

Department of Defense/Oxford House Feasibility Study

Final Report

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EXECUTIVE SUMMARY

Background

The Defense Appropriations Conference Report for FY 2000 directed the Department of Defense (DoD) to conduct a pilot project to improve treatment outcomes for alcoholism and drug addiction, with a specific recommendation that Oxford House, Inc (OHI) recovery homes be evaluated for potential effectiveness and cost efficiency. In FY 2001, funds were appropriated to support this endeavor. The Uniformed Services University of the Health Sciences (USUHS) developed a feasibility study to assess the potential contribution of Oxford House in the rehabilitation of military health care system beneficiaries with substance use disorders.

The study has had three aims: 1) Determine the need for a supportive alcohol/drug abstinent self-help living environment in the successful rehabilitation of military health care beneficiaries diagnosed with a substance use disorder; 2) Establish the outcomes of a group of patients referred to the Oxford House living environment over a one to two year period; and 3) Recommend to the Assistant Secretary of Defense for Health Affairs (ASD(HA)) any role Oxford House or the principles underlying Oxford House may have in the continuum of care for military health care beneficiaries.

Study coordination with Health Affairs, TRICARE Management Activity, the Services Drug and Alcohol Program managers, USUHS, the Henry M. Jackson Foundation for the Advancement of Military Medicine (HMJFAMM), and OHI began in October 2001. OHI focused its efforts in five regions, the National Capital Area, Tidewater, North Carolina, Nebraska/Iowa, and Alaska; and monitored its entire network of Oxford Houses for the presence of any DoD healthcare beneficiary. HMJFAMM provided the project manager and project support, facilitating contact between OHI outreach workers and treatment providers working within the military's drug and alcohol programs within the five designated regions. Monthly progress reports were generated and by the end of September 2003, OHI had identified 105 military healthcare system beneficiaries who had been residents within the OHI network of recovery homes.

Potential need and effectiveness for an Oxford House type recovery home were judged on three aims mentioned above. The study design only required systematic observation in order to better understand through program evaluation using process and outcomes analysis to determine whether there is a logical niche for OHI within a comprehensive recovery program. Allocated funding facilitated OHI to increase its number of rented homes within the five regions of interest while allowing OHI resources to improve its outreach efforts to military healthcare providers. OHI used its standard program evaluation methodology to gather qualitative and descriptive anonymous survey data for its report to the HMJFAMM. This final report presents conclusions of the feasibility study and recommendations to the ASD(HA).

Results

Aim One: Determine the need for a supportive alcohol/drug abstinent self-help living environment in the successful rehabilitation of military health care beneficiaries diagnosed with a substance use disorder.

Within the continuum of care and currently accepted factors used for patient placement, motivation for treatment, harm from continued use, relapse potential, recovery environment, and social support network are all predictors of treatment success. DoD no longer has readily available Level III (halfway house through residential treatment facility) treatment capability for either active duty or other TRICARE healthcare beneficiaries. This treatment capacity was widely available for active duty from the late 1970s through the early 1990s and was carefully linked to one-year aftercare follow-up within the patient's home installation and command. Published studies from that period reflected both high return-to-duty and abstinence rates. Personnel savings alone made these programs highly cost effective. Current treatment replaces Level III with Level II (intensive outpatient and day treatment/partial hospital programs) in which there is great emphasis on the individual patient but little emphasis on the importance of a therapeutic community that is key to a successful Level III program.

A supportive social network and recovery environment can be found in "clean and sober" homes, such as Oxford House. This type of living environment, in conjunction with outpatient treatment, may be a lower cost substitute for Level III care for patients motivated towards abstinence as a treatment goal. In this scenario, a decision to live in such a home is made by the home's current residents. Each resident must abide by house rules to remain a resident. All residents abiding by the rules may remain residents as long as they chose. A healthcare provider has no role in this decision-making process. However, any patient may elect to involve home residents as part of a supportive social network to work with a provider if the provider has this interest.

Interest was highly variable among different healthcare providers. Greatest interest was among those providers who have had the experience of working within traditional military treatment programs that had achieved high abstinence rates with high levels of command involvement that resulted in high return to duty rates (results achieved in programs that existed in the 1980s and early 1990s). Least interest has been shown within those treatment programs which do not focus on abstinence as the desired treatment outcome, do not incorporate therapeutic communities or focus on the importance of a "clean and sober" recovery environment within the continuum of care, and where return to successful active duty was not a primary treatment goal.

At no post or base within the five study regions was there a designated "alcohol-free" living environment within barracks or group living environments. At one location, where there was concern about alcohol's relationship to violence and injury, the option of having an Oxford House-like alcohol-free environment was discussed but went no further. Commanding officers clearly deferred treatment decisions to medical personnel.

A few active duty service members who were found to be living in Oxford House were fearful that their careers would be terminated should either command or healthcare provider discover they had self-identified a drinking problem and had chosen to live in Oxford House for its supportive alcohol and drug free living environment.

Within the context of military healthcare, only patients diagnosed with a substance use disorder might be evaluated for the utility of living in Oxford House, even though not prescribed. There was difficulty integrating into a treatment plan the fact that Oxford House is not a “medical treatment modality”; is open to any person who desires to live in a “clean and sober” environment; and is comprised of residents, complying with rules, residing in an Oxford House for as long as the resident feels necessary.

Each local Oxford House has considerable control over who might be an acceptable resident among those who apply. Generally, the applicant must want to remain abstinent for any non-prescribed psychoactive substance use and cannot be on methadone/opioid maintenance therapy, must be able to pay the rent, and must be seen by others as a person who will participate in the running and maintenance of the house. Oxford House is not an appropriate living environment for those military members who do not have abstinence as a treatment goal, have significant mental health illness where judgment is impaired and may result in potentially dangerous behaviors, and where resident anonymity cannot be preserved (all that might be known is a street address coinciding with a currently rented Oxford House).

In general, the military lifestyle can be accommodated. Difficulties might arise for long deployments where rent payment and house-care responsibilities would arise. These issues are worked out at the local house level at the time the person applies for residency and at the frequently held house meetings. When available, residents may stay temporarily at other houses when traveling. There is no cost to the Military Healthcare System. Oxford House costs the resident approximately \$80/week for rent and utilities. This can generally be covered through BAH for active duty personnel and would be less than a third of the income for anyone earning \$12,500/year or more. In addition, Oxford House’s central office and local outreach workers were willing to help set up an Oxford House on any base or post to make this recovery environment available to any active duty service member not on BAH.

Aim Two: Establish the outcomes of a group of patients referred to the Oxford House living environment.

As of 30 September 2003, approximately 105 residents self-identified themselves as TRICARE beneficiaries providing age, gender, beneficiary status. Most are retirees and have found living in Oxford House to be very helpful. Most would recommend Oxford House for others. Current medical practice may be missing the chance to identify addiction problems, or the importance of recovery environment in achieving successful outcomes. Specific numbers are found within the main body of this report.

These individuals came from throughout the Oxford House network of over 1000 houses. All Oxford House residents are asked to voluntarily fill out a survey that has been used for program management and for reports provided to different states in which Oxford House has a contractual arrangement for services. However, anecdotally, there is fear on the part of some active duty residing within Oxford House that any participation in the survey might jeopardize their careers. From an interim report, there is no evidence that TRICARE beneficiaries have fared any differently than any other residents. Descriptive data may be found in the main body of this report.

This study was specifically designed to be a program evaluation, not human research, thus its study design was exempt from Institutional Review Board (IRB) review. Data collection could not go beyond the normal business practice of Oxford House for program evaluation so TRICARE beneficiary experience was captured as though Oxford House was doing another program evaluation for state funding.

Of the 105 identified residents, all are abstinent. Most are retirees representing junior, mid-career and senior enlisted pay grades. All services are represented. Prior to living in Oxford House, residents came from a diversity of living situations, including from an owned or rented home, an apartment or room, a half-way house or VA hospital, jail, or being homeless. A few state they are on active duty, with at least one expressing high concern about maintaining anonymity lest the Service discover the person might have a substance use disorder. Self-reported health status ranges from “very good” to “not so good”. Many regularly attend Alcoholics Anonymous and/or Narcotics Anonymous.

Oxford House has identified a considerable amount (approximately one third) of its residents as veterans and has had an ongoing relationship with sections of the Veterans Administration (VA) dealing with homeless veterans. Results from that experience are part of the background section reported in detail within the main body of this report. TRICARE beneficiaries using Oxford House are mostly retirees, many who have been homeless, in jail, or also using VA healthcare services. Current medical practice may be missing the chance to identify addiction problems, or the importance of recovery environment in achieving successful outcomes.

There are two research studies being conducted by DePaul University on Oxford House funded by the National Institute of Alcoholism and Alcohol Abuse (NIAAA) as well as by the National Institute of Drug Abuse (NIDA). These protocols have undergone IRB review and are collecting valuable data on the outcomes related to living in an Oxford House.

Aim Three: Recommend to the Assistant Secretary of Defense for Health Affairs any role Oxford House or the principles underlying Oxford House may have in the continuum of care for military health care beneficiaries, specifically addressing active duty personnel, retirees and their families.

RECOMMENDATIONS TO THE ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

Recommit senior leadership to an effective treatment program and once again, set the national standard for treatment. DoD has lost its focus and urgency in effectively treating those with SUDs. Working with community support networks and healthy recovery environments will be critical in this effort.

DoD Health Affairs should have a full time senior officer as a dedicated program manager for substance abuse intervention programs that includes alcohol, illicit drugs and nicotine. DoD's drug and alcohol programs had traditionally been a commander's program; focusing on health improvement and protection, solidifying a continuum of care, and bridging the gap between living environment, command and worksite health, community-based health promotion, primary care and specialty care. It is within this context that highly cost-effective and successful traditional drug and alcohol treatment programs operated.

Improve identification of DoD personnel with potential Substance Use Disorders and provide effective treatment. Treatment programs have been proven to be both highly effective and cost efficient, saving up to \$19 dollars for every dollar spent, with local savings in the millions of dollars per year with the effective treatment that highlights both an abstinent healthy lifestyle and continued employment. There is no evidence that DoD has programs clearly compliant with US Code, Code of Federal Regulations, or its own current DoD Directives, Instructions and Policy as they relate to a robust ability to identify patients with substance use disorders and effectively treat those patients within a continuum of care that includes true Level III residential treatment with a supportive recovery environment.

For Oxford House to be considered as a viable option, it will require an endorsement at the senior level. The TRICARE Management Activity currently does not see the incorporation of Oxford House into the continuum of care as a health care issue; it is not a recognized benefit. By definition, a "clean and sober living environment" is not a "treatment" modality in the traditional sense, since no treatment provider prescribes placement into this type of community living environment. For Oxford House to logically fit into a continuum of care, there will need to be emphasis on the importance of use a "therapeutic community", social network and living environment in recovery.

