Acceptance Recovery Center: The Value of Aftercare for Ex-offenders with Substance Abuse Disorders.

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Abstract

Acceptance Recovery Center (ARC) is a newly opened treatment center and re-entry program for male ex-offenders with substance abuse disorders. The program focuses on accountability and substance abuse recovery for ex-offenders. Empirical evidence shows that programs like ARC can help reduce recidivism and improve the health of the individuals and community. This paper will highlight the benefits of programs like ARC, explore the opposition to such programs and offer possible suggestions for expanding such programs throughout Georgia and the United States.

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Substance abuse and addiction are clearly related to criminal activity and eventual incarceration for the substance abuser. To reduce the cycle of recidivism and to offer ex-offenders the opportunity to stay sober and discover a new way to live, programs like ARC are an invaluable source of treatment and re-teaching for substance abusers who want to release the hold of substances, embrace their life and live in the community as a productive and contributing member of society.

1. Acceptance Recovery Center

ARC opened for its first resident in January 2016. ARC is an American Society of Addiction Medicine (ASAM)[i] level 3 residential treatment facility. (ASAM, 2016) The mission statement of ARC "Acceptance Recovery Center is dedicated to providing education, shelter and support in a structured transitional therapeutic community for the displaced and addicted populations; empowering them to become productive members of society." (ARC, 2016) The founder and staff of ARC are motivated to improve the lives of their residents and to improve the community in the process.

Founder and director Brandy Witte Anderson

Brandy is a 32-year-old recovering addict. She is a single, heterosexual, White female who opened ARC as part of her life's mission to help as many people as possible recover from the horrors of addiction. Brandy's personal experiences with addiction go beyond the methamphetamines that were her personal drug of choice. She grew up with substance abusing parents. She is a survivor of childhood sexual and physical abuse. When she was 12, Brandy's mother went to prison on drug charges. Brandy left home before finishing the eighth grade and

lived on the streets until she went to the Oklahoma State Penitentiary on drug and weapons charges in 2005. While in prison, she not only rode a bucking bronco in the Oklahoma Prison rodeo[ii], she earned her GED and almost enough college credits for an Associate's degree. When she was released on Parole in 2009, she moved to Georgia, became a devout member of Narcotics Anonymous (NA) and enrolled in college. Brandy has a Bachelor of arts degree in Human Services Delivery and Administration from the University of North Georgia. She is also a Certified Addiction Counselor II (CACII) in the state of Georgia. While in college and after graduation in 2012, Brandy worked as the Case Manager for Angel House of Georgia in Gainesville, GA. The agency's director was rarely at the facility and she was not meeting many of the legal requirements for a non-profit organization. With classes like "non-profit management" and "grant writing" that Brandy had excelled in while in school, she had the knowledge and drive to make many improvements to Angel House. She was the force behind building a board of directors, finding outside sources of funding and speaking publicly to accountability courts, addiction professionals and many parole and probation officers. She made the local recovery and law enforcement communities aware of Angel House's services and gained many sources of support and referrals.

Under Brandy's leadership and guidance, Angel House experienced better retention, fewer relapses and better long-term outcomes. When she realized that she had basically reached her potential at Angel House, she quit her job and set out to open a new facility that would help more people by being larger and having a much more intensive treatment process. She originally thought that she would open a facility for women, but she came to realize that more long-term, low-cost alternatives were needed for men. She spent six months searching north Georgia for the right location while writing her business plan and securing financing.

The facility

The actual location is a 2 story apartment building with 16, 2 bedroom apartments. On the ground floor the first apartment is offices. Apartments 2,3,4, and 5 have had some of the walls removed to create what staff and residents refer to as the "the quad." The quad was designed for ARC's newer members it has room for 16 men. In the quad, there are 8 bedrooms, 4 bathrooms, several kitchens with many refrigerators, a room with 2 computers, a laundry room, 4 dining tables that look to seat 6-8 people each and a large common room with chairs. "Most of this furniture came from my house." Brandy tells me, "I slept in my office for a few months because at home I really only had a bed." There are another 4, 2-bedroom apartments that are used for residents who are further along in the treatment process. While not at capacity presently, the four apartments will house another 16 men. The staff and residents have done a lot of work to make ARC homey and functional. In a vacant lot across the parking lot there is a large vegetable garden. In the side yard by the office there are flowers and bushes planted, a few picnic tables and a charcoal grill.

