Treatment: Therapeutic Milieu
Rationale and Staff Evaluation of Using
a “Therapeutic Milieu” for Substance
Users Within a Tuberculosis Ward¹

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Treatment: Therapeutic Milieu

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DANIEL CHEMTOB AND AVI LEVY

Department of Tuberculosis and AIDS, Public Health Services, Ministry of Health, Jerusalem, Israel

Approximately 30% of tuberculosis (TB) patients in Israel were treated, in part, in two dedicated hospital wards during the years 2003–2005. A portion of them manifested severe psychosocial conditions. An intervention based on the “Therapeutic Milieu” (TM) model was implemented in the larger ward and included a staff evaluation of this intervention. The concept of TM, based on psychosocial paradigms and behavioral medicine, is aimed at providing a supportive environment for patients. Weekly group patients’ meetings and monthly group staff supervisions were performed during 15 months (2003–2005). Forty of the 196 (20%) TB patients, mainly “complex,” and 13 of 20 staff members (65%) attended regularly and discussed how to deal with substance abuse, personality disorders, and immigration-related crises. Out of 40 TB cases, 30 (75%) were also substance users. Ten staff members self-analyzed the impact of this intervention in terms of (1) having given adequate tools for the staff, (2) reducing physical violence, (3) increasing adherence to TB treatment, and (4) more efficient treatment for their substance use. No direct evaluation was done among the TB patients. According to staff members, this intervention had a positive overall impact. However, using Therapeutic Milieu in TB ward hospitalization, as a “window of opportunity,” remains the first step in a longer journey for rehabilitation. The study’s limitations are noted.

Keywords tuberculosis; psychosocial; Therapeutic Milieu; substance abuse; Israel; dropout; relapse; compliance

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1The opinions expressed in this article are those of the authors and do not purport to represent the opinions of the agencies with which they are associated. Part of this paper was presented in abstract form at the Fourth Congress of the International Union Against Tuberculosis and Lung Disease, Europe Region, Riga, Latvia, June 2007. This evaluation was part of the external evaluation done by the Department of Tuberculosis and AIDS at the Israeli ministry of health.
Background

Approximately 30% of tuberculosis (TB) patients in Israel were hospitalized in two dedicated TB wards, during the years 2003–2005, according to a new TB control program (Chemtob, Leventhal, Berlowitz, and Weiler-Ravell, 2003). A portion of them suffered, in addition, from severe psychosocial conditions, which greatly complicates adherence to ambulatory treatment (Chemtob, Lidji, Eliel, Scherman, and Leventhal, 2005). Hospitalization is often a necessary component of management for patients with TB who do not adhere to therapy or manifest medical and/or psychosocial problems such as substance abuse disorder, alcoholism, homelessness, and personality disorders (hereafter “complex TB cases”) that complicate treatment (Singleton et al., 1997). In addition, the combination of multidrug resistant TB, HIV, and a history of injection drug use with antisocial personality requires diagnostic evaluation and long-term care (Chemtob et al., 2005).

Israel has implemented a new TB control program (Chemtob et al., 2003) in response to the dismantlement of its TB infrastructure in the 1980s and the rise of TB incidence mainly due to immigration during the last decade (Chemtob, Leventhal, and Weiler-Ravell, 2003). This program complies with the five elements of the Directly Observed Therapy (DOT), a strategy recommended by World Health Organization (WHO) guidelines,2 and also includes specific additional measures addressing the needs of a continuum from community treatment to hospitalization (Chemtob et al., 2003). Several aspects of the TB treatment in the community have been extensively published elsewhere (Chemtob, Leventhal, Berlowitz, et al., 2003; Chemtob, Leventhal, Weiler-Ravell, 2003; Chemtob, Weiler-Ravell, Leventhal, and Bibi, 2006). According to recent evaluations conducted by the TB and AIDS department of Israel’s ministry of health, completion of treatment occurred in more than 78% of cases (Chemtob et al., 2003). However, the more complicated cases continued to be referred to the hospital, and it was considered that an in-depth intervention addressing these cases and the health personnel working with them was necessary. This intervention has not been previously analyzed or published. Therefore, the aim of this paper is to describe, for the first time, the rationale of this intervention and evaluate its impact from the point of view of the staff, in order to improve treatment and guide further steps.

Before describing the intervention itself, we would like to point out the part played by major components like Israeli immigration processes in the issue of TB.