Should there be further interest and resources in continuing a pilot program it would be better to plan around the military bases with treatment programs that are interested in working with Oxford House. This pilot program and other similar programs are aimed at moving a large system to think differently about recovery immediately following treatment. There is no cost to the Military Healthcare System to endorse and support any command desire to establish a drug and alcohol-free living environment.

Discussion related to recommendations:

From the 1971 Presidential Directive to DoD establishing the mandate for effective drug and alcohol treatment within DoD, until the establishment of TMA, DoD lead the nation in establishing highly successful cost effective treatment programs. Throughout this period, these programs had the personal interest of a Deputy Assistant Secretary of Defense for Health Affairs who also had a senior program director within Health Affairs who had specific responsibility for developing program policy and providing program oversight. This senior position no longer exists.

Programs succeeded because of the tight integration between commanders, treatment personnel and community prevention programs that targeted healthier lifestyles. There might be some senior leaders today who will see the benefit of how low-cost (no cost to the Government) structured living fits into an aftercare plan for a healthier drug and alcohol-free lifestyle. Good aftercare poses promise for decreasing the likelihood of relapse, improving the potential for successful military service, adding to the wellness of our members, and saving invested training dollars. The drug and alcohol treatment program had been possibly a unique DoD example of “people first” approach to treatment where full remission and return to full duty were the expected outcomes. This program had served as a national model and set practice guidelines for a range of services, to include deterrence drug testing, employee assistance programs and treatment, where a patient was followed for one year worldwide throughout the continuum of care. The approach was incorporated into the Military Health System (MHS) Enterprise Model supporting both readiness and treatment. This pilot program and other similar programs are aimed at moving a large system to think differently about recovery immediately following treatment. Returning to the barracks may work for some, but there are others who need and want the friendship and support found in a sober living environment. In this pilot program evaluation of Oxford House and DoD, sites were picked where Oxford Houses were already established or where Oxford House Inc., desired to establish a presence through the renting of new houses. This resulted in too many mismatched houses to base treatment programs. Additionally, if only one, two or three sites volunteer, pursue those who want to be players. These kinds of situations can be managed with closer interaction between the key players.

Senior leadership endorsement of structured living, such as Oxford House provides, for those who want it, help in getting the program recognized. For those motivated to abstinence, but with high relapse potential or living in a poor recovery environment, Oxford House is a low cost intervention that requires only the resident be able to pay rent and utilities while there is no medical cost nor need for medical documentation. In the absence of Level III treatment programs, Oxford House provides the only possible alternative to this level of care, operating at the community level outside of medical channels. Another platform for championing pursuit of a healthier living environment is the Wellness Programs that work collectively between line and medical. Senior line commanders for personnel in each of the services might wish to view temporary housing as a value-added option for all personnel who want to live in a responsible drug and alcohol-free housing environment. Without senior level endorsement or directive, utilization of Oxford House services will diminish as this pilot comes to an end.

FEASIBILITY STUDY BACKGROUND AND DEVELOPMENT

The Defense Appropriations Conference Report for FY 2000 directed the Department of Defense (DoD) to conduct a pilot project to improve treatment outcomes for alcoholism and drug addiction, with a specific recommendation that Oxford House, Inc. recovery homes be evaluated for potential effectiveness and cost efficiency. In FY 2001, funds were appropriated to support this endeavor.

Funding initially flowed from the Assistant Secretary of Defense, Health Affairs to TRICARE Management Activity, and was transferred to the Uniformed Services University of the Health Sciences (USUHS) for the purposes of this study. USUHS contracted with the Henry M. Jackson Foundation for the Advancement of Military Medicine (HMJFAMM) to work with Oxford House, International (OHI) to facilitate work that would be required to generate a final report on the feasibility study requested by Congress.

Kenneth Hoffman, M.D., M.P.H, through his faculty position at USUHS, was asked to serve as the Principal Investigator of this study. Through his assigned position as the Medical Director of the Military and Veterans Coordinating Board, he gathered background information concerning the Oxford House experience with the VA and coordinated with Roger Hartman at TRICARE Management Activity to meet with service drug and alcohol program managers to develop a study design that might be acceptable to all services and provide valuable information. Carolyn Barrett-Ballinger, through the HMJFAMM, was selected to the Project Manager based upon her expertise in the addiction treatment area and extensive knowledge and work within the military's treatment program at a headquarters level.

Scope and Objectives

Representatives from all branches of the Armed Services were briefed on the goals and objectives of the pilot project. Criteria for judging effectiveness of the project included but was not limited to:

- the understanding and willingness for health care providers to refer patients to a recovery house, specifically, Oxford House, where there is no onsite, credentialed treatment providers. Oxford House is not considered a treatment modality. Its residents strongly support compliance with treatment plans and use of self-help groups;
- the understanding and willingness for military commanders to support active duty personnel who volunteered for structured sober living such as Oxford House, or allow the concept of a living situation conducive to recovery to operate outside of a military environment;
- can the lifestyle of military health care beneficiaries be accommodated within an Oxford House living environment?

- does living in an Oxford House increase the likelihood of a clean and sober lifestyle among the voluntary group?

With feedback from the services' drug and alcohol representatives, the study design was written and submitted for IRB review. The Uniformed Services University of the Health Sciences (USUHS), in coordination with the Henry M. Jackson Foundation for the Advancement of Military Medicine (HJF), assumed responsibility for execution and oversight of the project. The HJF subcontracted with OH to provide the resources needed to accomplish the feasibility study. The HJF also provided the Program Manager, Carolyn Barrett-Ballinger, who had recently retired from serving as Program Manager for the Navy's drug and alcohol program.

Study Design and Methods - Summary

- There were two key target populations of interest: 1) installation and medical treatment facility healthcare providers who were involved in the treatment of patients with substance use disorders; and 2) any beneficiary of the Military Health Care System, with substance use disorders, with special attention to five regions, the National Capital Area, Virginia Tidewater Area, Nebraska/Iowa, North Carolina and Alaska. Inclusion/exclusion criteria were restricted to those beneficiaries who desired to lead a drug-free and healthy lifestyle. The pilot was aimed at understanding attitudes and referral potential of healthcare providers to refer patients with substance use disorders for Oxford House consideration and the experience of 120 military personnel, dependents or retired military and their dependents covered by TRICARE.
- Study design included three phases:
 - Methodology design, data collection tools, evaluation plan, orientation and training of persons involved with the pilot project;
 - Establish and maintain close contact with the Oxford House pilot sites as various evaluation activities were being carried out;
 - Data collection closeout, analysis, and report preparation.
- Data collection has been through careful observation with descriptive notes and through the administration of a survey OHI uses for program evaluation.
 - Results of that work follow in the next section. Survey results are reported in raw numbers based upon a denominator of 99 people who answered the survey, essentially representing a case series of beneficiaries who chose to live in Oxford House and answer the survey.

RESULTS

Goal: *Evaluate the potential effectiveness and cost efficiency of Oxford House recovery homes in the treatment of alcoholism and drug addiction in military health care system beneficiaries, and DOD civilian employees when appropriate.*

Conceptually, use of clean and sober recovery environments as part of a comprehensive approach to addiction treatment should be highly cost effective to a health care system. A study of two aims is used to achieve this conclusion and answer these questions. 1) Is the concept of Oxford House acceptable to military health care treatment providers who work with addicted patients? 2) Can the lifestyle of military health care beneficiaries be accommodated within an Oxford House living environment? 3) Does living in Oxford Houses result in a productive, “clean and sober” lifestyle among a group of approximately 120 military healthcare system beneficiaries?

Conclusions:

There are some significant barriers to incorporating a “clean and sober” living environment for use by military health care beneficiaries. Although highly successful and cost effective treatment has been available through the traditional military approach to alcohol dependence intervention, stigma appears to limit the numbers of individuals identified with a problem and limit application of multidimensional patient placement criteria that would include appropriate use of an alcohol-free living environment and social support network.

Military service members can function effectively within the military if they chose to live in an alcohol-free living environment. Within the scope of this study, no active duty service member living on a post or base in quarters designated for single enlisted personnel, to include medical holding companies, has an option to select quarters where alcohol use is prohibited. Oxford House provides such a living opportunity and has a strong social support network. Many Oxford House residents have prior military experience.

All residents have the required income needed to live in Oxford House. There is no cost to the Military Healthcare System. Oxford House costs the resident approximately \$80/week for rent and utilities. This can generally be covered through BAH for active duty personnel and would be less than a third of the income for anyone earning \$12,500/year or more. In addition, Oxford House’s central office and local outreach workers were willing to help set up an Oxford House on any base or post to make this recovery environment available to any active duty service member not on BAH.

***Aim One:** Determine the need for a supportive alcohol/drug abstinent self-help living environment in the successful rehabilitation of military health care beneficiaries diagnosed with a substance use disorder.*

Within the continuum of care and currently accepted factors used for patient placement, motivation for treatment, harm from continued use, relapse potential, recovery environment, and social support network are all predictors of treatment success. DoD no longer has readily available Level III (halfway house through residential treatment facility) treatment capability for either active duty or other TRICARE healthcare beneficiaries. This treatment capacity was widely available for active duty from the late 1970s through the early 1990s and was carefully linked to one-year aftercare follow-up within the patient's home installation and command. Published studies from that period reflected both high return-to-duty and abstinence rates. Personnel savings alone made these programs highly cost effective. Current treatment replaces Level III with Level II (intensive outpatient and day treatment/partial hospital programs) in which there is great emphasis on the individual patient but little emphasis on the importance of a therapeutic community that is key to a successful Level III program.

