Published in final edited form as:

Drugs (Abingdon Engl). 2014 ; 21(5): 347–356. doi:10.3109/09687637.2013.876974.

An Examination of the First Oxford House in the UK: A Preliminary Investigation

John M. Majer, Ph.D.,

Department of Social Sciences, Harry S. Truman College, 1145 W. Wilson Ave., Chicago, IL 60640 USA

Kim Beers, and

Center for Community Research, DePaul University, 990 W. Fullerton Ave., Suite 3100, Chicago, IL 60614 USA

Leonard A. Jason, Ph.D.

Center for Community Research, DePaul University 990 W. Fullerton Ave., Suite 3100, Chicago, IL 60614 USA

John M. Majer: jmajer@ccc.edu; Kim Beers: kbeers@depaul.edu; Leonard A. Jason: ljason@depaul.edu

Abstract

An exploratory investigation was conducted to examine the implementation of the first self-run, communal-living setting based on the Oxford House model, in the United Kingdom (UK). A cross-sectional, mixed methods design was used to examine the Oxford House model's total abstinence approach to recovery from substance use disorders among residents ($n = 7$) living in the first Oxford House established in the UK. Several measures commonly used in addiction research and personal narratives were used to assess residents' response to Oxford House living. Findings suggest that the Oxford House model is a post-treatment intervention that meets the needs of individuals seeking an abstinence-based recovery from alcohol and/or drug dependence in the UK.

Keywords

Substance use disorders; Recovery; Abstinence; Oxford House; United Kingdom; Personal Narratives

1. Introduction

Oxford Houses are self-run, communal-living settings consisting of residents who are recovering from substance use disorders through a total abstinence recovery model. The first Oxford House recovery home was developed in 1975 by a group of former substance-users in the United States. There are now over 1,600 Oxford Houses, most of which are in the United States. However, Oxford Houses have been expanding in other countries, as recent

Correspondence concerning this article should be addressed to John M. Majer, Social Sciences Department, Harry S. Truman College, 1145 W. Wilson Ave., Chicago, IL 60640, USA. jmajer@ccc.edu; 773-907-4068; Fax 773-907-4064.

Declaration of Interest

The authors report no conflict of interest.

studies have been conducted among Oxford House residents living in Canada and Australia (Ferrari, Jason, Blake, Davis, & Olson, 2006; Oxford House, Inc., 2011) and Ghana (Legler & Jason, 2012). The present study investigated the implementation of the first Oxford House that opened in the United Kingdom (UK) in July 2011, providing an exploration of the experiences among House residents to lend support in favor of replicating the Oxford House model in the UK.

1.1. Oxford Houses

Oxford House has grown to become the largest residential self-run, self-help program for persons recovering from substance use disorders in the U.S., currently serving over 10,000 adults worldwide (Jason, & Ferrari, 2010). Oxford Houses require residents to self-govern and assume positions of leadership within their Houses, according to established protocols (Oxford House, Inc., 2011) that foster consistency across Houses and create a supportive milieu. Residents hold weekly mandatory meetings to discuss any business related to the House, finances, or residents' compliance with established rules. There are no restrictions to a resident's length of stay as long as s/he participates in the democratic process, adhere to a House's self-determined rules, pay one's fair share of rent, and remain abstinent. The Oxford House model has been extensively studied in the United States and has been included in the Substance Abuse and Mental Health Service Administration's (SAMHSA) National Registry of Evidence-based Programs and Practices.

1.2. Oxford House Research

In one randomized clinical trial study of the Oxford House (Jason, Olson, Ferrari, & Lo Sasso, 2006), 150 individuals in inpatient treatment for substance use disorders in the state of Illinois (USA) were randomly assigned to either an Oxford House or "usual aftercare" condition upon their discharge. Over a two-year period, those assigned to the Oxford House condition reported significantly better outcomes related to substance use, income and criminal behaviors. In another longitudinal investigation (Majer et al., 2008), abstinence rates and psychological outcomes at one year were virtually similar among Oxford House residents with very high levels of psychiatric problem severity versus residents without any psychiatric problem severity, demonstrating that the Oxford House model is an appropriate source of care for residents with co-occurring psychiatric conditions. Taken together, findings from longitudinal investigations suggest that total abstinence, communal-living settings such as Oxford Houses provide residents with therapeutic benefits such as increased income (Jason) and reductions in both criminal activity (Jason et al., 2006) and psychiatric service utilization (Majer et al.), in addition to fostering their ongoing abstinence.

1.3. Abstinence and Social Support

Oxford House has flourished in the United States within a cultural context and treatment system that views recovery and abstinence as both achievable and desirable goals for persons with substance use disorders. For instance, one national study (Jason, Davis, Ferrari, & Anderson, 2007) followed 879 Oxford House residents with varying treatment histories over four, three-month periods. In the final assessment period, only 13% reported any substance use in the last 90 days, indicating that abstinence rates remained high over the long-term. In addition, social support networks that emphasize abstinence – an inherent facet

of the Oxford House model – have been significantly related to abstinence outcomes (Jason & Ferrari, 2010; Jason et al., 2006; Majer, Jason, Ferrari, Venable, & Olson, 2002a).

