Modified Therapeutic Community for Persons With Co-Occurring Disorders

The Modified Therapeutic Community (MTC) for Persons With Co-Occurring Disorders is a 12- to 18-month residential treatment program developed for individuals with co-occurring substance use disorders and mental disorders. MTC is a structured and active program based on community-as-method (that is, the community is the treatment agent) and mutual peer self-help. A comprehensive treatment model, MTC adapts the traditional therapeutic community (TC) in response to the psychiatric symptoms, cognitive impairments, and reduced level of functioning of the client with co-occurring disorders. Treatment encompasses four stages (admission, primary treatment, live-in reentry, and live-out reentry) that correspond to stages within the recovery process. The stage format allows gradual progress, rewarding improvement with increased independence and responsibility. Goals, objectives, and expected outcomes are established for each stage and are integrated with goals specific to each client in an individual treatment plan. Staff members function as role models, rational authorities, and guides.

The MTC model retains most of the key components, structure, and processes of the traditional TC but makes three key adaptations for individuals with co-occurring disorders: It is more flexible, less intense, and more personalized. For example, MTC reduces the time spent in each activity, deemphasizes confrontation, emphasizes orientation and instruction, uses fewer sanctions, is more explicit in acknowledging achievements, and accommodates special developmental needs.

When used in prison settings, MTC has included additional programmatic and operational adaptations to address the particular circumstances of offenders with co-occurring disorders. Programmatic alterations have included an emphasis on criminal thinking and behavior that recognizes the interrelationships of substance abuse, mental illness, and criminality, while operational adjustments have included adding security personnel to the treatment team and making other changes to comply with the security requirements of correctional facilities. In other community applications, outpatient substance abuse treatment programs have adopted certain features of the MTC model to improve services for their clients who have co-occurring disorders.

Descriptive Information

Areas of Interest	Co-occurring disorders
Outcomes	**Review Date: March 2008** 1: Substance use 2: Criminal behavior 3: Psychological problems 4: Employment 5: Economic benefit 6: Housing stability
Outcome Categories	Alcohol Cost Crime/delinquency Drugs Employment Homelessness Mental health
Ages	26-55 (Adult)
Genders	Male Female
Races/Ethnicities	Black or African American Hispanic or Latino White Race/ethnicity unspecified

Settings	Residential Outpatient Correctional
Geographic Locations	Urban Suburban
Implementation History	First implemented in 1992, MTC for Persons With Co-Occurring Disorders has been used at 25 sites with an estimated 21,000 participants. Outside the United States, the intervention has been implemented in Auckland, New Zealand, and Montreal, Canada.
NIH Funding/CER Studies	Partially/fully funded by National Institutes of Health: Yes Evaluated in comparative effectiveness research studies: Yes
Adaptations	Adaptations to the intervention have been made for a prison population, primarily to incorporate a programmatic emphasis on criminal thinking. In addition, some features of the intervention have been added to intensive day treatment programs in community outpatient substance abuse treatment centers.
Adverse Effects	No adverse effects, concerns, or unintended consequences were identified by the developer.
IOM Prevention Categories	IOM prevention categories are not applicable.

Quality of Research

Review Date: March 2008

Documents Reviewed

The documents below were reviewed for Quality of Research. The research point of contact can provide information regarding the studies reviewed and the availability of additional materials, including those from more recent studies that may have been conducted.

Study 1

De Leon, G., Sacks, S., Staines, G., & McKendrick, K. (2000). Modified therapeutic community for homeless mentally ill chemical abusers: Treatment outcomes. American Journal of Drug and Alcohol Abuse, 26(3), 461-480.

French, M. T., McCollister, K. E., Sacks, S., McKendrick, K., & De Leon, G. (2002). Benefit-cost analysis of a modified therapeutic community for mentally ill chemical abusers. Evaluation and Program Planning, 25, 137-148.

Study 2

Sacks, S., Sacks, J. Y., McKendrick, K., Banks, S., & Stommel, J. (2004). Modified TC for MICA offenders: Crime outcomes. Behavioral Sciences and the Law, 22(4), 477-501.

Sullivan, C. J., McKendrick, K., Sacks, S., & Banks, S. (2007). Modified therapeutic community treatment for offenders with MICA disorders: Substance use outcomes. American Journal of Drug and Alcohol Abuse, 33(6), 823-832.

