Touro Scholar

Department of Behavioral Science Publications and Research

School of Health Sciences

2017

Treating the Most Seriously Addicted Using Elements of Therapeutic Community: The Importance of Treatment Vocabulary

Arthur P. Sullivan
Touro College, asullivan75004@gmail.com

Penny Sullivan-Nunes

Edmundo Nunes

Follow this and additional works at: https://touroscholar.touro.edu/dbs_pubs

Part of the Substance Abuse and Addiction Commons

Recommended Citation

Sullivan, A. P., Sullivan-Nunes, P., & Nunes, E. (2017). Treating the Most Seriously Addicted Using Elements of Therapeutic Community: The Importance of Treatment Vocabulary. *International Journal of Business and Social Science, 8* (11), 11-19. Retrieved from https://touroscholar.touro.edu/dbs_pubs/46

This Article is brought to you for free and open access by the School of Health Sciences at Touro Scholar. It has been accepted for inclusion in Department of Behavioral Science Publications and Research by an authorized administrator of Touro Scholar. For more information, please contact touro.scholar@touro.edu.

Treating the Most Seriously Addicted Using Elements of Therapeutic Community: The Importance of Treatment Vocabulary

Arthur P. Sullivan, Ph.D
Touro College & University System
65 Broadway
NY, NY 10006, USA

Penny Sullivan-Nunes, M.S.
Ardsley Union Free School District
300 Farm Road,
Ardsley, NY 10502, USA

Edmundo Nunes, Ph.D.
Mamaroneck Union Free School District
1000 West Boston Post Road
Mamaroneck, NY 10543, USA

Abstract

The inadequacy of individual psychotherapy and pharmacotherapy for treating the severely addicted (those addicted to many substances, or if one, opioids) was addressed by the development of the therapeutic community (TC) treatment model. TC treatment was residential and lengthy, but effective: it enabled the most pernicious of addictions to be managed, relapses to be reduced, and the patients enabled to lead enjoyable lives with rewarding relationships, families, education, and employment. Years of budget difficulties have reduced the cost of TC treatment by reducing or eliminating elements of TC treatment, with commensurate loss of treatment gains for the patients. This paper highlights the TC elements that should be eliminated last and restored first to improve patient success.

Keywords: opioids, addiction, therapeutic community, TC, treatment, residential, length of treatment, Daytop, rehabilitation

1 The most seriously ill patients

It was long recognized that patients with persistent opioid use, even after many treatment episodes, were inadequately served by the prevailing psychiatric methods (Etheridge, et. al., 1995, 1997; Nemes et. al., 1999). Detoxifying the patients and keeping them substance-free for a period of weeks or months did not enable them to begin or resume a normal lifestyle. Making a new start on their schooling, finding a job, learning age-appropriate social skills and repairing the damaged family ties that had been ruptured by their behavior while using drugs, remained out of reach. Unsurprisingly, the frustration from the failed attempts to make gains in these areas coupled with guilt and other dysphoric feelings to which they were now sensitized led to relapses.

A different type of treatment was needed for these most severely addicted patients. Initially all of the patients in this group were males and opioid users. This treatment-resistant group was expanded to include females, multiply-addicted and dual diagnosis (mentally ill and chemically addicted or MICA) patients after the new model was developed and its effectiveness established. The new and different treatment model came to be called the therapeutic community (TC). The model was begun at Synanon in 1958 and was carried forward, in and around New York, principally by Daytop Village from 1963 (Sullivan & Biase, 1990) until its merger a half century later.

In the 1960s the clinical presentations of these patients were very similar. Most began substance use early, often establishing an opioid tolerance around age 13. The behaviors which surrounded this substance use included stealing money to pay for drugs. Initially the stealing was from family members. Taking cash, electronic equipment or jewelry was followed by selling the stolen non-cash objects for 10 or 20 dollars, regardless of their value, to have enough money for their next dose.

