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Therapeutic Communities Research Report

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What Are Therapeutic Communities?

Therapeutic communities (TCs) are a common form of long-term residential treatment for substance use disorders (SUDs). Residential treatment for SUDs emerged in the late 1950s out of the self-help recovery movement. Some such groups evolved into self-supporting and democratically run residences to support abstinence and recovery from drug use (Sacks & Sacks, 2010). Examples have included community lodges, sober houses, and TCs. During the 1960s, the first generation of TCs spread throughout areas of the United States, and today the TC approach (see "What is a Therapeutic Community's Approach?") has been adopted in more than 65 countries around the world (Bunt et al., 2008).

Historically, TCs have seen themselves as a mutual self-help alternative to medically oriented strategies to address addiction and most have not allowed program participants to use medications of any kind, including medications such as methadone (a long-acting opioid agonist medication shown to be effective in treating opioid addiction and pain) (De Leon, 2000; De Leon, 2015). Over the past 30 years, TCs' attitudes toward medications have gradually evolved, reflecting changing social attitudes toward addiction treatment and the scientific recognition of addiction as a medical disorder (De Leon, 2000; De Leon, 2015; Vanderplasschen et al., 2013). A growing number of TCs now take a comprehensive approach to recovery by addressing participants' other health issues in addition to their SUDs, incorporating comprehensive medical treatment (Smith, 2012) and supporting participants receiving medications for addiction treatment or for other psychiatric disorders (see "How Are Therapeutic Communities Adapting to the Current Environment?"). Many of today's TCs are also offering shorter-term residential or outpatient day treatment (De Leon, 2012; De Leon & Wexler, 2009) in addition to long-term residential treatment.

TCs have also been adapted over time to address the treatment needs of different populations. During the 1990s, modified TCs emerged to treat people with co-occurring psychiatric disorders, homeless

individuals, women, and adolescents (De Leon, 2010; Sacks et al., 2004b; Sacks et al., 2003; Sacks & Sacks, 2010; Jainchill et al., 2005) (see "How Do Therapeutic Communities Treat Populations with Special Needs?"). Also, as the proportion of offenders with SUDs rose during the same period, correctional institutions began incorporating in-prison TCs (often in separate housing units), and TCs are available for people re-entering society after prison with the goal of reducing both drug use and recidivism (Wexler & Prendergast, 2010) (see "How Are Therapeutic Communities Integrated into the Criminal Justice System?").

Initially, TCs were run solely by peers in recovery. Over time and in response to the changing needs of participants, many TCs have begun incorporating professional staff with substance abuse counseling or mental health training, some of whom are also in recovery themselves. Today, programs often have medically trained professionals (e.g., psychiatrist consultants, nurses, and methadone specialists) as staff members, and most offer medical services on-site (Dye et al., 2012; Perfas & Spross, 2007). According to a national survey of these programs, more than half of TC staff members are in recovery (Dye et al., 2012), and many have earned certification in addiction counseling or bachelors- or masters-level degrees.

What is a Therapeutic Community's Approach?

Therapeutic communities (TCs) have a *recovery* orientation, focusing on the whole person and overall lifestyle changes, not simply abstinence from drug use. This orientation acknowledges the chronic, relapsing nature of substance use disorders (SUDs) and holds the view that lapses are opportunities for learning (Vanderplasschen et al., 2013; De Leon, 2012). Recovery is seen as a gradual, ongoing process of cognitive change through clinical interventions, and it is expected that it will take time for program participants to advance through the stages of treatment, setting personal objectives along the way.

A recovery orientation is different from an *acute-care* model, which focuses on interrupting drug use and helping the patient attain abstinence during treatment episodes rather than overall lifestyle change (Vanderplasschen et al., 2013; De Leon, 2000; Sacks et al., 2008b; Perfas & Spross, 2007; De Leon, 2012). TCs encourage participants to examine their personal behavior to help them become more pro-social and to engage in "right living"—considered to be based on honesty, taking responsibility, hard work, and willingness to learn (De Leon, 2000; De Leon, 2015; Vanderplasschen et al., 2013; Vanderplasschen et al., 2014; Bunt et al., 2008; Dye et al., 2009). As program participants progress through the stages of recovery, they assume greater personal and social responsibilities in the community. The goal is for a TC participant to leave the program not only drug-

free but also employed or in school or training. It is not uncommon for program participants to progress in their recovery to take on leadership and staff roles within the TC.

