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What Did We Learn from Our Study on Sober Living Houses and Where Do We Go from Here?

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Abstract

Lack of a stable, alcohol and drug free living environment can be a serious obstacle to sustained abstinence. Destructive living environments can derail recovery for even highly motivated individuals. Sober living houses (SLHs) are alcohol and drug free living environments for individuals attempting to abstain from alcohol and drugs. They are not licensed or funded by state or local governments and the residents themselves pay for costs. The philosophy of recovery emphasizes 12-step group attendance and peer support. We studied 300 individuals entering two different types of SLHs over an 18 month period. This paper summarizes our published findings documenting resident improvement on measures of alcohol and drug use, employment, arrests, and psychiatric symptoms. Involvement in 12-step groups and characteristics of the social network were strong predictors of outcome, reaffirming the importance of social and environmental factors in recovery. The paper adds to our previous reports by providing a discussion of implications for treatment and criminal justice systems. We also describe the next steps in our research on SLHs, which will include: 1) an attempt to improve outcomes for residents referred from the criminal justice system and 2) a depiction of how attitudes of stakeholder groups create a community context that can facilitate and hinder the legitimacy of SLHs as a recovery modality.

Keywords

Sober Living House; Residential Treatment; Recovery House; Social Model; Communal Living

Introduction

Research continues to document the important role of social factors in recovery outcome (Polcin, Korcha, Bond, Galloway & Lapp, in press). For example, in a study of problem and dependent drinkers Beattie and Longabaugh (1999) found that social support was associated with drinking outcome. Not surprising, the best outcomes were predicted by *alcohol-specific* social support that discouraged drinking. Similarly, Zywiak, Longabaugh and Wirtz (2002) found that clients who had social networks with a higher number of abstainers and recovering alcoholics had better outcome 3 years after treatment completion. Moos and Moos (2006) studied a large sample of 461 treated and untreated individuals with alcohol use disorders over a 16 year period to examine factors associated with relapse. They found that social support for recovery was important in establishing sustained abstinence. Finally, Bond, Kaskutas and Weisner (2003) reached a similar conclusion in a 3-year follow up

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study on 655 alcohol dependent individuals who were seeking treatment. Abstinence from alcohol was associated with social support for sobriety and involvement in Alcoholics Anonymous.

A critically important aspect of one's social network is their living environment. Recognition of the importance of one's living environment led to a proliferation of inpatient and residential treatment programs during the 1960' and 70's (White, 1998). The idea was to remove clients from destructive living environments that encouraged substance use and create new social support systems in treatment. Some programs created halfway houses where clients could reside after they completed residential treatment or while they attended outpatient treatment. A variety of studies showed that halfway houses improved treatment outcome (Braucht, Reichardt, Geissler, & Bormann, 1995; Hitchcock, Stainback, & Roque, 1995; Milby, Schumacher, Wallace, Freedman & Vuchinich, 2005; Schinka, Francis, Hughes, LaLone, & Flynn, 1998).

Despite the advantages of halfway houses, there are limitations as well (Polcin & Henderson, 2008). First, there is typically a limit on how long residents can stay. After some period of time, usually several months, residents are required to move out whether or not they feel ready for independent living. A second issue is financing the houses, which often includes government funding. This leaves facilities vulnerable to funding cuts. Finally, halfway houses require residents to have completed or be involved in some type of formal treatment. For a variety of reasons some individuals may want to avoid formal treatment programs. Some may have had negative experiences in treatment and therefore seek out alternative paths to recovery. Others may have relapsed after treatment and therefore feel the need for increased support for abstinence. However, they may want to avoid the level of commitment involved in reentering a formal treatment program. Sober living houses (SLHs) are alcohol and drug free living environments that offer peer support for recovery outside the context of treatment.

Characteristics of Sober Living Houses

Sober Living Houses are structured in a way that avoids some of the limitations of halfway houses. The essential characteristics include: 1) an alcohol and drug free living environment for individuals attempting to abstain from alcohol and drugs, 2) no formal treatment services but either mandated or strongly encouraged attendance at 12-step self-help groups such as Alcoholics Anonymous (AA), 3) required compliance with house rules such as maintaining abstinence, paying rent and other fees, participating in house chores and attending house meetings, 4) resident responsibility for financing rent and other costs, and 5) an invitation for residents to stay in the house as long as they wish provided they comply with house rules (Polcin & Henderson, 2008).

SLHs have their origins in the state of California and most continue to be located there (Polcin & Henderson, 2008). It is difficult to ascertain the exact number because they are not formal treatment programs and are therefore outside the purview of state licensing agencies. However, in California many SLHs are affiliated with coalitions or associations that monitor health, safety, quality and adherence to a peer-oriented model of recovery, such as the California Association of Addiction Recovery Resources (CAARR) or the Sober Living Network (SLN). Over 24 agencies affiliated with CAARR offer clean and sober living services. The SLN has over 500 individual houses among it membership.

While some SLHs use a “strong manager” model where the owner or manager of the house develops and enforces the house rules, contemporary SLH associations such as CAARR and SLN emphasize a “social model approach” to managing houses that empowers residents by providing leadership position and forums where they can have input into decision making

(Polcin & Henderson, 2008). Some houses have a "residents' council," which functions as a type of government for the house.

Recovery Philosophy in Sober Living Houses

Central to recovery in SLHs is involvement in 12-step mutual help groups (Polcin & Henderson, 2008). Residents are usually required or strongly encouraged to attend meetings and actively work a 12-step recovery program (e.g., obtain a sponsor, practice the 12 steps, and volunteer for service positions that support meetings). However, some houses will allow other types of activities that can substitute for 12 step groups, provided they constitute a strategy for maintaining ongoing abstinence.

Developing a social network that supports ongoing sobriety is also an important component of the recovery model used in SLHs. Residents are encouraged to provide mutual support and encouragement for recovery with fellow peers in the house. Those who have been in the house the longest and who have more time in recovery are especially encouraged to provide support to new residents. This type of "giving back" is consistent with a principle of recovery in 12-step groups. Residents are also encouraged to avoid friends and family who might encourage them to use alcohol and drugs, particularly individuals with whom they have used substances in the past (Polcin, Korcha, Bond, Galloway & Lapp, in press).

Purpose

There are several primary aims for this paper. First is to summarize key outcomes from our study, "An Evaluation of Sober Living Houses," which was a 5- year study funded by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) (i.e., Korcha, Polcin, Bond & Galloway, 2010; Polcin, 2009; Polcin & Henderson, 2008; Polcin, Korcha, Bond & Galloway, 2010; Polcin, Korcha, Bond & Galloway, in press; Polcin, Korcha, Bond, Galloway & Lapp in press). Second is to expand on these findings by considering potential implications of our research for inpatient and outpatient treatment and for criminal justice systems. Third is to describe the next steps in our research on SLHs. These include plans to study the community context of SLHs by examining attitudes of community stakeholder groups (e.g., neighbors, local government officials, mental health therapists, criminal justice professionals and practitioners in substance abuse treatment programs). We also describe plans to conduct studies of resident subgroups, such as individuals referred from the criminal justice system.

Data Collection Sites

The study was designed to assess outcomes for 300 individuals entering two types of SLHs: 1) Options Recovery Services (ORS) in Berkeley, California was an adapted model of SLHs in that the houses were associated with an outpatient treatment program. 2) Clean and Sober Transitional Living (CSTL) in Sacramento County, California consisted of freestanding houses that were not affiliated with any type of treatment. The descriptions of CSLT and ORS that follow are summaries of Polcin and Henderson (2008), Polcin (2009) and Polcin, Korcha, Bond, Galloway & Lapp (in press).

Clean and Sober Transitional Living (CSTL)

CSLT is located in Sacramento County California and consists of 16 houses with a 136 bed capacity. Residency at CSTL is divided into two phases. Phase I lasts 30 to 90 days and is designed to provide some limits and structure for new residents. Residents must agree to abide by a curfew and attend at 12-step meetings five times per week. The purpose of these

requirements is to help residents successfully transition into the facility, adapt to the SLH environment, and develop a stable recovery program.

The second phase allows for more personal autonomy and increased responsibility for one's recovery. Curfews and requirements for 12-step attendance are reduced. All residents, regardless of phase, are required to be active in 12-step recovery programs, abide by basic house rules, and abstain from alcohol and drugs. A “Resident Congress” consisting of current residents and alumni helps enforce house rules and provides input into the management of the houses. Although the owner/operator of the houses is ultimately responsible, she/he defers to the Residents Congress as much as possible to maintain a peer oriented approach to recovery. In order to be admitted to CSTL prospective residents must have begun some type of recovery program prior to their application.

