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A Clean and Sober Place to Live: Philosophy, Structure, and Purported Therapeutic Factors in Sober Living Houses

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Abstract

The call for evidence based practices (EBP's) in addiction treatment is nearly universal. It is a noteworthy movement in the field because treatment innovations have not always been implemented in community programs. However, other types of community based services that may be essential to sustained recovery have received less attention. This paper suggests sober living houses (SLH's) are a good example of services that have been neglected in the addiction literature that might help individuals who need an alcohol and drug-free living environment to succeed in their recovery. The paper begins with an overview of the history and philosophy of this modality and then describes our 5-year longitudinal study titled, "An Analysis of Sober Living Houses." Particular attention is paid to the structure and philosophy of SLH's and purported therapeutic factors. The paper ends with presentation of baseline data describing the residents who enter SLH's and 6-month outcomes on 130 residents.

Keywords

Housing; Sober Living House; Recovery House; Social Model Recovery

Both addiction researchers and treatment providers are increasingly calling for more evidence based practices (EBP) (McCarty, September 6, 2006; Mee Lee, September 6, 2006; Miller, Zweben & Johnson, 2006). In recent years, considerable resources have been directed toward bridging research and treatment (Polcin, 2004). Perhaps the best known example of these efforts is the National Institute on Drug Abuse Clinical Trials Network (CTN) (National Institutes of Health, September 28, 1999). The CTN is an effort to conduct EBP trials in community based treatment programs to demonstrate generalization of EBP's to these "real world" settings.

While bridging research and treatment is an important goal in which the addiction field is making progress, community services that might play critical roles in the long term success of recovery have not received sufficient attention (Polcin, 2006a). Alcohol and drug dependent individuals with histories of homelessness, incarceration, and lack of social support for sobriety are particularly vulnerable to relapse without the provision of long term community based services that support sobriety.

This paper attempts to broaden the view of recovery beyond EBP's by describing the potential role of sober living houses (SLH's). The paper begins with a depiction of the history of SLH's along with a description of how the sober living philosophy of recovery evolved over time. Our 5-year longitudinal study funded by the National Institute on Alcohol Abuse and

Alcoholism titled, “An Evaluation of Sober Living Houses” is then described. Particular attention is paid to the structure, operations, and purported therapeutic factors of SLH’s. Finally, baseline findings from our research that describe the characteristics of individuals entering the houses and 6-month outcomes on 130 residents are presented.

Definition of Sober Living Houses

SLH’s are alcohol and drug free living environments for individuals attempting to maintain abstinence from alcohol and drugs (Wittman, 1993). They offer no formal treatment but either mandate or strongly encourage attendance at 12-step groups. SLH’s have been important resources for individuals completing residential treatment, attending outpatient programs, leaving incarceration or seeking alternatives to formal treatment (Polcin, 2006b).

Although there are similarities between SLH’s and other residential facilities for substance abusers, such as “halfway houses,” there are important differences as well. Unlike many halfway houses, SLH’s are financially sustained through resident fees and individuals can typically stay as long as they wish. Because they do not offer formal treatment services, they are not monitored by state licensing agencies. However, many sober living homes are members of SLH coalitions or associations that monitor health, safety, quality, and adherence to a social model philosophy of recovery that emphasizes 12-step group involvement and peer support. Examples of SLH coalitions in California include the California Association of Addiction Recovery Resources (CAARR) in the northern part of the state and the Sober Living Network in the south. Over 24 agencies affiliated with CAARR offer clean and sober living services. The SLN has over 250 individual houses among its membership. Outside of California, the “Oxford House” model of sober living is popular, with over 1,000 houses nationwide as well as a presence in other countries (Jason, Davis, Ferrari & Anderson, 2007). However, because there is no formal monitoring of SLH’s that are not affiliated with associations or coalitions it is impossible to provide an exact number of SLH’s in California or nationwide.

The History and Evolution of the Sober Living House Model

The earliest models of SLH’s began in the 1830’s and were run by religious institutions such as the YMCA, YWCA, and Salvation Army (Wittman, 1993; Wittman, Bidderman & Hughes, 1993). These “dry hotels” or “lodging houses” evolved in part out of the Temperance Movement, which sought ways for individuals to overcome social pressures to drink. These Temperance based SLH’s tended to be run by operators and landlords who had strong personal convictions about sobriety. Unlike many contemporary SLH’s, residents generally had little input into operations of the facility and landlords/operators frequently encouraged attendance at religious services.

