Therapeutic Communities: Confronting the Future

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EVOLUTION AND STATUS

- The evolution of the contemporary TC for addictions over the past 45 years may be characterized as a movement from the marginal to the mainstream of substance abuse treatment and human services.

- Currently TCs serve a wide diversity of clients and problems; they have reshaped staffing composition, reduced the planned duration of residential treatment, reset its treatment goals and to a considerable extent, modified the approach itself.

Evolution (Con't)

These changes are expected and consistent with the TC's own teaching, which stresses that *the only certainty in life is change itself.*

- However, as it assumes the characteristics of a mainstream public health entity, the future of the TC approach itself contains a profound and paradoxical threat—*the loss of its unique self-help identity-community as method-which has defined its success.*

THE CHALLENGE

To convert threat into an opportunity to advance its approach, the TC must address several issues three of which are briefly highlighted:

- *Funding and Planned duration of Treatment*
- *The Issue of Evidence*
- *Diversity and Quality of TC programs*
- *Clinical Practice and Fidelity of TC Treatment;*

Funding

Funding pressures have dramatically reduced the planned duration of treatment, This policy contradicts the science documenting the relationship between retention and outcomes in community and correctional TC studies.

- Thus, for the large majority of TCs that depend upon public funding, planned duration of treatment has been reduced often *below the threshold of time needed to yield positive outcomes.*

- This adjustment to funding pressures potentially *undermines the viability of the TC as a cost effective modality in the health care system.*

Funding

An informed funding policy must be guided by the current state of clinical and research knowledge which underscores the paradigm of *client- treatment matching.*

Matching: What We Know

- Client Severity-Treatment Intensity paradigm
- Cost of Mismatching: Overtreatment,
  Under treatment and Sufficient Treatment
- Self-Matching: Clients elect the intensity of treatment for various reasons (with exception of legal mandate).
- ***For clients with severe disorder in terms of substance abuse, social deviancy and psychological profiles, longer term residential TC is the treatment of choice.***

Funding-Planned Duration

The challenge to TCs is to modify programming based on the facts of matching. Three examples:

- Refine treatment-matching options for different levels of severity

- ✓ *Planned Duration and Treatment. Longer and shorter planned durations are offered in residential and non-residential settings*.

  Setting (intensity) depends upon client (severity) profile

Funding-Planned Duration

- Adjustment of clinical goals within the constraints of planned duration.

- ✓ *Shorter term programs cannot achieve the recovery goals of longer term treatment. If TCs reduce their planned duration to serve clients with severe disorder they must establish goals that can be realistically achieved in a shorter period of time.*

- ✓ *These goals center on motivating and preparing clients to continue in their recovery process beyond their briefer duration in residential treatment.*

Funding-Planned Duration

- Deploy Long term protocols of combined residential and non residential components. “Reconstitute time in program”.

- ✓ *Appropriate “dosage” (threshold) of treatment can be achieved by shortening the duration of residential treatment and extending the duration of nonresidential treatment and aftercare.*

- ✓ *Implement recovery oriented (Continuing care) systems. Link providers, and settings in a system which promotes recovery, rather than manage disease. (Example; ROIS)*

The Issue of Evidence

- In the universal call for evidenced-based treatments some critics have concluded that the TC is not an evidenced based treatment.

- What is the Evidence? Direct (based on TC outcome research) and indirect (based on non-TC research).

Direct Evidence

- **The "weight of evidence" from multiple sources of outcome research" documents that the TC is an "evidence based" approach and supports the hypothesis that the TC is an effective and cost- effective treatment for *certain subgroups of substance abusers***

- ✓ *Multi-program, multi-modality field effectiveness studies (e.g., North American DARP, TOPS, NTIES, DATOS,); European, Australian and Latin American studies.*
- ✓ *Single program case studies, (e.g., Daytop, Eagleville, Gateway, Phoenix House)*
- ✓ *Control and Meta analytic studies*
- ✓ *Cost benefit studies*

Indirect Evidence

- Evidence-based learning principles are contained in TCs: Examples:

  - Social role training: (Peer roles in the organizational structure)
  - Vicarious learning: (identification with others)
  - Behavior modification: (Consequential Learning; privilege/sanctions)
  - Efficacy training: (trial/error learning)

- These principles are naturalistically mediated; embedded in Community as Method.