Study 3

Sacks, S., McKendrick, K., Sacks, J. Y., Banks, S., & Harle, M. (2008). Enhanced outpatient treatment for co-occurring disorders: Main outcomes. Journal of Substance Abuse Treatment, 34(1), 48-60.

Supplementary Materials

Sacks, S. (2007). CTCR interview protocols--Baseline & follow-up. Unpublished manuscript.

Sacks, S., Banks, S., McKendrick, K., & Sacks, J. Y. (2008). Modified therapeutic community for co-occurring disorders: A summary of four studies. Journal of Substance Abuse Treatment, 34(1), 112-122.

Sacks, S., Banks, S. M., McKendrick, K., Sacks, J. Y., & Cleland, C. M. (2007). Meta-analysis for single investigators and research teams. Manuscript submitted for publication.

Sacks, S., Sacks, J. Y., & De Leon, G. (1999). Treatment for MICAs: Design and implementation of the modified TC. Journal of Psychoactive Drugs, 31(1), 19-30.

Sacks, S., Sacks, J. Y., & Stommel, J. (2003). Modified therapeutic community program for inmates with mental illness and chemical abuse disorders. Corrections Today, 65(6), 90-99.

Outcomes

Outcome 1: Substance use	
Description of Measures	In one study, substance use was evaluated using three self-report measures: frequency of alcohol intoxication, number of different types of illegal drugs used (0-17), and highest frequency of illegal drug use on a scale from 0 (none) to 8 (more than once daily). All three reports were obtained at baseline, at 12 months after baseline, and at each client's last follow-up point (long-term follow-up), which was more than 24 months after baseline, on average. In another study, substance use was evaluated using six self-report measures across the first 12 months after release from prison: any illegal drug use, alcohol used to intoxication, any substance use (combined measure of drug use and alcohol used to intoxication), frequency of alcohol used to intoxication, drug use severity, and days until substance use (relapse).
Key Findings	Homeless clients with co-occurring disorders were sequentially assigned to a low-intensity MTC condition, a moderate-intensity MTC condition, or usual care. Compared with the high-intensity MTC condition, the low-intensity condition placed fewer demands on clients (e.g., clients had more freedom to leave the facility) and provided clients with more staff assistance. Usual care incorporated a variety of treatment and nontreatment options that were typically less specific to the needs of homeless clients with co-occurring disorders, not as well organized, and less cohesive in perspective or approach relative to the MTC conditions. • At the 12-month follow-up, low-intensity MTC clients reported significantly less frequent alcohol intoxication ($p < .05$), fewer types of illegal drugs used ($p < .01$), and less frequent drug use ($p < .01$) than usual care clients. These differences remained at the long-term follow-up ($p < .05$, $p < .05$, and $p < .01$, respectively). • At the 12-month follow-up, low-intensity MTC clients reported significantly fewer types of illegal drugs used ($p < .01$) and less frequent illegal drug use ($p < .01$) than moderate-intensity MTC clients. These differences remained at the long-term follow-up ($p < .05$ and $p < .01$, respectively), at which time low-intensity MTC clients also reported less frequent alcohol intoxication than moderate-intensity MTC clients ($p < .05$). In addition, more low-intensity than moderate-intensity MTC clients were retained in treatment for 12 months (56% vs. 34%, $p < .002$). • At the 12-month follow-up, MTC clients who received 12 months of treatment (treatment completers) in either the low-intensity ($p < .01$) or the moderate-intensity ($p < .05$) condition reported less substance use than clients who received usual care for at least 9 months. • At the long-term follow-up, clients who received at least 12 months of treatment (treatment completers) in both MTC conditions reported less frequent alcohol intoxication ($p < .01$), fewer types of illegal drugs used ($p < .01$), and less frequent illegal drug use ($p < .001$) than clients who received usual care for at least 9 months. In a randomized controlled trial (RCT), male prison inmates with co-occurring disorders were assigned either to a 12-15 month in-prison MTC program modified for a prison population, followed by a voluntary, 6-month aftercare MTC program in a community corrections facility after release, or to a mental health treatment condition of variable duration (11 months, on average). Adaptations to MTC included a programmatic emphasis on criminal thinking and behavior, adjustments to comply with security guidelines, inclusion of security personnel on the treatment team, psychoeducational classes, and cognitive behavioral protocols. The control condition consisted of psychiatric medication services, weekly individual therapy and counseling, and mandated cognitive behavioral and anger management group therapy. • At the 12-month postrelease follow-up, both groups showed improvement in substance use, illegal drug use, and alcohol used to intoxication. However, relative to control group participants, a significantly smaller percentage of MTC participants reported substance use (56% vs. 31%, $p < .01$), illegal drug use (44% vs. 25%, $p < .05$), and alcohol used to intoxication (39% vs. 21%, $p < .05$). • At the 12-month postrelease follow-up, compared with MTC participants, control group participants were nearly three times as likely to report substance use and alcohol used to intoxication (odds ratio = 2.94) and more than twice as likely to report illegal drug use (odds ratio = 2.33). The effect sizes were medium and small, respectively. • On average, MTC participants relapsed later than control group participants (3.7 months vs. 2.6 months, $p < .05$). • At the 12-month postrelease follow-up, MTC participants had greater decreases in reported severity of drug use (82% vs. 64%, $p < .05$) and alcohol used to intoxication (63% and 28%, $p < .05$) relative to control group participants.

