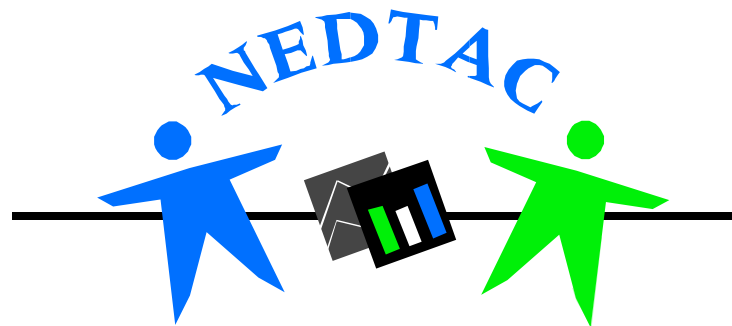


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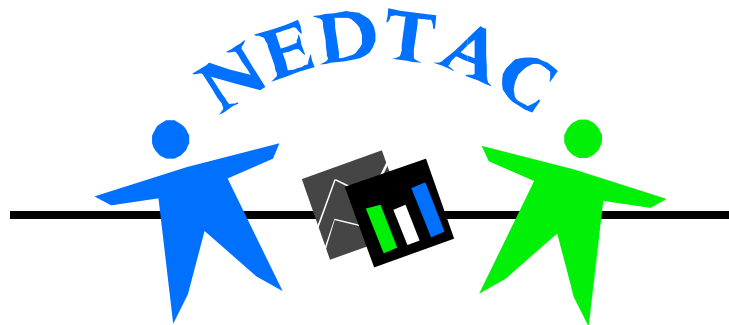
**THE SOCIAL MODEL APPROACH TO  
SUBSTANCE ABUSE RECOVERY:**

**A PROGRAM OF RESEARCH AND EVALUATION**

**PART ONE**

**April 1999**

**NATIONAL EVALUATION DATA AND  
TECHNICAL ASSISTANCE CENTER**



**THE SOCIAL MODEL APPROACH TO  
SUBSTANCE ABUSE RECOVERY:**

**A PROGRAM OF RESEARCH AND EVALUATION**

**April 1999**

**Prepared by  
Lee Ann Kaskutas, Dr. P.H.**

**Alcohol Research Group  
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This study was supported by Center for Substance Abuse Treatment, Department of Health and Human Services, Caliber/NEDTAC Contract No. 270-94-0001.

**CSAT**  
Center for Substance  
Abuse Treatment  
SAMHSA

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## FOREWORD

The Center for Substance Abuse Treatment (CSAT) Program Evaluation Branch established the National Evaluation Data and Technical Assistance Center (NEDTAC) to support the evaluation activities of CSAT's grantees and to advance the state of the art of evaluation of substance abuse treatment programs. The "*social model of recovery*," also known as the "California social model," is an area in the field of substance abuse treatment worthy of in-depth examination and evaluation, but no widely accepted strategy for evaluating social model programs has existed which could be used across programs. For this reason, the Alcohol Research Group (ARG) in Berkeley, California was asked to develop an evaluation methodology to evaluate social model programs.

ARG's effort has resulted in the following products:

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- *The Social Model: A Literature Review and History*
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- *Program Philosophy Scale (PPS) Manual: Guidelines for Scale Administration and Interpretation for Residential, Non-Residential and Detoxification Alcohol and Drug Programs*
- *Cost Checklist: Peer Helping and Hidden Costs in Social Model Programs*
- *Report of a Process Evaluation of Social Model Residential Programs*
- *Executive Summary of Report of a Process Evaluation Social Model Residential Program*
- *Social Model Program Outcomes.*

Collectively, the documents represent a thorough examination of social model programs and how they operate on a day-to-day basis.

We wish to thank Lee Ann Kaskutas, Dr.P.H. and staff from the Alcohol Research Group for their development of this material and Ron Smith, Ph.D., Jim Herrell, Ph.D., and Karl D. White, Ed.D. at the Center for Substance Abuse Treatment for their review and comment. We also wish to acknowledge the editorial support of Joshua Room and Erica Gordon Sorohan.

Sharon Bishop  
Project Director  
National Evaluation Data and  
Technical Assistance Center (NEDTAC)

## PREFACE

Social model recovery is an alternative to clinically-oriented, Minnesota Model substance abuse treatment. The social model approach dominated the public treatment system in California for many years due to its low cost and perceived effectiveness, but it is not well known outside of that state. An expert panel convened in 1993 at the University of California at San Diego by the Center for Substance Abuse Treatment (CSAT) called for the evaluation of social model programs so that the active ingredients of the model could be documented and its outcomes validated.

CSAT subsequently funded a process evaluation and instrument development project through the National Evaluation Data and Technical Assistance Center (NEDTAC). The project was conducted by the Alcohol Research Group (ARG); results are presented here. One goal of the project was to provide the field with a review of what was known about the social model approach, drawing from a literature base more fugitive than readily available. A second goal was to facilitate ongoing evaluation of social model programs by developing and piloting a standard evaluation design that programs could use as a guideline in program evaluation. Since social model programs had not been rigorously evaluated in the past, the overarching goal of the project was to create a foundation of knowledge about social model programs upon which others could build. The project had several components:

- Compile a comprehensive literature review of the social model approach
- Develop and pilot a rigorous process evaluation design
- Develop a checklist to measure the extent to which a program adheres to social model philosophy
- Measure hidden costs in social model programs
- Operationalize some of the potentially therapeutic activities involved in peer helping.

## **SPECIAL JOURNAL ISSUES**

Since the completion of the documents contained in this notebook, the study team has sought publication of the project work in scholarly journals. Two such journals agreed to dedicate an entire special issue to this project's work:

- *Journal of Substance Abuse Treatment*, Volume 15, Number 1, 1998
- *Journal of Contemporary Drug Problems*, Volume XXV, Number 4, Winter 1998

## **GRANT APPLICATIONS**

This body of work, done under CSAT contract, has also generated two National Institutes of Health (NIH) grant applications:

- One has been funded and is in progress now (NIAAA R01 AA11279-01A2)
- Another is currently under review (NIDA R01 DA12297-01).

Both grants study outcomes and costs of social model programs compared to medical model programs. The first grant compares day treatment in the social model setting versus the hospital setting. The other grant studies enrollees in a national HMO located in a large California city; within its managed care framework, the HMO offers both intensive outpatient treatment in its clinic and residential recovery in social model programs under contract to the HMO. Both studies are randomized clinical trials that consider services received during treatment, utilization of Alcoholics Anonymous and other self-help activities, and outcomes at 6 and 12 months.

Instruments developed by the project are used in each of the grant applications. The Social Model Philosophy Scale is used to verify that social model study sites adhere to the social model philosophy and that the comparison medical model site is not a social model program. The Event Form, developed by the project to provide a structure for observing groups and informal activities during treatment, is being used to characterize treatment provision at the grant study sites. The Codebook developed by the project for coding the ethnographic observation data is being used in the studies as an analytic qualitative tool for categorizing observations. The Helper Activity Checklist piloted in the original project has been integrated with the Treatment Services Review for use in these new studies, to assess the extent and types of peer helping activities undertaken by clients at the study sites.

## PRESENTATIONS

Project results have been presented at two conferences to date: the 124<sup>th</sup> annual meeting of the American Public Health Association (APHA) and the annual meeting of California Alcohol and Drug Abuse Counselors (CADAC). Presentation at APHA was refereed. APHA presentations included the lead talk at a session on Issues Relating Work or Employment with Drugs and Tobacco (Room, 1996), and a session on Drug and Alcohol Treatment Programs that included three talks: an overall comparison between social and medical model programs (Borkman & Kaskutas, 1996), use of the AA traditions (Karp, 1996), and therapeutic use of ritual in social model programs (Bryan, 1996). The CADAC presentations discussed the extent of social model philosophy evident in residential recovery programs in California (Keller, 1998) and the study design used in ARG evaluations of social and medical model programs (Witbrodt, 1998).

A presentation of the project's overall results was given as an invited talk under the Institute for Behavioral Research Distinguished Visiting Scholar series at the University of Georgia (Kaskutas, 1998). This comprehensive lecture included a summary of the project's literature review (including the history of the social model movement), the study design developed as a model for evaluating social model programs, the Social Model Philosophy Scale, and the overall results of the project's comparative process evaluation.

Borkman, T. J., & Kaskutas, L. A. (1996, November 20). Inside the black box of treatment: Comparing medical and social model substance abuse programs. Presented at the 124<sup>th</sup> annual meeting of the American Public Health Association, New York City.

Bryan, K. (1996, November 20). Program-specific mythology in a social model recovery home. Presented at the 124<sup>th</sup> annual meeting of the American Public Health Association, New York City.

Karp, R.C. (1996, November 20). Alcoholics Anonymous' Traditions and social model substance abuse treatment. Presented at the 124<sup>th</sup> annual meeting of the American Public Health Association, New York City.

Kaskutas, L.A. (1998, April 13). Social model treatment for substance abuse: A radical approach in a changing environment. Institute for Behavioral Research, University of Georgia Center for Research on Deviance and Behavioral Health, Distinguished Visitor Scholar Series. Athens, Georgia.



Keller, J. (1998, September 24). Measuring social model in California. Presented at the Annual Meeting of the California Association of Alcohol and Drug Abuse Counselors. Bakersfield, CA.

Room, J. (1996, November 19). Work and identity in substance abuse recovery. Presented at the 124<sup>th</sup> annual meeting of the American Public Health Association, New York City.

Witbrodt, J. (1998, September 24). Issues of recruitment and methodology in randomized control trials of social model recovery. Presented at the Annual Meeting of the California Association of Alcohol and Drug Abuse Counselors. Bakersfield, CA.

## **MASTER'S THESIS**

A Master's Thesis was undertaken using the materials from the original project as a foundation: Crawford, S. (1997). *Experiential Authority in a Social Model Organization*. Master's Thesis in Sociology, George Mason University, Virginia.

## **SUMMARY OF THE DOCUMENTS CONTAINED IN PART ONE**

*The Social Model Program: A Literature Review and History*. The literature review developed for the project is extensive and detailed, providing a compilation and critique of all available literature on the subject of social model recovery. Many of the documents reviewed are not published. An Advisory Panel was convened to help locate unpublished materials relevant to the topic; key source documents are listed in the social model bibliography. Since a definitive history of the social model movement was not available to the field, the project also conducted research to piece together the evolution of the social model approach, tracing the movement from its roots in Alcoholics Anonymous through the current controversies under managed care. Costs and outcomes of social model programs are synthesized. Distinguishing features of social model programs and comparisons with other approaches like Therapeutic Communities, Halfway Houses, inpatient hospitals, etc., are drawn. This review was brought together in a special journal issue on social model programs (see above). The literature review also served to familiarize the study team with the basic tenets of the social model approach before entering the field with the process evaluation (although there were no *a priori* hypotheses for the evaluation).

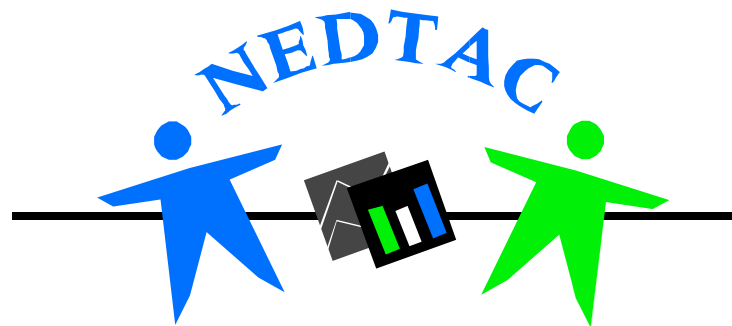
*Development of a Program Philosophy Scale for Substance Abuse Recovery Programs.* Based on the literature review, the process evaluation, and the extensive meetings with the Advisory Panel of social model leaders, a 33-item Social Model Philosophy Scale (SMPS) (originally called the Program Philosophy Scale [PPS]) was developed that distinguishes social model programs from others. A companion user's manual is available to assist program directors with the interpretation and underlying rationale of scale items. With funding from CSAT/NEDTAC, the scale is now being used to assess the extent of social model philosophy currently evident in public and private recovery homes in California. A presentation of those results was given at the annual meeting of the California Association of Alcohol and Drug Abuse Counselors (Keller, 1998). The SMPS has also been instrumental in delineating study sites in the two NIH grant applications mentioned above. The items and psychometric properties of the scale are reported in an article in one of the special journal issues.

Lee Ann Kaskutas, Dr.P.H.  
Alcohol Research Group, Berkeley

## ACKNOWLEDGMENTS

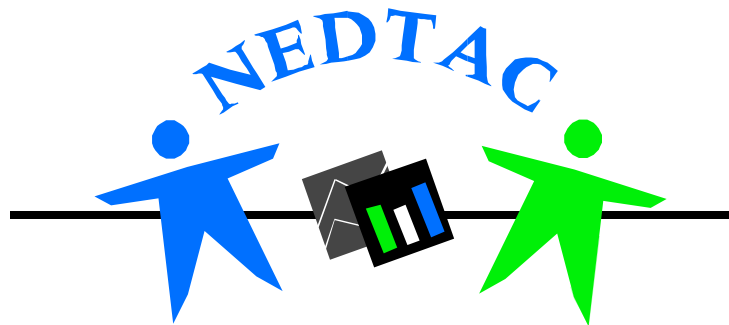
This volume is the result of the dedicated efforts of a number of individuals associated with the Program Evaluation Branch at the Center for Substance Abuse Treatment (CSAT), the funding agency. In particular, thanks are due to Jim Herrell, Ph.D., for his initial review and comments on the reports as originally submitted. The former National Evaluation Data and Technical Assistance Center (NEDTAC) Government Project Officer (GPO) Karl White, Ed.D., also reviewed the documents and provided direction and guidance as to the formatting and editing of the vast amount of rich material available for publication. Finally, the present GPO, Ron Smith, Ph.D., directed the final compilation and publication of this compendium of reporting on the social model approach to substance abuse recovery. Dr. Smith also played a central role in securing NEDTAC support for this project and in facilitating the project's design. Thanks are also due to NEDTAC staff member Erica Gordon Sorohan, whose editorial expertise was invaluable in the production of this collection of reports.

**NATIONAL EVALUATION DATA AND  
TECHNICAL ASSISTANCE CENTER**



**THE SOCIAL MODEL:  
A LITERATURE REVIEW AND HISTORY**

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TECHNICAL ASSISTANCE CENTER**



**THE SOCIAL MODEL:  
A LITERATURE REVIEW AND HISTORY**

**Prepared by:**

**Thomasina J. Borkman, Ph.D.  
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This study was supported by Center for Substance Abuse Treatment, Department of Health and Human Services, Caliber/NEDTAC Contract No. 270-94-0001.

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## FOREWORD

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Sharon Bishop  
Project Director  
National Evaluation Data and  
Technical Assistance Center (NEDTAC)

## ABSTRACT

This literature review examines the social and social-community models of alcohol recovery programs, two lesser-known but distinctive sociocultural approaches to ameliorating alcohol-related problems. Unlike patient-focused medical and psychological treatments for alcoholism, sociocultural approaches to recovery involve both the individual and his or her social and physical environment. Alcoholics Anonymous (AA) probably is the best-known example of a sociocultural approach to alcohol recovery. Social model principles closely align with those of AA, but social model programs operate according to distinctive philosophies and practices.

The story of social and social-community model programs is not well-documented, or at least, is not conventionally documented. Much of the writing on social model programs is “fugitive”—the canon largely comprises unpublished conference presentations and reports published locally. This review aims to fill a void by integrating the fugitive literature with the academic. This examination also relies on the oral history of the social model movement. The terminology of social model practitioners also departs from convention. In this document, when we discuss literature from social modelists, we use their terminology. When we discuss professional, peer-reviewed literature that describes research, we use professional terminology.

**I. FOUNDATIONS AND CHARACTERISTICS OF SOCIAL MODEL  
PROGRAMS**

## I. FOUNDATIONS AND CHARACTERISTICS OF SOCIAL MODEL PROGRAMS

The social model is a peer-oriented process of rehabilitation and healing. Social model programs are underpinned by the mutual help principles of Alcoholics Anonymous (AA). The seeds of social model programs were sown in the early days of AA, when AA members would bring recovering alcoholics into their homes to sober up and get back on their feet. From these beginnings, the social model paradigm of recovery evolved over the last 5 decades in tandem with an evolution in the public and professional conceptualization of alcohol problems. (See Appendix A for a history of the social model.)

From the 1940s through the 1960s, the person at risk for alcohol problems was seen as, somehow, especially vulnerable to alcohol. The *substance* alcohol was not seen as a problem for most people or the community. Social model programs of the day emphasized the recovery of the individual alcoholic. The term “social model” distinguished community-based programs from hospital-based treatment.

In the 1970s, a second conceptualization of alcohol problems emerged as social model practitioners began to see their efforts as different in kind, and not simply in degree, from medical treatments. Social model programs began to view recovery as a lifelong, experiential, peer-based learning process among recovering alcoholics.

The third and current conceptualization of alcohol as it relates to the social model recognizes that alcohol related problems affect not only the individual alcoholic but also the community at large. From this perspective, any problem resulting from alcohol use—from a hangover to a fatal traffic accident, from lateness for work to loss of a job—is considered an alcohol problem<sup>1</sup>. In its emphasis on community-based prevention and intervention, the social-community model parallels the current paradigm of public health, which similarly has shifted its emphasis from delivering services to empowering communities to prevent illness and promote health.

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<sup>1</sup> This conceptualization represents a shift away from the principles and traditions of Alcoholics Anonymous, which considers alcohol problems to stem from an individual’s inability to handle alcohol and which cautions against involvement in issues unrelated to an individual’s recovery.

## **1. EXPERIENTIAL LEARNING**

Social model programs promote health and well-being by fostering experience-based learning that enables an individual to change his or her values, attitudes, beliefs, or behaviors. Borkman (1983) describes experiential learning in part as “gaining information by learning and doing ... [it] is frequently conveyed verbally by stories of one’s experience, personal anecdotes, metaphors, or analogies.” In social model programs, staff draw on their personal experiences as successfully recovering alcoholics to guide their peers in the recovery process. Participants hear stories of successful and unsuccessful recovery, and they see these stories unfolding in the lives of their peers.

In experiential learning, Borkman (1983, p. 5-3) sees a two-step process at work. “First, from listening and observing during the peer group process, individuals gain some information or perspective on an issue. Second, the individuals can then try out the perspective or information gained from the group in their daily lives and assess its workability.” Borkman sees experiential learning as a process that extends beyond drinking; over time individuals learn to trust their own ability to solve problems experientially. The approach is embedded in day-to-day life. Since much of the challenge to an alcoholic is the return to normal life after “treatment” without the aid of alcohol, social model programs tend to prepare participants for what they will face upon graduation from the program and entry into the real world. For example, recovering participants help govern the social model facility. Participants learn to take responsibility for the consequences of their behavior (especially recovery-related behavior). They learn to rely on and help each other through sober support networks. Social model programs act as advocates for their participants and put them in contact with community resources to help them solve legal, family, financial, medical, employment, and other problems, but the job of social model programs is not to change the alcoholics. As they see it, their job is to create an environment in which the alcoholic changes himself or herself. (For a summary of key characteristics of social model programs, see Exhibit 1.)

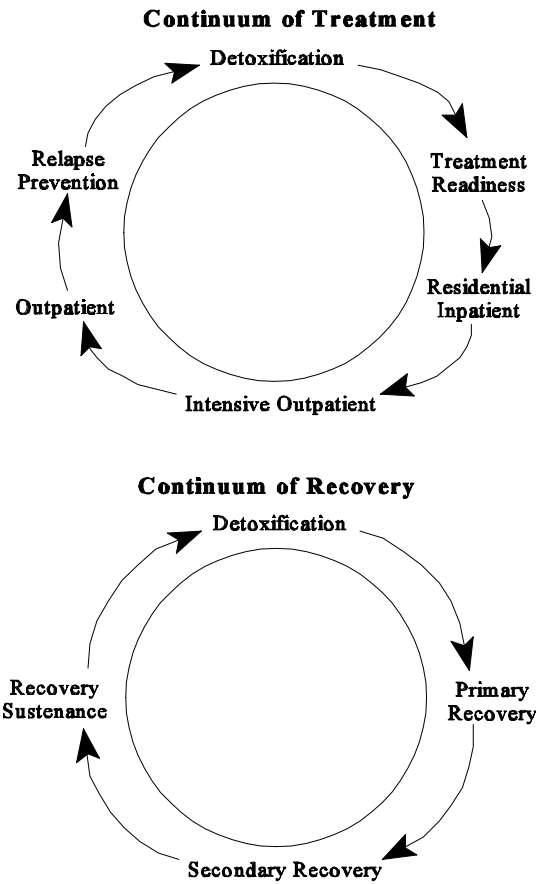
**EXHIBIT 1**  
**CHARACTERISTICS OF SOCIAL MODEL PROGRAMS**

- The social model recognizes an interdependency between the individual seeking recovery from alcohol and the wider world
- Social model programs try to create a social climate conducive to recovery; not everyone who needs recovery will be admitted
- Social model programs recognize experiential knowledge as the basis of authority
- Social model programs encourage individuals to consider recovery a lifelong learning process
- Management is vested in participants; staff act as coaches or guides
- Social model programs cultivate a homelike, rather than institutional, atmosphere
- The primary therapeutic relationship is between the person and the program.
- Everyone both gives and receives help.
- The basic principles and dynamics of Alcoholics Anonymous create the fundamental framework.
- Social model programs, in the spirit of AA, consider recovery “a gift of God” that affects one’s mental and spiritual life and all relationships with others.

**2. CONTINUUM OF RECOVERY**

Social model practitioners view recovery as a series of transitions from one level of involvement to another—from newcomer, to a person in stable recovery, to a volunteer who then helps newcomers. This continuum of recovery parallels the continuum of treatment under professional models. (See Exhibit 2.) Just as under the continuum of treatment, clients don’t necessarily pass through the phases of recovery sequentially, nor are they considered “cured” after completing a phase. They might return for services at any point on the continuum. Because

**EXHIBIT 2**



social model programs often are less specialized than their professional counterparts, they often incorporate multiple functions of the continuum.

Borkman points out a number of explicit differences between social model approaches and traditional professional alcohol treatment programs, including the following (see Shaw and Borkman, 1990, for a summary of Borkman's book):

- Social model programs do not have assigned case managers.
- Social model staff do not diagnose; referrals are made to outside sources as needed or appropriate.
- Providers are explicit role models who guide instead of direct participants.



- Staff, as well as residents, have a personal recovery and growth program.
- Staff at social model programs discuss their own experiences as an essential part of the experiential learning process.

Social model and treatment model programs have elements in common as well. For example, staff in both models show compassion toward alcoholics and treat clients/patients with dignity. Both strive to be noninstitutional. Proponents of each approach see alcoholism as a treatable disease that requires personal responsibility for recovery. Peer support and AA participation are valued in both the social and the medical models.

### 3. PHYSICAL SPACE

For social model programs, physical space and program philosophy are inseparable. The social model perspective on architecture and environment focuses on the social and behavioral aspects of the physical setting. The prime goal of the social model is to create a space where sobriety is the norm.

The social model literature does not suggest that the founders of the earliest social model homes (12-step houses) were explicit about architectural requirements. What was imperative during the movement's nascence was that the setting be non-institutional. For a halfway house, non-institutional meant not a jail or cell block. For a recovery home, non-institutional meant not a hospital or psychiatric ward.

In *Recovery from Alcoholism: A Social Treatment Model* (O'Briant et al., 1973), O'Briant, a physician, made explicit the need for a homelike setting in contrast to a medical one. (O'Briant's book also popularized the term *social model* beyond social modelists themselves.) O'Briant described in detail the physical arrangements of what he called an "alcoholic rehabilitation program" (i.e., a residential treatment program) and a residential detoxification program.

O'Briant's first social model detox program, Starting Point, was housed in an old downtown fire station in a California agricultural community. Recognizing that programs seldom build their own facilities and usually must adapt an institutional setting, O'Briant collaborated with architect Fried Wittman to further explore and document environmental issues applicable to social model programs. Their work, *Environmental Design for Social Model*

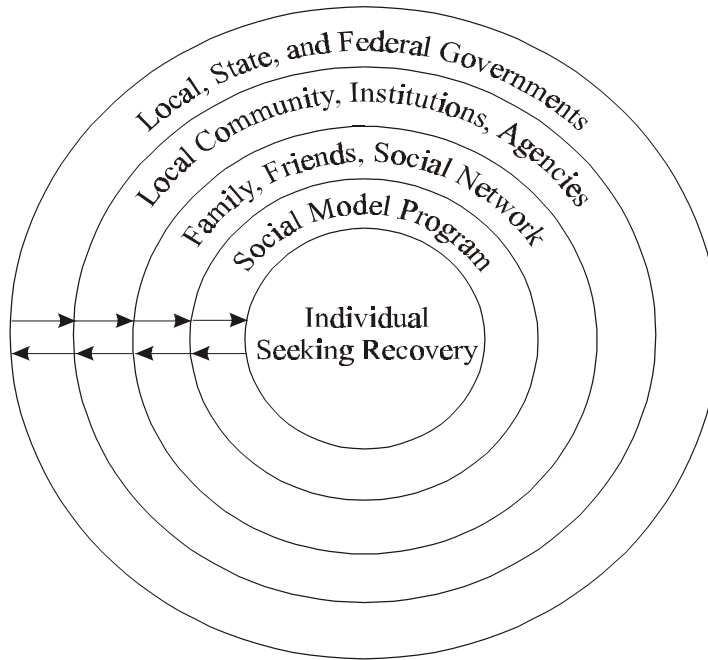
*Alcoholism Programs* (Wittman et al., 1976), addressed specific design requirements, including the following:

- **Location.** Social model programs are best located near, or accessible to, the local skid row area and a medical facility. Preferred zoning is mixed residential, commercial, and institutional.
- **Image and entry.** Buildings are not identifiable as alcoholism treatment facilities. Street entries are private, but visible and welcoming, with a doorbell. Doors are locked on the outside but not on the inside (as in a residence). The inside entryway is free from barriers, such as a reception desk. Secluded outdoor places (a backyard, a porch) offer spaces for socializing and contact with nature.
- **Circulation.** A central area for informal socializing is easily accessible from the main areas of the building.
- **Living areas.** Configurations allow distinct spaces (comfortably furnished and well-lit) for different activities, such as conversing, watching television, contemplating, or reading. The television does not dominate the living space.
- **Eating and cooking areas.** To minimize the institutional feel of a setting where food is prepared for, and served to, a relatively large number of people, seating areas are small (for four to six people). Snacks, coffee, and the dining room itself are always accessible without interfering with food preparation.
- **Sleeping areas.** Bedrooms function as sleeping areas, but not as places to escape from interaction. Private bedrooms are not essential, but sleeping spaces encompass personal “nooks.”
- **Staff areas.** Spaces for residents take priority; administrative areas are of secondary importance.

#### **4. THE SOCIAL-COMMUNITY MODEL**

Since the early 1980s, social modelists have discussed a social-community model in which their mandate extends beyond recovery to include prevention. The social-community model is explicitly a public health model, which examines the agent (alcohol), the host (the individual), and the environment (families, communities, and society). In recognizing the interrelationship of the agent, host, and environment, the public health model allows any intervention that would interrupt the relationship of these elements (Hayes et al., 1993; Miller, Manov, & Wright, 1990; Ryan & Reynolds, 1989).

**EXHIBIT 3**  
**INTERDEPENDENCY OF INDIVIDUAL**  
**AND SOCIETY**



The social-community model recognizes the need to promote change in the norms, values, policies, and practices regarding alcohol use in the wider community and society. (See Exhibit 3.) Social-community modelists assert that, just as people in recovery need to be held accountable for their behavior, others in the community need to be held accountable for behavior that contributes to and supports alcohol problems (Shaw, 1990a).

The community model envisions activities that would empower communities to choose sobriety. An ideal community would be a safe environment where a person would not be expected to drink (B. Miller, University of California at San Diego, 1988). Within the community model, prevention is viewed as an ongoing process, not an event. Interventions might include regulating the availability of alcohol or increasing prices through taxation. Another strategy would be mandating health warning labels, either on beverage containers or at the point of sale (Kaskutas, 1993a; Kaskutas, 1993b). Citizen action is essential in stimulating such interventions, and different groups are appropriate targets for different interventions (Shaw, 1990a).

For example, Cleo Malone, an African-American minister, described the challenges of a neighborhood recovery center's prevention efforts in a predominately African-American neighborhood, where change would not occur without the involvement of the African-American clergy (University of California, San Diego, 1988). It was necessary to overcome denial among the clergy that the community had an alcohol problem. Part of this effort entailed demonstrating to clergy the ways that the environment promoted alcohol use. Malone noted, for example, that suburban neighborhoods have grocery stores that include liquor sections, but that his neighborhood was home to large liquor stores with small sections for food. Thus, one prevention effort was to work with the community to stop the proliferation of liquor outlets and to increase enforcement of laws against sale of alcohol to minors.

Two social modelists from San Diego County, Ryan and Reynolds (1989), describe a systems approach to prevention. The systems approach seeks to modify the environment in ways that reduce both alcohol consumption and the resultant problems. Ryan and Reynolds describe the role of prevention professionals as:

- Understanding the complex community system in order to identify potential points of intervention
- Monitoring the long-term level and patterns of alcohol problems to provide a historical perspective and context to examine prevention successes or failures
- Supporting interventions, actions, and policies that are initiated principally by community members rather than by professionals.

Prevention professionals shape the public agenda by helping communities identify and define community alcohol problems and by providing support for reducing problems (Ryan & Reynolds, 1989, p. 2).

Wittman (1992a) states that community-level interventions should be two-fold: They should eliminate high-risk elements in the community's alcohol and drug environment, and they should provide opportunities that encourage sobriety and recovery support. Wittman groups high-risk elements into several categories and proposes possible responses:

- Economic—Work to increase the prices on alcoholic beverages.
- Physical—Work to limit the distribution of alcohol outlets, to limit the availability of high-alcohol content, low priced products, such as fortified wines, and to require responsible serving practices to avoid serving intoxicated persons.

- Social—Work to encourage individuals and groups to respect abstinence and moderation and to discourage high levels of drinking or drinking in high-risk situations.
- Institutional—Work to create policies for alcohol-free, alcohol-safe, and drug-free environments; develop employee assistance programs that clarify the agency’s expectations for employee’s uses or non-use of alcohol, as well as provide assistance for individuals with alcohol or drug problems.
- Public—Work to create policies for alcohol-free, alcohol-safe, and drug-free activities in public places and at public events.

Dodd (1988) states that the staff of community-based programs must become active in community affairs, service clubs, schools, and churches. By participating in these community contexts, they can keep community recovery needs and prevention issues on the agenda. Further, Dodd states that in accordance with the principles of mutual aid/self-help, individuals in recovery programs must be given the opportunity to help others in the community. Dodd suggests more than helping other people in recovery; he mentions activities such as delivering meals to shut-ins or volunteering at adult day care centers. Dodd suggests such activities should be a major part of recovery programs, rather than the sometimes endless classes on alcoholism and group counseling sessions. He contends that doing things for others is a good way to overcome self-centeredness, which is often a core element in addictions. Further, he contends, community-based initiatives would help to overcome a major element of denial in the community: the idea that alcoholics are different and unworthy people.

This chapter has provided an overview of the key elements of social model programs. The next chapter looks at specific forms that social model programs take within this framework.



## **II. DESCRIPTIONS OF SOCIAL MODEL PROGRAMS**

## II. DESCRIPTIONS OF SOCIAL MODEL PROGRAMS

The social model continuum includes detoxification from alcohol and drugs, primary recovery, secondary supportive recovery, and recovery sustenance, or lifelong support for recovering persons who are fully integrated with society. The continuum of recovery settings include the following:

- Social setting detoxification for withdrawal from alcohol
- Recovery homes for primary and supportive recovery
- Neighborhood recovery centers for primary, supportive, and sustaining recovery
- Sober living residences for sustained recovery.

Multi-service social model programs combine three or more of the previously mentioned settings. (For a discussion of other sociocultural approaches, see Appendix B.)

### 1. SOCIAL SETTING DETOXIFICATION

Social setting detoxification is a separate program, but not a stand-alone service. The medical care system, appropriately, treats medical complications of excessive alcohol use. Only about 5 percent of alcoholics need medical intervention during detoxification (O'Briant & Petersen, 1990).

A nonmedical approach to alcohol detoxification was developed in Toronto in 1970 by the Addiction Research Foundation. Toronto-style programs:

- Provide non-medical detoxification for alcoholics in an accepting and non-threatening atmosphere
- Serve as a starting point for referral to recovery programs and community resources
- Provide detoxification at lower costs than do established hospital methods (O'Briant & Petersen, 1990).

Such facilities pay careful attention to their physical setting, environment, and atmosphere. Ideally, facilities are located in a residential rather than an institutional building. Once a client feels better, staff evaluate his or her needs and explain to the client the community services



available. Detox staff are not seen as, nor do they act as, rescuers. The aim is for each admission to result in a referral to a program or a setting in which recovery can continue.

## **2. RECOVERY HOMES**

Recovery homes were the original social model programs. (Their cousins, residential treatment programs, are very similar, but operate with a case management system.) In the 1970s, the California Association of Alcohol Recovery Homes (CAARH) defined an alcoholic recovery home as “a community-based, peer-oriented residential facility that provides food, shelter, and recovery services in a supportive alcohol-and-other-drug-free environment for ambulatory and mentally competent alcoholics and family members” (Schonlau, 1990, p. 68). The definition remains current today.

The following features distinguish alcoholic recovery homes:

- A cheerful, warm, and accepting alcohol-free and drug-free environment is fostered to inspire recovering people to make positive lifestyle changes.
- Most of the recovery learning is through peer sharing. Recovery activities are primarily resident driven.
- Staff primarily focus on maintaining the environment and facilitating peer group learning.
- Attendance at scheduled recovery activities is the responsibility of the residents; most residents have a choice of activities in which to participate.
- Residents take initiative and responsibility for applying sanctions when rules are violated.
- Interaction with the community stimulates both community volunteer work in the home and resident/staff outreach activities in the community.

Also, social and recreational activities are an important part of recovery home programs for individuals who, in the past, may have thought of alcohol as an essential part of having fun.

Recovery homes do not provide medical or social services, but they will help residents obtain whatever services they might need from other service providers in the community. Usually, residents are given information and are expected to make contacts on their own, as part of efforts to take responsibility for themselves. Typically, recovery homes continue to provide services to former residents and their family members after the residents have moved away from the recovery home.

Social model proponents consider recovery homes to be primary, stand-alone programs, fully capable of fulfilling the service needs of most alcoholics, independent of medical and mental health alcoholism treatment programs (CAARH, 1974). Social modelists often must dispel the notion that recovery homes function to provide board and care for the homeless. CAARH noted in 1974 that “Alcoholic recovery homes are not board and care facilities; they do not provide elements of personal care, or caretaker supervision.” This means that recovery homes are able to serve most, but not all, of those seeking recovery. Only those able to feed, bathe, and function with a spirit of cooperation in a shared residential setting are appropriate (Schonlau, 1990).

Most recovery homes require residents to be at least 18 years old. Some programs have upper age limits of 60 to 65 years. Recovery programs have various lengths of stay. Schonlau states that recovery homes function best when there is not defined length of stay and that recovery homes generally do not set time limits unless required to do so by funding sources.

