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The Impact of AA on Non-Professional Substance Abuse Recovery Programs and Sober Living Houses

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Abstract: In addition to being a widely used and effective approach for alcohol problems, AA has been central to the development of several types of non-professional recovery programs. Known as "social model recovery," these programs were staffed by individuals in recovery and they encouraged program participants to become involved in AA as a way to address their drinking problems. In addition, they relied on the traditions, beliefs, and recovery practices of AA as a guide for managing and operating programs (e.g., democratic group processes, shared and rotated leadership, and experiential knowledge). This chapter reviews the philosophy, history, and recent changes in several types of these programs, along with a depiction of AA's influence on them. Programs examined include neighborhood recovery centers, residential social model recovery programs, and two types of sober living houses: California Sober Living Houses and Oxford Houses. Recent outcome evaluations on both types of sober living houses are presented.

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1. Introduction

A social movement of non-professionalized substance abuse recovery programs and sober living houses (SLHs) known as the "social model recovery" approach evolved since the 1940s from the philosophy and practices of Alcoholics Anonymous through the efforts of its members and is explained in this chapter. The characteristics, forms, and philosophy of social model recovery approaches—a generic form of self-help organization—are briefly summarized. A review of the history of social model development includes descriptions of Neighborhood Recovery Centers (NRCs), residential social model recovery programs, and SLHs. This chapter gives special emphasis to SLHs because they are currently the most prevalent and relatively pure type of social model recovery. Two variations in SLHs are noteworthy: California Sober Living Houses and Oxford Houses. The impact of AA on each type of SLH is described and research findings are summarized.

AA was the first generation of self-help/mutual aid that became the prototype for all twelve-step/twelve-tradition anonymous groups (Borkman, 1982, 1983). The principle of non-affiliation of AA with other groups or enterprises developed early in its history (White & Kurtz, this volume) but members committed to doing twelve-step service for fellow alcoholics created various social innovations to extend the assistance available to newcomers beyond AA meetings and the fellowship. These second-generation self-help organizations (Borkman, 1983) were twelve-step houses and social detoxes of the 1940s and 1950s. In these settings newcomers to recovery could sober up, live in an abstinent environment, attend AA meetings, and associate with recovering peers. However, social model detoxes and twelve-step houses were often run by charismatic leaders who did not involve or empower residents (Wittman, 1993). Thus, while they followed self-help/mutual aid ideas of personal recovery with the twelve steps, the twelve-step houses did not necessarily follow the organizational principles of AA which were not fully codified until the mid-1950s and were not quickly embraced even then.

The third generation might best be termed the social/community recovery model of the mid-1970s, 1980s, and later. These self-help organizations, more formalized than twelve-step groups, are usually 501(C)3 non-profit organizations with noticeable budgets that employ recovering staff to provide services to their peers and use the social technology of self-help and mutual aid (Borkman, 2007, p. 212). Free from the organizational constraints of AA's traditions (i.e., organizational principles), social model recovery expanded beyond individual recovery to embrace the community as a focus for intervention and prevention. Alcoholism became defined as a social disease that afflicts not just individuals but the community. "In the community, it is characterized by responses and practices creating social pressures to drink. The condition is also characterized by individual and community denial that alcohol is a drug" (Matthews & Weiss, 1990, p. 172).

Community-based social model recovery programs flourished in California during the 1970s and 1980s. At that time, publicly funded alcohol and drug programs in California were funded through counties. Borkman (1986, 1990) conducted a study to identify if social model alcohol programs in fact were being funded by county alcohol program administrators since many clinically oriented providers thought social model meant only non-medical, which also characterized their programs. Study results showed that social model programs, as they are defined here, were commonly funded. Many medium and large counties, including San Diego and Los Angeles, funded social model programs or an eclectic mix of clinical and social model programs exclusively. Borkman's (1990) categorization of the elements of social model program formed from that research comprised the basis for Kaskutas, Greenfield, Borkman, and Room's (1998) development of the Social Model Philosophy Scale (SMPS), which is described in detail below.

