Integrative Supervised Living: Conceptual Model for Dual-Providers

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Introduction

Community and Economic Development (CED) is the process of integrating economic and societal developments to foster the economic, social, and cultural well-being of communities. CED can improve quality of life through assessed needs, presented solutions, and the deployed resources that transforms specific conditions in society. Growth is a quantitative increase; development is focused change towards a particular goal. While each community may have specific developmental priorities, the entangled and wide-spread problems associated with alcohol and other drugs are possibly the most collectively devastating to CEDs throughout America.

According to the 2016 Surgeon General's Report on Alcohol, Drugs, and Health: *Facing Addiction in America,* "The accumulated costs to the individual, the family, and the community are staggering and arise as a consequence of many direct and indirect effects, including compromised physical and mental health, increased spread of infectious disease, loss of productivity, reduced quality of life, increased crime and violence, increased motor vehicle crashes, abuse and neglect of children, and health care costs" (p. 1). While evidence-based interventions are implemented to combat substance use disorder, substance abuse, and substance misuse; the most vulnerable, most affected, and most "at risk" population segment has received little to no mention.

Some of the most degenerative long-term consequences resulting from parental substance abuse are the neglects of children and the dissolution of families. The nation's drug addiction epidemic has created a crisis in foster care. The 2015 Adoption and Foster Care Analysis and Reporting System (AFCARS) data reveals child neglect and parental substance abuse are the first and second most frequent reasons for child removals from parental custody. The data presented does not identify the reasons for child neglect; however, it's safe to infer parental substance abuse and substance misuse played significant roles in many cases. Consequently, approximately fifty-percent of child removals from parental custody results directly or indirectly from parental substance abuse and substance misuse.

According to Ducci & Goldman 2012, "Twin studies have shown that the heritability of addictions ranges from 0.39 (hallucinogens) to 0.72 (cocaine). Twin studies indicate that genes influence each stage from initiation to addiction, although the genetic determinants may differ. Addictions are by definition the result of gene × environment interaction. These disorders, which are in part volitional, in part inborn, and in part determined by environmental experience, pose the full

range of medical, genetic, policy, and moral challenges" (Summary section, para 1). Due to the heritability and environmental factors concerning removals from parental custody; individuals in foster care, as a population segment, are some of the most at risk individuals to develop substance use disorders in the country. To effectively prevent substance misuse, that which precedes substance abuse and substance use disorder, it is necessary to discover the nature of the problem and its average age of onset.

The Surgeon General's Report (SGR) states, "The likelihood of substance use escalates dramatically across adolescence, peaks in a person's twenties, and declines thereafter. For example, the highest prevalence of past month binge drinking and marijuana use occurs at ages twenty-one and twenty, respectively" (p. 96). Assessing the situation, young adults transitioning to extended foster care are identified "core" target populations which need *selective* preventative interventions. Effective preventative interventions will reduce risk factors and increase protective factors. *Risk factors* include the initiations of substance use, persistent problem behaviors, rebelliousness, favorable attitudes towards substance use, and peer substance use. *Protective factors* include social, emotional, behavioral, cognitive, and moral competence; self-efficacy, spirituality, and resiliency (SGR). In order to better facilitate this target populations' transition away from risk towards protection, it is important to assess the extended foster care program designed to address this development most.

Supervised Independent Living (SIL)

According to the Texas Department of Family Protective Services (DFPS), the Supervised Independent Living (SIL) program was created to provide specific environments for young adults, ages eighteen to twenty-one, which could support their transitions to self-sufficiency. The approved SIL settings include apartments, non-college dorms, college dorms, shared housing, and host homes. The placements allow young adults to live independently while still receiving casework and important support services. The young adults are assisted in their transitions to independent living through identified education and employment goals, engaged life skills trainings, access to community resources, and the establishment of healthy and productive relationships. The young adults' increased responsibilities include managing their own finances, buying groceries and personal items, participating in social activities, and working with landlords. The SIL program is designed specifically to facilitate their journeys toward independent living before leaving paid foster care.

