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Therapeutic Communities: *Can-Do* Attitudes for *Must-Have* Recovery

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The therapeutic community (TC) in the United Kingdom was built out of a merging of the democratic TC tradition pioneered by Maxwell Jones and others immediately after the Second World War and after the American drug-free TC originating in the Synanon experiment in the late 1950s. This latter tradition traces its roots back through the mutual-aid fellowship Alcoholics Anonymous (AA). This article examines how AA principles were adapted for the TC and how this new approach impacted upon the early drug treatment network in the United Kingdom. The evidence base for TC methodology is briefly described along with a short analysis of the marginalization of the approach in the past two decades and the future possibilities for modified TCs for special populations.

KEYWORDS recovery, residential rehabilitation, therapeutic communities, UK drug policy

THERAPEUTIC COMMUNITIES: A SHORT HISTORY

The roots of the modern drug-free therapeutic community (TC) movement lie in the mutual-aid fellowship Alcoholics Anonymous (AA; Broekaert, Vandervelde, Soyez, Yates, & Slater, 2006; De Leon, 1997; Rawlings & Yates, 2001), which, in its turn, was the continuation of a long history of self-help recovery groups including the Washingtonians, the Jacoby Clubs, and the Blue Cross (Fédération Internationale de la Croix-Bleue; White, 2000; Yates & Malloch, 2010). In its early years, the TC attracted the interest and support of many medical practitioners and academics, and in Europe in particular, this led to a merging of TC practice with the social psychiatry

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innovations of Jones, Laing, Clarke, Mandelbrote, Basaglia, and others. This earlier European tradition of "democratic" TCs within the developing social psychiatry tradition (Clarke, 2003; Kennard, 1983; Vandevelde, 1999) both ensured the acceptance of the new addiction TCs and served to temper some of their more antitreatment attitudes (Kooyman, 1992; Ravndal, 2003; Rawlings & Yates, 2001). Indeed, in Europe, most addiction TCs were initially established by enthusiastic psychiatrists. However, despite this apparently ready acceptance within addiction psychiatry circles, it is equally true that TCs—and the mutual-aid fellowships from which they sprang—have continued to be viewed with some suspicion by many within mainstream addiction treatment (Best, 2010; Best, Harris, & Strang, 2000). In part, this seems to be a natural consequence of a traditional, infection control-focused view of substance use disorders as a phenomenon to be managed and contained. But in part also, it appears to stem from a concern that TCs have failed to establish evidential credentials in a field increasingly dominated by the demand for evidence-based treatments.

The drug-free TC, or "concept house," began with Charles Dederich's *Synanon* experiment in a derelict waterfront hotel in Santa Monica, CA, in 1958 (Rawlings & Yates, 2001; Yablonsky, 1965). While Synanon had grown out of Dederich's experiences as a member of AA for a number of years, he and his fellow travelers had identified two critical elements missing from the 12-step program, which they felt were necessary for successful recovery from heroin addiction. Firstly, because most of the heroin addicts they were dealing with had little experience of the work environment, they recognized that this particular group would need a more intensive intervention that combined therapy with a structured work program. Secondly, they had grown increasingly restless at AA's insistence on not challenging the individual's own story, or "cross talking" as it was then termed. Dederich and his fellow adventurers felt that there were numerous times when a fellow recoveree needed to be told, in no uncertain terms, that they were rationalizing their behavior or sugar-coating an unpalatable truth. It was out of these two beliefs that Synanon developed as a hierarchical structured program revolving around the "Game," an uninhibited maelstrom of verbal condemnation, insult, and abuse, later to be rebadged by Carl Rogers as the "encounter group" (Yates, 2003).

Bassin (1978) has described the despair that many professionals were feeling during that period, at the failure of existing treatment programs to do more than "contain the whirlwind" of destruction that howled around the drug addict. Although some research (Robins & Murphy, 1967; Winick, 1962) pointed to a natural "maturing out" of addicts in their 30s, there was little hope that existing treatment practice could achieve more than a minimal impact on the dramatic increases in levels of addiction.

