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Communal Living Settings for Adults Recovering from Substance Abuse

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Abstract

Research on treatment outcome for addictive disorders indicates that a variety of interventions are effective. However, the progress clients make in treatment frequently is undermined by the lack of an alcohol and drug free living environment supporting sustained recovery. This introduction to a special edition on Oxford Houses suggests that treatment providers have not paid sufficient attention to the social environments where clients live after residential treatment or while attending outpatient programs. The paper begins with a description of the need for alcohol and drug free living environments. The history of communal living for recovering addicts and alcoholics is then reviewed and the Oxford House model emphasized as a recent and widespread communal living option for recovering persons. The structure and philosophy of Oxford Houses are presented along with recent outcome studies providing support for their effectiveness. Three different perspectives are presented as ways of conceptualizing how residents in Oxford Houses benefit: social context theory, self governance/self care, and peer affiliation/identification.

Keywords

Oxford House; Sober Living House; Recovery Homes; Peer Helping

Communal Living Settings for Adults Recovering from Substance Abuse

There is growing consensus in the addiction treatment field that a variety of interventions appear to be effective (National Institute on Drug Abuse [NIDA], 1999). Reviews showed that addiction treatment results in substantial decreases in substance use and improvements in related problem areas, such as family relationships, legal problems, medical status, psychiatric symptoms, and employment. Reviews of cost-benefit studies suggest taxpayers save up to \$12 for every \$1 spent on adult treatment for addiction (NIDA, 1999), primarily through reductions in criminal justice and healthcare expenses. The types of services included in these reviews encompass the entire spectrum of inpatient, outpatient and methadone treatment.

Despite gains made as a result of treatment, at some point many clients experience episodes of relapse. Some clients require multiple admissions to treatment programs to sustain sobriety (NIDA, 1999). Maintaining abstinence from alcohol and drugs after completion of residential treatment or during outpatient treatment appears to be most challenging for clients who do not have stable living environments (Hitchcock, Stainback & Roque, 1995; Milby, Schumacher, Wallace, Feedman & Vuchinich et al., 1996) or social support systems that encourage abstinence (Moos & Moos, 2006).

Over the past 20 years the high cost of housing (especially in urban areas) was a major obstacle in creating stable living environments for persons in recovery worse. For instance, a frequent complaint by residential treatment providers is the lack of affordable housing for clients who leave their facilities. When clients are released from residential programs into economically deprived neighborhoods that do not actively support abstinence, the recovery they established in treatment may be lost. Outpatient providers face a similar dilemma. Even if clients are engaged in outpatient treatment, motivated for change, and making improvements, their progress may be mitigated if they reside in a destructive living environment that triggers relapse (Polcin, Galloway, Taylor & Benowitz-Fredericks, 2004).

Furthermore, individuals beyond persons in treatment may be impacted by the lack of alcohol and drug free living environments. For example, criminal justice offenders with a history of addiction problems released on parole rarely access adequate housing (Petersilia, 2003). Most ex-offenders are released to low income, high crime areas where they live with family or friends who may not be supportive of abstinence. In many parts of the country the rates of reincarceration for parolees is extraordinarily high. For example, in California, two-thirds of incarcerated offenders released on parole are reincarcerated within three years (Petersilia, 2003). Criminal justice research on parolees conducted by the Urban Institute (2006 January) suggests that the lack of satisfactory housing for offenders plays an important role in recidivism.

The enormous need for housing and recovery related social support among individuals abstaining from alcohol and drug use makes a Special Edition of *JGAR* on *Oxford House* necessary and relevant. This introduction to that special edition sets a context for the papers that follow by reviewing studies that document the importance of social support and housing stability on recovery outcome. The focus then shifts to a review of the history of communal living arrangements for alcoholics and addicts, starting with the early “dry hotels” or “lodging houses” (Wittman, 1993) and moving to contemporary abstinent living environments, such as sober living houses in California (Polcin, 2001; Polcin & Henderson, in press) and sober houses on college campuses (Botzet, et al., in press; Laitman, et al. in press). Finally, the Oxford House model is briefly described in terms of its history, structure, and operations (see Jason, Ferrari, Davis & Olson, 2006). After reviewing recent research on outcomes in recovery oriented communal living environments three conceptual views are presented as ways of understanding the improvements that residents make: 1) *social context theory* as described by Moos (2006), 2) *self governance/self care dynamics* described by Khantzian and Mack (1994), and 3) *peer affiliation/identification* as described by Vaillant (1975). Several of the papers that follow in this Special Edition, in fact, expand on these concepts and more specifically depict their influence on the Oxford House model.

