in residential settings. Consequently, there is an emerging science of integration that is beginning to explore the effectiveness of admitting opioid-dependent clients currently in substitution treatment in residential settings.

Sorensen et al. (2009) assessed the outcomes of treating clients in OST in a residential therapeutic community. Based on a sample of 231 therapeutic community clients, the study compared the 24-month outcomes of methadone-maintained clients (n = 125) with opioid-dependent drug-free clients (n = 106). Regarding a number of outcomes, notably retention in treatment and illicit opioid use, methadone clients were found to fare as well as other opioid users in therapeutic community treatment.

Wider health interventions

There is a variation in the degree to which clients in residential treatment receive services for health conditions other than drug dependence, such as HIV or hepatitis C virus (HCV). In particular, whereas several countries report that residential treatment facilities have referral systems in place for testing clients for HCV or HIV, only a few (e.g. Greece, Lithuania, the UK) mention residential facilities that offer on-site HIV/HCV testing and vaccination (hepatitis A and B). No HIV or HCV treatment delivery is reported in residential treatment facilities in Europe. The reasons cited by national experts for not offering routine testing and vaccination include the lack of facilities for testing and/or medical personnel for treatment. For example, in Denmark, residential treatment is separated from the healthcare system, so residential programmes do not have the necessary resources to offer medical interventions. Organisational factors thus appear to influence the provision of on-site medical services to clients in residential treatment.

Drug users are at high risk of hepatitis C infection and also constitute a group that is medically underserved. Advances in the treatment of hepatitis C infection with direct antiviral agents and a growing evidence base for its effectiveness among drug users indicate the potential for extending strategies to treat hepatitis C among drug users. To be successful, these treatments include an emphasis on medication adherence and appropriate management of side effects — residential settings are uniquely situated to provide comprehensive treatment and monitoring.

Rosedale and Strauss (2010), based on an analysis of qualitative descriptive data from 20 clients in three residential drug treatment programmes, reported on what clients in residential treatment think about depression and the risks of neuropsychiatric side effects associated with interferon treatment for hepatitis C. The results emphasised that residential treatment programmes offer a unique opportunity to undergo antiviral treatment because they capitalise on clients' heightened readiness for change. Along with that, clients' perceived insufficient knowledge about hepatitis C among psychiatric staff and clients' fear that hepatitis C side effects would sabotage addiction recovery

Integrated opioid substitution residential programmes in Spain

Opioid substitution treatment (OST) became widely available in Spain in the second half of the 1990s following a change in the Spanish legislation that lifted restrictions on prescribing methadone and gave rise to a dramatic increase in the number of heroin users entering this treatment. However, the use of substitution medicines in residential facilities (mainly therapeutic communities) did not occur until the late 1990s and the beginning of the 21st century, signifying a change in the then exclusively drug-free orientation and philosophy of these programmes.

According to 2012 data, about 67 500 opioid-dependent individuals receive substitution treatment in Spain. Although the majority (75–80 %) of clients receive this treatment in outpatient facilities, outreach programmes, pharmacies or prisons, about one-quarter receive substitution treatment in residential (traditionally drug-free) programmes. It is estimated that almost all residential facilities (a minimum of 90 %) offer continuation of OST to residents. Methadone is the most widely used medication.

Of the 131 residential facilities following the therapeutic community approach, about 90 % allow residents to benefit from OST. Of the 77 residential facilities applying cognitive–behavioural therapy or other psychotherapy, one specialises in the treatment of cocaine users only and the remaining 76 present no obstacle to clients who are in receipt of OST at the point of referral to residential treatment or wish to initiate OST while in residence.

Typically, therapeutic community residents who benefit from substitute medication are already engaging with an outpatient methadone prescriber at the time they are admitted into a therapeutic community. The safe dispensing of methadone prescriptions is carried out by available staff members at the therapeutic community, while the client is followed up by the outpatient facility's professionals who initiated substitution treatment for the client. In some therapeutic communities, methadone is both prescribed and dispensed, contingent upon availability of appropriate professionals (medical doctors or nurses) who are also responsible for the follow-up of clients. In contrast, methadone is typically dispensed in a conveniently located outpatient facility for clients engaging in cognitive–behavioural and other therapy programmes.

Some challenges for the future relate to (i) ageing users in OST programmes, who will require better coordination between health and social systems and services providers; (ii) remaining stigma attached to clients in OST, which will need to be resolved for the full acceptance of these individuals by all health and social service professionals and by society in general; (iii) broadening the range of substitute medicines, to include buprenorphine, buprenorphine–naloxone and others, available to clients in residential treatment, that is if their profile meets the required criteria, and independently of economic considerations about the cost of these medicines.

were reported. The study concluded with a recommendation about increased hepatitis C-specific psychiatric education and staff training to facilitate better use of residential treatment programmes for treating hepatitis C. Consequently, a training programme for staff has been developed, employing a motivational approach, and is available to guide the treatment of hepatitis C-infected drug users in residential programmes (Strauss et al., 2007).

Social reintegration interventions

Although 'social reintegration' is not defined consistently across EU Member States, it is accepted as a foundation for drug treatment. As such, it includes all those activities that aim to develop human, social and economic capital. The three 'pillars' of social reintegration are (i) housing, (ii) education and (iii) employment (including vocational training). Other measures, such as counselling and leisure activities, may also be used. Although recovery from drug use and rehabilitation of problem drug users (particularly in the traditional abstinence-oriented sense) are often focused on the relationship between an individual and drug use, social reintegration is also concerned with the position of the individual in wider society. Social reintegration interventions, including education, vocational skills training and employment-related interventions, are often an important element of residential treatment programmes. A recent EMCDDA Insights report provides fuller detail on the availability of these interventions in Europe and their effectiveness for drug users undergoing treatment including in residential settings (EMCDDA, 2012b).

Continuing care

How should we define continuing care? It is extended contact and support beyond the formal end of the residential treatment episode. The period immediately after leaving residential treatment is one of high risk of relapse to drug use and increased overdose related mortality (Ravndal and Amundsen, 2009; Davoli et al., 2007). Promoting and ensuring care and support is one possible way to sustain treatment gains.

Studies of continuing care following residential treatment (for a review, see McKay, 2009) suggest that the following may improve outcomes:

- monthly contact for the first year of recovery, with adjustments as necessary (up or down according to the client's level of functioning);
- extended contact for years, rather than months;
- availability of medications where necessary;
- availability of treatment options of varying types and intensities, should the need arise.

Continuing care may be provided in a variety of different ways, ranging from contacts and check-ups to supported accommodation. For example:

- the *Contracts, Prompts and Reinforcement (CPR) intervention* — a cognitive–behavioural approach designed to facilitate treatment and aftercare by maintaining clients' continuing engagement with services (Lash and Blosser, 1999; Lash et al., 2013);
- telephone-based follow-up — a programme that, after an initial face-to-face session, uses weekly 15- to 20-minute telephone calls to provide counselling in conjunction with behaviour monitoring (McKay et al., 2004; McKay et al., 2005a,b);
- recovery *management check-ups* — regular phone calls to (or other contact with) people who have left residential treatment to facilitate early detection of relapse, reduce the time to treatment re-entry when necessary and improve long-term outcomes (Scott and Dennis, 2003, 2009, 2011);
- Oxford Houses — abstinence support and accommodation in the community to former drug users who are willing to live together (Molloy, 1990; Jason et al., 2007).