Recovery homes charge fees and expect residents to pay when able. Schonlau reports that residents who are eligible for state unemployment or disability insurance, general relief, food stamps, or other sources of income are expected to apply. (In the past, some recovery homes discouraged these sources of income as counter to recovery.)

Recovery home programs maintain minimal records on each resident, usually no more than personal data for purposes of identification and for notifying next of kin in case of emergencies. Licensing requirements require an agreement of participation to be signed by each resident and programs are required to have a record of TB tests. Recovery homes do not maintain clinical case files because they do not provide clinical services. This remains a source of conflict between recovery home operators and various government officials and funders.

Recovery home programs are often structured to allow a considerable amount of informal interaction. Interactions frequently take the form of telling stories about incidents from the

storyteller's life and contribute to the recovery process. Extended observations of one recovery home (Barrows, 1980) indicate that informal interactions are frequent and generally focused on the alcohol problem. Barrows suggests that recovery homes facilitate recovery by providing opportunities for introspection and offering a setting that promotes information interactions.

### **3. NEIGHBORHOOD RECOVERY CENTERS**

The neighborhood recovery center (NRC) was developed by applying the social model philosophy and principles of recovery homes to non-residential programs (Shaw, 1990b). NRCs are community centers for individuals who are recovering from alcohol abuse and resource centers for others with an interest in alcohol problems (San Diego County Alcohol Programs, undated).

Borkman (1990c) suggests four physical features of an NRC: a reception desk and phone, a kitchen or coffee pot area, a meeting room, and a living room. The reception desk serves not as a gatekeeper, but rather to greet and direct strangers. Shaw (1990b) further suggests that the visitor should not even encounter a physical reception desk upon entering an NRC, but she stresses the importance of a newcomer being greeted. One sign of a well-functioning NRC is that everyone present—staff, volunteers, and participants—consistently greets visitors.

Coffee and refreshments provide the opportunity for fellowship and social bonding. The meeting room accommodates several meetings each day of the week—AA meetings, peer recovery meetings, educational sessions, etc. Some meetings are for people involved in the NRC program; others, such as AA or Al-Anon, may attract people from the community at large.

The living room in the NRC functions as a home-away-from-home for people who come in off the street. The living room—like the rest of an NRC facility—is warm and cheerful and inviting. Personnel in the NRC include paid staff, unpaid staff and other volunteers, and participants. Successful NRCs attract a cadre of dependable volunteers who perform many of the tasks required to make the NRC function.

Shaw emphasizes that an NRC is *not* a drop-in center. An NRC offers a variety of activities to assist recovery. Program participants seeking recovery are urged to attend and participate in these activities. Services offered in NRCs are not directed solely to the alcoholic. For example, programs for the family might be another way of reaching an alcoholic, so NRCs have activities suitable for families with children, such as barbecues.

Borkman notes that there seems to be more variability in service content and delivery among NRCs than among recovery homes. At the time of her study, NRCs were still in the process of development. Also, because NRCs are community-based programs, differences should be expected as individual programs respond to the needs of their neighborhoods (Borkman, 1983).

Some community modelists envisioned the creation of community recovery centers (CRCs), which would provide a variety of services for the individual and the community. The centers would offer a smorgasbord of social, recreational, educational, and supportive activities. Also available through CRCs or referral networks would be counseling and employment services and housing, legal, and welfare assistance. Centers would serve as community resources for information about alcohol-related issues, referrals to other alcohol services, and opportunities for volunteer activities (Wright, 1992; Wright, Clay, & Weir, 1990; see also Matthews & Weiss, 1990).

Shaw, for one, expressed concern about the expanded focus of a CRC. In the recovery process, most people come to believe they are fundamentally different from social drinkers, and, if they lose sight of this difference, they will lose sobriety. Further, if staff spend more time on prevention activities, the dynamics between staff and others would change. The staff would become more “different” from program participants and volunteers; they no longer would be neighborhood recovery peers.

#### **4. SOBER LIVING HOUSES**

Sober living houses, also called alcohol-free living centers (AFLC), and alcohol- and drug-free (ADF) housing, are low-cost, alcohol- and drug-free residential environments (Wright, 1990a). Unlike recovery homes, sober housing provides no structured recovery program and has few, if any, paid staff. Sober living houses are shared or congregate facilities for recovering alcoholics and addicts and their family members.

Originally, sober housing was simply a service for those recovering from alcohol or drug abuse. Beginning in the late 1970s, inexpensive housing began to disappear from many metropolitan areas. Along with the closing or reductions of state hospitals, many urban areas experienced an increase in homelessness and an increase among the homeless of serious alcohol, drug, and mental health problems. Sober housing began to look attractive to policy makers as a form of affordable housing for the homeless and low-income participants in recovery programs

and as part of a strategy to streamline services and reduce the costs of alcohol and drug services (Wittman, Biderman, & Hughes, 1993).

Reflecting the belief that we live in a society that generally equates the presence and consumption of alcoholic beverages as “normal,” sober living houses reverse this social norm and place a strong emphasis on abstinence from alcohol (Wright, 1990a). In sober housing, tenants have three basic obligations: They must not drink alcohol or use illicit drugs. They must follow house rules. They must pay their rent on time. Use of alcohol or illicit drugs will result in dismissal from the house. Most sober houses have one or more house meetings per week, which residents must agree to attend. Sober housing provides a peer group of fellow residents to support sobriety and participation in a sober environment (Wittman, Biderman, & Hughes, 1993; Wright, 1990a).

In practice, sober living houses vary considerably. They range in size from small, three-bedroom suburban houses to entire apartment houses or SRO (single room occupancy) hotels. Many sober living houses are satellites of community-based recovery organizations offering a range of recovery services at other sites. Sober houses may or may not have a paid manager. Some are quite structured, others have few rules. Some houses are fully democratic, with each resident having an equal share in the operation of the home.

Oxford House sober living systems provide one model for sober living facilities. The first Oxford House was founded when sober alcoholics decided to take over the halfway house in which they were residing, when it was closed by a county in Maryland (Molloy, 1990; O’Neill, 1990). The only rules of the house were that each resident would pay his own share of expenses and any use of alcohol or drugs would result in immediate expulsion. Members were encouraged to participate in AA or Narcotics Anonymous, but no meetings were held at the house. The experiment proved successful, and Oxford House opened additional houses. The Federal Anti-Drug Abuse Act of 1988 required each state to set aside \$100,000 as a fund to lend to recovering individuals who want to establish houses using the Oxford model: drug and alcohol free, democratic, and self-supporting.

Wittman notes the importance not just of establishing sober living residences, but also of forming communitywide associations of sober houses to support each other and work with other agencies in the community. A guidebook developed under contract with the State of California recommended that a trade association be formed that would ensure minimum quality standards (Biderman & Wittman, 1993). Networks or associations of sober housing have been established

in some communities. (Schonlau, 1995a). Wittman reports that member homes have not evolved to the point that they operate as a mutually supporting group (personal communication).

## **5. PROGRAMS FOR SPECIAL POPULATIONS**

How do social and social-community model programs serve special populations such as women, African Americans and other racial and ethnic groups, and people with disabilities? Unfortunately, the search for social model literature, both published and fugitive, yielded very few materials regarding social model programs for special populations. State or county government offices or CAARH offices may contain more information than our limited search in these places yielded. It appears that many alcohol service programs incorporate practices that have not yet been captured on paper, although some inroads have been made<sup>2</sup>. Materials that were located are discussed in the following sections.

### **5.1 Recovery Programs for Women**

Most of the documentation on the applicability of social model programs for special populations was produced by the California Women's Commission on Alcohol and Drug Dependencies (CWCADD). Laurie Drabble, executive director of CWCADD, wrote *Social and Community Model Services: Meeting the Needs of Women*, based on CWCADD meetings held in 1986 and 1987, with the support of the California Department of Alcohol and Drug Programs. The goal of the meetings was to share experiences and develop broad concepts of how social-community model programs could be applied to women. The position paper, a result of those meetings and other deliberations of the CWCADD, summarizes principles and suggestions that emerged concerning social and community model services for women.

The CWCADD found that: "The experience of alcoholism and other alcohol or drug problems is significantly different between women and men" (Drabble, 1992, p. 2). The needs of women were found to be diverse and based on many additional factors, such as race, ethnicity, disability, socioeconomic status, sexual orientation, religion/spiritual belief, age, and parenting status.

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<sup>2</sup> For example, Borkman (1986) did field work in 15 counties and 66 programs in 1985 as a consultant to the California Department of Alcohol and Drug Programs. Although her 1985 report did not include detailed descriptions on the programs she visited, she was interviewed for this section of the literature review regarding her experiences visiting programs for special populations.

Social and community models were viewed as separate but related. The social model services were defined as “peer-oriented, experientially based services that respect the inherent inclination and ability of individuals to recover and heal in a supportive environment.” The community model “supports the empowerment of individuals and communities to address these problems and relies on the experience and leadership indigenous to these communities” (Drabble, 1992, p.2).

The commission concluded that social model programs work quite well for women. “One of the primary strengths of the Social/Community [Model] is that it ... has developed out of the experiences of recovering alcoholics and out of the needs of communities with alcohol-related problems. As a result, the social/community model has the capacity to take different forms based on the experiences and unique needs of a given individual, population, or community.”

Many participants in the meetings saw a compatibility between the social/community model and the feminist principles of egalitarian models of organizing, empowering individuals and communities, reconceptualizing power to legitimize such different forms as experiential knowledge, and recognizing the interconnectedness between individuals and their environments.

The commission defined family broadly to include the “significant others” of women, not just legal spouses. The commission recommended that services be available for women who lost custody of their children because of their own alcoholism; for children so that their mothers could receive recovery services; and for children to deal with the impact of being raised in a family with an alcoholic.

The document also discussed the importance to women of:

- Self-government through active participation in developing their own recovery plans and in serving on resident councils, alumnae groups, or advisory groups
- Peer support from women and women-only services so that women do not carry out their larger societal learned social roles of supporting men and, in the process, neglect their own recovery
- Sexuality issues that need to be considered in women-only spaces with a non-judgmental attitude.

The paper also discussed how the “blurred” roles between staff and participant in conventional social model programs for men might be inappropriate for women in recovery: “While men may need to learn to help others, women may need to learn to put themselves first. ... Women are trained and expected to be ‘care-takers,’ and this can work against them in recovery. ... Many recovering women have been raped, battered, or suffered from incest as have other women; these experiences are damaging invasions of their personal boundaries. Healing involves being in a safe environment where they can learn to identify, establish, and defend personal boundaries.”

## **5.2 Case Study: Chrysalis**

One of the few women’s recovery homes to be documented is Chrysalis, which opened in Oakland, California, in 1980 (Rolando, 1988; University of California at San Diego, 1988). The Chrysalis program “is based on the belief that a woman’s experience with alcoholism and her experience as a woman are inseparable” (Rolando, 1988, p. 11). The program aims to help women identify their strengths and translate those strengths into higher self-esteem, jobs, and solid recovery programs.

By 1988, Chrysalis had served more than 400 women residents. The 15-bed facility offered nonresidential services to more than 1,200 women as well. Services extend to the families, children, and friends of participants and to women from the community at large. Most women who come to Chrysalis are homeless, unemployed, lack job skills, and have lost custody of their children. Most participants are white, but the number of African-American and Hispanic women participating increases each year.

Along with typical recovery home services, Chrysalis especially emphasizes that “sober living can be fun.” Chrysalis provides many recreational activities, family events, and field trips including AA dances and conferences. Moreover, participants engage in community education and prevention activities, including speaking at schools about their experiences with alcohol and other drugs and writing letters to legislators and county supervisors to increase their awareness of such alcohol issues as alcohol-related birth defects and the need for women’s services. Participants work closely with local community advocacy groups that advance women’s issues regarding alcohol problems, including the prevention of alcohol-related birth defects.

Volunteers, including alumnae and professionals, allow the program to develop a rich array of specialized services, such as workshops, courses, and educational sessions on topics including incest, child abuse, parenting, resume writing, job preparation, and personal growth.



The organic evolution of a successful social model program is evident at Chrysalis, in that some alumnae have started sober living houses “where two, three or four may live together to support one another financially and spiritually. These houses are close to Chrysalis and are set up with many of the same rules. Many of them house the children of the women as well. These children seem to fit in quite well, learning to work and play together and growing in awareness of the disease of alcoholism” (University of California at San Diego, 1988, p. 12).

By the mid-1980s, specialized social model programs for women were being developed in California, as well as some hybrid programs that included a large number of social model features along with some professional staff and treatment services. Borkman, as mentioned in the above footnote, visited 66 programs in 1985, including 21 designed for special populations. Six of these programs were for women: one was clinical, three were hybrids, one was a social model, and one was unclassifiable. The social model women’s program was a recovery home in Southern California. The hybrids included the first recovery home for Hispanic women in California and one of the first recovery homes for women with children.

The Hispanic women’s recovery home was distinctive in that all the staff who were professional psychologists or recovering alcoholics were Hispanic, and the Hispanic culture permeated the recovery home, often in subtle ways. Families were strongly emphasized, in keeping with Hispanic cultural values. Many family-oriented events were held, and every Sunday was family day. Often three generations—baby, father, and grandmother—gathered for the Sunday afternoon visit.

Hispanic cultural values sometimes conflicted with social model values. For example, the women’s recovery home had a policy that husbands had to agree to admit their wives to the program. The program thought it was being culturally appropriate by bowing to the reality that Hispanic husbands made decisions, such as whether or not their wives entered recovery for alcoholism. This policy conflicted with social model principles (and feminist principles) that women should decide for themselves whether to enter recovery services.

A study of participants in publicly funded programs in the county of San Diego, California, was conducted in the early 1980s; 20 percent of participants were female then, mostly white, non-Hispanic (San Diego County Department of Health Services, 1983). Anecdotal evidence indicates that the number of African American and Hispanic women in social model recovery increased during the 1980s and 1990s.

More research is needed to document the history of women's involvement in the development of social model programs since the 1940s and to obtain systematic data on women's experiences in current social model programs.

### **5.3 Recovery Programs for African Americans, Hispanics and Native Americans**

The literature search located even less material on social model programs for African Americans, Hispanics, and other ethnic groups than for women. The California State Department of Alcohol and Drugs funded commissions for African Americans, Hispanics, and Native Americans to develop position papers and strategies to increase services to these populations in the mid 1980s, but documents resulting from these commissions could not be located for this review.

Bi-Bett, Inc., a multiservice social model agency founded by David Brown, developed a social model program in an inner city neighborhood in Alameda County in the 1980s. One neighborhood recovery center, directed by a recovering African-American male, was housed in a converted pharmacy whose architecture was reminiscent of a bar setting (Borkman personal communication in 1996). Instead of drunk patrons and clanking alcohol bottles, one saw a child and her grandfather playing checkers, recovering neighbors sitting at the bar drinking coffee and talking recovery, sober recreational activities, and a warm safe atmosphere amidst the inner city turmoil.

The San Diego County outcome study of social model programs in the early 1980s oversampled African Americans and Hispanics; they were disproportionately male. The outcome in terms of abstinence rates was similar for African Americans and non-Hispanic whites, while younger Hispanics had lower rates of recovery.

Oxford Houses, the alcohol- and drug-free living houses that obtained start-up loans through the provisions of the Anti-Drug Bill of 1988, are self-sustaining facilities without formal recovery programs. By January 1995, there were 536 Oxford Houses around the country. National surveys by Oxford House, Inc., between 1988 and 1992, indicated that 35 percent of residents were African American, 5 percent were Hispanic, and 5 percent were other non-whites (Ferrari, et al., 1995). Females constituted 30 percent of Oxford House residents, a proportion similar to AA.

A recent study of Oxford House residents in the Midwest by psychologists gives some information on African-American residents of Oxford Houses. Male and Female African Americans in 15 Oxford Houses in Illinois and Missouri were surveyed in terms of their reactions to living in the house, their alcohol and drug history, several psychological measures, and demographics (Ferrari, et al., 1995). Thirty-three men and 32 African-American women were surveyed. The women lived mostly in five Oxford Houses in Missouri, while the men lived in houses in Illinois. An average of 4.5 African Americans were residents of each Oxford House. Their average length of stay was 4 months; their mean age was 34 years. No significant differences were found among the African-American males and females in terms of age, marital status, number of children, educational level, co-dependency level, and number of consequences suffered from alcohol and drug use. Findings showed that significantly more women than men had been sexually abused as an adult and had been diagnosed with an eating disorder. The reported criminal activities of females was more likely to be writing bad checks whereas significantly more males reported selling drugs or robbing other people's residences. Women reported more doubts about being able to influence their future than the men but had stronger perceptions that the Oxford House was a structured and safe environment. Males more often reported that they were rebuilding their personal adjustment skills and working on 12-step programs.

In summary, African Americans and Hispanics were found in social model programs in the 1980s and 1990s but, as with women, data are limited. No systematic data collection aimed at discovering the frequency and proportion of racial and ethnic groups in social model programs has been undertaken.

#### **5.4 Recovery Programs for People with Disabilities**

At one time, alcohol recovery homes specifically excluded people who were physically or mentally incapacitated because, program personnel said, recovery homes lacked the staff and facilities to care for them. Section 504 of the Federal Rehabilitation Act of 1973 (P.L. 93-516, Title V) required that the disabled not be denied access to any program receiving Federal funding. There are now various programs specifically designed for people with dual diagnoses—substance abuse and mental illness. Recovery homes, at times, admit residents with mental disorders, although they may limit the number of such admissions. In addition, there are recovery home programs specifically designed for people with particular disabilities, such as deafness (Fortney, 1992).

In the early 1970s, the Southern and Northern California associations of recovery homes and halfway houses merged into one—the California Association of Alcoholic Recovery Homes or CAARH. CAARH became an important political and moral force, defending social model recovery homes from bureaucratic government efforts to regulate them along with board and care facilities for the mentally ill, the mentally retarded, or those with other disabilities. In their own defense, recovery homes maintained that they admitted only physically and mentally able residents; this served to differentiate them from board and care facilities.

Since then, the Americans with Disabilities Act has passed, and many other changes have occurred in attitudes toward the capabilities of those with physical disabilities. Some social model programs have changed with the times, according to anecdotal evidence. Social model programs in one Northern California county have admitted recovering persons who use wheelchairs. In both a women's and a men's recovery home, there are persons who are HIV-positive and persons with other chronic physical problems. As with the other special populations, we lack systematic information about the extent to which people with disabilities are incorporated into social model programs.

The literature search located one paper presented at the Next Step Conference on Substance Abuse and the Deaf Community in Denver, Colorado, in July 1992. Olin Fortney, Program Coordinator for the Center for the Empowerment of Deaf Alcoholics in Recovery (CEDAR) presented a paper titled "A Place of Our Own" (Fortney, 1992), which described the 2-year-old neighborhood recovery center for deaf alcoholics and their friends in San Diego, California. San Diego County first provided modest funds for a sign language interpreter for deaf alcoholics in 1984. In 1990, the group received start-up funds from the San Diego County Alcohol Programs for a neighborhood recovery center for themselves. Three staff members (program coordinator, resources specialist, and a program aide/interpreter) maintain the facility with the help of volunteers. The services include literature and resources, sign language interpreters, workshops and educational sessions, and 12-step meetings. Participants are deaf, friends of the deaf, a few hearing people in recovery, sign language students in recovery, and those interested in sign language. Other counties also offer social model programs for the deaf, although literature on those programs was not located for this review. For example, the authors have personal knowledge of such programs in Los Angeles and Santa Clara, California, counties.

This chapter has described specific forms that social model programs take. The next chapter discusses, in detail, the structure and staffing of social model programs.



### **III. MANAGEMENT, STAFFING, AND ADMINISTRATION**

### **III. MANAGEMENT, STAFFING, AND ADMINISTRATION**

Social model programs configure their human resources, organizational structures, and physical spaces differently than conventional treatment programs. A staff of recovering alcoholics develop and manage a sober recovery environment and serve as role models. Participants and volunteers play a major role in governing and administering the program, including caring for the space the program occupies.

#### **1. ORGANIZATIONAL STRUCTURE**

Literature searches produced little written documentation on management, staffing, training, and volunteerism in social model programs, but available information provides a blueprint. Directors, staff, and many volunteers are recovering alcoholics and drug addicts with experiential knowledge about recovery. The recovering residents or participants are regarded as “prosumers”—providers as well as consumers of services. People in recovery are viewed as critical to the peer recovery process.

Peer-learning and the 12 traditions of AA underpin the kind of organizational structure and management that are appropriate in social model programs. These principles create, in effect, a democratic group process in which shared leadership rotates, and there is almost no hierarchy. But, most social model programs are legally incorporated 501(c)3 non-profit organizations, and legal incorporation as a non-profit organization requires the adoption of a hierarchical structure—a board of directors or trustees, a director, and staff.

Olof Marneus, director of a social model program in San Jose, California, observes, that in social model programs there is a “Zen-like quality to the recovery process .... Wellness, integration, and individuation seem to occur almost mysteriously in a non-analytical, intuitive, and informal fashion ... But social model programs are also formally structured organizations ... that meet the requirements for State licensing and certification ... these two elements, the personal/intuitive and the bureaucratic, are fundamentally opposed to each other. Still, they are equally essential to the management of social model programs.”

According to the literature, social model programs, such as recovery homes and neighborhood recovery centers, use elected resident councils to reconcile the tension between democratic peer process and the hierarchical non-profit organization. Resident councils balance the power of directors and staff. They help decide who to admit to the program and when to

evict someone for breaking rules, and address other resident concerns such as food, maintenance, transportation, and overnight passes.

## **2. MANAGEMENT AND STAFFING**

Social modelists stress that the major objective of managers and staff in social model programs is to provide and sustain a physical, social, and spiritual environment conducive to recovery. Staff often are alumni of the program in which they work. “Within a quality recovery home, visitors should not be able to distinguish the staff from the residents” (Schonlau, 1990, p.73).

Managers of social model programs need skills in planning, budgeting, program management, fiscal management, fund-raising, volunteer supervision, personnel, community relations, report writing, and facility maintenance. Staff members may be paid employees or unpaid volunteers (Borkman, 1993). Staff may or may not have degrees. Whether paid or unpaid, staff usually are expected to have the following knowledge and skills (Wright, Clay, & Weir, 1990, p. 83):

- Knowledge and understanding of alcohol problems and the recovery process
- Knowledge of community services and understanding of referral procedures
- Ability to plan and organize service activities
- Ability to lead and actively participate in group meetings or discussions
- Ability to document work activities.

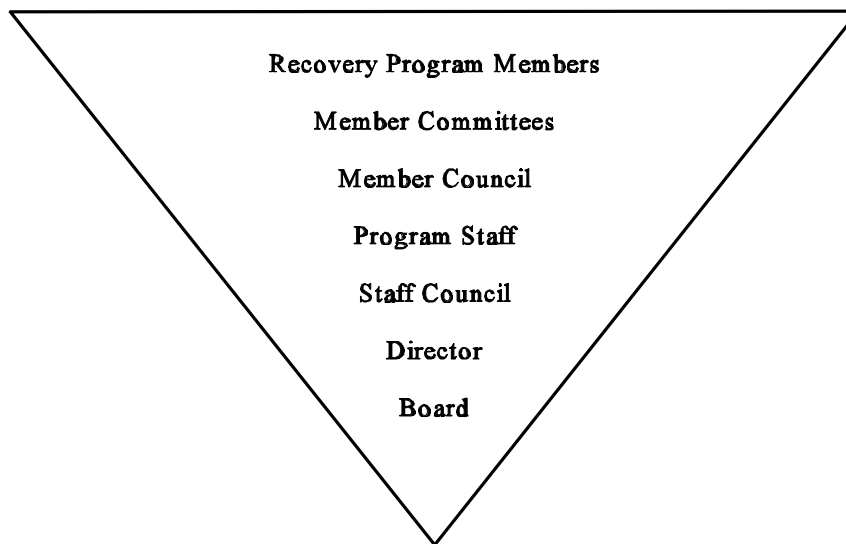
The requirements for an entry level staff position are usually a minimum amount of sobriety (1 or 2 years) and experience working in a recovery program (for instance, as a volunteer). According to Ken Schonlau, the lack of trained personnel for social model programs is a big problem. Usually programs have one staff member for every 10 residents for primary recovery (California Office of Alcoholism, 1975; Schonlau, 1990).

Social model director and founder of Bi-Bett, Inc., David E. Brown developed and articulated a distinctive philosophy of structure, management, and staffing for social model programs. Brown calls his innovation “Participatory Management.” The structure is an inverted pyramid of support and assistance: the recovering participants are viewed as the formal



governing group (the top of the pyramid) and the board of trustees are at the bottom. (See Exhibit 4.) According to Bi-Bett literature, this structure “puts into practice what the program itself preaches (advocates): (1) involvement, (2) esteem building, (3) values clarification, and (4) peer influence .... [This] design accepts the fact that most alcoholics have become failure-oriented. The limits of structure provide just enough support to allow members to experience success” (Bi-Bett Corporation, 1976, p. 29).

**EXHIBIT 4**  
**BI-BETT’S REVERSE PYRAMID OF PARTICIPATORY MANAGEMENT**



Bi-Bett asserts the following about the qualifications of effective staff: First, “personal recovery from alcoholism alone does not qualify a person to be an effective helper any more than a college degree guarantees that a person will be an effective helper.” Second, an ineffectual recovering alcoholic staff member can be as harmful as he or she is helpful: He or she can over-identify with the recoverer, become rigid, and reinforce and perpetuate negative and harmful behaviors as a role model.

The Bi-Bett literature also discusses the need for AA members to keep their role as recovering alcoholics separate from their work in the field of alcoholism. Bi-Bett distinguishes the roles as follows: 12-stepping is done by the AA member for himself. The AA traditions forbid an AA member to be paid for doing something for himself. Recovery staff are paid to assist or guide people in recovery build their self-esteem, clarify their goals, and establish recovery plans. They become role models as effective persons—not as recovering alcoholics.

Borkman (1983) observed two multiservice social model agencies, one in San Diego and one in Los Angeles. She found that staff kept definite boundaries from program participants. Staff did not have friendships or AA sponsor-like relationships with recoverers. Staff had formal authority stemming from their positions, but they tried to relate to participants in an egalitarian manner. Whether paid or unpaid, and regardless of the contributions made by volunteers, staff clearly were responsible for the operation and security of the facility.

### **3. TRAINING**

In social model programs, most staff training is on-the-job. Staff have mostly learned about alcoholism and recovery from attending 12-step meetings in AA or Al-Anon. Most recovery homes, however, send their staff to workshops and courses (Schonlau, 1990). In California, courses or training programs for social model staff and managers have been offered in a few California universities and through CAARH. The most consistent offerings have been from the University of California, San Diego, Extension Program on Alcohol, Drugs, and Tobacco; social model leaders and practitioners often teach the courses. CAARH formalized its 90-hour Institute for Social Model Training in 1991; its modules cover core knowledge; recovery program skills; ethics, law, and regulations; and self-preservation. The Institute is recognized by the Addiction Training Center located at the University of California, San Diego. Comprehensive data about social model staff training—the number of courses offered, their content, and the number of staff participating—have not been collected.

### **4. VOLUNTEERS**

The social model philosophy places volunteers at the heart of programs. Volunteers often are “graduates” of the programs where they volunteer, or they are AA members from the community. In social model programs, “volunteering” includes the mutual help that program participants give each other as part of their recovery.

Thriving volunteerism might be an indicator of how well a social model program is working, suggests Borkman. She found that in the California multiservice agencies she observed in Los Angeles in 1980, about 50 percent of participants in the social model programs were volunteers and alumni of the programs. Unpaid volunteers contributed an estimated 44 percent of staffing hours in one of the agencies. A well-functioning social model program has a lot of volunteers and spontaneously generated activities from volunteers.

Accounting and budgeting schemes usually leave out the efforts of volunteers, although there are efforts by researchers of non-profit organizations to develop ways of accounting in the balance sheet for volunteers' contributions. For example, Kaskutas (1996b) developed an activity checklist that can quantify the types and extent of peer helping among participants in a social model program. The next chapter discusses the costs and funding of social model programs.



## **IV. COSTS AND FUNDING**

## **IV. COSTS AND FUNDING**

All approaches to alcohol recovery or treatment play out against a financial backdrop. How much do services cost? Who pays for or funds services? And how does the individual or entity paying the tab calculate the worth—the cost-effectiveness—of the services received?

The first 12-step houses, halfway houses, and recovery homes were largely self-supporting. These programs charged fees and collected whatever they could from residents, but they seldom refused to accept an alcoholic interested in recovery who could not pay. One consequence was that the funding—and indeed, the survival—of recovery homes and halfway houses were precarious for many years. Now, after a few decades of relatively ample support, social model programs again find themselves on a slippery financial slope. The following sections examine the financial landscape upon which social model programs are built.

### **1. COSTS OF TREATMENT**

Several factors must be weighed when calculating the financial costs of alcohol and drug treatment. First, what are the costs of alternatives (including not providing treatment)? Second, what are the relative costs of different approaches? And finally, what additional research on costs is needed?

#### **1.1 Alternatives to Treatment**

The alternative to offering treatment—not offering treatment—is expensive. Various studies suggest that providing treatment for alcohol and drug abuse reduces use of health care services overall. Also, current policies that emphasize substance abuse as a criminal justice problem escalate costs of maintaining the criminal justice system. Both social and residential treatment programs alleviate these costs by substantially reducing criminal activity (and boosting employment) (Asher et al., 1995; De Leon, 1995a; Gerstein et al., 1994; Segars, 1995). Last, high rates of HIV infection and AIDS among substance abusers and their sex partners add to the financial burden placed on the health care system and on local and state governments. Substance abuse treatment might be the most cost-effective way to deal with these problems (Inciardi, 1995).

## 1.2 Relative Costs of Substance Abuse Services

With inflation, the actual costs of social model programs change constantly, so any figure given for costs soon will be obsolete. Nevertheless, the relative costs of different types of programs are somewhat constant.

For a variety of alcoholism treatments, a range of costs, as well as the most representative costs, were provided by Holder and colleagues (1991) in 1987 dollars; they have subsequently been readjusted to 1996 using the GDP deflator. Representative costs for medical inpatient facilities (acute care/general hospitals, community mental health centers, specialized alcoholism hospitals or units within hospitals, or specialized psychiatric hospitals) varied from \$303 to \$395 per day. Residential programs were substantially less expensive. Social model residential recovery facilities were \$50 per day. Based on these data, the daily cost of hospital treatment is six to eight times that of the daily cost of a social model recovery home. (See Exhibit 5)

The San Diego County Department of Health Services conducted a study of social model treatment programs between 1979 and 1982 (San Diego County Department of Health Services, 1983). During the period of the study, the cost per day for a social model recovery home was about \$17. During the same period, the daily cost for San Diego hospital-based programs was \$262—nearly 16 times more expensive (University of California San Diego Extension, 1993).

The State of California conducted a major assessment of its recovery services for alcohol and drug abuse, the CALDATA study (Gerstein et al., 1994), which reported more recent costs for the various types of treatment that received state funds. Social model residential programs cost \$34 per day, with an average stay of 79 days and an average cost per episode of \$4,405. Outpatient treatment cost considerably less at under \$8 per day, with an average length of treatment of 150 days and an average cost per episode of \$990. Methadone maintenance cost between \$6 and \$7 per day, depending upon whether it was limited or continuing. More recently, McCliggott (1995) reported that the average cost of hospital-based detoxification was \$745 per day as opposed to \$149 per day for a residential or social model detoxification program—hospital detoxification is five times more expensive. Social model programs consistently appear to cost less than medical and professional programs.

<b>EXHIBIT 5</b> <b>TYPICAL COSTS OF ALCOHOLISM TREATMENT BY FACILITY, SETTING, AND PROVIDER (ADJUSTED TO 1996 DOLLARS)</b>		
FACILITY, SETTING, PROVIDER	RANGE	MOST REPRESENTATIVE
Inpatient facilities (cost per day )		
Acute care/general hospital	315-642	376
Community mental health center	333	333
Specialized alcoholism hospital or units within hospitals	281-771	303
Specialized psychiatric or mental health hospitals	386-426	395
Residential facilities (cost per day)		
Residential alcoholism treatment	32-214	92
Social model residential recovery facility	47-53	50
Transitional/ stabilization care including halfway house	16-61	42
Intermediate care (cost per day)		
Hospital-based outpatient or day care	32-128	92
Ambulatory care (cost per hour/visit)		
Outpatient program	45-113	45
Social model nonresidential program per day	8-42	24
Individual counseling/therapy session in alcohol treatment program or community mental health center	17-100	54
Group counseling/therapy session in alcohol treatment program or community mental health center	13-34	20
Office visit general practioner physician		72
Counseling/therapy session, psychologist in private practice		107
Counseling/therapy session, social worker in private practice		79
Counseling/therapy session, psychiatrist in private practice		129

From: Holder, et al. (1991) *The Cost Effectiveness of Treatment for Alcoholism: A First Approximation*.  
 1987 dollar data were adjusted to 1996 using the GDP deflator.



### **1.3 Accounting for Costs**

Another issue for social model programs is that their program costs do not include the costs of all services used in recovery. Social model programs are not self-contained; by design, they use a variety of existing community services. Are social model programs inexpensive because the true costs of services used are not included? Preliminary work by Kaskutas (1996b) has quantified the extent of outside service utilizations at several dozen social model programs in California, suggesting that the total cost of services used by social model program participants can be documented.

## **2. FUNDING OF SOCIAL MODEL PROGRAMS**

The actual cost of a treatment or recovery service may be paid by the individual receiving treatment or by a third party—either an insurance company or a public entity. When localities and other public agencies fund community-based alcohol or drug services, they use several different mechanisms. They might use a fee-for-service approach. Or, an agency can contract for a number of spaces or beds in a program.

Individuals, or members of their families, pay for a relatively small portion (about 14%) of the services provided by speciality units providing treatment for alcohol problems (Institute of Medicine, 1990). The major sources of funding for social model programs during the 1980s and 1990s have been the Federal and state governments.

### **2.1 State and Federal Funding**

After the National Institute on Alcohol Abuse and Alcoholism (NIAAA) was established in 1971, it began to provide funding to states for alcohol services. (California, for example, allocated money to counties to generate or fund alcohol treatment programs, and county money became an important funding source for California social model programs.)

The Federal government provides alcohol and drug services through several mechanisms. First, the Federal government provides block grants to states to fund substance abuse services. Second, certain Federal programs provide direct services to specific populations: The Veterans Administration, the Armed Forces, the Bureau of Prisons, and the Indian Health Service all provide substance abuse treatment services to populations under their jurisdiction. Third, the Federal government will pay for certain alcohol and drug treatment services through insurance programs: Medicare and Medicaid, CHAMPUS (from the Department of Defense), and

CHAMP-VA (from the Veterans Administration). In addition, the Office of Personnel Management offers insurance coverage for certain Federal employees.

Medicare helps people 65 and older and certain disabled people with hospital and health care costs. Currently, Medicare pays for alcoholism and drug rehabilitation provided in a hospital or by certain licensed professionals, but anecdotal evidence suggests coverage might erode.

