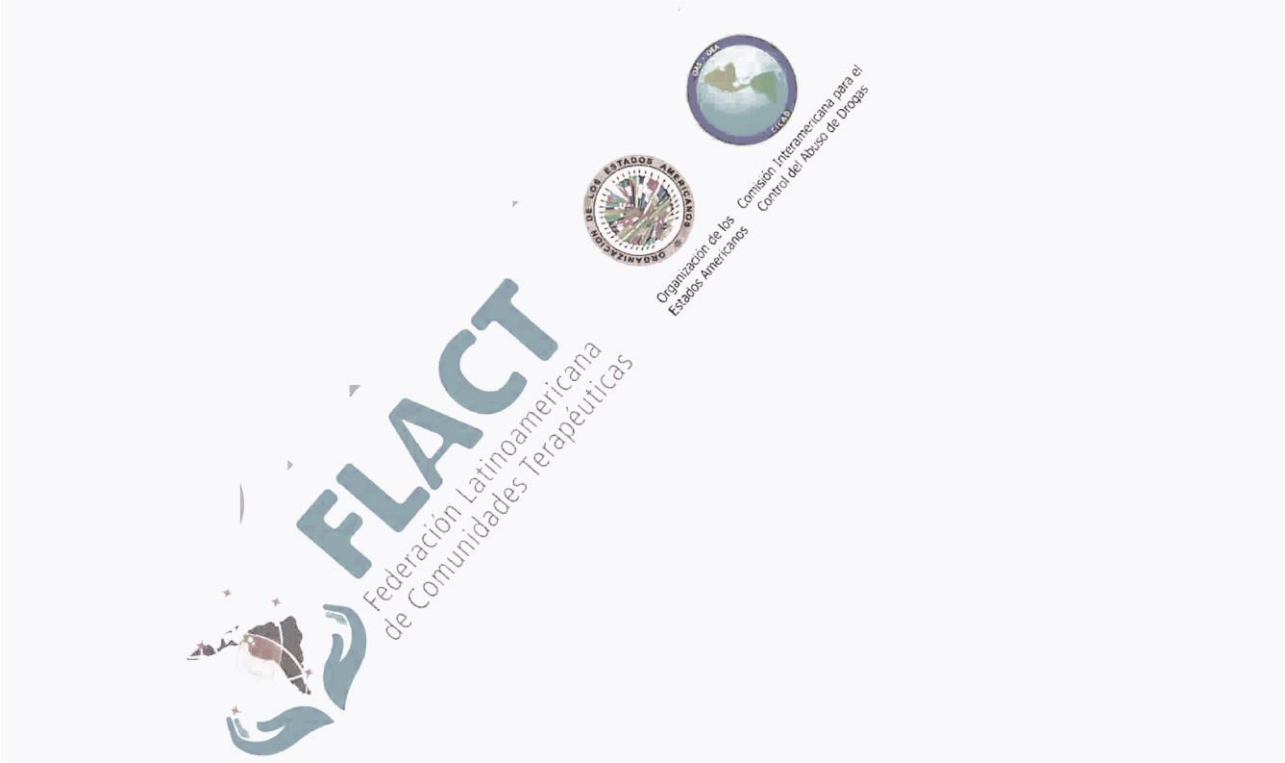
Guidance on Standards and Best Practices

For drug use treatment service providers on the use of the *Therapeutic Community Model*



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About this guidance

The therapeutic communities (TCs) model, with decades of consolidation, counts with a growing body of evidence that has guided the definition of specific accreditation standards. Additionally, there are international standards that have been developed as a product of expert consensus and the best available evidence in the field of treatment of psychoactive substance use disorders. It is best that specific standards dialogue with more universal standards, in order to guarantee the human rights of people who use drugs and the restoration of their comprehensive health, regardless of the model used in recovery.

This guidance offers a compendium of treatment standards for psychoactive substance use disorders that favor best practices, in setÝngs that are based on the therapeutic community model. It summarizes what are considered "best practices" in care, many of which were presented and worked on in the *Seminar for knowledge update on treatment services for drug users and their families, that are evidence-based and in accordance with standards of quality*, developed in 2021 by the Latin American Federation of Therapeutic Communities, FLACT.

It is also the product of an extensive bibliographic and scientific literature review that includes articles from indexed journals, results of published evaluative studies, and documents written by authors with recognized trajectories in the study, analysis, and contributions of the model. Additionally, analytical documents, academic theses, and other complementary and relevant works were taken into account.

The guidance is introductory, and does not seek to replace or duplicate the countless guides, guidelines, protocols, manuals, or reviews that already exist to guide the application of the therapeutic community model.

While there is no monolithic or sufÏciently inclusive view of all the aspects that exist and have existed, this guidance focuses on minimum aspects, for which there is broad consensus and that contribute to improving the quality of care of services and treatment for people with drug use disorders, as well as the recognition of its value and relevance as a treatment model.

Although the present guidance does not constitute a catalog or "inventory" of best practices, and therefore does not involve an exercise of "selection" and inclusion of experiences or interventions, these criteria served to guide the definition of what are considered "best practices" in the therapeutic community care model, as they are considered to be relevant, adequately evidence-based, consistent with consensus defined quality standards, and guarantors of the respect for ethical, bioethical and equity principles.

It is worth noting that much of the available literature on the therapeutic community model is in English, which is an important limitation for the Spanish-speaking public, but also an opportunity and an invitation to expand the availability of evidence and relevant literature in the Spanish language.

The guidance presents the historical landscape of the therapeutic community model from its origins to the present day; the theoretical, phenomenological, and epistemological foundation of the model; the integration of differential approaches to respond to the specific needs of population groups; the critical perspectives that have led to the implementation of best practice standards, principles and values that should guide its operation; a reflection on the integration of approaches that appear to be different from the paradigmatic point of view; and, a summary of good practice standards for long-term residential programs that complement the operating standards of therapeutic communities.

Purpose of this guidance

This guidance offers a minimum compendium of standards of best practice, that are evidence-based and consistent with universal standards of treatment and human rights, with the aim of helping to guide the work of the therapeutic communities' care teams in Latin America, the evaluation of services and interventions, continuous improvement, and the achievement of improved health outcomes.

Who is it addressed to?

The guidance is addressed to those responsible for the proper operation of therapeutic communities and their care teams.

History and origins of the therapeutic community as an intervention model

According to Veale et. al (2014) and Haigh (2015), the concept of therapeutic community (TC) as a concrete and defined entity is relatively recent, but its early origins can be traced back to the mid-13th century, when the first care modalities appeared for people with mental aflictions in residential units or villas where care was *communal*.

In the 18th century, the emergence of "moral treatment" is documented based on the ideas of William Tuke, who considered that people with mental disorders should be treated in the same way as "normal" people, based on prayer and rewards and no longer on punishments, in order to restore self-control; and Pinel, who, at the beginning of the 19th century, introduced *treatment through emotions*, and humanized care in asylums in France, ideas that were later taken to the United States for hospices or retreats in Pennsylvania.

Another tradition was also developed independently with residential educational communities in which psychotherapy was combined with *participatory democracy*. Its developments date back to the early 20th century in Chicago to care for infants in marginal urban environments. This idea was taken to England where it was applied to youth with behavioral problems, integrating *progressive education* and then implementing the idea of camps, school models, and transition hostels for people on probation.

In addition to the modalities in the educational field for infants and youth with behavioral problems, communities for people with disabilities or learning problems were developed. Many of these developments and their theoretical foundations also intersect with religious communities and the *Montessori* pedagogical model (Haigh, 2015).

However, the earliest therapeutic communities (TCs) are established in psychiatric hospitals and those known under the concept of *democratic* therapeutic communities, dating back to World War II, with three concrete experiments, two in military hospitals in Birmingham and another in London. Based on experiments like these, *intensive residential psychotherapy and analytical group psychotherapy* are consolidated.

In 1941, doctor Maxwell Jones, concerned about the soldiers who suffered from what was then known as "exertion syndrome," observed with interest how soldiers obtained better outcomes helping each other, than through the care team itself, particularly through sharing in group discussions the emotional charge of what they had experienced. According to Stocco (2017), Jones understood the importance of interaction and the organization of community life in a participatory environment and shared responsibility. The importance of this legacy, according to Veale et al. (2014), lies in the original focus on the dominant emotions of anger and fear in

traumatized soldiers, and in the effort to reconstitute their sense of responsibility and to strengthen their ability to deal with feelings of aggression towards others.

Jones later incorporated this modality to work with the people that were houseless, creating the social rehabilitation unit and later the Henderson Hospital, whose model became known as the "British model" of a *democratic* therapeutic community, which operated from the 1950s until its closure in 2008 (Haigh, 2015).

In the 1950s, the Jones model was rapidly expanded and popularized through *social psychiatry*, marked by the humanization of psychiatric treatment and respect for the individuality of the patient. In the following two decades, the main mental health hospitals in England had wards that operated under the concept of a therapeutic community. In these hospital setYngs, patients were involved in the therapeutic process, allowing them to participate freely and actively in the group experience and community life. In turn, there was integration between patients and professionals/operators who assumed joint and coordinated therapeutic roles (Haigh, 2015; Stocco, 2017).

Transference initiatives of therapeutic communities to community environments marked the beginnings of centers, units or outpatient hospitals, as well as the start of non-hospital residential units, in the shape of hostels. In 1962, a therapeutic community was created as a mental health unit in a prison environment and the same thing took place in parallel in California, both based on the Henderson model (Haigh, 2015).

This marked the beginning of the second generation of TCs characterized, according to Rapoport (cited by Veale et al., 2014), by the "permissiveness" to openly and authentically express emotions such as anger, based on catharsis, the definition of a structured *community life* based on limits and rules, a shared daily environment, mutual support between members and frequent group meetings. The basis was to *live-learning* through the *confrontation* amongst members, of the immediate consequences of their behavior, community life, self-awareness, democracy and deinstitutionalization. The TC was based on equity, on non-hierarchization, and on the active participation of all members in decision-making process to care for themselves and each other, in what is now known as a *culture of empowerment* that seeks self-eïcacy, self-worth and a sense of responsibility.

In 1958, the first therapeutic communities formally emerged in the United States, inspired by European developments and as an alternative treatment for people with drug use disorders. Synanon marked the beginning of abstinence-based treatments involving any drug use, as opposed to recovery (Haigh, 2015).

Nonetheless, analysts such as Stocco believe that the true origin of these therapeutic communities dates back to the 1930s with the emergence of the first strategies for people with addictive disorders in the United States, which were based on self-help and not on therapeutic, professional or rehabilitative approaches, giving rise to the 12-step model. This model marked the career of Dederich, who after being a member of AA, experienced different group dynamics and later decided to go live with other people who shared addiction problems like his, giving rise to Synanon, the first self-help TC.

De León himself acknowledges that it is not clear how the first expressions of the model in the 1940s influenced the development of TCs focused on the treatment of psychoactive substance use disorders (SUDs) that originated in the United States, which was characterized by renouncing the previous lifestyle, focusing on the present, *communal* work, and the values of honesty and sincerity (De León and Unterrainer, 2020).

The first versions were known as being *concept-based* or highly hierarchical therapeutic communities, which Maxwell Jones himself would later question for straying from the initial precepts of *open community*. He considered that they progressively isolated and closed themselves off, resisted criticism, and thus demanding an almost "devotional" obedience of their leaders, effectively transforming these into dogmatic spaces with authoritarian leadership styles, highly hierarchical, and distant from its initial origin of a *democratic* base (Briggs, 2002). However, Stocco recalls that these were a source of inspiration for programs that became world benchmarks for the TC model, such as Daytop Village and later in the 70s, with the emergence of other well-known ones such as Phoenix House and Odyssey House.

Indeed, Stocco, in consonance with Jones, defined these strategies as behavioral and hierarchical, distinct from others that more guided by the theories of social learning, psychology and educational theory. Considering the latter, projects were located in Europe and especially in Italy, with the emergence of Progetto Uomo, founded by Mario Picchi, patron of Proyecto Hombre in Spain and creator of the International School of Rome.

According to Garbi (2020), this initiative picked up and resumed aspects Daytop's group work, the comprehensive therapeutic-educational model, social isolation aimed at abstinence, and the rewards and punishments system. They also added therapeutic tools that understood treatment as a " therapeutic process" in phases: the first in which the work focuses on motivation and the relationship of the individual with the substances (admission); the second where adaptation to the structure and activities takes place (admission to the TC); and the third where a progressive transition to the social environment occurs (reinsertion). Additionally, it incorporated work with families through periodic encounters to achieve a supportive space paving the way towards discharge from the TC. Other innovations included the definition of individualized therapeutic objectives and the configuration of diversified teams that included professionals, volunteers and former patient/participant.

In the course of the 1970s and 1980s, according to Stocco, despite the complexity of the profile of patients/participants that were treated in Europe, who were primarily individuals dependent on heroin, that were marginalized, and highly exposed to contexts of violence and criminality, they did not count with psychopathological diagnoses or psychological profiles, where an ideologized approach prevailed in which, for example, relapse was considered a "betrayal". By the 1990s, the epidemiological profile changed, leading many TCs to evolve so as not to disappear and to maintain their relevance within the care services environment.

The *revised* therapeutic community model was founded on the notion that recovery begins with the recognition of an individual's unique circumstances, perceived goals and needs, and how they

live out their personal journey. Therefore, treatment must be tailored to the unique needs with which each individual arrives in the process (Haigh, 2015).

As De León states in his renowned book "Therapeutic Community: theory, model and method", the prototypes and experiments from which the therapeutic community originates to treat psychoactive substance use, are found in multiple forms of care and *communal* healing. Many of these have emerged as spiritual communities, others as communities of support and social protection, and still others as mental health care communities, which have evolved over time. According to Kennard (2004), the CT is an impervious plant that can be planted in a variety of landscapes.

Between the 1960s and 1980s, therapeutic teams consisted primarily of former patients/participants who underwent a TC and then joined the team, which led in many cases to the development of an anti-intellectual and anti-professional atÝtude from leaders of the initial TCs, thereby posturing a high cost for the model in different countries (Perfas, 2019).

This would explain why it was not until the 1980s, after four decades of implementation, that the first writings and studies on the model and its effectiveness appeared. In fact, it was not until the year 2000 that George De León published the first guidelines that accurately described the theory and practice behind this treatment modality in the field of psychoactive substance use disorders.

As Garbi (2020) points out, the scarce theoretical construction by those who were "pioneers" of traditional TCs, is due its distance from the academic world, privileging the world of praxis and the oral transmission of an experimental method that was enriched by through trial and error, but in turn limited its reach for a long time (see also: Boyling, 2009).

In the late 1980s and early 1990s, the increasing emphasis on professionalizing the addictive disorders treatment workforce, as well as accreditation standards, transformed the teams and ways of how many TCs operated in the United States and in Europe. Aspects such as training, research, the exchange of best practices, and *networking*, led to a "leap in quality" (Haigh, 2015; Stocco, 2017).

Adding to this was the growing evidence that demonstrated a strong association between trauma and substance use disorders, as well as comorbidity in mental health, creating new demands for the quality and comprehensiveness of care. This situation found a low response capacity from TCs that did not have the means to offer appropriate psychiatric care, pharmacotherapy, and follow-up. At that time, many traditional TCs were faced with budget cuts that prevented them to finance long residential stays, leading to the decline and disappearance of many of them (Perfas, 2019).

Something similar happened in Europe where Stocco also points to the capacity for invention and innovation, organizational flexibility in response to social changes, types of patients/participants, and intervention methodologies. With few exceptions, it was understood that a drug-free community was not feasible and that the doors should be opened to people that were under substitution and maintenance strategies, as well as psychoactive drug treatments, which today are part of many *community-based* programs.

Moving away from the "save and rescue" idea, the current notions pursue supporting and accompanying individual educational, psychotherapeutic and social inclusion projects which require greater articulation and cooperation with social-health services, with family networks, shelters and supportive service centers.

The TC context today offers differentiated treatments, of varied duration, for all types of patient/participant profiles, patients/participants, disorders, problems, comorbidities, life circumstances, and alternative sentences, among others. This versatility in service provision has allowed full integration into social and health care systems, allowing the residential experience to be a part of a broader individual project that foresees, as Stocco says, a communitarian "before" and "after," in collaboration with other services in the field. The idea of an *open* community, with borders that are permeable to the outside, was revisited and resumed, as Jones maintained from the beginning.

Case management allows personalized treatment with differentiated objectives, with a strong emphasis on social inclusion, with training, linkage to employment agencies, and support to be able to recuperate an autonomous life, as well as post-discharge accompaniment from the community. The group intervention paradigm is preserved, no longer focused on collectivizing experiences, but instead on personalizing the intervention and the individualized treatment program (Stocco, 2017).

In short, the evolution described by Stocco illustrates a TC that transcended and ceased to be a model based on rigid ideas of organization, undifferentiated interventions valid for all individuals, a focus on a closed and protected environment, the charisma of the leader, schematized rehabilitation, and undifferentiated rules that forced people to either adapt or be left out of the community and, therefore, denial of any chance of recovery.

