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Pioneer Series

David Deitch, Ph.D. and George De Leon, Ph.D. on Recovery Management and the Future of the Therapeutic Community

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Introduction

This is the second in a series of articles profiling pioneers of modern addiction treatment. This article engages two leaders of the international therapeutic community (TC) movement. Dr. David Deitch is one of the most singular figures in the American TC movement and one of the few people whose career transcends the infancy, adolescence, and maturation of TCs around the world. Dr. George De Leon has spent a career conducting and publishing scientific studies of TCs and using the results of these studies to guide the evolution of the international TC movement.

Scientific studies and treatment systems performance data buttress the call to extend acute care models of intervention into severe alcohol and other drug (AOD) problems to models of sustained recovery management (RM) (See White, 2008 for a review). RM models of care focus on service activities across four stages of long-term recovery: 1) pre-recovery identification and engagement, 2) recovery initiation and stabilization, 3) sustained recovery maintenance, and 4) enhanced quality of personal and family life in long-term recovery. Acute care models have traditionally focused only on stage two.

Pilots of RM in the United States reveal substantial changes in mainstream clinical practices, including:

- assertive outreach and engagement, recovery priming, expedited access, and therapeutic engagement;
- improved (global, strengths-based, continual) systems of individual, family, and community assessment;
- an expanded multidisciplinary team that includes greater integration of primary medicine, addiction medicine, addiction psychiatry, and indigenous peer-based recovery support services;

- a shift in the service relationship from that of the hierarchy of the expert-to-patient encounter to that of a sustained recovery partnership model;
- enhancements in the scope, quality, and duration of addiction treatment, with an emphasis on continuity of contact over time in a primary recovery support relationship;
- broadened locus of service delivery, including home- and neighborhood-based service delivery and co-location within indigenous non-stigmatized service sites, e.g., health clinics, community centers, churches;
- assertive linkage of individuals and families to communities of recovery and new recovery support institutions, e.g., recovery homes, schools, ministries, industries, social clubs, etc.;
- an emphasis on post-treatment monitoring and support, stage-appropriate recovery education, and if needed, early re-intervention services for all admitted clients/families for up to five years following completion of primary treatment; and
- the systematic collection of long-term, post-treatment recovery outcomes for all clients/families admitted to addiction treatment programs (White, 2008).

The focus of recovery management is to proactively manage the prolonged course of addiction and recovery careers rather than focus on what all too often end up being serial episodes of biopsychosocial stabilization. The following discussion will explore the evolution of the modern TC and what the emerging philosophy of recovery management will mean for the future of the American TC and other residential programs that have been profoundly influenced by the TC movement.

The Evolving Therapeutic Communities

Bill White: David, let me begin by asking you to introduce yourself to our readers and summarize the birth and early evolution of therapeutic communities (TCs) in the United States as you witnessed it?

David Deitch: It's a delight to participate with you and George to reflect on the evolution of the therapeutic community. I come to this discussion with a lengthy history of over 60 years in the addiction world. My first education was regrettably my early use of heroin, which I began at the age of 15. In 1951, I was arrested for drug possession and entered addiction treatment at

the federal prison/hospital in Lexington, Kentucky (known as “the farm”). Upon release, I finished high school and became excited about learning, particularly philosophy and psychology. I continued sporadic college education amidst a continued cycle of relapse, crime, and arrest. I was unable to get it together in spite of multiple treatments. At each institution, I tried hard to understand what was wrong with me. I attended every group, had great and caring psychiatrists, but always relapsed upon my return home. Then in 1961, I left New York in search of a new rumored “cure” called Synanon in Santa Monica, California.

Synanon was the beginning of the American TC movement and my first exposure to peer-based mutual help. It had everything—a charismatic leader, colorful ex-cons, con artists, motorcycle gang members, great jazz musicians, liberated women. We (recovering addicts) did everything, including security. Everybody started at the bottom and earned their way up. It wasn’t a treatment program; it was an amazing community, and everyone contributed to its magic. Synanon was a new society that honored the outsider, played to the rebel. It was a place where we entered to get clean and ended up seeing ourselves as the heroes of a new movement. These were the days before Synanon evolved into a cult and eventually imploded.

