



PLANNING COMMISSION AGENDA REPORT

MEETING DATE: DECEMBER 8, 2014

ITEM NUMBER: PH-2

SUBJECT: APPEAL OF DENIAL OF REASONABLE ACCOMMODATION REQUEST TO TREAT YELLOWSTONE RECOVERY, 3132 BOSTON WAY, AS A SINGLE HOUSEKEEPING UNIT AND ALLOW 15 INDIVIDUALS TO LIVE IN THE SINGLE FAMILY HOME

DATE: NOVEMBER 26, 2014

FROM: PLANNING DEPARTMENT/DEVELOPMENT SERVICES DIVISION

PRESENTATION BY: JERRY GUARRACINO, Assistant Director, CID

FOR FURTHER INFORMATION CONTACT: Jerry Guarracino, AICP (714) 754-5631
Jerry.guarracino@costamesaca.gov

DESCRIPTION

Applicant Yellowstone Recovery, located at 3132 Boston Way, requested an accommodation based on its residents' disabled status, seeking relief from the zoning code's limitation to allow up to six individuals to live in a residential care facility in an R1 zone, to be treated as a single housekeeping unit and to allow 15 residents.

BACKGROUND

Yellowstone Recovery,¹ located at 3132 Boston Way, Costa Mesa (the "Property") is a state licensed residential nonmedical alcoholism or drug abuse recovery or treatment facility, serving 15 adult males.² Under the City's Zoning Code, Yellowstone is a residential care facility, i.e., it is a residential facility licensed by the state where care, services, or treatment are provided to persons living in a community residential setting. CMMC § 13-6.

The Property is owned by Anna M. Thames, aka Dr. Honey Thames, and has been so owned since September 14, 2004. Dr. Thames's name appears as the property owner in City records as early as 2002. The Property has operated as a sober living home since as far back as May of 1998. County records show that the house on the Property is 2,500

¹ Yellowstone operates more than one facility in the City of Costa Mesa. For the purposes of this appeal, any reference to Yellowstone is limited to the facility located at 3132 Boston Way.

² Based on Applicant's existing state license, the Director assumes that Yellowstone Recovery only houses disabled individuals for the purposes of reviewing Applicant's reasonable accommodation request.

square feet, and is built on a 6,098 square foot lot. The Property currently has six bedrooms. A dressing room had been converted to a bedroom without permits, but has been reconverted to its intended use.

The Property is located in an R1 Single-Family Residential District zone. R1 zones are low-density, single family neighborhoods with a minimum lot size of 6,000 Sq. Ft., and a maximum density of 7.26 dwelling units per gross acre.

Residential care facilities housing 7 or more individuals are not permitted in R1 zones within the City. CMMC § 13-30, Table 13-30(8).³ Based on its state license for a 15-bed facility, Yellowstone appears to have been operating in violation of the City's code by housing more than 6 individuals in a group living setting who, as Applicant admitted, do not act as a single housekeeping unit. On June 5, 2014, Yellowstone requested the accommodation at issue in this appeal. On August 19, 2014, the City Attorney's Office, on behalf of Gary Armstrong, Director of Development Services denied Yellowstone's accommodation request.

On September 22, 2014, Yellowstone timely filed a request for an appeal hearing. The hearing was originally set before the Commission for October 13, 2014, pursuant to mutual agreement with the Applicant. On October 2, 2014, Applicant requested a continuance to the December 8, 2014 meeting due to a scheduling conflict.

ANALYSIS

Based on the limited information provided by Applicant, and staff's own research into the issue and consultation with experts in the field, the Director recommends denial of the reasonable accommodation requested, for the following reasons.

The Federal Housing Act Amendments, 42 U.S.C. § 3601 et seq., provide that a city "commits discrimination under the FHAA if it refuses to make reasonable accommodations in rules, policies, practices, or services, when such accommodation may be necessary to afford [the disabled] equal opportunity to use and enjoy a dwelling." Budnick v. Town of Carefree, 518 F.3d 1109, 1119 (9th Cir. 2008).

The FHAA requires a city to provide a requested accommodation if such accommodation "(1) is reasonable, and (2) necessary, (3) to afford a handicapped person the equal opportunity to use and enjoy a dwelling." Oconomowoc Residential Programs, Inc. v. City of Milwaukee, 300 F.3d 775, 783 (7th Cir. 2002); 42 U.S.C. § 3604(f)(3)(B).

1. Applicant has not met its burden to show that the requested accommodation is necessary to afford individuals recovering from drug and alcohol addiction the opportunity to the use and enjoyment of a dwelling in a single family neighborhood.

³ On November 20, 2014, Ordinance No. 14-13 took effect. This Ordinance requires group homes to obtain a special use permit, and makes them subject to certain operational restrictions. Yellowstone is a residential care facility, and the Ordinance does not apply to such facilities. The Ordinance made no change to the zoning code that affects Yellowstone.

The Applicant bears the initial burden to show that the requested accommodation is reasonable and necessary to provide an equal opportunity to use and enjoy a dwelling. Oconomowoc, 300 F.3d at 783.

Applicant has thus far failed to establish that the accommodation requested is “necessary” to afford its handicapped residents the equal opportunity to the use and enjoyment of a dwelling, and specifically to afford individuals who are recovering from drug and alcohol abuse this opportunity. In its June 5, 2014, letter, Applicant contends that persons “recovering from addiction are far more often successful when living in a household with at least eight other persons in recovery, particularly in the early stages of recovery. Barring more than three unrelated individuals from residing together, without regard to the size of the residential unit, interferes with the critical mass of individuals supporting each other in recovery.” (Underlining added.) The City does not dispute that supportive, group living can significantly increase the likelihood of success of a recovery program.

The City’s code, however, does not prevent three unrelated disabled individuals from living together. In fact, the City treats boarding house-style residential facilities for the disabled, (defined in the code as “residential care facilities”⁴ and “group homes”⁵), more liberally than it does actual boarding houses: residential care facilities and group homes of six or fewer residents are permitted in the R1 zone, whereas boarding houses are prohibited in the R1 zones. CMMC §§ 13-6, 13-30 (Table 13-30(4)-(9)). The City’s code, therefore, is more favorable to disabled individuals than it is to non-disabled individuals. See, Oxford House v. City of St. Louis, 77 F.3d 249 (8th Cir. 1996) (city ordinance defined permissible single family dwellings as including 8 or fewer unrelated disabled individuals, but prohibited more than three unrelated non-disabled individuals from living together – held that ordinance does not discriminate against the disabled, but rather favors them on its face).

As of the drafting of this report, Applicant has provided no evidence whatsoever that more than 6 residents in a supportive living environment are necessary for recovery or to be afforded the opportunity to the use and enjoyment of a single-family home. While living with seven other recovering individuals may provide the optimal recovery conditions, it appears from Applicant’s own letter that the number of residents reasonably “necessary” for successful recovery is three and above. The law does not require that the City’s Zoning laws provide for optimal conditions, but rather what may be necessary to afford the disabled the opportunity to use and enjoyment of a dwelling. According to the Applicant, only three people

⁴ “Residential care facilities” are “residential facilit[ies] licensed by the state where care, services, or treatment is provided to persons living in a supportive community residential setting. . . .” CMMC § 13-6. State law requires that local government treat residential care facilities of 6 or fewer as single housekeeping units, Cal. Health & Saf. Code § 11834.20, but residential care facilities of 7 or more are subject to local zoning ordinances.

⁵ “Group homes” are facilities that are “being used as a supportive living environment for persons who are considered handicapped under state or federal law.” Group homes do not include the following: “(1) residential care facilities; (2) any group home that operates as a single housekeeping unit.” CMMC 13-6.

living in a supportive group environment are “necessary,” and the City’s code amply meets this requirement.

The burden to demonstrate necessity remains with Applicant. Oconomowoc, 300 F.3d at 784, 787. Applicant must show that “without the required accommodation the disabled will be denied the equal opportunity to live in a residential neighborhood.” Oconomowoc, 300 F.3d at 784; see also, United States v. California Mobile Home Mgmt Co., 107 F3d 1374, 1380 (9th Cir. 1997) (“without a causal link between defendants’ policy and the plaintiff’s injury, there can be no obligation on the part of the defendants to make a reasonable accommodation”); Smith & Lee, Inc. v. City of Taylor, Mich., 102 F.3d 781, 795 (6th Cir. 1996) (“plaintiffs must show that, but for the accommodation, they likely will be denied an equal opportunity to enjoy the housing of their choice”). The proper inquiry “is not whether a particular profit-making company needs such an accommodation, but, rather do such businesses as a whole need this accommodation.” Bryant Woods Inn, Inc. v. Howard County, Md, 124 F.3d 597, 605 (4th Cir. 1997) (internal citations omitted); Smith & Lee Assocs. Inc. v. City of Taylor, Mich., 13 F.3d 920, 931 (6th Cir. 1993). The Applicant, therefore, must demonstrate that residential services facilities, as a whole, require this particular accommodation.

More specifically, Yellowstone Recovery has provided no evidence of a nexus between the disabilities claimed by its residents, and the inability of those residents to meet the City’s definition of a single housekeeping unit; no evidence whatsoever to demonstrate that, based on their disabilities, residents of residential care facilities cannot enjoy the use of a single family residence in an R1 zone that is limited to six residents; and no evidence that increasing the number of residents from 6 to 15 would be therapeutically meaningful. See, Bryant Woods, 124 F.3d at 605 (“nothing in the record that we can find suggests that a group home of 15 residents, as opposed to one of 8, is necessary to accommodate individuals with handicaps”).

Additionally, six or fewer recovering individuals residing together provides a sufficiently supportive environment, according to state law. Health & Safety. Code § 11834.25. The City is home to 22 state licensed facilities serving 6 or fewer residents citywide, and 14 such facilities in the R1 zones. It appears therefore, that 6 or fewer individuals meets the necessity requirement to afford individuals recovering from alcohol and drug addiction the opportunity to use and enjoy the dwelling of their choice.

Further, there is no indication in the case law, nor in professional papers that the Director has been able to locate, that 15 individuals in a single family home is necessary for recovering individuals to the use and enjoyment of the housing of their choice. In addition to its own research on this issue, the Director has consulted with three experts on this issue to ensure fairness. One of the experts, Pat Shields, will testify at the appeal hearing. Two additional experts have provided written opinions as part of the record (Joan Zweben, Ph.D., and Michael Brant-Zawadzki, M.D.,). Based on their training and experience, neither expert believes there is any basis in experience or the medical records that 15 adults are necessary for supporting living. In fact, they conclude that this number of individuals might, under certain circumstances, be detrimental to recovery.

In summary, based on Applicant's request, state law, and the existence of a number of sober living homes housing six or fewer individuals, increasing the number of residents to 15 does not appear to be necessary, on the whole, to afford individuals recovering from addiction to drugs or alcohol the use and enjoyment of a dwelling in single family neighborhoods.

2. The requested accommodation is unreasonable as it is likely to fundamentally alter the character of the neighborhood.

Without having established that the accommodation is necessary, Applicant asserts that the requested accommodation is reasonable. In its June 5, 2014, application, Yellowstone Recovery contends that the accommodation requested "would not cause the City any undue financial or administrative burdens nor would it undermine the purpose which the requirement seeks to achieve. . . ." The requirement referred to is that residential care facilities of 7 or more residents are not permitted in R1 zones.

Applicant has the burden to show that the accommodation requested is reasonable on its face. Once the applicant makes a *prima facie* showing of reasonableness, the burden shifts to the government to demonstrate unreasonableness or undue hardship. Oconomowoc, 300 F.3d at 784; Vinson v. Thomas, 288 F.3d 1145, 1154 (9th Cir. 2002). Assuming, without conceding, that the requested accommodation is necessary, the Director further concluded that Applicant did not meet its *prima facie* burden of showing that the requested accommodation is reasonable.

All that Applicant has provided is an unsubstantiated assertion that the requested accommodation is reasonable. However, Applicant ignores that a zoning accommodation may be deemed unreasonable if "it is so at odds with the purposes behind the rule that it would be a fundamental and unreasonable change." Oconomowoc, 300 F.3d at 784. Applicant made no mention of the purpose underlying the City's zoning limitation, or explain how the accommodation requested would not undermine that purpose. In fact, the Director contends that such allowance would fundamentally alter the character of single family neighborhoods and is thus unreasonable.

Allowing what amounts to a boarding house that houses up to 15 people in a single family neighborhood does effect a fundamental change to the residential character of the City's R1 neighborhoods. Both California's and the United States' highest courts have recognized that the maintenance of the residential character of neighborhoods is a legitimate governmental interest. The United States Supreme Court long ago acknowledged the legitimacy of "what is really the crux of the more recent zoning legislation, namely, the creation and maintenance of residential districts, from which business and trade of every sort, including hotels and apartment houses, are excluded." Euclid v. Amber Realty Co., 272 U.S. 365, 390 (1926).

The California Supreme Court, also, recognizes the legitimacy of this interest:

It is axiomatic that the welfare, and indeed the very existence of a nation depends upon the character and caliber of its citizenry. The character and

quality of manhood and womanhood are in a large measure the result of home environment. The home and its intrinsic influences are the very foundation of good citizenship, and any factor contributing to the establishment of homes and the fostering of home life doubtless tends to the enhancement not only of community life but of the life of the nation as a whole.

Miller v. Board of Public Works, 195 Cal. 477, 490, 492-93 (1925).

With home ownership comes stability, increased interest in the promotion of public agencies, such as schools and churches, and 'recognition of the individual's responsibility for his share in the safeguarding of the welfare of the community and increased pride in personal achievement which must come from personal participation in projects looking toward community betterment.'

Ewing v. City of Carmel-by-the-Sea, 234 Cal. App. 3d 1579, 1590 (1991), *citing Miller*, 195 Cal. at 493. It is with these purposes in mind that the City of Costa Mesa has created residential zones, including R1 zones for single family residences.

Specifically, the Housing Element, Land Use Designation of the City's General Plan sets forth the goal of Low-Density Residential areas as follows:

Low-Density Residential areas generally are intended to accommodate single-family residences on their own parcels. Other housing types include attached housing that provide a greater portion of recreation or open space than typically found in multi-family developments, and clustered housing which affords the retention of significant open space. Low-Density Residential areas are intended to accommodate family groups and outdoor living activities in open space adjacent to dwellings. In order to avoid land use conflicts, these areas should be located away from or protected from the more intense non-residential areas and major travel corridors. The density for this land use designation shall be up to eight units to the acre. *At an average household size of 2.74 persons per dwelling unit, the projected population density within this designation would be up to 21.9 persons per acre.*

2000 General Plan, Housing Element, p. LU-24 (italics added).

Short-term tenants, such as might be found in homes that provide addiction treatment programs of limited duration, generally have little interest in the welfare of the neighborhoods in which they temporarily reside -- residents "do not participate in local government, coach little league, or join the hospital guild. They do not lead a scout troop, volunteer at the library, or keep an eye on an elderly neighbor. Literally, they are here today and gone tomorrow -- without engaging in the sort of activities that weld and strengthen a community." Ewing, 234 Cal. App. 3d at 1591.

The federal courts have also recognized that a sharp increase in the number of occupants in single family residences can constitute a fundamental alternation of the neighborhood and

be at odds with the purposes for the creation of such neighborhoods. Smith & Lee Associates, Inc. v. City of Taylor, Mich., 103 F.3d 781, 797 n.14 (6th Cir. 1996) (“Given that in 1994 only one percent of all households in the United States comprised seven or more persons, see United States Dep’t of Commerce, Bureau of the Census, Statistical Abstract of the United States 58 (1995), and that the City’s Master Land Use Plan 2000 indicates that average family size in Taylor in 1990 was 2.84 persons, a rule requiring municipalities to allow [Adult Foster Care homes] to operate with twelve residents in areas zoned for single-family use might substantially alter the nature of such neighborhoods. The potential impact of a twelve-person AFC facility would be magnified now that Michigan may no longer disperse AFC homes throughout communities by refusing to license a proposed AFC home located within a 1,500 feet radius of an existing AFC home. Courts must inevitably draw lines. Although a nine-resident AFC home would not substantially alter the residential character of a single-family neighborhood, a twelve-resident AFC home is more likely to do so.” (Internal citations omitted.))

The use limitation at issue has as its core purpose the maintenance of the single family character of R1 neighborhoods. In light of the impacts that large numbers of transient residents have on such neighborhoods, the Director concluded that an accommodation to house 15 individuals in an R1 zone where the average household size is 2.74 persons⁶ per unit is unreasonable because “it is so at odds with the purposes behind the rule that it would be a fundamental and unreasonable change,” Oconomowoc, 300 F.3d at 784, to the City’s single family neighborhood where it is located.

3. Conclusion.

Based on the above, the Director determined that Applicant has not met its burden to show that the requested accommodation is necessary to afford its disabled residents an equal opportunity to the use and enjoyment of a dwelling in an R1 zone. Furthermore, the Director concluded that such an accommodation would be unreasonable as it would fundamentally alter the nature of single family neighborhoods within the City.

PUBLIC NOTICE

Code-required public notice was provided via the following methods:

1. Notice of this item was included in the Planning Commission Agenda for the December 8, 2014 Planning Commission Meeting and the Agenda was posted prior to the meeting per City standards.
2. Notice of the public hearing was mailed to the property owner.

⁶ According to the 2000 U.S. Census, the average number of occupants per California household is 2.90, and the average number of adult occupants is 2.2.

ENVIRONMENTAL DETERMINATION

This action has been reviewed for compliance with the California Environmental Quality Act (CEQA), the CEQA Guidelines, and the City environmental procedures, and has been found not to be a project, as defined in Section 15378 of the CEQA Guidelines. Notwithstanding the foregoing, if this action were found to be a project, it would be exempt from CEQA under Section 15321 for Enforcement Actions by Regulatory Agencies.

LEGAL REVIEW

The City Attorney has reviewed this report and its attachments and has approved this report as to form.

RECOMMENDATION

Recommend that the Planning Commission make the following findings:

- Denying the accommodation request based on the findings that the Applicant has not made the requisite showing and state the reasons therefore. A draft resolution has not been provided but staff will return with a resolution reflecting the Commission's findings.

In the alternative, direct staff to prepare a resolution consistent with one of the following:

- Finding that the Applicant has made a showing that its tenants are disabled, that although the use is not a single-family use, some additional accommodation is reasonably necessary and direct the Applicant to provide the documentation necessary for staff to perform the CEQA analysis. Staff suggests that if this is the Planning Commission's direction that a time frame be given and if the documentation is not provided within that time frame, that the Application be deemed denied. With the documentation, staff could perform an appropriate environmental review and perhaps suggest some conditions to mitigate against potential negative impacts to the neighborhood, if any are found.
- Granting the requested accommodation, based on the findings that the Applicant has demonstrated that its tenants are disabled, and that accommodation requested is necessary to afford the disabled the opportunity to the use and enjoyment of the residence of their choice. Further, the Commission finds that the requested accommodation is reasonable as it does not place an undue financial or administrative burden on the City, and is consistent with the single family use in the neighborhood. No further environmental review is necessary.


JERRY GUARRACINO, AICP
Assistant Director
Community Improvement Division


GARY ARMSTRONG, AICP
Director of Economic & Development
Services/Deputy CEO

- Attachments:
1. State of California, Department of Health Care Services, Licensed Residential Facilities and/or Certified Alcohol and Drug Programs listing, Orange County, as of March 17, 2014, pp. 2-3, 161.
 2. 3132 Boston Way zoning map printout
 3. Sec. 13-6 (Definitions) of Article 2 (Definitions) of Chapter I (General) of Title 13 (Planning, Zoning and Development) with Land Use Matrix (prior to November 20, 2014)
 4. Ordinance 14-13 with updated Land Use Matrix (effective November 20, 2014)
 5. RealQuest Property Detail Report for 3132 Boston Way
 6. June 5, 2014 reasonable accommodation request letter
 7. August 19, 2014 City's denial of reasonable accommodation request letter
 8. August 26, 2014, Yellowstone Recovery appeal request
 9. Emails between DCA Elena Q. Gerli and Yellowstone's counsel setting up hearing date for October 13, 2014
 10. Letter from City to Yellowstone Recovery, dated September 22, 2014 setting appeal hearing for October 13, 2014
 11. Emails between DCA Elena Q. Gerli and Yellowstone's counsel re continuing the hearing to December 8, 2014
 12. Letter from City, dated October 8, 2014, continuing appeal hearing to December 8, 2014
 13. General Plan 2000, Chapter 2, Land Use Element
 14. California Quick Facts, US Census Bureau
 15. Households and Families: 2010, 2010 Census Briefs
 16. Patricia A. Shields, expert witness, resume, qualifications and references
 17. Letter opinion from Joan Ellen Zweben, Ph.D.
 18. Joan Ellen Zweben, Ph.D., *Curriculum Vitae*
 19. Letter opinion from Michael N. Brant-Zawadzki, M.D., F.A.C.R.
 20. Michael N. Brant-Zawadzki, M.D., F.A.C.R., *Curriculum Vitae*
 21. *Community Context of Sober Living Houses*, Douglas L. Polcin, Ed.D., et al., NIH Public Access Author Manuscript, December 1, 2012 (published in final edited form as *Addict Res Theory*. 2012 December 1; 20(6): 480-491. doi: 10.3109/16066359.2012.665967)

22. *Residential Treatment of Substance Abuse Disorders, Core Therapeutic Elements and Their Relationship to Effectiveness*, Practice Committee Consensus Report, State Association of Addiction Services, April 2013
23. *Recovery Housing: Assessing the Evidence*, Sharon Reif, Ph.D. at al., *Psychiatric Services*, March 2014 Vol. 65 No. 3
24. *Residential Treatment for Individuals With Substance Use Disorders: Assessing the Evidence*, Sharon Reif, Ph.D. at al., *Psychiatric Services*, March 2014 Vol. 65 No. 3
25. *Sober living houses for alcohol and drug dependence: 18-Month outcomes*, Douglas L. Polcin, Ed.D., et al., *Journal of Substance Abuse Treatment* 38 (2010) 356-365

Distribution: Director of Economic & Development/Deputy CEO
Assistant Development Services Director
Senior Deputy City Attorney
Public Services Director
City Engineer
Transportation Services Director
Fire Protection Analyst
Staff (6)
File (2)

Applicant c/o:
Steven G. Polin, ESQ.
3034 Tennyson Street N.W.
Washington, D.C. 20015

COSTA MESA PLANNING COMMISSION
MEETING DATE: DECEMBER 8, 2014
EVIDENCE PACKAGE FOR PUBLIC HEARING NO. 2

SUBJECT: APPEAL OF DENIAL OF REASONABLE ACCOMMODATION REQUEST TO TREAT YELLOWSTONE RECOVERY, 3132 BOSTON WAY, AS A SINGLE HOUSEKEEPING UNIT AND ALLOW 15 INDIVIDUALS TO LIVE IN THE SINGLE FAMILY HOME

FROM: PLANNING DEPARTMENT/DEVELOPMENT SERVICES DIVISION

FOR FURTHER INFORMATION CONTACT: JERRY GUARRACINO, AICP (714) 754-5631

Jerry.guarracino@costamesaca.gov



Attachment No. 1

State of California, Department of Health
Care Services, Licensed Residential
Facilities and/or Certified Alcohol and Drug
Programs listing, Orange County, as of
March 17, 2014, pp. 2-3, 161.

**DEPARTMENT OF HEALTH CARE SERVICES
LICENSING AND CERTIFICATION BRANCH
STATUS REPORT**

This is an alphabetical list by county of all non-medical alcoholism and drug abuse recovery or treatment facilities licensed and/or certified by the Department of Health Care Services.

To view facilities within a specific county, simply click on the county name below. For easier browsing and navigation through this report, please access the [“Page and Bookmark”](#) View option on your Adobe Reader.

[Alameda County](#)

[Alpine County](#)

[Amador County](#)

[Butte County](#)

[Calaveras County](#)

[Colusa County](#)

[Contra Costa County](#)

[Del Norte County](#)

[El Dorado County](#)

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[Siskiyou County](#)

[Solano County](#)

[Sonoma County](#)

[Stanislaus County](#)

[Sutter County](#)

[Tehama County](#)

[Trinity County](#)

[Tulare County](#)

[Tuolumne County](#)

[Ventura County](#)

[Yolo County](#)

[Yuba County](#)

COMMENTS?

We are always looking for ways to improve this document. If you have any comments or suggestions, please e-mail them to iross@dhcs.ca.gov, or contact the Licensing and Certification Branch at (916) 322-2911.

LEGEND

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES LICENSED RESIDENTIAL FACILITIES AND/OR CERTIFIED ALCOHOL AND DRUG PROGRAMS

- Program Name:** The facility/program name.
- Legal Name:** The legal name of the entity having the authority and responsibility for the operation of the facility or program.
- Address:** The facility/program address. The location where services are provided.
- City/State:** Name of the city where the facility/program is located.
- Record ID:** The identification number issued by the Department of Health Care Services (DHCS), Licensing and Certification Branch, for licensed facilities or certified programs. The last digit tells if the facility/program is a nonprofit (N) or profit (P) entity.
- Service Type:** Indicates if the facility/program is:
- o RES - Indicates facility licensed by the Department of Health Care Services (DHCS), the licensing authority for 24-hour residential nonmedical alcoholism or drug abuse recovery or treatment facilities serving adults.
 - o NON - Indicates a nonresidential program which has voluntarily applied to DHCS for alcohol and/or drug certification.
 - o DETOX - Indicates a free standing, 24-hour nonmedical detoxification facility licensed by DHCS.
 - o RES-DETOX - Indicates a facility licensed by DHCS to provide 24-hour residential nonmedical alcohol and/or drug recovery, treatment, and detoxification services for adults.
 - o DHS - Indicates licensure by the Department of Health Services, the licensing authority for medical alcohol and drug recovery or treatment facilities whose programs are certified by DHCS. Typically, these are Chemical Dependency Recovery Hospitals.
 - o DSS - Indicates licensure by the Department of Social Services, the licensing authority for residential facilities for individuals in need of care and supervision whose programs are certified by DHCS. Typically, these are group homes.
 - o COR - Indicates the facility is under the jurisdiction of the Department of Corrections (locked facility) whose program is certified by DHCS.
- Resident Capacity:** Indicates the maximum number of residents authorized by DHCS to receive recovery, treatment, or detoxification services at any one time in the residential facility.
- Total Occupancy:** Designates the maximum number of residential facility participants plus any dependent children, staff, or volunteers who may be housed in the facility. This occupancy is approved by the State or local fire authority.

(The resident capacity and total occupancy are only indicated for licensed residential facilities. Certified nonresidential facilities show "0" as the resident capacity and total occupancy.)

Target Population: Describes the targeted population of the facility or program.

