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What about Sober Living Houses for Parolees?

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High recidivism rates for parolees might be reduced with the provision of a stable, drug-free living environment. This paper suggests that Sober Living Houses (SLHs) have been overlooked as housing options for alcohol and drug abusing parolees. Some of the strengths of these programs include: (1) they are financially self-supporting, (2) they mandate abstinence from substances, (3) they provide social support for recovery, (4) they mandate or strongly encourage attendance at 12-step mutual help programs, and (5) they have no maximum lengths of stay. A description of SLHs, their potential roles in criminal justice systems, and preliminary data on longitudinal outcome are presented. It is suggested that SLHs could provide drug-free living arrangements for parolees and facilitate the receipt of services for other problems as well.

Keywords: Sober Living; Sober House; Parole; Criminal Justice; Oxford House

Few facts in the criminal justice field have been better documented than the problem of recidivism among parolees. The Bureau of Justice Statistics (2005) reported that a majority, 55%, of state parole discharges in 2002 failed to complete their supervision. Petersilia (2000) used Bureau of Justice Statistics to point out that two-thirds of all parolees are rearrested within three years of their release. Part of the reason for these bleak findings may be that parole officers are overwhelmed with caseloads at times of up to 70 offenders. Hence, monitoring compliance with parole requirements becomes difficult and losing track of parolees is common (Petersilia, 2000). For example, in 1999 alone California parole officers lost track of about one-fifth of their parolees. Housing instability and homelessness contribute to problems tracking parolees. In some large cities, such as Los Angeles and San Francisco, 30–50% of parolees are estimated to be homeless (Petersilia, 2000).

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Substance use may be both a consequence and a cause of homelessness. Decades of research have consistently documented large proportions of prison inmates having alcohol or drug problems (e.g., Bureau of Justice Statistics, 1999; Greenfield, 1988; Petersilia, 2000). A study conducted in the late 1980s by Greenfield (1988) found 58% of a California sample of inmates had lifetime histories of alcohol abuse or dependence and about half had histories of drug abuse or dependence. More recently, the Office of National Drug Control Policy reported that up to 85% of all state prisoners need addiction treatment but only 13% receive it while incarcerated (Byrne, Faley, Flaim, Pinol, & Schmidtlein, 1998).

The combination of high prevalence rates of substance abuse and limited treatment is especially concerning given the consistent finding that legally mandated treatment with offenders is effective (e.g., Farabee, Prendergast, & Anglin, 1998; Polcin, 2001a). The Federal Bureau of Prisons TRIAD report (Pelissier et al., 2000) indicated that residential treatment for incarcerated prisoners with addiction problems resulted in positive effects on recidivism, drug use, and employment. Numerous studies have documented that the costs of substance abuse treatment programs are by far offset by reduced criminal justice costs (Farabee et al., 1998; Gerstein et al., 1994; National Institute on Drug Abuse [NIDA], 1999). Nevertheless, funds to expand treatment are often limited and non-treatment, self-sustaining alternatives for addressing addiction problems, such as Sober Living Houses (SLHs), should be explored. Although a full description of SLHs is provided below, they may briefly be described as alcohol- and drug-free residences for individuals attempting to establish or maintain sobriety (Polcin, 2001b).

Parolees face a variety of problems in addition to substance abuse, including mental health, medical, employment, and homelessness. Petersilia (2000) pointed out that nearly one-fifth of the inmates in US prisons have mental illness. In California, Greenfield (1988) found that 15% of prisoner inmates met criteria for serious mental disorders. Other problems needing attention among inmates and those who are paroled include illnesses such as hepatitis and HIV (Petersilia, 2000). Studies have shown that homelessness among parolees released from prison is high (up to 50% in some urban areas) and up to 60% of parolees are not employed one year after their release (Petersilia, 2000).

This paper suggests that few of the issues that parolees present can be adequately addressed without the provision of safe, stable, and drug-free living environments. Outside a social context that supports substance abuse recovery, parolees are at high risk for drug relapse and the variety of problems frequently related to addiction. Also, parolees without stable housing are unlikely to have sufficient stability in their lives to attend parole-related appointments promptly or comply with service provider suggestions.

