NATIONAL INSTITUTE ON DRUG ABUSE

Research Report

SERIES

THERAPEUTIC COMMUNITY

from the director

Each year, therapeutic communities (TCs) serve tens of thousands of people with varying degrees of drug problems, many of whom also have complex social and psychological problems. Research supported by the National Institute on Drug Abuse (NIDA) has helped document the important role TCs serve in treating individuals with drug-related problems.

Further research is being conducted on the treatment processes in TCs to better understand how TCs work. Links between treatment elements, experiences, and outcomes need to be further studied to fully appreciate and enhance the contributions of TCs. NIDA's research program is currently focused on expanding our knowledge of the TC treatment process and improving our understanding of organizational and management strategies to deliver more effective and efficient treatment services.

This Research Report is one of several aimed at providing information on approaches and modalities used to prevent and treat drug abuse. Based on over 30 years of scientific inquiry and observation, this report addresses some of the most frequently asked questions about TCs. Federal and other national resources are listed at the end of the report.

It is hoped that this Research Report will help establish a common framework and understanding about TCs for health care providers, researchers, policymakers, and individuals and their families in need of treatment for drug-related problems.

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What is a therapeutic community?

The therapeutic community (TC) for the treatment of drug abuse and addiction has existed for about 40 years. 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.

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.

Many individuals 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. Other TC residents have never acquired functional lifestyles. 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.

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.

How beneficial are therapeutic communities in treating drug addiction?

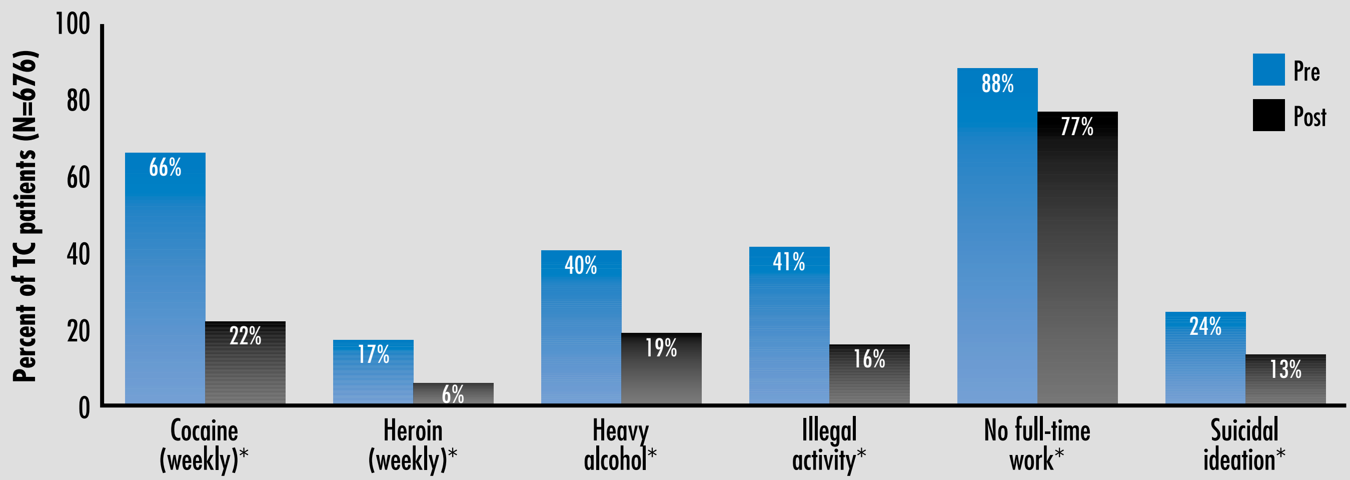
For three decades, NIDA has conducted several large studies to advance scientific knowledge of the outcomes of drug abuse treatment as typically delivered in the United States. These studies collected baseline data from over 65,000 individuals admitted to publicly funded treatment agencies. They included a sample of TC programs and other types of programs (i.e., methadone maintenance, outpatient drug-free, short-term inpatient, and detoxification programs). Data were collected at admission, during treatment, and in a series of followups that focused on outcomes that occurred 12 months and longer after treatment.

