

**THE THERAPEUTIC COMMUNITY
TREATMENT MODEL:
OVERVIEW AND ANALYSIS OF KEY
THEMES AND ISSUES**

**A joint study prepared by
The Social Planning Department, City of Vancouver
and The John Volken Society**

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**THE THERAPEUTIC COMMUNITY TREATMENT MODEL:
OVERVIEW AND ANALYSIS OF KEY THEMES AND ISSUES.
EXECUTIVE SUMMARY**

On July 25, 2002 City Council approved the following resolution:

THAT Council is prepared to consider a facility offering an abstinence-based residential program providing counselling, life skills training, education, vocational and trade training, and employment-oriented rehabilitation, which responds to the findings of a staff-proponent study of the experience with similar facilities in other cities, particularly regarding location characteristics, the ages and number of student-clients, staffing, partnerships with businesses in the community, and affiliations with established schools, colleges and universities, such a study, including on-site interviews where appropriate, to be at the proponents' expense and prior to submission of any rezoning or development application, as the case may be.

This report analyses the strengths and weaknesses of the therapeutic approach, or (TC) model. The report also makes general recommendations regarding the feasibility and appropriateness of a TC treatment facility operating in Vancouver.

Methodology

A joint team comprised of representatives from The John Volken Society (“The Society”) and The Social Planning Department, City of Vancouver (“The City”) carried out the research for this study. The research methodology involved (1) An in-depth literature review of therapeutic community theories, models and practices in North America; (2) A review of existing longitudinal studies on success rates of therapeutic community models; (3) Site visits to Phoenix House, Daytop Village, Covenant House and The Center for Therapeutic Community Research in New York City; Delancey Street and Walden House in San Francisco; as well as Covenant House in Vancouver.¹ (4) Follow up with City Planners and other relevant experts; (5) Compilation and analysis of data; and (6) Formulation of conclusions and recommendations.

¹ A description of the sites visited can be found in Section 2 of this report.

What is a Therapeutic Community?

The TC for the treatment of addictions is defined as follows:

“A therapeutic community is a drug-free environment in which people with addictive (and other) problems live together in an organized and structured way in order to promote change and make possible a drug-free life in the outside society. The therapeutic community forms a miniature society in which residents, and staff in the role of facilitators, fulfil distinctive roles and adhere to clear rules, all designed to promote the transitional process of the residents”(Ottenberg 1993 in Broekaert: 2001: 29).

Recent years have seen TCs adapt to serve the particular needs of a number of ‘special populations’ including adolescents, HIV positive and AIDS clients, homeless men and women, mothers and children, mentally ill chemical abusers and methadone clients² (DeLeon 2001b: 385).

Based on the research and analysis undertaken, the research team formulated the following recommendations:

RECOMMENDATIONS – PROGRAMMATIC

Therapeutic approach

- Carefully choose the resident group, and design an appropriate program to serve their specific needs. Expansion should be phased in gradually beginning with a small core group of staff and residents. Expansion should take place according to clear criteria defining success and readiness.
- Align the specific needs of the resident group with the goals of recovery, the planned duration of treatment, and the nature and extent of aftercare services (e.g. transitional housing, peer network, help finding and keeping a job, follow-up counselling).
- The resident group should comprise a majority adult population (approximately 25 – 40), as opposed to a majority youth population (under 25 years).

²Due to the abstinence-based focus of the TC, the presence of methadone treatment is not the norm. However, some TCs are beginning to experiment with methadone as an aspect of treatment (See DeLeon 2001b: 385 – 386, for more information).

Staffing

- Program staff should comprise a mix of self-help recovered professionals and other traditional professionals (e.g. nurses, physicians, lawyers, case workers, counsellors) who should be schooled in the specifics of the TC model.
- New TCs should establish affiliations with regional, national and international TC associations, teaching hospitals and universities to ensure high professional standards for program content, therapeutic approach, and staffing.

Research and evaluation

- Given the high drop-out rates of TC residents, existing research and pre- and post-evaluation tools should be consulted and used to set recovery goals, design the program, set staffing levels, and plan aftercare services.
- Research on outcomes for any new TC should be started at the earliest stage possible in the TC's operation, and carried through as an on-going feature of the TC.

RECOMMENDATIONS – OPERATIONAL AND GOVERNANCE

Optimal governance and management structure, on-going consultation

- New TCs should rely on experienced leadership in governance and management structures.
- Senior administrators and other paid professionals should preferably have first hand experience and on-going training in human service delivery generally, but also the specific challenges presented by the TC model in particular.
- On-going consultation should take place with social service providers, educational institutions, vocational training institutes. In addition, advisory groups comprised of residential and industrial neighbours should be established.

Funding

- TCs should develop a long-term funding strategy which is particularly attentive to phase-in and expansion stages when operational funding needs will necessarily be in transition.
- The long-term funding strategy should indicate how construction, operation and maintenance will be funded on an on-going basis.

Intake and referral, transitional planning

- The intake and referral process should be rigorous and thorough, with a careful match being made between the intake process, program design and residents' needs.
- Aftercare services should be carefully planned, with particular attention to the need for affordable housing for residents who complete the program.
- TCs should, where possible, undertake longitudinal follow-up research to track the success of graduates and help identify best practices, as well as program areas in need of improvement.

RECOMMENDATIONS – LOCATIONAL

Locational

- Any TC proposal should, where possible, comply with pre-existing City land policies, zoning by-laws and / or development plans.
- Health care services, including dental, should where possible, be delivered on-site.
- A detailed description of the proposed core programs should be included in the proposal. This includes a detailed overview of all intended uses for the proposed site.

Neighbourhood Impacts

- On-going consultation with residential and industrial neighbours about potential impacts should be established early on in planning stages.
- An advisory body made up of community representatives and social service provisioners should help guide the development and phase-in process.
- Even though the TC is a self-contained facility, the site should ideally be such that residents are removed from the area in which they were using drugs or engaging in other negative behaviours.

Phase-in criteria

- Where possible, new TCs should seek staff training from well-established TCs and recognized TC organizations who offer such services (e.g. Walden House or The Center for Therapeutic Community Research).

- TCs should start small and phase-in slowly. TCs should begin with a core group of 5 to 10 residents plus adequate staff, then add a few residents at a time.
- A clear and specific set of expansion criteria should be established early on in the proposal stages.
- The initial client group should be chosen very carefully, with a good match being made between client need and program design.

THE THERAPEUTIC COMMUNITY TREATMENT MODEL: OVERVIEW AND ANALYSIS OF KEY THEMES AND ISSUES

INTRODUCTION

On July 25, 2002 City Council approved the following resolution:

THAT Council is prepared to consider a facility offering an abstinence-based residential program providing counselling, life skills training, education, vocational and trade training, and employment-oriented rehabilitation, which responds to the findings of a staff-proponent study of the experience with similar facilities in other cities, particularly regarding location characteristics, the ages and number of student-clients, staffing, partnerships with businesses in the community, and affiliations with established schools, colleges and universities, such a study, including on-site interviews where appropriate, to be at the proponents' expense and prior to submission of any rezoning or development application, as the case may be.

This report analyses the strengths and weaknesses of the therapeutic approach, known as the therapeutic community (TC) model, described in the above motion. The report also makes general recommendations regarding the feasibility and appropriateness of a TC treatment facility operating in Vancouver, where no such facility currently exists.

Methodology

A team comprised of representatives from The John Volken Society ("The Society") and the Social Planning Department, City of Vancouver ("The City") carried out the research for this study. The research, including sites visits, was undertaken by representatives from the Society and the City. A steering committee comprised of the Executive Director of The John Volken Society and the City's Director of Social Planning supervised the study.

The research methodology involved (1) An in-depth literature review of therapeutic community theories, models and practices in North America; (2) A review of existing longitudinal studies on success rates of therapeutic community models; (3) Site visits to Phoenix House, Daytop Village, Covenant House and The Center for Therapeutic

Community Research in New York City; Delancey Street and Walden House in San Francisco; as well as Covenant House in Vancouver.³ (4) Follow up with City Planners and other relevant experts in New York City and San Francisco; (5) Compilation and analysis of data; and (6) Formulation of conclusions and recommendations.