Following the concept of "community as method," TCs use active participation in group living and activities to drive individual change and the attainment of therapeutic goals (Dye et al., 2009; Dye et al., 2012; Vanderplasschen et al., 2013; Vanderplasschen et al., 2014; Bunt et al., 2008). With an emphasis on social learning and mutual self-help, individual participants take on some of the responsibility for their peers' recovery. This aid to others is seen as an important part of changing oneself (De Leon, 2000; De Leon, 2015; Sacks et al., 2012a).

Another implication of the recovery orientation is that it is recognized that people will need options for ongoing support once they complete residential treatment at the TC to promote a healthy drug-free lifestyle and help them avoid relapsing to drug use (Hendershot et al., 2011). Relapse prevention is a part of many addiction treatment programs, aiming to increase awareness and build coping skills both to reduce the likelihood or frequency of relapse and its severity if and when it does occur. As they move toward completion of a TC program, participants are aided in connecting with formal aftercare and self-help groups in the community. This approach is consistent with care coordination, a highly emphasized component of health care reform.

Are Therapeutic Communities Effective?

Overall, studies find that therapeutic community (TC) participants show improvements in substance abuse, criminal behavior, and mental health symptoms; this is especially true of participants who enter treatment with the most severe problems (De Leon, 2010; Vanderplasschen et al., 2013).

Source: Hubbard et al., 2003.

Text description of graphic

The largest long-term outcome study of addiction treatment interventions to date was the NIDA-sponsored Drug Abuse Treatment Outcome Studies (DATOS), which examined the effectiveness of several types of drug abuse treatment programs in the United States, including TCs, methadone maintenance, outpatient drug-free treatment, and short-term inpatient programs. DATOS found TCs to be effective. Participants who showed improved behavior after 1 year continued do so after 5 years, which was also true of the other modalities studied(Hubbard et al., 2003).

Length of time in treatment was found to be important for TCs, as well as for other modalities. Participating for at least 3 months was associated with better outcomes at 1 year—a finding that is consistent with other research showing the importance of treatment duration. At the 5-year follow-up, TC participants showed significant improvements compared with the year before entering treatment, which was also true for methadone maintenance and outpatient drug-free treatment. Participants from all three treatment groups had reduced prevalence of weekly or more frequent cocaine use by 50 percent, decreased illegal activities by 50 percent, and increased full-time employment by 10 percent compared with the year before entering treatment. Among DATOS participants in TCs, better 5-year outcomes (such as reduced cocaine, marijuana, and problem alcohol use and illegal activity and increased full-time employment) were associated with remaining in treatment for 6 months or longer.

Research indicates that TCs modified for prisoners and people with co-occurring disorders are effective (see "How Do Therapeutic Communities Treat Populations with Special Needs?" and "How Are Therapeutic Communities Integrated into the Criminal Justice System?"). Participants with less severe problems participating in outpatient or day treatment at TCs also show increased positive outcomes (e.g., for social problems and psychiatric symptoms)(De Leon, 2010).

Studies consistently find a relationship between duration of treatment in a TC (i.e., retention) and aftercare participation and subsequent recovery (De Leon, 2010; Vanderplasschen et al., 2013). Dropout is a concern with all treatments for addiction, and TCs are no exception. Dropout is most likely during the first few months of treatment (Vanderplasschen et al., 2013).

What are the Fundamental Components of Therapeutic Communities?

According to therapeutic community (TC) theory, substance use disorders (SUDs) often erode social functioning, education/vocational skills, and positive community and family ties. Thus, recovery involves *rehabilitation*—relearning or re-establishing healthy functioning, skills, and values as well as regaining physical and emotional health. Some TC participants have experienced highly disordered lives and may never have acquired functional ways of living. For these people, the TC may be their first exposure to orderly life, and recovery for them involves *habilitation*—learning for the first time the behavioral skills, attitudes, and values associated with functional and healthy living.

TCs use a highly regulated daily regimen with clearly stated expectations for behavior and psychological and behavioral rewards (e.g., praise and increasing status in the group) for working hard and meeting expectations. TCs also focus on empowering individuals by highlighting the strengths of program participants. Disciplinary sanctions for violations help to maintain structure for TC participants and staff and ensure that participants' lives are orderly and productive.

Routines include morning and evening house meetings, job assignments, group sessions, seminars, scheduled personal time, recreation, and individual counseling. Work is a distinct component of the TC approach.