Families often made many efforts to help the child and end the stealing, but it usually ended when there was nothing more to steal or valuables had been adequately secured. Retail businesses were targeted next by these patients. Once money had been gotten, the patient visited the dealer to make the purchase. Then he retired to a hidden spot, often in a car or an unoccupied building, to use the drugs, experience the intoxication, and recover from it. Within a few hours, the cycle restarted. At every part of this process the patient was exposed to violence or arrest, and problems with law enforcement accumulated. Family members were contacted by the police, and relationships were further damaged by fruitless attempts to help the juvenile released in their custody, combined with the expense of bail and legal representation. This continued, punctuated by jail sentences for the patient, until every family member had had enough and would no longer respond to or assist the patient.

At that point the patient was left with the driving need for opioids maintaining his behavior. School attendance had long ceased, and court appointments were often missed. If the family could not keep the patient at home because of his behavior, he had become part of the homeless and addicted people whose medical care is minimal, diet is deficient, and social supports nonexistent. His need for intimacy, as he got older, was satisfied by brief clandestine sexual contacts with nameless, intoxicated and often diseased partners.

In spite of all the cumulative distress the patient experienced, and in spite of multiple courses of treatment, his susceptibility to the intoxication experience and the power of the experience maintained his behaviors largely unchanged as his lifestyle deteriorated.

2 Inadequacy of mental health treatment methods

The psychiatric profession, together with psychologists, social workers, and other helping professionals experienced frustrations of their own. Their best efforts would show minimal effects, and gains would repeatedly be erased by relapses. Patients would come for detoxification willingly enough, since it reliably, though temporarily, reduced the cost of their habit. Since most lived on the street, patients would more willingly stay for treatment after detox during the cold weather, then leave to resume drug use when the weather improved. While in treatment, neither group therapy nor individual therapy, which rely on open expression and participation, were very useful in the face of the patient's desperate manipulations, lies, and vain commitments (Sullivan et. al., 2015).

The AA treatment model, begun in the 1930s, was having notable success with alcoholics. It offered a safe group meeting space where guilt feelings could be reduced, distress could be divulged, problems could be shared and insight gained. A structure of meetings and sponsors made immediate assistance and daily personal support available at almost any hour of the day or night. But for the most seriously addicted such as described above, AA support did not seem to be enough, even after medically supervised detoxification. Without that constant support, the seriously addicted patients did not maintain sufficient contact to profit from the social learning available from the revelations of others, nor the sense of acceptance and belonging which would allow them to share their personal experiences and gain self-knowledge. Even the AA slogans, e.g. "fake it until you make it" or "a day at a time," which are quite useful in recalling and focusing on skills and procedures learned in AA when there is danger of relapse (Bassin, 1984), are ineffective if the underlying learning has not occurred.

Identifying the additional needed elements for successful treatment and creating a treatment that embodied these elements was done serially. After detox, an inpatient experience was designed, and the structure of the treatment process was modified continuously as less effective methods were replaced by more and more effective ones. The model which emerged from this process was a closed residential experience of 20-24 months (Etheridge, et. al., 1995, 1997; Therapeutic community, 2002). This was done at a site typically distant from the patient's home neighborhood. The patients and the staff members, who were recovered addicts, formed a drug-free community in which patients could live under close peer observation and supervision while learning the skills for daily living, and create a satisfying lifestyle without drug use (DeLeon, 2000).

3 Key components of the TC treatment

The central task for treating serious addiction was to find a reinforcer powerful enough to wrest control of the patients' lives from opioid use and the behaviors surrounding it, and anchor this powerful reinforcer securely in their awareness. This crucial reinforcer was the TC itself. The community was called a family, and it was a democratic one with clear roles and rules. The patients, typically estranged from their families of origin and families of procreation, could enjoy a real belonging, recognition, affection, and loyalty toward and from others.

The family was relentless: violation of one of the three "cardinal" rules meant exclusion from the family and all facilities. The three prohibitions were violence (or threats of it), drug use, or sexual contact. The exclusion was immediate and absolute, with no allowance for excuses or delay. All other inappropriate behavior was manageable within the established procedures of the community. But the family was also forgiving: exclusions were not final. There was a procedure through which the excluded patient could work his way back into full membership.

The other features of TC treatment are the ingredients which define the TC model (DeLeon, 2000). Salient examples of these include:

3.1. Behavior therapy was the primary form of therapy. Inappropriate behaviors were discovered, identified clearly, and extinguished. New behaviors were learned, often by shaping and social learning, and these functioned as interference learning by becoming replacements for the patient's former behaviors. Consequences were associated closely with drug use and with exhibiting any of the antecedent behaviors of drug use.