- o 1.1 – Co-Ed
- o 1.2 – Men Only
- o 1.3 - Women Only
- o 1.4 - Women/Children
- o 1.5 – Youth/Adolescents
- o 1.7 – Families
- o 1.8 – Dual Diagnosis
- o 1.9 – Co-Ed/Children
- o 1.10 – Co-Ed/Youth
- o 1.11 – Men/Youth
- o 1.12 – Women/Youth
- o 1.13 – Co-Ed/Child/Dual
- o 1.14 – Women/Child/Dual

Expiration Date: Expiration date of the facility's current license and/or certification.

**State of California, Department of Health Care Services
Licensed Residential Facilities and/or
Certified Alcohol and Drug Programs**

As of: 03/17/2014

Orange County

Program Name: DAYLIGHT AGAIN
Legal Name: WOODGLEN RECOVERY JUNCTION, INCORPORATED
Address: 329 EAST COMMONWEALTH AVENUE
City, State: FULLERTON, CA 92832
Phone #: (714)879-6916 Fax #: (714)578-2960

Record ID: 300042CN
Service Type: RES
Resident Capacity: 16
Total Occupancy: 16
Target Population: 1.1
Expiration Date 01/31/2014

Program Name: YELLOWSTONE, WROC
Legal Name: YELLOWSTONE WOMEN'S FIRST STEP HOUSE, INC.
Address: 3132 BOSTON WAY
City, State: COSTA MESA, CA 92626
Phone #: (888)941-9048 Fax #: (714)646-5296

Record ID: 300121AN
Service Type: RES
Resident Capacity: 15
Total Occupancy: 15
Target Population: 1.2
Expiration Date 03/31/2015

Program Name: YELLOWSTONE WOMEN'S FIRST STEP HOUSE, INC.
Legal Name: YELLOWSTONE WOMEN'S FIRST STEP HOUSE, INC.
Address: 2183 FAIRVIEW ROAD, SUITE 103 AND 111
City, State: COSTA MESA, CA 92627
Phone #: (888)941-9048 Fax #: (949)646-5296

Record ID: 300121HN
Service Type: NON
Resident Capacity: 0
Total Occupancy: 0
Target Population: 1.1
Expiration Date 10/31/2015

Program Name: YELLOWSTONE (WOMEN'S RECOVERY OF CALIFORNIA)
Legal Name: YELLOWSTONE WOMEN'S FIRST STEP HOUSE, INC.
Address: 154 EAST BAY STREET
City, State: COSTA MESA, CA 92627
Phone #: (949)646-5296 Fax #: (888)941-9048

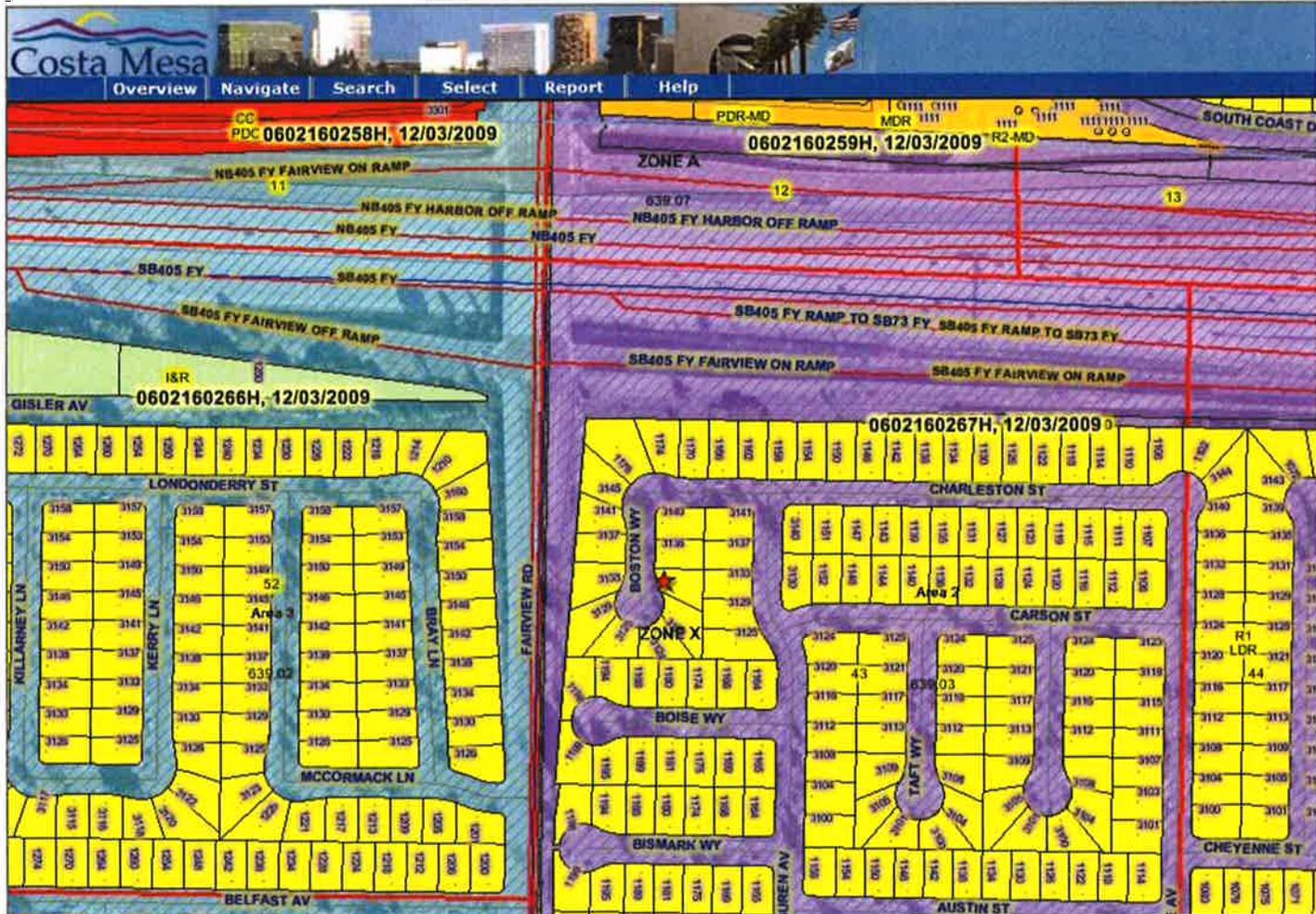
Record ID: 300121GN
Service Type: RES-DETOX
Resident Capacity: 6
Total Occupancy: 7
Target Population: 1.1
Expiration Date 05/31/2015

Program Name: THE YELLOWSTONE BRIDGE
Legal Name: YELLOWSTONE WOMEN'S FIRST STEP HOUSE, INC.
Address: 2028 FULLERTON AVENUE # A
City, State: COSTA MESA, CA 92627
Phone #: (949)646-4494 Fax #: (949)646-5296

Record ID: 300121FN
Service Type: RES
Resident Capacity: 6
Total Occupancy: 7
Target Population: 1.2
Expiration Date 08/31/2015

Attachment No. 2

3132 Boston Way zoning map printout



Attachment No. 3

Sec. 13-6 (Definitions) of Article 2
(Definitions) of Chapter I (General) of Title
13 (Planning, Zoning and Development) with
Land Use Matrix (prior to November 20,
2014)

Costa Mesa, California, Code of Ordinances >> TITLE 13 - PLANNING, ZONING AND DEVELOPMENT
>> CHAPTER I. - GENERAL >> ARTICLE 2. DEFINITIONS >>

ARTICLE 2. DEFINITIONS

Sec. 13-5. Purpose.

Sec. 13-6. Definitions.

Sec. 13-5. Purpose.

The intent of this article [is] to define certain words and phrases which are used in this Zoning Code. Additional definitions may also be given in conjunction with the special regulations contained in Chapter IX, Special Land Use Regulations, and Chapter XII, Special Fee Assessments.

(Ord. No. 97-11, § 2, 5-5-97)

Sec. 13-6. Definitions.

Abutting. Sharing a common boundary, of at least one (1) point.

Accessory building. A building or part of a building which is subordinate to, and the use of which is incidental to that of the main building or use on the same lot.

Accessory use. A use incidental and subordinate to, and devoted exclusively to the main use of the land or building thereon.

Adjacent. Same as abutting, but also includes properties which are separated by a public right-of-way, not exceeding one hundred twenty (120) feet in width.

Administrative adjustment. A discretionary entitlement, usually granted by the zoning administrator, which permits limited deviation from the strict application of the development standards contained in this Zoning Code, based on specified findings.

Adult business. See Chapter IX, Special Land Use Regulations, Article 1, Adult Businesses, for specific definitions and terms.

Alteration (structure). Any construction, addition or physical change in the internal arrangement of rooms or the supporting members of a structure, or change in the appearance of any structure, except paint.

Ambient noise level. The all-encompassing noise level associated with a given environment, being a composite of sounds from all sources, excluding the alleged offensive noise, at the location and approximate time at which a comparison with the alleged offensive noise is to be made.

Antenna. Any structure, including but not limited to a monopole, tower, parabolic and/or disk shaped device in single or multiple combinations of either solid or mesh construction, intended for

the purpose of receiving or transmitting communication to or from another antenna, device or orbiting satellite, as well as supporting equipment necessary to install or mount the antenna.

Antenna, amateur radio. An antenna array and its associated support structure, such as a mast or tower, that is used for the purpose of transmitting and receiving radio signals in conjunction with an amateur radio station licensed by the Federal Communications Commission.

Antenna, communication. All types of receiving and transmitting antennas, except satellite dish antennas and amateur radio antennas. Communication antenna includes, but is not limited to, cable television antennas, cellular radiotelephone cell antennas, FM digital communication antennas, microwave telephone communication antennas, and shortwave communication and other similar antennas.

Antenna height. The distance from the property's grade to the highest point of the antenna and its associated support structure when fully extended.

Antenna, satellite dish. An antenna intended for the purpose of receiving or transmitting communication to or from an orbiting satellite.

Antenna, whip. An antenna and its support structure consisting of a single, slender, rod-like element which is supported only at or near its base.

Apartment. A rental or lease dwelling having kitchen facilities in a structure designed or used to house at least one (1) family, as the term "family" is defined in this Zoning Code.

Assembly use. A use conducted in a structure or portion of a structure for the purpose of a civic, education, political, religious, or social function or for the consumption or receipt of food and/or beverages. Assembly use includes, but is not limited to, churches and other places of religious assembly, mortuaries, primary and secondary schools, trade and vocational schools, colleges, amusement centers, billiards parlors, bowling centers, establishments where food or beverages are served, motion picture theaters, physical fitness facilities, skating rinks, and dance, martial arts, and music studios. Assembly use does not include sexually oriented businesses.

Association (homeowners'). The organization of persons who own a lot, parcel, area, airspace, or right of exclusive occupancy in a common interest development and who have interests in the control of common areas of such project.

Attached (structure). Any structure that has a wall or roof in common with another structure.

Attic. Any non-habitable area immediately below the roof and wholly or partly within the roof framing.

Awning. A roof-like cover that projects from the wall of a building for the purpose of shielding the sun or providing an architectural accent.

Basement. A space wholly or partially underground and having more than one-half ($\frac{1}{2}$) of its height, measuring from floor to ceiling, below the average grade. If the finished floor level directly above the basement is more than four (4) feet above grade at any point, the basement shall be considered a story.

Building. Any structure having roof and walls and requiring permanent location on the ground, built and maintained for the support, shelter or enclosure of persons, animals, chattels or property of any kind.

Building height. The distance from the grade to the highest point on the roof, including roof-top mechanical equipment and screening.

Building, main. The building or buildings within which the principal use permitted on the lot is conducted.

Boardinghouse, large. A dwelling which has all of the characteristics of a small boardinghouse and which accommodates four (4) or more guests. Large boardinghouse includes, but is not limited to, a residence for a sorority or fraternity.

Boardinghouse, small. A dwelling which is designed or used to accommodate a maximum of three (3) guests, where guestrooms are provided in exchange for an agreed payment of a fixed amount of money or other compensation based on the period of occupancy.

Carport. A permanent, roofed structure, not completely enclosed which is used for vehicle parking.

Central administrative office. An establishment primarily engaged in management and general administrative functions performed centrally for other establishments of the same company.

Churches and other places of religious assembly. A type of assembly use which has the principal purpose of religious worship and for which the primary space is a sanctuary. Religious activities and services held in the sanctuary are conducted at scheduled times. The use may also include accessory facilities in the same or separate building that includes classrooms, assembly rooms, restrooms, kitchen, and a library. Other uses such as, but not limited to, day care facilities, nursery schools, schools, retail sales, and services to businesses, are not considered a primary function of churches and other places of religious assembly.

City. City of Costa Mesa.

Common area. Those portions of a project area which are designed, intended or used in common and not under the exclusive control or possession of owners or occupants of individual units in planned development projects or common interest developments.

Common interest development. A development as defined in State Civil Code Section 1350, containing two (2) or more common interest units, as defined in Civil Code Section 783; a community apartment project, as defined in State Business and Professional Code Section 11004, containing two (2) or more rights of exclusive occupancy; and a stock cooperative, as defined in Business and Professional Code Section 11003.2, containing two (2) or more rights of exclusive occupancy.

Conditional use permit. A discretionary approval usually granted by the planning commission which allows a use or activity not allowed as a matter of right, based on specified findings.

Convenience stores, mini-markets. A retail store, generally less than ten thousand (10,000) square feet in area, that sells a variety of convenience foods, beverages and non-food items. Fresh dairy products, produce and/or meat may be offered on a limited basis.

County. County of Orange.

Covered parking space. A garage, carport or parking space which is completely covered by a roof.

Density bonus. A minimum increase of twenty-five (25) per cent over the allowable residential dwelling unit density as specified by the zoning classification.

Development. The division of land into two (2) or more lots; the construction, reconstruction, conversion, structural alteration, relocation, or enlargement of any structure; any mining, excavation, landfill, or land disturbance; and any use or extension of the use of land.

Development review. The processing of a development plan when authority for approval is vested in the planning division.

Development services director. The director of development services of the City of Costa Mesa, or his/her designee.

Dormer. A vertical window in a projection built out from a sloping roof.

Driveway, common. A paved area for vehicle circulation and parking purposes which features joint use between two or more parties.

Driveway, individual. The paved area strictly leading to the garage/carport of a residence. This paved area serves vehicle parking purposes and does not extend beyond the garage/carport unless a curvilinear design is necessary for the turning radius.

Dwelling, single-family. "Dwelling, single-family" or "single-family dwelling" is a building of permanent character placed in a permanent location which is designed or used for residential occupancy by one (1) family. A single mobilehome on a foundation system on a single lot is a single-family dwelling. (See *Manufactured housing*).

Dwelling, multi-family. "Dwelling, multi-family" or "multi-family dwelling" is a building or buildings of permanent character placed on one (1) lot which is designed or used for residential occupancy by two (2) or more families.

Dwelling unit. One (1) or more rooms in any building designed for occupancy by one (1) family, and containing one (1) kitchen unit, including manufactured housing. (See *Manufactured housing*).

Easement. A grant of one (1) or more property rights by the owner for use by the public, a corporation or another person or entity.

Electronic game machine. Any electronic or mechanical device which upon insertion of a coin, slug, or token in any slot or receptacle attached to the device or connected therewith, operates, or which may be operated for use as a game, contest, or amusement through the exercise of skill or chance.

Emergency shelters. A facility that provides immediate and short-term housing for homeless persons that is limited to occupancy of six months or less. Supplemental services may include counseling and access to social programs. No individual or household may be denied to emergency shelter because of an inability to pay.

Entertainment (live). Any act, play, revue, pantomime scene, dance act, musical performance, or any combination thereof, performed by one (1) or more persons whether or not they are compensated for the performance.

Establishment where food or beverages are served. Any commercial use that sells prepared food and/or beverages for consumption on-site or off-site, either solely or in conjunction with an ancillary or complementary use. Excluded from this definition are grocery stores, convenience stores, movie theaters, and other such uses, as determined by the development services director, where the sale of food or beverages is clearly incidental to the primary use. All establishments selling alcoholic beverages for consumption on-site are included within this definition.

Family. One (1) or more persons occupying one (1) dwelling unit and living together as a single housekeeping unit.

Family day care home - large. A home which provides family day care to seven (7) to fourteen (14) children as defined in Section 1596.78 of the State Health and Safety Code.

Family day care home - small. A home which provides family day care to eight (8) or fewer children as defined in Section 1596.78 of the State Health and Safety Code.

Floor area ratio. The gross floor area of a building or project divided by the project lot area upon which it is located.

Garage. An accessory or attached enclosed building with doors, designed and/or used for vehicle parking.

Garage sale. An event for the purpose of selling or trading personal property. Garage sale includes yard sale.

General plan. The City of Costa Mesa General Plan as adopted or amended from time to time by the city council.

Grade. The lowest point of the finished surface elevation of either the ground, paving or sidewalk within the area between the building and the property line, or when the property line is more than five (5) feet from the building, between the building and a line five (5) feet from the building.

Gross acreage. The total area within the lot lines of a lot of land before public streets, easements or other areas to be dedicated or reserved for public use are deducted from such lot, and not including adjacent lands already dedicated for such purposes.

Gross floor area. The area of all floors within the walls of a structure except elevator and other vertical shafts (including stairwells) and elevator equipment areas.

Gross leasable area. The total floor area designed for tenant occupancy and exclusive use, including both owned and leased areas.

Group home. A residential facility designed or used for occupancy by persons that do not constitute a family.

Guestroom. A room occupied or intended, arranged, or designed for occupancy by one (1) or more guests.

Hazardous materials. Any material of quantity, concentration, physical or chemical characteristics, that poses a significant present or potential hazard to human health and safety or to the environment if released into the work place or environment; or any material requiring a Material Safety Data Sheet according to Title 8, Section 339 of the State Code of Regulation.

Height. See *Building height* and *Antenna height*.

Home occupation. Any business or commercial use conducted within a dwelling unit.

Hotel. Any building or combination of buildings generally three (3) or more stories in height containing six (6) or more guest rooms offering transient lodging accommodations to the general public and providing incidental guest services such as food and beverage service, recreation facilities, retail services and banquet, reception and meeting rooms. Typically, room access is provided through a main or central lobby.

Intersection. The general area where two (2) or more roadways join or cross.

Kitchen. Any room, all or part of which is designed and/or used for storage, refrigeration, cooking and preparation of food.

Landscaping. Plant materials such as lawn, groundcover, trees and shrubs.

Loft. An intermediate floor placed within a room, where the clear height above and below the loft is not less than seven (7) feet, and where the aggregate area of the loft does not exceed one third (1/3) of the area of the room in which it is located.

Lot.

- (a) A parcel of real property when shown as a delineated parcel of land with a number or designation on a subdivision map or parcel map recorded in the office of the county recorder, and created in conformance with the Subdivision Map Act and applicable local ordinances.
- (b) A parcel of real property when shown on a record of survey map or deed filed in the office of the county recorder, when such map or deed was filed as the result of and was made a condition of a lot division approved under the authority of prior ordinances.

Lot area. The total land area of a project after all required dedications or reservations for public improvements including but not limited to streets, parks, schools, and flood control channels. This phrase does not apply in the planned development zones where the phrase "site area", as defined in Chapter V, Development Standards, is used.

Lot, corner. A lot abutting on and at the intersection of two (2) or more streets which intersect at an angle that is equal to or less than one hundred thirty-five (135) degrees.

Lot, depth. The average of the horizontal distance between the front and the rear lot lines.

Lot, development. The master lot or project site upon which a development will be constructed.

Lot, individual dwelling unit. An individual building site or lot within a development intended for construction of a single attached or detached dwelling unit.

Lot, interior. A lot abutting only one (1) street, or a lot abutting two (2) streets which intersect at an angle greater than one hundred thirty-five (135) degrees.

Lot, width. The horizontal distance between the side lot lines measured at right angles to the lot depth at the front building setback line.

Manufactured housing. Detached housing that is built to the National Manufactured Housing Construction and Safety Standards Act of 1974, including structures known as manufactured homes and mobile homes. For the purpose of this Zoning Code, a factory-built single-family structure that is manufactured under the authority of 42 U.S.C. Section 5401, the National Manufactured Home Construction and Safety Standards Act, transportable in one (1) or more sections, built on a permanent chassis and used as a place of human habitation, shall be considered a single-family home and shall be reviewed under the same standards as a site-built structure.

Master plan. The overall development plan for a parcel or parcels which is depicted in both a written and graphic format.

Master plan of highways. The graphic representation of the city's ultimate circulation system contained in the general plan. It illustrates the alignment of the major, primary, secondary and collector highways.

Median. A paved or planted area separating a parking area, street, or highway, into two (2) or more lanes or directions of travel.

Medical marijuana dispensary. A facility or location where medical marijuana is cultivated or by any other means made available to and/or distributed by or to three (3) or more of the following: a primary caregiver, a qualified patient, or a person with an identification card in strict accordance with State Health and Safety Code Sections 11362.5 et seq. and 11362.7 et seq., which shall include, but not be limited to, any facility or location engaging in the retail sale, dispensation, or distribution of marijuana for medical purposes that does not have an active role in the cultivation of the marijuana product that it sells, dispenses, or distributes, or when its cultivation of the marijuana product is off-site from the facility or location for retail sale, dispensation, or distribution.

Minor conditional use permit. A discretionary approval granted by the zoning administrator which allows a use or activity not allowed as a matter of right, based on specified findings.

Minor modification. A discretionary entitlement granted by the planning division, which permits limited deviation from the strict application of the development standards contained in this Zoning Code, based on specified findings.

Mixed use development. The development of lot(s) or structure(s) with two (2) or more different land uses such as, but not limited to a combination of residential, office, manufacturing, retail, public, or entertainment in a single or physically integrated group of structures.

Mobile home. See *Manufactured housing*.

Mobile home park. Any area or tract of land where two (2) or more mobile home lots are rented or leased, held out for lease or rent, or were formerly held out for rent or lease and later converted to a subdivision, cooperative, condominium, or other form of resident ownership, to accommodate manufactured homes or mobile homes. A mobile home park also means a mobile home development constructed according to the requirements of Part 2.1 (commencing with Section 18200) of Division 13 of the State Health and Safety Code, and intended for use and sale as a mobile home condominium or cooperative park, or as a mobile home planned unit development.

Motel. Any building or combination of buildings of one (1) to three (3) stories in height having six (6) or more guest rooms with parking located convenient to the guest rooms and providing

temporary lodging for automobile tourists and transient visitors. Typically, guest rooms have direct access to available parking without passing through a common lobby area. Motels also include auto courts, tourist courts, motor lodges, motor inns and motor hotels.

Municipal Code. City of Costa Mesa Municipal Code.

Open space. An area that is intended to provide light and air, and is designed for either environmental, scenic or recreational purposes. Open space may include, but is not limited to, lawns, decorative planting, walkways, active and passive recreational areas, playgrounds, fountains, swimming pools, wooded areas; first floor decks; unenclosed patios with solid or lattice roofs; water courses; and surfaces covered by not more than five (5) feet in depth by projections which are at least eight (8) feet above grade.

Open space shall not include the following: driveways; parking lots; other surfaces designed or intended for vehicular travel; and upper floor decks, balconies or areas under projections which are less than eight (8) feet above grade.

Open space, common. An area of land reserved primarily for the leisure and recreational use of all residents of a planned development or common interest development and owned in common by them, generally through a homeowners' association.

Open space, private. An area of land located adjacent to an individual dwelling unit, owned or leased and maintained by its residents, and reserved exclusively for their use.

Organizational documents. The declaration of restrictions, articles of incorporation, bylaws, and any contracts for the maintenance, management or operation of all or any part of a project.

Parcel. Same as *Lot*.

Parkway. The area of a public street that lies between the curb and the adjacent property line or physical boundary definition, which is used for landscaping and/or passive recreational purposes.

Paved area. Ground surface covered with cobblestone, clay-fired bricks, concrete precast paver units, poured concrete with or without decorative surface materials, or asphaltic or rubber mixture which may include sand, stone, or gravel as an ingredient to create a hard surface. A graded natural surface or one covered with rolled stone or overlaid with loose gravel is not considered paved area.

Peak hour. The hour during the AM peak period (typically 7:00 a.m.—9:00 a.m.) or the PM peak period (typically 3:00 p.m.—6:00 p.m.) in which the greatest number of vehicle trips are generated by a given land use or are traveling on a given roadway.

Permitted use. Any use allowed in a land use zoning district without requiring a discretionary approval, and subject to the provisions applicable to that district.

Planned development. A land area which is developed as an integrated unit under single ownership or control and having planned development zoning designation.

Planning application. A broad term for any development project or land use which requires the discretionary review and approval of either the planning division, zoning administrator, planning commission, redevelopment agency or city council. Planning applications include administrative adjustments, conditional use permits, development reviews, variances, redevelopment actions, etc.

Project. See *Development*.

Property line. A line of record bounding a lot which divides one lot from another lot or from a public or private street or any other public space.

Property line, front. The narrowest property line of a lot abutting a public or private street. If two (2) or more equal property lines are narrowest, the front shall be that property line across which the development takes its primary access (if the primary access is determined to be equal, there shall be two (2) front property lines). However, for nonresidentially zoned property, any property line abutting a public street designated as a secondary, primary or major street on the master plan of highways shall be deemed a front property line. A nonresidentially zoned property shall have more than one (1) front property line when it abuts more than one street designated as secondary, primary, or major on the master plan of highways.

For R-1 zoned property located on corner lots, the front property line may be the property line towards which the front of the dwelling unit is oriented.

Property line, rear. The property line opposite the front property line. A corner lot with more than one (1) front property line shall have more than one (1) rear property line. Irregularly shaped lots may also have more than one (1) rear property line.

Property line, side. Any property line which is not a front or rear property line.

Property line, ultimate. The boundary of a lot after the dedication of land for use as public right(s)-of-way.

Public area - establishments where food or beverages are served. That portion of an establishment reserved for the exclusive use of the public for the receipt or consumption of food and/or beverages. For the purpose of this Zoning Code, public area shall not include restrooms, kitchens, hallways or other areas restricted to employees only.

Public hearing. A public proceeding conducted for the purpose of acquiring information or evidence which may be considered in evaluating a proposed action, and which affords to any affected person or persons the opportunity to present their views, opinions, and information on such proposed applications. "Mandatory hearings" are those required to be held by law, and "discretionary hearings" are those which may be held within the sole discretion of the hearing body.

Public right-of-way. A strip of land acquired by reservation, dedication, prescription or condemnation and intended to be occupied by a road, trail, water line, sanitary sewer and/or other public uses.

Recycling. The process by which waste products are reduced to raw materials and transformed into new products.