According to Veale et al. (2014), the practice of second generation TCs is guided by the integration of standards, by the accreditation of memberships and by the consolidation of *safe environments*.

For Comas (2010), recovering the "old" notion of TCs as a work methodology will make it possible to overcome the strong symbolic charge and the stigma that persists around this treatment modality in many countries, a product of bad practices and inconsistencies in its application.

For Perfas (2019), the model has proven to be resilient and highly relevant today, preserving the principles of "social learning", "culture of inquiry" and "learning community" as fundamental pillars. It is a treatment modality that facilitates change based on self-help and mutual aid, and allows the re-creation of life conditions and circumstances, in a regulated, organized, structured, pro-social and community environment (Kennard, 2004; Perfas, 2019).

Today its value and effectiveness are widely recognized, and there is a growing body of evidence and standards that have allowed the model to leave behind its experimental, alternative and controversial nature, moving towards a treatment modality with a trajectory of critical analysis, rationality and substantiation.

However, as Vanderplasschen et al. (2013) points out, despite the extensive research trajectory, the evidence of effectiveness based on the Cochrane hierarchy is still limited. The available systematic reviews present selection biases of certain types of TCs, biases in study design, or a predominance of an abstinence-based focus.

On the other hand, randomized studies have design limitations with high attrition rates in control groups or consider desired selection criteria such as high motivation or self-selection. Other reviews have moved away from TCs in prison setÝngs, as these have been studied most frequently, and others can be considered outdated. These authors conclude that there are few experimental studies with randomized and control designs, whose methodology is the most robust for obtaining quality evidence, and that not only focus on abstinence, but also measure different indicators of long-term recovery, including the influence of continuous care and post-discharge follow-up (see also: Fiestas & Ponce, 2012; De León & Untarrainer, 2020).

According to these authors, the results of the analysis show varied outcomes and prove a certain effectiveness in different recovery indicators, among them: drug use, crime, employability, psychological well-being and social relations. The difÏculty in determining conclusive outcomes lies precisely in the diversity of populations that have been studied in a variety of different environments, as well as in the difÏculty of replicating comparable conditions within these studies (Vanderplasschen et al., 2013; Vanderplasschen et al., 2014).

This has led them to conclude that rather than determining which type of TC or intervention is better than another, the question that should guide the search for evidence is: what kinds of people benefit most from which type of TC and at what point in their recovery process. Thus, for example, some non-randomized studies have shown similar results in residential programs of different orders and when compared with outpatient methadone maintenance programs, they show similar results, demonstrating that from a longitudinal perspective no intervention is superior to another. It is not, then, according to them, about demonstrating the differential effectiveness among TCs, but rather it is the personal assets, individual needs and goals, as well as the community resources that are available, which determine if the treatment in a TC is what is appropriate or not in a recovery process (Vanderplasschen et al., 2013).

Likewise, they conclude that the primary emphasis of outcome measurements in sought after aspects such as employment, alcohol or other drug use or recidivism, tends to underestimate more subjective outcome indicators such as: emotional well-being, quality of life or satisfaction with work, aspects that, in their opinion, should be included in the evaluation and study of the TCs, since this would allow to ascertain more precisely personal growth and well-being after treatment (Vanderplasschen et al., 2013).

In this regard, Broekaert et al. (2010) point out that from a phenomenological point of view, underlying the TC model, there is a critique of the empirical-analytical paradigm that promotes evidence-based practice, while it rejects, constrains and simplifies complex aspects of treatment, trying to reduce them to elements that can be measured and controlled. This ignores the essence of the treatment process and its phenomenological nature, which can be more adequately studied through qualitative methods. In this sense, it has been argued that no therapeutic process

per se can be evidence-based, only the interventions that compose it; nonetheless, these are not sufficient to determine the complexity of the treatment of which they are part of.

With these limitations in mind, the evidence agrees that there are two critical factors in obtaining better outcomes: *length of stay* in the TC and *ongoing support* after discharge from the TC (John Volken Academy, 2020).

Stays of at least six months to two years show better outcomes because they permit a better integration of new coping patterns, the acquisition or reacquisition of life skills, decision-making, conflict resolution, and emotional regulation. Extended stays in a community allow continuous social learning in highly structured and regulated conditions that facilitate the full integration and consolidation of new skills, until they become a person's norms and habits.

However, the evidence has also shown that the extended stays is a factor that contributes to the early abandonment of treatment, indicating that the longer-term programs present higher attrition rates, particularly in the early phases of the process, as well as lower completion rates. Paradoxically, there are no significant differences between groups when comparing standard duration programs of 12 months, with the abbreviated duration of 3 months or 6 months (Vanderplasshen et al., 2014).

Ongoing support and follow-up after leaving the TC are essential so that the person does not feel isolated after leaving, as the community reminds them that they are not alone, that they have a reinsertion plan, that they have consolidated support networks and that the group continues to be a solid base to which to return to periodically (John Volken Academy, 2020).

These factors lead to better outcomes in different areas such as employment, when the TC process has sufficiently reinforced vocational education, education for employment, and guidance and support networks to secure employment. Decreases have also been found in criminal behavior, psychoactive substances use, and negative or antisocial behaviors (John Volken Academy, 2020).

Improvements in family and social relationships have been identified in different studies, linked to continuous work with family networks to create the best support conditions and containment upon reinsertion, as well as when social skills, stress management and decision making skills were reinforced (John Volken Academy, 2020).

The therapeutic community as a method

The modern therapeutic community is an eclectic or transtheoretical model that combines multiple theories from the psychoanalytic, behavioral, cognitive-behavioral, humanistic, existential, and social learning traditions.

As Perfas (2019) states, it is a treatment model focused on practice, rather than on the development of theories that explain its effectiveness, thus it is not possible to identify a particular school of thought or theoretical orientation that characterizes it. However, such complexity and eclecticism does not mean that there is an absence of a specific and distinctive philosophical foundation or treatment approach, as this would reduce the practice of TC to a series of hollow group rituals.

This foundation was summarized by De León as *community as method*, defined as the intent with which individuals are taught to make use of the *community* to transform themselves. For this, the process must be led by *peers*, framed in a structure that empowers and enables emotional maturation in a controlled environment that replicates society and its dynamics. The team, as an integral part of the community, supports from the background, and intervenes only when necessary (De León and Unterrainer, 2020).

The *community* provides context and acts as a mediator for individual change and social learning. Said mediation determines what is expected of each community member and adjusting to these expectations implies permanent assessments of an individual's behaviors, atÝtudes and emotional management. For this, individuals must practice self-assessments, reinforce their motivation and renew their commitment to change, so that they can respond to what the *community* expects, in congruence with individual goals, personal growth and appropriate socialization, so that active participation in the *community* leads to change (De León and Unterrainer, 2020).

Hence, the model is mainly a self-help and mutual help model that occurs in a *community* that promotes health, well-being and individual growth, or as Comas (2008 in Garbi, 2020) states, a helping process that leads "to rationally build an alternative life project," changing patterns of behavior, thoughts and emotions that predispose a person, among other things, to drug use (Gowing et al., 2002; Perfas, 2019; De León and Unterrainer, 2020).

It is a social system and a treatment model at the same time. Firstly, it creates the conditions and context for the therapeutic process to occur, and secondly, it combines psychological, cognitive, behavioral, moral and social strategies and approaches designed to produce positive changes in behavior and conflict resolution. These two aspects intersect in a dependent and holistic system that ensures the *good practice of the tools and interventions* in the therapeutic community and provides the necessary context for individual change to occur (Perfas, 2019).

For De León and Unterrainer (2020), the concept of the *community as a method* constitutes the model of the program and its unique approach. A paradigm that comprises interconnected visions or perspectives that define what the disorder is, who is the person who suffers from it, what is the recovery process and what is considered a positive and healthy life.

From a disorder *perspective*, problematic use is considered a comprehensive disorder that affects the whole person and affects the functioning of many, if not all areas of a person's life. Cognition, behavior, and affect are altered. Thought patterns and self-values become disrupted and disorganized. Psychological, spiritual, moral and existential conflicts are experienced.

In other words, the person is affected as a whole, so the problem is not the drug itself, but the complexity of what underlies its use. According to De León, "addiction is a symptom" and not the essence of the disorder. Precisely this perspective differentiates the TC model from residential and traditional psychiatric treatments, whose primary drive is diagnosis-oriented symptom management.

Molina (2014) reinforces this approximation by bearing in mind that the disorder is complex, of a biopsychosocial nature, of a non-linear, multifactorial and systemic etiology, which prevents linear or simplistic visions or approximations, and demands multidisciplinary and dynamic approaches. Despite the evidence, reductionist and static approaches persist and have been perpetuated, despite having scarce outcomes.

From the attachment-based *therapeutic approach* perspective, the TC aims to break the bond with the substance and replace it with a bond with the *community*, which offers a safe environment to arrive in and belong to, as well as a solid base from which to start a new life.

This perspective justifies the extension of stays in TCs that, while sustained as *community as a method*, allow to intervene in depth, the multidimensionality of a person as an integral being, when you count with sufficient time to do it. It also points to the importance of retention indicators that consistently show better outcomes when it is higher and lower outcomes when it is lower.

A *positive and healthy life* perspective adheres to precepts and values that are considered essential in the self-help process, social learning, personal growth and healthy living. The emphasis is on the here and now and not a past which is only re-visited to illustrate current behavior patterns considered as dysfunctional and negative atÝtudes. Personal responsibility for the present reality and towards the future is encouraged.

Positive living refers to explicit values that guide the relationship with oneself, peers, significant others and society, and considers truthfulness and honesty, ethical work, learning to learn, personal reliability, economic self-sufficiency, concern and caring for others, community involvement, and good citizenship.

These ideological and psychological points of view are integrated into the teachings and methods that seek to achieve certain social and psychological goals, seeking to counteract behaviors and atÝtudes characteristic of active drug use. Sobriety, according to De León, is a prerequisite for

learning to live positively and healthily, while this way of living, in turn, is considered necessary to maintain sobriety (De León, n.d.).

The view of *recovery* involves, in the first place, change patterns in behavior, thought and affection that are considered negative, and that, according to De León, predispose someone to substance use. The goal is the achievement of a "drug-free and responsible" lifestyle. Stability in *recovery* depends on the achievement and integration of the psychological and social goals described above. Change occurs through *insight* and this, in turn, is obtained through experience. In this way, maintaining lifestyle changes and a positive personal-social identity requires the integration of behaviors, emotions, skills, atÝtudes and values (De León, n.d.).

Recovery encompasses: 1) the development process and incremental learning, by phases that approach pursued social and psychological goals; 2) *motivation* for continued change and timely detection of signs that would indicate early desertion of the process, understanding that change does not occur in a vacuum, but in interaction of an individual with the therapeutic environment, 3) *Self-help* and *mutual help* do not define a provided treatment, but one that is arranged for the individual in the TC environment by the team, peers and routine group activities, meetings, seminars and recreation, whose effectiveness depends entirely on the individual and their involvement in them. Mutual aid responds to the contribution that each individual makes for the change in others, as models, supporting others in daily interactions, in confrontation in meeting and exchange groups and, 4) *social learning* begins with the understanding that negative atÝtudes and behaviors are created and changed in social interactions, thus the *community* then fulfills the role of healer and teacher. The different roles and responsibilities acquired in community life support the learning process, as well as relationship dynamics. Without them, isolation and relapse occur. It is through others that *recovery* is stabilized (De León, n.d.).

For Boyling (2009), the notion underlying the psychodynamic and highly planned social environment of TC is the one that explains psychological discomfort and/or destructive and self-injurious behavior as a consequence of the social network in which one grew up or lived, so that these can be dealt with in a healthier and more constructive social network.

The *recovery-focused* perspective also presents differences with other support and treatment models, as it pursues not only abstinence or symptom control, but also changes in lifestyles and identities, based on modifying deviant or non-normative behaviors, as well as the development of positive and pro-social values.

The concept of *community* encompasses the social environment made up of peers, workers, professionals, managers and other members, with whose models of change or models of life, guide *recovery*. In this way, every member of the *community* plays a fundamental role as a mediator of therapeutic and pedagogical change (Goti, 2003 in Garbi, 2020). The influence of others and amongst members of the community must flow in such a way that they allow learning, assimilating social norms and developing effective social skills.

Returning to the antipsychiatry aspects and the *democratic* character that preceded the origin of TCs from the times of Maxwell Jones, it is clear that *communal* care was contrary to the imposing model of the doctor as a dominant factor and the patient as a passive and virtually null subject.

Instead, open communication, the continuous flow of information, decision-making and *community* problem solving were established.

The concept of the passive "patient" was set aside, enabling their participation as an active member of a *community* and as a subject that *negotiates* and gets involved in their own treatment and transformation processes. A change that, according to Carrizo (2010 in Garbi, 2020), incorporates the idea of *democracy* as a space where professionals and patients/participants meet for the deconstruction of hegemonic hierarchies, thereby resolving asymmetries without denying differences, and defining explicitly and complementarily the roles that each one fulfills within the *community* (Garbi, 2020).

Beyond the nuances, the current conception of TC (John Volken Academy, 2020), can be summarized as follows:

1) The *responsibility* you acquire towards yourself and others, taking the time to reinforce life skills and routines, learning positive patterns of individual and social behavior, becoming a positive role model for new members of the TC, acquiring increasing responsibilities and opportunities to exercise positive leadership.

2) Learn to *take charge* of one's own decisions and behaviors, developing a mature and responsible atÝtude towards the challenges and difficulties that are faced on a day-to-day basis, with less dependence on others, greater awareness and care for oneself and others.

3) The *structure* offered by the *community* contrasts with the chaos in the lifestyle characteristic of problematic drug use, and offers routine structures and explicit expectations, teaching them how to work with others, with an aim to reinforce skills that will be necessary in subsequent reinsertion.

4) *Participation*, which is fundamental in community life because it makes it easier to see others as a model and learn from one's own mistakes, based on active involvement in different environments of interaction, discussion, and group work.

5) A *safe environment* that insulates a person from external influences and judgment, allowing them to fully concentrate on treatment and the recovery process.

6) *Vocational education* and education for work that are essential to facilitate adequate reinsertion after the completing the process in the TC.

Other characteristic aspects include: a) *long-term* treatment that makes it possible to achieve deeper changes in different life dimensions; b) the *residential* modality which offers the opportunity to integrate and belong to the *community*; c) an *abstinence* base that aims for the person to reintegrate into their life without affective or toxic dependencies; d) the *recovery* base that seeks long-term stability, the realization of a life with meaning and full integration into social life; and, e) *work group* without which change cannot occur.

As previously stated, many of these last characteristics have been modified for different reasons, but mainly due to the need to adapt the model to external demands, among them, the viability

of financing long-term processes, the diversity of patient/participant profiles, the high comorbidity in mental health, substances and consumption patterns. These factors, over the years, have led many TCs to either adjust or disappear.

According to the WHO and UNODC (WHO/UNODC, 2020), the intensive support environment offered by long-term residential programs such as TCs, are ideal for people whose personal history has been characterized by parental abandonment, emotional neglect, physical abuse or sexual violence, trauma, interpersonal violence and social exclusion.

This means that the model is particularly relevant for people severely affected by drug use patterns that especially affect social integration; comorbid physical or mental health comorbidities, which may affect their safety and well-being in unstructured setÝngs; with extensive history of therapeutic failures or relapses after cost-effective or outpatient treatments; with social or economic limitations; with severe family or social problems and fragile social support networks; who are isolated or in social deprivation, who voluntarily want to abstain from consuming and who are willing to make major changes in their lifestyles and acquire new skills in a residential setÝng (WHO/UNODC, 2020).

The integration of differential approaches in the therapeutic community

The *revised* TC consists of a variety of programs that serve a variety of patients who, in addition to using drugs, have other problems. Among the modifications, we can find shorter lengths of stay that range from 3 to 12 months, outpatient models or day programs. In addition, they have specialized in population groups with specific needs and have integrated health care interventions, mental health, self-help groups, relapse prevention, among others, without substituting the foundation of the community as a method. (De León and Unterrainer, 2020).

The Mallorca Declaration of 2016 highlights the capacity of the TC to serve vulnerable groups such as women, children, the homeless, people living with HIV or other infectious diseases, co-occurring disorders, and offenders, among others.

According to Kennard (2004), there are a series of central, distinctive elements that are reconstructed as common ground and that allow the differential application of the model in a diversity of environments and with different populations. Among them the following stand out: a) the continuous learning environment in which everything that happens in terms of coexistence, in shared efforts, and in crises, is used as a learning opportunity; b) the tolerance among the members of a certain gradation of behaviors and dynamics that promote discomfort, or that could

be considered "deviant" in ordinary environments (this being one of the principles defined by Rapoport); c) the culture of honest inquiry in difÏcult moments that promotes the intentional and conscientious effort to identify and challenge certain positions or points of view considered acceptable. The reactivation and apprising of difÏcult situations that are common outside the community are recreated in the *community* to achieve new knowledge and develop skills to deal with them (Kennard, 2004).

