THE THERAPEUTIC COMMUNITY: AN ORGANIZATION IN TRANSITION

by

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Abstract

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This research looks at a type of total institution, the therapeutic community, with the objective of seeing what effect a change in goals has upon the structure and functioning of the organization. The change in goals is being caused by a change in the environment surrounding the TC. Traditionally this organization treated heroin-addicted individuals in a residential living situation. Now, the TC is faced with a potential population of multiple drug users, alcohol users, methadone addicts, and adolescents with a combination of drug and non-drug problems. How the TC adapts its treatment to this new population of clients is the problem investigated in this study.

The methodology involved extensive interviewing and observations in three TC's in the New York City area. The three specific organizations studied represent distinct subtypes, while at the same time not being atypical. Daytop Village is the oldest and one of the largest TC's in

the city. The leadership of this organization is composed of ex-addict as well as professional staff, and it is nonsectarian in orientation. It can be classified as a high-discipline, long-term treatment community, that has as its goal major character restructuring. Addicts Rehabilitation Center is a medium sized, Harlem-based agency with a nonprofessional staff. Its classification as a low-discipline, short-term treatment community that seeks to provide its clients with the tools to enable them to survive in their own environment puts ARC at the opposite end of the spectrum from Daytop. Samaritan Halfway Society is a smaller community in Queens with a professional and an ex-addict staff. It can be classified as falling somewhere inbetween Daytop and ARC concerning its discipline, length of treatment and goals. The three organizations selected for study thus form a trichotomy of therapeutic communities, the comparison of which enhances the overall research design.

The conclusions of the research indicate that the three TC's are changing certain goals in response to the new environment. Goal succession is occurring in each organization, although the degree and type vary with the individual programs. There appears to be a correlation be-

tween the type of TC and the nature of change. So, for example, Daytop Village (the high-discipline, long-duration program) is experiencing the least amount of goal succession. SHS and ARC (lower-discipline, shorter-duration programs) are experiencing greater degrees of goal succession. Yet the fact that all three organizations are changing to meet the demands of the new environment indicates that they are all trying to continue as viable treatment modalities for mental health problems.

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CHAPTER I

INTRODUCTION

Purpose

This study intends to look at a type of total institution, the therapeutic community (hereafter referred to as the "TC"), and see what effect a change in goals has upon the structure and functioning of the organization. As will be shown, the change in goals is being caused by a change in the environment surrounding the TC. The result is a shift in formal as well as in informal goals. This report attempts to delineate the new environment of the organization, to show what changes in goals have occurred, and then to see what additional changes in the organization have resulted from these initial shifts. Throughout this analysis, stress should be placed upon the concept of the TC as a total institution, and more specifically as a total institution in transition. This will form the theoretical basis for the discussion.

A situation somewhat analagous to the one about to be explored was examined by David Sills in his research on the National Foundation for Infantile Paralysis. This or-

ganization is an example of a national voluntary health association. Sills makes the point that while most large-scale organizations have a tendency toward goal-displacement (i.e., from a means, organization becomes an end), the Foundation does not. "The formal structure of the Foundation provides several safeguards against the dangers inherent in the vested interests of individuals in maintaining their positions."[1] One is the aspect of "voluntariness," and a second is the lack of upward mobility within the organization. In addition, there is a minimum of organizational rules in the organization, and this makes it difficult for volunteers to displace the goals of the campaign by paying too strict attention to legalities.[2] But while denying goal-displacement, Sills says that goal-succession does occur in the Foundation. After substantially eliminating polio, in part through the research it sponsored, the Foundation went into the prevention of childhood diseases in general. This, for Sills, represents an organization's successful adaptation to a changing social environment.

In using the term "goal-succession," Sills is dependent upon Peter Blau's earlier work, Bureaucracy in Modern Society. In this treatise, Blau says that the suc-

cession of goals is the reverse of the displacement of goals. As earlier objectives are obtained, they become stepping stones to new ones.[3] Charles Perrow defines the term more specifically. He states that in order to see whether goal succession did occur, one must consider different types of goals. Commenting on Sills' study, he states:

> The shift was from one childhood disease (polio) to all childhood diseases. But from the standpoint of output goals, there was no change: the organization's goal continued to be the financing of research and limited treatment in connection with human diseases or, more generally, it was still concerned with health. In terms of system goals, there was again no change. Even though the particular task of eradicating polio was accomplished, the goal of the Foundation continued to be organizational growth, as well as to continue to operate with the same distinctive structure: a highly centralized and powerful national office and highly decentralized local leadership with open membership. Finally, in terms of derived goals, one might say that the real goal was otherwise, the new arrangements were merely a means of providing the Foundation's top executives with positions of power and prestige in the national health field so that they could shape the nature of the country's health activities. Shifting from polio to other diseases was merely a means to this end, as was the decision to retain the same form of organizational structure. In sum, all these goal categories are useful and relevant. Which is chosen depends upon what is to be analyzed--the health system, the shift in products, organizational growth and structure, or the power accruing to the leaders themselves.[4]

Thus for Perrow, goal succession is not a meaningful term unless the specific type of goal is identified.

In one perspective, then, defining a change in goals as "goal-displacement" or "goal-succession" is a matter of semantics and may not be a fruitful question to ask. Yet the basic idea that some goal-change is occuring is valid. The task of this research is to explore the relationship between organizational response to a changing environment and changes in its goals. Specifically, as the TC experiences an increase in competition for clients (or residential members), it must by necessity seek them from new sources. This means that one or more new "populations" must be tapped--populations whose problems and need for TC-like services differ in some way from the population previously served.

Attracting new clients thus must involve reformulating existing goals. As will be shown, in the case of TC's this means retaining the original goal of treating drug addiction, and at the same time adding the new goals of, say, the treatment of alcoholism or the treatment of other mental health problems. Such a process clearly does not meet Sills' definition of "goal-succession," but does offer opportunity to employ Perrow's additional considerations. For our purposes, it may be

useful to conceptualize "goal-extension" in order to describe the situation in which an organization adds related goals to existing ones, typically justifying them on the grounds that they are logical extensions of existing goals, even though their implementation may eventually require substantial organizational change.

In light of these ideas, this study examines the TC as a special form of organization that seems to be experiencing goal-extension. To begin with, the therapeutic community is a unique form of "total institution."[5] Most TC's require the individual to enter a residential living situation for a period of time that may last up to a few years. Part of this time may be spent in a facility that is removed from the environment that the individual lived in previously. (In two of the three TC's studied here, upstate New York facilities were the locations where much of the treatment occurred.) The remainder of the "living-in" time may take place in a facility that is in the heart of an urban area. In both situations, there are no physical barriers that prevent the person from leaving. A resident may walk out the door at any time and not return. People may be stopped when they enter the facility, but this does not occur when they leave it. This fact differentiates the TC from many, but not all, total institutions.

While in the residential stage, life for the individual resembles life in the total institution. Rules are

strictly enforced, with any deviation punishable in a number of ways. Orders are frequently given, and they flow downward from a central authority. Residents at the same level are treated alike. Daily activities are tightly scheduled, with much of TC life done in the company of others. (The basis for treatment in the TC is the group encounter--a group therapy situation.) Also, and this is mostly true in the larger TC's, bureaucratic procedures become an ever-present aspect of daily life.

Erving Goffman's phrase "mortification of self" can be applied to the TC. As will be shown in the next chapter, the therapeutic community tries to "destroy" the previous identity of the resident, and remake the self into that of a responsible social individual. This process requires many of the procedures Goffman describes. So, for example, residents who break a TC rule might have their heads shaved or might be told to perform humiliating tasks. The loss of the "private part" of one's life is another mortification process that all TC residents experience. Then, too, the demand of the organization for total involvement of the personality precludes any differentiation of roles. This is still another step in the overall breakdown of the old self.

The concern in this study is how the TC, as a total institution with all the rigid organizational traits this entails, can adjust to environmental change in terms either

of potential clientele or of sources of financial support. From this central question, a number of hypotheses evolve. First, it may be hypothesized that if the TC is going to successfully adapt itself to a new situation, some succession of goals must occur. This might be in terms of formal goals or in terms of informal goals. Either way, the organization itself will be affected. Secondly, where some type of goal-succession has occurred, one would expect to find some form of role stress for the individual members. This might take the form of high staff turnover due to their inability to do the "new" job, or it might express itself in staff members' verbal indications of their uneasiness in the changing job situation. We may hypothesize this stress to be more acute at the lower end of the organizational structure (as opposed to the higher positions), since lower-level members have less control over their job-specifications.

The specific response to the environment may vary with the particular organization studied. Therefore, the three specific TC's chosen for study represent distinct subtypes, while at the same time being not atypical. Daytop Village is the oldest and one of the largest TC's in the New York City area. The leadership of this organiza-

tion is composed of ex-addicts as well as professional staff, and it is non-sectarian in orientation. It can be classified as a high discipline, long-term treatment community that has as its goal major character restructuring. Addicts Rehabilitation Center is a medium-sized, Harlem-based agency with a nonprofessional staff. The population of this organization is almost entirely black. Its classification (as a low discipline, short-term treatment community that seeks to provide its clients with the tools that will enable them to survive in their own environment) puts ARC at the other end of the spectrum from Daytop. Samaritan Halfway Society is a smaller community in Queens with a professional and an ex-addict staff. Its leadership has for years been shared by an Episcopalian minister and a rabbi. It can be classified as falling somewhere between Daytop and ARC in terms of discipline, length of treatment, and goals. Thus, the three organizations selected for study form a range of therapeutic communities, the comparison of which will enhance the overall research design.

The fact that three TC's are analyzed adds another dimension to this study. While being able to see the overall effect a change in the organization's environment

causes, it should be possible also to see the separate, and possibly different, adaptations of individual TC's to new surroundings. One should not expect to find great differences between the three, yet certain peculiarities in organizational behavior emerge. These findings can only add to the research, and they might add support for or against the initial hypotheses.

Methodology

The first TC approached for study was ARC. An introduction to the director of this organization was gained through the help of a fellow graduate student, who was himself a former director of ARC. Through the assistance of this former director, and the cooperation of the officials of the TC, permission to carry out the research was obtained. Staff members at all levels of the organizational hierarchy were interviewed, making sure that they represented all of the various departments of the TC. In addition to formal interviews, informal discussions and observations were used to gain a clearer picture of the functioning of the organization. The length of the interviews varied from a few minutes to a few hours. Likewise, the length of time spent at the TC fluctuated, going from a few hours a day to the major portion of the day. Care

was taken not to interfere with either the duties of the staff members or the activities of the residents.

Once the study was under way at ARC, contacts with the other TC's were initiated. At SHS, cooperation was facilitated because of the executive director's high regard for Prof. Charles Winick, the overseer of this research. In addition, the director of research at SHS was very cooperative, and helped this study immeasurably. Daytop Village was the last TC studied, and its administration was somewhat reluctant to have its staff members interviewed. The fear expressed at Daytop was that the research might be used as an evaluation of that agency. After this fear was assauged, the organization (especially the director of research) was glad to aid the study.

The study lasted from April 16 to September 3, 1975. During this period, interviews, informal discussions, and observations were carried out at each of the three TC's. Three to four weeks' time was usually needed to complete the work at each organization, and often it was necessary to return to the TC after the interviewing was finished for additional information. In the case of Daytop Village, a visit to the upstate facility was made. SHS, while having a TC upstate, often had the staff people from that

facility come down to the Queens location. This made it possible to conduct all interviews and discussions at the New York City residence. In addition to staff members, clients from each community were interviewed. The object of this procedure was to substantiate the staff's view of the clients, and to gain an accurate picture of the new drug environment.

The staff interviews covered a number of topic areas. The questions were altered somewhat for each TC, as well as for those in different positions within the organizations. Basically, the interviews were concerned with the changes occurring in the TC over the last few years. Staff members were asked about recent trends in substance abuse among clients, differences between the "newer"clients and the "older" ones, and rates of recidivism over the last few years. They were also asked questions concerning staff turnover, changes in treatment, changes in sources of referral, and other organizational developments. These opinions were supplemented with observations of activities in the TC's and with informal talks with the staff members and clients. The informal discussions proved very informative, since many staff people were more willing to be open in their answers when

they were not being written down.

Throughout the study, care was taken to guarantee the anonymity of the respondents. Most staff members and clients would use their first names, and these were their only means of identification. Where a person's full name was stated, only his or her first name was recorded. It was made clear to the respondents that they would not be identifiable in any written report of this research. Furthermore, each staff member's responses were kept in strictest confidence. It was necessary to assure the respondents of this in order to ease their concern about other TC members learning of their comments.

Additional data used in this research were obtained from TC publications. Both Daytop Village and ARC have annual reports that provide extensive information about their staff and client populations. Many of the statistical data used in this study come from these sources. SHS, however, does not have an annual publication. The research department of that agency provided me with certain needed information, wherever possible. The major problem with this procedure was that some data were not kept, or more often, were not readily available. As a result, some statistics for SHS are not as complete as

the corresponding ones for Daytop and ARC are.

All of the TC's studied were extremely cooperative in this study. Individual staff members and clients often went out of their way to facilitate the interviews. Many times people interrupted their busy schedules to provide answers to various questions. Individuals frequently used their break time or lunch time to be interviewed. Staff members took great pains to find clients or other staff members who were needed for additional interviews. All this was done in an atmosphere of friendliness and cooperation.

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[1]David Sills, The Volunteers: Means and Ends in a National Organization (Glencoe, Illinois: The Free Press, 1957), p. 70.

[2]Ibid.

[3]Peter Blau, Bureaucracy in Modern Society (New York: Random House, 1956).

[4]Charles Perrow, "Organizational Goals," in Organizational Systems, ed. Azumi and Hoge (Boston, Massachusetts: D. C. Heath and Co., 1972), p. 443.

[5]For an analysis of this concept, see Erving Goffman, Asylums (New York: Doubleday Anchor, 1961).

CHAPTER II

A THEORETICAL PERSPECTIVE

Organizations

Organizations are social collectivities that differ from groups, institutions and societies.[1] One obvious difference between the former and the latter is size. Groups are smaller than organizations, both of which are found in institutions, which in turn are located in societies. Yet, what exactly distinguishes organizations from other collectivities is not always easy to define. One view of organizations holds that "they are structured bodies designed to achieve specific objectives that are part of some larger institutional process."[2] This definition serves to distinguish organizations, which are formed to achieve specific objectives, from friendship groups, which are formed for the enjoyment of their members. It also distinguishes between organizations, and institutions and societies, which are often too large to be as effectively planned.

One approach to the study of organizations is to compare them on the basis of certain criteria. The result of this method of study is that typologies of organ-

izations are created. Two widely-used typologies are those created by Blau and Scott, and Etzioni. The Blau-Scott typology separates organizations on the basis of the criterion "who benefits?" (that is, the membership, the owners, the client group, or the members of society). Finally, Etzioni classifies organizations in terms of power and control. These typologies facilitate the study of organizations by permitting a comparison of different organizations with reference to a common variable.

Total Institutions

The total institution is a form of organization whose structure and functioning can partially be explained through the use of a typology. According to the Blau-Scott model, juvenile detention centers and state psychiatric hospitals are service organizations, where the clients receive the primary benefit; while state penal institutions and state hospitals are commonweal organizations, with the public being the prime beneficiaries. Using Etzioni's model, we see that juvenile detention centers and state penal institutions are considered predominantly coercive structures, while state psychiatric hospitals and delinquent reformatories are predominantly normative organizations.[3] The two typologies might differ as to their

particular classification of organizations, but the basis for differentiating between total institutions is the same. One variable is used to describe the major characteristic of an organization. In the case of total institutions, one distinguishing feature is whether the clients are there for their own good or for the good of society in general (i.e., whether the clients are there voluntarily or involuntarily).

The typologies point out key differences between total institutions, but they do not describe the characteristics that these organizations have in common. Erving Goffman popularized the concept of "total institution" in his exploration of certain types of behavior endemic to mental hospitals, but pointed out that the term can be applied to a number of other organizations that have similar traits. Among such organizations are homes for the aged, tuberculosis sanitaria, penitentiaries, concentration camps, army barracks, and monasteries. Goffman describes a total institution in the following words:

> First, all aspects of life are conducted in the same place and under the same single authority. Second, each phase of the member's daily activity is carried on in the immediate company of a large batch of others, all of whom are treated alike and required to do the same thing together. Third, all phases of the day's activities are tightly

> scheduled with one activity leading at a prearranged time into the next, the whole sequence of activities being imposed from above by a system of explicit formal rulings and a body of officials. Finally, the various informal activities are brought together into a single rational plan purportedly designed to fulfill the official aims of the institution.[4]

Perhaps most important in this description is the fact that a total institution is a "people processing" organization, utilizing bureaucratic procedures to accomplish its task. Since it is concerned with the most efficient method of dealing with its "raw material," people must be handled in "blocks," not as individuals. This is what makes the total institution quite different from the larger society, and it is the single factor that most affects its individual members. As Gresham Sykes says in his study of a maximum security prison, "It is not the solitude that plagues the prisoner but life en masse."[5]

In addition to these aspects of total institutions, there are other characteristics that make them "different" from society. Goffman discusses the "mortification of self" that occurs in most total institutions. This is the process whereby the "old self" is broken down and destroyed. It includes physical isolation from the rest of society; a loss of previous identity (hair, clothes, name, etc.); the overlapping of roles where there previously

was a differentiation of roles; a loss of the "private" part of the individual's life; the performance of humiliating tasks, etc. Once the old self has been "mortified," then it remains for the institution to build a new self. This process requires the inmate to behave in accordance with a system of rewards and punishments. Rewards are held out in exchange for obedience to the staff, and punishments, often severe, are the result of disobedience. Goffman feels that in order to understand behavior within the total institution one must take into account the mortification of self, the emergence of the new self, and the inmate social system that results from these processes.[6]

In a discussion of the total institution, a question that often comes up concerns the degree to which the stated or formal goals of the organization differ from the unstated or informal ones. As Goffman and others have observed,[7] treatment in mental hospitals is often secondary to the main objective of control. The same can be said for prisons and other total institutions that deal with "socially unfit" individuals. While it is important to distinguish between these two goals, it is also necessary to realize that one can have an effect upon the other. As Donald Cressey points out, an organization's official,

formal policy has important effects even on achievement of unstated, informal goals.[8] Thus, it becomes imperative, in an analysis of total institutions, to differentiate between the formal and informal goals, and also to look at the relationships between the two.

Erving Goffman's work points out the similarities between various types of total institutions, and also distinguishes these organizational forms from the larger society. The Blau-Scott and Etzioni typologies serve to classify organizations along certain variables, and in so doing, provide a basis for differentiating between total institutions. Likewise, approaches that point out the similarities and differences between therapeutic communities (a type of total institution) will be useful in the study of this form of organization.

Therapeutic Communities

The therapeutic community is a type of total institution that has its origins in a mental hospital situation. From this traditional "total institutionalized" beginning, the TC has developed into an organization that is quite varied in structure and quite unique. Yet the TC retains many of the characteristics of "older" total institutions--a rigid bureaucracy, a system of rewards and punishments,

a desire to "resocialize" the individual members, etc. Consequently, while the "modern" TC bears a strong resemblance to its precursor, it has expanded the original structure considerably.

The therapeutic community today is primarily a treatment modality for drug addiction, and drug-related problems. Traditionally, the TC was a drug-free approach, that tried to get addicts to help themselves. The individual's drug abuse was considered a product of errors in his socialization, and it was up to the TC to resocialize the person into a productive member of society.[9] While still adhering to its basic principles, the TC has varied its method and scope of treatment. Alcoholism and family problems are often treated along with addiction problems. Methadone to abstinence programs are incorporated into the TC modality. Part-time treatment, non-residential programs, and "preventive treatment" are all "non-traditional" aspects of the modern TC. Thus the TC, in some respects, does not resemble the classic total institution.

One important change that has occurred concerns the environment surrounding the TC. In the past, the TC organization depended heavily upon individuals who voluntarily entered treatment for its main population. Over the years,

this situation has changed. Now, more and more clients are being remanded to the TC in lieu of a prison sentence. This has changed the motivation of the individual resident, and the structure and functioning of the organization. In this respect, the TC is similar to a mental hospital, where some individuals enter voluntarily and others are there involuntarily. Yet one key difference is that the TC seems to be changing from a mainly "volunteer organization" to one that has mostly involuntary clients.

One result of this change in the environment of the TC's is that there is competition among the different organizations for clients. As will be brought out later, this competition tends to increase as the supply of clients decreases. Therefore, the TC's today have individual treatment programs that are designed to attract distinct types of clients. These differences between the organizations lead to the formation of sub-types of TC's.