An argument frequently heard in the popular press and even among various professional groups is that prison inmates and parolees are not motivated to address addiction or other problems. However, findings from studies by Greenfield (1990) suggest that prison inmates in fact are motivated for treatment of a variety of problems. For example, 96% indicated that they would be willing to accept services for alcohol, drug, or emotional problems after their release if they experienced these problems. Parolees

may be especially receptive of addressing these types of problems when coupled with supportive, drug-free living environments and they may be more likely to follow through with a referral.

The position of this paper is that SLHs offer enormous potential for improving the fate of many parolees in multiple problem areas: criminal justice recidivism, homelessness, alcohol and drug addiction, employment, and mental health. The paper begins with a description of SLHs, including basic principles, house operations, and historical background. Then, the mechanisms by which these housing arrangements can affect receipt of help for other problem areas are described. In addition to the advantages of SLHs for parolees, potential challenges and limitations are also noted. Finally, I present preliminary outcome findings on a study of SLHs which includes a comparison of findings for criminal justice referred residents vs. others.

What are Sober Living Houses?

SLHs are alcohol- and drug-free residences for individuals attempting to establish or maintain sobriety (Kaskutas, 1999; Polcin, 2001b). Kaskutas (1999) noted that SLHs vary a great deal in terms of physical characteristics. Some are small two or three bedroom houses and others are large, encompassing entire apartment complexes, single room occupancy (SRO) hotels, or multiple smaller houses. Unlike treatment programs, SLHs do not provide group counseling, case management, treatment planning, or a structure of daily activities. However, residents are either encouraged or required to attend 12-step meetings such as Alcoholics Anonymous. A social model of recovery is usually promoted that emphasizes shared leadership on a rotating residents' council, peer support for recovery, financial self-sufficiency, and resident responsibility for maintaining the facility. Governance and management by the residents' council is especially important because it facilitates responsibility, communication, and shared commitment. Without one, programs become 'manager driven' and dependent on the leadership style of the house manager.

Because SLHs are not licensed or required to report their existence to any agency or local government, it is difficult to ascertain their exact numbers. However, in California, Sober Living Housing Associations (SLHAs) such as the Sober Living Network (SLN) and California Association for Addiction and Recovery Resources (CAARR) report increasing membership of SLHs. SLHAs provide support, training, advocacy, referrals, and health and safety standards to SLHs that are members. They also promote a social model view of recovery that they believe facilitates the recovery process. The SLN reports that they have over 300 member houses in their organization. These are 'freestanding' houses that have no affiliation with formal treatment programs. CAARR has 64 member programs throughout the state that offer sober living services in houses that are an adjunct to formal treatment or as freestanding residences. The director of SLN, Ken Schonlau, estimates that SLHs exist in a majority of other states in all parts of the country (personal communication, August 15, 2005). Websites that advertise SLHs such as www.soberrecovery.com and www.sober.com list programs in all parts of the country.

Recent NIH-funded studies on SLHs in California (Polcin, Galloway, Taylor, Lopez, & De Bairracua, 2005) and Oxford Houses (one specific type of sober living residence) in seven different states (Jason et al., 2005) have shown promising longitudinal outcomes. These studies are long overdue because sober living and Oxford Houses have enjoyed increasing popularity and growth within the recovering community since the 1970s (Jason et al., 2005; Polcin, 2001b; Wittman, Biderman, & Hughes, 1993).

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 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 owners decide the rules and determine who gets admitted. Schonlau (2004) 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. While most houses advocate for a democratic or social model approach, a sizeable minority are manager driven.

Oxford Houses

A good example of the democratic model of running SLHs is the Oxford House model. Oxford Houses are rare in California but common in the other parts of the country. The Oxford Foundation is a large international organization with over 1,000 houses located throughout the USA. Oxford Houses can be conceived as one specific type of SLH. The Oxford Foundation has 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.

The Oxford model reflects principles that are central components to the social model philosophy of recovery as described by Borkman (1998), Kaskutas (1999), and Polcin (2001b). They also reflect principles that are promoted by SLHAs such as the SLN and CAARR. However, historically SLHs not affiliated with SLHAs have not been regulated by any standards and have had enormous leeway in terms of how houses are managed. For example, some have lacked an empowered residents' council and instead have been led by a powerful house manager. Frequently, these types of SLHs are owned by the house manager or the house manger is the signer for the rental lease and therefore has leverage to make decisions about house rules and operations unilaterally. Most of these types of SLHs have been for-profit organizations.

