The Evolution of Peer Run Sober Housing as a Recovery Resource for California Communities

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Abstract

Sober living houses (SLHs) are alcohol- and drug-free living environments that offer social support to persons attempting to abstain from alcohol and drugs. They use a peer-oriented, social model approach that emphasizes mutual support, financial self-sufficiency, and resident involvement in decision making and management of the facility. Although they represent an important response to the increasing call for more services that help sustain abstinence from drugs and alcohol over time, they are an under recognized and underutilized recovery resource. The purpose of this paper is to trace the evolution of sober living houses in California from the early influences of Alcoholics Anonymous (AA) in the 1930's to the establishment of current SLH associations, such as the Sober Living Network in Southern California. The paper describes key events and policies that influenced SLHs. Although initial research on outcomes of SLH residents has been very encouraging, there is a need for more research to guide improvement of structure and operations. The paper concludes with a discussion of implications for the growth of recovery services and for community housing policy.

Keywords

Sober living houses; social model; recovery housing; peer helping; housing policy

It has long been recognized that recovery from alcohol and drug addiction for some persons requires an alcohol- and drug-free living environment. Exposure to alcohol, drugs, relapse triggers, and friends and family who encourage substance use can derail recovery even for persons who are highly motivated. Recognizing that some persons with alcohol and drug problems lack a living environment supportive of recovery, treatment programs have offered services in residential forums where individuals can live while they receive treatment. Since the 1960's a variety of residential options have emerged that vary in terms of length of stay, organization of the milieu, staffing, and philosophy of recovery. Examples include therapeutic communities (De Leon, 2010), Minnesota Model programs (Anderson, McGovern, & DuPont, 1999), and Social Model programs (Borkman, Kaskutas, Room, Bryan, & Barrows, 1999). All of these modalities include formal services such as recovery groups, individual counseling, and case management delivered by paid staff. This paper focuses on the evolution of a distinct recovery option that does not include formal services

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or paid staff on site at the sober living residence, although some recovering residents are likely to be involved with these services off-site and most have a history of receiving some type of formal services. These houses are called free-standing Sober Living Houses or Sober Housing (Polcin & Borkman, 2008). "Free standing" here means the houses are not licensed by any official body, provide no on-site licensed professional services, and conform to local zoning and building safety codes for residential occupancy. These houses are ordinary housing found throughout the local community based on the history and land-use patterns of the city or county. Architecturally, they may be modified large single-family houses, converted duplexes, or remodeled small apartment buildings.

This article describes the evolution of sober housing in California from 1935 to the present. We begin with a description of 12-step housing as it grew directly out of the recovery principles and experiences of Alcoholics Anonymous (AA). The 12-step house is the original free-standing sober housing created, independently owned, and operated by recovering individuals for the sole purpose of supporting daily sober living. The original design ideas and operational practices created a foundation which remains in force today for several different forms of sober housing that have emerged over the last fifty years, including sober houses in California.

The paper then proceeds to review sober housing's relationship to four episodes in the development of California's policy to manage alcohol- and drug-related health and safety problems at the community and state level:

1. The demise of California's system of custodial care for alcoholics in state psychiatric hospitals and local jails (1950s and 1960s).

2. Replacement of the custodial care system with short-term methods for treatment of alcohol/drug dependency in professionally-managed settings that paid little attention to housing. The need for housing and longer term programs gave rise to a community-based social model approach to recovery.

3. Impact of public housing and urban redevelopment policies that denied housing to alcoholics/addicts and destroyed their habitat but eventually also provided essential protections for recovering people's rights to housing (1960s to 1992).

4. Retrenchment of federal and state support for residential treatment settings and housing for people with AOD problems coupled with an increase in California state prison-building between 1980 and 2010.

The paper concludes with discussion of the prospects for sober housing's continuing growth in California today. We review the current status of sober housing associations, the potential role that sober houses could play in responding to court mandated release of a large number of persons currently incarcerated in California State Prisons, and development of "intentional housing" models that might assist individuals with different problems in addition to drugs and alcohol.

Origins of Sober Housing within the AA Movement and the Formation of 12-Step Houses

The foundations of AA provided the guiding principles for peer-based sober housing: Strict sobriety (no drinking by residents on or off-site), full membership and participation in the community (pay rent and help with household management), fit quietly (anonymously) into the surrounding neighborhood, implement "good neighbor" policies toward the surrounding community, emphasize peer support for recovery, and pursue opportunities for 12-step work in the community.

One limitation of AA was that it did little to address the needs of members who sought a safe and sober place to live while they "worked their program" through the 12 steps. Many had been evicted and lost connections with family and friends. Many communities had limited rental housing stock and almost no alcohol-free housing except for the occasional boarding house or small hotel manager who personally did not rent to tenants who drank. However, an ample supply of low-cost serviceable housing was available in urban cores and other areas left behind in the post-war move to the suburbs. This housing was often poorly managed and was located in declining districts characterized by violence, public inebriation, prostitution, social isolation, and minimal public services. However, much of the physical housing stock was well-designed and durable, and the district often included surprisingly sound neighborhoods. Houses were often conveniently located in neighborhoods close to jobs and public transportation. Bargains were available for the enterprising and discerning house-hunter.

In the late 1940s a handful of experienced AA members who had acquired several years of sobriety started on their own initiative to fill the sober housing gap by providing "12 step" residences. To a large extent they relied on available low-cost housing in economically declining urban areas. Twelve step residences offered everyday living while maintaining strict sobriety policies (no drinking by residents on or off the premises) and encouraging attendance at AA meetings on site or in the community. Sober housing could be seen as a potential safe island rising out of a sea of "wet" neighborhoods characterized by declining businesses, large numbers of bars and liquor stores, and housing stock consisting of single-room occupancy (SRO) hotels, small apartments, and large old houses that had been converted into multi-occupancy dwellings.

In the late 1940s and early 1950s house operators had their pick of locations and house designs conducive to recovery-oriented daily living. They could take advantage of convenient locations and existing large single family houses. They could choose house layouts that were generously-designed large single family wooden houses, many with four or five comfortable bedrooms, large kitchens, and a spacious living room with a side parlor. A discerning eye could see beneath the shabbiness and deferred maintenance that the old buildings were attractive and well built. California houses built several decades earlier with old-growth Redwood were often well constructed and in extraordinarily good shape. Some of the original 12-step houses are still in operation as this is written, such as the First Step Home in San Francisco (http://www.arafirststephome.com/).