Each participant is assigned particular tasks or jobs that help teach responsibility and the importance of work, respect, and self-reliance. Vocational and educational activities occur in group sessions and provide work, communication, and interpersonal skills training.

A primary component of the TC is "community as method"—people live drug-free together in a residential setting in the community (although sometimes TCs are in prisons or shelters). Living in a TC with others who are engaged in self- and mutual-help is seen as a mechanism for changing their overall lifestyle and identity (De Leon, 2000; De Leon, 2015). In the TC, all activities and interpersonal and social interactions are considered important opportunities to facilitate personal change. Positive peer communications in a mutual-help environment also may be an important part of the therapeutic process (Warren et al., 2013b). A key element of living in a TC and the mutual-help process is the development of social networks through positive social interactions and bonding that can offer support

during treatment and after an individual leaves the formal treatment environment.

Because TCs emphasize social learning, participants form a hierarchy within the group. Those who have made progress in changing their attitudes and behaviors serve as role models for "right living" and help others who are in earlier stages of recovery (Perfas & Spross, 2007). For example, they offer "pull-ups"—very specific feedback on a behavior that a community member needs to change because it is not considered proper conduct. One study found that TC participants who conveyed more pull-ups to peers and reciprocated this type of feedback were more likely to graduate from treatment (Warren et al., 2013a).

TC activities—including group discussions with peers, individual counseling, community-based learning through meetings and seminars, confrontation, games, and role-playing—are a central part of the mutual-help process. Community meetings (e.g., morning, daily house, and general meetings and seminars) review the goals, procedures, and functioning of the TC. Individual and group work in TCs (including encounter groups and retreats) focus on changing negative patterns of thought and behavior and on building self-efficacy so participants learn to think of themselves as the primary drivers of their own change process (De Leon, 2010; Sacks et al., 2012a). TC participants are encouraged to be accountable for their behaviors and to set goals for their own personal well-being, positive participation in the broader community, and life after leaving treatment. An important therapeutic goal is to help people identify, express, and manage their feelings in appropriate and positive ways. In group activities, participants focus on behaving in ways that are acceptable in the TC community rather than how they behaved in the past.

How Is Treatment Provided in a Therapeutic Community?

Therapeutic community (TC) participants advance through three treatment stages on the way to completing the program (Bunt et al., 2008; Perfas & Spross, 2007; Dye et al., 2012). In the first stage, the individual assimilates into the TC and is expected to fully participate in all activities. Immersion into this drug-free community is meant to disrupt the individual’s identification with and ties to his or her previous drug-using life and replace these affiliations with new pro-social attitudes, behaviors, and responsibilities, and increase his or her knowledge about the nature of addiction.

The second treatment stage often incorporates evidence-based behavioral treatments—including cognitive-behavioral therapy (CBT) and motivational interviewing—to facilitate the process of change and enhance the "community as method" approach (De Leon, 2000; De Leon, 2015). The overall goal is to change attitudes and behavior, instill hope, and foster emotional growth, including self-management ability. Other therapeutic activities, including relevant interventions, address the person's social, educational, vocational, familial, and psychological needs. (For more information about approaches to addiction therapy, see Treatment.)

CBT is a form of psychotherapy that teaches people strategies to identify and correct problematic behaviors in order to enhance self-control, stop drug use, and address a range of other problems that often co-occur with them.

Motivational interviewing is an evidence-based treatment and counseling style that helps patients explore and resolve ambivalence about changing their behavior in a focused and goal-directed way.

"Community as method" is an essential and defining approach of TCs in which participating in a mutual-help community drives individual change and the attainment of therapeutic goals.]

In the third treatment stage, the participant prepares for separation from the TC and successful re-entry into the larger community by seeking employment or making educational or training arrangements with the TC's help. Because recovery is an ongoing process, aftercare services such as individual and family counseling are arranged to help individuals maintain the changes they have made during treatment, and TC participants are strongly encouraged to continue work in self-help groups after completing the program.

Historically, participants stayed in a TC for as long as they needed to progress through these treatment stages—typically, 18 to 24 months. In recent years, funding and insurance limitations have reduced the length of stay in many areas of the country to treatment durations of 3, 6, or 12 months (De Leon & Wexler, 2009). However, research clearly demonstrates that longer time in treatment is associated with better outcomes (De Leon, 2012) (see "How Are Therapeutic Communities Adapting to the Current

Environment?"). For example, individuals who have participated in a TC for a minimum of 90 days fare better than those in therapy for shorter periods (Simpson, 1981).