One of the principle tenets of the model is that any Oxford House resident who uses alcohol or illicit substances is immediately ejected from the House to preserve the sober living, abstinence-only social support environment for the remaining individuals in the House. In the abstinence-oriented culture of treatment in the States, it is not surprising that Oxford House residents are involved in abstinence-based, 12- step groups like Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) that provide social support for ongoing abstinence (Nealon-Woods, Ferrari, & Jason, 1995).

For instance, one longitudinal investigation (Majer, Jason, Ferrari, & Miller, 2011) found categorical (or immersed) involvement in 12-step groups among a US national sample of Oxford House residents predicted increased abstinence outcomes. However, some research has found that Oxford Houses may provide more immediate benefits such as increased self-efficacy for abstinence early in one's recovery according to a comparative study between Oxford House residents and 12-step members (Majer, Jason, & Olson, 2004), whereas a randomized clinical trial (Majer, Jason, Aase, Droege, & Ferrari, 2013) demonstrated that both Oxford House living and 12-step involvement were significant factors that increased the odds of total abstinence at two-years. In summary, the social support obtained through abstinence-based, communal-living settings such as Oxford Houses as well as through 12-step groups have been found to be effective components of treatment for substance use disorders in the United States.

1.4. Harm Reduction in the UK

The treatment landscape and culture around substance use disorders and recovery in the UK is notably different from that of the United States where abstinence-based interventions are most common. Until recent years, the orientation of treatment services in the UK had focused primarily on harm-reduction strategies that came to prominence in the late 80s and early 90s as a way to mitigate the HIV/AIDS epidemic through needle-swapping and methadone substitution programs for high-risk intravenous drug users (McKeganey, 2006).

The focus on harm-reduction extended beyond reducing the transmission of infectious diseases to the treatment of substance use disorders; as indicated in the government's 1998 ten-year drug strategy, and evidenced by clients' reports of their encounters with treatment services and by analysis of available community resources for treatment (McKeganey, Morris, Neal & Robertson, 2004; Best et al., 2010). A debate between harm-reduction and abstinence-based strategies raged, and although those from the harm-reduction side might not deny the ultimate "desirability of abstinence," they found it unrealistic that many with substance use disorders would be capable of achieving it. The Head of Policy for DrugScope, a London based drug policy think-tank had said of abstinence: "like many best-possible outcomes it is not always a realistic prospect, even for many of those who aspire to it," (Roberts, 2005, p. 263). However, others admonished harm-reduction, noting that at times treatment professionals set their aspirations too low for their clients, telling those who might ask to be removed from a methadone script that they were, "not ready to stop using,"

or simply assuming that recovery in the sense of total abstinence from drugs and alcohol would not be possible (Martin, 2005, p. 258).

1.5. Abstinence in the UK

Although preference for harm-reduction is still held by many within the drug and alcohol treatment system, policy shifted at the national level when in 2010 the UK government amended the national drug strategy, calling for, “abstinence-based treatment for some, drug-replacement over time for others...” (Government, 2008, p. 6). The strategy represents a shift towards a consumerist perspective in which a client’s care is tailored to their individual and dynamic needs (Trace, 2005). This perspective has allowed for a growing recognition of the necessity of abstinence-focused counseling, treatment, and after-care options for those with substance use disorders (McKeganey, 2011), paving the way for an increased availability of cost-effective post-treatment community support for long-term recovery such as 12-step groups.

Likewise, clients themselves have expressed abstinence related goals for their treatment (McKeganey et al., 2004). Best et al. (2010) described growing “recovery activity in local communities that is rich and diverse and that is progressing irrespective of funding support or research endorsement,” (p. 266). Grassroots recovery niches such as “Recovery Is Out There” (RIOT) in Burton, SMART Recovery UK, and a contingency of AA and NA support groups among others can be found throughout the UK (White, 2011). Despite these recovery movements and the recent shift in national policy, government services are still primarily evaluated in terms of increasing and maintaining the numbers of clients in substitution treatments (Best et al.). Access and use of National Health System treatment services by persons with substance use disorders is high in the UK demonstrating that treatment utilization is not a problem; rather, the system lacks appropriate long-term treatment exit support and strong linkages between service providers and community and self-help group support such as 12-step groups. It is possible that the Oxford House model could help address some of these gaps in aftercare services while also strengthening community support and recovery resources by serving as a bridge between treatment providers, 12-step groups, and the larger community.

1.6. The UK Oxford House

The UK Oxford House opened with a temporary charter from the Oxford House organization in July 2011 after one individual seeking long-term recovery solutions in his community learned of the Oxford House model and established this House in accordance with guidelines of the Oxford House Manual (Oxford House Inc., 2011). The implementation of a self-run, communal-living setting within the UK is highly unique. In addition, experts in the UK have noted the prevailing lack of long-term recovery and abstinence-based treatment services, and called for evidence to substantiate the need and efficacy of abstinence-based treatments for substance use disorders (Best et al., 2010). Although research has been plentiful in the United States, where both Oxford House and 12-step models for achieving and maintaining abstinence and long-term recovery are central, there is a dearth of such research within the UK.

The present study is an exploratory investigation of the first Oxford House implemented within the UK. Such an investigation might provide important preliminary information about the potential for the Oxford House model within the current treatment climate for substance use disorders in the UK. We wanted to examine whether the Oxford House model could be expanded in a culture that has yet to embrace a total-abstinence approach to treatment for substance use disorders and to determine whether the benefits of the Oxford House model could generalize in such a context. Thus, our major aims were to assess the presence of recovery resources (self-efficacy, use of 12-step groups, social support) and related characteristics (substances used, psychiatric symptoms) that are typically observed in abstinence-based investigations in the US, to explore participants' need for long-term aftercare in an abstinence-based residential setting. In addition, we aimed to assess whether the self-governance and peer social support components of the Oxford House model were important to UK residents.