Recycling and collection facility. A building or enclosed space used for the collection and processing of recyclable materials for preparation for shipment, or to an end user's specifications, by such means as baling, briquetting, compacting, flattening, grinding, crushing, mechanical sorting, shredding, cleaning or remanufacturing.

Recyclable materials. Reusable materials including but not limited to metals, glass, plastic and paper which are intended for reuse, remanufacture or reconstruction. Recyclable materials do not include refuse, hazardous materials or hazardous waste.

Redevelopment action. A discretionary review conducted by the redevelopment agency for applications for development in the redevelopment project area, based on the adopted redevelopment plan and specified findings.

Referral facility. A residential care facility or a residential service facility where one (1) or more person's residency in the facility is pursuant to a court order or a directive from an agency in the criminal justice system. Referral facility does not include any residential care facility containing six (6) or fewer residents that is required to be treated as a single-family residential use by state law.

Residential, single-family. Detached single-family home where there is no more than one (1) primary dwelling unit on a lot.

Residential, multi-family. Apartments, common interest developments, townhouses and similar multiple-family residential developments, including detached single-family homes where there is more than one (1) primary dwelling unit on a lot.

Residential care facility. A residential facility licensed by the state where care, services, or treatment is provided to persons living in a community residential setting.

Residential service facility. A residential facility, other than a residential care facility, boardinghouse, or single housekeeping unit, where the operator provides to the residents personal services, in addition to housing, including, but not limited to, protection, supervision, assistance, guidance, training, therapy, or other nonmedical care.

Room, bedroom. A fully-enclosed room designed or intended to be used for sleeping purposes within a residence. Within a single-family detached residence, a room meeting the definition of a home office shall not be included in the bedroom count.

Room, home office. A room designed and intended to be used for a household office or small business related activity within a residence. Within a single-family detached residence, this room is strictly not intended for sleeping purposes, and lacks direct access to a bathroom. The home office may also be referred to as a studio, den, study or library.

Second unit. A second dwelling unit established in conjunction with and subordinate to a primary dwelling unit. The second unit may be attached to the primary dwelling unit or located in a detached accessory building on the same lot. It may also be referred to as an accessory apartment, granny unit, granny flat, or in-law apartment.

Senior congregate care facility. A structure(s) providing residence for thirteen (13) or more senior citizens with kitchen, dining, recreational, etc. facilities with separate bedrooms and/or living quarters.

Setback. The required distance that a building, structure, parking or other designated item must be located from a property line or lot line.

Single housekeeping unit means that the occupants of a dwelling unit have established ties and familiarity with each other, jointly use common areas, interact with each other, share meals, household activities, lease agreement or ownership of the property, expenses and responsibilities; membership in the single housekeeping unit is fairly stable as opposed to transient, and members have some control over who becomes a member of the single housekeeping unit.

Single room occupancy residential hotel. A residential hotel, allowed in certain commercial zones, that contains units designed for long-term occupancy by a single person, although double occupancy may be permitted.

Slope. The degree of deviation of a surface from the horizontal plane, usually expressed in per cent or degrees.

Small lot subdivision. A residential development containing a maximum of 15 detached or townhome style units with no common walls where each unit is independently constructed on an individual parcel and the land is subdivided into fee simple parcels containing each unit. Each individual lot is provided with either a direct access to public street/alley or an easement access through a recorded subdivision map.

Specific plan. A plan consisting of text, maps, and other documents and exhibits regulating development within a defined area of the city, consistent with the general plan and the provisions of State Government Code Section 65450 et seq.

State. State of California.

Story. For purposes related to zoning regulations, a story is that portion of a building included between the surface of any floor and the surface of the floor next above it. If there is no floor above it, then the space between such floor and the ceiling next above it shall constitute a story. An attic shall not be considered a story. A basement or cellar shall not be considered a story, if the finished floor level directly above the basement or cellar is less than four (4) feet above finish grade at all locations. Any uncovered deck or activity area above the first story shall be considered a story.

Street. A public or private thoroughfare that provides primary access to adjacent land and local traffic movements. Streets do not include driveways which only provide access to parking areas.

Structure. Anything, including a building, located on the ground in a permanent location or attached to something having a permanent location on the ground.

Supportive housing. Housing with no limit on length of stay, that is occupied by the target population, and that is linked to onsite or offsite services that assist the supportive housing resident in retaining the housing, improving his or her health status, and maximizing his or her ability to live and, when possible, work in the community. Supportive housing that is provided in single family dwelling, multi-family dwelling units, residential care facilities, or boarding house uses, shall be permitted, conditionally permitted or prohibited in the same manner as the other single family dwelling, multi-family dwelling units, residential care facilities, or boarding house uses under this Code.

Tandem parking. An arrangement of parking spaces one behind the other, such that a parking space must be driven across in order to access another space. Tandem garage parking signified the placement of standard parking spaces one behind the other within the enclosed area of a garage.

Townhouse. A single-family attached dwelling unit located on an individual dwelling unit lot, and is part of a row of units that contains three (3) or more dwelling units.

Transitional housing. A development with buildings configured as rental housing developments, but operated under program requirements that call for the termination of assistance

and recirculation of the assisted unit to another eligible program recipient at some predetermined future point in time, which shall be no less than six (6) months. Transitional housing that is provided in single family dwelling, multi-family dwelling units, residential care facilities, or boarding house uses, shall be permitted, conditionally permitted or prohibited in the same manner as the other single family dwelling, multi-family dwelling units, residential care facilities, or boarding house uses under this Code.

Trip (vehicle). A one-way vehicular journey either to or from a site, or totally within the site i.e. internal trip. Each trip has two (2) trip ends, one at the beginning and the other at the destination.

Trip rate (vehicular). The anticipated number of vehicle trips to be generated by a specific land use type or land use classification. The trip rate is expressed as a given number of vehicle trips for a given unit of development intensity (i.e., trip per unit, trip per one thousand (1,000) square feet, etc.).

Uncontrolled environment. A location where there is the exposure (to radiofrequency radiation) of individuals who have no knowledge or control of their exposure. The exposures may occur in living quarters or work places where there are no expectations that the exposure levels may exceed the exposure and induced current levels permitted for the general public.

Underroof. All of the area within the walls of the building that a roof covers. Areas under porches, roof overhangs, garage protrusions, breezeways and other similar architectural design features are not considered as underroof.

Unit. A particular building or structure, or portion thereof, that is designed, intended or used for exclusive occupancy, possession or control of individual owners or occupiers, whether or not they have interests in common areas of the project.

Use. The purpose (type and extent) for which land or a building is arranged, designed, or intended, or for which either land or a structure is occupied or maintained.

Warehouse, mini. A structure or group of structures for the dead storage of customer's goods and wares where individual stalls or lockers are rented out to different tenants for storage and where at least one of the stalls or lockers has less than five hundred (500) square feet of floor area.

Warehouse, public. A structure or group of structures for the dead storage of customer's goods and wares where individual stalls or lockers are rented out to different tenants for storage and where all the stalls or lockers have more than five hundred (500) square feet of floor area.

Vacancy rate (common lot development conversion). The ratio of vacant apartments being offered for rent or lease in the City of Costa Mesa, shown as a percentage of the total number of apartments in the city.

Variance. A discretionary entitlement, usually granted by the planning commission, which permits departure from the strict application of the development standards contained in this Zoning Code, based on specified findings.

Yard. Any open space on a lot unoccupied and unobstructed from the ground upward, except an inside court.

Yard, front. The yard between the front line of a building and the front line of the lot upon which the building is located.

Yard, rear. The yard extending from the extreme rear line of the main building to the rear lot line on which the building is situated.

Yard, side. The yard extending from the front yard, or from the front lot line where no front yard is required, to the rear yard or rear lot line, between the side lot line and the nearest wall of the main building or any accessory structure attached thereto.

Zero lot line. The location of a structure on a lot in such a manner that one (1) or more of the structure's sides rest directly on a lot line.

(Ord. No. 97-11, § 2, 5-5-97; Ord. No. 98-5, § 4, 3-2-98; Ord. No. 00-5, § 1(a), 3-20-00; Ord. No. 01-16, § 1a., 6-18-01; Ord. No. 05-11, § 2a., 7-19-05; Ord. No. 06-18, § 1, 9-5-06; Ord. No. 09-3, §§ 1a., b., 5-19-09; Ord. No. 09-4, § 1a., 5-5-09; Ord. No. 10-13, § 1, 10-19-10; Ord. No. 10-14, § 1, 11-16-10; Ord. No. 11-10, § 1, 9-20-11; Ord. No. 13-1, § 2A., 3-19-13; Ord. No. 13-05, § 1, 12-3-13; Ord. No. 14-04, § 2A., 4-1-14)

Costa Mesa, California, Code of Ordinances >> TITLE 13 - PLANNING, ZONING AND DEVELOPMENT
>> CHAPTER IV. CITYWIDE LAND USE MATRIX >>

CHAPTER IV. CITYWIDE LAND USE MATRIX

Sec. 13-30. Purpose.

Sec. 13-30. Purpose.

The purpose of this chapter is to provide a comprehensive list of uses which are permitted, conditionally permitted, or prohibited in the various zoning districts, as represented by Table 13-30, Land Use Matrix. In evaluating a proposed use, the following criteria shall also be considered:

- (a) Uses determined as permitted may be subject to a discretionary review when construction is proposed, pursuant to Chapter III, Planning Applications.
- (b) Uses proposed in the planned development zones are subject to verification of consistency with the master plan adopted for planned development zones. A proposed use not expressly allowed by the adopted master plan may require additional discretionary review pursuant to Table 13-30, Land Use Matrix.
- (c) All listed uses in the matrix are subject to verification of compliance with density and floor area ratio limits, parking requirements and performance standards which may, in certain cases, prevent the establishment of the use.
- (d) Any proposed use not listed in the Land Use Matrix shall be reviewed by the development services director to determine its similarity to another listed use. If no substantial similarity exists, the proposed use shall require approval of a conditional use permit prior to establishment of the use.
- (e) For the purpose of Table 13-30, Land Use Matrix, the various zoning districts are labeled as follows:
 - Residential zones: R1, R2-MD, R2-HD, and R3
 - Commercial zones: AP, CL, C1, C2, C1-S, and TC
 - Industrial zones: MG and MP
 - Planned Development Residential zones: PDR-LD, PDR-MD, PDR-HD, and PDR-NCM
 - Planned Development Commercial zone: PDC
 - Planned Development Industrial zone: PDI
 - The Parking zone: P
 - Institutional and Recreational zones: I & R and I & R-S
- (f) For zoning districts located in a specific plan area, please refer to the appropriate specific plan text to determine if any additional regulations related to land uses are applicable.
- (g) For the mixed-use overlay district located in an urban plan area, please refer to the appropriate urban plan text for additional regulations related to development standards and allowable land uses as applicable.

TABLE 13-30
CITY OF COSTA MESA LAND USE MATRIX

LAND USES	ZONES																					
	R 1	R 2 M D	R 2 H D	R 3	A P	C L	C 1	C 2	C 1 S ¹	T C ¹	M G	M P	P D R L D ¹	P D R M D ¹	P D R H D ¹	P D R N C M ¹	P D C ¹	P D I ¹	I & R ¹	I & R S ¹	P	
RESIDENTIAL USES																						
1. Single-family dwellings(single housekeeping units)	P ⁴	P	P	P	.	.	.	.	.	.	.	.	P	P	P	P	P	P	.	.	.
2. Multi-family dwellings	.	P	P	P	.	.	.	.	.	P	.	.	P	P	P	P	P	P	.	.	.
2.1 Common interest developments, residential	.	P	P	P	.	.	.	.	.	P	.	.	P	P	P	P	P	P	.	.	.
2.2 Small lot subdivisions, residential	.	P	P	P	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
3. Mobile home parks	.	C	C	C	.	.	.	.	.	.	.	.	C	C	C	C	C	C	.	.	.
4. Boardinghouse, large	.	C	C	C	.	.	.	.	.	.	.	.	.	C	C	C	C	C	.	.	.
5. Boardinghouse, small	P	P	P	P	.	.	.	.	.	.	.	.	P	P	P	P	P	P	.	.	.
6. Residential care facility (6 or fewer persons - State licensed)	P	P	P	P	.	.	.	.	.	.	.	.	P	P	P	P	P	P	P	.	.
7. Residential service facility (6 or fewer persons - not State licensed)	P	P	P	P	.	.	.	.	.	.	.	.	P	P	P	P	P	P	P	.	.
8. Residential care facility (7 or more persons - State licensed)	.	C	C	C	C	C	C	C	C	C	P	.	.
9. Residential service facility (7 or more persons - not State licensed)	.	C	C	C	C	C	C	C	C	C	P	.	.
10. Referral facility (subjects to the requirements of section 13-32.2 Referral facility)	.	C ²	C ²	C ²	.	.	.	C ²	.	.	.	.	.	C ²	C ²	.	.	.	.	.	.

33. Nursery schools - see also day care facilities for 15 or more children	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	P	.
34. Parks and playgrounds	C	C	C	C	.	.	.	.	.	C	.	.	C	C	C	C	C	C	P	P	.

LAND USES	ZONES																					
	R 1	R 2 M D	R 2 H D	R 3	A P	C L	C 1	C 2	C 1 S ¹	T C ¹	M G	M P	P D R L D ¹	P D R M D ¹	P D R H D ¹	P D R N C M ¹	P D C ¹	P D I ¹	I & R ¹	I & R S ¹	P	
35. Public offices and facilities, such as city halls, courthouses, police/fire stations, etc.	C	C	C	C	C	C	P	P	P	P	C	C	C	C	C	C	C	C	P	.	.	
36. Schools: primary, secondary and colleges	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	P	.	
37. Schools: trade and vocational	.	.	.	.	.	MC	P	P	P	P	MC	MC	.	.	.	.	P	MC	P	P	.
38. Senior congregate care facility	.	C	C	C	C	C	C	C	C	C	.	.	.	C	C	C	C	.	C	.	.	
39. Swap meets	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	C	C	.
39A. Emergency shelters	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	P	*	*	*
40. Work furlough facility	.	C	C	C	.	.	C	C	.	.	.	.	.	C	C	.	.	.	C	.	.
SPECIAL SEASONAL EVENTS																						
41. Christmas tree lots; Pumpkin patches; Fireworks stands; Produce stands (subject to the requirements of TITLE 9, CHAPTER II, REGULATION OF CERTAIN BUSINESSES)	p ²	p ²	p ²	p ²	p ²	p ²	p ²	p ²	.					
COMMERCIAL AND INDUSTRIAL USES																						
42. Acupressure; Massage (subject to the requirements of	.	.	.	.	p ²	p ²	p ²					

54. Barber and beauty shops	.	.	.	.	.	P	P	P	P	P	.	.	.	P	P	P	P	P	.	.	.
55. Billiards parlors	.	.	.	.	.	.	C	C	C	C	C	C	.	C	C	C	C	C	.	.	.
56. Botanical gardens; Zoos	.	.	.	.	.	.	C	C	C	C	.	.	.	.	.	.	.	.	C	.	.
57. Bowling centers	.	.	.	.	.	.	C	C	C	C	.	.	.	.	.	C	C	.	.	.	.
58. Breweries; Distilleries	.	.	.	.	.	.	.	.	.	C	C	.	.	.	.	.	.	.	.	.	.
59. Reserved																					
60. Building supplies; Hardware stores (retail)	.	.	.	.	.	.	P	P	P	.	.	.	.	P	P	P	P	.	.	.	.
61. Business services—See Offices																					
62. Car washes	.	.	.	.	.	.	C	C	C	C	C	C	.	C	C	C	C	C	.	.	.
63. Carts—Outdoor retail sales in conjunction with an established business	.	.	.	.	.	MC	MC	MC	MC	MC	MC	MC	.	MC	MC	MC	MC	MC	MC	.	.
64. Catering	.	.	.	.	.	MC	P	P	P	.	P	P	.	.	.	.	P	P	.	.	.
65. Coffee roasting	.	.	.	.	.	.	.	.	.	.	MC	MC	.	.	.	.	.	.	.	.	.
66. Coffee roasting (in conjunction with establishments where food or beverages are served)	.	.	.	.	.	.	MC	MC	MC	MC	MC	MC	.	MC	MC	MC	MC	MC	.	.	.
67. Commercial art; Graphic design	.	.	.	.	P	P	P	P	P	P	P	P	.	.	.	.	P	P	.	.	.
68. Commercial testing laboratories	.	.	.	.	.	.	.	.	.	P	P	.	.	.	.	.	P	.	.	.	.
69. Computer and data processing	.	.	.	.	P	P	P	P	P	P	P	P	.	.	.	.	P	P	.	.	.
70. Contracting: General contractors; Operative builders	.	.	.	.	.	C	C	P	C	.	P	P	.	.	.	.	.	P	.	.	.
71. Convenience stores; Mini-markets (subject to the requirements of CHAPTER IX, ARTICLE 16, LIQUOR STORES,	.	.	.	.	.	.	C ²	C ²	C ²	C ²	.	.	.	.	C ²	C ²	C ²	.	.	.	.

103. Motor vehicle, Boat, and Motorcycle retail sales, leasing, and rentals WITH 1 or less outdoor display parking space and no service (subject to verification of parking availability)																					
103.1 Motor vehicle and boat dismantling for salvage purposes	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
104. Motor vehicle service stations	.	.	.	.	.	.	C	C	C	.	.	.	.	.	.	.	C	.	.	.
105. Motor vehicle service stations with concurrent sale of alcoholic beverages (subject to requirements of CHAPTER IX, ARTICLE 3, CONCURRENT SALE OF ALCOHOLIC BEVERAGES AND MOTOR VEHICLE FUEL)	.	.	.	.	.	.	C ²	C ²	C ²	.	.	.	.	.	.	.	C ²	.	.	.
106. Motor vehicle; boat; and motorcycle repair services (including body and paint work), NOT WITHIN 200' of residential zone (subject to subsection 13-54 (b))	p ²	p ²	p ²	.	p ²	p ²	p ²	p ²	.	.	.
107. Motor vehicle; boat; and motorcycle repair services (including body and paint work), WITHIN 200' of residential zone (subject to subsection 13-54 (b))	C ²	C ²	C ²	.	C ²	C ²	C ²	C ²	.	.	.

108. Nurseries (retail with no bulk fertilizer)	.	.	.	.	.	C	C	P	P	.	C	C	.	.	.	.	.	.	.	.	.	.
109. Offices: Central administrative	.	.	.	.	P	P	P	P	P	P	P	P	.	.	.	.	P	P	.	.	.	.
110. Offices: Engineering; Architectural; and Surveying services management; Consulting and public relations	.	.	.	.	P	P	P	P	P	P	P	.	MC	MC	MC	P	P	.	.	.	.
111. Offices: General	.	.	.	.	P	P	P	P	P	P	C	C	.	C	C	C	P	P	.	.	.	
112. Offices: Management; Consulting and public relations	.	.	.	.	P	P	P	P	P	P	P	.	C	C	C	P	P	.	.	.	.
113. Offices: Medical and dental	.	.	.	.	P	P	P	P	P	P	.	.	.	C	C	C	P	C	C	.	.	
114. Offices: Services to businesses such as bookkeeping and data processing	.	.	.	.	P	P	P	P	P	P	P	.	.	.	.	P	P	.	.	.	.
115. Off-street parking lots and structures including related maintenance buildings	.	.	.	.	C	C	C	C	C	P	C	C	.	.	.	C	C	C	C	C	C	P
116. Off-street parking lots and structures, incidental uses within	.	.	.	.	MC	.	.	.	MC													
117. Oil fields; Oil wells (see CHAPTER XIV, OIL DRILLING)	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
118. Pawn Shops	.	.	.	.	.	C	C	C	C	.	.	.	.	.	.	.	.	.	.	.	.	.
119. Photocopying; Blueprinting and related services	.	.	.	.	.	P	P	P	P	P	P	P	.	.	.	.	P	P	.	.	.	.
120. Photofinishing laboratories	.	.	.	.	.	.	.	.	.	.	P	P	.	.	.	.	.	P	.	.	.	.
121. Photofinishing stores	.	.	.	.	.	P	P	P	P	P	.	.	.	.	.	.	P	P	.	.	.	.
122. Photography: Commercial	.	.	.	.	MC	MC	MC	P	P	MC	MC	MC	.	.	.	.	P	MC	.	.	.	.

123. Photography: Portrait studio	.	.	.	.	P	P	P	P	P	P	.	.	.	.	.	.	P	MC	.	.	.
124. Physical fitness facilities	.	.	.	.	.	.	C	C	C	C	C	C	.	.	.	.	C	C	.	.	.
125. Printing and publishing	.	.	.	.	.	.	C	P	C	C	P	P	.	.	.	.	P	P	.	.	.
126. Recording studios	.	.	.	.	.	.	C	C	C	.	MC	MC	.	.	.	.	C	MC	.	.	.
127. Recycling and collection facilities for nonhazardous materials	.	.	.	.	.	MC	MC	MC	MC	.	MC	MC	.	.	.	.	MC	MC	MC	MC	.
128. Research and development laboratories	.	.	.	.	C	C	C	P	C	C	P	P	.	.	.	.	.	P	.	.	.
129. Restaurants—See Establishments where food or beverages are served																					
130. Retail: General—See also Pawn Shops, Supermarkets, Grocery stores, Convenience stores; or Liquor stores	.	.	.	.	.	P	P	P	P	P	.	.	.	C	C	C	P	C	.	.	.
131. Retail, incidental sales to the main use (subject to the requirements of section 13-54(a) incidental retail sales)	.	.	.	.	P	P	P	P	P	P	p ²	p ²	.	P	P	P	P	p ²	.	.	.
132. Retail: Nonstore	.	.	.	.	P	P	P	P	P	P	P	P	.	P	P	P	P	P	.	.	.
133. Rifle, pistol, and firing ranges	.	.	.	.	.	.	.	.	.	.	C	C	.	.	.	.	.	.	C	.	.
134. Sexually-oriented businesses (subject to the requirements of TITLE 9, CHAPTER IV AND TITLE 13, CHAPTER IX, SEXUALLY-ORIENTED BUSINESSES)	.	.	.	.	.	p ²	p ²	p ²	p ²	.	.	.	.	.	.	.	.	p ²	.	.	.
135. Skating rinks	.	.	.	.	.	.	C	C	C	C	C	C	.	.	.	C	C	C	C	C	.

Attachment No. 4

Ordinance 14-13 with updated Land Use
Matrix (effective November 20, 2014)

ORDINANCE NO. 14-13

AN ORDINANCE OF THE CITY COUNCIL OF THE CITY OF COSTA MESA AMENDING SECTION 13-6 (DEFINITIONS) OF ARTICLE 2 (DEFINITIONS) OF CHAPTER I (GENERAL), ADDING CHAPTER XV (GROUP HOMES), AND REPEALING AND REPLACING ARTICLE 15 (REASONABLE ACCOMMODATIONS) OF CHAPTER IX (SPECIAL LAND USE REGULATIONS), OF TITLE 13 (ZONING CODE) AND AMENDING THE CITY OF COSTA MESA LAND USE MATRIX - TABLE NO. 13-30 OF CHAPTER IV. (CITYWIDE LAND USE MATRIX) OF THE COSTA MESA MUNICIPAL CODE RELATING TO GROUP HOMES

THE CITY COUNCIL OF THE CITY OF COSTA MESA MAKES THE FOLLOWING FINDINGS WITH RESPECT TO THE ADOPTION OF THE FOLLOWING ORDINANCE:

WHEREAS, under the California Constitution, Article XI, Section 7, the City has been granted broad police powers to preserve the single-family characteristics of its single-family neighborhoods, which powers have been recognized by both the California Supreme Court and United States Supreme Court, the latter of which has stated that, "It is within the power of the legislature to determine that the community should be beautiful as well as healthy, spacious as well as clean, well-balanced as well as carefully patrolled"; and

WHEREAS, both the California Supreme Court and United States Supreme Court have held that cities have the right to regulate both the number of people who may reside in a single family home and the manner in which the single family is used as long as such regulations do not unfairly discriminate or impair an individual's rights of privacy and association; and

~~WHEREAS, individuals and families often purchase homes in single-family neighborhoods for the relative tranquility and safety that often accompanies such neighborhoods and with the expectation of establishing close and long-standing ties with their neighbors; and~~

WHEREAS, with these expectations, individuals and families commit to making what will be, for most of them, the single largest financial investment of their lives, as well as one of the most significant emotional investments; and

WHEREAS, the Federal Fair Housing Act Amendments ("FHAA") and the California Fair Employment Housing Act ("FEHA") prohibit enforcement of zoning ordinances which would on their face or have the effect of discriminating against equal housing opportunities for the handicapped; and

WHEREAS, a core purpose of the FHAA, FEHA and California's Lanterman Act is to provide a broader range of housing opportunities to the handicapped; to free the handicapped, to the extent possible, from institutional style living; and to ensure that handicapped persons have the opportunity to live in normal residential surroundings and

use and enjoy a dwelling in a manner similar to the way a dwelling is enjoyed by the non-handicapped; and

WHEREAS, to fulfill this purpose the FHAA and FEHA also require that the City provide reasonable accommodation to its zoning ordinances if such accommodation is necessary to afford a handicapped person an equal opportunity to use and enjoy a dwelling; and

WHEREAS, the Lanterman Act fulfills this purpose in part by requiring cities to treat state licensed residential care facilities serving six or fewer as a residential use; and

WHEREAS, in enacting this Ordinance the City Council of the City of Costa Mesa is attempting to strike a balance between the City's and residents' interests of preserving the single family characteristics of single-family neighborhoods and to provide opportunities for the handicapped to reside in single-family R1 zones that are enjoyed by the non-handicapped; and

WHEREAS, over the past several years the City, County and State have seen a significant increase in the number of single-family homes being utilized as alcohol and drug recovery facilities for large numbers of individuals (hereafter, "sober living homes"); and

WHEREAS, the increase appears to be driven in part by the Substance Abuse and Crime Prevention Act of 2000 (hereafter, "the Act") adopted by California voters which provides that specified first-time drug and alcohol offenders are to be afforded the opportunity to receive substance abuse treatment rather than incarceration; and

WHEREAS, the Affordable Care Act has significantly expanded the availability of health care coverage for substance abuse treatment; and

WHEREAS, the City of Costa Mesa has seen a sharp increase of sober living homes, which has generated community outcry and complaints including, but not limited to overcrowding, inordinate amounts of second-hand smoke, and noise; and the clustering of sober living facilities in close proximity to each other creating near neighborhoods of sober living homes; and

WHEREAS, this significant increase in sober living homes has become an rising concern for cities statewide as local officials are in some cases being bombarded with complaints from residents about the proliferation of sober living homes; conferences drawing local officials from around the state are being held discussing what to do about the problems associated with sober living homes; it has been the topic of several League of California Cities meetings; there have been numerous city-sponsored attempts at legislative fixes that have failed in committee; and litigation is spreading across the state as cities attempt to address the problem; and