The 12 step houses were privately owned and operated independently by recovering people. Referrals came through word of mouth based on the quality of life they offered for sober living and recovery. A house's bond with the community was its quality of sobriety and the personal integrity of its owners. The houses had no contractual connections to treatment programs or to correctional institutions, though they were informally known to the staff of these organizations. At the time, the local (municipal, county) "system of care" for public drunkenness and related misbehavior was based on a network of informal contacts between local public hospitals for general medical service, state psychiatric hospital wards for treatment of alcoholism, and the correction system's local drunk tanks and county jail farms. Chronic drinkers and public inebriates routinely re-cycled through this informal care system from the street to the drunk tank or the detox ward at the local general hospital, then on to a custodial setting either at the county jail farm or the state psychiatric hospital alcoholism ward. After getting sober and starting to regain their health, usually over a period from one to several months, patients/inmates were discharged back to the neighborhoods they had come from. At best there may have been a short-term arrangement for a sober bed, but there was no inter-service discharge planning or continued monitoring. Relapses were routinely expected. The chronic drinkers who cycled through this system repeatedly were characterized as "doing the loop" (Wiseman, 1970).

The 12 step house offered a way off this merry-go-round if the drinker took the initiative to start living sober day-to-day. The houses offered a real prospect for long-term sober living at a very reasonable cost (rental for one's room or bed), for as long as the resident wished, with freedom to come and go to participate as a full member of the surrounding community. The resident's only obligations were to remain sober, pay the rent on time, attend AA meetings, and help around the house.

Sober Housing and the Collapse of the California Custodial Care System

Prior to the 1950's individuals with serious alcohol or drug problems in California frequently became involved in California's custodial care systems (i.e., state psychiatric hospitals and local jails). However, these systems were in the process of being dismantled at the same time that 12 step houses began to open up. Two major developments sharply reduced the number of custodial beds available to persons with alcohol and drug problems. The changes began in the late 1940s and came into fruition in the late 1950s. First, California was replacing its aging state psychiatric hospital system that provided residential treatment for alcoholism in dormitory-type hospital wards. Second, there were changes in the local custodial system for public drunkenness, which included doing time in city drunk tanks and county jail farms. The purpose of this section is to describe the revamping of state psychiatric hospitals and local jails and their effects on persons with alcohol and drug problems and the prevalence of sober living houses.

Downsizing state psychiatric hospitals

By the late 1940s state hospital systems across the US including California had crumbled under years of neglect and abuse brought on by a public which refused to approve necessary staffing and maintenance levels. State health and hospital authorities could not provide the upkeep and staff budgets necessary to operate these large and expensive facilities and

became resigned to deferred maintenance, staff cutbacks, and continuing demands for service from the state (Deutsch, 1948). Concerns were being raised about the cumulative effects of therapeutic shortcomings when the facilities were not maintained and did not operate according to high standards (Gruenberg, Brandon, & Kasius, 1966). Additional concerns included subjugation of the individual to the social pressures and institutional demands of the ward environment (Wiseman, 1970) and the potential for over-control, abuse of power, and distortions of social relations based on imbalances of power (Goffman, 1961).

In response to these concerns there were marked reductions in the number of beds in state hospital institutions. Nationally, the number of patients in state psychiatric hospitals dropped from about 560,000 in the mid-1950s to about 100,000 in the mid-1970s (US Department of Health and Human Services, 1999). In California the number of beds fell from 37,500 in 1959 to 22,000 in 1967 (Lyons, 1984). Up to 40 percent of these admissions to state hospitals had problems with alcohol or drugs.

Another factor that led to the downsizing of state psychiatric hospitals was the discovery in the early 1950s of psychotropic drugs to control psychiatric symptoms which otherwise resulted in custodial hospitalization but now many believed could be treated on an outpatient basis. New treatment technologies based on recently-discovered psychotropic drugs and advances in professional outpatient treatment services became increasingly popular with treatment professionals, families, and the public as an alternative to long-term residential treatment services. Calls for action mushroomed into a political process that drove planners to replace the state's institutional custodial care system with a new system of community-based care delivered through local hospitals and clinics primarily on an outpatient basis (Gillon, 2000). Although some patients with chronic psychiatric disorders were able to find appropriate supportive housing in psychiatric halfway houses or board and care homes, many of those with alcohol or drug problems had few choices beyond single room occupancy hotels (Polcin, 1990).

The Short-Doyle Act: From the state psychiatric hospital to the community clinic

California helped lead the nation forward into the new era of deinstitutionalization of psychiatric patients from state hospitals with the passage of the Short-Doyle Act in 1957. The Act provided assistance to local governments to provide locally-administered and controlled community psychiatric health programs. In 1963 funding levels were increased by the state to boost local participation and expand the scope of services covered. However, California's de-institutionalization movement paid little attention specifically to alcoholics and addicts, although at the time the state psychiatric hospital and the local jail system were the sole public means for residential services to manage alcohol/drug problems. In practical terms, demise of California's state custodial care system for public inebriates meant the end of a system providing sober beds in state psychiatric hospitals and local jails. Although discredited at the time as demeaning and as ineffectual, these beds had served respite and care functions for large numbers of persons with alcohol or drug problems.

Decriminalization of public drunkenness

In addition to custodial care in state psychiatric hospitals, many persons with alcohol and drug problems were housed in local jails (drunk tanks) and county work farms that were part of local jail systems. In the 1960s, California cities relied heavily on these institutions as the response to charges of public drunkenness. However, a series of cases led to a US Supreme Court decision finding that chronic inebriation is an involuntary consequence of alcoholism, a disease, so homeless alcoholics arrested for public intoxication could not be convicted (McCarty, Argeriou, Huebner, & Lubran, 1991). Arrests for disruptive behavior while intoxicated or trespassing were then more likely to result in holding drinkers for a few hours without charging them. Judges stopped sentencing chronic drinkers to the county farm systems run by local criminal justice systems. Decriminalization at the community level left many public inebriates on the street and increased pressure on local medical resources for short-term detoxification and emergency care (Sweet, 2012).

Custodial care changes and the impact on sober housing

As custodial care systems that housed persons with alcohol and drug problems collapsed there was no corresponding increase in the supply of appropriate housing. Although some individuals released from custodial care did no doubt access 12-step recovery houses, there was no large increase in their numbers. One factor was low income neighborhoods with affordable housing suitable for 12-step houses continued to be sparse. In addition, there was limited outreach from public agencies to 12-step recovery houses as well as limited interest among 12-step house operators to explore prospects for 12-step houses to take a more active role in providing recovery housing.