Structure of the report

The report comprises four main sections: (1) Introduction: background and context; (2) An overview of the sites visited; (3) Themes for discussion and analysis: (3.1) Programmatic issues (the therapeutic approach, staffing, 'success rates' and outcomes); (3.2) Operational issues (including administration, governance, and funding); (3.3) Locational issues (including neighbourhood impacts, outreach, facility design, and size); (4) Conclusions and recommendations.

SECTION 1: WHAT IS A THERAPEUTIC COMMUNITY?

The therapeutic community (TC) can be understood as both a model and a treatment approach for people with substance abuse and related problems. In its current incarnation, two main types of TCs can be identified. The first, dating back to the 1940s, concerns itself with the treatment of psychiatric patients within and outside of hospital settings. The term, 'therapeutic community' was initially used to describe this type of TC. The second type of TC is abstinence-based, and aims to treat and rehabilitate persons with addictions and related problems (DeLeon 2001a: 79). This second type of TC, which emerged in North America in the 1960s, is the primary topic of analysis of this study. The TC for the treatment of addictions is defined as follows:

"A therapeutic community is a drug-free environment in which people with addictive (and other) problems live together in an organized and structured way in order to promote change and make possible a drug-free life in the outside society. The therapeutic community forms a miniature society in which residents, and staff in the role of facilitators, fulfil distinctive roles and adhere to clear rules, all designed to promote the

³ Covenant House Vancouver was only visited by the Social Planning Department's research team representatives.

transitional process of the residents”(Ottenberg 1993 in Broekaert: 2001: 29).

Recent years have seen TCs adapt to serve the particular needs of a number of ‘special populations’ including adolescents, HIV positive and AIDS clients, homeless men and women, mothers and children, mentally ill chemical abusers and methadone clients⁴ (DeLeon 2001b: 385). Even as they adapt and diversify, a number of ‘essential elements’ of the therapeutic community can be identified.

1. The physical environment

TCs can be found in a variety of settings including residential neighbourhoods and suburbs, industrial sites, and rural settings. However a number of facilities are found in inner-city areas, some near drug-affected urban neighbourhoods (DeLeon 2001b: 103). TCs operate in purpose-built structures, as well as a range of converted buildings such as tenement housing, hotels, schools, churches or nursing homes. The size, grounds and design of facilities also vary, but are generally adapted to the types of educational and vocational training offered by the TC. The residential capacity of a TC program commonly ranges from 50 – 150 residents. An ‘ideal’ size is often described to be in the range of 80 – 120 residents, although exceptions include Delancey Street which has a residential capacity of approximately 450 – 500 beds.

Therapeutic communities are not locked facilities but ‘semi-closed’ environments where residents choose voluntarily to live for a period of 3 to 24 months, and in some cases, longer. Although strict limits are placed on residents’ comings and goings, residents who comply with all house rules and program requirements may gradually earn privileges to leave the facility through day, overnight or weekend passes, particularly to visit parents, partners or children. An exception is found in the case of those residents mandated by the court to a certain length of stay in a TC. Court mandated residents who leave the facility without permission may have warrants issued for their arrest.

⁴Due to the abstinence-based focus of the TC, the presence of methadone treatment is not the norm. However, some TCs are beginning to experiment with methadone as an aspect of treatment (See DeLeon 2001b: 385 – 386, for more information).

The key interior spaces in a TC consist of areas where the operational, educational, and therapeutic activities of the program are held. Common spaces include lounges, seminar rooms, classrooms, training facilities, the dining room, and kitchen. Private spaces include administrative offices and conference rooms. Sleeping quarters are often dormitory style, segregated by gender, and sometimes by factors such as age or stage in the program. Some TCs have on-site medical and dental offices. Other hallmark features of the physical environment of the TC include the front desk, where all traffic in and out of the facility is monitored, and structure boards and charts which provide an 'up-to-the-hour' visual picture of the status and location of each resident in or out of the facility, often organized around the daily schedule and activities in the TC (DeLeon 2001b: 109 – 117).

2. Staffing

TCs are often staffed by a carefully chosen group of professionals who receive training in the specifics of the TC model. Experts suggest that program staff should comprise a mix of self-help recovered professionals⁵ and other traditional professionals (e.g. nurses, physicians, lawyers, case workers, counsellors) who must be integrated through therapeutic community-grounded training (DeLeon 2001a: 8). An average resident to staff ratio was cited as approximately 15:1, with smaller ratios found in TCs that serve a higher proportion of adolescent and other special needs populations (DeLeon 2001b: 120).

3. The social environment: peer dynamic and hierarchical structure

One of the characteristics that often distinguishes the therapeutic community from other treatment approaches is the use of the peer community to “facilitate social and psychological change in individuals” (DeLeon 2001a: 82). This means that the community itself is understood to form an integral part of the therapeutic approach to recovery. The assumption is that individuals are impacted most profoundly when they

⁵ 'Self-help recovered professionals' is a term used in TC circles to refer to professionals working in a TC environment who typically have first-hand experience with addiction and recovery, often through a TC approach.

meet and surpass community expectations (DeLeon 2001b: 95). As part of daily life in the TC, residents observe and monitor each other's participation and roles in the community. In this way, the peer dynamic is argued to be a persuasive influence in residents' desire to become more responsible and accountable, which then extends from the individual, to peers, and finally the entire community.

The highly structured environment of a TC can be seen in both the physical and social organization of the community. A TC generally consists of several work and training departments such as the kitchen, maintenance, administration, etc. Each department has specific responsibilities and internal hierarchy, with the departments themselves making up an overall hierarchical order (Broekaert 2001: 34). Each resident begins at the 'bottom' of the hierarchy (sweeping floors or cleaning bathrooms, for example), and works his or her way up through the ranks of more desirable jobs and departments. Sleeping quarters can also be arranged by seniority status, with more long-staying residents earning rooms with fewer roommates, or in some cases, private rooms.

4. Resident profile and special populations

Most residents of TCs are considered to have hit 'rock bottom' whether they voluntarily enter a community or arrive through the criminal justice system. Many residents have been drug addicted for years and have a history of criminal activity or other legal problems. Other common factors include multi-generational poverty and homelessness. The typical gender breakdown is approximately 3/4 male and 1/4 female, with many women residents having given up custody of children.⁶ Although many residents arrive with a host of health related problems, most TCs stipulate that residents must be healthy enough to undertake physical labour and participate in training programs and other group-related activities. Potential residents are generally deemed inadmissible in the case of a history of kidnapping, rape, arson, child molestation, suicide attempts,

⁶ The site visit research revealed that there are a number of issues unique to women's needs and experiences that are not always addressed in TCs due to the preponderance of male residents. Women residents may struggle with issues relating to previous caregiving responsibilities for children, and past experiences of male violence against women. The research revealed that women, like other 'special populations,' may require additional consideration when planning a TC program.

violence or serious mental illness. Unless a TC is specifically designed to accommodate a youth population, the age of residents can range from 18 – 68, with an average range being between approximately 28 – 40. TCs designed for a youth population are generally smaller in size, often have a much lower staff to resident ratio, and are widely perceived to bring specific challenges because of the population they serve.

The screening and intake process for TC residents is rigorous, typically involving an initial visit or phone call, admission to a waiting list, an orientation process, one or more intake interviews, medical, legal and psychological assessments, and consent to treatment. A thorough intake process is considered to be particularly critical in light of the high rate of drop-out which commonly reaches 50% within the first 30 days.

5. The treatment process: therapy, education and training

The elements of treatment at the TC typically include substance abuse treatment, education (General Equivalency Diploma or, in some cases, university courses), primary medical and dental care, vocational skills training (e.g. culinary arts, carpentry, general maintenance, mechanical systems, general contracting, computer skills, or substance abuse counselling), on- and off-site job placement, and in rare cases, on-site resident-run businesses. Other supports include legal services, advocacy, and life skills counselling. In some TCs, support groups are offered to groups based on ethnicity, sexual orientation, age and health status. Although residents may gradually earn the privilege of leaving the TC to attend a religious institution of their choice, there is no formal religious component to treatment, education or training. In fact, experts caution against the introduction of religion as an aspect of daily life in the TC (DeLeon 2002, personal communication).