2. Social Model Recovery

"Social model recovery" is a philosophy and set of practices that was initially developed by recovering alcoholics from Alcoholics Anonymous to assist themselves and their peers in recovery from alcoholism. Although "social model recovery" programs have evolved in many geographic locations where members of Alcoholics Anonymous wanted to help their peers with additional formalized programs, the model has been more fully developed, articulated, and documented in California than anywhere (Borkman, Kaskutas, Room, Bryan, & Barrows, 1998). The Institute of Medicine identified California's social model approach as "the most prominent example of the use of sociocultural model in formal treatment" (Institute of Medicine, 1990). Because of AA's 6th tradition of non-affiliation (12 & 12, 1952, p. 11) recovery efforts and programs that are inspired by AA or developed by members of AA cannot be referred to as AA recovery programs. Consequently, the origins and influence of AA and its beliefs and practices are often implicit in social model recovery programs rather than explicit. Observers have to know enough in detail about the AA terminology, beliefs, and practices to identify the origins of a program as being AA or other twelve-step related or special steps have to be taken to obtain that information. In this case Borkman (1983) has researched social model programs for years and interviewed co-founder and current CEO of Oxford House, Inc., Paul Molloy, and co-founder and Program Director of Sober Living Network, Ken Schonlau, about what AA ideas and practices were initially borrowed for their model. Over the years, in addition to the recovering alcoholics and drug addicts committed to the social model approach, many sympathetic professionals, government officials, and other non-recovering persons have been attracted to and supportive of it.

Major aspects of the social model philosophy of individual recovery which are grounded in the principles of AA have been formulated in more generalized concepts (see Shaw & Borkman, 1990; Kaskutas & McLellan, 1998; Room, 1998):

- Alcoholism and drug addiction are lifelong persistent problems which cannot be cured but can be arrested through abstinence and a program of individual recovery and mutual help.
- In the alcohol and drug-oriented society of the United States, recovering alcoholics/addicts need a safe abstinent social environment in which to recover; "the description of the social model mission is to provide a sober environment and alter the larger environment, with the ultimate aim of creating a culture where it is OK not to drink" (Wright, 1990, p. 4).
- Social model philosophy focuses on the development of an abstinent safe environment within which an individual alcoholic/addict recovers at his/her own pace.
- Social model programs assume many forms: social detoxification, twelve-step houses, recovery homes, community recovery centers, or sober living houses.
- Social model programs may be non-profit 501(C)3 organizations but the experiential knowledge and authority of recovering alcoholics/addicts controls and directs the organization.
- In social model programs the staff members are recovering peers who manage the environment, not the recovering individual.
- Recovering individuals are "prosumers" (consumers and providers—Toffler, 1980), not clients, who recover by helping others and themselves.
- Individuals are assisted in taking self-responsibility for their own plan of recovery from alcohol/drugs in social model recovery programs; accordingly residents, not staff, develop their own personal recovery plans (Borkman, 1998b).
- The physical settings should be home-like and non-institutional with places for privacy and reflection as well as open areas for sociability and mutual help activities (Wittman, 1990).
- Governance of programs is provided by a rotating "resident's council" which uses democratic participation of residents as a vehicle for making program decisions.

The pioneers developing social model approaches, such as Martin Dodd and Ken Schonlau, are experts on self-help and mutual aid approaches. In their development of social model residential recovery homes and neighborhood community centers they relied on AA principles and traditions. However, the social model programs of the 1980s went beyond AA traditions. They included more of an emphasis on the community and its contribution to alcohol and drug abuse problems as well as the need for advocacy to change harmful substance

abuse policies. These issues were beyond AA's traditions of non-involvement with outside issues. Thus, these early social model programs were increasingly open to the community. They were invested in being good neighbors and involved in activities such as hosting alcohol and drug-free community activities, taking residents to community AA meetings, and inviting their alumni to mentor residents or volunteer for staff duties (Barrows, 1998; Matthews & Weiss, 1990).

2.1. *Paucity of Published Literature*

Social modelists are primarily recovering alcoholics/addicts who are practitioners, not researchers or academics and consequently write little. Much of the written material about social model recovery is unpublished fugitive or grey literature of conference reports or agency memos with very little peer-reviewed research (Borkman et al., 1998; Room, Kaskutas, & Piroth, 1998). The earliest research in 1980 was an ethnographic description and comparison of two complex social model agencies in southern California directed by social model pioneers (Borkman, 1983). A later and substantial peer-reviewed research effort compared social model recovery programs to hospital day treatment which was reported in special issues of the *Journal of Substance Abuse Treatment* (Kaskutas & McLellan, 1998) and *Contemporary Drug Problems* (Room, 1998). This chapter reports on more recent social model studies describing outcomes in two types of SLHs: California Sober Living Houses (Polcin, Galloway, Taylor, & Benowitz-Fredericks, 2004; Polcin, 2006 October; Polcin & Henderson, 2008) and Oxford Houses (Jason, Davis, Ferrari, & Anderson, 2007; Jason, Olson, Ferrari, & Sasso, 2006).