	• Among clients with a history of polydrug use, MTC participants had larger reductions in reported substance use (odds ratio = 4.00), illegal drug use (odds ratio = 2.63), and alcohol used to intoxication (odds ratio = 3.45) than control group participants at the 12-month postrelease follow-up. These effect sizes ranged from small to medium.
Studies Measuring Outcome	Study 1, Study 2
Study Designs	Experimental, Quasi-experimental
Quality of Research Rating	2.7 (0.0-4.0 scale)

Outcome 2: Criminal behavior	
Description of Measures	In one study, criminal behavior was measured by two self-report items: number of different types of crimes committed (0-16) and total number of crimes committed for each type reported on a scale from 0 (none) to 9 (more than 500). Self-reports of criminal behavior were obtained at baseline, at 12 months after baseline, and at each client's last follow-up point (long-term follow-up), which was more than 24 months after baseline, on average. In another study, criminal behavior was measured by the following three self-report items across the first 12 months after release from prison: reincarceration, number of new illegal activities (0-17), and drug/alcohol-related offenses. Self-reports were cross-checked against department of correction records.
Key Findings	Homeless clients with co-occurring disorders were sequentially assigned to a low-intensity MTC condition, a moderate-intensity MTC condition, or usual care. Compared with the high-intensity MTC condition, the low-intensity condition placed fewer demands on clients (e.g., clients had more freedom to leave the facility) and provided clients with more staff assistance. Usual care incorporated a variety of treatment and nontreatment options that were typically less specific to the needs of homeless clients with co-occurring disorders, not as well organized, and less cohesive in perspective or approach relative to the MTC conditions. • At the 12-month follow-up, clients had a decrease in reported crimes committed and crime types regardless of treatment condition ($p < .01$). However, low-intensity MTC clients reported fewer crimes committed than moderate-intensity clients ($p < .04$). • At the long-term follow-up, low- and moderate-intensity MTC clients reported fewer crimes committed ($p < .001$ and $p < .05$, respectively) and fewer crime types ($p < .001$ and $p < .05$, respectively) than usual care clients. • At the 12-month follow-up, MTC clients who received at least 12 months of residential treatment (treatment completers) in either the low-intensity ($p < .01$) or moderate-intensity ($p < .05$) conditions reported fewer crimes committed and fewer crime types than clients who received usual care for at least 9 months. This difference continued to the long-term follow-up ($p < .001$). In an RCT, male prison inmates with co-occurring disorders were assigned either to a 12-15 month in-prison MTC program modified for a prison population, followed by a voluntary, 6-month aftercare MTC program in a community corrections facility after release, or to a mental health treatment condition of variable duration (11 months, on average). Adaptations to MTC included a programmatic emphasis on criminal thinking and behavior, adjustments to comply with security guidelines, inclusion of security personnel on the treatment team, psychoeducational classes, and cognitive behavioral protocols. The control condition consisted of psychiatric medication services, weekly individual therapy and counseling, and mandated cognitive behavioral and anger management group therapy. • At the 12-month postrelease follow-up, MTC participants had significantly lower reincarceration rates than individuals in the control condition (9% vs. 33%, $p < .01$), a difference that reflects a medium effect size (odds ratio = 3.85). MTC clients who chose to participate in the aftercare program had an even lower reincarceration rate than control group participants (5% vs. 33%, $p < .02$), a difference that reflects a large effect size (odds ratio = 7.69). • Time in treatment across any of the three conditions was a significant predictor of both reincarceration and criminal activity at the 12-month postrelease follow-up ($p < .01$). The average time to reincarceration was longest for MTC clients who participated in the aftercare program (170 days) and shortest for control group participants (108 days). • Compared with control group participants, MTC participants who participated in the aftercare program had significantly lower rates of criminal activity in general (67% vs. 42%, $p < .05$)