6. The daily regimen

Residents can expect a highly structured and demanding daily regimen within the TC. The typical day includes a 6:30 or 7:00 AM wake-up call, morning and evening house meetings, job functions, therapeutic groups, life skill seminars, vocational training sessions, some personal time, recreation, and individual counselling when necessary.

Weekend schedules are somewhat less demanding. Structure and routine are integral to the daily regimen.

7. Re-integrating into the community

An important part of the TC approach involves preparing the resident for re-integration, or 're-entry,' into the wider society. Some TCs insist that no resident leaves the program without a full-time job including benefits, a place to live and a support network. Family reunification is often incorporated into re-entry. The underlying philosophy is that re-entry is a transitional process over time requiring the development of a host of coping skills and supports. One of the supports most commonly identified as essential to resident success once they leave the TC is transitional housing and affordable longer-term housing for TC 'graduates.'

The remaining sections of this report will provide a more detailed overview and analysis of important elements of TCs. First, an overview of the sites visited during the September 2002 research trip will be provided in Section 2. Section 3.1 discusses programmatic issues, Section 3.2 examines operational and governance issues, and Section 3.3 looks at locational issues. Section 4 provides a summary of conclusions and recommendations.

SECTION 2: OVERVIEW OF SITES VISITED

The research team visited a total of seven sites in three cities: one in Vancouver, BC, four in New York, NY, and two in San Francisco, CA (*Table 2.1*). The goal was to gather information on a range of residential treatment facilities through direct observation, informal interviews and facility tours. It is important to note that not all of the facilities visited were necessarily based on the TC model. The Covenant House sites, for example, are not considered to be TCs, but were visited for the purpose of viewing other residential treatment facilities and / or transitional housing programs. As such, the

Covenant House facilities are not referred to directly in the report.⁷ Other sites, such as Delancey Street, does not identify as a TC, but was visited because it shares a number of essential characteristics of a TC.

It is also important to point out that two of the New York City sites visited, Daytop Village and The Center for Therapeutic Community Research (CTCR), are not treatment facilities. The Daytop Village site is the organization’s administrative headquarters in the City of New York, while the CTCR is an internationally renowned centre for research on the Therapeutic Community model.

Overall, the range of sites visited provided the research team with a valuable first hand understanding of variations in how TCs operate, as well as their respective strengths and weaknesses. In addition, the site visits were instrumental in helping the research team formulate a number of specific recommendations regarding the possibility of opening a new TC facility.

Site	Location	TC or Non-TC	Number of beds
Phoenix House Career Academy	Brooklyn, NY	TC	240
Daytop Village, New York Headquarters	New York, NY	TC	n/a
The Center for Therapeutic Community Research	New York, NY	n/a	n/a
Walden House (890 Hayes Street)	San Francisco, CA	TC	115
Delancey Street	San Francisco, CA	Non-TC	450 – 500

⁷ The Covenant House sites are not referred to directly in the report because they clearly operate under a different treatment model, and also because they serve a youth population (approximately 16 – 24 year olds). This age population brings with it a host of unique challenges and treatment approaches that are not within the mandate of the present study to address. The purpose of this study is to analyse the TC model as it relates to an adult client population.

Covenant House Rights of Passage program (16 – 24 year olds)	Vancouver, BC	Non-TC (Long-term transitional living program)	Currently 30, but will eventually have 49
Covenant House Rights of Passage program (18 – 21 year olds)	New York, NY	Non-TC (Long-term transitional living program)	145

Table 2.1 – Sites visited

The purpose of this section of the report is to provide brief overviews of the sites that were most relevant to the research: Phoenix House, Daytop Village, The CTCR, Walden House and Delancey Street. More detailed information about each facility or organization appears, where relevant, in the overviews and analyses in Sections 3.1 – 3.3 of the report.

OVERVIEW OF SITES THAT WERE MOST RELEVANT TO THE RESEARCH

1. Phoenix House (umbrella organization) (<http://www.phoenixhouse.org/treatment/adult.asp>)

“Phoenix House, founded in 1967, is the nation’s leading non-profit drug abuse treatment organization, treating nearly 5,500 people in eight states each day. Phoenix House run more than 100 programs in New York, California, Florida, Massachusetts, New Hampshire, Texas, Rhode Island, and Vermont, for residents and outpatients, adults and adolescents. Phoenix House programs have been remaking lives and strengthening families and communities for 35 years, by addressing drug problems with a tightly structured, highly disciplined treatment method in which clients learn to help themselves.”

Phoenix House Career Academy, Brooklyn, NY (site visited)

“Phoenix House Career Academy is the first drug treatment centre in the US to offer long-term residential treatment, intensive job training and comprehensive medical and dental services on one site. By bringing treatment and training together, Phoenix House introduces training earlier in the therapeutic process, reducing residents’ length of stay and making it possible to bring more drug abusers into treatment. This new approach creates a faster, more direct route

from welfare to work.“

Phoenix House Career Academy locational characteristics

“Phoenix Career Academy is housed in two former industrial buildings that have been fully renovated and modernized. The complex is located in the waterfront district of downtown Brooklyn, known historically as ‘Vinegar Hill.’”

2. Daytop Village Headquarters, New York, NY (<http://www.daytop.org/>)

“Daytop Village, founded in 1963 by Monsignor William B. O’Brien, is the oldest and largest substance abuse treatment program in the United States. Daytop operates 26 centres throughout the United States. The Daytop model of the therapeutic community is successfully used in sixty countries globally. Daytop has treated over one hundred thousand individuals, returning them to society as productive, responsible individuals.”

3. Center for Therapeutic Community Research (<http://www.ndri.org/ctrs/ctcr.html>)

“As the national center for the study of therapeutic communities (TCs), substance abuse and related issues, the Center for Therapeutic Community Research (CTCR) conducts systematic research on refining techniques and improving the effectiveness of treatment. In addition, it focuses on modifying the unique therapeutic community approach to special populations and settings such as mentally ill chemical abusers (MICAs) in community residences, adolescent substance abusers in residential TCs, and criminal offenders in corrections facilities. The CTCR is redefining an assessment instrument for measuring readiness for treatment, developing a system for classifying TC programs, and establishing a national TC database.”

4. Walden House, San Francisco, CA (umbrella organization) (<http://www.waldenhouse.org>)

“Walden House has provided behavioral health and substance abuse services to the community since 1969. In recent years, that community has expanded. Walden House is centered in the San Francisco Bay Area, yet delivers services throughout California. Based on the therapeutic community (TC) model of treatment, the program emphasizes self-help and peer support in a highly structured, humanistic environment. Services are available in a day treatment setting or variable length residential settings depending on each client’s unique needs. Our treatment staff understand that addiction cannot be treated without addressing the physical, cultural, emotional, economic and social experiences of each

person in treatment. Each of the services described works to heal the client in a comprehensive, holistic way.”

890 Hayes Street location, San Francisco, CA (site visited)

“This Walden House facility provides variable length residential treatment to approximately 115 men and women. Treatment includes legal, educational and vocational services, and various models of individual and group psychotherapy. The goal of Walden House is to provide the support necessary to live an alcohol and drug free lifestyle. Residents have access to comprehensive services including legal, psychological, advocacy, medical and counselling.”

890 Hayes Street Locational characteristics

The program operates in a renovated Victorian house located in San Francisco’s Hayes Valley District.

5. Delancey Street, San Francisco, CA

“Delancey Street Foundation is a self-help, abstinence based, long term residential, vocational, educational centre for ex-convicts and drug addicts. There are approximately 2000 residents located in five facilities throughout the USA including sites in New Mexico, New York, North Carolina, and Los Angeles. The headquarters is located in San Francisco.”

Delancey Street locational characteristics

“The Delancey Street site covers a land area of about 3 acres, with about 300,000 square feet of building area. The development is part of a redevelopment project area, and is in the middle of a community of high-density residential properties, both rental and condominium, mostly market rate with about 25% restricted income, with very high rents/sales costs (for the market rate units), and very low vacancies”.

