Recovery-based Models: Professionalized Therapeutic Communities for Addictions

Document produced by Dianova International, in collaboration with Asociación Proyecto Hombre

Definition

- *"Strongly oriented towards mutual aid, the therapeutic community (TC) model is based on a method that pursues cognitive and behavioural change in the person with addictive disorders, and in which group therapy is a fundamental component. This model, which is constantly adjusted and revised, considers participants as essential actors of a community work designed to guide them towards processes of socialization, and identification and repair of damages through various protocols and pre-established stages. The ultimate goal of TCs is to achieve a full reintegration of people into society."* (De Leon, 2004).
- This method is presently known as a Recovery-oriented Integrated System, or ROIS, i.e. a systemic approach that emphasizes partnerships between community providers to coordinate treatment, aftercare and social services. (De Leon, 2007; McGregor, 2012; Best & Grushkova, 2014; Vanderplasschen, Vandevelde and Broekaert, 2014).
- Essentially, the theoretical bases integrated in the professionalized TC model include the biopsychosocial model (APH, 2015), the development of individual skills, especially those related to people's daily and emotional lives ("life skills"), and the empowerment of participants – all of these are addressed in a systemic manner.

Objectives: To address participants' addiction problems in an intensive and comprehensive fashion, with activities of a psychotherapeutic, occupational, socio-educational, and medical-health nature. To foster personal abilities, the development of social and emotional skills, social support, and social and vocational integration; and to enable participants to become self-fulfilled individuals and constructive members of society.

Basic Operating Principles

1. Addiction TCs are treatment facilities dedicated to the treatment of substance use disorders and other addictions, as an **integral part of the health care network**. TC programmes are usually, but not always, implemented in residential settings. Participants live in these facilities around the clock together with their peers. The personnel do not live on site, but some of their members must be in attendance on a 24-hour basis.

2. Each participant's length of stay is determined by the completion of individual objectives. In addition, **the duration of programmes** may also vary (depending on the countries where they are implemented and the resources available) from 3 to 12 months.

3. TCs were originally designed for people with addiction disorders having specific profiles, including: males, opioid users or polydrug users, people with judicial problems, or individuals with a psychosocial disruption. Despite the wide-ranging profiles found nowadays among people with addiction disorders, the TC model has sought to remain consistent. TCs are now adapted to a variety of profiles through such modalities as: gender-responsive programmes such as specific treatment programmes for women with a history of violence and/or sexual abuse, and programmes for women with dependent children. It is essential that these programmes be designed rigorously, and not based on economic or statistical criteria (assessment of profiles based on psychotherapeutic criteria).

4. **Admissions are on a voluntary basis**. It is however required from the person that they be somewhat motivated to achieve changes in their lives. No form of physical coercion or psychological pressure should ever be used and individual rights must be respected at all times. When participants are derived from the justice services, they may face legal consequences should they drop out from the treatment programme. However, residents are free to leave the TC at all times.

5. Professionalized TCs must fully comply with **human rights legislation and strict minimum standards for treatment quality** (such as the World Federation of Therapeutic Community – WFTC Standards and Goals, the WFTC Code of Ethics, the EQUA-R models for adolescents, and the UNODC International Standards for the Treatment of Drug Use Disorders, in whose design several TC-based organisations have participated).

6. TC staff should include a **multidisciplinary team** (psychologists, therapists, physicians, psychiatrists, social workers, educators, administrative assistants, as well as

programme graduates, i.e. people having successfully completed the treatment programme), whose members contribute to each resident's treatment process, based on their areas of expertise and/or experience.

7. Professionalised TCs offer a **holistic model of care**, including medical, pharmacological, and psychiatric aspects. These aspects may be provided directly by the TC's structure, or by the addiction care network of which the TC is a part. As regards pharmacological follow-up, residents should be given the same types of treatment as in other resources in the network (principle of equivalence), including the possibility of dispensing methadone or other drug substitution treatments (provided that they are authorized) to residents who fit the profile and are likely to benefit from them, under the same protocols and supervision criteria.
8. TCs can be **public, private, or publicly funded and managed by civil society organizations**. In all cases, they must be part of the addiction care networks and comply with the criteria and protocols established by public administrations, including any type of evaluation conducted by the authorities (Comas, 2010)
9. As integral models of care, TCs should not be considered as mere healthcare resources. TC-based interventions include **psychosocial and educational components**, as well as a marked **orientation towards social reintegration** (especially towards employability). None of these components predominates and all are equally important for the treatment process.

