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Oxford House and Alcoholics Anonymous: The Impact of Two Mutual-help Models on Abstinence

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Abstract

Two examples of mutual-help approaches for substance abuse recovery are 12-step groups (AA and NA) and Oxford House. The present study examined the combined effects of AA and Oxford House residence on abstinence over a 24-month period with 150 individuals randomly assigned to either an Oxford House or to usual after-care. Among individuals with high 12-step involvement, the addition of Oxford House residence significantly increased the odds of abstinence (87.5% vs. 52.9%). However, among participants with low 12-step involvement, rates of abstinence were fairly similar across conditions (31.4% vs. 21.2%). Results suggested that the joint effectiveness of these mutual-help programs may promote abstinence.

Keywords

substance abuse treatment; 12-step groups; Oxford House

From a public policy perspective, understanding how mutual-help groups and self-help treatments might be alternatives to professional aftercare programs seems important (Humphreys, 2004; Tonigan, Toscova, & Miller, 1996). Unlike traditional treatments programs, self-help or mutual-help groups represent voluntarily gathered social support assemblies, working together on a common problem with self-directed leadership and the sharing of experiences (Humphreys). In general, self-help therapy was more effective and less expensive than traditional, professional-focused therapy (Humphreys). The best known example of mutual-help groups supporting abstinence is the *12-step program*, which includes groups such as *Alcoholics Anonymous (AA)* and *Narcotics Anonymous* (*NA*; McCrady & Miller, 1993).

Alcoholics Anonymous was created in 1935 as a self-help group for individuals in alcohol recovery to maintain sobriety through spirituality, social support, and progression through 12-steps treatment. Today, more people turn to AA to recover from alcohol addiction than any other program (McCrady & Miller, 1993; Weisner, Greenfield, & Room, 1995), with

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worldwide membership estimated at over 2,000,000 in 150 countries (Alcoholics Anonymous, 2006). Members progress towards recovery at their own pace through the sharing of experience, hope, and strength admitting powerlessness over alcohol through self-disclosure at each of 12 steps (Emrick, Tonigan, Montgomery, & Little, 1993). Unlike conventional alcohol treatments, AA is not time-limited, lacks professional involvement, charges no dues or fees, and keeps no membership lists at weekly meetings (Kurtz, 1979).

Numerous studies found AA participation related to improved alcohol use outcomes (e.g., Longabaugh, Wirtz, Zweben, & Stout, 1998; Montgomery, Miller, & Tonigan, 1995; Ouimette, Moos, & Finney, 1998; Pisani, Fawcett, Clark, & McGuire, 1993). A meta-analyses of AA effectiveness studies concluded that participation related to positive drinking outcomes and better psychological health, social functioning, employment situation, and legal situation (Emrick, Tonigan, Montgomery, & Little, 1993; Tonigan, Toscova, & Miller, 1996). Still, there is a general lack of longitudinal research exploring effectiveness of these programs (Humphreys, 2004), and researchers continue to debate the rigor and quality of AA outcome studies (Emrick et al., 1993; Humphreys; McCrady & Miller, 1993; Kownacki & Shadish, 1999).

Another mutual-help founded intervention for substance abuse based on a network of community-based recovery homes is called *Oxford House* (*OH*). OH was established in 1975 for persons who seek a supportive, mutual-help, residential setting with recovering peers in order to develop long-term sobriety skills (Jason, Davis, Ferrari, & Bishop, 2001). To date, there are over 1,250 dwellings across the USA, Canada, and Australia. Similar to AA, OH may be more cost-effective than other after-care treatments because each House group is financially self-supported and no professionals are involved. Each house is a rented, multi-bedroom dwelling for same-sex occupants, located in low-crime residential neighborhoods (see Ferrari et al., this issue). Houses operate democratically by majority rule govern by electing house officers every six months (Oxford House Inc., 2002). Residents may stay in an OH indefinitely, given that they avoid substance use and disruptive behavior.

