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THE SUPPORTIVE LIVING PROGRAM: APPLYING A SOCIAL MODEL RECOVERY APPROACH TO HIGH RISK PAROLEES

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THE SUPPORTIVE LIVING PROGRAM: APPLYING A SOCIAL MODEL RECOVERY APPROACH TO HIGH RISK PAROLEES

In 1992 the Supportive Living Program was established by the Center on Juvenile and Criminal Justice (CJCJ) as an alternative to traditional clinical approaches to substance abuse treatment for parolees. Funded by the California Department of Corrections and contracted through the San Francisco Department of Public Health, the program was a pioneering effort to apply social model recovery principles to high risk parolees.

Social model recovery programs are focused on building a person's intrinsic motivation to maintain a clean and sober lifestyle through personal growth, social interaction and supportive networks. Unlike traditional clinical approaches, social model recovery programs encourage and promote personal initiative and community involvement. Also distinct from clinical approaches, social model recovery program staff share similar backgrounds as program participants and are not selected based on clinical training. This emphasis on commonality rather than clinical preparation allows closer identification between clients and staff and facilitates the development of trust and support (Borkman 1986).

First introduced in the 1960s, social model residential recovery approaches where primarily reserved for alcohol abusers. The model's application with a range of substance abusers, particularly parolees, remains unexplored. This article provides a preliminary examination of CJCJ's efforts to establish the social model recovery approach as a viable option in a continuum of services to parolees with histories of substance abuse. The study will include an overview of substance abuse treatment models and an analysis of SLP program outcomes.

OVERVIEW OF CONVENTIONAL TREATMENT APPROACHES

Medical and psychological approaches have long dominated the field of substance abuse treatment. Founded on the belief that substance abuse is a curable condition that is best addressed through clinical methods, treatment is dispensed through didactic interactions that requires passivity under the guidance of a trained professional. The dependency on trained therapists is described by Wright:

> In most clinically or medically-oriented programs, a new patient or client is assigned to a therapist who has primary responsibility for managing that patient's case. The patient works with a therapist on an individual basis. The patient may be in one or more formal groups facilitated by the therapist, and may develop a relationship with other members in a group, but the patient's primary relationship is nevertheless with the therapist (1990, p. 7).

Prior to completing the program, the client must absorb a pre-established body of information that is designed to ready them for maintaining a clean and sober lifestyle. Clients are closely monitored and personal initiative is discouraged until the individual is deemed ready to assume responsibility outside the confines of the treatment program.

SOCIAL MODEL RECOVERY APPROACH AND EXPERIENTIAL LEARNING

Unlike the clinical model's hierarchical didactic approach where community interaction is discouraged, social model recovery maximizes self learning through immediate community involvement. The social model recovery approach was developed by practitioners in the alcohol recovery field and has only recently been recognized as an alternative to traditional approaches. In contrast to clinical models, experiential learning theory is the foundation for social model recovery. Experiential learning theory is based on the belief that learning, motivation, and self analysis is maximized when the individual is placed into demanding situations that immediately compel the person to assume personal responsibility. In this demanding situation, the individual is required to master skills and tasks that mirror real life circumstances (Gager 1978; Weider 1980, Borkman 1986).

As responsibility is assumed and necessary tasks are completed, new skills are acquired and the individual's confidence, motivation, and commitment grow (Bieler p. 522). Feedback and encouragement are offered by staff, who design tasks and challenges that

have graduated levels of difficulty. Tasks are designed to involve actions and decisions that have personal meaning and directly affect interpersonal relationships. For example, program participants are required to assist in meal planning and preparation. Although meal preparation is a routine task to most people, it is often a serious challenge to a parolee recently released from prison. However, failure to adequately complete the task directly affects the group and results in immediate feedback (Gager 1978, Wittman 1990).