America's major treatment facilities were recording depressingly high levels of relapse. Figures show that the relapse rate for the Riverside Hospital

in New York was almost 100% (Vaillant, 1966), while in the much-vaunted methadone experiment at the Rockefeller University Hospital in New York (Dole & Nyswander, 1965), almost 20% of those in the program for 6 months or more had been arrested; and this was found despite a screening process that rejected approximately 50% of volunteers to the program as being "unmotivated." Indeed, with a less rigid selection criteria, in a similar experiment in Canada, of 321 addicts recruited, a remarkable 264 (82%) dropped out of the program (Louria, 1968).

So the news that a group of ex-heroin addicts in California appeared to have stumbled onto the ingredients of a successful "cure" was greeted with excitement in some quarters and sheer incredulity in others. It was not long before a series of communities had been established using basic Synanon principles and often Synanon graduates. Phoenix House in New York and Daytop Village (Drug Addicts Treated on Probation) on Staten Island were among the first communities, and the movement quickly blossomed across the United States and was transposed to Europe (Broekaert et al., 2006).

EARLY IMPACT IN THE UNITED KINGDOM

Small, seemingly unimportant events often have enormous, unlooked-for consequences. When a young Ian Christie settled into his seat in an off-Broadway theatre during the spring of 1968, he was hardly likely to have thought that the clandestine tape-recording he made of the play would spark a virtual revolution in drug treatment across Europe. The previous year, Dr. Christie had taken up his first consultancy post at St. James' Hospital in Portsmouth, United Kingdom. As the new boy, he was given the least attractive job in psychiatry at that time—the addiction treatment unit (Christie, personal communication, September 2005). At that time—and for the first time since the publication of the Rolleston Report in 1926—British policy on drug treatment was about to undergo a momentous change, with general practitioners losing the right to treat addiction with drugs such as heroin and cocaine and the power to prescribe such drugs being vested in drug dependency clinics in psychiatric hospitals (Yates, 2002).

Christie recognized that this would dramatically increase referrals to the small unit he had inherited. He saw too that there would be an urgent requirement for new treatments. His arrival in New York had been inspired by a meeting with Griffith Edwards, a founding father of addiction treatment in the United Kingdom. Edwards himself shortly established Featherstone Lodge (later Phoenix House) in London after being inspired on a recent U.S. visit and advised a fact-finding trip to New York, which produced a short list of people and places to visit. The list included Phoenix House and Daytop Lodge where Christie spent an inspirational weekend. And he sat through a play called *The Concept* where the progress of an individual through this

new type of community was laid bare in shocking and emotional detail. Speaking of that time, he noted in a recent interview:

> *I am an atheist. Have been since I was 13. But that experience was literally like a religious conversion. At the time, I didn't recognize how powerful it was. But in fact, I came back from America and I was completely manic.* (Christie, personal communication, September 2005)

Armed with little more than his tape of the play, his recollections of a weekend spent at Daytop, and a boundless enthusiasm, Christie returned to Portsmouth and established a makeshift TC (Pink Villa Huts, later Alpha House) in the space of two astonishing, whirlwind weeks.

By a strange coincidence, Martien Kooyman, a young Dutch psychiatrist, was invited to see *The Concept* when it toured the Netherlands 2 years later, with a group of Daytop residents as the cast. Like Christie, Kooyman—who had been managing, without much enthusiasm, a methadone-prescribing clinic in Den Haag, the Netherlands—was astonished. Here in that theatre was living proof that, contrary to the mainstream view in European psychiatry—which held addiction to be an incurable relapsing condition—recovery was not only possible, it was emphatically so (Broekaert et al., 2006)!

To understand the extraordinary impact that concept-based TCs have had upon other UK drug treatment modalities, it is important to understand not only the general mood and nature of those other services at the time of their transposition but also the changes that had been seen in the treatment of the mentally ill and the socially dislocated during the previous decades.

In part, of course, the reason lies in the British view of addiction and drug use at that time. Because the focus of British drug policy (and consequently the British drug treatment system) was firmly upon heroin and cocaine, to the almost total exclusion of the more universally popular amphetamines (Spear, 2005; Yates, 1999), and because these drugs, with their associations with jazz music and Hollywood films, were seen as products of a wayward United States, it was perhaps unsurprising that postwar Britain viewed drug addiction as an American disease that would, presumably, respond to American treatment regimes. Of course, this reframing of the drugs experience as the "fault" of the outsider, the stranger, the foreigner, is common to most cultures (Inglis, 1975; Peele & Brodsky, 1975) and goes only part of the way to explaining a phenomenon of which the legacy within the UK drug field remains clearly discernable more than 40 years later.