The Influence of Social Support and Housing on Recovery Outcome

A variety of studies have shown that social support relates to recovery. For example, Beattie and Longabaugh (1999) found that general social support, defined as having individuals in one's social network who provide a general sense of well being, was associated with drinking outcome. However, alcohol specific social support (i.e. encouragement to avoid drinking) appeared to be more strongly associated with outcome and longer periods of time (15 months, as opposed to 3 months for general social support).

Interventions for addiction that emphasize social support for recovery have received strong support in the outcome literature. For example, a number of studies conducted by Moos and colleagues (e.g., Moos & Moos, 2006) showed that involvement in Alcoholics Anonymous (AA) was strongly associated with positive outcome. Further, involvement in AA appeared to be associated with positive outcome for individuals involved in formal treatment as well as those in the general population

A critically important part of an individual's social environment, however, is the person's living or housing situation. During the past two decades housing has become an increasingly important issue in the addiction outcome literature, in part because large proportions of individuals who are homeless have problems with drugs or alcohol (Robertson, Zlotnick & Westerfelt, 1997; Wenzel, et al., 1996). In a number of studies, housing assistance and housing status were associated with treatment outcome (e.g., Bebout, Drake, Wie, McHugo & Harris, 1997; Hitchcock, et al., 1995; Milby et al., 1996; Miescher & Galanter, 1996). Overall, these findings indicated that clients who were homeless or lived in substance using environments during or after treatment were more prone to relapse than clients living in environments supportive of sobriety.

History of Communal Living Arrangements for Individuals in Recovery

Although the topic of housing received focus only recently in the addiction literature, individuals in recovery from addiction and professionals who work within this field have known that providing alcohol and drug free living environments is important. Some of the early efforts to create sober living environments were reviewed extensively elsewhere (i.e., Polcin, 2001; Polcin & Henderson, in press) and are only briefly summarized in this article.

One of the earliest reviews of sober housing for alcoholics was provided by Wittman (1993). He noted that during the era of the Temperance Movement during the 1830's religious institutions, such as the YMCA and Salvation Army, developed "dry hotels" or "lodging houses" for alcoholics. These dwellings were designed to help individuals receive support for abstinence as well as exposure to religious instruction. The role of the residents in these facilities was quite different than Oxford House residents. Rather than being active participants in operations of the facilities (as in Oxford House: Ferrari, Jason, Olson, Davis & Alvarez, 2002), they were generally quite passive. House rules and operations were developed by managers of the facilities and residents were either required or strongly encouraged to attend religious services.

A second type of sober living facility developed during the late 1940's, after World War II when Alcoholics Anonymous (AA) was becoming prominent and housing availability was limited (Wittman, 1993). In Los Angeles, recovering AA members opened "twelfth step" houses to provide sober lodging to the growing number of alcoholics in the city. Managers of these houses either mandated or strongly encouraged attendance at AA meetings and house operations were generally the responsibility of the house manager or owner. This passive role of house residents was similar to "dry hotels" or "lodging houses" and contrasts markedly with the active role of Oxford House residents (Ferrari, Jason, Davis, Olson & Alvarez, 2004).

The Growing Need for Affordable Sober Living Environments

Despite the early efforts to provide sober living environments to alcoholics, the need for alcohol and drug free housing in the communities increased in recent years. The combination of cutbacks on publicly funded addiction treatment and tight housing markets resulted in an explosion of homelessness. As reviewed elsewhere (Polcin et al., 2004), homelessness affected nearly 6 million people from 1987 to 1993. Conservative estimates suggested about 40% of homeless suffered from alcohol problems and 15% from drug problems (McCarty, et al., 1991). In one county in Northern California, for instance, a study of homelessness revealed lifetime prevalence for substance use disorders of 69.1% (Robertson, et al., 1997).

Two prominent factors fueled the need for affordable alcohol and drug free housing, namely: 1) the deinstitutionalization of psychiatric hospitals over the last four decades (Polcin, 1990); and, 2) the explosion of the state and federal prison systems over the past 25 years (Petersilia, 2000, 2003). Neither individuals with psychiatric disorders leaving state psychiatric hospitals

nor parolees transitioning from prison into the community received the services they needed (e.g. housing, employment, substance abuse, medical and mental health). Thus, few achieved stable lifestyles in the community and many became vulnerable to recidivism and homelessness (Fischer & Breakey, 1991; Petersilia, 2000, 2003).