A DFPS Memorandum from 2011 states, "SIL providers will not be licensed, but through contract provisions will meet the identified needs of young adults in their SIL program." But are programs meeting the identified needs of the target population? Have their needs been properly assessed? Can providers accommodate the intended population's demand? Are there opportunities for growth and development?

The Texas Network of Youth Service's (TNOYS) article *Foster Care Funding and Redesign: Supporting the Best Possible Care for Texas' Children and Youth* (2016) voices similar concerns stating "the SIL program is facing a capacity shortage, and many youth in extended foster care are staying in emergency shelters intended for minors or other less than ideal placements." Additionally, TNOYS states "This time period is a critical one for getting young people the support they need to get on their feet and become healthy, independent adults"; but unfortunately, "roughly one in four youths who ages out of foster care ends up homeless after they transition." There is definitely a need for more providers, so why is there such a capacity shortage for this target population? TNOYS clarifies, "many providers who would like to operate SIL programs are not doing so because the state reimbursement rate is not adequate and they cannot afford to."

While groups advocate for higher reimbursement rates to increase incentive for SIL facility enrollment, what steps are being taking to implement *specific* preventative interventions within these environments? It appears the SIL program focuses more on increasing *protective factors*, while placing less emphasis towards reducing *risk factors* for the most "at risk" population in need of risk factor reduction. Are there established programs/providers which are proven to reduce *risk factors* of live-in residents? Could some of these programs/providers satisfy this population's need for safe and supportive housing?

Recovery Residence (RR)

Recovery residences (RR) are safe, sober, and supportive living environments which promote and facilitate the recovery process from substance use and its associated problems. RRs were one of the earliest and most important developmental components of the network of support and recovery-based institutions marking a major milestone in the history of recovery in the United States (Jason, Mericle, Polcin, & White, 2013). RRs elevate long-term recovery rates by enhancing quality of life during the lengthy recovery process and can serve as excellent environments to test and validate evidence-based practices. Jason et al. (2013), state "there is growing consensus that recovery from

substance use disorders involves three critical components: sobriety, improvement in physical, emotional, relational, and spiritual health, and positive community reintegration" (p.3). RRs can help engaged residents develop these components systematically by their willingness to comply with the policies, codes of conduct, and agreements determining continued residency.

As a result of residents "having a variety of problems in addition to substance abuse, such as homelessness, past criminal justice involvement, and chronic illness", and the operational evolution of routine intakes, transitions, and discharges; the RR operators have gradually adapted to, and become increasingly proficient at, serving the multi-dimensional needs of most residents (Callahan, Harvey, Jason, Mericle, & Polcin, 2016). Many thousands of RRs exist in the United States encompassing all levels of support, but until recently, uniform standards which all residences could adhere to did not exist. The National Association of Recovery Residences (NARR) was established to provide a unified national voice for RRs, and amongst other reasons, to ensure the highest level "gold" standard of operations is recognized. A growing body of research now supports the effectiveness of recovery residences sustaining abstinence and promoting gains in a variety of other domains. Consequently, health and human professionals will soon recognize the beneficial long-term recovery and independence outcomes produced from these living environments (Jason, Mericle, Polcin, & White, 2013).

RRs are specifically designed to reduce risk factors, but are they capable of increasing protective factors as well? A recent study of twenty-one recovery residence operators in Philadelphia generated some interesting findings pertaining to the missions of their RRs. When asking operators about their missions and desired outcomes for their residents, they "talked about wanting to help residents address their substance abuse, but more frequently, talked about fostering personal growth and development and providing safe and supportive environments for them" (Mericle, Miles, & Way, 2015, Mission section, para. 1). The residents' growths were fostered by developing the life, employment, and education skills to become empowered and productive members of society. Residents developed their character and conviction as they processed painful life experiences, took responsibility for their actions, and learned the necessary coping, resolution, and interpersonal skills to establish healthy long-term relationships (Mericle et al., 2015).