3. Types of Social Model Recovery Programs

The social model recovery movement evolved into several different types of recovery programs: neighborhood recovery centers (NRCs), residential social model recovery programs and two types of SLHs, California Sober Living Houses and Oxford Houses. In the early years of the social model movement NRCs and social model recovery programs were prominent. However, over the past several decades there has been a rather dramatic decline in the number of these types of programs (Kaskutas, Keller, & Witbrodt, 1999). Details about these changes and potential causes are discussed below. At the same time that publicly funded social model programs were decreasing, SLHs, which were financially self-sustaining via resident fees, were substantially increasing in number. Today, SLHs represent the purest form of social model recovery and our review of them is therefore somewhat more extensive.

3.1. *Neighborhood Recovery Centers*

Neighborhood recovery centers (NRCs) are non-residential social model recovery centers located in communities (Wright, 1990). Typically, open AA

meetings are held at the center, so anyone in the community can attend. In addition, they frequently host or coordinate AA social events, such as alcohol and drug-free parties, dances, or other social outings. Additional activities may include guest speakers who conduct educational workshops on a variety of topics related to recovery. Frequently NRCs are a resource for other types of services individuals might need (medical, psychiatric, legal, and vocational).

Perhaps most importantly, the NRCs offer a safe, alcohol and drug-free environment in which individuals can seek social support for continued sobriety and a variety of life stresses. Although many individuals in recovery attend AA meetings for exactly this purpose, the NCR creates an environment where they can seek support outside the context of a formal AA meeting. They are used by a variety of individuals with alcohol and drug problems, including those who are ambivalent about sobriety and still actively using, those with some initial success at sobriety, and those who are seeking social support after completing residential programs.

Like AA they tended to be democratically managed, but unlike AA they were funded primarily by local and state governments. This made them vulnerable to the demands of funding agencies that they adopt more professionally based approaches and they were subject to budget cuts.

3.2. Residential Social Model Recovery Programs

Residential social model recovery programs offer an alcohol and drug-free living environment for individuals where they can learn how to develop and maintain an abstinence program of recovery. During the first several decades of their inception (1970s and 1980s), residents in social model residential programs stayed for 6 months to a year or longer. However, in response to funding requirements, most of these programs now have lengths of stay of 2–6 months. Historically, they have strived to practice all of the aforementioned social model recovery principles that grew out of AA. One of the unique strengths of learning recovery within a residential social model setting is the opportunity to practice recovery strategies on a daily basis with other recovering persons. Daily stresses and conflicts within the program offer excellent opportunities for residents to learn how to apply the twelve steps of AA to other similar stressful situations they will encounter outside the program. In this way, AA recovery is learned, practiced, and refined within a safe and supportive environment. Like NRCs, residential social model recovery programs typically offer groups and workshops on a variety of issues related to recovery (e.g., relapse prevention, women's issues, dual diagnosis, physical or sexual trauma, etc.) in addition to offering AA meetings.

One important difference between residential social model programs and AA is staffing. Although typically all staff members in social model programs are in recovery from alcohol or drug problems, they are nonetheless paid employees. In contrast, AA subsides completely on the volunteer efforts of its member. Borkman et al. (1998) pointed out that the requisite skill sets needed

to work as a staff member in a residential social model recovery program were different than involvement in AA activities. In addition to sharing experiential knowledge about recovery from alcoholism, staff members in social model recovery programs needed to have skills related to conducting groups and workshops. Recovering staff were also expected to be knowledgeable about how to advocate for residents and be familiar with community resources they might need (medical care, mental health treatment, vocational training, etc.). Residential social model programs have no formal "treatment plan," as in a medical model program, but staff members were expected to assist residents in developing a "recovery plan" that described activities they planned to undertake as part of their recovery.

Perhaps the most significant difference between residential social model recovery programs and AA has to do with financing. While AA has subsisted on contributions since its inception, residential social model programs have typically sought funding from public and private funding agencies. However, funding source requirements are often based on medical treatments and not consistent with social model recovery principles (Borkman et al., 1998). For example, funding sources frequently require that services be delivered by licensed or certified professionals. Such professionals are rare in social model programs. Funding sources usually require calculations of specific types of treatment services delivered and formal treatment plans, neither of which are characteristic of social model recovery. Core social model principles such as the "helper therapy" principle, social support for sobriety, experiential learning, and democratic process are not considered in the development of funding standards.