Along with treatment and support, the above interventions may encourage adherence to antiretroviral medication and to promote general health, as well as providing a rapid and clear route back into structured treatment. Treatment systems ensure that referral pathways are in place, and residential treatment services have a rapid re-entry option.

Continuing care practices in Europe

In most Member States, many residential facilities offer a programme of aftercare or some form of therapeutic follow-up that is appropriate for individuals who need that level of support. Such programmes are reported to be of varying degrees of comprehensiveness.

The intensity and duration of care following a residential treatment episode depends upon the individual's needs; available supports range from longer-term and self-contained therapeutic programmes (e.g. Luxembourg, France, Spain) to less supervised half-way and quarter-way houses (e.g. Hungary, Slovenia) from which individuals are transitioning back into the community. Reported practices typically relate to access to housing, employment and educational support in the community and linkage with support groups and mutual aid groups or peer support (e.g. Narcotics Anonymous (NA)).

In England, a joint review carried out by the NTA and the Healthcare Commission (now the Care Quality Commission) (NTA and Healthcare Commission, 2007) found that 88 % of inpatient and residential services had policies to enable service users to effectively integrate into the community and to provide appropriate aftercare following the service user's exit. The NTA's report on the role of residential rehabilitation in an integrated drug treatment system found that residential rehabilitation is not an automatic door from the treatment system but an integral part of a network of services, and the majority of residential rehabilitation clients return to community-based treatment services for further structured support afterwards. Out of the 164 drug or drug and alcohol residential rehabilitation services listed by Drink and Drug News (DDN, 2011), 85 units offer aftercare and 69 units offer resettlement.

Continuing care in residential treatment in the Norwegian context: a case study

When treatment, employment and other support providers work in a unified way, clients are more likely to achieve their treatment and social goals. Each individual has distinct treatment and social needs, and providers need to work together closely to ensure that care planning is delivered in a seamless way.

In Norway, to ensure continuity of care for residential treatment clients, treatment and social services agree common referral and care pathways that make use of three-way review meetings to ensure that an integrated response to treatment and social needs is offered.

While the client is in residential treatment, a contact coordinator works with them in a range of domains, including participation in the Norwegian Labour and Welfare Organization qualification programme, assistance in finding accommodation, and domestic assistance and advice. The social services are notified in good time and with the client's consent about the range of municipal social services that an individual client would use. The discharge from residential treatment is thus prepared in cooperation between the client, social services and the residential treatment facility.

Drug users in need of long-term coordinated services are also entitled to an individual plan. The plan is intended to be a tool for cooperation between the client and a range of social services providers in the community. Furthermore, it also contributes to strengthening coordination between the relevant service providers — health, education, employment sectors — to ensure that the clients gets the help they need. Finally, the individual plan that is drawn up for clients is supposed to ensure that the risk of relapse after a stay in a residential treatment programme is reduced.

Although the provision of the range of social and therapeutic follow-up services is predominantly a responsibility of the municipalities, such services are sometimes offered by the residential facilities as an integral part of long-term rehabilitation. The local authorities can collaborate with voluntary organisations in a partnership, but the service is usually anchored in the Social Services Act to ensure that the rules concerning correct processing of cases are adhered to and legal rights are protected.

Impact of engagement with continuing care on treatment outcome

There is good evidence that participation in continuing care, including engagement with self-help groups, is important for sustained outcomes from treatments provided in residential settings.

In England, the National Treatment Outcome Research Study (NTORS), using a longitudinal, prospective cohort design, included 142 drug-dependent clients recruited at intake to residential treatment. It found that clients who attended mutual aid groups (e.g. NA) after treatment were more likely to be abstinent from opiates at follow-up, and more frequent NA attendees were more likely to be abstinent from opiates and alcohol than both non-attendees and infrequent (less than weekly) attendees (Gossop et al., 2008). The same conclusion about the beneficial effect of self-help group participation — in terms of increased abstinence rates at follow-up and reduced costs of continuing care — has been found in a number of studies, with a mixture of residential and outpatient attendees (e.g. Moos et al., 1999; Ritsher et al., 2002; Vederhus and Kristensen, 2006; Humphreys and Moos, 2007).

Countries with organisation at a regional level reported challenges to the maintenance of sufficient quality of nation-wide referral processes to and from residential treatment and related collaborative arrangements. For instance, in Austria, such processes and arrangements are typically able to ensure clients' moves from residential services to the community (and back) within one and the same region. However, as residential treatment facilities have national referral/catchment areas, it is vital that optimal collaboration links be established and maintained between all relevant service providers across geographical regions.

These findings suggest that residential treatment in Europe should be seen as an integrated part of the network of services that form national drug treatment systems. The data show that residential treatment is not necessarily an 'exit door' from the treatment system and that, when clients complete their treatment at a residential facility, they frequently return to community-based structured support services from other parts of the system before they are ready to complete their drug treatment.

5. Residential treatment clients

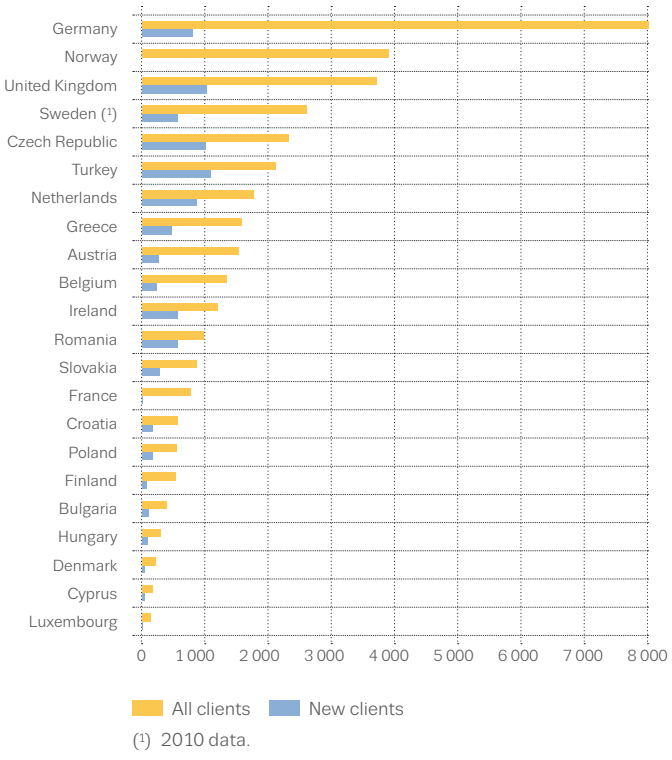
This section looks at the profile of treatment clients in residential programmes and provides an overview of some specific groups of using clients targeted by residential treatment. In line with the TDI protocol and definitions (see box), this part of the paper uses the term 'inpatient treatment' instead of 'residential treatment'.