After World War II many metropolitan areas increased in population. Along with a tighter housing market came more widespread alcohol related problems (Wittman, Bidderman & Hughes, 1993). At the same time, the era of self help recovery via Alcoholics Anonymous (AA) was emerging. In the city of Los Angeles, recovering AA members opened “twelfth step” houses to address the increased need for alcohol and drug free living environments. Managers of these houses either mandated or strongly encouraged attendance at AA meetings to facilitate residents’ recovery. Operations of the house were generally the responsibility of the house manager or owner. By the 1960’s Los Angeles supported several dozen such houses (Wittman, Bidderman & Hughes, 1993).

The need for sober housing increased during the 1970’s and continues today. Wittman (1993) observed that one reason for the increased need was the decline of affordable housing in metropolitan areas during the mid 70’s. Cities decreased rooming houses and single room

occupancy hotels that were frequently used as sober living residences. As a result, there were fewer SLH's available at the time when the need was high.

Other factors that contributed to the need for more SLH's was the deinstitutionalization of psychiatric hospitals without the provision of adequate community based housing (Polcin, 1990) and the decline of residential addiction treatment programs (Wittman, 1993). The result has been an explosion of homelessness. As reviewed elsewhere (Polcin et al., 2004), homelessness affected nearly 6 million people from 1987 to 1993. Conservative estimates indicate 40% suffer from alcohol problems and 15% suffer from drug problems (McCarty et al., 1991). In one county in Northern California, a study of homelessness revealed a lifetime prevalence for substance use disorders of 69.1% (Robertson & Zlotnick, 1997).

Newer Models of Sober Living Houses

An important exception to the decline of SLH's during the 1970's was the development of Oxford Houses (O'Neill, 1990). When a halfway house for substance abusers in Montgomery County Maryland closed, the clients continued their residence by paying rent and utilities themselves and implementing a shared, democratic style of managing the house. The residents were apparently satisfied with this new arrangement and the model rapidly expanded. While they are common in other parts of the country, they are rare in California, where other types of SLH's existed before Oxford Houses became widespread.

The Oxford House model offers a "social model" recovery philosophy (Kaskutas, 1999) that emphasizes peer support for sobriety and shared, democratic leadership in managing house operations. In addition, Oxford houses are financially independent of outside organizations and are financially self-sustaining. Although residents are not required to attend 12-step groups, they are generally encouraged to do so. Research in Oxford houses indicates that 12-step involvement is high, with about 76% of the residents attending 12-step meetings at least weekly (Nealon-woods, Ferrari & Jason, 1995).

Other types of SLH's have been more varied in their operations. The early "dry hotels" or "lodging houses" in particular were dominated by the influence of landlords or managers. Some SLH's today continue with a "strong manager" model of operations. Often, a person in recovery rents out rooms, collects money for rent and bills, evicts individuals for relapse and either mandates or strongly encourages attendance at 12-step meetings. The potential downfall of these types of houses is they do not capitalize on the strength of peer support and peer empowerment. Fortunately, many contemporary house managers have recognized the value of integrating social model recovery principles into house operations. These houses tend to have a residents council or a similar mechanism for resident empowerment and input into house operations. In California, SLH coalitions such as CAARR and the SLN require evidence of resident involvement in managing operations because peer support and empowerment are thought to be key factors in the success of SLH's.

An Evaluation of Sober Living Houses

"An Evaluation of Sober Living Houses" is a 5-year study funded by the National Institute on Alcohol Abuse and Alcoholism (Polcin, Galloway, Taylor & Benowitz-Fredericks, 2004). It aims to track 300 individuals over 18 months who live in 20 different SLH's administered by 2 different agencies. This report will focus on 6-month outcomes for 130 individuals residing in 16 sober living houses affiliated with Clean and Sober Transitional Living (CSTL) in Sacramento, California.

Study procedures included recruiting residents for the research within their first week of entering the SLH. All participants signed informed consent documents and were informed that

their responses were confidential. A federal certificate of confidentiality was obtained to further protect study confidentiality. Interviews were conducted at entry into the houses and at 6-month follow-up. We expected residents entering SLH's who had established sobriety would maintain that sobriety, while those with recent substance use would show significant improvement.

Primary outcome measures included the Addiction Severity Index (ASI) (alcohol, drug, medical, legal, family/social, and vocational severity scales) (McLellan, et al., 1992), six month measures of substance use (Gerstein et al, 1994), and the Brief Symptom Inventory to measure psychiatric severity (Derogatis & Melisaratos, 1983). In addition, we examined factors that correlated with outcome. Our protocol includes measures of social support for sobriety (Zwyak & Longabaugh, 2002) and involvement in 12-step groups (Humphreys, Kaskutas & Weisner (1998). To assess for DSM psychiatric diagnostic categories at baseline we used the Psychiatric Diagnostic Screening Questionnaire (PDSQ) (Zimmerman & Mattia, 1999).