A Typology of TC's

Therapeutic communities may be grouped according to their positions on four major variables: organizational goals, discipline, staff composition, and length of treatment cycle.[10] The fact that an organization's position on one variable does not always correlate with its position

on another variable precludes the formation of "pure types." Yet the variations among these four dimensions do help to differentiate between general subtypes of TC's.[11]

If one considers the various goals of TC's, programs differ in a number of directions. There are some programs that try to change the personality of the individual because they feel that the resident has psychological problems. Other programs aim at educational and vocational rehabilitation for the client, since this is what they feel will overcome his or her addiction. Still other programs are community-based, and try to involve their members in civic affairs as a method of treatment. Thus, in terms of goals, there are at least these three major positions that various therapeutic communities espouse.

Concerning discipline, there are also variations in organizational philosophies. At one end of the continuum are relatively demanding or "high-discipline" programs, while at the other end are less demanding or "low-discipline" programs. The former programs feel that the addict must be placed in a rigidly disciplined environment to make up for his lack of discipline in his prior lifestyle. These TC's regard the addict's adaptation to a disciplined situation as a signal of healthy resocialization. When

this resocialization is complete, the addict will be ready to reenter society, where discipline is expected of its members. The "low-discipline" programs place a greater emphasis on other aspects of TC life, and view the "high-discipline" programs as childish. These TC's feel that the addict is an adult, and consequently should not be exposed to childish forms of punishment.

Programs vary in terms of staff composition. Some favor a basically professional approach, while others believe in an ex-addict staff. The TC's that have an ex-addict staff feel that only a person who has been through the addiction process can treat another addict. They believe that a "gut-level" understanding of the problem is more useful than an understanding gained through education. The TC's that have a professional staff often employ ex-addicts as well. These programs think that while the ex-addicts are often useful in establishing rapport with the clients, professional insight is also needed to deal with the problems of addiction.

Finally, in the area of length of the treatment cycle, there are a number of plans, ranging from a "short" period to a "long" one. (A relatively long treatment cycle might be eighteen months or more, while a relatively

short cycle might be six months.) Here, the variation seems to be over the amount of resocialization needed by the clients. Programs that emphasize major character restructuring are likely to require a greater amount of time to accomplish their task. Programs that are interested in vocational and educational skills, or those that are interested in community involvement, often need less time to treat their clients. Therefore, the goals of the program have an influence on the length of the treatment cycle.

While most typologies are limited, the one outlined above does help explain the situation facing the TC today (see Figure 1). This typology indicates that the TC has evolved from a monolithic organization to the present "multi-modality network".[12] It also suggests that innovations in the basic structure of the TC were made partly in response to the new environment. Thus it is that we find the rigid discipline, long-term treatment of the traditional TC giving way to less demanding, short-term treatment facilities. These latter programs, feeling that the "new" client population was not going to do well in the more traditional treatment programs, initiated the move for change. One result of this diversification of

Figure 1

A THERAPEUTIC COMMUNITY TYPOLOGY

		Staff: Professional		Staff: Ex-Addict	
		High Discipline	Low Discipline	High Discipline	Low Discipline
Personality Change	Long Duration		X	Daytop	X
	Short Duration	X		X	
Vocational Rehabilitation	Long Duration		X		X
	Short Duration	X	SHS	X	
Community Involvement	Long Duration		X		X
	Short Duration	X		X	ARC

(X = non-viable cell)

communities is increased competition. As one group of investigators states:

> It is possible that the growing competition for clients among therapeutic communities will lead to the humanistic programs getting more clients at the expense of the programs in which discipline is more salient.[13]

Implications of the TC Typology

The possible directions that TC development can take are shown in Figure 1. Of the twenty-four potential combinations of TC characteristics, only some are viable organizational structures. So, for example, high-discipline, short-duration programs are unlikely to occur, as are low-discipline, long-duration ones. Also, any program aiming at personality change is not going to be of a short duration. Furthermore, programs that have community involvement as a goal are often short in duration.

The tendency, therefore, is for a number of TC's to fall into the same cell of the typology. One grouping of programs has the goal of personality change, is high-discipline, and long-duration, and can have either a professional or an ex-addict staff. Daytop Village, Odyssey House, and Phoenix House are examples of this type. At the other end of the typology are the TC's that aim at community involvement, are low-discipline and short-dura-

tion, and have either a professional or an ex-addict staff. Addicts' Rehabilitation Center, NARCO, and Infinity House are such programs. In between these two extemes are found the programs that have vocational rehabilitation as a goal. These TC's can be either low-discipline and short-duration or high-discipline and long-duration in nature, and can have either a professional or an ex-addict staff. Samaritan Halfway House is a TC that falls into one of these middle-range positions.

Not all of the TC's fit neatly into one cell or another of the typology. Odyssey House, for example, has a always had a mixture of professional and ex-addict staff members, and thus could really be placed in either of two cells. The same statement can be made for a number of other TC's, concerning one or more of the variables used in the typology. Thus, placing a TC in a particular category is based on the major distinguishing features of that organization. Some discrepancy might arise as to the exact cell chosen; but the general area of the typology would probably be agreed upon.

Daytop Village, one of the three TC's selected for study, is a clear example of a high-discipline, long duration program that aims at a major personality change in

its residents. It started out with mainly an ex-addict staff, and has gradually added some professional personnel to it. Daytop's large size, and its reputation as one of the oldest TC's in New York City, insulate it from minor fluctuations in client admissions. Yet Daytop is conscious of trends in drug treatment. The addition of more professional staff is one response to the increasingly complex problems of the new client population. One would expect this trend to continue in the future, especially if Daytop experiences a drop in admissions. If this TC maintains the existing goal of personality change, discipline will have to remain relatively high and the treatment cycle will have to stay relatively long. Yet some reductions in both areas would make the program more appealing to new clients. To the extent that Daytop Village experiences problems in attracting clients, the organization will lessen discipline, shorten the treatment cycle, and add more professional staff members.

Addicts Rehabilitation Center (ARC), the second TC selected for study, is at the opposite end of the typology from Daytop. It is a low-discipline, short-duration program that aims at community involvement for its members. It is staffed almost entirely by ex-addicts. ARC cannot

practically lessen its discipline or shorten the treatment cycle, as both are at a minimum right now. If community involvement is going to continue as the organization's goal, then the only change likely to occur is in the staff composition. And a change here is not that likely, since the leadership of the community is entirely ex-addict. ARC's response to the new environment will probably not be a change in its position in the typology; rather, it will broaden the scope of treatment within the existing framework of treatment procedures and organizational goals.

Samaritan Halfway House (SHS) falls somewhere in-between ARC and Daytop on the typology. It is a medium-discipline, medium duration program that has vocational rehabilitation and personality change as its goals. The staff is a mixture of professional and ex-addict members. This description of SHS does not clearly place it in any one cell. Yet the trend established over the last few years indicates that the TC is moving from a high-discipline, long-duration orientation to a lower-discipline, shorter-duration one. Also, while personality change was a major emphasis in the past, vocational rehabilitation is being given more attention now. Finally, SHS has been

moving steadily from an ex-addict staff to a more professional one, over the recent past. The response of SHS to the new environment can take a number of directions. Since it is a relatively small TC, and hence more vulnerable to client fluctuations, SHS will probably continue its development towards a lower-discipline, shorter-term treatment that is more professionally oriented. It is possible that the organizational goals might be expanded to include aspects of personality change and community involvement, in addition to more extensive vocational rehabilitation.

All three of the therapeutic communities selected for study are conscious of the new environment facing them. They realize that their clients are aware of the alternatives to TC treatment. Consequently, a competition for clients results, and this is forcing the TC's to make their respective programs more appealing. Reducing discipline and shortening the treatment cycle are two ways in which to make the programs more attractive. Broadening the scope of treatment to include a wider variety of mental health problems is another way to insure an adequate client population. The direction each TC will move in depends upon what viable alternatives are open to it. The typology described above attempts to show some of the possible opportunities for TC change.

Summary

In spite of the differences between the various types of TC's, most of their basic ideas and practices remain consistent. Resocialization is a primary focus in most organizations. This area of treatment faces the problem of reintegrating the client into the outside world. Toward this end, the TC seeks to provide the individual residents with skills, tasks, and role models (via TC staff members). Education, in the form of training for a high school equivalency diploma, is present in most agencies. Training in personal hygiene and counseling in general job-seeking techniques are other forms of resocialization that are often found in the TC's. Other practices are common throughout most organizations. Ceremonial observances of "benchmarks" (serving as rites of passage) are prevalent in many residencies. Disciplinary procedures, while varying in degree, are present universally. Group therapy, where an individual's feelings and ideas are ventilated, and where his behavior is scrutinized, is central to the treatment process of all TC's. The specific topic of the group might vary considerably, but the purpose is always to help the individual deal with his own and the group's behavior.[14] All of these functions of the TC are found in the various subtypes of the organization outlined above.

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[1]Talcott Parsons, The Social System (Glencoe, Illinois: The Free Press, 1951).

[2]K. Azumi and J. Hoge, Organizational Systems (Boston, Massachusetts: D. C. Heath and Co., 1974).

[3]The Blau-Scott and Etzioni typologies are compared in Richard H. Hall, J. Eugene Haas, and Norman J. Johnson, "An Examination of the Blau-Scott and Etzioni Typologies," in Richard H. Hall, Organizations: Structure and Process (Englewood Cliffs, New Jersey: Prentice-Hall, 1972), p. 49.

[4]Erving Goffman, Asylums (Garden City, New York: Doubleday & Co., Inc., 1961), p. 6.

[5]Gresham Sykes, The Society of Captives (Princeton: Princeton University Press, 1958), p. 4.

[6]See Goffman, op.cit., Chapter 1.

[7]For further discussion of this topic, see Thomas Szasz, Law, Liberty and Psychiatry (New York: Collier Books, 1963).

[8]See Donald Cressey, "Achievement of an Unstated Organizational Goal," in Complex Organizations: A Sociological Reader, ed. Amitai Etzioni (New York: Holt, Rinehart and Winston, 1961).

[9]See Chapter III for a complete discussion of the functioning of the TC.

[10]Systems Sciences Inc., "A Comparative Analysis of Twenty-Four Therapeutic Communities in New York City," funded by the Addiction Services Agency of New York City, 1973, p. 17.

[11]This typology is based on a comparative study of 24 TC's in New York City. Because of the quantity and diversity of TC's found in New York City, this typology should prove valid for the United States in general.

[12]System Sciences Inc., p. 18.

[13]Ibid., p. 36.

[14]Ibid., pp. 29-42.

CHAPTER III

ORIGINS OF THE THERAPEUTIC COMMUNITY

Maxwell Jones

In order to gain a more accurate view of the present situation of the therapeutic community, it is important to look at a history of this type of organization. This history covers a period of only three decades. Yet within this period of time, the TC has evolved from an experimental treatment process for mental illness to a widely used treatment for drug addiction. In this evolution, certain organizational changes have occurred. The basic ideas, however, have remained the same. This chapter describes the beginnings of the TC movement and the major ideologies that form its basis. Individual examples will illustrate the stages in the history of the TC.

The first therapeutic community was established in April, 1947, in England. At that time, a British psychiatrist, Maxwell Jones, was working in the Industrial Neurosis Unit at Belmont Hospital. The patients were "disabled persons"--i.e., persons who, on account of injury, disease (physically or psychologically determined), or congenital

deformity, were substantially handicapped in obtaining or keeping employment. The main function of the hospital was to study the problem of the chronic unemployed neurotic. Jones writes,

> Our population comprises in the main chronic neurotics and character disorders of a kind usually considered unsuitable for treatment by psychotherapy or physical methods. They are difficult to classify and include inadequate and aggressive personalities, schizoid personalities, early schizophrenics, various drug addictions, sexual perversions and the chronic forms of psychoneuroses.[1]

The idea Jones initiated was to gain a close association between staff and patients, and to get the patients to act as therapists for one another. Both groups were to share a set of norms that emphasize joint action to solve patients' problems.

> In a therapeutic community the whole of a patient's time spent in the hospital is thought of as treatment. Treatment to be effective will not only involve the handling of the individual's neurotic problems, but also an awareness of the fresh problems which the fact of being in a neurosis hospital will create for the patient, and what aspects of the social situation can be used to aid treatment. The patient, the social milieu in which he lives and works, and the hospital community of which he becomes temporarily a member are all important and interact on each other.[2]

Jones felt that by sharing problems with the group, patients would begin to take on the view that the group

has of them.

> By sharing a problem requiring a decision with the group--including the staff--patients are afforded the opportunity to play a responsible role and achieve some degree of group identity.[3]

Within the therapeutic community, decision-making opportunities afforded the patients may not be popular. It is easier for most people to blame authority figures for their problems than to accept the responsibility themselves. Thus, the community must delegate the authority from a central administration point to the problem area itself. Crucial to this is the position of the leader. Maxwell Jones mentions the idea of the medical director as leader ("task leader") and his deputy as "popular leader." He feels that the deputy should be able to use disaffection in the group to create a learning situation, rather than exploit it for his own ends.

> It would seem . . . that the danger in any hospital community arises if the patient is not allowed to develop his optimal potential as an individual or a leader; and this dimension of the role of the patient in hospital has generally been neglected.[4]

The leader should be able to create problem-solving situations where other individuals can display leadership qualities. Insofar as these leadership qualities are able to emerge, the therapeutic community is functioning well.

Feedback is basic to the therapeutic community. By

one patient's telling certain information about another patient, the whole group stands to benefit. Both the patients and the staff must be taught that feedback is indeed beneficial to the whole group. Tied in with this is the idea that free expression of feeling is necessary if social learning is to take place. Jones states that "to deny . . . the free expression of feeling is to limit the opportunity for social learning."[5] For him,

> social learning as practiced in a therapeutic community implies two-way communication motivated by some inner need or stress leading to the overt expression of feeling and involving cognitive processes and learning.[6]

Jones feels that one of the major difficulties in developing such a treatment setting is the presence of a well-established authority structure that is characteristic of most hospitals. Many people cannot adjust to the transition from an authority structure of a traditional nature to the type that is essential to the therapeutic community and its learning process.

> Some people can never get used to such a self-examination in a public setting, no matter how skillfully this is conducted. In fact, a large part of a hospital population, possibly the majority, finds this approach alien to their personalities. This fact sets a severe limitation of the possibility of developing therapeutic communities that involve all hospital personnel.[7]

Another problem Jones sees in the therapeutic com-

munity's ability to function involves its relationship to the society that exists outside the hospital.

> One great danger of a therapeutic culture developing within a hospital is that it may be too hospital-centered and tend to ignore the culture of the outside world. Any attempt to deviate too far from the norm of the society must inevitably lead to anxiety, misunderstanding, and rumor; it must damage the image and hence the usefulness of the hospital.[8]

Maxwell Jones' early work with the therapeutic community established certain basic principles that succeeding forms have followed. Group problem-solving, group responsibility, and leadership emerging from problem situations, are all concepts basic to the therapeutic community approach. Jones was also aware of the problems that might exist with this method of treatment. He realized that responsibility for decision-making might be opposed; that established authority structures are not easily changed; and that the world within the hospital does not always resemble the world outside it. These problems, together with the major innovative principles of Jones, are still part of the therapeutic community today. We will mention a number of Jones' ideas again, and we will see how the therapeutic community has evolved out of his original experiment.

Synanon

One of the first successful TC's in the United States is Synanon, founded in 1958 in California. Its founder, Chuck Dederich, borrowed heavily from the ideas of Alcoholics Anonymous, and applied these ideas to the treatment of drug addicts. But Synanon is quite different from A.A.

> Synanon emphasizes self-help, with a focus on individual self-reliance. This attitude reflects one of the major areas of contrast between Synanon and Alcoholics Anonymous. The latter builds upon man's reliance on a higher being. Synanon's emphasis is upon the individual's self-help and actualization.[9]

This follows the ideas developed by Maxwell Jones. In addition, Dederich conceives of the community as a type of family structure.

> The autocratic overtone of the family structure demands that the patients or members of the family perform tasks as part of the group. If a member is able to take direction in small tasks, such as helping in the preparation of meals, house cleaning, etc., regardless of his rebellion at being "told what to do," his activity seems to provide exercise of emotions of giving or creating which have lain dormant. As these emotional muscles strengthen, it seems that the resistance to cooperating with the group tends to dissipate. During this time a concerted effort is made by the significant figures of the family structure to implant spiritual concepts and values, which will result in self-reliance.[10]

The family structure tends to maximize group cohesion, and minimize the importance of the individual. This aspect is

further stressed throughout the various stages of the Synanon process.

One key element in the organization of Synanon (and of most other TC's) is the autocratic government, with the director as head. This is believed to be necessary because of the addict's undisciplined and impulsive past. The individual is made to follow orders from his "superiors" until he displays some sense of personal growth. The basis for the functioning of the autocracy seems to be the "charismatic authority" of Chuck Dederich.[11] His personality is responsible for the control he exerts over the members. As Yablonsky states:

> Because Synanon had no traditional or legal base at the outset, it depended heavily (and still does) on the qualities of Chuck's charismatic leadership. Chuck's charismatic capacity remains the basic element of leadership and power in Synanon.[12]

Yet as the organization develops, there is an increasing movement toward bureaucracy. This requires some authority to be delegated by Chuck. Ultimate power and control, however, still rest at the top.

The actual treatment process in Synanon depends heavily upon the autocratic structure of the organization. Beginning with the admission process, the newcomer is forced to admit that he is willing to try to conform to

the norms of the group, whose members will not tolerate any liking for drugs or drug addicts. "In the admission process, and throughout his residence, the addict discovers over and over again that the group to which he is submitting is antidrug, anticrime, and antialcohol."[13] After the addict is no longer on drugs, he is given a job commensurate with his ability at the time (e.g., washing dishes or mopping floors). "This is intended to give him a sense of security, satisfaction, and participation."[14] While traditional mental hospitals and prisons offer no way for the individual to rise from the position of "patient" or "inmate," Synanon presents the addict with an open stratification system. The individual can identify with the goals of the organization. It is also evident that "success" is possible, the evidence being that the administration consists of co-workers and colleagues. "Often for the first time in his /the ex-addict's/ experience, he begins to identify with a constructively oriented group of his peers."[15]

The entire Synanon experience is organized into a series of roles that represent degrees of competence. "As time of residence increases, responsibilities to the group in the forms of work and leadership, tend to increase."[16]

Advancement through the stages is not automatic. Some correlation between stage and length of residence exists, but ability to accept more diffuse roles is the prime criterion for higher status (see Figure 2).

In addition to the status hierarchy aspect of Synanon, the "synanon" process itself is an important part of the program. This is a kind of group psychotherapy in which all residents participate three times a week. These sessions, which may involve the weapons of ridicule, cross-examination, and hostile attack, seem to provide an emotional catharsis and seem to trigger an atmosphere of truthseeking, which is reflected in the social life of the family structure.[17] These sessions are closely related to "real life" problems which confront the member in the social system in which he resides. They also perform another important function. Due to their small size, they offer a primary group situation in face of Synanon's large growth in size and its consequent drift toward bureaucracy. Dederich, realizing this growth, anticipated change. In his words,

> The small "s" synanon is the contrived constructed primary-group formula for the maintenance of the secondary organization. The two put together produce the most effective type of human organization.[18]

FIGURE 2

DIVISION OF LABOR AND STRATIFICATION SYSTEM OF SYNANON

Graduates (Work and live outside)	Board of Directors (Policy-makers)
Stage III	
Assistant directors Attend school Business manager Department chiefs	Office manager Project directors Senior coordinators Work outside
Stage II	
Hustling crew Junior coordinators Kitchen crew staff	Nursery heads Office workers Service crew chief
Stage I-B	
Automobile crew Barber Electricity Housecleaning Kitchen help	Laundry Library Maintenance crew Plumbing Service crew
Stage I-AB	
Newcomers Sick, kicking addicts	Non-workers
Stage I-A	

The synanon sessions are one of the most innovative aspects of the Synanon treatment process. They are different from standard professional group therapy in a number of ways. First of all, the sessions are conducted by a group of peers, not a professional therapist. Secondly, the participants often reverse roles as "patient" and "therapist". Thirdly, everyone in the group is concerned with the development of each other member. This is because, ultimately, all individual growth is tied in with the organization's growth. Finally, the information presented in the group is usually something that is important and pertinent to all the members.[19] The basic belief that runs through all of the treatment is that people can help themselves without standard professional therapy. This was the idea that Synanon helped initiate for all TC's, and it has continued to be a major modality in many drug-free treatment programs.