Many of us who left before Synanon developed into such a closed community were called upon by different agencies to help start new therapeutic communities. Daytop Lodge was the first. The lead psychologist for the Brooklyn Department of Probation, Alex Bassin, and the Chief Probation Officer, Joseph Shelly, visited Synanon and embraced it as an answer to the growing heroin problem in New York. They sought funds from NIMH [National Institute of Mental Health] to place addicts on probation into a Synanon-like setting and recruited me to develop that program. In 1965, we, along with Monsignor William B. O’Brien, formed Daytop Village. Daytop Village marked a break from Synanon and set the model for future TCs in terms of acceptance of government funding, evaluation procedures, and external governance.

1965-1970 in New York was a breeding ground for TCs due in great part to the influence of Dr. Efren Raimirez, a psychiatrist recruited as New York City’s first “drug czar” by Major Lindsay. Efren, who had been trained in the Maxwell Jones TC model, persuaded me to use the term *therapeutic community* (TC) as a more scientific way to describe our method. Until that time, we had proudly used the term “A Humanizing Community.” Efren hosted regular meetings of key people interested in the treatment of heroin addiction. These meetings included Mitch Rosenthal, who developed Phoenix House; Judy Densen-Gerber, who founded Odyssey House; and a

young social worker, who helped create Samaritan Village. Within a few years, Daytop graduates went on to help build Gaudenzia in Philadelphia, Gateway in Chicago, Walden House in San Francisco, and Marathon House of New England. By the 1970s, a full fledged TC movement was spreading across the United States, Europe, and Asia. TC methods became more diverse across these different geographical, cultural, and political contexts. Since this period, I have had the privilege of observing and participating in the worldwide spread and evolution of the TC as a treatment for addiction.

Bill: Thanks, David. George, could you introduce yourself to our readers and add your thoughts on the early evolution of the TC movement?

George De Leon: As a jazz musician years before my career as a psychologist, I understood the drug problem through its impact on friends and fellow musicians, some of whom turned their lives around in Synanon. I had early contacts with Daytop Village and Synanon groups in New York, but my work in the TC movement began when Mitch Rosenthal asked me to bring my research skills to help in the development of Phoenix House circa 1967.

The powerful transformational effects of the TCs on individuals that I observed as a psychologist convinced me that the acceptance and advancement of this approach depended upon supportive research. Our first investigations were to understand the treatment process and are described in a now out of print volume (De Leon, 1974). However, research quickly shifted to establish the credibility of the TC through outcome studies. This resulted in a 1973 publication in the *Journal of the American Medical Association* of our initial report on the relation of time in the program to post-treatment reductions in criminality and drug use. The development of the TCs in general and research in particular led to the first national conference on TCs in 1976, funded by NIDA, which I coordinated. A conclusion in the *Proceedings* of that event appears prescient today in 2009:

The TC's evolution may be characterized as a movement from the marginal to the mainstream of substance abuse treatment and human services. Unlike its communal prototypes which have disappeared in history, the TC is a hybrid spawned from the union of a grassroots self-help movement and the rise of publicly supported addiction treatment. As a mainstream modality, today, the TC contains a profound and paradoxical threat—the loss of the unique self-help identity that has defined its success. (De Leon & Beschner, 1977)

Bill: What do you see as the most significant changes in the TC since its inception?

George: Today, the TC modality consists of a wide range of programs serving a diversity of patients who use a variety of drugs and present complex social-psychological problems in addition to their chemical abuse (see De Leon, 1997, 2008). Patient differences as well as clinical requirements and funding realities have encouraged the development of modified residential TCs with shorter planned durations of stay (3, 6, and 12 months) as well as TC-oriented day treatment and outpatient ambulatory models for cocaine and methadone maintenance clients. Correctional, medical, and mental hospitals, as well as community residence and shelter settings, overwhelmed with alcohol and illicit drug abuse problems, have implemented TC programs within their institutional boundaries. A wide variety of practices and interventions have been incorporated into the basic TC approach to address the diversity of client needs and profiles. These include, for example, pharmacologic adjuncts for substance abusers with serious non-drug psychiatric diagnoses as well as evidence-based non-medical interventions, such as motivational interviewing, relapse prevention training, cognitive behavioral strategies, and family therapies.