TC programs have responded to the changing health care landscape by enhancing their continuum of services, ranging from engagement to residential treatment to continuing care post-treatment. TCs often adjust their services as needed by matching various treatment options to problem severity, adjusting therapeutic goals to the planned duration, and combining residential and outpatient components to give participants the necessary time in treatment (De Leon, 2012).

How Do Therapeutic Communities Treat Populations with Special Needs?

As the demographics of people seeking treatment for substance use disorders (SUDs) have shifted, therapeutic community (TC) programs have adjusted to respond to participants' needs (De Leon, 2012). Today's TCs involve people with co-occurring mental health problems, youth (both those who are involved in the juvenile justice system and those who are not), individuals who are homeless, and those in the criminal justice system. During the 1990s, some organizations developed modified TCs that were at the forefront of addressing the special needs of these populations (Sacks et al., 2004a; Sacks et al., 2004b; Sacks & Sacks, 2010; Jainchill et al., 2005).

People with psychiatric comorbidities

Survey research suggests that 50 to 70 percent of participants in substance abuse treatment have more than one SUD and at least one other psychiatric disorder (Dye et al., 2012). Historically, substance abuse treatment has often failed to address these co-occurring disorders. However, increasing recognition of the high prevalence of psychiatric comorbidities among those with SUDs (and vice versa) and evidence that people with comorbidities have worse outcomes (Van Stelle et al., 2004) have prompted more addiction treatment organizations to address these co-occurring problems with integrated care (Sacks & Sacks, 2010; Sacks et al., 2008a; Perfas & Spross, 2007).

TCs for individuals with co-occurring substance use and mental disorders are designed for participants with the most severe mental illnesses—schizophrenia and other psychotic disorders, bipolar disorders,

and major depression (Sacks & Sacks, 2010). The current standard of care is to treat substance use and mental health disorders simultaneously, and many TCs offer mental health services on-site. Program participants are taught about mental illness, how it influences substance use and dependence, the process of simultaneous recovery from both substance use and mental disorders (dual recovery), and how to access mental health and social services in the community (Sacks et al., 2008a). Individuals receiving prescribed psychiatric medications are given the necessary monitoring and case management.

A review of four studies on TCs for people (902 in total) with co-occurring, mostly severe mental illnesses found that these individuals had better outcomes compared with those who received standard care, including greater improvements in substance use, mental health, crime, HIV risk, employment, and housing outcomes (Sacks et al., 2008a).

Homeless individuals

The problems of SUDs, mental illness, and homelessness often overlap. Some TCs have adjusted their programs to meet the particular needs of people who are homeless and have co-occurring mental and substance use disorders. These programs offer meetings and activities of shorter duration and provide more hands-on involvement from staff. Information about mental illness, SUDs, and other relevant topics is presented gradually and explained thoroughly, and there is a greater emphasis on assisting program participants (Skinner, 2005).

People with these co-occurring problems who had completed residential TC treatment (12 months, on average) in addition to aftercare in the form of a supportive-housing program with the TC approach showed better outcomes than those who did not participate in the housing program (Sacks et al., 2003). In supportive housing, people live in various community settings (group homes, apartments, and single rooms) and have access to counseling support and social services. Counselors provide assistance, conduct relapse-prevention groups, and offer individual therapy and case management; staff members help participants access day treatment, dual-recovery services, and self-help groups.

During residential TC treatment, homeless participants demonstrated reduced drug use and crime and maintained these gains during the supportive-housing aftercare program. Participants also showed steady improvements in psychological functioning and employment gains during both residential TC and aftercare and demonstrated significantly better outcomes than those who did not receive supportive housing (Sacks et al., 2003).

Women

Women with SUDs have a higher risk of depression or other mental health disorders, low self-esteem, criminal involvement, homelessness, a history of trauma (including from sexual abuse, sexual assault, and domestic violence), involvement in the sex trade, and HIV than men with SUDs (Covington & Bloom, 2006; Cooperman et al., 2005). They may also have minimal access to much-needed medical, mental health, and social services and lack marketable job skills and family support (Covington & Bloom, 2006). Both substance abuse and homelessness can lead to loss of child custody (Sacks et al., 2004b), and women may be mandated by the court to receive treatment or voluntarily seek therapy in response to this possibility.