Some characteristics of the houses themselves made it difficult for them to fill the housing gap created by the demise of custodial care. Since 12-step houses operated on a purely voluntary basis, most would not accept inebriates brought to the door by police. In addition, applicants to sober housing typically had to find a way to begin their sobriety before approaching the 12-step house. Individuals currently using or withdrawing from substances were usually not accepted. Therefore, they needed services for detoxification and establishment of initial sobriety in the community before they could apply for sober housing. These gaps in service were filled by "social model" (Borkman, 1990a) recovery programs that encompassed a broader spectrum of service needs, including detoxification and initiation of abstinence in residential recovery programs.

Sober Housing and California's Approach to Alcohol and Drug Treatment at the Community Level: The Rise of the Social Model Movement (1970s)

As a result of the deinstitutionalization of patients from state psychiatric hospitals California shifted public treatment for psychiatric illness and alcoholism/drug addiction from residential long-term care in remote settings to outpatient services close to home and community. This new system minimized use of inpatient hospitalization, confining 24-hour care to short-term treatment in specialized residential community facilities. However, state planners responsible for implementing Short-Doyle legislation ended up relying primarily on family members for living arrangements. For persons without family support, which

included many individuals with alcohol and drug addiction, they also relied on federal disability payments or county welfare checks to indigent patients to pay for secure lodging in board and care homes or low-income residences, such as marginal SROs (single-room occupancy hotels). Thus, the new community-based outpatient approach did not work well for many persons with alcohol or drug problems.

To develop community services that were more responsive to persons with alcohol problems California formed the Office of Alcohol Program Management (OAPM) in 1970 (Blacksher, 1990). OAPM was created partly in response to federal legislation (PL 91-616) that in 1970 established the National Institute on Alcohol Abuse and Alcoholism (NIAAA), a national agency for treatment, prevention, and research into alcoholism. The federal legislation required creation of a single state agency that could receive funds for treatment and prevention services and coordinate with the NIAAA on matters of research and public policy.

With support from OAPM, a small group of recovering people in several California communities formed a community of recovery persons who developed a treatment approach that applied AA principles to establishment of a community-level system of recovery. The "California social model" approach to alcohol and drug addiction in the community addressed both sets of issues overlooked by the Short-Doyle legislation: detoxification and management of public inebriation; and provision of residential settings to support recovery for both the short-term and long-term. One useful synthesis of social model recovery summarizes six key "traits" or "characteristics" (Wright, 1990):

- The basis of authority is the experiential knowledge of recovery (rather than expert knowledge)

- Primary therapeutic relationship is between person and program (rather than person/therapist)

- Everyone both gives and receives help (each participant is both consumer and prosumer)

- Basic principles and dynamics of AA create the framework for social model programs

- A positive sober environment is a crucial part of the program operation.

- Alcoholism is viewed as being centered in the reciprocal relationship between the individual and his or her surrounding social unit

Four community level social model settings

The social model recovery approach in the community included four components operating jointly at the local (primarily municipal) level: Social model detoxification, alcohol recovery homes, sober living houses, and community (neighborhood) recovery centers. The pioneers of social model recovery moved AA-based recovery beyond the individual 12-step house to create a community exoskeleton of recovery-conducive settings organized around alcohol recovery homes (Dodd, 1990; Dodd, 1997). The four kinds of settings comprise the essential "positive sober environment" offered by social model programs to the surrounding

community. Ideally, the program participant flows seamlessly between settings at his/her own pace in pursuit of a personal recovery experience. The following summarizes four types of social model settings essential to community programs.

(1) Social-model detoxification settings—In 1970 O'Briant and colleagues (1973) found from demonstration research in the City of Toronto that when alcoholics repeatedly appeared at hospital emergency services providers did not address their needs for subsequent help after detoxification. Patients were quickly discharged back to their customary environment, which resulted in many repetitions of the cycle. "Social model detoxification" was created to distinguish it from the medically-supervised version. The approach relied on a supportive socio-physical setting rather than a medical intervention. The goal was for staff, most themselves in recovery, to link clients to medical, social, housing and AA-oriented recovery services that would initiate longer-term recovery. Detoxification alone without engagement in additional services that helped maintain abstinence was viewed as unacceptable. Operators of this social-model detoxification programs found that only about 5 percent of public inebriates coming through their doors required immediate medical treatment. An analysis of the socio-physical design of the setting provided a model and a guideline for replication of architectural design and physical features of the social model detox setting (Wittman et al., 1976).

(2) Alcohol recovery homes—It was clear to proponents of the social model approach that there was a need for residential alcohol recovery services after initial detoxification. Alcohol recovery homes were designed to address this need. Schonlau (1990) proposed a model for physical design and operational features of the alcohol recovery home that was consistent with 12-step residences operated by recovering people. However, the alcohol recovery home was designed to be shorter in duration than 12-step residences and entail more structured groups and recovery activities. These programs provided an intense recovery-oriented residential experience that immersed the participant in a rich round of daily sober living organized around AA principles. The design of the recovery home created a setting that reinforced positive interactions between residents in all aspect of everyday living – eating, sleeping, hygiene, socializing, working on one's own personal recovery program, seeking services and contacts with significant others in the community. Care for the house itself (cleaning, cooking, light maintenance) was part of this experience. The day was punctuated with AA and household meetings and recovery groups in which residents mutually took responsibility for care of the setting and addressed issues of conduct and governance. For Schonlau, "the setting is the service," summed up the essential aspect comment often repeated by members of the California social model community. Or, as another early social model proponent put it, "Recovery for the individual alcoholic does not depend solely upon what happens 'inside' the person, but depends largely upon the personal and social surroundings in which he lives. Recovery homes initiate and encourage a new pattern of social relationships which aid abstinence and personal growth" (Blacksher, 1990, p. 220).

One limitation of this pure social model approach was that it did not meet state licensing and funding requirements for treatment programs. In 1973 OAPM worked closely with several

recovery home providers, organized as CAARH (California Association of Alcohol Recovery Homes), to establish clear objectives that complied with state requirements. These included the establishment of services and procedures required by the state, such as recovery plans, case notes, case management, and individual and group counseling. Although residential recovery houses are still in operation today, length of time in the residences have decreased. Originally, lengths of stay in residential recovery homes were up to one year and in some cases longer. Maximum lengths of stay have shortened significantly in recent years, often to just a few months.

(3) Free-standing sober housing (Sober Living Houses or SLHs)—The 12-step recovery houses described earlier in this paper significantly increased in numbers from their origins in the 1940's to the 1970's. Essentially, they used the same recovery approach emphasizing peer support and involvement in 12-step recovery groups. However, at some point the term "sober living houses" became a common designation for these homes. Some operators adopted this new term because they did not necessarily mandate that all residents engage in 12-step recovery groups and they would allow entry of individuals into the homes if they had alternative plans for sustaining abstinence. Unlike residential recovery homes, SLHs were not licensed by the state to provide "treatment" and did not require government funding to survive financially. Thus, they did not need to modify their approach to include professional services (e.g., counseling, case management, etc.) and were able to maintain a more "pure" social model recovery approach.