The groundbreaking work of Maxwell Jones, Tom Main, and others in the development of so-called "democratic" TCs, first at Hollymoor Hospital, Northfield, and later at the Henderson Hospital, have often been described (Broekaert et al., 1996; Kennard, 1983; Kooyman, 2001). However, with one or two exceptions, at least in the United Kingdom, these experiments were

kept within the broad tradition of inpatient psychiatric treatment and were largely unknown outside psychiatry.

Nevertheless, these developments were significant elements of broader changes within psychiatric treatment as a whole. For the previous century, psychiatry had been little more than a specialist branch of the criminal justice system, with psychiatrists providing incarceration and basic remedial treatment for the insane (Berridge, 1999). The impact of the work of Freud, Jung, Klein, and others coupled with the availability of new and powerful drugs had led to dramatic changes in postwar psychiatry. While some of these changes were purely about the use of psychoactive drug treatments to facilitate a more humane management of mental illness, others focused upon the "talking therapies" pioneered by Freud and others, including dynamic psychotherapy, psychoanalysis, and group work, while still others, such as the experiments with LSD and psychodrama at Powick Hospital (Sandison, 1997), were a conscious attempt to marry the two emergent traditions.

Foremost amongst this new radical group of doctors and therapists was the Scottish psychiatrist R. D. Laing. Laing had already been acclaimed for his experimental work in Scotland with the establishment of his "rumpus room" in a Glasgow hospital, when in the 1960s, he took the extraordinary step of moving his patients out of the psychiatric hospital altogether and establishing them in an anarchic TC—Kingsley Hall—in the east end of London (Cooper, 1967; Laing, 1994; Laing, Esterton, & Cooper, 1965). Laing and other members of the Philadelphia Association he established influenced, and in turn were influenced by, patient-led movements such as People Not Psychiatry and the emergent Italian movement Psychiatrica Democratica (Basaglia, 1988; Wilkinson & Cox, 1986). These were movements that brought together mental health patients, radical health workers, and social and political activists in a common cause to promote "community healing" outside the established, hospital-based psychiatric traditions.

Outside the confines of psychiatric medicine, there was a long tradition within Western Europe of the use of small, self-governing communities, particularly in the treatment of maladjusted children. Indeed, it is this work, focusing as it did upon therapeutic interventions with a resistant and antisocial group of young people, that offers the most compelling precedent for the American TC model imported into Europe in the early 1970s.

Among the earliest innovators was August Aichhorn, a Viennese schoolteacher in charge of a complex of reformatories for violent young men. His innovative approach in allowing a limited system of self-governance was noted by Freud and was promoted in the United Kingdom by Freud's daughter Anna, who influenced the early work of Maxwell Jones (Mohr, 1966).

Of equal, if not greater, importance was the work of the American innovator, Homer Lane, with his Little Commonwealth in 1913. Lane's approach, much influenced by Steiner, Montesori, Pestalozzi, and others, was a mixture of tough love, including some corporal punishment, extensive

self-government, and hard manual labor. Residents were divided into self-regulating "families" and were paid a wage for their work. This wage was pooled and used to clothe and feed the family. Those who idled and thus reduced the family's income were forcefully reprimanded by their peers in family meetings (Bridgeland, 1971).

Of all the inheritors of the Little Commonwealth innovations, the most important was perhaps David Wills. Wills, a former Borstal housemaster, was employed by the Q Camps Committee, later to evolve into the Planned Environment Therapy Trust, to manage a new experiment with delinquent youths, called the Hawkspur Experiment. Wills, who freely acknowledged his debt, drew heavily upon the work of Lane. The Hawkspur Camp was founded in 1936 with staff and residents living in tents and building their own accommodation. Much of the ethos of the camp was draw from the open-air school movement, but the tough love regime and the self-governing economy were pure Lane (Wills, 1967).

The work of these early innovators was replicated in work with maladjusted children across Europe, although the influence of this pioneering work upon the emergent democratic TC movement is rarely acknowledged. What does seem likely is that this tradition of confrontative group work and self-governance with young delinquents facilitated the establishment of the early addiction TCs, as they began to be imported into Europe in the early 1970s, and ensured that these apparently new ideas were accepted more readily than might otherwise have been the case.