From these experiences, personal growth and insight is increased and responsible behavior promoted. Periods of reflection and analysis through group and individual interactions are facilitated by staff to link practice with theory and transfer the experience's lesson to broader considerations (Gager 1978, Wright 1990). Also, unlike clinical models, the participants are not dependent on a professionally trained therapist. Learning is acquired from others with commonly shared experiences. These individuals can be staff or other program participants. According to Reynolds and Ryan:

> Social model programs do not provide services in the traditional definition of the term as understood in clinical/medical model settings. In social model programs, the basis of authority is experiential knowledge. Participants learn how to recover from alcoholism by going through the recovery process and interacting with people who have more experience in that process and are further along in their recovery, rather than by receiving a prescribed set of services provided by a clinician or therapists (1988, p. 32)

Appendix A outlines the differences between social and clinical model. The chart, originally developed by Borkman was adapted for the SLP program.

THE SUPPORTIVE LIVING PROGRAM

The Supportive Living Program is a 12-bed 120-day transitional residential program. Located in two San Francisco residential neighborhoods, each house accommodates 6 participants. The number of residents is limited to 6 participants at each site. The purpose for limiting the number of participants is to ensure a homelike environment. In addition, the sites are purposely located in residential neighborhoods to promote community involvement.

To be selected for the program, participants must:

- have a history of substance abuse and be at risk for relapse
- be on parole from the Department of Corrections and in danger of having their parole revoked
- are not in need of detoxification services, acute medical care, or hospitalization for other reasons (CJCJ 1996).

As part of the BASN, SLP was founded as a component of a continuum of treatment interventions established by the California Department of Corrections and administered through individual counties. Potential participants are referred through a privately contracted centralized case management system.

In accordance with social model and experiential learning principles, upon acceptance into the program, an individualized case plan is jointly developed by SLP staff and residents. The case plan defines a range of progressively challenging activities and serves as an outline of individual goals and objectives. Case plans are developed according to individual needs and typically include participation in education, employment, vocational training, family reunification, mental health, post-release housing, and life skills.

SLP staff is composed entirely of ex offenders and recovering substance abusers. Individual achievement and self reliance is promoted by maximizing resident participation in all aspects of program decision making. Feedback is provided by other residents and program staff primarily through group meetings. The role of staff in a social model recovery/experiential learning process is not to be the purveyor of information. According to Weider:

> The primary objective of a counseling relationship is to help a person identify his own problems and then to support this person in setting goals and strategies to resolve the problems. The basic role of a counselor is to provide a reality base for a client to view his problem, to assist the client in making the proper decisions to alleviate the problem, to provide encouragement for the person to achieve his goals relating to the problem, and to highlight the client's strength and abilities (1980, p. 45).

SLP participants are responsible for daily house maintenance activities including food preparation, clean-up, and general household chores. Menus and meals are planned and prepared by residents.

Participant-planned recreation group activities are scheduled weekly. These activities include movies, sporting events, plays, cultural events, and camping. Along with group activities participants are assisted in developing excercise and recreation routines. Memberships in local health and recreation clubs are purchased for individual residents.

Perhaps the most crucial and challenging activity is to acquire and maintain employment. Employment is considered essential to the development of long term sobriety and assimilation into the community. With employment comes a sense of accomplishment and contribution and a degree of financial stability to relieve potential stressors that contribute to relapse. Absent gainful employment the individual's chances of long term abstinence are greatly diminished.

Upon entry into the program, participants are assisted in locating employment or enrolling in a vocational training program and/or job readiness workshop. If the individual has marketable skills they are given support in seeking employment that matches their previous experience. Part of the agreement to participating in the program is a commitment to contributing a third of your income for rent and another third to a savings account. Upon completion of the program the savings are returned to the participant.

If employment cannot be immediately obtained, individuals are expected to perform community service. Community service is a vehicle for promoting commitment and a sense of contribution. Community service work by SLP participants has included ...