The basic ideas of Synanon resemble closely the therapeutic community principles initiated by Maxwell Jones. "Staff" and "patients" work together in problem-solving tasks. Daily problems become the basis for learning experiences. Individuals are made very much aware of the group process they are a part of. They "internalize

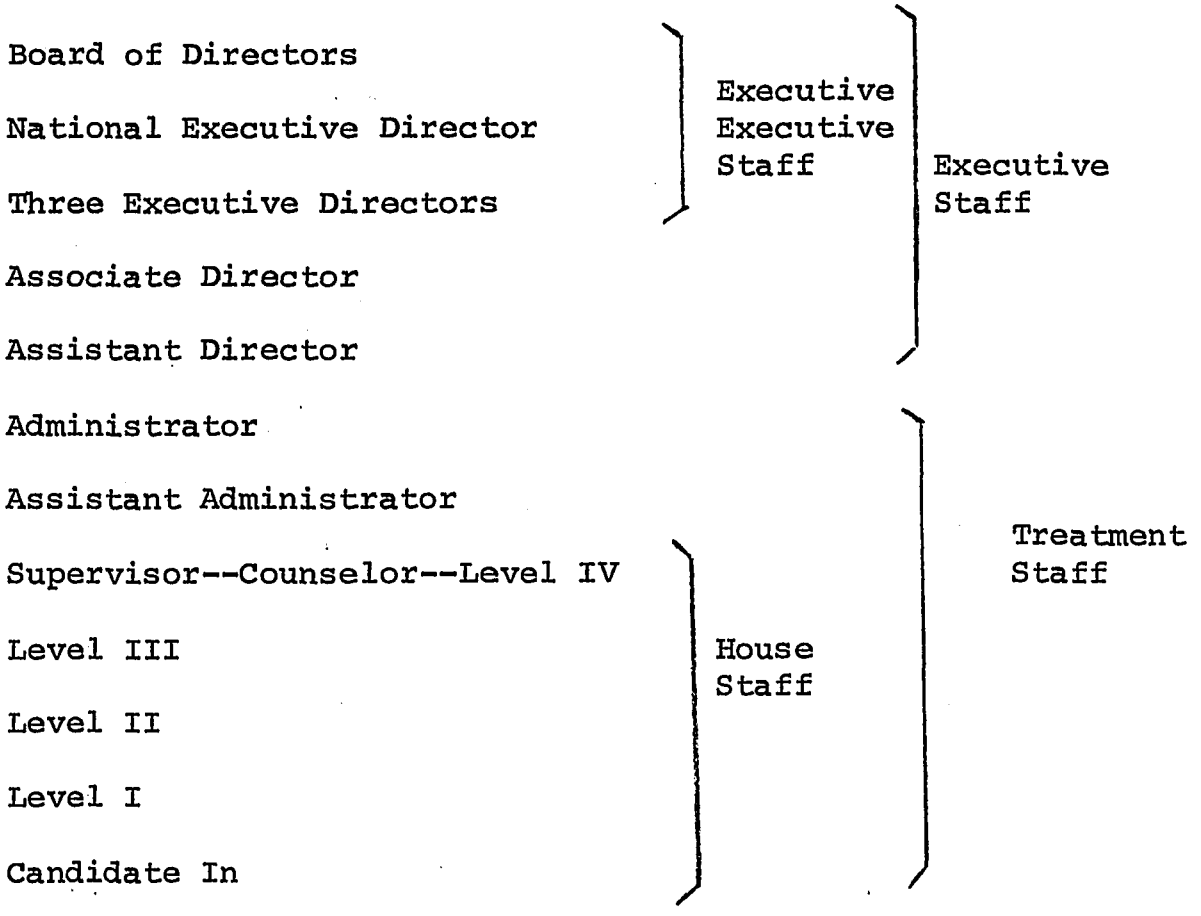
the expectations of others." They are made to demand truth from others and to give truth in return. Leadership and the assumption of responsibilities are both stressed. By applying the ideas of the therapeutic community to the treatment of drug addiction, Synanon started a movement that was to grow tremendously in the United States. With each new TC that evolved, some addition or change to the treatment modality took place. Yet the basic structure has remained the same.

Odyssey House

One concept Synanon believed in was the use of "non-professional therapists." As was mentioned previously, this procedure was quite different from the traditional thinking of many mental hospitals, prisons, etc. But other TC's, following the early lead of Synanon, did not agree entirely with this approach. Odyssey House, started in New York City in 1966, is one such example. While it follows closely the tenets of Maxwell Jones and Chuck Dederich, it also conceives of itself as being distinct from Synanon and Synanon-type treatment programs. In such programs, according to Odyssey House's founder Dr. Judianne Densen-Gerber,

FIGURE 3

HIERARCHY OF ODYSSEY HOUSE STAFF*



*Prepared through interviews with staff members.

> The ex-addict and the ex-addict alone is believed capable of understanding the problems that an addict faces. Professionals and indeed all "squares" are rejected and considered valueless to the rehabilitation process. Non-users are looked down upon as having made compromises to their integrity with a corrupt world. Education and intellectual expertise are considered of limited value and "gut level" intuition reigns supreme. Psychodynamics are unimportant, and commitment to function is emphasized. Little if any encouragement is given to return to the corrupt society at large and most ex-addicts do remain within the confines of the sheltered community.[20]

Odyssey House breaks with this thinking, using the structure of Synanon together with the more traditional psychiatric thinking of Maxwell Jones.

Odyssey House introduces the use of professional and ex-addict staff together in treatment. The professional staff member is a college-trained individual, quite often with some graduate school experience, who has also gone through a training period at Odyssey House. His or her understanding of group dynamics as well as the understanding of the sociopathic personality of the addict makes the professional staff member a leader in treatment. But due to the basic mistrust of the street addict towards "squares," an ex-addict staff member is needed to complement the professional. The ex-addict staff member, familiar with the process of group therapy, "bridges" the gap between the professional and the street addict. This

concept of "bridging" is frequently used by Odyssey House people, and it is looked upon as a key aspect of the entire treatment process.

Yet aside from this innovative approach used by Odyssey House, the organization itself is quite similar to Synanon-type TC's. Encounters, corresponding to the small "s" synanons, are the therapy sessions that are the major method of treatment. Rules are made explicit, and they are strictly enforced by senior members. As with Synanon, there are no guards, no bars, and no locks on the doors, so an individual may leave any time he wishes to. Peer pressure is the major force which is relied upon to keep the individual in the TC. Positive social interaction is rewarded through evaluations by other residents and staff. These evaluations partially determine upward mobility. And as with Synanon, upward mobility is the goal ingrained in each resident. As he or she moves through each level of the organization, the responsibilities increase. More rewards are earned, and the resident learns to accept authority by being an authority figure to others. By the final stage of the program (Level IV), the individual has begun his re-integration into society (see Figure 3).

Further similarities between Odyssey House and Syn-

anon might be mentioned. In both cases, a charismatic leader is at the head of the organization, and this principle follows closely the example of Maxwell Jones, who placed a great deal of emphasis upon the leader of the TC. Also, both Odyssey House and Synanon are self-help communities, and both stress problem-solving as a part of the therapy. But beyond these and other parallels, it is important to note that Odyssey House, and Odyssey House-type TC's represent a stage in the historical development of the organization in this country. Just as Maxwell Jones' basic idea was applied to a pragmatic situation by Synanon, so too did Odyssey House modify the Synanon approach to fit its own needs. Other TC's that emerged in the 1960's have borrowed heavily from Synanon-type or Odyssey House-type programs, or have used some variation of their basic structure.

Phoenix House

Another example of a successful TC that followed the Synanon example is Phoenix House. This organization, now the largest in New York City, adheres closely to the basic structure set up by Chuck Dederich in his pioneering effort. Phoenix House is similar to Synanon, Odyssey House, and most other TC's, in that it is a form of total

institution where coercion has been replaced with voluntarism. The individual can enter or leave without having any physical barriers placed in his path. In this TC, norms are enforced by peer pressure. An elaborate system of rewards and punishments exists. Upward mobility through the phases of the treatment program is encouraged. (The three stages of the treatment program--induction and detoxification, treatment, and re-entry--correspond closely to the stages of Synanon and Odyssey House.) In Phoenix House, "learning" is downgraded ("learning" here meaning formal education). This is in part due to the anti-professional orientation of this addict-run TC. As with Synanon, the "experience" of the individual is relied upon for treatment situations. And as with all TC's, the overall goal of Phoenix House is the creation of an alternative social system for the ex-addict.[21]

We can see in the example of Phoenix House the ways in which the basic ideas of Maxwell Jones and Chuck Dederich have been carried down to the present day. The structures of the TC's mentioned so far, as well as the structures of the organizations to be discussed in future chapters, all rely heavily upon the model of Synanon. Some major innovative practices were implemented, as the

use of "bridging" in Odyssey House shows. But in other cases such as Phoenix House, the original views of a non-professional self-help community are preserved intact. This is not to deny that many other changes in specific TC functioning have occurred. As we shall see shortly, the growth of the therapeutic community movement in the 1960's brought many new practices into existence. But it is clear that the basic structure and functioning of the organization has remained consistent, at least in the major therapeutic communities. The single factor that has caused the most recent, and perhaps the most dramatic, change is the new environment in which the TC finds itself. This will be discussed in the next chapter.

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[1]Maxwell Jones, The Therapeutic Community (New York: Basic Books, 1953), pp. 25-26.

[2]Ibid., p. 53.

[3]Maxwell Jones, Beyond the Therapeutic Community New Haven: Yale University Press, 1968), p. 10.

[4]Ibid., p. 45.

[5]Ibid., p. 71.

[6]Ibid., p. 69.

[7]Ibid., p. 94.

[8]Ibid., p. 19.

[9]L. Yablonsky, Synanon: The Tunnel Back (Baltimore, Maryland: Penguin Books, 1965), p. 88.

[10]L. Yablonsky and Chuck Dederich, "Synanon: An Analysis of Some Dimensions of the Social Structure of an Anti-Addiction Society," in Narcotics, ed. Wilner and Kassebaum (New York: McGraw-Hill, 1965), p. 194.

[11]For the classic discussion of charismatic authority, see Max Weber, "The Sociology of Charismatic Authority," in From Max Weber, ed. H. Gerth and C. W. Mills (New York: Oxford University Press, 1946).

[12]Yablonsky, p. 82.

[13]Volkman and D. Cressey, "Differential Association and the Rehabilitation of Drug Addicts," in Narcotic Addiction, ed. O'Donnell and Ball (New York: Harper and Row, 1966), p. 216.

[14]Yablonsky and Dederich, p. 200.

[15]Ibid., p. 206.

[16]Volkman and Cressey, p. 225.

[17]Yablonsky and Dederich, p. 194.

[18]Ibid., pp. 208-209.

[19]Yablonsky, pp. 151-152.

[20]Murphy and Densen-Gerber, "Therapeutic Community Treatment of Addiction," Odyssey House Publication, p. 2.

[21]See Nash, "The Sociology of Phoenix House--A Therapeutic Community for the Resocialization of Narcotic Addicts," in Phoenix House: Studies in a Therapeutic Community (1968-1973), ed. G. DeLein (New York: MSS Information Corporation, 1974).

CHAPTER IV

THE NEW ENVIRONMENT

The Present Situation

Throughout the 1960's, the growth of the therapeutic community was tied in closely with increasing public concern over drug abuse in the United States. As more money was allocated for the treatment and prevention of this illness, TC's began to proliferate. The present result is that there are now over 500 TC's in this country, with 62 communities serving 5,000 clients in New York City alone.[1] The cost of these and other programs to control drug abuse is staggering. In fiscal 1972, the federal government spent about $417,601,000 on drug-abuse activities. This sum included $125,822,000 for law enforcement, $196,139,000 for research, and $50,422,000 for education, prevention and training.[2] This does not include the expenditures of state and local governments, and of private agencies.

There are indications, however, that the money for treatment of drug abusers and consequently the growth of TC's may be reduced sharply. As an article from the New York Times of Sunday, April 6, 1975 states:

> Seven of the nation's drug abuse treatment centers organized yesterday in a consortium to prepare for what they foresee as a coming epidemic in drug use in the face of a decreasing amount of federal money to cope with the treatment.[3]

Why, one may ask, is this reversal of TC development taking place?

There are a number of answers to this question. To begin with, there were indications in 1973 and early 1974 that heroin addiction had reached its peak and was receding. Heroin-related deaths, widely used as an index to measure the number of active heroin addicts in a given population,[4] had levelled off or dropped in most major cities. Furthermore, the purity of street level heroin dropped to a low of 2 to 3 percent in 1973.[5] But what at first appeared to be a decrease in drug usage, now seems to have been a shift in drug abuse. Recent findings indicate that methadone deaths increased in cities where heroin-related deaths went down. Also, the purity of street level heroin appears to be increasing, especially in New York and Washington, D.C. (where levels as high as 7 percent have been reported). This seems to be due to the heroin coming in from Mexico, and to the "new" heroin coming in from Turkey (this resulting from Turkey's re-institution of poppy cultivation in 1974).

In addition, the use of other drugs, notably cocaine, alcohol, and marijuana, appears to be on the rise.[6]

This shift in drug abuse was pointed out by a number of authorities. In studies by the National Institute on Drug Abuse, reported in a New York Times article, it was found that "drug experimentation and use among American teenagers is soaring, and is beginning at an earlier age than before."[7] Dr. Robert L. DuPont, director of the institute, stated that while this was true, only one out of ten heroin users studied was said to be addicted to the drug (thus refuting the idea that drug use inevitably leads to addiction). He went on to say that the studies' findings

> led him to conclude that drug use and abuse was generational, that is, multiple drug use, popularized in the late nineteen-sixties, was resulting in a "contagious phenomenon" among young people, who tend to use drugs more than adults.[8]

Another authority on drug abuse, Dr. Judianne Densen-Gerber, calls attention to a geographical change in the pattern of addiction. In a New York Daily News article, she states that "New York was in the midst of a major heroin epidemic at a time when resistance is at its lowest."[9] Dr. Densen-Gerber goes on to say that

> the federal government has used statistics that show that the addict population has decreased on the East Coast; but the truth is that heroin addiction just shifted to California and then the Southwest.[10]

She warned that if New York once again became the distribution market, addiction in the city would skyrocket.[11]

The impact of this new drug "scene" on the TC was specified in a report for the City of New York's Addiction Services Agency, prepared in 1973, by System Sciences, Inc. The investigators state that any understanding of the TC today must take into consideration the environment in which the organization finds itself. They feel that the major changes which have occurred in this environment are as follows:

> The shift over the last decade from heroin as the primary drug of choice to polydependence, or "drug succotash;" the emergence of a substantial number of methadone addicts and the seemingly easy availability of illegal "street" methadone; the ready availability of ambulatory detoxification; the very large number of drug abusers who are referred for treatment by the criminal justice system; the ready availability of methadone maintenance programs; competition for clients among treatment modalities.[12]

These observations, together with the aforementioned ideas, indicate that the situation facing the TC's in the 1970's is quite different from that of the 1960's. These treatment agencies have changed in response to the changing pattern of drug abuse. Exactly how great this transform-

ation has been can be determined by looking at the drug environment of the 1960's.

The Past Situation

One way of gaining an accurate view of the drug environment facing the TC's in the 1960's is to look at the addicts entering treatment at that time. The ages, drug-use patterns, referral sources, and other characteristics of this population are reasonably indicative of the overall drug scene of this period. By comparing this client population with the present one, a valid contrast between the two populations, and hence the two environments, is gained.

A representative sample of the New York City Phoenix House program, interviewed in the summer of 1968, tells one something about the addict population of that time. Eighty-four percent of the sample were men and 16 percent were women. Thirty-two percent were 20 and under, 24 percent were between 21 and 26, and 44 percent were over 26. The median age was 24.5. Forty-five percent of the sample were black, 34 percent Puerto Rican, and 20 percent were white. Men and women had about the same age and ethnic breakdowns, and the various ethnic groups had similar age breakdowns. While all of the women were vol-

unteers, 40 percent of the 132 men in the sample were criminal commitments.[13]

Concerning the 132 males in the sample, all of them were heroin users. Seventy-five percent considered themselves addicted, with most of the remaining 25 percent feeling they were in danger of becoming addicted. The family backgrounds of these men tended to be troubled or unstable, with broken homes, alcohol problems, and financial problems quite prevalent. Furthermore, the men in the sample had extensive criminal histories. Eighty-three percent had been arrested at least once for non-drug related activities and 76 percent for drug-related crimes.[14]

> Fifty-two percent had been arrested at least once prior to heroin use. Seventy-five percent had been in jail or reform school, and of these 61% had been there four or more times prior to their present sentence. Seventy-two percent of those who had been arrested were first arrested at the age of 18 or younger. The most common criminal activities engaged in during heroin use were selling drugs and stealing.[15]

Interviews with 1,151 Phoenix House residents conducted between July 15, 1970 and July 15, 1971, show only slight changes in population demographies from the 1968 findings. For the 1970-71 period, the Phoenix population was nearly one-half black, one-third white, and about one-fifth Puerto-Rican. Males outnumbered females by about

three to one. The mean age of the residents was 23.2, and the median age was 21.1. Almost half of the Phoenix population came from broken homes, and 30 percent stated that their families had been on welfare at some time.[16]

Additional findings of the 1970-71 study confirm certain trends established in the earlier research.

> The mean age of first addiction (almost always heroin) was 18. More than 62% were confirmed addicts, averaging around four years of addiction. Although different drugs were tried and used, heroin was the drug of choice. Thus, despite increased multiplicity of drug abuse, the Phoenix program is clearly serving a young population whose chief difficulty is lengthy heroin addiction.[17]

Furthermore, there is still a high correlation between drugs and crime. Yet while over three-fourths of the population supported their habit through illegal means, a considerable number of individuals had engaged in criminal activity prior to chronic drug use. This leads one to conclude that "the association between crime and addiction is best understood when both are viewed as correlated anti-social expressions of underlying cultural and psychological disorder."[18]

The two studies point out a number of important factors concerning drug use in the 1960's. One is the declining age of addicts entering treatment (and possibly of the general addict population). In the 1968 Phoenix

program, the median age was 24.5; yet by 1970, the median age had dropped to 21.1. Secondly, more females seem to be entering treatment, confirming the belief that addiction is not just a male phenomenon. Furthermore, in this period, long-term heroin addiction continues to be the major drug problem of most of the using individuals. More multiple drug use appears to be a trend, but heroin is still the main drug of choice. Also, criminal activity is commonplace among the addict population, as is a background of a troubled home life. Both of these problems seem to be indigenous to the group of people that eventually enter into an addiction lifestyle. Thus, what existed in the late 1960's, as judged from these Phoenix House studies, was a population of long-term heroin users, with criminal histories and family problems, that was decreasing in age.

These trends are supported by findings of another TC, Odyssey House of New York City. In the summer of 1969, Odyssey House was being pressured by various agencies to treat intravenous heroin addicts under the age of sixteen. Proof of the need for a teenage treatment program was provided by the New York City Medical Examiner's office, which reported 224 teenage deaths in 1966. Yet

in 1969, there were no treatment facilities for addicted youngsters under 16.[19] Odyssey House thus became the first TC to set up a separate adolescent treatment unit.

Statistics from the adolescent treatment unit show that the average age of the addicted population was declining. Of the 840 children treated by 1970, 74 percent were males and 26 percent females. Forty-three percent were black, 26 percent white, and 30 percent Puerto Rican. Heroin was the primary drug used by 95 percent of the residents, yet 85 percent indicated that they used other drugs at the same time. Each resident has used drugs for an average of 2.8 years, and the average age of onset of usage was 13.5 years. Finally, 91 percent of the residents stated that they utilized illegal means to finance their habit.[20]

It must be emphasized that these population demographics are for individuals entering into a TC situation. Therefore, while being indicative of certain drug use patterns, they may not be representative of the entire population of drug users in New York City, or in the United States. But it must also be mentioned that in the 1960's, before the large-scale growth of methadone maintenance programs, drug-free treatment was a major modality used.

So the residents of the TC's in the 1960's were at least representative of the addicts in treatment at the time, and possibly they provided a fairly good index of general drug-use trends.

If this is the case, then certain patterns of abuse seem to have been established in the 1960's. For one, the average age of the addicted population has been decreasing from the mid-1960's through the late 1960's and to the present. Also, the age of onset of addiction has been declining over the same period. In addition, multiple drug use seems to have become increasingly prevalent during the last decade, although heroin was still the main drug of abuse throughout the 1960's. But what intensified these changes was, among other things, the ascendancy of methadone maintenance treatment programs in the 1970's. As methadone became easily available both legally and illegally, methadone usage increased and the need for TC treatment decreased. This is the situation that the TC's are in presently.

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[1]Information supplied by the Addiction Services Agency of New York City.

[2]A Report to the Ford Foundation, Dealing with Drug Abuse (New York: Praeger Publishers, 1972), pp. 303-304.