Whatever the reasons, these new TCs soon began to exert an influence upon the field of drug treatment in the United Kingdom, which greatly outstripped their actual practical involvement in the field. By the mid-1970s, concept-based TCs accounted for almost half of the residential rehabilitation beds in the United Kingdom (Yates, 1981). Although this is an impressive "territorial" claim, in terms of numbers of drug users presenting for treatment, TCs were actually a relatively small player. However, their influence was felt throughout the treatment field.

By the mid-1970s, medical staff working in drug dependency units was beginning to incorporate some of the techniques of TCs into the clinical setting. The aim was to provide a more therapeutic regime than the sterile interaction that had developed, largely dominated by staff–patient manipulation around dosage and type of substitute prescription (Mitcheson, 1994). Nonresidential treatment services too were influenced by the TCs, with some developing preentry "induction programs" (Strang & Yates, 1982; Yates, 1979), while others began to undertake group work modeled upon that found in TCs. Similarly, existing residential services were keen to adopt some TC practices, and a number of Christian-based houses began to develop a more hard-edged, confrontative approach to the interactions between residents and staff (Wilson, 1978).

COMMUNITY AS METHOD

At the heart of the TC modality lies the careful balancing of two complementary but polar-opposite elements. Firstly, the TC is characterized by its use of the community itself in creating a day-to-day environment that is designed to aid recovery and learning. De Leon (1997) notes:

> *What distinguishes the TC from other treatment approaches and other communities is the purposive use of the peer community to facilitate social and psychological change in individuals.* (p. 5)

Thus, the daily routine and structure is manipulated to ensure that each member of the community is presented with appropriate and relevant challenges and rewards. A therapeutic environment is not necessarily the same as a supportive one, although challenges must be set in a community within which each individual feels safe and cared for.

Secondly, the rigidity and daily pressure of the work routine is counterbalanced by the use of groups where the hierarchy is abandoned and the rules and ideology can be challenged. This encounter or resolution group system provides the safety valve to the "pressure cooker" of "being on the floor."

This careful juxtapositioning of two opposing elements is at the core of the early success of TCs. Indeed, this balance between a retaining and supportive structure and the provision of a safe haven within which to explore and share experiences of personal vulnerability are seen as central to recovery-oriented interventions in general (Best et al., 2010; Jason, Ferrari, Davis, & Olson, 2006; White, 2008). Subsequent developments in the United Kingdom and elsewhere that have seen the increasing professionalization of the staffing of TCs, while welcome in many respects, has in some cases undermined this delicate balance and damaged the fidelity of the model (De Leon, 2010). Many professional employees entering TCs from other areas of clinical work during that time assumed that individual counseling and group work were the therapeutic inputs, with working "on the floor" merely occupying the spaces in between. This view effectively misses the point. The central tenet of the TC is that it is the day-to-day environment that constitutes the therapeutic input. Formal interventions such as groups merely allow release, understanding, and goal setting.

Thus, creating a working environment that is pressurized, rigorous, and often stressful is the priority and needs to be recognized as the crucial element in the process. The emphasis on individual treatment planning is helpful but needs to be set within the TC context. TCs work by harnessing the power and energy of the group, both staff and residents, and there is a danger that this process can be partially undermined by too great a reliance on individual work. There is good evidence to support the use of interventions such as motivational interviewing, relapse prevention,

mindfulness, and other similar interventions that have been embraced by TCs in recent years. However, it should be borne in mind that these are enhancements and not a substitute for the primary TC treatment approach: community as method (De Leon, 2010).

TCs occupy a middle ground between mutual-aid fellowships and mainstream "clinical" treatment. The peer-support and role-modeling elements of mutual-aid fellowships are central to the TC process. The reward and punishment aspects of the resident hierarchy are in many ways similar to—and used in similar ways to—the 12 steps. The differences in the TC model are the intensity of the intervention and the use of challenge and confrontation to point out unacceptable behavior and attitudes. De Leon (2010) and others (Jason et al., 2006; McKeganey, Bloor, Robertson, Neale, & MacDougall, 2006) have argued that some drug users with severe dependence problems will require the intensity of a residentially based intervention. While the use of confrontation has been questioned by White and Miller (2007), De Leon (2000) has argued that it is central to the recovery process, and Jason and colleagues, reporting on a 15-year study of the Oxford House movement, reported that sober-house residents were broadly positive about confrontation and challenge and saw it as an important resource in maintaining their recovery.