Before reporting study findings that compare resident functioning at baseline and 6-month follow up, a description of the houses at CSTL will be provided that emphasizes SLH structure, operations, and philosophy.

Clean and Sober Transitional Living

CSTL was founded in 1986 by a recovering alcoholic and addict who had lost a brother to addiction and could not find affordable housing that was conducive to recovery. He and several roommates opened their own sober living house and the facility grew to the sixteen houses today. All of the houses are located in a suburb seventeen miles northeast of Sacramento, California. All houses are within a 9 mile radius of each other, which facilitates a sense of community and commitment.

Currently, about 90% of the residents pay their rent using their own funds; about 10% of the residents have their rent paid by SASCA (Substance Abuse Services Coordinating Agency), an agency created for graduates of Substance Abuse Programs in the California Department of Corrections.

CSTL embraces the Alcoholics Anonymous and Narcotics Anonymous philosophy of recovery and requires residents to be active members in those programs. The CSTL goal is to help the addicted person create a new, alcohol and drug-free lifestyle. To accomplish this goal, CSTL offers a long term, continuous clean and sober living environment and a culture of sobriety in a community of peers. Social support for sobriety is emphasized along with "experiential learning," where residents learn strategies from each other about how to succeed in recovery. In addition, residents support each other in informal ways, such as providing suggestions about where to find work or how to seek help for medical or psychiatric problems. Consistent with the principles of social model recovery, residents are empowered through participation in a "Resident Congress."

Phase System—One of the ways that CSLT has built upon the traditional sober living house model is through implementation of a phase system. Rather than all residents immediately having the same responsibilities and freedoms as soon as they enter the house, the phase system ensures more structure for new members and increasing freedoms for those who have resided in the house for a longer period. The program has found that increased limits and responsibilities early in the residence helps individuals adapt to the sober living environment. As they develop stability in their residence and recovery they tend to be more successful with the increased freedom and autonomy of phase II.

There are 6 Phase I houses with 71 beds. To minimize isolation and maximize accountability, bedrooms are shared by two or three people. All houses have 4 bedrooms with the exception

of the larger main house, which includes offices for the administrative staff and the general manager. This house also has a large community dining room offering home cooked dinners nightly. The fee of \$695 for Phase I houses includes rent, utilities, and family style meals.

There are 10 phase II houses and 65 beds, 61 of which have private rooms. Rent is \$395 for a shared room and \$495 for a private room and includes furniture and utilities; residents are responsible for food.

Policies and Operations—Before entering CSTL, prospective residents must have begun a program of recovery. Some may be clean and sober because of incarceration, yet they may be motivated to engage in sustained abstinence from alcohol and drugs. Others residents enter with a recent history of residential treatment, while others have become substantively involved in outpatient or self-help programs. Beyond that, decisions are made on a case by case basis.

All residents begin in Phase I, where they have the most restrictions and demanding chores. Residents in Phase I carry an AA/NA meeting card that is checked for compliance with the expectation that they attend five meetings per week. Residents must abide by a nightly curfew and sign in and out for accountability. To progress to Phase II, a resident must have been in Phase I a minimum of thirty days and have not been reprimanded for any violation of house rules for thirty days. The resident requests the General Manager put them on the waiting List for a Phase II house which usually has a thirty to ninety day wait. Phase II entails fewer restrictions and more freedoms. For example, meeting cards to validate 12-step meeting attendance are not required, there are no curfew requirements, and overnight guests are permitted twice per week.

CSTL offers no form of counseling but requires that residents agree to 7 conditions:

1. not drink any form of alcohol;
2. not use any mind altering substances;
3. attend five 12-step meetings per week;
4. attend the mandatory Sunday Night House Meeting (a two hour meeting where residents share what they did for their recovery that week as well as set goals for the following week and share how their week went overall);
5. obtain a sponsor and be active in a 12-step program;
6. sleep at CSTL at least five nights per week;
7. be accountable for whereabouts when off CSTL property

In addition to abiding by the above seven conditions, residents are required to complete chores and conduct themselves in a manner conducive to and consistent with recovery. Residents are encouraged to find employment if they are not already employed when they move in.