Women-only and mixed-gender TCs offer integrated mental health, substance abuse, educational, vocational, legal, and housing placement services that seek to address women's complex needs. Such programs generally place less emphasis on confrontation as a therapeutic tool (Sacks et al., 2004b, 2012a); they usually also provide services such as child care or child development centers. Goals are established to specifically focus on the relationship between the mother and her children. This can include improving awareness of parenting behaviors, developing problem-solving skills, understanding developmental stages, enhancing communication and emotional expression with children, and improving skills to address children's behavioral problems. For those who have lost child custody, staff work with the mother to prepare for family reunification, assist with arranging for visitation, and help with navigating the child protective services system (Stevens et al., 1997).

Women are also more likely to need therapy to address the multiple traumas, such as physical, sexual, and emotional abuse, that they have experienced (Sacks et al., 2004b). Seeking Safety, an evidence-based practice aimed at treating trauma-related problems and substance abuse, is implemented in some TCs. Women in such programs learn behavioral skills for coping with trauma and post-traumatic stress disorder. For example, lessons include how to set boundaries in relationships, engage in self-care, deal with emotional pain, and make healthier life choices.

As with men, women with SUDs are often incarcerated (see "How are Therapeutic Communities Integrated into the Criminal Justice System?"). Female inmates have higher rates of co-occurring mental disorders and exposure to physical and sexual abuse than their male counterparts (Sacks et al., 2012a). Prison is an opportunity to address their substance use and other behavioral problems (e.g., recovery from trauma, lack of employment skills, and need for parenting education) in a gender-

sensitive way. In addition to standard TC components for offenders of both sexes, gender-sensitive therapeutic approaches for women inmates enhance understanding of female roles and relationships and how they tie in with drug use.

Women with SUDs who participated in gender-sensitive, prison-based TC treatment demonstrated significantly better drug use and criminal activity outcomes a year after release than those in a comparison group who received CBT (Sacks et al., 2012a). They also demonstrated reduced exposure to trauma, improvements in mental health functioning, and a longer time (20 days) until re-incarceration compared with those who received CBT. Another study of women mandated to a TC found that participants who completed treatment had reductions in various measures of substance use; decreased incidences of risky sexual behaviors associated with drug use (which increases risk for sexually transmitted diseases), such as unprotected sex, sex trade, and sex with multiple partners; and less reported relationship violence/conflict (Cooperman et al., 2005). A study of homeless women with SUDs and co-occurring disorders who participated in a TC for 12 months found improvement in mental health symptoms as well as better physical health. After a year of treatment in the TC, women assumed financial responsibility for more of their children compared with those who participated in a regular TC program (Sacks et al., 2004b).

Adolescents

Adolescence is a major window of vulnerability for trying drugs and developing SUDs. Most who develop an SUD start using substances by age 18 and develop their disorder by age 20 (Dennis et al., 2002). Most do not seek or receive treatment, however, and if they do, it is typically because they have been referred by the juvenile justice system.

The adolescent TC is a modification of the adult TC that addresses the specific needs of the adolescent participant, providing a comprehensive and "holistic" treatment approach that recognizes and attends to the developmental issues that adolescents face in treatment and in their daily lives. The adolescent TC is based on a self-help model that utilizes intense positive peer pressure, family involvement, an organized work structure, vocational/life-skills preparation, and individual introspection to challenge participants and equip them for a drug-free lifestyle (Jainchill, 1997; Jainchill et al., 2000; Edelen et al., 2007; Foster et al., 2010; Becan et al., 2015). Based on the outcomes of long-term efficacy studies with adolescents in TC settings, such programs now integrate evidence-based approaches—particularly motivational

enhancement and trauma-informed care—as well as alternative therapeutic practices like art therapy, yoga, and meditation (Rivard et al., 2003; Hawke et al., 2003; Foster et al., 2010). The overall focus of this integrated interdisciplinary approach is to intervene in substance use and behavioral health disorders and to assist the adolescent in the successful mastery of significant developmental tasks.

Similar to the adult TC model, adolescent programs incorporate phases or levels of treatment and a sanctions-and-rewards system. In this system, participants earn status and privileges contingent on their progress toward meeting and exceeding treatment milestones (Jainchill et al., 2000). These programs incorporate family, vocational/educational, medical, and recreational services throughout treatment. Adolescent TCs also address co-occurring mental health disorders and factors leading to criminal activity that may have precipitated involvement with law enforcement and court systems. Adolescent substance users who are admitted to TC treatment typically have experienced a wide range of other life problems. These include psychological issues—such as depression, mood disorders, and violent tendencies—as well as poly-substance use and involvement with the juvenile justice system (Jainchill et al., 2000; Perry & Hedges Duroy, 2004). In light of this, the adolescent TC therapeutic process necessarily involves features that are distinct from those suitable for adults (Edelen et al., 2007).