3.2. Cognitive therapy methods were employed to give the patient insight into his own addiction problem and to create the constructs that would define his relationship and responsibilities to self and to others in order to establish and stabilize the new drug-free lifestyle. Cognitive and cognitive-behavioral therapy were delivered primarily in group sessions, since this was seen to be the only effective format.

3.3. Isolation at the TC facility reduced competition from external stimuli whch would distract patients or lure them toward relapse. Patients learned a full range of self-regulatory, social and work behaviors which excluded substance use in this environment. The rewards of these behaviors were experienced until they securely established an addiction-free behavioral repertoire.

3.4. The length of residential treatment, up to 24 months, was regarded as essential for establishing a complete repertoire of living behaviors for the patients. The research has repeatedly shown treatment outcome to be strongly related to length of time the patient spent in the TC residence (Condelli & Hubbard, 1994).

3.5. Peer observation and structured confrontation at all times prevented manipulation of the community by a patient (e.g. enjoying community privileges while continuing drug use surreptitiously) or failure to engage treatment completely.

3.6. Employment skills were first learned by performing the functions of the community, cleaning, preparing meals, maintaining the facility, caring for the grounds, etc. Some tasks were solo, others required working as a team member or as its leader. All work was reviewed in common and consequences closely associated with performance.

3.7. Education was advanced by instructing the members and guiding them through the GED process. After acquiring the GED, university study was made available at some facilities. The "miniversity," as it was called at Daytop Village, had good research outcome results both in terms of academic progress and gains in self-esteem (Biase et. al., 1986).

3.8. Roles were created to provide concentrated practice in specific skills for patients needing them. An example is the role of "relater." A patient with that job assignment spent work time circulating around the facility, engaging those he encountered in brief conversations. Those the relater approached were aware of his task and facilitated it, so the relater experienced success in many forms and skills improved reliably.

4 Effectiveness of the TC treatment model and its elements

The research associating or causally linking desirable treatment outcomes with length of treatment indicates that the entire structure is effective (Condelli & Hubbard, 1994, Edelen et. al., 2007, Hubbard et. al., 2003, Jainchill et. al., 2000, Nemes et. al., 1999). More specifically, separate research efforts have indicated effectiveness for various populations and with various modifications to the TC model. For examples, research has evaluated effectiveness with treatment-resistant addictions (Perry & Hedges-Duroy, 2004), with adolescents (Jainchill, 1997), with MICA patients (French et. al., 1999), with the homeless (DeLeon et. al., 2000, Mierlak et. al., 1998) and with criminal offenders and incarcerated patients (Sacks et. al., 2012, Martin et. al., 2011). DeLeon (2010) summarized the weight of evidence for the TC methods, as did the National Institute on Drug Abuse (NIDA, 2015). In additional to field studies, the body of literature includes some randomized controlled trials (RCTs), for example Guydish et. al. (1999), which compares 6-month outcomes with 12- and 18-month outcomes.

The very many elements in the TC model suggest that each element explains a portion of the treatment outcome, and some of the elements explain even more of the variability when used in tandem. The independent effectiveness of the elements is clear on theoretical grounds and most are independently supported as indicated by field research. The proportional contribution of the elements to patient improvement remains to be done.

A second body of research attributes significant gains to the TC methods in areas peripheral to the central goals of discontinuing drug use and remaining drug-free. Examples include self-concept changes (Biase & Sullivan, 1984), differential effectiveness in self-concept changes for males and females (Wheeler et. al., 1986), and cross-cultural outcomes (Biase & Sullivan, 1986).