These studies found that participation in a TC was associated with several positive outcomes. For example, the Drug Abuse Treatment Outcome Study (DATOS), the most recent long-term study of drug treatment outcomes, showed that those who successfully completed treatment in a TC had lower levels of cocaine, heroin, and alcohol use; criminal behavior; unemployment; and indicators of depression than they had before treatment.

Who receives treatment in a therapeutic community?

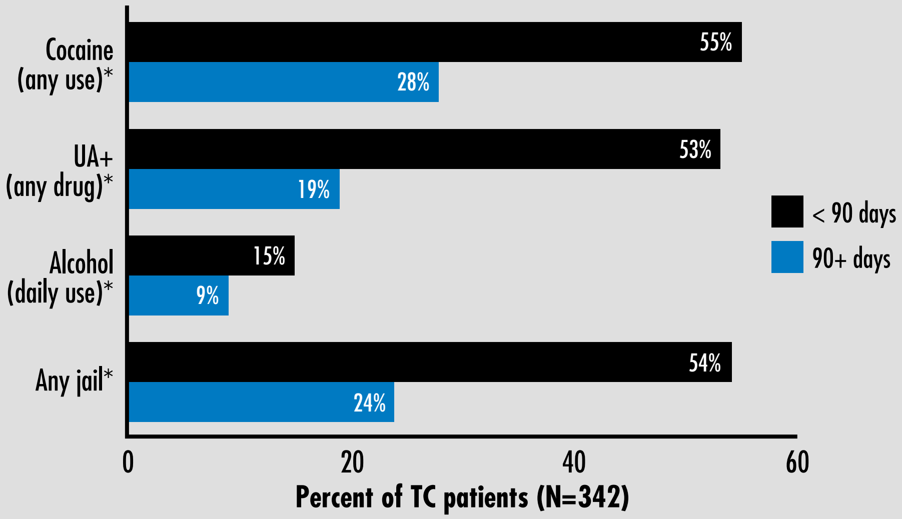
TCs treat people with a range of substance abuse problems. Those treated often have other severe problems,

Pre- and posttreatment self-reported changes among those in long-term residential TCs



*p<.01 for changes pre- and posttreatment.
Pretreatment measures are for the 12 months before admission. Posttreatment measures are for the 12 months after treatment.
Source: Hubbard et al., *Psychology of Addictive Behaviors*, 11:261-278, 1997.

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



*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.

Source: Simpson et al., *Psychology of Addictive Behaviors*, 11:264-307, 1997.

such as multiple drug addictions, involvement with the criminal justice system, lack of positive social support, and mental health problems (e.g., depression, anxiety, posttraumatic stress disorder, and antisocial and other personality disorders).

For example, in DATOS, which tracked 2,345 admissions to residential TC treatment between 1991 and 1993, two-thirds of admissions had a criminal justice status (e.g., on probation, on parole, or pending trial) at admission, and about a third had been referred to treatment from the criminal justice system. Nearly a third of admissions were women, and nearly half were African American. Sixty percent had prior drug abuse treatment experience.

What is the typical length of treatment in a therapeutic community?

In general, individuals progress through drug addiction treatment at varying speeds, so there is no predetermined length of treatment. Those who complete treatment achieve the best outcomes, but even those who drop out may receive some benefit.

Good outcomes from TC treatment are strongly related to treatment duration, which likely reflects benefits derived from the underlying treatment process. Still, treatment duration is a convenient, robust predictor of good outcomes. Individuals who complete at least 90 days of treatment in a TC have significantly better outcomes on average than those who stay for shorter periods.