The expansion of managed care during the 1980s and 1990s did much to decrease the prevalence of social model recovery programs. Kaskutas et al. (1999) noted that managed care standards for funding included treatment and organizational characteristics that were not consistent with social model programs. Using a scale that assesses the extent to which programs use social model recovery principles (the Social Model Philosophy Scale [SMPS]), Kaskutas et al. (1999) reported a substantial decline in the number of programs that can accurately be described as social model. In addition to providing an overall score indicating the level of social model philosophy used, the instrument has subscale measures that assess the program's physical environment, staff roles, the authority base, the program's view of alcohol problems, governance of the facility, and level of orientation to the community. The study by Kaskutas et al. (1999) surveyed 311 programs in California using the SMPS and found that 60% (N=187) considered themselves social model programs. However, only 30% of these programs met the criteria on the SMPS that would characterized them as "true" social model programs. In a comparison of 14 social model programs between 1995 and 1998 the same research team found a significant reduction in the use of social model philosophy. A major reason for these changes was attributed to modifications that programs were making in response to mandates from funding sources, especially managed care models of financing. Finally,

two randomized trials compared 6- and 12-month differences in alcohol and drug use and severity measures for clients seeking treatment in medical model versus social model programs. In general, substance use outcomes were similar for clients in the two treatment modalities in both studies (Kaskutas, Witbrodt, & French, 2004; Witbrodt et al., 2007), suggesting that clients do as well as when treated in non-medically oriented, social model programs.

Social model programs declined in number in spite of encouraging outcome findings in several studies and especially encouraging findings on cost. For example, Borkman et al. (1998) reviewed outcome studies on social model programs and noted that residents in these programs show significant improvement between program intake and 18-month follow-up (San Diego County Department of Health Services, 1983) and treatment completion and 15-month follow-up (Gerstein et al., 1994). Relative to other types of residential treatment, costs were significantly lower. In a more recent study, Kaskutas, Ammon and Weisner (2003–2004) conducted a naturalistic comparison of outcomes (*N*=722) between the social model and a variety of clinical and medical programs. At 1-year follow-up social model residents were more involved in AA activities than clients in other programs and they were less likely to report problems with alcohol or drugs. Among individuals across both types of programs, AA involvement and social support for sobriety predicted an absence of alcohol problems. Thus, individuals involved in AA tended to be either abstinent or drinking at levels that did not result in problems.

It is ironic that managed care emphasized cost reduction and documented outcomes, yet implemented funding standards that depleted a modality that appeared to have performed well on both counts. However, the benefits of the social model approach were noted by many alcohol treatment providers and some elements of social model recovery have been integrated into broad-based or hybrid treatment programs (e.g., encouraging involvement in twelve-step groups, hiring staff who are in recovery, advocating abstinence, facilitating peer support, and providing services outside a formal clinical office). These characteristics of social model recovery were found to be prominent in an evaluation of a broad-based treatment program (Polcin, Prindle, & Bostrom, 2002) despite an overall low rating on the SMPS. An outcome study that used repeated measures analysis of 48 study participants at baseline, 3 months post treatment, and 6 months post treatment revealed significant improvement on measures of alcohol use, heavy alcohol use, drug use, satisfaction with family relationships, arrests, overall health status, and self-esteem. Attendance at twelve-step meetings and having a sponsor were both associated with better alcohol and drug use outcomes.

4. Sober Living Houses

The place where traditional, non-professional, social model recovery is most prominent currently is in SLHs. Both California Sober Living Houses and Oxford Houses owe much of their grounding to AA ideas and practices. They

also have organizational differences with social model recovery programs that have allowed them to flourish.

Unlike residential recovery programs, SLHs are financially self-sustained by resident fees and generally not financed through insurance or public funding. In addition, because they do not offer formal treatment, they are not licensed or monitored by states. Their independence from funding sources and licensing bodies allows them to pursue a model of recovery on their own terms without external mandates. For example, instead of responding to rigid time lines of funding sources, SLHs allow residents to stay as long as they wish. While most SLHs require that residents engage in some type of recovery program, the recovery activities are generally developed by the residents and formal case management files are not kept. Because lengths of stay can be longer, most SLHs have some mechanism for substantive input into house management and operations. Involvement in management of the facility is especially important for residents who have been in the program for substantial periods of time and understand the program philosophy. Among other things, it is a way for them to "give back" to the community of residents.

