THERAPEUTIC COMMUNITIES FOR SUBSTANCE USE TREATMENT: HOW
PSYCHOSOCIAL INTEGRATION CAN BE INTEGRATED INTO RESIDENTIAL
RECOVERY

by

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A thesis submitted in partial fulfillment of the requirements
for the degree of

Master of Counselling (MC)

City University of Seattle
Vancouver BC, Canada site

November 18, 2016

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Abstract

Problematic substance use continues to be well publicized in academic writing and the mainstream media. Using a narrative literature review, I examine the history of substance use in Vancouver from the theoretical framework of Alexander's (2008) theory of psychosocial dislocation. I propose that an appropriate model of intervention is the Therapeutic Community (TC). The TC is set up to mobilize mutually supportive peer relations. These relationships are fostered through structured encounter meetings led by senior residents and an emphasis on working together for the benefit of the group. The TC has a history of providing an environment that produces beneficial outcomes for clients. Although TC research may lack the support of randomized controlled trials (RCT), research using methods suitable for analyzing TC outcomes has shown numerous positive results for participants. I propose that the benefits for TC participants in Vancouver can be enhanced through seeking psychosocial integration both in the TC and in the Greater Vancouver area. This can be accomplished through serving and seeking healing relationships with populations—both indigenous and immigrant—that have an experience of psychosocial dislocation.

Keywords: *therapeutic communities, substance use, psychosocial dislocation, first nations*

Acknowledgements

I am grateful to George De Leon for his guidance in my early stages of research.

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Chapter 1: Introduction to Psychosocial Dislocation Theory of Addiction, History of Substance Use in Vancouver, and the Development of the Therapeutic Community

The phenomenon of problematic substance use is well publicized. Newspapers often publish stories that turn attention towards illicit drug use. Institutions such as the Canadian Centre on Substance Abuse and the National Institute on Drug Abuse have been developed to study and engage this problem. Multiple solutions have been offered to curtail the problem, and it is estimated that at least $22.8 million is spent annually by the federal government (Government of Canada, 2015) and at least $1.3 billion by the government of British Columbia in 2008/09 (Ministry of Health Services, 2010) to address substance use. With such a large effort of time and money going towards this, it is important to have an accurate assessment of individual problematic substance users and their social environment.

A common experience for those engaged in problematic substance use is that of isolation. This resonates from the pages of Alcoholics Anonymous to peer reviewed literature (Alexander, 2015) to the anecdotal stories of individual users. These stories communicate that the feelings derived from substance use often numb the feeling of intense loneliness. Indeed, substance use, along with the associated risks, appears to be preferable to feeling lonely. Unfortunately, the continued use of substances, and engaging in behaviours that meet the needs for acquiring the substance, usually increase loneliness and the experience of isolation. Substance users may be dishonest with friends, stay away or hurt loved ones, and be unable to maintain work. This phenomenon can be expressed as an individual's fear of social connection, and at the same time an intense desire for relationship with a community.

One method to foster connection, both felt and in real relationships, is treatment in a communal environment which has been viewed by both researchers and clients as an effective means of engaging in recovery (De Leon, 2000). However, a common barrier for problematic substance users is a personal history of social dysfunction and interpersonal abuse. Because of this background, clients may experience a high degree of anxiety and apprehension engaging in the very relationships that are likely to improve their well-being.

In this thesis, I will focus on the Therapeutic Community (TC) setting for recovery because I believe that this treatment modality provides distinct conditions for social integration that may have been unmet over the span of a substance user's life. I will explain TC structure and propose that this structure provides an appropriate environment for the healing of the individual both relationally with others and in relation to self. I will review research regarding TCs. I will then draw attention to the theory of social dislocation as proposed by Alexander (2008) and integrate this into my proposals for TC practice.

1.1 Research Methodology

I have used a narrative literature review as my methodology for this study. A narrative review focuses on the explanation and importance of a problem, synthesizes previous research findings, and describes possibilities of addressing the problem (Baker, 2016; Rhoades, 2011). I discerned that this method was appropriate in order to bring attention to current research on TCs, as well as grounding my research in the context of previous studies (Rhoades, 2011). I have intended to use this narrative literature review to propose creative views and practices of substance use treatment in the city of Vancouver (Baker, 2016). In order to establish a historical

basis for my proposals, as well as highlight a strong tradition of TC research and practice, I have consulted studies from previous decades ranging back to the 1980s.

I deemed a literature review appropriate for the purposes of synthesizing the writings of numerous authors across North American and European contexts (Rhoades, 2011). Since the beginnings of TC practice and research, there have been multiple observations in the literature that the TC environment has undergone changes from its initial foundations. These changes have been strongly influenced by the paradigms of North America and Europe, as I will demonstrate below. To clarify the degree to which TCs adhere to foundational approaches, authors have used labels such as "TCs," "Modified TCs," and "TC-oriented." Service deliveries have varied from peer-delivery to professional involvement, residential houses to prison environments, and from populations of hundreds to small groups. This literature review will attempt to draw themes from the research in order to propose recommendations for beneficial practical treatment options in Vancouver.

I began my research by using the search terms "residential," "recovery," and "substance use" in the City University of Seattle's academic library. However, these words turned up few relevant results. In reading this handful of articles, a common term that was mentioned was "therapeutic community." Using this term to conduct further searches turned up many articles that were written over decades of study.

Another goal I had in developing my research in this area was that it would be applicable to the clients I currently serve. I have been working at a recovery centre for over a decade. It is a six month residential, abstinence-based program that provides a six month time period for men who want to change their patterns of substance use. To this end, I limited my article selection to research with adult populations. Furthermore, the clients that access my agency's service are not

officially mandated by the judicial system to attend the program, although there often are strong recommendations to participate from probation officers, lawyers, and police. With the goal of gathering studies that presented clients who had similar sources of social influence as my own clients, I excluded studies that were exclusive to prison-based populations and services. Nevertheless, I have included studies that address the interactions clients have had with the legal system and the changes that TC participants have experienced in their relationship to illegal behaviour. I have included these studies because many problematic substance users have had experiences with law enforcement, and it was difficult to draw from studies that did not include any mention of legal influences.

1.2 Key Terms

Substance user. For the purposes of readability, I have chosen the term "substance user" to describe individuals who use substances associated with addiction. This includes alcohol, illicit street drugs, and prescription medications. This term is not intended to reduce these individuals' identity to their struggle. Indeed, these people are brothers, sisters, daughters, sons, parents, and friends amongst many other roles they may have. I am grateful for the individuals who have shared their stories with researchers, as well as the people I have learned from in my own practice. Additionally, I have used the terms "resident," "client," "participant," and "members" to describe clients of TCs. I have done this with an intention to draw attention to the relationship between the individual and the TC community, as well as provide variation for reader interest.

Right living. This term is used to describe the standards that program residents are to adhere to. Coined by De Leon (2000) in relation to TCs, right living is a shared view of

community living that is obtained by maintaining abstinence from substances, participation in all elements of TC culture, being honest, and displaying care towards self, the community, and the environment. Right living provides a framework of orderly conduct for individuals who often arrive from lifestyles of chaos. Right living is not only for the communal environment of the TC; it is also intended to be a way of life for individuals after they transition from the TC. To sum up the need for right living, "Sobriety is the prerequisite for learning to live right but right living is required to maintain sobriety" (De Leon, 2000, p. 74).

Additionally, I use the following abbreviations throughout this paper:

TC - Therapeutic Community

AA - Alcoholics Anonymous

EBP - Evidence Based Practice

RCT - Randomized Controlled Trial

HT - Historical Trauma

1.3 Psychosocial Dislocation

In this paper, I will place my recommendations for TC treatment within the theoretical context of Alexander's theory (2008) of dislocation and within the environmental context of Vancouver, British Columbia. TC research has been guided by theory most prominently advanced by George DeLeon (2000). In brief, the TC outlook on the phenomenon of addiction is that it is a "disorder of the whole person" (De Leon, 2000, p. 37). Addiction permeates many, if not all, aspects of the substance user's life. Individuals often practise substance use as they try to cope with difficult and traumatic life circumstances. In order to numb uncomfortable memories and feelings, they will turn to substances rather than work towards resolving difficulties.

However, the substance use often serves to perpetuate lifestyle problems and the user's distress increases. TCs employ a paradigm of "Community as Method" (De Leon, 2000). In this view, engaging in the TC environment is a here-and-now therapeutic, experiential practice that grants the participants new life-skills and outlooks that will enable them to continue in ongoing sobriety after their stay at the TC.

In my research of Alexander's (2008) theory of addiction, I have found that it can be conceptualized as a companion to TC theory. Furthermore, I believe that the theory of dislocation provides a domain in which "Community as Method" can be practiced. I will elaborate on this idea below. Briefly, the theory of dislocation does not only account for the individual substance user. Alexander seeks to place the phenomenon of addiction within the context of the greater current society.

Alexander identifies the current free-market system as the context in which addiction is perpetuated (Alexander, 2008). The free-market is defined as "virtually every aspect of human existence [being] embedded within unregulated, competitive markets" (Alexander, 2012, p. 1477). He points to Europe before the 1500s and explains that at the time, the markets served society. That is to say, the production, trade, and acquisition of goods was practiced in a manner that ensured the functioning of the collective society. Currently however, societies serve the free-market. Alexander points to the example of the colonization across North America as First Nations communities were forcefully subjugated to embrace industry and removed from traditional territory (Alexander, 2008). Additionally, he highlights the English subjugation of the Scottish people with the objective of furthering their methods of production. The result of practices that devote energy and service towards the "market god"— a term Alexander (2008, p. 256) uses to personify the free market as a benevolent, all-powerful force—naturally produce

allegiance to the free-market system, weak interpersonal relationships, and social dislocation (Alexander, 2012). This dislocation is the individual experience of a socially disconnected society (Alexander, 2015). This experience of disconnection affects an individual's identity, as they do not sense a connection with their family, community, traditions, environment, faith, or God. The free-market needs these relationships to be weak in order for individuals to devote their effort to serving the 'market god' (Alexander, 2008). As energy is spent perpetuating this system, individuals experience an overwhelming consciousness of what Alexander calls "poverty of spirit" (Alexander, 2015, par. 15).

