Measuring social model in California: how much has changed?

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To examine the prevalence of social model philosophy in programs today and to study ways in which the philosophy may have eroded in recent years, a survey was mailed in 1998 to all state-licensed alcohol and drug residential programs in California (83% response rate). Analysis of the survey (Social Model Philosophy Scale, n=311) also identified specific ways in which social model programs differ from other types of programs such as medical/clinical model programs or therapeutic communities (e.g., by exhibiting more active 12-step community involvement). Results reveal that social model programs adhere decreasingly to social model principles in their philosophy and operation; for example, they now are more likely than not to keep complete case management files on all participants. Possible causes of this erosion, such as the growing dominance of managed care in the health-care world, are also discussed.

KEY PHRASES: *Social model, program philosophy, California treatment, 12-step treatment.*

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Publicly funded substance abuse treatment programs in California have traditionally followed a philosophy known as the "social model" approach (Borkman et al., 1998; Room et al., 1998), in which clients are immersed in the sober social network, culture, and values of the recovering community of program peers, program alumnae, and Alcoholics Anonymous and Narcotics Anonymous members (Barrows, 1998). Social model programs are self consciously oriented, not medically or psychologically oriented (Borkman, 1990; Schonlau, 1990), although the model was noted by the Institute of Medicine as an exemplar of the socio-cultural approach to treatment (Institute of Medicine, 1990). The social model approach referred to here is primarily a California phenomenon, where providers sustained an active social model movement (Shaw and Borkman, 1990) that shaped the face of public treatment services (influencing how counties received and allocated treatment dollars, and institutionalizing a peer-certification process conducted by fellow social model advocates (Borkman et al., 1996; Borkman et al., 1998; California Association of Alcoholic Recovery Homes, 1992; Institute of Medicine, 1990). However, as the substance abuse field has matured, like others (Di Maggio, 1991; Di Maggio and Powell, 1983) it too has become increasingly professionalized (Schmidt and Weisner, 1993), challenging the wisdom of the social model valuation of experiential knowledge in recovery (Borkman, 1990) and leading to increasing pressure for staff licensing and clinically oriented program certification requirements for providers desiring reimbursement of client fees (Crawford, 1998; Lewis, 1990a; Lewis, 1990b; Reynolds and Ryan, 1990; Wright, 1995). Related to this, the cost containment efforts of managed care have led to the ascendance of case management systems within the public sector, wherein licensed clinicians are required to develop and monitor the execution of patient treatment plans (Bois and Graham, 1993). While staff at other types of programs also have been hit by these increasing demands for documentation and monitoring of client progress for accountability purposes (Kaskutas et al., 1998c), this strikes at the heart of the social

model philosophy, where clients are expected (and entrusted) to take charge of (and responsibility for) their own recovery (Borkman, 1998; Schonlau, 1990). The increasing numbers of clients who are mandated to treatment from the prison and court systems has further compromised this basic social model tenet of client-initiated, client-driven recovery (California Association of Alcoholic Recovery Homes, 1974; California Association of Alcoholic Recovery Homes, 1992; California Office of Alcohol Program Management, 1974; Shaw, 1990).

Other, broad-ranging factors may also contribute to a compromise in the fidelity of an original model of care: these include changing social constructions of a problem (e.g., from a disease to a moral failing); changing philosophies within the larger professional field (e.g., from treatment to prevention); changing funding guidelines (e.g., implementing prospective payment and diagnosis-related groups or DRGs; shortened stays; more paperwork for accountability (and case management systems being required); changing characteristics of clients (e.g., from alcoholics to alcoholics and drug addicts, or from voluntary to mandated); changing characteristics of service institutions (particularly the shift from categorically segregated, addiction-focused agencies to agencies merged under large behavioral health or human service umbrellas); changing characteristics of service workers under the influence of credentialing/professionalization (i.e., shifting away from recovery as a priority for staff); and the movement through various developmental stages in the life of a professional field (particularly the shift from its grass roots origins to its evolution into formal organizations). Since the 1980s a number of these factors, especially the combination of professionalization under the managed care rubric, have affected the ways that social model programs have been allowed to function, often with detrimental results. The social model philosophy has been particularly compromised by shortened stays (in the name of cost containment), increasing demands for documentation and monitoring of client progress (for accountabil-

ity), and increasing numbers of clients who are mandated to treatment from the prison and court systems (Borkman et al., 1998; Borkman et al., 1997).