The Program

ARC's target population is high risk/high need men over 18 with a sincere desire to change. This means that the majority of the residents have had multiple failed recovery attempts. They have all been in and out of prisons and treatment programs. The admission fee for ARC is $500 (which also covers the first 2 weeks). The weekly rate is $160, but the staff will not turn anyone away because of inability to pay. The program lasts a year, consisting of 4 phases, followed by aftercare. Each phase allows more freedom and comes with more responsibilities for the resident. The treatment consists of individual and group counseling, daily morning meditation, relapse prevention, coping skills, MRT, 12 step instruction, anger management,

healthy relationships, life skills, and community based Alcoholics Anonymous (AA) and NA meetings. The staff is always reevaluating the population to see what kind of groups and interventions they need to offer.

The residents are responsible for getting and keeping a job (if physically able) daily chores, maintaining a weekly schedule and being held accountable for where they are at all times. Depending on which phase he is in, there are different amounts of required groups and meetings each week. Each resident is also responsible for working towards the goals in his treatment plan as well as any obligations he has with the judicial system. Each resident evaluates his compliance to rules, obligations and progress in weekly accountability meetings.

Interview

Since I knew that ARC had been open only 6 months, one of my first questions was about the challenges of opening a recovery residence as far as finding a location, getting zoning approval and if she had experienced community opposition. Brandy proudly pointed to the certificate of occupancy hanging on the wall of the group room (the living room of the apartment serving as an office.) She says that each city she visited while looking for a good location had different methods of zoning approval. Because of the criminal record and current probation and/or parole status of most of the residents, Brandy says that she had to look for a commercial area/multifamily residence. The residence is zoned as a personal care group home. Brandy had been hoping to purchase a residence for ARC, but when she found the apartments where ARC is located the owner was not willing to sell the property. The property was suffering from neglect and required a lot of work to be ready for occupancy. Brandy, along with a member of her board of directors negotiated for the monthly rental to be based on the number of occupants. Because

of the demographic she was planning to work with, she said she never looked for a location that was within a primarily residential area.

I asked how the agency selected their clients and if there was any demographic that she had been unable to reach. Brandy said that ARC is open to any high risk/high needs man that comes to them needing help. Brandy said that although she has done very little marketing yet, all of her clients have come from referrals from probation, parole or the accountability courts. When a man is referred and indicates that he is motivated for change a staff member will meet with him, often in one of the nearby correctional institutions to conduct an intake assessment. The potential client has to have motivation and readiness for change. He also has to be willing to get a job. assuming he is physically able. Brandy is adamant that ARC will not turn down a resident because of inability to pay. She said that they would like to serve more of the homeless population, but as of this time they have not tried to recruit more homeless clients, although several of their residents have been homeless at the time of admission.

Next, I asked Brandy about the demographics of the clients ARC serves. Since the agency opened in January, 2016 they have had 46 clients, they currently have 23 at the residence, unfortunately none of the 23 who have left have completed the program. Of the 46 men who have entered the program, 41 are Caucasian, 3 African American and 2 Latino. Education level of the 46 who have started the program 14 /46 have less than a high school education and one has had an Associate's degree, the remainder have had either a high school diploma or a GED. All have prison records. Economically, 9 of the 46 had jobs when they started the program. Of the 23 current residents 20 are employed, only 1 has health insurance through his job. Of the 46 residents 25 were classified as indigent at time of admission. The men have a combined total of

44 children. Brandy says that many were homeless at the time of admission, but that is not one of the characteristics she has been tracking.