5 The core of TC treatment

The core elements are those that produce stable cognitive change for managing reinforcers and anchoring behavior changes. The TC components and features captioned above are but a small sample of the parts of a complex system of engagement which fills 24 hours of each patient's day with therapeutic activity. The comprehensiveness and complexity of the TC would permit parts of the learning and skills to be forgotten, misunderstood, unpracticed, or modified. For the TC, the goal is maintaining the constructs which support sobriety in the patient's immediate consciousness. Without it, all the learning the patient achieved during treatment for living a sober and rewarding life will recede from consciousness and erode over time. A large, specialized vocabulary developed which covers all the aspects of treatment and embeds them in patients' consciousness and behavioral practice each day. For these reasons alone, patient acquisition and use of the vocabulary of the TC is essential. In the treatments using only a selection of TC features for budgetary reasons, significantly less effectiveness or none at all is to be expected.

Having a specialized vocabulary serves a number of other purposes as well. Clubs and organizations are aware of the benefits of having even a limited vocabulary used largely by members only. Current members teach new members, "our way of saying that is…" or "we call that a …," thus enhancing their feeling of belonging. Members experience recognition when group vocabulary is used outside the group, even if the meaning of the words used is not understood by non-members. For example, when someone refers to a second try as a "mulligan" he is recognized as a golfer, and conversation may turn to that topic. The more comprehensive the organization, the more extensive the specialized vocabulary. The military, physicians, or lawyers are good examples of this, where most of what they say in their professional capacities has to be translated for laypersons.

Similarly, the TC vocabulary serves a host of ancillary purposes. The shared vocabulary, for example, provides a convenient "pull up" or correction given to another patient when outside the facility. The words are fully understood by the patient but avoid embarrassing him in public, where the phrase is not understood. A reading of the sample of the TC vocabulary shown in Table 1 illustrates the comprehensiveness of the specialized vocabulary for creating and sustaining the gains made in TC treatment. The vocabulary also provides a skeletal map of the TC model. See also Bassin (1984).

Dye et. al. (2009) pointed out the usefulness of colloquial expressions used among TC residents. The instant authors are suggesting a far more critical role for the treatment's having and maintaining its proper vocabulary in positing it as the distillation and maintainer of the cognitions and behaviors necessary for living without substance use.

Table 1. Sample of therapeutic community vocabulary

Account for	(v.) Give an explanation for, or demonstrate that new learning has taken place by expressing it. Usage: account for the pot sink; this means give a statement of what was learned by this punishment.
Baby	(n.) A person's tendency to act in an immature, irresponsible, or otherwise childish way.
Bad status	(n.) A resident who has left treatment before completion (split) or a program graduate who has resumed drug use (fallen), and is no longer permitted to enter TC facilities or socialize with residents and graduates.
Belly	(n.) A spontaneous, uncensored response, or the source of spontaneous response and emotion within. Can mean conscience. Usage: come off one's belly, which means to express the uncensored, immediate response; to hold onto one's belly, which means to censor and appropriately decide not to express.

Bone	(n.) A verbal ploy or gambit, i.e., a topic for conversation.
Book	(v. or n.) To schedule someone for disciplinary action, e.g. a haircut. Also, the list of persons scheduled. Usage: to book someone, or to be in the books.
Brother	(n.) Any male resident.
Cardinal	(adj.) A cardinal rule, violation of any one of which terminates a residents stay at TC. There are three cardinal rules, prohibiting violence (or threats of it), drugs, and sexual contact at TC.
Carom shot	(n.) An indirect statement.
Chair	(n.) A physical chair a resident is required to sit in and cease all other activities while a decision is made. Either the resident's words or actions have revealed that commitment to treatment is uncertain, and the time on the chair is for finally resolving the matter. Usage: put one on the chair; to take the chair.
Clean up	(n.) A punishment. Usage: to be on clean up after a violation.
Closed	(adj.) Unwillingness to consider something. Usage: To be closed to something.
COD	(n.) The resident coordinator on duty, or the coordinator's office. This is the access point of residents to resolve matters, originate disciplinary actions, etc.
Contract	(n.) Agreement between two persons, usually to be mutually irresponsible.
Cop (to)	(v.) Admit.
Couch	(n.) A literal couch, on which a resident awaits a meeting, appointment, or other activity so as to be immediately available and not otherwise engaged.
Crackerbarrel	(n.) Discussion of one phrase of the unwritten philosophy by a group of members. Logistically, the wooden interconnected boards upon which they are written are separated and one is handed to each group.
Dead weight	(n.) A resident not participating fully in the treatment process.
Dishpan	(n.) A punishment job assignment of low status but indoors, consisting in washing pots and kitchen utensils. Synonym 'pot sink'.
Dope fiend	(n.) Generic term for all residents, referring to the remaining disposition to occasionally act like the addict they were in the past. Used of graduates as well, where it does not have the same negative impact.
Drop	(v.) To say or speak.
Drop a lug	(v.) To make a significant remark to someone. See 'lug.'
Drop a slip	(v.) Arrange to be in an encounter group with another specific resident or clinical staff member in order to question, challenge, or express feelings about that person freely. A responsible method for handling emotion.
Drop guilt	(v.) Admit violations. The admission is followed by punishment for the offenses admitted.
Expeditor	(n.) A job title, which includes management of the movements of people in the facility, keeping track of the comings and goings, and acting as messenger.
Extended brother/sister	(n.) A resident who has participated in an extended group with another.
Extended group	(n.) A group which continues for an extended time period, e.g., a full day.
Eyes	(n.) Romantic attraction. Can be an attraction to several persons, and is less strong than "feelings", q.v. Usage: to have eyes for someone.
Family	(n.) The entire group of persons associated with TC, or, the residents of a TC facility.
Feelings	(n.) Romantic attraction which has proceeded as far as being attraction to one person. Stronger than "eyes", q.v. Usage: To have feelings for someone.
First in the house	(n.) The first visit of outside guests a resident receives at the facility.