Medicaid is a joint Federal and state program to provide health care coverage to certain low-income individuals. From state to state, the services paid for by Medicaid vary. California, for example, offers the following drug abuse treatment services through its Drug/Medi-Cal: methadone maintenance treatment<sup>3</sup>, Naltrexone treatment (a drug treatment to aid in detoxification), outpatient drug-free counseling, day care habilitative treatment, and perinatal residential treatment services (Wright, 1995).

The Veterans Administration is the nation's largest provider of health care services, but only a minor funder of social model programs. Most VA medical centers have a medical model alcohol or substance abuse program. Sometimes, the VA will pay for services provided by community agencies. In 1980, the VA developed a halfway house program that incorporated community-based self-help and social model recovery programs, especially for veterans who had completed inpatient treatment and were at high risk for relapse.

## **2.2 Private Health Insurance**

Comparatively speaking, health insurance coverage for alcohol or drug abuse treatment is a recent phenomenon. When health insurance began to cover alcohol and drug abuse treatment, carriers for the most part paid for services provided in certain licensed facilities or by certain licensed providers. Thus, medical treatments and certain psychological treatments were covered, but social or non-medical residential treatments were covered to a lesser degree.

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<sup>3</sup> California faces a pressing funding issue related to methadone maintenance. Because of a lawsuit, methadone maintenance funded by Medi-Cal, the state's Medicaid program, must be provided to all clients who request it. Whenever a resident of a county uses methadone maintenance funded by Drug/Medi-Cal, the state deducts the cost from the county's state alcohol and drug program allocation. Some observers worry that this drain on funds will increase and leave California counties with no money to fund social model drug and alcohol services.

One consequence of the decisions by health insurance companies to pay for inpatient hospital treatment services for substance abuse was a remarkable increase in the number and utilization of proprietary, for-profit substance abuse programs<sup>4</sup>. This probably had some consequences for social model programs in that some people who might have gone to a recovery home for treatment went instead to a hospital-based program.

A recent development in third party health coverage is that an increasing number of employers, particularly large employers, are becoming self-insured; employers who are self-insured are free to choose which services they will pay for. They could authorize local recovery programs for substance abuse problems, or they could limit coverage to certified and credentialed professional providers.

Social model program administrators have been divided about the desirability of accepting third party health insurance. Many social model operators fear that if they provide services in the way that insurance companies ask, they no longer will be operating social model programs.

### **2.3 Start-up and Capital Funding**

Obtaining start-up capital and capital for expansion is a crucial issue for community-based programs. Government agencies find it easier and safer to contract with an existing agency to develop a new program or to expand capacity. An individual or group that wishes to establish a new program usually struggles to raise funds.

In the early days of social model programs, the task was not insurmountable. Most programs started when a group of AA members and others in the community found a location and put up money for a lease or down payment and start-up expenses. Today, starting a program is much more expensive. For example, the price of real estate has risen dramatically, and the stock of low-income housing has diminished. Besides finding a location, the site usually must be modified to meet fire, safety, health, and accessibility codes, which means that the individual or group that wants to establish a social model program must raise funds from private sources in the community.

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<sup>4</sup> Proprietary programs often are based on the Minnesota Model; see Appendix B of this report; Institute of Medicine, 1990.

Fund-raising is a vital skill for the establishment, operation, and expansion of community-based social model programs. Unfortunately, those individuals who are good program people—who are interested in working with people—often are not good fund-raisers and money managers. Ideally, the program person works out what a program would cost and then turns the financing over to others (University of California at San Diego, 1989).

Some public monies are available for constructing and financing housing and, in some cases, recovery programs are eligible for these housing grants. Obtaining such funds, of course requires skills in grant writing (which program operators might not have). Obtaining funding for start-up and expansion requires creativity and alertness to opportunities. There is a need to examine public policies so that community-based programs continue to be developed.

Related to the issue of start-up is the matter of affordable housing. All social model programs need adequate and affordable physical facilities, and for many individuals, affordable sober housing is essential to sustaining recovery. Wittman (1993) reports that as early as the 1970s there was a decline in the amount of low-income housing in general and in the amount of sober housing that had existed in many cities in the form of “dry” hotels and lodging homes. Wittman notes that the key to the affordability issue of sober housing for low income individuals is financial assistance. Conventional housing projects are able to raise funds through conventional loans and other market mechanisms. Wittman (1993) urges formal policies to expand the funding available to create housing for low-income residents in recovery.

## **2.4 Perspectives on Funding of Social Model Programs**

Since social model recovery does not provide services in the traditional sense of units of particular services following a diagnoses, Reynolds and Ryan (1990) argue that it is inappropriate to pay for social model services on a fee-for-service basis, as is common with most health care services. (The fee-for-service approach may not be appropriate for other health care, either, since the opportunity for greater profits can potentially distort the services that are provided.)

Reynolds and Ryan (1990) maintain that the most appropriate funding mechanism is block grants to communities on a capitation (“per head”) formula (in which coverage is promised for a certain population or number of heads, regardless of how many services the population ends up using). The block grant supports the public health approach, which suggests that solutions to problems require an integrated response examining the agent, the host, and the environment. Not

only can community programs respond to troubled individuals, but they can attempt to reduce problems in the community. Social model programs are designed to maximize utilization of services in that they do not track how many group sessions a participant attends in order to bill for those individual services. Reynolds holds that counties should make social model services available to all without a means test (1988), so that anyone in need of them is provided service regardless of ability to pay. Fee-for-service programs, in contrast, may be seen as reducing access, in which case they would be barriers to recovery. Counties, Reynolds argues, should contract with programs on a net cost reimbursement basis and not pay fees for units of service provided (Reynolds, 1988). Schonlau (1990) notes, however, that accepting any government funding (regardless of whether it is fee-for-service or not) has a negative effect on the autonomous operation of recovery homes (due to inevitable expectations associated with such funding dollars). These differing views illustrate the variety of issues to be considered in rationalizing payment systems for social model programs.

Wright suggested an innovative approach to organizing and financing substance abuse services—development of a recovery maintenance organization (RMO). The RMO would be funded on a capitation basis through contracts with the county or with private organizations, such as insurance companies, health maintenance organizations or large employers. The RMO would link a network of recovery homes and neighborhood recovery centers, which would provide recovery as well as prevention services (Wright, 1994; Wright, 1995); it could also include treatment programs of a more clinical nature.

What would happen if government no longer funded recovery homes? One possibility would be for recovery homes to change their design and become clinical programs. This has apparently happened in some states and in some California programs. Recovery homes for years operated without government funding; they survived with fees received from residents and from funds raised in the community. Given the rising cost of real estate and other expenses, continuing to operate without any third party funding probably is not a viable option.

On the other hand, without government funds, the programs would be free of many—but not all—requirements that come with public funding. The next chapter examines voluntary and regulatory requirements intended to assure that social model programs are of high quality.

## **V. QUALITY ASSURANCE**

## V. QUALITY ASSURANCE

Since enormous resources are spent each year for alcohol abuse treatment and drug abuse treatment (Rice et al., 1990), the public has an interest in assuring the quality of those services. Reynolds and Ryan (1990) note that the most common approaches to quality assurance in substance abuse treatment and recovery services involve the establishment of standards for personnel and for programs.

### 1. CREDENTIALS AND LICENSING

The credentialing of individual practitioners, in the substance abuse field specifically and in the health services field in general, has kept pace with the increasing professionalization of society. Credentialing presumes that there is a body of knowledge and skills that are necessary for particular practitioners to perform effectively. When credentials become licenses, an exclusive right to perform particular duties is established. Credentials and licenses also affect compensation.

The presumption that there is a discrete body of knowledge that is a prerequisite for recovery is antithetical to social model philosophy. Reynolds and Ryan and others assert that credentialing is inappropriate for the staff of social model programs. They argue that credentialing would increase staff costs and create a hierarchical environment that would undermine social model principles.

On the other hand, as Borkman notes (1986), many California county alcohol program administrators have complained about low, state-set salary scales and lack of basic benefits for social and community model program staff; some have gone so far as to assert that “we have created a cycle of poverty among caregivers in the system” (Borkman, 1986, p.30). The underlying assumption of their argument is that the justification for paying lower wages to social model staff is that they are not credentialed. The issue of compensation and staff skills needs more examination, both by social model practitioners and by public policy analysts (Borkman, 1986; Institute of Medicine, 1990; University of California at San Diego, 1989).

### 2. PROGRAM STANDARDS

The second approach to assuring the quality of services is the establishment of program standards. Standards based on a clinical view of alcoholism would be inappropriate for social model programs. But, standards specific to social model programs would be appropriate and

useful both for supporting and expanding social model services and for evaluating their effectiveness.

In California, for example, the program standards for social detoxification were primarily based upon environmental, not personnel, criteria. Acting on recommendations from the California Association of Alcoholic Recovery Homes (CAARH), in 1974, the state established a separate licensing category for alcoholic recovery homes, which assured that programs met minimum standards for fire, health, and safety. Optional certification helped identify recovery homes that merited public confidence and support (Office of Alcohol Program Management, 1974). To obtain certification, programs had to substantially comply with CAARH standards. (Some counties would contract with and fund only certified programs.). A similar approach might be applied for standards development for other types of social model programs. Adequate and appropriate program standards for social model programs must be developed and specified so that quality assurance can be evaluated.

### **3. TECHNICAL ASSISTANCE**

The availability of technical assistance is a particularly important issue for community-based programs in which founders have experience and expertise with recovery, but not necessarily with program management.

In one effort to fill the technical assistance void, the California Department of Alcohol and Drug programs convened the Los Angeles Sober Guidebook Planning Committee and contracted with the Institute for the Study of Social Change to develop a guide for the formation of a Los Angeles Community Alcohol and Drug Free Housing Association (Biderman & Wittman, 1993). Committee members were drawn from directors of social model recovery homes that had sober living houses and from members of sober living houses. The guidebook suggested that the proposed association develop and monitor minimal quality standards and provide technical assistance to operators to improve their facilities. The intent was to establish a peer-based quality assurance system, rather than one that involved the government or other third parties. In 1995, the Los Angeles County Sober Living Network was established, but it has not evolved into the kind of self-monitoring association envisioned. Meanwhile, Los Angeles County has retreated from advocating for sober housing (Wittman, 1996, personal communication).



#### **4. REPORTING REQUIREMENTS**

Sound social policy rests on accurate information. When Congress appropriates money for programs, spending bills require that programs collect data about people receiving services from those programs. But, data collection and reporting is a controversial issue for social model programs. Dodd, for example, vigorously maintains that Federal data reporting requirements are a threat to the very existence of social model programs. Dodd asserts that data required are based on a narrow clinical view of alcoholism as a disease found only in unique individuals and on a belief that alcoholics are untrustworthy and incapable of recovery without a cadre of professionals and case managers (Dodd, 1992). Dodd suggests that the model informing Federal data collection requirements is industrial, i.e., people are malfunctioning machines and clinicians function as technicians.

Reporting systems assume that all programs collect diagnostic data, extensive histories of alcohol and drug use and of past treatment, elaborate demographic data, and other information on client progress. Social model programs do not collect such data. Also, reporting systems assume that program staff maintain client records. Social model programs have quite different assumptions about recordkeeping.

For one thing, social model programs do not diagnose their participants. Self-diagnosis is accepted as valid. Diagnostic testing does not yield more reliable data than the social interaction: in either case, an applicant can lie about his or her drinking or drug use. More important, reliance on clinical diagnostic tests would undermine the social model thesis, because it would place greater value on professional knowledge than on experiential knowledge in recovery.

Second, records themselves—including attendance, treatment/recovery planning, compliance, and progress notes—are not the domain of staff at a social model program. Most of the paperwork on a social model participant is produced by residents themselves; for example, sign-in sheets that track attendance. Staff recordkeeping would establish a hierarchical relationship between staff and participants. Case management of a client's compliance and recovery would replace an honor system sustained by trust and peer review.

Borkman identified the link between data collection and social model integrity in 1980 when she was a Visiting Researcher at NIAAA. A director of a social model program in California that was receiving Federal grant money refused to fill out the “client” portion of the required NAPIS (National Alcohol Program Information System) questionnaire. Borkman was

asked to find out why. She found that because the program did not have “clients,” but participants for whom no diagnostic or historical data were collected, the director could not complete the client forms without changing the program, thus damaging its integrity. (The director completed NAPIS forms that asked about the facility and program as a whole because doing so did not compromise social model principles.) Borkman notes that government data collection systems ask providers for too much data and never explain why the data are wanted. Providers are not compensated for filling out forms. Consequently, forms are inaccurately or incompletely filled out, and the quality of data collected is often “awful” (University of California at San Diego, 1989).

Borkman suggests that a brief questionnaire (15 items) on the demographics of clients would not hamper a social model program and would provide necessary information on who is receiving recovery services. Collecting other types of information is more problematic. For instance, gathering information about people entering treatment might be appropriate for a residential program, but such information would not illuminate the relationship of clients with a neighborhood recovery center and would undercount those receiving help in areas with a network of non-residential facilities in place (University of California at San Diego, 1989).

The thorny issues associated with data collection and evaluation requirements have enormous implications for social model programs. For example, evaluation research suggests that social model residential programs cost less than medical models, but inexpensive programs that are ineffective waste, rather than save, money. Policy makers want to know whether a type of program is effective and for whom. The next chapter examines the issue of outcomes and related challenges confronting social model programs.

## **VI. OUTCOMES, EFFECTIVENESS, AND CHALLENGES**

## **VI. OUTCOMES, EFFECTIVENESS, AND CHALLENGES**

Social model programs often struggle to secure funding from public agencies and their “services” rarely are deemed reimbursable by third-party insurers. Why? Problems faced by social model programs fall into three broad categories:

- Uncertainty in the field about outcomes and about the populations best served by social model programs
- Questions of the legitimacy of experiential knowledge as the basis of authority
- Weakening of a focus in recovery/treatment on a preventive, community model.

Problems discussed here include those articulated by participants in the social model movement as well as those identified by the authors as part of this study. Social modelists might take exception to issues raised by the authors. Issues already addressed in the literature are so noted.

### **1. OUTCOMES**

The outcome literature suggests that non-medical, social model residential programs have similar outcomes to more expensive, clinically oriented residential approaches (San Diego County Department of Health Services, 1983; Gerstein, Johnson, Harwood, et al., 1994; Asher, et al., 1995). In fact, this contention—that social model programs are less expensive and just as effective as clinical approaches—remains open to challenge. (For a detailed discussion of outcome studies of social model programs, see Appendix C.)

Outcome studies are few in number and open to methodological critiques that make generalization difficult. For example, the one study that adequately and explicitly delineates social model programs from other residential programs (CALDATA) suffers from problems with the way the sample was drawn and from a low response rate. The one study that has an excellent sampling strategy and a good response rate (Villanova) does not clearly delineate which programs (and associated outcomes) would correspond to social model-type programs (i.e., programs are simply categorized as medical or non-medical in terms of approach). In addition, none of the studies has involved random assignment, so that issues arising from the potential for self-selection bias (whereby healthier people gravitate away from a certain type of program, because of insurance coverage or for other reasons) have not been addressed.

Social model programs *per se* have not been evaluated (University of California San Diego Extension, 1993), and there are no reports in the literature of a traditional, definitive randomized clinical trial involving social model clients who were followed longitudinally to assess outcome. The need to conduct well-designed outcome studies of social model programs was emphasized by an expert panel that was convened in 1993 by the Center for Substance Abuse Treatment, in response to concerns that social model programs had “seldom been evaluated in a manner parallel to evaluations conducted in other treatment settings” despite their perceived cost effectiveness (University of California San Diego Extension, 1993, page iv). Since then, only one study of social model programs has been explicitly funded—the process evaluation now underway at the Alcohol Research Group.

Our literature review located only two other specific studies of social model programs, one funded by NIAAA (Borkman, 1983) and another by the state of California (Borkman, 1986), both qualitative in nature. In general, process evaluations and other qualitative studies contribute to practitioners’ and funding agencies’ understanding of what actually occurs within a given program and what the therapeutic ingredients appear to be. But, such studies at best provide only anecdotal information regarding successful outcomes.

## **2. APPROPRIATE POPULATIONS**

The question “for whom does the social model work?” has not been addressed in the literature, but the question becomes especially salient in systems that serve alcoholics and drug addicts in the same programs or that serve both public clients and those with private health insurance in the same programs.

### **2.1 Drug Addiction**

Recently, social model programs have served addicts of other primary drugs, as well as alcoholics, but the relative appropriateness of the social model for drug addicts has not been addressed in the outcome or the process evaluation literatures. Nor, so far as we can tell, is the issue addressed among social model adherents. Given today’s trend toward merged public funding of alcohol and drug treatment, few social model programs could afford to exclude addicts even if they wished to do so. Also, much attention of late is focused on dual addictions.

Many social model clients are, in fact, dually addicted, but not all are, and given that peer-to-peer helper therapy forms the foundation of social model programs, the efficacy of

merged recovery settings bears direct consideration and study. Many AA meetings, in fact, discourage addicts from speaking a lot about their drug use, because of the “singleness of purpose” tradition that seeks to avoid diluting the focus on, and effectiveness of, mutual help to combat alcoholism (Alcoholics Anonymous World Services Inc, 1991).

Social model programs might not be as appropriate or helpful for drug addicts as the therapeutic community (TC), another type of peer-oriented recovery, which was designed specifically for drug addicts (Nebelkopf, 1993). TCs are qualitatively different than social model programs. They tend to be more hierarchically organized, more structured in nature, and more confrontational in their therapeutic approach. (The literature does not address whether these characteristics of TCs are important factors in sustained recovery for drug addicts.)

## **2.2 Socioeconomic Status**

Preliminary survey data suggest that 96 percent of the clients at the social model programs where we are conducting our process evaluation are low-income (less than \$850/month or less than \$10,200/year). About one-third do not have a high school diploma. One in five are covered by Medi-Cal or Medicare, and over half (54%) do not have any medical insurance coverage. It is not surprising that social model programs largely serve indigent populations as they are primarily funded by county alcohol and drug program departments, and an increasing number of beds now are earmarked for prison departees and are paid for by criminal justice department budgets.

How do the peer helper dynamic and peer identification operate across class differences? Would well educated participants look down on advice offered by someone less educated or advice that does not sound sophisticated?<sup>6</sup> Answers to these questions are unknown. Outcome data on social model programs are scarce, and outcome data on middle class participants in social model programs are scarcer still. Although they might join AA, most middle class people have private insurance and do not enter the public programs that are most likely to take a social model approach.

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<sup>6</sup> AA has faced this issue. AA implicitly discourages intellectualization and explicitly discourages alcoholics from viewing themselves as “terminally different” from their fellow alcoholics. Over time, AA members accept this wisdom. Similarly, newcomers at social model programs who initially feel intellectually superior to staff and peers, over time, might learn to appreciate the experiential wisdom that recovering staff and participants offer. Some clients might drop out before that happens.

Nevertheless, if social model programs are to survive in a managed care environment (that is, an environment in which employers contract with programs for coverage of alcohol and drug treatment), referral agencies will need to know how middle class and upper class clients are likely to fare in social model programs. Many group-support programs (such as Weight Watchers) successfully serve middle class clients, and social model programs might do so as well. (Clients privately insured under managed care probably would not be served by the same programs as public clients, social model or not.)

### **2.3 Mandated Participation**

A complex issue for public policy is whether to require an individual to participate in treatment or rehabilitation efforts. Certainly, society has an interest in reducing the problems that result from alcohol and drug abuse. An ethical issue is to what degree should we attempt to change people's behavior through requiring treatment. If people are required to participate in treatment or recovery, how effective can these efforts be when they are involuntary? Increasingly in recent years, various authorities have required participation in rehabilitation programs by drinking drivers and by other alcohol and drug offenders.

For social model programs, the issue is whether to accept anything other than voluntary clients. Both the state guidelines for recovery homes and the CAARH standards for recovery homes have maintained that all admissions should be voluntary (California Office of Alcohol Program Management, 1974; California Association of Alcoholic Recovery Homes, 1992). This requisite relates to fundamental theses of social model recovery. For example, essential to the operation of social model programs is the concept that everyone (staff, participants, and volunteers) both gives and receives help. How willingly will a resident participate if he or she has been remanded by the court? Is this resident a peer? Shaw reports one instance when including drinking drivers—involuntary clients—proved to have a detrimental effect on what had been a successful program: “Many alcohol program policy-makers thought that mixing the drinking drivers with the people at NRCs would motivate the drinking drivers to recovery. Instead the opposite happened. The drinking drivers proved deadly to the morale of the recovering folks” (Shaw, 1990b, p. 146).

There are degrees of coercion. At one extreme, a person may be ordered into treatment by some authority. Only slightly less coercive is the situation in which a person is given the choice of incarceration or treatment. Another type of coercion occurs when an alcohol abusing individual is given an ultimatum by an employer or a spouse. As Weisner notes, the presence of

coerced clients challenges basic social model principles about the lack of hierarchy between staff and participants and everyone both giving and receiving help (University of California at San Diego, 1986; Weisner, 1990). Many social model programs try to resolve this dilemma by accepting residents who express a willingness to participate in the program, while at the same time maintaining that the resident is always free to leave.

### **3. ISSUES OF LEGITIMACY**

The basis of authority of the social model lies in the social model staff's own experience as alcoholic drinkers and as recovering alcoholics. This strategy is open to criticism on several fronts.

#### **3.1 Experientially Based Authority**

In principle, a psychologist's training is based on documented studies of thousands of alcoholic clients (an "n of thousands"). In contrast, the training of a social model staff member is based on his or her own experience, an "n of 1." Also, what if the staff's experience is totally different from the client's stemming from differences in socioeconomic background, gender, ethnicity, or drug of choice? Social model programs remain vulnerable to the criticism that newcomers can be "turned off to recovery" because of lack of identification with staff and peers.

Social modelists argue that these criticisms misrepresent their programs. The "n of 1" issue *is self-correcting*, because participants are exposed to more than one staff member, to many alcoholics' stories at AA meetings, and to other recovering peers who are participating in the social model program. The participant hears about many different experiences and approaches and tries them out for himself or herself *as part of the experiential learning process*. Time is another crucial element for the social model; that is, it takes time to be exposed to sufficient stories with which one may finally resonate.

#### **3.2 Leadership Development**

Although never noted in the literature, social model programs may flounder because social model leaders have not *really* trained their staff on how to administer their programs. Social modelists have taught classes on the social model program philosophy, creating the impression that their knowledge and culture are being passed on; and indeed, some of it is. But, with the exception of David Brown, founder of Bi-Bett Corporation (Bi-Bett Corporation, 1976;



Bi-Bett Corporation, 1989), social model leaders have been silent on the issue of the social model theory or practice of *management*. Where is the body of experiential knowledge about managing social model programs?

Social model administrators have not equipped a new cadre of leaders with the understanding of how to maneuver around regulations and strings attached to funding without necessarily compromising the essential pieces of the social model approach. The successful social model leaders are those who have been able to survive and even thrive throughout many challenges to their survival, and that aspect of their knowledge (which goes beyond philosophy and integrates culture and program operation) has not been well articulated or shared. It is possible that the social modelist leaders (many of whom are charismatic leaders) are themselves not self-conscious enough about this important aspect of their accomplishment. In addition, social modelists need to prepare ongoing leaders to advocate for social model programs at the state level.

To develop a body of knowledge of social model program management, a large number of managers or directors from different social model programs would have to share and discuss the similar (and different) problems they have had, their individual contexts, and the ways they were resolved (and with what results). Creative solutions to funding challenges would need to be shared. Some means of articulating and preserving the knowledge of management that resulted would have to be devised. In the mid-1980s in San Diego, county-funded recovery home staff from all over the county met regularly to discuss common problems and means of resolving them. Such a mechanism could have generated experiential knowledge of managing a social model program if it continued long enough and was codified in some way.

In addition to addressing funding issues, social model management would need to cover matters such as how to handle manipulative, exploitative, or power hungry staff or participants. The latter is especially important for social model programs, as they are client-run in terms of day-to-day problem-solving, rule-making, and rule enforcement via the residents' council.

### **3.3 Recordkeeping**

Can the recordkeeping needs of case management (and, by extension, third party payers) be addressed without eliminating the crucial elements of social model? The answer seems to be a qualified "yes," if only because social model programs that currently exist have had to accommodate at least some such requirements in order to receive funding. Those programs have

shown that recovery planning can be done in a way that remains self-generated by the client, yet overseen by the staff. And client progress can be documented in a way that is accurate but not all-consuming.

A great danger of compliance, however, is that recordkeeping could overwhelm the staff's time and keep them from the all-important job of role modeling and maintenance of the recovery-conducive environment, which requires their presence in the daily workings and life of the social model residents' program. For social model programs to be truly embraced by third party payment systems will necessitate that third party payers not overload providers with recordkeeping; yet such paperwork helps the payers justify spending the money at a given program, for a given client. Much dialogue is required, although social modelists are not in a position to argue for compromises from funding agencies. Professional therapists at medical model programs also are overwhelmed by the paperwork required of third party payers, so much so that, to a large extent, what the payers are paying for is paperwork and not therapy time with clients. This would appear to be one area of controversy where social modelists and professional clinicians share a common problem and burden and could unite toward a common goal of reduced paperwork.

### **3.4 Professionalization**

Social modelists have resisted funding agency requirements to hire staff who are professionally degreed and licensed therapists or social workers because they see the staff role as one of a catalyst but never as a therapist doing treatment. The therapeutic dynamic at social model programs derives from peer helping and peer identification. Thus, while social modelists may compromise to get funding and may conduct one-on-ones with clients to jointly develop recovery plans and document progress, they probably would not conduct groups where a therapist guides and interprets participant stories and experiences for the clients.

To be certain, there are many occasions in which social model staff *do* guide discussions a certain way (e.g., away from talk about women or sports and back to recovery-specific issues) and *do* interpret someone's story in recovery terms. But the central thing they do along those lines is something that the professional therapist is trained *not* to do: evoke their own experience in similar situations—how they handled it, what problems they ran into, what advice their sponsor gave them, etc.

Do recovering people who also are professionally licensed therapists or social workers represent a solution? The issue has not been taken up in the social model literature we located, but the answer probably comes down to money. If the social model program can afford to pay the salary justified by professional credentials, then professionals who are themselves in recovery could be re-trained to adjust their therapeutic approach to the social model way. Unfortunately, a two-tiered hybrid system may evolve at some social model programs, in which there would be higher paid professionals in recovery as well as lesser paid staff in recovery. Valuing of professional over experiential knowledge in this way is antithetical to social model philosophy. This, then, is one area in which further compromise may threaten the therapeutic foundation of social model programs.

#### **4. PREVENTION AND PUBLIC HEALTH**

Since the early 1980s, social modelists have spoken of a social-community model in which their mandate extends beyond recovery to include prevention. There are several paths that may be taken by social model programs toward prevention goals:

- Sponsorship of sober events (such as picnics, bingo, dances, etc.) that are open to the community at large (held either at the social model site or another site in the community, such as a park)
- Community outreach and education in which social model staff, current participants, and/or graduates speak to community groups about recovery and about the influence of environment on recovery issues
- Involvement in community organizing in support of alcohol control policy, such as circulating petitions for an initiative to reduce alcohol outlets in the community.

When the third approach—community activism—is taken, controversy can arise. Some social modelists see “an army of thousands of recovering alcoholics who could be prevention experts in the community” (Crane, University of California at San Diego, 1988, p. 24). But, community activism might be a well-intended idea that, for many reasons, will not be successfully embraced.

##### **4.1 Prevention**

It is not clear how many social modelists also are social-community modelists. A 1987 survey of five county programs in Monterey County, California, asked providers about the extent to which they had adopted activities that focused on the environment (Shaw, 1990a).

Only one provider explicitly opposed the premise of trying to change community values, norms, and policies about alcohol as “detracting from the needs of individual alcoholics.” The other providers ranged from well aware of and involved in community-focused initiatives to unaware but interested and tangentially involved. Two of the five programs were social model, but unfortunately, the data are not reported in a way that clearly identifies them. (Shaw, 1990a, p. 209).

Of approximately 20 social model programs surveyed in 1996, using an instrument (Kaskutas, 1995) that assessed community prevention activities and other indicators of social model philosophy in which recovery programs were involved, very few of the social model programs actually were involved in prevention in the community (Kaskutas, 1996a). This includes programs that were otherwise *very* social model in their program structure, staff role, basis of authority, physical environment, and approach to recovery. These preliminary data suggest that the social-community model program might represent an ideal rather than an actual approach that has been successfully implemented in California social model programs. No program directors or social model leader has gone on record as being opposed to this direction toward community programs, but actual programs have not embraced the charge.

This may be, in part, due to the resistance among recovering people, which was documented in studies in both Marin and San Diego counties in California. Social modelist Bill Crane found that NRC participants in San Francisco (1988) were “interested in prevention in terms of individuals drinking too much and suffering the various consequences (page 24) (University of California at San Diego, 1988). Crane found that the recovering alcoholics they approached from the NRC were willing to participate in prevention-related activities, but did not seem interested in taking the lead or in working on prevention *planning* efforts.

A study of recovering people in AA in Marin County sponsored by the Marin Institute that same year (Kaskutas, forthcoming) obtained similar findings. The recovering people Kaskutas spoke with said they would sign a petition and maybe even go to a meeting if the issue at hand were personally close to them, such as a liquor store being licensed across the street from their child's school, but they would not be the person offering such a petition at a shopping mall, recruiting people to come to such a meeting, or planning the next step in a prevention activity agenda. A Marin man with 25 years of recovery said that he didn't even think that anything preventive could be done to stop an alcoholic from drinking to the point of hitting his or her bottom. A Marin woman, active in AA's general service organization and no newcomer to activist agendas, said that part of her reluctance to take an active role in prevention stemmed

from the AA traditions; she also was worried that too much prevention activity on her part might threaten her own recovery.

Crane pointed out to the NRC participants and others that the AA literature does not discourage members from participating *as individuals* in broader issues of alcohol problems, but he found that “they couldn't see themselves as just an individual. They saw themselves as AA members, and they would be violating the traditions” (page 24) (University of California at San Diego, 1988). The one successful attempt at preventive outreach that he noted had occurred when a group of recovering women formed an advisory committee that became interested in prevention; under the umbrella of that distinct organization, the active member found “a base which she could speak from” that did not compromise the AA traditions (University of California at San Diego, 1988, p. 25).

Which are the traditions that might cause people in recovery to be unwilling or at least uncertain about taking an activist role in preventing alcohol problems at the community level? AA's 10th tradition says that AA has no position on outside issues and should not be drawn into public controversies. Tradition six says that the AA group ought never endorse or lend the AA name to any outside enterprise. Tradition five, the “singleness of purpose” tradition, says that the AA group has but one primary purpose, helping the alcoholic.

Thus, despite AA's own public position regarding the freedom that recovering people have to work as individuals (not as AA members) on alcohol-related issues, 3 out of AA's 12 traditions can be interpreted by members as discouraging—or at least as not encouraging—its members to become involved in prevention activities.

In addition to these three traditions, there are other reasons why the recovering alcoholic might not want to focus on prevention. Some alcoholics have come to understand their path to drinking as being self-motivated, and thus do not feel comfortable taking the position of “blaming the environment” or “blaming the alcohol.” Asking people who cannot themselves drink normally to take action that would restrict normal drinkers puts the recovering alcoholic in something of a moral bind. Also, prevention activities might be stressful for some recovering alcoholics. Asking recent graduates of a social model recovery program to tackle the issue of alcohol in the environment places quite a burden on the shoulders of the recovering alcoholic.

## **4.2 Public Health**

Although social model graduates may be unwilling to take an activist role in alcohol problem prevention, other aspects of public health are actually part and parcel of what the social model participant does on a daily basis. Here we refer to the goal of community empowerment, which social model programs epitomize. Empowerment is:

an intentional ongoing process centered in the local community, involving mutual respect, critical reflection, caring, and group participation, through which people lacking an equal share of valued resources gain greater access to and control over those resources ... or simply a process by which people gain control over their lives (Perkins & Zimmerman, 1995, p. 570).

AA and social model programs are empowering because of the “helper therapy” principle: by helping a fellow alcoholic, the helpers are themselves helped; and helping a fellow alcoholic is, in fact, the main way the helpers stay sober themselves. The dynamic of the “helper therapy” principle at social model programs cannot be usurped by professionals, or it ruins it for the alcoholics who need to help other alcoholics to stay sober themselves.

From the public health standpoint, the challenge of empowerment lies in getting the community to effectively identify and then solve its own problems in a sustained effort. Most attempts at community organizing become frustrated because the public health professionals end up dominating the helping exchange, which ultimately fails because the help is externally derived. When the health educator leaves, the community is unable to sustain the progress made up to that point. Community empowerment is a huge challenge for substance abuse prevention, so it is understandable that recovering people would represent an appealing target cadre for prevention activism.

Now, consider social model programs. They were founded by the community of recovering alcoholics and thus are grounded in the AA community itself (instead of being started initially by professionals). The therapeutic dynamic at social model programs is based on the “helper therapy” principle of AA, which is not a result of professional studies or theories about treatment that professionals have discovered or can teach the social modelists about; rather, it was the wisdom of the alcoholic founders of AA (a stockbroker and a surgeon). Finally, because the “helper therapy” principle is self-sustaining, the spark that drives social model recovery does not rely on externally generated excitement about the program, it comes from the community

members themselves *who believe that the only way they can stay sober is to “give it away” to other alcoholics*. The only thing that is not self-sustaining at social model programs is their funding.

## **5. RECOMMENDATIONS FOR FUTURE RESEARCH**

Social model programs’ ability to obtain funding and other types of support hinges largely on demonstrating their effectiveness to policy makers. CSAT convened an expert panel in 1993 to make recommendations for evaluating the effectiveness of social model programs and about the optimal research objectives and designs (University of California San Diego Extension, 1993). The panel concluded that since the questions about social model programs were so numerous, it would be unwise to attempt to devise a single study to answer all important research questions. Rather, the panel recommended that a program of research be pursued.

The panel recommended that the study’s priority should be a quasi-experimental design to compare outcomes from social model programs with outcomes from other types of programs in California, chosen for their size, scope, community setting, and service population. Since social model programs are designed to influence individuals, their families, employers, and the surrounding community, the panel felt that random assignment of individuals would be inappropriate. The study, they felt, should recognize that there might be differences in the objectives of social model and clinical programs. Common goals would include sobriety and improved life functioning. Additional social model goals would include changes in interaction with the community and with sober social networks. For clinical programs, additional goals might include psychological insight and changes in psychiatric symptoms. Specifically, the priority study should be designed to answer three questions:

- Do persons entering social model recovery programs have outcomes as good as or better than those entering other types of programs?
- Are social model programs cost-effective in relation to other types of programs?
- Do social model programs work better for certain population groups, such as women or men, those of a particular socioeconomic status, or those with problems of greater or lesser severity than others? (University of California San Diego Extension, 1993, p. 1).

The expert panel recommended that other portions of the program of research on social model programs address the history, conceptualization, theory, structure, and functioning of social

model programs; the relationship of social model programs to the surrounding community; the relationship of social model recovery programs to the larger context of community health care; and the extent to which social model programs are found in the United States and variations within the social model framework in California and elsewhere. Among the specific questions developed were the following:

- What is the structure and process of activities leading to recovery in a social model program? In more conventional language, what kind of treatment goes on there?
- How do social model programs differ from other types of programs?
- Who is being served by social model programs? Do people seeking help in a social model program differ in any respect from people typically entering other kinds of treatment?
- What kinds of relationships do social model programs have with each other and with other types of agencies?
- How are individuals in social model programs involved in surrounding communities? (University of California San Diego Extension, 1993).