Options Recovery Services (ORS)

ORS is an outpatient substance abuse treatment program located in Berkeley, California that treats approximately 800 clients per year. Most of the clients are low income and many have history of being homeless at some point in their lives. Because a large number do not have a stable living environment that supports abstinence from alcohol and drugs, ORS developed SLHs where clients can live while they attend the outpatient program. Currently there are 4 houses with 58 beds. The houses are different from freestanding SLHs, such as those at CSTL, because all residents must be involved in the outpatient program. Most residents enter the houses after residing in a short term homeless shelter located near the program. At admission, nearly all residents are eligible for some type of government assistance (e.g., general assistance or social security disability) and use those funds to pay SLH fees. To help limit social isolation and reduce costs residents share bedrooms. Like other SLH models of recovery, residence are free to stay as long as they wish provide they comply with house rules (e.g., curfews, attendance at 12-step meetings) and fulfill their financial obligations. Also like other SLH models, each house has a house manager who is responsible for ensuring house rules and requirements are followed. ORS does not have any type of Residents Council, but house managers meet regularly with the executive director and have input into operation of the SLHs in during these contacts.

Procedures

Participants were interviewed within their first week of entering a sober living house and again at 6-, 12-, and 18-month follow up. To maximize generalization of findings, very few exclusion criteria were used and very few residents declined to participate. Primary outcomes consisted or self report measures of alcohol and drug use. Secondary outcomes included measures of legal, employment, medical, psychiatric and family problems. Some measures assessed the entire 6 months between data collection time points. Others, such as the Addiction Severity Index, assessed shorter time periods of 30 days or less.

Measures

1) Demographic Characteristics—included standard demographic questions such as age, gender, ethnicity, marital status, and education.

2) Addiction Severity Index Lite (ASI)—The ASI is a standardized, structured interview that assesses problem severity in six areas: medical, employment/support, drug/alcohol, legal, family/social and psychological (McLellan et al., 1992). Each of the six areas is scored for 0 (low) to 1 (high).

3) Psychiatric symptoms—To assess current psychiatric severity we used the Brief Symptom Inventory (Derogatis & Melisaratos, 1983). This 53-item measure assesses severity of psychiatric symptoms on nine clinical scales as well as three global indices. Items are rated on a 5-point scale and ask about symptoms over the past 7 days. We used the Global Severity Index (GSI) as an overall measure of psychiatric severity.

4) Six month measures of alcohol and drug use—These measures were taken from Gerstein et al. (1994) and labeled Peak Density and 6-month abstinence. *Peak Density* is the number of days of any substance use (i.e., any alcohol or drug) during the month of highest use over the past 6 months (coded 0-31). *Six-month abstinence* was a dichotomous yes/no regarding any use of alcohol of drugs over the past 6 months.

5) Arrests—This measure was taken from Gerstein et al. (1994) and was defined as number of arrests over the past 6 months.

Two additional measures were included as covariates because they assess factors emphasized by as important to recovery in SLHs.

6) Alcoholics Anonymous Affiliation Scale—This measure includes 9 items and was developed by Humphreys, Kaskutas and Weisner (1998) to measure the strength of an individual's affiliation with AA. The scale includes a number of items beyond attendance at meetings, including questions about sponsorship, spirituality, and volunteer service positions at meetings.

7) Drinking and drug use status in the social network—These measures were taken from the Important People Instrument (Zywiak, et al., 2002). The instrument allows participants to identify up to 12 important people in his or her network whom they have had contact with in the past six months. Information on the type of relationship (e.g., spouse, friend), amount of contact over the past 6 months (e.g., daily, once or twice a week) and drug and alcohol use over the past 6 months (e.g., heavy user, light user, in recovery) was obtained for each person in the social network. The drinking status of the social network was calculated by multiplying the amount of contact by the drinking pattern of each network member, averaged across the network. The same method is applied to obtain the drug status of the network member; the amount of contact is multiplied by the pattern of drug use and averaged across network members.

Hypotheses

Hypotheses suggested that we would find two types of longitudinal outcomes: 1) Individuals entering the houses with higher severity of problems would show significant improvement between baseline and 6 months and those improvements would be maintained at 12 and 18 months and 2) Individuals entering houses with low severity would maintain low severity at all follow up time points. It was expected that measures of social support for sobriety and 12-step involvement would be associated with primary outcomes.

The study design used repeated measures analyses to test how study measures varied over time. Because the two types of houses served residents with different demographic characteristics, we conducted disaggregated longitudinal analyses for each. For a more complete description of the study design and collection of data see Polcin et al. (2010), Polcin et al. (in press) and Polcin, Korcha, Bond, Galloway and Lapp (in press).

Data Collection

At CSTL we recruited 245 individuals within their first week of entering the houses. Most were men (77%), white (72.5%) and middle age (mean=38, se=0.65). Over 75% had at least a high school education or GED. The most common referral source was self, family or friend (44%) followed by criminal justice (29%) and inpatient treatment (15%). Over a third (35%) of the sample indicated that jail or prison had been their usual housing situation over the past 6 months and few reported any type of stable housing over the past 6 months. Just 7% reported renting an apartment as their primary housing, while 23% reported staying with family or friends and 12% reported homeless as their primary living situation

ORS had 4 houses, where we recruited 55 participants. Most were African American (59%), while 30% were white. The mean age was 43 years (se=1.2). Most residents had completed high school or a GED (73%). Nearly half of the residents had been self referred of referred by family or friends. About 24% were criminal justice referrals and a third had spent some time in a controlled environment during the month before entering the house. Many of the residents had histories of homelessness. When asked to indicate their usual housing situation the past six months, a third indicated homeless or in a shelter.

Follow up rates for CSLT were 72% at 6 months, 71% at 12 months ad 73% at 18 months. However, 89% of the sample (N=218) participated in at least one follow up interview. The proportions successfully followed up at ORS were similar at 12 and 18 months (76% and 71% respectively) but higher at 6 months (86%). To address the issue of missing data from individuals who we were not able to locate for follow up interviews, we used analytic methods that did not require participants to complete 0interviews at all time points to be include in the analysis. These included generalized estimated equations (GEE) and mixed model regressions. In addition, when we compared baseline characteristics of individuals successfully located and interviewed with those lost at follow up we did not find significant differences. However, individuals who we were not able to follow up did have shorter lengths of stay in the SLHs.

Main Findings

Detailed descriptions of analytic methods and statistical results have been reported in Polcin, Korcha, Bond, & Galloway (2010), Polcin Korcha, Bond, & Galloway (in press), and Polcin Korcha, Bond, Galloway & Lapp (in press). Our purpose here is to summarize the most salient and relevant findings for SLHs as a community based recovery option. We then expand on the findings by considering potential implications of SLHs for treatment and criminal justice systems. We also include a discussion of our plans to study the community context of SLHs, which will depict how stakeholder influences support and hinder their operations and potential for expansion.

Retention

Retention of residents in the sober living houses was excellent. Average lengths of stay in both types of sober living houses surpassed the National Institute on Drug Abuse recommendation of at least 90 days to obtain maximum benefit. The average length of stay at ORS was 254 days (se=169 days) and at CSLT it was 166 days (se=163).

Primary Outcomes

As hypothesized, there were two patterns of outcome for our primary outcome variables. One pattern was that residents reduced or stopped their substance use between baseline and 6 month follow up and then maintained those improvements at 12 and 18 months. This was the case for both substance use measures that assessed 6 month period of time: 1) complete

abstinence over the 6 months and 2) maximum number of days of any substance use during the month of highest use. For example, at ORS 6-month abstinence rates improved from 11% at baseline to 68% at 6- and 12-months. At 18 months abstinence was a bit lower, (46%) but still significantly better than the time period before they entered the houses. For CSLT, abstinence improved from 20% at baseline, to 40% at 6 months, 45% at 12 months and 42% at 18 months. Maximum number of days of use per month at ORS on average declined from 19 days per month at baseline, to 3 days at 6 months, 4 days at 12 months and 7 days at 18 months. CSLT declined from 19 days at baseline, to 11 days at 6 months, 9 days at 12 months and 13 days at 18 months.

Findings on the ASI alcohol and drug scales measuring the past 30 days reflected different patterns. At CSLT, residents entered with low alcohol (mean=0.16, se=0.02) and drug (mean=0.08, se=0.01) severity. Because severity was low there was limited room to improve on these measures. Nevertheless, we found significant improvement at 6 months for both alcohol (mean=0.10, se=0.02) and drug (mean=0.05, se=0.01). Those improvements were maintained at 12 and 18 months. At ORS, residents entered with even lower alcohol (mean=0.07, se=0.02) and drug (mean=0.05, se=0.01) severity that was maintained at 6, 12 and 18 month follow up. Potential reasons for low alcohol and drug severity at baseline included large proportions spending some time in a controlled environment during the 30 days before they entered the houses. In addition, many residents had begun working on a recovery program shortly before they entered the houses (e.g., attending 12-step meetings). In fact, the ORS program typically required 30 days of abstinence before being eligible to enter the residence.

It was noteworthy that a wide variety of individuals in both programs had positive outcomes. There were no significant differences within either program on outcomes among demographic subgroups or different referral sources. In addition, it is important to note that residents were able to maintain improvements even after they left the SLHs. At 12 months 68% had left ORS and 82% had left CSLT. By 18 months nearly all had left, yet improvements were for the most part maintained.