In light of the changing environment and pressures on treatment provision, this paper reports upon the degree of social model philosophy still at work in California recovery homes today. It analyzes areas where the philosophy has eroded and ways in which it has bent to accommodate managed care and other requirements. It is based upon empirical data collected from a survey of California residential substance abuse treatment/recovery programs.

The Social Model Philosophy Scale (SMPS) was designed to differentiate underlying philosophies of treatment at drug and alcohol treatment/recovery programs. With the convergence of medical, psychological and social model practices in modern treatment, the philosophy of treatment is often difficult to distinguish, making it hard to interpret (and determine the generalizability of) outcome study results. This 33-item scale is a quick, effective tool for determining where on the continuum of social model techniques a particular program rests. Programs with higher scores exhibit more accepted tenets of social model recovery. When the instrument was being developed and tested in 1995, a total score of 75% was considered a rough cutoff point for "true" social model programs; programs ranked by an expert panel as strongly social model scored above this mark (Kaskutas et al., 1998a).

Recent special issues of *Contemporary Drug Problems* and the *Journal of Substance Abuse Treatment* were devoted to the social model approach to substance abuse recovery (Kaskutas, 1998; Room, 1998). However, there has not been much research done on social model philosophy by the scientific community (Borkman et al., 1998). In particular, there has not existed an independent way of measuring or assessing how much a given program actually embodies the principles of the social model of recovery. The SMPS responded to an

expressed need on the part of the researchers to identify and clarify specific cardinal features of the social model of recovery and then translate these elements into a standardized measure. Since its development, the SMPS has been used as a training and quality-control tool, helping social model program directors identify ways their programs' structure and day-to-day operation had veered away from an expression of social model philosophical principles.

This paper presents a summary of the prevalence of social model philosophy in California today, comparing social model programs with other program types in the state and examining specific ways in which social model programs have fallen short of the social model ideal in recent years. It also looks at change over the last three years with a subsample of 14 programs that completed the SMPS during its development phase and again in 1998.

The SMPS has six domains: physical environment, staff role, authority base, view of dealing with alcohol problems, governance, and community orientation. Following is a description of the aim and content of each domain, as it relates to and distinguishes social model philosophy:[1]

I. *Physical environment.* The physical space is considered vitally important to the functioning of a Social Model Program, to the interactions between staff and participants, and to participants' willingness to feel a connection to and responsibility for their own recovery on the site. Six items explicate Social Model Programs' concerns for physical space, and may be said to measure a given program's distance from a clinical setting; efforts to diminish staff/patient hierarchy; reliance on informal counseling and interaction; and belief in participant "ownership" of the program and its trappings.

II. *Staff role.* The five items in this section focus on the Social Model goal of having staff mingle with the partici-

pants as peers and role models rather than as (distant) educators or therapists; they hope to encourage participants to take responsibility for their own recovery and for the maintenance of their environment while still making themselves as available as possible to participants.

III. *Authority base.* Social Model Programs by and large employ staff members who are themselves in recovery and very often alumni of the same program in which they work. The belief is that recovery from alcohol and drug problems imparts experiential knowledge, an invaluable resource upon which participants may draw; and professional knowledge is not valued above the experiential (Borkman, 1999). Five items measure how much a program values recovery/experiential knowledge, as well as knowledge of the particular program, as expressed both by staff members and alumni/volunteers from the community.

IV. *View of dealing with alcohol problems.* A distinguishing characteristic of Social Model Programs seems to be their understanding that participants need to: a) agree to take responsibility for their own recovery; and b) understand that alcohol and drug use are only part of the problem, and that they need a "whole-person" approach to their life-long struggle for recovery in order to succeed. Seven items seek to measure the program's interpretation of the participant's role in his or her own recovery.