Sober living houses fit readily into the social model system of care that was emerging in the 1970's. Many alcoholics who successfully completed social model detoxification or residential recovery programs needed to protect their sobriety by living in clean and sober housing in a safe neighborhood. Many faced return to a dysfunctional family, a dangerous neighborhood, or for other economic, legal and social reasons could not gain access to a reliable sober residence on their own. Sober living homes were excellent options for many of these individuals.

Like their forerunners, 12-step houses, SLHs were ordinary housing stock located in residentially-zoned neighborhoods in the surrounding community. Socially and operationally, they functioned similarly to surrounding households. Their one distinguishing feature is that all residents live sober and have signed an individual lease that terminates if they start drinking/using drugs. Typically each resident paid rent (conventionally, as in a rooming house or for an apartment) and has a personal recovery program of some type (usually anchored in AA meetings that are often off-site). The only "program" for the SLH is a weekly meeting to deal with household matters and to keep the household running smoothly.

Some SLHs had a system where day-to-day oversight of the house was provided by residents themselves through a democratically elected resident council. Such a model reflected the social model emphasis on empowerment of the residents rather than large power imbalances between managers and residences. House managers using this approach took care of the physical aspects of the residence (maintenance and capital improvements for the building, furniture and furnishings, equipment, bedding, food, clothing) but largely left

management of house rules, enforcement of rules, and recreational activities, and operations (e.g., cooking and cleaning) to the residents themselves. As Schonlau put it, "a good manager manages the residency but not the residents" (Schonlau, 1990, p.73). Permanent house managers (people with extensive recovery experience) managed the place, while current residents managed conduct and operations.

The household was a constantly-flowing social pipeline that mixed newcomers with longer-term residents, all of whom live a unified experience in recovery that encourages residents to help each other informally, at their own pace, as a routine part of daily living. Each resident is encouraged to "work his own program" through the 12-steps or some type of other alternative recovery plan. Usually from five or six to as many as a dozen renters might reside in an SLH – the number would be governed by the size of the property and general zoning occupancy restrictions. The SLH is "free-standing" in that it is part of a regular neighborhood and each resident lives an independent life. The SLH could be managed and owned by an alcohol recovery program or it could be affiliated with an independent owner/operator of the residential property.

(4) Neighborhood recovery centers (NRC)—The NRC is a non-residential facility intended to help recovering people engage in sober living as a form of normal living in the surrounding community. The NRC was designed to provide a community setting that supported recovery on a voluntary, self-directed basis. It offered a setting that is readily available and flexible for people at all stages of the recovery cycle and in many different living situations. This includes people completing a stay at an alcohol recovery home (Miller, Manov, & Wright, 1987), people living in sober living residences, and people in recovery residing with family, friends and independently (Matthews & Weiss, 1990).

Neighborhood recovery centers offered conveniently located, comfortable places for informal socializing, education programs, and networking among recovering people to programs to link to jobs, education, legal, and social/health services. The coffee pot symbolizes a welcoming place that encourages people to enter and engage in a variety of recovery-conducive activities (Borkman, 1990). The design of the setting emphasized warmth, informality, easy access, and no hierarchical spaces that would separate staff from participants or to create different classes of participants. A variety of activities and AA meetings were offered, as well as connections to AA meetings held at off-site locations. Heavy emphasis was placed on voluntary participation and volunteer activity to supplement work by a few paid staff. Staff of the NRC required special training and personal skills to create an orderly and welcoming facility under these conditions(Shaw, 1990).

Initially, sponsorship of the NRC setting (i.e., paying for the space and the few paid staff required to operate it) came from county alcohol/drug programs supportive of social-model recovery. However, county sponsorship also resulted in conflicts with social-model programs, which were focused on a voluntary "program of attraction" for recovering individuals. Social model programs resisted county demands to host mandatory DUI classes, court-ordered attendance at AA meetings, and participation in county-organized community prevention initiatives (Shaw, 1990).

Relationship of "social model" to "medical model" and other approaches

During the 1970s the community social model approach grew steadily. One important source of support was the California Office of Alcohol Program Management (OAPM) directed by Loran Archer. Additional support was garnered from the Department of Alcohol and Drug Programs (DADP), which was directed by Susan Blacksher from 1978 to 1991. These directors took the initiative to provide opportunities for social model advocates to make their case to the state for financial and regulatory support. The California social model community responded by forming the California Association of Alcoholic Recovery Homes (CAARH), a state-wide organization to advance the interests of the social model community. By the 1980s community social model approaches had become widespread and were competing successfully with clinical and medical treatment programs for county contracts to provide treatment/recovery services.

While there are many areas of agreement and overlap between client-oriented medical and social model principles (Dumont, 1968) (Sweet, 2012), there are also many opportunities for discord, misunderstanding and disagreement. Wright's six "traits" at the start of this section could be viewed as oppositional, appositional, and philosophically in conflict with clinical treatment (medical model) approaches to addiction. Finding workable relationships and bridges across the two approaches is a demanding task.

Questions about whether a workable balance can be found between "medical model" and "social model" approaches that operate independently and in a loosely-connected way, or whether the two sides should cordially agree to disagree on certain fundamental points, continue to the present day. Two major areas of concern stand out: First is the question of credentialing and certifying recovery specialists according to personal recovery experience (social model) or according to discipline-oriented professional/specialist training (professional/technical model). Second is the question of whether localities should designate sober-living recovery residences as routine housing not subject to specialized licensing and inspection requirements (social model, and the approach called for by federal regulations), or whether recovery residences should be especially regulated by some authority other than their recovering operators (professional/technical model). These philosophical and political questions persist while technical questions about the utility of various housing designs and operational practices for recovery outcomes are being scientifically pursued.

Social model policy for the community: Environmental risk management

Proponents of social model recovery recognized early on that certain alcohol environments in the community put everyone at high risk-not just alcoholics-for violence, car crashes and other injuries, social conflict, economic exploitation, and youth-related problems. The place-based and setting-oriented social model perspective dovetailed with public health and safety concepts holding that preventive control, management, and design of the entire community alcohol environment should apply to the three environmental domains: (1) where alcohol is sold in retail outlets, (2) public places and events where alcohol is present, and (3) social settings where alcohol is a major factor (Wittman &Shane, 1988).