Working with children and adolescents

The practice of working with infants, adolescents and youth has more than nine decades of development. The most emblematic approximations occurred in the 1930s with Kasinski, the Hawkspur Camp and the creation of *Planned Environment Therapy*, which became the first unified TC model for working with these populations.

From this perspective, children's social needs can be addressed through: shared responsibility within the community; emotional needs are worked on by paying attention to relationships with team members and through individual psychotherapy; and educational needs, through measures designed to promote motivation to learn, and emphasis on creative intervention work (Kennard, 2004).

Kennard emphasizes that shared responsibility is blended with love as a value. In this sense every child is worthy of respect and affection, regardless of their appearance, habits or disposition, and punishment should never be used to harm, hurt or humiliate.

Today there is a robust amount of theory that has expanded the understanding and knowledge about developmental psychology, the psycho-emotional and behavioral reality of children and youth with a history of affective deprivation, neglect, abuse and trauma, guiding interventions to achieve a better balance between the need for care and the need for control, and between giving love, expressing affection and defining limits.

Guarnaccia and others (2019) emphasize one of the fundamental duties of the TC: establishing a relational network that involves, supports and protects each child, and provides opportunities for personal development. From this point of view, these relationships involve the child's relationship with their peers, the relationship with the significant adults in their life, the relationships of these adults with other adults and the impact of these relationships on children. This presents an intricate complex relational structure that includes the different dimensions that make up the TC: the environment and space of the TC, sharing routines, the different relationships that occur in the dynamics of the community, both internal and external, and with the broader social and institutional context.

It has been found that the dimensions of social climate, which reflect the psychosocial characteristics of the environment and which strongly influence the functioning of the TC, have an association with individual behavior, more so than other contextual variables.

Several scales have been designed to measure the social climate and the quality of the "environment" in a TC, as well as the structure of the program intervention and the organizational climate with an emphasis on the team, its leadership capacity and accountability processes. According to Guarnaccia and others (2012), to date there were no specific tools to evaluate TC for children and adolescents, with the exception of the standards created by the Community of Communities and those of Sullivan and Paget in 2009, which is why they were given the task to construct and validate the SCIA questionnaire (*Standards for Communities for Children and Adolescents*).

The SCIA is an instrument made up of 143 items, divided into three sections: 1) core values (10 items), 2) core standards (15 items), and 3) outcomes (118 items divided into different measurement areas). There is a short version that considers 19 items.

The first section includes the basic principles and philosophy of TCs. Understanding that the values give context to the standards that, in turn, guide the services and the training of teams for the practice.

The second refers to the standards that define the basic requirements of a service that is guided by the TC approach. They are the foundation of good practice and define priorities.

Lastly, the outcomes section measures five areas:

a) Being healthy (34 items): refers to the possibility of enjoying a safe, supportive environment that favors healthy development, that allows play, learning and trusting relationships with adults and peers.

b) Being safe (23 items): refers to the possibility of feeling safe in an environment that allows the freedom to express thoughts, feelings and emotions, and encourages an exchange that favors knowledge and understanding of emotions and difficult behaviors.

c) Enjoyment/achievement (23 items): refers to the construction of a culture of living-learning based on responsibilities and not only on the demand for rights or privileges.

d) Positive contribution (20 items): refers to the possibility of developing a sense of belonging, value and appreciation towards oneself and others.

e) Achieving wellness (19 items): includes all actions aimed at providing social and emotional wellness, life decision-making, and empowerment, based on children and adolescents' development stage.

Working with women

According to Eliason (2006), there are differences both in the trajectory of use and its consequences between men and women. There are also differences in use patterns, in the barriers to access treatment, and in the triggers for use. Likewise, he also mentions differences in both in motives and types of criminal activity.

Differences are also observed in the motivations that lead to seeking treatment and their response. Women may feel more inclined to enter a TC due to socialization roles, as they are more likely to express their emotions and to seek support from others, as well as to enrich their perception of the value of motherhood when they have had children. On the other hand, women present greater difÏculties and barriers in the workforce and vocational training, which increases the risk of involvement in illegal activities for their survival.

In terms of mental health, between 25% and 64% of women deprived of freedom due to criminal activity, present a mental health diagnosis, the most common being depression and post-traumatic stress disorder, frequently associated with problematic drug use.

The explicit and practical integration of the gender perspective in treatment strategies is not a prerogative and cannot be postponed. There is vast evidence that show that the practices used in TCs, despite being multidimensional and holistic, have been designed to respond to male needs and although there certainly are specific programs for women, mixed programs are still the norm. According to Possick and Itzick (2018), it has been advised that mixed programs reinforce the invisibility and marginalization of women, who must face double marginalization, not only because of their drug use, but also because of their condition as women.

Gender-sensitive treatment programs consider multifaceted issues including prenatal care, childcare, parenting support, history of abuse, family and intimate relationships, and poverty. Psychosocial treatment should address coping skills, relapse prevention, relational issues, trauma, and other co-occurring mental health issues, as well as attention to practical issues such as medical care, employment, housing, and nutrition.

Within the TC framework, the methods that focus on group feedback and pressure through group work, as well as on the strict structure of rules and sanctions, and the organization rigidity of daily activities, with which it seeks to transform atÝtudes and behaviors of denial, dishonesty, criminal behavior and prostitution, can be problematic for women. Strong feelings of denial, shame, guilt, being overextended, and a lack of control are common among them. Although positive outcomes have been documented in women in conditions of high vulnerability or houselessness, few studies have explored the experience of women in the TCs, their perceptions and how these have an impact on their life conditions (Possick and Itzick, 2018).

The results of the referenced study indicate that when evaluating women's experience in treatment, women focus on aspects of social connection with others, more than on other aspects of the biopsychosocial models that are at the base of treatment strategies in TCs.

They defined three categories of analysis. The first refers to the sense of grievance and frustration around the family of origin and the desire to find something similar to a "home" in the TC, expressing frustration because the atmosphere is very different from their internalized or idealized conceptions of a home. The experience for some women is that of "suffering," which is contrary to the need for a warm and caring environment. For others it is the possibility of building "family" relationships and creating a sense of belonging, acceptance and unconditional love. Yet for others still, the TC is a surrogate family that fulfills parental roles from an instrumental or emotional point of view.

The second relates to the satisfaction or difÏculty of building intimate relationships in TCs. It is easier for women to share their thoughts and feelings in an individual counseling or therapy setÝng than in a group setÝng. Compared to their peers, they express difÏculty in establishing close relationships with other women in the TC and these relationships are perceived as being superficial in the midst of the daily routine. They express greater ease in relating to men, with the exception of those who have been victims of gender-based violence or sexual abuse, who prefer to avoid them.

They also identified the desire and need to have intimate relationships in order to obtain attention and feel loved. With such relationships being prohibited, many of them occur secretly, with the risk of being expelled for breaching the rules. Paradoxically, the researchers point out, in some cases these relationships can contribute to the recovery and reconnection processes with themselves and with others.

Finally, they analyzed the aspects of mixed TCs, a very common modality in Israel where the study took place. They highlight the different drug use trajectories in men and women, behavior patterns, and the fact that many women with problematic drug use must deal with male exploitation, leading them to question whether the mixed modality is appropriate and effective. An unexpected finding was that for some women in the study, this modality is preferable because it gives them a sense of reality and normality, despite this they prefer group work with women only, favoring discussions on topics such as sex or motherhood.

In summary, the power dynamics, social pressure and strict rules in TCs respond, according to the authors, to the need for men to internalize socially acceptable limits so as not to violate the rights of others, given that the focus is on the intersectionality of the male gender, crime, antisocial behavior and drug use.

However, the paradigm of power is not equally appropriate for women as their use trajectories are not usually characterized by aggression, violence or crimes against others. On the other hand, this paradigm seems contrary to gender roles considering that a woman who expresses her power is perceived as dominant, castrating and not feminine; nevertheless, if she does not express it, her self-esteem is affected, feeling helpless, and limiting their progress and recovery process. The study findings reflect feelings of powerlessness, shame, lack of privacy and the feeling of being attacked collectively, especially in the confrontational dynamics that evoke *bullying* techniques associated with masculinity, isolating them and affecting their sense of belonging (Possick and Itzick, 2018).

While denial is more common in men, shame and guilt are more common in women. Shame activates the desire to hide or not expose oneself, making it difÏcult to show vulnerability or acknowledge certain qualities in the presence of male peers. In this sense, although they prefer mixed environments, it is clear that they prefer "safe" spaces where they can feel more at ease exposing the most intimate aspects of their femininity.

On the other hand, women tend to attribute their problematic drug use to the lack of affective intimacy or connection with their family of origin, as well as early experiences of abuse or abusive relationships with their intimate partners. Consequently, women dealing with problematic drug

use seek emotional connection with others, and their self-acknowledgement depends on their ability to maintain meaningful relationships that give them safety and satisfaction. For many women, the atmosphere of the TC may feel familiar, but for others it may feel "cold" due to the rigidity and the disciplinary and vigilant role of authority figures, which contrary to the warmth and humane treatment that many seek, despite presenting themselves as strong women.

In practice, these findings indicate that in order to provide effective treatment for women dealing with SUD, it is essential to create an environment that reflects an understanding of the sociocultural context and the interdependent characteristics of social identities in terms of gender, ethnicity, age, disability, and socioeconomic status, which act as underlying factors for the oppression and inequality of women who use drugs. Social factors such as poverty, rigidity in gender norms, gender roles, and gender inequalities impact both access to and the way in which women respond to treatment.

The environment and atmosphere in which the treatment is offered must be safe and promote the development of women, as well as their capacities and skills, rather than focusing on their weaknesses or shortfalls, so that they can recover their sense of power, self-eÏcacy and reduce the perception of inequality and marginalization.

All TCs must offer group spaces exclusive for women, as well as meeting spaces and joint work with other women, their close networks and significant others, given the need for affective connection.

The authors conclude that confrontation techniques are inappropriate for women, as they increase anxiety and challenge the principle of safe environments (Possick and Itzick, 2018). For his part, Eliason (2006) points out that a strongly confrontational environment and close supervision can help define limits and structure for men with antisocial tendencies, but can lead to symptoms of post-traumatic stress in women contributing to an intensification of their sense of low self-worth and low self-esteem, especially among those with depression.

Wilde (2005) reiterates that the confrontational techniques, characteristic of the *community as a method*, may not be suitable for victims of abuse who benefit most from trusted, safe and women-friendly environments, questioning if this is possible in a treatment system predominantly dominated by men and designed for men. Evidence has shown that gender-sensitive treatments that respond to women's needs show promising outcomes and should go beyond providing the traditional methods in a women-only setÝng.

In accordance with gender roles, women often communicate indirectly to avoid hurting the feelings of others, and often take criticism as a reflection of their self-worth. Direct communication in TCs, usually public, can be "devastating" for some women. In the same way, women can find contradictory messages that require them to open up and show vulnerability in front of others, while at the same time close and intimate relationships are restricted because they are considered "pathological". All these aspects can be detrimental to the recovery process (Eliason, 2006).

Working with people with dual diagnosis or comorbidities in mental health

The concepts and approach for the treatment of mental health disorders that are concurrent with substance use disorders have transitioned towards acknowledging that those who present both conditions are, above all, people who cannot be reduced to labels or diagnostic categories. Davidson and others (2008) point out that this acknowledgement must move from rhetoric to action, since it is people who live with both conditions that know best what it is to deal with them and recover.

The deepening of the understanding of this dual phenomenon began in the late 80s and early 90s, time in which acronyms such as "MICA" (Mentally Ill Chemical Abuser) expanded and emphasized the concept of a "double problem" with subsequent "complications" for care systems. Over time, this perspective has transitioned towards the concept of *double recovery*, placing an emphasis on the person and no longer on the diagnoses. This challenge posed the need to reconcile treatment systems that have been fragmented, some to treat mental health and others to treat substance use disorders, and start thinking about *integrated* treatment and recovery models.

The integration of models, according to Davidson and others (2008), presumes that people recognize the need and possibility of taking control not only around drug use, but also their mental health conditions, greater consciousness and self-awareness od the sense of self, of the conditions with which one lives and of concrete tools to identify, manage and contain symptoms and triggers.

It also presumes improving their sense of self-worth and recognizing that the mental health condition is only one part of their life, as a prerequisite to advance in the recovery process and not as a product of recovery. Self-esteem and self-efÏcacy thus constitute fundamental aspects on the road to recovery, which is only possible with the active and significant involvement of the individual in social and community dynamics, as a dynamic process that is consolidated over time and not as an ending point. It is a process in which the individual takes an active role in their own recovery (Davidson et al., 2008).

They conclude that there are important similarities in the way people live their recovery process in mental health and substance use disorders. They highlight aspects such as hope, relationships, meaningful involvement, a sense of social and community belonging, the reduction of stigma, the redefinition of oneself (or of the self), and empowerment from the exercise of citizenship.

According to the researchers, mutual help dynamics and the hope of a cure are fundamental. Also, one's own belief that it is possible to recover and the perceived ability to manage symptoms and conditions that are endured, in an effective way, for which they recommend incorporating intensive family and relational interventions from the first phases of treatment, reinforced with motivational strategies such as motivational interviewing and counseling and brief interventions. Additionally, they point to the reinforcement of coping skills and management of complex daily situations, which improve the sense of control and self-control and which, according to the evidence, are associated with lower levels of anxiety and depression, lessening of traumatic

impact after episodes of victimization, a greater propensity to take action, protect health and physical integrity, and improved general health conditions.

Linking to social and community dynamics has a positive impact on reducing the feeling of isolation and has protective effects when living, for example, with HIV. However, the impact of stigma is critical because it compromises the quality of life, affecting access to employment, relationships, developing feelings of trust and reliability, or reinforcing the feeling of rejection and exclusion.

Overcoming structural barriers, fear of rejection and stereotypes, promotes recovery because it involves improving and expanding social networks, life satisfaction and self-esteem. In short, it is about improving the sensation of psychosocial well-being and quality of life, without reducing treatment to symptom or "deficit" management or containment, thus recognizing all aspects that contribute to the recovery process and integral human development (Davidson et al. al., 2008).

This so-called *recovery-oriented practice* is particularly recommended for those with dual diagnoses, which is why it is being increasingly integrated into concrete guidelines on mental health and psychoactive substance use in different countries. This approach understands recovery as a personal and social process that transcends mere symptomatic reduction, and sees the person as central to their own recovery and in the decisions around it. Unique experiences are recognized, as well as structural factors. In addition, it understands daily life as the ideal ground for change, promoting the exercise of citizenship and human rights (Brekke et al., 2018).

This approach identifies and incorporates a person's own goals, interests and strengths, which act as support base for their efforts to deal with and manage their condition, while pursuing the attainment of a meaningful life in the community and the improvement of their quality of life. Brekke and other collaborators (2018) point to a recognized risk in the distortion of the concept of recovery when it is defined on the basis of the person themselves or when it corresponds solely to standards defined by professionals, researchers or service workers.

These notions can vary significantly and lead to formal or informal practices that are incompatible or contrary to the approach, as well as challenging and creating dilemmas in healthcare teams. While in the field of mental health the possibility of managing and learning to deal with symptoms is recognized, in the field of substance use the foundation of total abstinence as a reflection of recovery can generate disagreements or conflicts with this approach, limiting its scope or preventing its application as a base for the provision of *integrated and comprehensive* services of the dual condition.

According to Brekke and collaborators, the debate between abstinence and the flexibility or tolerance of some levels of drug use, poses a paradox rather than a dilemma, since both harm reduction and abstinence are necessary approximations in the application of the *recovery-oriented approach*.

The reality is that concurrent mental health and substance use disorders have also posed the dilemma of carrying out sequential (one first and another later) or parallel treatments (two treatments by different service providers), finding that none of these modalities is ideal and that

it is necessary to improve the capacity of treatment services to *comprehensively* treat the person living with the dual condition (HHS/SAMHSA, 2011).

It is widely documented that people with comorbidities present worse treatment outcomes, higher relapse rates, high risk of suicide, high levels of living on the streets, greater incarceration, hospitalizations, and lower quality of life. Research in the field indicates that to be more effective, care *coordination and integration* is required, since the evidence associates better outcomes with integrated treatments rather than in sequential or parallel treatments.

What characterizes these integrated programs is that services incorporate pharmacotherapy for mental health and drug use conditions, psychoeducation, counseling, psychotherapy, and professional peer support groups (HHS/SAMHSA, 2011).

The transition of programs towards *integration* considers the continuous capacity improvement to attend to the complexity of the comorbidity, a process that must take place before providing services of this type. This implies a change in the program identity as a program that is *capable* of treating dual pathologies with quality, suitability and responsibility, without restrictions and regardless of the profile of the case being treated.