V. *Governance.* Again, to the end of encouraging participants to take responsibility for the sobriety and the security of their own environment, Social Model Programs try to design the framework for the establishment and enforcement of program rules to have as significant a participant role as possible. It is hoped that in participating in the governance and supervision of the program, participants will feel a more personal investment not only in the program but also in their own recovery, but more importantly will have an opportunity to practice

decision-making skills, particularly on those issues related to the maintenance of a sober living environment.

VI. *Community orientation*. Social Model Programs, acknowledging recovery as a life-long process which requires support for the many potential pitfalls, seek not only to provide recovery services during the program itself but also to introduce, connect and integrate them to a web of support in the wider recovery community. Important skills which Social Model Programs seek to teach include how to make and keep friends who are good sober influences, how to recognize and draw upon the socioeconomic resources the community provides, how to practice and enjoy socializing while sober, and always how to draw upon the support and experience of other people in more advanced stages of recovery.

Materials and methods

Between November 1997 and March 1998, a mail survey was conducted of all alcohol and other drug residential treatment programs that are licensed with the state of California. A mailing list of 417 licensed programs was supplied to the project by the California Association of Addiction Recovery Resources (CAARR), a state-wide association of social model recovery homes and the most complete source of information on social model programs in California. The SMPS, along with a cover letter explaining the purpose of the study and a stamped, self-addressed return envelope, was mailed to all the programs on this list. In the cover letter, the program director or other senior staff member was asked to take ten minutes to fill out the survey and return it. Directors were also invited to enclose their business cards if they wished to receive a copy of the survey's results, and about 70 did so.

A strategy of multiple mailings was used to increase the response rate (Dillman, 1978), and throughout the survey process, programs on the mailing list were eliminated from sub-

sequent mailings as information became available (detailed below). Just over 40% of the 417 programs on the original mailing list responded to the first mailing (n=168). Six weeks after the first mailing went out, another copy was sent to 220 programs that had not returned it or been eliminated, enclosing a new cover letter and another return envelope. An additional 43% of these programs returned this second mailing (n=95). Six weeks later, a third and final copy was sent to 112 remaining eligible non-responders, this time by certified mail, with yet another cover letter and return envelope. Again, an additional 43% responded (n=48). The use of certified mail allowed for tracking programs that had moved or gone out of business—information that was helpful in determining the number of actual eligible programs for use in calculating the final response rate.

Programs were eliminated from the sample for several reasons. About 16 of the programs on the original mailing list were eliminated because they were not residential substance abuse programs. Most of these programs offered day (outpatient) treatment and/or detox services only (n=13); a few were not substance abuse programs at all (n=3). There were a number of duplicate listings, usually due to a separate listing for a parent corporation (n=15). In addition, several of the programs on the list had gone out of business or relocated and left no forwarding address (n=12). If these programs could not be located through directory assistance, they too were eliminated from the sample. In the end, the sample size was set at 374 programs. Of these 374 programs, 311 returned completed questionnaires, a final response rate of 83%.

The SMPS cover sheet includes space for program name and address information, five preliminary questions, and a brief introductory statement about the questionnaire and how to fill it out. One preliminary question asks the programs to categorize themselves by checking one of the following options: social model, therapeutic community, medical/clinical model,

halfway house, or other. The instrument takes about 15 minutes to complete. It is usually completed by program directors.

The 33 items on the SMPS are each worth a maximum of one point. There are three different types of questions: (1) yes/no questions; (2) multiple-choice questions (with either two or three answer choices); and (3) percentage answers (asking for a percent between 0 and 100). Answers are converted to a one-point scale as follows: (1) either the Yes or the No answer is worth 1 point, with the other answer worth 0 points; (2) each multiple-choice answer is worth 1 point, 0.5 point, or 0 points; and (3) the percentage answer is converted to a 0–1 sliding scale by dividing it by 100 and then, in some instances, subtracting the answer from 1 (depending on whether the 100% end of the scale is worth 1 point or 0 points). For details on how each item is scored, please see the SMPS Manual (Room, 1996).