CSTL tests for drugs and alcohol at random in both Phase I and Phase II. If relapse is suspected, the resident is given an opportunity to admit to their use and a urine sample is taken. If the resident denies use and the urinalysis is positive, the resident is immediately terminated from the program. If the resident admits use, the resident is required to leave the property for 72 hrs and then appears before a “judicial committee” made of senior peer residents who then determine whether or not the resident is allowed to stay. Typical consequences for the first relapse are community service activities or attendance at ninety 12-step meetings in ninety days. Grounds for immediate termination include drinking or drug use on the property, taking a fellow resident out to use, acts of violence, and sexual misconduct.

If residents desire a change in the rules, they can make a request to the Resident Congress which is governed by current residents and alumnae. Residents also have an opportunity for input through their House Manager. The House Manager is a liaison between the residents and the General Manager and advocates for residents. The House Manager is someone who has demonstrated responsibility, integrity, is in good standing with the community and abides by rules and regulations and is chosen by the General Manager.

Who Goes to CSTL?—Data from our research on 211 individuals enrolled in the study has been presented at the Addiction Health Services Research (AHSR) Conference (Polcin, 2006, October 23–25). Baseline findings suggest that SLH's serve a variety of individuals in need of an alcohol and drug free living environment that supports recovery. The most common referral source was the criminal justice system (25%), followed by family/friend (23%), self (20%) and inpatient/residential treatment (13%). The role CSTL plays in addressing housing problems for those in the criminal justice system can also be seen in the fact that 35% of the sample indicated that jail or prison had been their usual housing situation over the past 6 months. Few incoming residents reported stable housing over the past 6 months. While 7% reported renting an apartment as their primary housing, 23% reported staying with family or friends and 12% reported homeless as their primary living situation. Ten percent indicate that a residential treatment facility was their primary living situation.

In terms of demographic characteristics, a majority were male (76%), white (72%) and never married (51%). The mean age was 36.5 (10.10).

While residents presented with a variety of substance abuse problems, those with methamphetamine (49%) and alcohol (44%) dependence were the most prevalent. This finding in part reflects the geographic area of the houses in the central valley area of California, an area known to have high rates of methamphetamine abuse. Other substances were less prominent: marijuana (25%) and cocaine (21%).

CSTL provides services to a large percentage of individuals who suffer from psychiatric symptoms. We used the Psychiatric Diagnostic Screening Questionnaire (Zimmerman & Mattia, 1999) to screen for prevalence of sixteen psychiatric disorders. Results indicated widespread mental health problems. Large proportions of the sample met screening criteria for various disorders: social phobia 46%, generalized anxiety 41%, post traumatic stress disorder 38%, major depression 35%, and psychotic disorders 30%. While the screening criteria were significantly lower than the symptom level required for a DSM diagnosis, it does indicate the existence of psychiatric issues that should be assessed and treated.

Despite the high prevalence of psychiatric severity, relatively few residents engaged in psychiatric services. Only 12% reported attending outpatient psychotherapy sessions and only 30% reported receiving psychiatric medications between baseline and 6-month follow up. Attendance in formal outpatient addiction treatment programs was also low, with 80% reporting no alcohol or drug treatment during the 6 month assessment period.

Six Month Outcomes—Six month follow up findings have been reported on 130 residents (Polcin, 2006, October 23–25). Findings indicated that residents made important improvements between baseline and 6-month follow up. Despite the finding that 56% had left the houses by the 6 month time point, 40% of the sample reported complete abstinence from alcohol and drugs between baseline and 6-month follow up. An additional 24% reported they had been completely abstinent five of the last six months.

To assess whether residents made improvement between baseline and 6-month follow up we conducted comparisons of study variables between the two time points. Because most of the

variables had data that were not normally distributed, we used a nonparametric analysis, Wilcoxon Signed Ranks Tests for 2 Related Samples. Results showed that residents made significant improvement over the 6-month period in terms of the number of months they used drugs or alcohol ($Z=-6.1$, $p<.001$). On average, residents used substances about 3 of the 6 months before entering the sober living houses. That declined by half at 6-month follow up, when they indicated they used substances 1.5 months on average. When we examined only those individuals who relapsed ($n=78$), we found a significant reduction in the severity of substance use between baseline and 6-month follow up. “Peak Density” (number of days of substance use during the month of heaviest use) (Gerstein et al., 1994) declined from an average of 23 days at baseline to 16 at 6-month follow up ($Z=-3.4$, $p<.01$). Other improvements were noted in the number of days worked ($Z=-5.0$, $p<.001$), percent arrested ($Z=-3.3$, $p<.01$) and severity of psychiatric symptoms ($Z=-3.4$, $p<.01$).