This dislocation, or poverty of spirit, is felt so intensely that an individual is likely to respond with behaviours that numb this awareness. Alexander places his description of addiction within this paradigm; "addiction is a way that needy people respond to what is missing or traumatic in their own lives and communities" (Alexander, 2015, par. 1). In other words, addiction compensates for a lack of psychosocial integration (Alexander, 2012). In this understanding, addiction is not solely focused on the individual addict, but on the environment in which a person seeks to meet their need for meaningful communion with their people, their place, and their purpose. That is not to say that individual distinctives such as biology, traumatic experiences, and family history do not influence a person's behaviour or susceptibility to addictive practices. However, social scientists outside of the field of addiction agree that the influence of societal forces is more powerful than individual aspects (Alexander, 2012).

Alexander proposes that the solution does not merely lie in individuals achieving abstinence from their addictive behaviours, but in helping people enter and participate in a healthy, purposeful community (Alexander, 2015). Alexander borrows the language of Erik Erikson and names this phenomenon "psychosocial integration" (par. 27). When persons are

integrated, they experience three conditions (Alexander, 2012). First, they acquire an individual identity. This identity is formed through healthy social relationships that recognize the role of the individual, as well as differentiate the roles of others. Second, individuals develop a sense of meaning and relationship to the material world. This can be pursued through his or her relationship to his or her land or the elements he or she interact with. Third, people are often validated by their community in their sense of the divine as members witness and give meaning to each other's sense of the unseen. This can be seen in shared creation narratives, religious ceremonies, or forming a sense of purpose and meaning. Alexander summarized psychosocial integration as a sense that one can "belong, yet still feel free" (2015, par. 28).

Critiques of Alexander's theory of dislocation point to the macro scale changes he envisions in order to curb the global spread of addiction. It is difficult to offer practical solutions that significantly alter macro-systems (Acker, 2012) or to present a preferred macro-system (Sharma, 2012). Alexander (2008) does not suggest how an ideal macro-system would function, but does identify actions of living in opposition to free-market society, which require strength, courage, and intentionality (Alexander, 2012). Specifically, he names the recovery movement as a micro-scale effort that seeks to develop an intentional community, which provides an environment for individuals to experience and grow into psychosocial integration (Alexander, 2015). I am convinced that this integrative environment Alexander describes is descriptive of a healthy, effective TC.

1.4 Historical Context of Vancouver

In order to provide a context for presenting the TC method in Vancouver, I will outline a brief history of this city. In order to discern the information to include in this paper I have

selected information that illustrates and informs Alexander's theory of dislocation. Additionally, I have included statistics and narratives that focus on Vancouver's culture as it relates to problematic substance use.

Early policies of British Columbia were significantly formed by James Douglas, of Scottish decent, who governed Fort Victoria beginning in 1851 (Hume, 2003). Under his leadership, he promoted the availability of British Columbia's gold to prospectors in California as their own gold rush declined. British Columbia experienced an influx of 30,000 prospectors who were drawn to the wealth of the land.

This massive influx of people occurred within the cultural tensions that were already being experienced between the First Nations and the Caucasian settlers (Alexander, 2008). However, Hume (2003) notes that Douglas himself engaged in multi-cultural practices that promoted harmony among those of varied cultural backgrounds. He married a Cree woman and maintained a long-lasting marriage. Additionally, he had a vision of all people enjoying freedom in the land. He welcomed African-Americans to prosper in British Columbia, much to the consternation of the Euro-Americans who had journeyed north.

British Columbia's resource-rich land, coupled with its industry, became well-known from the beginning of the twentieth century (Alexander, 2008). Indeed, in his research regarding the tourism of the time, Douglas (2004) asserted that, "it is the common remark of visitors from the United States that Victorians have mastered the art of combining business with pleasure" (p. 14). Additionally, early tourists were "intrigued by the economic opportunities and the wonders of industrial production that they saw in British Columbia" (Dawson, 2004, p. 16).

Many people from diverse culture groups came to settle in the Vancouver area (Alexander, 2008). In addition to the First Nations people of the land, Europeans, Asians, and

others from across North America moved to Vancouver with an eye to benefit from its potential profits. Unfortunately, the cultural acceptance practiced by James Douglas was not continued as Asian immigrants and First Nations peoples' rights as citizens of Vancouver deteriorated (Purvey & Belshaw, 2011).

The methods mobilized to control substances further aggravated the animosity between cultural groups. As Vancouver became known for the opium smuggling occurring in the city, Chinese workers were widely believed to be most prolific providers, as well as the most prominent users, of opium (Purvey & Belshaw, 2011). This belief was widely accepted despite the knowledge that opium use among Euro-Canadian citizens was most likely just as high (Murphy, 1922; Middleton, 1997). Additional measures were established by the federal government as they enacted the Opium Act in 1908, which was developed as an attempt to control the Chinese distribution of the drug (Middleton, 1997; Schaffer Library of Drug Policy, n.d.). In regards to alcohol, because of the reputation of Chinese peddling behaviours that were detrimental to society, they were not allowed to operate, or work at, liquor parlours. Regulations were developed in the early twentieth century, either by the Liquor Control Board (LCB) or by individual beer parlours, dictating who could be served alcohol in these parlours (Campbell, 2001). Status Indians and Asians were most likely to be targeted by these official regulations, while "blacks or mixed-raced couples" (Campbell, 2001, p. 79) were managed by unwritten rules from the LCB or individual parlour.

These official regulations for First Nations had been officially entrenched through the Indian Act of 1876 (Campbell, 2001). Canadian First Nations were denied full privileges to alcohol acquisition and consumption due to regulations that marginalized them both from their culture and from the customs of European settlers. The harm and detrimental behaviours that

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Native communities suffered due to alcohol was taken as evidence by European settlers that the First Nations were not civilized. To use alcohol, a First Nations individual had to renounce their federal Indian Status as a symbol of adopting the dominant culture. However, even this practice was not a guarantee that the individual would be allowed to drink. Liquor restriction could still be enforced if the individual was judged to be continuing in the Native way of life.

Alcohol regulations for First Nations people were gradually decreased after WWII. These changes were likely motivated after many First Nations soldiers fought and drank alongside Euro-Canadians oversees. First Nations were allowed in regulated beer parlours after 1951, but drinking was still prohibited on the reserves (Campbell, 2001). Drinking outside of these parlours had to be done secretively, further enforcing stereotypes of Natives drinking "in some back ally or beside the railway tracks" (Campbell, 2001, p. 103). Enforcement became highly discretionary in practice. People were arrested under liquor control laws simply for physically appearing to be, or acting in congruence with, First Nations stereotypes. As an example of the arbitrary enforcement of these laws, Campbell (2001) recounts an instance when servers at a liquor parlour served alcohol to First Nations individuals and were subsequently arrested. However, because these patrons did not look "Indian enough," the servers were later acquitted.

Equal access to alcohol was granted in 1962 to First Nations people and alcohol restrictions were removed from the federal Indian Act in 1985 (Campbell, 2001). However, the myth of the Native and "firewater" is still perpetuated today (Campbell, 2001; Alexander, 2008). This myth states that First Nations people have a genetic susceptibility to alcohol. As has been alluded to above, Alexander (2008) proposes that this phenomenon is better understood within the context of social pressures rather than individual factors.

As substance use increased in the city, so too did efforts to curtail its effects. In what would have been a revolutionary position at the time, the Vancouver police chief in 1914 advocated for medical treatment of substance users rather than criminalization (Demers, 2009). Further efforts to address problematic drinking continued with the establishment of Alcoholics Anonymous (AA) meetings in the city. According to AA's Vancouver archives, the group held its first meeting in December of 1944 (AA Archivist[1], 16, May, 2016, personal conversation). Other substance use treatment programs in the city gradually commenced operation in the years following such as the Alano Club in 1947 (Alano Club of Vancouver, 2003), Salvation Army Harbour Light in 1953 (The Salvation Army, 2012), Pacifica Treatment Centre in 1977 (Pacifica Treatment Centre, 2016), Turning Point in 1982 (Turning Point Recovery Society, n.d.), Union Gospel Mission in 1982 (Antill, 2008), Vancouver Recovery Club in 1983 (Vancouver Recovery Club, n.d.), Together We Can in 1993 (Together We Can, 2016), and the Insite Supervised Injection Site in 2003 (Vancouver Coastal Health, n.d.).

1.5 BC Substance Use

To assess the need for problematic substance use interventions, it is important to accurately gauge the severity of the problem. In order to ascertain this information I have cited a report issued by the Canadian Centre on Substance Abuse (CCSA) (2005). This report compares substance use between all Canadian provinces and territories. It is a landmark study because it included a research sample across the entire Canadian population (CCSA, 2008). Despite this meta approach, this survey is limited in that it addresses substance use by province and not by specific cities.

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[1] I have chosen to keep this individual's identity anonymous in alignment with AA tradition.