Secondary Outcomes

There were also improvements noted on the secondary outcome measures. At CSTL these included improvements on employment, psychiatric symptoms, and arrests. The pattern was again significant improvement between baseline and 6 months that was generally maintained at 12 and 18 months. The percent arrested 6 months pre-baseline was 42%, which dropped to 26% at 6-month follow up and 22% at 12 months. There was a light increase at 18 months (28%), which was still significantly lower than pre-baseline. Employment severity on the ASI improved from a mean of 0.76(se=0.02) at baseline to a mean of 0.53(se=0.02) at six months. At 12 months the mean was 0.54(se=0.03), which increased only slightly at 18 months (mean=0.59, se=0.02). Psychiatric symptoms improved from a mean of 0.83(se=0.05) at baseline to 0.69(se=0.05) at 6 months. By 18 months there was a bit of an increase (mean=0.72, se=0.06), which was no longer statistically significant but was still a statistical trend ($p<.10$).

At ORS there were similar patterns of improvement on employment and arrests. From baseline to 6 months the average score on the ASI employment scale improved from 0.61 (se=0.02) to 0.51 (se= 0.03) and was maintained at 12 and 18 months. The odds of being arrested were reduced from baseline to 6 months by 80% and even further reduced at 12 and 18 months.

Factors that Predicted Outcome

In addition to documenting longitudinal outcomes, we were interested in assessing factors that predicted outcomes. Using GEE models that assessed a variety of factors across data collection time points we found involvement in 12-step groups to be the strongest predictor of our primary outcomes. For CSLT, 12-step involvement was associated with being abstinent for at least 6 months ($p<.001$), lower maximum days of substance us per month ($p<.001$, and fewer arrests ($p<.01$). For ORS, 12-step involvement was associated with abstinent for at least 6 months ($p<.05$), lower maximum days of substance us per month ($p<.01$), and lower ASI legal severity ($p<.05$).

We also examined how drinking and drug use in the participant's social network related to outcomes. At CSLT we found heavier drinking and drug use in the social network was related to worse outcome on all alcohol and drug outcome measures ($p<.01$ for all variables). At ORS the findings were mixed. There was a significant relationship between maximum number of days of substance use per month and drinking in the social network ($p<.05$) and drug use in the social network ($p<.01$). However, there were no significant relationships between social network variables and abstinence. In addition, for the ASI alcohol and drug scales at ORS, the only significant association with social network variables was heavier drug use in the social network predicting ASI alcohol outcome ($p<.01$).

In a recent analysis of CSTL residents we looked at psychiatric severity as a predictor of alcohol and drug outcome using growth curve models (Korcha et al (2010). We found that a subgroup of about a third of the residents had significantly higher psychiatric severity than other residents and had significantly worse outcomes. Our work on identifying and describing these residents with worse outcome is continuing.

Limitations

There are several limitations to the study that are important to consider. First, we could not directly compare which type of SLH was most effective because there were demographic and other individual characteristics that differed between the two types of houses. Second, individuals self selected themselves into the houses and a priori characteristics of these individuals may have at least in part accounted for the longitudinal improvements. Although self selection can be viewed as a weakness of the research designs, it can also be conceived as a strength, especially for studying residential recovery programs. Our study design had characteristics that DeLeon, Inciardi and Martin (1995) suggested were critical to studies of residential recovery programs. They argued that self selection of participants to the interventions being studies was an advantage because it mirrored the way individuals typically choose to enter treatment. Thus, self selection was integral to the intervention being studied and without self selection it was difficult to argue that a valid examination of the invention had been conducted. In their view, random assignment of participants to conditions was often appropriate for medication studies but often inappropriately applied when used to study residential services for recovery from addiction.

Significance of the Study

Our study represents the first examination of sober living house residents using a longitudinal design. To date, our papers have looked at study findings in terms of the types of improvements residents make and factors associated with outcome, the substance of which has been summarized above. One of our aims here, however, is also to look at significance from the perspective of how SLHs might impact various service systems in the community. The promising outcomes for SLH residents suggest that sober living houses

might play more substantive roles for persons: 1) completing residential treatment, 2) attending outpatient treatment, 3) seeking non-treatment alternatives for recovery, and 4) entering the community after criminal justice incarceration.

Treatment Systems

The two types of recovery houses assessed in this study showed different strengths and weaknesses and served different types of individuals. Communities and addiction treatment systems should therefore carefully assess the types of recovery housing that might be most helpful to their communities. Several considerations are reviewed below.

Outpatient programs in low income urban areas might find the Options Recovery Services model of SLHs helpful. Relative to the other housing programs, this model was inexpensive and the houses were conveniently located near the outpatient facility. Typically, residents entered these SLHs after establishing some period of sobriety while they resided in a nearby shelter and attended the outpatient program. A significant strength of the Options houses was that residents were able to maintain low alcohol and drug severity at 12-month follow up.

There are several significant advantages of establishing SLHs associated with outpatient treatment as apposed to traditional halfway houses. First, residents in SLHs are free to stay as long as they wish after completing the outpatient program as long as they abide by program rules. This eliminates arbitrary discharge dates determined by the program, a procedure often used by halfway houses to free up beds. Rather, the resident is able to decide when he or she is ready to transition to more independence. Among other things, this eliminates the need to move to questionable living environments that might not support recovery due to time limitations. SLHs are also less costly than halfway houses, which are usually funded by treatment programs.

SLHs combined with outpatient treatment may be especially valuable to resource poor communities that do not have funds to establish residential treatment programs or have the income levels that could support freestanding sober living houses which are more expensive. Most of the rent for the Options SLHs was paid by General Assistance or Social Security Income, so a variety of low income residents could be accommodated. While the level of support is less intensive (and less expensive) than that offered in residential treatment, it is more intensive than the relative autonomy found in freestanding SLHs. Some residents probably benefit from the mandate that they attend outpatient treatment during the day and comply with a curfew in the evening. For some individuals, the limited structure offered by freestanding SLHs could invite association with substance using friends and family and thus precipitate relapse. This could be particularly problematic in poor communities where residents have easy access to substances and people who use them.

Freestanding SLHs

The roles that freestanding SLHs can play in communities are different from SLHs that are associated with outpatient treatment. First, freestanding houses are often used by individuals who have some previous experience with residential treatment. While some of these individuals transition directly from the inpatient program to the SLH, others enter the houses after some post-treatment period in the community. They may slip, relapse or feel vulnerable to relapse, but for a variety of reasons not want to reenter a formal treatment program. Nevertheless, they may feel the need to take action and get support for reestablishing abstinence. Freestanding SLHs can be a good match for these individuals because they offer support for sobriety outside the context of formal treatment.

Freestanding SLH's offer a limited amount of structure and no formal treatment services. Thus, they are optimal for residents who are capable of handling a fair amount of autonomy and who can take personal responsibility for their recovery. Despite these limitations, CSLT appeared to benefit many different types of residents who were referred from an array of personal and institutional sources (i.e., self, family, criminal justice systems, and inpatient treatment programs). Expansion of freestanding SLHs in communities might therefore ease the burden on overwhelmed treatment systems. In communities that are unable to fund a sufficient number of treatment programs for individuals with substance use disorders, freestanding SLHs might be a clinically and economically effective alternative. The availability of treatment slots for individuals released from jail or prison or particularly lacking. For some those offenders who are motivated for abstinence and capable of handling some degree of autonomy SLHs might be a viable and effective option for recovery that is currently underutilized.

Criminal Justice Systems

Prison and jail overcrowding in the U.S. has reached a crisis point. Each year more than 7 million individuals are released from local jails into communities and over 600,000 are released on parole from prison (Freudenberg, Daniels, Crum, Perkins & Richie, 2005). Although the need for alcohol and drug treatment among this population is high, very few receive services during or after their incarceration. In California, studies show that few offenders being released from state prisons have adequate housing options and in urban areas such as San Francisco and Los Angeles up to a third become homeless (Petersilia, 2003). Housing instability has contributed to high reincarceration rates in California, with up to two-thirds of parolees are reincarcerated within three years. In a study of women offenders released from jails in New York City 71% indicated that lack of adequate housing was their primary concern.

Despite the enormous need for housing among the offender population, SLHs have been largely overlooked as a housing option for them (Polcin, 2006c). This is particularly concerning because our analysis of criminal justice offenders in SLHs showed alcohol and drug outcomes that were similar to residents who entered the houses voluntarily. However, as reviewed elsewhere (i.e., Polcin, 2006c), SLHs need to carefully target criminal justice involved individuals so that they select offenders that have sufficient motivation to remain abstinent and are able to meet their financial obligations.

Where do We go from Here?