In practice, this means that if a program claims to be *integrated* or capable of serving dual diagnoses, it should not impose barriers to access for people with concurrent health conditions or require referral to other specialized programs. They must count with all the qualifications or accreditation requirements to offer specialized mental health services, in accordance with the regulations of their respective country, without this necessarily meaning that they are becoming a mental health service provider, but rather having the capacity to appropriately care for people who, in addition to a SUD, present one or more other mental health conditions, which should and can be adequately treated, according to the established standards.

To determine the capacity to provide *integrated* services, the difference between the work modalities in the two areas must be clear: 1) if what is offered is a coordinated action with another service provider, it is *coordination*; 2) if there are sources available to *consult* even informally, for a specific purpose or periodically, and clearly limited to an initial evaluation that could indicate whether the treatment offered is appropriate or not in a given case, this is considered to be a *consultation or inter-consultation*; 3) if formal collaboration is undertaken, in which responsibilities are shared for the person's care, clear agreements are established and progress reports are shared, this is *collaboration*; and if, on the contrary, 4) *integration* occurs, it requires the participation of both health services, mental health and substance use, in the construction of a single treatment plan that addresses both problems. For this, it is necessary to count with constant interaction and coordinated work during the assessment, re-assessment and treatment process for each case, establishing co-responsibility.

In other words, according to HHS and SAMHSA (2011), the consolidation of an integrated program implies the merging of service procedures and protocols that act in a coordinated and comprehensive manner to care for people with dual diagnoses.

Among the protocols and procedures, the following are emphasized:

1) Assessment of the two conditions, which includes screening (as a tool that detects the probability of having a specific condition, without the intent to diagnose), and an in-depth assessment that allows a specific diagnosis to be reached. These processes must occur from the onset and in a timely, routine, and systematic manner, using standardized tools and instruments that meet adequate psychometric domains. The assessment must *integrate* comorbidities and must be documented and registered, as well as be carried out by competent staff.

2) The clinical history includes the record of the history, the evolution and interaction between the different conditions.

3) The program is capable of serving people with both moderate and acute conditions, as well those that are severe, unstable and persistent. It may offer comprehensive treatment to stabilize the different conditions, without the need to refer the person to another provider.

4) In cases that are persistent, the program is capable of responding to the complex needs that surface in these cases.

5) Assessment and integration of the stages of change that consist of not only the motivation in regards to drug use, but also other areas of the person's life, informing decisions about the needs, levels and intensity of the required services.

6) Treatment plans that intervene the dual condition in an equivalent and specific ways, including the necessary medication in combination with other interventions. Each person has an individualized treatment plan and delineate the interventions aimed at treating the symptoms of specific disorders in combination with psychosocial interventions.

7) Evolution and progress are routinely and systematically assessed, thus what is recorded reflects clearly and in detail the changes for each condition.

8) The protocols for the comprehensive management of critical situations are explicit and in writing, and include case management around drug use or recurring symptoms, relapses, risk management tools for each case and the strategies and interventions that are foreseen for each case. The guidelines will aim to maintain the individual in the treatment program, with adequate adherence, including situations that warrant different management or referrals to another care service provider due to the severity of the symptoms. These protocols must be widely known by everyone on the team, to ensure strict compliance.

9) Stages of change and progress updates are routinely integrated into the individual treatment plan to determine what needs to be prescribed or what decisions need to be made. Ongoing reassessment should contribute to determining what best fits the stage of progression that the person is going through considering their comorbidities.

10) The prescription of medications requires having the required conditions for their acquisition, storage, custody, monitoring and provision. Medication plans and schemes must respond to an explicit and written protocol. Programs must have qualified staff with experience in pharmacy and pharmacotherapy that are fully integrated into the team and program operations, including the administrative and clinical perspectives.

11) The programs integrate a variety of techniques and praxes for stress management, anxiety, relaxation training, anger management, coping skills, assertiveness training, and problem solving. Similarly, it should include strategies with strong supportive evidence such as motivational techniques and cognitive behavioral therapies to treat anxiety disorders, depression, post-traumatic stress and axis II disorders such as personality disorders.

12) Pharmacotherapy is not considered treatment in of itself, so it cannot become the focus of treatment. Evidence shows that these disorders respond effectively to psychosocial and cognitive-behavioral interventions and that outcomes can be enhanced when combined with pharmacotherapy. In this sense, programs that do not meet all the standards can improve their service provision by delving into evidence-based techniques that show greater effectiveness. Interventions must be designed and provided to each particular case according to their specific situation.

13) Programs offer psychoeducation as a complement to the interventions demarcated for each case.

14) Work with the family is integrated and standardized as part of the treatment plan. This includes education and support groups, as well as specific counseling with the family or relationship partners.

15) They offer mutual aid groups or specific groups for those with a comorbidity. The dynamics and evolution in group work is integrated into the monitoring of each case, understanding that support is required in the transition process as well as accompaniment in order to find the best group strategies for each case.

16) They include formally integrating work with peers into the program, implementing it regularly with a focus on the comorbidity and as a support to the recovery process. This support work is routinely and systematically documented.

17) In preparation for discharge, a specific plan is defined that includes aspects of the transition, support, and follow-up for both types of disorders, without prioritizing one over the other. The protocols and procedures must be clearly defined for each case, including the management of relapse events or the exacerbation of mental health symptoms, ensuring prompt and timely readmission if required.

18) The programs integrate a perspective of hope in the recovery for comorbidities and define goals to achieve and maintain recovery, both for mental health and substance use.

19) As a support to the discharge process, linkages and availability of resources are defined, including mutual aid groups for both conditions, recognizing the specificities and needs in each case, and within a continuous care framework. Ideally, such resources should be available as part of the program itself and be indefinite.

20) The same applies to medication schemes. Programs must be able to prescribe, provide, and monitor indefinitely the treatment regimens as part of continuous care.

21) Programs must have competent health staff that are trained, experienced, and licensed to care for mental health disorders and prescribe psychotropic medications. Professionals must be an integral part of the therapeutic team to ensure adequate follow-up, adherence, and clinical management, seeking to minimize the use of drugs that cause dependence, for example, benzodiazepines.

22) *Integrated* programs must have a therapeutic team competent in mental health, in addition to a medical team in charge of clinical management. The teams must count with constant supervision and updates, as well as tools that allow individual and group supervision of professionals on a routine basis.

23) The protocols must include individualized and continuous follow-up of each case in which the patient/participant's participation is also included.

24) The programs maintain a network of professionals, peer workers and volunteers who can offer supervised support from the professional team. Training and updates must be constant to ensure that there is never a lack of competent staff in the team to adequately attend to comorbidities in mental health.

Considerations for working with families

Although work with families is not part of differential care, since it is considered essential in any program that provides quality services, here we will highlight some central aspects that should be taken into account when working with family and partners/couple.

Strengthening and heightening the understanding of family dynamics around problematic drug use began in the 1950s with the 12-step model, but it was only incorporated into treatment in the 1960s and 1970s. Since Synanon, CTs were understood as an extended family and isolation from the outside world included isolating one's family of origin, considering it unimportant in the process and even as part of the individual's problem. This practice was extended to many TCs inspired by this model, even considering a certain incompatibility between the family and the treatment, qualifying the relationships as "destructive influences" that should be avoided. This began to change in the 1970s when it was understood that treatment without a family led to

limited outcomes and that family work could prevent the outcomes gained from being affected or threatened.

Still at that time, there was no talk of family therapy, but of family groups that had an educational nature, while still considering that the tension in the relationships between residents and their families could be counterproductive, thus these reunions or encounters were conditioned to first reaching the stabilization of the individual. Once individuals were stabilized, families became relevant again for the reinsertion process (Soyez and Broekaert, 2005).

It was not until the late 1970s that family therapy began to be incorporated, although many TCs did not provide family therapy as part of treatment or include it on a consistent basis, occasionally considering it a complementary or additional service. In other cases, therapeutic and mutual aid groups were offered for multiple families. According to Soyez and Broekaert, there is a diversity of family work approaches in TCs, but in terms of therapy, it has been pointed out that these approaches require to be less focused on the problem and more directed towards change, such as brief family therapy or the family narrative approach.

However, the difÏculties to attain a constant and active involvement of all the members of the family that are concerned are clear, posing limits to family therapy. For this reason, family counseling prior to therapy could be useful, but it is demanding work and expensive.

Over the years, evidence has shown that the role of families is not only functional in the onset and continuation of the disorder, but also in the treatment itself and the recovery process. As has been previously said throughout this document, retention is essential for improving outcomes and the active involvement of family in the process improves retention (Soyez and Broekaert, 2005; Wand, 2013).

The increasing aperture of the TCs to the *outside world*, as part of their evolution, has included a revision of the role that families must fulfill within the treatment. The rooted origin of TCs in democratic and humanist perspectives has not always been as prominent as expected, but these origins frame the principle of trust in the potential of human beings to change and overcome addictive behavior, respect for human values, and honest encounters with others.

In this sense, according to Soyez and Broekaert, therapeutic work with families must also have a humanistic foundation and a *contextual* nature. Ivan Boszormenyi-Nagy's ideas have influenced work with families because he integrates the basic premises of the main approaches of family therapy and complements them with constructs of relational justice, thus creating a new way of thinking about the intervention. Later, these ideas gave foundation for *contextual therapy*, in which the context defines the situation in which the interactions and the dynamic balance between giving and receiving take place. Reliability and justice are forces of influence par excellence considering the relational reality and its dimensions, with the dimension of ethics or trustworthiness being the cornerstone of this approach. Nagy's work was also influenced by Maxwell Jones himself.

The active involvement of the family in the treatment and recovery process is particularly important for adolescents and youth because most of them have little or no family support. There

is drug use present in their families, or they do not have the capacity to participate in family therapy. Consequently, in many cases TCs often fulfill the role of surrogate family by substituting the absent family and supporting recovery through the different group and community dynamics.

According to Wand (2013), it is essential to assess the viability and convenience of involving or not involving the family in certain cases, as well as to clearly define the role that the TC plays as a surrogate family when the family of origin is absent. In such circumstances, TCs can provide safety, order, structure, acceptance, empowerment, and discipline, effectively acting as a substitute of the family and facilitating the recovery process.

In cases where it is possible to involve the family, Wand points to multidimensional family therapy or brief strategic family therapy as an alternative to evidence-based approaches. Regardless of the systemic approach applied, studies confirm that intervening directly with families increases retention rates, significantly reduces drug use, promotes pro-social roles and functioning, and improves family dynamics and health. It is worth noting that in the case of youth and adolescents, retention improves between 2 and 3 times the probability of obtaining positive outcomes after discharge.

Critical perspectives

The therapeutic community as a method or as a model has received multiple criticisms, and in the opinion of Molina (2014), some of them being "ferocious." In the 80s and 90s, the idea that these programs limited the rights and freedoms of people was consolidated, affecting their credibility and legitimacy, which was in turn reinforced with documented cases of inappropriate practices, lack of knowledge of fundamental precepts, and the incorporation of ill-suited teams in order to reduce operating costs. Recurrent situations like these in several countries, even led to the prohibition of the method in countries like France and Great Britain, until the emergence of a professionalized and modified modality.

Frequently, criticism has often come from within, both from practitioners and researchers, who have pointed to unexpected iatrogenic effects that could be even more severe than the presenting situation at baseline, as well as the futility of outcomes, normalization of failure, and criticism of correctional and re-educational actions that directly threaten rights, moral autonomy and personal values. All of this led to the dismantling of many programs, especially those that involved extremely high demands from participants, for being widely discredited. At the same time, this served to justify the disappearance of many programs, with public systems claiming to the lack of budget for their funding (Molina, 2014).

The requirement of professionalization, multidisciplinary teams and compliance with highly demanding standards to ensure the quality of these programs have made many of them unsustainable, regardless of whether they are considered viable, effective or profitable.

In the opinion of Molina (2014), there is no "more complete, comprehensive and specific method of care than that of the modern and professionalized TC" (p.94), as long as there are multidisciplinary teams, based on the needs of the beneficiaries, designed in a specific and hopefully participatory manner, evaluating processes and outcomes, with explicit and written protocols that clearly define objectives, methodologies, activities, monitoring and evaluation indicators, with transparency in regards to their methods and outcomes. He adds that these programs combine pharmacotherapy, psychotherapy and TC as part of a method that integrates "the best of each intervention" with continuous reviews and follow-up.

But the standards go beyond this and should focus, among other things, on widely agreed universal treatment standards based on scientific evidence. The TC model cannot and should not be contrary to them. When they have distanced themselves from the minimum standards, bad practices and unacceptable procedures have been evidenced that disregard ethical and bioethical principles. Many of these situations have been documented and exposed in the media in many countries, especially in Latin America, and this has contributed to reinforcing the stigma and resistance against TC, even in potential patients/participants who prefer to not to ask for help, rather than going to center that presents itself as such.

A report published in 2016 by the Open Society Foundations, entitled "No Health, No Help: Abuse as Drug Rehabilitation in Latin America and the Caribbean," provides a dramatic account of the multiplicity of irregularities that occur in internment centers of the region, many of which correspond to therapeutic communities. The report compiles the results of studies carried out in Brazil, Colombia, the Dominican Republic, Guatemala, Mexico and Puerto Rico between 2014 and 2015. It does not claim to be exhaustive, but it clearly detects patterns that are repeated in many countries, including forced internment in residential centers that subject people to practices that are abusive and of low-quality (OSF, 2016).

In 2013, the Special Rapporteur on torture and other inhuman or degrading treatment, presented his report to the UN Human Rights Council, in which he called on States to ensure the protection of the fundamental rights of individuals and to prevent conduct and actions that are classified as torture, inhumane and degrading, in private treatment centers.

On his end, the Special Rapporteur of the right to health "has condemned" these centers for attempting to illegitimately replace other evidence-based measures such as replacement or substitution treatments, psychosocial interventions, and treatments provided with a patient's full and informed consent.

On the other hand, the UN Working Group on Arbitrary Detention's 2015 annual report dedicates a chapter to arbitrary detention in the context of "treatments" for substance use or dependence disorders, considering this a health issue and therefore do not justify an arrest.

The origin of many of them is attributed to, among other factors, the States lack or absence of accreditation standards and minimum regulations to ensure the quality of treatment programs, thereby failing in their obligations. As it is a matter of physical and mental health, States must ensure the conditions of safety and appropriateness in the provision of health services for their citizens. Failure to do so prevents having tools and mechanisms that regulate the way these services operate and tacitly legitimizes practices that are contrary to national and international laws and best practices delineated by international organizations such as the World Health Organization or the United Nations Oïce against Drugs and Crime (OSF, 2016).

The proliferation of unregulated "treatment" centers undoubtedly responds to a felt need from communities and families that don't find alternatives. The low levels of funding for mental health and drug treatment programs in many countries limits the supply of regulated and quality services, leaving a large part of the growing demand unanswered. This explains why the largest proportion of treatment centers in the region are private and not public, why many of these centers operate without any regulation from the States, and why a significant proportion of people who require help, do not the find it or end up being "treated" in irregular and improper centers (see also: IDPC, 2013; CELS, 2016; Fiore and Rui, 2021).

All countries included in the report, count with standards that enable the functioning and operation of these centers, but these are subpar or are not met, and frequently with minimal monitoring. Registries rarely account for the existing supply of treatment centers and the number of unregistered centers exceeds the number of those that are registered in many countries.

The report documents bad practices such as taking people to treatment centers against their will, by force or through deception, even by police authorities themselves, and sometimes by pastors that conduct "spiritual patrols." Based on testimonies, it documents "shock therapies" that include beatings, torture, isolation and humiliating treatment, forced signed consent to "prove" that the person agreed to admission to centers, deprivation of freedom, constant surveillance and lack of privacy, severe sanctions, use of psychoactive drugs such as "chemical straitjackets" and threats. Many centers present degrading, unhygienic and overcrowded, as well as unsafe conditions. Spoiled food is served and individuals are subjected to prolonged periods of not eating.

Medical treatment and psychiatric care are absent in many centers that receive people with drug use profiles, whose withdrawal syndrome must be medically monitored and treated with medications, including substitution or replacement treatment. Mixing of all types of patients/participants is also present, without any consideration of gender, age, profile, needs or requirements.

There is also poor handling and management of personal information and medical records that without safeguarding their proper custody or confidentiality. Exploitation of labor that, far from being vocational education or work preparedness, is the way many people "pay" for their stay, thereby reinforcing social stigma and informal work.

Encountering death in these centers has been an unfortunate reality for many people due to causes as diverse as unidentified or inadequately treated illness, unmonitored or untreated

withdrawal syndrome, intoxications, injuries, suicide, and tragic events such as fires in closed centers that do not offer and prevent safety in an emergency.

What is reported configures a series of crimes that occur due to negligence and inaction of the States, making them complicit in allowing practices that violate human rights, and failing to comply with their obligations. Ending abuses, arbitrary detention, kidnappings, as well as monitoring "treatment" centers and supporting evidence-based treatment is the way forward to end these bad practices and comply with the provisions of the United Nations treaties and the Human Rights Convention. In cases where internment is an alternative to penal sentencing, the same obligations apply, including consent. If the person is not willing to be admitted to a center as an alternative measure, they must have access to due process (OSF, 2016).