[3]New York Times, Sunday, April 6, 1975.

[4]For a more complete discussion of drug-related deaths, see Michael M. Baden, "Medical Aspects of Drug Abuse," in New York Medicine, September 1968; and Michael M. Baden, "Investigation of Deaths of Persons Using Methadone," in Report to the Committee on Problems of Drug Dependence, 1970.

[5]New York Times, Sunday, February 9, 1975.

[6]Ibid.

[7]New York Times, October 2, 1975.

[8]Ibid.

[9]New York Daily News, December 22, 1975.

[10]Ibid.

[11]Ibid.

[12]System Sciences, Inc., "A Comparative Analysis of Twenty-Four Therapeutic Communities in New York City." Funded by the Addiction Services Agency of New York City, 1973, p. 11.

[13]Nash et al., "The Phoenix House Program," in Phoenix House: Studies in a Therapeutic Community (1968-1973), ed. George DeLeon (New York: MSS Information Corporation, 1974), p. 66.

[14]Ibid., p. 67.

[15]Ibid.

[16]George DeLeon et al., "Phoenix House: Who Comes for Treatment," in George DeLeon (ed.), op. cit., pp. 174-178.

[17]Ibid., p. 192.

[18]Ibid., p. 193.

[19]Judianne Densen-Gerber and J. Murphy, "The Changing Face of Addiction: An Adolescent Confrontation," prepared for presentation in the Scientific Program of the American Psychiatric Association's Annual Meeting, Washington, D.C., May 3-7, 1971, pp. 1-10.

[20]Ibid., pp. 11-12.

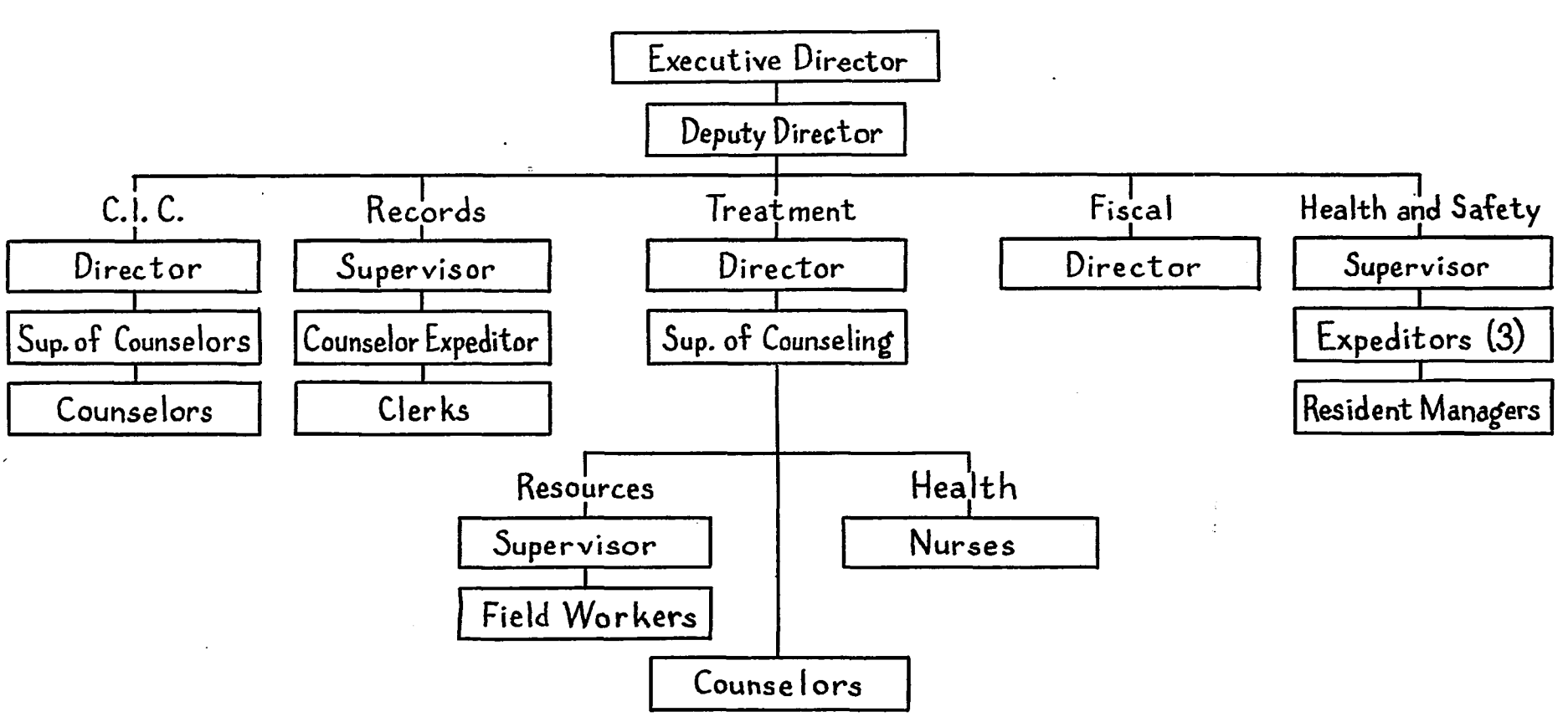
CHAPTER V

ADDICTS REHABILITATION CENTER

Structure

The Addicts Rehabilitation Center was founded in 1957 by the Manhattan Christian Reformed Church. It was designed as a "multi-service drug abuse rehabilitation program" to deal with the problems of addiction in the central Harlem area of New York City. Since then, ARC has evolved into an extensive treatment modality, consisting of two major program components. One part is the residential program or TC. This is a highly structured treatment process composed of four levels or stages. These are: probation, where there is intensive group counseling for six to nine months; pre-employment, designed to provide educational-vocational counseling; pre-re-entry, during which residents are either employed or enrolled in school or training programs; and re-entry, when an individual is given greater responsibility for himself and others. The other component, the Crisis Intervention Center (C.I.C.), provides a day-care program for non-residential members of the community. It helps people with drug-related problems and also assists individuals with social, legal, med-

Figure 4


ADDICTS REHABILITATION CENTER
Executive Director
Deputy Director
C.I.C.
Director
Sup. of Counselors
Counselors
Records
Supervisor
Counselor Expeditor
Clerks
Treatment
Director
Sup. of Counseling
Fiscal
Director
Health and Safety
Supervisor
Expeditors (3)
Resident Managers
Resources
Supervisor
Field Workers
Health
Nurses
Counselors

ical, and personal problems. Together, these two components serviced 1,364 people during the 1973-74 period. Of this number, 558 (41%) were residential members, and 806 (59%) were day-care participants.[1]

While this study focuses on the residential phase of ARC, it is important to keep in mind that the CIC is an essential part of the overall program as well. In addition to the responsibilities mentioned above, the CIC component (which is open 24 hours daily) acts as a referral unit for the TC. So, for example, a person might be referred to a local hospital for detoxification and then admitted to the residential phase afterwards. In other cases, detoxified former addicts might be sent from the CIC directly to the TC. Recently, people from the CIC component have been going into neighborhoods and hospitals to inform addicts and former users about the ARC program.

Trends in Alcohol Use

Discussions with staff members of the CIC clarified various trends in admissions. For one thing, an increasing number of people are coming to the CIC for help, and more of these individuals are alcohol abusers. One staff member stated that of a total of 15 new admissions a week,

about 5 (one-third) are alcohol users. The remainder are heroin addicts. These alcoholics tend to be males who have worked recently and who have a number of medical problems (e.g., kidney and liver diseases). It was also mentioned by a staff member that a good number of the alcoholics coming into CIC have used heroin at some time in their lives. Apparently these individuals went from heroin to alcohol as a primary drug of abuse. (In contrast to this present situation is the fact that one year ago only 10% of all new admissions were alcohol abusers.)

The CIC staff also said that a majority of the alcohol abusers came from hospital detoxification units. About 50% of all clients come from hospitals, with 30% being alcoholics and 20% being heroin addicts. The reason for the large number of hospital referrals is the recruitment program that was recently initiated by the CIC component. Staff members go to hospitals in New York City and tell detoxifying addicts and alcoholics about ARC. The success of this program is demonstrated by the fact that over the last year hospital referrals showed the greatest increase of all sources of client referral.

The evidence from the TC supports the preliminary findings of the CIC unit. More of the people entering

the TC are mainly or solely alcohol abusers. These clients tend to be older (in their thirties and older); they tend to be long-term users (20 years or more); they have non-criminal backgrounds (mainly public intoxication offenses); and they have many medical problems, including extreme nervousness. And, as mentioned before, the alcohol users have more extensive work histories than do the addicts. This composite picture of the alcohol abusers in the TC coincides with the information given by the CIC staff, even though the residential component takes in alcoholics from sources other than the CIC referral.

At the time of the interviews, ARC had 154 residents, 23 (15%) of whom were alcoholics.[2] While many alcoholics are admitted to the treatment program, they have a high dropout rate. (One counselor put the rate of recidivism for alcoholics at 80%.) This accounts for the relatively small number of alcohol users actually in the program. Another interesting fact about these clients is that they are mostly white. According to the records department, 20 of the 23 resident alcoholics were classified as white. This contrasts sharply with the rest of the residents, who are mostly all black. One reason for the alcoholic population being white is the fact that the re-

cruitment program operates in hospitals outside the Harlem area.[3] Thus, since 65% of all alcohol users come into the TC as a result of CIC referral, many are white.

According to a director of ARC, there are three reasons for the increase in alcoholic residents. One is that an active recruitment policy is being followed. A second is that alcohol is becoming a drug abused by more people, including more young people. Thirdly, alcohol is used in conjunction with methadone by many addicts. A fourth reason was voiced by another director of the program. He stated that since many of the alcoholics coming into treatment were heroin users at one time, their alcohol use is a form of "maturing-out" of addiction.[4] This means that as the addict terminates his use of heroin, he substitutes the use of a legal drug, alcohol. (This might also explain why the alcoholics who are coming into ARC are older.) Yet whatever reasons exist for the increase in numbers of alcohol users, the result is still a change in client population for the TC. And with this change, the program faces new problems.

Resulting Problems

One director feels that a few problems inevitably accompany any influx of alcoholics into a TC. Some prob-

lems are physical in nature. Nervousness seems to be common among alcoholics. These disorders are often treated by administering tranquilizers. This complicates the situation for ARC in terms of ideology because the community requires residents to give up all drugs. Other medical problems include illnesses related to liver and kidney damage. Many alcoholics have these ailments and their treatment imposes added financial burdens on the program. In addition to these physical problems, there are other difficulties facing the TC engaged in alcohol treatment. Often the alcoholics entering ARC "think of themselves as being better than addicts." They tend to be more "passive" than the addicts, and consequently the two groups don't mix much. This, according to the director, causes intergroup tensions which the community must try to alleviate.

Another view of the problems caused by alcoholic residents in ARC is voiced by an expediter. Alcohol users "see themselves as being different from addicts. They are not using dope, which they regard as being worse than alcohol." This individual says that he finds it harder to deal with the alcoholics than with the addicts. The former see the program as being "more lax" than other pro-

grams, such as A.A. Thus, since they view the program as not being too strict, they try to "get away with more." They drink when they are out on pass, and then they try to hide this fact from the counselors when they return. "They take advantage of the counselors' lack of knowledge." All of these factors, according to this expeditor, make it harder for the staff to deal with the alcoholic resident.

Many other staff members agree with these ideas. A female resident manager says that most of the alcohol users "look down on addicts." She states that "alcoholics often say they've never used drugs to show that they have never been that low." This view is shared by the program's part-time psychologist. He states that "While alcoholics tend to come from the same socio-economic classes as addicts do, they look down on drug use." Furthermore, alcoholics "don't really see the danger of their substance use."

Still another view of the alcohol users was expressed by a supervisor. While reiterating the idea that alcoholics want to be separated from addicts in a physical as well as a social sense, he also says that alcoholics have a positive quality that lends itself more easily to

treatment. This supervisor feels that alcoholics "tend to be straightforward in their manner. They don't lie like addicts do. Consequently, you do not have to be as strict with the alcohol users, and this makes the staff member's job a lot easier." Another "positive" view of the alcoholic residents in ARC is voiced by another supervisor. He believes that the alcoholic is able to explain why he started drinking, while the drug addict cannot account for his drug use. He goes on to say that "the alcoholic doesn't think he is cool. He is more aware of his position in society." These features of the alcohol abusers tend to make him more receptive to treatment. This point was supported by a house manager. He says that he relates better to the alcoholic clients because they "work better and obey orders more than the addicts do. Addicts offer more resistance to orders than do the alcoholics." Going further, the house manager states that "the alcoholic won't try to cover up his high. He admits his problem, and admits when he has relapsed into drinking. He is willing to accept his punishment when he is caught."

Responses to Alcohol Users

While some staff members see the new alcohol clients as being harder to deal with and others see them as being easier to relate to, both groups realize that this type of resident is "different" from previous types. In response to this different client population, ARC has initiated certain program changes. One new practice is the establishment of separate group therapy sessions for alcohol abusers. This is designed to make these clients feel more comfortable in a group of their peers, while at the same time encouraging the members to express problems that only alcoholics have.

Often, speakers from the Hospital for Joint Diseases run alcohol groups at ARC. In other cases, people from Alcoholics Anonymous come to the TC to give talks. In addition, alcohol abusers are encouraged to attend lectures and therapy sessions given at hospitals in the New York City area. These ideas reflect the treatment orientation of A.A. Many staff members, including the psychologist and a high-level director, feel that the community can learn from the A.A. approach. Thus they are willing to incorporate some ideas from a previously existing modality into the TC program. This indicates a broaden-

ing of the organization's scope of treatment, and an open-mindedness that lets "outside" ideas enter in.

Trends in Drug Usage

Besides having to deal with alcohol users, ARC is also facing a new and different type of drug abuser. These addicts tend to be younger multiple drug users, with heroin, methadone, and alcohol being the most frequently abused drugs. Often the addict has been using heroin and methadone on an alternating basis, and then he drinks heavily while on methadone to "boost" his high. Yet alcohol is not the primary drug of abuse (as is the case with the alcoholics described previously). Furthermore, according to the staff members, not many addicts come into ARC from a methadone maintenance program. Most have been using "illegal" or "street" methadone.

The type of drug use is not the only factor which makes this new client "different" from past ones. Many staff members state that the personalities of the multiple drug users are "unique." One director describes the new addict as having the "I-want syndrome." This type of persons "feels that he is owed something. He is not coming into treatment out of a need for help; rather, other pressures (family, courts, etc.) have forced him into ARC."

This director goes on to say that these newer users "have no respect for authority. They are not willing to sacrifice for a cause." Many other staff members agree with this assessment. They also agree that more and more addicts are coming from families that have drug use backgrounds. Often one or both parents have been, or are presently, drug users. This could indicate that treatment programs are now dealing with a "second generation" of drug addicts.

Staff members note further characteristics of the "newer" users. A counselor says that "they seem to have started use at an early age, and were heavily influenced to begin use by their peers. They wanted to be one of the group." She goes on to say that often pairs (a male and a female) of drug users come into ARC together. Usually, these pairs don't last (one of the members splits). A number of other staff members state that the newer addicts have a high rate of recidivism. It is not uncommon for clients to enter the program, drop out, and then reenter. According to a staff member in the employment section, many clients leave with a job and return without one. He says that about 50% of all people helped have been helped by the employment section before.

Another view of the newer clients is provided by a supervisor. He states that the new younger adolescents are short-term users (having used from 1 to 4 years). In addition, these clients "are hostile and resent authority." This makes it difficult for the staff members to work with these residents. This same idea is repeated by another supervisor. He says that the newer addicts "have less respect for authority. They see ARC as an authority-figure, and tend to resent it for its exercise of authority. They feel their drug problem is caused by society, not themselves. Consequently, they feel society owes them a solution to the problem it caused." These ideas were mentioned by a number of the staff members.

An expeditor adds another dimension to the picture of the young addict coming into ARC. He states that the new addicts are more aggressive. "They think they are tough. They view ARC as a jail, and thus put up the tough-guy front as they would if they were in jail." As a result, the younger clients don't listen to the expeditors or counselors. This individual feels that these residents are not interested in treatment or in helping themselves. This idea of the younger clients being more violent is voiced by a number of other staff members. As one counsel-

or puts it: "Younger addicts seem to have more criminal involvement. They appear to be more violent, and tend to do anything to get drugs." Another supervisor says the younger addicts "are more rebellious, and have a greater chance of conflict with authority figures at ARC."

The "immaturity" and "irresponsibility" of the younger users are mentioned in an interview with a house manager. He says that these addicts don't admit their drug problem. The younger addicts "are like babies. They are dependent upon their family, methadone programs, and society in general. While older addicts would hustle with their heads, younger ones would use violence. Methadone and welfare have made the younger addict less responsible and more dependent. The younger addict expects the staff member to give him a lot of leeway."

Further Responses of the TC

With these views of the "newer" addicts as a background, we now turn to the responses that the TC organization is making. Since most staff members recognize that the newer addicts are more prone to drop out, there have been a number of changes initiated in the treatment process itself. One has been an emphasis on the practical, pragmatic concerns of clients. A focus has been placed

on school, employment, and vocational training. Group therapy sessions reiterate this pragmatic approach. These sessions bring up everyday problems, and try to show the clients how to solve them. In addition to this change in therapy, a "buddy system" was started. This is a procedure whereby a person who has just come into the program is paired with someone who is finishing treatment. The idea here is to give the newcomer someone he can talk to on a one-to-one basis.

ARC has responded to the new client population in a number of other ways as well. Counselors no longer sit behind their desks. Rather, they go around the facility and deal with the clients' problems in a more active manner. The counselors thus become more involved with the everyday problems of the residents. A community meeting was initiated recently to bring staff and clients together. Both groups come to this "confrontation situation" in an attempt to solve the various problems that occur in the community. Two results of the new approach to clients are a more lenient pass policy and a change in the food program (a greater variety of food was gained).

Conflicts Within the TC

These responses to the newer addicts, and those

mentioned previously as reactions to the alcohol clients, have not eliminated all sources of stress for the organization. ARC is still faced with a number of problems. One is the continuing high rate of recidivism. Many staff members state that clients often enter, drop out, and then re-enter the program. People at the CIC estimate that 30% of all dropouts return at some time. The staff of the records department confirmed this fact, and added that the rate of re-admissions has been increasing over the last two years. This apparently is true for both the alcohol clients and the younger drug abusers. One reason given for the high rate of recidivism among alcoholics has to do with their physical and their psychological problems. According to one expeditor, the CIC component takes in many "mentally unbalanced" and "physically ill" alcohol users, just to make their intake record look good. Then, since ARC cannot deal with severe disorders, these people have to be referred to another agency or rejected. Often, they simply leave.

The trend in recidivism for the drug users is due, many people think, to the easy availability of alternative treatment modalities. It is often said that addicts today know they can leave ARC and go into a methadone program or

into another TC. These "options" that the client sees for himself affect his motivation to remain in the program. In addition, since the staff members are aware of the client's options, they too are put in a different position. The staff is now less rigid in enforcing rules and in handing out punishments. They do more to "keep the client," because they are aware of the fact that he can go somewhere else if he doesn't like it at ARC. The end result is that the staff member's job is harder now, due to the "strained relations" between staff and clients.

Other factors generate tensions between staff members and clients. One source of conflict is the difference in backgrounds between the ex-addict staff and the alcoholic clients. The former usually had been heroin-using individuals for a long period of time, and as a result have often been in prison for a significant part of their adult lives. When out on the streets, these users "hustled" for their drugs. They developed some type of "con" or "racket" that enabled them to get money for their habits. In the case of the alcoholic clients, there often was no hustle, and no major criminal justice involvement. Their lifestyle was quite different from that of the addicts. Many ex-addict staff members refer to the alcohol-

ic as a "passive" individual. This distinguishes him from the "aggressive" personality of the addict and ex-addict. This difference between the clients and the staff members is perceived by both groups. Alcoholic clients do not like the idea of being in an "addict" treatment program. They feel, as was mentioned previously, that they are "better than addicts." Staff members, on the other hand, feel "different" from the alcoholic clients, and often they are not sure how to deal with these people. As one supervisor puts it, "they [the staff] often seem to be confused [in their dealings with the alcoholic clients]."

Staff members also perceive age as a major distinction between themselves and the client population. This is true in spite of the fact that the actual difference is not great. The mean staff age is 28 years, and the mean age of residents is 25.8 years.[5] The staff person often refers to himself or herself as a former "hard-core dope fiend," with lots of "street" experience. The clients, on the other hand, are looked at as "kids who haven't really paid their dues." They have not been "down and out" like the dope fiend was. Their families, welfare, and methadone have made their lives "easier." Consequently, their motivation towards treatment is less intense. It is often mentioned that these younger clients resent authority

and are hostile to the staff. Many staff members feel that this difference has caused ARC much trouble and aggravation. As one house manager put it, "because the younger addict is more demanding, the house manager's job is getting harder. I feel I am put into the role of being a policeman."