Along with the need for outcome studies, there is a need for more process evaluation studies that can fully document exactly which aspects of social model programs promote, or fail to promote, recovery. Some people achieve recovery in social model programs—at least they credit their recovery to such programs. Furthermore, as recovery home personnel have often declared, success is relative. When a person has been drinking daily and, after treatment, has only occasional binges, is he or she a treatment failure or success? Such questions—or more accurately, the people in question—deserve thoughtful responses.





## **VII. CONCLUSION**

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The challenges facing social model programs primarily consist of gaps—gaps in funding, gaps in research, and gaps in acceptance. The wisdom that is embraced by social model philosophy has not yet been appreciated by professionals working in the field. In part, this is because academics have not analyzed the dynamic at work in these programs. Similarly, social modelists have not yet been able to come together themselves to find a common ground from which to work with professionals, researchers, or funding agencies.

The seeds of social model programs were sown in the first third of the 20th century. As we prepare to enter the 21st, social model programs exist in a dramatically different—and in many ways, harsher—environment than the one in which they evolved. Some social modelists fear their programs will become extinct; others fear that they will adapt beyond recognition. Indeed, as this review has discussed, many social model programs already have expired or evolved into something else.

Money and politics are not the only potent forces effecting change in social model programs. “The person that we served in 1964 is not the same person we are serving [now]!” observes social modelist and CAARH director Susan Blacksher. For example, she notes, the increasing imperative for social model programs to serve clients referred by the criminal justice system poses challenges, as “the ‘rules’ of probation or parole are at odds with the voluntary principles of the social model.”

“Many programs have changed to meet the needs of the person served,” says Blacksher. “We do need to talk about how the model must move and change to meet these needs, and not blame it all on other forces.”

Whether or not “pure” social model programs survive (and we fervently hope they do), we believe lessons of this movement enrich the fields of alcohol and substance abuse recovery in general and should be captured and shared. This review represents, we hope, one important step in that direction.

*Conclusion*

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**APPENDIX A**  
**HISTORY OF THE SOCIAL MODEL**

## HISTORY OF THE SOCIAL MODEL

The seeds of social model programs were sown in the early days of AA, when AA members would bring newcomers into their homes to sober up and get back on their feet. As the AA program was formalized into the 12 steps, this practice of helping other alcoholics was called “12 stepping,” and it became an integral part of recovery. Soon, AA members began to rent space elsewhere to meet the continuing need for sober residential settings. These spaces came to be called 12-step houses, and they were the earliest form of social model program.

In the United States, social model recovery programs multiplied and thrived primarily in California. It was California social modelists’ ability to influence state regulation of treatment that largely explains the inclusion of the social model in California’s continuum of services. Among the contributing factors were:

- A strong grassroots organization (the California Association of Alcohol Recovery Homes) of program directors who were recovering alcoholics and who favored the social model of recovery
- Vigorous advocacy by social model leaders
- State legislation and strong county-level executive support to enforce local decisions about types of programs to fund
- Federal funding without Federal strings
- Existing social model programs, which served as examples for new programs
- A national movement to deinstitutionalize and treat people in their own communities
- A state-endorsed, medically sanctioned approach to social model detoxification.

The first well-known and still existent social model “program” in California was started by a recovering AA member, Pat Wigger, who realized one evening that the newcomers who asked to be dropped off at street corners after AA meetings were homeless. In 1949, Wigger took steps that eventually created three hotels and other homes for recovering alcoholics and instituted the Mary Lind Foundation. Social modelists believe that the first Mary Lind home started the model of community participation that became the social model (Wright, Schonlau, & Dodd, 1996; personal communication).

These earliest social model residences in California (and elsewhere) did not have the peer-led group recovery component that today’s social model programs offer; they provided only a

sober environment for getting better. But, because of their AA traditions, these residences from the start exhibited the non-hierarchical structure that became a defining characteristic of social model programs.

In the 1950s, the social model residences spun off halfway houses for alcoholics. By 1961, these social model incarnations were referred to in California as recovery homes, in keeping with the notion of the continuum of recovery (Wiener, 1981). In 1961, 25 alcohol programs responded to a state survey of “recovery homes,” and many more soon were identified.<sup>7</sup>

During the same timeframe, California was trying to create umbrella strategies for dealing with alcohol problems, rather than relying on patchwork remedies of hospitalization or institutionalization for those in serious medical or psychological danger. In 1954, California developed its first formal plan of action for dealing with alcohol (Reynolds, 1973), providing funding (\$50,000) from a liquor license tax increase for demonstration alcohol treatment programs. Three years later, the state Department of Public Health created the Division of Alcohol Rehabilitation. The California legislature gave the social model movement another boost in 1963 when it authorized the interpretation of alcohol abuse as a total disability, which qualified alcoholics for Aid to the Totally Dependent. The McAteer Act of 1965 authorized the California Department of Public Health’s Division of Alcoholic Rehabilitation to fund local clinics for treating alcoholics. Beginning in 1967, the state could take advantage of Federal three-to-one matching funds to start rehabilitation programs for alcoholics.

During the early 1970s, the term social model surfaced in Canada. In 1972, the Addiction Research Foundation in Toronto was studying a non-medical approach to detoxification. The approach was discussed at a national meeting of halfway house directors in Florida, and several California social modelists visited the foundation. Reports on these activities contained the term “social model”; it later evolved to “social model of recovery,” a term some social modelists preferred to the also-used, more medically oriented term, “social treatment model.”

The social model movement continued to gather momentum in California, and in 1973, the state Office of Alcohol Program Management came out in favor of social model detoxification. In 1976, the office’s annual report to the state legislature asserted that

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<sup>7</sup> A founder of two early California recovery homes became a key political advocate for social model programs at the state and Federal levels. Tom Pike, a wealthy and politically active Republican, recovered in AA after unsuccessful attempts at treatment in various medical and psychological facilities. His political connections assured the movement’s access to the state and national policy makers. For example, Pike played a major role, along with Iowa Senator Harold Hughes (also a recovering alcoholic), in the passage of 1970’s Hughes Act, which created the National Institute of Alcoholic Abuse and Alcoholism and funded alcoholism treatment and research.

“detoxification services in a social setting are as effective as services provided in medical or hospital settings.”

Meanwhile, changes at the Federal level in the late 1960s and early 1970s were combining to encourage the “medicalization” of alcoholism:

- The Alcoholic Rehabilitation Act of 1968 stated that alcoholism should be treated as a health problem
- The Hughes Act of 1970 recognized alcoholism as distinct from mental illness
- The Uniform Alcoholism and Intoxication Treatment Act of 1971 served to decriminalized intoxication and “medicalize” detoxification.

Cumulatively, these acts shifted responsibility for the care of alcoholics—from the Federal government’s perspective, anyway—from the criminal justice system and the mental health care system to the medical establishment.

With this shift came funding, much of it for medical treatment of alcoholics. Between 1971 and 1973, the National Institute of Alcohol Abuse and Alcoholism (NIAAA, also formed by the Hughes Act), established 44 Federal alcohol treatment centers. (Two years later, the National Institute for Drug Addiction was founded and similarly served to institutionalize and Federally fund treatment for drug addicts.)

California, however, continued to march to a different drummer, one that led away from the medical establishment and toward social model programs. In 1972, the California legislature passed laws allowing police officers to take intoxicated persons to detoxification centers instead of to jail (O’Briant et al., 1973). The state’s Medi-Cal (Federal Medicaid) began reimbursing health care providers only for treatment of “medical complications” of alcoholism, which tended to curtail expansion of medical alcoholism treatment services.

Social model programs were not covered by Medi-Cal, either, but they dovetailed with California’s efforts to decriminalize and deinstitutionalize alcoholism problems. The Hughes Act allowed states to decide what treatments to fund; California further decentralized treatment and funding decisions to counties. Meanwhile, the state’s Office of Alcohol Program

Management<sup>8</sup>, part of the Department of Rehabilitation, agreed to allow funding of social model programs, provided that state-enforceable standards and practices for their operation were established. The Federal Joint Commission on Accreditation of Hospitals lobbied to put its own, hospital-based, accreditation policy in place. To avoid this outcome, directors of recovery homes throughout California mobilized to develop an alternative. Regional recovery home associations banded together as the California Association of Alcohol Recovery Homes (CAARH) and devised a system of peer review of social model recovery homes.

The convergence of local decision-making with state support gave social model programs in California a fair shot at securing funding. By 1974, 120 alcoholic recovery homes had requested certification from the state (Blacksher, 1990). Federal funds were secured to help social model programs meet building regulations that otherwise would have forced them to close, and the California Office of Alcoholism Management chose to certify alcohol services, instead of individuals, so that professional degrees or certificates were not required of counselors in publicly funded programs.

With the social model in full bloom, the seeds of the social-*community* model of recovery were planted. Several county alcohol program administrators—all strong social model advocates—promoted programs and policies that positioned the social model as a preventive model because of its explicit focus on the environment as crucial to recovery. They believed that through neighborhood involvement and intervention, they might have an impact on the larger environment, providing a safe zone for recovery that extended beyond the social model programs themselves. These administrators<sup>9</sup> instituted Neighborhood Recovery Centers (NRCs) and Community Recovery Centers (CRCs) during the late 1970s and early 1980s for non-residential (drop-in) populations. At these centers, people in recovery who had places to stay could find meetings and peer support. The centers also served as organizing sites from which the recovery community could educate the general populace about alcohol and drug problems. Although the centers did not evolve into the “social movement for change” or become the centers of political organization that their founders had hoped for, they did spawn a tradition of nonresidential recovery centers that persists.

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<sup>8</sup> The first director of California’s Office of Alcohol Program Management, Loren Archer, played a key role in the history of California’s social model programs. Some of Archer’s closest advisors were strong social model advocates. At their urging, Archer agreed to allow local funding of social model programs using Federal funds, provided a system of standards and practices be put in place. Later, at NIAAA, Archer helped secure funding for the first scholarly study of social model programs, conducted by Borkman in 1980.

<sup>9</sup> Bob Reynolds in San Diego county, Al Wright in Alameda County, and Troy Fox in Tulare County, among others.

Also, during these years, (1978-1981), a series of meetings took place in Marin County, California, that furthered the social model focus on prevention. These “think tank” discussions<sup>10</sup> brought together recovery home social modelists, prevention social modelists, and old-guard National Council on Alcoholism members. Over the next several years, these meetings produced a fusion between social model and public health model perspectives.<sup>11</sup>

Recent developments in the community model include a Social Model Consensus Panel that was convened by the California State Department of Alcohol and Drug Programs. This panel included directors of prominent social model programs, previous county alcohol administrators who had supported community model programs, and directors of CAARH. A draft document was developed by 1993 (Hayes, 1993), but it has not been completed or delivered to the state agency.

One of the distinctive ideas in this document that has not appeared in other social-community model writings is the concept of a “healthy community” and an understanding of how social-community model programs can contribute to converting unhealthy communities to healthy ones. The Social Model Consensus Panel developed the following list of characteristics of healthy communities:

- Low tolerance for harmful behavior; people engaging in harmful behavior will be questioned and confronted about that behavior.
- High concern for health and recovery of individuals.
- Education, prevention, and recovery services are easily available.
- Admissions from most recovering alcoholics and addicts that their patterns of use and abuse were dependent to some degree upon enabling relationships they had with family, peers, and other groups.
- Mutual help, support, respect, and love, which addresses low self-esteem.

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<sup>10</sup> The discussions were facilitated by Andy Mecca and included Dodd and Reynolds, Freid Wittman, James Moser, and Larry Wallack.

<sup>11</sup> During this period, Mary Ross established the idea of “the community as the client” and the “continuum of community recovery.” (Dodd, personal communication)

- Numerous opportunities presented to people to contribute in positive ways to the overall good.
- Ways in which people are recognized as having something valuable to contribute to the community from their very first day in recovery (Hayes et al., 1993).

But, even as the social model received its first scholarly attention (in the NIAAA-sponsored study conducted by Borkman in 1980), the climate that had been conducive to the growth of social model programs began to change. During the 1980s, the national War on Drugs was declared. The Federal government tightened its strings on alcohol funds. In 1986, the Health Care Financing Administration (HCFA) published guidelines for Medicaid coverage that excluded most residential programs including social model programs (Lewis, 1990).

While alcohol and drug programs were merging at the state level in California, similar scenarios played out at the county levels, and statewide the emphasis in funding shifted toward drug abuse treatment (more the province of medical treatment) and away from alcohol, and therefore, social model, recovery. Also in 1986, the Federal Office of Substance Abuse Prevention (OSAP) was formed to address both alcohol and drug abuse prevention. The Office of Treatment Improvement (OTI), chartered in 1989, similarly addressed both drugs and alcohol. OTI promoted a comprehensive treatment model that threatened social model programs in California altogether (Weisner, 1992).

Advocacy by social modelists eventually caused OTI to evaluate social model programs, and an expert panel was convened. The 1990 Institute of Medicine publication *Broadening the Base of Alcoholism Treatment for Alcohol Problems* recommended that “social and medical model programs be covered as long as the programs were licensed by the state or professionally accredited.” The IOM report also noted that “no adequate studies” indicated preference of one model over the other. This observation remains current: No data supports the current, nearly exclusive focus on funding medical model treatment.

In 1978, Susan Blacksher, a veteran of social model programs, was appointed Chief of the Alcohol Program Division when the California Office of Alcoholism was merged into the Department of Alcohol and Drug Programs. She observes that, for 10 years, the social model had been supported by some leaders, some county administrators, and the strong membership organization of CAARH, but starting in the mid-1980s, the department “...began to emphasize administration more than program. Fewer program people were in significant roles, and accountability began to be the ‘buzz’ word. The same type of scenario was taking place at the

county level.” Blacksher retired in 1991. Her position was eliminated and, some observers believe state support for social model programs further eroded.

Social modelists perceive consolidation of alcohol and drug treatment programs as the reason for their struggles for support because of the inherently different orientations of alcohol versus drug treatment. As health services researcher Constance Weisner observes: “Drug treatment has included more biomedical strategies within its purview than has alcohol treatment ... in recent years biomedical constituencies have been more powerful in a number of fields and could overwhelm the non-medical/social models increasingly found in alcohol treatment” (1992).

Reinforcing this trend, in the early 1990s a new drug, Naltrexone, was introduced as a treatment for alcoholism. Naltrexone reduces craving in alcoholics (and stops the effects of opiates in detoxified opiate users). Studies indicated that when properly administered under medical supervision, the drug results in high abstention rates. (Long-term studies are still under way.) Drugs such as Naltrexone have further medicalized the rehabilitative process and further distanced social modelists from the perceived new mainstream of treatment techniques.

Another threat to social model funding materialized in 1992 when a California state court ruled that “the State’s practice of allowing counties to determine whether and in what amount to provide Drug/Medi-Cal funded methadone treatment violated Federal law” (Wright, 1995). The ruling meant that, so long as the state provided any methadone maintenance services, such services have to be available to anyone who qualified. Counties couldn’t stretch their funds to cover alcohol services as well.

By 1996, the summary effect of statutory changes and court rulings was to limit alcohol treatment for poor people insured by Medi-Cal to programs with professionally credentialed staff. Medi-Cal hadn’t covered social model programs in the past, but now counties had no discretionary money to fund social model programs. To secure public funding at all, social model programs had to become clinical centers (Wright, 1995), and many did.

In sum, the current environment in California is essentially antithetical to social model programs:

- The organization of alcohol program directors is internally fragmented and politically ineffective.
- Legislation allows the state to dictate what types of programs are funded locally.



- Counties have merged alcohol services with drug services, and many have merged alcohol and drug programs into mental health administration, furthering a clinical emphasis in treatment.
- Federal matched funding requires case management reporting and professional credentialing, or at least the state has interpreted the requirements this way.
- Social model programs have had to modify their approach to accommodate funding, and few exemplary, pure social model programs remain open.
- The national movement toward managed care is clinical.
- A new drug to treat alcoholism offers a quick medical alternative to the social model's longer-term approach to recovery.
- CAARH and social model leaders are less effective lobbying forces than they were in the 1960s and 1970s.

How social model programs will fare under California's current shift toward managed care is unclear. Since social model programs are less expensive than other approaches, they could prove attractive. On the other hand, issues such as staff credentialing, case management, and recordkeeping could eliminate social model programs as an option under managed care plans. Some social modelists believe that such barriers could be overcome without destroying the basic social model in favor of a clinical model. Others argue that managed care would only further medicalize recovery.

**APPENDIX B**  
**SIMILAR PROGRAMS AND OTHER SOCIOCULTURAL APPROACHES**

## **SIMILAR PROGRAMS AND OTHER SOCIOCULTURAL APPROACHES**

The development of the social model of recovery from alcoholism, with its focus on the environmental context of change rather than the more usual individualistic focus of clinical professions, such as medicine and psychology, did not occur in isolation. Mutual self-help and the sociocultural focus on the relationship between the individual and the environment were important influences on developments that occurred in other fields contemporaneous to the emergence of the social model. The “therapeutic milieu” was developed to improve the treatment of mental patients. Halfway houses emerged to serve the mentally ill and ex-offenders, as well as alcoholics. Therapeutic communities were developed for the rehabilitation of drug addicts. Minnesota Model programs featuring a hybrid “biopsychosocial” model began treating both alcohol and drug abusers. These various movements stand in opposition to a general trend toward professionalization and the utilization of expertise to promote changes in or impose changes upon an identified patient or deviant. The following sections will consider these different approaches to utilizing the social environment to promote changes in individuals.

### **HALFWAY HOUSES**

One problem in reviewing the literature on “halfway houses” is that the term has been applied to very different types of residential programs for alcoholics (and for others). Some halfway houses serve as transitions between institutions and the community. Others resemble sober housing. Still others offer recovery services; some programs that would be called “recovery homes” in California are called “halfway house alcoholism programs” in other parts of the country.

The spread of halfway house/recovery home type programs for alcoholics appears to have begun in the 1950s, the same time that halfway houses for ex-offenders and the mentally ill began. The last known national survey of halfway houses, published by NIAAA in 1984, identified 842 units serving 37,452 individuals (Price, 1984).

In the five decades since halfway houses for alcoholics came into existence, there have been comparatively few studies of these programs. For example, for the years 1966 through 1995, the Medline database lists 109 entries for the subjects “alcoholism” and “halfway houses,” and nearly two-thirds of these appeared in the years 1970 through 1979. Since 1980, there has been an average of 2.1 listings per year. (“Recovery home” and “social model” are not Medline subject categories.)

It is difficult to formulate a general description of halfway houses for alcoholics since there appears to be considerable variation among programs. Rubington (1977, p. 352) defined the halfway house as a “transitional place of indefinite residence for a community of persons who live together under the rule and discipline of abstinence from alcohol and other drugs.”

The length of stay at halfway house programs historically has varied. A few programs are as short as 7 days post-detoxification. Many are a 4- to 6-week programs. Others run 6 months or longer.

Halfway houses charge fees to residents. Residents are aware of their responsibility to pay, and fees accrue from the time of admission, so residents feel pressured to begin work immediately. Some programs base the level of the fees on the ability of the resident to pay. Some observers fear that residents are encouraged to remain in the program for an excessive period of time so that fees continue to be received. Rather than a structured recovery program, these halfway houses provide what today is called sober living.

The number of beds in different programs varies considerably. A 1973 NIMH survey identified halfway houses that ranged in size from 5 beds to over 300. The median size of alcoholism halfway houses nationally was 18 beds. Two-thirds of all alcoholism halfway houses in the United States, and two-thirds of all the beds in halfway houses, were for males only.

Residents of halfway houses frequently have been characterized as homeless men (or less politely as skid row bums) or alcoholics “who have reached the depths of personal, social, and physical degradation” (Blacker & Kantor, 1960, p. 18). Pattison (1974) characterized halfway house residents as individuals who have experienced a breakdown of coping mechanisms and who turn to others, clergy or institutions, to rehabilitate them.

Staffing patterns vary considerably. The smallest homes for alcoholics may have only a resident manager and a cook. (Cooks were frequently mentioned as important in Association of Halfway House Alcoholism Programs literature. Good food helps create a homelike atmosphere and perhaps will entice people into entering or remaining in a program.) Larger programs employ more staff in more specialized functions. Nationwide, “recovered” or “recovering” staff comprise 60 percent of the total staff in alcoholic halfway houses. Some programs employ staff with graduate degrees, although these personnel also might be recovered alcoholics, addicts, or co-alcoholics (such as a spouse of an alcoholic).

Many halfway houses—but not all—emphasize AA, in contrast to social model programs, which specifically trace their origins to AA (Borkman, 1982). Halfway houses often mention providing milieu therapy or a therapeutic milieu. Some programs also use “reality therapy.”

Routines at halfway houses run the gamut from informal to highly structured. Some programs require residents to attend only one meeting each week. Others require attendance at a daily AA meeting and several other meetings weekly as well. Osborne and Cook (1977) found that among eight halfway houses in Ontario, the houses required either more than 25 hours per week of formal programming or less than 6 hours per week. Other studies suggest more of a continuum in the number of hours of formal programming at halfway houses. Sometimes, new residents have more structured formal programs, while veteran residents spend more time working either inside or outside the facility.

Halfway houses typically offer some education about the disease model of alcoholism and “group counseling” or community discussion of common problems. Individual counseling usually is available on an as-needed basis and take place spontaneously—every interaction between a staff person and a resident is an opportunity for promoting and strengthening recovery.

Rubington (1979), in a study of four halfway houses, found that at houses with more homelike atmospheres, the median stays were longer, and more of the residents were abstinent when they departed. Rather than emphasize a formal program, the homelike halfway houses tended to foster nondrinking associations with people outside the house, especially with AA members.

### **Halfway Houses for Ex-offenders**

The term “halfway house” is used in several different, though related, fields with possibly different connotations. While the term halfway house usually connotes a facility for those who have left an institution but who are not yet fully functioning in the community (a “halfway-out” house), other facilities have been established for those who have difficulties functioning in the community but who do not require full institutionalization (a “halfway-in” house). These facilities are found in both the fields of penology and mental illness.

In penology, the halfway house was developed to aid ex-offenders in their transition from being totally dependent inmates in prison to being participating members of society (Keller & Alper, 1970; McCartt & Mangogna, 1973; Powers, 1959). The ex-offender faces many challenges, including the stigma of having been in prison. More than half of all prison releases

are back in custody within a few months (Keller & Alper, 1970). The halfway house represents an attempt to reduce recidivism, as the inmate is gradually reintroduced to the community, perhaps by working during the day and living in the house at night. In the house, with others in similar circumstances, the ex-offender receives support and counseling for dealing with his or her problems of reintegration into society. Often “habilitation” rather than “rehabilitation” is mentioned as the objective of halfway house programs, since ex-offenders may have come from social backgrounds where their criminal activities were more or less the norm. More recently, because of their substance abuse prior to becoming incarcerated, some prisoners have been released to substance abuse rehabilitation facilities rather than to halfway houses or other facilities specifically for ex-offenders (Landy, 1960a).

The history of the halfway house for ex-offenders dates back over a century and a half to shortly after the development of the penitentiary. A Massachusetts commission in the early 1820s urged the establishment of what would now be called halfway houses. The difficulties confronting men released from prison were even then recognized to be largely the result of the social stigma of imprisonment and the related difficulty of finding employment. Some 40 years later, a halfway house for women released from institutions opened in Boston; it operated there for about 20 years. In 1845, in New York City, in spite of public indifference and hostility, a group of Quakers opened a halfway house that has survived to the present. In the late nineteenth and early twentieth centuries, other temporary shelters for ex-convicts opened in New York, Philadelphia, and elsewhere. There were isolated developments until the 1950s, when there appeared the beginnings of what is now a national halfway house movement for the care of offenders (Keller & Alper, 1970).

### **Halfway Houses for the Mentally Ill**

The treatment of the mentally ill is a second field where halfway houses are found. Reik (1953) is commonly credited with the first use of the term “halfway house” in the literature, although the term was used informally before that. In 1899, Holmes, who believed that “inebriety,” or drunkenness, was a form of latent madness, called for the establishment of a “halfway house”:

You cannot minister to a mind diseased. Not the prison, still less the workhouse, and assuredly not the certified inebriate reformatory, should be the home of these [habitually drunken] women. Sooner or later the State will provide a “halfway house” for those who live in the borderlands between sanity and insanity. When this is done rescue work may be easier (Holmes, 1899, p. 742).

When referring to the mentally ill, the term “halfway house” typically described a transitional residence for people with mental or emotional illness who no longer needed confinement in an institution but were not yet ready to cope with the usual family and community life (Sarcka, 1977). Reik wrote, “it seems logical to think that an environment intermediate between the mental hospital and the outside world—a ‘halfway house’—would make an important contribution to the rehabilitation of properly selected patients” (Reik, 1953, p. 617). Reik cited the Spring Lake Ranch, which had been operating in Vermont since the 1930s. Hundreds of patients had passed through this lay-operated facility, and apparently the program had been relatively successful. Reik suggested further consideration of the halfway house type of program, perhaps as adjuncts to state hospitals. The psychiatric halfway house has many antecedents. Sarcka writes:

The earliest recognized demonstration of family or noninstitutional care of the mentally ill took place in the fifteenth century in the town of Gheel, Belgium. From an early shrine, where families brought their mentally ill members for cure through miraculous healing power of Saint Dymphna, the town grew into a community where the townspeople opened their homes to unhealed pilgrims. This tradition continued in Gheel to this day. In eighteenth-century New England, some physicians took patients into their homes as part of the family. In 1881 halfway houses for the “insane poor” existed in England. Residences for the troubled and weary, run by organizations such as the Church, labor unions, and occupational groups to care for their own have appeared informally for centuries (Sarcka, 1977, p. 513).

A Mental After-Care Association was formed in England in 1879 to cope with the problems of the ex-patient in the transition between the hospital and the community. The association began by boarding patients in private homes to assist them through the difficult period of adjustment. The association soon concluded, however, that group homes were more suitable, and it opened a number of group homes so that the majority of its patients were placed in such homes (Huseth, 1961).

In 1954, Ruthland House in Boston, which for three-quarters of a century had been a temporary home for working women, became the first urban transitional residence for discharged mental patients (Landy, 1960b; Landy, 1965). Wechsler, in 1960, identified seven psychiatric halfway houses, all established since 1954 (Wechsler, 1960). Wechsler defined halfway houses as those transitional residences that provided a peer group of former mental patients during the initial period of adjustment to non-hospital life, during which time the resident was expected and

encouraged to establish independent relationships in the community and to find gainful employment. This definition excluded three additional facilities located in rural settings, including Spring Lake Ranch, which Wechsler called work-camp houses. In these, residents worked not in the community, but instead performed jobs on the facility—chores associated with the operation of a farm.

In 1962, Ghan found 13 psychiatric halfway houses in operation, using a definition that included what Wechsler had called work-camp houses; in 1963, Raush and Raush identified 40 such houses (Raush & Raush, 1968). In a 1969 survey, Glasscote et al. identified 128 halfway houses for the mentally ill that had been in existence for at least three and one-half years (cited in Cannon, 1975). A 1970 National Institute of Mental Health (NIMH) survey identified 241 halfway houses that dealt exclusively with the mentally ill; another 107 dealt with more than one class of patient within a single house, and of these, 64 percent were mentally ill and 16 percent were alcoholic (Cannon & Witkin, 1971). NIMH surveys in 1971 and 1973 identified 196 and 290 psychiatric halfway houses respectively (Ozarin & Witkin, 1975).

The rapid increase in the number of psychiatric halfway houses beginning in the 1950s was associated with a process of deinstitutionalization, in which the number of patients in mental hospitals declined even though admissions continued to increase. Since 1955, there has been a steady decline in the number of days of hospitalizations for mental illness. In 1988, the average daily inpatient census of mental patients was half of what it was in 1969; similarly, the median length of stay declined from 41 days to 15 days (Weitz, 1996). Several factors influenced these changes. First, as a result of the development and use of various drugs, including antipsychotics and major tranquilizers, many mental patients no longer required continuous hospitalization. Second, there has been an emphasis on a continuum of care, with specific treatments and aftercare tailored to the needs of different groups. Further, the value of maintaining patients as close to the community as possible was recognized. Finally, mental hospitals are expensive; it is far less expensive to care for a patient in a halfway house or as an outpatient than in a hospital (Sarcka, 1977). A comprehensive review of 10 studies, in which patients with serious psychiatric illness were randomly assigned either to inpatient care or to some mode of outpatient care, found no case where hospitalization outcomes were more positive than alternative treatments (Kiesler, 1982).

Psychiatric halfway houses typically provide a living situation with a minimum of regulations. A variety of social and rehabilitative activities may be offered. Although halfway houses are usually lay-operated, a close liaison is maintained with treatment professionals.



Halfway houses are often situated close to hospitals so that residents may continue to use hospital services (Huseth, 1958; Wechsler, 1961).

A variant of the psychiatric halfway house is not a transitional facility, but instead provides long-term residence for individuals who no longer require hospitalization but who are not capable of fully independent living. Such facilities, often known as “group homes,” have been established for elderly, mentally ill, mentally retarded, and other individuals (Huseth, 1961; Sarcka, 1977).

## **THE THERAPEUTIC COMMUNITY FOR DRUG ADDICTS**

In addition to supporting the mentally ill and those who have been incarcerated, halfway houses and residential rehabilitation facilities exist for the treatment of drug abuse. Since drug abuse has been a criminal offense, and many drug users have historically been incarcerated, residential treatment facilities for drug addicts have emerged as a natural offshoot from developments in penology as well as those in treatment and therapy (Berecochea & Sing, 1972; Yablonsky, 1962). While residential rehabilitation programs for alcoholics and drug abusers developed separately, they have many commonalities; in recent years, there has been considerable merging of what were formerly distinct treatment entities. The rationale used to argue for the merging of alcohol and drug treatment is that many drug abusers frequently use excessive amounts of alcohol, many alcoholics also abuse other drugs, and treatment and recovery programs are, therefore, increasingly dealing with people who have abused both alcohol and drugs *despite the programs’ nominally being there to serve alcoholics or drug abusers.*

Synanon was the prototype of what has come to be known as the therapeutic community or TC (Glaser, 1981). Synanon was best known for treating heroin addicts, but its members included non-addicted criminals and mainstream citizens, as well as drug addicts (Olin, 1980; Yablonsky, 1965). Following the founding of Synanon in California in 1958, therapeutic communities for the treatment of drug abuse multiplied rapidly. Within 15 years of the founding of Synanon, Sack (1974) estimated that there were over 1,000 therapeutic communities in the United States. Although Synanon itself degenerated into something of a cult centered on its founder (Mitchell, Mitchell, & Ofshe, 1980), the idea of the therapeutic community seems to have developed into a viable approach for treating substance abuse (De Leon, 1995a; De Leon, 1995b; Inciardi, 1995).

Among the reasons for the increase in the number of TCs has been public concern about drug abuse, and with this concern, there has been increased support for, and public funding of,

programs for treating drug abusers. The public support for TCs did not occur without concern from within the TC movement itself.

With this funding came public scrutiny, audits, licensing by bureaucratic agencies, outside boards of directors, and constraints regarding who could be accepted for help. Public funding added the language of the medical and academic communities, in which the rehabilitative processes of community became translated into the medical terminology of drug abuse treatment. First “interpreted” by academics, psychologists, and physicians as a medical rather than a community approach, then controlled by the constraints of public funding, some of those involved with TCs became concerned about the loss of uniqueness and integrity. Some TC voices complained that the only model developed by the underclasses for the underclasses—the Synanon model—had been co-opted by the very groups that had been unsuccessful with addicts in the first place (Muller, 1992).

These concerns from TC supporters are not unlike concerns raised by social model advocates; see, for example Dodd, 1992 and the discussion on social model program funding in the Resources section.

Originally, therapeutic communities accepted only voluntary applicants. However, by the late 1970s, most admissions were involuntary; drug users were increasingly being ordered into treatment by the criminal justice system (Weisner, 1990). There is growing literature in peer-reviewed professional journals describing therapeutic communities, including large-scale outcome studies (Asher, et al., 1995; Gerstein, et al., 1994).

With the proliferation of therapeutic communities, differences naturally arose among programs, but there are elements common to all. De Leon states that the quintessential element of the therapeutic community is what he terms “community as method,” (i.e., the purposive use of the peer community to facilitate social and psychological change in individuals). Basic to therapeutic communities is the belief that substance abuse is a disorder of the whole person. Recovery is a self-help process of incremental learning toward stable changes in values, attitudes, and behavior associated with maintaining abstinence (De Leon, 1995a). Thus, every activity in the therapeutic community is designed to promote educational and therapeutic change in the individual, and each participant in the community is a mediator of these changes.

The first requirement upon entering a therapeutic community is to become drug free (Brook, 1980). The addicts kick their habit “cold turkey”—without the aid of medications. Therapeutic communities and social setting detoxification programs have demonstrated that

withdrawing from an addictive substance in a supportive setting is less painful than previous experiences with withdrawal on the streets, in jails, or in hospitals (Brook, 1980; Sadd, 1987).

In therapeutic communities, residents perform all the duties of maintaining and operating the facility. Each resident has a job to do, and he or she is expected to perform satisfactorily. Residents without skills are given an opportunity to learn and practice, beginning with simple tasks such as sweeping floors or washing dishes (Brook, 1980; Askew, 1996). The amount of time residents spend working approximates the working day in the larger society (Brook & Whitehead, 1980). However, just learning job skills is not enough. For example, an angry person with antisocial values who does not know how to listen to authority will not last in a job, even with adequate job skills (Askew, 1996).

While therapeutic communities may use professional staff, the programs are peer oriented and, in varying degrees, peer controlled. The major therapeutic tool of therapeutic communities is the encounter therapy session, sometimes called “attack therapy.” At these sessions, which may occur daily or less frequently, each member of the community, regardless of status, is open to personal criticism and to support from fellow members of the community. These sessions have a no-holds-barred attitude; only physical violence is forbidden (Brook & Whitehead, 1980; Hampton-Turner, 1976).

Sugarman (1982) maintains that there are both democratic and authoritarian TCs, though he sees many similarities between the two. The democratic TCs trace their roots to the work of Maxwell Jones in organizing and utilizing a therapeutic milieu on a psychiatric ward. The “behavioral” or “hierarchical” or “authoritarian” TCs are those that evolved for reforming drug addicts. All TCs use peer pressure, and all TCs are quasi-self-sufficient groups. Both models of TC, and indeed all ongoing social groups, have sets of behavioral norms supported by group members and sets of positive and negative sanctions to enforce those norms. In hierarchical TCs, the sets of norms are much more extensive, more demanding, and more strictly enforced than those in democratic TCs. This is presumably because addicts need to learn self-control and because addicts have learned to be manipulative and would thus undermine any organization that was not tightly structured. Democratic TCs maintain that harsh demands may alienate clients and drive them away; they attempt to develop norms by consensus through democratic group process and maintain that this should result in more durable learning. Democratic TCs have been shown to be effective with many types of clients, but it is uncertain whether this approach is effective with drug addicts (Sugarman, 1982).

There are important similarities and differences between social model recovery homes for alcoholics and therapeutic communities for drug abusers. Both see substance abuse as a disorder of the whole person and recovery as more than simply not using and abusing alcohol and drugs. Both look to peer influences to promote resocialization, and both see the program community as the therapeutic agent. Therapeutic communities are more expensive (currently about \$61 per day as opposed to \$34 for social model programs; see Gerstein, Johnson, Foote, et al., 1984), because the TCs have more professional and clinical staff, probably because of the more serious mental and physical health needs of a population primarily composed of drug abusers, as opposed to a population primarily of alcohol abusers.