David: One of the most significant areas of change involves TC policies towards alcohol and the TC relationship with Alcoholics Anonymous (AA) and other community-based support groups. Dederich, Synanon's charismatic founder, deliberately distanced Synanon from AA and NA. Early members of the TC movement had no idea of the history, Steps, and traditions of these fellowships. Some early TCs developed drinking privileges that could be earned as one matured within the TC. But the reality was that alcoholism began to degrade and kill ex-addicts within the TC community who had influence, energy, and promise as future TC leaders. There was also a larger schism in the field in how alcoholics and opiate addicts were viewed—stereotypes that kept the fields separate for a number of years.

Coming to grips with alcohol as a TC issue and moving toward integrated treatment of multiple drug dependencies occurred at a time the TC was trying to define itself amidst powerful outside influences. Members who emerged as leaders (once public funding was part of the mix) then became staff. The concept of elders and change-agents slowly gave way to career paths and government regulation and demands for professional certification

and licensure. Present but dwindling was the belief that modeling recovery remained a critical component of the TC-guided process of recovery. The emergence of the TC as a professionalized movement in the 1970s was a painful process.

Bill: What was distinctive about the TC? What philosophies and practices historically separate the TC from all other addiction treatment modalities?

David: To begin with, the TC was, in its earliest stages, completely consumer driven. These consumers shaped its methods, philosophies, business practices, and pushed the whole person focus—different individuals' talents led to new activities, which were then incorporated into practice. Secondly, it remained unusually responsive to the “in the trenches” social problems that were becoming evident in the second half of the twentieth century. For example, TCs were on the front lines in working with HIV and AIDS in non-medical settings, and again, it used those very consumers to help guide and create services for this population. The same was true with homeless and then transgender populations. Each of these consumer groups helped construct services in the TC that were relevant to their needs.

Now admittedly, this adaptability can still be time and culture tied and as such, some TCs became rigid with outdated and questionable practices. This has created and continues to create both confusion and tension in the field. From the perspective of recovery-oriented treatment, the early TC format developed by consumers considered itself as the treatment plan, i.e., all people in it needed the same exact thing. Once it was considered a model deserving of funding, the funders demanded aspects of models they were familiar with—principally, the medical model—and as such, they wanted features such as treatment plans. While this was initially viewed with dismay, it led the way for new consumer driven adaptations like those mentioned above. The most lively and current adaptation is working with a wide variety of psychiatric co-occurring difficulties. This challenge has helped foster trans-disciplinary treatment plan development, which, unlike medical and other addiction treatment models (multi-disciplinary), always keeps the whole person front and center. Every person on the team, including other client members, is made aware of what problems are paramount (first things first) and brings appropriate attention to the problem. This has brought a re-evaluation of the TC's early rejection of medications and a change in the early view that so-called “psychiatric issues” were an excuse and cover for people to escape personal accountability.

George: Arguably, the therapeutic community for addictions (TC) is one of the first formal treatment approaches that is explicitly *recovery-oriented*. Surely, AA and similar mutual self-help approaches facilitate recovery, but these represent themselves as support, not treatment. Pharmacological approaches, notably, methadone maintenance, have historically defined their treatment goal as the reduction or elimination of illicit opiate use. Evidence-based psychological approaches, such as cognitive behavioral therapy (CBT), contingency contracting, and motivational enhancement (MET) focus upon reduction in targeted drug use. In the TC perspective, however, the primary goal of treatment is *recovery*, broadly defined as changes in lifestyle and identity reflected in abstinence from all non-prescribed drug use, elimination of social deviance, and development of pro-social behaviors and values (De Leon, 2000). Thus, what distinguishes the TC is its recovery-oriented perspective guiding a unique social psychological approach—community as method—which is designed to address changes in the “whole person.”