Regarding the effectiveness of Oxford House, two studies conducted by Jason, Ferrari, and colleagues included follow-up assessments of residents from 6 to 24 months. Results found that 62–69% of residents either remained in the house or left on good terms (Bishop, Jason, Ferrari, & Huang, 1998; Majer, Jason, Ferrari, & North, 2002). In addition, a large nationwide 12-month longitudinal study found that length of stay in Oxford predicted social support, self-efficacy, and abstinence (Jason, Davis, Ferrari, & Anderson, 2007). Jason et al. (2006) reported a randomized study that compared Oxford House residents with participants in usual after-care settings. At a two-year follow up, Oxford House residents had lower substance use (31% vs. 65%, respectively), higher monthly income ($989 vs. $440), and lower incarceration rates (3% vs. 9%).

The Oxford House organization encourages 12-step participation (Oxford House Inc., 2002), and most residents are involved in AA or NA (Flynn, Alvarez, Jason, Olson, Ferrari, & Davis, 2002; Nealon-Woods, Ferrari, & Jason, 1995). In addition, Majer, Jason, Ferrari, Venable, and Olson (2002) reported that time spent in Oxford House, combined with 12-step participation, related to increased levels of abstinence social support and abstinence self-efficacy. However, none of these studies jointly examined AA and OH models with the same individuals. Both mutual-help program may individually promote recovery through emphasis on positive social support, strict rules, abstinent living, and self-direction; alternatively, a combination of OH and 12-step groups might produce the most positive outcomes. The present study assessed how involvement in Oxford House *and* 12-step groups related to abstinence among individuals in substance abuse recovery randomly assigned into Oxford House or Usual Care conditions.

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Method

Procedure

We examined data from a longitudinal assessment of 150 individuals in substance abuse recovery from Northern Illinois (see Jason et al., 2006). In the present study, individuals discharged from residential substance abuse treatment facilities were randomly assigned to either a democratic, self-run, recovery home condition (Oxford House; $n = 75$) or to a usual after-care condition ($n = 75$). The control/comparison condition of usual care provided clients with several options prior to discharge, including referral to different forms of outpatient treatment, referral to self-help groups, or referral to other resources in the community.

All participants completed a baseline questionnaire assessment two to three days before discharge from inpatient substance abuse treatment programs. After participants entered the study, they were assessed every six months over a two-year period, creating a total of five assessments (i.e., baseline, 6, 12, 18, and 24 months), and paid $40 at each interview wave.

Measures

We obtained baseline demographic information (e.g., gender, race, substance disorder typology) from items on the 5th Edition of the *Addiction Severity Index-lite* (*ASI*; McLellan et al., 1992). The *ASI* assessed common problems related to substance abuse: medical status, drug use, alcohol use, illegal activity, family relations, and psychiatric condition. This inventory was used in a number of alcohol and drug use studies over the past 15 years with excellent predictive and concurrent validities (McLellan et al., 1993).

The *Form-90* (Miller & Del Boca, 1994) obtained a continuous record of alcohol and drug consumption and intensity within a 90-day time span. This measure gathered information related to employment, health care utilization, incarceration, and alcohol and other drug use over a 90-day retrospective (a reliable time frame for abstinence assessment; Miller & Del Boca). Test-retest reliability was excellent for core variables, including total consumption (0.91 – 0.97), drinks per day (0.88 – 0.93), percent days abstinent (0.96 – 0.98), and percent heavy drinking days (0.92 – 0.97). Even though this study employed six-month assessment intervals, Form-90 captured substance usage and 12-step participation during the last 90 days of each six-month period.