Within DoD's current approach to the treatment of substance use disorders (SUDs) and apparent desire to discharge those with SUDs from active duty, there may be little expectation for a successful treatment outcome. DoD's approach to SUDs no longer appears to place systematic emphasis on long-term successful drug and alcohol-free outcomes. Level III (residential) treatment capability no longer exists within DoD facilities within the United States; thus the importance of a therapeutic community is no longer appreciated to be a factor in a successful drug-free recovery program.

a. DoD credentialed providers who treat SUDs appear unwilling to refer patients to a recovery house as part of an overall treatment approach, although there are some notable exceptions (where providers are highly focused on successful outcomes and understand the successes of older DoD treatment programs). Oxford House provides a clean and sober recovery environment where all residents must remain abstinent in order to live in the house. Oxford Houses are located in "good neighborhoods" (e.g. relatively drug-free communities). Healthcare providers treating SUDs work within the environment of their specific medical facility and tend not to track patients into their home environment. Thus, it is difficult to understand the role of a "healthy community" (the importance of "recovery environment") as a factor in patient placement for treatment, mitigating the intensity of treatment, or probability for successful treatment.

b. Currently, treatment of SUDs is firmly seen as a medical responsibility, with little command involvement. Treatment has been cleanly separated from primary and secondary prevention programs that are of command and personnel interest. Oxford House appears to be a medical treatment issue from a personnel perspective. Thus, while command may clearly see the role of a 12-step program (such as Alcoholics Anonymous) for someone having a drug or alcohol problem, a drug free living environment like Oxford House (which is seen to be a "treatment issue") falls through the cracks.

c. Within the context of this project, Oxford House developed links with interested health care providers and established contact with any patient referred. The houses themselves operate relatively autonomously although houses within each region tend to group themselves together to operate as a chapter. At the chapter or state level, Oxford House has a network of outreach coordinators, some of whom became involved with the DoD project. Within this informal network, and frequently outside of the specific target sites of this project, outreach coordinators would identify residents who had DoD connections. Thus, there appear to be Oxford House residents who perform their DoD duties and live within an Oxford House without knowledge of their treatment providers or command.

i. Oxford House initially had difficulty matching infrastructure support with early site interest but did develop a placement capability for target intervention sites. This would have required an inventory of houses with unfilled occupancy. Since all Oxford Houses are rented, their survival depends on having relatively full occupancy where each resident pays an equal share of rent and utilities.

ii. The Oxford House central office appeared willing to work with local houses to assure DoD occupants would be fully able to meet military mission requirements. For residents who might travel on temporary duty, Oxford House tends to have an informal network so that occupants from one house might stay at another for brief periods when traveling.

Aim 1 specific findings and observations:

Consistent and intensive efforts were made to introduce key individuals within Oxford House and both the DoD treatment and personnel communities to one another at central and local levels. Project personnel also attended and presented at the Oxford House, Inc. conventions in Washington, DC and Seattle, WA. Monthly reports documented problems, solutions and progress made. A descriptive summary follows.

Pilot Project Working Group.

In December 2001, Service Treatment Program Directors were invited to a meeting to discuss the pilot program and to gain their support. All of the Services were represented. The Principal Investigator, Kenneth Hoffman, MD, MPH, Colonel, US Army gave an overview on the background of the project and how Oxford House can conceivably be of value in the support of the continuum of care.

Oxford House is intended for those who are serious about avoiding relapse. Residents volunteer to live in an Oxford House for an undefined period of time. The cost of living in a house is the responsibility of the individual. Typically the cost of living in an Oxford House correlates to a person renting a room. Active duty members can apply for BAH to off set the expense. Social Services/Family Service Centers have provided short-term assistance to family members seeking financial assistance in order to live in an Oxford House. The requirements of Oxford House are simplistic: remain abstinent, attend weekly house meetings and get involved in the in the day-to-day running of the house.

The Working Group discussed the treatment guidelines issued to the Service Surgeons General in 1997 by the Office of the Assistant Secretary of Defense (Health Affairs) that define the basic structure for military treatment programs. The guidelines support the patient placement criteria, levels of care, and specific domains developed by the American Society of Addiction Medicine (ASAM). One of many benefits derived from utilizing ASAM's guidelines for patient placement was the shift from a fixed length of stay to an individualized treatment plan based on the needs of the individual patient. Treatment was no longer based solely on a diagnosis of dependency or abuse. Matching patients to the appropriate level of care and implementing individualized treatment plans fostered the use of less confining and costly levels of service within the continuum of care. Military treatment programs are now in line with nationally recognized standards for delivery of effective and cost efficient treatment.

However, there is no consistent access to or use of structured living environments by DoD that assist in supporting relapse-free recovery. This is one area in which military treatment programs falls short of ASAM guidelines. Persons early in recovery (particularly active duty members) are returned to the same environment that may have contributed to their use of alcohol or drugs. Having options such as Oxford House supports the transition from treatment into recovery. The Working Group agreed that treatment services are wearing away and would likely continue to do so until DoD/TMA took a proactive interest and issued additional guidelines such as they did in 1997.

At the conclusion of the meeting, two of the services showed marginal interest in the project. The other two Services were eager to contact their respective treatment programs so that pilot sites could be identified and contact could take place.

Source Information

Without exception the most reliable source of data collection from the sites was word-of-mouth. At a minimum, monthly contact was made with the Clinical Director of a treatment program and the corresponding Outreach Coordinator for Oxford House at one of the five selected pilot sites. If a site showed interest, calls were made to arrange interviews, Coordinators were briefed on military base protocol, dates, time and security arrangements were established ahead of time so the introduction between the Clinical Director and the Outreach Coordinator would be unencumbered.

If a site initially showed no interest in participating, the Clinical Director was invited to contact either the local Outreach Coordinator or the HJF Oxford House Program Manager for further information. If sites had a change in their level of interest or were considering participating in the study, immediate contact was made. For example, Offutt Air Force Base (a Strategic Command treating Army, Navy, Air Force, family and retirees) was not interested in participating in the pilot project, however a staff clinician requested information about Oxford Housed and how they operated. An information package was prepared and the name and telephone number of the local Outreach Coordinator was provided. E-mail follow up was made one month later with the clinician. Although the command did not decide to participate in the pilot project, the inquiring clinician is now

more knowledgeable about Oxford House and is willing to provide information to her patient population about Oxford Houses when appropriate.

Although the information exchanged between clinicians and Oxford House Outreach Coordinators was accurate and useful at the local level, it was not documented in a manner that facilitated the development and maintenance of a standardized data collection system. Data collection was problematic throughout the duration of the pilot project precluding a global view of how the Oxford Houses involved in the pilot project were operating throughout the country.

- ❑ The project required the coming together of three very diverse groups (Oxford House, military medicine, and military operational leadership). All of the groups were briefed about the goals and objectives of the pilot project and question and answer sessions were conducted throughout the project. However, each of these groups acted with discomfort in exploring new territory that this project offered.
- ❑ Outreach Coordinators received tutoring about the bases that they visited. The Coordinator and the Clinical Director established meeting dates and times, however it was not unusual for the Coordinator (even with proper identification) to be denied access by base security personnel, mainly due to heightened post September 11th, 2001 security measures.
- ❑ Within Oxford House, the cost for outreach workers were part of the charge for setting up Oxford Houses as part of the contract OHI had with HJF. Outreach workers themselves are a valuable resource for Oxford House and represent a significant (albeit minor) infrastructure cost. The DoD project would not have been able to proceed without Oxford House designating these people, paying them to travel and explore the neighborhood that would be good environments for Oxford Houses and convenient for potential residents. Although each new house from the revolving loan can be set up with only a months deposit and first month rent, the “per house” set-up costs in excess were clearly attributable to the valuable work and time spent by these outreach workers. Outreach workers would also be expected to be helpful in the set-up of regional house chapters within which there is a higher level of quality control and adherence to Oxford House traditions.
- ❑ Oxford House, Inc now has a tracking and vacancy system in place. Such a system is critical in knowing at any given time where vacancies exist. The tracking system will also provide information as to why an individual may have left an Oxford House, i.e. the individual progressed to a point where an Oxford House environment was no longer needed, or the individual relapsed and was asked to vacate. Although a vacancy system now exists, some of the houses connected to the pilot project did not have functioning computers and Coordinators were often not well trained on computer use. This would have to be rectified in order for the vacancy system to be viable. For these reasons, most communications during the pilot project were done by telephone.

- ❑ As mentioned earlier, there are striking variations within the various military treatment programs. When a treatment program is fortunate to have a vocal and passionate leader, one who is knowledgeable in treating addictions and recovery, the program will command the lion's share of attention and resources. When leaders move on to other duty stations, the tempo is adjusted to match the new leadership style. Continuity in the delivery of care is nonexistent and the theme repeated by staffs during site visits was one of deep concern over the erosion of services.
- ❑ Military leaders tend to believe if there is a need for a service they will design and build it. The notion of utilizing an outside community resource such as Oxford House to help decrease the possibility for relapse and improve the potential for successful military service is a challenge that most of the services are not willing to face. With the exception of the Navy's program in the Tidewater Area, the temperament of the other services is status quo.

Information concerning each of the project sites is listed below. The sites are listed in random order.

- ❑ North Carolina. Fort Bragg, a large Army base, was interested in having Oxford Houses located on the base rather than off the base, as is the common arrangement. The Clinical Director expressed desire to travel to Washington, DC to discuss potential establishment of an on base Oxford House, however the negative attention involving Special Forces personnel closed the base to all but essential personnel and precluded further activity with Oxford House. Seymour Johnson Air Force Base was not interested in the pilot program. Patients not completing treatment or completing treatment with a questionable prognosis are generally separated from the Air Force.
- ❑ Nebraska/Iowa. Offutt Air Force Base is an ideal site as it is a joint military service base. However, the hospital Medical Director did not see a need for such services as Oxford Houses provides. Active duty personnel are generally separated from the military; family members and retirees tend to find support services on their own. The treatment program did not keep records on relapse rates since they treat a predominantly transient population.
- ❑ Alaska. Elmendorf Air Force Base and Fort Richardson Army Base share medical services in the Anchorage area. Until the start of the pilot program Oxford House did not exist in Alaska. Upon inception of the pilot program, Oxford House, Inc. hired an Outreach Coordinator for Alaska who was able to establish a house and integrate into the local community. Introductory calls were made to the Clinical Directors at Elmendorf and Fort Richardson and meetings were arranged. In summary, the Army only referred those members awaiting discharge to Oxford Houses. Unfortunately, those Soldiers relapsed before they were able to take residence in an Oxford House and were subsequently discharged. Elmendorf followed the same direction as other Air Force installations in that the Clinical Director saw little need for a living environment such as the Oxford House provides since personnel failing treatment are discharged. Currently, there are four Oxford

Houses in Alaska and more are being opened: eligible military healthcare beneficiaries occupy none. An important discovery was that there is a critical mass of Oxford Houses needed within a local area so that uniformity and consistency with the traditions of Oxford House are maintained. Three houses within a region tend to form chapters, and it is at the chapter level that the seasoned and committed residents volunteer their services to assure houses are complying with Oxford House traditions.

- Tidewater Area. Air Force, Army, Navy and Marine Corps personnel work and live in the Tidewater area. It also is home to a large retirement population. The Navy's largest base is located in the Norfolk area. The Head of the Addiction Rehabilitation Department, Naval Hospital, Portsmouth, and the staff were interested in being part of the study when the pilot was first announced. This is the same addiction treatment staff that first piloted the Patient Placement Criteria developed by the American Society of Addiction Medicine (ASAM). The treatment staff recognized that having a clean structured living environment was a critical step in the direction of recovery without relapse. The treatment teams and the Oxford House Outreach Coordinator worked together to plan a schedule that included having the Coordinator meet with patients and staff for one hour every other week.