Bill: What changes in TC practices do you feel were positive stages of maturation of the TC, and what changes do you feel may raise concerns about the integrity of the TC model?

David: The TC model must remain open to new problems and to new or better ways of handling complex problems. We know more now than ever before, but there’s a lot more to learn. For example, the knowledge regarding brain adaptation to chronic drug use has helped us better appreciate craving and relapse. Reward seeking behavior is a fact of human existence and for many drug users, particularly those at end stage addiction, there are very few (if any) reward sources left but drugs. For this population in particular, any pharmacotherapy that can reduce craving is a step we must take to help open and sustain a recovery pathway.

The long standing myth that an intervention, regardless of model type or duration, can provide a “cure” is over. To gain social approval, acceptance, and funding, TCs had to both buy in to the claim that they (and usually only they) could provide “cures.” I think most treatment models, including the TC, now recognize that recovery does not occur as a result of the TC stay, but rather we are there to start the recovery process.

George: We’ve summarized above a number of broad developments in the evolution of the TC. However, advances in specific TC practices, though not

uniformly incorporated in all programs, mark the maturation of the TC as a sophisticated treatment approach.

As David mentioned, we have witnessed the inclusion of medications in the TC treatment regimen. The key development here is the gradual rapprochement between the TC “drug free” and the mainstream medically assisted/mental health perspectives. Examples include psychotropic medications for substance abusers with serious non-drug psychiatric diagnoses and the integration of buprenorphine and methadone into specially modified TCs. TCs have been adapted for the seriously mentally ill, adolescents, and juvenile justice and criminal justice clients and now incorporate evidence-based practices, which are relevant to the special needs of these populations. This reflects TCs’ growing respect for individual differences.

The earlier adherence to a rigid view of individual change is altered in contemporary TCs. There is, for example, more flexibility in discharge and readmission policies. Dropout is no longer viewed as clinical failure but as an issue of motivation, readiness, and suitability for TC treatment.

Family involvement has also dramatically changed within the TC. Contemporary TCs accept the importance of family/significant other involvement in the treatment of the client. They have incorporated a range of family therapy, education, and social activities aimed at sustaining client participation in treatment and enhancing family health.

It is also noteworthy that TCs have abandoned questionable and harsh practices, e.g., shaved heads, stocking caps, wearing signs or baby diapers, employing toothbrushes (for cleaning urinals). These were rationalized as useful strategies for some clients in addressing the immaturity and social deviancy features of their disorder. Such practices were largely abandoned by the 1980s and are now prohibited by policy in contemporary TCs. (It should be noted that while harsh practices were unnecessary and appropriately abandoned, there is no compelling statistical or clinical evidence that they resulted in harmful outcomes.)

Bill: Could you both elaborate on fears you have about this loss of integrity of the TC model?

David: My principal worry about TC as a model is that treatment business needs and escalating regulatory demands conjointly erode the model. We already have seen cost-efficiency motivation result in utilizing large facilities—200 and 300 bed institutions—which then, due to size and

logistic management, end up (as a result of efforts to find efficiency) sacrificing interactive healing methods because they take too much time.

George: The adaptation of the TC to serve special populations in special settings, the diversity of staff composition, and the utilization of evidence-based practices all illustrate the remarkable flexibility of the TC. However, this evolution has been at the expense of advancing the TC as a unique social psychological model. What I am stressing here are three interrelated negative developments: the incremental drift away from implementing essential elements of the TC model; the incorporation of evidence-based practices and social services to substitute for rather than enhance community as method, the primary treatment element; and specifically, the abandonment of research and clinical efforts to refine and improve community as method.

TC Research Findings

Bill: George, you have spent much of your career researching the effectiveness of the TC. What conclusions can be drawn from this research to date?