WHEREAS, as of the date of adoption of this Ordinance, it is estimated that the City of Costa Mesa is home to 1,214 alcohol and drug recovery beds, divided as follows: 40 licensed residential facilities/certified alcohol and drug programs in residential zones, providing 398 beds; 94 unlicensed sober living homes in residential zones, providing 740 beds; and 1 sober living home on two separate parcels, providing 76 beds in a non-residential zone; and 28 nonresidential services facilities, providing support services such as administrative offices, therapy etc.; and

WHEREAS, the number of sober living homes in the City of Costa Mesa is rapidly increasing, leading to an overconcentration of sober living homes in the City's R1 neighborhoods, which is both deleterious to the single-family character of the R1 neighborhoods and may also lead to the institutionalization of such neighborhoods; and

WHEREAS, the purpose of sober living homes is to provide a comfortable living environment for persons with drug or alcohol addictions in which they remain clean and sober and can participate in a recovery program in a residential, community environment, and so that they have the opportunity to reside in the single family neighborhood of their choice; and

WHEREAS, recovering alcoholics and drug addicts, who are not currently using alcohol or drugs, are considered handicapped under both the FHAA and FEHA; and

WHEREAS, concentrations of sober living homes and/or the placement of inordinately large numbers of recovering addicts in a single dwelling can undermine the benefits of home ownership in single-family neighborhoods for those residing nearby and undermine the single-family characteristics of neighborhoods; and

WHEREAS, in some cases, operators of sober living homes have attempted to house inordinately large numbers of recovering addicts in a single-family dwelling in Costa Mesa; for example, in one case an operator has placed 15 beds in a single-family home; and there has been a tendency for sober living homes to congregate in close proximity (for example, five sober living homes are located next to each other on one street in a R1 zone); and

WHEREAS, the City has experienced situations in which single-family homes are remodeled to convert common areas such as family rooms, dressing rooms, and garages into bedrooms (in one case a patio was converted to a room where 6 beds were found) or to add multiple bedrooms for the sole purpose of housing large numbers of recovering addicts in a single dwelling; and

WHEREAS, it has been the City's experience that most, if not all, operators of sober living homes have taken the stance that the FHAA and FEHA prohibit the City from regulating them in any fashion, that they are free to house as many recovering addicts in a single home as they desire, and that they are not required to make any showing to obtain an accommodation from the City's zoning ordinances, which allow a sober living home to house up to six recovering addicts as a matter of right; and

WHEREAS, based on the City's experience it has become clear that at least some operators of sober living homes are driven more by a motivation to profit rather than to provide a comfortable living environment in which recovering addicts have a realistic potential of recovery, or to provide a living environment which remotely resembles the manner in which the non-disabled use and enjoy a dwelling; and

WHEREAS, this Ordinance and the balance of the City's zoning scheme have built in an accommodation for group homes to locate in the R1 neighborhoods as long as they are serving six or fewer tenants, whereas a similarly situated and functioning home with non-handicapped tenants would be defined as a boarding house and only be allowed three residents; and

WHEREAS, this Ordinance will provide a mechanism for a group home to seek additional accommodation above the six residents upon making a showing, as required by state and federal law, that such additional accommodation is reasonably necessary to afford the handicapped the right to use and enjoy a dwelling in a manner similar to that enjoyed by the non-handicapped; and

WHEREAS, permitting six or fewer residents in a sober living home and establishing distance requirements is reasonable and non-discriminatory and not only helps preserve the single family characteristic of single family neighborhoods, but also furthers the purpose for which sober living homes are established: (1) the State legislature in establishing licensed residential care facilities as a residential use, including group homes serving recovering addicts, found that six residents was a sufficient number to provide the supportive living environment that experts agree is beneficial to recovery; (2) Group Homes serving six or fewer have existed and flourished in the State for decades and there has been no significant efforts or suggestions to increase the number; (3) the City has received expert testimony stating that six is a reasonable number for a sober living facility and is sufficient to provide the supportive living environment that is beneficial to recovery and that larger numbers can actually reduce the chances of recovery; (4) a 2005 UCLA study found that 65-70% of recovering addicts do not finish the recovery programs into which they are placed and a comfortable living environment is a factor in whether recovering addicts will finish their programs; (5) drug and alcohol addiction is known to affect all income levels and there is no evidence in the record that individuals residing in sober living homes are financially unable to pay market rate rents and certainly the experience in the City of Newport Beach, where rents and property are among the most expensive in Orange County, is evidence that such addiction has a profound effect on the wealthy; (6) in any event, receiving rent from up to six individuals will provide sufficient income for operators of sober living homes and result in revenue which is well above market rate rents; (7) the evidence in the record indicates that in general operators of sober living homes do not incur significant costs over and above what landlords of other similarly-situated homes may incur; and (8) limiting the number of recovering addicts that can be placed in a single-family home enhances the potential for their recovery; and

WHEREAS, sober living homes do not function as a single-family unit nor do they fit the City's zoning definition of a single-family for the following reasons: (1) they house

extremely transient populations (programs are generally about 90 days and as noted, the 2005 UCLA study found that 65-70% of recovering addicts don't finish their recovery programs); (2) the residents generally have no established ties to each other when they move in and typically do not mingle with other neighbors; (3) neighbors generally do not know who or who does not reside in the home; (4) the residents have little to no say about who lives or doesn't live in the home; (5) the residents do not generally share expenses; (6) the residents are often responsible for their own food, laundry and phone; (7) when residents disobey house rules they are often just kicked out of the house; (8) the residents generally do not share the same acquaintances; and (9) residents often pay significantly above-market rate rents; and

WHEREAS, the size and makeup of the households in sober living homes, even those allowed as a matter of right under the Costa Mesa Municipal Code, is dissimilar and larger than the norm, creating impacts on water, sewer, roads, parking and other City services that are far greater than the average household, in that the average number of persons per California household is 2.90 (2.74 in Costa Mesa's R1 zones according to the City's General Plan), while a sober living facility allowed as a matter of right would house six, which is in the top 5% of households in Orange County according to the most recent U.S. federal census data; and

WHEREAS, all of six individuals residing in a sober living facility are generally over the age of 18, while the average household has just 2.2 individuals over the age of 18 according to the most recent federal census data; and

WHEREAS, the City utilizes federal census data and other information relating to the characteristics of single-family neighborhoods for among other things: (1) determining the design of residential homes, residential neighborhoods, park systems, library systems, transportation systems; (2) determining parking and garage requirements of single-family homes; (3) developing its General Plan and zoning ordinances; (4) determining police and fire staffing; (5) determining impacts to water, sewer and other services; and (5) in establishing impacts fees that fairly and proportionally fund facilities for traffic, parks, libraries, police and fire; and

WHEREAS, because of their extremely transient populations, above-normal numbers of individuals/adults residing in a single home and the lack of regulations, sober living facilities present problems not typically associated with more traditional single-family uses, including: the housing of large numbers of unrelated adult who may or may not be supervised; disproportionate numbers of cars associated with a single-family home which causes disproportionate traffic and utilization of on-street parking; excessive noise and outdoor smoking, which interferes with the use and enjoyment of neighbors' use of their property; neighbors who have little to no idea who does and does not reside in the home; little to no interaction with the neighborhood; a history of opening facilities in complete disregard of the Costa Mesa Municipal Code and with little disregard for impacts to the neighborhood; disproportional impacts from the average dwelling unit to nearly all City services including sewer, water, parks, libraries, transportation infrastructure, fire and

police; a history of congregating in the same general area; and the potential influx of individuals with a criminal record; and

WHEREAS, a 650-foot distance requirement provides a reasonable market for the purchase and operation of a sober living home within the City and still results in preferential treatment for sober living homes in that non-handicapped individuals in a similar living situation (i.e., in boardinghouse-style residences) cannot reside in the R1 zone; and

WHEREAS, housing inordinately large numbers of unrelated adults in a single-family home or congregating sober living homes in close proximity to each other does not provide the handicapped with an opportunity to "live in normal residential surroundings," but rather places them into living environments bearing more in common with the types of institutional/campus/dormitory living that the FEHA and FHAA were designed to provide relief from for the handicapped, and which no reasonable person could contend provides a life in a normal residential surrounding; and

WHEREAS, notwithstanding the above, the City Council recognizes that while not in character with a single-family neighborhood, that when operated responsibly, a group homes, including sober living homes, provide a societal benefit by providing the handicapped the opportunity to live in single-family neighborhoods, as well as providing recovery programs for individuals attempting to overcome their drug and alcohol addictions, and that therefore providing greater access to R1 zones to group homes, including sober living homes, than to boardinghouses provides a benefit to the City and its residents; and

WHEREAS, without some regulation there is no way of ensuring that the individuals entering into a group home are handicapped individuals and entitled to reasonable accommodation under local and state law; that a group home is operated professionally to minimize impacts to the surrounding neighborhood; and that the secondary impacts from over concentration of both group homes in a neighborhood and large numbers of unrelated adults residing in a single facility in a single home are lessened; and

WHEREAS, in addition to group homes locating in single-family neighborhoods other state-licensed residential care facilities for six or fewer persons who are mentally disordered or otherwise handicapped or supervised, are also taking up residence in single-family neighborhoods; and

WHEREAS, the purpose of group homes for the handicapped is to provide the handicapped an equal opportunity to comfortably reside in the single family neighborhood of their choice; and

WHEREAS, this Ordinance has been reviewed for compliance with the California Environmental Quality Act (CEQA), the CEQA guidelines, and the City's environmental procedures, and has been found to be exempt pursuant to Section 15061 (b)(3) (General

Rule) of the CEQA Guidelines, in that the City Council hereby finds that it can be seen with certainty that there is no possibility that the passage of this Ordinance will have a significant effect on the environment.

NOW, THEREFORE, THE CITY COUNCIL OF THE CITY OF COSTA MESA DOES ORDAIN AS FOLLOWS:

Section 1: The following definitions in Section 13-6 (Definitions) of Article 2 (Definitions) of Chapter 1 (General) of Title 13 (Planning, Zoning and Development) are hereby repealed, amended or added as follows:

Alcoholism or drug abuse recovery or treatment facility means adult alcoholism or drug abuse recovery or treatment facilities that are licensed pursuant to Section 11834.01 of the California Health & Safety Code. *Alcoholism or drug abuse recovery or treatment facilities* are a subset of residential care facilities.

Boardinghouse A residence or dwelling, other than a hotel, wherein rooms are rented under three or more separate written or oral rental agreements, leases or subleases or combination thereof, whether or not the owner, agent or rental manager resides within the residence. Boardinghouse, small means two or fewer rooms being rented. Boardinghouse, large means three or more rooms being rented.

Development Services Department means the Development Services Department of the City of Costa Mesa.

Disabled shall have the same meaning as *handicapped*.

Fair housing laws means the Federal Fair Housing Act, the Americans with Disabilities Act, and the California Fair Employment and Housing Act, as each statute may be amended from time to time, and each statute's implementing regulations.

Group home. A facility that is being used as a supportive living environment for persons who are considered handicapped under state or federal law. A group home operated by a single operator or service provider (whether licensed or unlicensed) constitutes a single facility, whether the facility occupies one or more dwelling units. Group homes shall not include the following: (1) residential care facilities; (2) any group home that operates as a single housekeeping unit.

Handicapped. As more specifically defined under the fair housing laws, a person who has a physical or mental impairment that limits one or more major life activities, a person who is regarded as having that type of impairment, or a person who has a record of that type of impairment, not including current, illegal use of a controlled substance.

Household includes all the people occupying a dwelling unit, and includes people who live in different units governed by the same operator.

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Integral facilities. Any combination of two or more group homes which may or may not be located on the same or contiguous parcels of land, that are under the control and management of the same owner, operator, management company or licensee or any affiliate of any of them, and are integrated components of one operation shall be referred to as Integral Facilities and shall be considered one facility for purposes of applying federal, state and local laws to its operation. Examples of such Integral Facilities include, but are not limited to, the provision of housing in one facility and recovery programming, treatment, meals, or any other service or services to program participants in another facility or facilities or by assigning staff or a consultant or consultants to provide services to the same program participants in more than one licensed or unlicensed facility.

Integral uses. Any two or more residential care programs commonly administered by the same owner, operator, management company or licensee, or any affiliate of any of them, in a manner in which participants in two or more care programs participate simultaneously in any care or recovery activity or activities so commonly administered. Any such integral use shall be considered one use for purposes of applying federal, state and local laws to its operation.

Operator means a company, business or individual who provides residential services, i.e., the placement of individuals in a residence, setting of house rules, and governing behavior of the residents as residents. Operator does not include a property owner or property manager that exclusively handles real estate contracting, property management and leasing of the property and that does not otherwise meet the definition of operator.

Planning division. The planning division of the Development Services Department of the City of Costa Mesa.

Referral facility. A residential care facility or a group home where one (1) or more person's residency in the facility is pursuant to a court order or directive from an agency in the criminal justice system.

Residential care facility. A residential facility licensed by the state where care, services, or treatment is provided to persons living in a supportive community residential setting. Residential care facilities include but may not be limited to the following: intermediate care facilities for the developmentally disabled (Health & Saf. Code §§ 1267.8, 1267.9); community care facilities (Health & Saf. Code §§ 1500 et seq.); residential care facilities for the elderly (Health & Saf. Code §§ 1569 et seq.); residential care facilities for the chronically ill (22 C.C.R. § 87801(a)(5); Health & Saf. § 1568.02); alcoholism and drug abuse facilities (Health & Saf. Code §§ 11834.02-11834.30); pediatric day health and respite care facilities (Health & Saf. Code §§ 1760 et seq.); residential health care facilities, including congregate living health facilities (Health & Saf. Code §§ 1265 – 1271.1, 1250(i), 1250(e), (h)); family care home, foster home, group home for the mentally disordered or otherwise handicapped persons or dependent and neglected children (Wel. & Inst. Code §§ 5115-5120).

[*Residential services facilities* is hereby deleted.]

Single housekeeping unit means that the occupants of a dwelling unit have established ties and familiarity with each other, jointly use common areas, interact with each other, share meals, household activities, and expenses and responsibilities; membership in the single housekeeping unit is fairly stable as opposed to transient, members have some control over who becomes a member of the household, and the residential activities of the household are conducted on a nonprofit basis. There is a rebuttable presumption that integral facilities do not constitute single housekeeping units. Additional indicia that a household is not operating as a single housekeeping unit include but are not limited to: the occupants do not share a lease agreement or ownership of the property; members of the household have separate, private entrances from other members; members of the household have locks on their bedroom doors; members of the household have separate food storage facilities, such as separate refrigerators.

Sober living home means a group home for persons who are recovering from a drug and/or alcohol addiction and who are considered handicapped under state or federal law. Sober living homes shall not include the following: (1) residential care facilities; (2) any sober living home that operates as a single housekeeping unit.

Section 2: Chapter XV (Group Homes) of Title 13 (Planning, Zoning and Development) is hereby added as follows:

Chapter XV: Group homes.

13-310 Purpose.

This chapter is intended to preserve the residential character of single-family residential neighborhoods and to further the purposes of the FEHA, the FHAA and the Lanterman Act by, among other things: (1) ensuring that group homes are actually entitled to the special accommodation and/or additional accommodation provided under the Costa Mesa Municipal Code and not simply skirting the City's boarding house regulations; (2) limiting the secondary impacts of group homes by reducing noise and traffic, preserving safety and providing adequate on street parking; (3) providing an accommodation for the handicapped that is reasonable and actually bears some resemblance to the opportunities afforded non-handicapped individuals to use and enjoy a dwelling unit in a single-family neighborhood; and (4) to provide comfortable living environments that will enhance the opportunity for the handicapped and for recovering addicts to be successful in their programs.

13-311 Special use permit required.

- (a) A group home that may otherwise be considered an unpermitted use may locate in an R1 zone with a special use permit provided:

1. An application for a group home is submitted to the director by the owner/operator of the group home. The application shall provide the following: (1) the name, address, phone number and driver's license number of the owner/operator; (2) the name, address, phone number and driver's license number of the house manager; (3) a copy of the group home rules and regulations; (4) written intake procedures; (5) the relapse policy; (6) an affirmation by the owner/operator that only residents (other than the house manager) who are handicapped as defined by state and federal law shall reside at the group home; (7) blank copies of all forms that all residents and potential residents are required to complete; and (8) a fee for the cost of processing of the application as set by Resolution of the City Council. No person shall open a group home or begin employment with a group home until this information has been provided and such persons shall be responsible for updating any of this information to keep it current.
2. The group home has six (6) or fewer occupants, not counting a house manager, but in no event shall have more than seven occupants. If the dwelling unit has a secondary accessory unit, occupants of both units will be combined to determine whether or not the limit of six (6) occupants has been exceeded.
3. The group home shall not be located in an accessory secondary unit unless the primary dwelling unit is used for the same purpose.
4. The group home has a house manager who resides at the group home or any multiple of persons acting as a house manager who are present at the group home on a 24-hour basis and who are responsible for the day-to-day operation of the group home.
5. All garage and driveway spaces associated with the dwelling unit shall, at all times, be available for the parking of vehicles. Residents and the house manager may each only store or park a single vehicle at the dwelling unit or on any street within 500 feet of the dwelling unit. The vehicle must be operable and currently used as a primary form of transportation for a resident of the group home.
6. Occupants must not require and operators must not provide "care and supervision" as those terms are defined by Health and Safety Code Section 1503.5 and Section 80001(c)(3) of title 22, California Code of Regulations.
7. Integral group home facilities are not permitted. Applicants shall declare, under penalty of perjury, that the group home does not operate as an integral use/facility.
8. If the group home operator is not the property owner, written approval from the property owner to operate a group home at the property.

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9. The property must be fully in compliance with all building codes, municipal code and zoning code
10. In addition to the regulations outlined above, the following shall also apply to sober living homes:
 - i. The sober living home is not located within 650 feet, as measured from the closest property lines, of any other sober living home or a state licensed alcoholism or drug abuse recovery or treatment facility.
 - ii. All occupants, other than the house manager, must be actively participating in legitimate recovery programs, including, but not limited to, Alcoholics Anonymous or Narcotics Anonymous and the sober living home must maintain current records of meeting attendance. Under the sober living home's rules and regulations, refusal to actively participate in such a program shall be cause for eviction.
 - iii. The sober living home's rules and regulations must prohibit the use of any alcohol or any non-prescription drugs at the sober living home or by any recovering addict either on or off site. The sober living home must also have a written policy regarding the possession, use and storage of prescription medications. The facility cannot dispense medications but must make them available to the residents. The possession or use of prescription medications is prohibited except for the person to whom they are prescribed, and in the amounts/dosages prescribed. These rules and regulations shall be posted on site in a common area inside the dwelling unit. Any violation of this rule must be cause for eviction under the sober living home's rules for residency and the violator cannot be re-admitted for at least 90 days. Any second violation of this rule shall result in permanent eviction. Alternatively, the sober living home must have provisions in place to remove the violator from contact with the other residents until the violation is resolved.
 - iv. The number of occupants subject to the sex offender registration requirements of Penal Code Section 290 does not exceed the limit set forth in Penal Code Section 3003.5 and does not violate the distance provisions set forth in Penal Code Section 3003.
 - v. The sober living home shall have a written visitation policy that shall preclude any visitors who are under the influence of any drug or alcohol.

- vi. The sober living home shall have a good neighbor policy that shall direct occupants to be considerate of neighbors, including refraining from engaging in excessively loud, profane or obnoxious behavior that would unduly interfere with a neighbor's use and enjoyment of their dwelling unit. The good neighbor policy shall establish a written protocol for the house manager/operator to follow when a neighbor complaint is received.
- vii. The sober living home shall not provide any of the following services as they are defined by Section 10501(a)(6) of Title 9, California Code of Regulations: detoxification; educational counseling; individual or group counseling sessions; and treatment or recovery planning.

11. An applicant may seek relief from the strict application of this Section by submitting an application to the director setting forth specific reasons as to why accommodation over and above this section is necessary under state and federal laws, pursuant to Section 13-200.62.

(b) The special use permit shall be issued by the director as a ministerial matter if the applicant is in compliance or has agreed to comply with subsections (a)(1) through (a)(9) above. The special use permit shall be denied, and if already issued, any transfer shall be denied or revoked, upon a hearing by the director under any of the following circumstances:

1. Any owner/operator or staff person has provided materially false or misleading information on the application or omitted any pertinent information;
2. Any owner/operator or staff person has an employment history in which he or she was terminated during the past two years because of physical assault, sexual harassment, embezzlement or theft; falsifying a drug test; and selling or furnishing illegal drugs or alcohol.
3. Any owner/operator or staff person has been convicted of or pleaded *nolo contendere*, within the last seven to ten years, to any of the following offenses:
 - i. Any sex offense for which the person is required to register as a sex offender under California Penal Code Section 290 (last 10 years);
 - ii. Arson offenses – violations of Penal Code Sections 451-455 (last seven years); or
 - iii. Violent felonies, as defined in Penal Code Section 667.5, which involve doing bodily harm to another person (last 10 years).
 - iv. The unlawful sale or furnishing of any controlled substances (last seven years).

4. Any owner/operator or staff person is on parole or formal probation supervision on the date of the submittal of the application or at any time thereafter.
5. The owner/operator accepts residents, other than a house manager, who are not handicapped as defined by the FHAA and FEHA.
6. A special use permit for a sober living home shall also be denied, and if already issued, any transfer shall be denied or revoked, upon a hearing by the director under any of the following additional circumstances:
 - i. Any owner/operator or staff person of a sober living home is a recovering drug or alcohol abuser and upon the date of application or employment has had less than one full year of sobriety.
 - ii. The owner/operator of a sober living home fails to immediately take measures to remove any resident who uses alcohol or illegally uses prescription or non-prescription drugs, or who is not actively participating in a legitimate recovery program from contact with all other sober residents.
 - iii. The sober living home, as measured by the closest property lines, is located within 650 feet of any other sober living home or state licensed alcoholism or drug abuse recovery or treatment facility. If a state licensed alcoholism or drug abuse recovery or treatment facility moves within 650 feet of an existing sober living home this shall not cause the revocation of the sober living home's permit or be grounds for denying a transfer of such permit.
7. For any other significant and/or repeated violations of this Section and/or any other applicable laws and/or regulations.
8. Revocation shall not apply to any group home, which otherwise would cause it to be in violation of this Ordinance, that has obtained a reasonable accommodation pursuant to Section 13-200.62.

13-312 Compliance.

- (a) Existing group homes must apply for a special use permit within 90 days of the effective date of this ordinance.
- (b) Group homes that are in existence upon the effective date of this ordinance shall have one (1) year from the effective date of this ordinance to comply with its provisions, provided that any existing group home, which is serving more than six residents, must first comply with the six resident maximum.

(c) Existing group homes obligated by a written lease exceeding one year from the effective date of the ordinance, or whose activity involves investment of money in leasehold or improvements such that a longer period is necessary to prevent undue financial hardship, are eligible for up to one additional years grace period pursuant to planning division approval.

13-313 Severability.

Should any section, subsection, clause, or provision of this Ordinance for any reason be held to be invalid or unconstitutional, such invalidity or unconstitutionality shall not affect the validity or constitutionality of the remaining portions of this Ordinance; it being hereby expressly declared that this Ordinance, and each section, subsection, sentence, clause and phrase hereof would have been prepared, proposed, approved and ratified irrespective of the fact that any one or more sections, subsections, sentences, clauses or phrases be declared invalid or unconstitutional. This Ordinance shall be prospective in application from its effective date.

13-314 – 13-350 [Reserved.]

Section 3: Article 15 (Reasonable Accommodations) of Chapter IX (Special Land Use Regulations) of Title 13 (Planning, Zoning and Development) is hereby repealed and replaced with the following:

13-200.60 Purpose.

It is the city's policy to provide reasonable accommodation in accordance with federal and state fair housing laws (42 USC § 3600 et seq. and Government Code § 12900 et seq.) for persons with disabilities seeking fair access to housing in the application of the city's zoning laws. The term "disability" as used in this article shall have the same meaning as the terms "disability" and "handicapped" as defined in the federal and state fair housing laws. The purpose of this article is to establish the procedure by which a person may request reasonable accommodation, and how the request is to be processed.

13-200.61 Applicability.

Any person seeking approval to construct and/or modify residential housing for person(s) with disabilities, and/or operate a residential care facility, group home, or referral facility, which will substantially serve persons with disabilities may apply for a reasonable accommodation to obtain relief from a Zoning Code provision, regulation, policy, or condition which causes a barrier to equal opportunity for housing.

13-200.62 Reasonable accommodations – procedure.

(a) Application required. An application for a reasonable accommodation shall be filed and processed with the Planning Division. The application shall include the

following information and be subject to the determinant factors required by this section.

(b) Submittal requirements. The application shall be made in writing, and shall include the following information:

1. The zoning code provision, regulation, policy, or condition from which accommodation is being requested;
2. The basis for the claim that the individuals are considered disabled under state or federal law, and why the accommodation is necessary to provide equal opportunity for housing and to make the specific housing available to the individuals;
3. Any other information that the director reasonably determines is necessary for evaluating the request for reasonable accommodation;
4. Documentation that the applicant is: (a) an individual with a disability; (b) applying on behalf of one or more individuals with a disability; or (c) a developer or provider of housing for one or more individuals with a disability;
5. The specific exception or modification to the Zoning Code provision, policy, or practices requested by the applicant;
6. Documentation that the specific exception or modification requested by the applicant is necessary to provide one or more individuals with a disability an equal opportunity to use and enjoy the residence;
7. Any other information that the Hearing Officer reasonably concludes is necessary to determine whether the findings required by Section (e) can be made, so long as any request for information regarding the disability of the individuals benefited complies with fair housing law protections and the privacy rights of the individuals affected;

(c) Fees. No application fee is required.

(d) Director action. Within 60 days of receipt of a completed application, the director shall issue a written determination to approve, conditionally approve, or deny a request for reasonable accommodation, and the modification or revocation thereof in compliance with this chapter. Any appeal to reasonable accommodation request denial or conditional approval shall be heard with, and subject to, the notice, review, approval, and appeal procedures prescribed for any other discretionary permit provided that, notwithstanding any other provision to the contrary, the standard of review on appeal shall not be *de novo* and the planning commission shall determine whether the findings made by the director are supported by substantial evidence presented during the evidentiary hearing. The planning

commission, acting as the appellate body, may sustain, reverse or modify the decision of the director or remand the matter for further consideration, which remand shall include specific issues to be considered or a direction for a *de novo* hearing.