The report makes an explicit call for the World Federation of Therapeutic Communities (WFTC) to critique and denounce the abuses committed, and to help educate the public as well as service providers on the importance of offering appropriate and evidence-based treatment. It is worth noting that the same year of this report, the WFTC issued the Mallorca Declaration.

The lack of regulation favors bad practices and abuses of power that in many cases include sexual abuse. The result of all this is that people who arrived needing help, then leave traumatized and terrified, with no intention of going through something similar again, facing conditions that favor relapse.

Bad practices are attributed to cases of iatrogenesis and post-traumatic stress, documented in studies such as that of Fanton (2014), who begins by pointing out that TCs are known for the use of confrontational and/or verbally aggressive techniques and the use of physical violence in extreme and isolated cases, which continue to be commonplace in many centers, despite the fact that empirical evidence has shown its ineffectiveness and iatrogenic potential. This is especially serious in cases of severe dual pathologies and psychotic spectrum, in which the use of confrontational and authoritarian practices could cause more damage, due to the fragility and instability of the psychic structures.

On the other hand, as indicated by Veale et al. (2014) there is no evidence indicating that the *permissiveness* of emotional expression or *confrontation* increases feelings of safety, belonging, or responsibility in the face of change. In contrast, aspects such as filial relationships, regulation of affection and security, based on attachment theory, are well-grounded in theory and practice. A debate that, according to the authors, is similar to that of punitive and restorative justice, the first based on shame (humiliation/punishment) and the second on guilt (responsibility/reparation).

Another critical perspective has been given from the field of sociology. When the phenomenon of drug use is ideologized and understood, for example, as a failure, moral incompetence or maladjustment, it is difficult to recognize it as a health issue, which is clearly included in the diagnostic manuals that guide clinical practice around the world, or as a social or biopsychosocial phenomenon, lending itself to anachronistic and "moralizing" practices that could well be compared to the most basic versions of "correctional", "reformatories" or "insane asylum" institutions.

TCs have been used to exemplify what Erving Goffman called "total institutions" that include treatment facilities as diverse as monasteries, forced labor camps, prisons, psychiatric hospitals, boarding schools or leper colonies. In them, regardless of their appearance, people go through a process of "mortification" to shed their "external" individual and collective identity, providing a headway to a new identity that may too be laden with stigma. There is a strict schedule, rules, walls, and surveillance that limits freedoms and autonomy. In some of them, communication with the outside world is restricted and people are segregated from the rest of society due to their inability to care for themselves or because they are considered to be a threat to themselves and others, thereby justifying their confinement.

The purpose of some of these alternatives, such as psychiatric hospitals, is to restore or isolate the failed constructions of the self, the certainties of the self, and mechanisms of habitual relations, thereby producing a process of deconstruction of the subject and the loss of traits of self-identity. Resistance is suppressed, punished, and isolated (Goffman, 2004).

These facilities and centers would fulfill the function of isolation, containment, and control of the "deviant" or "abnormal" person for whom a social identity is imposed with attributes that differentiate them when compared to others, reducing the person to a label, a category, or a concept with a strong symbolic weight that causes stigma, disgrace and disables them from full social acceptance for not meeting or deviating from established expectations. Thus, this then about "contaminated" social identities that are rejected and individuals aren't able to receive the expected treatment, consideration or respect, weighing them down with shame, guilt and even further marginalization (Goffman, 2015).

According to Castrillón (2008), people who consider themselves "drug addicts" acquire a singular "interdicted" identity in accordance with social and ethical values that press for a "social cure" to be carried out and transform social stigma. In the author's opinion, in the TCs two ideologies are intermingled, one that is Christian and the other that is secular, where both seek to "develop projects of social subjects" in the procurement of responses to the larger society.

For Castrillón, the social nature of the TCs from a logic of internment, places them within the different contemporary ways in which the "interdicted" individual is excluded, segregated and "purified" that are, in this case, based on psychotherapeutic and moral discourse. Reform and moral containment are exerted, assimilating it, according to Castrillón, to what Foucault called the "Great Confinement" as "moral prisons".

For this analyst, the TCs constitute a hybrid that combines ethical and moral conceptions, new and old visions, and values about the individual and society, framed in a therapeutic orbit that seeks "rehabilitation" from a place of moral transformation and methods aimed to cure, that are traversed by discipline, the construction of a new lifestyle and the incorporation of new individual and social identities, which are often consolidated into the category of a "recovering addict" or "recovered addict", extending control and scrutiny beyond an institution's borders.

After the emergence of the social and community psychiatry and antipsychiatry movements at the end of the 1960s, mental health disorders and problems began to be understood as relational problems, derived from the adaptation of the subject to their social environment. In this

framework, the pathology has an origin in the family and community, so treatment must be provided from that place and not in a hospital. These approaches arose as a critical reaction to the repression and inhumane practices that characterized these institutions for many years. Basaglia led this movement in Italy for TCs that replaced not only the walls with trees, but also radically transformed roles, therapeutic practices and power relationships (Pastor and Ovejero, 2009).

Nonetheless, the notions of a cure and rehabilitation was critically reviewed by Foucault in his thesis of the History of Madness, in which he analyzes the Psychiatric Reform movement, from which asylums and mental hospitals were closed under the pretense of replacing inhuman conditions and transitioning towards the medicalization of "madness", conceiving it no longer as a moral disorder, but as pathology and natural disorder. From a biopolitical perspective, this reform was a fallacy because it did not intend to liberate people with mental disorders, but rather to make the control over them more sophisticated, supported by a humanist discourse in which aspects such as that of *moral treatments* continued (Pastor and Ovejero, 2009).

A historical perspective allows us to see the discontinuities of concepts such as "madness", from the Middle Ages when it was considered "sacred", to Classicism or the age of reason in which it was reduced to "scandal" and even to "crime," thereby giving rise to the asylum. At the end of this era, the reform led to its conception as a disease, thereby liberating those that were ill from confinement and putÝng them under medical care, but as Strathern indicates alluding to Foucault, by liberating the body, the mind remained captive, no longer with chains, but with medication. With Freud at the end of the 19th century, "madness" ceased to be silenced and transitioned to talking on the couch, although simultaneously the power of psychiatry expanded, defined it, and also confined it.

Thus, the different *epistemologies* demarcate the assumptions, prejudices and atÝtudes that defined the ways of thinking in different moments in history, creating *discourses* comprised of beliefs, concepts, and practices or ways of acting and responding to phenomena (Strathern, 2002).

For Garbi and collaborators (2012), the different approaches to address problematic drug use, agree on the assumption that modifying drug use implies modifying the subject, that is, they pursue subjective transformations as a necessary condition to stop using. Thus, they define the TC as a "privileged strategy of subjectivation" that seeks to "create new subjects" and focus on confrontation as a technique that, according to the authors, includes a wide spectrum of interventions from compassion and genuine interest for others, to shouting, confrontation, accusation, humiliation and insult.

Through this, a person is expected to recognize and modify what is considered "illegal, dishonest or negative" from a moral perspective and that is associated with the lifestyle and the ways of "being" when using drugs. Thus, according to the authors, a modeling of the person and their subjectivity is observed, also contributing to this, the consciousness and upkeep of routines, actions, thoughts and emotions, inserted in power dynamics that de-subjectivize the individual in *treatment* with the pretense of creating a new subjectivity. This is the *ethos* par excellence of

the *community as method* which seeks subjective transformation adjusted to desirable tenets from a social perspective, where the "lack of commitment to change" is directed through confrontational techniques (Garbi at al., 2012).

The importance of the "confrontation" according to Goti (2000 in López s.f), is the construction of a vigilant and alert environment where information circulates and is known by all, creating a reciprocal perception among the residents themselves, which acts as a tool to pressure for individual change. Added to this are the different dynamics that occur within the community such as public confessions, sermons, assemblies, group dynamics, reward and punishment systems, from which the process of construction of subjectivity occurs.

All of this is consistent with a viewpoint of the problem as a *deviation*, and with the consequent approach to the problem from a perspective of social control that is aligned, in turn, with prohibitionist approaches, from a point of criminality and abstentionism, to address health issues. The construction of the "addicted", "drug addict" or "drug abuser," as a subject emanates from a logic of a pathway of drug-crime-disease that is characterized by "personal debauchery" and "social danger", an approach that omits the possibility that people can establish "other" relationships with drugs (Aureano, 2004 in López, s.f).

From the different aspects of practice that were reviewed, Maxwell Jones' *democratic* approach, the Oxford Group's tenet in which the moralizing criterion of "rehabilitation" is introduced and in which treatment acts as a turning point, the 12 steps in which the autonomy and rationality of the individual who consumes is denied and declared powerless, and the integration of all of them in the Synanon model that purports to recover autonomy from the entry and isolation in a *community*, there is a shared notion that the drug leads to the loss of autonomy, rationality and, sometimes, to complete alienation.

Beyond the nuances of each aspect of a TC, the phenomenological and epistemological conception of the *problem* is the basis of the practices and discourses that occur within it, which are aligned and linked to notions of what is considered "good" and "normal" outside and within the *community*, with external and internal social control mechanisms and the deconstruction of subjectivities.

The notion of drug use as "deviant" behavior, characterized by deficits in the personality, social and moral skills of the people who practice it, as well as the description of the TC model, with an emphasis on the reconfiguration of moral values and the encouragement of a "straight" living can lead to different understandings and interpretations about what is the best way to "enable" or "rehabilitate", leaving porous boundaries against bad practices.

The review of the critiques of the model and the method, leads to the conclusion that, above all, it is necessary to ensure that people receive the best possible treatment, reconciling the views of the model, with the universal standards of care and protection of physical health, mental health and human rights. Additionally, it is necessary to clearly determine the limits of treatment and care in cases in which the model and the interventions that compose it, may be counterproductive for the health and integrity of those who require help.

Care paradigms are diverse in the field of treatment, some of them will be more suitable for some people and not for others, but it is imperative in all cases to follow the guidance of standards and best practices in services and care, maintaining a critical look at what is being done and the impact that this can have on the integral well-being of individuals and the consolidation of their recovery process.

Being mindful of the bioethical principle of non-maleficence which responds to the maxim *primum non nocere* or "above all, do no harm", can avoid cases of iatrogenicity, trauma caused by treatments and other undesirable consequences derived from the dehumanization and degradation of the person who uses drugs.

Harm reduction from the therapeutic community perspective

According to Broekaert et al. (2010), the therapeutic community responds to a phenomenological-existential care paradigm in which the approach addresses the person as a whole and their social network, in order to facilitate health and well-being, as an intentional action that seeks the person's well-being through interventions. In this paradigm, the success of the treatment is measured from what people report about their experience of well-being. It seeks self-actualization and growth and it is inherent to humanistic psychology and pedagogy.

A different paradigm underlies harm reduction. It is set within a critical post-structural perspective that raises the need to assume a critical stance against society and its conservative positions to vindicate concepts such as inclusion, self-determination and the emancipation of vulnerable individuals. It proposes deconstructing the world and its narratives around uncertainty and relativity, aspects that are characteristic of human life. It elicits the preeminence of human rights and citizenship, as well as the rights to quality of life and quality care, which act as principles that guide the care and treatment of people with some type of disability and people who use drugs (Broekaert et al., 2010).

From this perspective, the absence of methodologies that are collaborative, empowering and inclusive in evidence-based medicine is questioned, contributing to undermining of the importance of social activism and compassionate treatment of people in conditions of vulnerability. From a place of social criticism, it is argued that non-privileged people should be empowered to fully exercise their civil rights, including those of self-determination and the freedom to choose treatment (Broekaert et al., 2010).

The latter is a bioethical principle that refers to the autonomy and self-governance of all people to act with *freedom and agency*, to do it with intent, with understanding and without coercion or influences to determine their actions. Respect for an individual's autonomy begins from always telling the truth, respecting privacy, protecting the confidentiality of information, obtaining consent to intervene and helping people make decisions when they request it. It starts from recognizing that each person knows better than anyone else what their interests are, so their conscience is respected as an expression of integrity (Beauchamp and Childress, 1994).

Consistent with this paradigm, harm reduction respects a person's will regarding their drug use, frees them from judgments or questioning, vindicates their right to health, information and care, humanizes how they are treated, and provides everything that the person needs without any requirements or conditions, so they can be as safe as possible, to dignify their living conditions and to care for and restore their health, even when they continue to consume substances.

The objectives are no longer focused on their use or consumption, but on their quality of life, well-being and care, modifying as much as possible, the circumstances that lead the person to take risks and harm. Certainly, abstinence is not a condition and their right to self-determination is recognized at all times.

Because of all this, harm reduction strategies and programs work with people from *where they are at*, regardless of the stage of motivation for change they find themselves in. They have a low threshold of requirements, they are integrated into the "natural" environment of people who use drugs, they search for them, they establish themselves in the field, working from there, commonly through peers.

Hughes (2008) describes harm reduction as a people-centered philosophy that engages people in behavior change processes even when they are not motivated to achieve abstinence, in order to avoid risky behaviors. In this sense, harm reduction challenges the notion of abstinence as a universal goal of treatment and vindicates the value of pursuing other complementary goals, which are more realistic and relevant for many people who, when using drugs, are at risk.

Certain incompatibility arises from the foundations, definition and minimum standards of TCs, since it is a drug-free treatment strategy that proposes sobriety and abstinence as the basis of recovery. As documented, many TCs have relaxed their stance on medication, including medication-assisted therapy and substitution, at least in the early phases. In these cases, what the evidence demonstrates is accepted, thus improving adherence to the process, retention and outcomes.

Although medication-assisted treatments are part of the package of harm reduction measures[1], this approach goes further. In these cases, more than harm reduction, one could speak of

[1] UNAIDS (2017). Harm reduction saves lives, https://www.unaids.org/sites/default/files/media_asset/harm-reduction-saves-lives_en.pdf WHO (2016), and Consolidated guidelines on HIV prevention, treatment and care for key populations, https://www.unaids.org/sites/default/files/media_asset/harm-reduction-saves-lives_en.pdf

affliction reduction, since when the technologies exist and one has the right to access them, there is no justification for denying them.

In fact, the World Federation of Therapeutic Communities (WFTC) presents as part of its standards their position on harm reduction, resolving that[2]:

1. Abstinence is a process goal in the TC, but TCs will give a voice to people and their decision-making process.

2. The interaction with social and health services networks will be based on treatment concepts aimed at abstinence and recovery, considering the precariousness of the concept of "addiction" as an incurable disease.

3. Strategies such as the syringe exchange or the prescription of drugs that produce dependency, without the mediation of a contact or intervention that seeks to improve people's quality of life, is considered inhumane and must be avoided. The prescription of substitute drugs should be a component of a program aiming for a person's "rehabilitation".

4. TCs treat people, not drugs. "Addiction" is a symptom of other problems that can be addressed once use and other reactive behaviors have ceased.

5. The treatment that occurs in TCs for "addiction" is harm reduction. However, harm reduction is not treatment. TCs should aspire to be part of an integrated treatment system that includes intramural, extramural, and outpatient care, day centers, substitution programs, detoxification clinics, prisons, and hospitals.

This position does not necessarily present an incompatibility with the harm reduction approach, on the contrary, it defines the place that a TC and harm reduction can occupy in the continuum of care for people with SUD. However, it suggests that the goal should always be the search for abstinence and the improvement of people's quality of life respecting their decisions, but also that harm reduction should not be limited to providing them with supplies or assuming that the person who suffers from a SUD cannot aspire to "a cure", which would lead to "capitulating" the efforts to seek abstinence or recovery.

The difference therefore lies in this last aspect, which clearly reflects the paradigmatic differences that underlie each approach. Thus, harm reduction from a certain perspective, could be considered a way of "capitulating" or giving up on recovery or resigning oneself to living a life with drugs. Ultimately, it is people who decide what they want and need, and in what way or at what rate they want to achieve their goals. Respecting a person's will is a principle of TCs, as it is of harm reduction. Both approaches seek to humanize people who use drugs, both trust in

[2] www.wftc.org - World Federation of Therapeutic Communities WFTC "Our Standards".

people's ability to change and improve their quality of life, both consider the role of peers as invaluable, and both agree that people should be at the center and not drugs.

For its part, the international harm reduction association, Harm Reduction International, defines harm reduction as "policies, programs, and practices that seek to minimize the negative health, social, and legal consequences associated with drug use, policies, and anti-drug laws". It is founded on principles of justice and human rights. It focuses on positive change and works without judgment, coercion, discrimination, or abstinence requirements as a precondition for care.

It includes multiple strategies that range from supervised rooms for drug use, syringe exchange programs, substance testing, overdose prevention and management, psychosocial support, support in basic services such as housing and employment, and education in lower risk substance use practices. These are evidence-based interventions that have been shown to be cost-effective and reduce the impact on individual and community health (HRI, 2022).