Just as age seems to separate staff and clients, so too it serves to separate the clients themselves. One staff member states that the older alcoholics tend to stick with other alcoholics and with older addicts. Younger residents keep to themselves. This segregation seems to occur as a result of the friction that exists between the alcoholics, who are mostly older, and the addicts, who are mainly younger. Staff members seem to think that the division of ARC into these two groupings, while causing some problems, is something that can be handled by the organization. A number of people who were interviewed said that they found it easier to work with the alcoholics because they held themselves responsible for their actions. Also, alcoholics tend to have a better work history, than addicts, and, as a result, they can find jobs more easily. Yet in spite of the "positive relationships" between staff and alcoholics, the conflict between addicts

and alcoholic clients is bound to increase the difficulties of the overall treatment process.

These conflicts and tensions seem to have a direct effect on the staff members themselves. Every director and supervisor interviewed mentioned the fact that there was a high rate of staff turnover in his department. (Approximately 57% of the staff members had been employed by ARC for less than a year; with another 21% employed for one to two years.)[6] This high turnover rate can be attributed to a number of things. One opinion, voiced by an expeditor, holds that staff members leave because they are "unable to deal with new clients, both alcoholics and addicts." Since these residents require a new type of treatment, a different approach by the staff is needed. Many staff persons cannot adjust to this treatment. The result is that they leave. Another reason was mentioned by an expediter. He feels that staff turnover "often occurs as a result of people not doing their jobs."

As the program has expanded, the problems of the staff have increased. This has led to confusion over the exact nature of certain staff jobs. One response to this confusion is for the staff person to resign. But there is another reason why people find it harder to do their

jobs. This expediter states that "there is a great amount of competition between staff members, and it has intensified recently. People step on other people to get ahead." Furthermore, "people seem to want to maintain things in a state of confusion in order to gain personal advantages. If they can quickly solve the confusion, and straighten things out, they can make others look foolish. This will make them look better." Thus, for this individual, the growth in size of the program, and the increased competition for advancement that accompanies this growth, are both responsible for people leaving their jobs.

While changes in client population and general organizational growth do appear to be linked with high rates of staff turnover, this is not a one-to-one causal relationship. But high staff turnover does seem to be endemic to all TC's. One reason for this is that as residents graduate from a particular program, one job they are qualified for is that of staff member. Moreover, since staff members gain in experience and self-confidence as they work within a TC organization, staff personnel frequently leave the program for other jobs. (Often these jobs are in the field of drug treatment.) This process of residents becoming staff members, as the latter leave for other jobs,

is part of the upward mobility concept that is basic to TC treatment. The result is that frequent changes in staff composition occur as a natural by-product of the organizational structure and goals.

Staff turnover, while high, is not something in itself that is alarming to the ARC organization. But the same cannot be said of the staff's relationships with the new clients. Staff members are not used to dealing with alcoholics and younger multiple-drug users. As a result, their interactions with these clients are subject to more stresses and strains. Treatment does not run as "smoothly" as before. Staff members often express their inabilities in dealing with newer clients, and the rate of staff turnover continues to be high. Two further changes in client population are likely to make this situation even more critical.

Additional Trends

One additional trend is the increase in the number of female clients in the program. Since the female component was started in 1971, the female population has grown steadily. By the 1973-74 program year, 122 (22%) of the 558 residents were females.[7] This increase has brought with it a number of problems. One has to do with pregnant

females who enter the TC. The mother can be kept in the program after the birth of her child, but ARC cannot provide for the infant. Referrals of the infants to other agencies are often made, but these are not always successful; when they are, the mothers often leave the program to be with their children. Perhaps more important than the problem of dealing with pregnant clients is the conflict that occurs between female residents and male staff members. While females do make up 38% of the staff,[8] the majority of high level staff positions are filled by males. The result of this, according to a male house manager, is that "female residents feel threatened by male staff members." This might be due to the past experiences of the female residents, many of whom were prostitutes, with males. Or, it might be part of the overall male-female relationship within the black community. Whatever the reason, the existence in the TC of conflict between female clients and male staff members is not conducive to treatment.

Another trend at ARC is the entry into the TC of young, homeless, non-drug using adolescents. (Over the last four months, according to one expediter, five of these "runaways" have come into ARC.) These clients often are

homeless youngsters in their early teens, who ran away from home and are now living "in the streets." Although they are not really "drug users," the TC feels that they have the potential for drug abuse. Thus they take these kids into the community as a form of "drug prevention." The TC organization is presently trying to develop ways of dealing with these residents, since a number of staff members feel this type of client will be increasing in the future.

Summary

"New clients'" reasons for entering ARC are quite varied. In the case of alcohol abusers, there is a policy of active recruitment. Since many alcoholics in the Harlem area are former heroin addicts, and since alcohol is being abused by more people (in general), it seemed logical for the TC to expand its program to deal with alcoholic clients. Expansion of the organization can also account for initiation of the female program, and its continued growth and development. Likewise, the recent attempts to deal with runaway adolescents indicate another direction in which the TC organization began expanding. Finally, the entrance of younger, multi-drug abusers into the program is simply indicative of the changing pattern

of addiction in New York City.

ARC appears to be dealing successfully with its new client population. The traditional goal of treating drug addiction is still basic to the organization, and the majority of residents are still heroin addicts. Yet the TC is beginning to deal with alcoholism and behavioral problems, although still on a relatively small scale. This is being done not out of a fear of running out of clients in the near future, but out of a desire to continue functioning in the long run. And while the transition to a multi-treatment community is not without problems for staff and residents alike, the ability of the TC to solve these problems of adjustment is directly related to its survival in the years ahead.

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[1]Addicts Rehabilitation Center, ARC Seventh Report, April, 1974, pp. v-vii.

[2]This information was supplied by the records department, Addicts Rehabilitation Center, New York City, April 22, 1975.

[3]The recruitment practices outside the Harlem area might account for the high dropout rates, since many people might not want to travel to Harlem.

[4]For a further discussion of the "maturing-out process of addiction," see Charles Winick, "The Life Cycle

of the Narcotic Addict and of Addiction," United Nations Bulletin on Narcotics, 16, 1964, pp. 1-11.

[5]ARC Seventh Report, pp. 39 and 51.

[6]Ibid., p. 43.

[7]Ibid., p. vi.

[8]Ibid., p. 40.

CHAPTER VI

SAMARITAN HALFWAY SOCIETY

Background and Structure

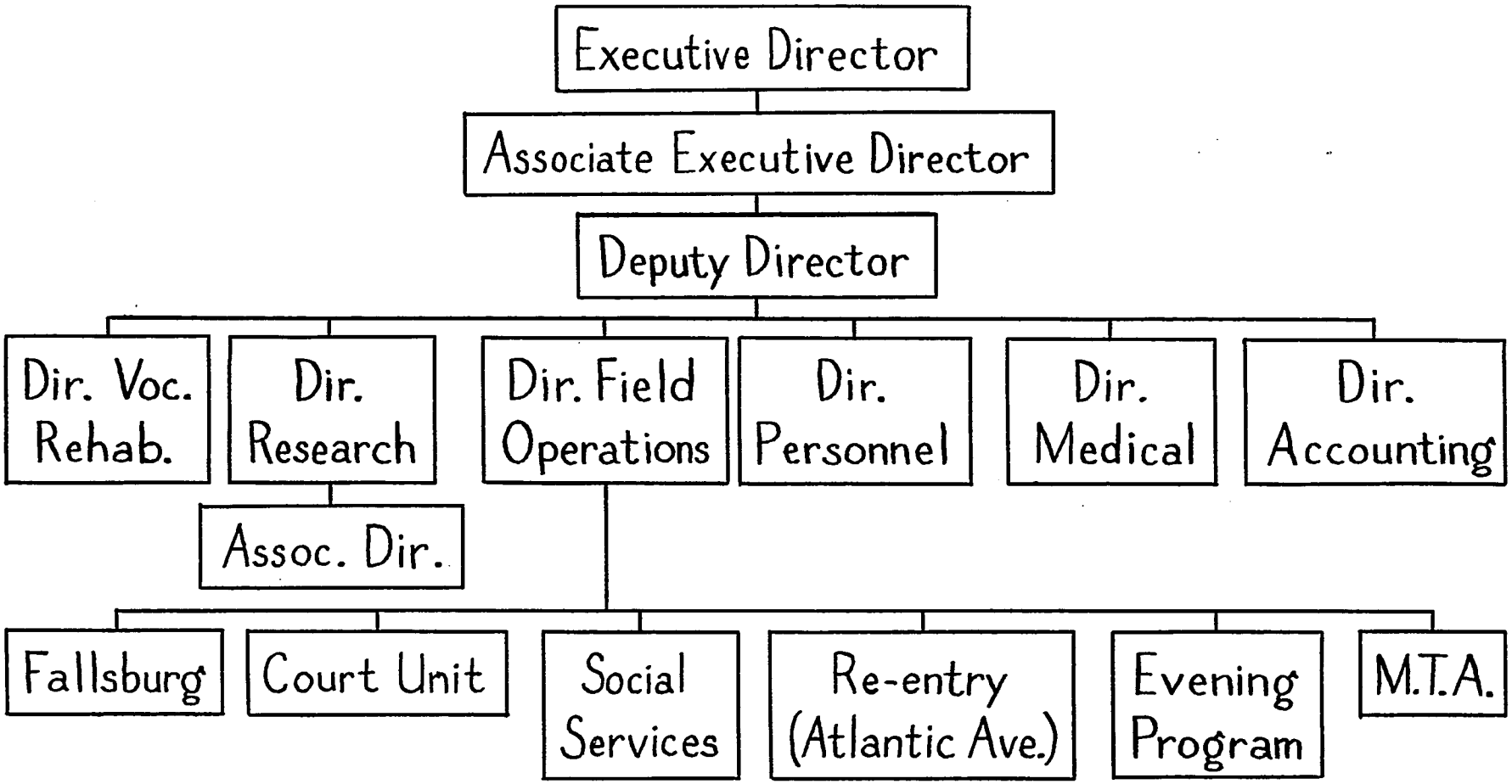
Samaritan Halfway Society (SHS) was founded in 1958 by Father W. L. Damian Pitcaithly, an Episcopalian priest, as a secular but religiously sponsored program to treat drug addicts. Initially, the treatment program was conducted in close proximity to St. George's Church, located in Astoria, Queens. But neighborhood residents objected strongly to having drug addicts near their homes. After a long struggle to keep the program near his church, Father Pitcaithly decided to locate SHS in another part of Queens. An industrial section in the Jamaica area was finally chosen as the program's home.

From its start as an evening program, SHS has evolved into a multi-treatment approach that includes a residential phase, a methadone-to-abstinence program, and an ambulatory drug-free component. These three programs are separate divisions of the overall SHS organization, although some interdependence does exist.

The methadone-to-abstinence (MTA) program is quite

Figure 5

SAMARITAN HALFWAY SOCIETY



new and has only a few participants. This is a residential program that tries to convert methadone users into drug-free individuals. It is one of the first such programs in the City of New York, and represents an attempt to deal with the escalating problem of methadone abuse. The ambulatory drug-free component is an evening program that seeks to help former drug users remain "clean." Many of these clients are people in the Queens area who work, and consequently can only be treated on a part-time basis. The residential component, or TC, is the part of SHS in which most of the staff and most of the clients are involved. The TC staff is currently used in the MTA and the evening programs, but this is only a temporary situation. Eventually, each component will have its own clinical staff and its own separate facility.[1]

The SHS therapeutic community consists of three stages: the first is intake or orientation, during which the client is introduced to the Samaritan ideology; the second stage is residential, during which the individual undergoes treatment at the Fallsburg, New York, facility; and the final stage is re-entry, which attempts to establish or re-establish the client's ties with the "outside" society. The length of time it takes to complete the pro-

gram varies, but the usual period is less than one year. During this treatment cycle the resident takes part in many group therapy sessions, has educational training (where needed), is treated for medical problems, is tested for psychological disorders, and receives vocational guidance help. These program dimensions are similar to the processes of most TCs. Yet, as in the other organizations being studied, treatment at Samaritan Halfway Society is changing, and this change is due to a number of different factors.

The New Clients

One impetus for treatment change at SHS comes from the new type of client drug-usage. As seems to be the case throughout New York City, clients coming into treatment today are younger and are multiple drug users. As of three years ago, heroin was the main drug abused by individuals entering SHS and the median age at entrance was about 21 years. Now, most clients are poly-drug users of non-opiates (amphetamines, barbituates, tranquilizers, alcohol), and their median age is about 16. (Of 89 residents, 18, or 20%, are under 16 years of age.)[2] In addition, most of the "newer" clients are high school dropouts who have no work histories and who have had minor juvenile

justice system involvements. Many of these younger clients come from homes where there is a major problem (alcoholism, drug use, abusive parents, etc.). Furthermore, there has been a racial change in the client population. From a basically white, middle class population, the TC has changed to a client population composed of 40% black, 40% white, and 20% Hispanic residents.[3]

Another dimension of change occurring in the composition of residents of SHS is the frequent absence of drug use in the younger clients' backgrounds. Many of the clients come into the TC as a result of family problems. These individuals, almost all of whom are under 16, might have used marijuana or another "soft" drug occasionally, but they are not hard drug users. Their main problem seems to be a lack of a cohesive family structure. The result is that now two groups of clients exist side by side in the TC. One is the under-16, non-drug using adolescent group. The other is a slightly older (16 to 21), multi-drug using population. Both of these "newer" types of clients produce a situation to which the TC must adapt. Its methods of adaptation are critical to an understanding of how the organization functions.

There is no doubt in the minds of most staff mem-

bers that change is occurring at SHS. There is some disagreement, however, over the direction this change is taking. One feeling is that the newer clients' age is the key factor and that this should dictate new courses of action for the TC. In line with this idea, many staff people mention the problems that have developed in relationships between the older staff members and the younger clients. A director states, "Younger people don't like dealing with older people and older people don't like dealing with younger people." Another director elaborated on the problems of the staff-client relationship: "Three years ago these conflicts started to surface. Staff members belittled the newer clients, saying they /the clients/ were not really drug users" (meaning that the clients were not the "hard-core heroin users" that the staff members once were). He goes on to say that the reason for the conflict is that many kids are smarter than the staff, at least in terms of formal schooling. Consequently, "the staff is unable to cope with the younger kids."

Other staff members agree that problems exist between older staff, as well as older clients, and adolescent residents. One counselor says that there is some resentment between "adults" and "adolescents" in the program.

This is because the "adults feel that they shouldn't have to bother with younger kids." Age differences, therefore, serve to isolate the adolescent resident from both the older clients and the older staff members. This compounds the problems of the overall treatment process. Staff members must now deal with two separate client populations, one "old" and one "young." Unfortunately, the staff members have many things in common with the "older" clients, while they have little, if anything, in common with the "newer" ones.

Changes in Treatment

The existence of conflict between the two age groups has not gone unnoticed at SHS. Staff members report that a number of changes have been implemented to deal with the problem. One response has been the setting up of separate therapy groups for the "younger" clients. This enables the problems of each client group to be discussed among peers. The "older" clients meet in their own therapy sessions to talk about their particular problems. In addition, a family group, consisting of the client and his parents, has been re-activated in order to help young clients with their family problems. Another response has been the expansion of educational classes (high school courses) to

meet the younger client's need for this type of training. All of these innovations are aimed at the needs of the younger residents.

Other changes in treatment are reported by staff members. A counselor says that now "the staff is more sensitive . . . and more one-on-one counseling is going on." This is done so that the client can relate to the staff member on a more personal basis. Group sessions have also been extended in length, with the result that now both the adult and the adolescent groups have more time to discuss their respective problems. Furthermore, punishments have been reduced in severity. (As an example, it was mentioned that rarely now is a resident's head shaved after he quits and then returns.) This practice has been employed less often because of the widely held belief that the younger clients cannot handle severe punishments.

A number of staff people mention the idea that treatment is easier now. One female member states that "treatment is more permissive now, and it is not as punishment-centered." She goes on to say that "many clients find it harder to function in a more permissive environment. The staff also finds it more difficult to function.

This is because the staff comes from a treatment that was quite rigid and structured." This same idea was expanded upon by a professional staff member. She states that most of the staff is from the "classic TC school" (Daytop, Synanon, etc.) and are accustomed to a rigidly run, punishment-oriented program. But the young clients are not from this same background, and "will not put up with the authoritarianism that characterized these early approaches." The staff, therefore, has had to change. Many staff members feel that this change has been successful. As one assistant director says, "discipline has lessened. Now the staff is more flexible in dealing with clients. Treatment is not given out collectively, but is geared to the individual." And as a director states, "there is a trend towards more flexibility and more individuality at SHS today."

While some staff members feel that the TC is changing to meet the problems posed by the new client population, others think that this change has been limited. A professional staff members says that the two age components (adolescents and adults) of the TC exist only in theory and not in practice. This is because the staff is not yet equipped to run a separate and distinct adolescent component. This opinion is shared by another professional

staff members. She states that no real changes in treatment have taken place. "They /the higher-level staff/ are aware that change has to occur, but they are not sure where to go." The reasons for this indecisiveness are: firstly, there is no "clinical overview" of treatment; secondly, there is a basic inconsistency in the treatment. This staff member supports her statement by recalling how, at one point in time, the TC will shave heads freely as a form of punishment, while at another point in time, they will not do this at all. She goes on to say that SHS "is not a typical TC. The professional staff at the top has had little program experience. The three people on top work independently of the rest of the organization. This causes a tremendous amount of paranoia." She supports her contention by pointing to the high rate of staff turnover at SHS. (Just about every other staff member also stated that staff turnover was high, but most of them admitted that this is normal for a TC.)

Other Characteristics of the New Clients

It is important to note that other changes in the client population of the TC are having an effect on the overall treatment process. In addition to being younger polydrug users, the "newer" clients are racially diverse.

But while the client population has changed in racial composition, the staff population has remained basically white. This has caused a number of problems for the TC. One is that it is difficult for a black client to relate to a white staff member. This seems to be especially true for the younger residents. Another problem concerns the Spanish-speaking clients in the program. These residents find it hard to communicate with the white staff members, few of whom speak Spanish. (This situation is changing, however; an Hispanic staff member states that SHS is hiring more Spanish-speaking staff, and this appears in turn to be attracting more Spanish-speaking clients.)

A major trend in the behavior of "newer" clients is their greater tendency to use violence. As one assistant director explains, "Younger kids come from a background of using violence in the streets." This seems to result in their "acting out" their problems while in treatment. Another staff member states that "in general, more clients today than ever before, are involved with violence. Their lifestyles actively involve expressing violence." Still another opinion comes from a female staff person who says that "Kids today enjoy having a gun--it is a big status symbol of sorts. Also, many clients today admit to enjoy-

ing forcible rape." These ideas point to the violent and aggressive nature of many of the younger clients coming into the TC. This is something that many staff members have a difficult time relating to, and it makes them more cautious in their approaches to the clients.

Another important development is the change in the sources of client referral to the TC. Previously, many clients came into the program voluntarily. Now, most of the older residents are referred by the criminal courts, and almost all of the younger ones are referred by the family courts. (SHS has a working relationship with the Queens Family Court, and as a result, persons in need of supervision--"P.I.N.S. offenders"--have been coming into the program at an increasing rate.)[4] This shift from voluntary referrals to court referrals has produced new attitudes on the part of the clients. As one director states, "Kids today are not that motivated and they have more alternatives for treatment . . . they seem to seek the easiest way out." Expanding on this idea, an assistant director says, "the typical person now /in the program/ is less motivated. One reason might have to do with the fact that there are so many programs in existence, one person need not show great motivation to get into any one

program." Furthermore, since these younger clients have not served as much "jail time" as the older clients, they are less appreciative of the TC.

This "lack of motivation" among the younger clients seems to be responsible for their higher rate of recidivism. This is because, as was stated previously, the existence of other TCs means that a person can always find another program to go to if he leaves the one he is in. A director elaborates on this idea when he says that "the split rate is higher now for two reasons: first, clients know they can go to another program; second, kids now can go home when they split, whereas older addicts of years past had no place to split to." This statement reflects the idea, held by many staff members, that the younger clients "have it easier" than the older addicts did. The prevailing feeling at SHS is that drug users today have more alternatives for treatment, and more sympathy from friends and relatives. The result is that these clients are not motivated to help themselves. They know they always have someone to "fall back on." As one director puts it, "Years ago you [the client] needed the community; now, the community needs you."