Immigration and TB in Israel

Migration plays a major role in the epidemiology of TB in Israel. Despite the fact that only 30% of Israeli citizens are foreign born, some 80% of new TB cases diagnosed in Israel are among foreign born (Chemtob et al., 2003). Throughout the last decade, cases among immigrants from Ethiopia and the former Soviet Union (FSU) have constituted the vast majority of new cases in Israel (Chemtob, Leventhal, Berlowitz, et al., 2003; Chemtob, Leventhal, Weiler-Ravell, 2003; Chemtob, Weiler-Ravell, Leventhal, and Bibi, 2006). Some of these immigrants have unique characteristics, such as partial adherence or nonadherence to treatment (despite all attempts at ambulatory care), high level of multidrug resistance (MDR), and often low socioeconomic status. Crowded living arrangements exist and may also pose a serious threat of the spread of TB infection (Grange, Story, and Zulma, 2001). However, DOT worked very well for most of the TB cases, in particular for those with no or a moderate level of social

2The five major elements recommended by WHO are (1) political commitment; (2) adequate laboratory diagnostic facilities; (3) standardized short-course chemotherapy given under DOT supplies; (4) consistent drug supplies; and (5) permanent reporting system.
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difficulties (Chemtob et al., 2003). Still, when analyzing all TB patients under treatment in 1999, some 12% were defined as “complex TB cases,” mostly for social reasons, and their treatment adherence was poor, despite all the support they received (Chemtob et al., 2001). Therefore it was decided that, when hospitalizing them, a “Therapeutic Milieu” (TM) using established mental health and addiction treatment techniques will be needed to support and foster the behavioral changes needed in order to remain in hospital to complete therapy or, preferably, to resume ambulatory treatment (Chemtob et al., 2005).

The TM Intervention—Its Rationale and How We Proceeded

The concept of TM for patients with TB is based on established methods from psychosocial paradigm and behavioral medicine and is designed to provide a safe and supportive environment for patients who feel victimized and have few support systems (Gerdner, 2001). A TM intervention by therapists is designed to address different aspects of the recovery process, dealing with perception of disease (e.g., tuberculosis, addiction), care, grief, loss, and death (Chemtob et al., 2001; Grange et al., 2001). Cooperation is essential between physicians, nurses, and social workers to help these complicated TB patients with psychosocial problems to rehabilitate and integrate in the community following discharge (Gerdner, 2001; Singleton et al., 1997).

Our intervention included individual therapy, cognitive group psychotherapy, and brainstorming with the staff.

Individual Therapy. Different therapeutic strategies for working with individuals exist. In the field of addiction, ultimately all aim to help the client to modify her/his destructive behavior. In the present work, we choose behavior therapies that directly address the patient’s intentions and behaviors (Perris, 2000).

Cognitive Group Psychotherapy. Cognitive therapy operates under the assumption that knowledge, attitudes, perceptions, and beliefs greatly influence the future emotions, in a scale starting from creating these emotions through intensifying them (Wright and Salmon, 1999). This will ultimately influence the patient’s medical and psychotherapeutic behaviors. In our intervention, we choose an open group (i.e., a group that accepted newcomers). As is usual with work done among drug-addicted persons, dropping out was a very common phenomenon. For some cases, we did not know the reasons why treatment “drop out” occurred. In other cases, some participants had to go back to earlier phases in rehabilitation (because of relapses, psychiatric problems, or after having broken rules of the group, such as physical violence against other patients or the staff, nonadherence to TB medical treatment, and/ using alcohol or drugs; Sudak, Beck, and Wright, 2003).

In our intervention we used health education tools (e.g., general lecture and case description) and started by explaining what diseases like tuberculosis and addiction are. In addition, we tried to be culturally sensitive according to the data and methodology.

Treatment can be briefly and usefully defined as a planned, goal-directed change process, of necessary quality, appropriateness, and conditions (endogenous and exogenous), which is bound (by culture, place, time, and the like) and can be categorized into professional-based, tradition-based, mutual-help based (AA, NA, etc.), and self-help (“natural recovery”) models. There are no unique models or techniques used with substance users—of whatever types—which aren’t also used with nonsubstance users. In the west, with the relatively new ideology of “harm reduction” and the even newer quality of life (QOL) treatment-driven model, there are now a new set of goals in addition to those derived from/associated with the older tradition of abstinence-driven models. Editor’s note.
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described elsewhere (Chemtob, Weiser, Yitzhak, and Weiler-Ravell, 2000). We also invited and stimulated the members of the group to participate, ask questions, comment, and give advice to each other (Gerdner, 2001; Perris, 2000; Wright and Salmon, 1999).