Gaining interest in Oxford House living was slow at the beginning. When an active duty member showed interest in Oxford House, the Outreach Coordinator met with the counselor to begin the process of finding a vacancy for the patient upon completion of treatment. Since residency in an Oxford House constitutes a departure from normal off base living arrangements, commands were requested to indicate their level of support for such an arrangement. However, feedback was poor and often neither the patient nor Outreach Coordinator were aware of whether or not the command approved of the Oxford House living arrangement.

At the time of the pilot project all of the male Oxford Houses were full. Some of the male patients placed their name on a waiting list but returned to their usual living environment while awaiting an opening. In September 2003, Oxford House Chesapeake opened for men; however there are no active duty members in the house at this time. Active duty women desiring placement in Oxford Houses were slated openings as they became available. However, some of the houses are not located in close proximity to the Naval Base, which presented transportation problems. On a positive note, active duty women who were in treatment and seeking placement in an Oxford House experienced little difficulty in obtaining short-term financial support (rent money) from Navy Relief until more permanent financial arrangements could be made.

- The National Capital Area. The Washington, DC area is unique in the delivery of healthcare services. The three major military medical facilities in the area have established numerous satellite clinics to better serve the patient population. Visits to the three hospitals and conversations with their respective staffs reveal there is little continuity in the delivery of care for persons with substance disorders. The one

similarity is that the substance disorders programs fall under the rubric of Psychiatry at each hospital. Hospital “A” seems to attract patients requiring complex care including the use of psychotropic drugs and prolonged therapy. Some of the nursing staff has made referrals to Oxford House for those patients waiting discharge from the military. Hospital “B” sees patients who are typically in need of less intensive care. For them a predetermined number of AA or other self-help meetings and regular visits with the command’s representative for substance abuse matters constitute a treatment plan. Hospital “C” has incorporated a behavioral healthcare model that is preferable for the volume of patients seen with both mental illness and substance addiction. Patients can enter the hospital through either portal and receive necessary care.

Currently some providers refer patients to Oxford House. Recently Oxford House, Inc. opened a house for men in the Fort Belvoir area. Contact has been made with the Clinical Director at Fort Belvoir and the Outreach Coordinator and the staff are working to arrange a schedule for the Coordinator to meet on a regular basis with patients and staff. Another Oxford House in proximity to Fort Belvoir is open and full, however there are no military residents at this time.

None of the hospitals in the National Capital Area has incorporated structured living into their treatment planning. While the inconsistencies in the delivery of care is not something that can be easily remedied, Oxford Houses have existed in the DC area for many years and could be of benefit to those members desiring to shore up their recovery.

Aim 1 Conclusions:

Within the context of military healthcare, only patients diagnosed with a substance use disorder might be evaluated for the utility of living in Oxford House, even though not prescribed. There was difficulty integrating into a treatment plan the fact that Oxford House is not a “medical treatment modality”, is open to any person who desires to live in a “clean and sober” environment, and its residents, complying with rules, are able to live in Oxford House for as long as deemed necessary.

In general, the military lifestyle can be accommodated. Difficulties might arise for long deployments where rent payment and house-care responsibilities would arise. These issues are worked out at the local house level at the time the person applies to the house members to be a resident and at the frequently held house meetings. When available, residents may stay temporarily at other houses when traveling.

***Aim Two:** Establish the outcomes of a group of patients referred to the Oxford House living environment*

The pilot project hoped to establish the outcomes of 120 patients referred to the Oxford House living environment over a one to two year period with specific attention to a) active duty military personnel, b) retired military personnel, c) family members of military personnel that may include spouses and minors eligible to enter Oxford Houses, and d) other populations closely affiliated with DoD and of command interest. This project fell short of the goal of establishing the outcomes from using Oxford House structured living environments for these different populations. Nonetheless, there is valuable information to be gleaned from the 105 DoD-related residents identified and from findings of an ongoing study conducted by DePaul University on the effectiveness of Oxford Houses in recovery. Survey findings from Oxford House indicate these residents are benefiting from living in a clean and sober recovery environment, and that this environment helps prevent relapse.

All Oxford House residents are asked to voluntarily fill out a survey that has been used for program management and in reports provided to different states in which Oxford House has a contractual arrangement for services. Although the pilot project was generally not able to link Oxford House structured living environments into an integrated treatment plan, valuable information was gleaned from this project that can serve to improve the continuum of addiction services across the military services.

- Data collection has been a problem. Oxford House has surveys to assess the impact living in an Oxford House has on its residents. According to verbal information active duty personnel are living in Oxford Houses; however, some are unwilling to complete a self-assessment survey for reasons of anonymity.
- The target population of 120 eligible military/beneficiary Oxford Houses residents could not be met; however, 105 were identified. Collection of data on these individuals should have begun as soon as the individuals were identified. Early collection of data, even on a smaller pool of people may have allowed for some long term program evaluation. Waiting for the target population to be met before commencing data collection slowed the project's momentum.
- Resident anonymity is crucial, and houses appear to work informally together to assure any resident committed to sobriety can move freely between houses. Informally, houses can provide temporary quarters for people traveling and most outreach workers appear eager to work with anyone interested in Oxford House.

Aim 2 specific findings and observations:

As of 30 September 2003, a total of 105 Oxford House residents self-identified themselves as TRICARE beneficiaries and analysis includes 99 who voluntarily filled out the standard survey Oxford House uses for program evaluation. Beneficiaries were found in many states. In Virginia Oxford Houses (covering two study areas, the NCA and

Tidewater), there were 23 beneficiary residents. In North Carolina Oxford Houses (covering Army, Navy, Marine and Air Force bases) there were 22 residents. However, in the Nebraska/Iowa area, there were only three residents, and in Alaska, only one resident. In other states, the following number of residents were found; Washington, 14; Illinois, 9; Missouri, 8; Louisiana, 6; Oregon, 6; Pennsylvania 2; Mississippi, 1; and Pennsylvania, 1. Only 6 residents stated they were currently on active duty, 75 were retired military and 18 were family members. (Among many house residents, there was high concern about potential career impact that may have hindered other active duty from volunteering to answer a survey.) All Services are represented; 53 Army, 18 Navy, 15 Air Force, 10 Marines and 2 Coast Guard. Among active duty and retirees, most all were enlisted; 38 E1-E4, 28 E5-E6, and 10 E7-E8 with only one officer.

Among the identified 84 men and 15 women, TRICARE beneficiary residents come from a broad background. Age groups include 10 less than 35 years old; 38 between 35 to 44 years old, 37 between 45 to 54 years old, and 14 older than 54 years old. Most all were either black (45) or white (44) with others including Hispanic, Asian and Native American. Marital status reflects expected problems associated with substance use disorders; 43 divorced and 15 separated; 24 never married or single; and only 11 currently married. Monthly income is relatively low; 19 earning <\$1000/mo, 33 earning \$1000-\$1499/mo, 14 earning \$1500-\$1999/mo, and 17 earning \$2000/mo or more (16 missing). This is not correlated with education; 5 with less than high school, 39 with high school, 43 with some college, 5 with four years college, and 3 postgraduates. Prior to entering Oxford House, 21 owned or rented a house, 22 lived in an apartment, 7 rented a room, 6 came from a halfway house, 6 came from a VA hospital, 8 were homeless and 3 came from jail. Almost half (48) had been homeless at least once and even more (69) had been in jail.

For all difficulties experienced, self-reported current health status was remarkably good; 32 stating “very good” and 51 stating “pretty good”. Living in Oxford House requires sobriety; 12 had one prior attempt, 21 had attempted twice, 38 had 3 to 5 prior attempts and 23 had attempted more than 5 times. Detoxification was frequently the only offered treatment; offered once to 17, twice to 14, three times to 16, and four or more times to 10. Independently of detoxification, 39 had been in one residential treatment program, 17 had been through residential treatment twice, 16 had been through residential treatment three times, and 14 had been through four to seven times.

Most residents appear to have found their way into Oxford House independently of any systematic medical referral process. Many attend 12 step programs, 61 regularly attending Alcoholics Anonymous and 42 regularly attending Narcotics Anonymous. Of those attending AA or NA, 37 are also receiving some type of regular counseling or therapy. Current medical practice may be missing the chance to identify addiction problems, or the importance of recovery environment in achieving successful outcomes.

Among this group, 69 regard Oxford House as very important in their recovery with another 9 stating that Oxford House is moderately or somewhat important. Most (78)

would recommend Oxford House to others. These individuals came from throughout the Oxford House network of over 1000 houses.

Aim 2 Conclusions:

As of 30 September 2003, approximately 105 residents self-identified themselves as TRICARE beneficiaries providing age, gender, beneficiary status. Most are retirees and have found living in Oxford House to be very helpful. Most would recommend Oxford House for others. From an interim report, there is no evidence that TRICARE beneficiaries have done any differently than anyone else. Current medical practice may be missing the chance to identify addiction problems, or the importance of recovery environment in achieving successful outcomes. Specific numbers are found within the main body of this report.

Anecdotally, there is fear some active duty residing within Oxford House that any participation in the survey might jeopardize their careers. There is the perception of career harm in the minds of some Oxford House residents should either the military healthcare provider or command discover that an individual has a treatable alcohol or other drug use problem, or has elected to live in a “clean and sober” living environment such as Oxford House. This perception limited participation of some, and may be real, as evidenced by the relatively number of young and junior enlisted retirees who may have been medically retired rather than treated for an undiagnosed substance use disorder and retained.

APPENDIX ONE: THE UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES (USUHS) STUDY PROTOCOL

Specific Aims and Objectives:

Dr. Hoffman developed a protocol entitled a “Feasibility Study to Assess the Potential Contribution of Oxford House in the Rehabilitation of Military Health Care System Beneficiaries with Substance Use Disorders” that had three key specific aims with objectives.