There are multiple directions one could go in pursuit of additional research on SLHs. For example, studies comparing different living situations for individuals in early recovery could help highlight the relative strengths and weaknesses of SLHs. In addition, longer follow up time periods could be assessed as well as outcomes for a wider variety of subgroups. These might include minority groups, larger samples of women, and a variety of individual level characteristics not assessed here (e.g., self efficacy and interpersonal skills). However, we have opted to look at two topics that we think are of immediate relevance to communities: 1) documenting and improving outcomes for criminal justice referred residents and 2) understanding the community context within which SLHs operate.

Improving Outcomes for Criminal Justice Referred Residents

Findings from our study suggested that alcohol and drug outcomes for residents referred from the criminal justice system were equivalent to that of voluntary residents. However, offenders did not fare as well as others in two areas: finding and maintaining employment and avoiding arrests. In addition, the numbers of criminal justice referred residents was

relatively small and an examination of a larger sample of offenders is warranted. Among other things, the larger sample would enable us to identify predictors of outcome among offenders. The field would therefore be better equipped to identify those offenders who are more likely to do well in SLHs.

In addition to studying a larger number of offenders, we hope to explore an innovative intervention designed to improve outcomes for these residents in terms of employment, arrests, and other areas. Toward that end, we are in the process of developing a Motivational Interviewing Case Management (MICM) intervention designed to help offenders successfully transition into SLHs, avoid rearrest by complying with the terms of probation or parole, and succeed in activities that support successful transition into the community (e.g., employment). Our intervention modifies motivational interviewing to address the specific needs of the offender population (Polcin, 2006b). Specifically, it helps residents resolve their mixed feelings (i.e., ambivalence) about living in the SLH and engaging in other community based services. Thus, the intervention is a way to help them prepare for the challenges and recognize the potential benefits of new activities and experiences.

Assessing the Impact of the Community Context

The fact that residents in SLHs make improvement over time does not necessarily mean that SLHs will find acceptance in the community. In fact, one of the most frustrating issues for addiction researchers is the extent to which interventions that have been shown to be effective are not implemented in community programs. We suggest that efforts to translate research into treatment have not sufficiently appreciated how interventions are perceived and affected by various stakeholder groups (Polcin, 2006a). We therefore suggest that there is a need to pay attention to the community context where those interventions are delivered.

As a next step in our research on SLHs we plan to assess how they are viewed by various stakeholder groups in the community, including house managers, neighbors, treatment professionals, and local government officials. Interviews will elicit their knowledge about addiction, recovery, and community based recovery houses such as SLHs. Their perceptions of the strengths and weaknesses of SLHs in their communities should provide data that can be used to modify houses to improve acceptance and expand to serve more drug and alcohol dependent persons. We hypothesize that barriers to expansion of SLHs might vary by stakeholder groups. Different strategies may be needed for those who lack information about SLHs, have beliefs that they are not effective, have allegiances to other treatment approaches, have views that minimize social factors in recovery, and live in communities where public policy hinders expansion of SLHs. Drug and alcohol administrators and operators of houses might therefore need different strategies to address the concerns of different stakeholders.

Conclusion

Many individuals attempting to abstain from alcohol and drugs do not have access to appropriate housing that supports sustained recovery. Our study found positive longitudinal outcomes for 300 individuals living in two different types of SLHs, which suggests they might be an effective option for those in need of alcohol- and drug-free housing. Improvements were noted in alcohol and drug use, arrests, psychiatric symptoms and employment. Owners and operators of SLHs should pay attention to factors that predicted better alcohol and drug outcomes, including higher involvement in 12-step meetings, lower alcohol and drug use in the social network, and lower psychiatric severity. Although criminal justice referred residents had alcohol and drug use outcomes that were similar to other residents, they had a harder time finding and keeping work and had higher rearrest rates. Areas for further research include testing innovative interventions to improve criminal

justice outcomes, such as Motivational Interviewing Case Management (MICM) and examining the community context of SLHs. Recognizing stakeholder views that hinder and support SLHs will be essential if they are to expand to better meet the housing needs of persons suffering from alcohol and drug disorders.

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Community Context of Sober Living Houses

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ABSTRACT

The success or failure of programs designed to address alcohol and drug problems can be profoundly influenced by the communities where they are located. Support from the community is vital for long term stability and conflict with the community can harm a program's reputation or even result in closure. This study examined the community context of sober living houses (SLHs) in one Northern California community by interviewing key stakeholder groups. SLHs are alcohol and drug free living environments for individuals attempting to abstain from substance use. Previous research on residents of SLHs showed they make long-term improvements on measures of substance use, psychiatric symptoms, arrests, and employment. Interviews were completed with house managers, neighbors, and key informants from local government and community organizations. Overall, stakeholders felt SLHs were necessary and had a positive impact on the community. It was emphasized that SLHs needed to practice a "good neighbor" policy that prohibited substance use and encouraged community service. Size and density of SLHs appeared to influence neighbor perceptions. For small (six residents or less), sparsely populated houses, a strategy of blending in with the neighborhood seemed to work. However, it was clear that larger, densely populated houses need to actively manage relationships with community stakeholders. Strategies for improving relationships with immediate neighbors, decreasing stigma, and broadening the leadership structure are discussed. Implications for a broad array of community based programs are discussed.

The premise of this paper is that it is insufficient to study the effectiveness of community based services without examining characteristics of the community context in which those services are delivered. How services are perceived by key stakeholder groups will affect whether they are implemented, the level of support they receive, and the types of barriers they encounter (Guydish, et al., 2007; Jason, et al., 2005; Polcin, 2006). As an example, we describe a study of the community context of Sober Living Houses (SLHs), which are alcohol- and drug-free living environments for individuals attempting to achieve sustained abstinence. The study compliments previous research showing that SLH residents make improvements in a variety of areas, including reductions in substance use, arrests, psychiatric severity and unemployment (Polcin et al., 2010). The community context of SLHs is assessed by conducting qualitative interviews with stakeholders, including managers of the houses, neighbors, and local key informants in one Northern California County. A typology of factors supporting and hindering operations and expansion of SLHs in the community is provided.

Alcohol- and drug-free housing

Few problems in the treatment of addictive disorders have been more challenging than helping clients find long-term, alcohol- and drug-free living environments that support sustained recovery. The progress that clients make in residential treatment programs is often jeopardized by the lack of appropriate housing options when they leave (Braucht, et al., 1995). For clients attending aftercare or outpatient treatment, progress is often jeopardized by their return to destructive living environments at the end of the treatment day (Hitchcock, et al., 1995). These are often the same environments that originally contributed to their addiction. Finding affordable housing has also become more difficult because of tight housing markets in urban areas and the rise in unemployment.

One approach to the need for alcohol- and drug-free living environments has been to refer individuals to residential treatment programs. However, as funding for residential services has decreased over the years it has become an option for very few. Even when clients are admitted

to residential services, the length of treatment is typically short, often only a few weeks. Although some programs have developed "half-way" or "step-down" living facilities, these too have maximum lengths of time after which residents must leave regardless of their readiness. Cost is an additional issue for halfway houses because frequently public and private funders are unwilling to pay for services that are not medically oriented. In addition, halfway houses tend to be available only to individuals who have completed rigorous inpatient treatment, which diminishes the potential pool of individuals who might make use of them.

Sober living houses

Polcin et al (2010) suggested sober living houses (SLHs) were an underutilized housing option for a variety of individuals with addictive disorders, including those completing residential treatment, attending outpatient treatment, being released from criminal justice incarceration, and seeking non-treatment alternatives to recovery. SLHs offer an alternative alcohol- and drug-abstinent living environment for individuals attempting to establish or maintain sobriety (Wittman, 1993, 2009). Residents are free to come and go during the day and are not locked into a group schedule, as is typical in most treatment programs. This allows residents to pursue activities vital to recovery such as finding work or attending school. Residents in most SLHs are afforded social support through shared meals, socialization with recovering peers, house meetings, and access to a house manager. To help residents maintain abstinence, SLH's use a peer oriented, mutual-help model of recovery that emphasizes social model recovery principles (Polcin & Borkman, 2008). As such, they emphasize learning about addiction through personal recovery experience and drawing on one's own recovery as a way to help others.

Although management of SLHs varies, some include a residents' council as a way to empower residents in operation of the facility. While SLHs offer no formal counseling or case management, they do either mandate or strongly encourage attendance at self-help groups such as Alcoholics Anonymous or Narcotics Anonymous. Costs of living at the facility are primarily

covered by resident fees. Although some residents are able to draw upon entitlement programs or financial help from their families, most must find work to meet house rent and fees. Because SLHs are typically not part of formal treatment systems, they are available to a broad range of individuals provided they follow basic house rules, such as maintaining abstinence from substances, paying rent and fees, attending house meetings and participating in upkeep of the facility.

SLHs are similar to Oxford Houses for recovery, which are widely known in the U.S. and developing in other countries as well (Jason, et al., 2005). Similarities between the two housing models include prohibition of alcohol and drug use, social support for sobriety, encouragement or a requirement to attend 12-step meetings and work a program of recovery, and no limit on how long residents can live in the house. The main difference is that Oxford houses have more regulations for structure, size, density and management of the houses. Similar to our outcome studies of SLHs, which are described below, research on Oxford houses has documented significant improvement of resident functioning over time. For a more complete description of similarities and differences between the two housing models see Polcin and Borkman (2010).