Results

Baseline Socio-demographic Analyses

No significant differences were found between the Oxford House and Usual Care conditions on baseline socio-demographic variables (Jason et al., 2006). Across both conditions, most participants were women (62%). As for ethnic status, this sample consisted of 77.3% African-American, 11.3% Caucasian, 8% Hispanic/Latino, and 3.3% others. The average participant was 37.1 ($SD = 8.1$) years old and had 12.0 ($SD = 2.1$) years of education. With regards to marital status, 60.5% were never married; 26.5% were divorced, widowed, or separated; and 12.9% were married. Regarding psychological status, 59.3% had a lifetime Axis I Mood or Anxiety disorder, and 27.6% reported a lifetime history of having been prescribed psychological medications. In terms of legal history, 43.9% of participants had been incarcerated at some point, with an average of 2.9 ($SD = 7.3$) lifetime incarcerations. In the 6 months prior to the start of the study, 93.3% of participants had used alcohol or drugs.

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Chi-square Analyses for Condition and 12-step Involvement

One participant was dropped from the following analyses due to reporting extreme and almost certainly false data regarding 12-step involvement along with other treatment variables. Table 1 shows the percentages in each condition participating in 12-step programs at each wave of data collection. At each time period, more individuals in the Oxford House condition attended 12-step groups than Usual Care. *Chi-square analyses* (condition [Oxford House or Usual Care] by 12-step participation [any or none]) indicated that this difference in utilization between Oxford House and Usual Care participants was significant during the 0–6 and 12–18 month periods of the study.

For all subsequent analyses, we dichotomized twelve-step participation with a median split for several reasons. Since the *Form 90* only assesses 12-step participation over a 90-day period, whereas data collections took place at 6-month intervals, we did not have a complete and continuous record of meetings attended over the course of the study. Also, because almost all participants attended at least a few 12-step meetings throughout the study, it would not be very meaningful to compare individuals who attended 12-step meetings with those who attended no meetings; thus, a median split divided 12-step involvement into high versus low (i.e., greater or less than 154 meetings attended during the study). This practice is supported in substance abuse literature, as previous studies have used related classifications of AA involvement (e.g., Alford, Koehler, & Leonard, 1991; Snow, Prochaska, & Rossi, 1994; Wallace, McNeill, Gilfillan, MacLean, & Fanella, 1988).

Table 2 reports 24-month abstinence rates based on condition (Oxford House vs. Usual Care) and 12-step participation (high vs. low) during the course of the study. Overall, Oxford House participants had higher 24-month abstinence rates than Usual Care participants, and the high 12-step participation group had higher rates compared to the low participation group. *Chi-square analyses* (abstinence [yes or no] by 12-step participation [high or low]) indicated that for both Oxford House (χ^2 [1, N = 75] = 24.75, p = .000) and Usual Care conditions (χ^2 [1, N = 74] = 10.32, p = .001), abstinence rates were significantly higher among those with high 12-step participation. In addition, *chi-square analyses* (abstinence [yes or no] by condition [Oxford House or Usual Care]) demonstrated that among individuals with high 12-step involvement (χ^2 [1, N = 74] = 10.80, p = .001), abstinence rates were significantly higher among Oxford House compared to Usual Care participants. However, no significant difference concerning abstinence was found between conditions among participants who were less involved 12-step groups. The Figure illustrates this interaction effect.

Discussion

Public health officials interested in mutual-help groups and self-help treatments explored alternative programs to professional treatment aftercare (Humphreys, 2004; Tonigan et al., 1996). In this study we provided the first systematic examination of two such mutual-help models for substance abuse treatment: 12-groups (i.e., AA) and a communal-living recovery model (OH). Given OH's emphasis on 12-step involvement (Oxford House Inc., 2002), it was not surprising that OH residents attended more 12-step meetings than usual care participants. At each time period, the majority of OH residents (between 78 and 95%) participated in these recovery groups. Usual Care participant rates in 12-step programs were similar but slightly lower (79 to 89%). Thus, one benefit of OH may be promoting 12-step utilization.