Sections 3.1 – 3.3 of the report provide more detailed information on, and analysis of important elements of TCs including programmatic issues, operational issues and locational issues.

SECTION 3.1: PROGRAMMATIC ISSUES

Introduction

From a programmatic perspective, the Therapeutic Community (TC) treatment model is characterized by a number of distinct elements. Among the most significant elements are (1) the therapeutic approach itself, (2) staffing issues, and (3) issues relating to “success rates” and outcomes. An overview and analysis of these elements is outlined below, including recommendations for best practices when planning and operating a new TC program. Examples drawn from the TC facilities visited during the September 2002 research trip are used to illustrate similarities and differences between TCs with regard to programmatic issues. An overview of relevant information pertaining to the TC intake process can be found in the introductory section of this report (page 6), so this information will not be repeated.

1. The therapeutic approach: What do residents experience?

One of the most distinctive components of the TC treatment model is the therapeutic approach itself. Although variation exists between various TCs, the therapeutic approach is typically based on concrete program stages distinguished by the attainment of specific goals. The process of moving through program stages is monitored not only by TC staff, but also by community of residents themselves, thus creating the ‘community peer dynamic’ described as essential to the TCs philosophy and operation. The end points of each program stage are well marked in terms of expected behaviour and attitudes. An example of a typical phased TC treatment model can be found in the following brief summaries.

Phase one

The first phase of a TC program can be described as the induction stage. Once the intake process of interviews and assessments is complete, new arrivals to the TC are often housed in rooms with six to eight bunkmates.⁸ Each room typically has a room

⁸ It is generally expected that new residents must be medically detoxified prior to beginning the program.

leader who is responsible for the orientation of the new resident to the rules and expectations of the TC. The new resident joins a daily encounter group made up of peers and professional counsellors. It is believed that the group serves the purpose of “challenging and overcoming negative behaviours.”

Work is often identified as one of the central components of the therapeutic approach. As such, job assignments or “functions” begin immediately for new residents, usually with basic housekeeping or maintenance chores. The work-centred approach is intended to serve multiple purposes. First, by beginning with general maintenance work, the resident acquires knowledge of the facility’s physical layout and organizational structure. Second, daily work is believed to instil an ethic of discipline and hard work that is desirable according to the TC treatment model. Third, putting new residents to work immediately reinforces the broader nature of the TC as a structured, merit-based program, where residents earn privileges and seniority by complying with all rules and behavioural expectations. In this case, the implied goal for the new resident is to move up a strict hierarchy of jobs and departments to more desirable positions. Lastly, the work is often physically demanding, leaving residents physically tired at the end of the day so that they have no time to think about leaving and returning to their previous lifestyle.

Evenings are usually spent in “encounter groups,”⁹ educational training groups or other study groups. Progression from phase one to phase two is made on the recommendation of staff members and, to a lesser extent, the broader peer group, and is typically judged on the basis of the individual resident’s attitude, work competence and peer relations.

⁹ “Encounter group” is a generic term describing a variety of scenarios that use confrontational methods as the main approach. The encounter group is the most common group format used in TCs. For detailed description of the rationale and method of this form of group process see DeLeon 2001b: Chapter 18.

Phase two

In Phase two the resident is expected to take on more responsibility for the welfare of others, particularly newcomers. At this stage, he or she is normally introduced to three vocational training areas. Training takes place during the daytime hours, with expected study time in the evening. Residents typically begin courses to improve literacy, develop computer skills and achieve a General Equivalency Diploma (GED). Residents are also typically expected to continue with their encounter groups, with the goal of adopting positive beliefs and attitudes toward themselves and others. By the end of phase two, residents are normally expected to have completed their GED, choose one vocation training area in which to specialize, participate in encounter groups, deal with more daily responsibility, and adhere to the rules and regulations of the facility.

Phase three

Entry into phase three normally begins when the resident has applied for, and has been accepted to train in a vocational area on a full-time basis, with the intention of completing a certificate in the program or trade, and finding related work outside of the facility after leaving. Residents may be reimbursed nominally for their vocational work. The money is saved so they will have money to begin their new lives once they exit the program. Staff typically ensure that residents have dealt with all outstanding legal issues (e.g. warrants, custody disputes) that may have arisen prior to entry into the program. During this phase, residents may be encouraged to attend social activities outside of the facility accompanied by other members, as well as re-establish contact with their families of origin. A family reunification program is sometimes established.

Re-entry preparation phase

At this point residents typically share accommodations and bathrooms with a smaller number of residents in a more home like setting. It is believed that by this phase, residents have acquired skills and coping abilities to allow them to “re-enter” society. These skills often include a GED, vocational training, computer literacy, and relationship and coping skills. If any money has been saved for the resident, these funds will be released with the expectation that a bank account will be opened for living expenses.

Residents are normally assisted in finding an apartment they can afford. Follow up by TC staff varies, but can take place on a frequent and regular basis. The general goal is that a gradual decline in the resident's attachment to the TC occurs as confidence, stability and success at job and life skills develop. Graduation from this phase is considered to be "final graduation."

Ensuring a well-planned program

The summary of program phases is intended to provide an overview of common elements of the therapeutic approach found in many TCs. It is important to point out, however, that the elements described above are not found in all TCs, nor are they necessarily practiced in the same way. *Table 3.1.1* (below) shows similarities and differences between elements of the therapeutic approach among three of the sites visited during the September 2002 research trip.

	Phoenix House Career Academy (Brooklyn)	890 Hayes Street, Walden House (San Francisco)	Delancey Street (San Francisco)
TC or non-TC	TC	TC	Non-TC
Staff	Paid staff	Paid staff	No paid staff
Number of residents	240	115	450 – 500
Typical client profile	Most residents arrive through the criminal justice system. Many are on probation in connection with substance abuse. 40% are self-referrals. 1/4 of clients are female. 3/4 male.	Many residents come to Walden House by way of the streets, jail or prison. Many are previous convicts who “have suffered a unique social pain due to their ethnicity or sexual orientation, leading them to drug abuse and dead ends.” Some are addicted mothers, struggling to raise their children.	70% of residents are paroled, probated or sentenced to Delancey as an alternative to prison. The average resident has been a hard-core drug addict for 10 years, and in prison 4 times. Multi-generational poverty. 30% have been homeless prior to entering Delancey. 75% male, 25% female. 1/3 Hispanic, 1/3 African American, 1/3 Caucasian.
Planned duration of treatment	15 month program with 6 month follow up.	90 days to one year. The average stay is 8 – 9 months	The minimum stay is 2 years. The average stay is 4 years, with no maximum stay. Residents may choose to live at Delancey Street indefinitely.
Highly structured / Phase format	Yes	Yes	Yes
Use of peer encounter groups	Yes	Yes	Yes
Educational training	Residents are encouraged to obtain a GED. Opportunity for post-secondary education in some cases.	Clients educational training as a fundamental part of their treatment.	Residents are encouraged to obtain a GED. Complete minimum 3 courses in humanities, arts and math. Opportunity for post-secondary education in some cases.

Vocational training	600 hours of vocational training in one of five areas: building maintenance, carpentry, culinary arts, office associates or counsellor training.	On-site vocational training in food service and maintenance.	Vocational training has strong entrepreneurial focus. Residents train and 'work' (without pay) in one or more of Delancey Street's on-site businesses.
"Re-entry" preparation	Six month aftercare program. Unless there extenuating circumstances, no client leaves without a full-time job including benefits, a place to live and a support network. Family Days are incorporated into re-entry.	Several treatment venues support clients as they prepare for re-entry. Once they are on their own, Continuing Care groups give clients a forum to discuss the challenges of independent living. Walden House also recognizes that the risk of relapse is an intrinsic part of recovery. For this reason, Relapse Prevention (RP) education is incorporated in clients' treatment plans while they are still in program.	Resident must write a proposal explaining why they would like to leave. If approved, the resident begins to look for a job. They must work for 90 days and save their money.