According to the CCSA, British Columbia was noted for having the highest likelihood of harm from alcohol. Harm was defined as, "adverse consequences [and] damage to friendships, social life and physical health. Negative verbal interactions are by far the most frequent type of harm attributed to the drinking of others" (CCSA, 2005, p. 33). Additionally, BC has one of the highest odds of not just engaging in harmful practices, but also of reporting harmful practices relating to alcohol. Furthermore, the province has the highest rate of harm to physical health due to alcohol use.

Regarding the use of drugs, BC has the highest rate of cannabis use and the highest rate of use for cocaine, heroin, and ecstasy. Overall, BC has the second highest reports of harm from illicit substance use. When compared to the rest of Canada, British Columbia has a demonstrated need for appropriate interventions to curtail problematic substance use.

1.6 Development of the Therapeutic Community

Communal healing has long been a restorative practice that benefits the well-being of the group and the individual. Ancient communities developed codes of conduct that members were to abide by if they were to maintain their relationship to the body (Broekaert et al., 2000; De Leon, 2000). As humanity adopted a scientific paradigm through which to understand the world, these healing communities changed in structuring their organization and practice. At the beginning of the twentieth century, the TC environment was first proposed in England as a curative milieu for individuals with psychiatric disorders (De Leon, 2000). Maxwell Jones is credited with cultivating a hospital setting that encouraged open, receptive communication between patients and staff (Broekaert et al., 2000). The professional and support staff were not seen as over and above the patients. Rather, they understood their role as creating, and engaging

in, a culture where patient distress was alleviated and personal well-being could be developed

and encouraged through open discussion and patient input into treatment and recovery.

During this time in North America, three organizations were formed that would be highly

influential to TC development: The Oxford Group, AA, and Synanon (De Leon, 2000). The

Oxford Group believed the healing process occurred through a belief in the power of God, as

seen in the Christian faith, confession of shortcomings and misdeeds, and helping others with

similar maladies. Although the Oxford Group was developed to help people with problematic

alcohol use specifically, several of the principles it advocated were used and expanded on in AA.

AA believed the only qualification for membership was the desire to stop drinking. Therefore,

specific religion adherence or beliefs were not prescribed. Members were encouraged to look for

healing from God or higher power as they understood this. They believed that this would make

membership more inclusive for atheists or agnostics. AA emphasized that recovery was

mobilized through interactions with other members, and passing on their stories of healing to

other people with problematic alcohol use that continued to drink.

Synanon moved further from specific religious beliefs towards focusing on the power of

the group to encourage recovery from substances. Started in Santa Monica, California in 1958

by a group of recovered substance users (Vanderplasschen et al., 2013), Synanon is considered

the first TC, although members never used that language to describe their community (De Leon,

2000). Chuck Dederich led the Synanon community towards what he believed would be an ideal

restorative culture (Broekaert et al., 2000).

Synanon was marked by residential living for its members, rather than the gatherings of

the Oxford Group or AA that occurred at specific times during the week. Sobriety was required

of all who resided in the community. The particular substance was not held as a standard for

membership, like AA. Accordingly, many drug users and poly-substance users availed themselves of the Synanon community. Interestingly, Synanon proportionally drew more women and visible minorities than AA (De Leon, 2000). Members of Synanon realized that it was the here-and-now interactions with the other residents that provided the space for developing their own individual well-being. Although the development and formation of group interactions may not have been intended to be replicated elsewhere, Synanon leadership implemented two prominent therapeutic activities that are now integral to modern TCs.

"The Game," as it was known at Synanon, or encounter group, as it has come to be known in other programs, focused on eliciting open dialogue regarding the current relationships between the individual community members (Broekaert et al., 2000; Goethals et al., 2011). The goal was to enlighten residents regarding their unconscious, detrimental patterns of relating to others, and change these into patterns aligning with the values of right living. The encounter group continues to be an integral practice in present day TCs (De Leon, 2000).

A second element started at Synanon that has been maintained through years of TC development is hierarchical leadership. Dederich regarded residents of Synanon as children and therefore they had to be educated towards right living (Broekaert et al., 2000). In light of this, he held himself as the ultimate authority within the Synanon community. This particular style of charismatic leadership is likely to have contributed to Synanon's decline and demise. However, there has been some sort of hierarchical leadership model in many elements of modern day TCs. Currently, this is most clearly seen in the administration of work responsibilities, as newer residents are most likely to be assigned menial tasks (De Leon, 2000). Hierarchical leadership can also be witnessed in the peer mentorship roles, as senior residents facilitate the encounter groups or other community meetings. During the time that American TCs were growing and

enhancing their approaches, European TCs were developing along similar lines, but with some significant differences.

As alluded to above, the first European TCs were developed in late 1960s with a strong influence from Maxwell Jones. At first, these TCs were used for personality disorders, with little attention towards substance use until the 1970s (Goethals et al., 2011). As European TCs began to enhance their ability to treat substance users, they developed their own means of management congruent with the paradigm initiated by Jones. The hierarchical leadership of the American TCs did not permeate the European TC culture (Broekaert et al., 2000). Rather, the democratic approach shaped by Jones was adopted (Goethals et al., 2011). In practice, this meant that all members of the European TC had input into decisions, while in American TCs, leadership decisions were made by those who had seniority. Although this description may seem like a clear distinction of leadership styles, Broekaert et al. (2000) clarify that these styles are two ends of a continuum, and most TCs have elements of both hierarchy and democracy in the governance of their community.

Additional differences in cultures can be seen in the everyday practice of these TCs. For example, European TCs have traditionally sought more involvement from family members (Goethals et al., 2011). American TCs held a different view of family influences. In the early development of American TCs, under the influence of the Synanon community, family relational patterns were viewed as destructive. Therefore, residents were pressured to disengage from family connections and instead strengthen their attachment to the TC.

Another major difference is that European TCs have utilized professional staff from their earliest days (Broekaert et al., 2000). Broekaert et al. (2000) assert that this continues to be the dominant staffing model for the majority of TCs in Europe. This staffing practice has gradually

been advanced within American TCs. Although Synanon itself emphasized keeping recovered substance users in the prominent positions of leadership and staff, TCs that grew out of Synanon, such as Daytop and Phoenix House in New York, began encouraging professional input in order to enhance their programming (Broekaert et al., 2000). While professional involvement in North America is currently not as prevalent when compared to European TCs, professional therapies are employed within the peer-support milieu.

As TCs matured throughout North America and Europe, and individual communities developed unique characteristics specific to their particular population, questions were raised as to what defined a TC, while maintaining the diversity of individual TCs. Organizations such as the Therapeutic Communities of America (TCA) and the World Federation of Therapeutic Communities (WFTC) were both founded in 1975 to establish codes of conduct for leadership and ethical standards of practice (Broekaert et al., 2000; TCA, 2015; WFTC, n.d.). Because of the unique environments of each TC, these multinational bodies established the following standards for TCs (Broekaert et al., 2000; Broekaert et al., 1998):

1) Integral elements to TCs, namely self help and aid from the peer group, are the foundation of the TC process.

2) Residents are to be integrated into the community in order to support a prolonged interaction within the TC.

3) Leadership is open to questioning and challenges.

4) Staff members, regardless of past history with substances of abuse, must maintain standards of competence.

5) The TC must continually revisit its purpose in order to preserve its healing identity. Changes within TC practice may take place in alignment with its purpose while maintaining quality of service.

6) Participants may be suspended from the program for violations of community standards.

7) TCs are strongly encouraged to participate in international bodies.

8) Staff must uphold and practice ethical standards.

9) The community shares in a) daily life, b) community norms, c) maintaining safety by preventing violence and drug use, and d) practicing concern for the well-being of the community and its structure.

In the 1980s, both American and European TCs were affected by funding reductions. Modified TCs were developed that altered the duration of stay along with changing their service delivery to account for specific populations, such as women, homeless people, incarcerated individuals, and those who were dually diagnosed (Goethals et al., 2011). TCs continue to be employed throughout the world. There are likely over 3000 TCs currently operating globally (De Leon, 2015). In further chapters, I will expand on the operational procedures of TCs and demonstrate their history of effective practice.

Chapter 2: Elements of the Therapeutic Community

Several themes arose in the literature on Therapeutic Communities (TC). While I have already mentioned some of the main differences that occur between American and European TCs in the previous chapter, this chapter will focus on the similarities that are customarily present in TCs around the world. Specifically, I will focus on the structure and management of TCs.

Traditionally, TCs have included residents participating in 24 hour communal living (Roberts, Galassi, McDonald, & Sachs, 2002). TCs have historically been understood to be highly confrontational, usually within a group context, with punitive consequences for residents who have violated group norms (Broekaert, Vandevelde, Vanderplasschen, Soyez, & Poppe, 2002). Examples of this view have been popularized in such Hollywood movies as Clean and Sober (Howard, Daniel, & Caron, 1988) and 28 Days (Topping & Thomas, 2000). As TCs have been adapted for specific populations, so too have the interventions changed to becoming based in dialogue rather than confrontational approaches (Broekaert et al., 2002). Throughout the changes, however, the understanding of substance use and the goal of right living (De Leon, 1989) remained.

Two themes emerged in the literature as researchers described how TCs orient their residents to right living. First, residents are motivated to grow in personal and social responsibility, even though the growth is experienced as uncomfortable. Second, residents are encouraged to persevere through the travails of growth using the mutual support of the community. Debaere, Vanheule, and Inslegers (2014) speak of the tension between a frustrating environment and a holding environment. The frustrating environment exacerbates personal discomfort, while the holding environment provides a safe place to experience the frustrating

experiences alongside supportive peers. Pearce and Pickard (2012) describe these two

phenomena as a call to responsible agency and an environment that meets the need for

belongingness. Responsible agency requires the ability to reflect on one's own behaviours, the

insight to identify the desired changes to these behaviours, and the initiative to enact those

changes (Dawson & Zandvoort, 2010).