	and lower rates of criminal activity related to alcohol and drug use (58% vs. 30%, $p < .03$) at the 12-month postrelease follow-up. These findings reflect a small effect size (odds ratio = 2.33 and 2.78, respectively).
Studies Measuring Outcome	Study 1, Study 2
Study Designs	Experimental, Quasi-experimental
Quality of Research Rating	2.8 (0.0-4.0 scale)

Outcome 3: Psychological problems	
Description of Measures	In one study, psychological problems (depression and anxiety symptoms) were measured using the Beck Depression Inventory (BDI) and the Short Form of the Taylor Manifest Anxiety Scale. The BDI is a 21-item self-report instrument that measures past-week depressive symptoms. Total scores vary from 0 to 63 and indicate whether depression is minimal (0-13), mild (14-19), moderate (20-28), or severe (29-63). The Short Form of the Taylor Manifest Anxiety Scale is a 20-item, true/false, self-report questionnaire measuring past-week anxiety symptoms. Self-reports were obtained at baseline, at 12 months after baseline, and at each client's last follow-up point (long-term follow-up), which was more than 24 months after baseline, on average. In another study, psychological problems were measured using the Global Appraisal of Individual Needs (GAIN) at baseline and the 12-month follow-up. The GAIN is a standardized, semistructured interview with eight main sections (background, substance use, physical health, risk behaviors, mental health, environment, legal, and vocational) that is designed to support the diagnosis, placement, and outcome monitoring of patients and the economic analysis of an intervention.
Key Findings	Homeless clients with co-occurring disorders were sequentially assigned to a low-intensity MTC condition, a moderate-intensity MTC condition, or usual care. Compared with the high-intensity MTC condition, the low-intensity condition placed fewer demands on clients (e.g., clients had more freedom to leave the facility) and provided clients with more staff assistance. Usual care incorporated a variety of treatment and nontreatment options that were typically less specific to the needs of homeless clients with co-occurring disorders, not as well organized, and less cohesive in perspective or approach relative to the MTC conditions. • At the 12-month follow-up, low-intensity MTC clients reported fewer depression symptoms than moderate-intensity MTC clients ($p < .02$). • At the long-term follow-up, low-intensity MTC clients reported fewer depression symptoms ($p < .001$) and fewer anxiety symptoms ($p < .03$) than clients who received usual care. • At the 12-month follow-up, clients who received 12 months of treatment (treatment completers) in both MTC conditions reported fewer depression and anxiety symptoms than clients who received usual care for at least 9 months ($p < .05$). In an RCT, clients with co-occurring disorders who were admitted to an outpatient substance abuse day treatment program were assigned to one of two intensive conditions: MTC modified for day treatment or usual care. Both conditions consisted of 3 hours of treatment per day, 3 days per week. The modified MTC condition incorporated community-enhancing meetings for dual recovery taken from the residential MTC model and added a psychoeducational seminar, trauma-informed addictions treatment, and case management. Usual care was a basic day treatment program that provided individual as well as group therapy and counseling that focused on substance use and relapse prevention. • At the 12-month follow-up, MTC clients had greater decreases in reported emotional problems ($p = .04$) and any emotional or psychological problems ($p < .001$) than usual care clients.
Studies Measuring Outcome	Study 1, Study 3
Study Designs	Experimental, Quasi-experimental
Quality of Research Rating	3.0 (0.0-4.0 scale)