Indirect Evidence

- Evidence- based Practices and Elements

- Peer mentoring; Peer feedback, tutoring;
- CBT, RPT,TC concepts: in Peer/staff Seminars;
- Motivational enhancement: peer support and group process; (focus on problem identification and desire to change).
- Goal Attainment: Program Stages and Phases
- Therapeutic Alliance: Community vs Therapist

Conclusion: The TC is an Evidenced Based Approach

- Distinction between evidence based practices and programs. ***TCs are evidenced based programs.***
- The evidence is both direct (outcome studies) and indirect ***(Evidenced- based elements and practices, are embedded within Community as Method).***
- Community as Method is the Primary Treatment. *Other evidenced informed strategies are incorporated to* ***enhance, not substitute for, community as method.***

TCs or Not TCs
Diversity of Programs

- The TC approach and model has been successfully adapted and modified for various populations and settings. However, within the wide diversity of programs that represent themselves as TCs many do not actually implement the TC approach that has proven success.

- This often results in variable treatment outcomes and fosters misperceptions of the therapeutic community as an effective evidenced based approach.

- The credibility of the TC modality in Health and Human services will require classification of the diversity of programs as well as the development of standards of quality assurance.

TCs OR NOT TCs: Classification

- A classification of TC programs is essential to assess their appropriateness and effectiveness for different populations. A suggested 3 category classification derived in part from earlier field survey studies is TC- Standard, TC- Modified and TC- Oriented.

- These broad categories are based upon the extent to which a program is guided by the TC theory (i.e., perspective on the disorder, recovery and right living), adheres to the method (i.e., Communty as Method) and retains essential components of the program model (e.g., community meetings, seminars, peer groups, resident organizational structure, etc.).

  - Standard and Modified programs may employ other evidence based strategies e.g., cognitive behavioral therapy (CBT), motivational enhancement therapy (MET, Seeking Safety, Family therapy etc.). These strategies are incorporated as *enhancements* of, not *substitutes* for, community as method, the primary treatment approach.

Clinical Practice

- TCs understandably have pursued financial solvency by expanding to serve a wide variety of populations e.g., mental health, homeless, corrections, juvenile justice and child care.
- Contracts have obligated TCs to meet regulations of community, state and federal agencies and often to incorporate practices based upon different professional views of treatment.
- As TCs modify they increasingly incorporate non -TC practices into their programs e.g. CBT, MET, DBT, Contingency Contracting, pharmacotherapy, varieties of Family therapy.

Clinical Practice

- The expansion outward of the TC has been at the expense of inward refinement of the approach itself.
- Some effects of these changes may be described in terms of *dilution* of the TC approach and *erosion* of treatment fidelity.
- TCs can refine *community as method* as the primary treatment ingredient through a focus on Fidelity.

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The Fidelity of Treament

- TC effectiveness and fidelity of treatment are closely related. High fidelity treatment produce better outcomes.
- The key strategies needed to assure high fidelity TCs are training and fidelity assessment.
- Training to fidelity involves three critical elements;1) a uniform definition of community as method 2) a teaching curriculum and 3) an appropriate training model.

A Uniform Definition

- The TC can be distinguished from other approaches and other communities in its use of community as a primary method of treatment.

- Community as method is defined as ***the purposive use of community to teach individuals to use the community to change themselves.***

- Teaching curricula: Teaching materials and manuals based upon a uniform definition of the TC must focus on the relationship between theory and practice: This can be summarized in 3 questions: **What, how and why we do what we do in therapeutic communities?**

Appropriate Training Models: TC Training Programs

- Experience indicates that training for workers in TCs requires combinations of didactic teaching of theory and practice as well experiential learning as participants in TCs. While conventional training approaches are useful, the most appropriate training model to be considered is the *TC Centers of Excellence*

- ✓ Selected high fidelity TC programs serve as the primary training sites for cadres of staff who rotate through these programs for several months. Direct daily experience in the roles and activities of the TC that are implemented correctly produces the most efficacious training effects.

- ✓ Analogous training models are found in conventional graduate and post doctoral health settings. These are based on the well grounded assumption that staff should learn their specialty in the "best teaching hospitals."

Fidelity Assessment

- Sustaining a “high fidelity” TC program requires not only training but ongoing evaluation. The latter is best conducted by fidelity assessment teams.

- These consist of experienced workers both from within and outside the program who periodically observe not only whether program elements are present but how well they are being implemented. The important contribution of these teams is to improve the quality of TC programming and practice toward achieving better outcomes.

Suggested Readings

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