2.1 Pro-Social Bonding

Next I will first turn attention towards how TCs provide a sense of belongingness. Upon

taking a closer look at the TCs provision of a sense of belongingness, I recognized that Roberts

et al. (2002) refer to this as pro-social bonding. Pro-social bonding, they explain, provides

support to residents, which enables them to break bonds with detrimental attachments to former

relationships, and establish new, healthy relationships with the TC community. This may be

their first exposure to caring relationships (Roberts et al., 2002).

A reoccurring theme in the literature is that many substance users require terminating the

relationships that have been associated with their substance use patterns. First and foremost,

residents must move from a relationship with their drug of choice to a relationship with a healing

community (Nealon-Woods, Ferrari, & Jason, 1995). Additionally, residents may have social

connections that present reminders of the life the individual is trying to move away from, and

these reminders may distract from their motivation to practice sobriety. Thus, separation from

outside influences that are detrimental to the culture of the community is seen as necessary for

both the safety of the individual and the community (Center for Substance Abuse Treatment,

1999). TC residents are encouraged to obtain "sufficient psychological distance from their old,

dysfunctional support systems and be more resistant to temptation" (Bleiberg, Devlin, Croan, &

Briscoe, 1994, p. 737). Separation from former relationships not only serves as an aid to relapse

prevention, but can also guard against physical harm. The lifestyle of active addiction may entail retribution for violence due to unpaid debts (Debaere et al., 2014), therefore many TCs have protective guidelines that limit contact with unhealthy relationships outside the community (De Leon, 1989). As most residents have experienced a history of missing healthy social support, the TC emphasis on pro-social bonding is an integral element of their service (Hambley, Arbour, & Sivagnanasundaram, 2010).

TC leaders and clients recognize that there may be a tremendous sense of discomfort as new clients limit or cease their contact with previous relationships. This discomfort can be aggravated as the resident orients their behaviour to right living. To transition to new and healthy relationships and behaviours, new TC residents are oriented and mentored by senior residents. It is this peer support that is integral to the TC change process. Indeed, De Leon (2000) clarifies that it is not distinct methods that produce change, but rather community is the method. Because the primary therapist is the community itself, peer-pressure can be viewed as a fundamental aspect of the therapeutic process (Center for Substance Abuse Treatment, 1999). This peer-pressure is used to continually motivate positive change (De Leon, 1989). As many of the treatment staff are previous residents, they are seen as role models (Bleiberg et al., 1994) and senior residents, who display the evidence of positive change, help mentor newer residents (Debaere et al., 2014).

This supportive, interrelated way of practicing life is likely to evoke discomfort for those who have had a history of abusive, harmful relationships. Therefore, the development of a sense of belongingness must involve contact that is, "frequent, stable over time, positive and expressive of mutual concern" (Dawson & Zandvoort, 2010, p. 637). It is this continual exposure over a prolonged period of time that is likely to effect change. As will be shown in

later chapters, length of stay in the TC community is correlated to beneficial outcomes for members.

As alluded to above, current TCs have been observed to be less confrontational than in the past (Dye, Ducharme, Johnson, Knudsen, & Roman, 2009). That is not to say that confrontation has been done away with. Rather, behaviours incongruent with right living are addressed in a public forum, such as a meeting, with the goal of having the group enabling beneficial change for the individual (Broekaert et al., 2000). In these groups, members develop a "reciprocal sense of fellowship, belongingness, and support" (Nealon-Woods et al., 1995, p. 316) rooted in a culture that encourages personal responsibility and a belief that one can change one's behaviour (Dawson & Zandvoort, 2010). This can differ from the insight-oriented or psycho-educational groups practiced in other therapeutic contexts, as the TC paradigm believes that growth does not depend solely on insight, but rather on taking responsibility for behavioural change in the present (Broekaert et al., 2000).

Because of this caring social support, residents are able to endure the confrontation that occurs through honest, here-and-now feedback within the TC (Roberts et al., 2002). The recognition that support is needed to maintain sobriety is also a motivation to persevere through these uncomfortable processes (Nealon-Woods et al., 1995). If there are infringements of right living, negative consequences are decided by the residents and must be appropriate and delivered with compassion (Dawson & Zandvoort, 2010). Broekaert et al. (2000) observe that the offender is not the only object of the confrontation. Productive confrontation also involves the member or members who initiate the confrontation to acknowledge how the offending behaviour is affecting them, allowing the initiator to practice a measure of vulnerability as they seek to restore the

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offender to the standards of right living. This mutual community concern encourages hope to a greater degree than concern solely expressed by a professional (Dawson & Zandvoort, 2010).

Finally, Timko, Yu, and Moos (2000) bring attention to the level of functionality for individuals who are likely to benefit from a TC. The authors identified the interaction between high and low functioning clients with high and low demand programs. High demand programs are defined as "expecting more order and organization, and clarity regarding program routines" (Timko et al., 2000, p. 395). Additionally, the authors found that "high expectations for patients' spontaneity and discussions of their personal problems was related to better patient functioning, more patient activity, and more use by patients of program services" (Timko et al., 2000, p. 390). Furthermore, clients in high demand programs initiated more social activity (Timko et al., 2000). The authors caution that pro-social bonding may be experienced as too difficult for low-functioning individuals (Timko et al., 2000). The TC environment may not be conducive to the growth of an individual who lacks the capacity for responsible agency and insight into how their behaviour interacts in a structured, pro-social environment.

2.2 Clear Guidelines

Because of the diverse cultures and histories of TC residents, there must be common understandings in order to provide effective therapy and safe living accommodations. Roberts et al. (2002) emphasize that it is advantageous to the TC culture that clear guidelines are established, communicated, and manifested in the behaviours of TC members. The need for clear guidelines was seen by TC leaders as necessary for individuals who had a long relationship with substances. It was assumed that substance users had failed to acquire "[internalized] traits such as responsibility, honesty, and attention to detail that are important to character

development" (Roberts et al., 2002, p. 61). Many substance users have witnessed patterns of injurious personal interactions, and have perpetuated their own detrimental social behaviours (De Leon, 2010). To address these deficits, TCs use clear guidelines to focus on an orderly, predictable environment (De Leon, 1989; Debaere et al., 2014).

A function of abiding by an agreed upon structure is that it serves as an aid to pro-social behaviour (De Leon, 2010). At first, guidelines are communicated clearly through orientations and policy manuals (Timko et al., 2000). As time passes and a resident engages with the community, expectations for community living are not just a set of rules that the resident acknowledges, but they are seen by the resident, and the TC community, as a means of embodying right living and are upheld by the residents (Debaere et al., 2014). Well-defined structure is dependent on the residents and staff communicating shared cultural values and reorienting members to the guidelines of the program in the cases when expectations have been violated (Center for Substance Abuse Treatment, 1999; Broekaert et al., 2000). A particularly innovative element in the TC culture is that the development of guidelines and program planning are not limited to management and staff. TC members are encouraged to provide input regarding program planning and activities through resident committees (Timko et al., 2000). An additional function of these guidelines is that it is not only for the here-and-now functioning of the community, but they are also developed with a view to the future. Roberts et al. (2002) maintain that adhering to the norms of the TC helps ensure success as residents live by these standards after they complete treatment at a TC.

While individual TCs develop their own distinct culture, there are guidelines that are common to TC practice. Primarily, there is an expectation that residents will maintain abstinence from addictive substances (Debaere et al., 2014). If a resident is found to be using,

either through the witness of another resident or through testing positive through urinalysis (Roberts et al., 2002), she or he will be asked to leave the community. While this provision protects residents from the substance use that they wish to stop, other guidelines seek to safeguard the pro-social element of the TC. When residents experience conflict, use of violence is not allowed, and residents are not allowed to avoid resolving the confrontation (Debaere et al., 2014). As will be shown below, the TC takes seriously a responsibility to empower its residents with tools to engage in healthy confrontation and conflict management. The strength of the TC environment is a function of how effectively the residents apply these tools (Debaere et al., 2014). Finally, most TCs provide same gender service to ensure safety for those who may have endured harm from members of the opposite gender (Nealon-Woods et al., 1995).

2.3 Life Skills

A third key element for TCs is the development of life skills for its members. As mentioned above, many individuals with a long history of substance use have directed their energy towards obtaining and using their substance of choice, rather than growing in their interpersonal relationship skills and capacity to handle unpleasant emotions. Problematic substance use has been viewed as an attempt by the user to numb or distract from unwanted feelings or memories.   These triggers became license to use addictive behaviours (De Leon, 1989). As patterns of substance use are strengthened, these people encounter difficulties exercising skills to deal with triggers in a beneficial manner (De Leon, 2010). In a TC, residents develop coping skills that are an alternative to impulsively using substances to distract from these sensations (Bankston et al., 2009). Debaere et al. (2014) highlight that TCs are a frustrating culture, and frustrations are likely to trigger strong, unpleasant emotional experiences.

In order to engage with this frustration in a healing process, residents must develop an emotional maturity in order to benefit from these situations.

Many residents have voiced that the TC was the place where they grew up and learned to delay satisfaction (Debaere et al., 2014). Maturing takes time and therefore it stands to reason that an individual who spends more time in a TC is more likely to experience favourable results from their stay. As will be shown in later chapters, a greater amount of time spent in a TC is the most reliable predictor of success (Debaere, et al., 2014). Yet maturing does not occur by passively spending time at a TC; there must be effort directed towards developing the capacity to delay gratification and enhance pro-social behaviour.

