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Oxford House Recovery Homes: Characteristics and Effectiveness

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Abstract

One of the largest examples of a community-based, mutual-help residential community for high risk substance abuse individuals is *Oxford House*. In the U.S., over 9,800 people live in these self-run dwellings where they obtain jobs, pay utility bills, and learn to be responsible citizens. Beginning with one single rented residence in the mid 1970s, Oxford Houses now number over 1,300. These rented homes are helping to deal with drug addiction and community re-entry by providing stable housing without any limits on length of stay, a network of job opportunities, and support for abstinence. An exploration of the research on these unique settings highlights the strengths of such a community-based approach to addressing addiction. New roles for psychologists in working with these types of support systems are identified.

Keywords

Substance abuse; Recovery homes; Oxford House; ex-offender

After treatment for substance abuse, whether by prison, hospital-based treatment programs, or therapeutic communities, many patients return to former high-risk environments or stressful family situations. Returning to these settings without a network of people to support abstinence increases chances of relapse (Jason, Olson & Foli, 2008). As a consequence, alcohol and substance use recidivism following treatment is high for both men and women (Montgomery et al., 1993). Alternative approaches need to be explored, such as abstinence-specific social support settings (Vaillant, 2003). Self-governed settings may offer several benefits as they require minimal costs because residents pay for their own expenses (including housing and food). Recovering substance abusers living in these types of settings may develop a strong sense of bonding with similar others who share common abstinence goals. Receiving abstinence support, guidance, and information from recovery home members committed to the goal of long-term sobriety and abstinence may reduce the probability of a relapse (Jason, Ferrari, Davis & Olson, 2006). This experience might provide residents with peers who model effective coping skills, be resources for information on how to maintain abstinence, and act as advocates for sobriety.

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Oxford Houses are single-sex adult dwellings, yet some allow residents to live with minor children. Individual members are expected to pay monthly rent and assist with chores. They are one of the largest self-help residential programs in the US. Unlike other aftercare residential programs, such as halfway houses, Oxford House has no prescribed length of stay for residents and there is no professional staff. Each House operates democratically with majority rule regarding most policies, and an 80% majority for accepting membership (Oxford House Manual, 2006). Residents must follow three simple rules: pay rent and contribute to the maintenance of the home, abstain from using alcohol and other drugs, and avoid disruptive behavior. Violation of the above rules results in eviction from the House (Oxford House Manual).

As of 2008, there were 321 women's Oxford Houses with 2,337 women, and 982 men's Oxford Houses with 7,487 men, for a total of 1,303 houses serving 9,824 people (Oxford House, 2008). There were Oxford Houses in 42 states and 383 cities in the US. Of the residents, 18% were veterans, and 91% were working with average monthly earnings of $1,480. Most residents had been addicted to drugs or drugs and alcohol (73%) whereas 27% had been addicted to only alcohol. Regarding race, 54% were White, 42% were Black, and 4% were other. Regarding marital status, 45% had been never married, 18% were separated, 33% were divorced, and only 4% were married. Fifty-three percent of residents reported prior homelessness for an average time of 6 months. In addition, 76% had been in for an average of 13 months. The average length of stay in an Oxford House was 10.1 months. The average cost per person per week was $98.75.

There appear to be considerable standardization of locations of Oxford Houses as well as what occurs in these settings (Ferrari, Groh & Jason, 2009). Ferrari, Jason, Sasser et al. (2006) studied 55 Oxford Houses across three diverse regions of the U.S and found that regardless of geographic location, Oxford Houses were rather similar in size and amenities that were available to residents (e.g. room air-conditioners, a utility room for laundry, a communal lounge for televisions, comfortable furniture in communal living areas. Observers (with high inter-rater reliability) noted that public transportation was available near the houses, and the streets and neighborhoods were clean and well-lit. These results, in fact, were replicated in Australian Oxford Houses (Ferrari, Jason, Blake et al., 2006).