Dodd (1995) maintains that social model recovery homes are more effective than therapeutic communities, because the shorter length of stay in the recovery home prepares the resident to participate in the broad AA culture that supports sobriety. The longer duration therapeutic community programs have a specific culture that supports sobriety within the program, but that TC culture is not available to support the resident once he or she leaves the therapeutic community.

Dodd points out that for recovery homes, the culture of alcoholism recovery (AA) existed in the larger community with its own language, symbols, rituals, and social associations. This meant that recovery homes acted as a “port of entry” (or settlement house) to the AA recovery culture. Stays were relatively short, and those newly acculturated had places to go and things to do. TCs had to invent a “culture of recovery from drug addiction” (Martin Dodd, personal communication). TCs developed their own language, symbols, rituals, and social associations. Dodd argues that this meant longer stays, less mobility, and more of a “clandestine” feel to the movement. According to Dodd, the language (and some rituals) of the AA culture have by now permeated the larger culture, but this is not necessarily so for the drug recovery culture.

Nebelkopf compared the strengths and weaknesses of the social model approach, the TC, the medical model approach, and what he called the educational model (which emphasizes the individual, sees problems as stemming from learned maladaptive behaviors, and utilizes cognitive and educational psychotherapy, often provided in private practice, to teach new behaviors).

The TC is clearly a social model in that it emphasizes community over individual. It evolved differently from most Social Model programs that started out to help alcoholics. The TC is usually a lot more structured than the Alcohol Recovery Home (Nebelkopf, 1993, p. 4).

According to Nebelkopf, the strengths of social model programs lie in their ability to address spiritual and emotional needs of residents, their emphasis on community involvement, and their cost-effectiveness. The strength of the TC is that it treats the “whole person,” provides adjunctive professional services, and offers special programs for special populations (although social model programs can serve special populations as well). Disadvantages of social model programs are seen by Nebelkopf as funding problems, projecting blame on the environment, and a lack of structure in their programming and operation. Disadvantages of the TC revolve around a lingering distrust of “professionals” (Nebelkopf, 1993, p. 6). Nebelkopf recommends that TCs move closer to the mainstream of treatment and require more academic education and training for staff. (See also Nebelkopf, 1986; Nebelkopf, 1989a; and Nebelkopf, 1989b.)

Both social model programs and TCs emphasize the development of a cohesive residential community. A key difference between the two approaches is the hierarchical nature of TCs in contrast to the democratic nature of social model programs, although Sugarman argues that democratically oriented TCs have developed as well (Sugarman, 1982). Nebelkopf argues that another key feature of social model programming is that social model program activities are “clearly not defined as treatment ... whether therapeutic or not” (Nebelkopf, 1993, p. 5). The social model program features, taken together, pose a “basic problem to most funding sources, which insist on case managers, provision of units of treatment service, and certification of program staff” (Nebelkopf, 1993, p. 4). TCs have not suffered from those types of funding difficulties because the current TCs use language that includes “treatment,” “case management,” and “individual therapy.”

The TC adapted, in the eighties, to the growing external demands for ‘accountability’ and adopted treatment planning, case management, and the use of professional services. At first, these Medical Model elements were seen as useless compromises to get funded. However, in time, treatment planning and case management were seen as clinical tools with some minor utility (Nebelkopf, 1993, p. 5).

Therapeutic communities have been criticized by others, also. Maho (1973) compares therapeutic communities to total institutions such as prisons, mental hospitals, or monasteries, which have almost complete control over the individual (Goffman, 1961) and practice re-socialization techniques, which can be compared to “brain-washing” such as was used by China and North Korea on prisoners of war (Mahon, 1973). In those cases, the process of “brain-washing” consisted of total imprisonment, forced introspection of the prisoner’s past life,

acceptance of the captor's view of guilt and innocence, confession and self-condemnation, and finally, re-education. The suggestion is that TCs might involve some of the same types of tactics.

Although control over the individual is not absolute, and sanctions are not necessarily extreme, the techniques of brain-washing are found, in some degree, in many rehabilitation programs. New recruits to a therapeutic community, for instance, typically sever all contact with the outside world; no association is allowed with family and friends. The new resident is without status, but the community offers new opportunities to earn status. The novice's former life is without value; in encounter groups and other special occasions, the novice is expected to voluntarily repudiate his former lifestyle. The TC emphasizes to the new resident that no one can magically cure him; the community is a self-help organization which provides the shop, tools, and co-workers, but the resident must rebuild his own life. Many sanctions are used in TCs, from a mild scolding, to head-shaving, to being expelled from the community (Mahon, 1973).

The TC is self-sufficient, and the group is all important. The new resident is part of a new "family," and the family structures the activities of the day or the resident. Peer group pressure is constant, and the resident is expected to expose his weaknesses to the peer community. Mahon's major complaint about therapeutic communities was that they do not prepare residents for life in the outside world and, thus, may fail to produce lasting change (Mahon, 1973).

Dramatic changes, however, are seen in some residents or patients, and these have been likened to a conversion experience (Cook, 1988b). As Frank has shown, there are similarities between religious conversion, thought reform, and psychotherapy (Frank, 1961), which Cook extends to include recovery.

## **MILIEU THERAPY**

"Milieu therapy," a concept from the field of mental illness, has become a generalized idea that is used to describe many residential rehabilitation programs—regardless of who the program is intended to serve.

In the past few years the term "milieu therapy" has become extremely stylish. Few hospitals or treatment programs will admit to not advocating a therapeutic milieu. Some treatment facilities, for example, state that the treatment given to their patients is milieu therapy when in fact little more than custodial care is given to them (Pisani, 1964, p. 172).

Although the phrase “milieu therapy” is commonly used, it remains poorly defined and serves to obfuscate rather than clarify the nature of residential rehabilitation facilities (De Leon, 1995a). Rather than “milieu therapy,” some feel that it is more precise to speak of a “therapeutic milieu,” which is a community treatment environment so organized that every human interaction is potentially useful for rehabilitation of residents (Abrams, 1969; Raskin, 1976). The term “therapeutic milieu” came into the literature from the work of Bettelheim and Sylvester (1948) in the field of mental illness. Maxwell Jones (1953) provides an early, widely cited example of manipulating a psychiatric ward environment such that there developed a therapeutic community in which the social unit of patients and staff was seen as the primary therapeutic agent. Managing such a unit poses many challenges, as was noted by Rapoport and Rapoport, who conducted a lengthy study of the Jones ward (Rapoport & Rapoport, 1958). The importance of being aware of environment has been demonstrated by Forizs (1959), Rosenhan (1973), Maines and Markowitz (1979), and others who have shown that the environment of the psychiatric hospital, the psychiatric ward, and the psychiatric halfway house can actually be anti-therapeutic.

Rehabilitation has been likened to a process of socialization or acculturation (Landy, 1960a). In conventional treatment, the staff and other personnel are role models of “normal” or “well” ways of behaving. In the therapeutic milieu, instead of the staff being authority figures and role models, emphasis is placed upon peer identification. With the therapeutic milieu, there is open communication between staff and patients or residents and a minimization of status differences (Landy, 1960). This often takes the form of a daily community meeting (Wolf, 1977). In addition, the patients or residents have certain decision making powers. In some situations, patients or residents as a group make decisions concerning discharges and passes; in other situations, decisions are made by consensus of both patients/residents and staff in the community meetings.

Some of the ideas of the therapeutic milieu—e.g., the community of peers serving as models for resocialization or rehabilitation, open communication between staff and patients and community decision making—are similar to those found in a variety of residential programs addressing the needs of alcohol abusers, drug abusers, ex-offenders, and those with mental problems. Such characteristics have long been found in social model programs of recovery.

## **MINNESOTA MODEL PROGRAMS FOR SUBSTANCE ABUSERS**

A hybrid model of treatment, which claims to reflect a “biopsychosocial” model, has been popular in recent years. Perhaps the foremost example of this approach is the Minnesota Model, an abstinence-oriented, comprehensive strategy for the treatment of addictions, which developed in Minnesota in the 1940s and 1950s (Cook, 1988a). It combines elements of professional treatment programs as well as those of AA, including the use of recovered staff. Early examples of the program model were found in residential rehabilitation facilities and at a state hospital (Pearson, 1950; Rossi & Bradley, 1960). More recently, Minnesota Model programs have become associated with the private sector and may, thus, be available only to those with resources to pay for residential treatment or those with health insurance that pays for inpatient substance abuse treatment. Conversely, insurance coverage for Minnesota Model programs brings with it a paying clientele and helps sustain and validate the approach.

The program philosophy is straightforward. First is the belief that alcoholics and addicts can change their behaviors, attitudes and beliefs. Second is the belief that alcoholism or chemical dependency is a disease. Third are the treatment goals of abstinence from all mood altering chemicals and improvement of lifestyle, and it is recognized that abstinence alone does not define a positive outcome. Fourth, the principles of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), in particular their spiritual emphasis, are central to the program (Cook, 1988a).

Minnesota Model programs in the United States are typically 3- to 6-week residential programs (somewhat longer in the United Kingdom), with a progression to aftercare, and include intense involvement with AA or NA and other services as individually required. The residential phase of the program includes group therapy, family counseling for the benefit of both the patient and other family members, and didactic education about addiction, recovery, and the 12 steps and traditions of AA/NA. In addition to professional staff such as physicians, psychologists, social workers, and clergy, recovering alcoholics and addicts serve as counselors (Cook, 1988a; also Steffen, 1994).

Minnesota Model programs utilize a therapeutic milieu similar to other residential and inpatient programs, i.e., the setting is organized so that every interaction will support rehabilitation. Originally, residents each day performed many hours of labor doing practical jobs such as laundry, cleaning, and maintenance; currently, there is less time spent on such tasks. During the program, residents are expected to regularly attend AA/NA meetings on-site or in the local community. There is a daily reading group examining AA/NA materials. In addition,



residents are expected to work through the first three to five steps of AA/NA during their stay (Cook, 1988a).

Cook (1988b) reviewed studies of Minnesota Model programs conducted by the Hazelden Foundation, which evaluated its own programs. Cook recalculated the provided success figures (which were "inflated") but still found that about two-thirds of patients had positive outcomes (either abstinence or improved) for both alcohol and drug use. Cook suggests that the success of Minnesota Model treatment compares favorably with other treatments. A regression analysis of post-treatment abstinence at 12-month follow-up found the following factors to be important: frequency of AA attendance, lack of post-treatment hospitalization, assessment of group and individual activities in treatment as helpful, better education, and "higher power" contact, i.e., increased prayer and meditation post-treatment (Laudergan, et al., cited in Cook, 1988b). These factors, however, accounted for less than 20 percent of the variance.



**APPENDIX C**  
**OUTCOME STUDIES OF SOCIAL MODEL PROGRAMS**

## **OUTCOME STUDIES OF SOCIAL MODEL PROGRAMS**

Demonstrating the effectiveness of any treatment for addictions is difficult. Although the popular image of the alcoholic or drug abuser is that of continuous compulsive use, actual practices of substance abusers vary. The natural history of alcoholism (and by extension, the natural history of any addiction) includes periods of abstinence, periods of unproblematic use, and periods of abuse (Vaillant, 1995). Relapse has been recognized as part of the recovery process (Nyswander, 1963). Any follow up contact with a substance abuser may find the person abstinent, or using alcohol or drugs in moderation and without problems, or abusing alcohol or drugs. Also, over the course of a substance abuse career, alcoholics and drug abusers are likely to have several different exposures to treatment. If and when a substance abuser does achieve sobriety, it has proven difficult to document which treatment led to recovery.

For social model programs, the difficulty of demonstrating effectiveness is compounded by the lack of published studies on outcomes of social model programs (including their cost effectiveness). As the Center for Substance Abuse Treatment (CSAT) noted, “Social model programs have seldom been evaluated in a manner parallel to evaluations conducted in other treatment settings” (University of California San Diego Extension, 1993, p. iv). Only two outcome studies of social model programs have been conducted, and these are reported only in government documents. Two additional studies examined Oxford Houses and a sober social club. These studies are discussed in detail in the following sections.

### **SAN DIEGO STUDY**

San Diego County conducted a study of clients who had used county-funded social model services (San Diego County Department of Health Services, 1979; 1981; 1982; 1983). The study targeted all clients entering alcohol recovery programs contracted with the San Diego County Department of Health Services, Alcohol Program. Programs included one social model detoxification center, one 7-day residential program (post detox), nine recovery homes (five men’s, three women’s, one co-ed), and seven non-residential neighborhood recovery centers (San Diego County Department of Health Services, 1983).

Intake interviews were completed with 513 persons entering recovery programs. Of these, a stratified random sample of 300 was selected for follow-up. Females and minority clients were over-sampled because of the preponderance of Anglo males in the population of alcohol service users. A second sample of 13 NRC clients was drawn, since the initial number had been fewer than desired for analysis. The total sample for follow-up was 313. The typical alcohol consumption of the sample at intake was extreme. Ninety-four percent reported typical

daily consumption of 5 ozs. or more per day of absolute alcohol. Seventy-five percent of the sample had previously received formal alcohol services. Eighty-seven percent had previously attended AA; 47 percent reported being regular AA attenders.

About one-quarter of the study sample had severe life problems. They reported high problem scores, a history of chronic unemployment, limited education and/or job skills, poor work histories, criminal behavior often dating to childhood, a generally transient lifestyle, and serious problems with other drugs. While 60 percent of the sample reported being in generally good health, a number reported health problems and physical deterioration. Ten percent of the sample reported being unable to work because of ill health, and another 18 percent reported some physical limitations in their ability to work.

At follow-up, respondents were classified as abstainers (those with 6 months or more of continuous abstinence), improved (those with no more than one problem drinking episode in the past 6 months or those who had not drunk five or more drinks in any day during the last 6 months), or unimproved (those who drank at problem levels in two or more of the past 6 months, or who drank steadily and had problems). Follow-up interviews were conducted at 6 months.

At the 18-month follow-up, 65 percent (n=198) of the surviving sample were interviewed. Eleven people (3.5% of the initial sample) had died; 12 people (4% of the surviving sample) refused to be interviewed; and 92 individuals (30% of the surviving sample) were not located. Thirty-three percent (n=66) of the respondents at 18 months reported abstinence for at least 6 months, 21 percent (n=42) were improved, and 45 percent (n=90) were unimproved. Higher rates of improvement were reported for women than for men (47% vs. 27% abstainers, 23% vs. 21% improved, and 30% vs. 53% unimproved). These results are reported in greater detail below.

Approximately equal percentages of clients from each intake program (detox, recovery home, NRC) had been interviewed at intake and, at the 18 month follow-up, of the initial detox groups, 76 percent had entered an additional program, with the majority (66%) entering the 7-day residential program. After the 7-day program, 39 percent entered a recovery home and 14 percent entered some other program. Of those not continuing, 17 percent were readmitted to some program, usually additional detoxification.

Of the initial recovery home and neighborhood recovery center (NRC) clients, far fewer reported using additional formal services after leaving the initial service (22% for recovery home, 9% NRC). Clients whose initial service was NRC were a distinctly different group than those

whose initial service was residential or detox. Those using NRCs generally had a shorter history of alcohol related problems, and fewer had severe disabilities. NRC clients were less likely to have previously received assistance with drinking problems (60% vs. 80% for detox and 87% for recovery home); more likely to be married (44% vs. 22% for detox and 24% for recovery home); and more likely to be at least middle class (47% vs. 32% for detox and 37% for recovery home). Although it was reported that there were no differences in education or occupation between the residential (detox and recovery home) and non-residential (NRC) clients, the NRC clients were three times as likely to be employed at intake as residential clients (63% vs. 20%). NRC clients were reported to have a shorter problem drinking history than detox or recovery home clients. Clearly, there was selection bias in client sorting of programs they chose to attend.

Recovery status at the 18 month follow-up varied depending upon the services used. NRC clients were the least likely to be abstaining, but also the least likely to be unimproved (see Exhibit 6.) Fifty-seven percent of clients who used only the detox were unimproved; only 24 percent were abstaining. Clients who used only the recovery home were the most likely to be abstaining (36.8%) with a similar percentage unimproved (39.5%). Levels of significance were not reported. Clients who used the detox and other services were more likely to be abstaining than those who used only detox, but less likely than those who used only the recovery home (see table 4). This suggests that either detox services are counter-productive in promoting recovery, or that there was some selection bias differentiating those clients who entered recovery services via detox and those who did not. The Villanova study, described below, found that medical detox was counter-therapeutic; i.e., clients who had only detox services were worse in the period following treatment than in the period prior to treatment (Asher, et al., 1995).

Overall, there was a reduction in the level of life difficulties reported at the 18 month follow-up, compared with intake (8.6% vs. 21.7% reported high level of difficulties). For abstainers at 18 months, none reported a high level of life difficulties (vs. 30.2% at intake).

At the 18-month follow-up, an increased percentage of the sample was working either full or part-time, compared with intake (34.9% vs. 23.2%). At follow-up, a higher percentage reported not being in the labor force because of a permanent disability (28.3% vs. 18.7% at intake). At follow-up, the median household income of those contacted increased to \$466 from \$300 at intake. The percentage of households with no income decreased from 17.8 percent to 6.6 percent. There was a substantial improvement in the health status of subjects at follow-up. Seventy-four percent reported no major illnesses (vs. 32.2% at intake).

<b>EXHIBIT 6</b>					
<b>RECOVERY STATUS AT 18-MONTH FOLLOW-UP BY TYPE OF PROGRAM USED</b>					
<b>SAN DIEGO DEPARTMENT OF HEALTH SERVICES STUDY</b>					
<b>RECOVERY STATUS AT 18 MONTHS</b>	<b>PROGRAM TYPE</b>				
	<b>Detox<sup>a</sup></b>	<b>D-7<sup>b</sup></b>	<b>D-7-RH<sup>c</sup></b>	<b>RH<sup>d</sup></b>	<b>NRC<sup>e</sup></b>
<b>Abstaining:</b> Subjects reporting 6 months or more continuous abstinence	24%	33%	31%	37%	22%
<b>Improved:</b> Subjects with one problem-drinking episode in last 6 months, or who had not drunk five or more drinks in any day during the last 6 months	19%	7%	12%	24%	41%
<b>Unimproved:</b> Subjects who drank at a problem level for 2 or more months during last 6 months, or who drank steadily and had problems.	57%	59%	58%	40%	38%
N=	21	27	26	76	32

Source: San Diego County Department of Health Services (1983), 18-month Participant Outcome Study: Final Report

<sup>a</sup> 3-day detoxification program

<sup>b</sup> 3-day detoxification program plus 7-day residential program

<sup>c</sup> 3-day detoxification program plus 7-day residential program plus recovery home

<sup>d</sup> Recovery home program

<sup>e</sup> Neighborhood recovery center

The authors of this study compared their results to the then-recently completed RAND national study of alcohol treatment centers (Polich, Armor, & Braiker, 1980). The San Diego study had higher rates of abstinence (33% vs. 25%) but also higher rates of unimproved (45% vs. 32%). The RAND study reported that some problem drinkers did achieve periods of drinking without problems, but that these patterns tended not to be stable and that relapse was common. The RAND authors also reported that periods of abstinence less than 6 months tended to be unstable.

The San Diego County study was ground-breaking in that it was the first outcome study of social model programs. It utilized a quasi-experimental design and took a systems approach, which recognized that the recovery process cannot be attributed to any one recovery service or facility, but to the recovery system.

Unfortunately, one consequence of a research design focused on examining the system is that it is difficult to evaluate the effectiveness or contribution of the component parts (i.e., the individual programs or types of programs) toward promoting recovery. It would have been

informative to have more information on the separate services (detox, recovery home, NRC), especially since there appears to be some selection bias among clients using the different services. The design of the study limits conclusions that can be made about the effectiveness of different elements in the social model recovery system (e.g., neighborhood recovery centers as opposed to recovery homes) in general or for various subpopulations, including women, minorities, or members of different socioeconomic classes.

## **CALDATA STUDY**

The State of California conducted a major assessment of its recovery services for alcohol and drug abuse, the CALDATA study (Gerstein, Johnson, Foote, et al., 1994; Gerstein, Johnson, Harwood et al., 1994a, Gerstein, Johnson, Harwood et al., 1994b). This study sampled counties, providers of four kinds of treatment within counties, and participants in the sampled treatment programs. Sixteen counties, 97 providers and approximately 3,000 individuals who were in treatment or who were discharged between October 1, 1991, and September 30, 1992, were selected to be representative of the 150,000 persons in treatment in the state. The types of programs sampled were residential, social model residential programs, outpatient programs, and outpatient methadone maintenance programs. Residential treatment is a broad category:

A variety of recovery services are employed in residential settings, which can provide a heavily structured and controlled environment. Some residential programs are oriented more toward individual counseling and a classical staff/therapist model, others stress group interaction or a gradual climb through successive roles and responsibilities as a milieu for assimilating new ideas, norms, and behaviors (Gerstein, Johnson, Harwood et al., 1994a, p. 5).

In contrast, “social model recovery houses” are:

a particular type of residential program seen more in California than other states which focus on recovering alcoholics, stressing peer support and communal sober living (Gerstein, Johnson, Harwood et al., 1994a, p. 5).

Of the providers selected for the sample, 20 percent declined to participate in the study. Least cooperative were the methadone maintenance programs, of which one-third declined to participate. Over 90 percent of the sampled residential and social model residential programs participated. From cooperating programs, a sample of participants were selected. After the samples were selected, CALDATA staff abstracted treatment program records to obtain



information on the characteristics of the sample and to obtain specific information on sample members so that they might be contacted (i.e., there was no baseline contact in the study; baseline data on the sample were abstracted from program records).

Sample members were contacted an average of 15 months after treatment (except for continuing methadone maintenance clients who were, by definition, still in treatment at time of contact). About 2 percent of the client sample died before attempts were made to contact them for follow-up. Approximately 7 percent of respondents refused to participate in the study. Sixteen percent of the sample could not be located. For various reasons (e.g., language problems, physical incapacitation, inaccessible locations), interviews were not completed with another 15 percent of the sample in time to be included in the study. Thus, from cooperating providers, a sample of 3,055 was selected for follow-up and interviews were completed with 1,826 (60%). The response rate for the sample of social model clients was 56 percent; for residential clients, 57 percent. The overall response rate considering the sample of providers and the sample of clients of providers was, unfortunately, only about 46 percent. The overall response rate for social model clients and residential clients was only slightly better (51% and 55% respectively).

The CALDATA design compared before-treatment and after-treatment behaviors for each individual. Before treatment, 71 percent of all treatment clients reported using alcohol five or more times in the 12 months prior to treatment. At the follow-up interview, 50 percent of clients reported using alcohol subsequent to their treatment. Thus, although there was a 30 percent reduction in reported alcohol use, a substantial proportion continued to use alcohol after undergoing treatment. The authors concluded that treatment had effects on behavior, and that treatment outcomes reported are cost-effective for society. Each day of treatment paid for itself, particularly in reduction in crime, and the benefits persisted through the second year after treatment. Alcohol and drug use declined after treatment, as did hospitalization and criminal activity (see pages 69-71 in Gerstein et al., 1994).

Residential treatments were more effective than outpatient treatments in reducing the number of substances used (reductions were 55% for residential, 54% for social model, 46% for outpatient, comparing the number of drugs used before treatment and after treatment). The number of days the main substance was used in the peak month of use before and after treatment was reduced 51 percent for residential, 55 percent for social model, 43 percent for outpatient. Further, the length of treatment (categorized as 0-1, 1-3, 4 or more months) increased the amount of change from before treatment to after treatment. For instance, for social model programs, the number of months in which the main substance was used before and after treatment was reduced

36 percent for 0-1 month duration, 52 percent for 2-3 months duration, and 52 percent for 4 or more months duration. For residential programs, these figures are 47 percent, 53 percent, and 63 percent, respectively.

Residential social model programs and residential treatment programs seemed to produce similar reductions in substance use comparing before treatment to after treatment, and these reductions increased with increases in the length of treatment. Social model and residential treatment programs both demonstrated better outcomes than outpatient treatment and methadone maintenance.

Criminal activity before and after treatment was reduced 80 percent for social model programs and 74 percent for residential treatment programs. When treatment was 4 or more months, reductions in criminal activity were quite dramatic: 82 percent of social model clients reported criminal activity in the months prior to treatment, but only 7 percent reported such activity after treatment—a 91 percent reduction. No other treatment modality resulted in as few as 7 percent of clients reporting criminal activity (Gerstein, Johnson, Harwood et al., 1994).

The CALDATA study found that length of stay improves outcomes for social model residential programs and for residential programs in general. Although intuitively it might seem that longer treatment should improve outcome results, this has not been supported by other research reports. In a review of controlled or comparative studies, Miller and Hester found no cases in which longer inpatient treatment produced superior outcomes (Hester, 1994; Miller & Hester, 1986). However, Hester suggests that there is evidence that people with more severe alcohol-related problems and greater social instability benefited from longer or more intensive treatment (Hester, 1994). For outpatient services, some studies found longer treatments improved outcomes, and others did not. Two studies of halfway house rehabilitation found that length of stay appeared to have little impact on outcome (Annis & Liban, 1979; Booth, 1981). Gerstein reports that for therapeutic community programs, the length of stay is the strongest predictor of outcome at follow-up (Gerstein, 1994). Given the CALDATA findings regarding the role of length of stay, this question merits inclusion in any further studies of social model residential program outcomes.

The results of the CALDATA study are promising. Although this study reports that social model and residential treatment programs have an effect in reducing substance use and related problems and that the reductions are increased with longer treatment, the study suffers from a high non-response rate. Additional refined studies of this type are needed.

## **SPECIAL POPULATION STUDIES**

Evidence on the effectiveness of social model programs for different populations is scant. Studies of individual programs have reported clients from a variety of backgrounds (Barrows, 1980; Borkman, 1983). The San Diego County study of its services (San Diego County Department of Health Services, 1983) reported considerable variation in its clientele: 11 percent upper or upper middle class, 27 percent middle class, 40 percent lower-middle class, and 23 percent lower class. At the 18-month follow-up, the outcomes for each SES group were remarkably similar:

- Abstainers
  - upper or upper middle class, 32 percent
  - middle class, 32 percent
  - lower middle class, 33 percent
  - lower class, 35 percent
  
- Unimproved
  - upper or upper middle class, 47 percent
  - middle class, 43 percent
  - lower middle class, 48 percent
  - lower class, 46 percent

This study reported a considerably higher rate of abstaining at 18 months for women than for men (47% and 27%, respectively); this difference was accounted for in part because women reported greater stability and a shorter history of severe drinking. White and African-American clients had similar rates of abstention (36% and 33%, respectively) and unimproved (43% and 44%, respectively). In the San Diego study, Hispanics were less likely to be successful (16% abstaining and 64% unimproved). In general, the evidence available supports a conclusion that social model programs are appropriate for various segments of society.

Some social model providers report that having a greater mixture of participants in a program was beneficial in promoting recovery (University of California at San Diego, 1989). This observation seems reasonable, in part because of the social model emphasis on changing the behavioral norms of individuals: Exposure to different individuals teaches one the range of norms within a community. More research is needed, however, to assess this important topic. A related issue is whether some other segment of the population is displaced when a certain part of the population is served by social model recovery homes. There are suggestions that this has

happened, especially when the new population being served brings its own funding stream. For instance, Reynolds reported that a VA hospital began sending veterans who had completed a 30-day inpatient program to recovery homes in San Diego County. The recovery homes received funding from the VA for these residents, but did not increase their capacity. Thus, fewer residents from the community were served, as patients from the VA, who brought their own funding, became more attractive to recovery homes as clients (University of California at San Diego, 1989).

## **OXFORD HOUSE STUDIES**

A group of researchers at DePaul University have embarked upon a project to study Oxford House alcohol- and drug-free residences (Jason et al., 1994; Ferrari et al., 1995; Jason, 1995; Jason et al., forthcoming; Nealon-Woods, Ferrari, & Jason, forthcoming). Westermeyer noted that for many medical and surgical problems as well as for substance abuse, non-treatment factors are keys to recovery (Westermeyer, 1989). For instance, nutrition and exercise (which are largely outside the control of hospitals and clinics) are key to recovery from numerous medical and surgical problems, from coronary artery disease to strokes to orthopedic problems. Citing Westermeyer's review, Jason and colleagues (Jason et al, 1994) suggest that non-treatment or post-treatment variables (such as a sober living environment) may be better predictors of successful recovery from substance abuse than the treatment modality itself.

## **SOBER LIVING STUDY**

One study of men admitted to alcohol- and drug-free houses found at 6-month follow-up that about one-third of the men remained in the houses, one-third had left voluntarily, and one-third had been evicted (generally for relapses of alcohol or drug use). The reasons reported for voluntary departures were generally to move in with significant others or relatives or to live alone (Jason et al., forthcoming).

## **SOCIAL CLUB STUDY**

Mallams and colleagues (Mallams et al., 1982) assessed the effect of an alcohol-free social club for those in recovery. Eighty-three individuals in recovery (outpatient) were randomly assigned to receive minimal or maximal encouragement to attend the club; those receiving maximal encouragement were significantly more likely to attend, they showed greater reductions in drinking, less behavioral impairment, and less time spent in drinking settings. This

study and those above suggest that a sober environment can contribute to increased rates of sobriety, which is a major element of the social model philosophy.

## **HALFWAY HOUSES AND OTHER TREATMENTS**

There is some research on halfway houses and other residential treatments, but it is not clear to what extent these programs reflect the social model. It is imperative that future research examine and identify program operational philosophy, since all recovery homes, halfway houses, or residential facilities do not operate using the same principles. As a part of the present research on social model programs, a Program Philosophy Scale (PPS) has been developed and found to differentiate and scale model programs, therapeutic communities, and medical inpatient programs (Kaskutas, 1995; Kaskutas, 1996a). Use of this scale, the first to be developed, would help establish what kind of program is being evaluated.

### **Halfway House Studies**

The only scientifically rigorous study of halfway house programs was conducted by Annis and Liban (1979) who followed a group of men admitted to halfway houses from detoxification facilities and a group of matched controls selected from the population admitted to detox centers during the same period. Within 3 months of discharge (from the halfway house or from the detox), about half of the men in both groups had a documented drunkenness episode (i.e., drunkenness arrest or detox readmission). Controlling for the length of time a resident remained in the halfway house did not affect the likelihood of a drunkenness episode within 3 months of discharge. One difference between the groups was that former halfway house residents when drunk were more likely than controls to refer themselves to detox and were, therefore, less likely to be arrested.

### **Inpatient Studies (New York)**

New York State funded an evaluation of the state-operated inpatient alcoholism rehabilitation units (Lyons, et al., 1982; Welte et al., 1979; Welte et al, 1981). Some of the programs were “community-based,” but most were located in state mental hospitals. One facet of this study developed scales to measure variations in treatment orientations, characterized as peer group, rehabilitation professional, or medical, and the impact of different treatment orientations of different subpopulations in treatment (Lyons et al., 1982). A rehabilitation treatment scale measured the frequency of use of family, occupational and relaxation therapy, and vocational counseling as well as the number of psychologists, social workers, rehabilitation

counselors, occupational therapists, and recreational therapists. Welte and colleagues found that the rehabilitation treatment scale was negatively correlated with outcome. The medical and peer group scales were not found to predict outcome (Welts et al., 1981).

The only demographic variable found to interact with treatment orientation was gender. Females had a significantly better outcome (i.e., were more likely to be abstinent) when treated with the medical orientation. The rate of abstinence for male alcoholics was approximately equal whether treated with medical, rehabilitation, professional, or peer group orientation (55% to 60% abstinent). For those male alcoholics drinking at follow-up, the amount consumed was slightly less for those treated with a peer orientation (only 6.1 oz. of absolute alcohol per day vs. 7.1 oz., for those treated with medical orientation). On the other hand, behaviorally impaired male drinkers (as opposed to alcoholics) had significantly higher rates of abstinence when treated with a medical orientation. In general, Welts et al., (1979) concluded that client demographic characteristics, client drinking characteristics, and length of treatment were more important than the orientations of the treatment staff.

As the programs were individualized with different treatment regimens and different lengths, Welts and colleagues (1981) examined the effect of the length of stay (i.e., the length of the program) on outcomes. In follow-up at 3 months and 8 months after discharge, the researchers found significantly fewer of those with longer treatments to be drinking. Length of stay was categorized as 1-30 days, 31-60 days, and 61+ days. A second analysis found that those with longer stays were drinking, on average, over 1 oz. of alcohol less per day than those who had shorter stays. This difference, however, failed to reach statistical significance.

### **Inpatient Studies (Pennsylvania)**

The 5-year Villanova study recently examined publicly funded substance abuse services in Pennsylvania (Asher et al., 1995). Eight different types of alcohol and drug treatment provided by four different funding streams were evaluated. The eight types of treatment were:

- Hospital detoxification (up to 7 days)
- Hospital rehabilitation (commonly stays between 8 and 30 days)
- Non-hospital residential detoxification (up to 7 days)
- Short-term, non-hospital residential rehabilitation (stays between 8 and 30 days)

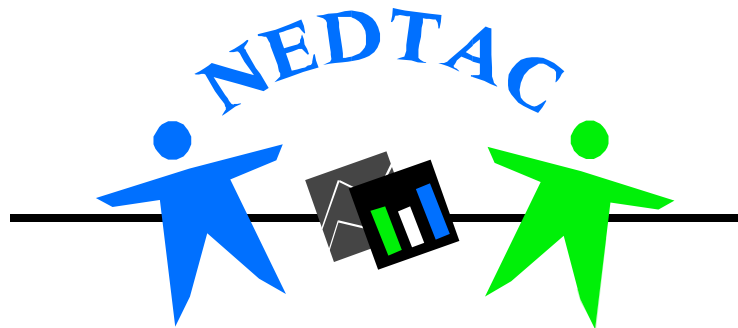
- Long-term residential rehabilitation (over 30 days)
- Intensive outpatient programs (three to five visits per week, with visits 3 to 6 hours per day for individual and group activities)
- Methadone maintenance
- Outpatient drug-free therapy (typically 1 hour, 1 to 2 times per week).

Over 10,000 individuals who had received services from a large number of providers were included in the study. The authors of this report considered the treatment needs of “public clients” to be fundamentally different from those of other client populations (i.e., public clients lack financial, social, emotional, and environmental resources available to other clients and deemed essential to recovery and adequate functioning in society).

The evaluation was unable to definitively answer whether residential care was better than outpatient care. But, the authors found that long-term non-hospital residential rehabilitation was statistically associated with positive changes in client outcomes, including reductions in arrests, violent crime, crimes against persons, property crimes, drug-related offenses, and public order crimes. This treatment is also associated with increases in employment and wages and a reduction in relapse and the need for subsequent alcohol and drug treatment. Short-term, non-hospital rehabilitation was also associated with positive client outcomes, but to a lesser extent. Non-hospital detoxification was not found to be associated with client outcomes (decrease in employment, increase in criminal activity, increased use of additional drug and alcohol services). Hospital rehabilitation was statistically associated with both positive and negative client outcomes; it appears to be most effective when used in combination with other services, typically non-hospital rehabilitation. Outpatient services, when used in combination with other services or when used for an extensive period of time, were associated with positive client outcomes. When used alone or for short durations, outpatient services were associated with negative client outcomes. Intensive outpatient programs were not associated with client outcomes.

