Therapeutic Communities in Latin America, Part I: A descriptive study of therapeutic communities in several countries in Latin America

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Abstract

Objective: In Latin America, little is known about the quantity or quality of Therapeutic Communities (TCs) that are available throughout different countries in the region and serve as rehabilitation centers for people with substance use disorders and related problems. The objective of this study was to identify and describe the quantity and quality of existent TCs in five countries in the region.

Design: A descriptive quantitative and qualitative multi-centered study was conducted to evaluate TCs in Argentina, Brazil, Colombia, Mexico and Peru.

Methods: With the support of each country's regulatory entity of TCs, a survey was conducted with those communities willing to participate in our study. The quality of the TCs was evaluated using the point system established by the De Leon criteria (De Leon G, editor. Community as method: therapeutic communities for special populations and special settings. Westport, Conn: Praeger; 1997).

Results: Of the 285 TCs identified in the five countries, 174 (61%) agreed to participate in the study. 70% of institutions received scores of 11/12 or 12/12 according to De Leon's criteria. It was also found that most criteria were met by over 90% of the institutions, although the items "separation from the community" and "meet-up groups between residents" were only met by 61% and 82% of communities, respectively. The main reasons for early termination of treatment were not accepting the norms of the institution, lack of financial resources and not feeling comfortable with the institution. 94% of the TCs provided services related to alcohol problems, 98% provided services related to problems with other substances, and 40% provided services for other types of abuses including compulsive gambling, sex offences, and other legal problems.

Conclusions: The TCs identified in our sample met the majority of criteria established by De Leon, with the main focus being the provision of substance abuse services. However, it is important that policies be put in place improve certain conditions that were lacking and investigate the reasons for dissatisfaction and/or early termination among these programs.

Key words: Therapeutic communities, substance abuse, treatment, rehabilitation, De Leon criteria, Latin America

Introduction

Substance use disorders are some of the most complex mental health problems due to the physical and social issues they generate and that compromise several aspects of the affected person's life, ranging from their cognitive abilities to their professional and social lives (1); abuse or dependence on psychoactive substances can generate disabilities and other problems that can impact quality of life and, in severe cases, even lead to death (2,3). Despite efforts to reduce use through informational and educational campaigns, consumption of both legal and illegal substances continues and has been documented to be common among adolescents and to be associated with HIV as well as other mental illnesses (4,5,3).

A study conducted in Latin America by the United Nations Office on Drugs and Crime in 2011, which involved a collaboration between seven nations in the region, evaluated the prevalence of psychoactive substances among patients that attended emergency rooms and found that among the participating countries, the most common substance used was tobacco, followed by alcohol and marijuana (6–8).

The treatment of patients with substance use and dependence has the end goal of helping the patient reduce and/or abandon the search for and compulsive consumption of the drug. However, treatment for such problems tends to be lengthy as most people who enter treatment are chronic substance users. In addition to the length of treatment, patients with these types of disorders often display relapse rates of up to 40 or 50%, and thus treatment programs must often be attended on more than one occasion (9). Currently, there are several methods used to treat substance use disorders, one of which are Therapeutic Communities (TCs), which are characterized as self-help groups to help rid of harmful behaviors and substance use and recover health through personal growth. This personal growth is realized through the separation from society by the patient's emersion in a residential program for a certain period of time that is directed by qualified staff and which is attended by other residents with similar disorders (10,11).

Because of the expansion of TCs on a global scale, several models have been developed with different standards that may be different than those suggested by the World Federation of Therapeutic Communities and which may have different rates of effectiveness and relapse (12). Thus, the general effectiveness of TCs has been questioned. Nevertheless, systematic reviews and meta-analyses have found that there is evidence to conclude that there are benefits of this type of therapy for the treatment and rehabilitation of people with substance use problems. Still, it is difficult to know whether there is a model that is better than others due to the paucity of studies that compare them (12-14).

As has been stated, it is necessary to evaluate the presence and availability of TCs on an international level in order to better assess their quality and be able to generate policies and interventions to improve them, as well as be able to better present this treatment method to patients and their families. To take the first step of this endeavor, and with the support of the Latin American Federation of Therapeutic Communities (FLACT), which regulates the TCs in the region, we conducted a multi-centered study to describe and compare quantitative and qualitative aspects of a sample of TCs in five Latin American countries.