The successful progression from early recovery to empowered independence may require long-term sober-living environments capable of both reducing *risk factors* and increasing *protective factors* systematically. Can RRs provide more adaptive support services to accommodate long-term

residents throughout the lengthy process towards independent living? Could these sober-living environments become the ideal settings for the "at risk" young adults who qualify for SIL placement? Will the vision of integrative supervised living create opportunities for public-private partnerships and executions of cross-sector CED?

Integrative Supervised Living (ISL) *Conceptual Model for Dual-Providers*

The 2014 Housing for Urban Development (HUD) report on *Housing for Youth Aging Out of Foster Care* states, "Each year, approximately 25,000 youth exit the foster care system before being reunited with their family of origin, being adopted, or achieving another permeant living arrangement. These youth often have limited resources with which to secure safe and stable housing, which leaves them at heightened risk of experiencing homelessness" (p.iii). The report determined there is an "inadequacy of housing supports for youth aging out of foster care" and concludes by stating "identify[ing] housing models that are most effective for preventing and ending homelessness amongst this population" is of the upmost concern (p. iii). So which housing model will facilitate this populations' lengthy process towards independent living most effectively? This proposal intends to prove long-term sober cooperatives, specifically shared-housing settings with on-site operators, are the ideal housing model to generated positive impacts and outcomes for stakeholders.

Proposal. The DFPS should utilize RR providers throughout Texas as a solution to the SIL capacity shortage. RR providers approved for SIL facility enrollment will create the foundation of the Integrative Supervised Living (ISL) dual-provider model. ISL dual-providers should reserve half their beds for young adults applying to the DFPS SIL program and the other half for recovery residents. ISL dual-providers will employ on-site operators to guide interventions and provide the needed support-services for all residents individually. Shared-housing is likely to be the most replicable and most effective housing setting for ISL dual-provider programs. Cooperative living environments can generate a synergistic component which fosters both personal and group developments. In order to help ensure successful integration, both the SIL and recovery resident applicants must meet the minimum placement criteria for ISL dual-provider programs. The ISL dual-provider program design intends to advance HUD's established program criteria also.

Criteria. The HUD report *Housing for youth aging out of foster care: A review of the literature and program typology* (2012) revealed the programs which met HUD's criteria for innovativeness, replicability, and geographic diversity all shared "cross-sector collaboration; blended funding

streams; integration of foster youth with other populations; unique program philosophies; and co-location of housing with services or other employment opportunities" as distinguishing features (p. 32). The ISL dual-provider model intends to incorporate these features and present practical solutions to prevent young adult homelessness as they age out of foster care.

Cross-Sector Collaboration. ISL dual-providers will likely generate cross-sector collaboration between DFPS, HUD, and RR providers. The ISL operators can remain in contact with DFPS caseworkers and document each young adult's progress throughout the duration of their extended foster care ISL program. ISL operators may evaluate program outcomes and generate important feedback loops for HUD and DFPS. ISL dual-providers may establish new environments for translational research and validations of evidence-based prevention practices.

Blended Funding Streams. ISL dual-provider programs permit the blending of funding streams from public and private sectors. The reimbursement rate and private payments from both the DFPS and the recovery residents may solve some of the funding obstacles experienced by RR and SIL providers individually. Additionally, ISL programs may generate opportunities to receive social impact financing from foundations and public-private partnership organizations which have similar missions and goals.

Integration of Foster Youth with other Populations. Young adults who apply for the extended foster care SIL program may be given options to select a long-term "shared-housing" sober cooperative as their desired SIL provider. Approved SIL applicants can integrate with established peer-groups at approved ISL dual-provider locations and gracefully adapt to, and evolve with, the collective group conscious moving forward. The young adults may benefit from the experience, strength, and hope of their peers in recovery and advance their journeys toward independent living together. Peer groups are a component of sober cooperatives. During house meetings peers provide constructive feedback to individuals needing guidance and practical solutions. As a result of their peers' expressed considerations and accountability; individual and group awareness expands, trust is established, and healthy relationships are formed.