Traditionally, stays in TCs have varied from 18 to 24 months. Recently, however, funding restrictions have forced many TCs to significantly reduce stays to 12 months or less and/or develop alternatives to the traditional residential model (see "How else can TCs be modified?").

For individuals with many serious problems (e.g., multiple drug addictions, criminal involvement, mental health disorders, and low employment), research again suggests that outcomes were better for those who received TC treatment for 90 days or more. In a DATOS study, treatment outcomes were compared for cocaine addicts with six or seven categories of problems and who remained in treatment at least 90 days. In the year following treatment, only 15 percent of those with over 90 days in TC treatment had returned to weekly cocaine use, compared to 29 percent of those who received over 90 days of outpatient drug-free treatment and 38 percent of those receiving over 3 weeks of inpatient treatment.

The relationship between retention and good treatment outcomes identified in DATOS has been replicated in many studies. However, many TCs have a high dropout rate, although about one-third of dropouts seek readmission. A significant research effort is underway to better understand and improve TC treatment retention by examining external factors, program services and processes, and attributes of individuals in treatment.

External factors related to retention include level of association with family or friends who use drugs or are involved in crime, and legal pressures to enroll in treatment. Inducements—sanctions or enticements by the family, employment requirements, or criminal justice system pressure—can improve treatment entry and retention and may increase the individual's internal motivation to change with the help of treatment.

In the TC, the level of treatment engagement and participation is related to retention and outcomes. Treatment factors associated with increased retention include having a good relationship with one's counselor, being satisfied with the treatment, and attending education classes. One study tested a strategy to enhance motivation by increasing new residents' exposure to experienced staff, in contrast to the more traditional approach of largely relying on junior staff as role models. The senior staff provided seminars for new residents based on their own experiences with retention-related topics. This strategy appeared to increase the 30-day retention rate and was particularly effective for those whose pretreatment motivation was the weakest.

Important attributes linked to treatment retention include self-esteem, attitudes and beliefs about oneself and one's future, and readiness and motivation for treatment. Retention can be improved through interventions to address these areas. One approach focuses on teaching cognitive strategies to improve self-esteem, develop "road maps" for positive personal change, improve understanding of how to benefit from drug abuse treatment, and develop appropriate expectations for treatment and recovery. This approach was particularly effective for individuals with lower educational levels.

What are the fundamental components of therapeutic communities?

Research spanning more than 30 years has identified key concepts, beliefs, clinical and educational practices, and program components common to most TC programs. These elements reflect the two principles that drive TC operations: the community as change agent and the efficacy of self-help.

Typically, TCs are residential facilities separate from other programs and located away from the drug-related environment. As a participant in the community, the resident in treatment is expected to adhere to strict and explicit behavioral norms. These norms are reinforced with specific contingencies (rewards and punishments) directed toward developing self-control and responsibility. The resident will progress through a hierarchy of increasingly important roles, with greater privileges and responsibilities. Other aspects of the TC's "community as method" therapeutic approach focus on changing negative patterns of thinking and behavior through individual and group therapy, group sessions with peers, community-based learning, confrontation, games, and role-playing.

TC members are expected to become role models who actively reflect the values and teachings of the community. Ordered routine activities are intended to counter the characteristically disordered lives of these residents and teach them how to plan, set, and achieve goals and be accountable.

Ultimately, participation in a TC is designed to help people appropriately and constructively identify, express, and manage their feelings. The concepts of "right living" (learning personal and social responsibility and ethics) and "acting as if" (behaving as the person should be rather than has been) are integrated into the TC groups, meetings, and seminars. These activities are intended to heighten awareness of specific attitudes or behaviors and their impact on oneself and the social environment.

How are therapeutic communities structured?

TCs are physically and programatically designed to emphasize the experience of community within the residence. Newcomers are immersed in the community and must fully participate in it. It is expected that in doing so, their identification with and ties to their previous drug-using life will lessen and they will learn and assimilate new prosocial attitudes, behaviors, and responsibilities.