History of Sober Living Houses

Much of the information on the history of SLHs reviewed here is taken from Polcin (2001b). Please see this publication for a more complete description of SLHs and their history.

Wittman et al. (1993) reviewed the history of SLHs and pointed out that Temperance Movement advocates in the 1830s influenced the development of several different types of sober lodging residence: rooming houses, SRO hotels, religious missions, and service organizations such as the Salvation Army. Many sober residences in the 19th century were run privately by landlords with personal convictions supporting sobriety. Unlike many contemporary SLHs, they did not practice democratic participation, shared leadership, or most other principles of social model recovery (Polcin, 2001b).

The city of Los Angeles has been a major center for SLHs (Wittman et al., 1993). After World War II the population of Los Angeles expanded considerably and the proliferation of alcohol problems resulted in the opening of 'twelfth step' houses. These were clean and sober residences managed by recovering Alcoholics Anonymous members. By the 1960s Los Angeles had several dozen 'twelfth step' houses. SLHs became increasingly popular in the 1970s when affordable housing began to disappear in Los Angeles and other metropolitan areas and homelessness increased.

A major development in the history of SLHs on the East Coast was the formation of Oxford House in 1975 in Montgomery County, Maryland (Polcin, 2001b). O'Neill (1990) described how a county-funded halfway recovery house was closed because of funding problems, the program participants decided to continue residing in the house by paying for rent and utilities themselves. They eliminated the treatment program rules, such as mandatory attendance at Alcoholics Anonymous meetings, curfews, and a six-month maximum length of stay. The only rules were that residents maintain sobriety and pay rent and utilities on time. However, most house members attended Alcoholics Anonymous meetings and others were encouraged to attend. A resident council was formed to attend to the business needs of the house and membership on the council was rotated to ensure a democratic decision-making process. There was no time limit on residency and individuals could stay as long as they liked. Anecdotal reports indicated that residents experienced an increased sense of independence and pride (O'Neill, 1990) and recent NIH outcome studies have confirmed these reports (Jason et al., 2005).

The demand for additional houses increased and other houses were formed. In 1988 the US Congress passed Public Law 100-690, the Anti-Drug Abuse Act, which provided the states money to loan to individuals wishing to develop sober living residences. Wittman et al. (1993) and more recently Wittman (2001) pointed out that service planners are increasingly interested in integrating tenancy in SLHs with participation in outpatient treatment programs. It is hoped that this approach can decrease the need for more expensive hospital inpatient or residential treatment. SLHs for criminal justice offenders remain largely untapped (Polcin, 2001b).

Advantages and Limitations of Sober Living Residence during Parole

One of the main advantages of using SLHs for parolees with a history of alcohol or drug abuse is the ease of keeping in touch with such individuals. Tracking parolees has been difficult for several reasons. First, as noted above, some parole officers have caseloads of 70 parolees (Petersilia, 2000). Second, a majority of parolees do not complete their

supervision and large proportions become homeless. While placement in a long-term residential treatment program might in many cases be optimal, there are typically few openings in such programs and they have long waiting lists. Additionally, under managed care and other funding regulations, the lengths of stay in such programs have continued to decrease, which presents the question of 'Where are they going to live' (Polcin *et al.*, 2004) after they leave treatment. In SLHs they can stay as long as they wish.

There are a number of additional advantages to using SLHs for parolees. Typically, they facilitate compliance with the requirements of parole. For example, like the terms of parole for most parolees who have addiction problems, SLHs mandate complete abstinence from drugs and alcohol (Polcin, 2001b). They usually have good informal relationships with a variety of community service providers, and they encourage residents to utilize community resources as needed (Kaskutas, 1999). This can facilitate compliance with community services such as drug treatment, mental health, or vocational training, which may be a mandated part of the parole contract. Without the provision of a safe and drug-free living environment that supports recovery, compliance with these mandated services can be difficult. Even if parolees are able to stay clean and sober in destructive environments, they may not have sufficient structure and support to keep appointments in community agencies. In addition, without the presentation of a better alternative to their previous lives, such as that offered by residence in a SLH, parolees are likely to revert to their previous antisocial lifestyles.