Contemporary Abstinent Living Environments

The need for drug and alcohol abstinent living environments overwhelms existing housing resources. However, a number of housing models are effective. In the addiction treatment field halfway or “step down” houses showed a great benefit for individuals leaving residential treatment programs as well as treatment programs for incarcerated offenders (Inciardi, 1996; Lockwood, et al., 1997; Martin, et al., 1995). Relative to individuals discharged into the community without supportive living environments, those men and women who found residence in halfway houses had better substance abuse, criminal justice and employment outcomes.

One problem with the halfway house model, however, is that lengths of stay are limited. A resident may have from several months to a year to adjust to life in the community and find alternative living arrangements. Frequently, pressures exist for residents to move out of a halfway house to open beds for others who seem to be more in need. Another criticism of the halfway house model is that they typically are financed using public funds and operated by professional staff within formal treatment systems. While some residents may require that level of structure and support, other individuals may benefit by taking on more responsibility and autonomy (Polcin, 2001; Polcin & Henderson, in press).

California Sober Living Houses

California sober living houses (SLHs) avoid some of the problems that residents of halfway houses encounter. Unlike most halfway houses, they are financially self-sustaining such that government funding is not necessary. Also, residents are free to remain at the facility for as long as they like provided that they abide by house rules and pay rent. Although they originated in California during the 1970's, some SLH programs may be found in other states. As described in more detail elsewhere (Polcin, 2001), SLHs are based on a social model recovery philosophy that emphasizes abstinence and mutual help among residents.

Although there are similarities among California SLHs, there are important differences as well. For instance, some SLHs implement social model recovery principles that emphasize empowering residents to be involved in house operations and management by participating in a democratically oriented residents' council. Other SLHs continue with a “strong manager” model of operations (Polcin & Henderson, in press), similar to that used by the earlier “dry hotels” and “twelfth step” houses described above. A house manager or owner rents out rooms, collects money for rent and bills, evicts residents who relapse, and encourages or mandates attendance at 12-step meetings. Some of these houses are for profit enterprises, prompting concern that they may be more focused on profit than recovery (Polcin, 2006a). Fortunately, several SLH coalitions emerged that either mandated or strongly encouraged houses to adopt social model principles into their programs, including mechanisms for resident input into house operations. These include the California Association of Addiction and Recovery Resources (CAARR) and the Sober Living Network (SLN). CAARR has about 64 member organizations that provide sober living services and the SLN has over 260 sober living houses.

Although California model SLHs operated for decades, only recently have outcome evaluations been conducted. Polcin and Henderson (in press) reported outcomes of 130 individuals residing in 16 sober living houses in Northern California. Relative to their functioning before they entered the houses, residents made significant improvement on measures of alcohol and drug

use, psychiatric symptoms, and employment. Forty percent of the individuals who entered the houses were completely abstinent over the 6 month assessment period and an additional 24% were abstinent 5 of the six months. Among those persons who relapsed after entering the houses, there was a less severe pattern of substance use relative to their use before entering. As expected, one of the factors that correlated with improved outcome was higher involvement in 12-step recovery groups (Polcin & Henderson, in press).

About a quarter of the residents in the SLHs were referred from the criminal justice system and had improvements similar to voluntary residents (Polcin, 2006b). 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 rearrested within three years.

College Dormitory Recovery Houses—A different model of sober housing was developed at Rutgers University in 1988 to address the needs of the growing number of college students with alcohol and drug problems (Botzet, et al., in press; Laitman, et al. in press). Because of widespread drinking among students in the general population it was felt that separate dormitories designed for students in recovery would provide them emotional, social and environmental support that would increase their chances at successful recovery. After implementation at Rutgers, 11 similar recovery dormitories have been developed at on other college campuses. Unlike California SLHs, students can only reside in the dormitories while they are students at the college. Although peer support for recovery is emphasized, these living arrangements are integrated into an overall treatment approach that requires regular sessions with alcohol and drug counselors on campus (Laitman, et al. in press).