In the figures that follow, all subtotal and total scores have been converted to percentages. For example, a program that received exactly 25 points out of the possible 33 on the total scale would have a percentage score of 76; a program that received 4 points out of a possible 6 on the physical environment subscale would have a percentage score of 67 on that subscale. On the other hand, answers to individual items are simply reported on the 0-to-1-point scale. In all cases, a higher score indicates a more "social model" program.

Results

Self-defined program types

The most common self-defined program type was social model (60%), followed by "social model" plus something else (usually either "therapeutic community" or "medical/clinical model"); these consider themselves "hybrid" programs, a mixture of social model elements with other influences (14%). An equal number (43%) were "therapeutic

community." Seven programs identified themselves as "medical/clinical model," and eight checked "halfway house." The remaining 23 programs checked "other" and wrote something in the blank space provided. Because the number of medical/clinical programs and halfway houses was low (n=15; 5% of the sample), we grouped these programs together with the 23 "other" programs for purposes of the analysis that follows. We refer to this group of 38 various program types (12% of the sample) as "other."

Average scores on SMPS and subscales (Table 1)

The overall mean score on the SMPS across all program types was 66, while among the self-declared social model programs it was 69, only three percentage points above the overall mean. In addition, some programs self-categorized by respondents as "social model" scored quite low on the scale: 10 of them below 50, with the lowest at 43. The overall subscale averages varied, from 81 on "authority base" to 40 on "governance," with the average subscale score for self-declared social model programs slightly above the average on all six subscales (but never by more than five percentage points). The governance and community orientation subscales revealed the most variation among program types, with social model programs averaging nearly 20 percentage points above programs grouped in the "other" category.

The vast majority of the high-scoring programs do call themselves social model. As mentioned above, a score of 75 is considered a cutoff point for "true" social model programs. Of the 64 programs that scored 75 or higher, 56 (87%) call themselves social model and another five (8%) are hybrids. *Using this dividing line of 75, 30% of the self-labeled "social model" programs in California (56 out of 187) can be called "true" social model, based on their responses to the SMPS.*

Within the category of self-declared social model programs, the mean on the subscales reveals some variation. While the total scale mean for the social model programs was 69, two of the subscales showed averages above the 75 mark: author-

TABLE 1

Averages and ranges for total scale and subscales, by program type

	social model	hybrid	therapeutic community	other	all programs
number of programs (N)	187	43	43	38	311
total scale					
average score (mean)	69	63	62	57	66
standard deviation	10.5	9.8	8.5	12.0	11.1
maximum score	91	85	77	76	91
minimum score	43	43	44	29	29
subscales: average scores					
I. Physical Environment	73	75	69	66	72
II. Staff Role	59	55	56	52	57
III. Authority Base	83	79	81	74	81
IV. View of Dealing...	65	54	57	54	61
V. Governance	45	36	33	27	40
VI. Community Orientation	79	72	70	60	75

ity base (83) and community orientation (79). In addition, two of the subscale means were significantly lower than the total scale mean: staff role (59) and governance (45). As will be discussed later, the low means on these two subscales appear to be due to a decrease in resident responsibility and a transfer of authority and decision-making power from residents to staff.

Individual item analysis for social model programs

The distribution of responses for the 187 self-declared social model programs is shown in the appendix. Looking at these individual items helps to answer the questions of what is happening with social model programs in California today, and in particular which specific items contribute to the relatively low total scores for the surveyed social model programs. There are seven items on which more than half of the social model programs received 0 points (questions 4, 5, 9, 19, 22, 24, and 27), and an additional three on which more than half of them received 0.5 points or less (questions 8, 10, and 26). With the addition of two other low-scoring items (questions 14 and 18), there is a total of 12 questions on which social

model programs scored, on average, lower than was expected. These 12 questions are presented below.