Outcome 4: Employment	

Description of Measures	Employment was evaluated using one self-report measure. Response options were 0 (none), 1 (part-time irregular or odd jobs), 2 (part-time regular), and 3 (full-time). Self-reports were obtained at baseline, at 12 months after baseline, and at each client's last follow-up point (long-term follow-up), which was more than 24 months after baseline, on average.
Key Findings	Homeless clients with co-occurring disorders were sequentially assigned to a low-intensity MTC condition, a moderate-intensity MTC condition, or usual care. Compared with the high-intensity MTC condition, the low-intensity condition placed fewer demands on clients (e.g., clients had more freedom to leave the facility) and provided clients with more staff assistance. Usual care incorporated a variety of treatment and nontreatment options that were typically less specific to the needs of homeless clients with co-occurring disorders, not as well organized, and less cohesive in perspective or approach relative to the MTC conditions. • At the 12-month follow-up, clients in both MTC conditions reported increased employment relative to usual care clients ($p < .001$). This difference remained at the long-term follow-up ($p < .001$ for low intensity and $p < .01$ for moderate intensity). • At the 12-month follow-up, MTC clients who received at least 12 months of treatment (treatment completers) in both MTC conditions had a greater increase in reported employment than clients who received usual care for at least 9 months ($p < .001$). This finding remained at the long-term follow-up ($p < .001$).
Studies Measuring Outcome	Study 1
Study Designs	Quasi-experimental
Quality of Research Rating	2.8 (0.0-4.0 scale)

Outcome 5: Economic benefit	
Description of Measures	Economic benefit was measured as the average incremental financial benefit over the cost of each condition, the net financial benefit over the cost of each condition, and the benefit-to-cost ratio associated with each condition, calculated in 1994 dollars. Financial benefits were evaluated as the estimated cost savings to society expected to accrue from self-reported declines in criminal activity, increased productivity (employment earnings), and decreased health care utilization occurring from 12 months before to 12 months after admission (baseline). Monetary conversion factors (unit cost estimates) were applied to changes in criminal activity, employment earnings, and health care utilization. The economic benefits of treatment were defined as the dollar value associated with changes in each of these outcome domains. Costs associated with the study conditions were calculated using the Drug Abuse Treatment Cost Analysis Program (DATCAP), an analysis package that estimates both the accounting and economic costs of program implementation, including the full value of all resources, such as donations and subsidies.
Key Findings	Homeless clients with co-occurring disorders were sequentially assigned to a low-intensity MTC condition, a moderate-intensity MTC condition, or usual care. Compared with the high-intensity MTC condition, the low-intensity condition placed fewer demands on clients (e.g., clients had more freedom to leave the facility) and provided clients with more staff assistance. Usual care incorporated a variety of treatment and nontreatment options that were typically less specific to the needs of homeless clients with co-occurring disorders, not as well organized, and less cohesive in perspective or approach relative to the MTC conditions. • On the basis of increased employment reported by MTC clients compared with usual care clients at the 12-month follow-up, the economic benefit per MTC client relative to usual care client was $720 ($p = .01$). • On the basis of decreased health care utilization reported by MTC clients compared with usual care clients at the 12-month follow-up, the economic benefit per MTC client relative to usual care client was $17,613 ($p = .01$). • The total average cost savings to society associated with less health care utilization, less criminal activity, and more employment reported by MTC relative to usual care clients was $305,273 ($p = .01$) per MTC client. When adjusted for outlying MTC clients, this figure decreased to $149,851 but remained significant ($p = .01$). • The average incremental economic benefit associated with less health care utilization, less criminal activity, and more employment reported by MTC relative to usual care clients was $273,698 ($p = .05$) per MTC client. When adjusted for outlying MTC clients, this figure decreased to $105,618 but remained significant ($p = .05$).