Methods

From 2011 to 2013, a multi-centered descriptive study was conducted to assess quantitative and qualitative characteristics of TCs in five countries in Latin America including Brazil, Mexico, Argentina, Peru and Colombia. Through the support of FLACT, the entities that regulate each country's TCs were contacted in order to identify all TCs that were registered with them in the year 2012. Once these TCs were identified, they were contacted through several avenues of communication to invite them to participate in the study. TCs were given a period of 7-8 weeks to accept or reject participation in the study.

For each TC that agreed to participate, an email or letter was mailed to the institution about the survey (adapted for each country), along with an introduction letter by the principal investigator, a letter from the Latin American president of FLCAT, and a letter from each country's president of therapeutic communities organization.

The questionnaire sent to each institution included questions about the TC's capacity for patients, the infrastructure of the institution, the health services provided, primary reasons residents had for terminating treatment program early, and questions regarding the main disorders treated. Additionally, a module was included to evaluate compliance with the criteria established by De Leon (10), which assess the quality of the institution using a score of 0 or 1 for each criterion, with a maximum sum score of 12 points. The De Leon criteria are described in Table 1.

Table 1. Description of De Leon Criteria (10)

Component	Brief description
Planned duration of treatment	The duration of the process varies depending on each individual case, even though a minimum intensive period is necessary to assure the internalization of the teachings of the Therapeutic Community.
Separation from community	In the residential context, the patients remain distanced from the exterior community for 24 hours a day for several months, until they gain permission otherwise.
Communal activities	With the exception of personal counseling, all activities are planned as to be carried out collectively.
Role and function of personnel	Independent of the professionals' exact role, staff members form part of the community. Therefore, their mission is to use their rational authority to facilitate rules of action in a proportionate manner that is in line with the self-help methodology of the community.
Residents as role models	Members that demonstrate model conduct and reflect the values and needs of the community are used as role models. It is the goal that all members of the community reach the point of being a role model.
Structured days	The daily organized activities tackle the disordered lifestyles of these residents and distract them from negative thinking and boredom, factors that can predispose them to drug use.
Work as an educational	In concordance with the self-help methodology, all residents are

Component	Brief description
and therapeutic tool	responsible for the daily management of installations. The different working roles transmit essential educational and therapeutic effects.
A vision of recovery and of a righteous life	There exists a formal and informal repertoire to instruct the perspective of the Therapeutic Community, especially its concepts relating to recovery through self-help and its vision of a righteous life.
Meet up groups among residents	The minimum common denominator that all meet-up groups should abide by is their focus on strengthening participants' consciousness regarding attitudes and behaviors they should strive to modify.
Consciousness training	All therapeutic or educational interventions should involve a strengthening of individual consciousness regarding the impact of one's behavior and attitude on oneself and one's social circle, as well as understanding the impact of other people's behaviors and attitudes both on themselves and their environments.
Training of personal growth	It is necessary to instruct individuals regarding how to identify their emotions, express them appropriately and manage them in a constructive way, through the interpersonal and social demands of the communal lifestyle.
Community of care	Throughout the program, the vision of the righteous life and self-help based recovery and the networks of residents are utilized to enrich the use of vocational, educational, and mental health services, as well as other types of care needed in the phases of convalescence and readmission.

Once responses were returned by each of the TCs, data were compiled and analyzed using Microsoft Excel, which was used to calculate proportions and rates to generate summary tables and graphics.

Results

I. Identified therapeutic communities and participation in the study

Of the 285 TCs identified in the five countries, 61% (n = 174) agreed to participate in the study, 27% (n = 77) were not able to be reached by any means and 12% (n = 34) did not wish to participate in the study (see Figure 1). Distributions of response rates by country are presented in Table 2. Even though the study had an overall acceptance rate of over 60%, it is noteworthy that in Brazil the rejection rate for participation was close to 50%.