Five of the low-scoring items concern staff role and responsibility, and the extent to which staff are involved in controlling or managing the everyday activities and decisions of residents:

- 54% of the self-categorized social model programs do not allow participants with a requisite amount of sobriety to leave the program site without staff permission, placing clients into a passive role and lessening their self-responsibility (#5).
- 49% report that rather than spending most of their time with clients, staff spend one-half of their time or less outside of the office while on site (#8).
- Rather than entrusting residents to deal with intoxicated peers, 62% of these programs say that when staff is not present and a participant shows up drunk, residents totally rely on staff to handle the situation and take no action until staff arrive (#9).
- Only 11% claim that staff avoids making appointments for residents; most (79%) say that when residents need to make and attend outside appointments, the staff encourages them to make their own but does make them when appropriate (#10).
- Representing a shift away from an exclusive emphasis on the value of experiential knowledge, 48% of these programs report that more than one-half of their staff positions now require a certificate or degree, or some kind of professional training (#14).

Three of the low-scoring items are from the governance subscale:

- 55% of self-categorized social model programs do not allow residents to make and enforce any of the program rules (#24).
- 47% do not allow residents or residents' council any power in decisions to end a participant's residency (#26).
- 72% do not allow residents or residents' council any power to punish or demote residents (#27).

Finally, four items reflect other changes—in the environment, clientele, and services offered at self-declared social model programs—that have serious implications for the amount of time and resources that are invested in managing and monitoring program participants:

- In a development that might erode the homelike atmosphere at a program and create distance between staff and peers, 74% of social model programs today have a reception desk to screen people upon arrival (#4).
- Contrary to social model values of self-motivation and voluntary participation, 39% say that more than one-half of their participants are mandated by some external institution or agency (#18).
- 64% keep a complete case management file for each participant, reducing trust and self-responsibility, and encouraging more of a passive patient sick role (#19).
- 64% do *not* provide vocational or academic training for participants (#22).

Changes in social model programs from 1995 to 1998 (Table 2)

What are some possible explanations for these low social model scores, for the existence today of so many self-declared social model programs that are lacking in key elements of the social model philosophy? An argument could be made that the low scores on some of these items do not reflect recent changes in social model but rather are indicative of ways in which actual social model programs have always fallen short of the ideal of social model philosophy. But we have two sources of evidence for believing that most of these low scores are attributable to relatively recent changes. One source is word of mouth, the witness of many social model program directors with whom we have shared these results (Keller, 1998). The other source is provided by the 14 social model programs that participated in the test administrations of the SMPS in 1995 (Kaskutas et al., 1998a) and were surveyed again in 1998. Although generalizability is limited because of their relatively small number, for these 14 programs we can find direct evidence of change over just the past three years.

TABLE 2

Averages and ranges for total scale and subscales, selected programs 1995–1998

	1995	1998
number of programs (N)	14	14
total scale		
average score (mean)	83	75
standard deviation	10.3	11.0
maximum score	95	89
minimum score	65	54
subscales: average scores		
I. Physical Environment	81	75
II. Staff Role	75	63
III. Authority Base	90	83
IV. View of Dealing...	82	77
V. Governance	79	63
VI. Community Orientation	87	84

The mean for these 14 programs dropped by eight percentage points, from 83 in 1995 to 75 in 1998. Based on paired t-tests, this decline was highly significant ($p<.001$). Scores in 1995 ranged from 65 to 95; in 1998 the range was 54 to 89. In 1995 six programs scored 90 or higher; in 1998 none did. Three of the subscale means revealed a significant decline based on paired t-tests: staff role ($p=.016$), authority base ($p=.021$), and governance ($p=.020$).

When we look at specific questions, we find that there was a significant decrease on five items (questions 4, 8, 9, 10, and 27). All five of these items were among the 12 low-scoring items from the general sample that were reported in the above section:

- The number of programs without a reception desk went from eight in 1995 to three in 1998 (#4).
- The number reporting that staff spend more than half the time outside of the office while on site went from 12 in 1995 to six in 1998 (#8).