County alcohol program officials who supported the California social model wanted to extend the scope of social-model thinking to public health and safety agencies and community organizations. That is, they wanted the community's own public agencies and organizations to work jointly to manage their own alcohol/drug environment in a safe, trouble-free manner (Wittman, 1990). They believed recovering people could play a major role in larger official and normative community processes to promote and protect health and safety in the three principal environmental domains of community alcohol availability-retail, public, and social settings (Goldberg & Wittman, 2005). Social modelists became familiar with local tools for community environmental risk management both to promote sober living as a community norm and to protect their own interests, particularly with respect to housing rights for recovering people, a topic covered in more detail in the next section.

The Influence of Public Policy on Sober Living Houses

All things considered, the 1970's and beyond should have been an exciting time for sober housing to expand. Social model recovery had become increasingly popular and a number of federal laws and policies were favorable for sober living houses. For example, The Fair Housing Act of 1968 prohibited discrimination against occupants by creating a "protected class" of occupants defined by race, color, religion, national origin, age, sex, pregnancy and citizenship. These protections were extended to include sober housing residents sharing a household by protecting their "familial status" (Fair Housing Act Amendments of 1988), and disability due to the disease of alcoholism (Americans with Disabilities Act of 1990). Nominally, definitions of "family" and inclusion of alcoholism as a disability indicated that public housing and urban redevelopment projects included recovering persons living in a dedicated sober environment.

Although there were trends and policies favorable to sober living houses, there were also a number of obstacles. These included 1) the limited stock of affordable housing available for sober living houses, 2) public housing and urban redevelopment policies that reduced the amount of safe affordable housing suitable for sober living houses, 3) the economic recession in the late 1970s and early 1980s that created a wave of homelessness, and 4) the federal government's "war on drugs," which led to large increases in the number of persons incarcerated in jails and prisons as a result of alcohol or drug related problems.

Public housing/redevelopment projects do not support sober housing

Starting with the Housing Act of 1949, the federal government has provided billions of dollars to assist in slum clearance, urban redevelopment, and construction of housing for low-income people. In practice, federal housing programs have recognized sober housing only through subsidies to recovering individuals through rent subsidies, such as Section 8 certificates, but have not provided direct support for dedicated sober housing projects. To the authors' knowledge, HUD has yet to approve a dedicated sober housing project based on enforceable agreements requiring strict sobriety among the residents. Instead, new public housing and urban redevelopment projects typically ended up destroying habitats for low-income people with alcohol/drug problems. This occurred through "blight" clearance and redevelopment projects in inner-city high density neighborhoods that demolished existing low-income housing stock, such as SROs (single-room occupancy hotels) that were home to

many chronic poverty-level drinkers and drug abusers, and did not replace the lost housing. In San Francisco, for example, a massive urban renewal project to build the Yerba Buena Center (convention center, art galleries, park, hotels, retail shops) cost approximately 4,000 units of low-cost housing but replaced only a small fraction of them (Peterson, 2005).

Public housing projects were built with federal funds; the state and local jurisdictions were then responsible for maintenance and operations for decades to come. Across the country, local housing authorities proved incapable of undertaking long-term management of large public housing projects built with federal assistance (Bristol, 1991). Local and state authorities were constrained by federal law in their capacity to recoup costs through rent payments from tenants, who were living in poverty in any case. Local government services (including police, social services, health services) were simply not able to keep pace with demands for physical maintenance, building safety and management and protection of tenants (Peterson, 2005; Bristol, 1991). Criminal activity, much of it gang related, became an explosive focal point (Newman, 1972). Starting in the late 1960s, public housing projects in many big cities became synonymous with drug-related gang activity that successfully challenged police authority and overwhelmed local housing site managers (Buntin, 2009). The problems were so severe that several of the very large projects were demolished (Bristol, 1991). Public housing and "the projects" were a dangerous neighborhood for recovering people seeking clean and sober living situations.

Federal fair housing legislation protects rights to sober housing

The Fair Housing Amendments Act of 1988 protects recovering people to live as a "family" (under the law's definition of unrelated persons living together for a common purpose). This opens the community's housing market for recovering people to reside in any residentially-zoned area, including areas zoned only for single-family houses. Sober living residents have the same rights as other residents living in the area, and so must be treated equally and fairly (must have reasonable accommodation). Sober living residents are protected against NIMBY (not in my back yard) discrimination by landlords, city officials, property owners, etc., who don't want recovering people living nearby. The FHAA prohibits unfounded local ordinances such as conditional use permits (CUPs) that seek to impose special restrictions on residents in recovery on grounds that their activities are a danger to public health and safety. CUP ordinances and similar restrictions require sound evidence, not conjecture, describing the empirical (factually-based) dangers. Since diligently-operated sober living residences are not viewed as problems by their neighbors (and are viewed in positive terms), and generate only a few (if any) police reports, attempts to impose special restrictions through land-use planning ordinances are not upheld by the courts (Parker, 2009).

Sober living operators have learned to fight efforts at restrictive zoning and land-use controls, and occasionally join forces with housing rights advocates and other organizations. These fights are matters of life and death for sober housing, since a loss would both impose highly burdensome practical restrictions and would set precedents allowing redoubled efforts to devalue sober living and the recovery movement. For example, the Sober Living Network (SLN), a Southern California organization dedicated to training and promulgation of sober housing, defeated attempts by the City of Los Angeles to impose unfounded and

destructive rental agreement requirements for sober living facilities. Starting in early 2012, SLN leadership engaged in a year-long organizing campaign that involved community meetings and a vigorous e-mail correspondence that included the authors of this article. Such attacks occur periodically in California cities for complex reasons summarized as NIMBY (Not in My Back Yard) discrimination by neighbors and local agencies concerned about substance abusers living next door. In fact, NIMBY fears are not well-founded. Formal research on neighbor reactions to sober living houses (SLHs) in operation has found neighbors either don't know (no problems reported) about them or admire them (positive comments reported) (Polcin, Henderson, Trocki, Evans, & Wittman, 2012).

Delivery of services in homeless shelters

An additional positive public policy development relative to sober housing involved responses to homeless alcoholics. Sharp increases in homelessness in the 1980s created new and challenging pressures on delivery of residential services for treatment/recovery in the context of homeless shelters. NIAAA Homelessness Demonstration research programs funded by the McKinney-Vento Homeless Assistance Act (P.L. 100-77) worked with homeless people with alcohol/drug problems in 23 cities. Focusing on contact through the homeless shelter system, these programs experimented with approaches to detoxification and short-term residential treatment that included various provisions for follow-up movement into sober housing. Projects in several cities developed formal programs to further develop and operate sober housing as an integral part of the NIAAA-funded treatment program (Boston, Birmingham, Newark, St. Louis). Wittman, a consultant to NIAAA for this research, attempted to characterize the variety of "sober houses" involved in these projects (Wittman, Biderman, & Hughes, 1993), provided a monograph highlighting the operations of several of the sites (Wittman & Madden, 1988), and prepared a guide to help local communities to develop housing for low-income people recovering from alcohol and other drug problems (Wittman, et al., 1993).