2. Materials and methods

2.1. Participants

Participants were seven Caucasian men with previous drug and/or alcohol histories who were living in an Oxford House in Redcar, England; these seven participants represented a convenience sample of the only residents living in an Oxford House in the UK at the time of data collection. Their average age was 46.86 (SD = 10.67) ranging from 29–60 years. Six participants had been living in the Oxford House for eight months whereas one had lived in the Oxford House for three months at the time of data collection. The participants volunteered for the study without financial incentive.

2.2. Procedures

The study was reviewed and approved by the institutional review board of a university in Chicago, Illinois, USA. Inclusion for the study was based on the criteria of living in the UK Oxford House. The seven participants of the study represented 100% of the individuals who had resided in the House when it opened in July 2011. Participants were engaged in a process of informed consent, verbally provided their informed consent via Skype, and were provided electronic copies of the consent form.

2.3. Design and analysis

We utilized a cross-sectional, mixed-method approach to data collection to obtain descriptive quantitative and qualitative data, and followed-up with some quantitative measures to assess residency status and rates of abstinence, employment, and education status at two-months via internet interviews. Averages and standard deviations were conducted to describe participants across several domains: socio-demographic characteristics, substance use histories and abstinence, psychiatric symptoms, and recovery resources. Although no inferential analysis of quantitative data can be done with such a small sample, the mixed-method design allowed for a wider exploration of replicating of the Oxford House model in the UK.

2.4. Quantitative measures

The *Addiction Severity Index-Lite* (ASI-Lite; McLellan, Cacciola, & Zanis, 1997), a briefer version of the *Addiction Severity Index* (ASI; McLellan et al., 1992), is a measure that assesses problems in areas commonly affected by substance use disorders: medical and psychiatric problems, drug use, alcohol use, illegal activity, family relations, and family history. The ASI has good internal consistency, and excellent predictive and concurrent validity (McLellan et al., 1992). The ASI-Lite has been demonstrated as being quite comparable to the ASI with good validity and reliability (Cacciola, Alterman, McLellan, Lin, & Lynch, 2007).

The *Situational Confidence Questionnaire* (SCQ-39; Annis & Graham, 1988) is a 39-item instrument that measures abstinence self-efficacy. Respondents are instructed to imagine themselves in each of 39 situations and to indicate how confident they are that they would resist the urge to use substances in each situation. The overall score of the SCQ-39 has also been demonstrated to be predictive of post-treatment drinking outcomes. Ross, Filstead, Parrella, and Rossi (1994) adapted this inventory for use with persons with various substance use disorders. We used the shortened version of the SCQ-39, the *Drug- Taking Confidence Questionnaire* (DTCQ), to measure participants' self-efficacy for abstinence. All subscales of the DTCQ have good reliability (alphas .79 to .95; Sklar, Annis, & Turner, 1997). Although we used the eight-item version (DTCQ-8) to minimize interview time, these items have been demonstrated to account for 95% of the variance in the total DTCQ scores and to correlate 0.97 with the total DTCQ score (Sklar et al, 1997).

The *Alcoholics Anonymous Affiliation Scale* (AAAS; Humphreys, Kaskutas, & Weisner, 1998) consists of 9 items regarding various 12-step activities, including recent and lifetime rates of 12-step meeting attendance. The AAAS has been used to provide an index of an individual's affiliation with 12-step groups even though it was designed originally for use with Alcoholics Anonymous members. The reliability of the AAAS is very good ($\alpha = .84$ to .87).

The *Interpersonal Support Evaluation List* (ISEL-12; Cohen, Doyle, Turner, Alper, & Skoner, 2003) consists of 12 items in a short form version that was administered to measure support external to the recovery home and 12-step networks. The internal reliability for the ISEL-12 ($\alpha = .80$ to .90; Cohen et al., 2003) is very good.

Nine questions from *Form-90* (Project MATCH, 1993) were used to assess living arrangements, drug and alcohol use, treatment, and AA attendance over the past 90 days. Form-90 has been used in a variety of inpatient and outpatient treatment centers as well as in research, and it has very good retest reliability ($r = 0.76$ to 0.99, Scheurich et al, 2005).

2.5. Qualitative measure

Participants were engaged in semi-structured interviews using a qualitative questionnaire created to obtain information about participants' experiences in Oxford House, social networks, and their recommendations for Oxford Houses in the UK. Biographical information was not specifically sought during interviews as questions were limited to relevant information in terms of substance use history, legal history, employment-financial

history, physical and mental health history, and social support in addition to participants' impressions of the Oxford House model. The qualitative questionnaire consisted of eight open-ended questions which explored three different areas: 1) individuals' personal experience, strengths and needs, prior to and during their stay in the Oxford House; 2) individuals' appraisal of the Oxford House model; and 3) individuals' needs assessment for Oxford Houses in the context of living in the UK.

