Therapeutic Communities (TCs) are place where different professional skills (psychologists, educators, youth and social workers ) and experiences of all members of a group come together to help patients regain their ability to adapt and relate with the outside world. As conceived by Jones, the role of the doctor in TCs is dynamically integrated in a group whose users and professionals/operators play equal roles that are coordinated in the therapeutic action.

1. **Origins of therapeutic communities for drug addicts and alcoholics**

The early experience of therapeutic community are related to the psychiatric field that have had a noteworthy effect on the organizational models of many therapeutic communities, but we must bear in mind that TCs had radically different origins in the field of addiction. The ideological paradigm changes completely because in cases of addiction a voluntary choice is made to become part of *Communitas,* which was first conceived as a group of people and then as a place that permitted - to use an expression coined by Jaques Le Goff - a response to the need for “affectionate anchorage”.

In the 1930s, the first assistance facilities for alcoholics and drug addicts arose not on in Europe but the United States, in a spontaneous form, and without even a “therapeutic” approach in the strictest sense but rather a rehabilitating purpose that was not even professional but based essentially on self-help.

The first TCs for drug addicts were characterized by factors such as: social isolation, collecting of experiences, presence of charismatic gurus (often with previous experiences of rehabilitation themselves), who motivated the treatment in an atmosphere of exaltation of alternative lifestyles. The group then held a clear leadership both from the symbolic and the pragmatic-experiential point of view in the organization of daily activities: educational and therapeutic group activities represented, indeed, the quintessence of daily and weekly work activities in therapeutic communities.

For over twenty years (the 1970s and 1980s), all community residents were thirty-something heroin addicts with numerous unsuccessful attempts at detoxification behind them and specific health, psychological, and social needs to be dealt with, who lived at the margins of society without steady jobs, often burdened with infectious diseases (HBV, HCV, HIV), familiar with situations of violence and alienation, and in many cases, criminal detention records. Patients also used to arrive at the communities without any psycho-pathological diagnosis, nor a psychological profile. Such was the lack of culture in the communities that the drug addiction symptom seemed to absorb every sphere of personality. In this context, also an ideological meaning came to be attached to the cure, and relapses were considered as **betrayals**. In brief patients had two options: to adapt to the place and the method, or being beyond any possibility of rehabilitation.

But things have changed radically since then. Starting from the 1990s, the epidemiological framework began changing in many ways in the face of more complex needs for assistance. Communities found themselves having to treat users who were no longer outcasts but people well integrated in society, such as habitual cocaine users, school-aged users of chemical synthesis drugs, young mothers with children afflicted with abstinence syndrome, young adults with concomitant psychiatric problems and other problems (gambling addiction), women with also eating disorders and second- or even third-generation drug addicts. The communities were necessarily required to evolve and truly make a great cultural leap forward if they did not wish to disappear from the rehab scene.

1. **Evolution: the professionalization of treatment programmes**

At the dawn of the third millennium, new therapeutic treatments, which focused more on the individual well-being of the patients rather than the group in its totality, were gradually emerging. As a consequence, the idea of a progressive customization of the treatments slowly made its way to the fore, with patients becoming key allies and active protagonists in their own therapeutic path. New treatment models emerged which enhanced the value of people as a whole, attempted to strengthen their resources and social skills, and involved families in psychosocial counselling programmes and psychotherapeutic treatments able to provide relational and contextual continuity to the treatments in order to prevent their failure. More care was placed in the pleasant and well informed use of free time, especially recovering - within treatment programme - the concept of "pleasure", which, in many ways, has great potential stabilizing people within broad frames that do not exclude the ability to experience pleasure in their everyday creative, expressive, sport and cultural, educational, and work activities.

1. **Today:** **the integration of Specialized Residential Services in the public system**

The development of therapeutic communities has shown a remarkable capacity for invention and innovation, which has been made possible by their great organizational flexibility which has led to continuous adaptation to social change, type of patients, and intervention methods. The most significant is, perhaps, the non-practicality of drug-free communities: barring a few exceptions, communities now accept guests with maintenance- or dosage-scaling therapies, such as the psycho-pharmacological therapies that have become an integral part of community rehabilitation programmes.

A real turning point came in the 1990s through intensive processes of training, research, study and exchange of good practices. Much of the credit must certainly be given to such international organizations as our Euro-TC.

This exciting networking activity allowed the TCs in Europe to make a qualitative leap in a path which, for the most part, has been self-produced with very few - if not zero - support from EU institutions. One might make an aside to address the topic of the EU institutions, which first closed a programme dedicated to the drug program and then incomprehensibly declassified it into programmes on factors which determine health, and then made it disappear altogether.

Most of the funds have been directed to the development of EMCDDA, based in Lisbon, which broadly is tasked with statistical analysis and data production, moreover with a clear bias towards analysing programmes with substitutes, leaving only residual room to the residential rehabilitation programmes. Therapeutic Communities are perhaps also mainly responsible for not attaching great importance to research activities, scientific output, the establishment of rigorous accountability practices, transparency on the effectiveness of treatments, criteria of appropriateness of the therapeutic paths or, more generally, to trustworthy organizational and cost/benefit analyses.

Today instead, the supply of treatments has dramatically increased by offering therapeutic paths that are increasingly targeted and individualized. The care model does not follow a method any more but it does outline instead a path that is integrated with other services in order to provide a wide range of possibilities. I would like to stress the concept of putting people at the centre of the treatment, together with all their needs. Another key point is their personal skills development.