George: Over forty years of research has generated a considerable knowledge base concerning the effectiveness of the TC approach. The TC's role in initiating long-term recovery outcomes is documented by the *weight of research evidence* from multiple sources, including multi-modality and single program field effectiveness studies conducted worldwide that involve thousands of individuals followed up to 12 years post-treatment; statistical meta-analyses involving comparative studies; a small number of randomized control studies; and by indirect evidence from social psychological studies supporting basic elements of the TC model.

Significant numbers of admissions to TCs reveal positive outcomes in reduction of drug use, reduction of criminality, increased employment, improved psychological status and quality of life, and reductions in medical and mental health expenditures. These personal outcomes of TC involvement obviously have significant cost benefits to society. Retention in treatment is the most consistent predictor of TC outcomes. Generally, the longer the stay in treatment, the better the post-treatment outcomes.

The evidence is compelling that the TC is an effective *treatment* for a certain subset of substance abusers. Those who benefit most display severe profiles in terms of substance abuse and associated social and psychological problems. Treatment effectiveness with these difficult populations is

strongly associated with fidelity to the TC model. Fidelity can be maintained with standards for program certification, appropriate fidelity and quality assessment methods, relevant staff training models, and curricula, which result in credentialed TC professionals. Aftercare is also essential to the stability of treatment effects. As planned duration of residential treatment decreases, there is a necessary increase in the range of outpatient recovery-oriented treatment and social services that TCs are offering.

The above asserts that the TC approach is effective for certain substance abusers and does not claim superiority or cure. Moreover, dropout is the rule across the major treatment modalities and analogously, the rates of non-adherence to medications for diabetes and hypertension is similar to the dropout rate for substance abuse treatment (McLellan, Lewis, O'Brien, & Kleber, 2000). Further, the time in program effects for TCs are reported almost universally, which underscores positive outcomes for many who do not complete treatment or enter the field. The effectiveness of a treatment should not be confused with retention, which remains a general problem in health care.

David: I am also uncomfortable with the claim that one major addiction treatment modality is superior to another. There is little evidence to support this, and I think such claims feed the social expectation that one approach offers a better “cure” than another model. TC approaches have critical and important dimensions that do help a number of people and yet fail to help others—a point that is evident if we look at the TC retention rates. Those for whom the TC is ill-suited are voting with their feet. Many of George’s early studies include people staying clean as a result of their new social definition as helpers and the social status of the TC as a new modality—our early expansion years. The newly defined ex-addict staff didn’t pay much attention to those who left and in fact, condemned them as losers. We viewed ourselves as cured and failed to realize that the source of our recovery maintenance was the fellowship of mutual help and support that came from our sustained connection with the TC. The cure was such an important part of our belief that when relapses occurred, they were hushed up or denied.

While George and I agree on most things, especially those related to improving practices in TCs, I think it’s important to recognize how much TC outcomes and practices vary from program to program, particularly across American, European, Asian, African, and Latin American contexts. Furthermore, what is considered community as method (as powerfully delineated and written by George) was principally formulated on practices in

North America and from the early 70s and 80s when the TC movement was a new, romantic, and powerful political force in New York. George's work is far more sophisticated and aspirational than practices within far too many TCs that remain unproven and potentially harmful.

Thirdly, the characterization of the problem as a problem of the whole person is essentially derived from early TCs, which referred to the problem as "character disorder"—a new descriptor developed in the 60s as more enlightened than "weak moral character" or "sinner." But even this new term created a pejorative, dehumanizing, stigmatizing view of the person seeking help for addiction. It contributed to staff in TCs and other treatment modalities in the early 1970s treating individuals in their care with contempt and control—that "my way or the highway" attitude. Those tough tactics were congruent with "the kick in the butt" that so many in the culture saw addicts as needing. Eventually, the TC evolved five areas of focus that distinguished the TC from other modalities: 1) behavior shaping, 2) emotional and psychological life, 3) intellectual, spiritual, and ethical life, 4) vocational and social survival life, and finally 5) bio-medical activity.

Bill: What are the most important questions yet to be answered about the effectiveness of the TC?

