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Re-conceptualizing Therapeutic Communities
in Secure Forensic Settings

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Statement of the Problem

As we progress into the 21st century, many policy makers and clinicians question whether the underlying cultural, structural, and programmatic characteristics of the traditional TC model have been lost as well as the effectiveness of this modality as modified by manage care strategies, HIPAA laws, and empirically-supported treatment (De Leon et al. 2000; Edelen et al. 2007; Sachs et al. 2008).

The Medicalization of Psychiatric Treatment

Under managed care, the doctor-patient relationship received decreasing attention while emphasis was placed more on the use of manualized therapies. This trend seems to devalue the published research on the efficacy of psychotherapy as well as limit the research agenda by focusing exclusively on molecular and chemical interactions to the exclusion of environmental, interpersonal and also intrapsychic interactions.

- Rise in the reliance on biomedical approaches to the brain and psychiatry
- Reliance on Empirically-Supported Therapies: Manualized Treatment

HIPAA Laws

The first-ever federal privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers took effect on April 14, 2003. Congress called on HHS to issue patient privacy protections as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These new standards provide patients with access to their medical records and more control over how their personal health information is used and disclosed. The privacy rule sets limits on how health plans and covered providers may use individually identifiable health information and requires that patients must sign a specific authorization before a covered entity could release their medical information to a life insurer, a bank, a marketing firm, or another outside business for purposes not related to their health care.

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Statement of the Problem (Continued)

Change in Patient Demographics

The new demographics include many patients who suffer from co-morbid and severe mental illnesses (i.e., severe emotionally unstable personality disorders, schizophrania and other psychotic disorders, bipolar disorders and major depression).

Research indicates that psychosis occurs at a higher prevalence within the population with intellectual disabilities compared with that reported for the general population (Jartus, 2010). The presence of an intellectual disability may interfere with the patient's ability to understand and enact the responsibilities associated with the therapeutic community.

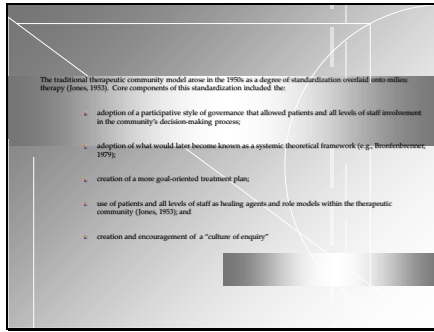
Movement away from the Community as Method Approach

- The use of psychiatric technicians, registered nurses, and nurse practitioners in the role of custodians rather than as the prime agents to promote healing
- To serve the changing patient populations, many MTCs have broken with the staffing pattern of the standard TC to employ more professional staff including psychologists, physicians, and psychiatrists.
- The dominance of and reliance on psychopharmacology for symptom management rather than the "Community as Method" to treat the community members' mental illnesses.

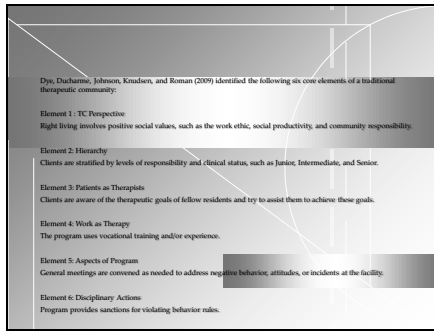
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It is the community: patients and staff working together toward recovery and healing, which accomplishes the positive change in the individual members. This joint practice is sometimes referred to as "Community as Method" and is a cornerstone in the traditional TC model. Important underlying principles of a traditional TC are that all involved are encouraged to be curious about themselves, each other, and the staff. All members participate in:

- the management structure,
- psychological processes,
- the group process, the institution and
- everything else pertinent to events and relationships within the community.

This set of underlying principles is known as the "culture of equity" – an openness to questioning, so that understanding is owned by all and not seen solely to reside in professionals (Crump, 2010, pp. 383-389).

The systemic framework of the traditional TC highlights how the actions of one person within the community has a ripple effect on other members and that every member will experience the consequences of these actions – whether positive or negative.

Each community member has responsibilities and must accept that each person's actions affect others.

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The Impact of HIPAA Laws

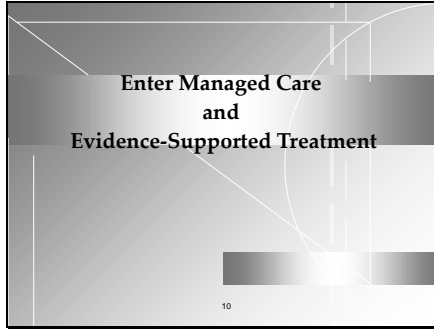
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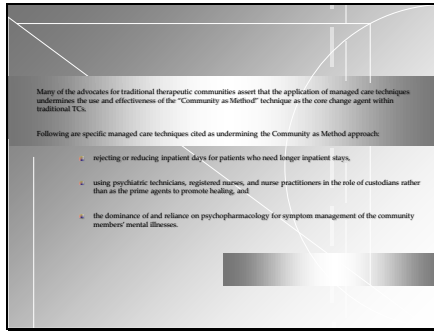
The HIPAA privacy rules prevent the sharing of patient information (e.g., treatment goals) without his written authorization.