Jason and colleagues (2005) studied neighbor perceptions of Oxford Houses and found very favorable views. However, they did not study other key stakeholders in the community, such as local government officials and criminal justice staff. They also did not aim to understand the impact of regulatory policies on the houses or what various stakeholders felt would improve relationships. Finally, the study was limited to Oxford houses and might not generalize to other types of recovery houses, including SLHs.

Purpose

The purpose of this study was to provide data that depicted the community context where SLHs operate. We wished to understand views about SLHs among key stakeholder groups and ways they support and hinder SLHs. To achieve our aim, we conducted qualitative interviews with key stakeholders in the same geographic area where we conducted a quantitative program

evaluation of SLHs, Sacramento County (i.e., Polcin, et al., 2010). We wanted to assess areas where stakeholder groups were in agreement about SLHs as well areas where they disagreed. The ultimate goal was to create a typology of factors supporting and hindering SLHs within as well as across stakeholder groups.

METHODS

Sample

To assess the community context of SLHs we conducted 43 in-depth qualitative interviews with 1) neighbors of SLHs (N=20); 2) SLH managers (N=17), which included the owner of the houses and the coordinator, and 3) key informants (N=6). Key informants included representatives from the criminal justice system, local government, housing services, and drug and alcohol treatment. The overall sample consisted of 18 women (43%), 3 from the SLH manager group, 4 key informants and 11 neighbors. Eighty six percent of the sample was white and ages ranged from 19 to 70. See Table 1 for a list of characteristics by stakeholder group.

TABLE 1 GOES HERE

Data collection site

Clean and Sober Transitional Living (CSTL) in Fair Oaks, California was one of our data collection sites for our earlier quantitative study (Polcin et al., 2010). Because the current study was designed to complement our previous work, we interviewed house managers at CSTL and neighbors who resided near one of the 16 CSTL houses. Key informants were recruited from Sacramento County, the county in California where CSTL is located.

CSTL is slightly more structured than some SLHs because the houses are divided into six phase I and ten phase II houses. Phase I houses are adjacent to each other and operate as one unit, which includes shared dining and meeting spaces. The close proximity provides residents a sense of community that facilitates their commitment to the program. Although much less restrictive than residential treatment programs, there is some degree of external control and structure. Phase I residents have a curfew, must sign in and out when they leave and must have

five 12-step meetings per week signed by the meeting chairperson. A minimum of 30 days in a phase I house is required before transitioning to phase II. The stability developed in phase I helps residents to be more successful in phase II, which includes increased freedom and autonomy. Phase II houses are conventional single-family homes and are dispersed in residential neighborhoods rather than part of a single complex.

Although CSTL houses are owned by one individual, there are a number of ways that residents are involved in management and operations. There is a "resident congress" that develops rules for the community, a "judicial committee" committee comprised of residents who enforce rules, and senior peers who monitor the behaviors of residents and bring rule violations to the attention of the judicial committee. In addition, each house also has one designated house manager and residents have an opportunity for input into the operation of CSTL through this person.

CSLT tests for drugs and alcohol at random and may conduct a test at any time if substance use is suspected. A positive test is grounds for dismissal from the house. However, a resident with a positive urine screen may appeal to the judicial committee for reinstatement. Other dischargeable offenses include drug use on the property, acts of violence, and sexual misconduct with other residents. For a more complete description of CSTL see the Polcin and Henderson (2008).

Our quantitative research on 250 CSTL residents who were tracked over an 18-month period showed significant improvement in multiple areas of functioning, including alcohol and drug use, employment, arrests, and psychiatric symptoms (Polcin et al., 2010). Importantly, residents were able to maintain improvements even after they left the SLHs. By 18 months nearly all had left, yet improvements were for the most part maintained. Although individuals with a wide variety of demographic characteristics showed improvement, those who benefited the most were those who were most involved in 12-step groups such as Alcoholics Anonymous and those who had social networks with few or no heavy substance users.

Procedures

All participants taking part in qualitative interviews were contacted by a research interviewer and asked if they were willing to participate. They were informed about the overall purpose of the study and if they agreed to participle they signed an informed consent document. Interviews lasted about one hour and participants were offered $20 for their time. All study procedures were approved by the Public Health Institute Institutional Review Board in Oakland, California.

Content of the interviews

The overall goal of the qualitative interviews for all three stakeholder groups (i.e., house managers, neighbors and key informants) was to identify areas of strength and weakness for SLHs as well as barriers to expansion. Therefore, there was considerable overlap in the questions asked of the three groups. Examples of questions asked of all three groups included:

> *What are the strengths of SLHs? What are the weaknesses? What type of impact have SLHs had on the surrounding neighborhood/community? What are the key barriers to operating and expanding SLHs? How might SLHs be improved?*

Because the three groups had different relationships with SLH facilities, there were also some differences in content of interviews. For example, house managers were asked:

> *What types of individual do well in SLHs? What types of individuals need a different environment? How often are residents asked to leave because they cannot pay rent and fees? How do you think management of the houses affects residents' experiences and outcomes? Are there specific local government policies that impact SLHs, such as housing, zoning or health policies? Describe some of the resistance, if any, that was encountered when this house first opened. How were the resistances over come? What actions were not effective? Describe how complaints or concerns from neighbors are handled.*

There were also questions that were specific to neighbors. Interviews with neighbors began by asking them whether they knew about SLHs in the neighborhood and when they first became aware of them. If they had no knowledge about SLHs the interviews was terminated. If they were aware of SLHs in the neighborhood they were asked:

> *How would you describe them as neighbors? Have you or other neighbors had complaints? Describe any interactions that you have had with SLHs in your neighborhood. Describe any specific ways that you think SLHs impact alcohol and drug problems in your community. What do you think of SLHs compared with other*

approaches to addiction, such as formal treatment programs or criminal justice consequences?

In addition to general questions asked of all the participants, key informant interviews contained questions designed to elicit information about policies and local laws that might impact SLHs. We queried these officials about their own views about SLHs, the roles SLHs might play in the larger addiction recovery system, and ways they think public policy could be modified to provide more support to SLHs. Examples of questions included:

What role does housing play for individuals attempting to establish sustained recovery? What is your sense of how well housing needs for individual with alcohol or drug problems are being addressed in your community? How would you describe your department's relationship with SLHs? Describe how SLHs support and hinder the mission of your department. How do local politics affect SLHs in your area?

Analytic plan

A triangulation design (Creswell & Plano-Clark, 2007) was created by drawing on data from the three different stakeholder groups (SLH managers, key informants and neighbors). A preliminary coding list was developed prior to the analysis of the interviews. These codes were based on key research interests, such as factors supporting and hindering SLHs. To analyze the qualitative interviews, we transcribed all sessions and entered text into a qualitative data management program, NVivo, for coding and analysis (Bazeley & Richards 2000; Richards 2002). Team members then coded transcripts independently and met to check coding accuracy and improve coding validity (Carey, Morgan, & Oxtoby, 1996).

RESULTS

The final coding scheme reflecting themes across all three stakeholder groups included codes depicting drug and alcohol problems in the local community, strengths and weaknesses of SLHs, barriers to operation and expansion, perceived impact of SLHs on the surrounding community, views about SLHs in comparison to other approaches to alcohol and drug problems (e.g., more intensive treatment and incarceration), and suggestions for improving SLHs. Some additional codes were applicable to some stakeholder groups but not others. For example, codes for

neighbors included knowledge about SLHs and interactions with SLHs near them. SLH manager interviews yielded codes depicting views about characteristics of good candidates for SLHs, the extent to which cost functioned as a barrier, the perceived impact of zoning laws and other local policies, SLH relationships with various professionals and local government, and past conflicts with neighbors and how those conflicts were resolved. Codes that were relevant to key informants included ways SLHs support goals of their departments and perceived impact of policies on SLHs.

Knowledge about SLHs

SLH managers provided extensive comments explaining how SLHs work to promote recovery. Typical was this description from a phase I manager.

> *…I believe that it [SLHs] definitely plays a substantial role in that it – I would say the biggest role it plays is it offers relief from isolation and that it can make people aware…That one doesn't have to worry about bills or that everything is inclusive is a very significant role as well.*

However, managers were only vaguely aware of problems and challenges the houses faced in relation to the larger community. They noted these issues were handled by the owner of CSTL. Managers offered little information in response to questions addressing the larger context of SLHs, such as the types of relationships CSTL has with local and state government, the effects of regulatory mechanisms (e.g., zoning laws), and how issues such as NIMBY (not in my back yard) were addressed at the community level.