(e) Grounds for reasonable accommodation. The following factors shall be considered in determining whether to grant a reasonable accommodation:

1. Special needs created by the disability;
2. Potential benefit that can be accomplished by the requested modification;
3. Potential impact on properties within the vicinity;
4. Physical attributes of the property and structures;
5. Alternative accommodations that may provide an equivalent level of benefit;
6. In the case of a determination involving a single family dwelling, whether the residents would constitute a single housekeeping unit;
7. Whether the requested accommodation would impose an undue financial or administrative burden on the City;
8. Whether the requested accommodation would require a fundamental alteration in the nature of a City program;
9. Whether granting the request would be consistent with the City's General Plan; and,
10. The property will be used by an individual with disability protected under fair housing laws.

(f) Findings. The written decision to approve, conditionally approve, or deny a request for reasonable accommodation shall be based on the following findings, all of which are required for approval. In making these findings, the director may approve alternative reasonable accommodations which provide an equivalent level of benefit to the applicant.

1. The requested accommodation is requested by or on the behalf of one or more individuals with a disability protected under the fair housing laws.
2. The requested accommodation is necessary to provide one or more individuals with a disability an equal opportunity to use and enjoy a dwelling.

3. The requested accommodation will not impose an undue financial or administrative burden on the city, as "undue financial or administrative burden" is defined in fair housing laws and interpretive case law.
4. The requested accommodation is consistent with the whether or not the residents would constitute a single housekeeping unit.
5. The requested accommodation will not, under the specific facts of the case, result in a direct threat to the health or safety of other individuals or substantial physical damage to the property of others.
6. Whether the requested accommodation is necessary to make facilities of a similar nature or operation economically viable in light of the particularities of the relevant market and market participants.
7. Whether the existing supply of facilities of a similar nature and operation in the community is sufficient to provide individuals with a disability an equal opportunity to live in a residential setting.
8. The requested accommodation will not result in a fundamental alteration in the nature of the City's zoning program.

(g) The City may consider, but is not limited to, the following factors in determining whether the requested accommodation would require a fundamental alteration in the nature of the City's zoning program.

1. Whether the requested accommodation would fundamentally alter the character of the neighborhood.
2. Whether the accommodation would result in a substantial increase in traffic or insufficient parking.
3. Whether granting the requested accommodation would substantially undermine any express purpose of either the city's General Plan or an applicable Specific Plan.
4. Whether the requested accommodation would create an institutionalized environment due to the number of and distance between facilities that are similar in nature or operation.
5. Any other factors that would cause a fundamental alteration in the City's zoning program, as may be defined in the Fair Housing Law.

13-200.63 Severability.

Should any section, subsection, clause, or provision of this Ordinance for any reason be held to be invalid or unconstitutional, such invalidity or unconstitutionality shall not affect the validity or constitutionality of the remaining portions of this Ordinance; it being hereby expressly declared that this Ordinance, and each section, subsection, sentence, clause and phrase hereof would have been prepared, proposed, approved and ratified irrespective of the fact that any one or more sections, subsections, sentences, clauses or phrases be declared invalid or unconstitutional. This Ordinance shall be prospective in application from its effective date.

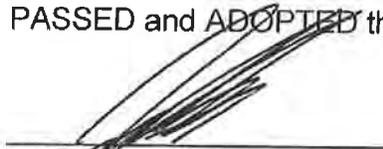
13-200.64 – 13.200.69 [Reserved.]

Section 4. Inconsistencies. Any provision of the Costa Mesa Municipal Code or appendices thereto inconsistent with the provisions of this Ordinance, to the extent of such inconsistencies and no further, is hereby repealed or modified to that extent necessary to affect the provisions of this Ordinance.

Section 5. Severability. If any chapter, article, section, subsection, subdivision, sentence, clause, phrase, word, or portion of this Ordinance, or the application thereof to any person, is for any reason held to be invalid or unconstitutional by the decision of any court of competent jurisdiction, such decision shall not affect the validity of the remaining portion of this Ordinance or its application to other persons. The City Council hereby declares that it would have adopted this Ordinance and each chapter, article, section, subsection, subdivision, sentence, clause, phrase, word, or portion thereof, irrespective of the fact that any one or more subsections, subdivisions, sentences, clauses, phrases, or portions of the application thereof to any person, be declared invalid or unconstitutional. No portion of this Ordinance shall supersede any local, state, or federal law, regulation, or codes-dealing with life safety factors.

Section 6. This Ordinance shall take effect and be in full force thirty (30) days from and after the passage thereof, and prior to the expiration of fifteen (15) days from its passage shall be published once in the ORANGE COAST DAILY PILOT, a newspaper of general circulation, printed and published in the City of Costa Mesa or, in the alternative, the City Clerk may cause to be published a summary of this Ordinance and a certified copy of the text of this Ordinance shall be posted in the office of the City Clerk five (5) days prior to the date of adoption of this Ordinance, and within fifteen (15) days after adoption, the City Clerk shall cause to be published the aforementioned summary and shall post in the office of the City Clerk a certified copy of this Ordinance together with the names and member of the City Council voting for and against the same.

PASSED and ADOPTED this 21st day of October, 2014.


James M. Righeimer
Mayor, City of Costa Mesa

ATTEST:


Brenda Green,
City Clerk

APPROVED AS TO FORM:


Thomas Duarte,
City Attorney

STATE OF CALIFORNIA)
COUNTY OF ORANGE) ss
CITY OF COSTA MESA)

I, BRENDA GREEN, City Clerk and ex-officio Clerk of the City Council of the City of Costa Mesa, hereby certify that the above Council Ordinance Number 14-13 was introduced at a regular meeting of said City Council held on the 7th day of October, 2014, and thereafter passed and adopted as a whole at the regular meeting of said City Council held on the 21st day of October, 2014, by the following roll call vote:

AYES: COUNCIL MEMBERS: Genis, Mensinger, Monahan, Righeimer

NOES: COUNCIL MEMBERS: Leece

ABSTAIN: COUNCIL MEMBERS: None

ABSENT: COUNCIL MEMBERS: None

IN WITNESS WHEREOF, I have hereby set my hand and affixed the Seal of the City of Costa Mesa this 22nd day of October, 2014.


Brenda Green, City Clerk

Table 13-20 (Partial Table)
City of Costa Mesa Land Use Matrix

LAND USES	ZONES																				
	R 1	R 2 M D	R 2 H D	R 3	A P	C L	C 1	C 2	C 1 S	T C	M G	M P	P D R L D	P D R M D	P D R H D	P D R N C M	P D C	P D I	I & R	I & R S	P
4. Boardinghouse, small	•	P	P	P	•	•	•	•	•	•	•	•	P	P	P	P	P	P	•	•	•
5. Boardinghouse, large	•	C	C	C	•	•	•	•	•	•	•	•	•	C	C	C	C	C	•	•	•
6. Residential care facility, 6 or fewer	P	P	P	P	•	•	•	•	•	•	•	•	P	P	P	P	P	P	P	•	•
7. Group homes 6 or fewer	P	P	P	P	•	•	•	•	•	•	•	•	P	P	P	P	P	P	P	•	•
7a. Sober living homes, 6 or fewer	P ⁵	P	P	P	•	•	•	•	•	•	•	•	P	P	P	P	P	P	P	•	•
8. Residential care facility, 7 or more	•	C	C	C	•	•	•	•	•	•	•	•	•	C	C	C	C	C	P	•	•
9. Group homes, 7 or more	•	C	C	C	•	•	•	•	•	•	•	•	•	C	C	C	C	C	P	•	•
9a. Sober living homes, 7 or more	•	C	C	C	•	•	•	•	•	•	•	•	•	C	C	C	C	C	P	•	•

⁵ 650 foot separation required between sober living homes, or a state licensed alcoholism or drug abuse recovery or treatment facility, CMMC 13-311(a)(10)(i).

Attachment No. 5

Real Quest Property Detail Report for 3132
Boston Way

Property Detail Report

For Property Located At :
3132 BOSTON WAY, COSTA MESA, CA 92626-2705



CoreLogic
 RealQuest Professional

Owner Information

Owner Name: THAMES ANNA M
 Mailing Address: 3132 BOSTON WAY, COSTA MESA CA 92626-2705 C020
 Vesting Codes: MW // SE

Location Information

Legal Description: N-TRACT; 5005 BLOCK; LOT: 41
 County: ORANGE, CA APN: 141-691-29
 Census Tract / Block: 639.03 / 2 Alternate APN:
 Township-Range-Sect: Subdivision:
 Legal Book/Page: Map Reference: 27-D3 / 859-A4
 Legal Lot: 41 Tract #: 5005
 Legal Block: School District: NEWPORT MESA
 Market Area: C3 School District Name:
 Neighbor Code: Munic/Township:

Owner Transfer Information

Recording/Sale Date: 09/14/2004 / 09/08/2004 Deed Type: GRANT DEED
 Sale Price: 1st Mtg Document #: 827598
 Document #: 827597

Last Market Sale Information

Recording/Sale Date: 03/29/2000 / 02/23/2000 1st Mtg Amount/Type: \$252,450 / CONV
 Sale Price: \$315,000 1st Mtg Int. Rate/Type: / ADJ
 Sale Type: FULL 1st Mtg Document #: 161440
 Document #: 161439 2nd Mtg Amount/Type: \$44,550 / CONV
 Deed Type: GRANT DEED 2nd Mtg Int. Rate/Type: /
 Transfer Document #: Price Per SqFt: \$126.00
 New Construction: Multi/Split Sale:
 Title Company:
 Lender: LONG BCH MTG CO
 Seller Name: TERRILL GEORGE S

Prior Sale Information

Prior Rec/Sale Date: 06/22/1988 / 06/1988 Prior Lender: GREAT WSTRN BK FSB
 Prior Sale Price: \$190,000 Prior 1st Mtg Amt/Type: \$171,000 / CONV
 Prior Doc Number: 296977 Prior 1st Mtg Rate/Type: / ADJ
 Prior Deed Type: GRANT DEED

Property Characteristics

Gross Area: 2,500 Parking Type: GARAGE/CARPORT Construction:
 Living Area: 2,500 Garage Area: Heat Type: HEAT AVAIL
 Tot Adj Area: Garage Capacity: 2 Exterior wall: STUCCO
 Above Grade: Parking Spaces: Porch Type:
 Total Rooms: 10 Basement Area: Pello Type: COVERED PATIO
 Bedrooms: 6 Finish Bsmnt Area: Pool: POOL & JACUZZI
 Bath(F/H): 1 / Basement Type: Air Cond:
 Year Built / Eff: 1964 / Roof Type: Style: TRADITIONAL
 Fireplace: Y / 1 Foundation: SLAB Quality: GOOD
 # of Stories: 2.00 Roof Material: WOOD SHAKE Condition: GOOD
 LAUNDRY
 Other Improvements: ROOM;COVERED PATIO;PATIO

Site Information

Zoning: R-1 Acres: 0.14 County Use: SINGLE FAM RESIDENCE (1)
 Lot Area: 6,098 Lot Width/Depth: 66 x 95 State Use:
 Land Use: SFR Res/Comm Units: / Water Type: PUBLIC
 Site Influence: Sewer Type: PUBLIC SERVICE

Tax Information

Total Value: \$394,941 Assessed Year: 2014 Property Tax: \$4,758.78
 Land Value: \$275,837 Improved %: 30% Tax Area: 15022
 Improvement Value: \$119,104 Tax Year: 2013 Tax Exemption:
 Total Taxable Value: \$394,941

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Attachment No. 6

June 5, 2014 reasonable accommodation
request letter

STEVEN G. POLIN, ESQ.
Attorney At Law

3034 TENNYSON ST. N.W.
WASHINGTON, D.C. 20015

TEL (202) 331-5848
FAX (202) 537-2986
SPOLIN2@EARTHLINK.NET

June 5, 2014

SENT VIA FIRST ELECTRONIC MEANS AND FIRST CLASS MAIL

Kathya M. Firlik, Esquire
Jones & Mayer
3777 N. Harbor Blvd.
Fullerton, CA 92835

RE: Reasonable Accommodation Request
Yellowstone Recovery
3132 Boston Way

Dear Ms. Firlik:

Chris Brancart of Pescadero, California and I are counsel to Yellowstone Recovery. I am responding to the notice of violation issued by Mike Tucker, Code Enforcement Officer to Honey Thames concerning the use of 3132 Boston Way, which is currently being utilized as a residence for recovering alcoholics and substance abusers by Yellowstone Recovery. The Notice of Violation states the use of 3132 Boston Way violates Section 13-30 of the City of Costa Mesa's zoning code by having more than six unrelated recovering alcoholics and substance abusers residing in a single family zone. The Notice of Violation also alleges that there is a violation of the International Property Maintenance Code in that the fire alarm system is inadequate. Finally, it is alleged that the use of 3132 Boston Way violates section 20-12(z) in that the use constitutes a public nuisance based on portions of the premises occupied for cooking, dining, living, sleeping is not designed or intended to be used for occupancy.

On behalf of Honey Thames, Yellowstone Recovery, and the residents of 3132 Boston Way, I am making a reasonable accommodation request pursuant to the Federal Fair Housing Act, 42 U.S.C. 3604(f)(3)(B), to the City of Costa Mesa it is requested that the City of Costa Mesa treat the residents as a family by treating the residents of 3132 Boston Way as a single housekeeping unit, and treat the use of dwelling as a single family use.

As it is presently construed, the City of Costa Mesa zoning code prohibits the use of any dwelling in an R-1 zoning districts that provide housing for more than six (6) recovering alcoholics and substance abusers. You should be aware that it is a violation of the Fair Housing Act to prohibit the establishment of housing for persons for disabilities in residential zones without providing for a means to allow such programs an opportunity to obtain a reasonable accommodation.

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We are requesting that the City of Costa Mesa pursuant to 42 U.S.C. 3604(f)(3)(B) as a reasonable accommodation treat the use of 3132 Boston Way as a "single housekeeping unit." The City defines a "single housekeeping unit" as *"the occupants of a dwelling unit have established ties and familiarity with each other, jointly use common areas, interact with each other, share meals, household activities, lease agreement or ownership of the property, expenses and responsibilities; membership in the single housekeeping unit is fairly stable as opposed to transient, and members have some control over who becomes a member of the single housekeeping unit."*

I. THE YELLOWSTONE CONCEPT

Yellowstone Recovery is a housing provider for recovering alcoholics and drug addicts. The dwelling located at 3132 Boston Way presently can provide housing for up to 15 unrelated persons and staff in recovery from alcoholism and substance abuse, residing together as the functional equivalent of a family. The City does not impose any numerical limitation on the number of persons who have reside together who are related by blood or marriage. This household function as the equivalent of a family and a single housekeeping unit and allows the recovering persons to provide one another with continual mutual support as well as mutual monitoring to prevent relapse.

Many persons in recovery cannot maintain the traditional family organization that the City's ordinance dictates. Treating the use of 3132 Boston Way as something other than a single family use, therefore, discriminates against groups of disabled persons, such as the residents residing there, which do not meet the City's definition of family and single housekeeping unit. In addition to the actual discrimination against the residents of 3132 Boston Way by the proposed enforcement of the City's zoning code, the ordinance also has a disparate impact on them by preventing them from living together in drug and alcohol free housing units. The potential recovery of people who are handicapped or disabled by reason of alcoholism or drug abuse is greatly enhanced by the mutual support and mutual monitoring provided by living with other recovering persons. Further, it is often critical that a person in the early and middle stages of recovery shares a bedroom with another recovering addict for mutual support and monitoring. The City's restrictions on groups of disabled persons that do not meet its definition of family effectively prohibit this type of living arrangement in single family dwellings, even though no similar restrictions apply to other groups of unrelated, non disabled persons, or to persons related by biology.

The residents of 3132 Boston Way are considered to be the "functional equivalent" of a family for several reasons. The residents have access to the entire house. The residents also participate equally in the housekeeping functions of the house. The quality and nature of the relationship among the residents are akin to that of a family. The emotional and mutual support and bonding given each resident in support of his recovery from drug addiction and alcoholism is the equivalent of the type of love and support received in a traditional family. The need of groups of unrelated recovering alcoholics and substance abusers to live in a structured, safe and therapeutic environment is necessary to the recovery process. It has been found that individuals who decide to

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live in sober housing programs, such as that offered by Yellowstone Recovery, are allowed to engage in the process of recovery from alcoholism and substance abuse, at their own pace. By living with other persons who are in recovery, the residents should never have to face an alcoholic's or addict's deadliest enemy: loneliness and isolation.

In addition, the residents live in at 3132 Boston Way by choice. The choice is usually motivated by the individual's desire not to relapse into drug and/or alcohol use again after that individual has bottomed out, i.e., lost jobs, home or family. It is also motivated by the desire that one must change their lifestyle, the manner in which they conduct their affairs, and the need to become a responsible, productive member of society.

II. REASONABLE ACCOMMODATION REQUEST TO BE TREATED AS A SINGLE HOUSEKEEPING UNIT

The residents of Yellowstone Recovery are considered "handicapped" under the 1988 amendments to the Federal Fair Housing Act, unlike those other groups of unrelated, non-disabled persons. See 42 U.S.C. 3600 et seq. Recovering addicts and alcoholics are specifically included within the definition of "handicapped individual." See, 42 U.S.C. 3602(h) and 24 C.F.R. 100.201(a)(2).

As members of a protected class under the Federal Fair Housing Act, the issue of whether the use of 3132 Boston Way as a "sober living home" is in violation of the City's zoning ordinances is not relevant to the question of there is a violation of the Federal Fair Housing Act.¹ *United States v. Borough of Audubon*, 797 F. Supp. 353 (D. N.J.), *aff'd* 968 F.2d 14 (3d Cir. 1992). Thus, any allegation that the use of 3132 Boston Way as a "sober living home" constitutes a violation of a local zoning ordinance does not abrogate its rights in claiming discrimination under the Federal Fair Housing Act. It is well established that the Federal Fair Housing Act prohibits discriminatory land use decision by municipalities, when such decisions are ostensibly authorized by local ordinance. *Association of Relative and Friends of AIDS patients v. Regulation and Permits Administration*, 740 F.Supp. 95 (D.P.R. 1990)(government agency's denial of land use permit to open AIDS hospice violated Fair Housing Act); *Baxter v. City of Belleville*, 720 F.Supp. 720 (S.D. Ill 1989)(on motion for preliminary injunction: city's refusal to issue special use permit under zoning law to develop to remodel building into residence for persons with AIDS violated Fair Housing Act). *See also* 42

¹The language of the FHAA itself manifests a clear congressional intent to vitiate the application of any state law that would permit discrimination based on physical handicap. See 42 U.S.C. § 3615 (expressly commanding that "any law of a State . . . that purports to require or permit any action that would be a discriminatory housing practice under this subchapter shall to that extent be invalid") *Astralis Condo. Ass'n v. Sec'y, United States Dep't of Hous. & Urban Dev.*, 620 F.3d 62, 70 (1st Cir. 2010)

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U.S.C. Section 3615 ("any law of a State, a political subdivision, or other jurisdiction that purports to require or permit any action that would be a discriminatory housing practice under this subchapter shall to that extent be invalid [under the Fair Housing Act]").

In addition, for purposes of this letter, 42 U.S.C. 3604(f)(3)(B) defines discrimination to include a "refusal to make reasonable accommodations in rules, policies, practices, or services, when such accommodations may be necessary to afford such [handicapped] person equal opportunity to use and enjoy a dwelling."

The legislative history to the Fair Housing Amendments Act of 1988 ("House Judiciary Report") is explicit as to the effect of the amendments on state and local land use practices, regulations or decisions which would have the effect of discriminating against individuals with handicaps. The amendments prohibit the discriminatory enforcement of land use law to congregate living arrangements among non-related persons with disabilities when these requirements are not imposed on families.

[Section 804(f)] would also apply to state or local land use and health and safety laws, regulations, practices or decisions which discriminate against individuals with handicaps. While state and local governments have authority to protect safety and health, and to regulate use of land, that authority has sometimes been sued to restrict the ability of individuals with handicaps to live in communities. This has been accomplished by such as the enactment or imposition of health, safety or land-use requirements on congregate living arrangements among non-related persons with disabilities. Since these requirements are not imposed on families and groups of similar size of unrelated people, these requirements have the effect of discriminating against persons with disabilities.

House Report, p. 24 (footnote omitted). Based on this clear expression of legislative intent, the courts have enjoined the application and enforcement of zoning and health and safety regulations which have a discriminatory impact on group homes for persons with disabilities. *Oxford House, Inc. v. Township of Cherry Hill*, 799 F. Supp. 450, 462 (D.N.J. 1992); *Oxford House, Inc. v. Town of Babylon*, 819 F. Supp 1179 (E.D.N.Y. 1993); *Marbrunak, Inc. v. City of Stowe*, 974 F.2d 43 (6th Cir. 1992).

The mutual support that the residents receive from each other is critical to addiction recovery. Persons recovering from addiction are far more often successful when living in a household with at least eight other persons in recovery, particularly in the early stages of recovery. Barring more than three unrelated individuals from residing together, without regard to the size of the residential unit, interferes with the critical mass of individuals supporting each other in recovery.

The reasonable accommodation requirement of the Fair Housing Act draws no distinction between "rules," "policies," and "practices" that are embodied in zoning ordinances and those than

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emanate from other sources. All are subject to the "reasonable accommodation" requirement. Thus, when a municipality refuses to make a reasonable accommodation in its zoning "rules," "policies," or "practices," and such an accommodation may be necessary to afford handicapped persons an equal opportunity to use and enjoy a dwelling, it violates the reasonable accommodation provision of the act, 42 U.S.C. 3604(f)(3)(B). See *United States v. Village of Marshall*, 787 F. Supp. 872, 877 (W.D. Wisc. 1991)(Congress in enacting the Fair Housing Amendments Act "anticipated that there were rules and regulations encompassing zoning regulations and governmental decision about land use").

Reasonable accommodation has been interpreted by the Courts in cases involving zoning ordinances to mean that a municipality must change some rule that is generally applicable to everyone so as to make its burden less onerous on the person with disabilities. *Township of Cherry Hill* at 465, ft. 25. See, *Casa Marie, Inc. v. Superior Court of Puerto Rico for the District of Arecibo*, 752 F. Supp 1152, 1169 (D.P.R.1990), *rev'd on other grounds*, 988 F.2d 252 (1st Cir. 1993)(noting that a court hearing a reasonable accommodation claim under the Fair Housing Act may "adjudge whether compliance with the zoning ordinances may be 'waived'"); *Horizon House Development Services v. Township of Upper Southampton*, 804 F.Supp. 683, 699-700 (E.D. Pa. 1992), *aff'd mem.*, 995 F.2d 217 (3d Cir. 1993)("affirmative steps are required to change rules or practices if they are necessary to allow a person with a disability to live in a community"). A request for a reasonable accommodation may even encompass as request for non enforcement of a zoning ordinance. *Proviso Association of Retarded Citizens v. Village of Westchester*, 914 F. Supp 1555, 1561-62 (N. D. Ill. 1996).

One of the purposes of the reasonable accommodations provision is to address individual needs and respond to individual circumstances. In this regard, courts have held that municipalities that municipalities must change, waive, or make exception to their zoning rules to afford people with disabilities the same access to housing as those who are without disabilities. *Town of Babylon*, 819 F. Supp at 1192; *Horizon House*, 804 F. Supp. at 699; *Township of Cherry Hill* 799 F. Supp at 461-63; *Village of Marshall*, 787 F. Supp at 878; *Commonwealth of Puerto Rico*, 764 F. Supp. at 224.

Here, accommodating the use of 3132 Boston Way as a "sober living home" would not cause the City any undue financial or administrative burdens nor would it undermine the purpose which the requirement seeks to achieve, that the City waives its unrelated rule requirement in its definition of family, especially in view of the State mandate not to interfere with the siting of "community residential facilities." See, *Village of Marshall*, supra at 877-78 (accommodation is unreasonable if it "undermine[s] the basic purpose which the requirement seeks to achieve"). The Fair Housing Act places an affirmative duty on the municipality to accommodate the needs of persons with disabilities. The Act demands that municipalities such as the City of Costa Mesa to change the manner in which its zoning ordinances are applied to afford the disabled the same opportunity to housing as those who are not disabled. *City of Plainfield*, 769 F. Supp at 1344 (accommodation reasonable where it "would not cause undue financial burden to the City").

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Permitting Yellowstone Recovery to continue to provide sober housing would not significantly compromise the policies reflected in any of the land use ordinances that the City would apply or enforce, as Yellowstone has been providing housing at this location since 2003. Another method of accommodating Yellowstone is to grandfather the use of 3132 Boston Way from the recent amendments to the City's zoning code. Nor is there any significant evidence that such an accommodation would significantly compromise the City's legitimate interests in the protecting the residential character of the surrounding neighborhood. Yellowstone is not requesting that the City of Costa Mesa to build housing, rather, rather it is requested that the City remove an obstacle to housing. *See, Town of Babylon, supra; Huntington Branch, NAACP v. Town of Huntington*, 844 F.2d 926, 936 (2d Cir), *aff'd* 488 U.S. 15 (1988).

If need be, Yellowstone Recovery can demonstrate that the proposed accommodation is reasonable, for the Fair Housing Act requires a showing that the accommodation "**may** be necessary to afford [handicapped] person[s] equal opportunity to use and enjoy a dwelling." 42 U.S.C. 3604(f)(3)(B). *See, Parish of Jefferson v. Allied Health Care, Inc.*, 1992 U.S. Dist. Lexis 9124 (E.D. La.) (The proper inquiry on a request for a reasonable accommodation is the number of unrelated persons who can reside together is to reasonableness of the request.) The City of Costa Mesa, by classifying 3132 Boston Way as something other than a single family use, is actually enforcing its definition of family in its zoning ordinance by utilizing more stringent requirements on groups of unrelated disabled individuals wishing to live together than on individuals related by blood or marriage or adoption or guardianship. *Parish of Jefferson, supra* (Zoning ordinance limiting the number of unrelated persons residing together as a family to four found to be in violation of the Fair Housing Act since it has the effect of discriminating against groups of handicapped persons by unnecessarily restricting their ability to live in residences of their choice in the community.) *Tsombanidis v. City of West Haven*, 180 F.Supp. 2d 262, *aff'd in part, rev'd in part*, 352 F.3d 565 (2d Cir. 2003). (Stringent enforcement of the City's three person rule has a greater adverse impact on disabled persons than non-disabled persons).