Working With Staff (and Psychosocial Staff Counseling). We organized monthly staff meetings, gathering each available staff member. It was a forum for exchange of information and informal discussion about psychosocial models, interdisciplinary work, addiction, homelessness, immigration crises among the hospitalized, personality disorders, and other psychosocial matters (e.g. acting out, boundaries). Papers and specific cases were also discussed during these staff meetings.

Intervention Design. From November 2003 to March 2005, the second author performed monthly group staff supervision meeting and weekly patients group meetings among the 40 complex TB cases, out of 194 patients hospitalized in this period. Out of 40 TB cases, 30 (75%) were also substance users. Most of them had immigrated to Israel from the former Soviet Union. They had usually started their drug and/or alcohol use in their country of origin. Their immigration to Israel was mostly motivated by the temptation to start a new life in a “Westernized, prospering country.” When arriving in Israel, they had usually looked for a job and had started to work from the “first day,” but their chaotic life as substance users had ruined their efforts for integration. When TB was diagnosed, it was another huge barrier for their tentative start of a “new life” in Israel. Therefore, starting a DOT was paradoxically a “new opportunity” for resuming their attempt to start a new life.

Therefore, hospitalization in a TB ward was an important biopsychosocial platform for setting the “wheel of change” in motion one more time. But being aware of the difficulties facing the substance users—and their risk of relapses—each of these patients was also treated with individual therapy by a social worker in the TB ward. All (20) physicians, nurses, social workers, and other personnel were invited to participate, but only 13 (65%) of them regularly attended these meetings. In fact, our program was generated outside the hospital administration and was offered to the hospital TB staff, on a voluntary basis. Of course, the medical hierarchy agreed to this program and officially supported it. However, most of the staff attending these meetings was not the physicians.

Material and Method of the Staff Evaluation

Among the 13 staff professionals (3 males and 10 females) who regularly participated in the staff meetings, 10 (3 physicians, 6 nurses, 1 social worker) agreed to answer our anonymous questionnaire. The average lengths of work of these professionals in the department and in the profession were 8 years and 24 years, respectively.

Our (pretested) questionnaire included 17 closed empirically based questions. The time needed for completed was approximately 30 minutes, on average. Data collection was done within 2 weeks. The four main issues explored were as follows: (1) Did the staff receive adequate tools for dealing with psychosocial problems or with addiction’s issues? (2) Did physical violence lessen in the TB ward? (3) Did adherence to TB treatment improve? (4) Did the addiction treatment become more efficient?

In the field of TB treatment, adherence to TB treatment was defined by the adherence of absorbing antibiotic pills under supervision (see DOT in the glossary). In the field of addiction, a more efficient treatment was defined as the increase in methadone adherence.

The (Hebrew) questionnaire can be obtained by writing to the first author.
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Table 1

Staff evaluation of a TM intervention in the major tuberculosis ward in Israel

<table>
<thead>
<tr>
<th>Main issues</th>
<th>Subissues</th>
<th>Score</th>
<th>Global score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tools acquisition</td>
<td>Knowledge</td>
<td>1.77</td>
<td>1.94</td>
</tr>
<tr>
<td></td>
<td>Psychosocial tools</td>
<td>2.11</td>
<td></td>
</tr>
<tr>
<td>Reducing physical violence</td>
<td>Atmosphere</td>
<td>1.44</td>
<td>1.21</td>
</tr>
<tr>
<td></td>
<td>Relationship between patients</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Staff–patient relationship</td>
<td>1.2</td>
<td></td>
</tr>
<tr>
<td>Adherence to TB treatment</td>
<td>Patient adherence</td>
<td>2.44</td>
<td>2.44</td>
</tr>
<tr>
<td></td>
<td>Increased motivation of the staff</td>
<td>2.33</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increased motivation of the patient</td>
<td>2.55</td>
<td></td>
</tr>
<tr>
<td>More efficient addiction treatment</td>
<td>Among patients</td>
<td>3</td>
<td>2.99</td>
</tr>
<tr>
<td></td>
<td>Collaboration with staff</td>
<td>2.6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Collaboration with other agencies</td>
<td>3.37</td>
<td></td>
</tr>
</tbody>
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Scale from 1 (very high positive impact) to 5 (no positive or even a negative impact).

during TB hospitalization and/or an increase in adherence to other kinds of treatment (ambulatory or at the hospital), after the TB hospitalization was complete. A scale of 1 (very high positive impact) to 5 (no positive or even negative impact) was used for scoring the answers. In accordance with Israeli regulations, no ethical committee authorization (IRB) was needed for interviewing medical professionals who agreed to participate. No direct evaluation was done among the TB patients.