Jason et al. (2003) used interviews and observations to better understand governance issues in the Oxford Houses. They found that residents utilized a number of strategies to confront behavioral issues, including imposing fines for not completing house duties, discussing interpersonal conflicts and behaviors such as isolation at business meetings, and developing behavioral contracts. Houses also implemented rewarding events for achieving goals. The Oxford House model of treatment for substance abuse issues is an intriguing concept based on self-governance and mutual support. The self-governing policies described above help create and nurture abstinence-specific social support networks. In the absence of professional staff, residents are forced to develop rules and policies, learn to self-govern, and assume positions of leadership within their houses. The democratic feature of the Oxford House program differentiates it from other types of residential care settings and recovery homes, where rules and sanctions for infractions may exist, but with less explicit efforts to encourage a supportive milieu

Limited research, however, is available regarding how Oxford House settings compare to other treatments. Using cross sectional data, Ferrari, Jason, Davis, Olson, and Alvarez (2004) compared the operational policies of 55 Oxford Houses to those of 14 Therapeutic Communities (TCs). Neither type of facility permitted self-injurious behaviors (e.g., physical self-harm or misuse of medication) or destructive acts (e.g., destroying site property or others' possessions). Oxford Houses, however, were significantly more liberal in permitting residents personal liberties compared to the TC facilities. For example, Oxford Houses permitted greater

flexibility in terms of residents' smoking in their rooms, sleeping late in the morning or staying out late at night, going away for a weekend, and having "private time" in their locked room with guests. Oxford Houses also were more likely than TCs to allow residents to have personal possessions (e.g., pictures, furniture) within the dwelling (Ferrari, Jason, Sasser et al., 2006).

Unfortunately, there have not been any outcome studies comparing TCs with Oxford Houses, although the first author currently has a NIDA funded study that is exploring this issue. There is considerable evidence for the effectiveness of TCs (DeLeon, & Rosenthal, 1989). Substantial reductions in recidivism rates have been found when in-prison Therapeutic Communities (TCs) are combined with community transition programs (Hiller, Knight, & Simpson, 1999; Wexler et al., 1996). As an example, Inciardi et al. (2004) found that at a five year follow-up, those individuals who participated in a combined TC and work release program had significantly less drug use and were significantly less likely to be re-incarcerated compared to those individuals in just the TC program or a no-treatment control group. Unfortunately, these TC programs often create a financial burden on society, and are not available to all that need them. Also, therapeutic community residents may stay only for a limited time before many return to former high-risk environments or stressful family situations (Goldsmith, 1992).

Limited research is also available comparing Oxford Houses versus more traditional recovery homes, which also tend to have supervising staff and less democratic self-governing principles. Harvey (2009) recently found that Oxford House residents had higher scores on social climate scales Involvement, Support, and Practical Orientation, Spontaneity, Autonomy, Order and Organization, and Program Clarity measures compared to a traditional recovery home. This study did not provide outcome data regarding residents' experiences living in these recovery communities. Few methodologically sound studies have emerged in the area of traditional recovery homes. In one of the few recovery home longitudinal studies, Polcin (2006) found that 51% of recovery home residents were abstinent from drugs and alcohol at a six-month follow-up. Regrettably, there are few studies reporting differential outcome data contrasting recovery home and therapeutic community residential treatments for substance abuse. In part, this is due to the fact that it is hard to provide systemic long-term outcome data on these hard to reach, highly recidivist populations.

The present article addresses the primary outcome studies conducted on one form of recovery home called Oxford House. We also examine whether settings such as Oxford Houses have an impact on their greater community. Finally, the implications for how clinicians might work with these types of community support settings will be reviewed.

Main Outcome Studies

Our NIAAA-Study

In a National Institute of Alcohol Abuse and Alcoholism (NIAAA) supported study, we successfully recruited 150 individuals who completed treatment at alcohol and drug abuse facilities in the Chicago metropolitan area. Over half of the individuals who participated in this study were women. Half the participants were randomly assigned to live in an Oxford House, while the other half received community-based aftercare services (Usual Care). We tracked over 89% of the Oxford House and 86% of the Usual Care participants throughout two years of the study. Results from this randomized study were encouraging, indicating significantly more successful outcomes including reduced recidivism for Oxford House than Usual Care participants 24 months after discharge from residential treatment (see Jason, Olson, Ferrari, & LoSasso, 2006).