The principles of this approach are summarized in:

1) **Respect for the rights of people who use drugs**. From a perspective of protection of civil rights and the improvement of public health, it is recognized that people who use drugs are citizens and, as such, have the right to life, by achieving the best possible state of health, access to social services, a right to privacy, to be free from arbitrary arrests, cruel, inhuman or degrading treatment.

2) **Commitment to the evidence**. Policies and practices from this approach are supported by a robust body of evidence that shows that they are viable, effective, safe, cost-effective in various social, cultural and economic setYngs, are easy to implement, low cost and have a positive impact on health.

3) **Commitment to social justice**. Harm reduction does not discriminate or exclude anyone for any reason. People must be able to access services without having to navigate complex pathways and without facing barriers. They must be able to actively participate in policies and programs that are intended to benefit them.

4) **Elimination of stigma**. The practice of harm reduction avoids moral judgments, terminology and language that contribute to the stigmatization of people who use drugs, because they reinforce stereotypes that harm and create barriers to access social and health services.

Preserving the life and health of people who use drugs is the fundamental impetus of harm reduction and this is achieved through positive changes that are facilitated, not imposed. Achievements, however small, are reinforced and valued (HRI, 2022).

In addition, harm reduction offers a bridge for people who have not considered giving up their substance use for various reasons and who, by accessing certain low-threshold services, could feel motivated to transform their living conditions and, eventually, reduce their levels of consumption or abstain from using altogether.

Generally, what guides this approach is: pragmatism, the focus on the damage associated with substance use practices, the prioritization of a person's immediate and realistic goals, the flexibility and diversity of interventions that maximize the reduction of negative effects of drug use, autonomy and assessment (Hughes, 2008).

Few documented experiences of abstinence-based programs that have incorporated harm reduction can be found in the literature. One of them was studied and published by the WHO in 2006 (WHO, 2006). It consisted of a therapeutic community in Australia called "We Help Ourselves" or WHOS, that in the face of the HIV crisis, reconsidered whether it should continue demanding abstinence or if it should adjust to the reality of the people they intended to care for. With no condoms, no sterile syringes, and no overdose information, they saw that people would get sick and die (Dolan et al., 2007; WHO, 2006).

Thus, not only abstinence, but the health and life of people were elevated as a priority. They carried out a series of adjustments to the program, opening a new line of intramural and extramural interventions that included information on HIV, other STIs, and access to preventive supplies such as condoms and syringes. Not only did they find a good reception of these changes, but also an improvement in the relationships between patients/participants and the team, improving the rates of retention and program completion, and a reduction of HIV risk behaviors. Although abstinence remained as a primary commitment, they opened up alternatives for people who found it difficult to commit to or maintain abstinence.

This specific experience is an example of a conciliation between two paradigms that appear to be exclusionary and contradictory with each other, managing to complement each other, without abandoning the superlative of recovery and abstinence (Dolan et al., 2007; WHO, 2006).

According to Hughes (2008), achieving a "friendly" approach with people, favors the construction of relationships of trust and respect that help attract and retain them in services effectively.

Although harm reduction can be understood as a step towards treatment, its value is not limited to only this, since it recognizes the complexity of the phenomenon of substance use and its underlying factors, such as trauma, poverty, racism, isolation and social exclusion, discrimination, social inequality and stigma, many of which increase the conditions of vulnerability of people who use drugs and can directly affect their ability or interest of accessing treatment, starting a process of recovery or stay in it.

Integrating a harm reduction perspective in the treatment of psychoactive substance use disorders implies not only recognizing the multifaceted aspect of substance use that ranges from severe involvement with the substance to total abstinence, but also recognizing that there are forms of substance use that are less risky than others. This is also connected to the phases of change, described as part of the Transtheoretical Model proposed by Prochaska and Di Clemente, since the harm reduction approach implies working with the person from where they are at in the process, even if they are in a stage of precontemplation or in full relapse. Respecting at all times what is a priority for the individual in a given phase or stage of change.

The realism and pragmatism that characterizes this approach stems from the recognition that: 1) complete abstinence works for some people, but not for all; 2) requiring abstinence to access or remain in treatment can demotivate many people and prevent them from asking for help of any kind; and, 3) relapse or recidivism in substance use is also very common in people who have gone through abstinence-based treatment modalities (Hughes, 2008).

According to Hughes, the sense of harm reduction is distorted when it is not known that it is an integrated approach to a care model that seeks to find a balance between public health and the right to self-determination. The prospect of integrating this approach into abstinence-based programs could be beneficial during the stabilization phase given that clearly abstinence is rarely achieved overnight, that relapse is part of the recovery process, and that the evidence demonstrates that, when a decision has been made about one's own use, having harm reduction alternatives available has little influence on whether or not a person continues to use or relapses (Hughes, 2008).

Harm reduction psychotherapy is an intermediary measure that falls under the "treatment" category. This approximation stems from understanding what the person wants to achieve regarding their drug use, making alternatives available that will include those aiming to manage the associated risks, including: transitions between drugs, between modes of administration, frequencies, amounts, circumstances of use, promotion of self-care strategies, and education on risks and harm (Hughes, 2006).

However, this approach does not focus solely on substance use but, like TCs, addresses the person as a whole, delves into the underlying motives for substance use, and offers tools for emotional management, anxiety management, identification and management of triggers and perceived benefits of using, as well as the reasons why it has been maintained over time and the functions it has fulfilled (see for example: Tatarsky, 2002; Denning and Little, 2011; Denning and Little, 2017).

In short, the stance of harm reduction is neutral, pragmatic, and welcomes what the person brings with them, without controversy, imposition or judgment, recognizing at all times that they themselves is who best knows their own history, their suffering, and the place that the drug has occupied in their life.

Since change does not happen overnight, accompaniment adjusts to the pace of change of the individual and their priorities, trusting in the resources with which they arrive, empowering them to regain control over their lives and decisions, recovering their sense of agency and prioritizing care and self-care to minimize risks and damage from changes in practices and rituals of substance use. It is unconditional acceptance, without trying to "change" the person or their subjectivity, which characterizes this approach, aspects that could be understood as contrary to the foundations of the *community as method*.

In this sense, a transition to an abstinence-based program involves several processes, including:

- Assess from within and with a critical eye the outcomes that are obtained.
- Recognize that people seek help and treatment, not punishment.

- Recognize that suffering and trauma underlie much of problematic substance use and increases with the consequences of use, thus interventions should not originate or cause further suffering or trauma.
- Establish whether you want to make treatment options available to people who are not prepared to contemplate abstinence as a condition of admission or to stay in treatment.
- Establish if there are relevant goals or goals that have value for the team and that are not necessarily linked to abstinence.
- Recognize that people who use drugs are unique and diverse, so treatments must be equally personalized and offer alternatives that respond to said diversity.
- Recognize that moderation or control over substance use is in many cases possible, and that the goals to be pursued regarding use, health or other areas of life, must be defined by the person or, with them, allowing them to recover their sense of agency and autonomy in their life
- Make the goals, norms, modalities, and interventions more flexible, since integrating the harm reduction perspective implies modifying the language and narrative around drug use, the person who uses them, and the type of "treatment" from which they could benefit
- Establish the boundaries and limits of the model that is applied and determine if harm reduction can help close the gaps, strengthen it or cause the opposite effect.
- Review aspects of the method itself that may be contrary to the definition, spirit and principles of harm reduction.
- Educate, train and sensitize the team around the harm reduction approach and determine what implications integrating this approach would have for the treatment model and method being applied, and if there is a willingness to make a transition in this sense, with all of which this implies.

Finally, both the TC and the harm reduction approach share the characteristic of being ideal for the care of people who, in addition to their substance use, present complex psychological and social conditions, people at high risk and vulnerability.

However, to integrate the harm reduction perspective, it is necessary to start from recognizing that judgment or the risk of being exposed to greater stigma, or having to face greater shame for practices or life choices, discourages seeking information, advice, services, help or treatment. People remain "in the shadows", marginalized and excluded, taking risks that can result in serious damage to their health and survival. Harm reduction, in addition to humanizing, dignifying, getÝng close to people who use drugs and respecting their will, seeks above all to save lives.

Summary of international standards for the treatment of substance use disorders

General context

A joint effort between the World Health Organization (WHO) and the United Nations OfÏce on Drugs and Crime (UNODC) led to the definition of treatment standards for psychoactive substance use disorders in 2009, their revision and issuance in 2016 as a draft, to be subjected to multiple field tests, consultations and reviews, with its consolidation in 2020 (WHO/UNODC, 2020).

Such standards are considered universal, evidence-based, integrating the broadest possible consensus and defining what is considered a best practice in the field of treatment of SUDs, for achieving greater effectiveness and consolidation of treatments that are supported by the evidence and ethics.

These standards are based on the definitions contained in ICD-11 for *dependence on substances and substance use disorders* as a broader category that includes intoxication, withdrawal syndrome and a range of mental health disorders induced by substance use.

They recognize that dependence on substances is rooted in the complex interplay of biological, psychological and social factors, including neurobiological mechanisms ranging from genetic vulnerability to the disruption of neural pathways in brain areas that regulate functions such as motivation, pleasure, memory and learning. At the psychological level, family factors stand out, among them, childhood neglect, early onset of abuse, and the modeling of risky patterns of consumption and dependence on substances. At the community level, they point to aspects such as poverty, displacement, norms favorable for drug use, among other factors that increase vulnerability to substance use disorders.

Added to these disorders are health conditions associated with risky health practices such as injections, infections such as HIV, viral hepatitis, tuberculosis, the risk of overdose, road injuries, other injuries, cardiovascular and liver problems, violence and suicide. All this having an incidence on the reduction of life expectancy due to high rates of morbidity and mortality concentrated disproportionately in young people.

On the other hand, the standards point out that the relationship between substance use disorders and other mental health disorders is complex. In some cases, they precede the start of consumption and increase the risk of developing substance use disorders, in others they are secondary to consumption, in part, due to the neurobiological changes associated with repeated exposure to substances. These risks are increased when repeated exposure to substances occurs before reaching full brain maturity, which is generally around age 25.

All of this has led to the conclusion that it is a complex, multifactorial health disorder that involves widely documented and studied biological and psychosocial mechanisms. Along the same lines, scientific advances have made it possible to develop effective approaches for the treatment and comprehensive care of people with substance use disorders that allow them to change their behavior and improve their health. The approach from a public health approach has promoted the development of interventions that reduce the short and long-term damage experienced by people who use drugs, and in particular those who inject drugs, preventing HIV and other infections, for example.

The growing recognition of the psychosocial, environmental, and biological determinants of this disorder, as well as its consequent complexity, has led to changing perceptions and recognizing the need to approach it with a multidisciplinary, integrated, and comprehensive approach guided by the public health principles and of the social determinants of health, among which are the social disadvantages and adversities that can be prevented and addressed.

Despite these developments and growing consensus, stigma and discrimination persist and are phenomena that people who use drugs and have associated disorders face on a daily basis, even in health care setYngs. This situation compromises and threatens the implementation of quality treatment interventions, limits the training of health professionals in the field, and limits the expansion of the availability and funding of treatment services. There is also resistance to recognize that, as the evidence indicates, these disorders can be managed from public health systems, just like other health disorders, delaying the transference from science to public policy and, ultimately, the implementation of evidence-based practices (WHO/UNODC, 2020).

In many countries, the "treatment" of these disorders remains in the hands of justice systems and defense ministries, thereby perpetuating the idea that it is a matter of public safety and not of public health. The biopsychosocial perspective has proven to be cost-effective, with good public safety outcomes with broad benefits for affected communities in terms of crime reduction, reduction of the public health impact, reduction of people living on the streets, unemployment and a reduction of demand for social welfare services, among others.

The standards also point out the importance of recognizing that the chronic condition and recurrence that often characterize this disorder require long-term care, offering sustained care and crisis management, with varying levels of intensity. Likewise, they point out that the changing nature of the phenomenon requires the constant adaptation of services to address consumption patterns, profiles, and associated health problems in a timely, effective, and efÏcient manner.

The gaps in access to treatment services have been repeatedly documented by UNODC and show that only 1 in 6 people access treatment in the world, and said proportion by region is 1 in 18 in Africa, 1 in 11 in Latin America and Eastern Europe, and 1 in 3 in North America.

In terms of gender, 1 in 3 people who use drugs is a woman, but only 1 in 5 people in treatment is a woman. In women who use drugs, a greater burden of disease is concentrated, this being 25% in contrast to 19% in men.

The reality of these figures demonstrates that the goals of universal access to health services are far from being achieved in the case of substance use disorders, a reality that is not compatible with the seriousness of the condition, the significant burden of associated illness and the high social costs in terms of lost productivity, health spending, costs to the justice and social welfare systems, among other social consequences. Consequently, investment in effective and quality treatment and care services will result in healthy development of families, communities and countries.

The purpose of treatment in the field of substance use disorders is to improve the health and quality of life of the people who suffer from them and the ultimate goal is to achieve the broadest possible recovery, opening the possibilities for variable goals ranging from suspension or reduction of drug use, improvement in health, well-being and social functioning, prevention of future damage by reducing risks of complications or relapse.

Apart from clinical effectiveness, treatment in the field must adhere to health care standards, being consistent with the United Nations Declaration on Human Rights and other conventions of this body, promote personal autonomy and promote social and individual safety. Like any other health service, interventions in the field must offer ethical and evidence-based care (WHO/UNODC, 2020).

International standards or guidelines for the treatment of substance use disorders define seven principles with their respective standards, for which we present a summary below.

Principle 1: Treatment should be available, accessible, attractive, and appropriate	
Description	Drug use disorders can be treated effectively in most cases if people have access to a wide range of services that cover the spectrum of issues that individual patients may face. Treatment services and interventions must be based on scientific evidence, and match the specific needs of individual patients at a particular phase or severity of their disorder. The services include: community-based outreach; services in non-specialized setÝngs; inpatient and outpatient treatment; medical and psychosocial treatment (including the treatment of alcohol and other substance use disorders as well as other psychiatric or physical health comorbidities); long-term residential or community-based treatment or rehabilitation; and recovery-support services. These services should be affordable, attractive, available in both urban and rural setÝngs and accessible, with a wide range of opening hours and minimal waiting time. There is a need to minimize all barriers that limit access to appropriate treatment services. Services should not only offer treatment for substance use disorders per se, but also provide social support and protection, as well as general medical care. The legal framework should not discourage patients from attending treatment. The need to ensure that the treatment environment is friendly, culturally sensitive and focused on the specific clinical needs and level of preparedness of each patient, encouraging rather than deterring their attendance.
Standards	
1.1	Availability of services at all levels of health care, from primary to specialized care.
1.2	Essential treatment services include: outreach services; screening and brief psychosocial interventions; diagnostic assessment; out-patient psychosocial and pharmacological treatment; management of drug-induced acute clinical conditions (such as overdose, withdrawal syndrome); inpatient services to manage severe withdrawal and drug-induced psychoses; long-term residential services; treatment of comorbid SUD and psychiatric and physical disorders; and recovery management services delivered by trained clinicians.
1.3	Selected and properly trained peers can work in treatment services, providing specific interventions aimed at helping identify patients, engage them and keeping them in treatment.
1.4	Essential treatment services for drug use disorders should be within reach of public transport and accessible to people living in urban and rural areas.
1.5	Extend low threshold and outreach services, as part of a continuum of care, to the 'hidden' populations most affected by drug use, but often unmotivated to receive treatment or that relapse after a treatment program.
1.6	The continuum of care must ensure multiple points of entry to treatment services.
1.7 and 1.8	Essential services must be available at different schedules for people with multiple responsibilities, must be affordable for people of different socio-economic conditions, and reduce out-of-pocket costs for them.
1.9	Services must provide access to social support, general medical care, management of comorbid conditions, including psychiatric care and care for physical health conditions.
1.10	People with SUD must have access to information about the availability of services through different means of dissemination.

Source: WHO/UNODC (2020). *International standards for the treatment of drug use disorders, revised edition incorporating results of field-testing.*

Principle 2: Ensuring ethical standards of care in treatment services	
Description	Treatment for drug use disorders should be based on universal ethical healthcare standards – including respect for human rights and the patient's dignity. This includes responding to the right to enjoy the highest attainable standard of health and well-being and avoiding any form of discrimination and/or stigmatization. Individuals with drug use disorders should, to the extent that they have the capacity to do so, make treatment decisions, including when to start and stop treatment, and its nature. Treatment should not be forced or against the will and autonomy of the patient. The patient's consent should be obtained before any treatment intervention. There is a need to maintain accurate and up-to-date clinical records, and guarantee the confidentiality of treatment records. It is critical to avoid circumventing health records in registering patients entering treatment. Punitive, humiliating or degrading interventions (such as beatings, chaining, withholding of treatment and food, etc.) should never be used. A strict code of ethics for staff should apply. Staff should refrain from advocating personal beliefs and should not use humiliating or degrading practices. The individual with a drug use disorder should be recognized as a person with a health problem who deserves treatment similar to that delivered to patients with other psychiatric or medical problems.
Standards	
2.1	In all cases, treatment services should respect the human rights and dignity of patients and never use humiliating or degrading interventions.
2.2	Patients must grant informed consent before treatment begins and have a guaranteed option to withdraw from treatment at any time.
2.3	Patient data should be strictly confidential. Circumventing the confidentiality of health records in order to register patients entering treatment should be prohibited. Legislative measures, supported by appropriate staff training and service rules and regulations, should ensure and protect the confidentiality of patient data
2.4	Staff of treatment services should receive proper training in the delivery of treatment in full compliance with ethical standards and human rights principles, and show respectful, non-stigmatizing and non-discriminatory atÝtudes towards patients/participants.
2.5	Service procedures should require staff to adequately inform patients of treatment processes and procedures, including their right to withdraw from treatment at any time.
2.6	Any research conducted in treatment services involving patients should be subject to the review of human research ethical committees. Ethical committees are encouraged to consider the opinions of people who have experienced drug use and drug treatment and are recovering from drug use disorders. The participation of patients in the research should be strictly voluntary, with informed written consent obtained in all cases.
2.7	Ethical standards of care in treatment services should apply to all populations with special treatment and care needs, without discrimination.