TCs have often been criticized for a perceived high dropout rate, particularly within the first months of treatment. However, this is not a problem particular to TCs. Morris and Schultz (1992), in a review of the evidence on treatment retention and compliance appertaining to a range of disorders requiring long-term interventions (including diabetes, hypertension, asthma, etc.), estimated treatment retention at approximately 50%, and various authors (McLellan, Lewis, O'Brien, & Kleber, 2000; O'Brien & McLellan, 1996; White, 2008) have argued that substance use disorders not only require similarly long-term focused treatment, but suffer from similar dropout rates.

Although retention in substitute prescribing treatment is somewhat superior to other addiction treatment modalities in this respect, it is by no means immune to this problem. Simpson, Joe, and Rowan-Szal (1997), in a study involving three methadone treatment programs in Texas, found that two thirds had dropped out within the first 12 months, with one third dropping out in the first 12 weeks. In Italy, D'Ippoliti, Davoli, Perucci, Pasqualini, and Bargagli (1998) surveyed 1,503 heroin addicts entering either methadone maintenance therapy (MMT) or a naltrexone detoxification with a community-based (ambulatory) program of group work and drug counseling. At the end of 12 months, 60% of the MMT clients had dropped out, while in the detoxification group, more than 80% had left treatment.

In various studies of retention in TCs, Lewis and Ross (1994) have noted that the dropout rates differ very little from other addiction treatment modalities. They argue that the bulk of dropouts occur within the first 12 weeks of treatment, with retention rates ranging from 60% to 70% and with a significant reduction in dropout thereafter. Ravndal and Vaglum (1994), in an

18-month study of a TC in Norway, found a retention rate of 25%. Broadly similar rates were reported by De Leon (1991), although De Leon notes that, at that time, retention rates had been improving in TCs throughout the 1980s.

While there has been a great deal of progress regarding the evidence base for various types of addiction treatment intervention, the field remains characterized perhaps more by what we do *not* know than what we *do*. More succinctly, most of the evidence indicates that treatment works, but very little is known about how it works or who it works best for. It is perhaps, therefore, not entirely surprising that many treatment plan decisions are, in practice, based more upon individual beliefs and assumptions than upon any scientific evidence.

Traditionally, residential rehabilitation in general, and TCs in particular, have been seen as effective but expensive interventions, suitable only for a minority of clients whose failure to comply with the requirements of other treatments deemed less expensive warrants the additional expense. As a result, TCs are generally found to cater to a significantly more damaged group of clients (De Leon, Melnick, & Cleland, 2008; Gossop, Marsden, Stewart, & Treacy, 2002; Holt, Ritter, Swann, & Pahoki, 2002; Yates, 2008) than corresponding populations in nonresidential treatment modalities. They have higher levels of mental ill health (Yates, 2008), use a wider range of substances with more frequency (Pitts & Yates, 2010; Yates 2008), and are more persistent users of a wide range of treatment and welfare services (De Leon et al., 2008; Gossop et al., 2002). While these findings are not particularly surprising, it is noticeable that such significant sample differences, with all the attendant implications for prognosis, are largely ignored in various comparative outcome and/or cost-based studies.

THE FALL AND RISE AGAIN OF TCS IN THE UNITED KINGDOM

Despite their early promise and radical approach, TCs in the United Kingdom were slow to adapt to the changing demography as the number of drug users began to spiral at the end of the 1970s (Yates, 1992). With the escalation in drug users came an expansion in drug treatment services, and TCs struggled to make their voice heard in what was now a substantial treatment field dominated by community-based services. This changing emphasis toward outpatient or ambulatory treatments echoed wider developments in UK psychiatry and social welfare. Increasingly, throughout the 1980s, the trend was away from large inpatient psychiatric hospitals and toward a range of treatments in the community. These changes were also accompanied by changes in the care of the elderly and of difficult-to-manage young people and ultimately resulted in the Care in the Community Act of 1990, which established an internal market in public health and further reinforced the "community good–residential bad" message (Yates, 2002, 2003).