	• The net benefit estimate ($253,337) and benefit-to-cost ratio (5:1) associated with a client participating in MTC relative to usual care suggested the economic benefit of MTC, but these findings were not statistically significant.
Studies Measuring Outcome	Study 1
Study Designs	Quasi-experimental
Quality of Research Rating	2.4 (0.0-4.0 scale)

Outcome 6: Housing stability	
Description of Measures	Housing stability was measured using the GAIN, a standardized, semistructured interview with eight main sections (background, substance use, physical health, risk behaviors, mental health environment, legal, and vocational) that is designed to support the diagnosis, placement, and outcome monitoring of patients and the economic analysis of an intervention.
Key Findings	In an RCT, clients with co-occurring disorders who were admitted to an outpatient substance abuse day treatment program were assigned to one of two intensive conditions: MTC modified for day treatment or usual care. Both conditions consisted of 3 hours of treatment per day, 3 days per week. The modified MTC condition incorporated community-enhancing meetings for dual recovery taken from the residential MTC model and added a psychoeducational seminar, trauma-informed addictions treatment, and case management. Usual care was a basic day treatment program that provided individual as well as group therapy and counseling that focused on substance use and relapse prevention. • At the 12-month follow-up, clients in both conditions had an increase in reported days rent was paid, a decrease in reported time spent in a shelter/emergency housing, and a decrease in reported time in a voluntary housing facility ($p < .05$). However, MTC clients reported more days of paying rent for housing than usual care clients ($p = .04$).
Studies Measuring Outcome	Study 3
Study Designs	Experimental
Quality of Research Rating	2.6 (0.0-4.0 scale)

Study Populations

The following populations were identified in the studies reviewed for Quality of Research.

Study	Age	Gender	Race/Ethnicity
Study 1	26-55 (Adult)	75.4% Male 24.6% Female	70.2% Black or African American 18.1% Hispanic or Latino 11.7% White
Study 2	26-55 (Adult)	100% Male	48.9% White 30.2% Black or African American 16.5% Hispanic or Latino 4.3% Race/ethnicity unspecified
Study 3	26-55 (Adult)	57.1% Female 42.9% Male	78.8% Black or African American 13.1% White 8.1% Hispanic or Latino

Quality of Research Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the Quality of Research for an intervention's reported results using six criteria:

1. Reliability of measures
2. Validity of measures
3. Intervention fidelity

4. Missing data and attrition
5. Potential confounding variables
6. Appropriateness of analysis

For more information about these criteria and the meaning of the ratings, see Quality of Research.

Outcome	Reliability of Measures	Validity of Measures	Fidelity	Missing Data / Attrition	Confounding Variables	Data Analysis	Overall Rating
1: Substance use	2.9	2.4	2.3	2.8	3.0	3.3	**2.7**
2: Criminal behavior	3.0	2.5	2.3	2.8	3.0	3.3	**2.8**
3: Psychological problems	3.8	3.8	2.0	2.5	3.0	2.8	**3.0**
4: Employment	3.0	2.5	2.0	2.5	3.0	3.5	**2.8**
5: Economic benefit	2.5	2.0	2.5	2.0	3.0	2.5	**2.4**
6: Housing stability	3.0	2.5	2.0	2.5	3.0	2.5	**2.6**

Study Strengths

Standard self-report instruments and measures were used and were augmented with collateral information in some cases (e.g., urine drug screens and department of correction records in the prison study). Self-reports of reincarceration are likely to be highly valid and reliable from the prison study, as they were checked against department of correction records. In the outpatient treatment study, housing was a good index of increased stability and reduced risk for homelessness. Intervention training was carried out by experts who provided ongoing supervision. The DATCAP economic analyses were strong in the homeless study.

Study Weaknesses

Reliability for the self-report of substance use and psychological problems was not specifically calculated in these study samples. In the absence of any independent verification, the validity of self-reported crime types and number of crimes committed as true index measures for criminal behavior in the homeless study is questionable. Additionally, there was no attempt to verify self-reported employment (e.g., using pay stubs) in the homeless study. Consequently, the cost-benefit analysis in the homeless study was weakened by the reduced reliability and validity of the behavioral change measures--self-reported criminal behavior and employment--on which it was based. There was no independent verification of intervention fidelity and no fidelity ratings for the usual care control groups in any of these studies.

Readiness for Dissemination

Review Date: March 2008

Materials Reviewed

The materials below were reviewed for Readiness for Dissemination. The implementation point of contact can provide information regarding implementation of the intervention and the availability of additional, updated, or new materials.