Number of inpatient treatment clients in Europe in 2011

In the 22 European countries providing data, around 35 000 drug clients entered inpatient treatment in 2011; 8 500 of these were entering for the first time. The number of clients entering inpatient treatment ranged from fewer than 300 clients in Luxembourg, Cyprus and Hungary, through more than 2 000 in the Czech Republic, Sweden, the UK, Norway

FIGURE 5

Drug users entering inpatient treatment in 2011, or the most recent year available, in 20 EU countries, Turkey and Norway



(1) 2010 data.

(2) 'Drug treatment is defined as an activity (activities) that directly targets people who have problems with their drug use and aims at achieving defined aims with regard to the alleviation and/or elimination of these problems, provided by experienced or accredited professionals, in the framework of recognised medical, psychological or social assistance practice' (EMCDDA, 2012d).

(3) 2011 data (n = 21: Belgium, Bulgaria, the Czech Republic, Denmark, Germany, Greece, France, Cyprus, Luxembourg, Hungary, the Netherlands, Austria, Ireland, Poland, Romania, Slovakia, Finland, the UK, Croatia, Turkey, Norway); 2010 data (n = 1: Sweden).

(4) 2013 Statistical Bulletin — Tables TDI-7 and TDI-2.

Methodological note: data source and additional caveats

The best available information source to describe the profile of drug clients entering residential treatment in Europe is the TDI; see Statistical bulletin (SB) (2). In line with TDI protocol and definitions, this part of the paper uses the term 'inpatient treatment' instead of 'residential treatment'.

Data are collected on six types of treatment centres/programmes, including inpatient settings. The category 'inpatient setting' refers to places 'where the clients may stay overnight and include therapeutic communities, private clinics, units in hospital and centres that offer residential facilities'. This definition is broader than the definition of residential settings used for this paper, although the terms 'inpatient' and 'residential' treatment are used interchangeably. The structure of TDI data does not allow for disaggregation of inpatient detoxification and residential treatment data; this is one general caveat which needs to be understood when interpreting the analysis presented in this part of the paper.

Another issue that may affect this part of the analysis is that country differences in the profiles of inpatient clients may be related to differences in organisation at the national level of the drug treatment system, the role of the inpatient sector and data coverage of inpatient clients, besides actual country differences among clients.

For the present analysis on clients who enter inpatient treatment, data were available from 22 countries (3). It should be noted that, in six EU countries not reporting inpatient data (4), the inpatient treatment is likely to play an important role in the national drug treatment, through either the system of therapeutic communities (Spain, Italy, Portugal and Slovenia) or the drug units in psychiatric hospitals (Latvia and Lithuania). Therefore, the European picture of inpatient treatment clients that is beginning to emerge should be taken with caution. In two countries (Estonia and Malta), all data on clients entering drug treatment are reported without a breakdown by the type of treatment centre and so could not be included in the analysis.

and Turkey, to about 8 000 inpatient clients reported by Germany ([5]) (Figure 5).

Inpatient clients as a proportion of all treatment clients

Drug clients entering inpatient centres represent only a small proportion of all reported drug clients; in 2011 they were around 11 % of all reported drug clients in Europe (7 % among new clients) ([6]) ([7]). The proportion reported to enter inpatient treatment varies by country (from 2 % in France to 79 % in Luxembourg). Those differences may be partly the result of variations in data coverage, ranging from 14 % to 100 % of existing inpatient units in the country, and resulting in an average of around 60 % of inpatient units in Europe being covered in data collection.

Data from 20 countries in 2011 show that, on average, one person commences inpatient treatment for every 11 people starting specialist outpatient treatment. However, substantial inter-country differences exist. Equal demand for both modalities is reported in five countries — the Czech Republic, Romania, Slovakia, Sweden and Norway — with between 40 % and 60 % of all treatment demands being for either outpatient or inpatient treatment. Eight countries (Belgium, Greece, Bulgaria, Ireland, Cyprus, Austria, Poland and Finland) reported that between 15 % and 40 % of all treatment demand was for inpatient treatment. In contrast, Denmark, France, Hungary, Croatia and the UK reported that fewer than 15 % of all demands were for inpatient treatment, indicating that residential treatment may play a lesser role in these countries. Possible reasons could be costs or geographic conditions (low population density tends to correlate with low availability of specialised services), but traditions and general characteristics of the healthcare system could also be factors (Table 2).

TABLE 2

Number of clients entering specialist outpatient and inpatient treatment in 20 Member States in 2011 and the percentage of all clients entering inpatient treatment

Country	Inpatient	Outpatient	Inpatient %
Luxembourg	128	35	79
Romania	984	758	56
Czech Republic	2 334	2 025	54
Slovakia	865	774	53
Sweden ([1])	2 606	2 549	51
Poland	550	792	41
Norway	3 921	4 896	44
Finland	535	908	37
Austria	1 526	3 037	33
Belgium	1 339	3 192	30
Greece	1 576	4 258	27
Bulgaria	394	1 584	20
Ireland	1 197	5 359	18
Cyprus	156	814	16
Netherlands	1 768	11 341	13
Germany	8 050	60 169	12
Croatia	563	7 102	7
Hungary	299	3 740	7
Denmark	214	5 472	4
United Kingdom	3 734	112 108	3
France	774	45 247	2
Total	31 745 ([2])	264 450 ([3])	11

Notes:
([1]) 2010 data.
([2]) More than 50 % of all inpatient clients are reported by the Czech Republic, Norway, Sweden, Austria, Belgium, Greece, Ireland, Germany and the UK.
([3]) More than 50 % of all outpatient clients are reported by Greece, Ireland, Germany, Denmark, France, the UK and Norway.

Characteristics of treatment clients in Europe in 2011: inpatient versus outpatient

This section describes clients entering inpatient treatment in 2011, with a focus on a number of sociodemographic features and patterns of drug use, and also includes a comparison with the profile of outpatient treatment entrants ([8]).

([5]) 2013 Statistical Bulletin — Table TDI-7.
([6]) This description is based on data from 20 countries for which data on both inpatient and outpatient treatment clients were available (2011 data, *n* = 19 countries: Belgium, Bulgaria, the Czech Republic, Denmark, Germany, Greece, France, Cyprus, Luxembourg, Hungary, Austria, Poland, Sweden, Romania, Slovakia, Finland, the UK, Croatia, Norway; 2010 data, *n* = 1 country: Ireland). Two countries reporting inpatient data are excluded: Turkey, which reports data only on inpatient clients, and the Netherlands, which does not disaggregate inpatient and outpatient data.
([7]) 2013 Statistical Bulletin — Table TDI-1.
([8]) The comparison includes data from 20 countries where data on both inpatient and outpatient treatment settings were available (2011 data, *n* = 19 countries: Belgium, Bulgaria, the Czech Republic, Denmark, Germany, Greece, France, Cyprus, Luxembourg, Hungary, Austria, Romania, Slovakia, Finland, Ireland, Poland, the UK, Croatia, Norway; 2010 data, *n* = 1 country: Sweden). A number of differences were identified and these are shown in Appendix 2. Two countries reporting inpatient data are excluded: Turkey, which reports data only on inpatient clients, and the Netherlands, which does not disaggregate inpatient and outpatient data.