Key informants varied in their perceptions about how much they knew about SLH. Those who felt most familiar with SLHs in general and CSTL specifically were those who worked most closely addressing alcohol and drug problems. Surprisingly, the representative from housing services had very little information about SLHs. When asked how familiar she/he was with SLHs the reply was, "not very." Although other key informants felt they had some general knowledge about SLHs, it was nonetheless limited. For example, one key informant stated, "I don't know that we spend a lot of time hanging out at programs to see what's going on."

Many of the neighbors also had a limited understanding of SLHs. In some cases they had no idea a SLH existed in the neighborhood; it seemed to them like any other house. For those who were aware that there was a SLH in their neighborhood there was often a fairly vague notion of the population served and how the program operated. Without information, some neighbors expressed fears that the residents were mostly parolees or that they included sex offenders. They did not seem to be aware that a minority (about 25%) of CSTL residents was referred from the criminal justice system (i.e., jail or prison) and CSTL does not accept individuals convicted of sex offenses.

Who succeeds and who fails

Many of the respondents, and especially house managers, had very strong ideas about who would be a successful candidate within the sober living environment. Paradoxically, many house manager respondents said that a person had to 'hit bottom' to benefit, yet they also noted potentially successful candidates needed to have enough strength to check themselves into a recovery program and to have the motivation to "push through." Success was viewed as more likely for residents of the SLH who had accepted substance abuse as a disease, one that isn't going away on its own.

> *….[to be successful] they have had to accomplish what we refer to as the first step in the program of AA… that there's no denying of their alcoholism, that they're passed that point; that they're willing to accept that they're an alcoholic, that their lives are unmanageable and they need to do something about it. I think that anybody who comes in these places too soon it's not going to work you.*

It was suggested that people who were too young and unmotivated might fail. Such individuals were not as likely to have hit bottom, were often still supported (or 'enabled') by family members and just did not have the long history of failures to motivate them. Prospects for success or failure were also influenced by the right kind of financial support. Most respondents felt that people who paid for their housing themselves from their own earnings did the best as opposed to those who had a family member footing the bill.

> *… A lot of the kids around here, the parents just let 'em run amuck and they did whatever they want and now they're in trouble and they're goin' "Mommy help me" and when they screw it up they still get help from mommy. A lot of these kids around here have been through a lot of programs… They're just not ready.*

On the other hand, many of the managers, all of whom were in recovery, said that they would never have made it unless the first few months had been paid for by a social agency, the criminal justice system, a family member or some other external form of support. Some felt that more people would be successful if the funds for maintaining themselves at the SLH were more easily available, especially for beginning recovery.

House managers also felt residents who are dual diagnosed with psychiatric disorders were more likely to have a low probability of success. It was felt that such individuals needed many more services than those provided for by the SLH and that some aspects of the housing situation might exacerbate these other problems (e.g. people with social phobia having to come in contact with many strangers on a daily basis or people with paranoia having to share space with other residents). In addition, it was felt that people with more severe mental disorders such as schizophrenia might need skilled personnel to monitor medications.

> *Well definitely those with dual diagnosis that we are not prepared to handle – and there are special cases I mean obviously if there is some illness that runs deeper than alcoholism there's no way they can get the help they need here, nor do they pretend that they can offer that sort of help. ..' And it's not like people here don't go see psychiatrists or therapists or whatever because I know there are more than one that do but just if the problems are running much deeper.*

People who had been coerced into coming to the SLH were also thought to be unlikely to succeed in the long-term. If an individual had chosen treatment instead of prison or parole, or were forced by the courts, it was thought that they would be less likely to be successful. Such individuals often end up as 'fake it to make it' individuals who try to get by with the bare minimum of effort.

> *… they just want to be clean enough just to satisfy the court; once they've got that done they're on their merry way.*

Strengths and weaknesses

Virtually all of the house managers and a majority of neighbors and key informants as well mentioned that the strengths of sober living houses are that they provide structure and support for a recovering substance abuser. The role models provided by the longer term residents, the social support and encouragement of staff and residents, the house rules and regulations and the availability of AA meetings all help to keep a person from relapsing. One of the house managers described the importance of social support for abstinence:

> *… a lot of people in their usual neighborhoods are family. Like it's not [a good area] for them to get clean 'cause they know a lot of people who they did drugs with. So being like a place where you can live with other people trying to do the same thing and are all about the same thing is really supportive and it helps you stay positively influenced to stay clean and get your life together…*

Another house manger emphasized the importance of a supportive community:

> *Community, everybody gettin' along, everybody helpin' each other. Everybody's always helpin' each other around here. If they see that you're down and out they'll ask you 'What's wrong?' or start the coffee or whatever and that's what it is people around here care about each other.*

On the other hand, the factor of density was mentioned as an area of strength and as a weakness, sometimes by the same respondents. Density of the SLH was viewed as an area of strength for house residents because it allows a range of services to be on hand (including meals, meeting places, AA and other types of classes) as well as a wide range of role models and positive normative pressure. Yet, because there are separate houses, the residents do not have the feeling of being in an institution; with one exception, the houses are approximately family-sized and offer the opportunities to build skills, develop social relationships and offer a degree of privacy. However, there is one neighborhood where there are six adjacent houses together in one complex. Some neighbors experienced this high density arrangement as having a negative impact on the surrounding neighborhood.

Impact on SLH residents and the surrounding community

Participants across all three stakeholder groups generally felt SLHs had a positive impact on the residents who lived in them and the surrounding community. This was particularly evident

when respondents considered the consequences of ignoring alcohol and drug problems or alternative approaches to dealing with them, such as criminal justice incarceration. House managers were particularly strong proponents of this view.

> *I think we've raised property value. There is no crime going on here. You've got seven houses here and the police don't get called. Cars aren't broken into, there's no burglary you know. I mean the level of integrity of the hundred people that live here is gonna be three times as high as the people living on the street…one over….*

Key informants, especially those who worked closely with SLHs and drug treatment, also had positive views about the impact of SLHs. For example, one stated, "I would think that it's just more people that aren't out there drinking and using." Other key informant comments included:

If they work I think they have a great impact…They're good citizens, neighbors, don't create a nuisance within our community, and I think they have a great impact.

The more you can be in a home as opposed to an institution or shelter to me that is beneficial to not only the individual but it's actually probably beneficial to the community at large too…

…if there were a lot of calls for service out there I'd be hearing about it…then we know there are other things going on that we've gotta address but it's usually not been [the case] with CSTL.

A number of neighbors had family members or friends who had a history of addiction problems. Their concern about family and friends who had addiction problems appeared to influence their views about the impact of SLHs.

> *Well I don't think that incarcerating people rehabilitates them. You know it's like my daughter if she was in that situation where she could at least was trying to get herself cleaned up and can go to a home, I'd be all for that.*
>
> *…my younger sister had a problem and so she's – so I know she's been in a couple in and out…It's rare you talk to anyone you know honestly that doesn't have a sister or brother, a parent , an uncle, you know what I mean..*
>
> *…Yeah they need help you know we have a daughter that's a meth user and so I'm all for anything that will help…Yeah and we've been estranged from her for the last 20 years…*

Although views about the impact of SLHs were generally favorable, concerns were raised about the potential for detrimental impact to residents and the surrounding community if the

houses were not well managed. This was the view even among house managers. The owner of CSTL emphasized the importance of standards and integrity.

We have a class here called Sober Living Specialist and it's a 36-hour class that I put together….What we're trying to do is create minimum standards and a high level of integrity. And it goes beyond just having a house, I mean you've got recovery integrity, you have fiscal integrity, you have community integrity you know. So we talk about ADA [Americans with Disabilities Act], we talk about FHA [Fair Housing Act]; we talk about structure and management; we talk about how to keep your books and pay taxes and be financially in integrity. We talk about confidentiality and do no harm and a code of ethics.

Phase I and phase II houses

Despite generally positive views about the impact of SLHs on surrounding communities, key informants and some phase I neighbors raised concerns about the impact when houses were too densely located in one neighborhood. One key informant commented:

Well, it changes the atmosphere; I think that when you walk through, you drive through and there's a group of adults sitting outside you often wonder what's that all about. Is it a halfway house, is it sober living? What's going on is it just about a big family and you know those sorts of things. So it makes you wonder about the neighborhood.

When we looked at the characteristics of the neighbors who had concerns it became clear that they lived in the vicinity of the six phase I houses that were densely located along a two block area in one complex. One neighbor stated, "I hate to say this, but I would say it's been negative. One would've been fine (laughs) but the whole block is too many for this small street." Some complaints of neighbors had to do with nuisance issues such as noise and parking.

…The only thing that gets people in the neighborhood kind of upset is if you have too many cars and sometimes if there's too many people there, if they have too many guests it'll get the neighbor across the street upset…

…I don't see them as strict enough…I mean they're lifting weights at all hours of the night, there is no – back there is no control of their language at all… every now and then obviously there are screaming and yelling matches and sometimes they are – they're just you know people have lost their cool.