Interviews were transcribed verbatim and analyzed by a modified analytic induction approach (Patton, 2002) in order to examine individual cases and comparative elements across cases. Interviews were read and coded several times, and patterns within and between cases were ascertained in illuminating themes which were also examined in order to assess the extent that emergent themes influenced each other. In total, baseline interviews lasted an average of 2.5 hours. Interviews at the two-month follow-up period lasted approximately 30 minutes and assessed for any changes in substance use, employment and financial support, and social support.

3. Results

3.1 Quantitative results

Socio-demographic information about participants is presented in Table 1. All participants listed alcohol as their primary substance of use, and some reported multiple substance use. Individuals in this sample reported a long history of alcohol use and extensive treatment history for it: the average years of alcohol use to intoxication was 26 years, and residents reported attending an average of nearly 20 alcohol treatment programs. In addition, participants reported an average of three and a half years of continuous abstinence.

Psychiatric, substance use, and treatment characteristics are presented in Table 2. Five participants reported that they were presently receiving a government benefit for a psychiatric disability, and most reported a history of serious psychological symptoms. Likewise, the majority of participants had a history of taking prescribed medication for a psychological problem and three were presently taking prescribed medication for a psychological problem. Only one participant was employed at baseline and the majority received financial support from the government through disability benefit, welfare, and unemployment compensation.

In terms of recovery resources, participants reported very high abstinence self-efficacy scores ($M = 97.0$, $SD = 4.4$) from a total maximum of 100. Participants social support scores were also quite high, averaging 3.8 ($SD = .3$) from a maximum of 4.0. Participants also reported regular AA meeting attendance, with an average of 285.6 meetings attended in the past year, with a weekly average of about 7 meetings in the past month.

At the two month follow-up time period, six individuals living in the house at baseline continued to reside in their Oxford House and all had remained abstinent from alcohol and non-prescribed drugs. Those who were enrolled in continuing education at baseline continued their studies or had received their certifications by the follow-up time period. Although there were no noteworthy changes in employment or financial support among the

House residents, several reported plans for future employment or for future education which they expected would lead them to realistic employment opportunities in subsequent months.

3.2 Qualitative results

The qualitative interview piece of the study yielded interesting phenomenological findings which could be mainly grouped into a handful of positive and negative themes relating to the participants' past and current experiences. All but one participant reported overall negative and poor support and functioning in the areas of financial and interpersonal support, psychological functioning, physical health and recovery support prior to moving into the Oxford House, though some reported relatively positive interpersonal support and recovery support stemming from AA and sober support networks prior to Oxford House.

3.3 Themes of support

"Support was zero really until I moved here in the Oxford House. Family and friends I'd lost, community members, no" (Participant 2).

"Physically not good, financially unstable, couldn't cope with sorting the finances..." (Participant 1).

"Was quite good from my family and from the fellowship [AA] they were good. There was always someone there if I needed someone from the groups" (Participant 7).

Participants also described their thoughts and feelings as they decided to move into the Oxford House. Generally, they expressed some worry and apprehensiveness, tempered by positive expectations relating to recovery.

"I knew that it would benefit me because I knew that I'd be around people in recovery and I knew that I wouldn't be as lonely unlike where I was living....Where I was I didn't know if I would stay sober for much longer there" (Participant 5).

"Element of fear in moving out and into Oxford House because had lived there such a long time...Felt uncomfortable about it but knew it was the best thing for my sobriety" (Participant 1).

"I was pretty confused....I didn't know anything about AA or Oxford House, I knew very little ...if I'd moved back to the house I was at, I would have gotten drunk, probably death within short time. My health would have declined" (Participant 2).

Participants generally reported positive improvements in interpersonal support, recovery support and psychological functioning when recalling their initial experiences living in the Oxford House.

"Knowing that there are other people here to help me, lift me, helps me get on. I'm a much more confident and happier person than before I lived in the Oxford House" (Participant 3).

“The most important thing was having support – people who knew the same experience and what I needed, especially the first few days and week or two... they were watching me to make sure I didn’t go back to drinking...[It’s] a happier life you know, it’s starting to get better. There’s a program I’m following. Living in a safe environment, having sober people around me. That’s the most important” (Participant 2).

3.4 Themes of abstinence social support benefits

Speaking about their support networks while living in the Oxford House, participants reported themes of support and improvements in psychological, physical, and interpersonal areas. Likewise, many report benefiting from the “24/7 recovery” support that the Oxford House offers.

“Very similar, probably do a lot more with people in recovery now since I live with them – a lot more psychological support cause since first thing we do the morning meetings meditation, physically more active” (Participant 4).

“It’s bigger, more diverse, it’s stronger” (Participant 6).

“There’s a lot more support, 24 hours a day support and being around the others. My relationships with others outside the house and family have changed, my family likes me again, people talk to me now, start trusting me again. That’s what Oxford House has done for me as well” (Participant 7).

Some participants expressed that living in Oxford House had not influenced them to look for other sources of treatment or support as they found that their treatment, recovery, and other needs were being met through the Oxford House and support group meetings.

“No because I think I’m getting all the support I need. This is quite structured, whereas other support wouldn’t be as structured” (Participant 5).

3.5 Themes of empowerment

Others, however, reported that living in the House had encouraged them to seek new forms of financial support and recovery support (starting to attend AA meetings and soliciting support from House members). Participants reported seeking employment, pursuing continuing education, preparing to open a landscaping and gardening business to employ others in recovery, applying for government grants to pursue joint business initiatives as a House, and participating in charity events.