Age and gender

Inpatient clients are reported to be slightly older (32 years) than outpatient clients (31 years) at treatment entry, although variations are reported by drug and by country. The biggest difference is seen among cannabis treatment clients (inpatient 27 years vs. outpatient 25 years). For those with primary opioid-use problems, inpatient clients were slightly younger (34 years) than outpatient heroin clients (35 years).

The social circumstances of clients varied between treatment settings and are generally more disadvantageous for inpatient than outpatient clients. Higher proportions of inpatient treatment entrants reportedly have no schooling or a basic level of education (inpatient 31 % vs. outpatient 22 %), are unemployed (inpatient 61 % vs. outpatient 48 %) and live in unstable accommodation (inpatient 16 % vs. outpatient 10 %).

Patterns of drug use

A higher proportion of primary users of amphetamines is noted in inpatient treatment (16 %) than outpatient treatment (6 %). Overall, clients entering inpatient treatment tend to have more precarious patterns of drug use, as shown by the higher proportions reporting injecting as the main route of administration for the primary drug for which they enter treatment (inpatient 22 % vs. outpatient 18 %) (Appendix 2).

Clients targeted in specialised residential treatment

Some countries provide specialised residential treatment tailored to the needs of specific subgroups of clients, including adolescents, people with dual diagnoses, and women and/or families with children, as well as other client groups.

Modifications to residential programmes to meet the treatment needs of young people are available in some Member States (e.g. Germany, Estonia, Ireland, Greece, France, Spain, the Netherlands, Portugal, Finland). These programmes vary in the treatment they provide. Nonetheless, common features include varying degrees of family involvement in the treatment and in the process prior to discharge and the availability of aftercare support for young people and their families. Typically, treatment for this specific group is reported to focus a lot more on personal plans and personal development than on drug dependence. As with other client groups, because each young person has unique issues and needs, programmes determine what is in the best interest of each individual before making treatment decisions (for more information, see Fournier and Levy, 2006).

Residential programmes with a special treatment focus on dual diagnoses are rarely reported. However, in a number of Member States (e.g. Belgium, the Czech Republic, Spain, Italy, Portugal, Slovenia, Finland, the UK), residential programmes are viewed on a continuum depending on how suited (e.g. in terms of medical staff available, appropriate certification of the programme) they are to serve drug-dependent clients who also suffer from a mental illness. (For reviews of research on residential programmes for people with severe mental illness and co-occurring substance use disorder, see Brunette et al., 2004; Drake et al., 2004.)

Specialised residential programmes specifically tailored to the needs of women and/or women and families with children exist in a number of countries (e.g. Belgium, Bulgaria, Germany, the Czech Republic, Ireland, Greece, Spain, France, Italy, the Netherlands, Portugal, Slovenia, Finland, the UK, Norway). In addition, some general programmes have been augmented with special groups that discuss women's issues, as well as individual and group counselling (for additional information, see Selected issue on *Pregnancy, childcare and family: key issues for Europe's response to drugs*, EMCDDA 2012c).

Older drug users represent a growing proportion of drug treatment demand, including in residential settings (EMCDDA, 2010). Whereas some countries (e.g. the Netherlands) report residential treatment programmes that cater for the needs of this ever-growing population of drug users, treatment experts in other countries (e.g. Spain) report that suitable (long-term) residential programmes that offer care and support to chronic, ageing drug users are yet to be fully developed.

Modifications to residential programmes to meet the treatment needs of migrant drug users exist in Germany, Spain and Greece, and some Member States report refocusing of existing facilities and therapeutic tools or establishing new residential programmes to address the needs of individuals with behavioural addictions such as gambling (e.g. Bulgaria, Italy, Ireland).

In a number of countries (e.g. Hungary), although residential treatment facilities are reported to be open to drug users with a range of needs, residential services are not specifically tailored for particular groups; rather, provision for specific subgroups of clients is provided within an universal treatment framework. In a time of constrained fiscal resources, this approach, with no separation of residential services according to specific client groups, is being increasingly seen as an attractive mechanism for efficient resource use. For instance, in Spain, although experts in the country agree on the need for specialised services for certain client groups, such as the dually diagnosed, there is a growing emphasis on a serve-all approach and in some autonomous communities there are an increasing number of examples of residential treatment catering for all client groups.

6. Organisational structure of residential treatment

This part of the paper examines the organisational structures of residential treatment, that is non-therapeutic attributes that may influence the treatment approach and the types of services provided to clients (Durkin, 2002). Structural aspects of treatment facilities include financing arrangements and management, ownership and quality management (Heinrich and Lynn, 2002; Olmstead and Sindelar, 2004).

Financing and costs

First, we review the main payers or funders of residential treatment services in Europe, before moving on to examine ownership and programme accreditation. Depending on the country, the funders of drug treatment services can include public sources, private sources and social health insurance.

When using the term 'public sources', we mean funds raised by governments through taxes, donor grants and loans (Schieber and Akiko, 1997). These sources are operated and managed at different administrative levels, from national to regional or local. In a number of European countries, healthcare is financed through health insurance, whereby workers and employers are obliged to contribute to health insurance funds which also finance drug treatment. Health insurance programmes may also receive government funds for unemployed individuals and other groups that are eligible for subsidised contributions. Other sources include donors, either international or domestic, financing drug treatment through grants, loans and in-kind contributions, as well as individuals who pay out-of-pocket fees directly to providers of residential treatment services.

In some comparative studies, the mode of financing is taken as the main or even sole indicator for describing healthcare systems. It is clearly important for clients' access to services whether they are entitled to healthcare on the basis of earmarked social insurance contributions or citizenship (which, in general, means tax financing) or it is necessary for them to make the payment privately (Mossialos and Thomson, 2003).

In Europe, governments are crucial payers for residential treatment in 21 of the 23 reporting countries (Table 3). The roles played by the various levels of government, however, differ between countries. In Poland and Portugal, residential treatment funding is provided solely by the central government. In 14 further cases, the central government provides a proportion of the funding for residential treatment, in a joint financing arrangement with:

- local bodies (Estonia, Lithuania, Hungary, the UK);
- local bodies and health insurance (Austria);
- local bodies and private sources (Spain, Sweden);
- local bodies, health insurance and private sources (the Netherlands);
- health insurance and private sources (Belgium, Slovenia);
- private sources (Bulgaria, Greece, Cyprus, Malta).

There are 11 countries where there is no central government involvement. Local bodies account for all residential treatment funding in Denmark, Italy and Finland, whereas local or regional bodies finance residential treatment in combination with funding from health insurance in the Czech Republic.

Funding of residential treatment by health insurance is reported by seven countries. In three of these (Germany, France and Luxembourg), health insurance is the sole funder, whereas it is a supplementary source in four others (Belgium, the Czech Republic, the Netherlands and Slovenia). The existence of private sources of funds is reported by nine countries (Table 3).