- Given the change in demographics among the patients in state hospitals, many of these individuals will not be able to give informed consent to share their information with other patients in the therapeutic community.
- Given the large percentage of cognitive and intellectual disabilities within this population, many of the patients require a poor manner to encourage and motivate participation in their daily treatment regime (Element # 1: TC Perspectives).
- The restrictions on sharing patient information in combination with large percentage of cognitive and intellectual disabilities may interfere with stratifying patients by levels of responsibility and clinical status (Element # 2: Hierarchy).
- The HIPAA prohibition on sharing patient information may undermine the use of patients as agents of change (Element # 3: Patients as Therapists).
- The restrictions on sharing information may also impact the content and processes of the regularly scheduled community meetings (Element # 5: Aspects of Program).

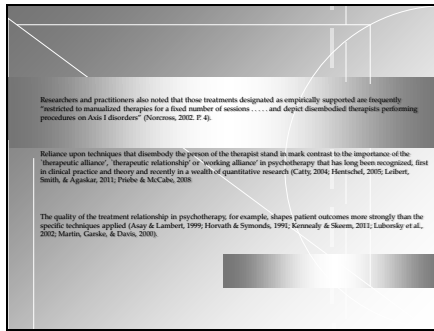
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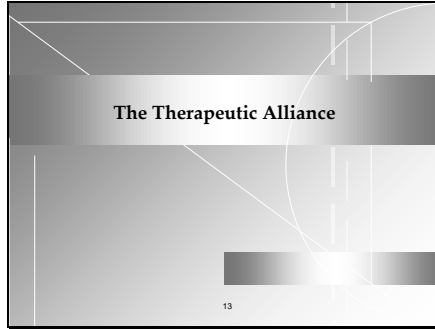
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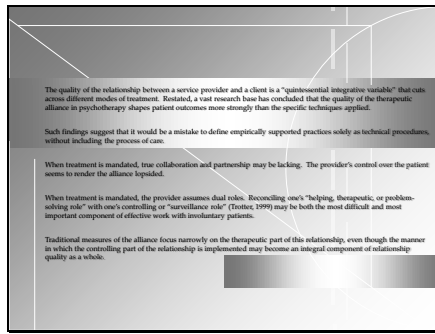
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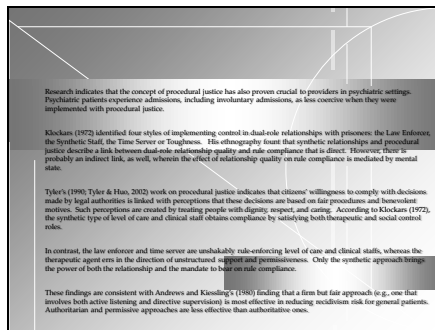
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This darker style of implementing control is labeled **Toughness** and is characterized by a positive orientation and expectations of independence and compliance, which do bode poorly for relationships. It is associated with lack of care and clinical staff confrontation within sessions, patient mistrust, treatment amotivation, and future rule noncompliance.

Angell and Mahoney (2007) found that limit setting in dual-role case management relationships introduced a parent-child like dynamic into the relationship. Along these lines, the Toughness concept seems to capture an authoritarian supervisory style.

Research on parenting suggests that authoritarian parents are highly demanding and directive but (unlike authoritative parents) are not responsive to their children's needs. "They are obedience- and status-oriented, and expect their orders to be obeyed without explanation" (Baumrind, 1991, p. 52).

The Toughness concept emphasizes an indifference to patients' stress and feelings, expectation of compliance, and punitiveness when expectations are not met. This darker side of dual-role relationships is consistent with Angell and Mahoney's (2007) qualitative finding that conflict and struggle over issues of power and control are an important negative aspect of treatment relationships.

The nature of the relationship is different in dual-role contexts than in strictly therapeutic ones: In mandated treatment, there is an emphasis on caring, fairness, trust, and an authoritative (not authoritarian) style.