1. Determine the need for a supportive alcohol/drug abstinent self-help living environment in the successful rehabilitation of military health care beneficiaries diagnosed with a substance use disorder. This will require:
 - a. Understanding the willingness for health care providers to refer patients to a recovery house, specifically, Oxford House, in which there is no onsite credentialed treatment providers;
 - b. Understanding the willingness for military commanders to refer active duty personnel to Oxford House, or allow the concept of a living situation conducive to recovery to operate within a military environment;
 - c. Determine the capability of Oxford House to work with potential residents who must also adjust to a military lifestyle. This will require:
 - i. Placement capability for personnel identified by their treatment team as potential candidates for residency in Oxford House
 - ii. Adapting to military mission requirements that may result in extended stays away from the assigned Oxford House, or a permanent change of station while residency in an Oxford House-like recovery environment is still within the individual's best interest.
2. Establish the outcomes of a group of patients referred to the Oxford House living environment over a one to two year period with specific attention to:
 - a. Active duty military personnel
 - b. Retired military personnel
 - c. Family members of military personnel that may include spouses and minors eligible to enter Oxford Houses
 - d. Other populations closely affiliated with DoD and of Command interest
3. Recommend to the Assistant Secretary of Defense for Health Affairs any role Oxford House or the principles underlying Oxford House may have in the continuum of care for military health care beneficiaries, specifically addressing active duty personnel, retirees and their families.

The full protocol was reviewed by the USUHS Institutional Review Board and found to be exempt since it was a study focused on program evaluation. USUHS contracted with the Henry M. Jackson Foundation for the Advancement of Military Medicine (HMJFAMM) to conduct this evaluation with Oxford House. HJF then subcontracted

with Oxford House to fulfill the aims and objectives of the protocol while also allowing Oxford House to operate as might be required to establish a productive relationship with DoD and DoD healthcare beneficiaries.

Methodology:

Concurrent and following proposal development, USUHS IRB review and contract agreements between USUHS, HJF and Oxford House International (OHI), TRICARE and service drug and alcohol program managers and consultants met to discuss the project and review the proposal as an advisory pilot project working group.

At that time, OHI already had a program evaluation tool it was using for various reports to different states to document program impact. This program evaluation tool was to be the core of any assessment for the experience of DoD-related residents with the expectation that OHI would generate a report to DoD similar to the ones already created for the states. Also, of note was the fact that DePaul University had two research grants from the National Institute of Alcoholism and Alcohol Abuse (NIAAA) and the National Institute of Drug Abuse (NIDA) to study Oxford House. The USUHS study was not to interfere with the normal program evaluation process already in place at OHI or with the studies being done by DePaul.

Target Populations:

Military healthcare system beneficiaries with substance use disorders living in the National Capital Area, Virginia Tidewater Area, Nebraska/Iowa, North Carolina or Alaska who desire to lead a drug-free and healthy life.

Aim 1:

Determine the need for a supportive alcohol/drug abstinent self-help living environment in the successful rehabilitation of military health care beneficiaries diagnosed with a substance use disorder. This will be accomplished in four steps: the first three steps will be conducted through interview with a qualitative analysis and attention given to the enthusiasm (or lack thereof) demonstrated to the concept, themes raised in the interview, willingness to engage in further conversations, and the desire for military treatment providers and commanders to move forward with a pilot project. The fourth step is for Oxford House to determine what role it might have in working with a military healthcare beneficiary population.

The **first step** is to better understand the willingness for both command and medical personnel to refer people to a recovery, alcohol and drug free healthy living environment in context of the overall drug and alcohol prevention and treatment program. Oxford House, Inc. will do a market and needs analysis that will require points of contact representing healthcare and command interests for each military base that might refer people to a recovery home. Options to be considered include:

- a. Traditional Oxford House as currently in place, and tobacco-free Oxford Houses for those 12 houses potentially created for this test project (in which there are neither healthcare providers nor medical treatment occurring on site);
- b. Utility of a transient living environment that would be alcohol and drug free for individuals on temporary duty status, or otherwise unable to commit to a longer term living situation because of military mission needs, etc.
- c. Potential for an alcohol, tobacco and drug free barracks that maintains a similar social structure to Oxford House, and may be open to any military person who desires to live in an alcohol free environment on a space available basis, with priority selection given to individuals referred by either command or healthcare providers.
- d. Potential for integrating the Oxford living situation more closely with treatment providers in context of a 28 day residential treatment program or outpatient program that may have the impact of mitigating the intensity of care that would otherwise be indicated.

Assuming the interviewee concurs with the value of having one or more of the four options, the **second step** is to estimate the potential number of referrals to each of the above options as a function of each of the following populations (as appropriate); active duty military personnel, retired military personnel, families of military personnel, reserve military personnel, and DoD civilians seen through the Employee Assistance Program.

Assuming that the interviewee has reservations about the value of having any one or more of the four options, the **third step** is to identify problems foreseen for each of the options as related to each of the potential populations and to determine if the problem identifies a conceptual or operational deficiency for which there is a potential solution. The narrative that identifies problems will also identify solutions to which the interviewee concurs.

Personnel responsible for accomplishing the first three steps of the first aim: Oxford House, Inc. would carry responsibility for these interviews, analyzing the data and writing the report prior to continuing to the next step. DoD Health Affairs and service-specific drug and alcohol program managers will be responsible for helping Oxford House interviewers gain access to the appropriate military base command and health care personnel.

The **fourth step** is to determine the capability of Oxford House to work with potential residents who must also adjust to a military lifestyle. This will require:

- a. Placement capability for personnel identified by their treatment team as potential candidates for residency in Oxford House
- b. Adapting to military mission requirements that may result in extended stays away from the assigned Oxford House, or a permanent change of station while residency in an Oxford House-like recovery environment is still within the individual's best interest.

While the first three steps address the potential benefit the military may receive by incorporating an Oxford House type recovery home into its overall approach to helping addicted individuals achieve long-term abstinence, this step focuses on the ability and desire to work with the military.

Personnel responsible for accomplishing the fourth step of the first aim: Oxford House, Inc. would carry responsibility for writing a report analyzing the impact accepting DoD personnel into its recovery homes would have on its overall operation and vision, and assess the degree in which it may be able to support military personnel.

Aim 2:

There are two steps to accomplish the second aim. The first step is to establish a means through which houses and beds are rapidly identified and tagged to military health care beneficiaries in accordance with a concept of operations developed in the first aim. The second step analyzes the experiences of those beneficiaries to better judge the value a peer-assisted residence program has in the military healthcare system.

The **first step** is to actually establish Oxford Houses or acceptable alternatives in areas supported by either command or healthcare providers, and begin to accept residents. To establish a viable presence to serve DoD target populations, Oxford House will

- a. Depending upon need, establish up to 12 houses to primarily serve 120 military personnel, their dependents and retired military and their dependents covered by TRICARE, focused on the target populations identified above; and
- b. Institute a real-time vacancy system to effectively open the entire network of Oxford Houses to a DoD preference for up to 120 slots during the twelve-month duration of the agreement.

Oxford House has proposed establishing up to 12 Oxford Houses that would allow house residents to be available to meet military mission requirements as per conclusions coming from the first aim. The following highlights areas in which Oxford House could most easily establish a presence of potential service to military healthcare beneficiaries based upon an established or desired presence in the civilian community. This information represents the status of Oxford Houses at the onset of the study:

Alaska: There are no Oxford Houses and military dependent individuals reside in the state. Senator Stevens expressed interest in opening such houses. Up to three houses would be established to cover populations located in Anchorage, and possibly Fairbanks.

Nebraska/Iowa: Recently OHI established nine Oxford Houses in Nebraska and Iowa dedicated to veterans. While there is an Air Force Base in Nebraska and only scattered other installations in the area, the benefit of establishing two houses in this location is the added support that can be provided to area veterans.

Virginia Tidewater Area: There are six Oxford Houses in the Tidewater area that provide a good base of support. The military presence in the area is very high. Up to three additional houses would be established.

North Carolina: There is a strong Oxford House network in the state including three VA houses. A strong military presence exists in Eastern North Carolina where there are 36 Oxford Houses. Experienced staff reside in the state, which may facilitate the opening of new houses. Up to two additional houses, near military bases, would be established.

The National Capital Area: The metro DC area has a large contingent of military and military dependents. Up to two additional houses would be established to serve the military community in this location.

Should a new Oxford House be created to meet the living requirement needs of military personnel, it is important that a new Oxford House be filled with residents as soon as possible so that the new group can pay its bills and organize into a supportive fellowship. Therefore, a new dedicated DoD house may include residents in recovery who are not necessarily military or their dependents. However, by making certain that vacant slots are known for all Oxford Houses, Oxford House, Inc. can assure that a minimum of 120 individuals will be able to reside in an Oxford House for at least one-year. To achieve real-time vacancy it is necessary for Oxford House, Inc. to implement a centralized reporting of vacancies, posting such vacancies on the internet and keeping the vacancy data up-to-date.

A key requirement is for Oxford House to establish an automated, inexpensive and easy to use tracking and reservation system. The system would probably need to track several domains of interest to both the specific Oxford House and to the individual applicant so that good potential matches could be found early in the search and placement process. These would include the following.

- a. House demographics and characteristics: number of residents; potential openings within the next week, month, and three months; weekly rent; location (for the military, include miles to different nearby bases to which a daily commute is reasonable); and desired resident (e.g. gender, age, other important characteristics).
- b. Individual demographics and characteristics: name, age, gender, substance use problem, work address, current address, usual means of transportation (e.g. has car, relies on mass transit, carpool), ability/willingness to pay weekly rent (max amount), desired placement date, anticipated length of stay (non-binding), and desired home (if known, using pick-list).
- c. A basic assumption is that all Oxford Houses have a telephone line and that the tracking/reservation system would be cheapest through use of a thin-client secure network (e.g. secure web). The system should be efficiently designed for slow modem, low end computers, and consider use through PDA devices.

Personnel responsible for accomplishing the first step of the second aim: Oxford House, Inc. would carry responsibility for acquiring or developing the appropriate reservation/tracking system.

The **second step** is to evaluate outcomes of all patients and other beneficiaries accepted into an Oxford House living situation over a one to two year period with specific attention to:

- a. Active duty military personnel
- b. Retired military personnel
- c. Family members of military personnel that may include spouses and minors eligible to enter Oxford Houses
- d. Other DoD personnel with health care benefits that may include Reserve and National Guard personnel, and DoD civilians referred through occupational health, health promotion and Employee Assistance Programs.

Assuming a qualitative need has been established, the second step is a pilot project that will establish a military set of residents in an Oxford House environment for a quantitative outcomes evaluation.

Oxford House, Inc. would work with the Henry M Jackson Foundation for the Advancement of Military Medicine (HJF) to implement the data collection necessary to make an evaluation of outcome for DoD military and military dependents that move into an Oxford House. A reasonable hypothesis based upon background reports is that 20% to 30% will relapse while in an Oxford Houses, while 70% to 80% will remain abstinent until they move out of an Oxford House.

The basic study design would gather high quality qualitative and descriptive data on a total population of 120 people, of which there might be a relatively small number of people in each of the four categories listed above. Through normal interaction between treatment providers, referral house and command, it will not be necessary to store information by individual name outside of records normally kept, nor share individual names with individuals outside of the normal patient treatment team and social support network.