Flip	(n.) A cognitive change which is reflected in behavior. Refers to an insight or experience which alters the person, sometimes profoundly, and particularly in the area of their self concept.
Floor	(n.) All non-private areas of the facility. To be "on the floor" is to be available for work or other interactions.
Give the barest	(v.) To admit to only the slightest responsibility for an offense in question.
GM	(n.) General meeting, of the entire body of residents in a facility. Syn. meeting of the whole family.
Go through changes	(v.) To experience suffering as one changes one's behavior, or, to experience the necessity of changing the way one looks at things to reconcile thinking with changed behavior.
Guilt	(n.) Unrevealed violations. Usage: to give one's guilt, which means admit the undetected violations, or to hold on to one's guilt, which means to fail to reveal them.
Haircut	(n.) A formal verbal reprimand given a resident by a group of other residents and a counselor. The resident being reprimanded usually is not allowed to reply or make any defense.
Invest	(v.) To participate actively in treatment, usually by making significant disclosures or commitment to change.
Jackpot	(n.) The largest penalty. One is in the jackpot when one is "shot down" to "spare parts" or "dishpan", q.v.
Jailing (it)	(v.) To behave as if in jail instead of in treatment, to fail to invest or engage in treatment, to perform the barest minimum.
Kick up	(v.) Remind one powerfully of a past event or situation, similar to re-experiencing it, and motivating one to behave as in the previous situation. "That kicks up the sneak in me."
Knock off	(n.) Not speaking with. Usage: to be on knock off with someone.
LE	(n.) A learning experience or punishment.
Loose	(adj.) Joking, not serious, or falling short of required standard of compliance.
Lug	(n.) A significant remark made to another. The remark may be humorous or serious, and have the intent to help or harm, but is received as weighty or important. Usage: a lug is 'dropped' on someone.
Marathon group	(n.) A group of extraordinary time length, e.g., more than a full day, with group activities punctuated by a few hours sleep in the group meeting room.
Mook out	(v.) To be depressed.
Night Man/Woman	(n.) Resident assigned to watch the residence overnight, be on duty, receive phone calls, and handle emergencies that may arise.
Nightowl	(n.) A resident assigned to remain awake and watch another resident all night who is ill or on suicide precautions.
Off Structure	(adj.) A resident exempted from following the days' order of events, e.g., because of illness.
Out of his/her shit	(adv.) A remark intended to be helpful which fails to be helpful because it reflects the speaker's problems more than the situation at hand.
Play (off)	(v.) To use as an excuse for not engaging in activities or work. E.g., to play off one's medical condition.
Point	(n.) A position occupied by an assigned resident in the front area of the facility from which comings and goings are easily observed and directions can be given.
Pot sink	(n.) A punishment job assignment of low status but indoors, consisting in washing pots and kitchen utensils. Synonym 'dishpan'.
Pull up	(n. or v.) A correction given to another, particularly by entering it on the agenda for morning meeting, or, the act of giving a verbal correction.