Table 3.1.1 – Similarities and differences between TC facilities

The site visit research revealed that most of the similarities and differences reflected in *Table 3.1.1* do not necessarily make for a more or less “successful” TC. Of much more significance is the importance of ensuring a well-planned TC program where the therapeutic approach and program composition are carefully matched to residents’ needs. Many operators and experts insist on the importance of aligning the specific needs of the resident group with the goals of recovery, the planned duration of treatment, and the nature and extent of aftercare services (e.g. transitional housing, peer network, help finding and keeping a job, follow-up counselling) (DeLeon 2001b: 384). Linked to this finding is the suggestion by experts in the field that a TC will not be viable if there are too many subgroups of clients with significantly differing primary issues (e.g. homelessness, drug addiction, mental illness). These beliefs underscore the importance of carefully choosing the client group and designing an appropriate program to serve their needs.

Although San Francisco's Delancey Street shares many essential characteristics of a TC, it does not formally identify itself as such. One of the most distinctive features of Delancey that sets it apart as an exception to the way most TCs are designed and run, is its entrepreneurial focus. While most TCs offer vocational training and apprenticeship as an aspect of the program, Delancey operates a number of on-site businesses that are run by residents, thereby providing "on the job" experience and training (without pay). Delancey Street's businesses include a moving company, a restaurant, a catering business, a print and copy shop and paratransit services. Unlike other TCs, where funding is drawn from a number of public and private sources, Delancey Street accepts no government funds. Instead, the Delancey Street businesses generate the majority of revenue to run the facility. The entrepreneurial focus of Delancey Street is cited by leading experts on TCs as a rare exception (DeLeon 2002: personal communication).

Another, perhaps more contentious feature that sets Delancey Street apart from most other TCs, is the fact that it operates with no professional staff, with residents performing all functions in the facility including therapeutic aspects of treatment. Unlike the majority of other TCs, Delancey Street residents can choose to live at the facility indefinitely. Consequently, long-term residents often take on job functions that would be performed by professional staff in other programs. The no-staff model is controversial, with experts and operators holding varying opinions on the desirability of such an approach. The important role played by professionally trained staff at TCs is outlined below.

2. Staffing

With the exception of Delancey Street, all of the TC operators who were visited during the September 2002 research trip insist on the importance of intensive and on-going training of professional staff. The commonly held view is that program staff should comprise a mix of self-help recovered professionals and other traditional professionals (e.g. nurses, physicians, lawyers, case workers, counsellors) who should be schooled in the specifics of the TC model (DeLeon 2001a: 8). A representative from Phoenix House explained that adequately trained, qualified staff are instrumental in setting the tone and

helping develop the 'clinical peer dynamic' of the TC. The emphasis on building the professional capacity of a TC can also be seen in the trend towards staff credentialing and program accreditation. One particular accreditation body whose expertise is often sought by TCs is the Commission on Accreditation of Rehabilitation Facilities (CARF). CARF is an independent, not-for-profit organization that has accredited more than 3,700 rehabilitation organizations in the United States, Canada, and Sweden. CARF develops and maintains practical and relevant standards of quality for a range programs including TCs.

Affiliation with regional, national and international TC associations, teaching hospitals and universities is another trend which clearly demonstrates the perceived importance of setting professional standards for program content, therapeutic approach, and staffing. Prominent TC organizations include [The Association of Therapeutic Communities](#), [Therapeutic Communities of America](#), [The European Federation of Therapeutic Communities](#) and [The Center for Therapeutic Community Research](#). In conjunction with a number of TCs worldwide, these organizations have been instrumental in helping to develop meaningful tools to help define "success rates" and measure outcomes at TCs.

3. Defining success: Research and evaluation

The attempt to determine what constitutes 'success' in the TC model is a challenging task. Success is described by one expert as follows:

"In the eyes of the therapeutic community staff, the successful therapeutic community graduate may be someone who takes no drugs, has no further convictions, and leads a busy and orderly life" (Rawlings 2001: 210).

Indeed, many of the studies conducted by TCs and independent research institutes show reasonable rates of success according to the above criteria. However even when rigorous screening and in-take processes are conducted, drop-out rates are high, in most cases 50% within the first 30 days. Some studies show that of those who stay

beyond the first month, approximately 60% of residents complete TC programs, 1/3 of those graduates will relapse to drug use.

To date, there are not many independent longitudinal follow-up studies of TC “graduates.” One particularly important source of information can be found in the Drug Abuse Treatment Outcomes Studies (DATOS) initiated in 1990 by the US National Institute on Drug Abuse (NIDA).¹⁰ There are a number of important conclusions reached by the DATOS research that are echoed both in studies carried out by individual TCs, as well as information gathered during the September 2002 site visit research trip. One of the most significant findings is that retention predicts outcome. What this means is that the longer a resident remains in the TC program, the more likely they are to achieve the program goals and avoid returning to previous patterns and behaviours. This finding is important for the obvious reason that it underscores the link between good program planning and “successful” outcomes. Another important finding is that retention rates are linked to the integral role played by well trained professional staff in guiding residents through the therapeutic process. In both cases, poor program planning and staffing decisions clearly result in higher rates of resident drop-out. Although DATOS provide important insights about current US trends and outcomes in relation to TCs, questions remain about the transferability of findings to a Canadian context.

The common focus on post-treatment outcome in TC research can be understood in light of the fact that reductions in drug use and reconviction often reflect the real concern of funding agencies and public interest (Rawlings 2001: 211). At the same time, a number of “pre-testing” methods have developed that are designed to help ensure that good decisions are made in setting up new TCs. Examples of these tools include a scale of essential TC elements, client matching protocols, and a treatment environmental risk index.¹¹

¹⁰ More information about DATOS findings can be found at <http://www.datos.org>.

¹¹ DeLeon G. and Melnick, G. 1993. Therapeutic Community Scale of Essential Elements Questionnaire (SEEQ); DeLeon G. and Melnick, G. 1998. The Client Matching Protocol (CMP); Jainchill, N., Messina, M. & Yagelka J. (1997). Treatment Environmental Risk Index (TERI).

Recommendations – Programmatic

The findings of the research team point to a number of specific recommendations. The recommendations are outlined in *Table 3.1.2*.

Therapeutic approach	Staffing	Research and evaluation
Carefully choose the resident group, and design an appropriate program to serve their specific needs. Expansion should be phased in gradually beginning with a small core group of staff and residents. Expansion should take place according to clear criteria defining success and readiness.	Program staff should comprise a mix of self-help recovered professionals and other traditional professionals (e.g. nurses, physicians, lawyers, case workers, counsellors) who should be schooled in the specifics of the TC model.	Given the high drop-out rates of TC residents, existing research and pre- and post-evaluation tools should be consulted and used to set recovery goals, design the program, set staffing levels, and plan aftercare services.
Align the specific needs of the resident group with the goals of recovery, the planned duration of treatment, and the nature and extent of aftercare services (e.g. transitional housing, peer network, help finding and keeping a job, follow-up counselling).	New TCs should establish affiliations with regional, national and international TC associations, teaching hospitals and universities to ensure high professional standards for program content, therapeutic approach, and staffing.	Research on outcomes for any new TC should be started at the earliest stage possible in the TC's operation, and carried through as an on-going feature of the TC.
The resident group should comprise a majority adult population (approximately 25 – 40), as opposed to a majority youth population (under 25 years).		

Table 3.1.2 – Programmatic Recommendations

SECTION 3.2: OPERATIONAL AND GOVERNANCE ISSUES

When considering ways to ensure a well functioning TC, a number of operational issues arise. Factors to be considered include (1) optimal governance and management structures, (2) adequacy and reliability of on-going operational funding, (3) intake and referral systems, (4) transition planning for residents who complete the program. This section of the report provides an overview and analysis of these issues by examining the evidence gathered from site visits and other relevant research. As the overview will demonstrate, the most noteworthy finding of the research regarding operational issues

is that clearly defined goals, well-planned programs and experienced leadership in governance and management structures are central to the success of TCs.