A critical therapeutic objective in adolescent TCs is cognitive restructuring, a process of altering the attitudes that underlie antisocial, unhealthy behaviors—such as thinking that aggression is the only way to solve a problem or acting out to deal with difficulties—and replacing them with attitudes that support personal responsibility and pro-social behaviors (Jainchill et al., 2005). The integration of life-skills development (e.g., through participation in art therapy, vocational education, and a 12-step program) is paramount to accomplishing this, as these skills support pro-social adolescent development (Aromin et al., 2008).

As with any population and substance abuse treatment modality, enhancing motivation and retaining adolescents in TC programs is critical. In NIDA-supported research, six adolescent TCs assessed the effectiveness of the Treatment Readiness and Induction Program (TRIP) for increasing treatment motivation and, ultimately, retention (Becan et al., 2015). Findings suggested that TRIP directly increased adolescents' problem recognition, which in turn increased the desire for help and treatment readiness—important aspects of therapeutic motivation.

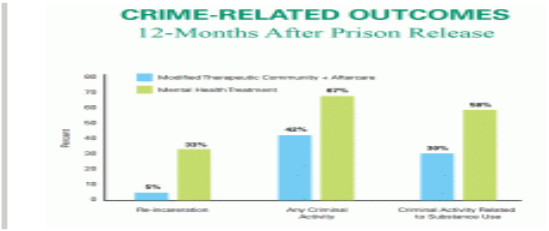
Several studies have suggested that TCs are successful in reducing substance use and criminal behaviors common among the adolescents who participate in these programs (Jainchill et al., 2000; Morral et al.,

2004; Perry & Hedges Duroy, 2004). In addition, TCs have been shown to help adolescents develop pro-social skills and learn to cope with family issues (Jainchill et al., 2005; Morral et al., 2004; Gordon et al., 2000).

How Are Therapeutic Communities Integrated into the Criminal Justice System?

More than half of U.S. prison inmates meet the criteria for a substance use disorder (SUD), a figure that is about five times higher than the general population (Belenko et al., 2013). Also, an estimated 4 in 10 offenders in state prisons across the country have been diagnosed with co-occurring substance use and psychiatric disorders (Sacks et al., 2012b). Integrating SUD treatment with criminal justice has been found to reduce recidivism and to be a cost-effective way to decrease substance use and improve related outcomes and public safety (Wexler & Prendergast, 2010).

Some prisons have incorporated therapeutic communities (TCs) modified for the special needs of offenders, and a growing number of community TC programs are providing aftercare for people released from prison (Wexler & Prendergast, 2010). TCs for offenders differ from other TCs in several ways (Wexler & Williams, 1986). As with all offenders, inmates participating in a TC must work during their incarceration. However, they also spend 4 to 5 hours each weekday in treatment (Sacks et al., 2004a), with an emphasis placed on living honestly, developing self-reliance, learning to manage their strong emotions (e.g., anger), and accepting responsibility for their actions (Wexler & Prendergast, 2010). The CBT elements of treatment concentrate on developing the participant's insight into how his or her perception (or perhaps misinterpretation) of events affects emotions and thoughts that justify criminal behavior. Ideally, therapeutic facilities are separate from the rest of the prison so participants in treatment can live together in a community based on mutual help. Treatment staff members, who include ex-offenders, act as role models and lead social learning activities. In-prison TCs emphasize role models to show "right living" and use peer influence to reinforce changes in attitudes and behavior.

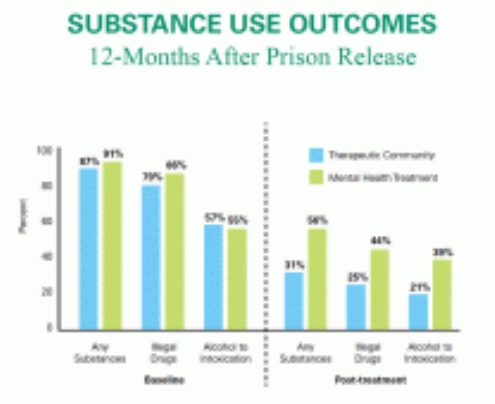


Source: Sacks et al., 2004a

Text Description of Graphic

Treatment also commonly addresses discharge planning to provide participants with the information they need to access community services upon release for finding housing, training, and treatment and generally facilitate re-entry into the community. The best outcomes are seen when inmates participate in community-based TC treatment during the transition from incarceration to community re-entry and continue care after discharge to prevent relapse and return to social connections and environments formerly linked to drug abuse and crime (Wexler & Prendergast, 2010; Prendergast et al., 2004).