This opinion of "clients having it easy" is rein-

forced by staff members' experiences with probation officers. A number of people state that probation officers now go along with whatever the client wants. So, for example, if a client leaves one program,and is put back in the custody of his probation officer, that officer may refer him to another program. There often is no attempt to return the client to the program from which he split. This is different from the situation in the past, when a probation officer would always try to refer the client back to the program he had left.

Shifts in Organizational Structure

While changes in the client population have mainly affected the relationships between residents and staff members, there has also been a change in the staff members' relationships with each other. One recent trend is the increase in the administrative staff's participation in treatment. As one assistant director explains, "Years ago, input was just clinical. Now the executive staff joins with the professional and non-professional clinical staff in making key decisions. Also, until two years ago there was no communication between administrative and clinical staff. This has changed." But this view is not shar-

ed by everyone at SHS. A professional staff members says that "Professionals and ex-addict staff members do not mix well. Many non-professionals are denied access to written records of clients on the grounds that they will not understand the clinical language used in the reports." This staff member contends that because she has viewed these records, this is not true. (It should be pointed out here that of a total of 80 staff members at SHS, 30 are considered "clinical" and 50 are designated "non-clinical." Of the 30 clinical staff, 25 are ex-addict personnel. None of the 50 non-clinical staff members are ex-addicts.)[5]

In spite of the conflict mentioned above, one trend that seems to be occurring at SHS is the move towards a more professional staff orientation. Presently over 80% of the clinical staff members are ex-addicts. Many of these people have graduated from the Samaritan program or from one of the other major TCs in the New York City area. Yet there is growing pressure by many higher level officials to increase the participation of the professional in the TC treatment process. One director states that since the new client differs from the staff member in terms of background characteristics, "there might be a need for a

more professional staff that can deal with many types of family problems. The present staff [referring to the ex-addict staff] has a limited range of skills." Another director expresses the same idea, that a more professional orientation is needed, but he does not see this as forthcoming. "The idea at SHS is not to rock the boat. Since the TC is a crisis-oriented organization, it does not respond unless there is an urgent need" (meaning that the TC would have to be faced with a life or death situation before it would react).

The concern of the TC for a professional approach is expressed by a high-level official who outlined the future goals of the organization. He feels that the younger clients who come into SHS have problems that can be classified as "drug symptomology." This means that for these younger people, their drug and alcohol use are symptoms of more basic problems. Therefore, the TC must move towards more comprehensive treatment along the lines of a community mental health program. Because these multi-problem adolescents have been taken into the program, the medical staff has been increased, "psychological time" has been increased; clients' parents groups have been formed to help parents understand their children's problems, and a

staff training program, conducted by a professional counselor to help the staff deal with the problems of the younger clients, has been initiated. All of these innovative practices are aimed at helping the TC deal with the multi-problem individual.

Summary

SHS is thus responding to a new client population by making changes in the treatment process as well as in the nature of the staff membership. The objective of the organization is to deal with the various mental health problems that seem to plague many young people today. Towards this end, a residential MTA program has been started, the evening program has been continued, and the TC has become more "individualized" and more "professionalized." These changes have not occurred without some problems. Staff members still find it difficult to relate to the "newer clients." The "more professional" orientation of treatment is often alien to the ex-addict staff member, who only feels comfortable with the "old way." Rates of recidivism remain high. But the problems are just a part of the organization's adaptation to a new environment. If the TC is able to solve these problems in the process

of formulating new goals, then it will be able to survive in the future.

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[1]At the time of this writing, the methadone-to-abstinence (MTA) program has moved into the old facility in Jamaica, Queens, and the administrative staff has moved to new offices nearby.

[2]Information obtained from the research department of Samaritan Halfway Society (SHS).

[3]Ibid.

[4]P.I.N.S. offenders are individuals under the age of 16 who have committed an offense such as truancy or running away from home. They are not to be confused with "juvenile delinquents," who are persons less than 16 who commit acts which, if done by an adult, would constitute a crime.

[5]Information obtained from research department of SHS.

CHAPTER VII

DAYTOP VILLAGE

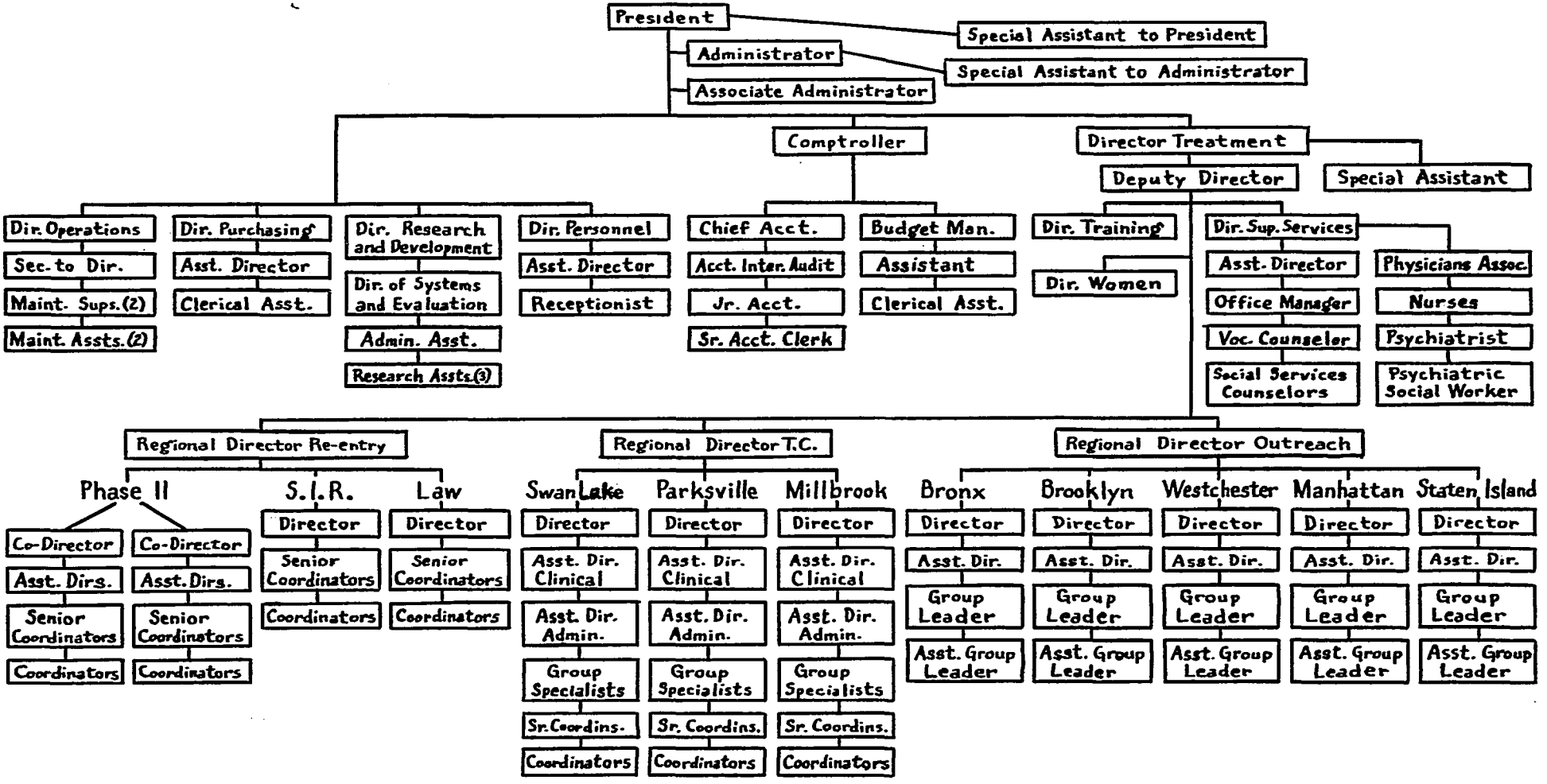
Background Information

Daytop Village, founded in 1963, is one of the largest TC's in the New York City area. It employs 163 people and has a large main building in midtown Manhattan, outreach centers in five counties of New York State, and three residential facilities located in upstate New York. During the 1973-74 fiscal year, a total of 1,740 individuals contacted Daytop for rehabilitation services. Of this number, 607 (35%) entered the residential TC program.[1] At present, there are slightly over 500 clients in the TC modality.

The Daytop TC program is quite similar to most other residential programs. There is a screening and induction process prior to admission into the TC. Once the individual is accepted into Daytop Village, he or she is sent to one of the organization's residential facilities, which are located in Parksville, Swan Lake, or Millbrook. This "in-residence" or "first phase" is where educational training occurs and where the bulk of the treatment pro-

Figure 6

DAYTOP VILLAGE



cesses are conducted. Phase I usually lasts up to nine months, after which time the resident enters Phase II. This is a combination of in-residence and out-of-residence treatment, and usually takes no more than seven months. During the in-residence part of Phase II, the resident lives in the main building in Manhattan, and either works or goes to school on the outside. The out-of-residence stage refers to the point at which the resident works and also lives outside of Daytop.[1] When the resident has successfully completed Phase II of the program, he is considered a terminated resident in good standing. If residents continue to lead successful and productive lifestyles following program completion, they will then become graduates of Daytop.[2]

In addition to the TC modality, Daytop Village also provides ambulatory treatment units within each of its Outreach Centers. These units are designed to provide non-residential treatment to younger "soft core" drug abusers. They try to help the individual through the use of group therapy, cultural and educational activities, and job counseling. The object of this ambulatory treatment is to help the individual see the problems of his lifestyle and to then help him develop an alternative.[3] If

the Outreach Center feels the individual can only be helped in a residential situation, it can then act as a referral agency for the TC. This seems to occur quite often.

The New Clients

An overview of the "newer clients" that enter the Daytop Village TC suggests that they represent the general addict population in treatment in New York City. Of the 607 new entries into the TC from April 1, 1973 to March 31, 1974, 84% were males and 16% were females. (This fact that treatment is "male oriented" is true of most modalities, and is something that has been subject only to recent minor changes at Daytop.) Racially, 42% were black, 10% were Puerto Rican, 47% were white, and 1% were "other." This composition is not much different from the case in 1971 when 37% were black, 16% were Puerto Rican, and 47% were white.[4]

In the 1973-74 period, the median age of people entering the TC was 23.1 years, while in prior years it had been 22 years. This increase in median age of entries might be explained by a number of factors. First, it is known that more new clients than before had prior drug treatments. Therefore, it is possible that people enter Daytop after having tried one or more other treatments.

Second, and tied in with the first idea, is the fact that 23% of the entries had methadone maintenance as a prior treatment in the 1973-74 period, whereas only 13% had had it in the prior years. This could indicate a shift in clients' treatment preferences, from methadone maintenance to drug-free.[5]

Like other TC's, Daytop saw in the 1973-74 period an increase in the number of clients who used methadone illegally in the streets. During this period, 62% of the clients used illegal methadone, compared with 35% who had used it in 1972. Of the 129 people who were treated in methadone maintenance programs prior to entering Daytop, 88% had also used methadone illegally. In addition, there appears to be a growing trend in poly-drug use among addicts. It was found that over 50% of the new entries had abused six or more different drugs at some time in their lives. Furthermore, 78% of the total number of new entries used alcohol, with 20% stating that they had a problem with it. Yet, heroin was still the primary drug used by 72% of the residents.[6] This picture seems to confirm the reports of other treatment programs that the newer clients tend to be multi-drug users who often use illegal methadone and alcohol.as well.

Two additional characteristics of the newer clients should be mentioned. One is that there was an increase in the percentage of new entries with arrest and conviction histories. In the 1973-74 period, 89% of all residents had been arrested as compared to the prior year's figure of about 62%. Also, 76% of all new entries had been convicted as compared to the previous figure of about 36%. While arrest and conviction rates seem to be increasing, referral practices have been constant over the last few years. In the past fiscal year 44% of the new clients were referred by legal agencies, and 39% were referred by family or friends.[7]

Staff Views of Clients

The staff members consider the newer clients to be a "different kind of addict." These clients are poly-drug users who did not have to "hustle" on the streets, due to the easy availability of methadone. The newer clients are not considered "hard-core users" or "down-and-out dope fiends." These terms are used by the ex-addict staff members to describe their own past lifestyles. Thus, the general attitude of most staff members is that the clients today have had an easier time of it. As one coordinator says, "Younger clients have little street experience.

They were not hard-core users, and money was easy to come by for them." Another staff person agrees, saying that "Clients are immature; they are no longer hard-core dope fiends."

Additional statements reinforce this definition of the newer clients. An assistant director says that "The younger kids have no sense of responsibility. They have been given everything. Kids are more self-centered. They have a give-me attitude." Another assistant director states that the younger clients "do not have as much fear as a hard-core user about returning to the streets." The younger clients are considered to be less motivated towards treatment and less afraid of returning to their former lifestyles. Since these clients have never really experienced "hard times" (according to the staff members), they do not appreciate the rewards of the TC.

Changes in Treatment

In the face of a new and different client population and the recognition of this by the staff, Daytop Village has initiated certain "innovative" treatment practices. One is the greater flexibility and tolerance concerning homosexuality and marijuana usage. Almost every staff member mentioned the idea that Daytop now accepts

the fact that a person has a right to be a homosexual. In the past, if a person admitted that he was a homosexual, the Daytop staff would try to change his behavior to heterosexuality. Now, a client's homosexuality is accepted and the problems he or she faces are discussed openly. Likewise, marijuana use by a friend of a client is not grounds for dissolving the friendship. Previously, this was the case. Now, if an acquaintance of a client uses marijuana, the client is advised to attempt to convince the friend to stop using the drug.

The more tolerant attitudes towards homosexuality and marijuana usage carry over to other areas as well. In the past, if a person in the re-entry stage used alcohol or drugs, he was automatically sent back upstate for additional treatment. Now, the circumstances surrounding the incident are examined, and the individual is frequently dealt with at the Manhattan facility. Also, if a client previously split from the TC, he had to re-enter the program. Now, a "splittee" may be referred directly to an outreach center, where he can attend therapy sessions while living at home, and can finish the program via outreach treatment.

In addition to being more tolerant, treatment now

is more "sensitive" and more "individually oriented." As a coordinator says, "Treatment is more sensitive to the needs of the new clients. It is not as rigid as before." He points out also that the staff is "no longer dealing with the group--now we deal with the individual. So now, if a person messes up, he is dealt with, while before, if a person messed up, the group was punished." These ideas are reinforced by another coordinator, who states that "the response of Daytop to newer clients has been the program's becoming sensitive to the needs of the individual clients. The program is not as rigid as it once was." He goes on to point out a way in which the TC has become more sensitive to the clients' problems. He states that now "the staff realizes that young kids /after completing treatment/ might wish to return to their families. Previously /referring to the late 1960's/, because clients were older, Daytop urged everyone who graduated from the program to go out on his own. Now, because of younger clients, the alternative of going back to live with parents is kept in mind by the staff."

These staff members as well as many others use the terms "sensitive" and "individual" to describe the more flexible approach currently used by the TC in its dealings

with the newer clients. Often this flexibility means a reduction in the severity of the punishments used against the clients. As one assistant director states, "We don't use physical learning experiences now. There is more flexibility in dealing with people. Learning experiences are now justified." Reiterating this idea, a coordinator says, "Punishments are less severe, and are given out as each situation dictates. They are not given out universally, as occurred before." The general attitude at Daytop, consequently, seems to be one of increased tolerance of client misbehavior.

The more flexible philosophy of the TC has had a direct affect on other aspects of the treatment process. One change is in the amount of time that a client spends in an upstate facility. Previously, he might be there for 18 months; now he will probably be there for 6 months. As a result, the entire treatment cycle has been reduced to a one-year period. Also, within the therapy sessions, there is more emphasis on practical problems. There is less yelling and less emotional involvement, with more discussions of the daily problems that the residents face. As one coordinator says, the new approach "makes people learn to think for themselves."

A fourth change in the treatment process is the increase in professional help used by the TC. In the past, the treatment staff was made up entirely of ex-addicts. Recently, some professional medical people were added, including a full-time psychiatrist and a full-time psychiatric social worker. In addition, seminars are conducted for the staff by psychologists and psychiatrists brought in from the outside. Another move towards greater professionalism is the help provided to Daytop by the Training for Living Institute. This organization has assisted the TC in instituting new procedures for dealing with the clients. While the treatment staff is still composed mainly of ex-addict personnel, the increased use of professionals seems to signify a future trend for the organization.

Changes in Referrals

One of the most significant changes occurring at Daytop is the shift in sources of referral for the TC. As was stated previously, 44% of the clients were referred by the courts in the 1973-74 period. In past years, the courts were, similarly, a major referral source. But over the last year or so, the courts have not been as important as before. One reason is the impact caused by the

Rockefeller drug laws. These laws have reduced plea bargaining, and have thus resulted in more drug-related felons going to jail. As a member of Daytop's law department says, "Years ago, because of plea bargaining, more clients came into treatment. Now everyone goes to trial. The backlog in court cases this has caused has further added to the difficulties in this department." The law department has responded by increasing its scope of operations to include court units in all five boroughs of New York City and the counties of Westchester, Nassau, and Suffolk as well. As yet, however, the effect of this expansion has not been felt by the TC.

Along with the decrease in the number of court referrals, there has been a corresponding increase in outreach center referrals. Originally, the outreach program was set up to deal with "soft-core" users on a daily 9:00 a.m. to 5:00 p.m. basis. The program, however, has grown tremendously. (Over the last five years, outreach has been expanded from a program servicing 30 clients to one which now serves 310 clients.) In addition to this growth in size, outreach has added new services. An evening program was started about one and one-half years ago to deal with older, "hard-core" users. This was designed to be an intro-

duction to the residential TC, and it has been very effective as a referral source. Public schools have been set up in four of the five outreach centers, in order to provide younger clients with educational training. A vocational counselor is also available to outreach centers. A parents' program has recently been added to outreach, and presently about 90% of all outreach clients have parents that are attending evening meetings.

The shift from court referrals to outreach referrals is something that the Daytop organization is aware of. As in the induction rate from outreach into the TC has increased, the recruitment policies of the outreach centers have received greater emphasis. The outreach staff recruits clients from the daytime programs, and also recruits people from methadone clinics, detoxification facilities, and other local drug treatment programs. The reasons for this policy are stated by a high level official in the Daytop Village organization: "In these times, because of contract levels /the number of clients each TC is required to have for funding purposes/, competition from other TC's, etc., we are out recruiting. Funding pressures necessitate recruiting."

Problems in Treatment

Most staff members think that the newer clients are more difficult to treat. One coordinator puts it this way: "Newer clients are harder to deal with. They don't feel that they are dope fiends. Younger clients are here because their parents forced them to be here. They don't feel there is anything wrong with using drugs." Another coordinator thinks the newer clients are harder to deal with because "They don"t want to sacrifice that much. They don't want to give up much of their time /for treatment/." These general feelings are reinforced by specific problems that the staff members experience in their dealings with the residents. In most cases, the problems that arise in the treatment of the newer clients are due to basic differences between the clients and the staff members.

While the newer clients are not really younger than those of prior years (the median age for the 1973-74 period was 23.1 years), the staff members perceive them as being "younger," and often refer to them as such. Besides, the staff people tend to be in their late 20's and early 30's, so the clients really are younger than the staff. Underlining the age difference are other differences be-

tween the staff and the clients. There are discrepancies in past drug-use patterns, previous lifestyles, and prior treatment experiences. The combined effect of these factors reinforces a general feeling in the staff members that there is an increasing difference between themselves and the new clients.[8]

Another "difference" causing some concern among Daytop staff members is the diverse racial composition of the client population.[9] While the residents have about equal numbers of whites and blacks, the staff is still largely white. Some blacks have recently become lower-ranking staff members, but their number is still small. This fact is noticed by both residents and staff. As an assistant director says, "Over the last five years, Daytop has gone from a lily-white program to an integrated one. Yet the staff above the regional level are all lily-white." One result of this is, as the same respondent points out, that "all the people who dictate power do so from a white, middle-class, married background. They try to impose their values on the staff and residents." Another problem involving racial differences is mentioned by a coordinator. He states that there is job discrimination within the Daytop organization, and supports this contention by saying

that the public relations and law departments ("better jobs") are staffed mainly by white residents and graduates, while the kitchen and maintenance workers ("poorer jobs") are mostly blacks.