Maturity in the TC culture can be demonstrated by an individual's capacity to engage in healthy social behaviour, constructive communication, and responsibility towards work (Roberts et al., 2002). To aid TC members in their pursuit of these behavioural objectives, staff often assign residents to practice new actions. Tools such as worksheets are provided to guide a resident in productive communication, (Debaere et al., 2014), prevent relapse (Reif et al., 2014), and to promote leadership roles (De Leon, 1989). As members demonstrate a responsibility towards their community they are given greater authority and leadership within the TC thus reinforcing these new skills (De Leon, 1989; Roberts et al., 2002).

TCs place a specific emphasis on respect for work (De Leon, 2000; Roberts et al., 2002). The word "work" refers to two distinct, yet related meanings. In the first meaning, work describes the tasks residents perform in the TC environment (De Leon, 2000). These tasks include grounds maintenance, kitchen and meal preparation, cleaning the facility, gathering and organizing donations, and supervising work teams. Consistent with the TC culture of residents advancing through stages of responsibility, there is often a hierarchical structure for assigning

work duties (Debaere et al., 2014). Tasks are commonly assigned according to seniority (De

Leon, 1989) from comparatively unskilled labour to management tasks.

The second meaning or work refers to the personal development that occurs as residents

progress in their capacity to handle frustrating situations that occur while they perform their

tasks. As De Leon says:

> The individuals themselves engage in their own recovery by participating in the change-
>
> potential activities, in and out of programs. In the TC programs a central activity is peers
>
> assisting each other in their participation. The word work underscores the effort the
>
> individual makes (not a medicine or a counsellor) in changing themselves by
>
> participation and practice (16, March, 2016, personal conversation).

TC members profit from this focus on work by developing a determined work ethic, which in

turn increases their employability. Additionally, there is a strong correlation between the

development of work abilities and decreased substance use (Roberts et al., 2002).

2.4 Staffing

Recently, TCs have undergone changes in how they have staffed their communities. In

the early years, recovered substance users who completed the TC program became staff and

continued to serve as role-models for newer members (De Leon, 1989; Debaere et al., 2014).

Currently, TCs accept the role of staff members with professional credentials, either as a core

component, or on a consultant basis (Center for Substance Abuse Treatment, 1999). While this

has been a characteristic of European TCs for many years, American models are currently

engaged in staffing their programs with professionals as core employees (Goethals et al., 2011).

This progression has been advantageous to TCs as these professionals have enhanced the

treatment experience for clients with other serious co-occurring concerns, such as mental health, homelessness, or physical limitations (Dye et al., 2009).

With these changes in the staffing of TCs, the question arises, "How has this changed TC service delivery?" In a study of current programs adhering to traditional TC elements, researchers discovered that staff with a history of recovery from substance use and who have completed the TC program are more likely than professional staff members to adhere to traditional elements of TCs, such as peer-confrontation and hierarchical structure (Dye et al., 2009). With numerous TC programs having a variety of staffing compositions and therapeutic techniques, there may be a concern that the term "Therapeutic Community" loses its distinctiveness. Therefore, it may be more accurate to describe some modified TCs as "TC-oriented" (Goethals et al., 2011, p. 1028).

In this chapter I have presented core elements that are integral to the functioning of TCs. Pro-social bonding is paramount to TC residents experiencing a caring supportive environment. As the residents recognize this support, they are able to make efforts towards right living. In the next chapter I will discuss the effectiveness of TC treatment.

Chapter 3: Effectiveness of the Therapeutic Community

In this chapter, I will explore the effectiveness of treatment in a TC environment by presenting a summary of outcomes from multiple studies. I have drawn from literature from the past three decades, as there is a long history of TC practice and research. I will then discuss the critiques of these studies, and argue for the validity of TC treatment. Finally, I will present a discussion of the literature that attempts to explain the phenomenon of client dropout and retention.

3.1 Effectiveness

This section will discuss and demonstrate the effectiveness of TCs. The effectiveness of TCs is understood as the degree to which community members meet the goals of abstinence from substances and manifest right living.

TC treatment has been found most effective in relation to changing an individual's use of substances and decreasing their criminal behaviour. In regards to substance use, Malivert et al. (2012) have found that clients' use of substances decrease in correlation with participation in and adherence to the TC program and lifestyle. In their systematic review of 12 studies, they write that all 12 reported a decrease in participants' substance use during the program when compared to a baseline measurement taken at intake. Additionally, Malivert et al. (2012) record that all of these studies performed follow-up measures at intervals ranging from six months to six years after program completion. These interviews also reported a decrease in participants' substance use. In a narrative review, Vanderplasschen et al. (2013) examined 16 studies that compared TC treatment to control groups that were 1) treated with a usual standard of care, 2) treated in a

shorter TC or TC day program, or 3) not being treated at the time (e.g., incarcerated or on a waitlist). They found that in nine of these studies, TC participants reported lower relapse rates or longer times between treatment and relapse at a one year follow-up compared to the respective control group. De Leon (2010b) states that TCs have not only been effective for those whose presenting problem is exclusively substance use. This treatment has also been effective in promoting well-being and diminishing substance use and distress for those substance users with compounding difficulties, such as psychiatric conditions, homelessness, methadone maintenance, and mothers with children. Indeed, clients accessing the services of TCs usually have higher level of dysfunction (Yates et al., 2010). Condelli and De Leon (1993) write that TCs are more effective at retaining clients compared to outpatient abstinence-based programs, but the retention rates are lower when compared to methadone maintenance programs (Condelli & De Leon, 1993). This may be due to the lack of extra-therapeutic supports for those utilizing outpatient services, while those who participate in methadone maintenance programs do not report the high distress levels that TC participants disclose. For TC participants who relapse to substance use, there is a longer time of abstinence after TC treatment when compared to other individuals who relapsed after engaging in different modes of service (Vanderplasschen et al., 2013).

From a criminal involvement perspective, TC treatment is associated with reduced financial expenditures for society due to participants ceasing criminal behaviour while engaging in a TC, as well as economic benefits due to their increased employability after they complete treatment (De Leon, 2010b). While treatment completion is not necessarily associated with sustained abstinence from substances, it is associated with reduced recidivism (Vanderplasschen et al., 2013). It is significant that drug use and criminal activity considerably decline while in a TC environment (De Leon, 2010a) since, unlike a prison based program where the clients are

confined, TC participants still have access and opportunity to return to substance use or illicit behaviour even while they are living in a TC.

The statistical findings of TC outcomes related to substance use and criminality are varied, as different TC communities have been studied using multiple research instruments and methodologies. In addition to the systematic and narrative reviews that I have already mentioned, researchers have demonstrated several positive outcomes in their studies of TC effectiveness. De Leon (1989) writes that in both national and program-based studies 30% of clients who participate in a TC are able to sustain abstinence from drug use and cease criminal activity. He notes that an additional 30% of program participants report meaningful improvements compared to their life before engaging in a TC, even though they do not report abstaining from substance use or criminal behaviour. Mierlak (1998) found that 75% of participants who completed two years of TC treatment remained abstinent from drugs and criminal involvement compared to 50% of participants who completed one year and 25% for those who did not complete treatment. In measurements of clients who drop out of treatment and clients who complete treatment, 40–60% of dropouts improve over baseline, while 90% of residents who complete improve over baseline (De Leon, 2010a)

It is not only in substance use and criminality that TC clients experience beneficial results. Improvement has been demonstrated in many realms, including anxiety, depression, impulsive behaviour, and personality disorders (Blankston et al., 2009; Dawson & Zandvoort, 2010; De Leon & Wexler, 2009; Taylor, Crowther, & Bryant, 2015). Clients have described an increased sense of well-being (Pearce & Pickard, 2012) and self-concept (De Leon, 2010b). A sense of belonging that is experienced in the TC environment has been linked to lower risk of suicide and aggressive behaviour (Pearce & Pickard, 2012). Additionally, employment rates

were higher for TC participants (Vanderplasschen et al., 2013). While these benefits from treatment are likely to be maintained (Vanderplasschen et al., 2013) the effects tend to level off after one year post-completion (De Leon, 2010a)

A theme that I observed in the literature is that one factor is frequently linked to beneficial outcomes. A prolonged length of time in TC treatment is most clearly correlated with favourable outcomes (De Leon, 2010a; De Leon & Wexler, 2009; Malivert et al., 2012; Vanderplasschen et al., 2013; Yates et al., 2010). Compared to residents who dropped out prematurely, residents who completed treatment "remain at significantly improved levels… after years of follow-up" (De Leon, 2010a, 121). Engagement in an aftercare program is also a strong indication of sustained success (De Leon & Wexler, 2009; Vanderplasschen et al., 2013), with at least 90 days in aftercare being correlated to maintaining outcomes (De Leon & Wexler, 2009). Yates et al. (2010) emphasize "TCs are effective for those who remain in treatment long enough for treatment influences to occur" (p. 97).

An important perspective to take into account when considering the effectiveness of TCs is an economic approach. Governments have placed a high precedence on cost effectiveness for substance abuse treatment since the early 1990s (Broekaert et al., 2002). In the United Kingdom, this focus has resulted in a preference for funding short-term programs (Dawson & Zandvoort, 2010). However, while there have been numerous studies devoted to the cost effectiveness of substance abuse treatment, there have been relatively few studies on this topic in relation to TCs (De Leon, 2010a).

From this small sample, it has been observed that TCs are effective from a financial perspective when accounting for two main factors. First, TCs provide a savings for society due to a reduction in public service use. This means that TC clients are not engaging in anti-social

behaviour that results in hospitalization or incarceration (De Leon, 2010a; De Leon, 2010b).