“The support’s always there. I know if I have a problem I can go to anyone in the House. They want to help. Also going to AA was influenced by members of the House. I started going to AA when I moved into the House after getting out of the hospital” (Participant 2).

“I don’t think I’d have lasted in college if I hadn’t been living in the House. And financially we’re looking into areas to get some government grants to start up a business get a business plan sorted out and what not” (Participant 3).

“I’ll continue to do the gardening and growing our own vegetables and charity work” (Participant 7).

“We joined all kinds of community initiatives and have been involved in cleaning up the general area of the building not just our own space... We also did a big charity event called Children in Need... and our event was a sponsored swim of the English Channel” (Participant 6).

These responses – be it that participants did not seek other forms of treatment because their recovery needs were met through Oxford House living and Alcoholics Anonymous, and that living in an Oxford House had supported them to successfully pursue educational, community, charitable, and recovery-related initiatives – speak to the positive impact that these seven individuals feel that living in the Oxford House has served in their lives.

3.6 Appraisal of the Oxford House model

Participants also responded to questions that directly assessed their appraisal of the Oxford House model’s effectiveness for others, rather than only their perceptions of its effect on their own lives. They reported reasons why an individual might like living in an Oxford House similar to some of the recovery and interpersonal support oriented benefits they mentioned in their personal experiences. They also assessed a persons’ acceptance of Oxford House in terms of where he or she is at in the recovery process; that is, those who are “not ready for recovery” or to “stop drinking and drugging” will reject the Oxford House due to the guidelines and rules that regulate the House. However, if a person is committed to achieving long-term sobriety, they expect that the individual would like to live in an Oxford House.

“People who are dedicated to recovery will like it and benefit a lot from it – perfect opportunity to move along in recovery and get well. But it’s quite strict with rules and regulations and could seem quite blunt for someone if they weren’t really into recovery yet” (Participant 4).

“Can’t see any reason why they wouldn’t like it. I never got any support when I got out of rehab, only my own flat. I needed to be around other [recovering] alcoholics and that’s what I think is the fantastic opportunity that the Oxford House offers people” (Participant 7).

They also made specific comments that relate to the Oxford House’s implementation in the UK context as they perceive it; they noted that prejudice against AA and abstinence, and ignorance within the community about recovery are barriers for the expansion of the Oxford House model.

“I like [Oxford House] to be better known what it stands for and what it is to people...I’d like that to be known for alcoholics out there who have really zero support from the community here” (Participant 2).

“One of the problems we have is there’s not much recovery in England and sometimes I go to GPs and explain the model to them and they say I’ve been a GP for 30 years and an alcoholic will always relapse...[Others] are ignorant of the

possibility of recovery and not actually believing that someone could recover. There's a lot of prejudice against AA and NA" (Participant 6).

These last comments are particularly salient and they echo previous discussion of the way that abstinence is viewed by society at large; particularly the medical profession in the UK. Overall, there is an over-arching theme within our sample that represents a voice in favor of abstinence-based recovery in the UK, indicating the need for ongoing support to sustain long-term abstinence.

4. Discussion

The prevalence rates of alcohol and substance use histories, along with the endorsement of several recovery resources and ongoing total abstinence at two-month follow-up, suggest that communal-living, abstinence-based settings such as the Oxford House model might be appropriate treatment interventions for persons with substance use disorders living in the UK. Participants reported frequent AA meeting attendance, a finding that is consistent across Oxford House studies (Jason & Ferrari, 2010; Jason et al., 2007; Majer et al., 2002a). The high rates of self-efficacy for abstinence and social support are consistent with previous investigations involving Oxford House residents in the US (Jason et al., 2007; Jason et al., 2006; Majer et al.; Majer et al., 2004), suggesting that self-run recovery homes such as Oxford House are instrumental in fostering recovery resources among residents. In addition, the prevalence rates of psychiatric symptoms in the present study are consistent with previous Oxford House research (Majer et al., 2008; Majer, Jason, Ferrari, & North, 2002b). Although these descriptive data in the present study come from a very small sample, taken together with participants' personal narratives, they provide highly consistent preliminary evidence that suggests the Oxford House model could be replicated in the UK.

In addition, the present study revealed that for participants who had relatively long periods of abstinence prior to living in their Oxford House, the House helped not only their ability to maintain their abstinence but also to improve other areas of their lives. Personal narratives in the present study revealed their concerns increased from abstinence-related goals and recovery resources to full reintegration into society. The results of this study, particularly residents' personal gains from living in the UK Oxford House in addition to their involvement with others, suggest that their personal improvements from Oxford House living generalize to the broader community through charitable work and common House initiatives. These findings are consistent with previous research on the second-order effects of the Oxford House model that benefits both residents and their communities (Jason, Schober, & Olson, 2008).

Although participants' personal narratives revealed that they lacked support for abstinence and recovery in their community, they also expressed a strong desire for a safe and supportive setting - one which for them had been fulfilled by the Oxford House, consistent with previous investigations (Jason & Ferrari, 2010; Jason, Olson, & Foli, 2008; Majer et al., 2002b). However, the implementation of an Oxford House in the UK differed from what is typical of Oxford Houses in the United States where they have been replicated and studied. Participants' comments are consistent with Roberts (2005) and Martin (2005) in that

many policy-makers and practitioners in the UK simply do not believe that abstinence is a realistic option with doctors recommending harm-reduction methods for persons with substance use disorders.