The Villanova study clearly shows that all treatments are not equally effective with public clients. Non-hospital rehabilitation seemed to be effective in promoting recovery, but the report of the research does not adequately describe the nature of the service. It is not possible to determine the nature of the non-hospital programs or the extent to which they might reflect a social model philosophy. It would be useful if future outcome studies would utilize discriminatory scales, such as the PPS, which describe and differentiate residential rehabilitation programs, since they are not all equivalent.

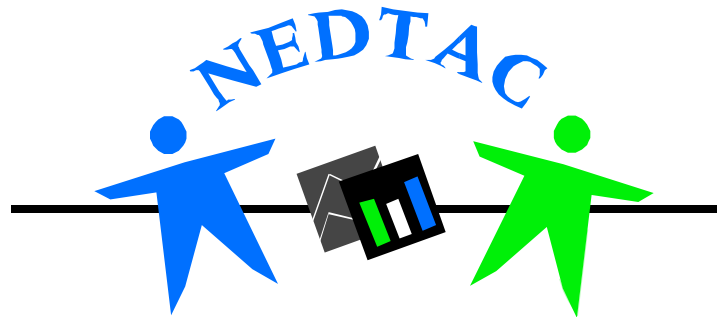
**NATIONAL EVALUATION DATA AND  
TECHNICAL ASSISTANCE CENTER**



**EXECUTIVE SUMMARY OF THE SOCIAL MODEL:  
A LITERATURE REVIEW AND HISTORY**



# NATIONAL EVALUATION DATA AND TECHNICAL ASSISTANCE CENTER



## EXECUTIVE SUMMARY OF THE SOCIAL MODEL: A LITERATURE REVIEW AND HISTORY

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This study was supported by Center for Substance Abuse Treatment, Department of Health and Human Services, Caliber/NEDS Contract No. 270-97-7016.

**CSAT**  
Center for Substance  
Abuse Treatment  
SAMHSA

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## FOREWORD

The Center for Substance Abuse Treatment (CSAT) Program Evaluation Branch established the National Evaluation Data and Technical Assistance Center (NEDTAC) to support the evaluation activities of CSAT's grantees and to advance the state of the art of evaluation of substance abuse treatment programs. The "*social model of recovery*," also known as the "California social model," is an area in the field of substance abuse treatment worthy of in-depth examination and evaluation, but no widely accepted strategy for evaluating social model programs has existed which could be used across programs. For this reason, the Alcohol Research Group (ARG) in Berkeley, California was asked to develop an evaluation methodology to evaluate social model programs.

ARG's effort has resulted in the following products:

- *The Social Model: A Literature Review and History*
- *Executive Summary of The Social Model: A Literature Review and History*
- *A Bibliography for the California Social Model For Alcoholics*
- *Development of a Program Philosophy Scale for Substance Abuse Recovery Programs*
- *Program Philosophy Scale (PPS) Manual: Guidelines for Scale Administration and Interpretation for Residential, Non-Residential and Detoxification Alcohol and Drug Programs*
- *Cost Checklist: Peer Helping and Hidden Costs in Social Model Programs*
- *Report of a Process Evaluation of Social Model Residential Programs*
- *Executive Summary of Report of a Process Evaluation Social Model Residential Programs*
- *Social Model Program Outcomes.*

Collectively, the documents represent a thorough examination of social model programs and how they operate on a day-to-day basis. This report provides an executive summary of The Social Model Program: Literature Review and History.

*Foreword*

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We wish to thank Lee Ann Kaskutas, Dr.P.H. and staff from the Alcohol Research Group for their development of this material, and Ron Smith, Ph.D., Jim Herrell, Ph.D., and Karl D. White, Ed.D. at the Center for Substance Abuse Treatment for their review and comment.

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Technical Assistance Center (NEDTAC)

## ABSTRACT

Social-community model for substance abuse treatment evolved out of Alcoholics Anonymous (AA), and embodies a different program philosophy than professionally-based treatment models, including different assumptions, sources of knowledge, and practice. This paper summarizes a comprehensive report on a literature review of the social model program philosophy and history conducted in 1996. The full review synthesizes the development, social construction, and current status of the social or community model of recovery and of Social Model Programs (SMPs) based on an analysis of the available literature, much of it fugitive. SMPs began in the 1940s in California and have evolved into publicly-funded, legally incorporated, nonprofit organizations that provide a continuum of recovery services. The characteristics of SMPs are described and the range of services are presented, including social setting detoxification, residential recovery homes, non-residential neighborhood recovery centers, sober living houses, and programs for special populations. SMPs are staffed by recovering alcoholics, and their structure is based on the 12 Traditions of AA, which emphasize democratic group processes, shared and rotated leadership, and a minimal hierarchy. Social model philosophy is aimed at empowering the individual, while addressing the environment, as well as the individual and the agent. The social model approach to treatment, thus, has much in common with the public health approach to prevention. Preliminary outcome research on social model program cost effectiveness suggests that residential social model programs are less expensive than other approaches, yet may offer similar outcomes in terms of substance use and improvement in other areas affected by drinking and drug abuse, such as employment or family relationships.

## **I. INTRODUCTION**

## I. INTRODUCTION

A variety of responses to chronic alcoholism and drug addiction have emerged in the last 30 years, among them a distinctive program philosophy known as the social or community model of recovery. Programs incorporating this philosophy are variously referred to as recovery homes, neighborhood recovery centers, and sober living facilities. A review of social model literature was conducted by the Alcohol Research Group (ARG) as part of a larger effort funded by the Center for Substance Abuse Treatment (CSAT).

The design for the overall study approach was developed to respond to recommendations made by an expert panel convened by CSAT in 1993 (University of California at San Diego, 1993). This expert panel identified three areas in which research on social model was most needed: a multi-site, quasi-experimental outcome and cost-effectiveness study comparing social model programs with other substance abuse treatment programs in similar circumstances; research identifying the structure and process of social model recovery ingredients that would be the equivalent of "treatment" in professionalized programs; and a comprehensive review of the literature addressing the history and evolution of social model programs, and the extent to which they have been evaluated. Operating on the assumption that it is first necessary to articulate the criteria for and meaning of social model recovery before an effective outcome study can be initiated, the larger study has attempted to elucidate the internal processes and historical development of social model programs in order to lay the groundwork for intensive outcome evaluation.

The approach taken was to design and implement four synergistic study components to address the need for a clear understanding of what the social model treatment process *is*, as well as *how* and *from where* it evolved. The full study comprises a literature review; development of a Program Philosophy Scale (PPS) to assess the extent to which a given program adheres to social model philosophy; development of a Peer Helping and Cost Checklist to assess hidden costs associated with social model programs and quantify value-added contributions that arise from peer helping; and conduct of a comprehensive process evaluation of two social model programs with a medical model program as a control site, in order to identify the active ingredients of treatment and recovery as dictated by the different philosophies. Completion of the research on these issues provides the necessary building blocks for a subsequent outcome evaluation of social model programs.

The literature review constitutes the first of the four study components; it not only answers specific questions related to the history and evolution of social model programs requested by the CSAT panel, but it was also a necessary first phase in the development of the

Program Philosophy Scale (PPS) and the Peer Helping and Cost Checklist, study components which enable researchers to operationalize and *measure* important facets of social model recovery with accuracy and reliability.

There is little published literature on SMPs. They were developed by non-medical, non-academic practitioners, most of whom were themselves in recovery. Much of the writing on SMPs has been “fugitive,” consisting of unpublished conference presentations and reports published locally by California state agencies or SMP associations (such as the California Association of Alcoholic Recovery Homes). A notable exception is the 1973 book by O'Briant et al. on “social treatment,” a professionalized version of SMPs, hailed by social modelists as among the earliest publications on social model philosophy (O'Briant et al., 1973). Academic publishing milestones have also included a report published by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) describing ethnographic research with two southern California social model agencies (Borkman, 1983); four reports from the University of California, San Diego on proceedings from four social model conferences between 1986 and 1990; the Institute of Medicine’s book, *Broadening the Base of Alcoholism Treatment* (1990), which singled out California social model as exemplar of the sociocultural approach; and an edited collection of articles, now out of print, from social model pioneers (Shaw & Borkman, 1990).

SMPs evolved in the late 1940s out of Alcoholics Anonymous (AA), founded in 1935. An important idea in AA is the 12th Step, in the course of which recovering alcoholics reach out to help other alcoholics as a way of sustaining sobriety. Known in academic circles as the “helper-therapy principle” (Reissman, 1965), and in AA as 12-Stepping or 12-Step work, a major principle fueling AA and SMPs is that alcoholics are themselves helped when they provide service to others. Another key tenet of AA is that the best person to help an alcoholic recover is a recovering alcoholic. The information conveyed to others seeking recovery is, thus, referred to as experiential knowledge by academics (Borkman, 1983), to indicate that the basis of authority is grounded in experience in recovery rather than in formal professional training. Borkman has described experiential learning, in part, as:

gaining information by practicing and doing; it is a process of developing and trusting knowledge acquired by personal lived experience. Experiential information is frequently conveyed verbally by stories of one's experiences, personal anecdotes, metaphors or analogies (Borkman, 1983, p. 5-1).



SMPs use experiential educational processes akin to AA, i.e., *education is gained through experiential peer support — not by instruction* (see Kaskutas, Marsh & Kohn, 1997). Other similarities to AA include participant involvement in running the program (self-governance) and in maintaining it (self-support), and the avoidance of hierarchy. Unlike AA, SMPs act as advocates for participants and put them in contact with community resources for addressing legal, family, medical, and employment problems. Some encourage the community to create sober activities and environments. SMPs have paid staff, accommodate funders and regulatory agencies, and provide clients with educational sessions, relapse prevention groups and other structured activities that go beyond AA paradigms of the 12 Steps and telling one's story.

Social-community model incorporates different assumptions, language, modes of knowledge, and practices than professionally-based treatment models. Many see social model programs as a poor man's substitute for a medical approach, lacking doctors and hospitals, rather than recognizing it as a distinctive alternative paradigm. The Institute of Medicine (1990) has broadly categorized treatment approaches as medical, psychological, or sociocultural and selected the California social model as "the most prominent example of the use of the sociocultural model in formal treatment" (p. 52). Sociocultural models see alcohol problems as stemming from a lifetime socialization process in a particular social and cultural milieu that implicitly or explicitly encourages alcohol drinking. The units of treatment involve both the person and his or her social and physical environment, in contrast to the individual focus of biological and psychological models (Institute of Medicine, 1990; Armor, Polich & Stambul, 1976).

The medical treatment model is currently greatly favored, despite the low cost alternative that SMPs appear to represent. One review of treatment costs (Holder *et al.*, 1991) offers comparative data (in 1987 dollars) on social and medical model program costs per day. Hospital-based inpatient costs ranged from \$230 to \$300 per day vs \$38 for social model residential; outpatient is \$70 per day for medical vs \$38 for social model non-residential. Based on these national data, *inpatient hospital treatment is at least six times as expensive, and outpatient hospital-based programs are twice as costly, as social model counterparts*. State analyses of SMP costs are provided in Section IV below.



## **II. HISTORY OF THE SOCIAL MODEL MOVEMENT**

## II. HISTORY OF THE SOCIAL MODEL MOVEMENT

The history of social model programs in the U.S. is largely a California story, where convergence of federal and state action in the presence of strong grassroots leadership allowed the movement to expand beyond private homes of AA members into established institutions. The following sections summarize the regulatory, social, and programmatic history of social model programs.

### 1. SOCIAL CONSTRUCTION OF THE SOCIAL MODEL MOVEMENT

California's 1965 McAteer Act enabled state funding of local clinics for treating alcoholics (Blacksher, 1990). As Federal legislation urged that alcoholism be treated as a health problem (Alcoholic Rehabilitation Act of 1968) distinct from mental illness (Hughes Act of 1970), and that intoxication be decriminalized (Uniform Alcoholism and Intoxication Treatment Act of 1971; Regier, 1979), California's Medicaid policy was written to cover reimbursement for medical complications from—but not treatment for—alcoholism (Blacksher, 1990). This policy discouraged medical settings from offering alcoholism services, and non-medical, non-hospital services sprang up to fill the gap (Blacksher, 1990). In addition, the state legislature granted approval for police to bring alcoholics to detoxification centers, some of which were non-medical (O'Briant, 1973), and it offered financial incentives to counties that placed mentally ill people in community programs rather than in state hospitals (O'Briant et al., 1973).

The Joint Commission on Accreditation of Hospitals argued that its accreditation guidelines, which favored medical approaches, ought to be used to determine eligibility for government funding. In response, directors of recovery homes throughout the state formed the California Association of Alcoholic Recovery Homes (CAARH) in 1972 to design an alternative peer review system for social model recovery homes. This development, along with a governmental structure that granted local control over program decision-making, allowed social model programs to grow and remain non-medical. State legislation was passed that further localized control (SB204), empowering counties to decide for themselves how they would respond to availability of federal funds. In 1974, 120 recovery homes requested state certification (Blacksher, 1990), and numbers continued to grow as federal funds helped SMPs meet building regulations. Due in large part to social model leaders' advocacy, the state chose to certify alcohol *services* instead of individual *providers*, so that professional certificates/licenses were not required in publicly-funded programs (Blacksher, 1990). In 1976, the state Office of Alcohol Program Management reported that social setting detoxification was as effective as services provided in medical or hospital settings (Blacksher, 1990), and its Director (Loran

Archer) was amenable to non-medical models for long-term residential treatment, as well (Pike, 1979).

The environment did not remain as conducive to social model recovery, as federal and state actions medicalized and professionalized substance abuse treatment. In 1978, California merged handling of alcohol and drug issues in a Department of Alcohol and Drug Programs (ADP). This action had the effect of emphasizing drug abuse treatments (more the province of medical treatment) at the expense of alcohol (often social model) recovery. To consolidate planning and reporting, in 1980 the state instituted an Alcohol Services Reporting System, thought to distort SMP functioning (Borkman, 1983; Borkman, 1986; Borkman, 1990b), and ADP considered professional licensing of *individuals*, transferring the basis of authority from experiential knowledge to clinical training. At the federal level, the Office of Substance Abuse Prevention (OSAP) was formed (in 1986) to address alcohol and drug abuse prevention, and the Office of Treatment Improvement (OTI) received a dual alcohol and drug charter (1989) that promoted a medicalized “comprehensive treatment model,” and greatly threatened the existence of SMPs (Weisner, 1992). The advocacy efforts of the social model movement were fragmented and ineffectual against these federal and state actions.

In 1990, the California social model was highlighted in the seminal report *Broadening the Base of Alcoholism Treatment for Alcohol Problems*, which recommended social model be evaluated and funded (Institute of Medicine [IOM], 1990). The IOM recommendation has not yet resulted in the direction of substantial attention to evaluation of social model recovery; the U.S. treatment system focuses more exclusively on medical treatment or medical hybrids such as the Minnesota Model (Institute of Medicine, 1990). Around the same time the IOM report was published, a new drug (Naltrexone) was announced which held out the promise of a medical solution to some challenges of early recovery (such as craving). This development has furthered the distance between social modelists and the perceived new mainstream of treatment, and it pushes regulators closer to adopting requirements dictating the presence of medical personnel during the rehabilitative process. Similarly, a 1992 lawsuit in California, which was decided in favor of Methadone maintenance “on demand,” has led the ADP to mandate that “the first use of alcohol and drug State General Fund money is to provide Drug/Medicaid services” (Wright, 1995, p. 8). This specification has left little or no discretionary funding available to support social model recovery programs.

The sober living residence is one vital aspect of social model that remains strong, partly due to favorable housing legislation. The state ADP supported a guidebook and an association

that set standards (Wittman, Biderman, & Hughes, 1993). By 1996, an advocacy organization and over 500 sober living homes were found in LA county alone (Sober Living Network, 1995).

## 2. EVOLUTION OF THE SOCIAL MODEL APPROACH

Social model practices and terminology in California have gone through three somewhat distinct stages (Borkman, 1982). At first, the label “social model” was to a great extent just another way of saying “non-medical” in describing a facility that was community-based (not a hospital); did not have a physician or psychiatrist directing the program; and did not use medications in the course of detoxification (Borkman, 1990a, p. 46).

By the 1970s, California social model practitioners began to see their efforts as *different in kind, not simply in degree* from medical treatments. Key features of Social Model Programs (SMPs) were further identified in this second stage of social model evolution (Borkman, 1990a; U.S. Center for Substance Abuse Treatment, 1993). SMPs:

- Are Alcoholics Anonymous-based
- Incorporate a social network and environment where abstinence was regarded positively
- Incorporate an experiential basis of authority
- Do not coerce participation
- Allow alumni and program participants to help run the program
- Provide a home-like, not institutional, physical environment.

These features have been operationalized in a 33 item checklist that differentiates SMPs from medical and other approaches in six areas: **physical environment**—homelike vs institutional; **staff role**—peer vs hierarchical relationship; **basis of authority**—experiential vs professional; **view of recovery**—client vs staff driven; **governance**—participatory vs non-participatory; and **community orientation**—integration vs introduction. (See Kaskutas et al., 1996 for further information on the development of the checklist.)

A third conceptualization of SMPs emerged in California in the 1980s as the social-community or the community model, which considers alcohol problems to involve not just individual alcoholics or problem drinkers, but also the family, the local neighborhood, the

community, and general society. Its proponents recognized the need to promote not only individual recovery but also change in the norms, values, policies, and practices regarding alcohol in community and society. The community model examines the context in which drinking occurs and seeks ways to modify the environment. The social-community model is, thus, analogous with the contemporary public health model in that it is explicitly involved with prevention (Borkman, 1990a). The social-community model is a grassroots example of public health service development, formulated by recovering persons and their allies, not by treatment or political professionals. Not all social modelists are also social *community* modelists (see Shaw, 1990 and Borkman et al., 1996), and studies reveal difficulties in implementing the community approach, since many social modelists adhere to the AA tradition of no involvement in social causes (University of California at San Diego, 1988; Kaskutas, forthcoming; Alcoholics Anonymous World Services Inc., 1991).

Social Model Programs are also able to support the recovery needs of special populations. For example, the California Women's Commission on Alcohol and Drug Dependencies found SMPs compatible with feminist principles of egalitarian organizing, empowerment, legitimizing experiential knowledge, and seeing the interconnectedness between individuals and their environments (Drabble, 1992, p. 3). A study of Chrysalis, a women's recovery home in Oakland, California, open since 1980, shows how its distinctive elements support women's recovery needs (Rolando, 1988; University of California at San Diego, 1988).

The California Department of Alcohol and Drugs has funded commissions to increase services to minorities, but the only specific data located in our extensive search was a brief mention of Palavra Tree, a SMP for minorities in San Diego, in the proceedings of one of several social model meetings convened by the University of California at San Diego (1988). Minorities are over represented in public programs and, therefore, perhaps more represented in social model.

Some SMPs have been adapted to serve the disabled and the very ill, since SMP participants can be wheelchair-bound or HIV-positive, or may have chronic physical problems. For example, Fortney's (1992) description of the Center for the Empowerment of Deaf Alcoholics in Recovery (CEDAR) depicts a neighborhood recovery center of, by, and for deaf substance abusers. CEDAR developed in 1990 in a grassroots effort assisted by start-up funds from the San Diego County Department of Alcohol Programs (Borkman, et al., 1996).

### **III. SOCIAL MODEL SERVICES**



### III. SOCIAL MODEL SERVICES

Similar to treatment delivery systems developed by professionals using medical or psychological models, social model services comprise a continuum of care, including **detoxification** from alcohol and drugs, **primary** recovery, **secondary** supportive recovery, and **sustaining** lifelong recovery. Services are provided in a variety of facilities, in a variety of ways, to a variety of participants, and the programs are organized and staffed very differently than medical model programs.

#### 1. FACILITIES

Unlike the medical model which primarily treats the individual alcoholic, social model has always considered the *environment* to be at least as important as the *individual* and the *agent* (alcohol or drugs) (Lilienfeld & Lilienfeld, 1980; Wittman, 1992). In social model, the individual alcoholic's problem is seen as intertwined with social network, overall lifestyle and underlying values, *as well as* the loss of ability to drink normally. The program must reconstruct “the social living space of the alcoholic through the provision of new social and physical arrangements” (O’Briant et al., 1973, pp. 62-63; Room, 1996). Types of facilities that provide SMP services are described below.

##### 1.1 Detoxification

A non-medical approach to alcohol detoxification was developed in Toronto in 1970 by the Addiction Research Foundation and brought to California in 1972 by social model leaders who urged state agency funding for this approach. It focuses on a home-like atmosphere in which no medications are used to relieve symptoms. It has been estimated that only 5 percent of alcoholics need medical intervention during detoxification (O’Briant & Petersen, 1990). Alcoholics in treatment who manifest acute symptoms of withdrawal are referred to nearby emergency rooms or medical clinics to receive the required medical care.

##### 1.2 Recovery Homes

Standards for recovery homes have been developed by the California Association of Alcohol Recovery Homes (CAARH) (1992) for the estimated 400 recovery home facilities in California. As with social model detoxification services, recovery homes do not provide in-house medical or legal services, but they assist residents in obtaining whatever services they need in the community. For example, services for alcohol-related gastroenteritis or liver problems and psychological issues are addressed at SMPs by referral to hospitals and other community

facilities. Public aid and employment issues, custodial and other legal issues, or education are referred to local human service agencies specializing in those areas; although residents often initiate their own referrals, recovery home staff maintain an ombudsman role to insure that the referral agency follows through in helping the resident. Residents are taught to access and deal effectively with human service and criminal justice agencies to resolve outstanding child custody, drunk driving, or financial issues. Recovery home programs maintain minimal records on each resident, fulfilling only legal and health requirements. They do not keep clinical case files such as those found in a medical program, because recovery home operators maintain they do not provide clinical services.

To engender the taking of individual responsibility for one's recovery, SMP recovery homes utilize participant government, participant involvement in program upkeep, and payment for one's stay when able. Residents who are eligible for state unemployment or disability insurance, general relief, food stamps, or other sources of income are expected to apply for that assistance (Schonlau, 1990). Most California recovery homes contract services for a designated number of residents with the county alcohol program, which pays a portion of the operating expenses. Recovery homes may also have contracts with the Veterans' Administration or with state prisons to reserve beds for restricted classes of residents.

Social model recovery homes provide environments in which individuals manage their own recovery; the typical length of stay is between three months and a year. Unlike residential treatment programs, which have adopted a case-management method, recovery home services are characterized by participant control (Schonlau, 1990). While facilities offering clinical case-management programs schedule activities and use counselors and therapists to transmit recovery information, at social model recovery homes *the peer group serves as the primary motivator* for the new resident to participate in recovery activities.

Staff at recovery homes are responsible for creating environments conducive to experiential learning with peers; staff believe that important peer learning occurs in the informal interactions among and between residents. Thus, bedrooms in residential facilities are comfortable places to sleep *but not refuges from interaction*, and a priority is placed on indoor and outdoor spaces for socializing and program activities; staff space occupies locations of secondary importance (O'Briant, et al., 1973; Wittman, et al., 1976). Extended observations of one recovery home (Barrows, 1980) indicate that informal interactions are frequent, and contribute to the recovery process rather than being "dead time" between formal groups. Residents are expected to attend community AA meetings, and social and recreational activities are stressed for individuals who may previously have thought alcohol was essential to having

fun. Some employment and job services such as resume writing, part-time jobs, and information about training opportunities are usually available to residents in the facility.

### **1.3 Neighborhood Recovery Centers (NRCs)**

Neighborhood recovery centers apply SMP principles to *non-residential programs* (Shaw, 1990; San Diego County Alcohol Programs, undated). Activities include AA and other 12-step meetings, peer support groups, and educational meetings geared to program participants, family members, and the community at-large (Borkman, 1983). NRC personnel include paid staff, unpaid staff and other volunteers.

There was hope of expanding on success of early NRCs to establish Community Recovery Centers (CRCs) including a focus on *prevention efforts* at the level of public policy and the community (Wright, 1992; Wright, Clay, & Weir, 1990; see also Matthews & Weiss, 1990). As with the social community model approach, the CRC idea has been criticized by some for its potential to shift attention away from suffering alcoholics and their families to the immense task of changing society at large, and for the potential clash of paradigms between the person in recovery and the prevention specialist (Shaw, 1990; UCSD, 1988; Kaskutas, forthcoming).

### **1.4 Sober Living Houses**

Sober living houses, also called alcohol-free living centers or alcohol and drug-free housing, are low-cost alcohol- and drug-free residential environments (Wright, 1990). Unlike recovery homes, sober houses have no structured recovery program and little if any paid staff. Sober houses provide a peer group of fellow residents to support sobriety and a sober environment (Wittman, Biderman, & Hughes, 1993; Wright, 1990) with only three obligations: no alcohol or illicit drugs; follow house rules; and pay rent on time.

### **1.5 Similar Facilities**

Oxford House and Halfway House movements offer services that are residential in nature and supportive of recovery in ways similar to social model sober living facilities. Although never referred to as “social model,” Oxford House sober living systems are very similar in terms of their approach to long-term recovery. The first Oxford House was founded when sober alcoholics decided to take over their halfway house when it was closed by the Maryland county which had been running it (Molloy, 1990; O'Neill, 1990). The Anti-Drug Abuse Act of 1988 required each state to set aside \$100,000 to lend to recovering individuals who wanted to

establish houses using the Oxford model: drug and alcohol free, democratically run, and self-supporting. Because of the strength of the social model movement in California, Oxford Houses are not found there; nor are programs labeled as “social model” found outside California.

In the substance abuse field, it is difficult to find a clear statement in the literature which distinguishes social model residential recovery homes or sober living houses from halfway houses (see Borkman, et al., 1996). Some early halfway houses would today be called long-term sober housing, while others offered various explicit recovery services and evolved into social model recovery homes. Most current halfway houses have little in common with social model recovery homes, as they are residential treatment programs with professional staff who diagnose and use case management techniques (Ken Schonlau, personal communication). Especially after the mid 1970s, many states (but not California) funded residential treatment facilities that they called halfway houses.

## **2. ORGANIZATION AND STAFFING**

SMP structure is based on the 12 Traditions of AA; SMPs seek to create democratic group processes in which leadership is shared and rotated and there is little hierarchy. Legal incorporation as a not-for-profit organization requires adoption of some hierarchical structure, with a board of directors overseeing the program director and staff, but to the extent possible SMPs diminish professional hierarchy in favor of participatory management (Bi-Bett Corporation, 1976; Bi-Bett Corporation, 1989; Brown, 1979). Recovering participants are viewed as the top of an inverted pyramid, followed by the program staff, and then the board of trustees at the bottom. Individuals and groups of recovering participants are given as much authority as they can handle responsibly (Bi-Bett Corporation, 1976, p.29).

SMPs configure human resources differently than professional treatment programs. Directors, staff and volunteers are usually alcoholics and drug addicts with experiential knowledge of recovery. Recovering residents/participants are “prosumers” - “providers” as much as “consumers” of service, and persons in recovery are viewed as critical to the peer recovery process (Borkman, 1990b). Programs are client-run in day-to-day problem solving, rule-making and enforcement by a Residents' Council of participants who have been sober in the program for a designated time period. There appear to be self-correcting mechanisms that discourage resident abuse of power, in part via AA Traditions 2 (“Our leaders are but trusted servants, they do not govern.”) and 12 (“Place principles before personalities.”) (Alcoholics Anonymous World Services Inc, 1991; see Karp, 1997).

Recovering alcoholics and substance abusers who staff SMPs are often alumni of the programs in which they work, sometimes with degrees in related fields (Dodd, 1990; Schonlau, 1990). Social model emphasizes that the peer recovery process within programs does not need to be managed or controlled; the major objective of the director and his or her staff is to provide and sustain a physical, social, and spiritual environment conducive to recovery. Requirements for an entry level staff position are usually a minimum specified length of sobriety (one or two years) and working a recovery program; volunteer or other experience working in a recovery program may also be required. Personal recovery alone does not make an effective helper (Brown, 1979); a staff member must be able to focus on others and avoid rigidity, and staff should not have friendships or AA sponsor-like relationships with residents. Staff must demonstrate understanding of substance abuse problems and the recovery process, knowledge of community services, and ability to lead group meetings. Managers need additional planning and budgeting skills.

Most staff training is gained while on-the-job, and staff have mainly learned about alcoholism and recovery from attending 12-Step meetings in AA or Al-Anon. Most recovery homes also send their staff to workshops and courses (Schonlau, 1990), and courses or training programs for social model staff and managers have been offered in a few California universities and through CAARH (see Colthurst, 1991 for a list of training assistance resources). CAARH formalized its CAARH Institute for Social Model Training in 1991, offering a 90-hour curriculum that includes recovery home skills and experiential exercises along with traditional subject matter.

In contrast to professional training, which is based on theories and practices generalized from documented studies of thousands of alcoholic clients (an n of thousands), the basis of authority in social model programs lies in staff experience as alcoholics and as alcoholics in recovery (an n of 1, in research terms, where n refers to the size of the sample upon which one generalizes). Social model staff augment personal experience with stories heard at AA meetings, and social model clients similarly hear about many different experiences and approaches and try them out for themselves as part of the experiential learning process (Borkman, 1983). Outliers, and other stories that do not resonate, become only one among many.

The social model philosophy of peer recovery puts volunteers at the center of the program. Volunteers are often program alumni or AA members from the community who participate as part of sustaining their own recovery. Spontaneous generation of peer activity and participant helping may be a major indicator of how well a SMP is working (Borkman, 1983). Accounting and budgeting schema usually leave out the efforts of volunteers, who can often

work as full-time staff. Since volunteering is such an important part of the social model philosophy, and the “volunteering” of program participants who give to each other is an essential part of the peer recovery process, an activity checklist is now available (Kaskutas, 1996) to quantify the types and extent of peer helping among program participants.

## **IV. EFFECTIVENESS OF SOCIAL MODEL SERVICES**

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Noting that “SMPs have seldom been evaluated in a manner parallel to evaluations conducted in other treatment settings” the Center for Substance Abuse Treatment (CSAT) convened an expert panel in 1993 to make recommendations for evaluating SMP effectiveness and to suggest optimal research objectives (University of California San Diego Extension, 1993, p. iv). The panel described a quasi-experimental outcome study design as its highest research priority, considering it necessary to compare outcomes from SMPs with those from other types of California programs chosen for comparability in size, scope, community setting, and service population. Since SMPs are designed to influence individuals, their families, employers, and the surrounding community, the panel felt that random assignment of individuals would be inappropriate. The study, they felt, should recognize that there might be differences in the objectives of social and clinical model programs, and the recommended outcome study should answer the following three questions (UCSD Extension, 1993):

- Do SMPs have outcomes as good or better than other types of programs?
- Are SMPs cost-effective in relation to other programs?
- Do SMPs work better for some groups (women or men, particular socioeconomic status, or those with problems of greater or lesser severity)?

As with the recommendations made by the IOM (1990), the recommendations of the CSAT expert panel have not yet led to funding of such a study. Only two outcome studies have specifically included SMPs: a county-level study in San Diego County (San Diego County Department of Health Services, 1983) and CALDATA, a state-level study in California (Gerstein et al., 1994a; 1994b; 1994c). Results of these studies have been reported only in relatively obscure government documents and are not part of standard outcome literature; they are presented in some detail below, including findings on comparative program costs. Recent research at the Alcohol Research Group (Kaskutas, et al., 1996; Kaskutas, 1996; Kaskutas, et al., 1997) to differentiate between social model and other programs and to analyze hidden costs associated with SMPs is also highlighted.

### 1. SAN DIEGO COUNTY STUDY

Follow-ups conducted 18 months after treatment intake with clients from 18 SMPs in San Diego (n=198; response rate=65%) found 33 percent abstaining, 21 percent improved, 45 percent unimproved (i.e. multiple problems or heavy drinking). As a point of comparison, the 1980



RAND study of national alcohol treatment centers had found proportionately fewer persons abstaining at follow-up (25%) compared to the social model graduates, but also reported lower rates for unimprovement (32%) than were found in the social model study (Polich et al., 1980). Higher improvement rates were reported for women than for men in the San Diego study (e.g. 47 percent of women were abstaining). Neighborhood recovery center clients in the county were the least likely to be abstaining (22%), but also the least likely to be unimproved at follow-up (38%). Over half the detox-only clients were unimproved and only about one quarter were abstaining. *Clients who used only the recovery home were the most likely to be abstaining (37%), with a similar percentage unimproved (40%).* Levels of significance were not reported. In addition to changes in level of substance abuse, the San Diego study found reductions in level of life difficulties at 18 months following the intake interview:

- No abstainers reported a high level of life difficulties
- An increased number worked full- or part-time versus intake (35% vs 23%)
- The median household income had increased from \$300 to \$466
- The percentage of households with no income had decreased from 18 percent to 7 percent
- There was a substantial improvement in health status.

The study also found large cost differences. Between 1979 and 1982, the cost per day for a social model recovery home was about \$17 compared to \$262 for a San Diego hospital-based program — *nearly 16 times more expensive* for medical program treatment (UCSD Extension, 1993).

## **2. CALDATA STUDY**

Clients from social model and non-social model *residential* programs in California were included in this more recent study, which found at 15 months after treatment (n=1,826, response rate=46%) that social and non-social model (classic staff-as-therapist model with some individual counseling) program graduates reduced number and frequency of substances used. Social model programs provided longer stays and were still less expensive, with costs per treatment episode averaging \$2,712 compared to \$4,405 for non-SMPs (Exhibit 1). A relationship was found between substance abuse measures and length of treatment, with somewhat stronger results in non-social model residential, and no difference in reduction among the social model residential group staying longer than three months (Exhibit 2). The finding that

length of stay is related to substance abuse has not been universally supported (Hester, 1994; Miller & Hester, 1986) although recent studies involving less impaired clients have reported better outcomes with stays beyond 20 days (Gottheil, et al., 1992); see also Finney, et al., 1981.

<b>EXHIBIT 1 COSTS AND LENGTH OF STAY AT RESIDENTIAL TREATMENT SERVICES</b>		
<b>COST CATEGORY</b>	<b>SOCIAL MODEL</b>	<b>NON-SOCIAL MODEL</b>
Cost per day	\$34	\$61
Average stay	79 days	69 days
Avg episode cost	\$2,712	\$4,405

<b>EXHIBIT 2 PERCENT REDUCTION IN NUMBER OF MONTHS OF SUBSTANCE USE PRE-POST TREATMENT</b>		
<b>LENGTH OF STAY</b>	<b>SOCIAL MODEL</b>	<b>NON-SOCIAL MODEL</b>
<1 month	36%	47%
1-3 months	52%	53%
4+ months	52%	63%

Length of stay was also related to criminal justice outcomes. Reductions in criminal activity were greater among social model clients (80%) than clients in residential clinical treatment (74%), with lengths of stay four months or more among social model clients demonstrating the strongest effect: only 7 percent of such clients reported criminal activity at follow-up, while 82 percent had reported it in the months prior to coming to the SMP.

### **3. ALCOHOL RESEARCH GROUP (ARG) RESEARCH**

Problems with reliably distinguishing social model services from other offerings complicate interpretation of outcomes across sites using different treatment models. In addition, since SMPs use a variety of existing community services, their costs do not include all services used by clients; this suggests hidden costs might absorb cost benefits associated with social model. CSAT provided funding to ARG for analysis of hidden costs associated with SMPs, and for quantitative and qualitative ways of differentiating social model from other treatment models.