The following case examples illustrate the programs activities and approaches:

> Case Example 1.
> John D. entered the program when he was 40 years old. A poly drug user with a long history of heroin, cocaine, and alcohol addiction, John was given little chance of succeeding. He had spent most of adult life in state prison with repeated commitments for robbery and burglary. Each time upon his release he

would immediately revert to drug use and petty crime. As his drug use escalated his crimes would become more serious as he struggled to support his habit.

Prior to his referral to the program, John was on the verge of violating his parole and being returned to prison. As a last resort, he was referred to CJCJ. During his initial interview John was told by SLP staff that the program required personal initiative and that there would be no authority figure dictating his actions. His success in the program would be determined by personal determination and commitment. John assured CJCJ staff that he wanted to come to the program and asserted his desire to participate in the development of personal objectives.

During the development of his personal case plan, John informed SLP staff that because of his substance abuse history additional treatment would be necessary for him to stay clean and sober. He expressed a desire to attend outpatient therapy at Walden House. Walden House is a San Francisco-based drug treatment program that provides a more traditional clinical approach. With assistance from SLP staff, John was referred to Walden House where he attended four weekly therapy sessions in addition to his three in-house weekly group sessions.

John exhibited many of the patterns common to most program participants. Initially participants are enthusiastic, but as they settle into their routines they often become complacent and restive. John's first major crisis occurred when his ex-wife, who was also in recovery, started calling him asking for help when she began using again. On two occasions John went to meet her in an area known for drug activity. When it was brought to the group's attention, John was remained that he could not help someone else until he was in control of his own problems. From that point on, he became a model participant.

Within twenty-two days of being in the program, he acquired a full-time job as waiter in an upscale restaurant. Along with his therapy sessions, John also adopted a vigorous exercise program.

John graduated from the program in 1999. Since that time he has remained gainfully employed and is married and is preparing to purchase his own home.

He remains sober and continues to participate in NA. In addition, he still maintains regular contact with project staff.

Case Study 2
Anthony, age 29, was paroled from Avenal State Prison with a criminal history that began when he was 14 years old. After graduating from the California Youth Authority at the age of 18, he quickly became involved with poly substance abuse, including cocaine and heroin. To sustain his drug needs, he engaged in burglary, theft, and drug sales.

Upon entry into the program, Anthony displayed strong motivation and made it known that he wanted to graduate as soon as possible. Though initially cautioned about the danger of relapse, he participated in his SLP group meetings and regular N/A meetings.

Although he had little employment history, Anthony was hired as a part time laborer with a landscaping company. Anthony showed excellent motivation and was soon given full time hours. With his steady progress, Anthony opted to leave the program early and move into a specially arranged living situation with a recovering mentor. Two years after graduating, Anthony continues to work full time, participate in NA, and maintain a support system through his mentor and program staff.

Additional Program Elements

In 1995, with foundation funding, CJCJ added an additional pilot component to the Supportive Living Program. To test the possible expansion the program's continuum of services, surrogate homes were developed for participants who needed an additional period of support after graduating from the primary program. CJCJ provided two beds in homes of carefully screened mentors. This program component was intended to assist those participants who have no family or other stable form of residential support.

The program was developed in response to the need to provide living arrangements for graduates with few other options. Many SLP participants do not have responsible family support systems and require an extended level of support beyond the maximum time allowed by SLP. The program was modeled on a similar program initiated years earlier

by Allen Wiggenhorn, a parole agent with the California Department of Corrections (CDC) in Indio, California.

Although never formally adopted by the CDC, the program provided a model that was consistent with SLP's emphasis on individual initiative and community integration and provides a possible program component for the future.

SLP Program Effects

The Bay Area Services Network was California's first successful attempt to implement a comprehensive continuum of substance abuse treatment services for high-risk parolees. As part of this continuum of care, SLP was widely recognized as a nontraditional residential approach with many benefits. The following is a brief summary of data compiled on the SLP program, with the addition of available data on the population served by other BASN residential programs, which include Walden House (WH) and the Haight Ashbury Free Clinic (HAFC). Data was supplied by the Epidemiological Data Center of the City of San Francisco Department of Public Health.