- When staff is not there and a participant shows up drunk, 12 of the programs in 1995 said residents play a role in helping out with the situation, while only six of them said this in 1998 (#9).
- There were eight programs that avoided making outside appointments for residents in 1995, but only one such program in 1998 (#10).
- Finally, the number of programs that allow residents some authority to punish or demote other residents went from 12 in 1995 to six in 1998 (#27).

How social model programs differ from other types of programs

What differences does the SMPS reveal between social model programs and other types of program? Roughly half of the questions reveal a significant difference between social model programs and other programs, while roughly half do not. Following are the items that do the best job of distinguishing between social model programs and other program types. We do not see significant differences in physical environment or staff role, other than the fact that self-declared social model programs are more likely to have staff who are in recovery (#13). Rather, the differences (based on chi-square significance tests) appear to revolve around language, client involvement in governance, and community involvement. Social model programs are more likely . . .

- to call themselves a "recovery" rather than a "treatment" program (#17).
- to refer to participants as "residents" rather than "clients" or "patients" (#20).
- to have a residents' council (#25).
- to allow residents to share in the decision to end a participant's residency (#26).
- to have at least some members of the community in attendance at AA or NA meetings hosted on site (#28).
- to have a higher percentage of participants find AA or NA sponsors before leaving the program (#30).
- along with therapeutic communities, to engage in community relations (#32).

- along with therapeutic communities, to have regularly scheduled clean and sober social events (#33).

On the other hand, social model programs are much less likely than therapeutic communities to provide vocational or academic training for participants (#22).

Interestingly, two questions showed no variance at all. Nearly every program, of whatever type, provides a comfortable group area for participant socializing (#3) and encourages participants to engage one another in informal activities and conversation (#23).

Discussion

The results suggest that social model programs have accommodated the demands of managed care (and field professionalization, funding requirements, government regulations, and other factors noted in the introduction) by forgoing some (but not all) core social model tenets in order to survive. In general, social model programs have become more and more dependent on outside sources of revenue, and those outside sources of revenue have become more and more tied to bureaucratic regulations and standards. Many Medicare and Medicaid systems at the county level are now contracted out to managed care companies, or at least refashioned on the managed care model. Managed care companies are putting pressure on everyone not just to cut costs but to do so by documenting and assessing services received and benefits gained at every turn. This pressure reverberates through federal, state, and county agencies that are charged with managing the enormous caseload of public clients, which in turn affects private programs that offer direct services to these clients.

Low scores on some of the items can reasonably be attributed to the influence of managed care and government regulations. For example, the increase in reception desks to screen people

upon arrival (#4) is due to specific state licensing requirements that all intakes be documented by the program. For details on California's extensive licensing requirements, see the state's Licensing Application Booklet for residential recovery facilities.[2] Another example is the increase in the amount of time staff spend inside the office while on site (#8). This change is clearly attributable to an increase in the amount of paperwork that programs are required to process in order to meet the documentation needs of HMOs and of county and state agencies. Managed care companies require advance approval for most services in the area of alcohol and drug treatment, and this approval depends upon a detailed specification and justification of needed services.

Other effects are less direct but are consistent with managed care influences. For example, cost-cutting pressure has resulted in shorter stays at all programs. Clients who are present at a program for shorter periods of time have less opportunity to develop the skills and responsibility that are necessary conditions of taking ownership of their own recovery and the program as a whole. This ownership, a key component of the social model ideal, has been compromised as a result of the decreased stay. The decrease in ownership and responsibility on the part of participants is most notable on the governance subscale items 24, 26 and 27 and questions about residents' dependence on staff (e.g., 9 and 10).

The increase in documentation means that more and more programs are expected, if not required, to have ready-to-hand information contained in a complete case management file (#19). When a client is sent to a program from another agency, that agency expects a detailed report of the client's progress and may also have other expectations, such as drug-testing, that the program needs to fulfill. With the increase in documentation comes necessarily an increase in monitoring. Clients have less "freedom" to do their own thing when their every move must be documented and explained. Even a simple thing like daily attendance records can change the tenor

of a program. For example, a majority of social model programs do not allow participants to leave the program site without staff permission (#5) because the programs are expected to keep accurate attendance records documenting the actual amount of time a client is present at the program site. "Staff permission" may take the form of a simple sign-out sheet by the door, but even this represents a change from the way social model programs have traditionally been run: on the basis of trust and voluntary attendance.