III. ALL CODE REQUIREMENTS ARE SUBJECT TO THE FAIR HOUSING ACT

Yellowstone Recovery residents are individuals who are handicapped by alcoholism or drug abuse. Yellowstone Recovery can demonstrate that the ability of recovering alcoholics and drug addicts to live in a supportive drug free environment in a quiet residential area is critical to their recovery.² These individuals are more likely to need a living arrangement such as the one 3132

²Other programs similar to the housing provided by Yellowstone Recovery have successfully demonstrated the need of recovering individuals to reside in quiet residential areas in order to enhance the recovery process. *See Borough of Audubon*, 797 F. Supp at 360 (Based on the testimony, we find that the OH-Vassar residents' addictions substantially limit their ability to live independently and to live with their families. Accordingly, we find that the

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Boston Way provides, wherein groups of unrelated individuals reside together in a residential neighborhood for mutual support during the recovery process. *Township of Cherry Hill*, 799 F. Supp. at 450. "When that home is also a therapeutic environment critical to maintaining continued recovery from alcohol or drug addiction, eviction is life threatening. Depriving such individuals of housing, or evicting them, would constitute irrational discrimination that may seriously jeopardize their continued recovery." See *City of Plainfield*, 769 F. Supp at 1345. This action by the City of Costa Mesa would completely preclude the opportunity of 3132 Boston Way to exist within the City and to provide housing to handicapped persons in recovery from alcoholism and drug abuse. Courts have uniformly held that municipal services include the application and enforcement of zoning, building, housing and fire codes. This was made clear by the legislative history to the Fair Housing Act:

[Section 804(f)] would also apply to state or local land use and health and safety laws, regulations, practices or decisions which discriminate against individuals with handicaps. While state and local governments have authority to protect safety and health, and to regulate use of land, that authority has sometimes been sued to restrict the ability of individuals with handicaps to live in communities. This has been accomplished by such as the enactment or imposition of health, safety or land-use requirements on congregate living arrangements among non-related persons with disabilities. Since these requirements are not imposed on families and groups of similar size of unrelated people, these requirements have the effect of discriminating against persons with disabilities.

House Report, p. 24.

In *Casa Marie, Inc. v. Superior Court of Puerto Rico for Dist. of Arecibo*, 752 F. Supp. 1152, 1171 (D.P.R. 1990) it was noted that

This brief review of the legislative history convinces us that Congress' intention in enacting and amending the Fair Housing Act was to provide broad and far-reaching relief against discrimination in housing similar to the broad remedial scheme of other Civil Rights

residents are "handicapped" under the Act, and are entitled thereby to the protections of the Act. We do not think that the list of major life activities set forth in the regulation was meant to be all-inclusive. Even if it were, the residents would still satisfy the definition because their inability to live independently constitutes a substantial limitation on their ability to "care for themselves.")' *City of Plainfield*, 769 F. Supp at 1339-40. (In addition to losing their residence, which may in itself be an irreparable injury, plaintiffs would also lose the benefit of their therapeutic and supportive living environment, and may relapse. . . For a non-handicapped individual, the disintegration of a family unit is traumatic for recovering alcoholics and drug addicts, it may be devastating.)

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statutes... [I]tis obvious that state courts could be used to apply facially-neutral zoning laws, building codes, restrictive covenants, and other state statutory law related to the regulating housing. Housing is an area replete with state law rules and regulations and private contracts.

Application of zoning, building, housing and fire codes that affect housing for persons with disabilities and that may be utilized to impose terms, conditions and requirements that may result in the denial of housing are subject to challenge under the Fair Housing. These code requirements are also subjects to the reasonable accommodation provision of the Act. *See, Gallagher v. Magner*, 619 F.3d 823, 829 (8th Cir. 2010)(application of property maintenance and housing codes are subject to disparate impact analysis under the Fair Housing Act); *New Jersey Coalition of Rooming & Boarding House Owners v. Mayor of Asbury Park*, 152 F.3d 217, 221 (3d Cir.1998)(compliance with building, housing, health and safety code regulations for licensing purposes in determining intentional discrimination against housing for disabled persons); *Wis. Cmty. Servs. v. City of Milwaukee*, 413 F.3d 642, 646 (7th Cir. 2005)(If a zoning or building-code rule bears more heavily on disabled than on other persons, the city must change the rules to the extent necessary to redress the adverse effect); *Tsombanidis v. W. Haven Fire Dep't*, 352 F.3d 565, 571 (2d Cir. 2003)(The Fair Housing Act and the Americans with Disabilities act apply to zoning regulations, property maintenance codes, state building code, and the state fire code); *Marbrunak, Inc. v. City of Stowe*, 974 F.2d 43,47 (6th Cir. 1992)(safety requirements for groups of disabled persons contained in City's zoning code subject to review under the Fair Housing Act); *Alliance for the Mentally Ill v. City of Naperville*, 923 F. Supp. 1057, 1074 (N.D. Ill1996)(under the Federal Fair Housing Act, a municipality may impose special requirements on a Residential Board and Care Occupancy only if such requirements are 'warranted by the unique and specific needs and abilities of those handicapped persons'; *ProvisioAss'n v. Village of Westchester*, 914 F. Supp. 1555, 1562 (N.D. Ill1995) (municipality refusal to waive sprinkler requirement as a reasonable accommodation which was required by the Life Safety Code found to have violated the Federal Fair Housing Act).

III. THE BUILDING AND FIRE CODE REQUIREMENTS ARE UNREASONABLE

A fire clearance was granted to Yellowstone for the use of 3132 Boston Way as recently as 2011. Any suggestion that Yellowstone is out of compliance with IPMC Sec. 704.1 is without merit or foundation. The imposition of any additional fire safety requirements than that already imposed in not only unreasonable for constitutes evidence of intentional discrimination.

Even assuming that the building and fire code provisions might apply here, there are practical limitations in complying with them. Compliance with the automated sprinkler systems

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requirement would require major construction throughout the house. The Life Safety Code recognizes that modifications to existing structures are often unreasonable and impractical.³

Neither code is an inflexible instrument. For instance, the Life Safety Code gives the City and its officials discretion when applying the Code to existing structures as long as a reasonable degree of safety is provided since the Code recognizes that there may be situations where the requirements for existing buildings would not be practical. See, Section 1-5.4 and A-1-5.4.⁴ The commentary to Section A-1-5.4 takes into consideration the hardships of strictly applying the Code to existing structures.⁵

³Section 1-2.2 of the Life Safety Code states:

"The Code endeavors to avoid requirements that might involve unreasonable hardships or unnecessary inconvenience or interference with the normal use and occupancy of a building, but insists upon compliance with a minimum standard for fire safety consistent with the public interest."

The comments to 1-2.2 states that the Code "takes into consideration the normal occupancy of a building and attempts not to interfere with the normal use of a building or set requirements that would cause unreasonable hardships and unnecessary inconvenience."

⁴Section A-1-5.4 states:

"In existing buildings, it is not always practical to strictly apply the provisions of the Code. Physical limitations may require disproportionate effort of expense with little increase in life safety. In such cases, the authority having jurisdiction must be satisfied that reasonable life safety is assured.

In existing buildings it is intended that any condition that represents a serious threat to life be mitigated by application of appropriate safeguards. It is not intended to require modifications for conditions that do not represent a significant threat to life, even though such conditions are not literally in compliance with the Code.

⁵The Commentary to Section A-1-5.4 states in part:

"In existing buildings, it is not always practical to strictly apply the provisions of this Code. Physical limitations may require disproportionate effort or expense with little increase in fire safety. In such cases, the authority having jurisdiction should be satisfied that reasonable life safety is ensured. In existing buildings, it is intended that any condition that represents a serious threat to life be mitigated by application of appropriate

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The residents who reside at 3132 Boston Way have absolutely no unique need for additional fire safety requirements that are normally not required for housing for people without disabilities. No similar requirements have been imposed on the other single family dwellings in the City. Moreover, there are both programmatic and fiscal burdens that will be created by requiring the installation of a hard wired fire alarm system.

Any claim additional code standards are necessary insures the safety of the homes' residents is an argument that was rejected in *Marbrunak, Inc. v. City of Stowe*, 974 F.2d 43 (6th Cir. 1992). In *Marbrunak*, the City of Stowe imposed special safety requirements on a residence for four developmentally disabled adult women in keeping with the city's zoning ordinances. The Sixth Circuit found that an ordinance which imposes mandatory safety requirements for disabled persons residing in single family dwellings to be in violation of the Federal Fair Housing Act because the same onerous safety and permit requirements were not imposed on other single family uses. The court explained that a city "may impose standards which are different from those to which its subjects the general population, so long as that protection is demonstrated to be warranted by the unique and specific needs and abilities of those handicapped persons." *Marbrunak*, 974 F. 2d at 47. The Stowe ordinance failed this test because it imposed "blanket" fire and safety restrictions on all homes where developmentally disabled persons lived, regardless of the abilities of the residents. *Id.* at 47. The Court stated:

. . . [t]he requirements are based upon generalized perceptions about the inability of developmentally disabled persons to live safely in a "normal" home. The City would require that Marbrunak install an alarm system interconnected to a ceiling sprinkler system, yet it offers no evidence that any of the residents of the home are hearing impaired or otherwise unable to respond to the standard smoke alarms with which the home is already equipped . . . The City requires Marbrunak to install doors with push-bars that swing outward with lighted exit signs posted above each door of the home without offering any evidence that the residents are or would be unable to use the types of doors already in the home, and without showing how the women would need lighted exit signs to find them. The City requires Marbrunak to install fire walls and flame retardant wall covering without showing why such renovations are needed to ensure the safety of the residents. In sum, the requirements have little or no correlation to the actual abilities of the citizens upon whom they are imposed.

Id. at 47. See, also *Potomac Group Home Corp., supra.*; *Bangerter v. Orem City Corp.*, 46 F.3d 1491, 1503 (10th Cir. 1995)(because the disabled are a protected class under the Federal Fair House Act, special requirements imposed on them must be more than "rationally related to a legitimate governmental purpose).

safeguards. It is not intended to require modifications for conditions that do not represent a significant threat to life, even though the circumstances are not literally in compliance with the Code."

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In *Alliance for the Mentally Ill v. City of Naperville*, 923 F. Supp. 1057, 1074 (N.D. Ill 1996), it was held that the provisions of the state building code regarding safety requirements for lodging and rooming houses as applied to groups of disabled persons violated the Federal Fair Housing Act. The court held that residents of lodging and rooming houses are not a protected class under the constitution or under any statute, whereas handicapped persons are a specifically protected class under the Federal Fair Housing Act. The Court stated:

[A] municipality may impose special requirements on residents of lodging and rooming houses provided that such requirements bear a rational relationship to some legitimate governmental purpose. Undoubtedly, such requirements could rest on generalized assumptions about residents of lodging and rooming houses. For example, a municipality could impose special requirements on lodging and rooming houses based on the assumption that the residents do not know one another, do not stay for long periods of time, do not know about the safety features of the house, and so forth. By contrast, under the Federal Fair Housing Act, a municipality may impose special requirements on a Residential Care/Assisted Living Facility only if such requirements are 'warranted by the unique and specific needs and abilities of those handicapped persons.'

Id. at 1074. See, also *Provisio Ass'n v. Village of Westchester*, 914 F. Supp. 1555, 1562 (N.D. Ill. 1993) (municipality's refusal to waive sprinkler requirement as required by the state building code violates the Federal Fair Housing Act).

As the United States District Court wrote in regard to a group home safety regulation in Montgomery County, Maryland, a safety code requirement is unlawful as applied to people with disabilities if it "has no necessary correlation to the actual abilities of the persons upon whom it is imposed . . ." *Potomac Group Home Corp. v. Montgomery, County*, 823 F. Supp. at 1300 (any safety requirements imposed upon disabled persons must correlate "to the actual abilities of the persons upon whom it is imposed). No such correlation exists here.

A reasonable application of your zoning laws would be to recognize the residents of Yellowstone Recovery as a family and its use as a single family use. It is not rational to classify the premises as something other than a single family use. In the alternative, Yellowstone Recovery requests that you waive any limitation on the number of unrelated disabled persons who can reside together in a single family zone and to hold in abeyance the enforcement effort currently underway.

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I hope you find this information useful. I would like to discuss this matter with you or any other representative of the City of Costa Mesa and in doing so I request that the City hold in abeyance any efforts to enforce the cease and desist order.

Please call me if you wish to discuss this matter, otherwise please govern yourself accordingly.

I look forward to discussing ways to resolve this matter with you.

Sincerely yours,

A handwritten signature in black ink, appearing to read "Steven G. Polin". The signature is stylized with multiple overlapping strokes and a long horizontal line extending to the right.

cc: Yellowstone Recovery
Christopher Brancart

Attachment No. 7

August 19, 2014 City's denial of reasonable accommodation request letter



JONES & MAYER

ATTORNEYS AT LAW

3777 NORTH HARBOR BOULEVARD • FULLERTON, CALIFORNIA 92835
(714) 446-1400 • (562) 697-1751 • FAX (714) 446-1448

Richard D. Jones*
Partners
Martin J. Mayer

Richard L. Adams II
Jamaar Boyd-Weatherby
Baron J. Bettenhausen

Michael Q. Do
Thomas P. Duarte
Kathya M. Firlík

Ryan R. Jones
Robert Khuu
Gary S. Kranker

Harold W. Potter
Denise L. Rocawich
Yolanda M.
Summerhill
Ivy M. Tsai
Emily Y. Wada

Kimberly Hall Barlow
James R. Touchstone

Christian L. Bettenhausen
Paul R. Coble
Keith F. Collins

Elena Q. Gerli
Katherine M. Hardy
Krista MacNevin Jee

Christopher F. Neumeier
Gregory P. Palmer
Danny L. Peelman

*a Professional Law
Corporation

Of Counsel
Michael R. Capizzi
Dean J. Pucci
Steven N. Skolnik
Peter E. Tracy

Consultant
Mervin D. Feinstein

August 19, 2014

Steven G. Polin, Esq.
3034 Tennyson Street N.W.
Washington, D.C. 20015

Via facsimile and U.S. Mail

Re: Reasonable Accommodation Request pursuant to 42 U.S.C. § 3604/Yellowstone Recovery/3132 Boston Way

Dear Mr. Polin:

Thank you for your letter dated June 5, 2014, requesting that the City of Costa Mesa grant Yellowstone Recovery a reasonable accommodation to consider its operation in an R1 zone to be a single housekeeping unit, even though its current use -- housing up to 15 recovering alcoholics and substance abusers -- does not meet the City's zoning code definition of a family, and the individuals living at 3132 Boston Way do not function as a single housekeeping unit. Jones & Mayer serves as the City of Costa Mesa's City Attorney's Office, and I write this letter on behalf of Gary Armstrong, Development Services Director for the City. In consultation with our office, the Director has carefully reviewed and considered your client's request, and denies the request for the reasons outlined herein.

As you are aware, the City of Costa Mesa's zoning code provides that residential service facilities housing 7 or more individuals, and which are not operating as a single housekeeping unit, are not permitted in R1 zones within the City, and may only operate in R2 and R3 zones pursuant to a Conditional Use Permit. CMMC §§ 13-6; 13-30, Table 13-30(4)-(9). Yellowstone

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Recovery is located at 3132 Boston Way, in an R1 zone, and currently appears to be operating in violation of the City's code by housing more than 6 individuals in a group living setting, who do not act as a single housekeeping unit.

The Federal Housing Act Amendments, 42 U.S.C. § 3601 et seq., provide that a city "commits discrimination under the FHAA if it refuses to make reasonable accommodations in rules, policies, practices, or services, when such accommodation may be necessary to afford [the disabled] equal opportunity to use and enjoy a dwelling." Budnick v. Town of Carefree, 518 F.3d 1109, 1119 (9th Cir. 2008).

The FHAA requires a city to provide a requested accommodation if such accommodation "(1) is reasonable, and (2) necessary, (3) to afford a handicapped person the equal opportunity to use and enjoy a dwelling." Oconomowoc Residential Programs, Inc. v. City of Milwaukee, 300 F.3d 775, 783 (7th Cir. 2002); 42 U.S.C. § 3604(f)(3)(B). Your client bears the initial burden to show that the requested accommodation is reasonable and necessary to provide an equal opportunity to use and enjoy a dwelling. Oconomowoc, 300 F.3d at 783.

In your letter, you assert that the accommodation requested "would not cause the City any undue financial or administrative burdens nor would it undermine the purpose which the requirement seeks to achieve. . . ." The requirement, as articulated above, is that residential facilities for the disabled of 7 or more residents, other than single housekeeping units, are not permitted in R1 zones. However, you make no mention of the purpose underlying this requirement, or explain how the accommodation requested would not undermine that purpose. In fact, such allowance is not in keeping with the purpose. Allowing residential facilities in R1 zones that do not function as single housekeeping units, but as the equivalent of boarding houses, where as many as 15 transient residents live fundamentally undermines the purpose of the requirement at issue.

A zoning accommodation is not reasonable if "it is so at odds with the purposes behind the rule that it would be a fundamental and unreasonable change." Oconomowoc, 300 F.3d at 784. Having what amounts to a boarding house that houses up to 15 people in a single family neighborhood does effect a fundamental change to the residential character of the City's R1 neighborhoods. Both California's and the United States' highest courts have recognized that the maintenance of the residential character of neighborhoods is a legitimate governmental interest. The United States Supreme Court long ago acknowledged the legitimacy of "what is really the crux of the more recent zoning legislation, namely, the creation and maintenance of residential districts, from which business and trade of every sort, including hotels and apartment houses, are excluded." Euclid v. Amber Realty Co., 272 U.S. 365, 390 (1926). In Miller v. Board of Public Works, 195 Cal. 477, 490, 492-93 (1925), the California Supreme Court stated that:

It is axiomatic that the welfare, and indeed the very existence of a nation depends upon the character and caliber of its citizenry. The character and quality of

manhood and womanhood are in a large measure the result of home environment. The home and its intrinsic influences are the very foundation of good citizenship, and any factor contributing to the establishment of homes and the fostering of home life doubtless tends to the enhancement not only of community life but of the life of the nation as a whole.”

“With home ownership comes stability, increased interest in the promotion of public agencies, such as schools and churches, and ‘recognition of the individual’s responsibility for his share in the safeguarding of the welfare of the community and increased pride in personal achievement which must come from personal participation in projects looking toward community betterment.’” Ewing v. City of Carmel-by-the-Sea, 234 Cal. App. 3d 1579, 1590 (1991), *citing* Miller, 195 Cal. at 493. It is with these purposes in mind that the City of Costa Mesa has created residential zones, including R1 zones for single family residences.

Specifically, the Housing Element, Land Use Designation of the City’s General Plan sets forth the goal of R1 (low-density residential areas) as follows:

Low-Density Residential areas generally are intended to accommodate single-family residences on their own parcels. Other housing types include attached housing that provide a greater portion of recreation or open space than typically found in multi-family developments, and clustered housing which affords the retention of significant open space. Low-Density Residential areas are intended to accommodate family groups and outdoor living activities in open space adjacent to dwellings. In order to avoid land use conflicts, these areas should be located away from or protected from the more intense non-residential areas and major travel corridors. The density for this land use designation shall be up to eight units to the acre. *At an average household size of 2.74 persons per dwelling unit*, the projected population density within this designation would be up to 21.9 persons per acre.

2000 General Plan, Housing Element, p. LU-24¹ (italics added). Short-term tenants, such as tenants in boarding house-style residential facilities, have little interest in the welfare of the neighborhoods in which they temporarily reside -- they “do not participate in local government, coach little league, or join the hospital guild. They do not lead a scout troop, volunteer at the library, or keep an eye on an elderly neighbor. Literally, they are here today and gone tomorrow - - without engaging in the sort of activities that weld and strengthen a community.” Ewing, 234 Cal. App. 3d at 1591.

¹ The Housing Element of the City of Costa Mesa’s General Plan can be found here: <http://www.costamesaca.gov/modules/showdocument.aspx?documentid=6599>. The General Plan in its entirety can be accessed here: <http://www.costamesaca.gov/index.aspx?page=1159>.

Steven G. Polin, Esq.
August 19, 2014
Page 4

The use limitation at issue, thus, has as its core purpose the maintenance of the single family character of R1 neighborhoods. In light of the impacts that large numbers of transient residents have on such neighborhoods, nothing in your letter provides any support for your client's assertion that an accommodation to house 15 individuals in an R1 zone where the average household size is 2.74 persons per unit is reasonable.

Additionally, your client fails utterly to establish that the accommodation is "necessary" to afford a handicapped person the equal opportunity to use and enjoy a dwelling. In your letter, you contend that persons "recovering from addiction are far more often successful when living in a household with at least eight other persons in recovery, particularly in the early stages of recovery. Barring more than three unrelated individuals from residing together, without regard to the size of the residential unit, interferes with the critical mass of individuals supporting each other in recovery."

The City's code, however, does not bar more than three unrelated disabled individuals from living together. In fact, the City treats boarding house-style residential facilities for the disabled, i.e., residential services (or care) facilities, more liberally than it does actual boarding houses: residential services facilities (whether licensed or unlicensed) of six or fewer residents are allowed as of right in the R1 zone, whereas boarding houses may be located in R1 zones only if they house three or fewer individuals. CMMC §§ 13-6, 13-30 (Table 13-30(4)-(9)). The City's code, therefore, is more favorable to disabled individuals than it is to non-disabled individuals. See, Oxford House v. City of St. Louis, 77 F.3d 249 (1996) (city ordinance defined permissible single family dwellings as including 8 or fewer unrelated disabled individuals, but prohibited more than three unrelated non-disabled individuals from living together – held that ordinance does not discriminate against the disabled, but rather favors them on its face).

Your client provides no evidence whatsoever that more than six residents in a supportive living environment is necessary for recovery or to be afforded the opportunity to the use and enjoyment of a single-family home. As articulated above, the City of Costa Mesa allows up to six disabled individuals who are not living as a single housekeeping unit to reside in an R1 zone. While living with eight other recovering individuals may provide the optimal recovery conditions or may increase the profits for your client in running such a house, it appears from your own letter that the number of residents reasonably "necessary" for successful recovery is three and above. While your letter indicates that more than 8 is "optimal," this is not the same as what is reasonably necessary to afford the disabled the opportunity to the use and enjoyment of the housing of their choice. According to the data in your letter, only three are "necessary," and the City's code meets this requirement.

The burden to demonstrate necessity remains with your client. Oconomowoc, 300 F.3d at 784, 787. Your client must show that "without the required accommodation they will be denied the equal opportunity to live in a residential neighborhood." Oconomowoc, 300 F.3d at 784; see also, United States v. California Mobile Home Mgmt Co., 107 F.3d 1374, 1380 (9th Cir. 1997)

Steven G. Polin, Esq.
August 19, 2014
Page 5

(“without a causal link between defendants’ policy and the plaintiff’s injury, there can be no obligation on the part of the defendants to make a reasonable accommodation”); Smith & Lee, Inc. v. City of Taylor, Mich., 102 F.3d 781, 795 (6th Cir. 1996) (“plaintiffs must show that, but for the accommodation, they likely will be denied an equal opportunity to enjoy the housing of their choice”). The proper inquiry “is not whether a particular profit-making company needs such an accommodation, but, rather do such businesses as a whole need this accommodation.” Bryant Woods Inn, Inc. v. Howard County, Md., 124 F.3d 597, 605 (4th Cir. 1997) (internal citations omitted); Smith & Lee Assocs., Inc. v. City of Taylor, Mich., 13 F.3d 920, 931 (6th Cir. 1993). Your client, therefore, must demonstrate that residential services facilities, as a whole, require this particular accommodation.

More specifically, your client has provided no evidence of a nexus between the disabilities claimed by the residents of Yellowstone and the inability of those residents to meet the City’s definition of a single housekeeping unit; no evidence whatsoever to demonstrate that, based on their disabilities, residents of residential services facilities cannot enjoy the use of a single family residence in an R1 zone that is limited to six residents; or that increasing the number of residents from six to 15 would be therapeutically meaningful. See, Bryant Woods, 124 F.3d at 605 (“nothing in the record that we can find suggests that a group home of 15 residents, as opposed to one of 8, is necessary to accommodate individuals with handicaps”).

In sum, Yellowstone Recovery has not met its burden to demonstrate that the accommodation requested is reasonable, nor that it may be necessary to afford disabled individuals the use and enjoyment of the residence of their choice. Therefore, the City of Costa Mesa hereby denies Yellowstone Recovery’s request for a reasonable accommodation to allow Yellowstone to operate in an R1 zone with up to 15 residents.

Should your client wish to appeal this determination to the Planning Commission, please file a written notice of appeal, including a brief summary of the reasons for the appeal, with the City Clerk within 7 days of the date of this letter, pursuant to Section 2-305(2) of the Costa Mesa Municipal Code. Otherwise, please inform your client that Yellowstone Recovery must come into compliance with the City’s Zoning Code within 30 days of the date of this letter.

If you have further questions please do not hesitate to contact me or Gary Armstrong, Development Services Director, at the City of Costa Mesa, (714) 754-5270.

Very truly yours,



Elena Q. Gerli
Deputy City Attorney
City of Costa Mesa

Attachment No. 8

August 26, 2014, Yellowstone Recovery
appeal request

STEVEN G. POLIN, ESQ.
Attorney At Law
Admitted to DC & MD

3034 TENNYSON ST. N.W.
WASHINGTON, D.C. 20015

TEL (202) 331-5848
FAX (202) 331-5849
SPOLIN2@EARTHLINK.NET

August 26, 2014

SENT VIA FIRST ELECTRONIC MEANS AND FIRST CLASS MAIL

Jim Fitzpatrick, Chair
Planning Commission
City of Costa Mesa
77 Fair Drive
Costa Mesa, CA 92626

Gary Armstong, Director
Development Services
City of Costa Mesa
77 Fair Drive
Costa Mesa, CA 92626

RE: Appeal of denial of reasonable accommodation
request
Yellowstone Recovery
3132 Boston Way

Gentlemen:

Chris Brancart of Pescadero, California and I are counsel to Yellowstone Recovery. Please consider this letter to be notice of Yellowstone Recovery's appeal of the denial of its request for a reasonable accommodation as outlined in the letter dated August 19, 2014 by Elena Q. Gerli, Deputy City Attorney. (Attached)

The nature of the requested accommodation is detailed in our letter dated June 5, 2014, which is attached. The requested accommodation is to treat the use of 3132 Boston Way as a single housekeeping unit and waive the limit of six persons who may reside together in an R-1 zone. 3132 Boston Way has been used by Yellowstone Recovery since 2001 as a residence for up to 15 recovering alcoholics and substance who have lived and functioned together as a single housekeeping unit. The grounds for appeal of the denial is as follows:

- The burden of proof was impermissibly shifted to Yellowstone Recovery to demonstrate why granting the requested accommodation would not cause a fundamental alteration to the City's zoning code.
- The denial ignores the therapeutic benefit that is necessary to the recovery of the Yellowstone residents by having more than six (6) unrelated alcoholics and substance abusers residing together as a single housekeeping unit.

