The Therapeutic Community as an Evidence Based Practice

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References

- International Journal of Therapeutic Communities 31, 2 Summer 2010
  - This entire issue is devoted to the issue of the Therapeutic Community (TC) as an Evidence Based Practice (EBP).
- National Institute on Drug Abuse Research Report on Therapeutic Communities
How when did the Therapeutic Community Begin?

- In Europe, after WWII, in England.
- Maxwell Jones “democratized” hospitals dealing with “shell shock” victims.
- The aim of therapeutic communities was a more democratic, user-led form of therapeutic environment, avoiding the authoritarian and demeaning practices of many psychiatric establishments of the time. The central philosophy is that clients are active participants in their own and each other's mental health treatment and that responsibility for the daily running of the community is shared among the clients and the staff. 'TC's have sometimes eschewed or limited medication in favor of group-based therapies
In the United States in 1958, an avid Alcoholics Anonymous (AA) member, Charles Dederich began an organization called Synanon.

While it evolved out of AA, it began to attract heroin addicts. And, since heroin addiction was considered incurable, the success achieved by Synanon quickly drew national, then international attention.

By 1968, the Ford Foundation traced 2,600 programs in the US which evolved from Synanon
More History

- In 1976, Therapeutic Communities of America (now known as Treatment Communities of America) was organized—and continues today as the national organization of TCs.
- In the same year, WFTC (the World Federation of Therapeutic Communities) held the first of 24 successive conferences. National and regional associations of therapeutic communities from around the world (every continent except Antarctica) belong to WFTC.
QuickTime™ and a
DV/DVCPRO - NTSC decompressor
are needed to see this picture.
What is a TC?

- The therapeutic community (TC) for the treatment of drug abuse and addiction has existed for over 50 years in the US.
- In general, TCs are drug-free residential settings that use a hierarchical model with treatment stages that reflect increased levels of personal and social responsibility.
- Peer influence, mediated through a variety of group processes, is used to help individuals learn and assimilate social norms and develop more effective social skills.
What’s Different about TCs?

- TCs differ from other treatment approaches principally in their use of the community, comprising treatment staff and those in recovery, as key agents of change.
- This approach is often referred to as "community as method." TC members interact in structured and unstructured ways to influence attitudes, perceptions, and behaviors associated with drug use.
In addition to the importance of the community as a primary agent of change, a second fundamental TC principle is "self-help."

Self-help implies that the individuals in treatment are the main contributors to the change process.

"Mutual self-help" means that individuals also assume partial responsibility for the recovery of their peers -- an important aspect of an individual's own treatment.

“You can do it, but you can’t do it ALONE!”
Some people admitted to TCs have a history of social functioning, education/vocational skills, and positive community and family ties that have been eroded by their substance abuse. For them, recovery involves rehabilitation -- relearning or re-establishing healthy functioning, skills, and values as well as regaining physical and emotional health.

But of all the treatment modalities dealing with substance abusers, TCs take the most disturbed clients. Most TC residents have never acquired functional life-styles. For these people, the TC is usually their first exposure to orderly living. Recovery for them involves habilitation -- learning for the first time the behavioral skills, attitudes, and values associated with socialized living.
DeLeon’s Essential Elements

- Participant Roles
- Membership Feedback
- Collective formats to catalyze individual change
- Shared Norms & Values
- Structure & Systems
- Open Communication
- Relationships
Pre- and posttreatment self-reported changes among those in long-term residential TCs

*<.01 for changes pre- and posttreatment.
Pretreatment measures are for the 12 months before admission. Posttreatment measures are for the 12 months after treatment.
Length of Stay & Outcomes

1-year outcomes for shorter and longer stays in TC treatment

<table>
<thead>
<tr>
<th>Measure</th>
<th>&lt; 90 days</th>
<th>90+ days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cocaine (any use)*</td>
<td>28%</td>
<td>55%</td>
</tr>
<tr>
<td>UA+ (any drug)*</td>
<td>19%</td>
<td>53%</td>
</tr>
<tr>
<td>Alcohol (daily use)*</td>
<td>9%</td>
<td>15%</td>
</tr>
<tr>
<td>Any jail*</td>
<td>24%</td>
<td>54%</td>
</tr>
</tbody>
</table>

*p<.01 for all four measures.
Cocaine use, alcohol use, and being jailed are self-report measures for the 12 months after treatment. UA+ indicates a positive urinalysis test at the followup interview.
TCs & Dual Diagnosis

Figure 2: Offenders with co-occurring disorders
Reincarceration outcomes 12 months post release

Control (Mental Health)

33%

prison MTC only

16%

prison MTC + aftercare MTC

5%

Total n=139
n=64
n=32
n=43

adapted from Sacks, S., Sacks, J., et al. (2004)
Prison TCs

Recent Evaluations of In-Prison Therapeutic Community (TC) Treatment

- No Treatment
- TC Only
- TC + Aftercare
- IPTC + Aft

% Rearrested (18 Months) Key-Crest
1
56
59
24

% Reincarcerated (3 Years) R.J. Donovan/Amity
2
75
78
27

% Rearrested (3 Years) Kyle NewVision
3
57
61
41

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Conclusion

The overwhelming conclusion looking at research and outcome studies over many years in many countries is that TCs are very effective--particularly with the most challenging populations.
Additional resources