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INCREASING THE NUMBER OF MUTUAL HELP RECOVERY HOMES FOR SUBSTANCE ABUSERS: EFFECTS OF GOVERNMENT POLICY AND FUNDING ASSISTANCE

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ABSTRACT: As a form of aftercare, Oxford House (OH) is a recovery home that is democratically operated by residents, with no designated limit on length of stay. These homes are behaviorally based settings that provide clear consequences for any substance use or disruptive behavior. What is unique about these settings is that training, supervision, and implementation of the contingencies is provided by the residents. In order to increase the number of these mutual-help recovery homes, two groups of states utilized state funds to hire recruiters and set up a loan fund to establish new OHs. Using a multiple baseline design, findings indicated that this intervention involving the hiring of recruiters and a loan program was effective in facilitating increases in the number of U.S. OHs in each group of states. An immediate increase in the opening of new houses occurred when the intervention was introduced, resulting in the opening of 559 new OHs across these states.
Key Words:

A review of the literature on the effectiveness of substance abuse recovery programs indicates high recidivism rates for both men and women within one year after successful completion of inpatient treatment for immediate detoxification, including 52-75% of all substance abusers dropping out during treatment (Montgomery, Miller, & Tonigan, 1993). Individuals who leave these programs frequently return to high crime areas or families that continue to use illegal drugs, and such environments typically increase the probability of relapse.

Oxford House (OH), founded in 1975, illustrates a community-based approach toward substance abuse abstinence. Unlike traditional residential care where trained professionals mandate and enforce rules and policies, or therapeutic communities where residents have a maximum length of stay, OH offers same-sex residential communities where participants live without the involvement of professional treatment staff and where there are no time restrictions on length of stay (Oxford House Manual, 1988).

Similar to 12-step programs, members of an OH receive abstinence support from peers; however, unlike these mutual-help support groups, there is no single, set course for recovery that all members must follow (Nealon-Woods, Ferrari, & Jason, 1995). In fact, residents of OH are free to decide personally whether to seek psychological or substance

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abuse treatment by professionals and/or participate in 12-step programs such as AA (Alcohol Anonymous) or NA (Narcotics Anonymous).

Besides the setting aspects noted above, it is important to understand that each OH operates democratically with majority rule. Residents elect OH officers (e.g., President, Secretary) every six months who facilitate the handling of clerical responsibilities (e.g., convene weekly OH meetings, collect rent). The OH members maintain financial independence with each resident paying rent and doing chores. Neglect of financial responsibilities, disruptive, anti-social behaviors, or resuming drugs or alcohol use result in eviction (Oxford House Manual, 1988). Each house holds weekly business meetings in which the residents collect rent (*M* weekly rent = $70-$90) and discuss household matters.

OHs provide individual members with negative contingencies (e.g., fines), positive reinforcement, and group rewards, and these contingencies clearly indicated that the house's rules and regulations are enforced in a consistent fashion (Jason, Olson, Ferrari, Layne, Davis, & Alvarez, 2003). When members initially enter these settings, they are provided a booklet of rules, and considerable time is invested in meetings with OH members to learn the system. The strongest form of reinforcements may be found in the social support activities represented by the helping relationships process. For instance, ongoing friendships among OH residents occur, and members frequently engage in stress-reducing activities such as bowling, shopping, and barbeques that are healthy substitutes to spending time alone and/or using addictive substances. Because the residents themselves, in a democratic fashion, develop the contingencies for setting rules and regulation, OH members become invested in those rules, as opposed to policies created by an external authority such as treatment staff (cf. Ferrari et al., 2003).

Since 1992, researchers have begun to study this self-help organization (e.g., Jason et al., 1994). This series of studies is summarized elsewhere (cf., Ferrari, Jason, Olson, Davis, & Alvarez, 2002; Jason, Davis, Ferrari, & Bishop, 2001). For example, in one study, Jason, Ferrari, Groessl, Dvorchak, and Molloy (1997) examined the characteristics of OH residents compared with persons associated with other substance abuse recovery programs, as reported in the literature (e.g., Beattie et al., 1992). The client-demographic profile of OH residents matched the typical profile characteristics reported on recovering substance abusers from more traditional programs That is, in OHs, typically residents were never married (53%), Caucasian (58%), male (70%), had at least completed high school (71%), employed with an adequate income to live independently (69%), reported use of other drugs along with alcohol (53%), and experienced homelessness at some point in their past lifetime (64%).

Another study examined the characteristics and perceptions of men from Illinois OHs (Jason, Ferrari, Smith et al., 1997). These men claimed that a psychological sense of community and a structured setting where successful abstinence from substance use was strictly enforced were reasons for choosing to reside in a OH. In addition, considerable psychiatric co-morbidity among OH residents has been found, consistent with other studies with substance abusers (Majer, Jason, Ferrari, & North, 2002). Majer et al. also reported that 69.2% of the residents studied either remained residents or left the house on

good terms. In another sample, Bishop, Jason, Ferrari, and Huang (1998) also found similar positive outcomes with another sample of OH residents.

