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Introduction to the Special Issue: Architecture Enhances Mutual Aid in Sober Living Houses

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This special edition of the journal addresses the social model approach to recovery from alcohol and drug problems as it is implemented in residential settings. The essence of social model recovery is an emphasis on peer support, abstinence from alcohol and drugs, and peer empowerment in decision making. The papers presented are timely because the addiction field is increasingly recognizing two important issues: 1) many persons with alcohol or drug problems who receive brief treatment interventions do not sustain recovery and 2) a major reason for relapse is the lack of an alcohol- and drug-free living environment.

The addiction field has long recognized that the social environment influences recovery from alcohol and drug problems. For example, mutual-help programs such as Alcoholics Anonymous emphasize the importance of developing social networks that deter substance use and support abstinence. Nowhere is the issue of social influence more salient than where one lives. Residing in a living situation that encourages substance use is common in the U.S., particularly among subgroups of individuals, such as persons who are homeless or transitioning into communities after being released from jail or prison.

As an alcohol and drug treatment provider I have experienced this problem firsthand. When I worked in residential treatment programs there were often few good options for where individuals could live once they completed treatment. The improvements made in treatment were therefore short lived once they left the program. In outpatient programs, I frequently found my efforts to facilitate recovery were undermined by the influence of destructive living environments that encouraged substance use. Long-term alcohol and drug free residential recovery homes, such as the Sober Living and Oxford Houses discussed in this edition, can address these problems by facilitating sustained recovery. In addition, Sober Living and Oxford Houses can be resources for individuals who want to stop alcohol and drug use but do not want to do that through formal treatment.

Although efforts have been made to address the need for alcohol- and drug-free housing, they have not come close to adequately addressing the scope of the problem. Recently, providers of residential recovery services in the United State have renewed their efforts to expand services. These activities resulted in formation of a national organization of providers of residential recovery services. The National Association of Residential Recovery

(NARR) was founded in 2011 by a group of individuals representing over 40 sober living, recovery residence, halfway house, and other organizations from across the country. NARR is a private, nonprofit organization with a current membership that includes over 1900 recovery residences. In addition to providing health, safety, and organizational standards for member programs, NARR has been instrumental in describing the variety of residential recovery settings in the U.S. and what is known about their organization, operations, and outcomes (National Association of Residential Recovery, 2012). NARR is explicitly committed to promoting research that identifies empirically based practices and standards for a range of residential recovery programs.

Members of NARR all have in common the fact that they emphasize social model principles such as peer support and peer involvement in decision making. However, NARR members include a wide variety of different types of residences that are classified into four levels based on administration, residence setting, treatment and other types of services offered, and staffing. Level I houses are the most consistent with social model recovery principles because they represent residences that are democratically run by the residents themselves, financially self-sufficient, do not include professional treatment staff who provide counseling or case management services, and are located in single family residential areas. As NARR levels increase, there is more oversight and structure. For example, level IV houses have an organizational hierarchy and paid treatment staff that provide on-site treatment services. They are often licensed by states as treatment programs and are typically larger than single family dwellings. Although residents often have input into decision making, ultimate authority in level IV residences typically rests with treatment staff.

The papers presented in this special edition add to the literature by focusing on aspects of recovery homes that have received limited attention: 1) the history and evolution of California sober living houses (SLHs), 2) a conceptual model for analyzing architectural characteristics of residential recovery facilities and their influence on outcome, 3) a personal experience account from an operator of California SLHs with documented favorable outcomes, 4) employment outcomes for women residing in Oxford Houses, and 5) how the NARR criteria and a measure of social model recovery principles (the Social Model Philosophy Scale) can be used to understand different types of recovery homes.

The first paper by Wittman and Polcin reviews the history of the SLHs in California. It is remarkable that California SLHs have existed since the 1940’s and currently number nearly 800 homes, yet very little has been written about them. The paper traces the evolution of the sober living house movement beginning with the early “12 step houses” that drew upon the 12 step self-help program of Alcoholics Anonymous. A variety of policies and events that influenced SLHs over the years are then described along with influences from the social model recovery movement in the 1970’s and 80’s. The paper ends with recommendations for operations of existing SLH facilities and implications for housing and recovery policy.

The topic of the second paper addresses an issue frequently minimized or ignored entirely in the addiction recovery field: the influence of architectural design on recovery. Wittman, Jee, Polcin and Henderson present a conceptual model for assessing architectural characteristics of sober living houses and how they influence recovery processes. A case study of one sober

living organization in Northern California (Clean and Sober Transitional Living) is used to illustrate beneficial architectural designs. The paper ends with a call for formal evaluation studies assessing how architectural design characteristics are associated with long term recovery outcome.

The next paper is a personal experience report from Don Troutman, the owner and operator of Clean and Sober Transitional Living (CSTL). He recounts how his own experience of recovery led to and informed development of CSTL. Mr. Troutman's story is a good example of experiential learning, an essential component of social model recovery. Experiential learning is a way that individuals in recovery share knowledge and insights gained from their experiences to help others. The evolution of CSTL was not without challenges and Mr. Troutman describes how he successfully addressed a myriad of issues that could have derailed his program. Finally, his description of how CSTL is operated and managed illustrates important issues for house managers and operators to consider.

Perhaps the best examples of "pure" social model recovery settings are Oxford Houses, which are the focus of the fourth paper. Oxford houses are entirely run by the residents themselves using democratic voting processes. They do not offer any professional services on site but do require residents to develop an abstinence oriented recovery plan. The paper by Brereton et al describes a study of women in Oxford Houses that targets two concepts relevant to all types of social model programs: "reciprocal responsibility" and social network characteristics. Reciprocal responsibility refers to the extent to which residents give and receive help and higher scores on this measure were associated with higher employment. In addition, when women had social networks that included members of Oxford houses retention in the houses was longer.

The paper by Mericle and colleagues illustrates how the four levels of recovery homes described by NARR can be used to understand services and operations among a diverse sample of homes in Philadelphia. They supplemented the NARR criteria with the Social Model Philosophy Scale (Kaskutas et al., 1998) to show how social model recovery principles were implemented in different types of recovery facilities. Results showed that recovery housing in Philadelphia is diverse in terms of management, integration of social model philosophy, operations, and types of services offered. Overall, this paper provides a compelling strategy for how providers and researchers can go about understanding the array of different types of recovery residences that exist in the U.S.

Although the papers in this edition offer diverse contributions to the field of residential recovery, there is a unifying theme throughout all of them that emphasizes the primary importance of peer support. In this way they are consistent with fundamental principles that have guided 12-step recovery groups such as Alcoholics Anonymous for decades. They affirm what George Vaillant contended nearly 40 years ago (Vaillant, 1975), that the path out of addiction was like the path out of adolescence. It occurred primarily through connection and identification with one's peers.

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