Sober Housing, Federal Retrenchment of Support for AOD Programs and State Prison-Building

From the early 1970s to the mid- 1990s the California social model for recovery enjoyed state and county support for establishment of comprehensive peer-based sober living services operating at the community level. The California Department of Alcohol and Drug Programs worked with leading social model practitioners to establish state-wide communications and develop shared standards and practices. Ten California county alcohol/drug programs actively promoted and supported this community social model approach to recovery. However, by the mid-1990s the social model movement began to lose support at federal, state, and county levels. Two major developments played important roles: 1) the U.S. declared a "war on drugs" during the 1970's that replaced a recovery-oriented approach to drug and alcohol problems with a criminal justice response and 2) budget cuts dramatically reduced funding for all types of treatment.

"War on drugs" as public policy

During the 1970's the Nixon administration in the U.S. declared a "war and drugs" as an official policy toward drug and alcohol problems. Although there were some efforts to increase access to treatment, the primary response consisted of a criminal justice approach emphasizing arrests and incarceration for even low-level offenses. Increasingly, persons with drug problems or illegal behavior associated with drinking were incarcerated for lengthy periods of time (Polcin (2014)). Incarceration of persons with drug or alcohol problems increased so rapidly and consistently over the past four decades that the U.S. reached the point where it imprisoned more of its population than any other industrialized country (Walmsley, 2006). At the conclusion of 2005 one in every one hundred thirty-six adults in the U.S. was incarcerated in criminal justice institutions (Pew Charitable Trusts, 2009). When individuals on probation and parole are added, the proportion is a striking one in every thirty-two.

Not surprising, overcrowding of criminal justice institutions has become a serious problem from both a financial and human rights perspective. In 2011 the U.S. Supreme Court ruled that prisons in the state of California must release over 30,000 residents currently incarcerated in state prisons because the extent of overcrowding constituted cruel and unusual punishment and was therefore in violation of the Eighth Amendment to the U.S. Constitution. Unanswered questions resulting from the ruling include: where are these individuals going to live, how will they access the services necessary to successfully re-enter the community, and who is going to assist them with problems such as their high risk for HIV and drug abuse? It is currently unclear what role sober living houses might play in helping parolees transition from prison into the community.

Budget cuts and funding requirements reduced support for social model programs

While funding for state prisons has skyrocketed, funding for treatment programs of all varieties has decreased. Reductions began under President Reagan, who made deep cuts that led to instability at the state and local level. Planning services to underserved populations became difficult and created competition for funds, especially for very low-income and homeless people with alcohol/drug problems (McCarty, Argeriou, Huebner and Lubran, 1991). The federal government also realigned its treatment policies to provide greater federal direction for state efforts and to focus on clinical managed-care approaches under a revised federal block grant program for treatment of alcoholism through a single state agency (Borkman, Kaskutas and Barrows, 1999, p. A-6). This meant more federal requirements and greater financial support for short-term residential detoxification and treatment in licensed facilities and outpatient services delivered by professional and specialized staff emphasized counseling, case management, and medication. Clinical programs spent little time grappling with issues of safe and sober living situations for clients. This approach undercut the social model generally, and sharply curtailed on-going efforts to improve the quality of settings for services through experiential learning. Under new federal and state requirements, social model alcohol recovery homes had to modify their operations to include clinical elements and to conform to treatment, reporting, and certification requirements based on clinical models.

Effects of these federal shifts on the California social model approach were devastating. Borkman, Kaskutas and Barrows (1999) concluded in 1999 that the California program environment had become "essentially antithetical" (p. A-7) to pure social model programs to the point "social model programs have had to modify their approach to accommodate funding and few exemplary, pure social model programs remain open" (p. A-8).

A further complication was that "pure" social model alcohol recovery programs developed concurrently with other forms of non-medical residential programs starting in the late 1960's and early 1970s (Borkman, Kaskutas and Barrows, 1999; Polcin, 2000). Three forms of residential care emerged – halfway houses (step-down programs after clients completed residential substance abuse treatment or clients with co-occurring psychiatric and substance use disorders), therapeutic communities (primarily for rehabilitation from illicit drug abuse), and Minnesota Model programs (hybrid treatment/recovery programs that combined social model homelike settings and AA meetings with clinically-driven staffing and therapeutic activities). The "true" social model residence – one managed by its residents without staff and with no more than a resident manager – now had competition. While all these facilities nominally operated alcohol/drug free settings, house rules and conditions regarding strict sobriety varied based on special needs of residents who had other problems in addition to alcohol.

Formal research to study sober housing and social model approaches

Although it did not support continued social model program operations, the NIAAA did support formal exploratory research into the design and operation of social model programs (e.g., Borkman, 1980), followed by formal research to define social model approaches to recovery and to assess the outcomes of social model services compared to non-social treatment services (Kaskutas, Ammon & Weisner, 2003–2004; Kaskutas, Zavala, Parthasarathy & Witbrodt, 2008). Study findings showed comparable outcomes for residential service stays, but at lower cost for social-model stays (about 60% of costs at non-social model facilities).

More recently, studies of sober living houses in Northern California (Polcin, Korcha, Bond, & Galloway, 2010c) tracked outcomes of 300 sober living house residents over 18 months. Improvements were found on measures of abstinence, peak density of alcohol and drug use (maximum number of days of alcohol or drug use during month of highest use), arrests, psychiatric symptoms, and employment. Importantly, improvements were noted at 6 months and for the most part maintained at 18 months, and residents maintained improvements after they left the SLH facility. Support was found for two social model recovery principles: social support and 12-step involvement. Substance use in the social network predicted worse outcome and higher involvement in 12-step groups predicted better outcome. These and other favorable findings for residential recovery homes, such as Oxford House studies (Jason, Olson, Ferrari, & Lo Sasso, 2006), led to a community of researchers studying recovery residences (National Association of Recovery Residences, 2012) and to increased attention to the recovery outcome experiences for residents in social model residences (Polcin, Mulia, & Jones, 2012).

Resiliency of Sober Living Houses

Although the integrated, four-setting community social model needed to modify its services to adapt to state licensing and funding requirements to survive, sober living houses based on the original 12-step house model continue largely unchanged. Anecdotal reports backed up by recent outcome research (Polcin, et al., 2010c) have demonstrated the benefits of SLHs for a wide variety of recovering residents including 1) residents entering the homes after completion of residential treatment, 2) residents residing in the homes while they attended outpatient treatment, 3) individuals who were referred from the criminal justice system and 4) individuals who were interested in an alternative recovery option that did not include formal treatment. As Table 1 indicates, the number of SLHs in California has increased significantly over the past several decades. Nearly 800 houses are currently affiliated with sober living associations in the California and they have a capacity to service nearly 10,000 individuals at any given time point.