The World Health Organization defines health as a state of complete physical, mental and social well-being. I asked her about her thoughts about the affect ARC has on these 3 separate aspects of health? Brandy says that for most of the men their physical health improves quickly. Since most have been incarcerated, they have usually been living on high carbohydrate diet and forced inactivity. With the help of a local food bank, there is plenty of food available and the agency has a weekly community dinner where everyone eats together. There are also bi-weekly healthy cooking classes for the men to learn how to cook their own healthy meals. Mental health is improved through weekly counseling sessions, daily psychoeducational groups, and for those who need it community mental health for diagnosis and treatment of mental disorders. Social health is improved by association and relationships formed with others in recovery through living at the agency, attendance at AA and NA and finding an AA or NA sponsor who helps guide the resident through the 12 steps.

ARC is doing very important work by helping their clients with addiction, which is a tragic and often fatal disease. How have the residents handled other health needs? "Dental" says Brandy, we have not been able to get anyone treated for dental problems. It is one of the biggest health concerns among the residents, "If someone is sick or hurt, we use the emergency room, I know that is bad, but what other choice do we have?"

I asked Brandy what program completion would look like. She says that 12 months is the standard length of the program, at the time of program completion the resident will have worked with a sponsor to complete the first 6 of the 12 steps, will have done a 1st step presentation to the rest of the group, have completed MRT and healthy relationship classes. They will need to have

a sponsor and a home group as well as be current on all legal obligations, including permission from the court. After care usually lasts 6 months, but the client can continue to attend groups as long as he wants. When asked about family involvement in the clients' treatment process, Brandy says that she is planning to develop a family therapy and goal setting class, at this time however, there is some, but not much involvement with the families of the residents. Family members are encouraged to at least try a few Alanon groups.

Finally, I asked about the differences in working with men versus working with women, since she and I had worked together in a women's facility together for so many years. She said that the men had far more relapses, more than once she has had several men go out together and come back drunk or high. She also said "I thought there would be less drama with men, but there is just as much drama, if not more." We agreed that drama was something that close living quarters brings about and that substance abusers, in early recovery, are practically prone to drama. She said she was afraid that she wouldn't relate as well with men as she had with the women at her previous job, but said that she felt just as close, involved and empathetic as she had when working with women. Her eyes welled with tears as she showed me a 30-day keyring that one of her residents had earned from his NA group. She said "he gave this to me the day he picked it up at a meeting, I should have thrown him out after the third relapse, but I had a feeling about him. I thought that he could make it through."

My reaction to interview questions

The first question I asked was about finding a suitable location for ARC. Brandy worked on this for about 6 months. I think her choice of location is very suitable, and she has worked to insure that she is within all applicable laws in Athens/Clark county. She even showed me the required exit signs and recycling bins.

Next we discussed how the clients are recruited and the demographics of ARC's residents. Brandy told me that the agency is applying for ASAM level three certification which includes residential facilities for high-risk/high need clients. (ASAM, 2016). This is a difficult population to choose. Her clients all have multiple failed recovery attempts and prison records. Since the program is a yearlong and ARC has not been open that long, they could not have had anyone complete the program yet. However, the outlook is not terrific because they have already lost exactly half of the men who started their treatment at ARC. Some were dismissed from the program for behavioral issues or multiple relapses, most of those who have left are currently incarcerated because completion of the program was a condition of parole. I applaud Brandy and the ARC staff for choosing to work with such a difficult population. I am concerned that a low success rate will hurt the agency's opportunities when they are applying for grants. Brandy and I have successfully co-written a grant before and I was planning to help write one to see if we could get any sort of fund started for dental care. I am also very impressed with ARC's staff and board's decision not to turn anyone away from their services because of lack of money. For an agency that is primarily self-funded, waiting to get the initial payment shows a true dedication to the cause that team ARC is working towards.