Source: WHO/UNODC (2020). *International standards for the treatment of drug use disorders, revised edition incorporating results of field-testing.*

Principle 3: Promoting treatment for drug use disorders through effective coordination between the criminal justice system and health and social services	
Description	Drug use disorders should be considered primarily as health problems rather than criminal behaviors and as a rule, people with drug use disorders should be treated in the health care system rather than the criminal justice system. Not all people with drug use disorders commit crimes and even if they do, these are typically misdemeanors or low-level crimes committed to fund drug use. This typically stops with the effective treatment of the drug use disorder. The criminal justice system should collaborate closely with the health and social systems to ensure that treatment for drug use disorders in the health care system takes precedence over criminal prosecution or imprisonment. If imprisonment is warranted, treatment should also be offered to prisoners with drug use disorders during their stay in jail and after their release as effective treatment will lower the risk of relapse, overdose death and reoffending. In all justice-related cases people should receive treatment and care of a standard equal to that offered in the community.
Standards	
3.1	Treatment for drug use disorders should be provided predominantly in health and social-care systems. Effective coordination mechanisms with the criminal justice system should be in place to facilitate access to treatment and social care services for people in contact with the criminal justice system.
3.2 and 3.3	People with ongoing criminal proceedings who present a SUD must have criminal treatment alternatives as a partial or complete alternative to incarceration. The alternatives must have a legal framework that safeguards this right.
3.4	Criminal justice setÝngs should provide opportunities for individuals with drug use disorders to receive parity of treatment, health and social care that are available in the community.
3.5	Treatment interventions should not be imposed on individuals with substance use disorders in the criminal justice system against their will.
3.6	The interventions available must be integrated and comprehensive, containing the essential services (principle 1) applicable in this setÝng.
3.7	Training for criminal justice system staff, including law enforcement and penitentiary system officers and court professionals, should be in place to ensure recognition of medical and psychosocial needs associated with drug use disorders and to support treatment and rehabilitation efforts.
3.8	The treatment of drug use disorders in the criminal justice system should follow the same evidence-based guidelines and ethical and professional standards as in the community.
3.9	Treatment for drug use disorders and comorbid conditions should be an essential part of the social reinsertion of prisoners with drug use disorders. Additionally, there is a need to ensure the continuity of treatment for drug use disorders in all cases through the effective coordination of health and social care services in communities and criminal justice setÝngs. This will reduce the risk of relapse, overdose and reoffending.
3.10	E All efforts should be made to reduce the burden of stigma and prevent discrimination directed at people with mental and substance use disorders who attend medical services while in contact with the criminal justice system.

Source: WHO/UNODC (2020). *International standards for the treatment of drug use disorders, revised edition incorporating results of field-testing.*

Principle 4: Treatment should be based on scientific evidence and respond to the specific needs of individuals with drug use disorders	
Description	Investments and interventions to treat SUDs must be guided by the accumulated body of scientific knowledge on the subject. The high standards required to approve pharmaceutical, psychosocial or medical innovations should also be applied to the treatment of SUDs. Any pharmacological, medical or psychosocial intervention must be supported by research or by recognized organizations in the field. Any intervention must be considered to be safe, effective and that it has been adequately evaluated with clinical studies. The duration and intensity must be based on evidence-based clinical practice guidelines. Treatments must be defined on a case-by-case basis to respond to the particular needs and conditions of each patient, and must be carried out by multidisciplinary teams that offer a comprehensive response. There is a need to plan and deliver treatment services for drug use disorders using the approach required for treating chronic conditions, rather than the acute care model, that is, from the logic of long-term treatment and care.
Standards	
4.1	Resource allocation for the treatment of drug use disorders should be guided by existing evidence of the effectiveness and cost-effectiveness of treatment interventions
4.2	A range of evidence-based treatment interventions of different intensity should be in place at different levels of health and social care systems, with the appropriate integration of pharmacological and psychosocial interventions within a continuum of care.
4.3	Treatment services should be gender-sensitive and oriented towards the needs of the populations they serve, with due respect for cultural norms and the involvement of patients in the service design, delivery and evaluation.
4.4 and 4.5	Primary care health professionals must be trained in the identification of substance use, diagnosis of the disorder, other comorbidities and their proper management. Treatment at the primary level should be supported by specialized services, particularly for cases of high severity or with physical or mental health comorbidities.
4.6 and 4.8	Every program should have, as much as possible, multidisciplinary teams trained to provide evidence-based services for SUDs. At a minimum they must be competent in medicine, psychiatry, clinical psychology, nursing, social work and counselling. It is important that they involve staff with experience of life in the field and who are in recovery. The training of the team must be continuous and include different educational levels, both university and continuing education.
4.7	Individual needs should determine the duration of treatment, with no pre-set limits and the possibility of modification at any point, based on the patient's clinical needs.
4.9 and 4.10	It is necessary to keep updating the treatment guidelines according to new evidence that emerges in terms of effectiveness, to identify the needs of patients/participants of the programs, and to carry out evaluative research. It is also appropriate for treatments assess their performance in contrast with other comparable programs.
4.11	1 The development of new treatment interventions should be conducted through the clinical trial process and overseen by an authorized human research ethics committee.

Source: WHO/UNODC (2020). *International standards for the treatment of drug use disorders, revised edition incorporating results of field-testing.*

Principle 5: Responding to the special treatment and care needs of population groups	
Description	The diversity of subgroups of people with SUD requires special consideration, for relevant and specialized care. Groups with special needs include but are not limited to: women and pregnant women, children and adolescents, older adults, ethnic groups, migrants, sex workers, people with diverse gender identity and sexual orientation, people with low educational levels, with comorbidities, in contact with the justice system and anyone who requires social welfare support such as people who live on the street or the unemployed. Treatment plans must be tailored to their unique needs and consider specific vulnerability factors as well as stigma. Children and adolescents should not receive treatment in the same environment as adults and services should include health, education and social welfare in a collaborative structure with families, schools and social services. Women may require special protection and attention tailored to the violence they may have experienced, just like their children, therefore coordination with protective services is required. To obtain maximum benefit, this may require exclusive environments for them, and the provision of sexual and reproductive health services and support in parenting skills.
Standards	
5.1	Service provision for drug use disorders and service treatment protocols should reflect the needs of specific population groups.
5.2, 5.3 and 5.4	Programs for children, adolescents and women must be differentiated to obtain the best outcomes. This includes facilities, environment, staffing, and differentiated treatment plans. In the case of minority groups, they must be sensitive to cultural norms, ensuring that there are no barriers with interpreters and mediators.
5.5	Social assistance and support packages should be integrated into the treatment services for people with drug use disorders, particularly those without social support, such as those who are homeless or unemployed.
5.6	Outreach services should be in place to establish contact with people with drug use disorders who may refrain from seeking treatment because of stigma and marginalization.
5.7	Efforts are required to reduce the burden of stigma, structural barriers to treatment, as well as ensure measures that promote self-efficacy for people with SUD.

Source: WHO/UNODC (2020). *International standards for the treatment of drug use disorders, revised edition incorporating results of field-testing.*

Principle 6: Ensuring good clinical governance of treatment services and programmes for drug use disorders	
Description	Good quality and efÏcient treatment services for drug use disorders should have accountable and effective methods of clinical governance. The treatment program, policies, procedures and coordination mechanisms should be clearly defined and known by all program staff, including administrative staff, and patients. It should reflect current research evidence and respond to the patient/participant's needs. Organizations should have in place a variety of measures to support their staff and ensure the constant provision of good quality services.
Standards	
6.1	Treatment policies and plans for substance use disorders should be formulated by relevant governmental and other authorities, and should be based on the principles of universal health coverage, the best available evidence and developed with the involvement of key stakeholders, including patients, family and community members and NGOs.
6.2	Written service policy and treatment protocols should be available, known to all staff and guide the delivery of treatment services and interventions.
6.3	Staff working in specialized services for SUDs should be qualified, certified, and receive on-going evidence-based training, support and clinical supervision. Clinical supervision, mentoring, safety protection measures and other forms of support are needed to prevent 'burnout' among staff members.
6.4	Policies and procedures for staff recruitment and performance monitoring should be clearly articulated and known to all.
6.5	A sustainable source of adequate funding should be secured and proper financial management and accountability mechanisms put in place. The budget should include resources for on-going staff education, and the evaluation of service quality and performance.
6.6	Services for the treatment of drug use disorders should network and link with all levels of health care including primary and specialized health services, social services, and others as appropriate in order to provide comprehensive care to their patients.
6.7	Patient record and data collection systems in line with international indicators should be in place to ensure accountability and continuity of treatment and care, while respecting patient confidentiality.
6.8	Patient record and data collection systems in line with international indicators should be in place to ensure accountability and continuity of treatment and care, while respecting patient confidentiality.
6.9	Patterns of drug use and related health and social consequences and substance use, psychiatric and physical health comorbidities should be regularly monitored and outcomes made available to help the planning and governance of treatment services.

Source: WHO/UNODC (2020). *International standards for the treatment of drug use disorders, revised edition incorporating results of field-testing.*

Principle 7: Treatment services, policies and procedures should support an integrated treatment approach, and linkages to complementary services require constant monitoring and evaluation	
Description	In response to a complex and multifaceted health problem, comprehensive treatment systems should be developed. No treatment modality exists that could on its own adequately cater for all. The response should be wholistic and tailored to the needs of individuals. Whenever possible, different services need to be engaged in treatment delivery with appropriate coordination, including: psychiatric, psychological and mental health care; social care and other services (including for housing and job skills/ employment and, if necessary, legal assistance); and other specialized health care services (such as services for HIV, HCV, TB and other comorbid health conditions). It is vital to monitor, evaluate and adapt the treatment system constantly. This requires multi-disciplinary planning and the implementation of services in a logical, step-by-step sequence that in consistent with policies, needs assessment, planning, implementation and evaluation of services, outcomes and quality improvement.
Standards	
7.1	Treatments must be individualized, holistic, and integrated, in coordination with complementary services within and outside of the health sector.
7.2	Links between efforts to prevent drug use, treat drug use disorders and reduce health and social harms associated with drug use should be established and operational.
7.3	It is necessary to articulate efforts and integrate work with families, communities, social services, the justice system, primary care and specialized services, safeguarding the confidentiality of patient information.
7.4	Service planning must be consistent with the extent and nature of the problem, as well as with the characteristics of the population that requires them.
7.5	The roles of national, regional and local agencies in the different sectors responsible for the delivery of treatment and rehabilitation of drug use disorders should be defined, with mechanisms established for effective coordination.
7.6	Quality standards should be developed with appropriate mechanisms for ensuring compliance, quality assurance or accreditation.
7.7	Each service should have mechanisms of clinical governance, monitoring and evaluation in place, including clinical accountability, continuous monitoring of the patient's health and well-being, and intermittent external evaluation
7.8	Information on the number, type, and distribution of available services, their coverage, and utilization must be monitored to inform planning and programming, based on needs.

Source: WHO/UNODC (2020). *International standards for the treatment of drug use disorders, revised edition incorporating results of field-testing.*

Residential and long-term programs are categorized, according to international standards, as specialized treatments. They have a minimum duration of three or more months, depending on the needs of the individual. When the duration and intensity of the treatment are appropriate, the possibilities of internalizing and consolidating and maintaining the changes that have been achieved improve. The duration of the stay must be adjusted to each particular case.

These treatments offer services to people with SUD, that live in a *communal* setÝng with other

people with similar conditions. In doing so, they explicitly commit to abstain from using alcohol or other psychoactive substances, reside there, and participate in intensive daily routines.

The programs offer a variety of interventions that occur in different spaces, including: community meetings/assemblies, group work, individual psychosocial interventions, self-help and mutual aid groups, active participation in community life, life skills development, and vocational training. Admission to these programs typically requires explicit acceptance of the rules and regulations of the treatment setÝng.

Residential treatment differs from other shelter or boarding services that do not offer treatment, even though individuals may attend treatment programs on an outpatient basis. They also differ from compulsory treatment or detention centers in which people are confined involuntarily and in which an evaluation, diagnosis or treatment processes with ethical standards rarely occurs (WHO / UNODC, 2020).

The "drug-free" condition of these therapeutic setÝngs helps isolate people from chaotic and stressful environments, reduce exposure to triggers and cues that may lead to use, helping to maintain abstinence and move toward recovery. The most traditional programs only offer psychosocial care. Modern approaches include medication to reduce cravings and manage comorbid mental health symptoms (WHO/UNODC, 2020).

In accordance with international standards, residential and long-term programs, which include therapeutic communities, must take into account the following in each phase and component:

Admission:

- Regardless of the variable admission criteria that must be clearly described, the admission process must be voluntary and consented to explicitly and in writing.
- People who aspire entry to treatment must know in advance the details of the program, its philosophy, objectives, methods it implements and the rules.

  They must know their obligations and rights regarding privacy, non-discrimination and confidentiality, as well as the role of teams and staff, regulations regarding visits and outside communication, as well as administrative aspects, costs and payment methods.

  All this information is part of the program's admission policies and must be part of the contract signed by all parties, which includes the expectations of the person regarding the program and their individual goals.

- In cases of non-admission into the program, the reasons for doing so must be explained verbally and in writing, offering referral options to other providers, without violating the right to confidentiality.

  Staff in charge of the initial assessment must count with a previously constituted and known network of resources, in order to be able to adequately refer the person to

alternative networks.

- Everyone on the team must have a thorough understanding of the policies, procedures, regulations, and the different cases with their individual goals.

Assessment:

- The assessment must be carried out by competent personnel to conduct a comprehensive, extensive and in-depth assessment of psychosocial and medical aspects allowing the team to identify individual needs of each case and the relevance of the program.

  In cases presenting significant physical or mental health conditions, a decision must be made whether the person should be referred for specialized care, which will require written consent.

- The beginning of the therapeutic relationship occurs in the initial meeting which allows the team to become familiar with the case and the person to become familiar with the residential program. This will facilitate decisions regarding the entry to services to be made by the individual as well as decisions in regards to admission by the team.

- Once informed consent for voluntary admission has been obtained, individual needs and medication schedules should be discussed with referring agencies or treating physician. This includes defining a withdrawal management plan, if necessary.

- The individual treatment plan must be based on a comprehensive assessment, which must count with standardized procedures and instruments such as the ISA Addiction Severity Index, among others.

- At minimum, the areas to be assessed include: previous history of short and long-term treatment and perceptions about it, general health status, disabilities, mental health including history of trauma and abuse, violence and risk of suicide, psychological and interpersonal functioning, current living conditions and support networks, family life, couple and intimate relationships, dependent children, friendships, subjective networks, education, employment, educational and work history, level of vocational training, vocational needs, sources of income (legal and/or other), legal problems, recreational activities and interests.

- The assessment is an ongoing process that is complemented over time. Certain areas will need to be reassessed after a period of withdrawal, keeping in mind that intoxication and withdrawal discomfort can influence diagnoses, a person's full understanding of the nature of the program and what it requires, and even consent. Community life and interaction with intervention teams and peers allows the identification of character traits, of their personality and social functioning, that are useful to determine with more precision, the individualized treatment plan.

Commitment to the treatment program:

- The levels of motivation and commitment to the program can positively influence the outcomes. The variables that can affect retention are: the degree of motivation for treatment, the levels of substance use before admission, the history of contact with the justice system, the strength of the therapeutic bond, the perception of usefulness and functionality of the treatment, and warmth and empathy from the care team.
- During the first three weeks, the risk of dropping out or relapsing is greater, so special attention should be paid to individualized treatment and interventions to explore and reinforce the motivation to remain in the process, with an understanding that psychological discomfort can be intense in the early stages with symptoms such as insomnia, anxiety, irritability and desire to consume. Ambivalence is natural in these early stages and this can influence a person's adaptation to program norms.
- To address ambivalence and improve motivation, one must: offer an empathic, warm and understanding atmosphere; create a therapeutic alliance based on trust from the onset; respond in a timely manner to a person's requests for help; clearly inform them of the philosophy, expectations, therapeutic approaches, retention, health outcomes and common difficulties that arise in the early stages of the process; address a person's immediate concerns and priorities before those of the program itself.
- The first 72 hours demand constant support and accompaniment, requiring the designation of a peer worker to accompany the patient.
- Define a realistic and individualized plan that reflects and responds to the identified needs and that is flexible enough to adapt to the process and progress of each particular case.
- Recognize and tolerate the heterogeneity of individuals, particularly in group processes and interventions.
- Create an atmosphere of care, respect and support, recognizing that confrontation can lead to feelings of anger and early abandonment of the process.
- Guiding and informing individuals in regards to the challenges they may face throughout the process of change helps to provide certainty and create credibility in the process.
- Develop motivational strategies focused on the individual case.