4.1. Housing issues

Socialized housing differs in the UK context in that it typically provides smaller housing units for residents (e.g., two bedroom apartment style-housing). In contrast, most Oxford Houses in the US are single house structures made up of individual or shared bedrooms, and greater shared living spaces. Such ideal housing structures was not available for the UK Oxford House residents who lived in six adjacent individual apartments within one overall housing unit, where a spare room of one of the apartments was converted into a communal space where House meetings and other group meetings are held.

In addition to the physical aspects of the setting, the UK Oxford House differed in terms of the average length of complete abstinence among its residents. Most individuals who move into Oxford Houses in the United States typically come directly from abstinence-based professional treatments (Jason & Ferrari, 2010; Jason et al., 2007). Although only one resident entered the UK Oxford House directly from treatment, and the overall average length of total abstinence prior to living in the house was 3.5 years, which is considerably higher than average rate (just under a year) in the United States according to a US national study (Jason et al.). That participants expressed such a need for this type of full time abstinence-based support in qualitative interviews after most had already achieved longer-term abstinence before entering the Oxford House speaks to the continuing and long-term need for abstinence support even for those who have become drug and alcohol free. In addition, UK Oxford House residents expressed a desire to open more Oxford Houses and to recruit residents who are newly abstinent in future Houses in addition their present House (i.e., after residents decide to leave) in order to provide safe and supportive, abstinence-based residential settings that are lacking in their community.

4.2. Employment concerns

The majority of UK Oxford House residents were unemployed, contrary to what has been found in Oxford House studies in the US (Jason et al., 2007; Jason & Ferrari, 2010). A major tenet of the Oxford House model is that residents who are unemployed and able to work must be actively job searching for a certain number of hours a day (Oxford House Inc., 2011). There is a strong emphasis on obtaining and maintaining employment so that each resident contributes a fair share of rent. One longitudinal study of Oxford House in the United States showed that employment at six months was an important predictor of abstinence at two years (Jason et al., 2006). Within the context of the present study, societal and cultural factors play a strong role in the difference around this employment piece, as substantial and longer-term government benefits are available to individuals who have been diagnosed with chronic and severe substance use disorders. It is not surprising, given this context, that the majority of residents received some form of government benefit or disability compensation, and thus were unemployed.

Ashton (2007) discussed the need for both housing and employment for persons recovering from substance use disorders in order to emerge from welfare dependency despite extensive and intensive disadvantage, emphasizing the need for viable sober-living housing and desirable employment opportunities as alternatives to unemployment and disability benefits for this population. The higher degree of government entitlements granted to persons recovering from substance use disorders in the UK and the employment opportunities available to these individuals are realities that may challenge the replication of the Oxford House model in this context, or may inform a need to adapt the model within the UK. However, participants in the present study had several plans for employment and business ventures, and at the two month follow-up interview they estimated three-fourths of the residents would be earning their own income within the next few months. These UK Oxford House residents' initiatives to create and obtain employment opportunities for themselves fit with the Oxford House model. Nonetheless, local community initiatives are needed to foster employment opportunities that might engender a reciprocal link between persons recovering from substance use disorders and their community involvement in the UK.

4.3. Post-analysis follow-up and Limitations

We contacted residents prior to writing the final draft of this report and discovered that all of them had remained abstinent for nearly two years since the opening of the UK Oxford House. Three of the original UK Oxford House residents were still residing in the House while the others had successfully transitioned into their community without relapse. In addition, House residents have begun developing small businesses that center around sales, developing a green-house, and residential moving services. We also discovered costs for residents' previous service utilization in the past 10 years had been collected on all House residents. Estimates of these costs were based on residents' personal recollection of utilizing services that included hospital and medical care (overnight hospital stays, ambulance transport, GP and psychiatric nurse visits, medications), substance detoxification and counseling interventions (home, centre, and hospital detoxifications, individual and group therapy), legal issues (court, restitution for damages), unemployment and other benefits (JSA, housing), and other types (bankruptcy, child support). Taken together, the costs for previous utilization of services over the past decade were estimated at just over £1.4 million for these seven residents.

Although evidence from our mixed-method approach to examining the first UK Oxford House suggests that the Oxford House model can be replicated in the UK, there are some limitations in the present study. For instance, a larger sample size would have permitted the use of inferential statistical analyses whereas the descriptive nature of our quantitative data is quite limited in this respect. Likewise, AA meeting attendance is only one way of assessing 12-step involvement when other approaches have been used in other investigations. Finally, the use of self-reported data at one time-point is another limitation of the present study, as repeated measures might have provided more information in relation to changes in recovery resources, employment, psychiatric symptoms, abstinence rates, and community involvement over time. Further research with multiple assessment intervals and other outcomes including economic factors and community perceptions is needed to better understand the effectiveness of Oxford House model within other cultural contexts such as

the UK. In addition, comparative investigations that examine the Oxford House model in relation to other treatment services, and research that examines both the challenges and successes encountered in opening new Oxford Houses in a culture where abstinence-based models are gaining interest are recommended.

5. Conclusions

The present study investigated the implementation of the first Oxford House in the UK. We found UK Oxford House residents reported personal characteristics and recovery resources that are typical of Oxford House residents. In addition, UK Oxford House residents embraced the Oxford House model, identifying their need for long-term support for their ongoing abstinence that Oxford House provided them. In addition, these residents became involved in their communities which may represent a second-order effect of the Oxford House model. In fact, we have very recently discovered that the first UK Oxford House has been continuously active in Redcar for the past two years, and plans are underway to open a second Oxford House. Overall, results in the present study suggest that the abstinence-based communal-living dynamic of the Oxford House model has potential to assist individuals recovering from substance use disorders as well as build communities in the UK.