TC Programmes

TC-based addiction programmes are manifold and include the following:

- Residential treatment programmes for adults over 40 years of age, opioids or polydrug users,
- Treatment programmes for minors with severe behavioural problems and other problems arising from addictive behaviours,
- Treatment programmes for women with or without dependent children, and/or pregnant – programmes are gender-sensitive and interventions are customized to better fit each of these women's individual needs,
- Integral treatment programmes for beneficiaries with dual pathology, i.e. patients who simultaneously have an addiction and a mental health disorder,
- Prison-based addiction treatment programmes and aftercare services,

- Treatment programmes for non-substance related disorders, especially those involving behavioural, cognitive, and emotional disruption,
- Programmes for families, especially solution-oriented intervention programmes of short duration and support groups for family members.

Relationship with other Addiction Services

TC-based interventions are a further step in the treatment process of people with substance use disorders and other addictions. These interventions may precede or be followed by other processes, including harm reduction programmes, and reintegration services, across a continuum of care. For this reason, it is essential to implement a coordinated networking system between the different resources involved in matters of addiction treatment and follow-up. In addition, it is also necessary to coordinate with other involved parties (justice system, employment bureaus, housing and health services, etc.) in order to establish an adequate technical coordination with social networks.

TCs address intensively and tangibly such functional goals as self-reliance and comprehensive activity. In that sense, recovery-based models are particularly relevant, since they allow for genuine training on life skills (schedules, sleep, food, hygiene, housework, social skills, emotional skills, values, decision making, conflict resolution, social support planning, etc.).

A number of studies have endeavoured to carry out a long-term evaluation of the efficiency and social impact of therapeutic communities. According to European studies (notably in San Patrignano, Italy, and the Asociación Proyecto Hombre, Spain), TC interventions improve self-care behaviour, and social and emotional skills. In addition, they help reduce criminal activities, increase social support, and promote a more active participation of people in their communities. Recovery outcomes appear to be best among such populations as opioid users over 40 years of age, women (particularly in tailored programmes) and young people (in adapted programs, such as Dianova's early intervention programs). These findings are similar to those of studies conducted in professionalised TCs in North America and Australia in the late 20th and early 21st centuries.

Current Challenges

Professionalised TCs have encountered a series of challenges during the 21st century that need to be resolved in order to continue the process of recovery of people with addiction problems. These challenges are as follows:

- **Financing and sustainability of services.** In view of the economic crisis, governments are now inclined to develop services that are cheaper, although not always as professionalized or with the same level of service quality as that offered in TCs with a multidisciplinary staff and a residential setting. In addition, centres and programmes have to be financially self-sufficient so as to be able to fulfil their mission independently of political, administrative or other influences. Programmes should also continue to be based on technical criteria, and sustainability should not depend on any change made in these criteria.
- **TC effectiveness as an evidence-based model.** In the last ten years, research into recovery-based models, mediators and modulators, their results and cost-benefit assessment, has made significant progress. While further research is needed, the use of experimental or quasi-experimental methodology has made it possible to validate the professionalized TCs among these recovery-based models (De Leon, 2007; Grushkova, Best &White, 2012; Vanderplasschen, Vandevelde y Brockaerst, 2014).
- **Use of the term TC.** Non-professional treatment service providers and private clinics have appeared across the world, claiming to be therapeutic communities. Some of them, however, do not comply with the basic principles of recovery-based services and even operate in violation of human rights. These practices should be denounced and rooted out. Genuine professionalized TCs operate according to a structured, validated methodology and they comply with the standards and criteria established for efficient interventions targeting substance use disorders and other addictions. These standards have shaped the TC model for over 30 years, it is therefore essential to combat these practices and preserve deontology and people's rights (Comas, 2010).
- **Adjustment to crisis and emergencies.** The emergence of COVID has posed a huge challenge for the continuity of TC services, which have had to implement new safety, treatment, and admission protocols.

Links of interest

World Federation of Therapeutic Communities (WFTC)

WFTC Standards and goals for therapeutic communities

Latin-American Federation of Therapeutic Communities (FLACT)

European Federation of Therapeutic Communities (EFTC)

Treatment Communities of America (TCA)

Australasian Therapeutic Communities Association (ATCA)

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