Furthermore, increasing alarm at the spread of HIV/AIDS ensured that after less than a decade in the wings, medicine returned to center stage. Almost overnight, the priority client changed from the drug user who wanted to stop using to the one who did not and who therefore presented the greatest risk for the spread of the virus. Effectively, the new political imperative was infection control—now newly labeled as harm reduction—and not recovery. TCs, the arch proponents of recovery, found themselves on the margins of the debate without making any conscious movement. This increasing marginalization was reinforced by changes in the UK public funding of care and resulted in a reallocation of resources to local authorities. This left TCs—which in the United Kingdom had traditionally served a geographically diverse population—negotiating per-capita funding with a large number of local authorities who were only too aware that the purse was limited and that other, more "worthy" causes needed to be funded from within the same allocation. As a result, most TCs in the United Kingdom found themselves under pressure to shorten program lengths, abandon practices with which some funders were uncomfortable, and ensure a higher ratio of "professional" staff. Ironically, as the UK TC movement began to accommodate changes for reasons of survival, they began to lose those distinctive elements that made them a valued contributor to the treatment panoply.

Paradoxically, during the same period, TCs began to be explored by treatment planners within the UK prison system. There is extremely good evidence for TC interventions in custodial institutions (Inciardi, Martin, & Butzin, 2004; Inciardi, Martin, Butzin, Hooper, & Harrison, 1997; Wexler et al., 1997; Wexler, Melnick, Lowe, & Peters, 1999), as there is for the effectiveness of TCs with particularly damaged, dually diagnosed clients (Sacks, De Leon, McKendrick, Brown, & Sacks, 2003; Sacks, Sacks, De Leon, Bernhardt, Staines, 1997; Sacks, Sacks, McKendrick, Banks, & Stommel, 2004).

Clearly, the future for the TC now lies in niche marketing of a kind already beginning to be apparent in some areas. To ensure continued existence and integrity, TCs will in the future, need to target those areas where they can make the most impact and achieve the most good. This means designing modified TCs for particularly vulnerable populations such as the homeless and those with coexisting disorders and establishing TCs in areas where they are likely to attract a higher proportion of their traditional client group, such as in prisons and detention centers. It also means TCs working to reposition themselves as a "senior partner" in the growing UK recovery movement.

The past 5 years in the United Kingdom have seen a resurgence of interest in recovery as a central focus of addiction interventions. In part, this has grown out of a sense of dissatisfaction among the media, policymakers, and service planners with the limited goals of current mainstream addiction treatments. This was perhaps best exemplified by the public debate that followed the BBC's challenging of the National Treatment Agency's annual

report in 2007, which appeared to show that only 3% of the treatment population were leaving treatment drug free (Ashton, 2008). In part also though, this passion for recovery appears to have been grounded in a very grassroots revolution, led by service users themselves expressing their disenchantment with a treatment regime that appeared to place a higher priority upon infection control and reductions in offending than on their aspirations to achieve an abstinence-based recovery. This has resulted in the emergence of a number of peer-support initiatives, based loosely upon 12-step principles but espousing a far more muscular approach than that practiced by the traditional mutual-aid fellowships (Gilman & Yates, 2010).

Sociologically, what is fascinating about these recent developments is their startling similarity to the emergence of TCs in the United Kingdom in the early 1970s. Once again, recovery-oriented services are being demanded by a largely service-user led group, joined by practitioners and academics who feel that services can—and should—do more than simply manage and contain the drug-misuse phenomenon. Once again, the movement at its core appears to be profoundly "antitreatment," because "treatment" has increasingly come to be seen as an agent of repression seeking to undermine individual recovery in the service of broader social imperatives. Once again, this is happening at a time when belief in recovery within mainstream treatment services is at an extremely low ebb (Yates, McIvor, Eley, Malloch, & Barnsdale, 2005). Back then, the newly emergent TCs were seen as dangerously close to the fashion for hippy communes and thus dangerously leftwing. Now, this new recovery movement tends to be characterized as a rightwing, outdated, and impractical crusade based more upon faith than science. In both versions, the distortion is aimed at discrediting an aspiration that is seen by mainstream treatment as hopelessly idealistic.

What is clearly required now is for the TC movement and other longtime proponents of abstinence-based recovery to join together with the new recovery movements to reassert the evidence base for recovery. Half a century of field-based outcome studies have shown that recovery through TCs and other peer-support-based interventions is not only possible but scientifically proven (Best et al., 2010; De Leon, 2010; White, 2008).

As long as the recovery movement continues to be distracted by the (already answered) question of *if* such interventions work, the questions of *how* they work and who they work best for will remain unanswered.

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