Positive outcomes also emerged in terms of substance use (31.3% of participants assigned to the Oxford House condition reported substance use at 24 months compared to 64.8% of Usual

Care participants), employment (76.1% of Oxford House participants versus 48.6% of Usual Care participants reported being employed at the 24 month assessment) and days engaged in illegal activities during the 30 days prior to the final assessment ($M = 0.9$, $SD = 4.43$ for Oxford House; $M = 1.8$, $SD = 6.12$ for Usual Care participants). In this study of 150 participants, 87% of the female participants had children, but 50% of these women reported having lost custody of their children due to their addictions. Two years after entering Oxford House, 30.4% of all the women assigned to the Oxford House condition had regained custody of their children while only 2% (1 woman) had lost custody. On the other hand, in the Usual Care condition, only 12.8% of all the women regained custody of their children, while 4% (2 women) lost custody.

In this same study, we examined the combined effects of 12-step involvement and Oxford House residence on abstinence over a 24-month period (Groh, Jason & Ferrari, 2009). Among individuals with high 12-step involvement, the addition of Oxford House residence significantly increased the rates of abstinence (87.5% vs. 52.9%). Results suggested that the joint effectiveness of these mutual-help programs may promote abstinence and extended our previous research indicating that OH residents frequently engage in 12-step program use (Nealon-Woods, Ferrari, & Jason, 1997).

Economic data also were supportive for participants in the Oxford House condition over the course of the two-year study. Oxford House participants earned roughly $550 more per month than participants in the usual care group. Annualizing this difference for the entire Oxford House sample corresponds to approximately $494,000 in additional benefits to those in the Oxford House condition. The lower rate of incarceration (3% versus 9%) in the study among Oxford House versus usual care participants corresponded to annualized savings for the Oxford House sample of roughly $119,000. Together, the productivity and incarceration benefits yield an estimated $613,000 in savings accruing to the Oxford House participants.

In 2007, the Oxford House organization received about $1.6 million in grants from state and local governments to pay outreach workers to develop and maintain networks of individual Oxford Houses in nine States and the District of Columbia. Only 6% of these costs were for general and administrative costs of Oxford House, Inc. During 2007, the inhabitants of Oxford Houses expended approximately $47,814,156 to pay the operational expenses of the houses. If the Oxford Houses had been traditional, fully staffed halfway houses, the cost to taxpayers would have been $224,388,000 (Oxford House Inc., 2007). In the current cost-conscious environment by local, state, and federal governments, Oxford House represents an important network of recovery homes that promote abstinence for individuals needing ongoing support after an initial episode of substance abuse treatment.

Our NIDA-Study

Our next large scale completed study received funding from the National Institute on Drug Abuse (NIDA). This study examined abstinence-specific social support and successful abstention from substance use in a national sample of over 900 Oxford House residents. Results were quite positive; only 18.5% of the participants who left Oxford House during the course of the one-year study reported any substance use (Jason, Davis, Ferrari, & Anderson, 2007). Additionally, over the course of the study, increases were found in the percentage of their social networks who were abstainers or in recovery. Finally, latent growth curve analyses indicated that less support for substance use by significant others and time in Oxford House predicted change in cumulative abstinence over the course of the study.

Within this large study, we analyzed psychiatric severity data such that we compared residents with high versus low baseline psychiatric severity (Majer, Jason, North, Davis, Olson, Ferrari et al., 2008). No significant differences were found in relation to residents' number of days in

outpatient and residential psychiatric treatment, abstinence rates, and Oxford House residence status. These findings suggest that a high level of psychiatric severity is not an impediment to residing in self-run, self-help settings such as Oxford House among persons with psychiatric co-morbid substance use disorders.