Rash	(n.) Short for rationalization.
Rat Pack	(v.) To gang up on someone; a group pressuring an individual.
Reach out	(n.) A hug, non-sexual in nature, delivered by either gender to either gender.
Relater	(n.) A person assigned simply to speak with others. Usually a penalty assignment for failing to do this sufficiently.
Respect	(v.) To admit, express, or to think something is worth expressing. Usage: One respects one's feelings, means the person revealed and acknowledged feelings they otherwise might have denied or repressed.
Secondary	(n.) The second most senior person. For example, a "room strength" is the senior, and by extension most responsible, person in a dorm room; the secondary is next most senior and responsible.
Seek good feelings	(v.) Mildly romantic interplay, not explicitly sexual, engaged in for pleasure.
Shaved head	(n.) Literally, for men, a close crew haircut; for women, wearing a stocking cap to cover the hair. The practice is a visible investment in the treatment process; it is falling into disuse.
Shingle	(n. or v.) A job title, indicating that a resident is second in command on the job or project, or, to act as the second in command.
Shoot a Curve	(v.) To bypass the proper chain of command.
Shoot down	(v.) To give a resident the penalty of loss of job status and assignment to menial work, including loss of group participation and other deprivations. See also "shot down."
Sell a Ticket	(v.) Make a threat.
Spare parts	(n.) The lowest resident status and the work done by those on punishment or 'shot down,' consisting typically in heavy outdoor labor.
Special	(n.) A counseling session which includes one or more staff, the resident, and one or more of the resident's significant others. Takes place during a visit to a facility by the significant others.
Split	(v.) To leave treatment before completion.
Splitee	(n.) A person who has left TC treatment before completion.
Squat	(v.) To leer, or view body parts of others in a sexual or suggestive manner.
Street Behavior	(n.) Undesirable behavior which fits the stereotype of an active addict's behavior.
Strength	(n.) A person who is senior in rank or responsibility among a group of residents, but without a specific job title conferring the seniority. Usage: room strength, which means the senior resident in a dormitory room.
Structure	(n.) The daily order of events in the residence.
Stuff	(v.) To fail to recognize one' feelings, or to fail to express them.
Take to Group	(v.) To submit a request to be assigned to the same encounter group with another resident or staff member for an opportunty to challenge, interrogate, or express emotion such as anger toward that person. Usage: take someone to group.
Throw out a bone	(v.) To begin a topic of conversation, or change a conversation to a new topic.
Tight	(adj.) Strict observance of requirements and regulations. Usage: tight house, which means a facility in which all privileges have been suspended while observance is raised to a strict level.
Walking papers	(n.) Permission for a new resident to move about the facility unescorted. The status is achieved by demonstrating a knowledge of the staff and the whereabouts of necessary places and things in the facility.
WAM	(n.) Acronym for walking around money, a reward given to residents of a few dollars for minor expenses.
Weak	(adj.) Vulnerable. Usage: to feel weak, which means experiencing ordinary vulnerability in a distressing way.

Weekend alone	(n.) A privilege accorded advanced residents of returning to NYC without an escort for an entire weekend.

6 Reducing the TC treatment experience

The distribution of money spent on substance abuse treatment in 1986 was 50% for inpatient treatment (acute hospital setting), 27% outpatient treatment, and 17% residential treatment (TCs, specialty care centers & nursing home care). The distribution of substance abuse treatment has trended towards the following (for 2009): 21% inpatient treatment (this represents a 58% reduction in percent allocated), 39% outpatient treatment (a 44% increase in percent allocated), 31% residential treatment (82% increase in percent allocated), and 4% for prescription drugs (buprenorphine for heroin and opioid treatment). Despite the increase in the *percentage* of substance abuse spending allocated to residential treatment services versus other addiction treatment services, the amount of money spent on substance abuse treatment decreased from 2% of all-health spending in 1986 to 1% of all-health spending in 2009: it dropped 50%. (Mark, et. al., 2005) This has been the cause of the reductions in the TC model itself from no minimum length of stay, to 24 months, then to 6-12 months, and now to as little as 60 days. These reductions have occurred in spite of research that supports the length of stay in a TC correlating to better outcomes in terms of recovery status, employment status, and psychological functioning (Condelli & Hubbard, 1994, Edelen et. al., 2007, Hubbard et. al., 2003, Jainchill et. al., 2000, Nemes et. al., 1999). The net result has been more opioid addicts' being treated with a briefer, less effective TC treatment.