Collaboration would be established between the HJF and the military treatment facility referring patients into and Oxford House recovery home to receive from the HJF a unique identifier for use in the data gathering efforts of Oxford House in support of this analysis. This gives the military treatment facility the option of not providing the name and other individual identifiers of an individual patient as data are given for the purpose of program evaluation.

Within DoD, the Army has standard data collection forms that are completed for all personnel sent to the Army Drug and Alcohol Prevention and Control Program for evaluation and treatment. The Patient Intake/Screening Record (PIR)(DA Form 4465-R)

collects identifiers, demographics, diagnosis, and treatment decision. The Patient Progress Report (PPR) (DA Form 4466-R) collects identifiers, diagnosis changes, changes in treatment level of care, treatment progress and treatment termination. Under the Privacy Act of 1974, established routine uses of these forms include statistical analysis for program evaluation, trend data and other research purposes. Release of information “to qualified personnel conducting scientific research, management, or financial audits or program evaluation” does not require written consent. Except for Active Duty service personnel, completing these forms are voluntary. The key outcome measure for this pilot study, treatment progress and successful treatment, are contained within the DA Form 4466-R. Other services have similar mechanisms for tracking personnel enrolled in their substance abuse treatment programs.

Following enrollment into a drug and alcohol treatment program, follow-up for up to a year is routine. A succinct summary for standard follow-up progress notes, which track ASI and the American Society for Addictive Medicine (ASAM) dimensions for care, has become a current standard within treatment programs interested in outcomes management. Monitoring abstinence, appropriate use of medication, attending self-help group meetings, obtaining a sponsor within a self-help group, meeting work expectations, resolving legal and family problems, achieving a spiritual equilibrium, and working with recreational time and significant relationships are all part of the recovery process and would be monitored as parameters related to treatment success.

Data Collection Specifics:

Systematic observation by the HJF Project Manager would result in the collection of qualitative data. The data would be used to describe the experience of Oxford House, Inc. and the DoD throughout the project to assess whether there was a viable market for Oxford House, Inc. within the military community.

For those of the target population, as found, OHI would identify DoD healthcare beneficiaries by age, beneficiary type (active duty, family member, retired), and rank if appropriate.

Past and current substance use history would incorporate items currently asked on the North Carolina Network of Oxford House Self-Administered Questionnaire to include the following:

- a. Demographics: Race/ethnicity; marital status; years schooling completed.
- b. Substance use disorder history: Number of quit attempts; current length of time abstinent; how many times in detox (without treatment); how many time in a residential treatment program (and other treatment programs); use of 12 step programs and, if used, how many meetings/week; arrests/jailed while intoxicated and, if yes, how many times and for how long; last home prior to Oxford House; general health rating; and
- c. A standard progress note that would include the following: Vital signs (when appropriate); assessment on maintaining abstinence; whether patient has a 12-step program sponsor; work/job problems; court/legal problems; spiritual

assessment (e.g. at step two or three in a 12 step program, or ability to accept help from others and to help others); family (in supportive/non-supportive, stable/unstable family); sleep problems (expected early in recovery); use of free-time for recreation;

- d. Co-morbid conditions requiring therapy or medications, alone or together.

Analysis would be straightforward, calculating frequencies describing the characteristics of people entering Oxford Houses and using demographic information to cross-tabulate and identify potential differences according to gender, paygrade, health care beneficiary status and service status, and existence of a dual diagnosis and significant social problems. Decisions on patient success and progress will be based upon a review of the progress notes with success measures being 1) achieving abstinence and 2) satisfactory performance and success consistent with ongoing employment.

Considering the nature of this demonstration project, it is better to gather the qualitative experience of military health care beneficiaries who might benefit from the recovery environment offered by Oxford House. Therefore, there is no requirement that the evaluation use a control group nor is there a requirement that tracking last beyond a point after which relapse becomes unlikely. More quantitative outcome studies should take place in collaboration with others currently beginning to study Oxford House, such as the DePaul University team or the Veterans Administration. If this proves to be the next step, Oxford House would cooperate with the HJF to develop a research grant that would include survey design and data evaluation. Currently, the VA and De Paul University have worked with Oxford House, Inc. in developing protocols that pass Institutional Review Board review for human use. As this project progresses, there will be coordination of the DoD project with existing and proposed projects with the Department of Veterans Affairs and DePaul University.

Personnel responsible for accomplishing the second step of the second aim: Oxford House, Inc. would carry responsibility for data collection, and collaborating with referral sources and HJF for data collection. Analysis would be done through HJF.

Aim 3: Recommend to the Assistant Secretary of Defense for Health Affairs (ASD(HA)) any role Oxford House or the principles underlying Oxford House may have in the continuum of care for military health care beneficiaries, specifically addressing active duty personnel, retirees and their families.

Combining information from the reports generated from the first two aims, a final report would be generated to the ASD (HA) regarding the utility of using recovery homes and alcohol/drug/tobacco-free living environments within a military environment. Any further studies would also be recommended as well as the potential for DoD, VA and the Department of Health and Human Services (DHHS) interagency collaboration for outcomes evaluation and research for individuals suffering from substance use disorders.

Personnel responsible for accomplishing the third aim: HJF would be responsible for writing the final report.

Timeline: In months starting from time grant is awarded:

	1	3	5	7	9	11
Aim 1						
Step 1	xxxxx					
Step 2	xxxxx					
Step 3	xxxxx					
Step 4	xxxxx					
Step 5	xxxxx					
Aim 2						
Step 1	xxxxxxx					
Step 2	xx					
Aim 3						xxxxxxx

Human Use:**Purpose:**

This demonstration project is being conducted at the request of the Department of Defense to study the potential benefit the Oxford House living environment may have in minimizing the potential for relapse in individuals identified with substance use problems and whether Oxford House may be a useful benefit to different DoD health care beneficiary populations. This will require that DoD treatment providers, commanders and Oxford House officials determine whether the Oxford House concept is useful as is, or can be adapted to military lifestyle, in which an individual, who has been diagnosed and treated for a substance use disorder may need to abstain from the use of alcohol or other addictive drugs.

Study population:

Approximately 120 military health care beneficiaries that includes active duty and retired military personnel, and their immediate family members who are in areas determined by both DoD and Oxford House to be within the demonstration project. Oxford Houses are intended for individuals who can live independently and, therefore, would be inappropriate for adolescents and children under the age of 18, individuals unable to pay rent (usually less than \$80/wk), or for individuals who require skilled or long-term nursing care. Individuals unable or unwilling to abstain from alcohol or other addictive substance use would also be excluded from consideration as per the rules governing Oxford House.

Recruitment:

Patients who would benefit from using Oxford Houses would have that option mentioned to them. Patients could then decide whether they wanted to try Oxford House. With patient consent, Oxford House would be contacted to find an available place and an interview arranged. Patients must be interviewed by house members before a decision is made to accept the applicant. The decision to enter an Oxford House is a voluntary decision made between the applicant and current Oxford House residents, based upon a decision that the applicant wants to enter, values a drug and alcohol-free lifestyle, has the means to meet financial obligations, and can contribute to the running of the house.

Individual data sources and Confidentiality of Records:

Requested data from the military are those currently collected for the express purpose of program evaluation and are data currently shared with military command. The individual knows the data collection purpose at the time data is collected. Oxford House currently collects data for the purpose of program evaluation. These data elements also are within the standard for patient histories that would concurrently document a potential problem of the patient's recovery environment and the potential benefit of using Oxford House as an alternative living situation. Although it is permissible to pass patient information between

health care facilities, patient identities would be kept confidential. A case-series analysis would be done with unique identifiers that maintained patient confidentiality.

Possible risks:

Oxford Houses provide an alternative living situation from the normal living situation of the individual diagnosed with a substance use disorder. The individual is required to conform to the expectations of other Oxford House residents, to include participation in the running of their specific residence, payment of rent and other required bills, and abstaining from addictive drug use. Residents are strongly encouraged to use self-help programs and comply with their medical treatment plan. Inappropriate behavior, failure to pay bills and relapse are grounds for dismissal from Oxford House. This would result in the stress of finding a new living situation.

Procedures for minimizing risk:

Patients in the drug and alcohol treatment program who would be considered for Oxford House are those for whom there is ongoing follow-up care within the drug and alcohol program. Patients would be expected to maintain contact with the program and to discuss issues related to their diagnosis and progress, to include their living situation at Oxford House. In the event that it was felt that the Oxford House living situation was not beneficial, patients would be recommended to change their living situation and move out of Oxford House. Moving out of Oxford House is an expected event occurring at any time chosen by the resident or by the Oxford House members.

Benefits of Participation:

Oxford House is not a normal offering to individuals within the military health care system but has been found to be effective in preventing relapse in civilian populations. This is an alternative to returning to a living situation that existed at the time a patient developed a substance use disorder and could create a high risk for relapse.

Other options available:

Usual options currently available include a return to the prior living situation, or working with both command and families to create a supportive social network. These options would continue to be used within this demonstration project.

APPENDIX TWO: CONTRACT WITH THE HENRY M. JACKSON FOUNDATION FOR THE ADVANCEMENT OF MILITARY MEDICINE (HJF) AND OXFORD HOUSE, INC.

To accomplish the feasibility study, a contract was established between the Henry M. Jackson Foundation for the Advancement of Military Medicine (HJF) and Oxford House. The contract contained seven parts:

- A. Establishment of twelve new Oxford Houses,
- B. Provision for maintenance of the twelve new houses,
- C. Establishment of a separate revolving loan fund to provide start-up loans to establish the eleven new houses,
- D. Establishment of a vacancy system to facilitate use of any Oxford House by the target population,
- E. Cost coverage for evaluation of the project,
- F. Cost coverage for coordination needed to integrate the target population into the houses and with military treatment providers, and
- G. Cost reimbursement for about \$15,000 of equipment to help Oxford House, Inc. carry out the project.

With this contract, Oxford House has had two key objectives. First, the establishment of twelve new Oxford Houses was intended to provide additional recovery beds sufficient to offset the use of recovery beds throughout the network of Oxford House by the target population. The target population is made of those covered by Defense Department healthcare costs; e.g., TRICARE coverage for active and retired members of the armed services and their dependents. While there was some hope to establish new houses close to military installations in order to promote use by active military and their dependents, to date none of the established houses are filled with target population residents. However, as work has progressed there is a belief that houses close to Fort Belvoir, Virginia, Andrews Air Force Base, Maryland, and the Portsmouth Naval Hospital, Virginia will attract more active service personnel in recovery. The second objective was to provide lump sum funding to permit Oxford House to carry out the project.