Ferrari, Jason, Olson, Davis, and Alvarez (in press) examined the policies from a national sample of 55 U.S. OHs compared to 14 therapeutic communities (TCs). Both types of facilities possessed more traditional rules, such as not permitting self-injurious behaviors (e.g., physical self-harm) or setting destructive acts (e.g., destroying site property). OHs, compared to the TC aftercare facilities, however, were significantly more liberal in permitting residents personal liberties. The OHs also permitted greater flexibility in terms of residents' smoking in their rooms, sleeping late in the morning or staying out late at night, staying away overnight on weekends, and having "private time" in one's locked room with guests. In addition, the OH respondents were more likely than persons in TCs to permit residents to have their own personal possessions (e.g., pictures, artifacts, and furniture) within the dwelling.

Ferrari, Jason, Sasser, Davis, and Olson (in press) found that OHs were generally located in attractive mid- to high-SES neighborhoods, where very few intoxicated persons, drug dealers, or homeless persons were observed but many setting amenities (e.g., grocery stores, post offices, banks, and medical centers) existed. In fact, Jason, Roberts, and Olson (2004) noted that neighbors believed that OH residents were "good neighbors," helpful and non-disruptive.

In 1988, Congress passed an "Anti-Drug Abuse Act" that included a provision to encourage state-level expansion of self-run, self-supported recovery homes such as OH. In early 1989, the U.S. Alcohol, Drug Abuse, and Mental Health Administration issued guidelines to all states requiring the establishment of *revolving loan funds* in which each state would set aside $100,000 from their available state funds for the expansion of these homes. Individuals were then able to borrow up to $4,000 from this state loan fund to help with initial month's rent, a security deposit, and to purchase furniture and other items necessary to establish a house.

Some states also provided separate financial assistance for the hiring of outreach workers to facilitate the opening of OHs. These recruiters, as state-employees, worked at securing appropriate single-family homes for rent as OHs and obtaining the start-up amenities needed to create a small group residence. Recruiters also provided traditional treatment facilities with information about the OH program and local house sites, in order that persons who complete treatment may have the option of seeking residence in a OH. The recruiters, however, did not engage in personally selecting residents since that function was reserved for OH residents as mandated by OH policies (see Oxford House Manual, 1988).

We believe that, given current economic and social climates, there is a need to take a more systemic approach in understanding reasons for the expansion of the OH model across the United States. This can be accomplished by inspecting archival data on the expansion of OHs, and examining whether favorable and reinforcing state policies contributed to this organizations expansion. Providing government funding and personnel to create new OHs likely represented critical resources toward expansion of this mutual-help communal living program across the U.S. Loan funds often provided the financial

resources needed to assist initial rent payments, as well as provide furniture for OHs. Recruiters also provided the expertise to arrange for the establishment of the OHs, as well as disseminate information to the substance abuse recovery community about the OH concept of recovery. The present study hypothesized that there would be an expansion in the number of OHs in those states where federal funds and outreach workers were established.

METHOD

Intervention

Also mentioned earlier, the 1988 Congressional "Anti-Drug Abuse Act" allocated federal funds to any state for the start-up of OHs. A group of recovering substance abusers, through the support of an established OH, requested $4,000 from their state in an interest-free loan. Loans were then repaid to the state fund for subsequent use in the start-up costs of additional OHs in that state.

Loan payments were also used as resources to hire outreach workers or recruiters. Thirteen states provided separate state-level funding to hire from 1-4 outreach workers to start up OHs. These recruiters either worked for the state, a contractor within the state (such as a substance abuse agency) or with the central OH Office located in Maryland. Each OH recruiter at one time lived in an OH, therefore, these persons were intimately familiar with how OHs were managed. Recruiters were responsible for locating homes in relatively low crime areas, securing the lease for the houses, and making sure each house was furnished. In addition, recruiters set up the phone, gas, and electricity for each new house.

Once the houses are established, the recruiters visited substance abuse treatment settings and discussed the new house with staff and residents who were soon to complete their substance abuse treatment plan. Once a house was filled with 6 to 8 men or women, the recruiter often stayed at the House for the first few months to ensure all residents knew the rules and socially enforced the agreed upon policies.

Subsequently, the recruiter began the process with another OH, continuing to check-in with the prior house members to ensure the OH continued to function smoothly. Because there were weekly meetings, including all House members, this was a natural-setting for the OH recruiter to return easily to the House to assess how well the residents were assuming OH responsibilities.