Kim, Davis, Jason, and Ferrari (2006) examined the impact of relationships with parents, significant others, children, friends and co-workers on substance use and recovery among this national sample of Oxford House residents. They found that children provided the only type of relationship that was able to affect both substance use and recovery in a positive direction. D'Arlach, Olson, Jason, and Ferrari (2006) found that the children residents had a positive effect on the women's recovery, and this positive effect was identical for both mothers and non-mothers. It is possible that these positive effects are due to the fact that having children present leads to increased responsibility among all House residents, aiding in recovery. Women also reported that Oxford House residents helped one another with child care. Ortiz, Alvarez, Jason, Ferrari and Groh (2009) found that Houses with men and children had the highest rates of long term recovery, and perhaps men in recovery who take care of their children are in situations more advantageous to sustained recovery and have more resources compared to others.

Within this large national data set, we also examined ethnic differences. Within our sample, 58.4% were Caucasian, 34.0% were African American, 3.5% were Hispanic, and 4% were other. African-Americans were over represented in the sample. Flynn, Alvarez, Jason, Olson, Ferrari, and Davis (2006) found that African Americans in Oxford House maintain ties with family members yet develop supportive relationships by attending 12-step groups and living in Oxford House. These different social networks are able to provide support for abstinence to African Americans.

Less than 4% of our sample with Hispanic, and this led us to examine possible reasons for this under-representation. Alvarez, Jason, Davis, Ferrari, and Olson (2004) interviewed nine Hispanic/Latino men and three Hispanic/Latina women living in Oxford House. Only two individuals were familiar with Oxford House prior to entering residential treatment; the others had never heard about the program. Participants decided to move to an Oxford House based on information they received from counselors and peers indicating that Oxford House would facilitate their recovery. Prior to entering Oxford House, participants were concerned that House policies would be similar to those of half-way houses they had experienced (i.e., too restrictive).

Half the individuals interviewed also had concerns about being the only Hispanic/Latino House member. Despite their initial concerns, participants reported overwhelmingly positive experiences in Oxford House, with the majority of interviewees indicating that they "blended into the house" within their first few weeks. Most participants reported regular contact with extended family members and stated that family members supported their decisions to live in Oxford House. The most commonly endorsed suggestion for increasing Hispanic/Latino representation in Oxford House was to provide more information regarding this innovative mutual-help program. Residents indicated that personal motivation for recovery was a necessary component of their success in Oxford House (Alvarez, Jason, Davis, Ferrari, & Olson, 2007). Additionally, mutual help, social support, a sober living environment, and accountability emerged as strongly-endorsed therapeutic elements of the Oxford House model. Finally, consistent with a broad conceptualization of recovery, residents reported that living in Oxford House helped them remain sober but also facilitated the development of life skills and a new sense of purpose along with increased self-esteem.

There were only seventeen American Indian participants in our national NIDA study (Kidney, Alvarez, Jason, Ferrari, & Minich, 2009). Nevertheless, American Indians were no more likely to report more severe substance use, psychological problems, criminal histories, or lower incomes than other groups. In addition, American Indians were more likely to report being on parole or probation and being referred for aftercare by the legal system. Moreover, American Indians reported greater disharmony within their recovery residences than Caucasians, but there were no significant ethnic differences in length of stay in Oxford House.

Finally, Mortensen, Jason, Aase, Mueller, and Ferrari (2009) studied this national sample of Oxford Houses for six years following the completion of our study in order to investigate factors related to whether the Oxford Houses remained open or closed. Results indicated a high sustainability rate (86.9%) during a six year period of time. Houses that remained open had significantly higher incomes of residents than houses that eventually closed. No other significant differences were found between the two groups of houses, including sense of community among residents, neighborhood or policy characteristics, and house age. It appears that adequate house income seems to be a necessary factor for houses continuing to function over time.