APPENDIX THREE: BACKGROUND SUMMARY OF DOD TREATMENT PROGRAMS AND OXFORD HOUSE, INC.

Accomplishing the first aim required background research into the foundation for both the DoD drug and alcohol treatment program and into Oxford House. A summary of that background work follows.

Background of Drug And Alcohol Prevention And Treatment Programs Within The Department Of Defense:

Alcohol use in the military has been historically widespread and commonly accepted, as long as use is “responsible” and in keeping with military tradition. Within the US military, use generally reflects community standards within the segment of the population that opts to join the military. Alcohol use in the military has also been closely associated with other pleasure-seeking activities and psychoactive drugs. Although both military and political leadership accepted “responsible” use of alcohol, it was concern over illicit use of other psychoactive drugs within active duty personnel serving in Vietnam that triggered current military drug and alcohol prevention and control programs.

In 1971, President Nixon signed the executive order to initiate a military drug and alcohol prevention program. This led to the Hughes Act and specific law that requires the military to manage and treat drug and alcohol related problems. The Department of Defense (DoD) has taken these laws and developed the 1010 series of directives and instructions to be used by different DoD departments and services to develop implementation regulations to meet their Congressional mandate (<http://www.dtic.mil/whs/directives/>). These programs have had three key foci: deterrence testing for common and easily detected illicit drugs; education to prevent harmful use of alcohol or early intervention when harmful use is detected; and treatment when a substance use disorder diagnosis is present. This has resulted in a blended program that uses personnel, health promotion, occupational health, and medical program resources with each military service creating a comprehensive program consistent with its needs and personnel retention goals. Yet, even with improved policy and programs, alcohol has continued to take a considerable toll. In one of the few studies using the Alcohol Related Disease Impact (ARDI) software developed by the Center for Disease Control (CDC) as a spreadsheet macro, the Air Force reported 23% of its examined 283 deaths in 1990 as attributable to alcohol-related causes, accounting for 2300 years of potential life lost before age 65 (Stout, R. W., M. D. Parkinson, et al. (1993). “Alcohol-related mortality in the U.S. Air Force, 1990.” *Am J Prev Med* 9(4): 220-3).

In 1990, the last published outcome study of the DoD standard approach to the treatment of military personnel with a diagnosis of alcohol dependence reported achieving a 77% one to two year abstinence rate and a 90% occupational retention rate (1). Factors behind this high success rate were discussed as possibly attributable to a strong supportive social network involving commanders and families, a strong residential treatment therapeutic community, health promotion treatment components, and a comprehensive one-year follow-up program for relapse prevention. This treatment approach took place at the Tri-

Service Alcohol Rehabilitation Department (TRISARD) that was subsequently closed in favor of a less comprehensive approach to treatment that curtailed components related to the therapeutic community and building a supportive social network (Wright, C., D. M. Grodin, et al. (1990). "Occupational outcome after military treatment for alcoholism." *J Occup Med* 32(1): 24-32). The presence of a strong aftercare program, which involved both command and treatment providers following inpatient residential treatment, accounted for a finding of no difference in long term outcomes between six and four week residential treatment programs when linked to the Navy's outpatient aftercare program (Trent LK (1998). "Evaluation of a four- versus six-week length of stay in the Navy's alcohol treatment program." *J Stud Alcohol* 59(3): 270-9). Even with a standard six-week rehabilitation program, a contracted cost study done by Caliber Associates in the 1990 time period reflected a gross return on investment (ROI) of \$13 for every dollar spent. Much of this savings related to personnel costs of attrition and retraining. In a September 2003 retrospective chart review, Portsmouth Naval Hospital estimated a 19:1 benefit/cost for a brief intervention with individuals suffering from an alcohol use disorder. Savings were achieved by avoidance of re-admission to medicine. Both identification and intervention were relatively rare events. The authors estimated that had all with substance use disorders had been identified and treated, the hospital might have avoided costs of \$10M in that one year alone (Storer RM (2003): "A simple cost-benefit analysis of brief interventions on substance abuse at Naval Medical Center, Portsmouth". *Mil Med* 168: 765-8).

Today, the DoD is obligated to both identify, treat and rehabilitate members of the armed forces who are dependent on drugs and alcohol under public law Title 10 US Code Chapter 55 section 1090: "The Secretary of Defense and the Secretary of Transportation with respect to the Coast Guard when it is not operating as a service in the Navy, shall prescribe regulations, implement procedures using each practical and available method, and provide necessary facilities to identify, treat, and rehabilitate members of the armed forces who are dependent on drugs or alcohol."

Following and triaging a patient through a continuum of care, DoD Health Affairs policy (memorandum 97-0029) supports the American Society of Addiction Medicine (ASAM) Patient Placement Criteria (PPC). The PPC can be outlined and described as follows:

Five Levels of Care:

- Level 0.5: prevention and education for population engaging in risky behaviors
- Level I: outpatient treatment
- Level II: intensive outpatient treatment and partial hospitalization
- Level III: halfway houses and medically supervised residential treatment
- Level IV: inpatient hospital treatment, medically monitored

Six dimensions for placement consideration:

- 1: Intoxication and withdrawal (life threatening to none)
- 2: Biomedical conditions (bedridden to none)
- 3: Emotional and behavioral conditions (life threatening to none)

- 4: Treatment acceptance/resistance (highly accepting to highly resistant)
- 5: Relapse potential/Potential for continuing use (high to little)
- 6: Recovery environment (social network great to terrible, consider command needs)

Assess community resources and available treatment:

Problems within dimensions 1, 2, and 3 may justify placement into any level of care.

Problems within dimensions 4, 5, 6 may justify care up through Level III. However, Level IV not a good substitute for Level III.

The therapeutic community created through TRISARD represented the most intensive level of ASAM Level III care, in which health care providers are an integral part of the treatment milieu.

Prior to the closure of TRISARD, the Center for Training and Education in Addiction Medicine (CTEAM) at the Uniformed Services University of the Health Sciences (USUHS) became engaged in a business process re-engineering project using Integrated Definition (IDEF) Modeling. Army Drug and Alcohol Prevention and Control Program (ADAPCP) Treatment Clinics were carefully assessed to determine their value added activities. A data model was created to support desired activities that were patient-centered and supported the provider with essential data and outcomes management.

The IDEF models highlighted the importance of social network and patient social status, thus supporting the importance of a supportive democratic self-help recovery home such as Oxford House that requires all members to maintain abstinence. Community support networks, such as 12 step programs or a clean and sober recovery environment are not defined within any level of care. Strong social support helps mitigate the intensity of care, thus a strong recovery home would diminish the need for placement into a half-way house or residential treatment program with a patient willing to accept and engage in treatment.

Drug and alcohol programs in the military are relatively unique when compared to other medical programs, and lend themselves to outcome evaluation through the collection of data not normally available to other health care programs. Within the normal business process of enrolling and tracking active duty personnel, treatment providers work with the Commanding Officer (CO). The CO must approve and support enrollment into treatment, giving a clear message that the person has potential for a viable career and that the CO endorses the proposed treatment plan. The CO is expected to be part of an ongoing evaluation process over the course of treatment during which time the CO assesses job performance and the ability of the patient to meet administrative requirements. The treatment counselor, with input from the CO, determines whether treatment has been effective and when maximal treatment benefit has been reached.

A rationale for treatment is the identification of a poor recovery environment. At this time, throughout the DoD continuum of care, there is no consistent access or use of

recovery in the treatment of patients with substance use disorders. Although Oxford House, by current definition, is not contained within the ASAM PPC since there are no treatment providers directly involved in the management of patients at Oxford House, Oxford House specifically targets those individuals who would benefit from a strongly supportive recovery environment (dimension 6) and with individuals who believe this support is needed to prevent relapse (dimension 5). Oxford House tends to accept only those individuals who are strongly motivated and committed to maintaining abstinence; patients resistant to treatment (dimension 4) would not be suitable candidates for Oxford House living.

The IDEF models also identified a cost of care based upon activities performed. Normally, costs have been based upon place of treatment; e.g. hospital or outpatient. Accounting codes listed a TRISARD patient as a hospital inpatient, carrying the cost of about \$1000/day. Family members attending the program and living within the walls of the hospital were listed as borders. They received education, rather than therapy, with the goal of making critical life decisions with an estimated cost of \$200/week that paid for both beds and a part-time social worker. Independent of the accounting method in current use, IDEF activity models highlighted a common set of activities that should occur at all levels of care at varying levels of intensity using a variable set of resources. If activity-based cost accounting is used, total cost would be in the range of \$175-\$300/day. Oxford House mitigates the need for treatment, or the intensity of recommended treatment, by assuring a healthy recovery environment. It costs residents an average of \$72.50/week for rent and utilities.

The Defense Appropriations Conference Report for FY2000 directed the Department of Defense (DoD) to conduct a pilot program to improve treatment outcomes for alcoholism and drug addiction with a specific recommendation that Oxford House recovery homes be evaluated for their effectiveness and cost efficiency. Oxford House has worked with the Veteran's Administration (VA) to improve the lives of veterans with significant histories of addiction, homelessness, and imprisonment. To date, Oxford House has worked most directly with VISN 6 and VISN 14, establishing six Oxford Houses for veterans in VISN 6 and nine for VSIN 14. Preliminary, unpublished, analysis indicate that the project has worked well, potentially achieving the same success noted in an evaluation of Oxford Houses in North Carolina, which showed that about a third of all Oxford House residents are veterans in an environment in which approximately 80% achieve a clean and sober lifestyle. Currently VA funding for Oxford Houses has been taken from an account designed to support homeless veterans. In the future, there is the potential for \$500,000 a year ongoing funding in pending legislation proposed by Heather French to develop additional Oxford Houses. Oxford House would like to establish a closer link to the DoD health care system, developing a culture in which an Oxford House recovery home is readily available to patients who would benefit from this environment for as long a time as needed.

In FY 2001, Congress appropriated \$750,000 and directed the DoD to initiate an Oxford House feasibility study. Colonel (Dr) Kenneth Hoffman, Medical Corps, United States Army, was appointed as the Principal Investigator tasked to conduct a program

evaluation of how Oxford House might fit within the needs of DoD in providing a full range of addiction treatment services, to include self-help recovery homes.

Background of Oxford House:

Oxford House, Inc. is a nonprofit Delaware corporation that serves as the umbrella organization of all individual Oxford Houses. It is recognized as qualifying under §501(c)(3) of the Internal Revenue Code. Its principal place of business is 1010 Wayne Avenue, Suite 400, Silver Spring, Maryland 20910. Oxford House, Inc. has, as its mission, to have Oxford House residents assume leadership in making recovery without relapse a normal expectation of effective treatment.