The Oxford House Model

The largest organized model of providing alcohol and drug free housing in communal living environments is *Oxford House Inc.* Currently, there are over 1,200 houses throughout the U.S., Canada, and Australia. All houses are gender specific and located in quiet, middle class neighborhoods (Ferrari, Jason, Sasser, Davis & Olson, 2006). Although Oxford Houses do not require any specific involvement in treatment or 12-step groups, many residents are involved in these types of services. For example, Nealon-Woods, et al. (1995) found that 76% of a sample of 134 male residents in Oxford Houses attended 12-step meetings at least weekly. Like the 12-step model of recovery, Oxford Houses adopt a goal of abstinence, and substance use while residing in an Oxford House is grounds for discharge (Ferrari et al., 2004). As the subsequent papers in this special edition show, Oxford Houses have been effective with a range of populations.

The origins of Oxford House set the direction for the housing model that followed. Briefly, after a halfway house operated by a treatment provider in Silver Springs, MD closed, the residents continued living there by paying rent and bills themselves. They agreed to support each other in the recovery process and mandated that any use of substances by a resident would require that they leave. They did not mandate any involvement in treatment or attendance at AA; those decisions were left to the residents themselves (Davis, Olson, Jason, Alvarez & Ferrari, 2006). Residents were apparently satisfied with this arrangement and houses began expanding. The pace of expansion increased when a federal law was passed (Public Law 100–690), which required states to loan money to individuals or groups for start up costs associated with alcohol and drug free residences. For a more detailed description of the history of Oxford Houses see O’Neil (1990) or Jason, Ferrari, Davis and Olson (2006).

The Oxford House model of communal recovery housing offers a number of advantages over traditional modes of treatment. Oxford Houses are readily replicable (Ferrari et al., 2004,

2006). The Oxford House Manual (2006) describes specific requirements for how many individuals may live in a house, minimum amount of square footage, and types of neighborhood where they can be established. Because all costs are covered by residents, Oxford Houses may be immune to many external threats that detrimentally affect treatment programs (e.g., managed care models of funding).

A particular advantage of the Oxford House model is that guidelines provided by the “Oxford House Manual” (2006, September) stipulated the use of organizational principles consistent with a social model philosophy of recovery. For example, all houses are rental properties and management of house operations requires a shared, rotating leadership structure (Ferrari, Jason, Blake, Davis & Olson, 2006). Thus, a “strong manager” type of house with one person in a position of authority is not possible (Jason, Braciszewski, Olson & Ferrari, 2005). Each member of the house takes responsibility for paying rent and meeting household costs (Ferrari et al., 2004). This opportunity for shared responsibility and empowerment within a communal living environment is an integral part of the philosophy of recovery (Ferrari, et al., 2002).

Outcome Research

Leonard Jason, Joe Ferrari, and their research group at DePaul University conducted a wide range of studies on Oxford Houses over the past 14 years culminating in a recent book *Creating Communities for Addiction Recovery* (Jason, Ferrari, Davis & Olson, 2006). Many of their Oxford House studies were reviewed in the papers that follow. Here, I examine two major analyses of long term outcome of Oxford House residents.

The first study, Jason, Olson, Ferrari, and Lo Sasso (2006), examined 150 individuals completing residential treatment programs. Half these participants were randomly assigned to usual aftercare and half to Oxford Houses. At 24 month follow up, individuals assigned to the Oxford house condition had significantly better outcome on measures of substance use, income, and incarceration. One limitation of that study, however, was that all Oxford Houses were located in Illinois. A second limitation was their study findings might only be generalized to individuals completing residential treatment.

The second outcome study, Jason, Davis, Ferrari, and Anderson (2007) circumvented both of these concerns. A large, *national US* sample of Oxford House residents were recruited (N=897) without respect to treatment history. Oxford House residents were recruited into the study and interviewed at three 4-month intervals. Rates of abstinence during the final interview were high. About 13.5% of the respondents reported using alcohol or drugs the past 90 days. Consistent with social model recovery philosophy, social support for sobriety was associated with abstinence. A second important finding was the high rate at which residents found employment. Throughout the course of the study employment ranged from 79% to 86%.

Conceptual Perspectives on How Oxford Houses Help

The growth and success of Oxford Houses begs the question of how they help residents. This section will attempt to conceptualize how Oxford Houses help by briefly identifying three conceptual perspectives: social context, self governance/self care, and peer affiliation/identification.]