Second, TC residents are more employable after their stay, and therefore are in a better position

to contribute to society (De Leon, 2010b).

When evaluating the cost effectiveness of TCs, some programmatic elements must be

considered. The peer-support that encourages right living reduces the need for professional staff.

This equals a financial savings when compared to the staffing expenditures of hospitals, prisons,

or other institutions (De Leon & Wexler, 2009). There is also a need to account for residential

needs. The expenses of housing, facility maintenance, and food are all integral to the functioning

of a TC and cannot be easily delineated from the cost of clinical services (De Leon, 2010a).

Furthermore, there is a need to consider the higher administrative costs at the initial stage

of a client's program (De Leon, 2010a). As I will discuss below, there is a high dropout rate

during the first 30–60 days in a TC. It may appear that there is a disproportionally high

expenditure of funds designated towards these residents who leave prematurely, and display

minimal improvements. On the other hand, a resident who stays for the duration of the TC

program accumulates a higher total treatment cost, but as I wrote above, the benefits for these

individuals increase as a function of their increased time spent in the TC.

3.2 Validity of TC Research

In numerous studies over the past decades, as mentioned above, participants who have

engaged in a TC environment have demonstrated positive change in multiple areas of life.

However, there have been criticisms of these studies. In this section I will discuss questions

regarding the validity of the evidence, proposals of appropriate research paradigms, and present

possibilities for the best use of this research.

Evidence-based practice (EBP) has been accepted by practitioners, funders, and researchers as a measure for acceptable service procedures. In order to establish credibility with regard to these parties, it is important to establish if the TC is an EBP, and if not, how could the TC best be understood. Advocates for TC treatment have raised acknowledged objections about the TCs place among EBP (e.g. Bellasich & De Leon, 2012; De Leon, 2010a; De Leon, 2015; Vanderplasschen et al., 2013). This has been due to a history of poor methodological studies (Malivert et al., 2011); a high drop-out rate, which may compromise the validity of results (Vanderplasschen et al., 2013); an inability to achieve random assignment of participants (Vanderplasschen et al., 2013); evidence judged as spurious due to client self-report (De Leon, 2010a); and not meeting the demands of a randomized controlled trial (RCT) (Bellasich & De Leon, 2012; De Leon, 2015; Vanderplasschen et al., 2013).

TC research has been conducted differently than the medical research model, an approach deemed to meet the "gold standard" (De Leon, 2015, p. 1106) of research design. Researchers who practice according to the medical model first demonstrate the efficacy of a particular treatment in ideal circumstances before the treatment is implemented in real world conditions (De Leon, 2015). However, according to De Leon (2010a; 2010b; 2015), TC research has a tradition of following practice. This tradition can be observed from the beginning of the Synanon community as their leadership developed practices that seemed to bring about positive outcomes for group members. It was later that most evidence of positive outcomes was obtained through field outcome studies (De Leon, 2010a) and this observational evidence provided valuable data (De Leon, 2015).

Both De Leon (2015) and Broekaert et al. (2010) address criticisms levelled at TC research. De Leon (2015) asserts that it may be more accurate to assess TCs by the same

standard that educational programs are measured by due to the experiential and educational goals of the TC. In framing research this way, participants are viewed as dynamic agents in achieving beneficial goals, rather than passive subjects that TC treatment acts upon. Furthermore RCT may not be an appropriate research design as client self-selection to participate in a program is an intrinsic element of the TC process (De Leon, 2015), in opposition to the inherent method of random placement of participants in RCTs. Broekaert et al. (2010) suggest that the empirical research paradigm may not be the most appropriate study design for examining TC outcomes. Rather a phenomenological paradigm may be better suited to investigate TCs. "Phenomenological research concerns meaningful action, critical dialogue, inter-subjectivity, and particularity, and a cycle of planning, action, evaluation, change and improvement, based on subjective interpretations" (Broekaert et al., 2010, p. 232). This is more appropriate because TCs are more than their individual parts, and to be comprehensively studied, a qualitative research model such as the design Broekaert et al. (2010) propose is essential.

In a further argument, De Leon (2010a) advances his premise that TC treatment for substance use is an evidence-based treatment. Because TCs are "a multi-interventional treatment for a multidimensional disorder" (De Leon, 2010a, p. 123) the TC's dynamics may be too complicated to be studied by RCT (Yates et al., 2010). However, there is strong acceptance that the practices that TCs use are evidence based. These include peer tutoring, monitoring the therapeutic alliance, motivational enhancement, behaviour modification, and goal attainment (De Leon, 2010a). Within the TC environment, these evidence based interventions have proven to be effective (Yates et al., 2010). However, Broekaert et al. (2010) argue that only the interventions that are practiced within the TC environment, and not the TC process itself, can be evidence-based. From my research, I agree with Broekaert et al. (2010). I believe that TC research, as

presented in the systematic studies mentioned above, has not met uniform criteria in the methodology of research or the measurements of TC outcomes. Therefore the evidence gathered by the studies I have mentioned does not strictly meet standards for EBP[2]. However, while TC research may not meet these standards, it appears to me that there is enough evidence to demonstrate that it is an appropriate treatment for a particular population of substance users, as I will demonstrate below.

Instead of equating the RCT as the gold standard of research designs and EBP as the criterion for interventions, De Leon (2015) argues that the research design itself should not be the standard of by which TCs are judged. Research should be tailored to be appropriate for the subject studied and the evidence that is discovered should be considered by whether or not it advances the knowledge base.

Adapting research design to service provision would be an appropriate course of action due to the prerequisite of client self-selection. Although this is counter to the random placement required by RCTs, "motivation and self-selection are considered to be crucial ingredients of the treatment process" (Vanderplasschen et al., 2013, p. 2). Rather than focus on the practices of the TC, research could be shaped to ascertain which clients are most suitable to TC treatment (Vanderplasschen et al., 2013). Taking this approach may be quite beneficial to understanding the dynamic relationship between the TC and the individuals who access their services. After all, numerous outcome studies have shown TC effectiveness (Yates et al., 2010) but not one treatment has been shown to produce higher beneficial outcomes. Different treatment approaches have demonstrated comparable results, and research could be beneficial to discern

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[2] There are several critiques of using EBP as the standard for therapeutic practice (e.g. De Leon, 2010a; Epstein, 2011; Lilienfeld et al., 2013; Zayas,, Drake,& Jonson-reid,2011). It is beyond the scope of this paper to discuss this criticism.

who would benefit most from a particular mode of treatment delivery (Vanderplasschen et al., 2013). Put another way, it may be more helpful to conceptualize that a particular treatment is appropriate at a certain time for a specific individual who desires to change her or his relationship to substances (Broekaert et al., 2010).

3.3 Retention

TCs have been shown to produce numerous benefits for the population they serve. As I referred to above, multiple studies have demonstrated that these benefits are more likely to be realized when a client is able to maintain her or his relationship with the TC for a sustained duration of time. This leads me to the final topic of this chapter. What is known about the factors that enhance retention and diminish dropout?

De Leon writes that, "retention can be understood as a continuing interaction between client diversity and treatment (program) factors" (1991, p. 236). In other words, there is a dynamic relationship and tension between a heterogeneous population and a homogenous program structure. Retention is more than simply staying in residence at the TC. It is a continual engagement and investment by both the individual and the group. The individual modifies her attitudes and behaviours to align with TC philosophy, and the program leaders and members maintain an openness to monitoring their own therapeutic practice to best meet the needs of the individuals in their community.

I have noticed several factors in the literature that lead to both dropout and retention. At times, various studies have presented findings that are at odds with former conclusions. One element that has been found consistently is that dropout usually occurs in the early stages of TC involvement. Condelli and De Leon (1993) discovered that clients were most likely to drop out

during the first 90 days after admission. Yates et al. (2010) assert that it was often in the first 12 weeks. De Leon et al. (2000) maintain that the likelihood of dropout remains high during the first 30–60 days, and then levels off significantly.

Factors associated with dropout are varied. Clients are more likely to drop out earlier in a program because of personal reasons (De Leon, 1991) such as work, family pressure, or wanting to use. They have also been found to think that their substance use problem is not as severe when compared to others and they often do not believe that they need to stay in treatment. Low motivation and lack of readiness for the work of the TC has been correlated to a high risk of drop-out (De Leon, 2001). Additionally, clients early in their treatment may experience ambivalence regarding diminishing or ceasing substance, and this ambivalence can be a motivation for dropping out of treatment (Klag, Creed, & O'Callaghan, 2010). Finally, in another study regarding early client dropout, participants who identify a high degree of beneficial change early in their program may drop-out believing that they have attained the skills required to maintain their treatment goals (De Weert-Van Oene et al., 2001) and therefore believe they are no longer requiring treatment. A quick rise in perceived benefits may be a signal that the client is at risk for prematurely leaving the program. De Leon (1991) advocates staff actively monitor newly admitted clients for signs of drop-out. If a resident manifests these behaviours, senior staff or residents, as representatives of the community, can take the opportunity to reach out to the new resident. They are able to extend the invitation to the resident to reengage with the TC and communicate that the new resident has significance and importance in the community.

Clients who drop out later in a program are more likely to leave because of difficulties with the program, such as problems with staff or no longer wanting to abide by the schedule (De Leon, 1991). Those who dropped out were less likely to perceive strong therapeutic alliance (De

Weert-Van Oene et al., 2001). Complaints against work requirements are a common predictor of drop out (Mierlak, 1998). Furthermore, drop out is correlated to client perception of a detrimental atmosphere in the community, an unorganized program, and ambiguous expectations of TC participants (Carr & Ball, 2014).