In the financing dimension, the proportion of residential treatment budget as a percentage of the overall drug treatment budget is an important indicator for describing drug treatment systems. An earlier analysis of 2009 data that includes three countries (the Czech Republic, Germany and Luxembourg) indicates that, in each of the different countries, residential treatment consumes a different share of the total allocation of drug treatment resources, ranging between 8 % (Germany) and 43 % (the Czech Republic) (EMCDDA, 2011).

Beyond the examination of funding allocation for residential treatment, unit costs, typically presented in treatment studies as the daily cost of providing a client with a particular sort of treatment, are a crucial indicator for characterising residential

TABLE 3
Funders of residential drug treatment in Europe

Public health–central government	Public health–local government	Health insurance	Private sources
Belgium	Czech Republic	Belgium	Belgium
Bulgaria	Denmark	Czech Republic	Bulgaria
Estonia	Estonia	Germany (1), (2)	Greece
Greece	Spain	France	Spain
Spain	Italy	Luxembourg	Cyprus
Cyprus	Lithuania	Netherlands	Malta
Lithuania	Hungary	Austria	Netherlands
Hungary	Netherlands	Slovenia	Slovenia
Malta (2)	Austria		Sweden
Netherlands	Finland		
Austria (2)	Sweden		
Poland	UK		
Portugal			
Slovenia (2)			
Sweden			
UK (2)			

Source: Reitox national focal points.
Notes:
(1) Health insurance includes both health and pension funds.
(2) Public funding includes welfare funds or social budgets.

treatment. Treatment interventions and the level of professional staff involvement are among the factors that have an impact on unit costs. Although the examination of residential treatment costs, as a simple costing of treatment exercise or in the context of an economic analysis of the cost–benefit variety, is crucial to determine if and how (long-term) residential treatments fit the present global public spending cut plan, the data available for unit costing are very limited. Based on data from three national focal points, residential treatment per client per day was estimated to range from EUR 31 ([9]) (Hungary) through EUR 107 ([10]) (the UK) to EUR 622 (Cyprus) (year of reference: 2011).

Regarding access to residential treatment providers, the share of public funding indicates the extent to which it is considered a public responsibility to guarantee entry for those who require drug treatment in a residential setting. For the individual client, another indicator of the financing dimension is the level of private out-of-pocket payments. In the general health field, a number of studies have shown how private cost sharing reduces health service utilisation and increases inequality (e.g. Thomson and Mossialos, 2004; Van Doorslaer et al., 2006).

Of the nine countries that indicate that residents (and/or their families) contribute financially to residential treatment, the Netherlands, Spain, Slovenia and Portugal provide data. In the Netherlands, since 2012, in some cases, clients are required to pay contributions of EUR 5 per day (EUR 145 per month). However, there are no full monthly cost data to estimate clients' contributions as a proportion of the total monthly residential treatment fee. There are groups of clients in residence in the Netherlands that are exempt from fees. These groups include (i) young persons (17 years of age or less), (ii) clients who are compulsorily placed in residential treatment and (iii) crisis admissions. In Spain, a client's financial contribution to residential treatment typically constitutes a small proportion of the total cost of the treatment episode. Typically, a client's contribution ranges between EUR 7 and EUR 27 per day (EUR 200 and EUR 800 per month respectively), although there are cases where clients bear the total cost of their residential treatment. In private residential facilities in Spain, monthly fees of between EUR 1 000 and EUR 5 000 are paid in full by residents. In Slovenia, clients in residential treatment programmes pay up to 20 % of the total treatment fee.

Type of ownership

The type of ownership indicates the type of entity responsible for the operation of the residential facility. Data suggest that, in Europe, residential facilities fall into three categories:

- government, which breaks down into
  - state/federal,
  - local/regional;
- private, for profit;
- private, non-profit.

In all of the countries in Europe, the public sector (i.e. governments, state, local or both), shares a varying degree of ownership of residential treatment provision. Spain, Austria, Finland, Sweden and Portugal report ownership of residential treatment by private, for-profit, entities. Although a number of countries (e.g. Bulgaria, Greece, Austria, Luxembourg, Finland, Spain, Sweden, Romania, the UK) report that the responsibility for the operation of some residential treatment facilities lies with private non-profit organisations (also known as non-governmental organisations (NGOs), as the vast majority of NGOs are non-profit), relevant data are limited.

Nonetheless, in Austria, it can be established that, of the 24 reported residential facilities, the legal structure behind 21 % is an NGO. In Sweden, the distribution of publicly operated and private for-profit companies is almost equal, 40 % and 42 % respectively, whereas NGOs own the remaining 18 % of residential treatment facilities.

The picture, however, is more complex, as there is subcontracting of the provision of residential treatment services (along with clinical staff training and working with the local community) by governments to NGOs. In some cases (e.g. in Spain and Italy), religious entities manage residential treatment facilities on behalf of the state.

Although NGOs in Europe have a history of commitment to addressing the treatment and rehabilitation needs of drug users, this has been predominantly done through granted subsidies. Recent years, however, have seen formal subcontracting of residential treatment services to NGOs becoming a prominent and common arrangement. For example, in Spain, in order to ensure transparency and equity in the dispersion through NGOs of public money for residential drug treatment, the government agency for control and intervention systems has installed a mechanism whereby, akin to the participation regulation of the private sector in providing public services, NGO-provided residential drug treatment services are purchased by government agencies in a context of competition and bidding. Similar arrangements can also be observed in the UK.

Commentators on international NGOs note that present-day NGOs are often legal corporations with full-time staff and governing boards; their organisational structures are more formal and complex and their operations are more strategic and business-like (Breslow, 2002). Although continuing support from governments and collaborative relationships between NGOs and governmental organisations may be

([9]) Maximum base funding that can be requested for the treatment of a client per day in residential settings.
([10]) Costs are considerably higher when detoxification is included.

strengthening NGOs' capacities, recent accounts from Spain suggest that, in some few cases, NGOs may be perceived as lacking a commitment to public interest, a strong professional profile and suitable management. Nonetheless, in other cases, they are perceived as innovative, flexible and readily adaptable to changes and composed of committed individuals.

Quality management

Quality of treatment across the European countries is ensured by applying evidence-based guidelines and finding a consensus on standards. Accreditation systems based on external evaluations are in place and, in some cases, access to funding is linked to quality assessment. As in many other fields of interventions in drug demand reduction, European countries put in place a variety of different approaches. Efforts to learn from each other and fasten the achievement of harmonisation are also undertaken.