A number of papers that follow in this special edition expand upon these three general frameworks. For example, social context and peer factors in Oxford Houses are addressed by Graham et al. (this issue) in their report on “psychological sense of community.” A paper by Viloa et al. (this issue) examines peer influences in terms of the role and prevalence of helping others among Oxford House residents. Groh et al. (this issue) present data depicting how 12-step involvement interacts with the social environment within Oxford Houses to produce better

outcomes. Intra-psycho issues relevant to Oxford House residents are addressed as well. For example, Ferarri et al. (this issue) describe a study on self regulation among Oxford House residents and report that it is associated with length of sobriety. A number of papers in this edition describe recovery for specific populations of Oxford House residents, such as women with children, criminal justice involved individuals, and ethnic minorities. Future papers might examine how the dynamics of change for these groups are similar and different to the larger population of Oxford House residents.

Social Context

A recent paper by Moos (2006) summarized the social context perspective on substance use and recovery by emphasizing four related theories: social control, behavioral economic, social learning and stress and coping. Each has implications for understanding what is helpful to residents of Oxford Houses.

Social control refers to the bonds that individuals have with family, school, work, and other social institutions that can help shield individuals from substance use. These relationships motivate individuals to engage in pro-social behaviors that contribute to the community and refrain from anti-social and destructive behaviors. Social organization, structure, cohesion, and monitoring behavior all contribute to social control. Within Oxford Houses, the social bonds that residents have with each other, the larger recovery community, and mutual-help groups such as Alcoholics Anonymous help shield them from relapse. Although Oxford Houses allow for substantial autonomy among residents, there are some clear structures and guidelines that facilitate recovery oriented behaviors, social organization, and cohesion. Examples of social control within Oxford Houses include monitoring residents' sobriety, requiring that residents take part in house meetings and leadership positions, and implementing house and regional social events that build cohesion among residents.

The second social context theory is behavioral economics, which is closely related to social control theory. It addressed the question of what behaviors are reinforcing for individuals. Is the individual engaged in non-substance activities that they experience as reinforcing? For individuals attempting recovery from addiction, have they learned to meet their physical, emotional, and social needs in ways that do not involve substance use or related behaviors? Residence in an Oxford House exposes residents to alternative ways of getting their needs met that substitute for alcohol and drug use. Some aspects of the environment are reinforcing in and of themselves, such as general social support, support for sobriety, and recreational activities that are shared among residents. For many residents, the requirement that they be involved in decision making and leadership positions in the house is reinforcing in terms of building self esteem and a sense of self efficacy. Residents also provide each other with suggestions and resources for alternative ways of getting needs met.

The third aspect of Moos' (2006) social context perspective on addiction is social learning theory. He suggests that adult and peer role models play strong roles in the development of addiction problems which typically begin in adolescence. Similarly, role models play important roles in recovery. Oxford Houses provide a peer focused model of recovery where new residents learn from those with more recovery experience. In addition to adapting recovery behaviors modeled, residents also adopt attitudes and norms that support a recovery lifestyle.

Stress and coping theory is the final component to Moos' view of how the social context influences the onset of addiction as well as recovery from it. Essentially, individuals use substances in response stressful life circumstances, some of which are exacerbated by social disorganization within institutions and neighborhoods. One advantage of residence in an Oxford House is that in general they tend to be located in middle class areas that are not high crime or drug use areas. This helps decrease stress and the potential for relapse. Beyond that,

residents role model stress management strategies for each other and they share recovery resources for managing stress.

Self Governance/Self Care

A different way of conceptualizing how Oxford Houses help comes from the work of Khantzian and Mack (1994), who emphasized how self governance and self care can be enhanced within a supportive group of recovering individuals. Although their paper addressed how addicts and alcoholics change in Alcoholics Anonymous meetings, many of the concepts presented also apply to other group environments, such as Oxford Houses.

Rather than emphasizing processes within the social environment that lead directly to behavioral change, Khantzian and Mack (1994) explored how the social environment effects internal emotional states that frequently lead to substance use. They noted that many individuals suffering from addiction have powerful emotional experiences that they have difficulty managing and which leave them vulnerable to relapse. The authors suggested the external support provided by AA helped compensate for internal vulnerability. In addition, the honest sharing of life stories in AA facilitated self-examination and self-expression among individuals who otherwise would not examine their internal states let alone share them with others. The support and understanding that frequently take place as a member tells their story can provide a powerful corrective experience that helps them heal some of their affect deficits. Over time, AA members are able to develop more mature and flexible management of the affective states.