Completion Rate (All Programs):

In fiscal years 2001 and 2002, the SLP program has enjoyed an average completion rate of 67.5%. This rate of program completion compares favorably with other BASN residential program completion rates for the same period such as WH (50%) and HAFC (39.1%).

Length of Stay (All Programs): Research overwhelmingly concludes that the longer the period of care, the better the outcomes for program participants. In 2001 and 2002, CJCJ's SLP on average maintained 40% of all clients in the program 2-6 months with 9% remaining for a 6-9 month period. Walden House and Haight Ashbury Free Clinic residential programs retained clients for competitive periods on average within the same time frame. Average length of stay for the 2-6 month period was longest at Walden House, at 63.5%, yet only 3.75% of clients remained in the program past the 6 month period. Haight Ashbury had the shortest period of residential care, with 38% of clients remaining for a 2-6 month period and 5.5% staying in the program longer than 6 months.

Population Description (SLP): Fiscal year 2001-2002 is the most recent period for which data has been compiled on the Supportive Living Program. From July 1, 2001 through June 30, 2002, SLP served 91 clients. Among this population, 48 percent were poly-drug

users citing "alcohol and other drugs" as their primary problem. An additional 25 percent indicated heroin as their primary drug of choice, cocaine and methamphetamine users made up 13.3 percent and 11.6 percent of the population respectively.

Employment (SLP): An assessment of employment factors before and after program participation indicates that employment is a stabilizing factor in successfully completing SLP. Employment rates upon entry into the program are exactly even for program graduates and dropouts (20%), while program graduates show a significant rise in employment upon completion of the program (64%) compared to program dropout (34%) when they leave the program.

Recidivism (SLP): Data that measures the number of clients that re-offend within a given period is considered an essential performance measure for programs providing services to offender populations. Of the 91 clients who completed the program, 11 were readmitted within the same period measured for relapse or a technical violation of parole.

Conclusion

While recidivism data is an incomplete measure of overall program performance, preliminary figures suggest that applying social model recovery principles to high-risk offenders is a viable alternative to the more traditional clinical oriented approaches. An effective continuum of substance abuse services recognizes differences in individual learning styles and the importance of providing an assortment of program modalities. Because sobriety requires individual, personal motivation, programs must focus on long-term client's needs and developing their capacity to maintain sobriety and function once they leave the residential setting's protected environment. Based on these criteria, the social model experiential approach, measuring success by low recidivism rates, is worthy of consideration because it reflects the program graduate's ability to remain sober and function in society.

APPENDIX A

Social and Clinical Models: Distinctive and Common Elements

Elements Elements of	Distinctive Elements of Social Model	Common Elements	Distinctive Clinical Model
Physical environment of treatment/recovery	Home-like setting encourages peer interaction. Clients help maintain the facility.	Non-institutional, non-hospital; wards, friendly	Office setting-reception desk and waiting room, comfortably appointed
View of dealing with drug problems.	Recovery is a Lifelong process, requiring continuous support.	Alcoholism is a treatable disease.	Relatively time limited, treatment plus aftercare and follow-up is the primary approach.
Metaphor of relationships.	Extended family, staff and clients integrated.	Less distance between staff and clients than in physician/patient relationship. Staff are caring, committed people.	Professional client relationship with established boundaries. Accessibility by appointment.
Peer orientation	Peer group interaction of recovering peers at different phases of sobriety is essential element of recovery.	Peer oriented (recovering peers support each other).	Encourage peer support as an element of treatment.
Orientation to AA/NA and self-help groups	12-step programs are the foundation of many concepts and practices vital to social model recovery.	Endorse AA/NA; encourage clients to participate in AA/NA and other self-help groups. AA/NA meetings held in facility.	Orient clients to AA/NA for support, especially for aftercare and follow-up.
Authority Vknowledge base	Experiential knowledge of recovering peers is the major basis of authority. Peers at various phases of recovery are role models for each other. Degrees are less relevant.	Experiential knowledge of recovering peers recognized as important. School-based knowledge of degreed staff recognized as important.	Professional knowledge of degreed staff is the major basis of authority. Degreed staff supervise and train other staff. Non-degreed recovery alcoholics are called paraprofessionals. Having some recovering staff is considered important.
Method of learning other life skills.	Experiential learning; learn by doing and practicing. (Action leads to attitude change, leads		More emphasis on didactic learning: learn and then do.