Although the residential capacity of TCs can vary widely, a typical program in a community-based setting accommodates 40 to 80 people. TCs are located in various settings, often determined by need, funding sources, and community tolerance. Some, for example, are situated on the grounds of former camps and ranches or in suburban houses. Others have been established in jails, prisons, and shelters. Larger agencies may support several facilities in different settings to meet various clinical and administrative needs.

In DATOS, there was an average of one counselor reported for every 11 residents in treatment. About two-thirds of the counseling staff had themselves successfully completed drug abuse treatment programs. Increasingly, TCs rely on degreed staff (e.g., social workers, nurses, and psychologists) for some aspects of treatment.

What is daily life like in a therapeutic community?

The TC day is varied but regimented. A typical TC day begins at 7 a.m. and ends at 11 p.m. and includes morning and evening house meetings, job assignments, groups, seminars, scheduled personal time, recreation, and individual counseling. As employment is considered an important element of successful participation in society, work is a distinctive component of the TC model.

In the TC, all activities and interpersonal and social interactions are considered important opportunities to facilitate individual change. These methods can be organized by their primary purpose, as follows:

- **Clinical groups** (e.g., encounter groups and retreats) use a variety of therapeutic approaches to address significant life problems.
- **Community meetings** (e.g., morning, daily house, and general meetings and seminars) review the goals, procedures, and functioning of the TC.
- **Vocational and educational activities** occur in group sessions and provide work, communication, and interpersonal skills training.
- **Community and clinical management activities** (e.g., privileges, disciplinary sanctions, security, and surveillance) maintain the physical and psychological safety of the environment and ensure that resident life is orderly and productive.

How is treatment provided in a therapeutic community?

TC treatment can be divided into three major stages.

Stage 1. Induction and early treatment typically occurs during the first 30 days to assimilate the individual into the TC. The new resident learns TC policies and procedures; establishes trust with staff and other residents; initiates an assisted personal assessment of self, circumstances, and needs; begins to understand the nature of addiction; and should begin to commit to the recovery process.

Stage 2. Primary treatment often uses a structured model of progression through increasing levels of prosocial attitudes, behaviors, and responsibilities. The TC may use interventions to change the individual's attitudes, perceptions, and behaviors related to drug use and to address the social, educational, vocational, familial, and psychological needs of the individual.

Stage 3. Re-entry is intended to facilitate the individual's separation from the TC and successful transition to the larger society. A TC graduate leaves the program drug-free and employed or in school. Postresidential aftercare services may include individual and family counseling and vocational and educational guidance. Self-help groups such as Alcoholics Anonymous and Narcotics Anonymous are often incorporated into TC treatment, and TC residents are encouraged to participate in such groups after treatment.

Can therapeutic communities treat populations with special needs?

Research shows that those with special or complex needs can be treated in TCs. For example, individuals with co-occurring mental illness and substance abuse may be treated in TC-oriented programs based in shelters, community residences, day treatment clinics, partial hospitalization settings, or on hospital wards. Community-based TC programs provide effective treatment for clients with criminal involvement, but successful TC programs for drug-involved offenders have also been established in correctional settings. Other special populations with substance abuse problems that may benefit from TC-oriented programs include adolescents, women and their children, persons with HIV/AIDS, and homeless people.

Specialized treatment strategies and services are often incorporated as part of the TC for these populations. Support may include child care services for mothers; programs aimed at normalizing the developmental process for adolescents; access to mental health and social services for individuals with co-occurring mental illness and substance abuse; attention to changing criminal thinking and behavior for the criminal offender; and links to medical and social services for those with HIV/AIDS. Individualized treatment, including lengths of stay tailored to the person's needs, is especially important due to the complexity of possible problems. In addition, TC clinical and management activities may need to be modified in terms of disciplinary sanctions, peer interactions, and degree of confrontation in groups.