Looking at these two mutual-help programs separately, participants with high 12-step participation consistently had higher 24-month abstinence rates than participants with low participation. In fact, regardless of condition, participants who attended more 12-step

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meetings reported more than twice the likelihood of being abstinent than individuals who attended fewer meetings. This result was consistent with previous research on AA participation and improved alcohol use outcomes (e.g., Emrick et al., 1993; Longabaugh et al., 1998; Montgomery et al., 1995; Ouimette et al., 1998; Pisani et al., 1993; Tonigan et al., 1996). Oxford House residents also had higher abstinence rates overall than usual aftercare participants, consistent with past research (see Jason et al., 2006).

Regarding the combined impact of these programs, OH residents who were more involved in AA and NA had the highest rates of abstinence at 24 months (87.5%). Furthermore, the lowest rates of abstinence were reported among usual care participants with low 12-step involvement (21.2%). While abstinence rates did not differ significantly between conditions, among high 12-step attendees, OH residents had a major advantage over usual care participants. A combination of these two mutual-help programs might have produced the best outcomes for OH residents because of the joint emphasis on positive social support, strict rules, abstinent living, and self-direction. These two programs offered adults in recovery settings to develop a strong sense of community with similar others who share common abstinence goals (Ferrari et al, 2002). Receiving support for abstinence, guidance, and information from others committed to maintaining long-term recovery may enable addicts to avoid relapse.

There were several limitations of this study. Those participants assigned to the OH condition were brought to the Houses by the recruiters to ensure that they were actually included in that condition, whereas the usual care participants did not have this additional support. Future studies might provide equal support to adults in usual aftercare conditions to ensure equivalent contact with research staff. Also, while collateral report data confirmed self-reports of abstinence, biological confirmations of abstinence were not utilized in the present study. We also chose to dichotomize our variables in order to study the effects of either utilizing or not utilizing these mutual-help recovery tools (i.e., OH and 12-step programs); future studies may utilize continuous data to answer these questions to produce greater variability and ability to detect effects. Nonetheless, results of this study clearly point towards the joint effectiveness of these two mutual-help programs in promoting abstinence.

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References

Alford GS, Koehler RA, Leonard J. Alcoholics Anonymous-Narcotics Anonymous model inpatient treatment of chemically dependent adolescents: A 2-year outcome study. Journal of Studies on Alcohol 1991;52:118–126. [PubMed: 2016871]

Bishop PD, Jason LA, Ferrari JR, Huang CF. A survival analysis of communal living, self-help, addiction recovery participants. American Journal of Community Psychology 1998;26:803–821. [PubMed: 10085534]

Emrick, CD.; Tonigan, JS.; Montgomery, H.; Little, L. Alcoholics anonymous: what is currently known?. In: McCrady, BS.; Miller, WR., editors. Research on Alcoholics Anonymous: Opportunities and Alternatives. New Brunswick, NJ: Rutgers Center for Alcohol Studies; 1993. p. 41-77.

Flynn AM, Alvarez J, Jason LA, Olson BD, Ferrari JR, Davis MI. African American Oxford Houses residents: Sources of abstinent social networks. Journal of Prevention and Intervention in the Community 2006;31:111–119. [PubMed: 16595391]

Humphreys, K. Circles of Recovery: Self-Help Organizations for Addictions. Cambridge, UK: Cambridge University Press; 2004.

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Jason LA, Davis MI, Ferrari JR, Bishop PD. Oxford House: A review of research and implications for substance abuse recovery and community research. Journal of Drug Education 2001;31:1–27. [PubMed: 11338963]

Jason LA, Davis MI, Ferrari JR, Anderson E. The need for substance abuse after-care: A longitudinal analysis of Oxford House. Addictive Behaviors 2007;32:803–818. [PubMed: 16843612]

Jason LA, Olson BD, Ferrari JR, Lo Sasso T. Communal housing settings enhance substance abuse recovery. American Journal of Public Health 2006;91:1727–1729. [PubMed: 17008561]

Kownacki RJ, Shadish WR. Does Alcoholics Anonymous work? The results from a meta-analysis of controlled experiments. Substance Use and Misuse 1999;34:1897–1916. [PubMed: 10540977]

Kurtz, E. Not-God: A History of Alcoholics Anonymous. Center City, MN: Hazelden; 1979.