George: David's comment raises a brief point of clarification. Early descriptions of the addict often referred to personality or character disorder. Diagnostic studies generally confirmed these descriptions in showing a prominence of Axis 2 categories, e.g., anti-social personality and to a lesser extent, narcissistic and borderline personalities. However, the term "whole person" was adopted to reflect the common clinical observation supported by research that substance abusers in TCs display a multidimensional disorder, including cognitive, emotional, and behavioral problems, all of which must be addressed to initiate a recovery process.

There is still skepticism among some critics concerning the cost benefit of the TC given the relative lack of randomized, double blind control trials. This and other related questions define a new research agenda for the TC. First, we need randomized controlled trial studies, but these must be guided by the complexity of the TC approach. Second, we need research on how to improve the TC in such areas as engagement and retention, accelerating clinical progress, and isolating the relative effectiveness of program elements. In particular, community as method is a powerful approach that needs to be better understood and refined to realize its potential. Third, research is needed on appropriate models for staff training

in the TC approach. The increase in traditional mental health, human services, and correctional professionals in TC staff compositions requires effective training models that assure fidelity in implementing community as method.

David: Unlike George, I do not think we have, as yet, TC research that thoroughly examines if length of stay matters. I think that without experimental design, random assignment, and controls, the model will still provoke skepticism. Permit me one example: most researchers have concluded (as has George) that a minimum dose of at least 90 days participation is necessary to create some recovery direction. If we closely examine TC retention across the board nationally, we see that by day 30, we generally have lost 25% to 30%; by day 90, 30% to 40%; and by 120 days, about 50%. The only exception to this that I know of is when LOS [length of stay] is clearly described as short-term treatment—where, to the best of my ability to rationalize, people stay longer because they can see light at the end of the tunnel. Yet most TCs behave as if their members are going to stay considerably longer and frequently plan treatment content and sequence on this paradigm. Secondly, even when mandated to care on an average of six months as we have seen in “in-custody” TCs across the nation, once the halo effect—of initial enthusiasm, new social work role, and definition for the first wave of treated “ex-cons”—waned, outcomes plummet.

My thinking is we need to seriously examine length of stay in the context of what is provided and when.

George: The relationship between retention and outcomes has been demonstrated in the major treatment modalities, including TCs, implying a “dose” related effect. In general, we can say that more is better. Also, clients mandated to community-based TCs show similar findings to “voluntary” clients, relating longer time to positive outcomes. The studies of prison-based TCs also support the time in program effects obtained in community-based populations. For example, completion of 9-12 months of prison-based treatment followed by 6+ months of TC aftercare in the community produces significantly reduced recidivism and drug use (see Special Edition: Drug Treatment Outcomes, 1999) compared to prison-based treatment alone. It is true that most completers of prison TCs do not elect aftercare, which underscores the importance of the above issues of motivation and engagement. Length of stay has always served as a proxy for dosage, that is, for time-correlated treatment activities. It is not time alone but engagement

in these activities that facilitates individual change (De Leon & Wexler, 2009).

Recovery Management and the TC

Bill: RM calls for the historical reversal of the decreased duration of treatment across levels of care sparked by an aggressive system of managed behavioral health care. Do you see a day when treatment dose is extended beyond what have been ever-shortened lengths of stay?

George: Reductions in planned duration of (residential) treatment in the early (acute) stages of recovery have resulted in extending the period of continuing care or aftercare. In the best cases, TCs have adapted to this change in several ways: formulating more realistic goals for the shorter time in primary residential treatment; better assessment of individual differences as to the need for residential treatment (matching), and developing firmer links with aftercare resources, including greater involvement with 12-step groups.

In a recovery-oriented framework, individuals learn to use the challenges of daily living in natural environments to advance incremental change in their recovery. The key issue for TCs is to prepare the individual for those challenges within shorter planned durations of primary treatment. This means that individuals obtain a “threshold dosage” of treatment to achieve early to mid stage recovery goals. These emphasize their commitment to utilize aftercare treatment as well as social and community resources of the system to facilitate their continued change process.