In addition to the problems posed by having more blacks in treatment, Daytop is facing other difficulties as more females enter the TC. Females have been coming into treatment at an increasing rate, although they still make up only a small percentage of the total population (16%). One problem for females at Daytop is that they are a minority in a male-oriented program. This does not help their self-image, nor does the fact that many of them were prostitutes on the outside. Furthermore, a lot of the therapy is focussed on destroying the client's previous self-image. One female staff member says that "in group sessions, females could not think of any positive things about women." Another female staff member expands on this idea by saying that "Women do not see themselves as a group." Going on, she states that "women do not look to each other for support, but they look to the men." Thus the females in the TC display a great dependency upon male residents and staff members.

Another problem concerning females at Daytop is

that few women residents go on to become staff members, and fewer still remain in staff positions. One reason for this is that females in the TC cannot see themselves as staff members, a position which connotes authority and responsibility, due to their poor self-image. Another reason is that the male staff members do not support females as equals. According to one female staff member, there are a lot of underlying antagonisms between lower-ranking male staff and female residents. One attempt at remedying this situation is a recent proposal establishing a separate facility for women while they are upstate for the first four months of treatment. This facility would be staffed with females, requiring an increase in female professionals. Yet, as a female staff member says, "There has been opposition from men in Daytop for a separate facility for women."

The newer clients coming into Daytop have had an effect on still other aspects of the treatment process. One area that has felt the impact directly is the medical unit. More clients than ever before have serious medical problems. There are more cases of liver infections because of the increase in the number of addicts who are also heavy users of alcohol. Many females have vaginal in-

fections, possibly because of frequent prior lifestyles as prostitutes. Also, about 50% of all entering clients have venereal disease. In addition, since many clients have to be detoxified from methadone, barbituates, and alcohol, the physical condition of these individuals is often quite run down. As one medical staff member puts it, "Medical problems today are more severe than ever before because kids abuse themselves more. They use anything they can get their hands on." These problems have been met by the TC with an increase in medical personnel. (This increase is made possible by Medicaid funding.) The success of the organization's ability to deal with medical problems in the future seems to depend upon continued financial support.

Often the response Daytop has made to the new clients has exacerbated the problems of treatment. One example of this has to do with the more "sensitized" and more "individualized" approach to treating the residents. Some staff members feel this does not work, because the newer clients need more discipline. One coordinator says, "The more flexible concept does not work. Since there are great variations among residents, letting each individual do his own thing often leads to confrontations be-

tween residents." Another staff member tells how the more "sensitized" approach to homosexuality is not always effective. She states that "Now homosexuality is tolerated and talked about at Daytop. . . . /however/ the problem is that often the homosexual's homosexuality is discussed to the exclusion of any discussion of his other problems (drinking, addiction, etc.)." These two examples show that, while the flexible approach used in treating the newer clients is generally functional, it can have negative consequences.

The new policies on client referrals also present impairments to TC functioning. There is a general feeling at Daytop that clients today are aware of alternative treatment modalities, and are therefore less motivated towards any single treatment form. This change in the attitude of the clients is mentioned by a high level staff member: "He /the client/ can be selective, he can shop around for treatment." This respondent goes on to say that probation officers often contribute to this "shopping around," by telling clients that if they do not like one program they might try another one. This means, for example, that if a client does not like Daytop, he can go back to his probation officer and request another program.

Accordingly, this takes the threat of punishment (being sent back to jail) away from the Daytop staff. This situation is further complicated by the intake of "soft-core" clients who have no court system backgrounds. These people come mainly from the outreach centers, and their motivation for treatment is likewise considered minimal. One director comments on these types of clients by saying that "Kids who come into the program with no court involvement often leave. This is because there is no pressure on them to stay." The change in referral policies, therefore, is considered by many staff members as the main reason for higher split rates and lower motivation levels among the newer clients.

Additional Problems of the Organization

A number of other problems affecting Daytop Village seem to be related to the relatively large size of the organization. A number of staff members feel that the TC, because it is the second largest one in the New York City area, is overly concerned with its image. This concern is often thought to influence key decisions by high level Daytop officials. One assistant director states that an example of this "image-conscious decision making" is the recently purchased facility in midtown Man-

hattan. He says that "the house on 40th Street was bought to make Daytop a showcase. The idea is to show politically important people what the model program is like and what the model junkie is like. The idea here is to raise funds, but the effect is to create an illusion." Another example of this "image-conscious decision making" is the newly renovated female floor in the midtown facility. A senior coordinator says that one high level official undertook the renovation of the female quarters with the objective of making them a model treatment residence. To accomplish this, it was necessary to take floor space away from the male living areas. The result is that now the females have ample living facilities, while the males' quarters are overcrowded.

A further problem in the TC has to do with feelings of antagonism between lower ranking and higher ranking staff members. An assistant director states that clinical staff turnover is high because the staff members are financially exploited. He says that the higher ranking officials "are always looking at us /lower ranking staff members/ as if we need the program and should not complain /about low wages/." Since the lower ranking staff often "do not wish to rock the boat," they either keep quiet or

leave. This person goes on to say that more high level staff members think their positions of power within the organization extend to include even social relations between themselves and lower ranking staff people. These "feelings of superiority" causes conflicts among the staff and hinder communication within the organization. Another staff member agrees with these ideas. He says that the "staff is not treated right. Promotions are not based on ability, but rather on length of service. This is demoralizing to staff members.

Many of the problems facing Daytop Village are directly related to the size of the organization. As the TC has grown, so too has the bureaucracy needed for administration and treatment. Thus bureaucracy creates significant problems for the TC, yet it also enables Daytop to maintain its basic approach to treatment in the face of an ever-changing environment. While other TC's are altering their treatment modalities to fit new and different client populations, Daytop is still primarily serving heroin-oriented individuals. The changes that have taken place at Daytop are revisions of the traditional treatment concept, and this trend can be expected to continue in the future.

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[1]Daytop Village, Inc., 1973-74 Annual Report on the Therapeutic Community and Ambulatory Treatment Programs of Daytop Village, Inc., p. 2.

[2]Ibid., pp. 8-14.

[3]Ibid., p. 29.

[4]Ibid., p. 20.

[5]Ibid., pp. 20-21.

[6]Ibid., pp. 21-22.

[7]Ibid., pp. 22-23.

[8]The terms "staff" and "clients" designate two types of reference groups--the "normative type" and the "comparison type." See Robert K. Merton, Social Theory and Social Structure (Glencoe, Illinois: The Free Press, 1949), p. 283 ff.

[9]Although the program statistics indicate that the racial composition has remained fairly consistent over the last four or five years, most staff members state that the program has gone from a mainly white program to one that is fully integrated. The reason for this is that many staff members are referring to the situation in the mid- to late-1960's, when in fact Daytop was mostly white.

CHAPTER VIII

CONCLUSIONS

The three TC's studied in this paper are adapting to a new environment in a variety of ways. The specific type of response varies with certain characteristics peculiar to the individual organization. So, for example, the treatment philosophy, the staff composition, the geographical location, the length of treatment, and the sources of client referral, all combine to influence the organizational response. Yet while there are substantial differences between the specific modes of adaptation, there are also many basic similarities. Change is occurring in all three TC's, with treatment practices and concepts being altered and revised. Goal-succession is apparent in each organization. Many specific forms of adaptation, while not identical, are at least parallel (e.g., active recruitment and "part-time" communities). The organizations, therefore, are not following totally distinct courses of action. But both the similarities and the differences among the TC's must be clarified in order fully to understand how such an organization functions in transition.

Addicts Rehabilitation Center

Addicts Rehabilitation Center (ARC) is a low-discipline, short-term, community-based TC with an ex-addict staff. These features of the organization have remained basically unchanged in the face of its new environment. The discipline in the TC does not emphasize physical punishments, the treatment cycle is about six months in duration, and the staff is still composed almost entirely of ex-addicts. ARC remains "Harlem-oriented," although the recruitment of alcoholics has been expanded to include "outside" areas. The Crisis Intervention Center is responsible for this active recruitment policy, and it is also in charge of the relatively new day-care treatment program. Both of these policies represent two major innovations by the TC organization. The day-care program lets the organization handle large numbers of clients on an ambulatory basis, and also acts as a referral source for the TC. The active recruitment policy is a further source of referrals, especially for alcoholic patients.

The increase in alcohol-using clients is a significant change in the resident population of ARC. These people are often older and white; as a result, they do not fit in with the other residents (they tend to be older be-

cause many have "matured out" of heroin addiction, and they tend to be white because of recruitment activities outside of the Harlem area). Often, too, alcoholics have many physical problems, something that makes treatment more difficult. Further, these clients tend to isolate themselves from younger residents, due to the difference in age, and do not relate well to the ex-addict staff because of the difference in lifestyles. One consequence of all these factors is that the rate of recidivism for alcoholic clients is quite high.

In addition to the problems posed by alcohol-using clients, ARC is facing the dilemma of treating young multiple-drug users. These clients are more aggressive than past residents, and more antagonistic to authority. As a result, the younger residents are frequently involved in conflicts with older staff members. These conflicts often revolve around the client's unwillingness to obey specific rules of the TC. The staff blames this opposition to authority on the personality of the younger client, and on the ready availability of alternative treatment modalities (especially methadone maintenance programs). These factors are also postulated as the reasons for the high rate of recidivism for the newer clients.

ARC is responding to the problems created by the influx of alcoholics and young multi-drug users into the program in very pragmatic ways. Separate alcohol therapy groups are run for the alcohol-using clients. Educational and employment opportunities have been expanded for the younger clients. Staff members are trying to be more involved with individual clients. Yet age seems to be the factor that causes the greatest number of problems in treatment. Older staff members find it difficult to relate to younger residents, who are perceived by the staff as being "young and aggressive." In addition, younger clients isolate themselves from older clients. But age serves also as a positive factor. While barriers to communication do exist between ex-addict staff members and alcoholic clients, age seems to be a common bond that enables these two groups to maintain some rapport. To counter the age difference between staff members and clients, younger staff people are being trained to treat the younger residents. Also, treatment staff members are making individual attempts to gain a better understanding of the newer clients' problems.

These treatment problems of ARC are likely to continue, at least into the near future. In addition to the

difficulties the organization has in adapting to alcoholics and younger clients, it is facing an increase in the number of female residents and of homeless, non-drug using adolescents. The increase in female residents necessitates changes in treatment procedures. Females often have children, or are expecting children, and this means that some provisions must be made to take care of these dependents. (Presently, the children are referred to other agencies.) As the number of female residents increase, the need for more female staff members also increases. ARC is making some attempt to get more higher level female staff people, but this has not been fully successful. Both of these areas of female treatment will require more effort in the future.

Likewise, the problems of dealing with non-drug using adolescents are just beginning. (ARC has only five such individuals at present.) These adolescents are being treated as a form of "drug prevention," since they are considered as "good candidates" for becoming drug users. However, adolescents with family problems must be treated differently than active drug addicts, and the TC has not yet developed a new treatment modality for these clients. This new modality must be forthcoming if ARC is going to

deal effectively with non-drug using adolescents.

Samaritan Halfway Society

Many basic characteristics of the Samaritan Halfway Society (SHS) organization have been changed to meet the demands of the new drug environment. Discipline has been loosened, the duration of the TC program has been reduced, and character restructuring is not as heavily emphasized as before. More professional staff are being added, and educational and vocational programs are being expanded, in an attempt to deal with the newer clients. Perhaps the most important change is the recent opening of the residential methadone-to-abstinence (MTA) program of SHS. This is one of the first such programs in New York City and it represents a direct response to the increased use of methadone by many addicts. The introduction of the MTA component, along with the continued operation of the therapeutic community and the ambulatory drug-free programs, demonstrates the great degree of change that is taking place in the organization's structure.

The new environment that SHS is facing is one in which there are more younger multi-drug using clients, more black and Hispanic users, and more non-drug using adolescents. The TC has gone from a mostly white, middle-class

client population, to one composed of 40% blacks, 40% whites, and 20% Hispanics. In addition, the new client population has a large number of non-drug users who are under 16 years of age (about 20% of the total population is in this group). As a result of these changes, SHS is experiencing a number of conflicts. One conflict involves the two different age groups found within the TC. Most of the ex-addict staff members are graduates of one of the TC's in New York City and consequently, they tend to be in their late twenties and early thirties. Likewise, the professional staff is in the same age range, due to the time spent in professional training and prior work experience. In contrast to these "older" staff members are the "young" clients, many of whom are in their teens. The two age groups often have difficulties in understanding each other. The staff's view of the younger client as "antagonistic to authority" and as "not caring about anything" creates barriers to effective treatment. The client's view of the staff as "too demanding" and "too rigid" exacerbates this problem.

Age is not the only factor which differentiates the staff from the residents. The background of SHS as a "white, middle-class" TC led to the organization's

building an almost entirely white staff. Yet as the racial composition of the clients changed, the staff's racial composition did not. This has caused certain problems to arise, particularly between white staff members and Hispanic clients. (These problems mainly concern difficulties in communication between Spanish-speaking clients and non-Spanish speaking staff members.) Some attempts have been made recently to correct this situation (i.e., hiring more black and Hispanic staff members), but conflicts remain.

SHS has initiated some changes in the treatment process to meet the needs of its clients. Separate group sessions have been organized for younger clients so that they can discuss their particular problems with their peers. Treatment has been "sensitized" and discipline has been reduced in an attempt at preventing residents from leaving the program. But the major problem of motivating the client is not so easily solved. Many staff members feel that because of the various alternative treatment modalities existing today, clients cannot be motivated to the degree that they were in the past. This position is supported by the fact that most referrals to SHS come from the family and the criminal courts, and fewer

are addicts admitting themselves for treatment.

The TC has also responded to the changing environment by shifting to a more "professional" orientation. The top three positions in the TC are filled by professional staff, and the same is true for many positions in the medical, research, vocational rehabilitation, and accounting departments. Even the field operations department, which is mainly staffed by ex-addicts, has hired professional case workers. This increase in professional staff members has not occurred without some problems. Conflicts have arisen between professionals and ex-addict personnel. But in spite of the conflicts, SHS seems headed for a more professional approach to the treatment of addiction and mental health problems. The response of the organization to a changing environment, therefore, has been to broaden the scope of treatment and to change from a non-professional to a professional staff orientation.

Daytop Village

Daytop Village is the traditional type of therapeutic community, following closely the organizational structure of Synanon. It is a high discipline, long-term treatment modality that aims at character restructuring. The treatment staff is composed almost entirely of ex-addict

staff members. Even this organization, however, has changed to meet the needs of a new client population. Ambulatory treatment, initiated through the outreach center programs, has been a major new program. Within the TC itself, additional changes have occurred. The program has been shortened, in most cases, from 18 months to 6 months. Punishments are not as strict as they were previously, and the organization is more tolerant of certain forms of behavior (e.g., homosexuality). Treatment is now considered to be more "sensitized" and "individualized." Professional staff people have been hired to complement the functioning of the ex-addict treatment staff. All of these changes have been implemented in order to deal more effectively with the new client population.

As in the other TC's studied, Daytop Staff members view the newer clients as being "different from themselves." While the Daytop staff is mostly older, white, former heroin addicts, the clients are often younger, black and Hispanic, former multi-drug users. In addition, many staff members feel that the newer clients lack the proper motivation towards treatment. This, the staff members think, is due to the existence of many alternative treatment modalities, as well as to the reduction in court remands to

the TC. The end result of these "differences" is that the staff members regard their jobs as being more difficult than ever before.

In spite of the fact that Daytop is experiencing certain difficulties in adjusting to the new client population, this organization is not undergoing any drastic structural changes. Staff members have had to become attuned to the problems and needs of the residents. Services such as medical treatment have been expanded to meet the increased medical problems of clients. More female staff members are being hired because of the increase in female residents. But these do not reflect major changes in treatment ideology. Daytop is not taking in any alcoholic clients, nor is it dealing with non-drug-using adolescents. The major emphasis is still on the treatment of drug addiction. This situation is able to continue because Daytop enjoys the reputation of being one of the "biggest and best" TC's in the New York City area,, The organization, therefore, continues to have more clients than it can handle. (Daytop has been over its contract level for the last few years.)

The administration is not particularly concerned about keeping the residential population up to funding

levels because it is felt that the reputation of Daytop Village will continue to attract many clients from the courts and the outreach centers. Consequently, the organization is expanding existing services, rather than initiating new ones. A separate female program and more professional staff are two plans for the future that are receiving a great deal of attention. Beyond this, Daytop does not anticipate any major treatment innovations in the near future.

Similarities in TC Responses

All three of the TC's studied realize that a "new and different" client is entering treatment now, and all of the organizations are responding to the new environment in a number of basically similar ways. Discipline, while not initially at the same level in each community, has been eased in all three. The treatment cycles have been reduced in duration, and more attempts have been made to deal with the clients on an individual basis. Conflicts between staff and clients have been recognized and they are often discussed in group sessions. These similar responses of the TC's have been followed by other parallel behaviors of the organizations.

All three organizations have established some form of outpatient treatment. ARC has a Crisis Intervention Center, which provides non-residential help to members of the community. SHS has an evening program that attempts to treat working addicts on a part-time basis. Daytop's outreach centers offer a variety of daycare programs, mainly for addicts who wish to live at home. These programs allow the organizations to provide alternatives to residential treatment, and thereby to expand the total scope of the services offered to the client population. Furthermore, these components often serve as referral sources for the TC itself. Clients entering the part-time treatment program can then seek out residential treatment if they need it.

The recruitment practices of the part-time TC components are aided by other organizational policies. So, for example, ARC sends out spokesmen to hospital detoxification units in an attempt to get clients for the TC program. SHS has liason people in the Queens Family Court who seek out adolescent referrals for the TC. Daytop, via the outreach centers, recruits addicts from various communities throughout the New York metropolitan area. All of these organizations realize that some form of recruit-

ment is needed to keep the TC functioning. This is especially true in the present environment, where many alternatives to TC treatment exist. Each TC studied has thus taken a somewhat similar path of active recruitment.

The three TC's studied are very much aware of the fact that alternatives to TC treatment exist. Staff members in each organization point out that this seems to cause poor client motivation and high rates of recidivism. The idea is widely held that clients know of the alternative treatment modalities, and therefore "shop around" before going into any particular program. If the client does not like the program he selected, he can simply drop out and enter another one. Most staff members agree that this situation makes it hard for the TC's to keep clients in treatment, because there is no longer the belief that a particular TC is the client's last chance. (The organizations studied all place the greatest blame for poor motivation on the numerous methadone maintenance programs operating in New York City. These, they feel, are the alternatives that clients seek out most frequently.)

These responses of the TC's indicate that the different organizations are adapting to the new environment in a number of common ways. Each community is concerned

with organizational survival and growth, and each is implementing new policies to achieve these goals. This behavior represents the organizations' successful adaptation to a changing social environment. The form the adaptation takes varies with the specific type of TC.

Variations in TC Responses

The greatest degree of change in organizational structure seems to be occurring in the low-discipline and medium-discipline types of TC, while the least amount of change is taking place in the high-discipline type of organization. ARC, a short-term, low-discipline type, is expanding its treatment to include alcoholics and non-drug using adolescents. SHS, a "middle-range" organization, is dealing with non-drug using adolescents, multi-drug using clients, and methadone users who want to become drug-free in a residential program. Daytop, a high-discipline TC that aims at major character restructuring, is still concerned primarily with drug-users, although the treatment process is being changed in the face of a new type of client.

A significant change that is taking place in the medium-discipline type TC is the move toward greater professionalism. SHS has a professional and ex-addict treatment staff, and professional leadership at the higher lev-

els of the organizational bureaucracy. The philosophy of this TC is that as more diverse client problems are confronted, a more professional staff is needed. Therefore, SHS is increasing the size of the professional staff in order to deal with the new and different client population. (One result of this increased professionalism is that staff conflicts develop between the ex-addicts and the professional members. This type of conflict is not prevalent in the other two TC's, because both of those organizations have predominantly ex-addict treatment staffs. Other forms of staff conflict exist in ARC and Daytop. Often these conflicts are clashes between personalities. The result is that all of the TC's studied have high rates of staff turnover, and this seems to be a problem endemic to the field of TC drug treatment.)

One important variable, useful in explaining the degree of TC change, is the size of the organization. Daytop is the largest TC studied, with over 500 residents and 163 staff members (a 1-to-3 staff/client ratio). SHS is the smallest, with 80 residents and 80 staff members (a 1-to-1 ratio). Daytop's position as a large organization with an extensive bureaucracy allows it to be confident of its supply of clients; at the same time, its size

prevents Daytop from changing its treatment policies readily. Daytop's size also permits it to be relatively free of concern about the future existence of the organization. For this reason, Daytop is not adopting new treatment modalities as rapidly as are the other TC's. ARC and SHS are comparatively small. They are aware of the fact that a decrease in clients can be a direct threat to their existence. Thus they have initiated substantial changes in both the structure and functioning of their organizations. By broadening their scope of treatment, they are increasing their chances of survival.