Impacts Beyond Oxford House: Community Perceptions

Because the Oxford House organization was frequently confronted with a variety of community reactions to the presence of an Oxford Houses, our team decided to explore attitudes of neighborhood residents toward Oxford Houses (Jason, Roberts, & Olson, 2005). We found that neighbors who lived next to an Oxford House versus those a block away had significantly more positive attitudes toward a) recovery homes, b) the importance of individuals in recovery to have the ability to live in residential neighborhoods, c) neighbors' roles in providing a supportive environment to those in recovery, and d) a self-run recovery home on their block. Oxford House residents are often considered good neighbors, and when neighbors get to know these residents, they often feel very positive about these homes. Many individuals who lived a block away did not even know that a recovery home existed in their neighborhood, and the attitudes of these individuals who did not know the Oxford House members was less positive in general about these types of recovery homes. In addition, property values for individuals next to recovery homes were not significantly different from those living a block away. These findings suggest that well-managed and well-functioning substance abuse recovery homes elicit constructive and positive attitudes toward these homes and individuals in recovery (Ferrari, Jason, Sasser et al., 2006).

We were also interested in exploring whether rates of crime increased in locations where there were Oxford Houses. We investigated crime rates in areas surrounding 42 Oxford Houses and 42 control houses in a large city (Deaner, Jason, Aase, & Mueller, 2009). A city-run Global Information Systems (GIS) website was used to gather crime data including assault, arson, burglary, larceny, robbery, sexual assault, homicide, and vehicle theft over a calendar year. Findings indicated that there were no significant differences between the crime rates around Oxford Houses and the control houses. These results suggest that well-managed and governed recovery homes pose minimal risks to neighbors in terms of criminal behavior.

We also designed a study to assess the types of contributions that Oxford House residents report making to their neighborhoods and communities. Jason, Schober and Olson (2008) found that Oxford House members reported participating in the community for about 10.6 hours per month. The majority of participants were involved in activities around their recovery. Sixty-three percent were involved in mentoring others in recovery. Forty-four percent of the sample was involved in administering and running support groups. Involvement around recovery also included involvement in large community initiatives, as 39% of participants reported involvement in informing or advising agencies or local leaders and 32% reported involvement

in community anti-drug campaigns. For some, this involvement also included speaking at political events (16%), and attending community meetings (30%), and public hearings and forums (21%). Other general community activities reported by participants included working with youth (32%), fundraising (30%), and volunteering time with community organizations (23%). These findings indicate that Oxford House residents are not only working on their own recovery, but also working to make positive changes in their communities.

Group homes like Oxford House sometimes face significant neighborhood opposition, and municipalities frequently use maximum occupancy laws to close down these homes. Towns pass laws that make it illegal for more than 5 or 6 non-related people to live in a house, and such laws are a threat to Oxford Houses which often have 7–10 house members to make it inexpensive to live in these settings. Jason, Groh, Durocher, Alvarez, Aase, and Ferrari (2008) examined how the number of residents in Oxford House recovery homes impacted residents' outcomes. The Oxford House organization recommends 8–12 individuals residing in each House (Oxford House, 2006). Homes that allow for 8 or more residents may reduce the cost per person and offer more opportunities to exchange positive social support, thus, it was predicted that larger Oxford Houses would exhibit improved outcomes compared to smaller homes. Regression analyses using data from 643 residents from 154 U.S. Oxford Houses indicated that larger House size predicted less criminal and aggressive behavior. These data were used in 5 court cases, which were successful in arguing against closing down Oxford Houses that had more than 5 or 6 non-related residents.

Conclusion

Our overall findings that emerged from two large NIH-funded grants suggest that Oxford House provides an effective and inexpensive alternative for many individuals attempting to recover from addictions to alcohol and other drugs (Jason, Davis et al., 2007; Jason, Olson et al., 2006). Our findings from a number of other studies indicate that Oxford House may be appropriate for a variety of individuals recovering from substance abuse, including those with histories of legal involvement and co-occurring mental health conditions. Oxford House appears to provide a substance-free environment where recovering individuals may live without restrictions on length of stay, and residents report that residential settings devoid of relapse triggers help them remain substance-free (Jason et al., 1997; Alvarez et al., 2007). Given the high costs associated with professional treatment, it is critical to identify more affordable community-based models that might provide long-term support in order to break the cycle of relapse (for more details, see also Jason, Ferrari, et al. 2006; Jason & Ferrari, 2009).