Women

Women who enter drug abuse treatment often have many serious problems. Many suffer from low self-esteem, depression, or other mental health disorders; are in abusive relationships; have little access to medical, mental health, and social services; lack marketable job skills; and have child custody concerns.

Both women-only programs and mixed-gender programs can be helpful in treating the drug problems of women. As might be expected, women-only programs and programs that serve higher percentages of women usually provide more services that women need. The evidence suggests that these services can contribute to significantly longer lengths of stay in treatment, which is related to better treatment outcomes.

Newer TC approaches for treating women with drug addictions often focus on issues related to family and children. Some model programs have found that allowing a woman's children to live with her in the TC can improve her mental health and lengthen retention. Although evidence tends to support the benefits of specialized services for women, more research is needed to determine the optimal structure of TC treatment in meeting women's needs.

Adolescents

The closely supervised residential TC environment provides benefits for troubled youth. A study on adolescent drug treatment outcomes showed that adolescents treated in TC programs were more likely than those in outpatient drug-free programs to have prior drug abuse treatment experience, more severe problems, and a criminal justice history. Despite being more difficult to treat, however, adolescents in these programs had significantly improved outcomes in drug use, psychological adjustment, school performance, and criminal activities.

Another study compared the outcomes for adolescents referred through probation to TC treatment to outcomes for those referred to group homes with no specialized drug treatment services. The group homes were the same size and offered the same length of stay as the TC setting. The study found robust reductions in drug use, criminal behavior, and measures of psychological dysfunction at 3 months for all placements. However, after that period, those in the TC sustained or increased their improvements in problematic behaviors, while those in the group homes did not.

Several studies have examined longer term effects for adolescents participating in TCs. For example, one study followed adolescents treated in six TCs. One year after treatment, these adolescents showed significant declines in alcohol, marijuana, and other illicit drug use, as well as reductions in criminal activity and other deviant behavior. Although the planned length of stay varied among the six participating TCs, completing treatment was significantly related to better outcomes. Reductions in drug use were also strongly related to having good relationships with counselors and to avoiding deviant peers after treatment. Posttreatment criminal activity was higher for those who associated with deviant peers.

It is often necessary to modify some of the traditional components of the TC to accommodate adolescent developmental differences and to facilitate their maturation. The modifications may include less hierarchy and confrontation and greater priority to education than work. For example, many TCs for adolescents have an onsite school. In addition, such programs offer a range of family services that require family participation. After formal treatment is completed, continuing care is often arranged.

Individuals with co-occurring mental health disorders

Individuals with co-occurring mental health and substance abuse disorders are among the most difficult to treat. Such individuals often have serious and complex impairments in multiple areas, in addition to drug abuse and mental illness. TCs can be adapted to treat individuals with mental disorders, including, in some cases, the use of psychotropic medications to treat serious mental illness. A recent study compared a TC for people who were homeless, mentally ill, and substance abusers to a community residence based on a traditional mental health treatment model. In the mental health model, individuals were housed within a less restrictive alternative to the psychiatric hospital by coupling a high level of personal freedom with counseling, skills training, and monitoring of medication compliance. The TC provided integrated mental health and drug abuse treatment in a highly structured, hierarchical environment that stressed mutual self-help and treatment community participation. Those in the TC showed more improvement on all measures of psychopathology than those in the community residence. In addition, the TC program retained the most impaired individuals longer than did the community residence. The investigators concluded that the increased structure provided by the TC may be a better option for this population than the less restrictive community residence model.

Another study that tested modifications to the TC to accommodate homeless drug abusers with co-occurring mental health problems included greater flexibility in program requirements, reduced duration of activities and level of confrontation, and greater responsiveness to individual needs. A second set of modifications, for a low-intensity TC, allowed residents greater freedom to leave the facility during the early stages of treatment, offered services in day treatment settings outside the residence, decreased the level of peer responsibility, and increased the amount of direct staff assistance. The modified TCs were compared to "treatment as usual," which consisted of a heterogeneous mix of alternatives often encountered after discharge from shelters or psychiatric facilities. Analyses comparing the outcomes of modified TC treatment to the usual options found that drug use was reduced in both groups, although participation in the modified TCs led to significantly greater improvements for criminal activity and indicators of depression.