The Program Philosophy Scale (PPS), which differentiates SMPs, therapeutic communities, and medical inpatient or outpatient programs (Kaskutas et al., 1996) was developed for use in program evaluations. A process evaluation (Kaskutas et al., 1997) resulting from the project reports on two social and one medical model program. Qualitative research conducted over several months revealed differences in several program areas, including: staff roles (Room, 1997a), didactic education (Kaskutas, Marsh, & Kohn, 1997), client governance (Borkman, 1997), program administration (Karp, 1997; Bryan & Kohn, 1997), use of community resources (Barrows, 1997), and the work ethic (Room, 1997b). Using an activity checklist developed by the ARG, outside service utilization at several dozen SMPs in California was averaged (Kaskutas, 1996) at \$1,356 a week per client including medical visits and tests. The study also found differences in cost and in average length of stay between the social and medical model sites: The average 10-day stay at the medical model study site costs \$4,750, while the typical 90-day stay at the two social model study sites costs \$3,150 and \$3,600.

## **V. DISCUSSION**

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Core requirements of most funding agencies are in conflict with functioning as a true SMP. For example, to insure that quality standards of care are maintained, funders often rely on staff credentialing, which is a problem when basis of authority is experiential and not professional. To bill for services, funders require detail of groups attended and treatments provided to participants, but SMPs believe their function is to maintain an environment to facilitate recovery and not to provide treatment service units.

Some (Reynolds and Ryan, 1990) argue that credentialing would increase social model staff costs and create a hierarchical environment, justifying lower wages for uncredentialed social model staff (see also Nebelkopf, 1993). Similarly, reporting systems that collect extensive diagnostic data and precise information on client progress not only burden staff with paperwork, but also run counter to SMP reliance on self-diagnosis and self-directed recovery.

The gulf here is wide. Reliance on diagnostic tests based on clinical criteria undermines a social model thesis of authority derived from experience. Social model staff do not develop recovery plans for participants, which would be perceived as undermining the social model goal of participant responsibility for recovery. In addition, SMPs rely on an honor system and a desire for recovery to sustain primarily peer review. Staff record keeping would establish and maintain a hierarchical relationship between staff and participants. It would seem that at least some of the guiding principles of social model programs are in direct conflict with the emerging requirements of insurance companies and other funders for increased levels of detailed reporting.

Since the 1980s many social modelists have favored a social community model which widens the focus beyond treating the individual alcoholic to establishing an environment conducive to abstinent behavior. This is less a treatment model than a public health approach to primary *prevention*; social modelists have argued that "a reduction in social stimuli intended to increase alcohol and other drug consumption will mitigate individual characteristics which may predispose someone to have alcohol and other drug problems" (Hayes et al., 1993, p. 7). Public health is generally seen as a prevention model (as is social community model), but *social model represents a public health-oriented treatment model* because of its grounding in the community. One goal of public health is sustained empowerment, enabling communities to identify and solve problems without professionals. Public health and community psychology journals, conferences, and graduate school courses are frequently dedicated to the topic of empowering communities in a manner not reliant on professional health-seeking interest and activity (see McMillan, et al., 1995; Maton & Salem, 1995). Community organizing attempts often flounder because public

health professionals dominate helping exchanges; this ultimately fails because help is externally derived.

SMPs and AA are empowering because of the “helper therapy” principle, i.e., by helping a fellow alcoholic, the helpers are themselves helped. Helping a fellow alcoholic is a main way helpers stay sober. This derives from AA's 12th and final Step, that he who has “tried to carry this message to alcoholics” finds that “by the divine paradox of this kind of giving he has found his own reward, whether his brother has yet received anything or not” (Alcoholics Anonymous World Services, 1991). Because the “helper therapy” principle is self-sustaining, social model recovery does not rely on professional impetus; motivation comes from community members who believe the only way they can stay sober is to “give it away” to other alcoholics.

Although many (if not most) public alcohol detoxification and treatment programs in California adhere to the social model philosophy, the number of service agency SMPs elsewhere is unknown since no census has been conducted to identify them. A few SMPs are known to exist in such places as the District of Columbia, and Oxford Houses are located in at least 17 states. Should the social model approach be proven effective, programs using social model principles could be identified using the Program Philosophy Scale (Kaskutas et al., 1996; Room, 1996). Since SMPs have been shown to be much less costly than other treatment approaches (San Diego County Department of Health Services, 1983; Gerstein *et al.*, 1994a; Borkman *et al.*, 1996; Kaskutas *et al.*, 1997), an important area for future research is the longitudinal study of social model clients across time. Without such data, it is impossible for policy makers and providers to accurately assess the resource to the community that SMPs may represent.

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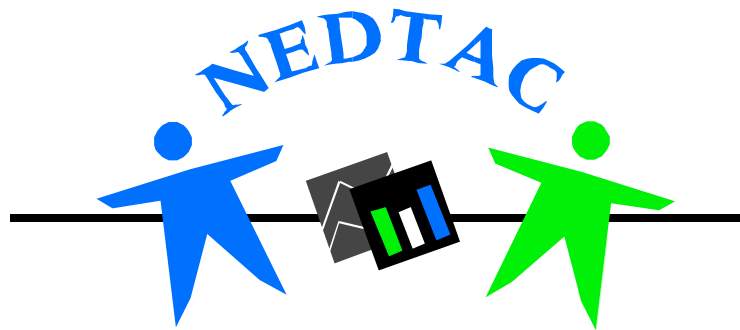
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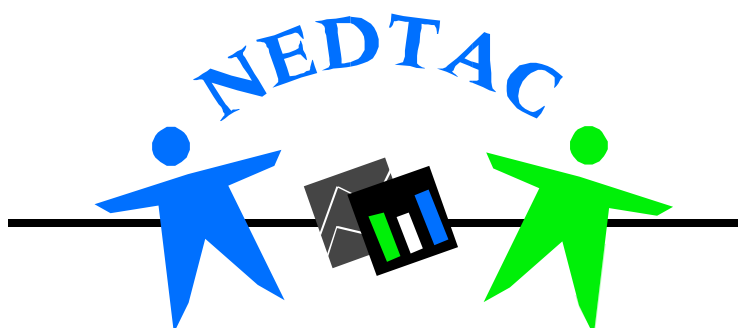
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**NATIONAL EVALUATION DATA AND  
TECHNICAL ASSISTANCE CENTER**



**A BIBLIOGRAPHY FOR  
THE CALIFORNIA SOCIAL MODEL  
FOR ALCOHOLICS**

# NATIONAL EVALUATION DATA AND TECHNICAL ASSISTANCE CENTER



## A BIBLIOGRAPHY FOR THE CALIFORNIA SOCIAL MODEL FOR ALCOHOLICS

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This study was supported by Center for Substance Abuse Treatment, Department of Health and Human Services, Caliber/NEDS Contract No. 270-97-7016.

**CSAT**  
Center for Substance  
Abuse Treatment  
SAMHSA



## FOREWORD

The Center for Substance Abuse Treatment (CSAT) Program Evaluation Branch established the National Evaluation Data and Technical Assistance Center (NEDTAC) to support the evaluation activities of CSAT's grantees and to advance the state of the art of evaluation of substance abuse treatment programs. The "*social model of recovery*," also known as the "California social model," is an area in the field of substance abuse treatment worthy of in-depth examination and evaluation, but no widely accepted strategy for evaluating social model programs has existed which could be used across programs. For this reason, the Alcohol Research Group (ARG) in Berkeley, California was asked to develop an evaluation methodology to evaluate social model programs.

ARG's effort has resulted in the following products:

- *The Social Model: A Literature Review and History*
- *Executive Summary of The Social Model: A Literature Review and History*
- *A Bibliography for the California Social Model For Alcoholics*
- *Development of a Program Philosophy Scale for Substance Abuse Recovery Programs*
- *Program Philosophy Scale (PPS) Manual: Guidelines for Scale Administration and Interpretation for Residential, Non-Residential and Detoxification Alcohol and Drug Programs*
- *Cost Checklist: Peer Helping and Hidden Costs in Social Model Programs*
- *Report of a Process Evaluation of Social Model Residential Programs*
- *Executive Summary of Report of a Process Evaluation Social Model Residential Programs.*
- *Social Model Program Outcomes*

Collectively, the documents represent a thorough examination of social model programs and how they operate on a day-to-day basis. This bibliography presents an exhaustive listing of citations covering the history and philosophy of social model programs.

We wish to thank Lee Ann Kaskutas, Dr.P.H. and staff from the Alcohol Research Group for their development of this material, and Ron Smith, Ph.D., Jim Herrell, Ph.D., and Karl D. White, Ed.D. at the Center for Substance Abuse Treatment for their review and comment.

Sharon Bishop  
Project Director  
National Evaluation Data and  
Technical Assistance Center (NEDTAC)

## **ABSTRACT**

This bibliography presents an exhaustive listing of citations covering the history and philosophy of social and social-community models of alcohol recovery programs, two lesser-known but distinctive sociocultural approaches to the treatment of alcoholism. Unlike patient-focused medical and psychological treatments for alcoholism, sociocultural approaches involve both the individual and his or her social and physical environment. Social model principles align closely with those of Alcoholics Anonymous (AA), but social model programs operate according to distinctive philosophies and practices.

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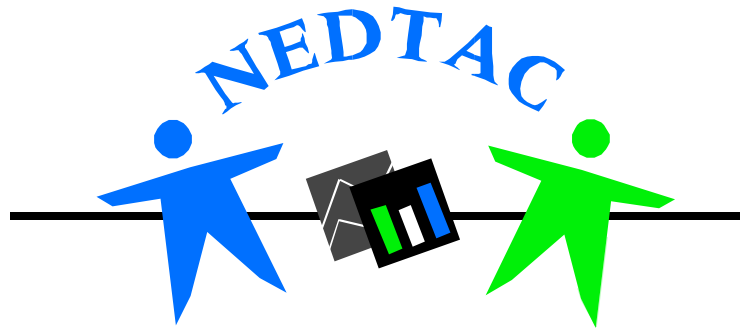
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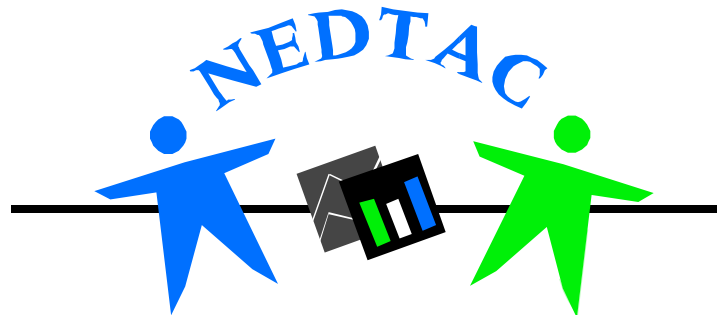
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**NATIONAL EVALUATION DATA AND  
TECHNICAL ASSISTANCE CENTER**



**DEVELOPMENT OF A  
PROGRAM PHILOSOPHY SCALE  
FOR SUBSTANCE ABUSE RECOVERY PROGRAMS**

# NATIONAL EVALUATION DATA AND TECHNICAL ASSISTANCE CENTER



## DEVELOPMENT OF A PROGRAM PHILOSOPHY SCALE FOR SUBSTANCE ABUSE RECOVERY PROGRAMS

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This study was supported by Center for Substance Abuse Treatment, Department of Health and Human Services, Caliber/NEDS Contract No. 270-97-7016.

**CSAT**  
Center for Substance  
Abuse Treatment  
*SAMHSA*

## FOREWORD

The Center for Substance Abuse Treatment (CSAT) Program Evaluation Branch established the National Evaluation Data and Technical Assistance Center (NEDTAC) to support the evaluation activities of CSAT's grantees and to advance the state of the art of evaluation of substance abuse treatment programs. The "*social model of recovery*," also known as the "California social model," is an area in the field of substance abuse treatment worthy of in-depth examination and evaluation, but no widely accepted strategy for evaluating social model programs has existed which could be used across programs. For this reason, the Alcohol Research Group (ARG) in Berkeley, California was asked to develop an evaluation methodology to evaluate social model programs.

ARG's effort has resulted in the following products:

- *The Social Model: A Literature Review and History*
- *Executive Summary of The Social Model: A Literature Review and History*
- *A Bibliography for the California Social Model For Alcoholics*
- *Development of a Program Philosophy Scale for Substance Abuse Recovery Programs*
- *Program Philosophy Scale (PPS) Manual: Guidelines for Scale Administration and Interpretation for Residential, Non-Residential and Detoxification Alcohol and Drug Programs*
- *Cost Checklist: Peer Helping and Hidden Costs in Social Model Programs*
- *Report of a Process Evaluation of Social Model Residential Programs*
- *Executive Summary of Report of a Process Evaluation Social Model Residential Programs*
- *Social Model Program Outcomes.*

Collectively, the documents represent a thorough examination of social model programs and how they operate on a day-to-day basis. This paper reports on the methodology used in creating items for the Program Philosophy Scale (PPS), a 33-item questionnaire designed to differentiate

underlying philosophies of treatment at drug and alcohol treatment/recovery programs, i.e., the extent to which a program is based on the social model philosophy of recovery.

We wish to thank Lee Ann Kaskutas, Dr.P.H. and staff from the Alcohol Research Group for their development of this material, and Ron Smith, Ph.D., Jim Herrell, Ph.D., and Karl D. White, Ed.D. at the Center for Substance Abuse Treatment for their review and comment.

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Project Director  
National Evaluation Data and  
Technical Assistance Center (NEDTAC)

## ABSTRACT

The Program Philosophy Scale (PPS) is a 33-item questionnaire designed to classify the extent to which a given treatment program follows a social model approach to treatment, and thereby discriminate among different approaches to residential alcohol and drug treatment. The PPS was developed to enable consistency in describing, labeling, and delineating the type of treatment philosophy used in substance abuse treatment programs. Using the PPS, it is possible to assign a relative ranking to program philosophy as implemented at a given site, with scoring from 0 to 100. Higher scores reflect a greater degree of adherence to social model philosophy, while lower ones indicate more traditional, hierarchical and professionally-oriented treatment approaches, i.e., non-social model.

This paper reports on the methodology used in item creation and final item selection including a description of preliminary item creation, selection, and review, subscale development and analysis, item analysis and final selection, and validity testing. The PPS has six rational domains: Physical Environment, Staff Role, Authority Base, View of Alcohol Problems, Governance, and Community Involvement. The final refined version of the 33-item residential PPS is presented in an Appendix. The non-residential and the detoxification versions of the PPS use subsets of the items (25 items and 20 items, respectively). Test-retest analyses have shown that the information obtained from the PPS is consistent across time, administrators and respondents.

## **I. INTRODUCTION**

## I. INTRODUCTION

Substance abuse treatment programs in the United States usually follow either a disease (medical) model, a social learning (psychological) model, or a social community model in designing a treatment regime for clients. However, the quantitative assessment and rank ordering of the philosophy that guides substance abuse treatment programs has been a difficult subject to approach by those working in treatment research. Programs often incorporate components from each model in their overall approach to service provision. Thus it is difficult to compare results from individual outcome studies across program types. Differing treatment philosophies are generally represented by multi-dimensional theoretical constructs that do not easily lend themselves to assessment by quantitative means.

We wish to be clear that the social model philosophy is not being presented as a “gold standard” for treatment or recovery programs, against which others must be compared. The Program Philosophy Scale (PPS) is intended to provide an instrument that may be used to consistently identify the program philosophy being followed in a given program, i.e., to measure the extent to which a given treatment program follows a social model approach to treatment. Using the PPS, it is possible to assign a relative ranking to program philosophy as implemented at a given site, with scoring from 0 to 100: higher scores reflect a greater degree of social model orientation. The ability to classify treatment approaches should be particularly helpful to program evaluators in their interpretation of program outcomes.

This paper reports on the methodology used in item creation and final item selection for the PPS. An initial 100-item scale was formulated by reviewing the literature on social model approaches and by convening an expert panel to review preliminary items. The scale was administered at 38 diverse programs, and reliability and correlation analyses were conducted using SPSS to eliminate redundant items and items that did not differentiate across program types. Additional validity testing was conducted by asking three county alcohol program managers to rank the same programs; high consensual validity was found. The final version of the PPS contains 33 questions for use in residential programs; a questionnaire for non-residential programs contains 25 items, and a version suitable for administration in a detoxification setting contains 20 items. Scores on the six domains or subscales (Physical Environment, Staff Role, Authority Base, View of Alcohol Problems, Governance, and Community Involvement) correlate with the overall score at  $r = .92$ .

Comprehensive results of the final analyses of the completed PPS checklists are reported, including correlation between individual items and subscale and overall scores. Relative program rankings were obtained based on the PPS administrations at 27 residential programs, 7 non-



residential programs, and 1 detoxification program. Test-retest analyses have shown that the information obtained from the PPS is consistent across time, administrators and respondents.

## **II. PROGRAM PHILOSOPHY SCALE DEVELOPMENT**

## **II. PROGRAM PHILOSOPHY SCALE DEVELOPMENT**

The PPS was developed by an iterative process of item creation and topical organization, testing and analysis, consideration of resultant program rankings, and item revision and elimination. The overall process is shown in Exhibit II-1 and is summarized below.

A bank of items was created based on a review of the social model program literature, most of which was focused on residential settings. The items were grouped into logical content areas so that summative subscale scores and a summative overall scale score could be calculated. The preliminary instrument was tried at 14 programs, and results were reported to an expert advisory panel. The panel suggested many new items and a subset of programs were re-contacted about their answers to those items. Feedback from respondents and interviewers identified which new items should be retained for further testing and scale development; those items were re-administered at 14 programs, and at 4 new programs. Data from the preliminary checklist administrations were analyzed for reliability and scale and subscale cohesiveness, and items were eliminated based on statistical coefficients.

As a test of validity, a group of substance abuse program administrators from the counties where the checklist had been tested, who were blind to the instrument, independently ranked the same programs for “social modelness” (on a scale from 0 to 10). Relative rankings were compared to those obtained from the preliminary checklist. Copies of the final residential and non-residential checklists were then forwarded to the advisory panel with a request that they contact as many social model programs as possible, so that the checklist could be administered at additional programs to provide enough cases for statistical analysis of scale reliability. This request yielded an additional 20 completed checklists.

A total of 38 completed PPS checklists were thus available for final scale analysis (the original 14 cases, 4 interim cases added during item expansion, and 20 from the panel). Of these, seven were non-residential programs and were analyzed separately; because of their small number, results are less stable. Another of the 38 programs was a social model detoxification program, which was separately scored due to inappropriateness of some items for that type of setting. Three additional residential programs were eliminated from the analysis due to large amounts of missing data on the returned checklists. Thus, 27 residential program checklists were included in the statistical analysis reported in the “Results” section of this paper.

**EXHIBIT II-1**

**PROGRAM PHILOSOPHY SCALE DEVELOPMENT CYCLE**

TYPE OF VERSION	HOW DERIVED	# ITEMS	# TOPICAL AREAS	# PROGRAMS WHERE ADMINISTERED	HOW TESTED	NEXT STEP	WHERE CHECKLIST SHOWN	WHERE RANKINGS SHOWN
<b>Preliminary</b>	<ul style="list-style-type: none"> <li>■ Review of Social Model literature</li> <li>■ Advice of expert panel</li> </ul>	97	7	18	<ul style="list-style-type: none"> <li>■ Reasonableness of program rankings and subscale scores</li> <li>■ Reliability                             <ul style="list-style-type: none"> <li>-item to overall scale (R)</li> <li>-item to subscale (R)</li> </ul> </li> <li>■ Cohesiveness of subscales</li> <li>■ Administerability</li> <li>■ Redundancy</li> </ul>	Cut bad items: <ul style="list-style-type: none"> <li>■ have no variance</li> <li>■ don't correlate to overall scale</li> <li>■ take away from overall scale cohesiveness</li> <li>■ respondents could not reliably answer</li> <li>■ were overly abundant or repetitive</li> </ul>	Appendix A	Exhibit II-3
<b>Final</b>	Statistical analysis	33	6	38	<ul style="list-style-type: none"> <li>■ Reliability</li> <li>■ Cohesiveness (Exhibit III-2)</li> </ul>	Publish scale for use in outcome studies	Appendix B	Exhibit III-1

The sections that follow describe in detail the development of the checklist items, include information on how the PPS is scored, and present a detailed explanation of the criteria used to statistically eliminate items to create a parsimonious final checklist. Results on consensual validity of the PPS using expert administrators to rank programs independently are also reported.

## **1. CHECKLIST DEVELOPMENT**

The following sections describe the creation of the Program Philosophy Scale (PPS), which is presented in its entirety in Appendix A. Preliminary item creation, selection, and review, subscale development and analysis, item analysis and final selection, and validity testing are all discussed in detail.

### **1.1 Item Creation for Preliminary Checklist**

Preliminary item creation was driven by a review of the literature dealing with medical versus social model approaches to substance abuse treatment (Baker, Sobell, Sobell, & Cannon, 1976; Borkman, 1983; Borkman, 1992; Dodd, 1991; Institute of Medicine, 1990; O'Briant, Lennard, Allen, & Ransom, 1973; Saquet-Shire, 1981; Wittman, 1992). Thomasina Borkman's seminal paper (Borkman, 1990) comparing clinical and social model services provided a starting point for creating 18 relevant topical areas that would need to be covered in a checklist whose goal was differentiation of program philosophy: physical environment, view of dealing with alcohol problems, metaphor of relationships, peer orientation, Alcoholics Anonymous (AA) orientation, authority/knowledge base, method of learning sober life skills, recovery/treatment approaches, preferred staff requirements, major staff role in recovery/treatment, ratio of recovering to degreed staff, attitude toward volunteers, prized values, community orientation, record keeping, terminology, principles for integrating services, and indicators of quality.

Alcohol recovery homes and treatment programs were selected for checklist testing based on the project team's familiarity with alcohol programs in the Bay Area of Northern California (resulting in coverage of at least half of the well-known programs in the area). Items were added to the initial bank of items as questions arose during preliminary administration at these cooperating treatment sites. For example, respondents' questions about the meaning of an item might suggest two different constructs that each needed to be tapped, leading to rewording of the initial item and crafting of a new one.

In all, early iterations of the preliminary checklist (ranging from 73 to 97 items, and from 18 to 7 topical area groupings) were administered at 14 medical and social model programs and therapeutic communities. The preliminary checklist was administered in person at nine programs and via telephone interviews with the program director at five programs. Administration time ranged from 10 to 40

minutes (average 20 minutes). All subsequent versions of the checklist at these 14 programs were administered via telephone.

## **1.2 Checklist Review by Expert Panel**

Following the initial item development phase, the preliminary checklist and administration results at 14 programs were reviewed by an expert advisory panel who knew the social model recovery philosophy. The panel included prior state and county alcohol program administrators, current local social model treatment program managers, scientists involved in substance abuse treatment research and self-help studies, and an architect familiar with social model facilities, environments, and programming. The experts met as a group to discuss the goals for the checklist, the individual preliminary checklist items, and the rational organization of items by topical content area. The results of administration of the preliminary checklist and resultant program rankings were also presented to the panel. The derivative component scores obtained for the PPS subscale topical areas were highlighted for panel members to show how the PPS overall score and ranking were obtained for programs known to be social model, medical model, or therapeutic communities.

The panel reviewed the PPS and suggested additional items. Original item wording was also modified in some cases. Further, the panel identified items they deemed especially salient for inclusion based upon their perceived importance to the social model program approach; these items were overweighted to reflect this emphasis. The resultant preliminary checklist contained 101 items with a possible maximum of 140 points when weighting of items was considered.

New items were administered at a subset of 8 of the original 14 programs. Many of the newer items were subject to a high degree of perceived and real item redundancy. Items that were difficult to administer and resulted in confusion or in generally unreliable responses from program directors were eliminated based on feedback to that effect. The remaining new, nonredundant items were administered at the original programs and at the three program sites where the scale development team had been involved in a 6-month process evaluation. Data from these checklist administrations were analyzed as described below.

### **1.3 Final Item Selection**

Statistical analyses were conducted to eliminate items with low variance across programs and items that did not correlate with the overall scale. In addition, items were identified that did not correlate with the individual subscale in which they were placed; these items were moved to another rational subscale. Conversely, items were retained if they were believed by the experts or authors to be crucial to social model program operation. The final Program Philosophy Scale consisted of 33 items.

The initial subscales (of which there were seven) were also analyzed, both to determine internal cohesion of items within a subscale and to assess the relationship between the subscale scores and the overall scale scores. Due to the relatively small number of cases, factor analysis was not used. One subscale was eliminated as a result of those analyses as discussed in Section 3.2. (See Kaskutas, 1996, for a more detailed description of the development of the final version of the PPS.)

A non-residential version of the PPS was created in order to eliminate items which, taken at face value, seemed inappropriate for administration at programs where participants did not spend the night. Eight items were deleted from the residential version of the PPS to create a revised checklist that seemed on face value to be more appropriate for use in the non-residential setting. Four of the deleted items (rules made by residents, existence of a residents council, resident power to terminate peer's stay, and resident power to punish peers) comprised the entire Governance subscale. Other deleted items are distributed across two of the remaining five subscales. One item from the Physical Environment subscale (can participants leave site without staff permission) and three items from the Staff Role subscale (do participants involve staff if peer drinks, does staff make appointments for participants, and does responsibility increase with length of stay) were considered inappropriate for non-residential settings.

Another version was created in which items inappropriate for a short term social model detoxification setting were eliminated. A total of 13 items were deleted from the residential version of the PPS to develop the detoxification PPS items. In addition to the eight items deleted to form the non-residential version (discussed above), five more items were eliminated. These include one item from the Authority Base subscale (are people with long-term sobriety on site at the program often, getting involved with participants), two items from the View of Alcohol Problems subscale (is this a recovery or a treatment program; and does the program provide vocational or academic training), and two from the Community subscale (do participants engage in community relations; and are sober social events regularly scheduled). Thus the detoxification version of the PPS has a total of 20 items across five subscales. (The Governance subscale was deleted for the detoxification and the non-residential versions.)

## **2. SCORING OF THE PPS**

Since some items included in early versions of the checklist had been weighted to reflect their importance to the social model philosophy, two sets of scores were available for analysis during the scale development process, i.e., a percentage based on the weighted score and another based on the unweighted score. Parallel analyses based on the weighted and unweighted results were conducted to determine item suitability for retention in the scale. Specifically, unweighted and weighted data were analyzed separately, and results were contrasted. Decisions regarding item retention were based on consideration of statistical results, i.e., p-values, Pearson correlation coefficients (between items, between items and subscale, and between items and overall scale score) and Cronbach's alpha coefficients.

On the unweighted form of the items (applicable to all checklist versions), possible individual item scores range from 0 to 1; fractional scores are earned for items asking for a percentage, which is converted into a proportion for scoring. On the weighted form of the items (applicable to all but the final checklist, which did not have any weighted items), item scores ranged from 0 to as high as 3 for several items. The overall scale scores for each program are created by summing the individual unweighted or weighted item scores, depending on whether a weighted or an unweighted score is desired (during scale development, weighted scores were analyzed separately from the unweighted ones). Subscale scores, consisting of the sum of the individual items in a given subscale topical area, were also created and analyzed.

## **3. ITEM ANALYSIS**

Data from the multiple checklist administrations that led to the final Program Philosophy Scale checklist were entered into SPSS for statistical analysis during the scale development process. Statistical procedures included correlational analyses and reliability testing. Correlation analysis yields Pearson's r correlation coefficients and associated p-values; for each item, two sets of correlations were considered: (1) item correlation with the summative subscale score, and (2) item correlation with the summative overall scale score.

Reliability analysis produces Cronbach's alpha coefficients (a measure of internal consistency or reliability), corrected item-to-total correlations, and alpha's with item deleted. Reliability analyses were conducted to yield three different levels of analysis; these are, in order



of importance: (1) between individual items and the overall summative scale score, (2) between individual items and the relevant summative subscale score, and (3) between subscale scores and the overall scale score (i.e., summative subscale scores were treated as items in reliability analysis of subscales-to-scale).

### 3.1 Individual Item Deletion Criteria

A series of criteria were used to assess item functioning, as summarized in Exhibit II-2. Performance on each of these criterion was considered in making decisions to delete or retain items.

<b>EXHIBIT II-2</b>	
<b>CRITERIA FOR ITEM DELETION AND SUBSCALE REVISION</b>	
1.	Item variance: Correlation of item to subscale score and item to overall scale score both demonstrate no variance ( $r = 1$ ).
2.	Correlation of item to overall scale score: $r < .5$ or $p > .1$
3.	Correlation of item to subscale score: $r < .5$ or $p > .1$
4.	<i>Subscale</i> score correlation (3 above) is less important than <i>overall</i> scale score correlation (2 above).
5.	For weighted items: Failing criterion (2) and (3) using both weighted data <i>and</i> unweighted data.
6.	For unweighted items: Improvement of overall scale alpha by .1 if item deleted. For weighted items: Improvement of overall scale alpha by .2 if item deleted.
7.	For subscales: Correlation of subscale score to overall scale score: $r < .5$ or $p > .1$

- Criterion 1: Items for which there was no variance across programs were eliminated. Specifically, data were examined to determine whether any variables had the same value for all cases. These items were not retained, as they added no information to the discriminatory scale.
- Criterion 2: Items were flagged for potential deletion if the correlation between the item and the overall score did not each achieve statistical significance of  $p \leq .10$ , or did not yield a correlation coefficient greater than or equal to .5 .
- Criterion 3: Although it was a less important criterion, items were considered for deletion if the correlation between the item and the subscale score did not each achieve statistical significance of  $p \leq .10$ , or did not yield a correlation coefficient greater than or equal to .5.

Regarding Criterion 2 and 3, if the correlation was lower than .5, the significance level was usually higher than .10, so that the companion criteria of significance level and correlation coefficient were simultaneously satisfied or not satisfied. However, for a minority of items, this agreement did not hold.

A hierarchy of elimination criteria was enforced in considering Criterion 2 and 3, as described below.

- Criterion 4: Although flagged for potential deletion as described above in Criterion 2 and 3, if a given item did correlate at .5 or greater with the overall score, the item was at that point retained. Thus, items might be retained even though the correlation between the item and the subscale was less than .5. This criterion was adopted because the topical areas represented by subscale scores were conceptually derived and were used as organizing principles in developing and administering the checklist. The relationship between a given item and the overall scale score was considered to be the more important criterion. It was considered less important that items within a subscale were cohesive.
- Criterion 5: For borderline items (i.e., items with a p-value slightly higher than .10) that were weighted (implying the items had been judged especially important by the expert panel), the decision to reject or retain the item was further informed by a comparison of the weighted and the unweighted correlation coefficients and p-values. Items failing the above criteria using both the weighted data and using the unweighted data were further flagged for deletion. Those failing the above criterion when considering the weighted data but meeting the criteria when considering the unweighted data (or vice versa) were also flagged for potential deletion. A hierarchy of deletion criteria was enforced within Criteria 5, such that items failing to meet the criterion in *both* the unweighted and the weighted form were considered less eligible for retention than those only failing with *either* the weighted or the unweighted form of the item.
- For example, a weighted item might have correlated at  $r = .8$  with the overall weighted summative score but only correlated at  $r = .2$  with the overall unweighted summative score. Since the use of conceptually-based weighting, emphasizing items' perceived a priori importance, was nonetheless an exploratory strategy, and an unweighted scale ultimately would offer a greater advantage, we preferred to select items which performed well in both cases. Thus, items would have been considered less desirable than another item for which both the weighted and the unweighted correlations were above  $r = .5$ .
- Criterion 6: Items were deleted when the overall alpha coefficient (not the subscale alpha) improved by more than .1 when the item was deleted from the scale (e.g., alpha with item removed went from .7 to .8). However, exceptions were made to this

elimination rule. For example, the deletion criterion was relaxed for items that had been weighted due to their salience to social model program operation. For those key items, an improvement of .2 in the overall scale alpha score with the item deleted was required.

### **3.2 Topical Area Deletion Criteria**

Individual items were eliminated if they did not meet the criteria described above, based upon their correlation to the overall scale score and to the subscale score. Topical areas were also subject to revision and elimination, that is, the entire subscale was examined, as described below in Criterion 7. To accomplish this, subscale scores were entered as variables into the reliability procedure of SPSS, and their relationship to the overall scale score was analyzed.

- Criterion 7: Criterion 2, 5, and 6 were also applied to the subscale scores. For example, one topical area (AA Orientation) was eliminated because it did not correlate strongly with the overall scale score and did not demonstrate cohesion among its items (low subscale alpha). However, three of the items within the AA Orientation subscale exhibited high correlation with the overall scale. These were retained and placed in two other topical areas which seemed reasonable given their content. “Mandated attendance” and “encouraging informal conversations” were added to the View of Problems subscale 4, items 2 and 6; “help finding a sponsor” was added to the Community subscale 6, item 2, as shown in Appendix A. Reliability analyses were again conducted to determine the extent to which the re-situated items fit within the subscale; in some cases the result was slightly lower scores for subscale-to-overall scale correlations and alphas.

## **4. CONSENSUAL VALIDITY**

Validity testing was conducted, in the course of which three experienced substance abuse program administrators (referred to here as expert administrators) ranked the treatment programs where the PPS had previously been administered. This panel consisted of an executive director of a large social model service organization and two county alcohol and drug program administrators; one expert administrator was also a member of the expert advisory panel described previously. The expert administrators were contacted by telephone and asked to rank 15 social and medical model programs in terms of how much the program philosophy epitomized social model practice, based on “their own idea of what it meant to be a social model program.” They were told to imagine the perfect social model program as deserving a score of 10; a completely non-social model program would be assigned a score of zero. The individual expert administrators ranked the programs with which they were familiar. Coverage was such that with three exceptions, all programs already rated using the PPS were ranked by at least two of the three experts. Two of the three expert administrators were blind to the content of

the instrument items and used their own idea of what it meant for a program to be medical or social model in its approach.