… they [should] cut the size of it and not have so many people over there in so many houses and that they exercise control when they have these large groups and stuff over there. Because these groups have to be coming from more than just those houses because there's been times when I saw hundred or more people there and cars are parked not only up and down the entire street but over in the Safeway parking lot there's so many people there. And I just don't understand why they need that many people at one time.

A few phase I neighbors expressed fears about safety, the potential for an increase in crime, and declining values of houses in the neighborhood. However, when pressed by the interviewer, they had difficultly providing examples of these issues. A phase I neighbor stated she assumed housing values would fall as a result of the SLH in their neighborhood, but did not elaborate or provide examples of declining values. Another neighbor described concerns about crime:

…there were a couple of incidences where in the night…we had a couple of break-ins and you don't know if it was them or not.

Interviewer: So I'm wondering if the break-ins were close to each other and how long ago it was or how recently?

Well, one of them was 5 years ago, the other one was in '89.

The concerns raised by some neighbors of phase I houses were not unanimous. Different points of view from phase I neighbors included:

Well, for me like I say to me it's positive that there's been a positive impact…the crime situation has reduced. I mean we were broken into three times here before…madhouse came.

It seems to be a big success. They have on you know specific nights of the week and specific nights of the month they have a lot of people gathered there in support of the people that are graduating from the program or hopefully successfully moving on from that program. So I have a lot of support for that, I've known several people in my lifetime through friends or employees that have been working for us that had issues with drugs and needed to clean up. And so I think it's a huge benefit to helping people get back on track and finding that support system and other people that are going through the same situations that can be there for each other and be a good support structure for each other.

Another phase I neighbor succinctly summed up the pros and cons of having a large community of phase I houses:

…because you have it the way it is the level of support is incredible as opposed to having the phase 2 houses which are more isolated. But of course you have to work to get that and…having large phase I houses is probably a good thing but it you know it is in a residential neighborhood area and so you create a traffic issue and the streets line up, I mean that's what they have to do. And we were real worried 'cause we thought that whole frontage area was gonna be gone on this latest modification and it was like okay now what are they gonna do? But it isn't, and they are considerate, they do a good job, but it is a lot –they have a lot of people on Sunday night.

Reactions from neighbors of phase II houses were nearly all positive. Neighbors were either unaware that a SLH existed in their neighborhood and when they did know about one they were perceived as good neighbors. One neighbor of a phase II house reported a positive incident with a SLH resident who lived next door. During a violent late night altercation with his wife, he was forced to leave his home. He found refuge and counsel from his next-door neighbor. It was then he learned this was a SLH. In another neighborhood, a single mother reported feeling "safe" because of the SLH residents living across the street. They kept an eye on her house and reported to her when a group of teenagers climbed the fence to her property. She also commented that the SLH residents were good role models for her teenage son.

Residents of phase II houses were viewed as quiet and they maintained their properties well. A few reports suggested there was admiration among neighbors for the changes the residents were attempting to make in their lives:

> *…I would hope that people would be more observant and respectful to them because they chose to take a different road with their life…they're trying to make a difference for their lives and themselves and their families so I would hope people would respect that.*

One phase II SLH manager told a story of a neighbor expressing appreciation for their work recovering from alcohol and drug problems.

> *…she likes to bake a lot so she brought me like cake, right and she's like 'hi, I'm so and so. I live next door and I just came down here to support you and tell you that I'm so proud of you and I like what you guys are doing here and keep doing the right thing' and I was like "who are you?"…they're like an awesome old couple next door and they have a couple grandchildren and like I said I walk out of the house, they ask me how I'm doing.*

Improving the community context

All three stakeholder groups felt the reputation of CSTL in the local community benefited from a variety of volunteer activities in which residents participated. These included involvements in activities such as hosting a Christmas holiday party open to the local community and volunteering to support various events (e.g., parades, Veteran's Day activities and seasonal festivals). One house manager noted:

…so we do stuff like volunteer so that we don't get a [bad] name. Because you know a lot of us we stole a lot, we hurt a lot of people through our actions. So when we give back it shows the community that we're not like that now. We're trying to change. We're still people. We just had problem and we're fixing it now.

Phase I neighbors felt providing more information about SLHs and developing forums for more interaction would be good ways to improve relationships:

> *"Well maybe if they had more interaction with the community as far as letting the community know what's goin' on, what their goals are, what their success rate is.*

Other suggestions from phase I neighbors included distributing brochures about CSTL to local neighbors, inviting them to attend a question and answer meeting at the main facility, and promoting a neighborhood barbeque. One man appeared to be frustrated not having the phone number for whom to call if there were concerns. Another felt intimidated by the residents and feared he would be misunderstood if he raised his concerns. One neighbor suggested CSTL residents get involved in volunteer work, apparently not aware that CSTL residents were already involved in a variety of volunteer activities.

It is important to note that like neighbors of CSTL, house managers also felt increased contact and communication would improve relationships. Managers felt many concerns that neighbors had were based on fear rather than information about the program:

> *I would challenge the skeptics to come spend a day or two around here and see how the people are; see how these places work; see what they promote, what kind of lifestyle they promote and you know see if their opinion hadn't changed in that period of time.*

Another house manager felt similarly:

> *Like come on in and check it out. Bring a city council member, bring a newspaper reporter, you know bring whoever you'd like and come and see. It's not a cult….its people trying to better themselves.*

Finally, like one of the neighbors, the coordinator of CSTL expressed a wish that residents could be involved in more volunteer activities, mentioning breast cancer awareness as an example.

Regulatory impact on SLHs

There is no state or local licensing of SLHs. Because anyone can set up a SLH and operate it as they wish, stakeholders felt there was a need for standards for SLHs. When asked about

obstacles to expanding SLHs, several house managers noted that standards were important for both the houses and the operators, "I think there should be more strict guidelines on who can operate these places." One of the key informants noted, "…you know licenses or having somebody in the neighborhood that would involve you know the code of enforcement people." There was a clear sense among all participants that poorly run houses were a threat to all SLHs and they therefore needed to be dealt with "swiftly because they are the ones that make it bad for everybody else." None of the participants mentioned that CSTL was a member of the California Association of Addiction and Recovery Resources (CAARR), which does certify SLHs for compliance with basic safety, health, and operations standards.

There were differences of opinion among stakeholders about the need for a special use zoning permit. A few neighbors and key informants felt that any house containing more than six individuals required a special use permit or it would violate zoning laws. The owner challenged that contention citing the Americans with Disabilities Act and the Fair Housing Act:

> *…since we are considered disable Americans, which the total public and the whole government want to ignore… we're protected by the Fair Housing Act which says that people with addiction have to be treated like any other family. They can live together; they can have more than six people. Now if the county wants to limit it to six people and then anything over six people you get a use permit then that should apply to every family in Sacramento County as well.*

When we asked house managers about the impact of regulatory laws and policies on SLH operations the nearly unanimous response was that these issues that were dealt with exclusively by the owner of CSTL. This individual is active in the local community and also has connections in state government. It is important to note that some of the earlier critics of CSTL now support the program. The owner attributes much of this shift to familiarity; the fact that critics were able to get to know him personally and observe what actually goes on in the houses.

Typology of factors supporting and hindering SLHs

Table 2 shows a summary of factors that support and hinder SLHs from the vantage point of different stakeholders.

TABLE 2 GOES HERE

DISCUSSION

Overall, there was significant support for SLHs across stakeholder groups. To some extent, our finding that phase II houses were either viewed favorably by neighbors or were not perceived as different from any other house in the neighborhood replicates the study by Jason et al (2005) of Oxford Houses. Even when neighbors or key informant had criticisms of phase I houses, they nevertheless supported the importance of this type of service in the community and viewed it as preferable to alternative responses to alcohol and drug problems (e.g., criminal justice).

Concerns about phase I houses appeared to center mostly on issues such as the larger size and higher density of these houses in one area, as well as related concerns about noise and traffic. Only a few mentioned issues related to resident behavior, such as offensive language and leaving cigarette butts in the area. It is worth noting that even the most critical phase I neighbors supported the importance of recovery programs and sober housing as a concept. They tended to want the program to have more control over resident behavior and find solutions to the high density of houses and corresponding problems such as limited parking.

CSTL faces a dilemma in that the larger, higher density phase I houses were viewed as helpful to recovery by house managers and even by one of the neighbors. The large complex of adjacent phase I houses creates a sense of independent living blended with extensive support and some degree of structure, both of which are felt to be essential to recovery. The design also allows the owner, coordinator, house managers, and senior peers to monitor the behavior of new residents and address problems promptly. One could argue that the increased oversight and sense of community in phase I prepares residents for success in phase II, and thus leads to stable phase II houses in the community. Given the current scenario, the program might consider collaborating with neighbor about ways to address issues such as parking and traffic congestion. Examples might include holding some meetings off-site or developing alternative places to park

when large meetings are held at the facility. Efforts to maintain a "good neighbor" policy by enforcing rules that limit noise, offensive language, cigarette butts, etc. are clearly important.