Although residents entered the SLH’s with relatively low ASI scores for Alcohol (mean=.17) and Drug (mean=.08) scales, there were nonetheless significant improvements at 6 months for alcohol ($Z=-2.9$, $p<.01$) and drug ($Z=-2.8$, $p<.01$) scales. Significant improvement was also noted on the ASI employment scale ($Z=-6.1$, $p<.001$) (Polcin, 2006, October 23–25).

What Factors are Associated with Outcome?—One of the goals of the research was to identify factors that were associated with outcome. Interestingly, referral source was not associated with outcome and those with criminal justice mandates did as well as those who entered voluntarily (Polcin, 2006b). The two factors that appeared to be the strongest factors associated with 6-month outcome were: 1) measures of psychiatric severity and 2) involvement in 12-step groups (Polcin, 2006, October 23–25).

A modified version of the Alcoholics Anonymous Affiliation Scale was used to assess 12-step involvement groups (Humphreys, Kaskutas & Weisner, 1998). The scale was modified to include other types of 12-step meetings besides Alcoholics Anonymous, such as Narcotics Anonymous. This measure included more than attendance at meetings; it also assessed activities such as getting a sponsor, sponsoring others, participating in meetings, and volunteering for service work (e.g., set up chairs, organize literature, and clean up after meetings). Psychiatric severity was measured using the BSI (Derogatis & Melisaratos, 1983).

Logistic regression models were used to assess whether selected variables from 6-month assessments were associated with 6-month outcome. As Table 1 indicates, involvement in 12-step groups such as Alcoholics Anonymous or Narcotics Anonymous was strongly associated with the number of months individuals used substances over the past 6 months. As involvement in 12-step groups increased, individuals were about half as likely ($OR=0.56$) to be members of the higher use group (defined as using substances during 2–6 months versus 0 to 1 month).

Involvement in 12-step groups was also a significant predictor of ASI alcohol severity. Table 2 shows that those with more involvement were less likely to be associated with higher alcohol severity ($O.R=0.75$).

The other variable that was associated with 6-month outcome was psychiatric severity. At 6 months, those with higher psychiatric severity were nearly three times more likely to be members of the high alcohol severity group. As shown in Table 3, psychiatric severity at 6 months also predicted higher ASI drug severity ($OR=2.1$).

Limitations—There are a number of limitations that should be apparent. First, the sample was limited in size, geographic diversity, and type of SLH’s studied. Results obtained from other areas of the country, other types of SLH’s (particularly “strong manager” houses), or larger sample sizes could yield different results. Second, the study was descriptive and did not

include comparison with individuals in a control group. We therefore do not know whether comparable individuals would do better or worse in other types of living arrangements. Finally, the results only examined 6-month outcomes. Whether these results hold over longer periods of time is unknown.

Conclusion

The addiction treatment field must progress beyond the types of evidence based treatments recommended in the literature if it is to succeed in helping large number of individuals achieve sustained sobriety. Sober living houses are an excellent example of an underutilized modality that could help provide clean and sober living environments to individuals completing residential treatment, engaging in outpatient programs, leaving incarceration, or seeking alternatives to formal treatment.

This paper has reviewed the historical roots of SLH's along with the evolution of the SLH philosophy of recovery. Findings from our study on SLH's show they are utilized by a variety of individuals and that residents show improvement at 6 month follow up in a variety of areas, including substance use, work, arrests and psychiatric symptoms. While psychiatric severity is high and improves at 6 months, relatively limited numbers of residents receive adjunctive psychiatric services and higher psychiatric severity is associated with poorer outcome. Consistent with the sober living philosophy of peer support for recovery, higher involvement in 12-step groups such as Alcoholics Anonymous was associated with better outcome.

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Table 1

Logistic regression of 6-month variables predicting number of months used any substances at 6-month follow up (0–1 versus 2–6) (N=130)

6-month Variable	OR	CI
AA/NA Involvement	0.56 ^{***}	0.43 – 0.73

^{***} $p < 0.001$, controlling for age, sex, race, and psychiatric severity

Table 2

Logistic regression of 6-month variables predicting ASI Alcohol Severity (Dichotomized) (N=130)

6-month Variable	OR	CI
AA/NA Involvement	0.75 [*]	0.60 – 0.94
Psychiatric Symptoms (BSI)	2.8 ^{**}	1.3 – 5.8

*
 $p < 0.05$,

**
 $p < 0.01$, controlling for age, sex, race and alcohol related social support

Table 3
Logistic regression of 6-month variables prediction ASI Drug Severity (Dichotomized) (N=130)

6-month Variable	OR	CI
Psychiatric Symptoms (BSI)	2.1 [*]	1.0 – 4.2

^{*} $p < 0.05$, controlling for age, sex, race, and drug related social support