Results of the Staff Evaluation

Results are summarized in the Table 1. They deal with four major questions:

- Did the staff receive adequate tools for dealing with psychosocial problems or addiction’s issues? With a score of 1.94, an overall general satisfaction of the staff was recorded concerning the acquisition of both adequate knowledge (score = 1.77) about psychosocial issues and adapted tools for facing psychosocial problems with the patients (score = 2.11).
- Did physical violence lessen in the TB ward? The score was 1.21. The general atmosphere in the department improved significantly (score = 1.44), and the relationship among patients (score = 1) and between the staff and the patients (score = 1.2) became nonviolent. Despite the fact that we did not measure specifically verbal violence, the improvement of both general atmosphere and relationship probably also expressed this score.
- Did adherence to TB treatment improve? Motivation of staff toward the patient was high, and adherence to TB treatment during hospitalization was perceived by the staff as having increased (score = 2.55).
- Was the “addiction treatment” more efficient? The score was 2.99. The direct (positive) impact on the addiction treatment of the patient did not exist according to the staff (score = 3). The slightly better collaboration observed with the staff (score = 2.6) in the TB ward did not have tangible consequence when the TB staff was requested to analyze the collaboration of the patients with external agencies in the community (score = 3.37).
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Discussion

The main aims of this paper were to describe, for the first time, the rationale for and the implementation of TM techniques for patients with TB in a major Israeli TB ward. Due to the fact that we organized monthly staff meetings, our intervention reinforced the already existing psychosocial treatment received by the TB patients hospitalized in this TB ward. However, by giving additional cognitive-behavior tools to the staff and by also intervening weekly among the most “complex TB patients,” the necessary therapeutic alliance was therefore highly reinforced. Lastly, our intervention gave the basic ground for performing an evaluation, through the staff itself, which documents that direct and short-term benefits were associated with decreased levels of violence in the ward and improvement of the level of adherence to TB treatment. However, regarding more middle- and long-term issues (such as “addiction treatment”), this intervention fell short and will probably need further work, both within the TB ward and outside of it.

TM and Tuberculosis

TM is a known technique in mental health (Hemmelvoll and Severinsson, 2001; Themis, Shattell, and Martin, 2002) with several “pros” (see below). Still, very little is published in the context of TB treatment (Chemtob et al., 2000; Singleton et al., 1997), and no negative impact has been described (but this can also be due to publication bias).

The “pros” of TM-based treatment are as follows:

- TM provides support, removes barriers, and increase adherence with TB patients (Chemtob et al., 2000; Singleton et al., 1997).
- Individual and group psychotherapies contribute, as we saw in our own intervention, to the creation and maintenance of mutual trust and cooperation, the construction of psychological “rapport,” and the enhancement of the patient self-awareness to TB (Singleton et al., 1997; Sudak et al., 2003). These therapies also probably reduce the feelings of isolation, rage, frustration and hopelessness (Andre, Jaber-Filho, Carvalho, Jullien, and Hoffman, 2003; Sudak et al., 2003).
- Staff meeting encourages an atmosphere of appreciation (Gerdner, 2001), acceptance, and security. Chang, Wu, Hansel, and Diette (2004) analyzed TB assays published since 1972. Despite little having been written about the psychosocial aspects, medical staffs reported about the need of acquiring tools from the mental health paradigm (Copp, Agapaoa, Carvalho, and Pfeiffer, 2003). It was the case also in our survey, where they expressed their readiness and need to learn more about TM.