Data

Archival records provided by the OH National headquarters (M. Brown, personal communication, September, 2003) served as our primary data. These records focused on all OHs opened within13 states, starting in 1980 and continuing to 2002, that had both revolving fund loan programs as well as recruiters used to open new OHs. It should be noted that while the loan programs functioned during this period, the recruiter programs

started at two different time points for 13 states. For 10 states, recruiters were hired during the year 1989-1990. For the remaining three states, recruiters were hired several years later, during 1998-1999.

As an assessment of the reliability of these data, independent checks were conducted. Research staff from DePaul University called the state recruiters and confirmed the number of OHs opened in that state during the specific time frame. The reports from the National office closely matched the independent checks for the number of OHs, and inter-rater reliability was 96.1%. As a further check, in three states, two recruiters independently confirmed OHs that had opened, and inter-rater reliability was 99%.

RESULTS

Figure 1 presents the cumulative data on OH openings over the targeted time frame from 1977 to 2002. Each line on this figure represents the number of new OHs in a particular State. As noted in the top section of the figure, during the baseline period when the governmental interventions (i.e., establishing a revolving loan fund plus OH recruiters) were not in effect, no new OHs were opened. In contrast, an immediate increase in the opening of new OHs occurred when the intervention was introduced, resulting in the opening of 515 new OHs across these states.

The bottom section of Figure 1 indicates that during the baseline time period from 1990 to 1998, few houses opened in the second group of houses where the services to open new Houses provided by a Recruiter was not established in that state. In fact, only three houses were started across these states during the baseline phase. However, when the Recruiter resources were provided to this second group of OHs, immediate increases in the number of cumulative houses was again evident, such that a total of 44 houses opened during the intervention phase.

DISCUSSION

This study indicates that state-level resources can impact the growth of OHs. Key factors that seemed to influence the growth of the homes were the state's provision of a loan program as well as the hiring of recruiters to both open and monitor OHs. States hired these recruiters to increase the actual number of OHs. The results of the present study suggest that strategic placement of federal and state resources can influence the creation and expansion of community-based resources in the form of recovery homes for former substance abusers.

Often it is difficult to extend behavioral management techniques on a daily basis once a client leaves a treatment center. However, in organizations such as OHs, residents can reinforce each other throughout the day by praising completed work, and by reminding each other about the benefits of greater competence and meaningful, positive friendships. The behavioral systems within OHs involve negative contingencies (e.g.,