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The quality and effectiveness of each staff's dual-role relationship with patients is dependent on the consistent use of six therapeutic skills. These include:

- 1. the use of reflection (statements that reflect content or meaning offered by the patient),
- 2. providing affirmations (statements that complement the patient's efforts or characteristics),
- 3. providing support (understanding, supportive, reassuring, or compassionate comment not captured by reflect or affirm),
- 4. advising (giving advice, making a suggestion, or offering a possible action),
- 5. providing direction (giving an order or command), and
- 6. the ability to use confrontation (disagreeing, contradicting).

In alignment with the use of motivational interviewing techniques, staff must be alert for two forms of patient behavior:

- 2. change talk (statements that indicate moving forward, in the direction of compliance with conditions) or
- 1. resistance (statements that are inconsistent with or show movement away from compliance).

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Modified Therapeutic Communities

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Melnick and De Leon (1999) noted that many of the key elements of long-term traditional TCs are not feasible within secure forensic hospital settings. For example, MTCs situated within these settings require adjustments to the participatory style of governance of the traditional TC model (De Leon, 1993, 2000) to address the needs of judicially committed patients and Mentally Disordered Offenders through establishing therapeutic alliances that blend care and control.

These adjustments have occurred in response to issues related to the mandated nature of treatment provided by state hospitals, the adoption of a variety of Administrative Directives adopted to address the dual-role placed on their staff and changes in the demographics of their patient group. Hence, the majority of patients suffer from co-occurring and severe mental illnesses (i.e., severe emotionally unstable personality disorders, schizophrenia and other psychotic disorders, bipolar disorders and major depression).

The modified therapeutic community (MTC) was developed in the 1990s (De Leon, 1993; Sacks, De Leon, Bernhard, & Sacks, 1997, 1998; Sacks, Sacks, & De Leon, 1999). As compared to the traditional TC approach, the MTC incorporates:

- 1. increased flexibility;
- 2. reduction in the duration of various activities;
- 3. less confrontational group therapy;
- 4. increased emphasis on orientation and instruction;
- 5. fewer sanctions;
- 6. more explicit affirmation for achievements;
- 7. greater sensitivity to individual differences; and
- 8. greater responsiveness to the special developmental needs of the patients, all of which serve to maximize social learning opportunities.

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Several core principles and methods of the traditional TC theoretical framework are retained in the MTC approach that include:

- 1. providing a highly structured daily regimen;
- 2. fostering personal responsibility and self-help in managing life difficulties;
- 3. using patients as role models and guides within their peer community rather than as change agents.

Staff continue to be harnessed as healing agents within a strategy where the community provides both the context for and mechanism of change. Key mechanisms of change include:

- 1. the therapeutic relationships;
- 2. regarding change as a gradual, developmental process that assists patients to move through progressive treatment stages;
- 3. stressing work and self-reliance through the development of vocational and independent living skills; and
- 4. promoting prosocial values within healthy social networks to sustain recovery (Sacks, Banks, McKendrick, & Sacks, 2008, pp. 112-113).

attention to the context of the community toward creating an optimal healing environment

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Jonas and Cher (2004) equate clinical manipulation of secure forensic therapeutic contexts with the creation of an optimal healing environment (OHE) where the social, psychological, spiritual, physical, and behavioral components of health care are oriented toward support and stimulation of healing and the achievement of wholeness. Their view links important aspects of therapeutic milieu with the framework from the optimal healing environment literature.

The optimal healing environment framework complements this expanded systemic approach to support patient-centered care, continuous healing relationships, safety as a system priority, and cooperation among clinicians within a holistic practice atmosphere (Mahoney, Falyo, Napier, & Goetz, 2009, p. 423).

The Samuels Institute, a nonprofit organization dedicated to research on healing, has developed a model that suggests that healing is the result of intention, personal wholeness, relationships, healthy lifestyle, collaborative medical care, healing organizations, and healing spaces. "This inclusive view of what is needed for healing is not new."

But this view is beginning to change as health care organizations are becoming aware of the growing body of evidence that shows the benefits of a healing environment, and are incorporating ideas generated by such studies into new facilities.

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Setting a New Stage for MTCs

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Resources

Return the therapeutic alliance as the center-piece of the MTC model

- Utilize all staff as agents of change
- Pair clinicians, nurses, and level of care staff to co-facilitate individual and group therapies
- Utilize the patients as role models and mentors rather than as agents of change

Work with administrative staff on re-writing ADs to allow "Ward Government" the ability to take on community responsibilities (e.g., oversee the HCAP System)

Establish greater communication between the therapeutic community and CINREP toward discharge planning and re-integration into the larger community/society

Re-train the level of care staff on how to establish and maintain therapeutic relationships.

Pair clinical and level of care staff in providing group and individual therapies.

Redistribute the disciplinary functions to all of the unit staff.

Provide initial and ongoing training to all the unit staff **and** patients on the MTC model.

Initially, set up MTCs as specialized treatment units.