SLHs may also be a good fit for many parolees because most SLHs empower residents to have input into the management of the house. Residents are challenged then to take responsibility for the working of their recovery program and fulfilling house expectations. These types of responsibilities are typically not experienced while incarcerated, yet they are essential to successful adaptation in the community. Most residents find employment to meet their financial obligations. Frequently they receive help, advice, and job leads from other residents. Some residents may have costs covered by an outside agency, family members, or their own existing resources. Hence these individuals may not need to work to cover costs. In these cases the house usually requires them to have some type of positive daily structure in place of work.

Assessing Readiness for Entering Sober Living Houses

Most SLHs require an assessment for entry into the house that is conducted by the house manager, the residents' council, or both. Typically, they want to see that the potential resident has begun a program of recovery, either through 12-step programs, other mutual help programs, or treatment. They want to see evidence of ability or at least motivation to meet the house financial obligations. Finally, they want a person who can contribute to the recovery oriented environment; someone who can support the recovery of others.

The issues addressed in the assessment interview present significant questions and potential limitations about the viability of SLHs for some parolees:

(1) What if the parolee has limited financial resources, no job, and has not worked in many years?

SLHs have responded to these issues in several different ways. As mentioned above, other residents are frequently good resources for potential jobs, some of which do not require previous experience (e.g., manual labor). Hence, some residents entering the house are able to find work quickly. Here of course, the resident must be highly motivated and willing to work for low wages. Additionally, some houses are flexible and will either front or loan one month's rent for highly motivated residents or allow a prospective resident to sleep on the couch and use the common areas until they find work. However, these are temporary arrangements and usually residents are only given a month or so leeway. Finally, some agencies which fund treatment and ancillary services will pay for residence in a clean and sober living environment, such as SLHs, while the individual attends outpatient treatment. Such is the case in California's Proposition 36 program, which mandates drug treatment rather than incarceration for nonviolent first time offenders (Wittman, 2001).

(2) What if the person is not motivated for recovery or not ready to take on the level of responsibility necessary to reside in a sober living community?

This person probably requires a more intensive and structured treatment environment. Even if they are not motivated, they may nonetheless succeed in criminal justice mandated treatment. Numerous studies have found that criminal justice mandated clients do as well and in some cases better than voluntary clients (Farabee et al., 1998; Polcin, 2001a). A critical gap in the recovery treatment systems, however, is where do clients go after they have completed the residential treatment program? In addition, where do they live when they are involved in outpatient treatment? While some treatment programs have 'transitional' or 'step down' houses that are a structured part of aftercare treatment, beds are usually limited and few of the clients who need them get them (Polcin, 2001b). Thus, SLHs are an untapped resource for addressing the important question of where clients are going to live after completing residential treatment or while they engage in outpatient treatment.

(3) What if the parolee has severe mental health issues that preclude the level of autonomy required in SLHs?

Many SLHs are able to accommodate people with significant mental health problems, particularly when symptoms are well controlled with medications and other treatments. Most houses will allow residents to use Social Security Disability or General Assistance to pay rent and fees, as long as the amounts are sufficient to cover resident costs. Some individuals may need more intensively monitored 'supported housing' programs (Rog, 2004). These are houses in the community usually occupied by individuals with serious mental illness, many of whom also have problems with alcohol or drugs. They are affiliated with mental health programs and partially funded by the mental health treatment systems. Residents may occasionally work, but most are likely to be involved in outpatient day treatment or other types of structured activities. The

'supported housing' program within a mental health treatment system is often a good alternative for individuals too disabled to succeed in a typical sober living home.

Preliminary Offender Outcomes in Sober Living Houses

'An Evaluation of Sober Living Houses' is a five-year study funded by the National Institute on Alcohol Abuse and Alcoholism (Polcin, Galloway, Taylor, & Benowitz-Fredericks, 2004). It aims to track 300 individuals living in 19 different SLHs administered by two different agencies: Clean and Sober Transitional Living (CSTL) in Sacramento, California and the Options program in Berkeley, California. CSTL operates freestanding houses, while Options operates houses affiliated with their outpatient program. Interviews are conducted at baseline and 6-, 12-, and 18-month follow-up. Planned comparisons include an examination of resident outcomes relative to outcomes in a nearby social model treatment program. Other comparisons will examine outcomes for subgroups of residents within the houses, such as criminal justice referrals.

