Published in final edited form as:
J Psychoactive Drugs. 2010 December ; 42(4): 425–433.

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

Douglas L. Polcin, Ed.D.[*], **Rachael Korcha, M.A.**[*], **Jason Bond, Ph.D.**[*], and **Gantt Galloway, Pharm.D.**[**]

[*]Alcohol Research Group Public Health Institute 6475 Christie Avenue, Suite 400 Emeryville, CA 94608-1010

[**]California Pacific Medical Center St. Luke's Hospital San Francisco, CA

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

Phone (510) 597-3440 Fax (510) 985-6459 DPolcin@arg.org

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.

Acknowledgments

Supported by R01AA14030 and R21DA025208

References

Beattie MC, Longabaugh R. General and alcohol-specific social support following treatment. Addictive Behaviors 1999;24:593–606. [PubMed: 10574299]

Bond J, Kaskutas LA, Weisner C. The persistent influence of social networks and Alcoholics Anonymous on abstinence. Journal of Studies on Alcohol 2003;64:579–588. [PubMed: 12921201]

Braucht BG, Reichardt CS, Geissler LJ, Bormann CA. Effective services for homeless substance abusers. Journal of Addictive Disease 1995;14:87–109.

De Leon G, Inciardi JA, Martin SS. Residential drug abuse treatment research: are conventional control designs appropriate for assessing treatment effectiveness? Journal of Psychoactive Drugs 1995;27(1):85–91. [PubMed: 7602444]

Derogatis LR, Melisaratos N. The Brief Symptom Inventory: An introductory report. Psychological Medicine 1983;13:595–605. [PubMed: 6622612]

Freudenberg N, Daniels J, Crum M, Perkins T, Richie BE. Coming Home From Jail: The Social and Health Consequences of Community Reentry for Women, Male Adolescents, and Their Families and Communities. American Journal of Public Health 2005;95:1725–1736. [PubMed: 16186451]

Gerstein, DR.; Johnson, RA.; Harwood, HJ.; Fountain, D.; Sutter, N.; Malloy, K. Evaluating recovery services: The California drug and alcohol treatment assessment (Contract No. 92-001100). California Department of Alcohol and Drug Programs; Sacramento: 1994.

Hitchcock HC, Stainback RD, Roque GM. Effects of halfway house placement on retention of patients in substance abuse aftercare. American Journal of Alcohol and drug Abuse 1995;21:379–390.

Humphries K, Kaskutas L, Weisner C. The Alcoholics Anonymous Affiliation Scale: development, reliability, and norms for diverse treated and untreated populations. Alcoholism: Clinical and Experimental Research 1998;22:974–8.

Korcha, RA.; Polcin, DL.; Bond, JC.; Galloway, GP. Psychiatric distress and substance use outcomes among sober living residents; 33rd Annual Research Society on Alcoholism Scientific Meeting; San Antonio, TX. Jun. 2010 p. 26-30.

McLellan AT, Cacciola J, Kushner H, Peters F, Smith I, Pettinati H. The fifth edition of the addiction Severity Index: Cautions, additions, and normative data. Journal of Substance Abuse Treatment 1992;9:199–213. [PubMed: 1334156]

Milby JB, Schumacher JE, Wallace D, Freedman MJ, Vuchinich RE. To house or not to house: The effects of providing housing to homeless substance abusers in treatment. American Journal of Public Health 2005;95:1259–1266. [PubMed: 15983278]

Moos RH. Theory-based processes that promote the remission of substance use disorders. Clinical Psychology Review 2007;27:537–551. [PubMed: 17254686]

Moos BS, Moos RH. Treated and untreated individuals with alcohol use disorders: Rates and predictors of remission and relapse. International Journal of Clinical and Health Psychology 2006;6:513–526.

Petersilia, J. When Prisoners Come Home: Parole and Prisoner Reentry. Oxford University Press; New York: 2003.

Polcin DL. How Health Services Research Can Help Clinical Trials Become More Community Relevant. International Journal of Drug Policy 2006a;17(3):230–237.

Polcin DL. Reexamining confrontation and motivational interviewing. Addictive Disorders and their Treatment 2006b;5(4):201–209.

Polcin DL. What about sober living houses for parolees? Criminal Justice Studies: A Critical Journal of Crime, Law and Society 2006c;19:291–300.

Polcin DL. A model for sober housing during outpatient treatment. Journal of Psychoactive Drugs 2009;41(2):153–161. [PubMed: 19705677]

Polcin DL, Henderson D. A clean and sober place to live: Philosophy, structure, and purported therapeutic factors in sober living houses. Journal of Psychoactive Drugs 2008;40(2):153–159. [PubMed: 18720664]

Polcin DL, Korcha R, Bond J, Galloway GP. Sober Living Houses for Alcohol and Drug Dependence: 18-Month Outcomes. Journal of Substance Abuse Treatment 2010;38(4):356–365. [PubMed: 20299175]

Polcin DL, Korcha R, Bond J, Galloway GP. Eighteen month outcomes for clients receiving combined outpatient treatment and sober living houses. Journal of Substance Use. in press.

Polcin DL, Korcha R, Bond J, Galloway GP, Lapp W. Recovery from addiction in two types of sober living houses: 12-month outcomes. Addiction Research and Theory. in press.

Schinka JA, Francis E, Hughes P, LaLone L, Flynn C. Comparitive outcomes and costs of inpatient care and supportive housing for substance-dependent veterans. Psychiatric Services 1998;49:946–950. [PubMed: 9661231]

White, WL. Slaying the dragon: The history of addiction treatment and recovery in America. Chestnut Health Systems; Bloomington, IL: 1998.

Zywiak WH, Longabaugh R, Wirtz PW. Decomposing the relationships between pretreatment social network characteristics and alcohol treatment outcome. Journal of Studies on Alcohol 2002;63:114–121. [PubMed: 11925053]