Figure 1. Participation rate among identified TCs

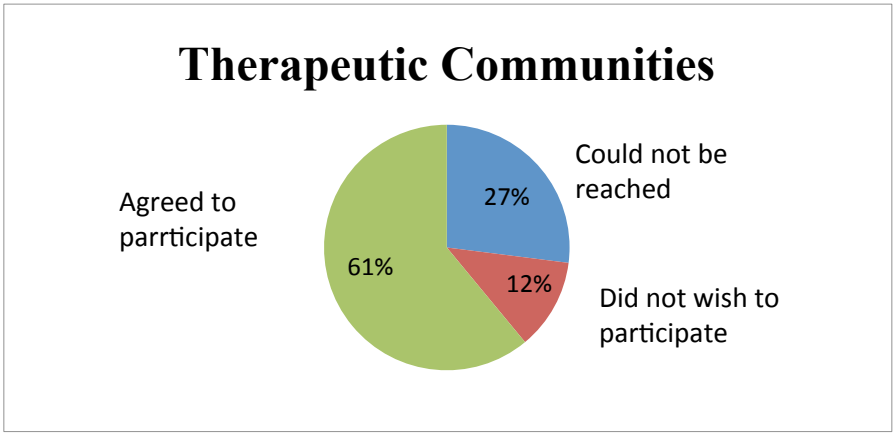


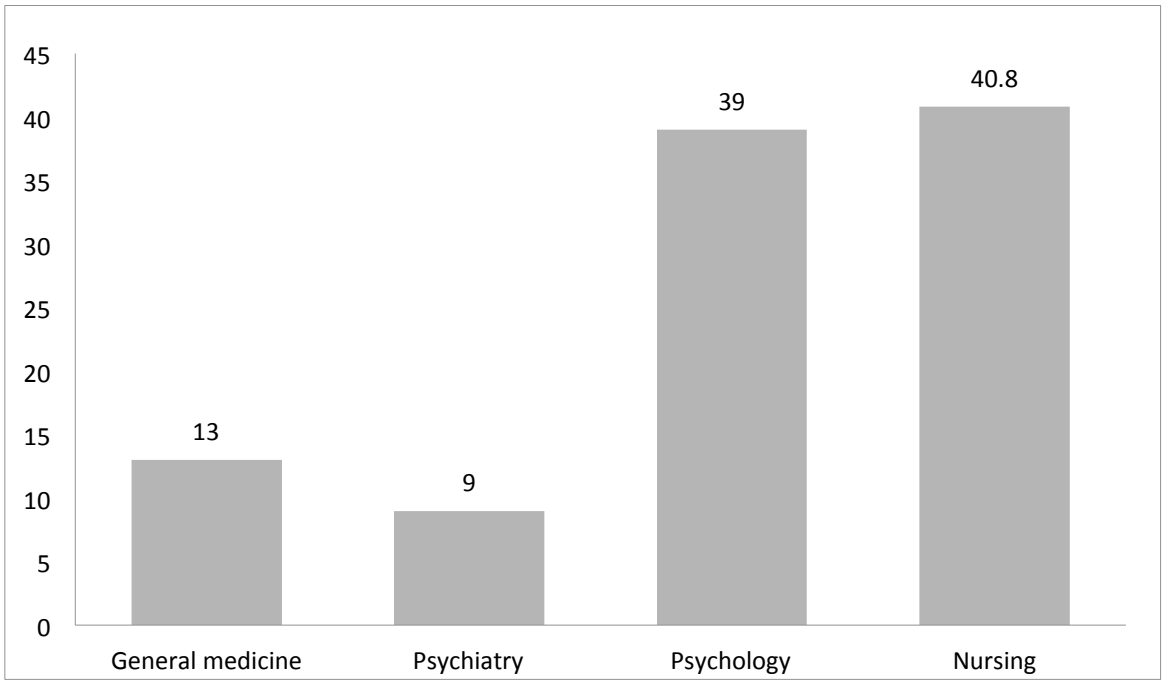
Table 2. Distribution of response rates by country

	Brazil		Colombia		Mexico		Peru		Argentina		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Total TCs	43	100	68	100	20	100%	101	100	53	100	285	100
Could not be reached	3	7.0	18	26.5	0	0%	54	53.5	2	4%	77	27%
Did not wish to participate	20	46.5	1	1.5	0	0%	2	2.0	11	21%	34	12%
Agreed to participate	20	46.5	49	72.1	20	100%	45	44.6	40	75%	174	61%

II. Health services offered

The survey inquired about health services that were offered at the TCs and the number of hours in which TC professionals, including general medicine doctors, psychiatrists, psychologists and nurses provided services. The service that held the most hours of operation was nursing with an average of 41 hours/week, ranging from the lowest with 4 hours/week to the highest with 168 hours/week, followed by psychology services that operated an average 39 hours/week. Psychiatric services was the service that had the lowest hours of operation with an average 9 hours/week, ranging from 4 hours in Brazil to 20 hours in Argentina.