1. Optimal governance and management structures

A comparison between three programs of governance, management, funding sources, and operating budgets is shown in *Table 3.2.1*.

	Phoenix House Career Academy (Brooklyn)	890 Hayes Street, Walden House (San Francisco)	Delancey Street (San Francisco)
Governance	Non-profit society, Board of Directors	Non-profit society, Board of Directors	Non-profit society, Board of Directors
Management	Paid staff	Paid staff	No paid staff
Funding sources	Government contracts, client fees, and third-party payments make up the majority of the Phoenix House budget. Contributions from foundations, corporations and individual donors are also a significant source of funding.	50% criminal justice funding, 50% other funders (city, county, etc). Other funding: contracts, government, grants, donations, and resident fees. There is no cost to the participant if he or she cannot afford it.	No government funding accepted. Delancey Street businesses and training schools generate the majority of revenue to run the facility. In addition, cash donations bring in approximately \$1 million USD, while in kind donations bring in the equivalent of approximately \$5 – 7 million USD.
Operating budget	<i>No data available</i>	\$50 million USD for all Walden Street facilities in the State of California	No yearly operating budget. Monthly meetings are held to review expenses. An approximated yearly budget is \$4.5 million USD. 75 – 90% of operating funds are generated from Delancey Street businesses.

Table 3.2.1 - Funding sources, operating budgets, revenues and expenditures

As indicated in table 3.2.1, all of the sites visited during the September 2002 research trip function as non-profit societies, guided by a board of directors. Most of the sites visited are operated by paid professional staff. In most TCs, funding is drawn from a range of sources including public and private organizations. The exception is San Francisco's Delancey Street which accepts no government funding. The majority of

Delancey's revenue derives from its businesses and training schools. Like most other TCs, however, Delancey Street does accept cash and other in kind donations.

Regardless of the structure of operation and governance, a strong message that emerged from the research is the importance of drawing on experienced leadership in governance and management structures. Paid professionals with first hand experience in human service delivery generally, but also the specific challenges presented by the TC model in particular, were identified by most TC operators as instrumental in defining key objectives, maintaining organizational and financial stability, and achieving high resident retention rates in TCs. With the exception of Delancey Street, all of the TCs that were visited during the September 2002 research trip operate with an experienced cadre of paid professional staff who, in conjunction with the board of directors, are responsible for the overall management of the TC. Furthermore, the research found that most operators encourage all staff, from senior administrators to counsellors and therapists, to seek on-going training in the specifics of the TC model. An exception can be found with Delancey Street, which does have a board of directors, but no paid staff, relying instead on long-term residents who often take on job functions that would be performed by professional staff in other programs. Senior Delancey staff do, however, receive other benefits.

Another common element of governance and management found at many TCs is on-going consultation with social service providers, educational institutions, and vocational training institutes. In addition, some TCs have formal advisory boards made up of neighbours and service providers.

2. Adequacy and reliability of operational funding

The formulation of a long-term funding strategy indicating how construction, operation and maintenance will be funded on an on-going basis is a common staple of most TCs. This type of funding strategy is particularly critical during phase-in and expansion stages when operational funding needs will necessarily be in transition. Another important planning tool for non-profit TCs are yearly audited financial statements which non-profit

TCs are required by law to produce. The benefit of yearly financial statements is that they provide the opportunity to track success in achieving the goals set in long-term strategies, as well as demonstrate good financial management.

With regard to the adequacy and reliability of operational funding, Delancey Street is again the exception. According to Delancey Street representatives, the organization does not have a yearly operating budget or a systematic long-term funding strategy. In place of an operating budget, monthly meetings are held to review expenses. Overall, the research found that on-going, long-term financial planning is the preferred way to ensure successful outcomes.

3. Intake and referral systems

The screening and intake process for TC residents is normally very rigorous and thorough. The intake process can include an initial visit or phone call, admission to a waiting list, an orientation process, one or more intake interviews, medical, legal and psychological assessments, and consent to treatment. *Table 3.2.2* shows intake and referral characteristics in three programs.

	Phoenix House Career Academy (Brooklyn)	890 Hayes Street, Walden House (San Francisco)	Delancey Street (San Francisco)
Referrals	Many residents are referred from courts. 40% are self-referrals. Many are on probation in connection with substance abuse.	Many residents come to Walden House by way of the streets, jail or prison.	70% of clients are paroled, probated or sentenced to Delancey as an alternative to prison. The average client has been a hard-core drug addict for 10 years, and in prison 4 times.
Intake process	Intake interviews, medical, legal and psychological assessments, orientation, consent to treatment.	To be admitted to a Walden House adult treatment program, prospective clients must make an appointment for a screening interview with the Intake Department. The interview consists of an evaluation of prospective clients' drug treatment and mental health needs.	Intake interviews, assessments, orientation, consent to treatment.

Table 3.2.2 – Intake and referral systems

The number of common intake and referral characteristics shared by the programs listed above is indicative of the commonalities across TCs generally. The most important message to be taken from this important aspect of TC operations is that the intake and referral process should be carefully matched with the defined program goals and the needs of the chosen resident group. Another important element that should be noted is the relatively high proportion of residents who are referred through the criminal justice system. In this capacity, questions arise as to how critical this corrections-based referral system is to the overall success of TCs. In the Canadian context, such referrals may or may not be expected or allowed, underscoring the importance of carefully considering linkages to a range of referral systems. A related issue for consideration is the decision about whether or not the TC will be local-serving only or open to referrals from a wider geographical area. If the decision is to accept referrals from a wide geographical area, impacts on the City of Vancouver must be considered, particularly in relation to risks associated with high drop-out rates.

4. Transitional planning

Another critical aspect of TC operations corresponds with the final phases of treatment when residents are being prepared to leave the facility. Unless there are extenuating circumstances, most TCs aim to ensure that no resident leaves the program without a full-time job, a place to live and a support network. A host of challenges were identified by operators and experts in the field regarding the nature and extent of aftercare services. First, because many programs are becoming shorter in duration (mainly due to funding challenges), the need for adequate aftercare has been escalating in recent years, in some cases dramatically. This increase has added to already existing challenges to meet the aftercare needs of residents in this critical phase of treatment. Second, among the most pressing needs in aftercare services is transitional and supported housing that is safe and affordable, a social need that has proven a challenge in many cities and rural areas alike across Canada and the US. Lastly, as indicated in the programmatic section of the report (section 3.1), an important aspect of good governance and operations is follow up research designed to ensure the continued success of TC ‘graduates’ after they leave the program. However, many TCs have indicated that they lack the funds to undertake meaningful longitudinal research that would enable TCs to track the success of their graduates, thereby identifying best practices, as well as program areas in need of improvement.

Recommendations – Operational and governance

The findings of the research team point to a number of specific recommendations. The recommendations are outlined in *Table 3.2.3*.

Optimal governance and management structure, on-going consultation	Funding	Intake and referral, transitional planning
New TCs should rely on experienced leadership in governance and management structures.	TCs should develop a long-term funding strategy which is particularly attentive to phase-in and expansion stages when operational funding needs will necessarily be in transition.	The intake and referral process should be rigorous and thorough, with a careful match being made between the intake process, program design and residents’ needs.

<p>Senior administrators and other paid professionals should preferably have first hand experience and on-going training in human service delivery generally, but also the specific challenges presented by the TC model in particular.</p>	<p>The long-term funding strategy should indicate how construction, operation and maintenance will be funded on an on-going basis.</p>	<p>Aftercare services should be carefully planned, with particular attention to the need for affordable housing for residents who complete the program.</p>
<p>On-going consultation should take place with social service providers, educational institutions, vocational training institutes. In addition, advisory groups comprised of residential and industrial neighbours should be established.</p>		<p>TCs should, where possible, undertake longitudinal follow-up research to track the success of graduates and help identify best practices, as well as program areas in need of improvement.</p>

Table 3.2.3 – Operational and governance recommendations

SECTION 3.3: LOCATIONAL ISSUES

Introduction

Therapeutic Communities operate in a wide variety of settings including residential, industrial, mixed residential / commercial, and rural sites. TC facilities consist of purpose-built structures, as well as a range of converted buildings such as tenement housing, hotels, schools, churches or nursing homes. As highly structured, self-contained programs, TCs are designed to enhance the clients’ experience of community within the residence (DeLeon 2001b: 101), while at the same time seeking to minimize the facility’s impact on the surrounding community. However, in determining the feasibility and appropriateness of any new TC facility, a number of locational issues must be considered carefully.