Although the effects of AA on operations within SLHs are evident, policies about attendance at Alcoholics Anonymous meetings vary. Oxford Houses do not make involvement in AA or NA mandatory, although they do require some type of recovery plan. California SLHs vary, with some requiring attendance at meetings and others not having such a requirement. Either way, studies on twelve-step attendance in SLHs have shown high levels of twelve-step involvement. Nealon-Woods, Ferrari, and Jason (1995) found that 76% of a sample of 134 male residents in Oxford Houses attended meetings at least weekly. Polcin and Henderson (2008) reported on 16 California SLHs (*N*=300) that required attendance at five twelve-step meetings per week.

The discussion below provides a brief history of California and Oxford SLHs, along with a description of their structure, operations, and recent research documenting outcomes. It is to be noted that Oxford Houses are a more recent development and their residences are more homogenous. California SLHs vary more in terms of their structure and how they are managed.

4.1. History of California Sober Living Houses

The forerunners of contemporary SLHs in California were organizations in the 1800s that simply rented out rooms to individuals who were attempting to establish sobriety (Wittman, Biderman & Hughes, 1993). In a review of the history of SLHs Wittman et al. (1993) pointed out that Temperance Movement advocates in the 1830s influenced the development of different types of sober lodgings: rooming houses, single room occupancy hotels, religious missions, and service organizations such as the Salvation Army. Most of these residences were run privately by landlords with personal or religious convictions about supporting sobriety. Unlike many contemporary SLHs, these early sober houses did not practice principles of social model recovery, such as democratic participation, shared leadership, and experiential learning about how to develop a

sober lifestyle. Instead, these early facilities were largely managed by the landlords or owners who developed and enforced house rules.

Another significant development in the history of SLHs occurred in the city of Los Angeles (Wittman et al., 1993). In the late 1940s the end of World War II created an influx of returning veterans, many of whom retuned to large urban areas such as Los Angeles. Thus, the population of Los Angeles expanded considerably and along with it the proliferation of alcohol problems. To address the increasing prevalence of alcoholism some individuals in recovery through AA opened "twelfth step" houses. These were clean and sober residences managed by recovering AA members. By the 1960s Los Angeles had several dozen "twelfth step" houses and they had begun to expand to other cities as well (Wittman, 1993). A key difference from the earlier types of housing was the emphasis on Alcoholics Anonymous recovery principles. Residents were encouraged or required to attend twelve-step recovery meetings and the house managers often were a type of role model for recovery.

Although twelfth step houses emphasized recovery through Alcoholics Anonymous, most of these houses did not emphasize an egalitarian, peer-oriented system of managing the houses. Instead, the houses operated in a more hierarchical manner, with the house manager or landlord making most house decisions and enforcing the rules. Thus, opportunities for taking on responsibility and experiential learning were limited.

SLHs continued to increase in popularity in the 1970s when affordable housing began to disappear in Los Angeles and other metropolitan areas and homelessness increased (Wittman et al., 1993). However, influenced by Alcoholics Anonymous, a new model of operating houses was emerging. Rather than a "strong manager" model, the new social model approach emphasized shared, democratic governance and rotating leadership on a residents' council (Borkman, 1983, 1998a). The social model approach to recovery emphasized recovery in Alcoholics Anonymous, and most residents were involved in a twelve-step recovery program. However, in keeping with the philosophy of Alcoholics Anonymous, attendance at Alcoholics Anonymous meetings was usually voluntary. Residents were challenged to take responsibility for their recovery as well as governance of the facility.

4.2. Contemporary California Sober Living Houses

The California model of SLHs continue to be the most prevalent in California but can now be found in many other states throughout the United States (K. Schonlau, Sober Living Network, personal communication, August 15, 2005). Because they are not treatment providers and therefore not licensed or required to report to any agency or local government, it is difficult to ascertain their exact number (Polcin, 2001). However, in California, Sober Living House Associations (SLHAs) such as the Sober Living Network (SLN) and California Association for Addiction and Recovery Resources (CAARR) report increasing membership. Ken Schonlau of SLN reports that over the past 5 years

their membership has increased from 136 to 260 houses (K. Schonlau, Sober Living Network, personal communication, July 9, 2007). Susan Blacksher of CAARR estimates their membership has doubled over the same time period (S. Blacksher, personal communication, July 11, 2007). They currently have 64 organizations that provide sober living house services to a variety of individuals. Some of the CAARR houses have affiliations with formal treatment centers (e.g., provide housing after an individual completes residential treatment) while others do not. SLHAs such as CAARR and SLN provide support, training, advocacy, referrals, and health and safety standards to SLHs that are members. They also have standards that promote a social model view of recovery.