	to learning.)		(Info/knowledge leads to attitude change, leads to action.
Recovery/treatment approaches	Clients participate in developing recovery plan; self-help peer group emphasis on sharing experience \, strength, and hope; 12-step program central to recovery. Spiritual emphasis (not religious) as in AA/NA.; clients set many of the rules. Staff are not responsible for individual's recovery; staff are responsible for managing sober setting conducive to individual and peer mutual self-help.	Structured program for clients. Info/educational sessions, group sessions, social/recreational sessions. Refer clients to vocational, medical, legal, and other resources as needed. Resident Council (primarily residential programs.)	Resident Council assigns chores and resolve interpersonal differences. Counselors structure individual and group interactions to foster clients taking responsibility.
Preferred requirements for staff	Maintain a sober environment conducive to recovery. Be a recovery role model.	Experienced working in alcohol/drug programs.	Professionally trained in clinical applications
Major staff role vis-à-vis recovery/treatment	Staff maintain case files.	Staff want clients to take responsibility for their own recovery.	Counselor, therapist, or group facilitator; staff have cases, maintain files and progress notes on each client.
Ratio of recovering to degreed staff	Recovering staff in majority.		Degreed staff in majority.
Attitude towards volunteers.	Volunteer opportunities give recovering peers a chance to do service following 12-step principles. Volunteers substitute for and are treated as paid staff.	Volunteers are useful and contribute to the program.	Volunteers are used selectively, as adjuncts to and not substitutes for paid staff.
Some prized values.	Rigorous honesty, interdependence (mutual aid and self-help). Strength through vulnerability. Increased client involvement in program operation.	Clients take responsibility for recovery. Compassion for persons affected by alcohol problems. Staff respect client and serve them with dignity.	Professionalism: efficiency of operation; specialization; client achieving independence and insight.
Community orientation	Public information and education generally are integrated with recovery activities; demonstration	Public information and	Public information and education generally are separated from

	of clients recovery and prevention are two sides of the same coin. Clients do services for/in the community. Wide variation in the degree of "community model" orientation.	education (prevention) are important. Since 1985, prevention concepts have broadened to include media advocacy, public policy, and community organization.	treatment activities. Wide variation in the degree of "public health model" orientation.
Record keeping.	Clients are encouraged to complete their recovery plans. Individual case records are de-emphasized.	Records comply with federal, state, and county record-keeping requirements. Internal records useful for program management are maintained.	Emphasis is on appropriate, complete, and accurate case file with progress notes on each client following accepted professional practice. Case records are critical to managing the client. Cases are reviewed to show program quality. Progress notes are considered important indicators of counselor's competence.
Terminology.	Recovery, participant, resident, guide.		
Principles of integrating various services.	Generalization to maximize combining services into one program; involve peers at different stages of recovery together.	Federal/state funding terminology influences program terminology.	Treatment, therapy client, counselor, case record.
Indicators of high quality programs.	Extended family-like network of relationships; "loving, accepting setting." clients "own" the program and contribute spontaneously to it. High volunteerism rate. Alumni return to interact with new . clients, alumni, or staff initiate or refine services as needs surface or change.	Federal/state funding requirements and standards. Staff believe that a high percentage of clients achieve sobriety in their program. Clients develop sober lifestyle, become self-supporting, and grow as persons. Staff receive satisfaction through their work.	Specialization; complex division of labor (team approach) with coordination. Separate functional services into specialized programs. Procedures, policies, programs, and case records are well documented according to professional standards. Well-trained and supervised staff. Adequate units of service and data produced.