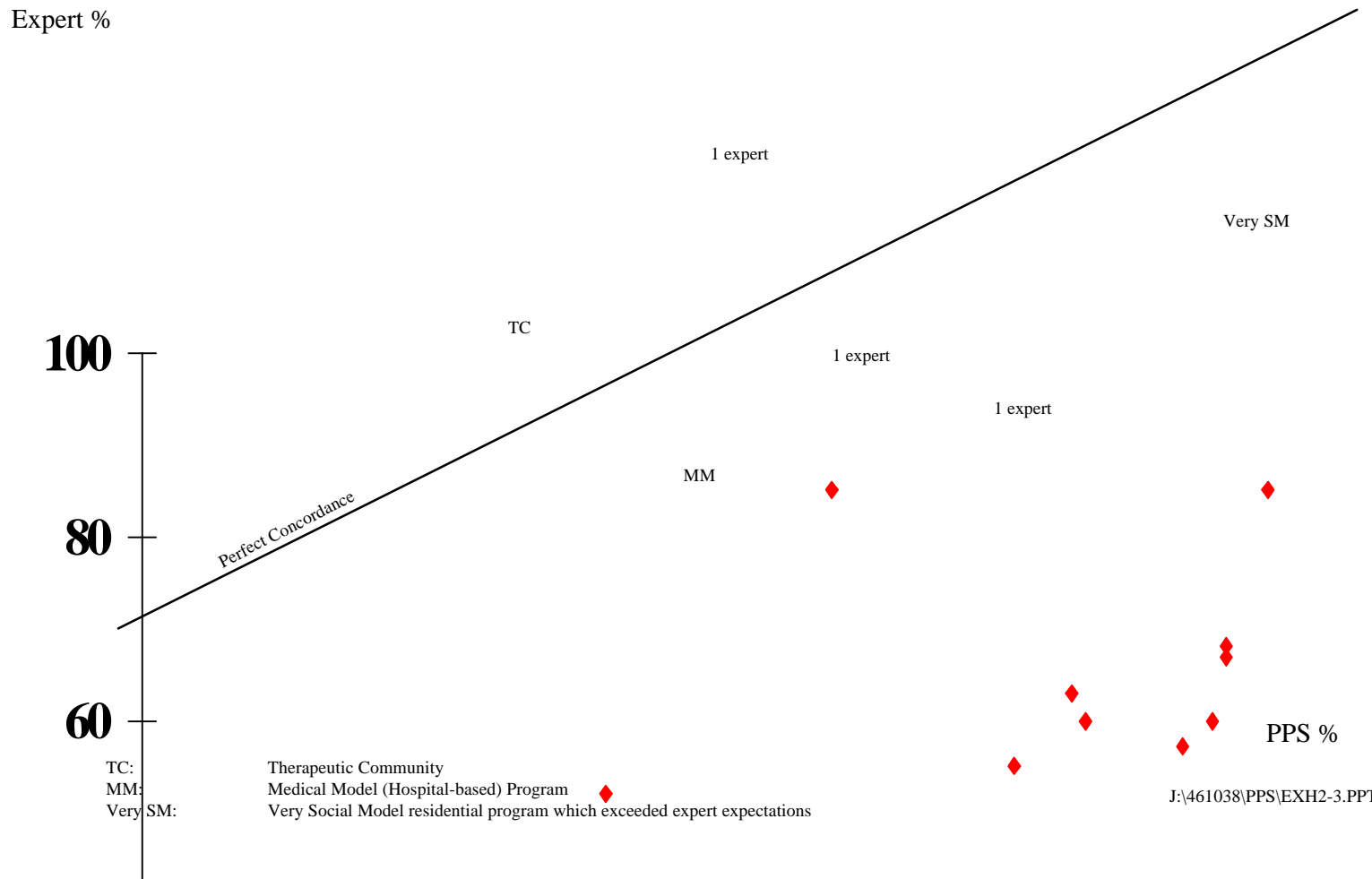
The relative program rankings derived from the PPS and from the three expert administrators are shown graphically in Exhibit II-3. Scores clustering near the diagonal suggest programs where experts and PPS scores were concordant. Outliers highlight areas where it seems likely that expert administrators are probably not accurate in their understanding of the daily operations of programs they ranked. In cases where expert administrator ranking(s) diverged considerably from the relative ranking based on prior empirical administrations of the PPS, individual items and subscale scores from which the overall PPS rankings were derived were carefully analyzed. The unweighted PPS demonstrated higher consensual validity than the weighted PPS.

Scores assigned to a program by the expert administrators were averaged to obtain an overall experts' score for each program. These rankings were generally consistent with the relative program rankings obtained by PPS administration, suggesting high consensual validity (see Exhibit II-3). Seven of the 15 programs received scores by the experts that were within 10 percentage points of the score obtained from the PPS. For 9 of the 15 programs, PPS rankings were no more than one relative ranking higher or lower than those assigned by the experts. Considering only the 12 programs which were ranked by more than one expert administrator, expert rankings were no more than one level higher or lower than those based on the PPS for 9 programs, yielding what may be referred to as an "index consistency" of 75 percent. Finally, for the 12 programs ranked by more than one expert administrator, the experts themselves agreed with one another 7 out of 12 times (58%). Thus, the PPS appears to be at least as accurate as a group of knowledgeable experts in assessing the program philosophy at work in substance abuse recovery settings.

We believe this to be the case in large part based on statements made by the expert themselves when ranking the programs. For example, the expert administrators several times said that they "weren't all that familiar with that program," but that they would "give it their best shot," or that "based on the name, I think I know what that program is probably all about." Thus, we found that one medical model program that works very hard to incorporate social model principles was ranked quite low by the expert administrators. In fact, the program merits a higher ranking because of its strong community orientation, but that would not be evident unless the expert was familiar with that aspect of the program's operation. Similarly, a therapeutic community program was ranked almost 30 percentage points higher by the expert administrators than by the PPS, but the community's focus on tight, staff-controlled governance suggests much less of an actual social model approach. A third outlier is a social model program that scores very high on the PPS, receiving the highest score obtained in all 15 administrations, but was ranked lower by the experts. In that case, it is likely that the expert

administrators were unaware of the inner workings of the program that contribute to its extreme social model score, e.g., its strong adherence to grounding of authority in experiential learning and empowerment of the peer-based residents' council.

### EXHIBIT II-3 COMPARISON OF PROGRAM PHILOSOPHY SCORES FROM PPS AND EXPERTS



### **III. RESULTS OF CHECKLIST ADMINISTRATION**

### **III. RESULTS OF CHECKLIST ADMINISTRATION**

Results of the final analysis of the completed PPS checklists are reported in this section, including the statistical analysis of subscale and overall scale cohesiveness, correlation between individual items and subscale and overall scale scores, and relative program rankings obtained based on the PPS administrations at the 27 residential programs, 7 non-residential programs, and 1 detoxification program. Results from the residential programs are presented first and in greatest detail, reflecting the original focus of the project on residential social model settings. The non-residential PPS checklist results are then described, followed by a brief word about the detoxification PPS.

The description of results is followed by a perspective on the distribution of the program scores based on types of programs (such as Therapeutic Communities, hybrid social model programs, etc.) that tend to cluster at various sections along the continuum of the social model approach. In that discussion, we refer to “losing points” on a given subscale to highlight how the component subscale scores contribute to a program’s overall score on the PPS. This is not intended in any way as a criticism of any program’s approach. Further, no presumption is made regarding the relative value of a given program approach.

#### **1. RESIDENTIAL VERSION OF PPS**

Statistical results of the 27 residential program cases were excellent: Cronbach’s alpha of .92 (item alpha) suggests high cohesion between the individual items and the overall scale score. Analysis of each of the six subscales yielded intra subscale alpha coefficients ranging from .57 to .79, suggesting moderate to good cohesion among the individual items in a given subscale. In addition, correlations between an individual subscale and the overall scale score range from .61 to .84, indicating moderate to strong relationships between subscales and the overall scale score. Each of these aspects of the scale and subscale are described in detail below.

##### **1.1 Overall Scale Analysis**

In addition to the alpha reliability score reported above, the overall scale was analyzed in terms of the individual items’ relationships with the overall scale score; results are shown in Exhibit III-1. Correlations between individual items and the overall score range from lows of .04 for an item in the View of Problems subscale (do participants engage in informal activities together) or .10 for an item in the Staff Role subscale (% staff time spent outside their office), to



**EXHIBIT III-1**  
**CORRELATION AND RELIABILITY ANALYSIS OF PPS, RESIDENTIAL (33 ITEMS)**  
**OVERALL  $\alpha = .92$  (n = 27)**

	Correlation to Subscale	Correlation to Overall Scale	Item Alpha for Subscale
	R	R	(Intra Subscale $\alpha$ )
<b>SUBSCALE 1. PHYSICAL ENVIRONMENT (6 pts)</b>		.82	.62
Program site is not part of a hospital or clinical setting	.43	.56	
What is the % of rooms not dedicated to staff offices?	.42	.42	
Is there a comfortable group area, a living room or sofas, for participant socializing?	.46	.46	
Does the site operate without a reception desk to screen people upon arrival?	.49	.49	
Can participants with a requisite amount of sobriety leave the site without staff permission?	.30	.54	
Are participants involved in food preparation?	.38	.58	
<b>SUBSCALE 2. STAFF ROLE (5 pts)</b>		.61	.57
Does the staff eat with the participants?	.35	.42	
What is the estimated % of time staff spends outside of the office when on site?	.25	.10	
If staff isn't there or in immediate vicinity and a participant shows up drunk, do residents	.47	.51	
■ Handle the situation themselves and not involve staff (1 pt)?			
■ Play a role but also rely on staff (.5 pts)?			
■ Totally rely on staff (i.e. call them, etc. but take no action until staff arrive) (0 pts)?			
When residents need to make and attend outside appointments (doctor, court, etc.), the staff	.47	.38	
■ Avoids making appointments for residents (1 pt)			
■ Encourages residents to make their own but makes them when appropriate (.5 pts)			
■ Makes nearly all appointments for residents (0 pts)			
Does resident responsibility increase with their length of stay at the program?	.18	.43	

**EXHIBIT III-1 (CONTINUED)**  
**CORRELATION AND RELIABILITY ANALYSIS OF PPS, RESIDENTIAL (33 ITEMS)**  
**OVERALL  $\alpha = .92$  (n = 27)**

	Correlation to Subscale	Correlation to Overall Scale	Item Alpha for Subscale
	R	R	
<b>SUBSCALE 3. AUTHORITY BASE (5 pts)</b>		.83	(Intra Subscale $\alpha$ ) .71
Are any alumnae on staff?	.41	.41	
What % of staff are in recovery?	.41	.65	
According to program policy, a certificate or degree, including CAC or CADAC, <ul style="list-style-type: none"> <li>■ Is <u>not required</u> for any position (1 pt)</li> <li>■ Is <u>not required</u> for a % of staff positions (enter % of positions not requiring certificate)</li> <li>■ Or some kind of professional training is required for all positions (0 pts)</li> </ul>	.57	.60	
Over a normal 7 day week, are 50% or more of the participants sober 4 days or greater	.57	.77	
Are people with long-term sobriety on site at the program <ul style="list-style-type: none"> <li>■ Often, getting actively involved with the participants (1 pt)?</li> <li>■ Only via structured self-help (such as H&amp;I or events led by alum) (.5 pts)?</li> </ul>	.51	.56	
<b>SUBSCALE 4. VIEW OF DEALING WITH ALCOHOL PROBLEMS (7 pts)</b>		.73	.70
Is this program a recovery program (1 pt) or a treatment program (0 pts)?	.53	.74	
Are less than 50% of the participants mandated by any external institution or agency?	.31	.32	
In terms of recordkeeping, for each participant the program keeps a: <ul style="list-style-type: none"> <li>■ Factsheet plus progress notes (even a recovery plan) (1 pt)</li> <li>■ Complete case management file (0 pts)</li> </ul>	.38	.37	

**EXHIBIT III-1 (CONTINUED)**  
**CORRELATION AND RELIABILITY ANALYSIS OF PPS, RESIDENTIAL (33 ITEMS)**  
**OVERALL  $\alpha = .92$  (n = 27)**

	Correlation to Subscale	Correlation to Overall Scale	Item Alpha for Subscale
<b>SUBSCALE 4. VIEW OF DEALING WITH ALCOHOL PROBLEMS (Continued)</b>	R	R	(Intra Subscale $\alpha$ )
Are participants ever referred to by staff <ul style="list-style-type: none"> <li>■ As residents or participants (1 pt)?</li> <li>■ As clients (.5 pts)?</li> <li>■ As patients (0 pts)?</li> </ul>	.81	.76	
Are staff ever referred to by participants <ul style="list-style-type: none"> <li>■ As staff or advocates or guides (1 pts)?</li> <li>■ As counselors (.5 pts)?</li> <li>■ As therapists (0 pts)?</li> </ul>	.46	.41	
Does the program provide vocational or academic training for participants?	.36	.45	
Are participants encouraged to engage one another in informal activities & conversation?	.08	.04	
<b>SUBSCALE 5. GOVERNANCE (4 pts)</b>		.84	.79
Are there rules made by the residents that the residents (not the staff) enforce?	.58	.63	
Is there a residents council?	.79	.73	
Do the residents or residents council have the power to end a participant's residency <ul style="list-style-type: none"> <li>■ On their own, without approval from staff (1 pt)?</li> <li>■ In a decision reached jointly with staff (.5 pts)?</li> <li>■ Or does the staff make the decision and residents have no say (0 pts)?</li> </ul>	.38	.59	
Do the residents or residents council have the authority to punish or demote residents?	.69	.72	

**EXHIBIT III-1 (CONTINUED)**  
**CORRELATION AND RELIABILITY ANALYSIS OF PPS, RESIDENTIAL (33 ITEMS)**  
**OVERALL  $\alpha = .92$  (n = 27)**

<b>SUBSCALE 6. COMMUNITY ORIENTATION (6 pts)</b>		.70	.73
At AA meetings hosted on site are there typically <ul style="list-style-type: none"> <li>■ One-third or more of attendees from the surrounding community (1 pt)?</li> <li>■ Some members from the community but less than one-third of those attending (.5 pts)?</li> <li>■ No members of the community in attendance (0 pts)?</li> </ul>	.43	.34	
Does the program help participants find a sponsor if they are having trouble finding one?	.33	.21	
What % of participants find sponsors among AA members before leaving the program?	.62	.52	
Are there formal links with the community such as job search, education, family services, health and/or housing programs that participants may easily use?	.73	.76	
Do program participants engage in community relations and interactions (car washes, tree trimming, litter abatement, neighborhood fairs, "Alcoholic Olympics," softball or volleyball "recovery leagues") to promote such concepts as "Celebrate Recovery," "It's OK not to Drink," kinship with other recovery communities and goodwill for recovery services ?	.42	.62	
Are sober social events "regularly" scheduled (each participant can attend at least one)?	.41	.52	

moderate correlations of .42 for items in the Physical subscale (% rooms not dedicated to staff offices) and in the Staff Role subscale (staff eats with participants), to the highest correlations of .77 on an item in the Authority Base subscale (% sober 1 month or more) and .76 in the View subscale (participants not called clients or patients) and the Community subscale (formal links for jobs, education, housing, etc).

Although some items demonstrate low correlation with the overall scale score, only three have correlations less than .20 with the overall scale, and another four items have correlations in the .30 range. Over one-half the items (55%) have correlations of .50 or greater with the overall scale. This suggests heterogeneity of scale items, while the high Cronbach's alpha coefficient (.92) suggests a cohesive and reliable overall scale.

### 1.2 Subscale Analysis

Three sets of analyses are presented for the subscales: alpha reliability tests for the individual subscales (reflecting internal subscale cohesion among the items comprising the subscale); correlation between summative subscale scores and the score for the overall scale; and correlations between the subscales. The analyses are summarized below.

Exhibit III-2 indicates that correlations between the six subscale scores and the overall scale score range from .61 to .84, with Governance, Authority Base and Physical Environment exhibiting the highest correlations, Staff Role and Community Orientation the lowest. Staff role similarly has the lowest intra subscale alpha, suggesting that it is the least cohesive of the subscales.

<b>EXHIBIT III-2</b>		
<b>RELIABILITY AND CORRELATION COEFFICIENTS—RESIDENTIAL PPS</b>		
<b>SUBSCALE</b>	<b>INTRA SUBSCALE ALPHA</b>	<b>CORRELATION TO OVERALL SCALE</b>
<b>Staff Role</b>	.57	.61
<b>Community Involvement</b>	.73	.70
<b>View of Alcohol Problem</b>	.70	.73
<b>Physical Environment</b>	.62	.82
<b>Authority Base</b>	.71	.83
<b>Governance</b>	.79	.84

*Results of Checklist Administration*

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In general, the subscale scores on internal subscale cohesiveness are similar in relative ranking to the subscale correlations to the overall scale, with the exception of Physical Environment which has a relatively low subscale score but a relatively high correlation to the overall score. Further analysis of the items comprising the Physical Environment subscale helps to understand this result. Two items in the six item subscale, “leaving site without permission if sober long enough” and “involvement in food preparation,” have the lowest correlations to the subscale total (which explains the low subscale cohesion), but among the highest correlations to the overall scale.

Exhibit III-3 shows that correlations between the subscales on the residential version of the PPS range from .42 (between Staff Role and View of the Problem) to .78 (between View of the Problem and Governance). All correlations achieved statistical significance at  $p < .03$  or less:

<b>EXHIBIT III-3</b>					
<b>CORRELATIONS BETWEEN THE SUBSCALES ON THE PPS</b>					
<b>(RESIDENTIAL VERSION)</b>					
<b>SUBSCALE</b>	<b>STAFF ROLE</b>	<b>AUTHORITY BASE</b>	<b>VIEW OF PROBLEM</b>	<b>GOVERNANCE</b>	<b>COMMUNITY ORIENTATION</b>
<b>Physical Environment</b>	.61	.75	.65	.71	.70
<b>Staff Role</b>		.57	.42	.59	.46
<b>Authority Base</b>			.72	.72	.67
<b>View of Problem</b>				.78	.51
<b>Governance</b>					.65

## **2. NON-RESIDENTIAL VERSION OF PPS**

The non-residential version of the scale was analyzed for subscale and overall scale cohesiveness, correlation between individual items and subscale, and overall scale scores, and relative program rankings, yielding mixed results. Since the checklist items were developed based on a literature which primarily addressed residential settings, more research is needed (including observation of non-residential social and medical model programs) to develop appropriate items for administration in a non-residential setting. We report here on the seven non-residential cases included in our analysis.

Although the reliability coefficient for the overall non-residential scale is high (Cronbach’s alpha coefficient = .93; see Exhibit III-4 on the following pages), individual item correlations to the individual

subscales and to the overall scale suggest that some of the remaining items are also inappropriate. One item (% of participants sober a month or more) did not exhibit any variance across the seven programs considered here. Another item (does the program provide vocational or academic training) exhibited a negative correlation with the subscale ( $r = -.57$ ) and with the overall scale ( $r = -.51$ ). Two items in the Community subscale and another in the View of Problems subscale have correlations below .20, and in general the correlations are lower than those obtained with the residential version of the PPS.

The intra subscale alpha coefficients shown in Exhibit III-5 are lower on the non-residential version for all but the Physical Environment subscale. However, the summative subscale score correlations to the overall non-residential scale score are higher than those obtained on the residential scale for all but one of the subscales (Physical Environment). The reliability and correlation coefficients obtained on the non-residential PPS are summarized below.

<b>EXHIBIT III-5</b>		
<b>RELIABILITY AND CORRELATION COEFFICIENTS—NON-RESIDENTIAL PPS</b>		
<b>SUBSCALE</b>	<b>INTRA SUBSCALE ALPHA</b>	<b>CORRELATION TO OVERALL SCALE</b>
<b>Staff Role</b>	.53	.85
<b>Community Involvement</b>	.66	.88
<b>View of Alcohol Problem</b>	.47	.93
<b>Physical Environment</b>	.93	.82
<b>Authority Base</b>	.67	.98

As presented in Exhibit III-6 (on page 25), all but one of the correlations between subscales on the non-residential version of the PPS are significant: Physical Environment correlates with the Staff Role subscale at .70,  $p = .08$ . All others were significant at  $p < .05$  or less, and range from .76 (between Physical Environment and Community Orientation) and .89 (between Physical Environment and Authority Base).

**EXHIBIT III-4**  
**CORRELATION AND RELIABILITY ANALYSIS OF PPS, NON-RESIDENTIAL (25 ITEMS)**  
**OVERALL  $\alpha = .93$  (n = 7)**

	Correlation to Subscale	Correlation to Overall Scale	Item Alpha for Subscale
	R	R	(Intra Subscale $\alpha$ )
<b>SUBSCALE 1. PHYSICAL ENVIRONMENT (5 pts)</b>		.82	.93
Program site is not part of a hospital or clinical setting	.96	.79	
What is the % of rooms not dedicated to staff offices?	.86	.67	
Is there a comfortable group area, a living room or sofas, for participant socializing?	.96	.79	
Does the site operate without a reception desk to screen people upon arrival?	.96	.79	
Are participants involved in food preparation?	.62*	.90	
<b>SUBSCALE 2. STAFF ROLE (2 pts)</b>		.85	.53
Does the staff eat with the participants?	.76	.90	
What is the estimated % of time staff spends outside of the office when on site?	.76	.56	
<b>SUBSCALE 3. AUTHORITY BASE (5 pts)</b>		.98	.67
Are any alumnae on staff?	.70	.90	
What % of staff are in recovery?	.45	.47	
According to program policy, a certificate or degree, including CAC or CADAC,	.32	.53	
■ Is <u>not required</u> for any position (1 pt)			
■ Is <u>not required</u> for a % of staff positions (enter % of positions not requiring certificate)			
■ Or some kind of professional training is required for all positions (0 pts)			
Over a normal 7 day week, are 50% or more of the participants sober 4 weeks or greater?	0 variance	0 variance	



**EXHIBIT III-4 (CONTINUED)**  
**CORRELATION AND RELIABILITY ANALYSIS OF PPS, NON-RESIDENTIAL (25 ITEMS)**  
**OVERALL  $\alpha = .93$  (n = 7)**

	Correlation to Subscale	Correlation to Overall Scale	Item Alpha for Subscale
	R	R	(Intra Subscale $\alpha$ )
<b>SUBSCALE 3. AUTHORITY BASE (5 pts) (Continued)</b>			
Are people with long-term sobriety on site at the program <ul style="list-style-type: none"> <li>■ Often, getting actively involved with the participants (1 pt)?</li> <li>■ Only via structured self-help (such as H&amp;I or events led by alum) (.5 pts)?</li> </ul>	.59	.79	
<b>SUBSCALE 4. VIEW OF DEALING WITH ALCOHOL PROBLEMS (7 pts)</b>		.93	.47
Is this program a recovery program (1 pt) or a treatment program (0 pts)?	.32	.58*	
Are less than 50% of the participants mandated by any external institution or agency?	.74	.90	
In terms of recordkeeping, for each participant the program keeps a: <ul style="list-style-type: none"> <li>■ Factsheet plus progress notes (even a recovery plan) (1 pt)</li> <li>■ Complete case management file (0 pts)</li> </ul>	.20	.31*	
Are participants ever referred to by staff <ul style="list-style-type: none"> <li>■ As residents or participants (1 pt)?</li> <li>■ As clients (.5 pts)?</li> <li>■ As patients (0 pts)?</li> </ul>	.88	.96	
Are staff ever referred to by participants <ul style="list-style-type: none"> <li>■ As staff or advocates or guides (1 pts)?</li> <li>■ As counselors (.5 pts)?</li> <li>■ As therapists (0 pts)?</li> </ul>	.60	.78	
Does the program provide vocational or academic training for participants?	-.57*	-.51*	
Are participants encouraged to engage one another in informal activities & conversation?	0 variance	0 variance	

**EXHIBIT III-4 (CONTINUED)**  
**CORRELATION AND RELIABILITY ANALYSIS OF PPS, NON-RESIDENTIAL (25 ITEMS)**  
**OVERALL  $\alpha = .93$  (n = 7)**

	Correlation to Subscale	Correlation to Overall Scale	Item Alpha for Subscale
	R	R	(Intra Subscale $\alpha$ )
<b>SUBSCALE 6. COMMUNITY ORIENTATION (6 pts)</b>		.88	.66
At AA meetings hosted on site are there typically <ul style="list-style-type: none"> <li>■ One-third or more of attendees from the surrounding community (1 pt)?</li> <li>■ Some members from the community but less than one-third of those attending (.5 pts)?</li> <li>■ No members of the community in attendance (0 pts)?</li> </ul>	.16*	.12*	
Does the program help participants find a sponsor if they are having trouble finding one?	.11*	.02*	
What % of participants find sponsors among AA members before leaving the program	.48*	.71(*)	
Are there formal links with the community such as job search, education, family services, health and/or housing programs that participants may easily use?	.38*	.58*	
Do program participants engage in community relations and interactions (car washes, tree trimming, litter abatement, neighborhood fairs, "Alcoholic Olympics," softball or volleyball "recovery leagues") to promote such concepts as "Celebrate Recovery," "It's OK not to Drink," kinship with other recovery communities and goodwill for recovery services?	.68	.90	
Are sober social events "regularly" scheduled (each participant can attend at least one)?	.68	.90	

<b>EXHIBIT III-6 CORRELATION BETWEEN THE SUBSCALES ON THE PPS (NON-RESIDENTIAL VERSION)</b>				
<b>SUBSCALE</b>	<b>STAFF ROLE</b>	<b>AUTHORITY BASE</b>	<b>VIEW OF PROBLEM</b>	<b>COMMUNITY ORIENTATION</b>
<b>Physical Environment</b>	.70*	.89	.79	.76
<b>Staff Role</b>		.86	.87	.81
<b>Authority Base</b>			.96	.89
<b>View of Problem</b>				

\* not significant at  $\leq .05$

### 3. DETOXIFICATION VERSION OF PPS

With only one detoxification program in the sample of completed PPS checklists, it was impossible to run reliability statistics. Future work on the non-residential PPS should be done in tandem with a related development effort for a PPS applicable to social model detoxification settings. For purposes of this report, we note that use of the detoxification version of the PPS at the detoxification program included here, resulted in a higher score (84%) than the result obtained with the residential version of the PPS (66%), as discussed below.

### 4. DISTRIBUTION OF PROGRAM SCORES

The overall scale score is the percent of points received out of the total score possible (i.e., the number of points received is divided by the maximum possible number of points), yielding a score on the scale that ranges from 0 to 100. For example, a program scoring a total of 20 points on the 33 point residential PPS would have an overall scale score of 20/33 or 61 percent. The scale is unipolar, with 100 percent representing the “ideal type” of a pure social model program, and a score of 0 indicative of a program that exhibited no subscription whatsoever to characteristics associated with social model philosophy. Specific programmatic approaches such as therapeutic communities and clinical programs are thus placed on the social model continuum along with the more “pure” social model programs. In fact, a range on the continuum may empirically be identified where hybrid social model, therapeutic communities, and hospital-based clinically oriented programs are likely to lie. Program scores for each type of program based on the PPS administrations reported here are shown in Exhibit III-7. Overall PPS scores as well as subscale scores are included.

**EXHIBIT III-7**  
**RESULTS OF ADMINISTRATION OF PROGRAM PHILOSOPHY SCALE**

**A. RESIDENTIAL PROGRAMS, 33 ITEMS (n = 27)**

<b>PROGRAM TYPE<sup>ID #</sup></b>	<b>PHYS. ENV.%</b>	<b>STAFF ROLE%</b>	<b>AUTHORITY BASE%</b>	<b>VIEW OF DEALING%</b>	<b>GOVERN.%</b>	<b>COMM. ORIENT.%</b>	<b>TOTAL%</b>
<i>SM Residential<sup>33</sup></i>	98	92	100	100	88	98	97
<i>SM Residential<sup>6</sup></i>	98	90	100	100	100	83	95
<i>SM Residential<sup>38</sup></i>	98	65	100	100	100	90	92
<i>SM Residential<sup>15</sup></i>	98	90	100	100	88	67	91
<i>SM Residential<sup>23</sup></i>	83	70	100	100	88	100	91
<i>SM Residential<sup>24</sup></i>	83	67	100	100	100	88	90
<i>SM Residential<sup>22</sup></i>	96	74	85	100	88	92	90
<i>SM Residential<sup>28</sup></i>	98	86	100	96	88	67	89
<i>Structured HH<sup>13</sup></i>	98	90	100	79	63	67	83
<i>SM Residential<sup>25</sup></i>	65	72	98	100	75	82	83
<i>SM Residential<sup>40</sup></i>	81	62	90	86	88	98	84
<i>SM Residential<sup>31</sup></i>	82	47	96	93	75	99	83
<i>SM Residential<sup>1</sup></i>	81	80	94	55	88	99	81
<i>SM Residential<sup>16</sup></i>	82	82	98	79	75	73	81
<i>SM Residential<sup>5</sup></i>	63	88	83	79	63	100	80
<i>SM Residential<sup>32</sup></i>	60	74	77	64	63	100	73
<i>SM/MM Mix Resid.<sup>19</sup></i>	100	70	80	64	13	92	73
<i>Structured HH<sup>8</sup></i>	78	78	98	62	50	58	71
<i>SM Residential<sup>39</sup></i>	65	76	88	43	50	80	66
<i>SM Residential<sup>11</sup></i>	82	82	40	50	75	72	66

**EXHIBIT III-7 (CONTINUED)**  
**RESULTS OF ADMINISTRATION OF PROGRAM PHILOSOPHY SCALE**

**A. RESIDENTIAL PROGRAMS, 33 ITEMS (n = 27) (CONTINUED)**

<b>PROGRAM TYPE<sup>ID #</sup></b>	<b>PHYS. ENV.%</b>	<b>STAFF ROLE%</b>	<b>AUTHORITY BASE%</b>	<b>VIEW OF DEALING%</b>	<b>GOVERN.%</b>	<b>COMM. ORIENT.%</b>	<b>TOTAL%</b>
<i>SM Residential<sup>14</sup></i>	80	26	86	57	50	72	63
<i>Therapeutic Comm.<sup>20</sup></i>	63	66	78	50	0	57	54
<i>SM Residential<sup>26</sup></i>	47	76	72	43	38	42	52
<i>MM Short-stay Res.<sup>17</sup></i>	63	40	60	43	0	83	51
<i>Short-stay HH<sup>21</sup></i>	47	55	52	57	0	35	43
<i>Dual Diag./MM Res.<sup>9</sup></i>	30	34	20	29	0	25	24
<i>MM Residential<sup>7</sup></i>	12	20	38	57	0	3	24

<b>EXHIBIT III-7 (CONTINUED)</b>						
<b>RESULTS OF ADMINISTRATION OF PROGRAM PHILOSOPHY SCALE</b>						
<b>B. NON-RESIDENTIAL PROGRAMS, 25 ITEMS (n = 7)</b>						
<b>PROGRAM TYPE<sup>ID#</sup></b>	<b>PHYS. ENV.%</b>	<b>STAFF ROLE%</b>	<b>AUTHORITY BASE%</b>	<b>VIEW OF DEALING%</b>	<b>GOVERN.%</b>	<b>COMM. ORIENT.%</b>
<i>SM Non-residential<sup>35</sup></i>	98	95	100	100	100	99
<i>SM Non-residential<sup>37</sup></i>	98	90	95	86	100	94
<i>SM Non-residential<sup>36</sup></i>	98	90	100	86	92	93
<i>SM Non-residential<sup>27</sup></i>	100	90	100	93	67	89
<i>SM Non-residential<sup>10</sup></i>	97	90	80	71	63	78
<i>SM Non-residential<sup>34</sup></i>	80	25	67	57	46	58
<i>MM Non-residential<sup>12</sup></i>	10	38	46	48	29	35

<b>C. DETOX PROGRAMS, 20 ITEMS (n = 1)</b>						
<b>PROGRAM TYPE<sup>ID#</sup></b>	<b>PHYS. ENV.%</b>	<b>STAFF ROLE%</b>	<b>AUTHORITY BASE%</b>	<b>VIEW OF DEALING%</b>	<b>COMM. ORIENT.%</b>	<b>TOTAL%</b>
<i>SM Detoxification<sup>3</sup></i>	78	90	100	90	68	84

## 4.1 Residential Programs

As shown in Exhibit III-7, scores on the PPS for the 19 programs that identified themselves as “social model residential” range from a high of 97 percent to a low of 52 percent, with 13 scoring above 80 percent. None of the programs in this range (i.e., from 81% to 100%) of the scale scored lower than 70 percent on the Physical Environment, Authority Base, View of Alcohol Problem, and Governance subscales. This suggests areas where the strongly social model oriented programs do not appear to compromise, while the Staff Role and Community Orientation subscales drop below 70 percent even for several programs with quite high (above 80%) overall scores.

The six social model programs scoring between 52 percent and 80 percent may be considered hybrid programs which have many characteristics of social model philosophy. They may have compromised some social model principles in order to receive funding or to accommodate evolving client needs that contraindicate complete implementation of certain areas of the social model philosophy. For all but two of the programs in the hybrid range, the Physical Environment score remains above 70 percent, suggesting that the Physical Environment area represents an important part of the remaining social model philosophy at such programs.

Two structured halfway house programs completed the PPS, scoring 83 percent and 71 percent. Scores on the Governance and Community Orientation subscales range from 50 percent to 67 percent for such programs, while scores on Physical Environment and Authority Base remain relatively high. These subscale scores suggest that halfway houses continue to stress and value their environment and the contribution of recovering persons in daily program operation and management.

The one therapeutic community included here scored 54 percent, with the Authority Base subscale the only area scoring above 70 percent. The therapeutic community program scored 0 percent on the Governance subscale, *as do the remaining four non social model programs with scores below 60 percent.* With a larger sample of therapeutic community programs, their range on the scale can be circumscribed.

Since many medical model programs do include some social model program principles within their operation, they accrue points on the scale as well. Two programs which identified themselves as qualified medical model programs (short stay residential and mixed social model residential) received scores of 51 percent and 73 percent, respectively. The two self-identified





medical model programs scored 24 percent overall on the PPS. More research is needed to determine whether this range represents Minnesota Model programs.

## 4.2 Non-Residential Programs

Overall PPS scores from the seven non-residential program sites range from 35 percent to 99 percent (Part B of Exhibit III-7). Three programs received scores in the 90 percentile and higher, with the main discriminatory subscale on the highest scoring programs being the View of the Problem subscale; this was not the case for the residential version. In addition, half of the non-residential social model programs received scores below 70 percent on the Community Orientation subscale. Community outreach may receive less emphasis in non-residential social model settings.

One program that self-identified as social model but also as *outpatient* scored 58 percent; a residential program managed by the same organization which is known to be strongly oriented towards social model philosophy scored 92 percent on the PPS. Changes in degree of emphasis on social model philosophy may be made by organizations expanding to the non-residential setting, although it also is possible that the items on the non-residential PPS simply do not accurately identify strong social model programs.

A clinically-oriented outpatient program scored 35 percent on the non-residential PPS; when the residential PPS was used, that program scored 28 percent. For all except the medical model non-residential program, scores on the Physical Environment subscale for the non-residential programs included here remain at or above 80 percent.

## 5. DISCUSSION

The PPS is intended for use as a program descriptive indicator to assist in the interpretation of outcome study results. The quantitative assessment and rank ordering of the philosophy that guides substance abuse treatment programs has been a difficult subject to approach by those working in treatment research. Treatment philosophy is generally represented by a theoretical construct which does not lend itself easily to assessment by quantitative means and may in fact be multi-dimensional.

In spite of these difficulties, the scale development methodology used to develop the PPS has produced an instrument with high reliability and cohesion. The

instrument is also practical in that it takes a short time to administer and requires little previous training for a prospective

interviewer. The comprehensive manual for administering the PPS (Room, 1996) describes the reasoning behind the inclusion of individual items and creation of subscales.

Clearly, more research is needed to determine what items are appropriate discriminators of social model philosophy in the non-residential setting (which includes day treatment, outpatient, intensive outpatient, etc.). As funding agencies become more focused on cost cutting and turn to outpatient solutions to accomplish that goal, the need for such a descriptive instrument should become increasingly evident. Similarly, more work is needed with other detoxification program sites to determine the feasibility of administering the items selected for retention in the detoxification version of the PPS, to develop potential new items that are appropriate discriminators for social model philosophy in the detoxification setting, and to assess the psychometric properties of the resultant detoxification Program Philosophy Scale.

It is important to underline that the methodology applied here could potentially be used to develop similar scales for assessing other treatment philosophies and other areas of clinical intervention in need of standardized assessment, especially when there are too few programs to make factor analysis feasible (as will often be the case for program-level analyses)

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