Our research examined the nature and outcomes of the Oxford House model of substance abuse recovery. We worked with the needs of diverse groups, including ex-offenders, minority groups including Native Americans, and women and women with children. Our efforts involved a commitment to collaborative research with a grass-roots organization, assessing change at multiple levels with a multidisciplinary team of economists, biostatisticians, social, developmental, clinical and community psychologists.

For over 18 years, our research team used cross-sectional, operant (Jason, Braciszewski, Olson, & Ferrari, 2005), and longitudinal designs; employed quantitative and qualitative methods, and used self-report, observational (Jason, Ferrari, Freeland, Danielewicz, & Olson, 2005), and organizational data to assess Oxford Houses. We collected data at the individual, house, and state levels, and at times compared data over these different levels of analysis. We believe that selecting multi-level, multi-methods approaches allowed us to better clarify complex phenomena that we were studying.

We also believe that Oxford Houses and other community-based support system provide social scientists with rich opportunities to explore a vast array of psychological and sociological constructs. Because of space constraints, we were not able to review other topics our Oxford House research group has explored, but they include criminal and aggressive behaviors (Aase, Jason, Olson, Majer, Ferrari et al., 2009), anxiety (Aase, Jason, Ferrari, et al., 2006–2007), hope (Mathis, Ferrari, Groh, & Jason, 2009), optimism (Majer, Jason, & Olson, 2004), tolerance (Olson, Jason, Davidson, & Ferrari, 2009), self-regulation (Ferrari, Stevens & Jason, 2009), social climate (Horin, Alvarez, Jason, & Sanchez, 2007), social support (Groh, Jason, Davis, Olson, & Ferrari, 2007), altruism (Viola, Ferrari, Davis, & Jason, 2009), sense of community (Bishop, Jason, Ferrari, & Huang, 1998; Graham, Jason, & Ferrari, 2009), employment issues (Belyaev-Glantsman, Jason, & Ferrari, 2009), and even specialized Oxford Houses for deaf residents (Alvarez, Adebanjo, Davidson, Jason, and Davis (2006). Clearly, psychologists with interests in community based support networks for substance abusers have ample research topics worthy of exploration, and this research may have public policy implications.

We currently have received NIH support to begin researching individuals leaving jail and prison with substance abuse problems. This line of research could be expanded to other levels or target groups, such as men and women with substance abuse returning from foreign wars in Iraqi and Afghanistan. Reports of post-traumatic illnesses and substance abuse among returning veterans suggests that cost effective programs like Oxford House need closer federal attention. Our work with African Americans suggests that the Oxford House model meets cultural needs of this group; but culturally-modified houses might need to develop to meet the needs of Spanish-speaking Latinos due to their lack of representation within Oxford Houses. Our group has recently received a federal grant to explore this new type of culturally modified recovery home.

Clearly, it is important to improve the quality of the data for outcomes research with residential substance abuse treatment. Both NIDA and NIAAA have health services research study sections that are willing to review these types of applications. It is hoped that more researchers will consider developing grant proposals in this area, particularly as research focusing on the solution of applied problems is becoming a larger priority area for the federal government. With adequate funding, large clinical trials can emerge and adequate personnel can be employed for the arduous task of tracking over time these at-risk samples.

Implications for Clinical Practice

Alcoholism and substance abuse affects over 20 million Americans, and thus is the most prevalent mental disorder facing our nation (Jason, Ferrari, Davis, & Olson, 2006). Many psychologists are involved in the delivery of services to those with substance abuse addictions. Each year, 600,000 inmates are released back into communities, and many are released with ongoing drug addictions (substance abuse within correctional facilities ranges from 74 to 82%; Keene, 1997). One of the strongest predictors of criminal recidivism is substance use (Bureau of Justice Statistics, 2005). According to Horgan, Skwara, Strickler, Andersen, and Stein (2001), societal costs attributed to substance abuse in the United States alone is greater that $500 billion, which includes substance abuse treatment and prevention, medical and criminal costs, accidents, and losses of earnings. Of those with substance use addictions/dependence, only about 10% even reach any type of substance abuse treatment. This suggests a large need for creative new types of screening methods to identify patients in need of treatment. Almost all medical problems are first identified by primary care and referred to specialists, but this is not the case with substance abuse disorders, where most individuals first approach specialist substance abuse treatment settings. The Office of National Drug Control Policy is currently considering recommending that primary care settings should identify people with substance

abusers in primary care settings in order to refer more patients to detoxification and treatment. If this occurs, there will emerge unique opportunities for psychologists in both screening and referral.