Longabaugh R, Wirtz PW, Zweben A, Stout RL. Network support for drinking, Alcoholics Anonymous and long-term matching effects. Addiction 1998;93:1313–1333. [PubMed: 9926538]

Majer JM, Jason LA, Ferrari JR, North CS. Comorbidity among Oxford House residents: A preliminary outcome study. Addictive Behaviors 2002;27:837–845. [PubMed: 12201387]

Majer JM, Jason LA, Ferrari JR, Venable LB, Olson BD. Social support and self-efficacy for abstinence: is peer identification an issue? Journal of Substance Abuse Treatment 2002;23:209–215. [PubMed: 12392807]

McLellan AT, Kushner H, Metzger D, Peters R, Smith I, Grissom, et al. The fifth edition of the Addiction Severity Index. Journal of Substance Abuse Treatment 1992;9:199–213. [PubMed: 1334156]

McCrady, BS.; Miller, WR. Research on Alcoholics Anonymous: Opportunities and Alternatives. New Brunswick, NJ: Rutgers Center of Alcohol Studies; 1993.

Miller WR, Del Boca FK. Measurement of drinking behavior using the Form 90 family of instruments. Journal of Studies on Alcohol Supplement 1994;12:112–118. [PubMed: 7722987]

Montgomery HA, Miller WR, Tonigan JS. Does Alcoholics Anonymous involvement predict treatment outcome? Journal of Substance Abuse Treatment 1995;12:241–246. [PubMed: 8830150]

Oxford House, Inc. Oxford House Manual. Silver Springs; MD: 2002.

Ouimette PC, Moos RH, Finney JW. Influence of outpatient treatment and 12-step group involvement on one-year substance abuse treatment outcomes. Journal of Studies on Alcohol 1998;59:513–522. [PubMed: 9718103]

Project MATCH Research Group. Matching alcoholism treatments to client heterogeneity: Project MATCH three-year drinking outcomes. Alcoholism: Clinical and Experimental Research 1998;22:1300–1311.

Pisani VD, Fawcett J, Clark DC, McGuire M. The relative contributions of medication adherence and AA meeting attendance to abstinent outcome for chronic alcoholics. Journal of Studies on Alcohol 1993;54:115–119. [PubMed: 8394956]

Snow MG, Prochaska JO, Rossi J. Process of Change in Alcoholics Anonymous: Maintenance Factors in Long-Term Sobriety. Journal of Studies on Alcohol 1994;55:362–371. [PubMed: 8022185]

Tonigan, JS.; Toscova, R. Mutual-help groups: Research and clinical implications, appears. In: Miller, WR.; Heather, N., editors. Treating Addictive Behaviors. New York: Plenum Press; 1998.

Tonigan JS, Toscova R, Miller WR. Meta-analysis of the Alcoholics Anonymous literature: Sample and study characteristics moderate findings. Journal of Studies on Alcohol 1996;57:65–72. [PubMed: 8747503]

Wallace J, McNeill D, Gilfillan D, MacLean K, Fanella F. Six month treatment outcomes in socially stable alcoholics: Abstinence rates. Journal of Substance Abuse Treatment 1988;5:237–252.

Weisner C, Greenfield T, Room R. Trends in the treatment of alcohol problems in the U.S. general population, 1979 through 1990. American Journal of Public Health 1995;85:55–60. [PubMed: 7832262]