Acknowledgments

The authors appreciate the financial support from the National Institute on Drug Abuse (Grant DA19935), Bethesda, MD, USA.

References

- Annis, HM.; Graham, JM. Situational confidence questionnaire. Toronto: Addicton Research Foundation; 1988.
- Ashton M. The new abstentionists. *Druglink*. 2007;1–25.
- Best D, Bamber S, Battersby A, Gilman M, Groshkova T, Honor S, White W. Recovery and Straw Men: An Analysis of the Objections Raised to the Transition to a Recovery Model in UK Addiction Services. *Journal of Groups in Addiction & Recovery*. 2010; 5:264–288.
- Cacciola JS, Alterman AI, McLellan AT, Lin YT, Lynch KG. Initial evidence for the reliability and validity of a “Lite” version of the Addiction Severity Index. *Drug and Alcohol Dependence*. 2007; 87:297–302. [PubMed: 17045423]
- Cohen S, Doyle WJ, Turner R, Alper CM, Skoner DP. Sociability and susceptibility to the common cold. *Psychological Science*. 2003; 14:389–395. [PubMed: 12930466]
- Ferrari JR, Jason LA, Blake R, Davis MI, Olson BD. This is my neighborhood: comparing United States and Australian Oxford House Neighborhoods. *Journal of Prevention & Intervention in the Community*. 2006; 31:41–49. [PubMed: 16595385]
- Government, H. *Drugs: Protecting families and communities: The 2008 drug strategy*. London: UK; 2008.
- Humphreys K, Kaskutas L, Weisner C. The Alcoholism Anonymous Affiliation Scale: Development, reliability, and norms for diverse treated and untreated populations. *Alcoholism: Clinical and Experimental Research*. 1998; 22:974–978.
- Jason LA, Davis MI, Ferrari JR, Anderson E. The need for substance abuse after-care: Longitudinal analysis of Oxford House. *Addictive Behaviors*. 2007; 32:803–818. [PubMed: 16843612]
- Jason LA, Ferrari JR. Oxford House Recovery Homes: Characteristics and Effectiveness. *Psychological services*. 2010; 7:92–102. [PubMed: 20577571]
- Jason LA, Olson BD, Ferrari JR, Lo Sasso AT. Communal housing settings enhance substance abuse recovery. *American Journal of Public Health*. 2006; 96(10):1727–1729. [PubMed: 17008561]

- Jason, LA.; Olson, BD.; Foli, K. Rescued lives: The Oxford House approach to substance abuse. New York: Routledge; 2008.
- Jason LA, Schober D, Olson BD. Community involvement among residents of second-order change recovery homes. *Australian Community Psychologist*. 2008; 20:73–83. [PubMed: 23730338]
- Legler R, Jason LA. Formative evaluation of a community-based recovery home in Ghana, Africa. *Annals of Research*. (in press).
- Majer JM, Jason LA, Aase DM, Droege JR, Ferrari JR. Categorical 12-step involvement and continuous abstinence at two- years. *Journal of Substance Abuse Treatment*. 2013; 44:46–51. [PubMed: 22498012]
- Majer JM, Jason La, Ferrari JR, Miller SA. 12-Step involvement among a US national sample of Oxford House residents. *Journal of substance abuse treatment*. 2011; 41:37–44. [PubMed: 21353447]
- Majer JM, Jason LA, Ferrari JR, Venable LB, Olson BD. Social support and self-efficacy for abstinence: Is peer identification an issue? *Journal of Substance Abuse Treatment*. 2002a; 23:209–215. [PubMed: 12392807]
- Majer JM, Jason LA, Ferrari JR, North CS. Comorbidity among Oxford House residents: A preliminary outcome study. *Addictive Behaviors*. 2002b; 27:837–845. [PubMed: 12201387]
- Majer JM, Jason LA, North CS, Ferrari JR, Porter NS, Olson BD, Davis MI, Aase D, Molloy JP. A longitudinal analysis of psychiatric severity upon outcomes among substance abusers residing in self-help settings. *American Journal of Community Psychology*. 2008; 42:145–153. [PubMed: 18581228]
- Majer JM, Jason LA, Olson BD. Optimism, abstinence self-efficacy, and self-mastery: A comparative analysis of cognitive resources. *Assessment*. 2004; 11:57–63. [PubMed: 14994954]
- Martin P. Critique of ‘What are drug users looking for when they contact drug services: Abstinence or harm reduction?’ by Neil McKeganey, Zoë Morris, Joanne Neal, & Michele Robertson. *Drugs: Education, Prevention, and Policy*. 2005; 12(4):257–259.
- McKeganey N. The lure and the loss of harm reduction in UK drug policy and practice. *Addiction Research & Theory*. 2006; 14:557–588.
- McKeganey N. Abstinence and harm reduction: can they work together? *The International journal on drug policy*. 2011; 22:194–195. [PubMed: 21550791]
- McKeganey N, Morris Z, Neale J, Robertson M. What are drug users looking for when they contact drug services: abstinence or harm reduction? *Drugs: Education, Prevention, and Policy*. 2004; 11:423–435.
- McLellan, AT.; Cacciola, JS.; Zanis, D. The Addiction Severity Index-Lite. Center for the Studies on Addiction. University of Pennsylvania/Philadelphia VA Medical Center; 1997.
- McLellan TA, Kushner H, Metzger D, Peters R, Smith I, Grissom G, et al. The fifth edition of the addiction severity index. *Journal of Substance Abuse Treatment*. 1992; 9:199–213. [PubMed: 1334156]
- Nealon-Woods MA, Ferrari JR, Jason LA. Twelve-step program use among Oxford House residents: Spirituality or social support in sobriety? *Journal of Substance Abuse*. 1995; 7:311–318. [PubMed: 8749790]
- Oxford House, Inc. Oxford House Manual. MD: Silver Springs; 2011.
- Patton, MQ. Qualitative research and evaluation methods. 3rd ed.. Thousand Oaks, CA: Sage; 2002.
- Project MATCH Research Group. Project MATCH: Rationale and methods for a multisite clinical trial matching patients to alcoholism treatment. *Alcoholism: Clinical and Experimental Research*. 1993; 17:1130–1145.
- Roberts M. Comment on “What are drug users looking for when they contact drug services: Abstinence or harm reduction?” by Neil McKeganey, Zoë Morris, Joanne Neal, & Michele Robertson. *Drugs: Education, Prevention, and Policy*. 2005; 12(4):261–263.
- Ross AA, Filstead WJ, Parrella DP, Rossi JJ. A comparison of high-risk situations for alcohol and other drugs. *American Journal of Addictions*. 1994; 3:241–253.
- Scheurich A, Muller MJ, Anghelescu I, Lorch B, Dreher M, Hautzinger M, Szegedi A. Reliability and Validity of the Form 90 Interview. *European Addiction Research*. 2005; 11:50–56. [PubMed: 15608472]