A study of 715 male inmates in California randomly assigned either to a TC or to no treatment found generally high rates of re-incarceration within 5 years after prison release, but re-incarceration rates were lower among those who received TC treatment (76 percent) compared with no in-prison therapy (83 percent) (Prendergast et al., 2004). The study found no differences in heavy drug use or employment rates. Further analysis indicated that men who completed an aftercare TC program after release from prison showed lower rates of re-incarceration (42 percent) and higher rates of past-year employment (72 percent) compared with those who completed in-prison treatment but did not participate in aftercare (86 percent re-incarcerated and 56 percent past-year employment, respectively).

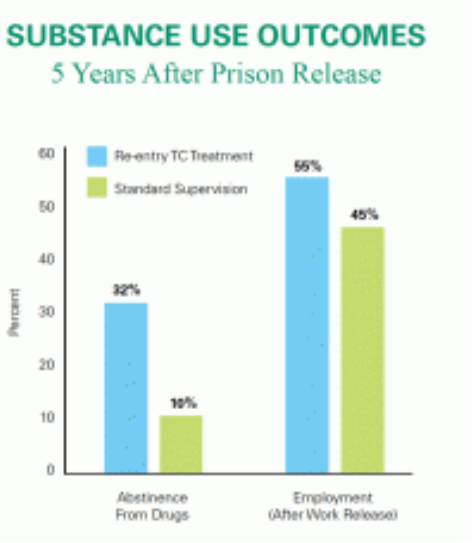


Source: Sullivan et al., 2007

Text Description of Graphic

In a Colorado study, male inmates randomly assigned to a 12-month TC designed for inmates with co-occurring disorders (some of whom chose to continue community-based TC treatment upon release) had lower rates of re-incarceration (9 percent) compared with those who received mental health treatment while in prison (33 percent), as well as greater declines in alcohol and drug use (Sacks et al., 2004a). Offenders who participated in both in-prison TC and aftercare demonstrated lower rates of re-incarceration, any criminal activity, and substance-related criminal activity than those who received mental health treatment. Men who relapsed during the year after prison release were four times more likely to re-offend compared with those who maintained abstinence from alcohol and drugs, 49 percent versus 19 percent, respectively (Sullivan et al., 2007).

Delaware's correctional system has a work-release program in which offenders receive a paying job in the community about 6 months prior to their release dates but must return to a work-release facility (or prison) when not at work. Compared with ex-offenders who received standard supervision during work-release, those who participated in a transitional TC for 3 months prior to 3 months in the work-release program showed higher rates of abstinence from drugs and employment (Butzin et al., 2005). During the 5-year period after prison release, offenders who participated in the transitional TC relapsed in an average of 28.8 months compared with 13.2 months among those who received standard supervision. The Delaware study has now extended the follow-up to 18 years after prison release, finding a persistent and strong reduction in new arrests among TC participants (Martin et al., 2011).



Source: Butzin et al., 2005

Research indicates that TC-based aftercare can improve the outcomes of offenders who have re-entered the community(Burdon et al., 2007), even when they have not participated in an in-prison TC (Sacks et al., 2012b). TCs can provide aftercare for ex-offenders in residential or outpatient modalities, and both have been shown to be equally beneficial (Burdon et al., 2007). Lower rates of re-incarceration are linked with longer duration (more than 90 days) of TC treatment (Sacks et al., 2012b).

How Are Therapeutic Communities Adapting to the Current Environment?

Provision of medications for addiction treatment

Generally, the adoption of medication for the treatment of opioid use disorders has been slow due to a variety of attitudinal and infrastructural barriers (Volkow et al., 2014). However, societal understanding of substance use disorders (SUDs) and mental illnesses as biological disorders has grown, and with that has come wider acceptance and use of medications in the treatment of addiction, including

maintenance treatments for opioid addiction using the opioid agonist and partial-agonist drugs methadone and buprenorphine. Detoxification from opioids without the support of medications has shown little success in reducing illicit opioid use (Fullerton et al., 2014). Randomized controlled trials (RCTs) of methadone maintenance treatment, particularly when dosage is managed appropriately, indicate that this medication has a positive impact—including improved treatment retention; reduced illicit opioid use; and decreased drug-related HIV risk behaviors, mortality, and criminality. A meta-analysis of RCTs suggested that methadone maintenance treatment appeared more effective than behavioral treatments in retaining patients in treatment and reducing heroin use (Mattick et al., 2003). RCTs of buprenorphine maintenance treatment strongly indicate that this medication improves treatment retention and reduces illicit opioid use compared with placebo (Thomas et al., 2014).

