ELSEVIER

Journal of Substance Abuse Treatment 38 (2010) 356–365

Journal of Substance Abuse Treatment

Regular article

Sober living houses for alcohol and drug dependence: 18-Month outcomes

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

[a]*Alcohol Research Group, Public Health Institute, Emeryville, CA 94608-1010, USA*
[b]*California Pacific Medical Center, St. Lukes Hospital, San Francisco, CA 94139, USA*

Received 8 November 2009; received in revised form 11 February 2010; accepted 11 February 2010

Abstract

Objective: A major challenge facing many individuals attempting to abstain from substances is finding a stable living environment that supports sustained recovery. Sober living houses (SLHs) are alcohol- and drug-free living environments that support abstinence by emphasizing involvement in 12-step groups and social support for recovery. Among a number of advantages, they are financially self-sustaining and residents can stay as long as they wish. Although SLHs can be used as housing referrals after inpatient treatment, while clients attend outpatient treatment, after incarceration, or as an alternative to treatment, they have been understudied and underutilized. **Method:** To describe outcomes of SLH residents, we interviewed 245 individuals within 1week of entering SLHs and at 6-, 12-, and 18-month follow-up. Eighty-nine percent completed at least one follow-up interview. Outcomes included the Addiction Severity Index (ASI), Brief Symptom Inventory (BSI), and measures of alcohol and drug use. Covariates included demographic characteristics, 12-step involvement, and substance use in the social network. **Results:** Regardless of referral source, improvements were noted on ASI scales (alcohol, drug, and employment), psychiatric severity on the BSI, arrests, and alcohol and drug use. Substance use in the social network predicted nearly all outcome measures. Involvement in 12-step groups predicted fewer arrests and lower alcohol and drug use. **Conclusion:** Residents of SLHs made improvements in a variety of areas. Additional studies should use randomized designs to establish causal effects of SLHs. Results support the importance of key components of the recovery model used by SLHs: (a) involvement in 12-step groups and (b) developing social support systems with fewer alcohol and drug users.

Keywords: Sober living house; Residential treatment; Recovery house; Social model; Social network; 12-Step

1. Introduction

Sober living houses (SLHs) are alcohol- and drug-free living environments for individuals who are attempting to maintain abstinence and develop a recovery-oriented lifestyle (Polcin & Henderson, 2008). Despite research showing that living environments supportive of recovery are associated with better outcome (e.g., Braucht, Reichardt, Geissler, & Bormann, 1995; Hitchcock, Stainback, & Roque, 1995; Schinka, Francis, Hughes, LaLone, & Flynn, 1998), SLHs have been largely overlooked by policymakers and researchers. This article represents a first step toward correcting this oversight. After reviewing selected studies that show alcohol and drug use is associated with characteristics of social networks and living environments, SLHs are introduced as an underutilized resource for alcohol- and drug-free housing. The article then describes an exploratory investigation of outcomes for 245 individuals entering SLHs along with factors associated with outcome. The primary aim of the study was to provide preliminary data that could be used to support implementation of controlled studies comparing outcomes of residents in SLHs with outcomes of individuals with addictive disorders in other living environments.

1.1. Social networks and living environments

The characteristics of one's social network are strong predictors of alcohol and drug treatment outcome (Beattie & Longabaugh, 1999; Moos, 2007; Zywiak, Longabaugh, &

* Corresponding author. Alcohol Research Group, Public Health Institute, 6475 Christie Avenue, Suite 400, Emeryville, CA 94608-1010, USA. Tel.: +1 510 597 3440; fax: +1 510 985 6459.
E-mail address: dpolcin@arg.org (D.L. Polcin).

0740-5472/10/$ – see front matter
doi:10.1016/j.jsat.2010.02.003

Wirtz, 2002), and involvement in 12-step programs such as Alcoholics Anonymous (AA) appears to be especially helpful (Bond, Kaskutas, & Weisner, 2003; Moos & Moos, 2006). Studies have also shown that provision of housing that is supportive of recovery is important, particularly for individuals who are homeless or reside in destructive environments that encourage substance use (Braucht et al., 1995; Hitchcock et al., 1995; Schinka et al., 1998). These findings indicate that individuals completing treatment who remain homeless or return to substance using environments are more prone to relapse than clients living in environments supportive of sobriety.