In a number of areas there was significant agreement among stakeholder groups. Most of the factors supporting and hindering SLHs were identified by participants from at least two groups. For example, the importance of volunteering was mentioned by most of the house managers as well as some neighbors. Size and density were viewed as hindrances by neighbors, especially those who lived near phase I houses, as well as some of the key informants. Both house managers and key informants viewed characteristics and activities of the owner as important to the success of CSTL. Neighbors and managers both felt increased communication and familiarity with SLH operations could help improve relationships. Nuisance problems (e.g., parking) were viewed as a hindrance by neighbors and key informants and all three groups felt that even a limited number of poorly run houses could threaten the viability of all SLHs. Adopting "good neighbor" practices was viewed as essential by nearly all participants.

Communication with neighbors

One of the clearest findings was that both house managers and phase I neighbors felt the need for more communication and interaction. Phase II neighbors, in contrast, were fairly unanimous in their praise of SLHs in their neighborhood and thus felt little need to take action to improve relationships. Given the current stability and successes of phase II houses, the best approach might be to leave well enough alone.

Phase I neighbors and managers proposed specific suggestions for increasing communication that could be readily implemented. These included neighbors attending open houses at the program, the program distributing brochures about CSTL to local neighbors, neighbors spending a day at the program to experience what actually goes on, the program implementing a neighborhood barbeque and developing regular meetings with managers and neighbors to address questions and concerns that arise.

It should be mentioned that the owner of CSTL reported some previous efforts in this regard that were not very successful. One involved going door to door in the neighborhood to introduce the program, which yielded some negative comments and threats. The other involved some ice cream socials that were poorly attended. On at least two occasions letters were sent out to neighbors containing a brief description about CSTL and contact numbers. It is not clear why these efforts were not more successful. It could be that developing a meaningful and sustained impact on the surrounding neighbors will require regular and varied activities, such as regular social events, more substantive forums to address neighborhood issues and problems, and a monthly or quarterly brochure that is distributed to each neighbor.

Although CSTL residents are involved in extensive volunteer work in the local area, there may be a need for more of those activities in the immediate neighborhood. Several immediate neighbors did not appear to be aware of volunteer activities in which CSTL residents participate and they suggested volunteering would improve relationships with the community.

Addressing stigma

House managers believed that stigma plays a strong role in biasing some neighbors against SLHs and their residents. This view was shared by participants in our previous work (e.g., Polcin et al., in press), where addiction counselors and mental health therapists rated stigma as the main obstacle to expanding SLHs. Stigma was rated as a higher obstacle than practical issues such as not have sufficient financial resources to pay for residence in a SLH. In our interviews for this study we found negative assumptions about SLHs when neighbors expressed concerns about increasing crime and decreasing housing values but were not able to support their claims with specific examples.

A good way of addressing stigma was suggested by several house managers. They argued convincingly that the more the local community understood about the day to day operations of CSTL and the residents who lived there the more they would support SLHs in this and other communities. Instead of relying on preconceived biases and notions, they would increasingly

base their views on observations about what occurs and interactions with residents. Contact with stigmatized groups as a way to decrease stigma is a strategy supported by a variety of stigma researchers (e.g., Corrigan et al., 2001). It might be particularly helpful to create forums where successful residents could interact with neighbors and share the stories about addiction and recovery. In addition to decreasing negative assumptions about addicts and alcoholics, such interactions might offer hope to families who have a member suffering from a substance use disorder.

Managing community relations

A number of managers and key informants noted how the owner was well connected within the local community (e.g., president of the local chamber of commerce) and used those connections in service of CSTL. A notable limitation of this scenario is that mobilizing community influences in ways that support CSTL was the purview solely of the owner. There is considerable risk that if this individual were not around, the relationships with local and state officials would evaporate. It was striking how little house managers and residents knew about critical issues directly affecting the viability of CSTL, such as zoning laws, the Fair Housing Act, Americans with Disabilities Act, and initiatives at the state level to limit SLHs. Increasing their knowledge of and involvement in these issues would leave the program less vulnerable. This could be accomplished through delegating house managers to attend selected meetings and discussion with the owner about how to best represent the interests of CSTL.

Implications for community based programs

Study findings suggest important considerations, not only for SLHs, but for community based programs more generally. One area where there was nearly unanimous agreement across stakeholder groups was the importance of being good neighbors. Therefore, community based programs need to have policies and resources that ensure upkeep of the facilities to standards consistent with the local neighborhood. Further, there need to be policies in place to contain potentially destructive behaviors, such as drug use and other behaviors that would be

experienced as unacceptable (e.g., destruction of property). For example, "Housing First" models for substance use disorders that tolerate alcohol and drug use would not do well in the neighborhoods we studied. To avoid open community resistance, it would seem that these types of harm reduction services would need to be located in areas where substance use is more tolerated. In addition, community based programs need to have mechanisms for handling complaints from neighbors. While CSTL was praised by key informants for responding to complaints promptly, a few phase I neighbors were unsure whom to contact and others felt intimidated and that left them feeling frustrated and more negative toward the program. Phase II neighbors did not express this uncertainty and seemed comfortable approaching residents of phase II houses.

Another consideration is how to handle the issue of anonymity. We found that small, sparsely populated phase II houses were viewed favorably or were unknown to neighbors. One workable option for community programs in such circumstances might be to maintain a relatively low profile and simply blend in with the local community. However, when programs are larger and their presence is obvious, it may be necessary to directly address the concerns of local neighbors, especially to counteract negative assumptions associated with stigma. Such a strategy requires forums for such interaction to occur. Both house managers and neighbors had suggestions in this regard, ranging from neighborhood barbeques to information meetings that describe the program and respond to neighbor questions and concerns.

All of our stakeholder groups emphasized the importance of volunteer work. The specific types of activities that community programs get involved in might be dependent in part on the types of clients served and their capabilities. However, it seems that some very public way of showing involvement in and support for the community is important to garner support.
In part, volunteer work might be viewed as important because volunteer work contradicts assumptions associated with the stigma of addiction, such as crime and exploitation of others.

It was clear from our interviews that the owner of CSTL had a long history of successfully managing challenges to CSTL and navigating through the political and regulatory environment. He appeared to persevere using a combination of knowledge about his rights and applicable laws, involvement in local and state politics, and personal relationships that he was able to develop with individuals who were once his adversaries. Such an individual can be invaluable to the development of successful organizations. However, there are serious questions about how the program could maintain its position in the community and its political strength if this individual were not around. CSTL and other community based programs might do well to consider shared models of leadership and responsibility (e.g., Polcin, 1990) for promoting the program's agenda within political and regulatory circles.

Limitations

There are some inherent limitations in our study that are important to note. First, all of the interviews took place in one Northern California County and the issues relative to SLHs there might not generalize to other geographic regions. Second, all of the house managers were part of CSTL and all of the neighbors resided near CSTL facilities. Although CSTL has implemented the sober living house principles promoted by the California Association of Addiction and Recovery Resources in California, there may be individual factors that are unique to CSTL that limit generalization of results. Other SLHs with different characteristics (e.g., size, management, cost and house rules) might have different issues. Finally, the results are specific to SLHs and might not generalize to other types of housing, such as halfway, step down and Oxford houses.

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Table 1.
Sample characteristics by stakeholder group

STAKE-HOLDER GROUP	GENDER		RACE				MARITAL STATUS				
	MALE	FEMALE	WHITE	BLACK	HISPNIC	MIXED RACE	SINGLE	MARRIED	DIVORCED	SEPARATED	WIDOW/ WIDOWER
House Managers N = 17	14 (82%)	3 (18%)	15 (88%)			2 (12%)	10 (59%)	1 (6%)	4 (23%)	2 (12%)	
Neighbors N = 20	10 (50%)	10 (50%)	18 (90%)	1 (.05%)	1 (.05%)		3 (15%)	13 (65%)	1 (5%)	2 (10%)	1 (5%)
Key Informants N = 6	2 (33%)	4 (67%)	5 (83%)	1 (17%)			1 (17%)	5 (83%)			

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Table 2.
Factors supporting and hindering sober living houses

	Supporting	Hindering
House Managers	Volunteering	Poorly run houses
	Characteristics of Owner	Stigma
	Familiarity with SLHs	Criminal Justice Mandated
	Addressing Complaints Promptly	Dual Diagnosis
	Scope of Addiction Problems	Finances
	Communication	
Neighbors	Volunteering	Poorly run houses
	Familiarity with SLHs	Nuisance Problems
	Addiction in Family	Perceptions of Crime
	Good Neighbor Behaviors	Perceptions that housing values decline
	Addressing Complaints Promptly	Large houses
	Communication	Densely populated houses
Key Informants	Characteristics of Owner	Poorly run houses
	Addressing Complaints Promptly	Nuisance problems
	Scope of Addiction Problems	Zoning Laws
		Large houses
		Densely populated houses
		Finances

Note: Poorly run houses include factors such as poor appearance and lack of resident accountability.
Nuisance problems include factors such a noise level, parking, offensive language and cigarette butts.