Social living entrepreneurs

The variety of successful sober houses in California all have one element in common with the original 12-step house: A dedicated owner/operator who understands sober living and takes a "hands-on" approach to assure that the house operates well in all respects, from small details to political and social relationships with the surrounding community. The term 'social living entrepreneur ' was coined by Don Troutman, whose houses constitute a case study reported in this special edition (Wittman, Jee, Polcin & Henderson, this edition). Troutman echoes other social model pioneers (e.g., Schonlau, Dodd, Ross, Brown, and Davey) who created a combined vision of safe and sober places to live while working on one's recovery. Putting this vision into action required nuts-and-bolts knowledge about recovery, drive and personal commitment, and the community connections necessary to work in the local housing market. Sober living house (SLH) thus becomes a potential community recovery resources based on the quality of management for the individual house and the willingness of the surrounding community system of services to participate with referrals and supports.

Oxford Houses

Oxford Houses represent one type of sober living residence that is extremely popular outside of California (over 1,200 nationwide), but limited to only a few houses inside the state. The origins of Oxford Houses began in 1975, long after 12-step recovery homes were already established in California. There was therefore less of a need for them in the state.

The origins of Oxford House provide a compelling example of a sober house surviving the loss of public agency support. O'Neill (1990) describes how he and others recovering residents in a state funded sober house in Maryland learned that the funds for rent and counseling were being cut. The residents decided among themselves they could maintain their own recovery if they could keep living together in the house. They therefore signed a lease to continue living in the residence and made a commitment to each other to continue abstinence and working on a recovery program. Other groups of individual took up this idea

and started additional houses. The result is the Oxford House Charter and the creation of resident-run sober houses now operating nationwide (O'Neill, 1990).

Unlike sober living houses in California, Oxford Houses are all non-profit. Also unlike the homes in California, there is no house manager or owner. Houses are rented and leadership positions within houses are rotated among all members. Oxford House Inc. provides training and assistance for houses that require help and all houses are held to basic standards of health, safety, and quality of operations. Like sober living houses in California, formal studies of Oxford Houses are limited. However, a group of researchers from DePaul University led by Dr. Leonard Jason has conducted a variety of studies demonstrating excellent longitudinal outcomes (National Association of Recovery Residences, 2012).

Associations of sober living houses in California

Sober living associations in California provide peer-based oversight that allows highly dispersed, independently owned and operated sober housing to function as a reliable recovery resource according to certain standards for training, operation, transparency, and mutual monitoring to assure fidelity to 12-step principles and surrounding community/ neighborhood standards. Two sober housing associations operate in California using two different models. The oldest is the California Association for Addiction Recovery Resources (CAARR, formerly the CAARH that helped launch the social model movement in California). CAARR operates primarily in Northern California and membership includes treatment/recovery programs that provide a variety of services in addition to sober housing. Membership also includes free-standing sober living house operators. The Sober Living Network (SLN, in Southern California) originated as the sober living house arm of a four-setting community social model program, CLARE, operating under the direction of Ken Schonlau in one California city. As CLARE responded to state and federal requirements that compromised the original peer-based recovery oriented basis for CLARE, Schonlau left to found and direct the Sober Living Network, which continues to thrive following his passing a few years ago. These associations continue to add members as they provide consultation, guidance, support, training, and health and safety standards to member houses (see Table 1). Both SLH organizations are independent peer-based coalitions whose governance and income come from members and charitable foundations, rather than from public agencies.

Discussion: Where do Sober Living Houses Stand Today?

SLHs in California are now thriving in the mainstream market place for private rental residences. They do this independently (similar to the original 12-step houses) or as members of a sober living association of other SLHs. Models of SLH operations have expanded in recent years. Some SLHs are now organized into a two-stage recovery program that starts with intense exposure to peer-based sober living in a highly-organized and more restrictive setting (e.g., curfews) that prepares the resident for independent living in an affiliated SLH. (See Polcin and Henderson [2008] for a description of this model as it is used at Clean and Sober Transitional Living in Fair Oaks, CA). In addition to two-stage models, SLHs are increasingly used as part of hybrid models that provide professional clinical services to the residents while also making room for AA meetings and recovery-

oriented living. These three forms of organization provide a highly flexible community context for the growth of SLHs as a new form of housing (called "intentional housing" by some proponents) to meet America's growing and changing needs for new physical housing forms to accommodate new social and economic forms of "family."

Interest in community-based recovery services more broadly conceived has increased among national organizations including the National Association of Recovery Residences (NARR) and the Substance Abuse and Mental Health Services Administration (SAMHSA). NARR was only recently formed and has developed new standards for recovery homes of all types. They are active in promoting expansion of community based recovery and additional research to document outcomes. The Society of Community Research and Action (SCRA), Division 27 of the American Psychological Association has teamed up with NARR to develop a policy statement on the value of recovery residences in the United States (Jason, Mericle, Polcin & White, 2013).

SAMHSA has been active in promoting a "Recovery Oriented System of Care" (ROSC) (Kaplan, 2008) that emphasizes the therapeutic value of professional as well as nonprofessional support from peers, family, and faith communities. SAMHSA is joining a growing coalition of organizations that view addiction as a chronic condition in need of assistance over the long term. However, that assistance can come from frequently overlooked sources of support, including peer support in residential recovery programs such as sober living houses.

Recommendations

(1) Continue to establish free-standing SLHs, both independently and in cooperation with community treatment/recovery programs and other health, social, and correctional agencies that provide services to people in recovery. This approach will involve cooperation with non-social model services providing detoxification and emergency services; non-social model forms of residential rehabilitation in facilities staffed by professional and specialists; and linkages to other helping agencies.

(2) The California Department of Corrections should consider SLHs as potential living arrangements for the tens of thousands of state prisoners being release into communities on parole. While not all parolees are appropriate for residence in a SLH, (see guidelines suggested by Polcin [2006] to assess appropriateness of parolees for placement in sober housing), it seems fair to say they could play a much larger role than they have to date.

(3) Following the example suggested by the CSTL case study elsewhere in this journal (Wittman, Jee, Polcin & Henderson, this edition), consider the benefits of two-stage models of sober living houses that include exposure to an intense experiential training phase as an introduction to sober living followed by a move to more independent living in SLHs. This approach could do much to revive the California community social model described above.