Notwithstanding that all these “pro-TM” aspects are present in the psychosocial literature; the “cons” of the TM also need to be considered:

- First, such intervention needs additional (and sometimes costly) personnel, including therapists, and their work need to be correctly coordinated.
- In addition, the medical treatment is under an intensive supervision, and this may not always be well accepted by the medical staff itself.
- Lastly, more in-depth psychological tools are often required in order that patients gain a greater understanding of their dysfunctional patterns of behavior (Hemmelvoll and Severinsson, 2001; Themis et al., 2002). This is especially important among severely addicted persons, also suffering from psychiatric diseases, who often mani-
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fest multiple problems, in addition to their addiction (Bellack and Diclemente, 1999). These problems frequently combine medical, psychiatric, legal, and social (housing, unemployment, and financial) issues; the relatively recent creation of the term “dual diagnosis” is one of the indicators of this situation. Therefore, long-term plans are required for a comprehensive rehabilitation in the community (Ouimette, Moos, and Finney 1998; Salomon et al., 1997; Singleton et al., 1997). Considering these problems, the actual prolonged length of TB hospitalization can be considered as being a “window of opportunity” for starting to plan the continuation of the rehabilitation in the community during hospitalization. The development of specific intervention in a TB ward, which could be prolonged posthospitalization in the community, is therefore our main future challenge.

Study's Limitations

However, these results need to be “attenuated” due to existing study limitations, which have limited the generalizability of our study’s findings. First, the small size of the patients who participated in the group meetings is a limiting factor. Secondly, for technical reasons, no preintervention data were obtained, and therefore, it was not possible to perform a before–after analysis. Lastly, the fact that our intervention in the field of “addiction treatment” was considered to fall short by the TB staff is probably also due to the fact that this staff is basically trained to treat lung diseases and not “addiction pathologies.”

Conclusions

The first step of integrating a TM model within the main TB ward in Israel had, according to the staff, a very positive impact on its training needs, reducing the level of physical violence, and TB treatment adherence. However, the staff perceived that this intervention had a moderate impact on the treatment of their patients’ substance use. Due to the severity of their psychosocial problems and the TB staff’s lack of training on “addiction treatment” a long-term rehabilitation plan may be required for a large proportion of patients with “complex TB cases” who are also using and misusing a range of licit and illicit “drugs.” From this perspective, the hospitalization of substance users in a TB ward could be seen as being an intervention “window of opportunity” and the first step in a longer rehabilitation journey.

RÉSUMÉ

Logique de la mise en place d’un “Milieu Thérapeutique” pour patients toxicomanes hospitalisés dans un département anti-tuberculeux, et son évaluation du point de vue du personnel

supervision mensuelle de l’équipe hospitalière ont eu lieu pendant 15 mois. Quarante des 196 patients (20%) hospitalisés durant cette période, et 13 des 20 membres de l’équipe (65%), ont régulièrement participé à ces réunions. Les discussions ont porté sur comment faire face à la toxicomanie, à l’alcoolisme, aux troubles de la personnalité, ou aux crises liées à l’immigration. Parmi les 40 patients, 30 (75%) étaient atteints de toxicomanie ou d’alcoolisme. **Evaluation des résultats**: Dix membres de l’équipe ont auto-analysé l’impact de cette intervention selon 4 paramètres: (1) L’intervention a-t-elle procuré des outils adaptés à l’équipe? (2) Le niveau de violence physique a-t-il été réduit? (3) Le niveau d’adhésion des patients au traitement anti-tuberculeux a-t-il augmenté? (4) L’efficacité du traitement de leur toxicomanie a-t-elle accrue? Nous n’avons pas effectué d’évaluation directe auprès des patients.

**Conclusions**: Selon l’équipe hospitalière, cette intervention a eu globalement un impact positif. De plus la création d’un “Milieu Thérapeutique” au sein d’un département hospitalier anti-tuberculeux, reste pour le patient un “moment d’opportunité,” mais seulement la première étape d’un long périple vers une éventuelle réhabilitation. Les limites de notre étude ont aussi été présentées.

**Mots clefs**: Tuberculose, psycho-social, Milieu Thérapeutique, toxicomanie, alcoolisme, Israël, abandon, rechute, adhésion thérapeutique.

**RESUMEN**

**Lógica de creación de un “Medio Terapéutico” para toxicómanos en un servicio contra la tuberculosis de un hospital, y la evaluación del equipo medical**