Therapeutic interventions:

- Highly complex residential programs that care for people with comorbidities must provide medical and psychiatric care, in addition to the rest of the interventions listed below.
- Long-term residential treatments are generally "drug-free" setÝngs that offer:

- Individual psychosocial interventions, individual therapy and group therapy
- Reinforcement interventions and the acquisition of life skills
- Self-help and mutual aid groups
- Regular meetings and assemblies
- Peer support
- Non-confrontational group work, gender-specific groups
- Medication-assisted treatment that is medically supervised, when necessary
- Vocational training and workforce education, including counseling to prepare for the reinsertion process
- Structured relapse prevention programs
- Leisure and recreational activities
- Family interventions and therapy
- Emotional management techniques, among others.

- As in any other therapeutic environment, verbal confrontation or techniques that humiliate or embarrass a person should be avoided, as well as punitive procedures, physical restraint, or any other intervention that compromises the safety and dignity of a person.

- The therapeutic methods with the greatest supportive evidence are: cognitive behavioral therapy, contingency management, motivational therapy and interventions, family and couples therapy, social skills training, and relapse prevention.

- Other therapeutic interventions that can support the recovery process and help explore interests, even when in the process of reinsertion, are: art therapy, creative therapy, movement therapy, meditation techniques, relaxation, and physical activity, among others.

Documentation and confidentiality:

- All physical or electronic records of patient information must be kept in a secure place, with restricted access to the people on the team in charge of the treatments.

- Minimum required documentation includes: signed informed consent and agreement with the rules and regulations of the program; signed confidentiality agreement and ethics policies; case assessment for each patient or participant; treatment plan and case management for each patient or participant; regular updates and recordkeeping with details of progress and changes in the treatment plan; discharge record and follow-up plan with a detailed summary of individual treatment.

Discharge and follow-up:

- Many people need ongoing psychosocial and pharmacological care after discharge from a long-term residential program. It is necessary to define a referral plan to other providers or to provide continuous care by the program itself.

- Before discharge it is necessary to assess physical and mental health conditions; motivation to follow-up and continuous care; the reinsertion plan that should include employment, vocational development, education to facilitate the return to the community; the acquisition and improvement of emotional management skills; a relapse prevention plan based on the identification and management of triggers; the ability to access and manage renewed networks of support and care; and the ability to develop new interests and leisure activities to support time management that sustains ongoing recovery processes.

- Offering a support process in the transition is fundamental, allowing them to spend more time outside or being able to return and maintain contact with the program.

Therapeutic care team:

- Optimal care generally requires a multidisciplinary team and volunteers.

- Therapeutic communities and other types of long-term programs require some degree of medical supervision that includes psychiatric mental health professionals who are permanently on-site or available several times a week.

- Programs that care for people with severe mental health comorbidities must have permanent 24-hour psychiatric medical staff.

- Counselors, therapists, nursing and social work personnel must be present in the program permanently.

- Persons in recovery and former residents who have previously worked in other treatment programs can offer valuable role models and accompaniment to people in treatment, and should count with counseling or group therapy training, and have professional supervision.

- For professionals who are just beginning their work in a long-term residential program, it is recommended that they familiarize themselves with life in the program by spending time in it, before or immediately after joining.

Safety considerations:

- Treatment programs must ensure physical and psychological safety conditions for residents and therapeutic teams, as well as an environment that is favorable to learning and personal growth.

- The facilities and physical infrastructure must have minimum conditions that guarantee safety, warmth and a dignified life in the community, differentiating them from a prison or a hospital, without this implying the suspension of duly prescribed and supervised medical and mental health treatment schemes. These should not be discontinued without proper medical supervision.
- Medications must be stored, administered and dispensed, following the standards required for controlled substances and prescription medications.

- The control policies to ensure a "drug-free" environment must be explicit, as well as the procedures in cases of non-compliance.
- Reporting protocols and proportional handling of incidents regarding safety, abuse of power, violence, physical or sexual abuse must be defined.
- Procedures for the management of visits should be defined, in terms of monitoring and supervision, especially in the early phases of the process.
- In cases of suspensions, expulsions or voluntary discharges, the person should be given guidance on the risks of relapse, overdose and their management, and be provided with information on care and treatment options, support or how to request help when needed.

Effectiveness Indicators:

- In addition to the different aspects that need to be assessed before discharge from the residential program, effectiveness can be assessed based on process indicators that account for the services offered, the goals that the person was able to meet during their stay, and objective long-term outcomes measures for the person after discharge from the program. Among them:
    - Proportion of people who complete the treatment plan
    - Proportion of people who received follow-up, ongoing care and recovery management activities post discharge
    - Proportion of people who, having completed the treatment plan, remain abstinent after follow-up at regular intervals (every six months, for example).
- It is worth remembering, as has been previously stated in this guidance, that progress and recovery indicators must go beyond abstinence and be sensitive to subjective notions of progress in well-being, quality of life, employment, integration and community involvement, among others. Aspects that are an integral part of the process in therapeutic communities as a model.

Summary of requirements for long-term residential programs/services
1. The service counts with a structured and planned therapeutic program
2. Every patient/participant goes through a comprehensive evaluation process
3. Each person counts with a written treatment plan, based on the results of the assessment, which is constantly updated
4. Each person participates in a structured and consistent program of daily individual and group activities
5. The service ensures the appropriate clinical management of each case, based on evidence
6. Privileges are clearly and rationally defined and are known by everyone
7. The service assumes the responsibility of maintaining and improving the overall health of the people under its care
8. There are written protocols and procedures for managing treatment and medication schemes
9. The service is equipped to prepare residents to achieve an independence and autonomy after discharge
10. The service complies with minimum quality and infrastructure standards that ensure safety conditions and a dignified life for residents
11. The situations that lead to the suspension or expulsion of treatment are clearly defined and in cases of voluntary or involuntary discharge, individuals and families are directed to alternative paths of care and help
12. The service counts with a code of ethics that guides the professional practice, that of volunteers and peer operators, and ideally counts with an external commission that helps monitor and prevent situations of abuse of power
13. There are defined protocols for handling risk situations concerning safety, violence, poisoning, attempts or risk of suicide
14. There are safeguards for the safety and well-being of residents and the therapeutic team, as well as protocols for handling situations that put safety at risk
15. Discharge responds to the person's progress in their individual plan and recovery process
16. Any violation of fundamental rights and confidentiality must be reported, recorded and acted upon immediately
17. Personal information and medical records are kept under strict custody
18. The treatment for SUD is specialized care for which there is qualified personnel, with credentials and licenses that enable them to provide it
19. Treatment of withdrawal syndrome and medication-assisted treatment must be integrated into the psychosocial treatment plan, have strict medical supervision, and differential management by type of substance or substances involved in the dependency.

Source: WHO/UNODC (2020). *International standards for the treatment of drug use disorders, revised edition incorporating results of field-testing*.

Minimum standards of best practices in the therapeutic community

Several guidelines, statements and standards have been issued by different organizations to guide best practices in therapeutic communities dedicated to the treatment of psychoactive substance use disorders. As indicated in the introduction of this guidance, the intent is to offer a summary of those minimum aspects that constitute best practices in the model and that are fully consistent and coherent with the international standards that were described in detail in the former chapter.

The main tools available correspond to those issued by the World Federation of Therapeutic Communities (WFTC), the Community of Communities (C of C of the United Kingdom), the Mallorca Declaration (WFTC), and those of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

World Federation of Therapeutic Communities (WFTC) Standards	
Declares	A call for a holistic approach to healing that includes all disciplines: medical, psychiatric, social services, as well as CT-trained service delivery staff.
Declares	TCs represent a type of treatment directed primarily towards recovery from drug use, through personal growth, which requires abstinence from psychoactive substances, including prescription drugs that are used illicitly.
Standards	WFTC members must:
1.	Recognize the human rights and civil rights of all people connected to a TC, explicitly defining the rights, privileges and responsibilities of patients/participants and therapeutic teams.
2.	Confer to each person within the TC with the right to be free from threats or abuse of power from any individual member or group.
3.	Explicitly state the philosophy and objectives of the program.
4.	Adopt rules and regulations for your TC that protect against the apparent or actual non-compliance of local or national laws.
5.	Operate in environments that maximize the provision of opportunities for physical, spiritual, emotional and aesthetic development, as well as the safety of all its members.
6.	Facilitate the structure of a community based on the integrity, goodwill and humanity of all its members in which the dignity of people is a valued priority.
7.	Train and provide adequate supervision to the therapeutic team.
8.	Manage transparent accountability processes before an external executive or community committee in periodic annual meetings, allowing for the supervision and responsible development of program activities and of the facilities.

9.	Produce an annual financial audit report authorized by members of the external community or executive committee.
Declares	The WFTC requires its members to adhere to standards and objectives, as well as compliance with regulatory criteria established by the federation, for membership applications or renewals.

Source: WFTC. Our standards.

The basis of best practices in TCs is summarized in the 2016 Mallorca Declaration, which establishes the commitments and general principles that will guide aspects of its operation and functioning until 2026.

The first of the principles mentioned refers to the commitment to the universal conventions of human rights and the objectives of sustainable development. The second reiterates the importance of research and evidence-based practices. The third points to the broad participation and consensus that led to the Declaration. The fourth highlights the specificity, clarity, realism and viability of what it proposes. Lastly, the will to ensure a broad dissemination of the consensus among different interested sectors is made explicit.

Highlights of the Declaration[3]:

1) The need to adapt interventions to the needs of patients/participants and their cultural, economic, social and religious diversity.

2) Prioritize and reinforce the integration of the gender perspective in treatment.

3) Strengthen follow-up "to improve" social reinsertion and reduce relapse episodes.

4) Highlight the role of the family and other social networks during treatment and encourage them to commit and get involved during the process.

5) The requirement of interdisciplinary teams of professionals "that include professionals with life experience" to address the complexity of the problem from a biopsychosocial perspective. The CT staff must be known for their professionalism, service vocation and passion for helping people.

6) The staff must have training and on-going development training, tutoring, care and external supervision, taking care of their well-being and minimizing the risk of "burnout".

7) Leadership must be dynamic, inspiring and at the service of the community. Leadership must evolve within the organization and must be renewed in a carefully planned manner.

[3] WFTC, WFTC Institute, Projectehome and Asociación Proyecto Hombre (2016). Declaration of Mallorca

8) Transparency and accountability must be pillars of the operation of the TCs, since they contribute to obtaining and maintaining credibility.

9) A call for the development of quality research that offers evidence, as well as cost-effectiveness studies and publications, that contribute to the sustainability of the TCs and to demonstrate the value of the model among stakeholders.

10) A call to expand and diversify funding sources, to recognize the role they play in response to problems related to drug use and other addictive behaviors, highlighting the role they play "in the fight against the stigmatization of the addicted population".

11) The presence and promotion of the "TCs movement" will be reinforced in international events and forums, which includes raising awareness "about the harmful consequences of addiction" on social networks, thus supporting dissemination efforts to increase visibility and recognition of the effectiveness of the model.

Core values of the Community of Communities (C of C) that define the practice and approach of TCs	
Bond	Building healthy bonds is an evolutionary requirement of every human being and must be understood as a fundamental human right.
Containment	Personal development, growth and change require environments that offer safety, containment and support.
Respect	People need to feel valued and respected by others in order to be healthy. Each person is unique and no one should be defined or described only by their problems.
Communication	All behavior is significant and manifests something that deserves to be understood.
Interdependence	Personal well-being stems from one's ability to build relationships that recognize a mutual need.
Relationships	Understanding how relationships are established with others, and from others towards oneself, favors the construction of better intimate, family, social and work relationships.
Participation	The ability to influence one's environment and relationships with others is necessary for personal well-being. GetÝng involved in decision-making is necessary to participate, take responsibility and develop a sense of belonging.
Process	There is no single or correct answer, it is useful to reflect before acting reactively and immediately.
Balance	Positive and negative life experiences are necessary for the evolution and healthy development of individuals, groups and communities.
Responsibility	Each individual is responsible for the group and the group, in turn, has a collective responsibility with all its members.

Source: Royal College of Psychiatrists' Center for Quality Improvement. *The Development of Core Standards and Core Values for Therapeutic Communities*, 2008.

Fundamental Standards of TCs (Community of Communities - C of C)
1. The community meets regularly
2. The community recognizes the association between emotional health and the quality of interpersonal relationships
3. The community clearly defines limits, rules and mechanisms to enforce them, and is open to their revision
4. The community tolerates certain risks in order to promote positive change
5. Community members create a safe environment for community work
6. Community members consider and discuss their atÝtudes and feelings among each other
7. Power and authority in interpersonal relationships is used responsibly and is open to questioning
8. Community members assume various roles and levels of responsibility
9. Community members share time in formal and informal activities
10. The relationships between the people of the therapeutic team and residents are characterized by informality and mutual respect
11. Community members make decisions collectively that influence the functioning of the community
12. The community has effective leadership that supports its democratic processes
13. All aspects of life are subject to discussion in community
14. All behavior or emotional expression is subject to community discussion
15. Every member of the community has a shared responsibility towards other members of the community

Source: Royal College of Psychiatrists' Center for Quality Improvement. *The Development of Core Standards and Core Values for Therapeutic Communities*, 2008.

The TC Survey of Essential Elements Questionnaire (SEEQ)

In 1999 Melnick and De León (cited by Vanderplasschen et al., 2014) developed the SEEQ based on the theoretical framework of the TC model defined by De León in 1995. Their proposal arose in response to growing concerns about quality and effectiveness of the TC approach. It is a 139-item scale that measures six dimensions, each with a series of domains.

The dimensions correspond to components of the TCs, while the domains correspond to the philosophy and fundamental elements of hierarchical drug-free treatment, typical of concept-based TCs.

This instrument, according to Vanderplasschen et al. (2014), evaluates generic aspects that are common and transversal in the TCs, which can be summarized as: 1) a perspective of *recovery* and a *straight life* strongly linked to the approach and structure offered by the treatment; 2) a

vision of peers as "guardians" of community values; 3) a system of daily activities that ensure community participation and that gradually involves the external community; 4) the use of sanctions to regulate non-compliance with the norms; 5) psychosocial development through behavior modification techniques, educational activities and work; and, 6) a process perspective in which members go through three different stages, each with particular goals and expectations.

The future of therapeutic communities

The therapeutic community model has evolved over the years, preserving aspects that are characteristic and central. The first generation of TCs gave foundation to the community as a therapeutic method. The second generation incorporated the professionalization of the team and leveraged evidence-based practice. The third consolidated and integrated new insights in neuroscience and advances in social learning theories.

Currently, several different generations of CTs coexist, the most common being the 2nd and 3rd generation models in North America and Europe, although many of them retain some aspects of the first generation of CTs, based on the idea of *concept-homes* that originated with Synanon and which were later theorized and standardized by researchers such as George De León. Over time, aspects of the original *democratic* idea dating back to Maxwell Jones have been rescued.

The growing body of evidence around the effectiveness of the model, especially in North America, constitutes an on-going debate given that, according to Vanderplasschen et al. (2014), it requires methodological maturity, since there is still a lack of randomized and control studies that has prevented this treatment and care model from being prominent, with the exception of some countries such as Spain, Italy and Poland.

According to the authors themselves, the future of TCs depends on how the model can demonstrate that it has an impact and good outcomes, at reasonable costs. In this sense, the *modified TC* offers promise because it is suitable for different setÝngs, including prisons, and because it offers alternatives to respond to the needs of highly vulnerable populations such as people who live on the streets and people with comorbidities.

Although there is tension between the paradigms that underlie TCs and harm reduction, many TCs have relaxed their rules and allow drug substitution programs. Others have explored this approach in order to close existing service and care gaps, understanding the concept of the continuum of care and the complementarity of services. Similarly, the length of stay has been reduced to an average of 12 months or less, the inclusion of volunteer roles and a greater emphasis on mutual aid groups. All of this must be evaluated, always safeguarding the quality of services, an aspect on which is central for the future of this model and the role it can play in response to the SUD.

Aspects of standardization, accreditation and qualification largely define the programs that are viable and acceptable. For its part, the TC movement around the world has made efforts to reconcile these demands as well as to advance in evaluative research, without sacrificing its foundations, in order to continue demonstrating the value of the model in the midst of the many

existing treatment alternatives.

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