One part of the interview that disturbed me the most is talking about health care for the clients, including both the availability of health care and the dimensions of health, as described by WHO and Barr (2014) The residents at ARC are former substance abusers and primarily come from and remain in a lower SES. When we were discussing the kind of jobs that the men have in order to pay their weekly fees, child support and other living expenses, Brandy indicated that most of the residents work in the construction business as contract laborers, a few work in various restaurant jobs. Construction is a famously unstable industry, meaning that employment

will be inconsistent. Both food service and day laborers would be considered high demand, low control jobs. These industries require employees to work quickly at repetitive tasks and the employee has little to no control over the work environment, hours worked or what type of work they will be doing on any given day. This type of high demand, low control work environment creates a high stress psychosocial work environment. This type of stress is linked to cardiovascular disease, depression, alcohol dependence and poor self-rated health. (Siegrist & Marmot, 2004, p. 1467) When the health factors involved with excessive stress combine with lack of preventative care, conditions brought about by the high stress environment will not be alleviated or even treated with medication. By looking at the effect of the combined factors on the multi-dimensional model of health, these men are at high risk for disease and premature death. (Barr, 2014, p. 10) In many ways, the improvements that ARC is helping men make in their lives regarding all aspects of their health are remarkable improvements, but the lack of actual medical and dental care is an important obstacle to overcome. This is not a factor that ARC staff or board of directors can change. It may be possible, at some point, that they will find a better way to work within the existing health care system.

Proposal

Addiction is a horrible disease, but in the United States we still find it necessary to treat this disease as a crime leading to an out of control prison populations and billions of dollars being spent to incarcerate the affected individuals but very little is being spent to treat them and create a healthier and safer population. According to the Substance Abuse and Mental Health Administration (SAMHSA) about 8.5% of the US population had an illicit (or alcohol) substance use disorder requiring treatment, but only about 18.5% of those needing treatment received any type of treatment and only about half of those received treatment from a specialty treatment

center. (NIH, 2015) The numbers are just as bad for state prisons where one in seven are incarcerated for drug offenses[iii], but 53% of those incarcerated meet the criteria for a substance use disorder. (Olson & Lurigio, 2014) In the majority of state prisons, self-help (such as NA) groups are the only resource for substance use disorder treatment. About 15% of the incarcerated population who meet criteria for substance use disorder receive any professional treatment. Not all substance abusers are addicts, but many will require help to find meaning and purpose to their lives. It is difficult if not impossible to identify the substance users who will embrace life and accept help once it is offered, meaning that sometimes people will surprise even the most knowledgeable treatment provider. There is, however, hope for anyone willing to at least try to find a better life. People only know what they know. Many people, throughout the United States accept as fact that they will spend some portion of their life incarcerated. If they do not know that there are alternatives, how can they ever embrace a life free from substances, crime and violence.

My proposal is that everyone convicted of a crime involving substance use should have treatment and/or education for substance abuse made available to them, at least while in prison. Olson and Lurigio (2014) found that offenders who participated in treatment while incarcerated and a TC once released had a 44% reduction in recidivism compared to offenders who received no treatment. Of course there would have to be different levels of treatment available and different security measures in place for people who have committed different types of crime. I am not suggesting that an individual who has committed violence against another person should be sent to a place like ARC, where accountability is an essential part of the program, but the doors are open and anyone could walk out the door. I would like to create a situation where people who are disenfranchised and have had a life that steered them towards substance use are

provided the opportunity to learn how to live without using substances as a crutch or escape. ARC would fall into the realm of what SAMHSA describes as a therapeutic community (TC). While ARC is a non-profit organization and accepts donations, the residents are the people paying a weekly fee that keeps the facility in business. Therefore, most of what is required is building or remodeling facilities and recruitment and training for people to manage and work in these facilities.

Another proposal is for health screenings and at least minimal health care for chronic conditions for people either incarcerated or released from incarceration who meet the criteria for substance use disorders. ARC's clients, for instance, have no health insurance and no way to pay for screenings of chronic illnesses. Substance abusers are much more likely than the general population to suffer from a variety of chronic illnesses, many of which can be controlled if identified and treated. Conditions such a cardiovascular disease, hypertension, respiratory illnesses, cirrhosis of the liver, sexually transmitted diseases, HIV and Hepatitis C are just some of the illnesses that are associated with substance use disorders. (Schulte & Hser, 2014) The mortality rate for people with substance use disorders, compared to the general population is double for women and triple for men. (Ross, et al., 2015). Screening people for physical illnesses when they are identified as substance abusers could, at the very least, help control the transmission of some of these communicable diseases.