7 Conclusions and recommended use of TC treatment elements

Budget exigencies have been forcing modifications and reductions for more than two decades (Etheridge et.al., 1997) and are likely to continue. Often the fully isolated, residential, 2-year program with the full TC model can no longer be afforded. In order to use as much of this TC treatment as possible for the patients that need it, within the limits of available funds, various modifications are being used. Residential treatment has been reduced to partial hospitalization or outpatient treatment. The two years has been reduced to two or three months. The isolation of a remote facility has been replaced by residential facilities in the local community or even the patient's immediate neighborhood, from which the patient can end treatment on impulse or sudden acute desire for a drug. Treatment professionals have increasingly taken over the role of providers (Smith, 2012; Volcow et. al., 2014). Peer observation, confrontation, and enforcement of cardinal rules has diminished (Perfas & Spross, 2007).

As the pieces of TC treatment are assembled, cafeteria style, in a given program, the available budget must be spent in the manner which gets the maximum treatment effect. Long before the outcomes of treatment for patients such as length of and quality of recovery bevome available for research, process variables will serve to guide the structuring and ongoing modifications in the program. The instant authors propose using patient acquisition and use of the vocabulary of the TC as the primary process variable. It is easily observed in treatment, and as the vocabulary itself is the vector by which many of the treatment gains are realized and retained, provides ongoing evidence of the usefulness of the program for the patients.

8 References

Bassin A. (1984). Proverbs, slogans and folk sayings in the therapeutic community: a neglected therapeutic tool. *J Psychoactive Drugs* 16(1):51-6.

Biase, D. V., & Sullivan, A. P. (1984). Successful development of self concept with therapeutic community residents: A five year research study [Presented at the Eighth World Conference of Therapeutic Communities]. Rome, Italy.

Biase, D. V. & Sullivan, A.P. (1986). Emerging cross-cultural therapeutic community research. *Journal of Psychoactive Drugs* 18 (3), 199-201.

Biase, D. V., Sullivan, A. P., & Wheeler, B. L. (1986). College training in a therapeutic community. In G. DeLeon, & J. Zeigenfuss (Ed.), *Therapeutic communities and addictions*. Springfield, IL: Charles Thomas Publishers.

Condelli, W.S., & Hubbard, R. L. (1994). Relationship between time spent in treatment and client outcomes from therapeutic communities. *Journal of Substance Abuse Treatment* 11:25-33.

DeLeon, G. (2000) *The Therapeutic Community: Theory, model and method*. NY: Springer

De Leon G. (2010). Is the therapeutic community an evidence-based treatment? What the evidence says. *International Journal of Therapeutic Communities* 31(2), 104-128.

De Leon, G.; Sacks, S.; Staines, G.; and McKendrick, K. (2000). Modified therapeutic community for homeless mentally ill chemical abusers: Treatment outcomes. *American Journal of Drug and Alcohol Abuse*, 26(3):461-480.

Dye, M. H., Ducharme, L. J., Johnson, J. A., Knudsen, H. K., & Roman, P. M. (2009). Modified therapeutic communities and adherence to traditional elements. *J Psychoactive Drugs* 41:275-283.

Edelen, M. O., Tucker, J.S., & Wenzel, S. L. (2007). Treatment process in the therapeutic community: associations with retention and outcomes among adolescent residential clients. *J Subst Abuse Treat* 32:415-421.

Etheridge, R. M., Craddock, S. G., Dunteman, G. H., Hubbard, R. L. (1995). Treatment services in two national studies of community-based drug abuse treatment programs. J. Substance Abuse 7(1): 9-26.

Etheridge, R.M., Hubbard, R.L., Anderson, J., Craddock, S.G., & Flynn, P.M. (1997). Treatment structure and program services in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors* 11:244-260.