Despite their importance, many individuals seeking to abstain from alcohol and drugs have difficulty establishing social support systems that reinforce sobriety and finding long-term, stable housing that is free of alcohol and drugs. Individuals with limited incomes who relapse are at risk for additional problems, such as homelessness, medical problems, psychiatric disorders, and arrests for misdemeanor nuisance crimes (Milby et al., 2003; Polcin, 1999). The impact of these problems on local communities is significant. For example, in one county in California, Robertson, Zlotnic, and Westerfelt (1997) examined substance use disorders among the homeless and found that 69% had a history of a substance use disorder and most (52%) had a current alcohol or drug disorder. Other studies have shown that poor heavy drinkers who become homeless frequently become major burdens to health, welfare, and criminal justice systems (Tamm, Schmidt, & Weisner, 1996).

1.2. Characteristics of SLHs

SLHs are not formal treatment programs and therefore are not obligated to comply with state or local regulations applicable to treatment (Polcin & Henderson, 2008). Thus, to a large extent, SLHs are free to operate as they wish. However, there are critically important principles that are emphasized in the literature on the SLH model of recovery (e.g., Polcin & Henderson, 2008; Wittman, 1989) and by Sober Living House Associations that have been formed to support and monitor them (e.g., The Sober Living Network in Southern California [SLN] and the California Association for Addiction and Recovery Resources [CAARR]). The essential characteristics of the contemporary SLHs model include (a) an alcohol- and drug-free living environment for individuals attempting to establish or maintain abstinence from alcohol and drugs; (b) no formal treatment services but either mandated or strongly encouraged attendance at 12-step self-help groups such as AA; (c) required compliance with house rules such as maintaining abstinence, paying rent and other fees, participating in house chores, and attending house meetings; (d) resident responsibility for financing rent and other costs; and (e) an invitation for residents to stay in the house as long as they wish provided they comply with house rules (Polcin & Henderson, 2008). For a more detailed description of traditional SLHs along with modified SLHs associated with outpatient treatment, see Polcin, Korcha, Bond, Galloway, and Lapp (in press).

SLHs have their origins in the state of California, and most continue to be located there (Polcin & Henderson, 2008). It is difficult to ascertain the exact number of SLHs that exist because they are not formal treatment programs and are therefore outside the purview of state licensing agencies. However, in California, many SLHs are affiliated with coalitions or associations that monitor health, safety, quality, and adherence to a peer-oriented model of recovery, such as CAARR or SLN. More than 24 agencies affiliated with CAARR offer clean and sober living services. The SLN has more than 300 individual houses among its membership.

There are similarities between SLHs and other residential facilities for substance abusers, such as “halfway houses.” Both are designed to promote recovery in a nonclinical homelike environment. Still, there are important differences as well. Unlike most halfway houses, SLHs have the advantage of being financially self-sustaining through resident fees. Most residents meet their financial obligations through work, but others have access to family support or government entitlement programs such as social security income. A second difference is that the residents of SLHs can stay as long as they wish, provided they meet their financial obligations and abide by the rules, such as maintaining abstinence from drugs and alcohol. Finally, there is typically no requirement about involvement in formal treatment for most SLHS. Individuals in halfway houses have usually completed residential treatment or are attending outpatient programs (Polcin & Henderson, 2008).

An alternate housing model for recovery from addiction that is similar to SLHs is the Oxford House Model (O’Neill, 1990). There are a number of similarities between SLH and Oxford Houses, including an emphasis on peer support for recovery, no provision of formal treatment services, a requirement that residents abstain from alcohol and drugs, financial self-sufficiency, and an open-ended length of stay (Polcin & Borkman, 2008). Both are ordinary houses located in residentially zoned areas (Wittman, 2009). As such, they fall under the protection of the Fair Housing Amendments Act of 1988 (FHAA) regarding the right to live in any residentially zoned area and personal privacy under the Fourth Amendment. The FHAA prohibits housing discrimination by allowing people with disabilities to live together for a shared purpose, such as mutually assisted recovery and maintenance of an abstinent lifestyle. For a more complete description of the zoning and legal issues that apply to Sober Living and Oxford Houses and recent challenges to these regulations, see Wittman (2009).

There are also a number of differences between the SLH and Oxford House models. First, SLHs have the option of requiring residents to attend 12-step meetings as a condition of residency. Oxford Houses generally encourage but never mandate attendance at 12-step meetings. Second, Oxford house rules require that each house be managed by a rotating