Unique Program Philosophy. The ISL dual-provider model has a unique philosophy and can combine program components in innovative ways. Evidence-based recovery practices intend to sustain abstinence for individuals recovering from substance use disorders while *selective* preventative interventions intend to mitigate or eliminate the initiations of substance use for some of

the most “at risk” individuals in the country. The ISL dual-provider model may establish long-term sober cooperatives increasing average stays to two or more years. With half the beds filled by approved SIL applicants remaining for three years or more hopefully, residents at an ISL dual-provider should experience a more stable environment compared to traditional RRs where there is typically much higher resident turnover. Many programs encourage residents to “have a sponsor” but few programs encourage residents to sponsor someone else. Recovery residents shall be encouraged to sponsor the young adults in ISL programs, and by doing so, can strengthen their personal recovery even more. The in-house sponsors can provide an additional layer of support for the young adults by helping with shopping and short travel requests as well. The sponsor/sponsee relationship, in many cases, is one of the most transformational components of the recovery and prevention process.

Co-location of Housing and Support-Services. ISL dual-providers shall combine sober housing with other support services as well. All residents will likely engage in conflict resolution, negotiation, general life skills development, home maintenance, meal preparation and serving, interviewing, the voting process, and long-term strategic planning. Operators can assist residents with their college enrollments and FAFSA paperwork, employment searches and resume building, financial planning and budgeting, the discovery of community service opportunities, the family unification process when this is a case goal, and transition planning to secure permanent housing when necessary.

Geographic Diversity and Program Replicability. The abundance of RRs throughout the country should establish the geographic diversity of potential ISL dual-providers. These residences are usually strategically placed near bus stops, convenience stores, and local colleges satisfying their target population’s positive community reintegration needs. NARR and SIL facility checklists have very similar requirements. The intensity of services required by RR and SIL providers are very similar as well. These similarities will likely facilitate successful replications of ISL dual-provider programs once the design concept becomes a working model.

Additional Benefits of the ISL Dual-Provider Model. In addition to eliminating or significantly reducing the degree of substance use young adults will engage in, successful ISL dual-provider programs may decrease likelihoods of becoming homeless as they age out of foster care too. The ISL model’s dual provider status can create an additional layer of security assisting their transitions to independent living. As young adults leave paid foster care they will already live in a safe, secure, and

supportive environment. They shall be granted the opportunity to make rental payments, at the same location, to the same ISL dual-provider that provided those services throughout their duration in extended foster care. Operators can continue to provide important support-services for the young adults who would be independent citizens at that time. The recently transitioned young adults can receive help creating realistic budget projections considering they will then be responsible for timely rent, car, insurance, and any additional expense payments. Operators can provide proof of residencies, payment histories, letters of recommendation, and any additional transition planning responsibilities for the young adults during their final stages of community reintegration. The young adults will hopefully enter communities successfully as empowered, independent, and productive citizens.

Conclusion

The entangled and wide-spread problems associated alcohol and other drugs are limiting humanity's potential. Children have become the victim. Community leaders must assess this need, present solutions, and inspire the deployed resources to transform this specific condition existing in society. While the implementations of *universal* and *indicated* interventions raise awareness on the large scale and treat the immediate needs of substance abusers in treatment, what action is society taking to help some of the greatest victims of the nation's drug epidemic?

Individuals in foster care are highly at risk to develop substance use disorders. Those transitioning to extended foster care are entering a crucial time period in which substance use must be avoided. Extended foster care programs focus on increasing *protective factors*, yet reducing their *risk factors* is likely more important to the long-term success of this target population. RRs are prevalent throughout the country and are proficient reducing the risk factors needed to maintain safe, sober, and supportive environments. SIL programs have a serious capacity shortage and need more providers. RRs have available beds and can accommodate more residents. SIL providers are reluctant to establish programs due to the current reimbursement rates. DFPS reimbursement rates could positively transform the financial conditions of many RR providers.

HUD assessed the need to end homelessness amongst young adults aging out foster care and demanded a solution. Long-term sober cooperatives, specifically shared housing with on-site operators, is the ideal proposed housing model for this population. Forming public-private partnerships is necessary to develop this housing model. Will resources be deployed to transform the

Integrative Supervised Living (ISL), conceptual model for dual-providers, to that of a verified working model for future disseminations?

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