The elements that are correlated to retention are as varied as those correlated to dropout. One theme that emerged from the literature was the relationship between retention and a client's involvement in the criminal justice system. Participants were more likely to stay if they had been referred by or were involved with the justice system (Carr & Ball, 2014; Condelli & De Leon, 1993; Mierlak, 1998; Vanderplasschen et al., 2013). Furthermore, referred clients from such agencies as family services, community counselling, or hospitals, were observed to stay longer than self-referrals (De Leon, 1991).

Participants who had experienced similar environments to TCs were also more likely to stay. They were more likely to stay if they had previous experience with large groups (Condelli & De Leon, 1993), completed a prolonged commitment (Mutter et al., 2015), and had a history of employment (Mierlak, 1998). Moreover, Mierlak (1998) found that an individual's job experience has a higher correlation to retention compared to an individual's criminal history.

Program completion has also been linked to older age, single substance of use (as opposed to multiple substances) (Vanderplasschen et al., 2013), the client's perception of her or his need of a program, his or her expectation of required treatment length, the circumstances that factored into the decision to enter a program (Condelli & De Leon, 1993), and readiness for treatment and self-efficacy (De Weert-Van Oene et al., 2001). Surprisingly, while family involvement in the therapeutic process has been correlated to retention (Carr & Ball, 2014), marriage has been linked to premature termination (Mutter et al., 2015). From my experience,

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these seemingly conflicting findings may be explained by the differences between the support of family members and the needs of a spouse. It is common for TC residents to be estranged from their family, and often their spouse as well, while engaging in substance use. When they make the decision to participate in a TC, this decision can have a different effect on the dynamics in relationship to family and spouse. While family is often encouraging and supportive of the TC resident to continue in treatment, their spouse more often will want them to return home, especially if the spouse is at home caring for children alone.

In light of these factors, I believe it is integral to identify how a TC can enhance the elements that lead to retaining clients. As highlighted above, the client's perception of the program has been correlated to dropout. Therefore, it is integral to be mindful of the TC atmosphere. This includes positive peer-interactions (Warren et al., 2013), a sense of responsibility to the community (Carr & Ball, 2014), program participation (Warren et al., 2013), and the therapeutic alliance (De Leon, 2001; De Weert-Van Oene et al., 2001). Retention can be enhanced through ongoing relationships with long-term residents and senior staff (De Leon et al., 2000) who have had the knowledge and experience to beneficially intervene when symptoms of dropout are manifest in the behaviours of residents. Finally, ongoing monitoring of the therapeutic relationship between the individual client and her or his counsellor has been attributed to client retention (De Leon, 2001; De Weert-Van Oene et al., 2001), therefore, it is beneficial to maintain a regular practice of gauging the client's perception of the alliance and their progress towards their therapeutic goals (Miller et al., 2015).

In this chapter I have described a history of TC research and outcomes from these studies. I have identified critiques to these studies and provided responses to these criticisms. Finally, I discussed factors associated with client retention and drop out. I will now propose

recommendations for TC programming that accounts for this research and is relevant for a TC in

Vancouver.

Chapter 4: Conclusion and Suggestions

In this final chapter, I will explore methods for strengthening a sense of psychosocial integration among TC residents. I have specifically drawn attention to actions that are applicable to the context of Vancouver. As I wrote in my first chapter, Vancouver has a history of ideologies and practices that dislocate individuals and groups for the purposes of increasing the influence of free-market structures. Rather than suggest a treatment approach that replicates the colonial methods used over a century ago by imposing a correct method or competitive practice, I propose that a TC paradigm can be applied in a manner that is relevant to the cultures they interact with. In reference to Alexander's theory of dislocation (2008), I will seek to provide suggestions that locate TC theory and method within the historical context of Vancouver, while describing practices that can serve to increase psychosocial integration.

4.1 First Nations Population of Vancouver

Alexander (2008) writes that a key element to reducing addiction among all people in Canada is addressing the psychosocial dislocation of the original inhabitants. He describes pre-colonial First Nations living in an integrated system, dependent on relationships between individuals and the community, and between the community and their land. As I described in my first chapter, this way of life was greatly disturbed by British colonists who saw the natural resources of the land as a source of profit and the inhabitants as inconsequential. Currently, while society may be more conscious of environmental concerns, it seems that these are secondary to the desire for using the land's resources to maintain and increase the free-markets (Alexander, 2008). This relationship to the land can be re-envisioned so that the population who

currently live in Vancouver are able to maintain a sustainable, life-giving connection. To increase a sense of psychosocial integration with the land, it is beneficial to acknowledge the people who first inhabited the territory.

According to Statistics Canada's 2006 census, 196,075 people in British Columbia identified as aboriginal (Statistics Canada, 2010). Within this population, 40,310, or 20%, live in metro Vancouver. This population increased by 9% increase from 2001. Because of this significant population percentage, coupled with a notable five-year increase in population, it is integral to be sensitive to the experience of First Nations people.

The 2006 census data listed several factors associated with psychosocial dislocation among aboriginal respondents. When compared to non-aboriginal people, the data showed:

- higher incidences of children living with a single parent

- less likelihood of youth attending school

- lower rates of completing post secondary education

- higher unemployment rates

- lower income

- one third of aboriginals living below the low income cut-off

- a higher likelihood to be living in homes needing major repairs

Additionally, although I have not found specific statistics, Alexander (2008) and Maté (2009) both assert that there are higher rates of substance use and higher rates of being afflicted by substance use among the aboriginal population.

4.2 First Nations Treatment Research

In my search for research using the terms "Therapeutic Community" coupled with "First Nations," "Aboriginal," "Native American," or "Indian" very few relevant results were returned. One author, Gone, had multiple articles (2011; 2013). In fact, Gone (2011) calls attention to a lack of peer-reviewed psychological articles regarding Native American treatment. Furthermore, research into this topic has primarily concentrated on treatment located on reservations or in rural settings.

Similar to the TC theory that community is method (De Leon, 2000), much of the focus on First Nations treatment is contained in the concept that culture is treatment (Alexander, 2008; Gone, 2013). However, Gone (2011) clarifies that First Nations treatment delivery should be subject to research into treatment efficacy. He adds that popular treatment does not equal effective treatment. Indeed, there is a lack of literature regarding effectiveness of First Nations approaches (Gone, 2013). There appear to be no studies utilizing RCT for mental health provision involving substantial numbers of First Nations participants (Gone, 2013).

However, as I explained in the previous chapter, research results are most beneficial when appropriate research methods are employed. Indeed, I found similarities in the criticism of the research regarding First Nations treatment and TC treatment. In both methods, isolating specific healing factors is very difficult (Gone, 2013; De Leon, 2010a). Additionally, Gone (2013) asks a question in regards to client self-selection, echoing Broekaert et al. (2010) and De Leon (2010a; 2015). Rather than asking about the effectiveness of First Nations cultural treatment, a more appropriate question is what client population is this treatment most effective for? Finally, from my research, it seems that further study into First Nations treatment in an

urban context would be beneficial. This is especially salient considering that 20% of the aboriginal population of British Columbia resides in Metro Vancouver.

4.3 Methods

As I have demonstrated through this paper, effective treatment for substance use will take into consideration the psychosocial dislocation experienced by groups and individuals. This is especially poignant for a First Nations population who experienced centuries of cultural violation. Treatment that honours cultural practices and recognizes the experience of social dislocation, or historical trauma, will facilitate a higher level of psychosocial integration that focuses more on the societal factors contributing to addiction, rather than seeing addiction as primarily an individual disease or shortcoming (Alexander, 2008; Gone 2011).

Two terms are important to define: culture and historical trauma (HT). First, culture can be understood as "the socially patterned and historically reproduced systems of semiotic practices that both facilitate and constrain human meaning making" (Gone, 2011, p. 188). Culture is grounded in history and dynamic in the present. Second, HT is trauma imposed on a distinct population over multiple generations resulting in "psychosocial disruption and disorder" (Gone, 2013, p. 684). Although symptoms of HT may manifest similarly to post-traumatic stress disorder (PTSD), HT is more complex. Whereas PTSD is confined to an individual, "HT is described as a collective phenomenon" (Gone, 2013, p. 687). More so, HT is applicable when the collective trauma is experienced over generations. The awareness of HT when working with First Nations in Vancouver is integral because a shared experience of conflict may require a communal effort towards recovery (Gone, 2013)

Gone (2013) highlights three pillars of healing: "reclaiming history, cultural interventions, and therapeutic healing" (p. 690). I will turn my attention towards the latter two

pillars before addressing the first. Many treatment centres that service First Nations clients have integrated cultural practices into their programming. As of 1985, sweat lodges have been incorporated into 45% of substance use treatment programs funded by the United States Indian Health Service (Gone, 2013). That number continues to grow. Additionally, many cultural practices such as "talking circles, pipe ceremonies, sweat lodges, and other tribally specific cultural practices for therapeutic purposes" (Gone, 2013, p. 696) are offered in these programs. When compared to Western-based professional therapeutic practice, this approach to First Nations treatment has more of a communal and relational approach. This includes involving multiple generations in cultural practices (Alexander, 2008), counsellor availability around the clock (Gone, 2011), recognizing the importance of "community renewal" (Gone, 2011, p. 196) rather than limiting interventions to individual or group treatment, and incorporating practices guided by spirituality rather than EBP (Gone, 2011). This therapeutic healing through spiritually-focused interventions is especially relevant for a First Nations population. Gone (2013) hypothesizes that the explanation for beneficial change is "spiritual transformations and accompanying shifts in collective identity, purpose, and meaning-making" (p. 697).