The community setting is now able to provide differentiated treatments, such as: social emergencies and chronic cases, minors, couples, mothers with children, cocaine addicts, gambling addicts, patients with dual diagnosis, women with a combination of illnesses with eating disorders, and convicts serving their sentences as an alternative to prison sentences. Owing to all these types of treatment, therapy programmes vary in their specific methods, and in the duration of residence, which may vary from some months to some years. There are communities capable of allowing into their residents group also a mixture of problems by, for instance, hosting a limited number of patients with psychiatric disturbances, and other communities specialized in welcoming mothers with children. In both cases, the method adopted envisages the use of multi-professional skills provided by qualified personnel. The great step forward taken by therapeutic communities in Europe in latter years has undoubtedly been their full inclusion into the organization of social and health services. And the residential experience can be part of a more extended individual project with a “before” and an “after” that involves the communities in collaboration with other territorial services.

In certain respects, the treatment-chain culture has been resumed and reworked for integration among various services with differentiated tasks and goals, and authentic case management can be said to be practised. This treatment customization is also based on the paths of re-socialization and social inclusion through training activities, connection with employment agencies or others that provide support in obtain greater autonomy in regard to income and housing and, above all, the possibility to participate in a rehabilitation programme only after being “discharged” from the communities, in order to contribute to improving the quality of life on the whole and preventing further risk factors from occurring.

The progressive introduction of increasingly innovative devices tools, though, does not yet bring a true innovation in the treatments. The intervention paradigm is still that of the group: the latter lost focus and leadership but maintains all of its importance in managing patients within the community: the focus simply shifted from the collecting experiences to customizing the interventions, and to individual treatment programmes. In any case, compared to the first therapeutic community models, centred on their charismatic founder gurus, with the changes of the late 1990's and early 2000s, the question now is: what caused this change? Some possible answers are:

1. progressive inclusion of qualified professionals;
2. exchange of good practices at several levels;
3. notes-exchanging between professions and experiences;
4. management training;
5. better horizontal communication between operators.

Study visits and the staff exchange, fostered and promoted by European and international federations of therapeutic communities, such as Euro-TC, have been accompanied by strengthening the ties among the reference communities and territory, which has boosted the professionalism of the initiatives and their integration into the national and regional health systems. Ideology has decreased while competence has increased.

The evolution over time of the TC model can be graphically portrayed in a chart which, with keywords, shows the transition from the early organizational model to the later one, closer to our times.

|  |  |
| --- | --- |
| Before ('70s, '80s and '90s) | After (the '00s and '10s) |
| Charismatic leader and staff made up of former addicts Professionalization and staff integration  Emphasis on the location and protection/isolation of patientsIntegration into the territory and social fabricDrug-free condition and absence of medicines in the TCCustomization of therapies and use of medicines Enhancement of patients' skillsLack of attention to patients' skills Flexibility of time-scales and methods Long-term treatments and methodological rigidity Emphasis on the group and communal experiences Focus on subjectivity  |

In the first model, in some ways, the centrality of the substance and the emancipation from it completely absorbed the attention of operators and patients, and everything revolved around the theme of being able to remain completely drug-free in a highly value-orientated environment of mutual affection and loyalty. Therapeutic communities were very similar to a "total institutions" with the goal to schedule the whole life of their patients in the short, medium and long term; places where individuals - with their needs and subjectivity - were put in the background with respect to the institutions' agenda of inhibiting and censoring attitudes and behaviours that were not in keeping with their strict rules.

In the second model, that of the 2000s, drugs and their use were seen instead as a symptom of a wider problem, which involves the psycho-physical sphere, the patient's general state of health and the emotional, sentimental and the family dynamics both before and after joining the community. In this case, the rehabilitation treatment was managed with a multi-modal and multi-focal approach, and a set of skills that complemented each other: in this clinical-educational therapeutic approach, the treatment was developed with the crucial usage of surrogates, pharmaceuticals and drugs that supported patients in their transition from a symptomatic condition to a new psycho-physical balance, and full reintegration into social and professional contexts under the heading of health and wellness.

Finally, we must not forget that the organizations which today use therapeutic communities not only offer rehabilitation services but also can be seen as systems of civil society that are actively engaged in prevention, association-creation and volunteer work. They also promote a wider awareness of promoting healthy lifestyles - e.g. sport - as well as being a legal bulwark acting against the widespread micro criminality. In terms of their structure, as they are non-profit, these organizations pay special attention to the welfare of their staff by investing in enhancing their empowerment in decision-making and skills enhancement as well as their professional growth through regular training. In short, they are organizations which promote civic engagement and produce a widespread social value.

1. **Conclusions**

To sum up, I would like to mention the new challenges that TCs are facing today: I refer to the downsizing of welfare policies in many European nations caused by the current economic stagnation. A serious threat is posed for the future of therapeutic communities by the combined effect of all the following factors: the fall in interest of public opinion and political institutions; the policies of normalization of the problem accompanied by the massive use of substitutive pharmaceuticals administered as a priority, albeit not exclusively; the diminished perception of the individual; the social damage caused by addictions; and the scarce appeal of solidarity accompanied by public spending containment. In many nations, we are witnessing a fall in their numbers. This is not necessarily a bad thing because an important selection process directed towards organizational and management quality is now under way, together with a better use of public resources. However despite the progress made in improving the assistance offered and the fact that therapeutic communities play an important role in treatment policies, the biggest concern is the problem of defining a European strategy which defines rules and goals while contributing to better regulating the sector through transparent rules for protecting the operators and, most of all, the patients who may benefit from this great type of treatment.