Populations involved in the criminal justice system

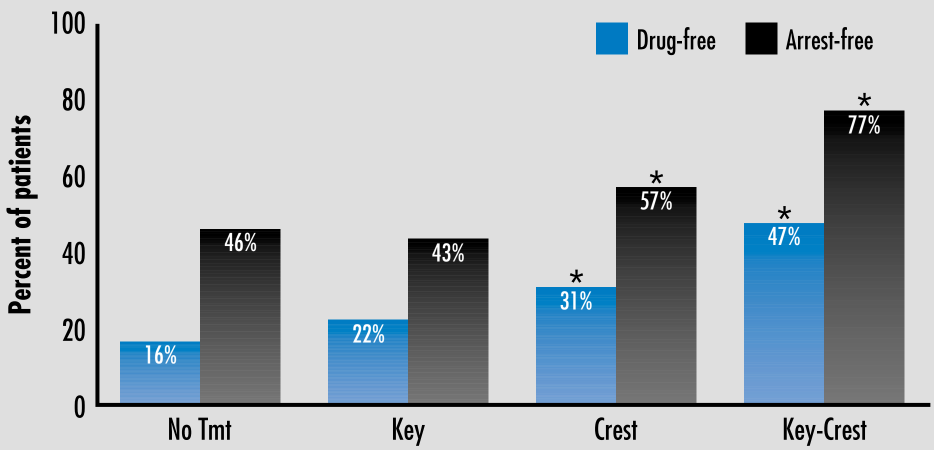
As drug abuse and crime are often linked, many drug-abusing or addicted individuals also are involved with the criminal justice system. Some of the most extensive research studies on TCs have been conducted on treatment for populations involved in the criminal justice system. These studies have found benefits for prison-based TC treatment in preparing inmates to return to the community and for creating a safer, better managed prison environment. Drug-involved offenders have the best outcomes when they participate in community-based TC treatment while transitioning from incarceration to re-entry to the community.

One such study followed drug-abusing and addicted inmates in the Delaware Correctional System to determine the effectiveness of a continuum of care on relapse to drug use and recidivism to criminal activity. The continuum of care began in prison with a State-funded TC program called The Key. Inmates transitioned back into the community through a work-release program that allowed them to work in the community but required their return to a secure facility overnight. Some inmates were randomly assigned to usual work release, and some were assigned to Crest, a TC work-release program. In the third stage of treatment, some who had completed the Crest work-release TC and were living in the community continued in an aftercare program, which provided continued monitoring by TC counselors, outpatient counseling, group therapy, and family sessions.

One year after scheduled completion of work release, significantly higher percentages of inmates who had participated in Crest or in both Key and Crest were drug-free and arrest-free than those assigned to usual work release. Further, outcomes for those who participated in both Key and Crest were better than for all three other groups.

At 3 years after work release, Crest treatment graduates and especially those who continued with aftercare had significantly

Delaware Correctional System participants in prison TC (Key) and work release TC (Crest)
Drug-free and arrest-free 1 year after work release