SHS is the smallest TC studied, and the one that is the most "professionally" oriented. This organization is also the most innovative of the three TC's. The residential MTA program is one of the first in New York City, and it is expected that these residents will eventually make up a significant proportion of the overall population. Non-drug using adolescents already comprise 20% of its clients, and this percentage is likely to increase in the future. These innovative practices of SHS are closely related to both the size of the organization and the organization's professional leadership. The movement toward professionalism reflects the ideology of the organization's

leaders and is necessary in diversifying the scope of TC treatment. This policy is facilitated by the relatively small size of the organization, which allows the TC to implement treatment changes rather quickly.

ARC is also a relatively small TC, and it has responded to a new environment by making certain basic changes in treatment. The alcoholic treatment program is aimed at the increased number of methadone users who abuse alcohol, and at the significant number of heroin addicts who "mature out" into alcohol use. The acceptance of non-drug using adolescents is justified as a form of preventive treatment for potential drug users. The implementation of these changes in treatment is possible because of ARC's small size and low-discipline, short-term treatment philosophy. These characteristics produce a less rigid organizational structure that is more conducive to accepting change. ARC has not moved towards a more professional orientation in treatment because its top leadership is composed of ex-addict staff members. Yet the organization's response to a changing environment is a viable one, and one that involves new goals for the TC.

Daytop Village is a large TC, one of the best known drug treatment modalities in New York City. It is a high-

discipline, long-term treatment organization that aims at major character restructuring. These characteristics mean that Daytop is not changing its treatment goals in order to attract a more diversified client population. (The threat of a declining population of drug-using individuals is not evident.) Yet while Daytop is not taking in alcoholic clients or multi-problem adolescents, the organization is changing certain treatment policies. Discipline has been reduced, and more professionals are being added to the staff. But there have been no major changes in the organization's goals. Daytop continues to offer treatment for drug addiction as a primary goal.

In this study, the high-discipline, long-term treatment TC that aims at major character restructuring is also the largest organization with the most extensive bureaucracy. The low-discipline, short-term treatment TC and the middle-range TC are relatively small organizations. It is difficult, therefore, to single out one factor that is responsible for the degree of an organizations successful adaptation to a changing environment. It does seem that the smaller organizations, with their less extensive bureaucracies, their shorter-term treatment, their low discipline, and their decreased emphasis on character re-

structuring, are both more interested in and capable of implementing changes in organizational goals. The larger organization, more confident of a continued supply of clients and more rigid in its treatment procedures, is less likely to experience goal succession.

It must be reiterated that all three TC's are changing to meet the needs of the new client population, although the degree of change varies from one organization to the next. While all of the TC's are changing certain procedures, not all of them are altering basic organizational goals. Daytop Village has changed some treatment policies, but it has retained the basic goal of drug treatment. SHS, on the other hand, has identified new goals in addition to the major one of drug treatment. Now this organization seeks to transform methadone-using residents into drug-free individuals, and also to treat the non-drug problems of adolescent clients. Furthermore, SHS is moving towards the goal of being a general mental health treatment program. ARC, likewise, has expanded its goals. Alcohol treatment is now a major component of ARC, and the problems of non-drug using adolescents are also being dealt with in its residential program. In view of this, it is clear that the greatest degree of goal succession

is occurring in the smaller, lower-discipline type TC's, while the least degree of goal succession is taking place in the larger, high-discipline type organization.

Trends in the Future

The modes of adaptation presently being followed by the TC's are likely to be continued in the future. Change will occur in all of the organizations with the degree of change varying from type to type. Most of these changes are linked to the social environment. The drug environment of the next few years is likely to be a mixture of many elements. Methadone usage will continue to increase, as will the alcohol and multi-drug use associated with methadone. Heroin use will probably follow a cyclical pattern, in accordance with the supply of the drug in this country. Adolescent drug use will continue, and the non-drug related problems of this age group will also persist. Alcohol use among adolescents seems to be on the rise and this is likely to continue in the future.

Specific changes in the current TC populations are indicative of future trends, and thus of future problems. So, for example, the increase in female clients is something that will go on for a number of years to come. The TC's, however, have only begun to adapt to this new popula-

tion of residents. Significant numbers of female staff members have not been added in the three organizations studied, especially in higher-level positions. The special problems of females (their self-image, physical ailments, etc.) are being dealt with only on a limited basis. None of the three TC's has a separate female program, and only Daytop Village is planning such a program. These areas will need more attention if the TC organizations are going to help their female clients.

Minority group members, especially Hispanics and blacks, have been increasing in significant numbers in TC populations in New York City. This increase has been taking place over a number of years. Of the three communities studied, SHS and Daytop have realized the greatest change. They have both gone from mainly white organizations to ones with approximately 40% white, 40% black, and 20% Hispanic populations. ARC, an almost entirely black TC, has also experienced a change in racial composition of its clients, although this has not been as dramatic as with the other two organizations (many of ARC's alcoholic clients are white). The problem with all of the TC's is that they have not changed their staff populations in accordance with the new client populations. There are

few minority staff members at the higher levels of Daytop Village and SHS. While ARC can continue as a black-oriented TC catering to black clients, Daytop Village and SHS cannot have a racially mixed client population and a mainly white staff. Some change is taking place at these two TC's, but more is needed in the future.

Another change in the populations of the TC has been the increase in "younger" clients who are entering treatment. Staff members at all three of the TC's studied state that these clients are "different" and are therefore harder to deal with. Even at Daytop Village, where the newer clients are not really as young as those in the other TC's, this same statement was frequently heard. Some of the TC's have responded to this problem by setting up separate treatment groups for younger clients, or by hiring younger staff members. But generally, the TC's are faced with a situation where an "older" staff is treating "younger" clients.

This discrepancy in age is bound to increase in the future as the staff members get older, even if the clients do not continue to get younger. The critical fact, however, seems to be that the staff members perceive the clients as being younger, and react to them accordingly.

This is not to deny that there are some real differences in lifestyles and drug-use patterns. But the differences are exacerbated by the belief that the clients are "younger," and thus more immature and more irresponsible. All of the TC's studied need to do more to convince the staff members that the actual differences between themselves and the clients are less than the perceived differences. This is essential for future success in TC treatment.

As the problems of the entering clients become more extensive, the need for professionally trained staff members increases. The newer residents of the TC are not the traditional heroin addicts of the 1950's and 1960's. They are methadone addicts, multi-drug users, alcoholics, and adolescents with family problems. Often the ex-addict staff member cannot deal with all of these pathologies. Increasingly, the TC's are turning to professional personnel to supplement their existing staff functions. Of the three TC's studied, SHS is the most oriented towards professional staff members, while ARC is the least so inclined. Daytop is starting to increase its professional personnel, although at a slower rate than SHS. In the future, SHS seems likely to become much more professionally oriented, with a corresponding decrease in its ex-addict staff

members. Likewise, Daytop is headed towards a more professionally trained staff; yet it will probably retain a substantial number of ex-addict personnel. ARC does not appear to be concerned with adding professional people to its staff. This might be a major problem for their organization in the future.

All of the TC's studied here are changing to meet the needs of the new environment. Treatment procedures and goals are being redefined in face of the clients who are now entering the TC. Goal succession is occurring in the three organizations, with the clearest examples being in ARC and SHS. Yet the organizations have not completed the process. Additional changes in the drug environment may well necessitate new goals for the TC. The future of the organization depends upon its ability to respond to new situations in a positive way. If the TC can do this, it will continue to be a viable treatment modality for various social illnesses.

Implications of the Research

The direction TC change is taking is inevitable in light of the organizational structure and goals outlined previously (see Figure 1). Daytop Village has reduced discipline and shortened the treatment cycle while retaining

the goal of personality change. By keeping this organizational goal, Daytop has placed limits on both the degree of discipline reduction and the treatment cycle duration. Yet this TC has also added to its original goal by including drug prevention programs in the basic organizational structure. These programs, together with the more complex problems of the new TC clients, have necessitated the addition of professional staff members. This has caused Daytop to move towards a more professional approach to the treatment and prevention of drug addiction. For Daytop, this is a viable alternative to a high-discipline, long-duration, ex-addict staffed treatment that aimed solely at changing the personalities of hard-core heroin addicts.

SHS has also reduced discipline and shortened the treatment cycle. This has caused SHS to become more committed than ever before to the goal of vocational and educational rehabilitation, since it is difficult to accomplish personality change in a low-discipline, short-duration program. A further impetus for this change is coming from the newer clients who are entering the TC. As more problem adolescents enter SHS, a more professional orientation to treatment is needed. Therefore, professional staff members are being added to deal with the non-drug

using clients. And since the professional staff place greater emphasis on vocational and educational rehabilitation than do the ex-addict staff, the move in this direction is accelerating. For SHS, consequently, the move to a lower-discipline, shorter duration program and the addition of a more professionally-oriented staff is leading to a firmer committment to the goal of vocational and educational rehabilitation.

ARC is a program that has not had to implement extensive changes in these areas in order to attract clients. Furthermore, this TC remains committed to the goal of community involvement via an ex-addict run treatment program. This means that the avenues of organizational change open to ARC are somewhat limited. Since this is the case, the TC has responded in the only way open to it--namely, by taking in a wider variety of clients. Alcoholics and problem adolescents are being treated along with drug addicts. The goal of drug treatment has thus been expanded to include the treatment of other personality problems.

The goal succession occuring in the TC, therefore, is of two types. The first is a change from the goal of treatment of drug addiction to the more general goal of treatment of mental health problems. The second type is

the gradual shift from the goal of personality change to that of vocational and educational rehabilitation. This latter form of goal succession is aided by the increased competition among TC's for new clients. As the competition increases, the severity of discipline and the length of treatment decrease. Since vocational and educational rehabilitation are more conducive to a short-term, low-discipline program, this becomes a more viable treatment goal.

Accompanying these forms of goal succession is the need for a more professional staff. The increased need for professional staff members often means a corresponding decrease in the need for ex-addict staff members. As the demand for ex-addict staff lessens, their position in the TC organization becomes more precarious. The uncertainty of their future in the TC can cause anxiety or stress for the ex-addict staff members. Neither result is a positive one for the organization.

A major reason for the occurrence of the process of goal succession in the TC has to do with organizational funding. Since the amount of money each TC receives depends upon the number of residents it has, there is tremendous pressure to attract clients. As the new drug en-

vironment of the 1970's has reduced the potential client population of the TC's, the competition between these organizations has increased. The program changes discussed above are responses to this increased competition. It is still too early to see if the process of goal succession in the TC is going to enable it to survive in a viable form. It does seem, however, that a more stable method of funding for this type of organization (one not based on the number of TC residents) would decrease the amount of competition between programs and would minimize the problems of transition that the organization is experiencing.

The trends established in the TC, up to this point, indicate a continuation of the process of goal succession. The move towards the treatment of general methal health problems, and the increased utilization of vocational and educational rehabilitation, seem to be well established. Likewise, the increase use of professional staff members appears to be a new direction to TC treatment. The development of the therapeutic community is likely to continue in the present direction if funding procedures remain constant. However, a change in these procedures can have a deciding effect on the future of the organization.

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Implications for Organizational Theory

As discussed in Chapter II, neither "goal-succession" nor "goal-displacement" seems an adequate term to describe the sort of changes in the goals of the therapeutic communities that have been documented above. The TC has clearly not experienced goal-succession, if one means by this that the organization has achieved the goal of eliminating drug addiction and has now moved on to new challenges. Rather, the TC has retained its original goal of drug treatment while extending it to include one or more additional mental health problems. It is clear, also, that the idea of goal-displacement is not directly applicable. Although one might view the TC's willingness to accept new types of clients as indirect proof that organizational survival has now become more important than curing drug addicts, it would be difficult to demonstrate any decline in the overall strength of the TC ideology or in staff members' dedication to serving their clients.

What has occurred, instead, is more complicated. Whether for purposes of organizational survival or, more idealistically, in order to maintain maximum utilization of existing facilities, the TC's have sought out new sources of clients. The new clients, in turn, have posed

new problems for the TC's, which have begun to result in changes in organizational structure. It may be suggested, in light of this analysis, that the concept of goal-extension may be more useful in describing some forms of organizational change than either goal-succession or goal-displacement.

If goal-succession is a possible consequence of complete organizational success in achieving a specific, one-time goal (e.g., eliminating polio), and if goal-displacement is often a consequence of organizational success in achieving a continuing goal (e.g., a secure corner of the market, or long-term political supremacy), then goal-extension falls midway between these types. It involves aspects of both of them, but offers additional insight into the complex relationship between organizational ideals and organizational structure.

In particular, the concept of goal-extension facilitates an appreciation of the way in which organizational ideology may remain intact while at the same time its logical extension can eventually, and in specific ways, produce change in organizational structure. In the case of the therapeutic communities studied here, this process is still underway. As the more "vulnerable" TC's move toward

shorter-term, more pragmatic treatment modalities, it is possible that they will find it necessary to make significant changes in their explicit goals. For the present, however, their goals have not changed so much as they have been extended--and the long-range consequences of this type of goal-change have not yet come clearly into view.

BIBLIOGRAPHY

Azumi, K., and Hage, J. Organizational Systems. Cambridge, Massachusetts: D. C. Heath and Co., 1972.

Addicts Rehabilitation Center. ARC Seventh Report. New York: Addicts Rehabilitation Center, April, 1974.

Blau, Peter. The Dynamics of Bureaucracy. Chicago: The University of Chicago Press, 1955.

_____. Bureaucracy in Modern Society. New York: Random House, 1956.

Blau, Peter, and Scott, W. Formal Organizations. San Francisco: Chandler, 1962.

Blaurer, Robert. Alienation and Freedom: The Factory Worker and His Industry. Chicago: The University of Chicago Press, 1964.

Blum, R. H. Society and Drugs (Vol. 1). San Francisco: Jossey-Bass, 1969.

Brill, L., and Lieberman, L. Authority and Addiction. Boston: Little, Brown and Co., 1969.

Brinkerhoff, Merlin, and Kunz, Philip. Complex Organizations and Their Environments. Dubuque, Iowa: W. C. Brown and Co., 1972.

Casriel, B. So Fair a House. Englewood Cliffs, New Jersey: Prentice-Hall, 1963.

Chein, I. Road to H. New York: Basic Books, 1965.

Cressey, Donald. "Achievement of an Unstated Organizational Goal." In Complex Organizations: A Sociological Reader, Edited by Amitai Etzioni. New York: Holt, Rinehart and Winston, 1961.

Daytop Village, Inc. 1973-74 Annual Report on the Therapeutic Community and Ambulatory Treatment Programs of Daytop Village, Inc. New York: Daytop Village, 1974.

DeLeon, George, ed. Phoenix House: Studies in a Therapeutic Community (1968-1973). New York: MSS Information Corporation, 1974.

Densen-Gerber, J., Casaclong, I., and Harris, N. "Preventive Education via Out-Patient Storefronts." Prepared for presentation in the Scientific Program of the American Psychiatric Association's Annual Meeting, Washington, D.C., May 3-7, 1971.

Densen-Gerber, J., and Herzich, L. "The Odyssey House Program with a Statistical Analysis of the Residents in the N.A.C.C. Facility." New York: Odyssey House Publication.

Densen-Gerber, J., Murphy, J., and Record, S. "The Changing Adolescent Addiction: A Changing Pattern." Prepared for presentation in the Scientific Program of the American Psychiatric Association's Annual Meeting, Washington, D.C., May 3-7, 1971.

Dole, V. P., Nyswarder, M.F., and Warner, A. "Successful Treatment of 750 Criminal Addicts." Journal of the American Medical Association 206 (1968): pp. 2708-11.

Etzioni, Amitai. A Comparative Analysis of Complex Organizations. New York: The Free Press, 1961.

_____. Complex Organizations. New York: Holt, Rinehart and Winston, 1961.

Ford Foundation Report. Dealing with Drug Abuse. New York: Frederick A. Praeger Publishers, 1972.

Fort, Joel. The Pleasure Seekers. Indianapolis, Indiana: Bobbs-Merrill, 1969.

Gerth, H., and Mills, C. W. From Max Weber. New York: Oxford University Press, 1946.

Goffman, Erving. Asylums. Garden City; New York: Doubleday & Co., Inc., 1961.

Hage, Jerald. and Aiken, Michael. Social Change in Complex Organizations. New York: Random House, 1970.

Hall, R. H., Haas, J. E., and Johnson, N. J. "An Examination of the Blau-Scott and Etzioni Typologies." In Organizations: Structure and Process. Edited by Richard Hall. Englewood Cliffs, New Jersey: Prentice-Hall, 1972.

Hoenig, G. "The Infinite Resilience of Drug Abuse." In The New York Times, Sunday, February 9, 1975.

Jones, Maxwell. The Therapeutic Community. New York: Basic Books, 1953.

_____. Beyond the Therapeutic Community. New Haven, Connecticut: Yale University Press, 1968.

Lefton, Mark, and Rosengren, William. "Organizations and Clients: Lateral and Longitudinal Dimensions." American Sociological Review 31 (December 1966): 802-11.

Lennard, H., and Bernstein, B. Patterns in Human Interaction. San Francisco: Jossey-Bass, Inc., 1970.

Lindesmith, A. R. Addiction and Opiates. Chicago: Aldine Publishing Co., 1968.

March, J.,and Simon, H. Organizations. New York: John Wiley and Sons, Inc., 1958.

Merton, Robert K. Social Theory and Social Structure. Glencoe, Illinois: The Free Press, 1949.

Murphy, J., and Densen-Gerber, J. "Therapeutic Community Treatment of Addiction." Prepared for presentation in the Scientific Program of the American Psychiatric Association's Annual Meeting, Washington, D.C., May 3-7, 1971.

New York Daily News. December 22, 1975.

New York Times. Sunday, April 6, 1975.

_____. Sunday, February 9, 1975.

_____. October 2, 1975.

O'Donnell, J. A., and Ball, J. C., eds. Narcotic Addiction. New York: Harper and Row, 1966.

Odyssey House. The Odyssey House Method. New York: Odyssey House Publication, n.d.

Parsons, Talcott. The Social System. Glencoe, Illinois: The Free Press, 1951.

Perrow, C. "Organizational Goals." In Organizational Systems. Edited by K. Azumi and J. Hage. Cambridge, Massachusetts: D. C. Heath and Co., 1972.

Robins, L. N., and Murphy, G. E. "Drug Use in a Normal Population of Young Negro Men." American Journal of Public Health 57 (1967): 1580-96.

Rohrs, C., Goldsmith, B., and Densen-Gerber, J. "Odyssey House: Drug-Free Treatment Failures." New York: Odyssey House Publication, n.d.

Rosengren, W., and Lefton, M. Organizations and Clients. Columbus, Ohio: Charles E. Merrill Pub. Co., 1970.

Rosenthal, M. "The Phoenix House Therapeutic Community: An Overview." In Phoenix House: Studies in a Therapeutic Community (1968-1973). Edited by George DeLeon. New York: MSS Information Corporation, 1974.

Selznick, P. TVA and the Grass Roots. Berkeley, California: University of California Press, 1949.

Sills, D. The Volunteers: Means and Ends in a National Organization. Glencoe, Illinois: The Free Press, 1957.

Sugarman, Barry. Daytop Village--A Therapeutic Community. New York: Holt, Rinehart and Winston, Inc., 1974.

Sykes, Gresham. The Society of Captives. Princeton: Princeton University Press, 1958.

Systems Services, Inc. "A Comparative Analysis of Twenty-Four Therapeutic Communities in New York City." Funded by the Addiction Services Agency of New York City, 1973.

Szasz, Thomas. Law, Liberty and Psychiatry. New York: Collier Books, 1963.

Volkman, D.,and Cressey, D. "Differential Association and the Rehabilitation of Drug Addicts." In Narcotic Addiction. Edited by J. A. O'Donnell and J. C. Ball. New York: Harper and Row, 1966.

Waldorf, Don. Careers in Dope. Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1973.

Wilner, D. M., and Kassebaum, G. G., eds. Narcotics. New York: McGraw-Hill, 1965.

Winick, Charles. "Drug Addiction and Crime." Current History 52 (June 1967): 349-54.

_____. "The Life Cycle of the Narcotic Addict and Addiction." United Nations Bulletin on Narcotics 16 (1964): 1-11.

Yablonsky, Lewis. Synanon: The Tunnel Back. Baltimore, Maryland: Penguin Books, 1965.

Yablonsky, Lewis and Dederich, C. "Synanon: An Analysis of Some Dimensions of the Social Structure of an Anti-Addiction Society." In Narcotics. Edited by D. M. Wilner and G. G. Kassebaum. New York: McGraw-Hill, 1965.

Zwerin, M. The Silent Sound of Needles. Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1969.