A major reason for the expansion of SLHs in California and elsewhere has been the increasing difficulty in getting residential social model recovery programs funded. In response, pioneers of California social model programs such as Ken Schonlau, Martin Dodd, and others focused on expanding SLHs because they would not be vulnerable to external funding mandates (i.e., they were self-supporting whereas residential social model recovery programs were not). In addition, they could remain loyal to social model recovery principles that were threatened by the professionalization and medicalization of treatment (Borkman, Kaskutas, & Owens, 2007; Shaw & Borkman, 1990). To ensure health and safety standards of SLHs a number of recovering AA members and leaders of social model programs got together to coordinate an effort to identify and certify high-quality SLHs in order to distinguish them from weak houses with bad reputations. This effort was incorporated in 1995 as the Sober Living Network to be an umbrella organization for coalitions of high-quality SLHs (Borkman, April 30, 2007).

Unlike Oxford Houses, which are described below, California SLHs vary a great deal. Kaskutas (1999, April) noted that some are small apartments or houses, while others are large, comprising entire apartment complexes, single room occupancy hotels, or multiple smaller houses. Historically, SLHs tended to emphasize voluntary admissions. However, in recent years, residence in a sober living facility has become part of some criminal justice offenders' release plans (Polcin, 2006). Although SLHs continue to emphasize a peer-oriented model of recovery and do not offer treatment services as part of the residence, some have affiliations with outpatient treatment programs or serve as aftercare living sites for individuals completing residential treatment.

California model SLHs can be designed as for-profit or non-profit organizations. One of the criticisms of some for-profit houses is that they can be designed and operated more with an eye toward maximizing the owner's financial return rather than with fidelity to the principles of social model recovery. These types of SLHs tend to have a "manager-driven" style of running the house, where the owner or manager decides the rules and determines who gets admitted. The director of the SLN, Schonlau (2004, April), differentiates SLHs that are "supervised homes" from those that are "democratic homes." the former being more manager driven and the latter more consistent with the

principles of social model recovery. In recent years, SLHAs such as CAARR and SLN have established guidelines that require or strongly encouraged houses to implement a democratic style of management. For a more detailed description of California Sober Living Houses see the recent paper by Polcin and Henderson (2008).

4.3. *Oxford Houses*

While published histories describing the origins of Oxford House often leave out the influence of AA (e.g., O'Neill, 1990), Paul Molloy, co-founder and currently CEO of Oxford House, Inc., described such an influence in a recent interview (P. Malloy, personal communication, Oxford House, Inc. offices, Silver Spring, MD, 2007). According to him, the 13 co-founders who were in a halfway house in Silver Spring, MD, regularly attended AA meetings when they were told the county was closing their facility. Molloy and other co-founders complained about the threat of losing their sober housing to their seasoned AA sponsors and friends. Their elders responded, "Get off the pity pot! What can you do about it?" They discussed the huge price tag of operating a halfway house with professional staff to monitor them. They decided they did not need any staff but could manage on their own. Each resident would pay their share of rent and utilities with extra for staples. Another long-term AA member from the community loaned them the *750 security deposit. Molloy asked an old friend in Vermont whose sponsor was Bill W., the co-founder of AA, to help them apply AA principles in developing the house; he took the bus from Vermont, visiting them for several days to talk about how AA ideas and practices could be translated to the sober rental housing. Within 6 months their cash reserve had accumulated enough that when other alcoholics/addicts wanted a place to live, they considered "Should we buy a new TV or other material goods or help other alcoholics by opening a new house?" The AA's twelfth step of helping other suffering alcoholics/addicts was applied and a second house was opened. Three or four of the original residents including Molloy and O'Neill moved into the second house to provide experience and act as role models for how to run such houses O'Neill (1990). The practice of seasoned Oxford House members moving to a new house became an important organizational principle for how to promulgate the Oxford House culture as they opened many new houses.

While an exhaustive analysis of the influence AA initially had and subsequently NA and other twelve-step fellowships continue to have on Oxford House is beyond the scope of this paper, the organization and structure of Oxford House is significantly patterned on the AA traditions which are the principles of the organization. Similar to local AA groups which are autonomous (Traditions 4 and 6), self-run (Tradition 8), financially self-supporting by their members (Tradition 7) with democratic and rotating leadership (Traditions 2 and 8) (12 & 12, 1952), Oxford Houses have nine traditions adapted as appropriate from AA's twelve traditions. The Oxford House traditions stipulate in their *Oxford House Inc.* (2006) that an individual Oxford House

is to be autonomous (OH Tradition 5), run democratically by residents who elect new officers every 6 months (OH Tradition 2), without professional staff (OH Tradition 7), and to be financially supported by residents' rent (with the exception of an initial loan which has to be repaid) (OH Tradition 6). Interestingly, the OH Tradition 4 maintains that OH is not affiliated with AA organizationally or financially, "but Oxford House members realize that only active participation in Alcoholics Anonymous and/or Narcotics Anonymous offers assurance of continued sobriety" (OH Manual, 2006, p. 20). Finally, like AA, OH has but a single purpose: its Tradition 1 reads "Oxford House has as its primary goal the provision of housing and rehabilitative support for the alcoholic and drug addict who wants to stop drinking or using drugs and stay stopped" (OH Manual, 2006, p. 17).