Availability and adherence to guidelines

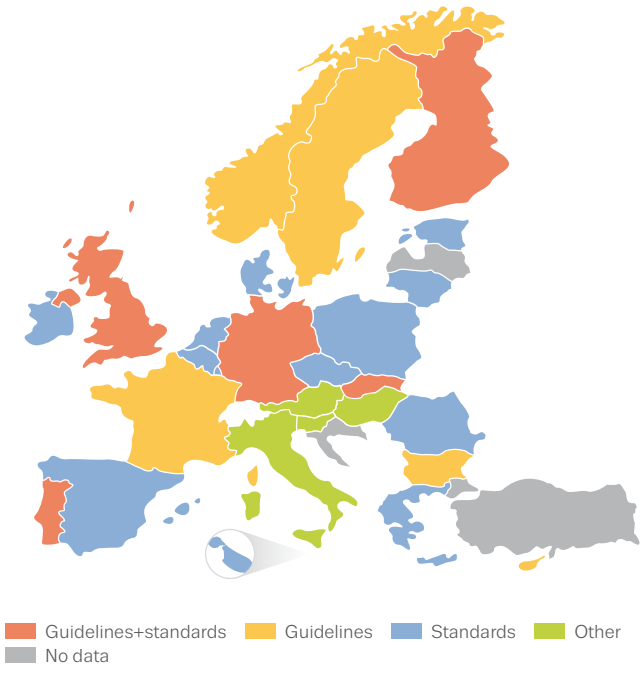
Figure 6 highlights the availability of instruments for quality management in residential treatment in Europe.

Quality tools for residential treatment have been developed by some international organisations, such as the World Federation of Therapeutic Communities (WFTC), which requires its members to respect eight standards. These standards elaborate on the concept of human rights, with emphasis on respect and transparency of philosophy goals and regulations. They are aimed at providing 'maximum opportunity for physical, spiritual, emotional and aesthetic development' of clients and carer ([11]). The practical aspects covered by the standards include training and supervision of staff and accountability to an external executive or community board.

Almost all the reporting countries mention some form of public authorisation of residential treatment facilities. The relevant guiding requirements are set by legal documents which can refer to national guidelines.

Guidelines specifically targeting therapeutic communities are available in Bulgaria, Cyprus and Portugal. In other countries, residential facilities may adopt guidelines which are broader in scope, as is the case in Germany, France, Slovakia, Finland, Sweden, the UK and Norway. The Bulgarian guidelines, published in 2009, include concepts, aims and a normative framework of psychosocial rehabilitation (including residential programmes), the criteria for monitoring and assessment, basic ethical principles and definition of an ethics charter for the staff. The Portuguese guidelines focus on the promotion of integration among public sector and private therapeutic communities, synthesise the legal instruments scattered among many different documents and describe the activities of the responsible body for the coordination of rehabilitation facilities. Compliance with the national guidelines for residential treatment is also mandatory in Cyprus.

FIGURE 6
Quality management in residential treatment programmes in Europe



Service standards, staffing levels and minimum requirements for staff qualifications

Standards applied to therapeutic communities are reported by at least 18 countries ([12]). These standards can be developed nationally or locally and others emanate from international certification agencies (such as International Organization for Standardization (ISO) 9000 or the European Foundation for Quality Management; for more detail, see http://www.emcdda.europa.eu/best-practice/standards/treatment).

Most European countries provide some indication about the educational background required to work in a therapeutic community. Typically, psychiatrists and other medical specialties including nurses, psychologists and social workers are mentioned. In Bulgaria, the conditions under which former drug users can be employed in a therapeutic community are defined and, in Greece, there are training programmes for ex-users who are considered 'special therapists'. In Germany,

([11]) http://www.wftc.org/standards.html
([12]) Portugal, Finland, Germany, Slovakia, the UK, Spain, Denmark, Greece, the Netherlands, Belgium, Luxembourg, Malta, Poland, Romania, the Czech Republic, Estonia, Ireland and Lithuania.

other professions such as physiotherapists or vocational therapists are mentioned and clear restrictions to the employment of not specifically qualified professionals are included in the guidelines set by the Pension Insurance Association. Germany is also one of the countries, along with Bulgaria, Finland and Portugal, which report a predefined minimum staff level. In Lithuania, the competences of psychiatrists and nurses are determined by the Ministry of Health, which also requires that licensed health practitioners renew their licence for practice every five years; this was recently extended to social workers.

The systematic inclusion of client perspectives as quality criteria is described by the Portuguese, Bulgarian, Spanish, German and Luxembourgish reports. In the Netherlands, the use of the Consumer Quality Index (CQ-I) became mandatory for the institutes for mental healthcare and addiction in 2012. This index includes questions about patient experiences with the information on treatment they received, the attitude of the caregivers, the available treatment options and the satisfaction with treatment. The data can be used, for example, by the managers of addiction care organisations to improve their care and by insurers to monitor the patient experiences at the facilities they contracted. The addiction care organisations were obliged to use the CQ-I questionnaires in a sample of their clientele. These questionnaires were created under supervision of the programme 'Visible care' (Zichtbare zorg), which was established in 2007 by the Ministry of Health, Welfare and Sport. There were plans that these activities would be taken over by a new Quality Institute in 2013, but it is not yet clear if or how the measurements will continue.

An accreditation system based on external evaluation constitutes the main approach in the Czech Republic, where sets of standards are in place for each type of intervention, including the therapeutic communities. Independent and qualified supervision provided by personnel trained under the international aegis of the European Association for Supervision (EAS) ([13]) is a central feature of the Czech quality system. In the UK, healthcare and social care are decentralised responsibilities, so that each of the four countries (England, Northern Ireland, Scotland and Wales) has a different regulatory body in charge of quality control. The principles around which those systems are created differ, but all include ethical issues, guarantees about the individuals providing the interventions (in England, a criminal record check is also requested), the appropriate promotion of health and well-being of patients and the accountability of the organisation.

([13]) http://www.easc-online.eu/

Programme outcome documentation and evaluation

Evaluation of residential treatment programmes for use by providers to improve their programmes can consist of assessing activity such as referrals, bed or occupancy rates, programme retention, average duration of stay, existence of treatment plans and referral rates to continuing support and care. These can be evaluated by comparing standards (set by the programme itself or funders and/or accreditors) with actual practice. Such measures will be available in every programme and require little additional resource. In addition, client treatment expectation and satisfaction surveys and focus groups are useful in providing feedback from the resident and their family.

Activities related to outcome evaluation are reported by 15 countries ([14]) with noticeable differences in the implementation. In some cases, these are systematically performed at the service or central level or they can be performed as occasional studies by external bodies. In Lithuania, quality evaluation is delegated to audit groups created within the services. These groups are expected to develop procedures and protocols and to set target indicators. They also need to design processes to deal with complaints by patients and initiate inquiries into the quality of services. In Germany, monitoring and evaluation of the health system is performed at the central level. Approximately half of all the inpatient facilities for people with substance-related disorders, eating disorders and pathological gambling behaviour provide statistical data to the 'Deutsche Kerndatensatz' (KDS) (German Core Data Set). Furthermore, rehabilitation services are compelled to submit detailed reports on their activities following some specific guidelines.

Recent examples of the use of evaluation systems to develop practice are reported by Austria and Poland. In Austria, for instance, the Carina treatment unit has regularly performed evaluation studies, in which some critical points were identified. These were the lack of adoption of evidence-based guidelines and the length of waiting times. Of particular interest is the analysis of the reasons for patient dropout. The largest number of dropouts were registered shortly after the start of treatment, typically owing to family relations, cravings for drugs and emotional instability, especially among the younger clients. In Poland in 2010, the Helsinki Foundation for Human Rights published a report on monitoring clients' rights in drug treatment centres. On the basis of the report, the Ministry of Health proposed the formal adoption of the existing standards to improve the protection of clients' rights.