David: Depending on drug use and mental health severity, social and vocational resources are the key factors for us to consider in type of placement and initial duration. Regardless, what will count is the value of the exposure in terms of content and sequence—and this is best responded to by validated assessments that can measure needs and measure whether what we are practicing is actually effective.

Bill: A recovery advocacy movement emerged in the early 2000s that exerted a major influence on calls to shift addiction treatment toward a model of sustained recovery management (RM). These advocates argued that addiction treatment, through its professionalization and commercialization, had become disconnected from the larger and more enduring process of long-term recovery and that addiction treatment had

become too isolated from local communities. Do you feel those are apt criticisms of the modern TC?

David: I absolutely do think these criticisms are overdue and accurate. As I mentioned above, the claims for cure and uniqueness and supposed competitive gain meant that (early) TCs viewed themselves as a single event intervention (with regards to duration). The TCs fixed the problem. Early concepts of service, community building, fun, and vibrant alumni helping to sustain the TC were slowly lost. Careerists replaced “change agents.” Staff counselors replaced careerists, and licensing or certification and funder demands created commercialism. TCs were developed as alternatives to big costly bureaucratic institutions. They are now big businesses, highly bureaucratic, but still less costly—but something had to go: service to community, humility, time consuming interactive healing practices, and a good bit of “counselor” enthusiasm as those on the front line became inundated with management and regulatory demands.

The recovery movement is timely, necessary, and has already provided a boost to TCs fortunate enough to work in proximity to active recovery management groups.

George: A disconnection from the recovery process by TCs is also evident but relates to broader issues that include the professionalization and commercialization of addiction treatment. In the evolution of the substance abuse treatment system, support has been inconsistent for recovery-oriented approaches in general and for TC programs in particular. This reflects policy and ideological issues that have disconnected the TC from the process of long-term recovery.

Funding pressures have dramatically reduced the *planned duration of treatment*, often below threshold levels of time needed to initiate a stable recovery process. This policy contradicts the science documenting the relationship between retention and recovery outcomes in both community and correctional TC studies.

The contemporary call for evidence-based *strategies* has focused upon treating specific behaviors such as drug use. This contrasts with evidence-based *programs* such as TCs, which are multi-interventional approaches designed to address the multidimensional “disorder of the whole person.”

The *fidelity* of TC programs has declined in part as a reaction to these various issues. Efforts to shorten program duration to treat serious abusers engenders less favorable outcomes; the incorporation of various evidence-based strategies (e.g., Cognitive-Behavioral therapy [CBT] or motivational

enhancement [MET]) while useful, has substituted for rather than enhanced the active ingredient of the TC *community as method*.

As TC agencies have strived to fit into mainstream medical/mental health/human services frameworks and to compete for and comply with contract requirements, regulations, and funding priorities, they gradually have drifted from their missionary goal to advance long-term recovery to that of managing disease.

Bill: Advocates of RM are calling for substantial changes in service practices within addiction treatment. Some of these recommendations have a historical mustiness about them. Do you see any of the early TC in these recommended changes?

David: I certainly see an enthusiasm, a zealotry, and emerging orthodoxy in its claims very much like early TCs. But that's okay; it's provoking new thinking for all of us.

George: I agree with David's characterization of the recovery phenomenon as similar to that of the early TCs. More specifically, TCs always stressed that sustaining recovery must include key elements, such as drug free peer networks for support and informal counseling, reintegration with healthy families, and constructive use of mental health and human services.

Bill: Perhaps we can further explore how some of the RM practice changes will affect the future evolution of the TC. Let's start with the issues of attraction and engagement. The RM model calls for assertive community outreach, lowered thresholds of engagement, and a focus on enhancing treatment retention rates. How do you see the status and future of American TC practices in these areas?

George: The RM approach must acknowledge the proposition that the population of substance abusers varies in severity of substance abuse disorder, psychological health, lifestyles, and habilitation. For certain subgroups of substance abusers, a residential 24/7 TC will be necessary to initiate a recovery process. For these individuals, the TC has struggled with the issues of attraction and engagement, particularly since it is viewed as a high demand treatment (which is appropriate for a high severity client). Admission and clinical practices have altered to increase early engagement with some modest success, e.g., motivational enhancement, provision of pharmacological adjuncts, reductions in planned length of stay, increased

flexibility in re-admission criteria, increased vocational training, and family involvement (including children with parents who are residents). Research is needed to further explore these and other engagement strategies.