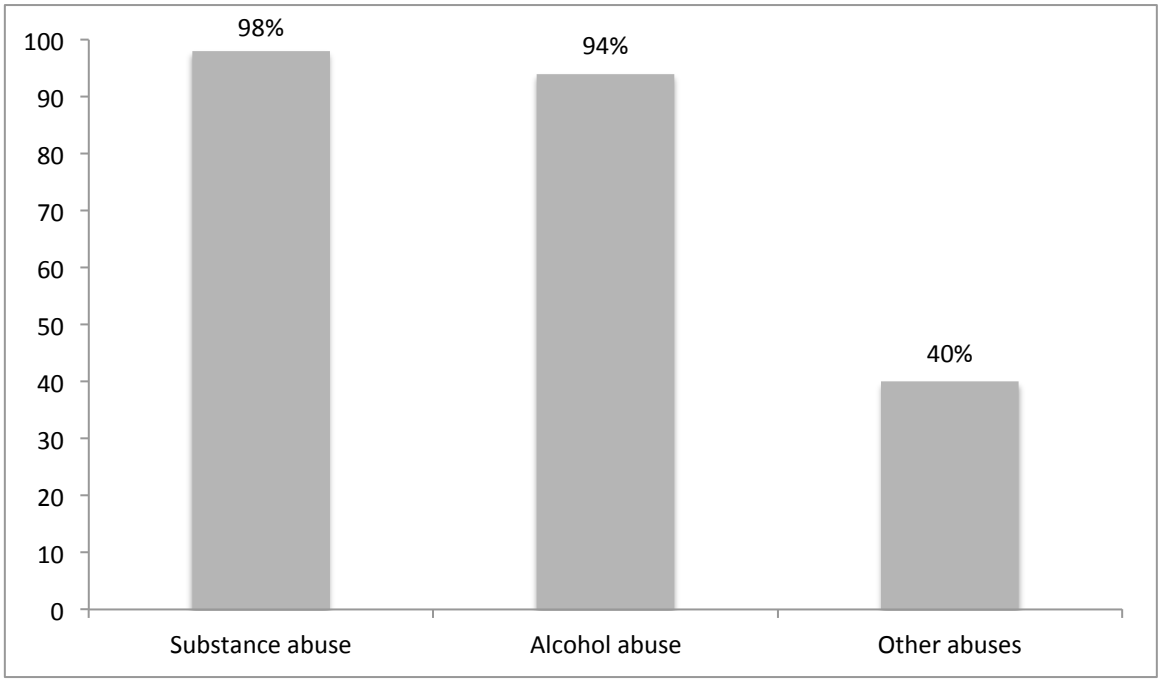
Figure 2. Hours of operation of health services offered at TCs



III. Types of substance use problems treated

Abuse of illicit substances was the most frequent abuse treated in 98% of TC's (n=170), followed by alcohol abuse, treated in 94% of TC's (n=164) and other types of abuses including compulsive gambling, sex offences, and other legal problems, treated in at 40% of TCs (n=70).