([14]) Spain, Austria, Slovenia, Bulgaria, Denmark, Germany, Greece, the Netherlands, Slovakia, the UK, Cyprus, Belgium, Malta, Romania and the Czech Republic.

Examples of systemic approaches to learning from errors are the clinical governance and error management approaches that are ongoing in England and Germany. In England, all providers are expected to designate a clinical governance lead in their service according to the guidelines of the National Institute on Drug Abuse (NIDA, 2012). The four main pillars of clinical governance have been incorporated by the World Health Organization (WHO, 2013): professional performance (technical quality), resource use (efficiency), risk management (the risk of injury or illness associated with the service provided) and clients' satisfaction with the service provided. Clinical governance is a holistic approach to evidence and good practice, which encompasses each component of a service provider, including patients' opinions, in a continuous process of improvement (Scally and Donaldson, 1998).

Links between financing and quality assurance

In recent years, residential facilities for drug treatment have faced growing pressure to monitor outcomes. Interest in the monitoring of outcomes has, in some cases, coincided with concerns about the quality of treatment and care in these facilities and sparked debate over the appropriate role of residential treatment in drug treatment systems that are dominated by community-based services. At the same time, leaders in the field of residential treatment have adopted a set of core principles to guide the delivery of residential treatment. Among these principles is the expectation that residential facilities measure outcomes that can be used to inform the development of quality improvement efforts and to demonstrate the value of residential treatment to families and other stakeholders.

A number of European countries ([15]) report that some form of relationship exists between funding and quality assurance. In some cases, activity ensuring reciprocity between the quality of treatment services, as measured by an external body, and the funding allocated to the service is undertaken at a local level, and only in a few countries are systems to link funding with quality control centrally implemented.

Some Spanish communities, for example, include standardised quality criteria (such as ISO 9000) as a prerequisite for granting subsidies. In the autonomous community of Valencia, a quality accreditation process took place in 2011 through a public institute operating under the Ministry of Health. Finland is another country where quality assessment is mainly performed in the context of local benchmarking. In the tenders for outsourcing service providers, public bodies insert exclusion criteria based on quality. In Lithuania, the facilities funded from the state or municipal budgets are not bound to respect quality criteria. In contrast, the therapeutic communities funded by the European Social Fund need to fulfil the criteria set by this agency.

In France, there is a mixed local–central system in which residential facilities have to submit a detailed annual report to the territorial delegation of the regional health agency to justify the use of the budget. At a national level, 'RECAP' (Recueil commun sur les addictions et les prises en charge (Common Data Collection on Addictions and Treatments)) collects these data for evaluation.

In Germany, where quality criteria are set by the pension insurance companies, the link with reimbursement is clearer, whereas in Malta, Cyprus, Portugal and Slovenia performance reports are evaluated by the ministries responsible for funding. In contrast, in two other countries — Croatia and Hungary — regulations and legal acts are reported to set the link between therapeutic performance and financing.

7. Conclusions

The history of residential treatment provides some insights into the development of drug treatment per se, as, in most countries, the first type of treatment offered to drug users was in residential settings.

Residential treatment programmes provide a multidisciplinary approach to enable drug-dependent individuals to gain control over their drug use and to achieve and maintain improvements in health, social and lifestyle domains. Psychosocial and pharmacological services are provided as part of a structured therapeutic process that begins with the withdrawal/detoxification process and extends to aftercare planning following a residential treatment episode.

Although, historically, residential treatment programmes have been exclusively drug free, our data indicate that the importance of providing medication to substitute for the use of illicit drugs is coming to be appreciated as an essential part of treatment. This requires additional medical staff capacity to ensure that clinical guidelines, in relation to medication prescription, are adhered to. The peer community is a powerful tool that can be employed to support and monitor medication adherence and encourage dose reduction.

The combination of psychosocial and pharmacological interventions is congruent with the idea that addiction is a persistent condition that requires medication to improve functioning (McLellan et al., 2000). From this perspective, pragmatic and science-based interventions are the solutions

([15]) Spain, Slovenia, Portugal, Finland, Sweden, Denmark, the Netherlands, the UK, France, Cyprus, Italy, Luxembourg, Poland, Romania and the Czech Republic.

emphasised, not necessarily based on what is 'correct' from a given ideological perspective.

The development and implementation of evidence-based clinical guidelines and service standards can play an important role in quality assurance and improving processes in residential treatment. However, it should be noted that the nature of standards and guidelines for complex psychotherapy-based approaches may differ from those being developed and implemented for medical-based treatments (e.g. opioid substitution treatment), in that the former are likely to be less operational and directive. Nonetheless, a considerable number of countries note the existence and use of such documents, with critical implications for maintaining a culture of accountability, ensuring quality and consistency of service provision and informing uniform staff training models.

This review shows that residential programmes are a mixture of services reflecting the philosophy of one or more treatment approach. It is beyond the scope of this paper to establish the extent to which current residential treatment networks (as part of overall drug treatment systems) are a result of ad hoc responses and adjustments or how far planning and coordination have guided their development in different countries. European countries can benefit from a systematic need assessment and exploration of the ways in which integration of treatment components in residential and outpatient settings can be delivered to yield added value to compensate for additional financial investment. The value will need to be examined at the level of the individual, their family and society at large, as well as accounting for clients' subjective views of their treatment experience and satisfaction as a recognised marker of adherence to clinical standards.

The current way of providing residential treatment involves rethinking the timeframes within which people stay in residential treatment. Speculatively, the question is whether there is a trend to shorten the planned duration of treatment, coupled with a widespread development and expansion of adjunct outpatient and aftercare services by residential facilities. These adjunct programmes have been established in recognition of the need to provide some continuity between the residential and community environments. A related notion is the recognition that, although behaviour change can occur within the treatment milieu, the change is not necessarily transferable when people return to their families and communities.

One of the strengths of this paper is the variety of sources used, such as national or regional healthcare statistics, government reports, national surveys, scientific papers published in national or international journals and references to websites with databases. However, the approach chosen is descriptive, and thus the paper provides a mosaic of historical accounts; availability of residential drug treatment, including for specific client groups; reviews of current national discussions about residential treatment; and areas of achievement, opportunity and challenge.

In taking this forward, increased data collection, monitoring and residential treatment evaluations applicable across national frontiers would be fruitful. If such data collection and monitoring can be combined with national drug service frameworks or programmes, this could take quality assurance in (residential) drug treatment delivery in Europe a step forward.

It should be added that, although in this paper we consider residential treatment provision from European and national perspectives and talk about 'the Danish' or 'the German' experience, regional variations can be wide and therefore comparative analyses can be more meaningful when they are performed between regions, as well as across national frontiers. Therefore, future monitoring of (residential) drug treatment provision can include measures at both national and regional levels.