Because they viewed themselves as an alternative to medical treatment for addiction, therapeutic communities (TCs) historically held a strict no-drug policy, which extended to psychiatric medications and medications for addiction treatment (Perfas & Spross, 2007). As evidence has increasingly demonstrated that incorporating medications into treatment improves outcomes compared to behavioral treatment alone, a growing number of TC programs now accept patients receiving them or even incorporate medications in the treatment services they provide.

TCs supporting individuals receiving maintenance therapy with addiction medications educate both staff and participants about those medications to counter the misconception that they are a "crutch" (Greenberg et al., 2007), one of the attitudinal barriers historically impeding their wider adoption. Individuals on medications for addiction treatment participate in groups where they learn about their medications and the need to keep regular appointments once they return to the community.

Shortened planned treatment durations and outpatient programs

Until recently, TCs had no specific length of stay, following the belief that individuals should progress through the program at their own pace. However, the rising cost of health care and tightened budgets among public agencies have shortened lengths of stay in addiction treatment programs, putting pressure on TCs to limit long-term residential therapy (De Leon, 2012; De Leon & Wexler, 2009). Over the past two decades, expected stay length has shortened, initially to around 24 months, and now to 6 to 12 months (De Leon & Wexler, 2009; De Leon, 2010; Vanderplasschen et al., 2013). Financial constraints are now putting pressure on TCs to shorten planned treatment durations even further, although studies consistently show that

90 days is the minimum duration of treatment needed to realize long-term benefits (De Leon, 2010; Vanderplasschen et al., 2013).

Responding to health care reform

Public financing funds the majority of substance abuse treatment services, which is not true of general health care (Buck, 2011). Recent health care reforms such as Medicaid expansion, the Mental Health Parity and Addiction Equity Act, and the Patient Protection and Affordable Care Act (ACA) are expanding access to and coverage for substance abuse treatment for greater numbers of people. These changes, coupled with declines in state spending, are providing incentive for addiction treatment to integrate more with general medical care (Buck, 2011), provide more evidence-based treatments, and improve tracking of patient outcomes (Smith, 2012).

One aspect of the ACA presents potential opportunities, along with some challenges, to TCs. To improve access to health care for those who have been underserved and marginalized, health care reform guidelines recognize an organization that meets particular criteria as a Federally Qualified Health Center (FQHC or a "medical home," also called a "patient-centered medical home"). A TC that joins with a medical partner has an opportunity to become a FQHC if the collaborating organization can demonstrate the capability to provide integrated health care that includes both primary care and preventive services. A recent report describes the merger of Walden House (a well-established TC) with the Haight Ashbury Free Clinics to act as a medical home that provides integrated health care services for people with addiction, co-occurring disorders, and other problems (Smith, 2012). More research is needed on the effectiveness of these modified TC approaches, particularly in the context of health care reform and the changing addiction treatment landscape.

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Where Can I Get Further Information About Therapeutic Communities?

NIDA's website includes:

- Information on drugs of abuse and related health consequences
- NIDA publications, news, and events
- Resources for health care professionals, educators, and patients and families
- Information on NIDA research studies and clinical trials
- Funding information (including program announcements and deadlines)
- International activities
- Links to related websites (access to websites of many other organizations in the field)
- Information in Spanish (en español)

NIDA websites and webpages

- www.nida.nih.gov/related-topics/treatment
- researchstudies.drugabuse.gov
- irp.drugabuse.gov

For physician information

- NIDAMED: www.nida.nih.gov/nidamed

Other websites

Information on TCs is also available through the following:

- The Therapeutic Community (3-video set) by George De Leon: *The Therapeutic Community Perspective, Community as Method,* and *Components of a Generic Therapeutic Community* www.psychotherapy.net/video/george-deleon-therapeutic-community
- Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, TC Training Curriculum *(discontinued)*
- Treatment Communities of America (TCA)

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