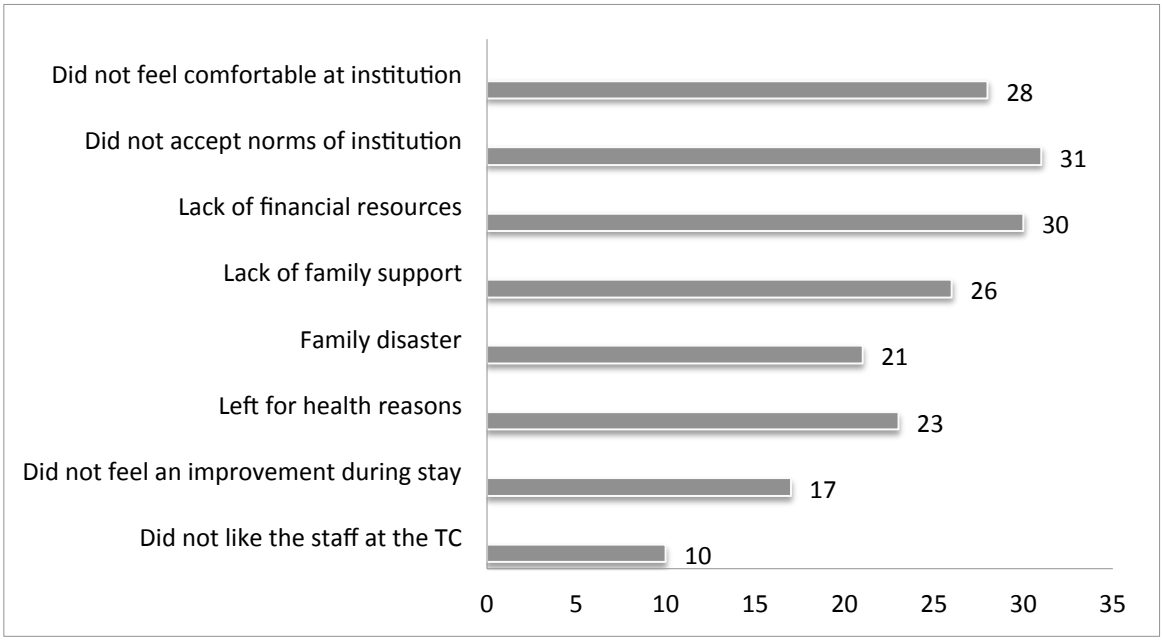
Figure 3. Proportion of TCs that treat the following abuses



IV. Reasons for early termination of treatment programs

The principal reasons institutions reported for patients terminating their treatment programs early were similar across countries. The main reason was not accepting the norms of the institution (31%), followed by lack of financial resources and lack of family support. Less frequent reasons were also similar across countries, with the rarest reason being not liking the staff of the institution (10%) (see Figure 4).

Figure 4. Reasons for early termination



V. Overall global score according to De Leon criteria

In this section of the survey, TCs were awarded a point for each completed De Leon criterion (data from Argentina and Peru was excluded as they used a different measuring scale). 84% of the 89 TCs surveyed for this section received a score of 10 or more (see Table 3).

Table 3. Global Score on De Leon criteria

De Leon Criteria	Brazil		Colombia		Mexico		Total	
	n	%	n	%	n	%	n	%
Less than or equal to 8/12	0	0	2	4.1	0	0	2	2.2
9/12	2	10	6	12.2	4	20	12	13.5
10/12	1	5	10	20.4	3	15	14	15.7
11/ 12	6	30	18	36.7	9	45	33	37.1
12/12	11	55	13	26.5	4	20	28	31.5
Total	20	100	49	100.0	20	100	89	100.0

VI. Individual score on De Leon criteria

An individual assessment of TCs was performed in order to identify which De Leon criteria were most and least met (excluding Peru which did not complete this section) and is presented in Table 4. Most criteria were met in over 90% of the evaluated TCs included in the sample, with the highest criterion met across countries being "communal activities," "consciousness training," and "training of personal growth." The criterion least met in Brazil was "planned duration of treatment" (only 75% met this), the criterion least met in Colombia was "separation from community" (only 47% met this), the criterion least met in Mexico was "role and function of personnel" (only 35% met this), and the criterion least met in Argentina was "residents as role models" (only 55% met this).

Table 4. Individual assessment of De Leon criteria

Criteria	Brazil		Colombia		Mexico		Argentina		Total	
	n	%	n	%	n	%	n	%	n	%
Continuity of care	19	95	49	100	19	95	37	92.5	124	96
Training of personal growth	20	100	48	98	20	100	39	97.5	127	98
Consciousness training	20	100	48	98	20	100	38	95	126	98
Meet up groups among residents	16	80	41	84	20	100	29	72.5	106	82
A vision of recovery and of the righteous life	20	100	46	94	18	90	35	87.5	119	92
Work as an educational and therapeutic role	18	90	43	88	20	100	39	97.5	120	93
Structured days	19	95	49	100	20	100	39	97.5	127	98
Residents as role models	18	90	47	96	19	95	22	55	116	90
Role and function of personnel	20	100	47	96	7	35	39	97.5	113	88
Communal activities	20	100	48	98	20	100	39	97.5	127	98
Separation from community	17	85	23	47	14	70	24	65	54	61
Planned duration of treatment	15	75	39	80	17	85	39	97.5	110	85

Discussion

Throughout Latin America, TCs are widespread and well established, and are largely registered with their national regulatory agencies. One of the first findings of this study was that the number of established CTs was not related to the number of inhabitants of each country, and countries with a much larger population, such as Brazil, had less CTs than countries with fewer inhabitants, such as Peru. This may be partly because Peru had already conducted several training sessions to proliferate the TC strategy (15), or because there may be other TCs in Brazil not registered with the regulatory agencies.