Because of early popularity and success, Oxford Houses rapidly expanded. In addition, the federal government passed an anti-drug bill (Public Law 100–690) which provided money to states to loan to individuals wishing to set up sober living residences. This law made expansion more viable. Oxford House, Inc. is currently a large international organization with over 1,200 houses located throughout the United States, Canada, and Australia. Although Oxford Houses have proliferated in the United States and in other countries as well, there is only one in California. The California SLH model of SLHs had taken root in the state earlier and continues to be the predominant model in the state (Polcin, 2001).

Relative to California SLHs, Oxford Houses are far more homogenous. They are designed and structured in a way that ensures compliance with social model recovery principles. Oxford Houses have mandatory requirements for houses to use a democratic organizational structure, share and rotate leadership within the houses, rely on peer support for recovery, and finance housing costs using resident funds. In addition, member houses receive training workshops on how to facilitate a sense of community, mobilize commitment to the house, manage daily operations, and practice recovery skills from peers. A final difference with SLHs is that the Oxford model has regulations that require 6–10 members in each house. Although attendance at twelve-step meetings is not required, a majority are involved in twelve-step programs (Nealon-Woods et al., 1995). Similar to most SLHs, residents can stay as long as they like and they are free to decide whether to pursue professional treatment for substance abuse and other problems. There are no minimum requirements for sobriety before entering, although most enter after completing detoxification or residential treatment programs (Jason, Olson, et al., 2006). For a complete description of Oxford House philosophy, structure, operations, and resident characteristics see the recent book by Jason, Ferrari, Davis, and Olson (2006).

4.4. Outcome Studies on Sober Living Houses

Despite the expansion of both models of SLHs there has been limited systematic research. About 10 years ago Dr Leonard Jason and colleagues at

DePaul University began a program of research on Oxford Houses culminating in a recent book (i.e., Jason, Ferrari, et al., 2006) and publication of two longitudinal outcome studies (Jason, Davis, Ferrari, & Anderson, 2007; Jason, Olson et al., 2006). California model SLHs have been even less extensively studied. However, in 2003 Polcin and colleagues (Polcin et al., 2004) began a 5-year study of 20 California SLHs. While the investigation is ongoing, preliminary results on 6-month outcomes have been reported (Polcin, 2006, October). Reviewed below are the major findings to date from both of these investigations, beginning with the studies on Oxford Houses.

4.4.1. Outcome Research on Oxford Houses

Although there has been a plethora of publications on Oxford Houses by Jason and colleagues, two papers present their major longitudinal outcome findings (i.e., Jason et al., 2007; Jason, Olson, et al., 2006). In the study by Jason, Olson et al. (2006), 150 individuals completing residential treatment programs were randomly assigned to aftercare as usual or residency in an Oxford House. At 24-month follow-up individuals assigned to the Oxford House condition had significantly better outcome on measures of substance use, income, and incarceration. Among those assigned to aftercare as usual, 64.8% reported some alcohol or drug use over the previous 6 months versus 31.3% for the individuals assigned to the Oxford House condition. Monthly income for residents in the Oxford House condition was *989 versus *440 in the usual aftercare condition. Among individuals assigned to the Oxford House condition 3% reported that they had been incarcerated. Among individuals in the usual aftercare group the incarceration rate was three times as high (9%). Thus, residence in Oxford Houses appears to benefit the individuals who reside there and they have economic benefits for the society as well.