Critique of proposals

The primary critique of my proposals would be the financial resources that would be necessary to implement these changes. Many people argue that drug treatment is not effective because relapse is common, therefore spending money and time to treat everyone who is affected by substance use disorders is a waste of resources. Between 40-60% of the people who complete

drug treatment will relapse. (NIH, 2016) That number does not even include those who drop out during treatment. Secondly, substance abusers do not get better when they stop using because of a court mandate or because they can get out of prison if they attend treatment. Research has been done regarding people attending court mandated alcohol education and treatment after incidences of arrest for drunk driving. Overall, it was found that the use of court mandated treatment was, at best, marginally effective against recidivism. (Dill & Parker, 2004)

Another valid argument against my proposal was that once someone has committed a crime, he or she should serve their entire sentence and should not be released early because they are "getting help." There is an obvious incentive built into this proposal for people to lie about their commitment to change in order to go to a lower security facility so they can "get treatment." Many people would be concerned about public safety if a therapeutic community was put in their neighborhood or near a school, playground or even a mall where children and young adults congregate. People would be concerned that if the residents of the TC were to relapse that they may try to finance their habit by selling drugs to the children in surrounding areas.

The proposal on health care comes with its own issues. Health care is very expensive and many people cannot afford the medication, treatments and screenings that they need. There are still about 30- 40 million Americans who do not have health insurance because they cannot afford to pay the premiums. (Barr, 2014, pp. 10-11) It would be unfair to people who have stayed within the law but cannot get their health needs met, to have convicted criminals getting healthcare funded by the government.

The good and the bad

Certainly, people who argue that the relapse rate for substance abusers is too high for our society to depend on substance abuse treatment to solve any of the problems related to crime and

drug use make a very valid point. I would not suggest that we just open the doors to the prisons and let everyone go to treatment instead. The use of substance abuse treatment both in prison and once an offender is released should be on a case by case basis. The person has to demonstrate a desire to change, otherwise treatment will probably be ineffective and the individual would probably be too hard to manage once he or she was out in the community. (Dill & Parker, 2004) Brandy and the staff at ARC defiantly believe that willingness to change is a key component of success for the men in their program. One way for the person to demonstrate his or her willingness is to start treatment while the person is still incarcerated. The treatment needs to be provided by a trained professional, as much as I support AA and NA, a volunteer mentor is not in the position to evaluate an inmate's desire for change, nor should they be put in the position of answering questions about inmates. (the groups are anonymous, after all) People who will work at a program while they are still incarcerated are demonstrating at least some interest in recovery. Also, when discussing relapse, the relapse rate of 40-60% is not higher than the rate of relapse for other chronic health conditions. When a patient is treated for hypertension or diabetes and treatment is discontinued, the relapse rate for both illnesses is about 60%, the same as the relapse rate for substance use disorders. (NIH, 2016) Substance use disorders are chronic relapsing diseases. Treatment never really ends.

I think it is also important to note that the National institute on Drug Abuse (2014) reports that the financial cost of treatment for a prisoner is about 25% of the cost of incarceration and is almost twice as effective at preventing recidivism. There are also other significantly reduced costs to taxpayers when drug users stop using. Overall, both violent and property crimes are directly correlated to substance abuse in the community. (Olson & Lurigio, 2014) When

fewer people are abusing drugs, fewer people are crime victims and the costs of law enforcement decreases in the community.

As far as my proposal on medical screenings and at least minimal treatment for substance abusers. First of all, it is the right thing to do. Substance abusers often have less education, less family support and fewer employment opportunities than the general public. (Olson & Lurigio, 2014) The chances are not good that chronic health problems will be discovered if not done as part of an intake screening for a treatment facility. Also, screenings for diseases like HIV and Hepatitis C are a matter of public health. If a person does not realize that he or she has one of these communicable and sexually transmitted diseases, that person will not know to protect sexual partners or, in the case of relapse, know not to share needles.

How can social workers help?