French, M.T., Sacks, S., De Leon, G., Staines, G. & McKendrick, K. (1999). Modified therapeutic community for mentally ill chemical abusers: Outcomes and costs. *Evaluation & the Health Professions* 22:60-85.

Guydish, J., Sorensen, J. L., Werdegar, D., Chan, M., Bostron, A. & Acampora, A. (1999). A randomized trial comparing day and residential drug abuse treatment: 18-month outcomes. *Journal of Consulting and Clinical Psychology* 67(3):428-434.

Hubbard, R. L., Craddock, S. G., & Anderson, J. (2003). Overview of 5-year followup outcomes in the drug abuse treatment outcome studies (DATOS). *J Subst Abuse Treat* 25:125-134.

Jainchill, N. (1997). Therapeutic communities for adolescents: The same and not the same. In: DeLeon, G. (ed). Community as Method. Westport, CT: Praeger.

Jainchill, N., Hawke, J., De Leon, G., & Yagelka, J. (2000). Adolescents in TCs: One year post-treatment outcomes. *Journal of Psychoactive Drugs* 32(1):81-94.

Mark, T.L., Coffey, R. M., McKusick, D. R., Harwood, H., King, E., Bouchery, E., Genuardi, J., Vandivort, R., Buck, J., Dilonardo, J. (2005). National Estimates of Expenditures for Mental Health Services and Substance Abuse Treatment, 1991–2001 SAMHSA Publication No SMA 05-3999. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Martin, S.S., O'Connell, D.J., Paternoster, R., Bachman, R.D. (2011). The long and winding road to desistance from crime for drug-involved offenders: the long-term influence of therapeutic community treatment on re-arrest. *Journal of Drug Issues* 41:179-196.

Mierlak, D.; Galanter, M.; Spivak, N.; Dermatis, H.; Jurewicz, E.; and De Leon, G. (1998). Modified therapeutic community treatment for homeless dually diagnosed men. Who completes treatment? *Journal of Substance Abuse Treatment* 15:117-121.

Nemes, S., Wish, E. D., & Messina, N. (1999). Comparing the impact of standard and abbreviated treatment in a therapeutic community. Journal of Substance Abuse Treatment 17:339-347.

NIDA. (2015, July 23). Therapeutic Communitites. Retrieved from https://www.drugabuse.gov/publications/research-reports/therapeutic-communitites on 2017, October 16.

Perfas FB, Spross S. (2007). Why the concept-based therapeutic community can no longer be called drug-free. *J Psychoactive Drugs* 39:69-79.

Perry P. D. & Hedges-Duroy T. L. (2004). Adolescent and young adult heroin and non heroin users: a quantitative and qualitative study of experiences in a therapeutic community. *J Psychoactive Drugs* 36:75-84.

Sacks, S., Chaple, M., Sacks, J. Y., McKendrick, K., & Cleland, C. M. (2012). Randomized trial of a reentry modified therapeutic community for offenders with co-occurring disorders: crime outcomes. *J Subst Abuse Treat* 42:247-59.

Smith, D. E. (2012). The medicalization of therapeutic communities in the era of health care reform. *J Psychoactive Drugs*. 44:93-95.

Sullivan, A. P., & Biase, D. V. (1990). *The treatment community at the quarter century mark*. New York: Daytop Village.

Sullivan, A. P., Sullivan-Nunes, P., Nunes, M. (2015, August). Words that heal: Rapid results from cognitive therapy. *International Journal of Business and Social Science, 6*(8), 53-60.

Therapeutic community. (August 2002). NIH Publication Number 02-4877. Retrieved October 1, 2017 from https://archives.drugabuse.gov/pdf/RRTherapeutic.pdf

Volkow, N. D., Frieden, T. R., Hyde, P. S., & Cha S. S. (2014). Medication-assisted therapies—tackling the opioid-overdose epidemic. *N Engl J Med*. 370:2063-2066.

Wheeler, B. L., Biase, D. V., & Sullivan, A. P. (1986). Changes in self concept during therapeutic community treatment: A comparison of male and female drug abusers. Journal of Drug Education, 16 (2), 191-196.