Jim Fitzpatrick
Gary Armstrong
August 26, 2014

- The denial fails to take into consideration that recovering alcoholics and substance abusers have one or more impairments which substantially limits one or more major life activities, i.e. the ability to live independently without the use of drugs or alcohol.
- The request to waive the limitation of the number of unrelated persons that can reside together as a family, waiver of single lease requirements, and treatment as a single housekeeping units are reasonable requests.

Please do not hesitate to contact me at 202-331-5848 or email me at spolin2@earthlink.net if you have any questions or need additional information.

Sincerely yours,



Steven G. Polin

cc: Chris Brancart
Yellowstone Recovery
Isaac Zfaty

Attachment No. 9

Emails between DCA Elena Q. Gerli and
Yellowstone's counsel setting up hearing
date for October 13, 2014

Elena Q. Gerli

From: Elena Q. Gerli
Sent: Monday, September 15, 2014 11:37 AM
To: steven g. polin; Christopher Brancart
Subject: RE: Yellowstone reasonable accomodation appeal hearing date

Mr. Polin: as I have not received confirmation from your office about this matter, I will give the City Clerk direction to send you a letter notifying you that the hearing date is set for October 13, 2014. If you them wish to request a continuance, you may do so.

Please let me know if I can be of further assistance.

Sincerely,

Elena Q. Gerli
Jones & Mayer
3777 N. Harbor Boulevard
Fullerton, CA 92835
(714) 446-1400
(714) 446-1448 fax
(714) 745-3632 cell

From: steven g. polin [spolin2@earthlink.net]
Sent: Monday, September 08, 2014 8:58 AM
To: Elena Q. Gerli; Christopher Brancart
Subject: Re: Yellowstone reasonable accomodation appeal hearing date

I am confirming with yellowstone. will let you know when I know

Steven G. Polin
Law Office of Steven G. Polin
3034 Tennyson Street, NW
Washington, DC 20015
202-331-5848
202-331-5849 (fax)
spolin2@earthlink.net

(Admitted in D.C. and MD)

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stored or retained by anyone other than the named addressee(s), except with the express consent of the sender or the named addressee(s). Thank you.

From: Elena Q. Gerli
Sent: Monday, September 08, 2014 11:54 AM
To: Christopher Brancart
Cc: spolin2@earthlink.net
Subject: RE: Yellowstone reasonable accomodation appeal hearing date

Mr. Polin: please confirm that October 13, 2014 works for your clients as the date of the appeal hearing. Thank you.

Sincerely,

Elena Q. Gerli
Jones & Mayer
3777 N. Harbor Boulevard
Fullerton, CA 92835
(714) 446-1400
(714) 446-1448 fax
(714) 745-3632 mobile

From: Christopher Brancart [mailto:cbrancart@brancart.com]
Sent: Wednesday, September 03, 2014 11:56 PM
To: Elena Q. Gerli
Cc: spolin2@earthlink.net
Subject: Re: Yellowstone reasonable accomodation appeal hearing date

I will provide you with the packet that will also be given to the commissioners about 10 days before the hearing. Mr. Brancart, please advise if you are withdrawing or amending today's PRA request. Please also provide me with the materials that you intend to submit to the commission in a timely manner.

Thank you. I will discuss withdrawal with Steve and get back to you.

On Wed, Sep 3, 2014 at 4:30 PM, Elena Q. Gerli <EQG@jones-mayer.com> wrote:

Mr. Polin: per our conversation, please disregard the notice of the hearing taking place on September 8, 2014. I have confirmed that a Planning Commission meeting is scheduled for Monday, October 13, 2014. The City is not closed on Columbus Day, so the meeting will proceed as usual.

Please confirm by return email that you would like the hearing on that day, and not on September 22.

I will provide you with the packet that will also be given to the commissioners about 10 days before the hearing. Mr. Brancart, please advise if you are withdrawing or amending today's PRA request. Please also provide me with the materials that you intend to submit to the commission in a timely manner.

Once I receive confirmation that October 13, 2014 is agreeable, the city clerk will issue a new notice.

Sincerely,

Elena Q. Gerli

Jones & Mayer

3777 N. Harbor Boulevard

Fullerton, CA 92835

(714) 446-1400

(714) 446-1448 fax

(714) 745-3632 cell

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Christopher Brancart
Brancart & Brancart
(650) 879-0141 (voice)
(650) 879-1103 (fax)

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No virus found in this message.

Checked by AVG - www.avg.com

Version: 2014.0.4765 / Virus Database: 4015/8175 - Release Date: 09/08/14

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Attachment No. 10

Letter from City to Yellowstone Recovery,
dated September 22, 2014 setting appeal
hearing for October 13, 2014



CITY OF COSTA MESA

P.O. BOX 1200 • 77 FAIR DRIVE • CALIFORNIA 92628-1200

DEVELOPMENT SERVICES DEPARTMENT

September 22, 2014

Steven G. Polin, ESQ.
Attorney At Law
3034 Tennyson Street. N.W.
Washington, D.C. 20015
Spolin2@earthlink.net

Dear Mr. Polin,

This letter is being sent as an acknowledgment of the receipt of your appeal of the denial of reasonable accommodation request for, Yellowstone Recover, located at 3132 Boston Way in the City of Costa Mesa as outlined in your letter dated August 26, 2014. Consistent with City procedures this appeal has been scheduled for Planning Commission Consideration on October 13, 2014. The Planning Commission meetings are held in the Council Chamber at 77 Fair Drive, starting at 6:00PM. A pre-meeting, also open to the public is held in Conference Room 1A, just off the City Hall Lobby, at 5:30 PM, prior to Planning Commissions meetings.

A staff report with attachments will be provide to you, when the Agenda Item has been finalized. This would typically occur on Friday October 3, 2014. The staff report will be emailed followed by a hard copy for your convenience.

If you have any questions or concerns regarding this appeal, please contact me at 714-754-5631 or jerry.guarracino@costamesaca.gov ; or Elena Q. Gerli, Deputy City Attorney, at 174-446-1400 or EQG@jones-mayer.com .

Sincerely,

Jerry Guarracino, AICP
Assistant Director
Community Improvement Division

cc: Chris Brancart
Yellowstone Recovery
Gary Armstrong
Elena Q. Gerli
Jim Fitzpatrick, PC Chair

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Attachment No. 11

Emails between DCA Elena Q. Gerli and
Yellowstone's counsel re-continuing the
hearing to December 8, 2014

Elena Q. Gerli

From: Elena Q. Gerli
Sent: Thursday, October 02, 2014 11:31 AM
To: Steven Polin
Cc: Christopher Brancart; Honey Thames; Isaac Zfaty
Subject: RE: Yellowstone reasonable accomodation appeal hearing date

Steve: December 8, 2014 works, so the hearing will be scheduled for that meeting. You will receive a confirmation letter from the City with the new date in a few days.

Please let me know if I can be of further assistance.

e

Elena Q. Gerli

Jones & Mayer

3777 N. Harbor Boulevard

Fullerton, CA 92835

(714) 446-1400

(714) 446-1448 fax

From: Steven Polin [spolin2@earthlink.net]
Sent: Thursday, October 02, 2014 11:24 AM
To: Elena Q. Gerli
Cc: Christopher Brancart; Honey Thames; Isaac Zfaty
Subject: Re: Yellowstone reasonable accomodation appeal hearing date

Thanks
Sent from my iPhone

> On Oct 2, 2014, at 12:03 PM, "Elena Q. Gerli" <EQG@jones-mayer.com> wrote:

>

> Thanks Steve. Stand by I will check with the City to make sure we're good with the date and get back to you today. I don't anticipate any problems.

>

> e

>

> Elena Q. Gerli

>

> Jones & Mayer

>

> 3777 N. Harbor Boulevard

>

> Fullerton, CA 92835

>

> (714) 446-1400

>

> (714) 446-1448 fax

>

> (714) 745-3632 cell

>

>

> From: steven g. polin [spolin2@earthlink.net]

> Sent: Thursday, October 02, 2014 9:00 AM

> To: Elena Q. Gerli; Christopher Brancart

> Cc: Honey Thames; Isaac Zfaty

> Subject: Re: Yellowstone reasonable accomodation appeal hearing date

>

> Elana, I have back to back to back to back jury trial scheduled from

> the middle of october until the middle of november as well as other commitments.

> December 8 is the best earliest date that I am available. So I am

> requesting that Yellowstone matter currently scheduled from October

> 13, 2014 be rescheduled until December 8, 2014.

>

> thanks

>

>

>

> Steven G. Polin

> Law Office of Steven G. Polin

> 3034 Tennyson Street, NW

> Washington, DC 20015

Elena Q. Gerli

From: steven g. polin <spolin2@earthlink.net>
Sent: Thursday, October 02, 2014 9:00 AM
To: Elena Q. Gerli; Christopher Brancart
Cc: Honey Thames; Isaac Zfaty
Subject: Re: Yellowstone reasonable accomodation appeal hearing date

Categories: Moved to Laserfiche

Elana, I have back to back to back to back jury trial scheduled from the middle of october until the middle of november as well as other commitments.
December 8 is the best earliest date that I am available. So I am requesting that Yellowstone matter currently scheduled from October 13, 2014 be rescheduled until December 8, 2014.

thanks

Steven G. Polin
Law Office of Steven G. Polin
3034 Tennyson Street, NW
Washington, DC 20015
202-331-5848
202-331-5849 (fax)
spolin2@earthlink.net

(Admitted in D.C. and MD)

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-----Original Message-----

From: Elena Q. Gerli
Sent: Thursday, September 25, 2014 4:09 PM
To: steven g. polin ; Christopher Brancart
Cc: Honey Thames ; Isaac Zfaty
Subject: RE: Yellowstone reasonable accomodation appeal hearing date

Hi Steven - I have yet to hear from you about this. Currently the hearing is set for October 13, 2014, and will continue to be set for that date until the City receives a written request for a different date. An email to me will suffice, but I actually need a response from you with a firm date.

Please feel free to call if I can be of assistance.

Thank you for your cooperation.

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Sincerely,

Elena Q. Gerli

Jones & Mayer

3777 N. Harbor Boulevard

Fullerton, CA 92835

(714) 446-1400

(714) 446-1448 fax

(714) 745-3632 cell

From: Elena Q. Gerli
Sent: Monday, September 22, 2014 11:10 AM
To: steven g. polin; Christopher Brancart
Cc: Honey Thames; Isaac Zfaty
Subject: RE: Yellowstone reasonable accomodation appeal hearing date

Hi Steven - got it. How about October 27? That is the next PC meeting.

Here is the city calendar, you can see when the meetings are.
<http://www.costamesaca.gov/index.aspx?page=28>

Sincerely,

Elena Q. Gerli
Jones & Mayer
3777 N. Harbor Boulevard
Fullerton, CA 92835
(714) 446-1400
(714) 446-1448 fax
(714) 745-3632 mobile

-----Original Message-----

From: steven g. polin [mailto:spolin2@earthlink.net]
Sent: Thursday, September 18, 2014 9:58 AM
To: Elena Q. Gerli; Christopher Brancart
Cc: Honey Thames; Isaac Zfaty
Subject: Re: Yellowstone reasonable accomodation appeal hearing date

Elena, I was just reminded that we will be in new york that weekend for a family wedding. the travel makes it impossible for me to be in cm on the 13th. lets talk about dates in november or december, when im available.

Steven G. Polin

Law Office of Steven G. Polin
3034 Tennyson Street, NW
Washington, DC 20015
202-331-5848
202-331-5849 (fax)
spolin2@earthlink.net

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-----Original Message-----

From: Elena Q. Gerli
Sent: Monday, September 15, 2014 2:37 PM
To: steven g. polin ; Christopher Brancart
Subject: RE: Yellowstone reasonable accomodation appeal hearing date

Mr. Polin: as I have not received confirmation from your office about this matter, I will give the City Clerk direction to send you a letter notifying you that the hearing date is set for October 13, 2014. If you them wish to request a continuance, you may do so.

Please let me know if I can be of further assistance.

Sincerely,

Elena Q. Gerli

Jones & Mayer

3777 N. Harbor Boulevard

Fullerton, CA 92835

(714) 446-1400

(714) 446-1448 fax

(714) 745-3632 cell

From: steven g. polin [spolin2@earthlink.net]
Sent: Monday, September 08, 2014 8:58 AM
To: Elena Q. Gerli; Christopher Brancart
Subject: Re: Yellowstone reasonable accomodation appeal hearing date

I am confirming with yellowstone. will let you know when I know

Steven G. Polin
Law Office of Steven G. Polin
3034 Tennyson Street, NW
Washington, DC 20015
202-331-5848
202-331-5849 (fax)
spolin2@earthlink.net

(Admitted in D.C. and MD)

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From: Elena Q. Gerli<mailto:EQG@jones-mayer.com>
Sent: Monday, September 08, 2014 11:54 AM
To: Christopher Brancart<mailto:cbrancart@brancart.com>
Cc: spolin2@earthlink.net<mailto:spolin2@earthlink.net>
Subject: RE: Yellowstone reasonable accomodation appeal hearing date

Mr. Polin: please confirm that October 13, 2014 works for your clients as the date of the appeal hearing. Thank you.

Sincerely,

Elena Q. Gerli
Jones & Mayer
3777 N. Harbor Boulevard
Fullerton, CA 92835
(714) 446-1400
(714) 446-1448 fax
(714) 745-3632 mobile

From: Christopher Brancart [mailto:cbrancart@brancart.com]
Sent: Wednesday, September 03, 2014 11:56 PM
To: Elena Q. Gerli
Cc: spolin2@earthlink.net
Subject: Re: Yellowstone reasonable accomodation appeal hearing date

I will provide you with the packet that will also be given to the commissioners about 10 days before the hearing. Mr. Brancart, please advise if you are withdrawing or amending today's PRA request. Please also provide me with the materials that you intend to submit to the commission in a timely manner.
Thank you. I will discuss withdrawal with Steve and get back to you.

On Wed, Sep 3, 2014 at 4:30 PM, Elena Q. Gerli <EQG@jones-mayer.com<mailto:EQG@jones-mayer.com>> wrote:
Mr. Polin: per our conversation, please disregard the notice of the hearing taking place on September 8, 2014. I have confirmed that a Planning Commission meeting is scheduled for Monday, October 13, 2014. The City is not closed on Columbus Day, so the meeting will proceed as usual.

Please confirm by return email that you would like the hearing on that day, and not on September 22.

I will provide you with the packet that will also be given to the commissioners about 10 days before the hearing. Mr. Brancart, please advise if you are withdrawing or amending today's PRA request. Please also provide me with the materials that you intend to submit to the commission in a timely manner.

Once I receive confirmation that October 13, 2014 is agreeable, the city clerk will issue a new notice.

Sincerely,

Elena Q. Gerli

Jones & Mayer

3777 N. Harbor Boulevard

Fullerton, CA 92835

(714) 446-1400

(714) 446-1448 fax

(714) 745-3632 cell

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Christopher Brancart
Brancart & Brancart
(650) 879-0141 (voice)
(650) 879-1103 (fax)

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Elena Q. Gerli

From: Elena Q. Gerli
Sent: Thursday, September 25, 2014 1:09 PM
To: steven g. polin; Christopher Brancart
Cc: Honey Thames; Isaac Zfaty
Subject: RE: Yellowstone reasonable accomodation appeal hearing date

Importance: High

Hi Steven - I have yet to hear from you about this. Currently the hearing is set for October 13, 2014, and will continue to be set for that date until the City receives a written request for a different date. An email to me will suffice, but I actually need a response from you with a firm date. Please feel free to call if I can be of assistance.

Thank you for your cooperation.

Sincerely,

Elena Q. Gerli

Jones & Mayer

3777 N. Harbor Boulevard

Fullerton, CA 92835

(714) 446-1400

(714) 446-1448 fax

(714) 745-3632 cell

From: Elena Q. Gerli
Sent: Monday, September 22, 2014 11:10 AM
To: steven g. polin; Christopher Brancart
Cc: Honey Thames; Isaac Zfaty
Subject: RE: Yellowstone reasonable accomodation appeal hearing date

Hi Steven - got it. How about October 27? That is the next PC meeting.

Here is the city calendar, you can see when the meetings are. <http://www.costamesaca.gov/index.aspx?page=28>

Sincerely,

Elena Q. Gerli
Jones & Mayer
3777 N. Harbor Boulevard
Fullerton, CA 92835
(714) 446-1400

(714) 446-1448 fax
(714) 745-3632 mobile

-----Original Message-----

From: steven g. polin [mailto:spolin2@earthlink.net]
Sent: Thursday, September 18, 2014 9:58 AM
To: Elena Q. Gerli; Christopher Brancart
Cc: Honey Thames; Isaac Zfaty
Subject: Re: Yellowstone reasonable accomodation appeal hearing date

Elena, I was just reminded that we will be in new york that weekend for a family wedding. the travel makes it impossible for me to be in cm on the 13th. lets talk about dates in november or december, when im available.

Steven G. Polin
Law Office of Steven G. Polin
3034 Tennyson Street, NW
Washington, DC 20015
202-331-5848
202-331-5849 (fax)
spolin2@earthlink.net

(Admitted in D.C. and MD)

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-----Original Message-----

From: Elena Q. Gerli
Sent: Monday, September 15, 2014 2:37 PM
To: steven g. polin ; Christopher Brancart
Subject: RE: Yellowstone reasonable accomodation appeal hearing date

Mr. Polin: as I have not received confirmation from your office about this matter, I will give the City Clerk direction to send you a letter notifying you that the hearing date is set for October 13, 2014. If you them wish to request a continuance, you may do so.

Please let me know if I can be of further assistance.

Sincerely,

Elena Q. Gerli

Jones & Mayer

3777 N. Harbor Boulevard

Fullerton, CA 92835

(714) 446-1400

(714) 446-1448 fax

(714) 745-3632 cell

From: steven g. polin [spolin2@earthlink.net]
Sent: Monday, September 08, 2014 8:58 AM
To: Elena Q. Gerli; Christopher Brancart
Subject: Re: Yellowstone reasonable accomodation appeal hearing date

I am confirming with yellowstone. will let you know when I know

Steven G. Polin
Law Office of Steven G. Polin
3034 Tennyson Street, NW
Washington, DC 20015
202-331-5848
202-331-5849 (fax)
spolin2@earthlink.net

(Admitted in D.C. and MD)

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From: Elena Q. Gerli<mailto:EQG@jones-mayer.com>
Sent: Monday, September 08, 2014 11:54 AM
To: Christopher Brancart<mailto:cbrancart@brancart.com>
Cc: spolin2@earthlink.net<mailto:spolin2@earthlink.net>
Subject: RE: Yellowstone reasonable accomodation appeal hearing date

Mr. Polin: please confirm that October 13, 2014 works for your clients as the date of the appeal hearing. Thank you.

Sincerely,

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Elena Q. Gerli
Jones & Mayer
3777 N. Harbor Boulevard
Fullerton, CA 92835
(714) 446-1400
(714) 446-1448 fax
(714) 745-3632 mobile

From: Christopher Brancart [mailto:cbrancart@brancart.com]
Sent: Wednesday, September 03, 2014 11:56 PM
To: Elena Q. Gerli
Cc: spolin2@earthlink.net
Subject: Re: Yellowstone reasonable accomodation appeal hearing date

I will provide you with the packet that will also be given to the commissioners about 10 days before the hearing. Mr. Brancart, please advise if you are withdrawing or amending today's PRA request. Please also provide me with the materials that you intend to submit to the commission in a timely manner.
Thank you. I will discuss withdrawal with Steve and get back to you.

On Wed, Sep 3, 2014 at 4:30 PM, Elena Q. Gerli <EQG@jones-mayer.com<mailto:EQG@jones-mayer.com>> wrote:
Mr. Polin: per our conversation, please disregard the notice of the hearing taking place on September 8, 2014. I have confirmed that a Planning Commission meeting is scheduled for Monday, October 13, 2014. The City is not closed on Columbus Day, so the meeting will proceed as usual.

Please confirm by return email that you would like the hearing on that day, and not on September 22.

I will provide you with the packet that will also be given to the commissioners about 10 days before the hearing. Mr. Brancart, please advise if you are withdrawing or amending today's PRA request. Please also provide me with the materials that you intend to submit to the commission in a timely manner.

Once I receive confirmation that October 13, 2014 is agreeable, the city clerk will issue a new notice.

Sincerely,

Elena Q. Gerli
Jones & Mayer
3777 N. Harbor Boulevard
Fullerton, CA 92835

(714) 446-1400

(714) 446-1448 fax

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--
Christopher Brancart
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Attachment No. 12

Letter from City, dated October 8, 2014,
continuing appeal hearing to December 8,
2014



CITY OF COSTA MESA

P.O. BOX 1200 • 77 FAIR DRIVE • CALIFORNIA 92628-1200

DEVELOPMENT SERVICES DEPARTMENT

October 8, 2014

Steven G. Polin, ESQ.
Attorney At Law
3034 Tennyson Street. N.W.
Washington, D.C. 20015
Spolin2@earthlink.net

Dear Mr. Polin,

This letter is being sent as an acknowledgment of the receipt, of your request for a continuance of the appeal of the denial of reasonable accommodation request for Yellowstone Recovery, located at 3132 Boston Way in the City of Costa Mesa as outlined in your email to Elena Gerli, Deputy City Attorney, dated October 2, 2014. Consistent with City procedures this appeal had been scheduled for Planning Commission Consideration on October 13, 2014. However, pursuant to your request, due to a scheduling conflict of counsel, this items has been continued until December 8, 2014, which you indicated was the best and earliest date that you are available.

As indicated previously the Planning Commission meetings are held in the Council Chamber at 77 Fair Drive, starting at 6:00PM. A pre-meeting, also open to the public is held in Conference Room 1A, just off the City Hall Lobby, at 5:30 PM, prior to Planning Commissions meetings.

A staff report with attachments will be provided to you when the Agenda Item has been finalized. This would typically occur on Friday November 28, 2014. The staff report will be emailed followed by a hard copy for your convenience.

If you have any questions or concerns regarding this appeal, please contact me at 714-754-5631 or jerry.guarracino@costamesaca.gov ; or Elena Q. Gerli, Deputy City Attorney, at 174-446-1400 or EQG@jones-mayer.com .

Sincerely,

Jerry Guarracino, AICP
Assistant Director
Community Improvement Division

cc: Chris Brancart
Yellowstone Recovery
Gary Armstrong
Elena Q. Gerli
Jim Fitzpatrick, PC Chair

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Attachment No. 13

General Plan 2000, Chapter 2, Land Use
Element



CHAPTER 2 LAND USE ELEMENT

2.1 PURPOSE

The Land Use Element serves as the long-range planning guide for development in the City by indicating the location and extent of development to be allowed. More than any other element, the Land Use Element will have a major impact on the form and character of Costa Mesa over the next 20 years.

Through the implementation of the Land Use Element, the City seeks to accomplish the following:

- ◆ Establish and maintain an orderly pattern of development in the City;
- ◆ Establish a land use classification system that implements land use policies;
- ◆ Identify acceptable land uses and their general location; and
- ◆ Establish standards for residential density and non-residential building intensity for existing and future development.

The essential components of the Land Use Element are the General Plan Land Use Plan Map (Exhibit LU-4) and the goals and policies that guide future development. While the General Plan Land Use Map may be seen as the most essential component of the entire 2000 General Plan, it is basically a graphic representation of the policies expressed by all of the 2000 General Plan's elements. Users of this document are advised to refer to the policies as well as the diagram when evaluating proposed development and capital improvement projects.

The requirements for the Land Use Element are contained in Government Code Section 65302(a). The element must designate the general distribution, location, and extent of land used for housing, business, industry, open space (including agriculture and parks), education, public buildings and lands, and waste disposal

facilities. Standards for population density and building intensity in each planning district are also required.

2.2 RELATIONSHIP TO OTHER GENERAL PLAN ELEMENTS

The Land Use Element serves as the primary means of integrating the policies in other elements of the 2000 General Plan with the proposed pattern of land uses designated on the General Plan Land Use Map. The Housing Element contains policies for residential development, which also are considered in the Land Use Element. The Circulation Element provides for the maintenance of a transportation network that will support the ultimate land uses established on the Land Use Map. The Safety Element identifies hazards that need to be considered in land use planning for the City. The noise contours in the Noise Element are used as a guide to establish the land use patterns to ensure that future development minimizes exposure of residents to excessive noise. The Open Space and Recreation Element designates sites for community open space uses which are considered along with other provisions of the Land Use Element. The goals and policies of the Community Design Element establish criteria for quality development, which are also coordinated with development-oriented policies of the Land Use Element.

2.3 SUMMARY OF EXISTING CONDITIONS

This section provides an overview of existing land use patterns throughout the City. Statistical land use information is summarized in Table LU-1, *Land Use Designations (2001)*. Vacant parcels in the City as of September 2001 are shown in Exhibit LU-1, *Vacant Land*.

RESIDENTIAL AREAS

The Low-Density Residential land use designation covers 27 percent of the net acreage of the City and its sphere of influence. This high percentage of low-density is not unique to Costa Mesa, but is found throughout several communities in Orange County. The accelerated demand for suburban homes experienced in the mid 1950s and 1960s resulted in the conversion of thousands of agricultural acres to large single-family housing tracts. Today this use remains predominant in Costa Mesa. New opportunities for large-scale, single-family development are limited with less than two acres of undeveloped Low-Density Residential land remaining. Recent single-family construction has taken the form of in-fill development, especially in the area east of Newport Boulevard but at a higher density than traditional single-family neighborhoods.