The response rate for participation in this study (61%) was similar to what has been observed in similar studies of TCs, such as one that was conducted in Europe and the United States (16) that had a response rate of approximately 64%. The response rate is important as it affects our ability

to identify the strengths and weaknesses of TCs as well as formulate public health policies to improve these centers.

Another noteworthy finding of our study was that of the hours of operation of the health professionals working in TCs. Although the results were not homogeneous, across countries generally the nursing staff held the highest hours of operation, probably due to the fact that these professionals perform day and night shifts to care for patients. Another finding that caught our attention was the few hours of operation devoted by psychiatrists, who are the health professionals which are most expected to involved in care of patients with a substance use disorders (9,14). These findings are consistent with results from studies conducted in other countries, including that by Jacob et al., which found a shortage of nurses and trained mental health professionals as well as a deficiency of beds and specialized units for the management of mental illness (17).

The disorders most frequently treated by the TCs were drug use disorders followed by alcohol use disorders and lastly other types of abuses, which varied depending on the country. The above finding is consistent with reports from other countries that have found that most TCs principally treat abuse of substances other than alcohol (15,18).

The primary reason for early termination of treatment by participants that was identified by institutions was not accepting the norms of the institution, which is similar to the main reasons reported by other studies such as that by Lopez-Goni et al. (19). The least common reason reported for leaving treatment early was not getting along with the staff at the TC, again, a result similar to that found by Lopez-Goni (19). It is interesting that the need to consume drugs or other substances was not among the primary reasons for early termination of treatment (19,20).

The vast majority of TCs in our study received a score equal to or higher than 10 points when evaluated according to the De Leon criteria. However, it is difficult to compare these findings to those of other studies, as this is the first to evaluate the quality of TCs using the De Leon criteria. The most frequently met criteria were "communal activities," “training of personal growth," and "structured days." The least met criteria were "separation from community" and "residents as a role model." A study conducted among TCs in England that used another set of similar criteria to evaluate their programs found that the most frequently met criteria were providing feedback for behaviors, living and learning through community, and establishing clear roles of staff. This study found the least frequently met criteria to be lack of personnel, establishment of daily activities, and meet-up groups between residents (21).

In another study by Goethal et al., TCs were compared between Europe and the United States using the Survey of Essential Elements Questionnaire (SEEQ), which evaluatess elements such as the perspective of the TC, its treatment structure, the community as a therapeutic agent, formal therapeutic elements, and processes. This study found that European TCs generally abided by the elements of patient participation and the role of the family in treatment (16).

Among the strengths of our study is the use of a large sample in the region that included five countries and over 100 TCs, which allowed us to evaluate similarities and differences across the TCs in the region. In addition, our study is the first in Latin America to evaluate the quality of TCs on a regional level, allowing for comparisons between this region and others around the world, and setting the stage for future studies to be developed in the region regarding the role of TCs.

Among the limitations of our study, it is important to highlight the high non-response rate of approximately 41%, which indicates a lack of collaboration between institutions and limits our ability to assess the strengths and weaknesses of TCs overall, as it is possible that the TCs that wished not to participate are characteristically different than those that did participate in this study. Moreover, no information was provided regarding the type of TC that participated, such as whether they took place within a prison complex or whether they held a spiritual or scientific orientation. This is different from studies conducted in places such as Thailand (18), Europe and the United States (16), that did contain this detailed information. Lastly, the exclusion of the De Leon criteria assessments from the TCs in Peru limits the interpretation of our results as we cannot assess whether the TCs in Peru indeed met qualification criteria for offering adequate treatment plans for patients.

Conclusion

The present study has allowed us to conduct a mixed methods assessment of the quantity and quality of a sample of TCs in Latin America and highlight some major strengths and weaknesses of these institutions. These findings will allow us to develop more studies in the future and to generate stronger public health policies that standardize and improve treatment and recovery plans throughout therapeutic communities in Latin America.

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