Preliminary data on 73 residents (20% female, 33% non-white) revealed that approximately 45% were still residing in SLHs six months post baseline. Participants interviewed at six-month follow-up indicated that over half (51%) had been completely abstinent from drugs and alcohol over the past six months. Among those who had relapsed, we nonetheless found significant reductions in six-month measures of alcohol ($p < 0.001$) and drug ($p < 0.0001$) use. Baseline and six-month comparisons on the Addiction Severity Index (ASI) revealed improvement on employment ($p < 0.01$) and legal ($p < 0.05$) severity. Residents entered SLHs with relatively low ASI alcohol (M = 0.15, SD = 0.28) and drug scores (M = 0.07, SD = 0.10) and improvements at six months were not significant. In addition, ASI medical severity did not differ between the two time points, nor did psychiatric problems as measured by the Brief Symptom Inventory.

Interestingly, few differences were found when we compared those who were in jail or prison during the 30 days prior to entering the house ($n = 20$) with those who were not ($n = 53$). Mann–Whitney tests for independent samples found no significant differences between those in jail vs. not in jail at baseline or six-month follow-up. When we examined the amount of change from baseline to six-month follow-up, again we found no difference between those who had been in jail or prison vs. those who had not. It should be noted that multiple areas of functioning were assessed, including six areas on the ASI (alcohol, drug, medical, legal, family/social, and vocational) (McLellan et al., 1992), six-month measures of substance use (Gerstein et al., 1994), social support for sobriety (Zywiak & Longabaugh, 2002), and psychiatric functioning (Derogatis & Melisaratos, 1983).

Conclusion

Parole departments face major challenges trying to keep track of the increasing number of parolees. A majority of parolees fail to complete their supervision and

about two-thirds are rearrested within three years. The vast majority of offenders have some type of substance abuse problem and many others present problems with metal health, medical, employment, housing, and medical problems. Perhaps the most important challenge for parole departments is finding adequate resources to address the multitude of different problems that parolees present. This paper has argued that addressing the issues for those with addiction problems requires the provision of a safe, clean, and sober living environment. SLHs provide such an environment and also support compliance with other types of services that are often mandated by parole (e.g., mental health treatment, medical care, vocational training). SLHs may not be an appropriate choice for parolees who have little desire to stay clean or those who have few financial resources and are unlikely to succeed in work. However, they appear to be a viable option for many parolees and some houses have flexibility in terms of how soon payments must be made. In addition, some treatment funding agencies, such as California's Proposition 36 program will pay for some or all of the fees required. Preliminary data assessing SLHs show that residents made a variety of improvements from baseline to six-month follow-up and that those who were in jail or prison before entering the SLH improved about as much as those who were not incarcerated. Future analysis will involve larger numbers of subjects who will be assessed at 12 and 18 months as well.

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Resources

A variety of organizations are available to individuals and institutions who are interested in learning more about sober living houses:

1. California Association of Addiction and Recovery Resources (CAARR), 2921 Fulton Avenue, Sacramento, CA 95821-4909, USA. Tel: +1 916 338 9460; Email: www.CAARR.org
2. Oxford House, Inc., 1010 Wayne Avenue, Suite 400, Silver Spring, MD 20910, USA. Tel: +1 301 587 2916; Email: www.oxfordhouse.org
3. Sober Living Network, PO Box 5235, Santa Monica, CA 90409, USA. Tel: +1 301 396 5270; Email: www.soberhousing.net

References

Borkman, T. (1998). Resident self-governance in social model recovery programs. *Contemporary Drug Problems*, 25(4), 741–777.

Bureau of Justice Statistics. (1999). Substance abuse and treatment, state and federal prisoners, 1997. *Bureau of Justice Statistics Special Report*. Washington, DC: US Department of Justice.

Bureau of Justice Statistics. (2005). *Probation and parole statistics*. Washington, DC: US Department of Justice.

Byrne, C., Faley, J., Flaim, L., Pinol, F., & Schmidtlein, J. (1998, August). *Drug treatment in the criminal justice system.* Washington, DC: Office of National Drug Control Policy.