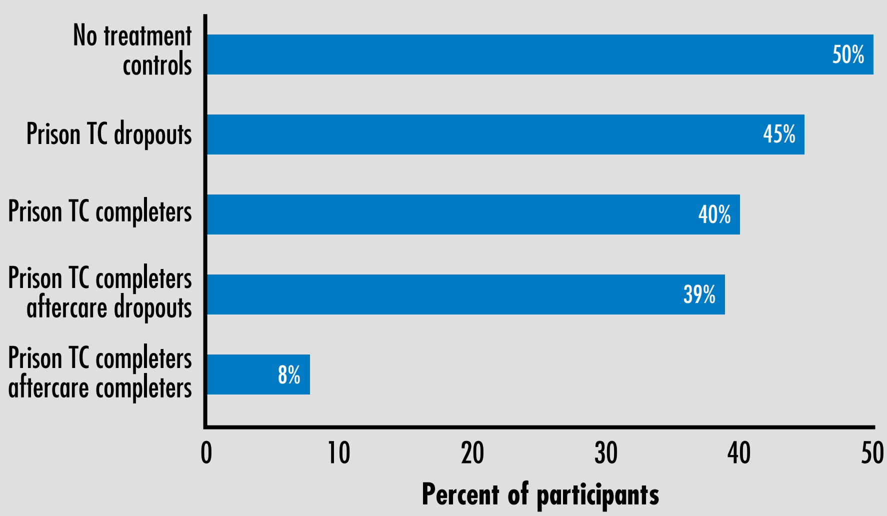


*p<.05 from no treatment.

Percentages show any use of drugs (either self-reported or detected by urinalysis) and any arrests in the year after work release. Note that prisoners were allowed to access treatment on their own, and some of those in the no treatment condition did receive services that were not part of the Key or Crest programs. Total number of patients was 448.

Source: Martin et al., *The Prison Journal* 79:294-320, 1999.

R.J. Donovan Correctional Facility participants in prison TC (Amity) and community-based TC aftercare (Vista)
Re-incarceration rates 12 months after prison release



Bars show the percentage of individuals re-incarcerated in the year following release from prison. Total number of participants was 715.

Source: Wexler et al., *Criminal Justice and Behavior*, 26:147-167, 1999.

better outcomes than those who dropped out in terms of avoiding both relapse to drug use and re-arrest. This study also highlights the value of continuing treatment of offenders during their transition back into the community.

Another study conducted in the R.J. Donovan Correctional Facility in San Diego, California, investigated the effect of the TC on criminal recidivism for inmates with drug problems. This study compared rates of re-incarceration and time until re-incarceration for those randomly assigned to a prison-based TC (the Amity program) to rates for a no-treatment control group. After prison, some who completed the Amity program chose to enter Vista, a community-based TC aftercare program designed to complement and continue the prison program's curriculum. Those who benefited most were the individuals who continued and completed treatment in Vista.

Similar outcomes were found at 3 years after release from prison. Only 27 percent of those completing Vista treatment had been returned to custody, compared to 75 percent of the no-treatment controls. Among those who were re-incarcerated, the amount of exposure to treatment was significantly related to the number of days until return to custody, with greater treatment exposure related to a longer time until re-incarceration.

Persons living with HIV/AIDS

Several studies have shown that the TC can be effective in caring for HIV-infected substance abusers and in modifying risk behavior to reduce HIV transmission. In the late 1980s, when AIDS was considered a terminal illness, several approaches to modifying the TC were developed to provide a comprehensive, multilayered therapeutic milieu addressing the multiple problems of individuals with HIV/AIDS.

One such model in New York merged modified TC principles with nursing home standards of medical and psychiatric care to improve physical and psychological health. This model has evolved in step with advances in treatment for AIDS. Another modified TC model in San Francisco was designed to engage HIV-infected persons in treatment, retain them, and link them to appropriate medical, psychiatric, and other social services. The modifications to this TC included providing these individuals with accelerated entry into the program, a more comprehensive assessment, a higher ratio of professional mental health and medical staff, and greater attention to staff issues such as stress, grief, and burnout.

Several studies have found that TC treatment reduces HIV risk by reducing injection drug use. Length of treatment, an important predictor of drug use outcomes, may also be important in reducing some HIV risk behaviors. In a study conducted in San Francisco, reductions in injection drug use and risky sexual practices were found for both a traditional TC and a modified day-treatment TC. The longer the person was in treatment, the less likely he or she was to engage in risky behaviors.