For many individuals with substance abuse problems, entry into the existing continuum of services begins in a detoxification program. In the optimal case, an individual completes the detoxification process and then moves through a time-limited therapeutic program, but these programs are becoming briefer as federal, state and local sources of funding for these services has decreased (Jason, Olson & Foli, 2008). Detoxification program readmission represents a potential indicator that services received have not facilitated sustained recovery. It has been suggested that for a substantial portion of addicted persons, detoxification does not lead to sustained recovery. Instead, these individuals cycle repetitively through service delivery systems (Richman & Neuman, 1984; Vaillant, 2003). Recidivism rates within one year following treatment are high for men and women, and 52–75% of all alcoholics drop out during treatment (Montgomery et al., 1993). These kinds of programs are also expensive (Schneider & Googins, 1989).

These findings provide a challenge to psychologists working in the addiction field. The missing element for many patients is supportive settings following treatment for substance abuse, and the expansion of these types of settings is an important activity for psychologists. Vaillant (1983) noted that environmental factors may be key contributors to whether or not individuals maintain abstinence, and these factors include the support one receives for abstinence among their support networks. Moos (2006 Moos (2007) pointed to other individual, biological, and socio-environmental factors that predicted abstinence maintenance. Moos (1994) maintained that effective interventions for recovering individuals might be those that engage clients and promote naturally-occurring healing processes, such as self-help based treatments. Abstinence-specific social support may be critical to facilitating abstinence among persons with substance use disorders. Such social support is often acquired and utilized through participation in mutual-help groups (Humphreys, Mankowski, Moos, & Finney, 1999), where individuals are likely to develop peer networks consisting of abstainers and others in recovery. Investment in abstinence-specific social support was reported to be one of the best post-treatment prognostic indicators of recovery (Longabaugh et al., 1995; Zywiak, Longabaugh & Wirtz, 2002).

Oxford Houses represent one type of community support that psychologists could refer patients to, and this can be accomplished by reviewing the website for Oxford House, where all houses and current vacancies are listed (see http://www.oxfordhouse.org/locate_houses.php). Professional-practicing psychologists may make a referral to an Oxford House by asking the patient to call the Oxford House and set up an appointment with the house members for possible entry into that house.

Of course, no one particular type of treatment setting is appropriate for all individuals. Individuals early in their recovery or with particular interpersonal characteristics might need more of a structured and professionally-led milieu in order to maintain abstinence given the freedoms that are provided in Oxford Houses. In our national NIDA data set (Jason et al., 2007), 43% of participants had a history of psychological medications, 30% had attempted suicide, 46% had a history of physical abuse, 35% had a history of sexual abuse, 40% had one or more inpatient psychiatric treatments, and 40% had one or more outpatients treatments. In the past 90 days, the sample had an average of 1 day of residential treatment for psychiatric problems and an average of 3 sessions with a counselor for psychiatric problems. Certainly, it is clear that the sample of Oxford House residents do have significant mental health problems and that they do utilize mental health services outside of their Oxford Houses. Although there are no on-site clinical services, effective outreach can be accomplished by mental health

professionals becoming aware of the existence of these abstinent specific settings, and informing residents that they are willing to provide supportive therapy services to residents.

Given the expanding federal deficit and obligations to fund social security, it is even more important for psychologists to consider inexpensive ways to remediate inequities within our society. The Oxford House model suggests that there are alternative social approaches that can transcend the polarities that threaten our nation (Jason, 1997). We believe that there is much potential in the Oxford House model for showing how intractable problems may be dealt with by actively involving the community.

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