The reception desk (#4) and increased paperwork (#8) are obviously results of this increased emphasis on client monitoring. It also may help to explain why residents must get staff involved when a participant shows up drunk, rather than "handling the situation themselves" (#9): the fact of drunkenness, not to mention its consequences, must be documented for communication to all interested parties. In fact, many programs did not answer #9, considering it "not applicable" because the staff at their program are "present 24/7": 24 hours a day, seven days a week.

With the increase in documenting and monitoring, there has been of necessity a shift in governance responsibility from the residents to the staff, who must be well trained in how to document and monitor. This need for additional training in skills that are not typically gained experientially, through the process of recovery alone (Borkman et al., 1998; Kaskutas et al., 1998b), is reflected in the increased number of staff positions requiring professional training and certificates (#14). Although most programs retain a residents' council, this council has less and less real governing power, since trained staff and outside agencies now dictate how the program is run and how individual "cases" are moved through the system. Thus residents tend not to create and enforce program rules (#24), and they certainly do not have the power to end a participant's residency (#26) or to punish other residents (#27). These decisions, especially ones that affect a client's status at

the program, must be made by staff, who are able to answer to the outside agencies.

Still other influences have played a role in the lower scores. One of the biggest changes is demographic: according to several social model directors we have spoken with, social model programs are serving more dually diagnosed clients and more clients mandated from the prison and court systems (#18). This change may partially explain the decline in residents' responsibility and government authority at the programs. Clients with more serious mental health problems are less able to make their own outside appointments without staff assistance (#10) and can be less trusted if they leave the program site without staff permission (#5). Mandated clients tend to lack the necessary motivation and devotion both to their own recovery and to the recovering community to handle serious decision-making responsibility—e.g., dealing with a drunk resident without needing intervention by the staff (#9) or handling the power of being able to punish or demote other residents (#27).

Probably one of the most startling findings for social model programs, especially when compared with therapeutic communities, is the lack of vocational or academic training for participants (#22). When several social model program directors were questioned about this difference, they said that social model does not emphasize job training because it tends to interfere with the recovery process for many clients. They felt this is particularly true with clients who have severe employment problems: a focus on these issues in the early phases of recovery tends to distract such clients from the primary problem, their addiction. Job training and education are viewed as needs to be tackled only during the secondary phase of recovery. As lengths of stay have decreased and the severity of substance abuse and mental health problems among clients has increased, many social model programs have been forced to cut so-called "secondary" services altogether. Also, some funding streams no longer reimburse sub-

stance abuse programs for groups that focus on employment-related issues.

The SMPS has proved useful both in identifying common areas shared by social model programs, and others and in distinguishing elements that differentiate social model from other philosophies. Many social-model-oriented items are no longer endorsed by social model programs, highlighting areas where social model programs have changed with the times and that can no longer be used to distinguish social model programs from other types of program. Nonetheless, some specific items still do a very good distinguishing job. Some of these "distinguishing" items are in fact ones on which social model programs scored quite low—but other programs scored even lower: for example, social model programs are still less likely than other types to keep case management files on participants (#19), and they are more likely to allow residents to have a say in decisions to end a participant's residency (#26).

The two questions with no variance (3 and 23) are very telling of the extent to which all programs acknowledge the importance of social interaction with peers during the treatment/recovery process. Nearly all the programs in California have implemented what are surely two of the easiest ways to incorporate peer interaction into their program's operation: they "encourage participants to engage one another in informal activities and conversation" (#23), and they "provide a comfortable group area, a living room or sofas" (#3) for these informal social interactions to take place. These results remind us that even as social model has declined in the state, some of its principles are alive and thriving not only in social model programs, but in all kinds of programs.

Notes

1. These descriptions of social model philosophy and the SMPS subscales are excerpted from the SMPS Manual (Room, 1996).

2. Form ADP 5085-L, which can be obtained from the Department of Alcohol and Drug Programs, 1700 K Street, Sacramento, CA 95814-4037; (916) 322-2911.