Overview of MTC dissemination materials

PowerPoint slides for training and technical assistance series:

- Co-Occurring Substance Use and Mental Disorders (COD)--Diagnoses, Symptoms, and Clinical Tips
- Evidence-Based and Consensus Practices for Treatment of Persons With Co-Occurring Disorders
- Modified Therapeutic Communities for People With Co-Occurring Disorders--Research Findings
- Modified Therapeutic Community for Clients With Mental Illness & Chemical Abuse (MICA) Disorders--Description of the Program
- Modified Therapeutic Community (MTC)--Principles of Implementation
- Overview of Screening and Assessment

Sacks, S., De Leon, G., Bernhardt, A., & Sacks, J. (1996). Modified therapeutic community for homeless mentally ill chemical abusers: Treatment manual. New York: National Development and Research Institutes/Center for Therapeutic Community Research.

Sacks, S., Sacks. J. Y., & De Leon, G. (1999). Treatment for MICAs: Design and implementation of the modified TC. Journal of Psychoactive Drugs, 31(1), 19-30. PubMed

Readiness for Dissemination Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the intervention's Readiness for Dissemination using three criteria:

1. Availability of implementation materials
2. Availability of training and support resources
3. Availability of quality assurance procedures

For more information about these criteria and the meaning of the ratings, see Readiness for Dissemination.

Implementation Materials	Training and Support Resources	Quality Assurance Procedures	Overall Rating
3.5	2.5	2.5	**2.8**

Dissemination Strengths

The well-designed treatment manual provides program content, clear steps for implementing the program, and information on the intervention's goals and intended audience. Training and consultation are provided by the program developers to support initial and ongoing implementation. Several tools are provided to support quality assurance.

Dissemination Weaknesses

It may be difficult for implementers to see how the program materials fit together to frame an overall approach to implementation. Limited information is provided on staff roles, especially their interrelationships. The training materials include only minimal discussion of staff supervision. Detailed information addressing continued direct supervision of front-line staff to support quality assurance is not provided. The overall design for quality assurance is unclear.

Costs

The cost information below was provided by the developer. Although this cost information may have been updated by the developer since the time of review, it may not reflect the current costs or availability of items (including newly developed or discontinued items). The implementation point of contact can provide current information and discuss implementation requirements.

Item Description	Cost	Required by Developer
Program materials	Free	Yes
2-day stakeholder/system introduction	$5,000 plus travel expenses	No
3-day intensive staff training	$6,000 plus travel expenses	Yes
2-day follow-up training	$2,500 plus travel expenses	No
2-day site observation and technical assistance visit	$2,000 plus travel expenses	No
Biweekly technical assistance phone calls (for months 1-6 of implementation)	$125 per hour	No
Monthly technical assistance phone calls (for months 7-12 of implementation)	$125 per hour	No
TC Scale of Essential Elements Questionnaire (SEEQ)	Free	No
TCU Organizational Scales (TCU ORC)	Free	No
Dual Diagnosis Capability in Addiction Treatment (DDCAT)	Free	No
Dual Diagnosis Capability in Mental Health Treatment (DDMHT)	Free	No

Additional Information

The average cost of providing this intervention to one client with co-occurring disorders for 12 months is $29,255 (1994 estimates), about the same as the cost of providing 12 months of standard residential treatment ($29,638, also 1994 estimates).

Replications

Selected citations are presented below. An asterisk indicates that the document was reviewed for Quality of Research.

Sacks, S., Banks, S., McKendrick, K., & Sacks, J. Y. (2008). Modified therapeutic community for co-occurring disorders: A summary of four studies. Journal of Substance Abuse Treatment, 34(1), 112-122.

* Sacks, S., McKendrick, K., Sacks, J. Y., Banks, S., & Harle, M. (2008). Enhanced outpatient treatment for co-occurring disorders: Main outcomes. Journal of Substance Abuse Treatment, 34(1), 48-60.

* Sacks, S., Sacks, J. Y., McKendrick, K., Banks, S., & Stommel, J. (2004). Modified TC for MICA offenders: Crime outcomes. Behavioral Sciences and the Law, 22(4), 477-501.

* Sullivan, C. J., McKendrick, K., Sacks, S., & Banks, S. (2007). Modified therapeutic community treatment for offenders with MICA disorders: Substance use outcomes. American Journal of Drug and Alcohol Abuse, 33(6), 823-832.

Contact Information

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Consider these Questions to Ask (PDF, 54KB) as you explore the possible use of this intervention.

Web Site(s):

- **http://www.ndri.org/ctrs/cirp.html**