Advocating for social justice is one of the most important obligations of a social worker. "Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people." (NASW, 2008) Prisoners and substance abusers are two oppressed populations that need the help of social workers to achieve any level of social justice. The fact is that both groups (incarcerated individuals and substance abusers) are fair game for discrimination and open and outright hatred by the general public. People with substance abuse disorders are often blamed for their disease and considered disposable humans. Social workers can study addiction theories, attend conferences on substance abuse disorders and the latest and best treatment modalities. In other words, the first step is to inform the helpers. The more we, as social workers, know about substance use disorders, identification of the disorders and treatment options, the more we can help our community and the people suffering

from substance use disorders. There is no way that we can work in the helping professions without coming across clients who will need help with these disorders.

We can also help by knowing the local treatment facilities and advocating for the facilities, the clients and the workers. We can collaborate with these facilities to help create a safety net for their clients and to help create more programs and policies that can help the treatment centers be effective in their work. We can help educate the community and policy makers on the benefits of substance abuse treatment.

Concluding remarks

My visit to ARC was both celebratory (I am so proud of Brandy and all she has accomplished) and eye opening, even with everything that Brandy and her staff can do to help, educate, advocate and work their fingers to the bone; they cannot save anyone. They can only open the door, give the directions and the emotional support and hope that their client is strong enough to walk through the door. It is heartbreaking work, but it is needed so badly. Most people with substance use disorders never get help. Most never get the opportunity to heal. They end up either dead or in endless cycle of prison and release.

Quality substance abuse treatment in prison, not simply a volunteer, and aftercare programs with substance and support of local law enforcement, policy makers and medical facilities are necessary to start curbing the drug problem in this country. As a society we have to become willing to provide at least the minimal healthcare to people who we don't find "deserving." The spread of HIV and Hepatitis C is frighteningly real, shouldn't the carriers of these diseases at least know that they have them? Not only as social workers, but as members of the human race, it is time that we stop letting substance abuse be another qualifier of human worth.

2. References

ARC. (2016). *About us*. Retrieved from Acceptance recovery ceter: http://acceptancerecoverycenter.org/mission/#

ASAM. (2016). *Quality and practice*. Retrieved from American Society of Addiction Medicine: http://www.asam.org/quality-practice/guidelines-and-consensus-documents/the-asam-criteria/about

Barr, D. (2014). *Health disparities in the United States: Social class, race, ethnicity.* Baltimore, MD: John Hopkins University Press.

Dill, P., & Parker, E. (2004). *Court-Mandated Treatment for Convicted Drinking Drivers*. Retrieved from National Institute on Alcohol Abuse and Alcoholism: http://pubs.niaaa.nih.gov/publications/arh291/41-48.htm

NASW. (2008). *National Association of Social Workers*. Retrieved from Code of Ethics: https://www.socialworkers.org/pubs/code/code.asp

NIH. (2015). *DrugFacts: Treatment Approaches for Drug Addiction*. Retrieved from National institute on Drug Abuse: https://www.drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction

NIH. (2016). *Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition)*. Retrieved from National Institute of Drug Abuse: https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-qu

Olson, D., & Lurigio, A. (2014). The long-term effects of prison-based drug treatment and aftercare services on recidivism . *Journal of Offender Rehabilitation* , 600-619.

Ross, L., Vigod, S., Wishart, J., Waese, M., Spence, J. D., Oliver, J., . . . Shields, R. (2015). *Barriers and facilitators to primary care for people with mental health and/or substance use issues: a qualitative study.* Toronto, ON: BMC Family Practice.

Schulte, M., & Hser, Y. (2014). Substance use and associated health conditions throughout the lifespan. *Public health Review*, 1-28.

Siegrist, J., & Marmot, M. (2004). Health inequalities and the psychosocial enviornment--two scientific challanges. *Social Science & Medicine*, 1463-1473.

Footnotes

[i] ASAM approval pending

[ii] The Oklahoma prison rodeo was discontinued in 2009, due to shortage of staffing at the prison. Brandy was in the rodeo in 2007 (the second year women participated) She appears in the documentary “Sweethearts of the Prison Rodeo,” (2009) at the time she was known as “foxie.”

[iii] The majority of prisoners incarcerated for distribution or trafficking are in federal prisons.