In the city of Vancouver, there are a number of venues for First Nations cultural practices. The Aboriginal Friendship Centre Society on Hastings Street has provided a number of services since 1963 centre on Hastings Street provides a number of services (Vancouver Aboriginal Friendship Centre Society, 2016). These activities include groups for residential school survivors; skill building for developing healthy families; advocacy for families engaged in the Child Protection program; and evenings devoted to recognizing specific tribes. Down the street at the PNE Fairgrounds local Nisga'a tribe members annually celebrate Hoobiyee—the Nisga'a New Year (Nisga'a Ts'amiks Vancouver Society, n.d.). This is a celebration of Nisga'a

culture that is open to all people. Events include traditional dances, stories, and singing.

Additionally, in 2013 the First Nations Health Authority became the first provincial health

authority in Canada to devote their efforts towards restoring and maintaining First Nations

wellness (First Nations Health Authority, 2016). These measures include providing the province

with a First Nations paradigm for wellness; addressing issues regarding environmental health;

and encouraging traditional healing practices. Even though these organizations are taking

meaningful steps to revitalizing First Nations identity, many of these cultural practices were

developed for a homogenous group who were intimately connected to their ancestral land. As

the people and geography of Vancouver have changed over the last centuries, there is currently a

need to integrate these traditions and rituals into the present societal milieu.

4.4 Cultural Fusion

The First Nations population in metro Vancouver coexists in a multicultural society. It is

prudent to consider this reality when considering appropriate cultural interventions. Gone (2011)

emphatically states, "no indigenous people should be imprisoned by a postcolonial nostalgia for

a 'pristine' pre-modern era" (p. 199). First Nations culture will not return to pre-colonial times

as society and the geographical environment have changed (Alexander, 2008).

Alexander (2008) has used the term "cultural fusion" (p. 376) to describe the

intermingling and amalgamation of diverse cultures. This notion captures the richness and

distinction of contributing cultures, while recognizing that as they interact, much can be learned.

Through embracing the reality of this cultural hybridity, effective approaches can be developed

that incorporate both Indigenous and Western practices (Gone, 2011).

A meaningful first step to generating effective therapeutic rapport with First Nations clients in a TC is acknowledgement of the value and benefits of their cultural practices (Gone, 2013). This is more than a token gesture. The intention is to humbly recognize that there is wisdom to be gained from First Nations' culture, just as there is wisdom in Western approaches. No matter where specific therapeutic techniques originated, it is the responsibility of staff and senior residents to present recovery practices that are relevant to the clients' worldview and theory of change. The key has been that when mainstream Western interventions were effective among First Nations clients, they were reinterpreted in a manner appropriate for the client (Gone, 2011). Furthermore, many of these effective practices have incorporated a strong dimension of spirituality (Gone, 2011). First Nations counsellors have attributed the success of AA among First Nations clients to the prominence of spirituality. Additionally, AA does not prescribe an understanding of a Higher Power. Rather, First Nations can draw upon their own relationships and history to shape their understanding of their Higher Power.

One creative way in which First Nations people have reclaimed their history, the first pillar of Gone's (2013) three pillars of healing, is through a project initiated by the City of Vancouver called the Vancouver Dialogues Project (Wong & Fong, 2012). This project was established to address the concern among First Nations people that "their history, culture and heritage are not well understood by others living within their traditional territory" (Wong & Fong, 2012, p. 19). For recent immigrants, there seemed to be a lack of opportunities to learn about the story of the Coast Salish people. In this project, small groups of 10 to 15 participants met to learn from the personal stories of First Nations people. Overall, 123 people participated. These people reported having a new understanding of the complex history of the colonization and racism that First Nations have experienced.

The concept of the Vancouver Dialogues Project could be advantageous to the TC experience. For many substances users, their most active relationship is with their drug of choice. Even when in recovery, it is common to hear in 12-Step meetings, "My name is… and I'm a grateful recovering alcoholic or addict." An initiative similar to the Vancouver Dialogues Project may invite TC members to consider themselves in a new relationship to the land they live in and the people who originally inhabited the land. For First Nations TC residents, this could be an opportunity for their story to be heard and validated by their peers in recovery.

4.5 The TC and the Greater Community

In the TC literature, I have found that their use of the word "community" is limited to the immediate context of the TC itself. While TC programming may take into account the benefits that families and communities experience as TC participants engage in healing practices, these benefits have been described in the literature as latent effects. The immediate goal of treatment is for individual healing through the TC comprised of residents and staff. From my research, I believe that Alexander's (2008) theory of dislocation can be applied to TC's to create a more holistic approach to recovery by enhancing psychosocial integration. This can occur when the understanding of community is expanded to include the society the TC interacts with, and that land that it exists in.

Alexander (2015a) has observed that recovery from addiction can, and does, occur when individuals find a new sense of meaning through strong relationships with their community and their land. Many of the individuals have perpetuated actions that have actively damaged their relationships with others and the environment. Alexander (2015a) also draws attention to the damage that occurs to these relationships when they are neglected. Individuals caught up in

addiction do not have the attention or energy to engage in actions that preserve their relationships or the environment (Alexander, 2015a).

When individuals engage in actions that protect and enhance their relationship with others and their environment, they have the potential to further solidify their recovery from substance use. Psychosocial integration can be experienced as individuals work towards a shared sense of purpose and identity (Alexander, 2015a). I will now turn my attention to how these efforts can be performed in Vancouver.

One event that I have participated in is called Keep Vancouver Spectacular (City of Vancouver, 2016). In this event, over 15 clients of a residential recovery program took part in a gathering of people who picked up garbage around the Commercial Drive area. Participants reported a sense of camaraderie and purpose as they cleaned up city parks and alleys that they had previously visited for the purposes of using substances. In a humorous twist, the Vancouver Community Police helped facilitate Keep Vancouver Spectacular. A number of clients reported it was their first positive interaction with police!

I am also intrigued by an interesting initiative that was implemented in Colorado. A program called Jaywalker Lodge has enhanced recovery programming with opportunities for their clients to serve local and distant communities. These opportunities have included large-scale disaster relief, community development on Native American reservations, and helping at animal shelters (Reed & Sanson, 2014). They have partnered with organizations such as Habitat for Humanity, Aspen Homeless Shelter, and Colorado Animal Rescue (Jaywalker Lodge, 2016).

Staff and residents have identified several benefits derived from these endeavours (Reed & Sanson, 2014). Recovering substance users have often perpetuated actions that have damaged their relationships to their family and greater community. Through performing acts of service

that honours their community, participants gain a greater self-esteem out of efforts contingent with psychosocial integration. These integrating actions build participants' capacity to engage in meeting the needs of the greater community, rather than solely on self-gratification. As I mentioned earlier, Alexander (2015b) describes an integrated society as one whose members know their role and how their roles contribute to the whole community. This is true for the members of the Jaywalker Lodge service teams. As the projects are planned, roles and responsibilities are formalized in order to achieve a common goal, helping participants experience healthy interdependence within their team. Finally, after each day of service, the program participants meet together to debrief the day. In this way, members turn their attentions towards creating a common story and making meaning of their service to the community.

I would like to see a program like this for a Vancouver-based TC. I envision that this could occur through partnerships with First Nations bands. Like Jaywalker Lodge, the TC participants would first need to achieve a measure of emotional and physical stability in their recovery. First Nations communities could be approached through band members who are senior residents or former clients of the TC. The team from the TC, comprised of both staff and residents, would partner with the leadership of the band to ascertain the needs of the community and how the TC team could meet the needs. Lencioni (2010) advises that when engaging in a process to determine needs and methods to meet these needs, providers are wise to ask questions that draw on the wisdom of the client—in this case, the First Nations community. Not only is this approach respectful towards the agency of the community leadership, but it may also prevent replication of traumatic or colonial approaches.

This proposal has several beneficial goals. First, in building a relationship with the band, it communicates that people outside of the their immediate community are concerned with

forming a healthy relationship with them. The relationship between First Nations and non-aboriginals can be re-patterned to a vibrant partnership where both groups learn from each other. This learning is a second valuable goal. Like the Vancouver Dialogues Project, TC members can hear the stories of the people of the land in order to appreciate the history of First Nations people. The effects of HT from survivors can be witnessed and validated by non-aboriginals. TC members can discuss how they benefit from, and can contribute to, this culture. Third, TC residents or graduates who are originally from the band may deepen their sense of integration with their First Nations community. Band members who are living in an urban setting may feel a strong sense of dislocation from their original people and land. This sense of dislocation may be mitigated if they can experience a healing, restorative interaction with their people. In turn, these returning band members may provide an example of TC 'right living' that inspires the recovery of other band members who struggle with substance use.

4.6 Conclusion

In this paper I have presented a history of Vancouver from the perspective of Alexander's theory of dislocation (2008) and how addiction functions to diminish the sense of dislocation. With this understanding of dislocation and addiction, I proposed the TC paradigm as a means of providing an environment for recovery and establishing new patterns of psychosocial integration. I demonstrated that although TC research may not align to the gold standard of RCT, the evidence is strong that TCs provide beneficial outcomes for clients who choose to engage in the TC experience. Finally, I highlighted some current practices that encourage recovery from substance use through healing interactions with their immediate relationships in society. As I wrote in the opening chapter, the psychosocial dislocation evidenced in society is so large in

scale that efforts towards curbing this momentum seem overwhelming. Yet there are groups and individuals who continue to encourage hope-filled practices that serve to benefit individuals and communities as they strive towards an integrated relationship with themselves and the world around them.

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