- Sklar SM, Annis HM, Turner NE. Journal of Addictive Behaviors. 1997; 22(5):655–670.
- Trace M. Comment on ‘What are drug users looking for when they contact drug services: Abstinence or harm reduction?’ by Neil McKeganey, Zoë Morris, Joanne Neal, & Michele Robertson. Drugs: Education, Prevention, and Policy. 2005; 12:267–268.
- White W. Grassroots recovery support in the UK: An interview with Laura Graham, Addiction Recovery Foundation. Addiction Today. 2011 from <http://www.addictiontoday.org/addictiontoday/2011/08/grassroots-recovery-william-white-laura-graham.html>.

Table ISocio-demographic Characteristics of UK Oxford House Residents ($n = 7$)

	<i>n</i>	Mean (SD)
Demographics		
Race		
White (note Hispanic)	7	
Age		46.9 (10.7)
Education completed (years)		12.9 (4.0)
Marital status		
Divorced	5	
Never married	2	
Religious preference		
Protestant	1	
Catholic	3	
None	3	
Employment History^a		
Usual employment pattern		
Full time	2	
Retired/disability	5	
Usual occupation		
Business managers, lesser occupations	1	
Small business owner	1	
Clerical and sales	1	
Semi-skilled	2	
Unskilled/unemployed	2	
Receive a benefit for a psychiatric disability ^b		
No	2	
Yes	5	
Income & Financial Support^{b,c}		
Employment income		291.4 (753.6)
Unemployment compensation		37.1 (98.3)
Welfare		190.1 (345.7)
Disability benefit		283.6 (258.4)
Days paid for working		3.1 (7.5)

^a Lifetime^b Last 30 days^c Amounts listed in pounds

Table IIFrequencies of psychological and substance-related characteristics ($n = 7$)

	<i>n</i>	Mean (SD)
Psychological History		
Days experienced psych problems ^b		1.0 (1.7)
Prescribed Rx for psych problems ^a	3	
Taking Rx for psych problems	4	
History of depression ^a		
No	1	
Yes	6	
History of anxiety ^a		
No	1	
Yes	6	
History of hallucinations ^a		
No	6	
Yes	1	
History of violent behavior ^a		
No	1	
Yes	6	
History of thoughts of suicide ^a		
No	1	
Yes	6	
History of attempted suicide ^a		
No	3	
Yes	4	
Time in Recovery		
Months living in OH		7.3 (1.9)
Months current sobriety		42.7 (37.5)
Lifetime substance use ^a		
Alcohol		27.4 (10.4)
Alcohol to intoxication		26.0 (9.9)
Heroin		0.1 (0.4)
Methadone		1.4 (3.8)
Sedatives/hypnotics/tranq		4.7 (7.7)
Cocaine		1.3 (2.2)
Amphetamines		1.9 (2.5)
Cannabis		2.7 (3.9)
Hallucinogens		1.0 (1.5)
Inhalants		0.6 (0.8)
Mult substance/day		7.9 (7.9)
Treatment history		

	<i>n</i>	Mean (SD)
Days attended AA meetings ^b		26.9 (4.1)
# alcohol DTs ^a		4.1 (7.1)
# drug overdose ^a		1.1 (1.2)
# alcohol treatments ^a		19.9 (14.3)
# alcohol Tx detox only ^a		4.0 (4.9)
# drug treatments ^a		0.3 (0.8)
# treated in hospital for substance related problem ^a		0.9 (1.2)

^a Lifetime

^b Last 30 days