In an 'age of austerity' with shrinking treatment budgets in Europe (and beyond), the question is how residential treatment programmes need to develop and how they can target areas where they can make the most impact and achieve the most good at an acceptable cost. This is likely to mean demonstrating that they can engage effectively with a range of target groups, including, but not limited to, polydrug users, users of stimulant drugs for whom no efficacious pharmacotherapy is available, opioid users who may not be able to benefit from substitution treatment in the community, and people with non-substance addictions such as gambling. It is difficult to predict what the future holds for residential treatments. However, as these programmes are more resource-intensive and costly than outpatient alternatives, to respond to cost-saving demands, they are likely to continue developing and defining themselves as generic programmes that are able to provide a range of interventions, which may have the benefit of improved links with community services. Coupled with this, we are likely to see shorter programmes, quasi-residential choices and an increasing focus on tailoring residential treatment programmes to the needs of stimulant users for whom there is no effective pharmacotherapy. Finally, to ensure the continued contribution of the residential treatment component in national addiction services systems across Europe, improving the amount of information on quality assurance, monitoring and treatment effectiveness is likely to be of great importance.

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Appendix 1

Number of residential facilities applying different treatment approaches

Country	Therapeutic community/ TC principles ([1])		12-step/ Minnesota	Psychotherapy/cognitive–behavioural therapy	Psychotherapy/ other	Combined	Total
	Reported by NFPs	Reported within a research study					
Belgium	14	8	0	17	0	0	31
Bulgaria	2	3	3	10	5	0	20
Czech Republic	18 ([2])	10	0	15	0	0	33
Denmark	14	1	4	11	0	2	31
Germany	0	:	0	0	0	320	320
Estonia	1	1	4	0	3	0	8
Ireland	13	2	15	0	0	80	108
Greece	6	11	0	0	1	5	12
Spain	131	129	0	32	45	0	208
France	11	11	0	0	33	0	44
Croatia	30	:	0	0	0	0	30
Italy	708	798	0	0	0	0	708
Cyprus	1	1	0	0	2	0	3
Latvia	3	2	1	0	0	0	4
Lithuania	15	19	10	0	0	0	25
Luxembourg	2	1	0	0	0	0	2
Hungary	10	14	2	1	1	0	14
Malta	3	7	1	2	1	0	7
Netherlands	4	8	0	0	0	76	80
Austria	0	9	0	22	2	0	24
Poland	59	85	12	0	8	0	79
Portugal	68	57	0	0	0	0	68
Romania	5	3	2	0	5	0	12
Slovenia	7	4	0	0	0	0	7
Slovakia	13	19	0	0	0	20	33
Finland	0	4	0	0	0	75	75
Sweden	0	1	0	0	0	311	311
United Kingdom	18	10	40	27	0	53	138
Turkey	0	:	:	:	:	:	:
Norway	4	5	10	26	25	0	65
Total	1 160	1 223	104	163	131	942	2 500

Note: ':' means 'no data'.

([1]) Data on therapeutic community (TC) programmes reported in this publication are sourced from the Reitox national focal points (NFPs) network. In most countries, different numbers of TCs per country were identified in the context of a research study focused on TCs in Europe (EMCDDA Insights, 2014) because of the extended data sources used. The results from the two different data collections are presented in separate columns; the figures reported by the NFPs are used in the present analysis.

([2]) Czech Republic: reporting range, n = 15–20 TCs, of which the mean (n = 18) is taken for the calculation of the total number of residential facilities.

Appendix 2

Sociodemographic characteristics and patterns of drug use among clients entering inpatient and outpatient treatment in selected countries in 2011

	Number of clients	
	Inpatient	Outpatient
Gender		
Females	7 625/30 340 (25 %)	57 779/248 597 (23 %)
Males	22 715/30 340 (75 %)	190 818/248 597 (77 %)
Age at first use		
<20	15 345/23 949 (64 %)	127 683/202 682 (63 %)
20–30	6 631/23 949 (28 %)	56 13/202 682 (28 %)
30–40	1 475/23 949 (6 %)	14 415/202 682 (7 %)
40	498/23 949 (2 %)	4 454/202 682 (2 %)
Age at entering treatment		
<20	1 936/31 602 (6 %)	35 530/263 535 (13 %)
20–30	13 224/31 602 (42 %)	93 172/263 535 (35 %)
30–40	10 416/31 602 (33 %)	83 267/263 535 (32 %)
40	6 026/31 602 (19 %)	51 566/263 535 (20 %)
Source of referral		
Self-referred/family/friends	9 234/30 238 (31 %)	100 603/243 860 (41 %)
Other drug treatment centres	8 375/30 238 (28 %)	18 36/243 860 (8 %)
General practitioner/hospital/other medical source/social services	9 390/30 238 (31 %)	51 523/243 860 (21 %)
Court/probation/ police	1 768/30 238 (6 %)	58 701/243 860 (24 %)
Other	1 471/30 238 (5 %)	14 673/243 860 (6 %)
Educational level		
Basic education (*)	7 005/22 420 (31 %)	26 759/243 860 (22 %)
Living status		
Living alone	8 265/23 470 (35 %)	40 002/137 410 (29 %)
Living alone with child	1 297/23 470 (6 %)	8 455/137 410 (6 %)
Living in unstable accommodation	3 696/23 470 (16 %)	13 557/131 356 (10 %)
Labour status		
Unemployed	15 365/25 374 (61 %)	102 658/214 520 (48 %)
Primary drug		
Opioids	13 910/30 887 (45 %)	123 592/246 239 (50 %)
Cocaine	1 766/30 887 (6 %)	21 159/246 239 (9 %)
Amphetamines	5 015/30 887 (16 %)	15 635/246 239 (6 %)
Cannabis	4 745/30 887 (15 %)	74 286/246 239 (30 %)
Frequency of use (daily users)		
Opioids	4 041/7 923 (51 %)	31 010/49 477 (63 %)
Cocaine	372/1 355 (27 %)	1 665/6 316 (26 %)
Amphetamines	1 415/4 597 (31 %)	1 859/9 973 (19 %)
Cannabis	1 590/4 337 (37 %)	20 923/46 045 (45 %)
All drugs	9 196/21 236 (43 %)	59 162/121 151 (49 %)
Route of administration (injecting)		
Opioids	6 261/21 236 (29 %)	43 792/121 847 (36 %)
Cocaine	774/4 753 (16 %)	2 497/27 685 (9 %)
Amphetamines	2 226/9 172 (24 %)	2 127/23 886 (9 %)
All drugs	9 981/44 905 (22 %)	49 206/272 921 (18 %)

Notes:
Only countries reporting clients for both inpatient and outpatient treatment centre types are included.
Countries included in the analysis (n = 20): Belgium, Bulgaria, the Czech Republic, Denmark, Germany, Ireland, Greece, France, Croatia, Cyprus, Luxembourg, Hungary, Austria, Poland, Romania, Slovakia, Finland, Sweden (2010 data), the UK and Norway.
(*) Basic education corresponds to the following International Classification of Education: never went to school/never completed primary school/primary level of education.

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EMCDDA, Praça Europa 1, Cais do Sodré, 1249-289 Lisbon, Portugal
Tel. (351) 211 21 02 00 | info@emcdda.europa.eu
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