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Appendix Social Model Philosophy Scale (SMPS)—the proportion responding in the "social model" direction is shown for each item

I. PHYSICAL ENVIRONMENT

1. Is the program site a part of a hospital or clinical setting? **NO - 97%**
2. What % of rooms is dedicated to staff offices? **Less than 10% of rooms - 41%**
3. Is there a comfortable group area, a living room or sofas, for participant socializing? **YES - 99%**
4. Does the site have a reception desk to screen people upon arrival? **NO - 26%**
5. Can participants with a requisite amount of sobriety leave the site without staff permission? **YES - 46%**
6. Are participants involved in food preparation? **YES - 83%**

II. STAFF ROLE

7. Does the staff eat with the participants? **YES - 78%**
8. What is the estimated % of time staff spends outside of the office when on site? **75% or more of time - 23%**
9. If staff is not there or in the immediate vicinity and a participant shows up drunk, do residents... **handle the situation themselves and not involve staff? - 2%** (versus play a role but also rely on staff or totally rely on staff)
10. When residents need to make and attend outside appointments (doctor, court, etc.), does the staff... **avoid making appointments for residents? - 11%** (versus encourage residents to make their own but make them when appropriate, or make nearly all appointments for residents?
11. Does resident responsibility increase with their length of stay at the program? **YES - 91%**

III. AUTHORITY BASE

12. Are any alumni on staff? **YES - 86%**
13. What % of staff are in recovery? **100% of staff - 51%**
14. According to program policy, what % of staff positions require a certificate or degree (including CAC or CADAC), or some kind of professional training? **0% of staff - 32%**
15. Over a normal 7-day week, have 50% or more of the participants been clean and sober for 4 weeks or longer? **YES - 94%**
16. Are people with long-term sobriety on site at the program...**often, getting actively involved with the residents? - 79%** (versus only via structured self-help, such as H&I or events led by alumni)

IV. VIEW OF DEALING WITH ALCOHOL PROBLEMS

17. Is this program... **a recovery program? - 65%**

18. Are more than 50% of the participants mandated by some external institution or agency? **NO - 61%**

19. In terms of record-keeping, does the program keep for each participant... **a fact sheet plus progress notes (even a recovery plan)? - 36%**

20. Are participants ever referred to by staff...**as residents or participants? - 77%** (versus as clients or as patients)

21. Are staff ever referred to by participants...**as staff or advocates or guides? - 50%** (versus as counselors or as therapists)

22. Does the program provide vocational or academic training for participants?
YES - 36%

23. Are participants encouraged to engage one another in informal activities & conversation?
YES - 97%

V. GOVERNANCE

24. Are there rules made by the residents that the residents (not the staff) enforce?
YES - 45%

25. Is there a residents council? **YES - 79%**

26. Do the residents or residents council have the power to end a participant's residency..**on their own, without approval from staff? - 3%** (versus in a decision reached jointly with staff or the staff make the decision and residents have no say)

27. Do the residents or residents council have the authority to punish or demote residents?
YES - 28%

VI. COMMUNITY ORIENTATION

28. At AA (or NA) meetings hosted on site are there typically... **1/3 or more of attendees from the surrounding community? - 40%**

29. Does the program help participants find a sponsor if they are having trouble finding one?
YES - 68%

30. What % of participants find sponsors among AA (or NA) members before leaving the program?
more than 90% of participants - 39%

31. Are there formal links with the community such as job search, education, family services, health and/or housing programs that participants may easily use?
YES - 95%

32. Do program participants engage in community relations and interactions (car washes, tree trimming, litter abatement, neighborhood fairs, "Alcoholic Olympics," softball or volleyball "recovery leagues") to promote such concepts as "Celebrate Recovery," "It's OK not to Drink," kinship with other recovery communities and goodwill for recovery services? **YES - 81%**

33. Are clean and sober social events "regularly" scheduled (each participant can attend at least one)?
YES - 88%