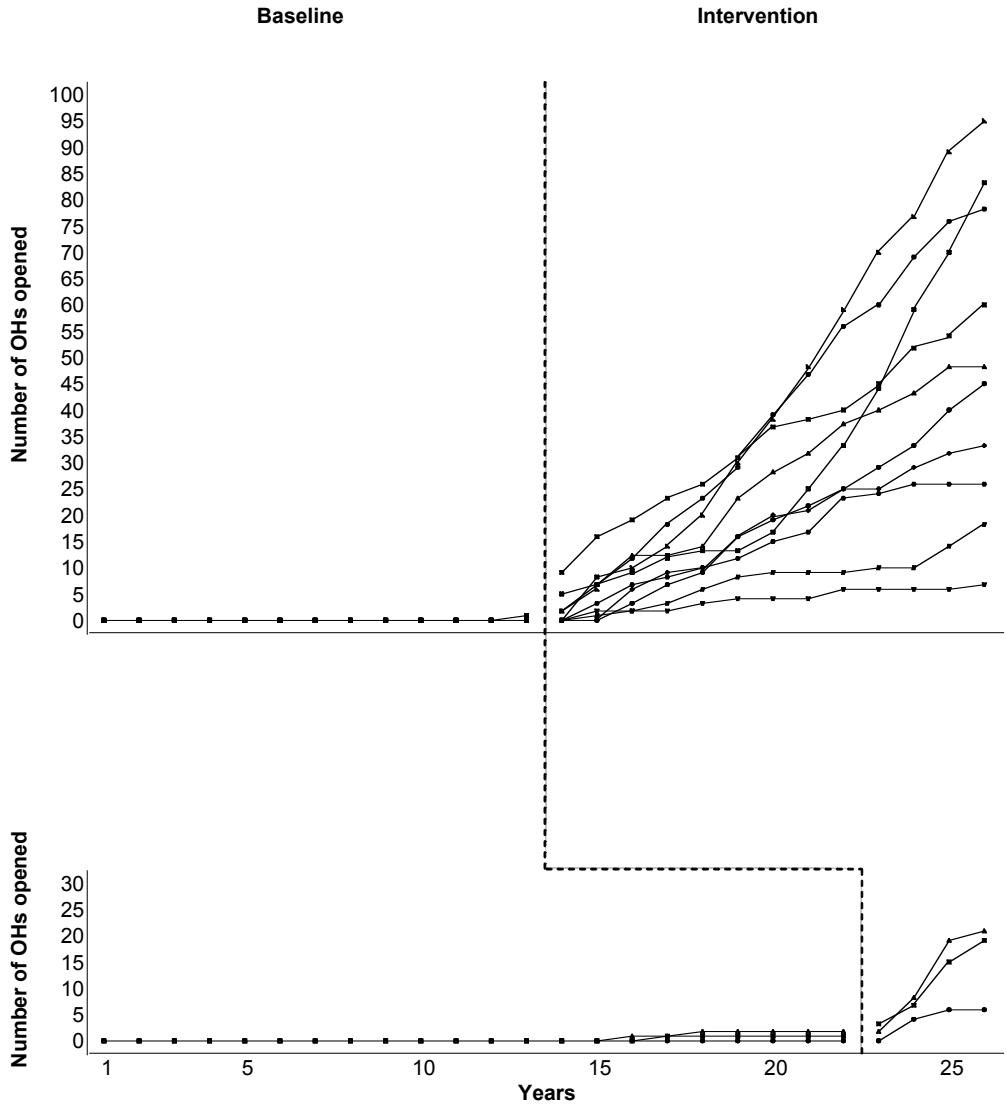

Figure 1. Cumulative Number of New Oxford Houses Opened in Two Groups of States over Time As a Function of Recruiters plus a Loan Fund Intervention.

fines), positive reinforcement, and group rewards. When members initially enter these settings, they are provided a booklet of rules, and considerable time is invested in meetings with OH members to learn the behavioral system. Many new residents find the structure within OH reassuring, as older residents quickly acclimate the new members to the rules.

It is possible that the behavior management system that has been created by OH may offer residents abstinence social support networks and increased self-efficacy. Because the contingencies were developed by the residents themselves, in a democratic fashion, they might be more palatable to the members than rules imposed by an external authority. Members are exposed to a variety of high-risk situations for using drugs, and those who have been members of the House for longer periods of time may act as successful role models for dealing with these high-risk situations. Receiving abstinence support from OH members committed to the goal of long-term abstinence in a setting that has clear rules and policies may enable residents to engage in successful coping responses in these situations, increasing self-efficacy and thereby reducing the probability of relapse. OHs may provide residents with peers who can "teach" effective coping and controlling skills, be resources for information on how to maintain abstinence, and act as advocates for abstinence.

One limitation with the present study is that we did not have data on the effects of these houses on their surrounding communities. If, for example, the expansion of OHs across the U.S. resulted in great tensions within neighborhoods, it might be argued that there were negative second-order effects of increasing the number of these types of recovery homes. A recent study, however, investigated the attitudes of neighborhood residents of OH. Jason et al. (2004) interviewed individuals who lived next to OHs versus adults who lived a block away. Results indicated that those adult neighbors who lived next to an OH versus those persons residing a block away had significantly more positive attitudes toward recovery homes in general and regarding a self-run recovery home on their block. Furthermore, property values for persons living next to recovery homes were not significantly different than the property values of homes a block away. These findings together suggest that well-managed and well-functioning substance abuse recovery homes, such as those created within the OH model, may elicit constructive and positive attitudes by the general adult public toward recovery homes.

Another limitation with the present study is that we do not know how effective the OHs were on decreasing recidivism among the residents. Several studies mentioned in the introduction found positive short-term benefits for OH residents (cf., Ferrari et al., 2002; Jason et al., 2001, for details). It should be noted that currently our research group is investigating long-term outcome effects of OH residence with a NIH supported study, where we recruited 150 people who finished substance abuse treatment at an alcohol and drug abuse facility in Illinois. Half of the participants were assigned to live in an OH, while the other half of the participants received regular after-care services after leaving this facility. Each group of participants was interviewed every six months over a two-year period of time. This study will look at the effects of OHs on recovering alcoholics'

sobriety and their belief that they have the ability (i.e., self-efficacy) to maintain abstinence.

Clearly, as compared to most other treatment modalities, OHs have a relatively low financial cost to society. It seems this cost-effectiveness factor is largely due to the self-run nature of the model, where residents gain employment and pay their own share of rent. Our research group is currently working with an economist to evaluate costs and savings associated with this model, and findings will be released at a later time. The establishment of OHs across the US, from 1988 to 2002, occurred with no apparent "drain" on state budgets or public tax bases. The present study suggests that federal and state resources, in the form of a loan fund and the provision of recruiters, were effective in increasing the number of OHs. Under modern managed care, private and public sector inpatient drug and alcohol facilities have reduced their services dramatically. Thus there is a tremendous need to develop, evaluate and expand lower cost, residential, non-medical, community-based care options (such as OHs) for people in recovery from addictions.

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