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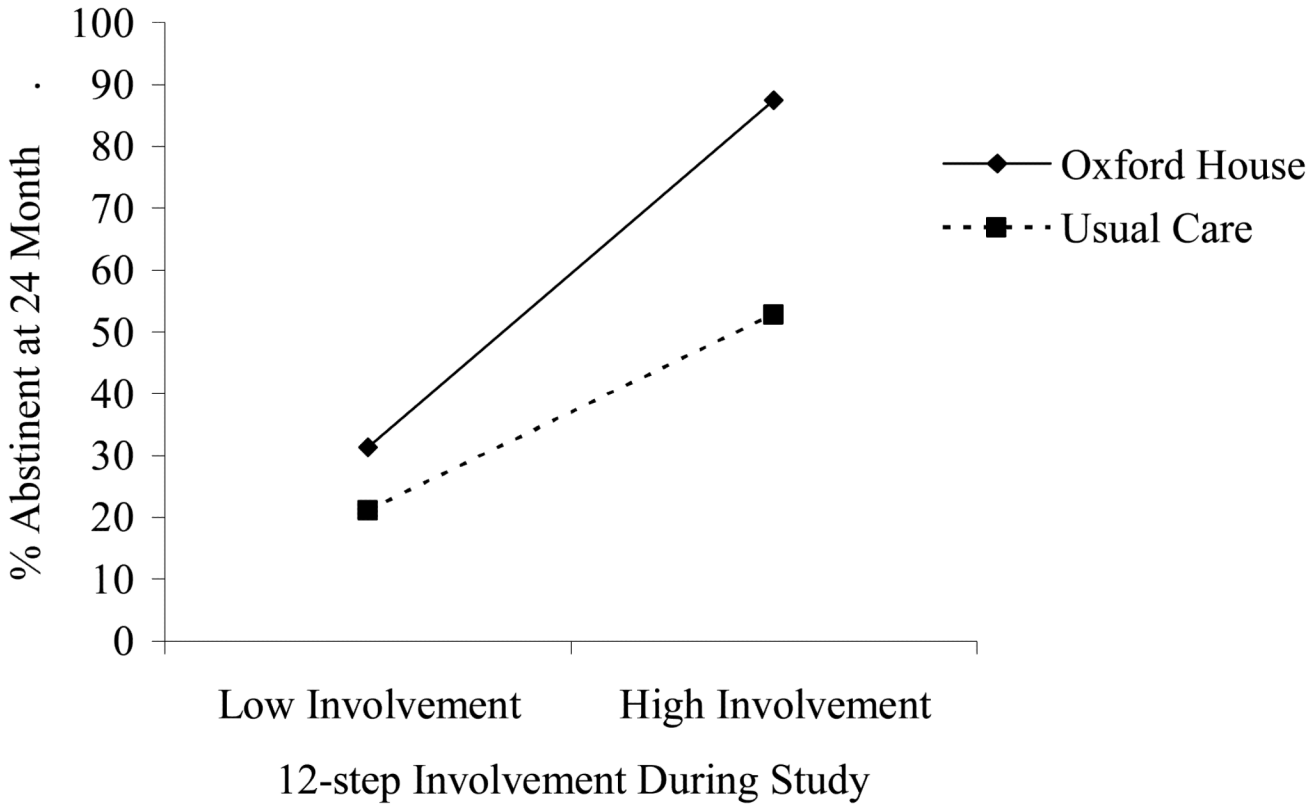

Figure.
Interaction between condition and 12-step involvement during the study as related to rates of abstinence at the 24-month assessment.

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Table 1

Chi-Squares for 12-Step Involvement by Condition across Different Time Intervals

Time interval	**% participating in 12-step groups**		***Pearson chi-square***
	Oxford House condition	Usual Care condition	
0–6 months	91	79	3.81*
6–12 months	83	82	.02
12–18 months	88	63	10.57**
18–24 months	78	65	2.75
Entire course of study	95	89	1.45

n = 149

* $p \leq .05$.

** $p \leq .01$.

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Table 2

Chi-Squares for 24-month Abstinence by 12-step Involvement during Study

	Low 12-step involvement		High 12-step involvement		
Condition	**% abstinent**	***n***	**% abstinent**	***n***	***Pearson chi-square***
Oxford House	31.4	35	87.5	40	10.3*
Usual Care	21.2	40	52.9	34	24.7*
Pearson chi-square	2.0		10.8*		

n = 149

* $p \leq .001$.