How else can therapeutic communities be modified?

More recently, research efforts have sought to determine how to modify TCs to accommodate the realities and constraints of a managed care health environment. Major adaptations being tested include the impact of shorter lengths of stay and the use of a day treatment model.

Shorter lengths of stay

Originally, the TC was envisioned as an alternative community that had no specific length of stay. As the TC developed into a mainstream treatment modality and external pressures emerged to manage treatment resources more efficiently, the expected length of treatment became shorter—first to around 24 months and now to around 12 months.

One study compared two TCs differing in the length of residential stay. The planned treatment duration was 12 months in each program, but one was designed as a 9-month residential/3-month outpatient program and the other was a 6-month residential/6-month outpatient phase. No statistically significant differences in outcomes were found between these treatment designs, except that the program with the 9-month residential phase produced better employment outcomes. However, successful outcomes depended more on completing both phases of the programs than on the length of the residential phase.

The day treatment TC

The day treatment TC is less intensive than residential TC treatment but more intensive than the typical outpatient drug treatment program. Day treatment TCs employ a community approach and the principles of mutual self-help. They can be helpful in preparing a person for entry into a residential program or may serve as a "step down" modality after the residential phase is complete. Day treatment TCs can also provide comprehensive, self-contained treatment for those who may not need residential care.

In a study comparing a day treatment TC with a traditional residential TC, the day treatment TC produced outcomes comparable to the traditional TC, including reduction in alcohol and drug use and improvement in many problem areas. Possibly because of poorer retention rates, the day treatment program was not as successful as the traditional TC with those who had severe social and psychiatric problems. The traditional residential TC also had better outcomes for employment, an area heavily emphasized in most residential TC program. However, for those with less severe mental health and social functioning problems, the day treatment TC may be more cost-effective.

Resources

NIDA

General Inquiries: NIDA Public Information Office, 301-443-1124

Inquiries about NIDA's treatment research activities:

- **Division of Treatment Research and Development, 301-443-6173**
- **Division of Epidemiology, Services, and Prevention Research, 301-443-4060.**

www.drugabuse.gov

Center for Substance Abuse Treatment (CSAT)

CSAT, a part of the Substance Abuse and Mental Health Services Administration, supports treatment services through block grants, disseminates findings to the field, and promotes their adoption. CSAT also operates the National Treatment Referral Hotline (1-800-662-HELP). CSAT publications are available through the National Clearinghouse on Alcohol and Drug Information (1-800-729-6686). *www.samhsa.gov/csat*

National Clearinghouse on Alcohol and Drug Information (NCADI)

NIDA educational resources on drug addiction treatment and publications from other Federal agencies are available from this source. Staff provides assistance in English and Spanish and has TDD capability; call 1-800-729-6686. *www.health.org*

National Institute of Justice (NIJ)

NIJ supports research, evaluation, and demonstration programs on drug abuse in the contexts of crime and the criminal justice system. For information and publications, contact the National Criminal Justice Reference Service at 1-800-851-3420 or 301-519-5500. *www.ojp.usdoj.gov/nij*

Therapeutic Communities of America (TCA)

TCA is an association of member organizations that advocate for and promote understanding of TCs. TCA increases knowledge of the TC philosophy and methodology; develops and promulgates standards of quality for TC programs and practitioners; provides members with information, networking, and forums to promote the TC methodology; and creates a supportive atmosphere for members in their individual efforts and national representation. For more information, call 202-296-3503. *www.tcanet.org*

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- Publications and communications (including *NIDA NOTES*)
- Calendar of events
- Links to NIDA organizational units
- Funding information (including program announcements and deadlines)
- International activities
- Links to related Web sites (access to Web sites of many other organizations in the field)

NIDA Web Sites
www.drugabuse.gov
www.marijuana-info.org
www.steroidabuse.org
www.clubdrugs.org

NCADI
Web Site: www.health.org
Phone No.: 1-800-729-6686

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