For the future, lower demand TC-oriented programs in non-residential settings can target other subgroups of clients incorporating lower thresholds and other strategies for engagement. The objective in these (and all bona fide treatments), however, is to initiate a recovery process, which for some may result in their electing to enter higher demand residential TC programs.

David: The RM approach, as I mentioned above, is provoking wonderful discussions among those TCs. I am familiar with its creating “remember when” stories about the excitement when TCs did community outreach and engagement as well as community organizing but with a regrettably high threshold of admission at that time.

In many TCs already, tactics to promote better engagement and acceptance are occurring: broader and more flexible policies regarding lapse and relapse as well as greater movement toward multiple forms of outpatient practices with greater emphasis on social cohesion and activities.

Bill: One of the most distinctive qualities of the RM model is its call for assertive and prolonged (up to five years) post-treatment recovery check-ups, sustained stage appropriate recovery education for individuals and families, and when needed, early intervention. Do you see the American TC moving in this direction?

George: The relationship of the TC and the Recovery Management initiative can be conceptualized in two perspectives. First is the specific role that TC programs assume in recovery-oriented systems of care. This perspective is illustrated in a recovery-oriented integrated system (ROIS) model currently in development in correctional settings (De Leon, 2007). Briefly, ROIS clients move in small peer cadres through a continuum of settings: a prison-based TC, a TC-oriented corrections-based transitional center, a TC-oriented post-release residential halfway house, followed by parole supervision and ambulatory treatment in the community. In each setting, the goals of re-entry and recovery are *mutually* pursued. Treatment interventions, social services, and surveillance activities are guided by a common perspective on the disorder and recovery. Thus, in this model, it is continuity of perspective (*recovery*), method (*TC-oriented*), and community (*peer relationships*) that constitutes an integrated system of care. (When parolees separate from

ROIS, however, they must enter a system that includes the main elements of the RM model.)

The second perspective is how TCs inform the recovery management initiative and reciprocally, how recovery management informs the TC model. In the shorter term TC, the individual uses the program to identify problems, understand recovery, and initiate change. In the ongoing time beyond the TC, the individual uses the real world resources for continuing change. These resources, to a considerable extent, are defined by the RM elements.

David: This movement to sustained recovery support is now occurring. TCs are finding multiple ways to link with mutual help recovery groups. The whole purpose of our work is to provide a continuum of care that promotes recovery management—acute care of any type as stand alone is a failed concept.

Bill: In closing, let me ask you about other changes in the TC model you foresee that will enhance long-term recovery outcomes?

David: Certainly TCs with this spirit of mobilizing mutual help will continue. They will learn more about assessment practices, and as they incorporate—as many have—various evidence-based practices, sequenced appropriately and along a full continuum of care (in which people can enter and exit at any point) as well as the need for assertive connection of people to recovery support groups in the community, they will thrive.

Those that do not permit people to enter a full continuum of care with constant links to and reinforcement for recovery groups of all forms based in the community will essentially atrophy and fail.

George: I think training and assessment are two critical areas of needed change. We need a framework to teach recovery-oriented concepts to staff and residents beginning in the primary treatment period in TCs. This would include curricula on the perspective of recovery (lifestyle and identity change), a staged framework of recovery that details profiles of clinical change that can be directly assessed on a regular basis, and a protocol for utilizing the RM elements beyond the TC.

In the assessment area, we need uniform tools for the continual evaluation of recovery changes. These include a) primary clinical issues, which may require treatment b) stage-related recovery issues, i.e., how individuals are meeting the challenges in the stage process, and (c) recovery

management checkups—how reliably individuals are adhering to the tools and daily practices for sustaining recovery.

Bill: Thank you both for your participation in this series.

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