The site visit research conducted in September 2002 supports other existing research showing that TCs operate in a variety of locations, and in a range of sizes.

- Brooklyn's Phoenix Career Academy is housed in two former industrial buildings that have been fully renovated and modernized, and make up approximately 86,000 square feet of building area. The complex is located in the waterfront district of downtown Brooklyn, known historically as Vinegar Hill, and more recently known as DUMBO (Down Under the Manhattan Street Overpass). DUMBO is an area in transition from industrial to mixed uses. The Phoenix House facility houses 240 residents.
- Delancey Street in San Francisco provides another example of a TC facility located in a former industrial district that is now a mixed use district. The Delancey site comprises about 3 acres, with about 300,000 square feet of building area. The development is part of a City-led Redevelopment Project Area (South Beach), and is in the middle of a community of recently built high-density residential properties. Delancey houses 450 to 500 residents.
- Lastly, the 115 bed Hayes Street TC operated by Walden House in San Francisco is located in a renovated Victorian house in a middle class residential neighbourhood. Before being converted into a TC, the house once functioned as an AIDS hospice, and before that, a convent.

While this range of sites and facilities may suggest that location has little to do with the programmatic success of a TC, the research reveals a number of important considerations relating to locational characteristics, size of the facility, neighbourhood impacts, and other similar issues.

1. Situating a new TC: The relation to existing City land policies

Significantly, most of the TCs that were visited by the research team in September 2002 figure within existing land use mandates, even when rezoning was required. For instance, the site of Phoenix House Career Academy is located in an area undergoing transformation from predominantly industrial uses to mixed uses. According to Sarah Goldman, a New York City Planner, the attraction of investment, new retail, residential

and commercial uses to this area is linked closely to a rapid decline in industrial activity that has left the area under-utilized. In a deliberate effort to reactivate the area, attract amenities and increase a pedestrian presence, the City of New York is approving a growing number of rezoning applications. According to Ms. Goldman, these rezonings have enjoyed wide support from local Chambers of Commerce, Neighbourhood Associations and Economic Development Agencies.

Similarly, by the time San Francisco's Delancey Street opened its doors in 1990¹², the surrounding area was already undergoing tremendous transformation. In 1981 the area was designated as the South Beach Redevelopment Area. Prior to that time, the area had been an industrial zone that had fallen into disuse and was largely vacant. A representative from the San Francisco Redevelopment Agency suggested that the Delancey Street facility was approved for development on the site, in part, because the proposal corresponded with the broader conversion goals of the area.

The development of TCs in areas that have already been designated as 'let go' areas, or even more explicitly, as officially slated redevelopment areas, can be argued to have significant benefits. First, any possible negative neighbourhood impacts due to incompatible uses are reduced, while opportunities for positive community outreach are increased. Second, as mixed use facilities themselves, TCs can more easily become an integral part of a similarly mixed use neighbourhood. Third, if the area is already in transition, a TC might face less opposition to locating there early on. Fourth, pre-existing land policies that discourage or prohibit mixed-use development (e.g. industrial districts or port lands) can be protected. Fifth, in the case of specifically designated industrial areas, protection against rising land values that could undermine the intended use of the area is put in place. The risk of rising land values is perhaps the most significant possible negative impact of a new TC that chose to locate in an incompatible area.

¹² Although the Delancey Street Foundation was founded in 1971, the facility visited during the September 2002 research trip (600 Embarcadero in San Francisco), was not opened for operation until 1990.

Such increases would be particularly detrimental in the case of sites where rising land values could undermine the intended use of the area.

Neighbourhood compatibility and scale of facility

The TC facilities that were visited during the September 2002 research trip were generally in keeping with the size and character of other buildings in the surrounding area. Buildings that are similar in scale to surrounding structures have lesser impacts on the surrounding area. It is therefore desirable that compatible size and character are considered when planning a new TC facility. This recommendation underscores the importance of compliance with existing land use policies.

Building guidelines and type of facility

In addition to complying with general land use policies and development plans, a TC facility would need to comply with the appropriate land use and any procedures or guidelines relating to that use. In Vancouver, a proposed TC would be a Special Needs Residential Facility (SNRF), likely in the Group Living category, in that the facility would provide congregate living in a therapeutic environment, with participation in the programs a mandatory part of residence. Development permits for SNRFs are often granted with the understanding that operators must, on a pre-determined basis, demonstrate their compatibility with neighbourhood life. Factors used to determine compatibility can include a requirement to prove the credibility and experience of the operator in delivering the proposed service, confirmation of adequate numbers of professionally trained staff, and demonstration of linkages to appropriate referral systems. In this sense, added to questions about the physical characteristics of the proposed facility and surrounding land uses, are considerations relating to the unique nature of the TC as a facility that delivers residential, educational, vocational and therapeutic services under one roof.

2. Size of facility and phase-in criteria

Closely linked to building guidelines is the question of the optimal size of a TC and criteria for expansion. The residential capacity of a TC program can range from 30 to

500 residents, however a commonly cited 'ideal' size is 80 – 120. In all cases, there was strong consensus among operators of the facilities that were visited during the September 2002 research trip, on the need to start small (5 – 10 residents plus adequate staff) and expand slowly. In this regard, it is particularly important that a clear and specific set of expansion criteria is established early on in the proposal process.

Other common recommendations about the size of the facility and phase-in criteria can be identified. These recommendations reinforce findings outlined in previous sections of this report. First, it was felt that the initial client group must be chosen very carefully, with a good match being made between client need and the program. Second, operators felt that alongside the careful choice of an initial client group, a core group of professional staff should be trained in the specifics of the TC model. This view coincides with independent studies of the TC model which insist that program staff should comprise a mix of self-help recovered professionals and other traditional professionals (e.g. nurses, physicians, lawyers, case workers, counsellors) who must be integrated through therapeutic community-grounded training (DeLeon 2001a: 8). Third, well-established TCs and TC research centres went so far as to suggest that new TCs should seek TC-specific training services available to assist them in establishing themselves.

3. Neighbourhood impacts & community relations

In the case of all of the sites that were visited during the September 2002 research trip, there was a high degree of initial neighbourhood opposition to the TC proposal followed by a vast improvement in relations. For example, New York's Daytop Village operates twenty facilities in the New York area. In every case, there was severe opposition to development because of the population served. San Francisco's Walden House reported similar levels of initial opposition. To combat the negative perception of TCs, operators generally engage in extensive outreach work in an attempt to earn the perception of being a 'good neighbour.' At Phoenix House, for example, although the wider Brooklyn community fought the proposal initially, the operator reports that relations improved quickly once contact was made with neighbourhood associations

and concrete efforts were made to give back to the community. Examples include neighbourhood clean-ups, providing space for community association meetings, helping to build new playgrounds for children, participating in neighbourhood art projects, and hosting open houses for the community. Similarly, the San Francisco Redevelopment Agency reported that the Delancey Street project is perceived as a very positive part of the community, in part, because of the community work they have initiated.

The September 2002 site visits and subsequent follow up with City Planners from the cities in question, revealed no major negative community impacts reflected in formal complaints about, or conflicts with a TC. However, it was not possible to consult with individual business operators, local residents or other tenants in the areas in question, who may have been able to provide additional first-hand feedback about the TC in their respective area.

The mitigation of many negative neighbourhood impacts may be attributable to a number of factors. First, the self-contained nature of the TC means that most interaction with the surrounding neighbourhood is generally planned and controlled. Second, although TCs are not locked facilities, strict limits are placed on residents' comings and goings so the possibility of undesirable street activity associated with TC residents is reduced. Third, by establishing themselves in areas where pre-existing shifts in land use have taken place (from industrial to mixed uses, for example), TCs minimize the possibility of incompatible uses that can result in conflict.