The first Oxford House was established in 1975 when Montgomery County, Maryland closed a 13 resident halfway house for recovering alcoholics and drug addicts located in Silver Spring, Maryland. The 13 male residents of the halfway house rented the building, developed a self-help system of operation and operated the house themselves. When they took over the operation of the house, the men immediately voted to remove the six-month residency limitation applicable to the county-run halfway house. Then and today a resident may live in an Oxford House for as long as he or she stays clean and sober and pays an equal share of household expenses. This policy is feasible because all Oxford Houses are rented and, in theory, when a house is full some of the residents should be able to rent another house to establish another Oxford House.

National expansion of Oxford House began in 1989 following enactment of the federal Anti-Drug Abuse Act of 1988, PL 100-690. §2036 of that law required each state receiving federal block grants to combat alcoholism, drug addiction and mental illness to establish a \$100,000 self-help recovery home revolving loan fund. Oxford House was the model for “self-help recovery homes.” Today, there are 7,893 men and women living in 957 Oxford Houses throughout the United States. Oxford House, Inc., as the umbrella national organization, expends about \$1.4 million a year to maintain and expand the existing network of Oxford Houses.

From the beginning, Oxford House, Inc. used a charter mechanism to make certain that Oxford Houses maintained minimum standards of operation. Specifically, each Oxford House receives a charter from the umbrella organization that has three requirements: [1] the group must be democratically run, [2] the group must be financially self-supported, and [3] the group must immediately expel any resident who returns to using alcohol or drugs. The charter affords the new house the opportunity to use the Oxford House Manual[©] and to become part of an Oxford House Chapter and Oxford House, Inc.

The equal share of household expenses [now averaging about \$82 a week per person] paid by the residents of Oxford House out distances by far the amount of money used to maintain a central services office to expand Oxford House and to keep existing houses on track. Last year Oxford House residents spent \$33,043,296 of their own money to pay the household expenses to operate the national network of Oxford Houses. In other

words, for every dollar spent by Oxford House, Inc. residents spend more than \$24 of their own money to operate self-run, self-supported Oxford Houses.

Based on the success of Oxford House expansion under the Anti-Drug Abuse Act of 1988, members of Congress began to request the utilization of Oxford House in areas other than under the state block grant program. For example, in 1992 drug courts began to be used as an alternative to incarceration of some individuals addicted to alcohol and drugs. By the end of 2000, there were over 750 drug courts throughout the country. Oxford House had integrated its service to drug court participants in at least three states – Washington, North Carolina and Oregon. By 1998, there were nearly 600 Oxford Houses throughout the country.

The US Department of Veterans Affairs entered into an agreement with Oxford House, Inc. to establish houses in both VISN 6 [parts of Virginia, North Carolina and South Carolina] and VISN 14 [Iowa and Nebraska]. Oxford House's objective is to improve the lives of veterans with significant histories of addiction, homelessness, and imprisonment. To date, Oxford House has worked most directly with VISN 6 and VISN 14, establishing six Oxford Houses for veterans in VISN 6 and nine for VSIN 14. Preliminary, unpublished, analysis indicate that the project has worked well, potentially achieving the same success noted in the North Carolina evaluation in which about a third of all Oxford House residents are veterans in an environment in which approximately 80% achieve a clean and sober lifestyle. VA funding has come from the homeless VA money with potential for \$500,000 a year ongoing funding in the pending Heather French legislation to develop more Oxford Houses. Oxford House would like to establish a closer link to the DoD healthcare system, developing a culture in which an Oxford House recovery home is readily available to patients who would benefit from this environment for as long a time as needed.

As a consulting firm to Oxford House, Rea and Associates studied the impact Oxford Houses had in the treatment of veterans in VISN 6 and 14, and concluded that:

“1. Addiction is a chronic, lifelong disease. Similar to many such diseases it requires both medical attention and life-style changes that are often initially disregarded but ultimately will be accepted or the patient will die. Addiction among discharged veterans is an apparent chronic condition.

2. The dynamic interaction between veterans, addiction, and homelessness has been clearly documented.

3. Similar to the public sector, VA treatment has moved to a Managed Care Model emphasizing outpatient care. The most apparent failure of this system of treatment for both public sector and VA is the high number of ill housed and marginally employed patients for whom out-patient care is not effective.

4. Similar to the public sector addiction treatment systems, VA services, even when provided in a Domiciliary and followed by a stay in a Grant and Per Diem House, have

no permanent, low cost, long-term, supportive environment in which these veterans may live. Because of this lack of post treatment, low cost, long term, supportive housing, many public sector and veteran patients relapse many times either placing repeated demands on VA's limited medical system or personally giving up on sobriety.

Benefits of Oxford Houses in relationship to the above described social and health problems:

1. Life-Style changes among veterans who have been treated in a traditional outpatient program are at best difficult if there is no supportive living environment and role models for them to follow. Oxford House offers both a supportive living environment and longer term residents who function as role models for recovery.
2. Many sources document the range of veteran homelessness to be between 25-40%. The trauma of leaving civilian life and home, entering the military, possibly facing combat, experiencing unusual stressors resulting in Post Traumatic Stress Disorder partially explain why the ratio of veteran homelessness is considerably higher than any other identifiable group. Oxford House is both an efficient and an effective means of dealing concomitantly with addiction and displacement for veterans.”

When interviewing residents for VISN 6 and 14, as well as evaluating the program in North Carolina, Rea and Associates concludes:

- “1. Houses were largely in very clean, well cared for, stable, middle class neighborhoods. They were near parks, bus routes, jobs, and shopping. They were distinguished from most of the places I have been able to place a Grant and Per Diem program in that the economics of the VA funding system and the operating costs required me to site them in less desirable neighborhoods. In some cases they were actually in high crime/high drug arrest areas and not conducive to developing a drug free lifestyle.
2. The veterans demonstrated a remarkably high degree of pride in "their" house. This was reflected in how they cared for their home; lived in their home--every thing in place, clean and well organized; and spoke reverently of their house and the other veterans as highly valued in their recovery.
3. All described good to exceptional relationships with their neighbors. In several cases the Oxford House members were highly visible in neighborhood clean-up activities or on an ongoing basis aiding an elderly and disabled homeowner. This kind of community participation does not seem to occur at the Grant and Per Diem program sites. A healthy acceptance of personal responsibility is manifest in the way each member describes their life and its relationship to their housemates, neighbors, and family. Again this is in contrast to many Grant and Per Diem program houses where there is a sense of “Entitlement” that seems to get in the way of full recovery and reintegration into independent living.”

Rea and Associates recommended that “a VA team including prominent Addictionologists, Psychiatrists, Doctors, and Homeless POCs (perhaps others with more direct field experience in working with addicted/dual diagnosed veterans) be assembled to work with Oxford House assessing VA's clinical criteria for placement of veterans in VA's broad range of in-patient, domiciliary, and post-treatment housing programs. This would improve the "fit of Oxford House in the VA's continuum of care and aid VA in looking critically at its resources to assure that patients are placed in the most cost-effective and clinically effective facilities.”

As related to the active duty military: “The residents collectively have experienced considerable hardships in life, some of which is related to their military service. Many became addicted in the service, as it is a part of that culture, contrary to what many at DoD believe. Some saw combat and experienced PTSD; they left the service with little in the way of transition planning and support and experienced difficulty in adapting to the new and rapidly changing civilian culture; for them they had difficulty in converting their military experience into civilian jobs and had extended periods of unemployment---leading to greater drug or alcohol use--resulting in involvement with the criminal justice system and leaving the criminal justice environment becoming homeless; many lost contact or used up their welcome with wives and family finding themselves incredibly isolated. Many then lost many essential civilian social skills, which made them even more difficult to find work, relationships, and remain drug free. One resident summed it up well when he said that his Oxford House was "...a little 'haven' that teaches me how to deal with different kinds of people...”

Oxford House is developing a history of working with researchers and state officials to establish outcome measures. Within North Carolina, Oxford House residents are asked to anonymously answer an annual questionnaire that gathers demographic information, consequences of alcohol/drug use prior to coming to Oxford House, current recovery status, and impact Oxford House has had on that status. The August 2000 annual survey received responses from 72% (383/535) of the residents living in one of the 75 Oxford Houses in North Carolina. Oxford House has published a report, “Oxford House and North Carolina; a Partnership that Works, 1991-2001”, which highlights the findings from its surveys and includes a financial analysis of great cost savings. Questions used in the survey are well written and reasonable for inclusion in this project, and would permit comparison of other populations using Oxford House with the population of North Carolina.

The VA is actively involved in an independent assessment of Oxford House effectiveness. This protocol attempts to study the impact Oxford Houses has on improving the lives of homeless veterans through confidential data collection on Oxford House residents who are veterans. Evaluation forms are completed by a designated member of an Oxford House. Since this level of data collection is not within the normal operations of Oxford House, the operating procedure that will allow data collection is being negotiated.

Researchers at DePaul University have been studying the impact of Oxford House on recovery outcomes. In a recent article, Jason, et al, describe the potential benefit of self-help communal living settings (e.g. Oxford House) may have in achieving long-term recovery rates from substance use disorders. Both NIAAA and NIDA have recently awarded grants to DePaul University focused on evaluating the effect Oxford House has on long- term recovery. Through a randomized design, the first grant will determine whether the intention to use Oxford House in a comprehensive treatment plan improves recovery outcomes over the usual treatment plan. The second grant will involve a large survey of Oxford House residents that will ascertain a history of substance use disorders through measures on the Addiction Severity Index and other measures such as a time line look-back, the Alcohol Abstinence Self Efficacy Scale, measures of social coping, self-regulation, and the perception of individual progress as seen through the eyes of important others that are identified by the study participant. In a telephone conversation with the investigators, there appears to be a reasonable expectation that there will be a large number of veterans that may be included in the survey, and that there could be an enhanced focus on homes that may also include DoD health care beneficiary populations should funding an enhanced protocol be possible.

In evaluating its own program, Oxford House reports a very high abstinence success rate, reaching 80% among its residents. It is closely aligned with 12-step programs. Oxford House residents closely monitor each other for signs of relapse or change in healthy behavior.

In 2000, leaders of the Senate Appropriations Committee (Senator Ted Stevens [R. AK] and Senator Daniel Inouye [D. HI]) added a provision to the FY 2000 Defense Appropriations Bill requesting that the DoD undertake a pilot project for integrating Oxford Houses into the treatment protocol for active and retired members of the armed services. In the FY 2001 Defense Appropriations Bill, Congress earmarked \$750,000 specifically for DoD to study the feasibility that a self-help recovery home, such as Oxford House, might have within the DoD.