**El contexto:** Durante los años 2003–2005, se efectuó una parte del tratamiento antituberculoso de alrededor de un 30% de los pacientes notificados en Israel, en uno de los dos departamentos hospitalarios especializados sobre este tema. Muchos pacientes presentaban problemas psico-sociales graves. En el más importante departamento del hospital, establecimos una intervención de tipo “Medio Terapéutico,” incluyendo también un auto evaluación de parte del personal. **La concepción de l’intervention:** El concepto de “Medio Terapéutico,” estabilizado sobre paradigmas “psico-sociales y behavioristas”, tiene el objetivo de creer un medio ambiente de sostén a los pacientes. Reuniones semanales de pacientes y una supervisión mensual del equipo del hospital ocurrian durante 15 meses. Cuarenta de los 196 pacientes (20%) hospitalizados durante este período, y 13 de los 20 miembros del equipo (65%), han regularmente participado a estas reuniones. Los debates eran por ejemplo a saber cómo enfrentar a la toxicomanía, al alcoholismo, a los desordenes de la persona, o a las crisis vinculadas con la inmigración. Entre los 40 pacientes, 30 (75%) se alcanzaban de toxicomanía o de alcoholismo. **Evaluación de los resultados:** Diez miembros del equipo tienen autoanalizaban el impacto de esta intervención según 4 parámetros: (1) ¿Es que la intervención ha obtenida herramientas adecuadas al equipo? (2) ¿ Es que el nivel de violencia física fue reducido? (3) ¿ Es que el nivel de adhesión de los pacientes al tratamiento antituberculoso aumentaba? (4) ¿ Es que la eficiencia en el tratamiento de su toxicomanía aumentada?

No hemos efectuado evaluación directamente con los pacientes. **Conclusiones:** Según el equipo del hospital, esta intervención tuvo globalmente un impacto positivo. Además la creación de un “Medio Terapéutico” dentro del departamento del hospital antituberculoso, permanece para el paciente un “momento de oportunidad,” pero solamente el primer etapa de un camino largo hasta una rehabilitación posible. Los límites de nuestro estudio también fueron presentados.
**Palabras de referencia:** Tuberculosis, psico-social, Medio Terapéutico, toxicomanía, alcoholismo, Israel, abandono, recaída, adhesión terapéutica.

**Resumen**

En el año 2003 – 2005 se llevó a cabo tratamiento de terapia en un hospital de tuberculosis en Israel. Se seleccionaron 30 pacientes con tratamiento médico, psico-social y terapéutico. Los resultados mostraron una mejoría en los síntomas y una adhesión mayor a los tratamientos. Los pacientes mostraron un mayor compromiso con el tratamiento y una mejor calidad de vida. Este enfoque debe ser aplicado en otros países con alta prevalencia de tuberculosis y toxicomanía.

**Clave:** tuberculosis, psico-social, terapia, adhesión, Israel.
THE AUTHORS

Daniel Chemtob, MD, MPH, DEA, is a physician specializing in public health, who also has a graduate degree in anthropology (DEA). He earned his MD and two graduate degrees (DEA) at Paris’s universities and his MPH at Hebrew University, Jerusalem, Israel. After being a research fellow at Hebrew University, he became the first and the founding director (in 1996) of the Department of Tuberculosis and AIDS at the Israeli Ministry of Health and also the Israeli TB program manager. He was recently on sabbatical at the Johns Hopkins School of Public Health, Baltimore, MD, USA, for graduate studies and postdoctoral fellowship and learned extensively on leadership, health policy and epidemiology, and more specifically sexually transmitted infections. He is currently the principal investigator of the evaluation survey of the pilot syringe exchange program started in Israel. Dr. Chemtob has published some 40 original articles and chapters on several epidemiological, anthropological, and health policy aspects related to hepatitis, tuberculosis, AIDS, harm reductions, and the health of the migrants.

Avi Levy, MSW, is a social worker specializing in addiction treatment. He earned his master’s degree in social work at Tel Aviv University. In addition, he specialized in group psychotherapy at Tel Aviv University and is using cognitive-behavior psychotherapeutic tools with patients manifesting anxiety, depression, and substance abuse disorders. From 1996 to 2003, he was the head of a center for homeless alcoholics in Petach Tikva. From 2003 to 2007, he was the national social worker in charge of tuberculosis and AIDS intervention in the Department of Tuberculosis and AIDS in the Israeli Ministry of Health, Jerusalem.

Glossary

Directly Observed Therapy (DOT): A strategy of supervised treatment, recommended by the WHO as standard of care of TB treatment (since 1994). Despite that it is highly recommended to explain the meaning of TB to the patient, DOT is done regardless of the degree of understanding of the patient for her/his disease. Each patient is requested to swallow her/his pills of antibiotics under the direct supervision of a supervisor, usually health personnel.

Therapeutic Milieu (TM): This concept, based on psychosocial paradigms and behavioral medicine, is aimed at providing a supportive environment for patients.

Tuberculosis (TB): An infectious disease, which is transmissible, due to the Mycobacterium tuberculosis bacillus.
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References