Derogatis, L. R., & Melisaratos, N. (1983). The Brief Symptom Inventory: An introductory report. *Psychological Medicine,* 13(3), 595–605.

Farabee, D., Prendergast, M., & Anglin, D. (1998). The effectiveness of coerced treatment for drug-abusing offenders. *Federal Probation, 62*(1), 3–10.

Gerstein, D. R., Johnson, R. A., Harwood, H. J., Fountain, D., Sutter, N., & Malloy, K. (1994). *Evaluating recovery services: The California drug and alcohol treatment assessment* (Contract No. 92-001100). Sacramento: California Department of Alcohol and Drug Programs.

Greenfield, T. K. (1988, October). *A study of major mental disorders in California prisons: Survey methodology and preliminary estimates.* Paper presented at the annual meeting of the American Academy of Psychiatry and Law, San Francisco.

Greenfield, T. K. (1990, August). *Voices from the California State prisons: Utilization and amenability to treatment during and after incarceration.* Paper presented at the annual meeting of the Society for the Study of Social Problems, Washington, DC.

Jason, L. A., Ferrari, J. R., Davis, M. I., Olson, B. D., Alvarez, J., & Majer, J. (2005, August). *Need for community: The Oxford House innovation.* Paper presented at the American Psychological Association Conference, Washington, DC.

Kaskutas, L. A. (1999, April). *The social model approach to substance abuse recovery: A program of research and evaluation.* Rockville, MD: Center for Substance Abuse Treatment.

McLellan, A. T., Cacciola, J., Kushner, H., Peters, F., Smith, I., & Pettinati, H. (1992). The fifth edition of the Addiction Severity Index: Cautions, additions, and normative data. *Journal of Substance Abuse Treatment,* 9, 199–213.

National Institute on Drug Abuse (NIDA). (1999). *Principles of drug addiction treatment* (NIH Publication No. 99-4180). Washington, DC: Author.

O'Neill, J. (1990). History of Oxford House, Inc. In S. Shaw & T. Borkman (Eds.), *Social model recovery: An environmental approach* (pp. 103–107). Burbank, CA: Bridge Focus Inc.

Pelissier, B., Rhodes, W., Saylor, W., Gaes, G., Camp, S. D., Vanyur, S. D., et al. (2000, September). *TRIAD drug treatment evaluation project final report of three-year outcomes: Part 1.* Washington, DC: Federal Bureau of Prisons Office of Research and Evaluation.

Petersilia, J. (2000). When prisoners return to the community: Political, economic, and social consequence. *Sentencing and Corrections,* 9, 1–8.

Polcin, D. L. (2001a). Drug and alcohol offenders coerced into treatment: A review of modalities and suggestions for research on social model programs. *Substance Use and Misuse,* 36(5), 589–608.

Polcin, D. L. (2001b). Sober Living Houses: Potential roles in substance abuse services and suggestions for research. *Substance Use and Misuse,* 36(2), 301–311.

Polcin, D. L., Galloway, G. P., Taylor, K., & Benowitz-Fredericks (2004). Why we need to study sober living houses. *Counselor: The Magazine for Addiction Professionals, 5*(5), 36–45.

Polcin, D. L., Galloway, G. P., Taylor, K., Lopez, D., & De Bairracua, I. (2005, June). The ecology of sober living houses: Adapting to recovery from addiction. *Society for Community Research and Action 10th Biennial Conference,* University of Illinois, Urbana-Champaign.

Rog, D. J. (2004). The evidence on supported housing. *Psychiatric Rehabilitation Journal,* 27(4), 334–344.

Schonlau, K. (2004, April). *Sober and congregate living: Definitions of two types.* Santa Monica, CA: The Sober Living Network.

Wittman, F. D. (2001). Prevention, community services and Proposition 36. *Journal of Psychoactive Drugs,* 33(4), 343–352.

Wittman, F. D., Biderman, F., & Hughes, L. (Eds.). (1993). *Sober living guidebook for alcohol and drug free housing* (California Department of Alcohol and Drug Programs, ADP 92-00248).

Zywiak, W. H., & Longabaugh, R. (2002). Decomposing the relationships between pretreatment social characteristics and alcohol treatment outcome. *Journal of Studies on Alcohol,* 63, 114–121.

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