One of the limitations of the study by Jason, Olson, et al. (2006) was the limited geographical area from which the sample was drawn (i.e., the state of Illinois). A second limitation was that the sample only included individuals completing residential treatment. The second study of Oxford Houses (i.e., Jason et al., 2007) addressed both of these limitations. The study consisted of a US national sample of Oxford House residents (N=897), a majority of whom had a history of receiving some type of substance abuse treatment. However, unlike the first study, completion of a residential treatment program was not required for inclusion. Study participants were recruited into the study and interviewed at three subsequent 4-month intervals. During the final interview, only 13.5% of the respondents reported using alcohol or drugs during the previous 90 days and social support for sobriety was associated with abstinence. The average number of days participants used substances was low—3.7 days for drugs and 5.6 for alcohol. This suggests that many individuals either relapsed recently or were able to readily re-establish their recovery after their relapses. When study participants reported having social networks that supported abstinence and discouraged substance use, they were more likely to be abstinent. The

proportion of residents reporting employment throughout the study was high, ranging from 79% to 86%. The authors identify several limitations, including self-selection bias and a modest follow-up rate of 68% for the final interview.

4.4.2. An Evaluation of California Sober Living Houses

"An Evaluation of Sober Living Houses" is a study funded by the National Institute on Alcohol Abuse and Alcoholism that is designed to track longitudinal outcomes of 300 individuals residing in 20 different SLHs in northern California over an 18-month period (Polcin et al., 2004). The houses are operated by two different organizations. One operates four houses that are associated with an outpatient treatment program. Residents who live in the houses are required to attend the outpatient treatment program and can continue their residence after completing treatment. The other organization operates 16 more typical SLHs in that they are not affiliated with any formal treatment. These houses have characteristics more commonly associated with social model recovery (e.g., contains a resident's council and has no requirement for formal treatment). Therefore, the findings reported here will be limited to these 16 houses.

While data collection for the study is ongoing, preliminary 6-month outcomes on 130 residents (24% female, 28% non-white, and mean age of 36.5) have been encouraging (Polcin, 2006, October). The research team has been able to locate and interview about 77% of the study participants at the 6-month time point. At 6 months 44% were still residing in the SLHs. Approximately 40% indicated no use of alcohol or drugs during the 6-month assessment period. An additional 24% indicated they had been abstinent 5 of the last 6 months. A comparison of residents' alcohol and drug use during the 6 months *before* entering the SLHs with the 6 months *after* revealed a significant decrease in the number of months they use substances. Before entering the houses residents use 3 of the last 6 months and that declined to 1.5 during the subsequent 6 months. Those who did relapse had less severe patterns of use. Among those who relapsed, maximum monthly use before entering the SLHs was about 23 days per month and after it declined to 16 days. Other areas of improvement were noted as well. They included significant improvement on measures of employment, arrests, and psychiatric symptoms. As expected, one of the factors that correlated with improved outcome was higher involvement in twelve-step recovery groups (Polcin, 2006, October).

An interesting finding was that a quarter of the residents were referred from the criminal justice system. Historically, social model and AA recovery have emphasized that recovery should be voluntary rather than coerced. However, outcomes at 6 months indicated that residents referred from the criminal justice system had improvements that were similar to voluntary residents (Polcin, 2006). The author pointed out that SLHs might be useful in playing a more prominent role in helping to reduce very serious overcrowding problems in state prisons, especially in California, where recidivism rates result in two-thirds of state prison parolees being reincarcerated within 3 years.

5. Conclusion

AA's influence on recovery from alcoholism has gone beyond impacting individuals who attend AA meetings. It has also evolved into a social movement of recovering persons who developed a "social model" approach to recovery. Social model recovery programs constitute a variety of community-based recovery programs, including neighborhood recovery centers, residential recovery programs, and SLHs. Developing a program of recovery through involvement of AA is central in each of these modalities. However, AA has also influenced the organization, operations, and recovery philosophy of these programs. This chapter has described how social model programs integrated key AA concepts into their recovery philosophy and organizational operations. AA characteristics that influence social model recovery programs include (1) empowerment of members in decision making and management; (2) experiential learning; (3) developing a peer community offering social support for sobriety; (4) latitude in residents developing their own recovery activities; (5) an emphasis on the twelfth step or "helper therapy" principle, where residents benefit when they help other residents or contribute to the program in some manner; and (6) residents taking responsibility for their recovery.

While social model residential recovery centers have declined in recent years due to funding and licensing requirements, some broad-based or hybrid models have integrated some characteristics of the social model approach (e.g., an emphasis on involvement in AA, hiring staff in recovery, and a goal of abstinence) but not others (e.g., a resident's council). While additional studies on these types of programs are needed, one recent study (i.e., Polcin et al., 2002) indicated that some social model recovery principles can be integrated into broad-based programs with positive outcomes. However, California SLHs and Oxford Houses currently offer the best examples of unencumbered social model recovery and both appear to be expanding in numbers. This chapter has reviewed recent outcome research that documents resident improvements in a variety of areas in both types of residences.

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