Residence in an Oxford House is separate from being a member of AA. However, many of the mechanisms of how they help may be similar. Albeit more informally than in an AA meeting, Oxford House residents nonetheless often share their addiction and recovery stories with each other in ways that might be similarly helpful. In addition, the social support and structure within the houses may help residents manage their emotions states more effectively, particularly in terms of not using substances to manage them. Finally, as with the AA Fellowship, there is frequently an experience of being part of something larger than oneself that is reassuring and helps contain powerful affect.

The role of human relationships in helping AA members govern their feelings and care for themselves without resorting to substance use seems equally applicable to the Oxford House setting: "AA stresses the importance of human interdependence. It replaces a chemical solution for disordered impulses, distress, and suffering with a human one," (Khantzian & Mack, 1994, p.90).

Peer Affiliation/Identification

Over 30 years ago Valliant (1975) described how peer relationships were vital to successful transition out of drug addiction. Although his paper technically addressed sociopathy, Valliant (1975) noted that many narcotic addicts often presented similar symptoms and responded to similar interventions. He suggested that external control over drug use and related behaviors that were destructive to self and others was a prerequisite of recovery. Many individuals with sociopathy and/or addiction problems were thought to be incapable of modifying destructive and antisocial behaviors on their own. Thus, therapists who did not provide containing interventions left these clients feeling abandoned. Vaillant (1975) suggested residential treatment settings could provide the containment needed by implementing "realistic but not punitive" (p.178) confrontation of the consequences of their behavior.

For Valliant, antisocial behaviors were viewed in part as attempts avoid anxiety and flee from human intimacy, which was experienced as frightening. Only when such behaviors were thwarted could the client be open to the type of honest human encounter that facilitates

recovery. Finally, Valliant suggested that conventional individual therapy was not sufficient for individuals with narcotic addiction. The paths out of addiction were believed to be like the paths out of adolescence; they came from identification with peers (Valliant, 1975).

While Oxford houses do not offer the intensive level of supervision that Valliant advocated, they do offer containment over destruction behaviors by providing peer administered consequences in response to them. In addition, Oxford Houses provide peer pressures to avoid destructive behaviors such as substance use. Any use of substances while residing in an Oxford house is explicitly prohibited and is grounds for eviction. Other destructive behaviors are prohibited as well, such as acts of violence and theft. Resident imposed penalties for proscribed behaviors and can range from eviction, to a written contract mandating improvement, to a fine.

Although sanctions for destructive behaviors are important, the sense of belonging to something larger may be an equally potent way that Oxford Houses contain destructive behaviors. Oxford Houses offer an invitation to their residents to take part in a community of recovering individuals that provides a sense of social support, understanding, empowerment, and nurturing that has been absent from the lives of many. The identification and affiliation that Oxford House residents develop with peers who similarly struggle with inclinations to run from their anxiety, affect, and feelings of intimacy provides the groundwork for the path out of addiction and into recovery.

Conclusion

Although a variety of treatment and self help approaches for addiction have been shown to be effective, many individuals are unable to sustain the improvements they make because they are unable to find living environments that support their recovery. Housing costs in the United States and elsewhere have made matters worse by driving addicts and alcoholics with limited resources into high crime areas where they are likely to relapse. Vulnerable populations, such as criminal justice offenders and individuals with psychiatric disorders have a particularly difficult time finding alcohol and drug free housing and they comprise large proportions of the homeless.

All of these conditions make this special edition on Oxford Houses timely and significant. Although a variety different communal housing models have been used to provide alcohol and drug free housing to individuals suffering from addiction, none are currently more popular or widespread than the Oxford House model. Oxford Houses have the advantages of being financially independent, peer managed, and easily replicable. Outcome studies have shown they can be effective for a variety of individuals.

Research on Oxford Houses to date has documented positive longitudinal outcomes. Confirming an important part of the recovery philosophy, studies have also found that social support for sobriety is associated with better outcome. However, more research is needed on the mechanisms of how Oxford Houses affect positive change in residents. It would be particularly interesting to examine variations in the social environments of houses and correlate social environment characteristics with outcomes.

Three different ways of conceptualizing how residents improve have been presented: social context, self governance/self care, and peer affiliation/identification. The ways in which a number of the papers that follow in this special edition expand on these perspectives have been described and a suggestion has been made to address whether specific populations within Oxford Houses have similar or different mechanisms of change compared to the overall population of residents.

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