4. Educational and vocational training

Educational training provided by a TC typically consists of the goal of obtaining a General Equivalency Diploma (GED), some post-secondary coursework, and in exceptional cases, a university degree. Vocational skills training can include culinary arts, carpentry, general maintenance, mechanical systems, general contracting, computer skills, or substance abuse counselling. Other common supports provided at the TC include legal services, advocacy, and life skills counselling.

The site visit research revealed that at most TCs, the majority of educational and vocational training is delivered on-site. At Phoenix House Career Academy, for example, one of the two contiguous buildings that make up the facility is houses classrooms and training facilities where residents learn skills ranging from carpentry and mechanical systems to culinary arts and office work. In this regard, San Francisco's Delancey Street figures as an exception, in that the facility operates a number of on-site businesses that are run by residents, thereby providing 'on the job' experience and training. Delancey Street's businesses including a moving company, a restaurant, a catering business, a print and copy shop and paratransit services. The entrepreneurial focus of Delancey Street is cited by leading experts on TCs as a rare exception (DeLeon 2002: personal communication).

In the case of most TCs, because the majority of educational and therapeutic training is delivered on site, there appears to be little disruption on surrounding streets, and generally low impacts on traffic, noise and parking. However, the greater the number of partnerships with educational institutions, vocational training organizations or job placement sites that are not centralized in the TC, the greater the potential for neighbourhood disruption depending on the nature of the surrounding area.

Correspondingly, if a proposed TC chose to adopt the unusual entrepreneurial focus of the Delancey Street model, where fully operational businesses are located in or near the TC, increases in traffic, noise, parking, and general impacts on the nature of the neighbourhood, might be felt depending on the type of activity already located in the surrounding area.

5. Healthcare services

Most TCs provide some level of primary health and dental care either on or off site. As a requirement for admission, many TCs insist that residents must be healthy enough to undertake physical labour and participate in therapeutic aspects of treatment. However, the reality is that most residents arrive with a number of underlying health issues relating to their past experiences with addiction, homelessness, or incarceration.

Common health conditions include diabetes, hepatitis, HIV and asthma. A range of

opinions exist on the costs and benefits of providing a full spectrum of health care services on site. Phoenix House, for example, describes its decision to provide primary health, dental and eye care on-site, as a critical aspect of their program. Other programs, such as the Hayes Street location of Walden House in San Francisco, facilitate off-site trips for their residents to visit medical practitioners.

The primary advantage to on-site health service is twofold. First, on-site health care reduces possible disruptions to the neighbourhood in the form of increased traffic to and from the site. And second, on-site care reduces the exposure of residents to negative external influences that might lead to relapse or failure to complete the program.

Recommendations – Locational

The findings of the research team point to a number of specific recommendations. The recommendations are outlined in *Table 3.3.1*.

Locational	Neighbourhood Impacts	Phase-in criteria
Any TC proposal should, where possible, comply with pre-existing City land policies, zoning by-laws and / or development plans.	On-going consultation with residential and industrial neighbours about potential impacts should be established early on in planning stages.	Where possible, new TCs should seek staff training from well-established TCs and recognized TC organizations who offer such services (e.g. Walden House or The Center for Therapeutic Community Research).
Health care services, including dental, should where possible, be delivered on-site.	An advisory body made up of community representatives and social service provisioners should help guide the development and phase-in process.	TCs should start small and phase-in slowly. TCs should begin with a core group of 5 to 10 residents plus adequate staff, then add a few residents at a time.
A detailed description of the proposed core programs should be included in the proposal. This includes a	Even though the TC is a self-contained facility, the site should ideally be such that residents are removed from	A clear and specific set of expansion criteria should be established early on in the proposal stages.

detailed overview of all intended uses for the proposed site.	the area in which they were using drugs or engaging in other negative behaviours.	
		The initial client group should be chosen very carefully, with a good match being made between client need and program design.

Table 3.3.1 – Locational recommendations

SECTION 4: SUMMARY OF RECOMMENDATIONS

RECOMMENDATIONS – PROGRAMMATIC

Therapeutic approach

- Carefully choose the resident group, and design an appropriate program to serve their specific needs. Expansion should be phased in gradually beginning with a small core group of staff and residents. Expansion should take place according to clear criteria defining success and readiness.
- Align the specific needs of the resident group with the goals of recovery, the planned duration of treatment, and the nature and extent of aftercare services (e.g. transitional housing, peer network, help finding and keeping a job, follow-up counselling).
- The resident group should comprise a majority adult population (approximately 25 – 40), as opposed to a majority youth population (under 25 years).

Staffing

- Program staff should comprise a mix of self-help recovered professionals and other traditional professionals (e.g. nurses, physicians, lawyers, case workers, counsellors) who should be schooled in the specifics of the TC model.
- New TCs should establish affiliations with regional, national and international TC associations, teaching hospitals and universities to ensure high professional standards for program content, therapeutic approach, and staffing.

Research and evaluation

- Given the high drop-out rates of TC residents, existing research and pre- and post-evaluation tools should be consulted and used to set recovery goals, design the program, set staffing levels, and plan aftercare services.
- Research on outcomes for any new TC should be started at the earliest stage possible in the TC's operation, and carried through as an on-going feature of the TC.

RECOMMENDATIONS – OPERATIONAL AND GOVERNANCE

Optimal governance and management structure, on-going consultation

- New TCs should rely on experienced leadership in governance and management structures.
- Senior administrators and other paid professionals should preferably have first hand experience and on-going training in human service delivery generally, but also the specific challenges presented by the TC model in particular.
- On-going consultation should take place with social service providers, educational institutions, vocational training institutes. In addition, advisory groups comprised of residential and industrial neighbours should be established.

Funding

- TCs should develop a long-term funding strategy which is particularly attentive to phase-in and expansion stages when operational funding needs will necessarily be in transition.
- The long-term funding strategy should indicate how construction, operation and maintenance will be funded on an on-going basis.

Intake and referral, transitional planning

- The intake and referral process should be rigorous and thorough, with a careful match being made between the intake process, program design and residents' needs.
- Aftercare services should be carefully planned, with particular attention to the need for affordable housing for residents who complete the program.

- TCs should, where possible, undertake longitudinal follow-up research to track the success of graduates and help identify best practices, as well as program areas in need of improvement.

RECOMMENDATIONS – LOCATIONAL

Locational

- Any TC proposal should, where possible, comply with pre-existing City land policies, zoning by-laws and / or development plans.
- Health care services, including dental, should where possible, be delivered on-site.
- A detailed description of the proposed core programs should be included in the proposal. This includes a detailed overview of all intended uses for the proposed site.

Neighbourhood Impacts

- On-going consultation with residential and industrial neighbours about potential impacts should be established early on in planning stages.
- An advisory body made up of community representatives and social service provisioners should help guide the development and phase-in process.
- Even though the TC is a self-contained facility, the site should ideally be such that residents are removed from the area in which they were using drugs or engaging in other negative behaviours.

Phase-in criteria

- Where possible, new TCs should seek staff training from well-established TCs and recognized TC organizations who offer such services (e.g. Walden House or The Center for Therapeutic Community Research).
- TCs should start small and phase-in slowly. TCs should begin with a core group of 5 to 10 residents plus adequate staff, then add a few residents at a time.
- A clear and specific set of expansion criteria should be established early on in the proposal stages.
- The initial client group should be chosen very carefully, with a good match being made between client need and program design.

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Links

Drug Abuse Treatment Outcomes Studies (DATOS):
<http://www.datos.org>

National Institute on Drug Abuse
<http://www.drugabuse.gov/>

Association of Therapeutic Communities:
<http://www.therapeuticcommunities.org/faq.htm>

European Federation of Therapeutic Communities:
<http://www.eftc-europe.com/>

Center for Therapeutic Community Research
<http://www.ndri.org/ctrs/ctcr.html>

Phoenix House
<http://www.phoenixhouse.org/treatment/adult.asp>

Daytop Village
<http://www.daytop.org/>

Walden House
<http://www.waldenhouse.org>