(4) The experiences and designs of SLHs for recovery from addiction might have implications for how entrepreneurs could develop housing that accommodates emerging new life-styles that include new self/mutual help orientations. There is a need for a new

definition of "family" that includes "intentional families" to which new communal living arrangements can respond. There is also a need to explore new forms of housing architecture – design and operation – that can be responsive to these new developments.

Directions for Research

Although SLHs have existed for decades, research on them continues to be limited. Part of the problem is that SLHs emerged as a grass roots movement of persons in recovery rather than an intervention introduced by academics or researchers. There were therefore few proponents of SLHs who were well positioned to scientifically investigate outcomes or disseminate the strengths of the intervention in publications (Polcin & Borkman, 2008). What follows below are suggested directions for the study of SLHs. Many of these suggestions are consistent with suggestions made in a recent report on residential recovery settings published by the National Association of Recovery Residences (2012), a group that combines sober housing practitioners, researchers, and officials.

Design, operation and outcomes—Ground-breaking work on the social model approach in general (e.g., Kaskutas, 1998) and sober living houses in particular (Polcin, et al., 2010c) at the Alcohol Research Group create a basis for further research and development. New activities that add to earlier work might include: (1) Evaluate sober living houses as a function of organizational operations, physical design, spatial layout and neighborhoods. Such investigations would examine relationships between recovery experiences, physical design, furnishings, operational practices, and location. (2) Explore how these factors influence recovery outcomes. In particular, there is a need for longer term outcomes beyond the 18 month outcomes reported by Polcin et al., 2010c or the 24-month outcomes reported by Jason et al, 2006.

Reducing Offenders' HIV Risk: MI-Enhanced Case Management with Drug Free Housing—(R01 DA034972) is a recently funded 5-year study supported by the National Institute on Drug Abuse. The study is being conducted at the Alcohol Research Group (principal investigator – Polcin) and is designed to assess the effectiveness of sober living houses combined with supportive case management for persons on probation or parole. The study targets reduction in HIV risk, drug and alcohol use, arrests, re-incarceration, and psychiatric problems over a 12-month period. The intervention attempts to achieve these goals via residence in a sober living environment and by providing 1) help settling in and adapting to the house environment, 2) assistance finding work or job training, 3) strategies that help improve compliance with terms of probation or parole, and 4) assistance accessing needed services in the community.

Relationship of sober living houses to the surrounding community—Sober housing by all reasonable indicators should be viewed as a welcome community asset, yet NIMBY (not in my back yard) challenges persist. What are reasons for these challenges and how can they best be addressed? In a study of the community context of sober living houses, sober living house managers, neighbors and local officials reported very few problems between sober houses and the local community (Polcin et al., 2012a). These findings as well as research described in the NARR (2012) report suggest NIMBY concerns are not based on

actual conflicts between neighbors and sober houses. More work is needed to understand what motivates NIMBY activists, but stigma about addiction and lack of knowledge about the disease concept of addiction were viewed as contributors to NIMBY in a study of recovery counselors and psychiatric health practitioners (Polcin et al., 2012b).

There are additional questions needing more attention that relate to the methods and strategies needed to maintain positive relationships with neighbors, officials, and service providers. To what extent should sober living houses maintain anonymity in the neighborhood? To what extent should they actively build cordial relationships with neighbors? When should SLHs invoke their federal rights to fair housing? What circumstances make it important to assert these rights, and what are most effective ways to do so?

Financing sober living houses—Currently, most SLHs operate on standard private housing market models – monthly rent payments by the residents, who may be subsidized from a variety of sources according to arrangements that are the responsibility of the tenant, not the owner/operator. This "fair-box" approach seems viable for many applications, and it avoids many pitfalls. However, there are a number of questions needing more focus. What shortcomings do SLHs encounter, for example, with difficulties in access to loans to make initial changes and improvements? Should there be more government support in this regard and how might that effect SLH autonomy and operations? Should there be other funding/ financing models? Does it make sense to subsidize an individual who has limited financial resources who may require some time to generate an income? How does that affect experience in the home and how might it affect other residents?

Quality control and community standards; use permits, licensing and certification—Claims are often made that requiring state licensing or certification will help guarantee that sober housing is operated appropriately. The social model approach rejects this claim on practical and theoretical grounds in favor of peer-based monitoring systems in which sober houses supervise each other. Both CAARR and SLN work on this latter basis, but this approach has not been formally studied and self-monitoring standards have not been reviewed or critiqued by researchers or other parties who could provide balance and perspective.

The identity of sober housing as a community institution—There is a need for more attention from researchers and community planners toward the concept of "intentional housing" as it might apply to various groups. The original four-setting social model (detoxification centers, residential recovery programs, sober living houses and neighborhood recovery centers) was dedicated sui generis to creating a community environment that protects and honors sobriety for participants according to 12-step principles. Other issues and relationships were of secondary importance. But recent developments indicate that sober housing can be thought of as a subset of what has been called intentional housing – housing in which a group of people not personally related to each other live together for a common purpose. High costs in the housing market and changing social patterns for urban living are breaking down long-standing assumptions about housing architectural design and social patterns of use. Can sober living houses as a concept be expanded to broader communal

living arrangements that target intentional housing for groups organized for specific purposes? Examples might include communal housing for housing veterans, persons with specific disabilities, or persons who share other life circumstances (e.g., single parents).

Conclusion: Sober housing and the American Dream

The American Dream includes the idea that each person or family has a room or a living unit to call his or her own, a place that is private, safe, and can be used to express one's self in its décor and customs for its use. It seems to us that sober living houses survive in large part because the SLH expresses this dream. Ken Schonlau expressed it through founding the Sober Living Network dedicated to the proposition that every community should offer a safe, sober, affordable and decent place to live while in recovery. The SLN's sole mission is to provide ordinary housing that promotes this end, and when needed to assert the recovering community's rights to do so free of undue influence from state and local regulators, meddling from the treatment community or unjustified attacks by neighbors. Ken's stubborn insistence on this core mission created a durable organization that continues to thrive following the passing of its founder. Ken's legacy symbolizes the continuing spirit that prompted the first 12-step house operators to act on their own initiative to provide peer-based, recovery-oriented sober housing. It seems fair to say there will always be a place for sober housing in the community in the same way that there will always be a place for AA, even though alcohol/drug treatment and recovery programs and philosophies come and go, and public support waxes and wanes.

Acknowledgments

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Table 1

SLH Frequencies in California as of August 2013[*]

Organization	Total Number of SLH beds affiliated with organization	Total Number of SLH residences affiliated with organization	Number of affiliated members who operate SLH housing	Number of cities where SLH housing operates
SLN	6,450	490	315	95
CAARR	3,524	301	139	96

[*] Data provided by SLN and CAARR organizations.