Medium and High-Density Residential Land Uses account for 21 percent of the net acreage of the City. In many instances, existing residential development density exceeds the allowed number of dwelling units per acre

Insert Exhibit LU-1
Vacant Land

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TABLE LU-1: LAND USE DESIGNATIONS (2005)

Land Use Designation	Residential Density DU/Acre*	Floor Area Ratio	Acres Developed	Acres Undeveloped (1999)	Total Acres	% of City
Low-Density Residential	≤8	Same as Neighborhood Commercial	2,143.4	1.8	2,145.2	26.6%
Medium-Density Residential ^{1,6}	≤12	Same as Neighborhood Commercial	777.3	30.7	808.0	10.0%
High-Density Residential ^{1,6}	≤20 ²	Same as Neighborhood Commercial	824.1	42.0	866.1	10.7%
Commercial-Residential	≤17.4	0.20/High Traffic 0.30/Moderate Traffic 0.40/Low Traffic	42.6	0.9	43.5	0.5%
Neighborhood Commercial ⁶	-	0.15/High Traffic 0.25/Moderate Traffic 0.35/Low Traffic 0.75/Very Low Traffic	42.4	2.5	44.9	0.6%
General Commercial ⁶	≤20	0.20/High Traffic 0.30/Moderate Traffic 0.40 Low Traffic 0.75/Very Low Traffic	605.1	20.8	625.9	7.7%
Commercial Center ⁶	≤20 ≤40 site-specific density for 1901 Newport Blvd ³	0.25/High Traffic 0.35/Moderate Traffic 0.45 Low Traffic 0.75/Very Low Traffic 0.70 Site-Specific FAR for 1901 Newport Blvd ³	29.4	63.3	92.7	1.1%
Regional Commercial	≤20	0.652/0.89 ⁴	114.7	0.0	114.7	1.4%
Urban Center Commercial	≤20 ⁵ ≤100 Site-Specific Density for South Coast Metro Center ⁵	0.50 Retail 0.60 Office 0.79 Site-Specific FAR for South Coast Metro Center ⁵	134.2	26.2	160.4	2.0%
Cultural Arts Center	Varies ⁷	1.77 ⁷	49.0	5.0	54.0	0.7%
Industrial Park	≤20	0.20/High Traffic 0.30/Moderate Traffic 0.40/Low Traffic 0.75/Very Low Traffic	696.5	17.7	714.2	8.8%
Light Industry ⁶	≤20	0.15/High Traffic 0.25/Moderate Traffic 0.35/Low Traffic 0.75/Very Low Traffic	375.5	6.6	382.1	4.7%
Public/Institutional	-	0.25	1,281.3	0.5	1,281.8	15.9%
Golf Course	-	<0.01	560.1	0.0	560.1	6.9%
Fairgrounds	-	<0.10	146.4	0.0	146.4	1.8%
Total			7,822.0	218.0	8,040.0	100.0%

1. Within the Medium- and High-Density Residential designation, existing residential units legally built in excess of the dwelling units per acre standard may be rebuilt at the same higher density subject to other zoning code standards. The allowable density or number of units to be redeveloped would be limited to the 1990 General Plan density with a 25% incentive bonus for Medium-Density or a 50% incentive bonus for High-Density; or the existing number of units, whichever is less. 2. See High-Density Residential text regarding areas in North Costa Mesa where the density allowance exceeds 20 units per acre. 3. See Commercial Center text. 4. See Regional Commercial text. 5. See Urban Center Commercial text. 6. See text for Mixed-Use Development provisions. 7. See Cultural Arts Center text for additional discussion.

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within Medium and High-Density Residential designations. This is primarily the result of changes in the 1990 General Plan that reduced residential densities. This change was primarily a reflection of the community's concerns for quality of life issues related to traffic and a more appropriate balance between the amount of land devoted to multi-family and single-family development. The density of these existing legal, non-conforming residential developments is accounted for in the growth and traffic projections of this 2000 General Plan.

COMMERCIAL AREAS

Commercial land use designations encompass 13 percent of the City's land area. The 1,086 acres designated for commercial uses contain approximately 16.6 million square feet of commercial space. These uses are spread throughout the City, divided into seven commercial designations and one mixed-use designation (Commercial-Residential) (refer to Table LU-1). South Coast Plaza contains the largest single concentration of retail uses in the City. It accounts for 30 percent of the City's commercial square footage and 25 percent of the retail sales. Within this same area, the development in the Town Center area contains 20 percent of the City's office space.

The Harbor Boulevard commercial district encompasses almost one-third of Costa Mesa's commercial land. The district is responsible for 40 percent of the City's retail sales, indicating that Harbor Boulevard's trade area is of a regional scale. The major factor for this is the concentration of new car dealerships on Harbor Boulevard.

The 92-acre East 17th Street commercial district contains a variety of commercial uses, including retail, service, and office. The area generally serves local residences and businesses. One-tenth of the City's retail sales is attributable to East 17th Street businesses.

INDUSTRIAL AREAS

Industrial land use designations encompass 1,097 acres of land in Costa Mesa. These uses are primarily concentrated in three major districts: the Southwest District, the Airport Industrial District, and the North Costa Mesa Industrial District (refer to Table LU-2). The Southwest District is the City's oldest industrial area and the two other areas are more recently developed industrial parks located in the northwest and northeast sections of the City.

The Southwest District contains 312 acres and represents 88 percent of the City's land designated for Light Industry. This area contained a substantial amount of industrial development before the City was incorporated. The area contains several large manufacturing firms as well as a high percentage of smaller industrial operations, frequently in multi-tenant structures. The Southwest District is one of Costa Mesa's major employment centers employing approximately one-fourth of the City's employees engaged in manufacturing-related jobs. Forty-one (41) percent of the manufacturing employers are located in this district.

The 390-acre Airport Industrial Area is a portion of the much larger Irvine Industrial Complex, which extends into the cities of Irvine and Tustin. This area is characterized by large parcels and wide landscaped setbacks. Several firms have located their main or regional headquarters in the area and are often the single tenants in large structures.

**TABLE LU-2
INDUSTRIAL AREAS**

Industrial Area	General Plan	Total Acres
Southwest	Light Industry	312
Airport	Industrial Park	390
North	Industrial Park	323
Other	Light Industry	72
	Total	1,097

The third industrial area is the 323-acre industrial park located between the San Diego Freeway, Fairview Road, the Santa Ana River, and the northerly City limits. This district is a part of a larger industrial area which extends northward into the City of Santa Ana. The primary users of this industrial area are large single-tenant manufacturing firms and corporate offices. Included within this district is the 14.5-acre portion of the Home Ranch area located north of South Coast Drive and west of Susan Street.

The remaining 72 acres of land designated for light industrial uses are located in five smaller pockets in various sections of the City. These areas are generally characterized by small parcels in areas, which were designated for industrial uses by the City's original zoning plan.

PUBLIC AND INSTITUTIONAL AREAS

Costa Mesa contains a relatively high percentage of land designated for public and institutional use. A total of 1,281 acres is specified in this category. When combined with the golf course and fairgrounds designations, these uses constitute 25 percent of the City's area.

This high proportion is primarily the result of past actions of various governmental entities. The development of the Santa Ana Army Air Base during World War II was the first major land acquisition by a governmental agency. This site has since been divided and remains largely in public ownership. The current users of the site are: Orange Coast College, Costa Mesa High School, Davis Middle School, Presidio Elementary School, TeWinkle Park, the National Guard Armory, Orange County Fairgrounds, Costa Mesa Farm Soccer Complex, Civic Center Park, City Hall, and Vanguard University.

A major land acquisition by the State in 1950 was responsible for the public ownership of the Costa Mesa Golf and Country Club, and Fairview Park. In 1950, 750 acres were acquired for a State institution. Today, the Fairview Developmental Center occupies 111 acres of the original 750 acre site. The golf course and most of Fairview Park belong to the City. Acquisitions by the City and County have expanded this area to include the Talbert Regional Park site adjacent to the Santa Ana River and the adjoining City Canyon Park.

Three golf courses exist within Costa Mesa and its sphere of influence. The previously mentioned Costa Mesa Golf and Country Club is the only one of the three open to the public.

The 150-acre Orange County Fairgrounds is owned by the 32nd District Agricultural Association and as such, the City has limited land use control. The site is developed with an outdoor amphitheater; exhibit halls, and equestrian facilities. The Fair Board maintains a master plan, which depicts the future development of the site.

LAND USE BALANCE

BALANCE OF LAND USES

Promoting a balance among the various land uses is one of the primary purposes of the Land Use Element. The diverse needs of the community require that land be designated for different uses in order to accommodate these needs. Human beings need places to live, work, shop, relax, and play. Providing sufficient quantities and locations of land for the various human uses and needs is a key ingredient of a functional urban environment.

HOUSING, POPULATION, AND EMPLOYMENT PROJECTIONS

Providing a land use arrangement that encourages a correlation of employment and housing opportunities is a local and regional responsibility. Providing sufficient commercial land to support residential development is primarily a local responsibility, although commercial uses, which serve regional needs are provided as well. Sufficient land must also be established to meet the recreational needs of the local community, although regional needs are often accommodated by land within individual cities.

Table LU-3, *Population, Housing, and Employment*, presents historical data for Costa Mesa's population, number of housing units, and employment opportunities, and includes projections to the year 2020. The table is based upon OCP-2000 Projections. Data, which is available for the 2000 Census, as of September 2001, has also incorporated in the Land Use and Housing Elements.

**TABLE LU-3
POPULATION, HOUSING, AND EMPLOYMENT**

	1980	1985	1990	2000 ¹	2020 ¹
Population	82,562	85,127	94,900	106,237	118,764
Housing	33,998	35,326	39,000	40,577	42,469
Employment	56,828	73,372	87,553	88,294	106,708
Notes: ¹ OCP-2000 Projections, Center for Demographic Research, California State University, Fullerton.					

JOBS/HOUSING RELATIONSHIP

The City's current variety and distribution of land uses enables people to live near their jobs, to shop within a reasonable distance from their homes or work, to use recreational areas, and to conveniently carry out other daily activities. Information available from the 1990 Census indicates that 32 percent of the employees who reside in Costa Mesa also work in the City. An additional 51 percent work within 20 minutes of their homes.

The City recognizes the importance of providing both job and housing opportunities, and, therefore, this 2000 General Plan provides specific policies and actions to address this issue.

BALANCE OF INDUSTRIAL AND COMMERCIAL USES

Since 1980, the amount of commercial acreage has increased while industrial acreage has slightly declined.

Current marketplace interest is in high-tech business parks and is moving away from light manufacturing structures. The high-tech business park developments are often more similar to office uses than traditional manufacturing uses. This has significant implications for parking requirements and estimates of traffic generation and employment.

There is also increasing marketplace pressure to utilize industrial areas for commercial uses due to lower land costs, product costs, etc. If this trend continues, the balance between commercial and industrial uses could change significantly.

Costa Mesa has established commercial areas, notably along the major arterials, the South Coast Metro Area (north of the I-405), and the Redevelopment Area (in the vicinity of Harbor Boulevard and 19th Street), which could be negatively impacted by the expansion of commercial uses into industrial zones. If commercial users are allowed to use the less expensive industrial space, the commercial zones may then begin to deteriorate as vacancy rates in commercial buildings increase.

2.4 KEY ISSUES

Often, the full impacts of development are not felt until an area is built to or near the intensity/density capacity of the general plan. The different types of development issues, along with their impacts and appropriate mitigations, are discussed below.

RESIDENTIAL DEVELOPMENT ISSUES

Early subdivisions in Costa Mesa established patterns that markedly affect the design of current developments. Prior to the City's incorporation, much of the eastside and the westside south of Wilson Street were subdivided into parcels approximately 300 feet deep. Many lots were further divided, resulting in lot widths of 60 to 66 feet. Many of these lots were vacant for a number of years; development of others consisted mainly of single-family homes with large garden areas.

As Costa Mesa grew and development pressures increased, construction on these narrow, deep lots often took the form of multi-family apartments. A typical site plan consisted of a driveway along one side of the parcel, units on the other side, and little usable open space except for a small area at the rear of the lot. This development pattern decreased overall land use efficiency because of the need to provide separate driveway access to each parcel.

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In the late 1970s, the problems associated with development of small, narrow, deep lots were officially addressed with the adoption of several specific plans. The specific plans encouraged lot consolidation by providing zoning incentives in the way of density increases.

The Placentia/Hamilton/Pomona/19th Street Specific Plan adopted in May 1979 allowed increased density on separate, smaller parcels if two or more parcels were developed as a single project. This unified development concept, illustrated in Exhibit LU-2, *Residential Lot Combination Opportunities*, permitted maintenance of separate ownerships while allowing the design flexibility of a larger site. The use of easements, deed restrictions, shared driveways, walkways, parking, and common open spaces give the impression of a single, unified development. Consistent architecture and landscaping themes also help to achieve the intent of lot combination.

Many of the constraints relating to narrow, deep lots also apply to small parcels. The same inefficiencies and hazards of multiple driveways also result. Of particular concern is the issue of constructing an additional unit while retaining the existing unit. The location of the existing unit severely constrains design and placement of the second unit.

Previous development standards establish 7,260 square feet for R2-MD as the minimum area for multi-family residential lots except individual lots within common-interest developments, known as small-lot subdivisions. Division of existing parcels according to this standard increases the number of subdivision-related development problems. To prevent continuation of this trend, minimum parcel area requirements for newly created multi-family lots was increased in 2001. For example, the Downtown Redevelopment Plan contains a minimum area requirement of 18,000 square feet for new multi-family parcels.

Common interest developments (i.e. an undivided interest in common in a portion of real property coupled with a separate interest in air space) also became popular in the 1970's. Since the mid- to late-1980's, small lot, single-family detached residential developments have become an emerging trend in homeownership. Along with the popularity of this type of housing has come a number of problems associated with individual lot sizes, building setbacks, building mass, neighborhood compatibility, and the provision of landscaping, open space and parking. Impacts to adjoining residential units often include decreases in natural light and fresh air as well as "overbearing" and "dwarfing" existing units.

Neighborhood compatibility issues surrounding small-lot residential developments occurring on long, narrow properties have intensified in recent years, especially throughout Costa Mesa's eastside. New development standards were created for small-lot subdivisions in 2001. These standards increased the minimum lot size and parking requirements for this type of development. Discretionary review and approval procedures were also added to ensure compatibility with the existing surrounding neighborhoods.

COMMERCIAL DEVELOPMENT ISSUES

Although most of the issues experienced with small parcels and narrow, deep parcels are related to residential development, a number of older commercial properties are subject to the same constraints. Most of the smaller commercial lots have been combined over the years to create larger building sites, but some,

Insert Exhibit LU-2, Residential Lot Combination Opportunities

mostly those developed in the City's early years, prior to incorporation, have substandard parking facilities. Along the east side of Newport Boulevard, many small parcels retain the original residential structures - some of which have been converted to commercial use.

Commercial intensity incentives could be offered in the form of increased building height or lot coverage. As building height limits are established primarily to protect adjacent properties, increased height on a larger parcel, where the structure can be further removed from the property line, would achieve the same purpose. Present development standards require commercial buildings to be set back from adjacent residential properties by a distance equal to twice the height of the commercial structure. The statutory height limit, however, is two stories, except that additional height may be granted by discretionary review and approval. This mechanism could be used to provide commercial lot consolidation incentives.

Increased lot coverage allowance is another potential incentive. Greater coverage can be achieved by eliminating the required side yard setback. Additional site planning efficiencies are realized as the number of driveways is reduced. Elimination of driveways through lot consolidation reduces the number of potential traffic conflict points, as well as improving on-site circulation.

Land use compatibility and traffic are also issues addressed in the 1996 "Newport Boulevard Specific Plan". Newport Boulevard has always served as the main thoroughfare in Costa Mesa's traditional downtown area. The area's first commercial buildings were constructed along the boulevard and many of the original buildings still stand today, particularly in the 1800 block.

Along Newport Boulevard, north of 19th Street, commercial uses have always had more limited exposure and visibility due to the one-way traffic flow and wide separation from land uses to the west. The boulevard's linear nature, one-way traffic flow, diversity of ownership patterns, and random mix of land uses contribute to its lack of unity and identity which in turn makes it difficult to attract new patrons and/or compatible businesses.

As an incentive to encourage private commercial redevelopment, the Newport Boulevard Specific Plan provides for an increase of 0.05 FAR over the Neighborhood Commercial land use designation. Based on the proximity of residential development that abuts the rear of many of the parcels along Newport Boulevard, and the fact that vacant land for residential development is very limited, the specific plan provides for residential development or neighborhood serving commercial as the most compatible land uses. The "Commercial-Residential" designation allows a complementary mix of residential and commercial uses, unlike any other land use designation in the 2000 General Plan. It is anticipated that individual parcels would be developed as either a commercial or residential use. A mix of both commercial and residential on one parcel would only occur in a Planned Development zoning district. Residential development would be encouraged provided that certain development standards are met pursuant to the Newport Boulevard Specific Plan. Density would range from 12 units per acre to 17.4 units per acre.

LAND USE COMPATIBILITY

As Costa Mesa continues to grow and to become more intensely urbanized, the potential for increased conflicts between existing and new land uses will also grow. The redevelopment of underutilized properties will continue to add more

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intense uses to the existing land use mix as the availability of developable land decreases and property values increase. This will create an overall increase in population and employment and all of the associated impacts of traffic congestion, noise, public safety, etc.

Residential infill projects in the way of small lot subdivisions could have negative impacts on established smaller scale neighborhoods. The design quality of such subdivisions is a key issue to be addressed during the design review process. The preservation of stable, quiet, and homogeneous neighborhoods is a prime concern of this 2000 General Plan.

One area that is experiencing a disproportionate amount of land use conflict is "Westside" Costa Mesa. The Westside was among the earliest areas in the City to develop and is characterized by a considerable diversity of people, land uses, job opportunities, and housing choices.

In an effort to address issues relating to economic redevelopment, deterioration of the 19th Street corridor, incompatible land uses (particularly in the area south of 19th Street), lack of code enforcement, deteriorating infrastructure, and blighted appearance of the streetscapes, the City Council commissioned the "Westside Specific Plan". Although not adopted, the plan will be used as a resource document for future planning and improvement work efforts in the area.

NOISE

The Noise Element defines noise as unwanted sound. Although this definition could encompass a wide spectrum of sound types, the most common noise sources in Costa Mesa are traffic and aircraft. Thus, existing and future noise levels have been examined and the Noise Element provides information on community noise impacts and appropriate mitigation measures.

AIRPORT CONSIDERATIONS

Both the Federal Aviation Administration (FAA) and the Airport Land Use Commission for Orange County have concern for the safety of air navigation around John Wayne Airport. Under Part 77 of the Federal Aviation Regulations (FAR), the FAA requires notice of proposed construction in excess of certain heights, which may affect the safety of aircraft operations. The authority of the FAA in these matters extends only as far as issuing a notice of hazard to air navigation; the FAA does not have jurisdiction to prohibit construction. The issuance of a hazard notice, however, may adversely affect the ability of a developer to obtain financing and insurance.

The FAA standard that is of most of concern in Costa Mesa is the horizontal surface for John Wayne Airport. This surface is 203.68 feet above mean sea level and extends nearly two miles from the airport.

The South Coast Plaza Town Center Master Plan (the area east of Bristol Street and north of the I-405) was approved subject to the condition that building height be limited to that specified by FAR Part 77 unless evidence is presented that the structure will not pose a hazard to air navigation nor interfere with instrument guidance systems. Evidence may be in the form of an FAA determination of no hazard.

A number of Town Center structures have received City approval although they encroach beyond the established horizontal surface elevation. In all cases obstruction lighting was required, and in some cases minor adjustments to seldom-used flight patterns were necessitated, but the safety of aircraft operations in the airport vicinity has not been compromised.

The horizontal surface established by the FAA places restrictions on future development proposals similar in scale to the Town Center buildings. These developments will also be required to provide mitigation for potential hazards to air safety.

The California Public Utilities Code provides for creation of countywide commissions to work towards achieving compatible land uses in the vicinity of airports. Commissions are required to formulate comprehensive land use plans, which may include acceptable uses, height restrictions, and other building standards, such as noise insulation. The Airport Land Use Commission for Orange County (ALUC) has established a planning area surrounding John Wayne Airport which sets forth standards for acceptable land uses and provides for review of development plans for properties within its planning area.

The Airport Environs Land Use Plan (AELUP), adopted by the Airport Land Use Commission, specifies acceptable uses proximate to the airport. These are defined as uses that will not subject people to adverse noise impacts, will not concentrate people in areas with high potential for aircraft accidents, and will not adversely affect navigable airspace or aircraft operations. Due to the small number of off-airport accidents in the history of John Wayne Airport, the ALUC has not found it necessary to designate an accident potential zone.

The AELUP for Heliports establishes regulations and restrictions for the siting of heliports and helipads/helistops. The purpose of the AELUP for Heliports is to protect the public from the adverse effects of aircraft noise by ensuring that heliports/helipads are sited in areas of compatible land use.

A heliport is a small airport suitable only for use by helicopters, typically containing one or more helipads. A helipad or helistop is a designated area, including any buildings or facilities, intended to be used for the landing and takeoff of helicopters. Helipads/helistops may or may not be located within heliports. Refueling and overnight maintenance of helicopters are permitted on heliports but prohibited on helipads/helistops.

The City will ensure that each applicant, seeking a Conditional Use Permit or similar approval for the construction or operation of a heliport or helistop, complies fully with the state permit procedure provided by law and with all conditions of approval imposed or recommended by the Federal Aviation Administration (FAA), by the Airport Land Use Commission for Orange County (ALUC) and by Caltrans/Division of Aeronautics. This requirement shall be in addition to all other City development requirements.

The City will also ensure that development proposals including the construction or alteration of a structure more than 200 feet above ground level, reference North American Vertical Datum 1988 (NAVD88), must fully comply with procedures provided by Federal and State law, including with the referral requirements of the ALUC, and filing a Notice of Landing Area Proposal (Form 7480-I). This requirement shall be in addition to all other City development requirements.

The City of Costa Mesa is opposed to any expansion of operations at John Wayne Airport due to noise impacts to existing residential uses, as well as air quality, traffic, and economic impacts to potentially displaced businesses.

LAND AVAILABILITY

In 2000, only a small portion of the land (213 acres) within the City and sphere of influence was vacant and ready for development (refer to Exhibit LU-1, *Vacant Land*). The limited amount of vacant land results in an increased demand for redevelopment of existing properties. This trend is not new in Costa Mesa, and the extent of private redevelopment can be expected to increase.

In considering future general plan amendments, attention must be given to potential impacts on existing development and impacts on the character of neighborhoods. Methods to promote the orderly transition of areas to other uses or densities should be developed. Such methods could be in the form of zoning regulations or specific plans. Similar methods may also be applicable to promote the retention of historic structures, rental housing, mature vegetation, and other existing socially or environmentally significant components of a neighborhood.

REDEVELOPMENT

Many factors - physical, economic, and social - contribute to the need for redevelopment. The most obvious indicators are the visual and economic effects of deteriorating properties due to age and/or lack of maintenance, declining property values, high business turnover rates, declining sales activity, or high vacancy rates. Usually, the physical impacts can be mitigated by appropriate repair and rehabilitation, but occasionally, when combined with other economic constraints, complete removal of the structures and redevelopment of the site is the most economically feasible approach.

The City adopted the Redevelopment Plan for the Downtown Redevelopment Project (Project Area No. 1) on December 21, 1973. During the first decade of the Redevelopment Plan, activities centered around public improvements within Lions Park, including construction of a fire station and neighborhood community center. Across from the park, a 75-unit privately owned apartment complex for low- and moderate-income senior citizens was built. Since 1980, street improvements including realignment of 17th Street, widening of 19th Street, and Harbor Boulevard redesign and construction, have been completed. The Pacific Savings Plaza was completed in 1982, and the retail and office complex known as the Costa Mesa Courtyards was constructed in 1985. Façade improvements for 26 store fronts were completed in 1986. In 1989, a 185,000 square foot multi-level center (Triangle Square) was completed.

The role of the City in redevelopment may take the form of providing incentives or assistance for private redevelopment, providing stimuli to spark private improvement activities, or becoming actively involved in associated public development or redevelopment projects.

INCENTIVES

The primary incentive the City can offer to encourage private redevelopment is flexible land use regulations such as increased density, increased lot coverage and height or relaxed parking standards. Incentives can be used not only to encourage redevelopment of existing properties, but also to influence the type

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and design of new development. An example is the flexible setback standards for new commercial development in the Newport Boulevard Specific Plan area.

The most obvious incentive for the recycling of existing structures is economic savings to the developer. The City might add to this incentive by waiving or reducing development fees. Again, the reduced traffic impact fee schedule for projects in the Newport Boulevard Specific Plan area is an example.

Financial assistance to owners of properties in need of rehabilitation may ease the burden of making the necessary improvements. Since 1975, Costa Mesa's applications for Community Development Block Grants, under the Federal Housing and Community Development Act of 1974, have included programs of grants and low-interest loans for rehabilitation of low- and moderate-income owner-occupied housing units. Low-interest loans for owner/investors of rental housing are also available when a majority of tenants are low- and very low-income.

STIMULI

The upgrading of public facilities can also act as a stimulus to new development or private property improvement. Paving of streets and alleys; installation of landscaped medians, parkways, curbs, gutters, and sidewalks; correction of drainage problems; construction of parks; construction of public parking facilities and upgrading or undergrounding of utility services do much to improve the image of a community. As the image of an area is elevated, the level of pride and interest is also raised, and this is often reflected in higher levels of property maintenance and increased improvement activity. The City should remain vigilant for opportunities to upgrade public facilities to stimulate private property improvement.

PUBLIC SECTOR REDEVELOPMENT

Local governments are authorized to create redevelopment agencies and redevelopment project areas under §33000 *et seq.* of the California Health and Safety Code (Community Redevelopment Law). Redevelopment areas as defined by the declaration of State policy must be designated on the basis of being blighted.

The concept of redevelopment is based on the premise that public participation and assistance are necessary in order to correct the blighting influences and obsolete and inefficient development and ownership patterns of older communities. The function of redevelopment offers a variety of ways to solve the development problems of otherwise undevelopable properties.

In the early 1970's, concern began to grow about the physical, economic, and social condition of Costa Mesa's traditional "downtown". The area is identified by the intersection of the two most heavily traveled streets in the City: Harbor Boulevard and Newport Boulevard.

As one of the oldest parts of Costa Mesa, the downtown area contained commercial and residential properties in declining condition. The large number of small, separately owned parcels made private assembly of land difficult.

Because the problems of the area were not likely to be solved by private development, the City adopted the Redevelopment Plan for the Costa Mesa

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Downtown Redevelopment Project (Project Area No.1) on December 21, 1973 (see Exhibit LU-3).

In 1983, the Redevelopment Agency requested that a panel of members of the Urban Land Use Institute (ULI) help to identify a redevelopment strategy for Project Area No. 1. The panel concluded that the "downtown" area needed a strong retail core with medium-density residential use surrounding the service and retail activities. To achieve tangible results, the ULI panel recommended giving high priority to expansion and development of a "superblock" area.

The Costa Mesa Courtyards, Triangle Square, Parcel "A", and Borders Books are projects which were developed to fulfill this recommendation.

COMMUNITY DESIGN

In recent years, the City Council has expressed concern with the aesthetic qualities of the community. Some areas are experiencing a significant amount of blight while others lack a clear identity to distinguish them from other areas of the City. Neighborhoods should be unified through design to achieve "cohesiveness." Roadways are challenged by sign clutter, commercial strip development, blank walls, and the absence of streetscape amenities and landscaping.

As a result of the Council's concern, a Community Design Element of the 2000 General Plan was created to provide for the promotion of quality design and construction for buildings, structures, paths, districts, nodes, landmarks, natural features, and significant landscaping. The Community Design Element of the 2000 General Plan strives to establish a strong visual image for the community that emphasizes quality design, compatibility in form and scale, and the incorporation of significant landscaping.

Insert Exhibit LU-3, Downtown Redevelopment Project Area

REGIONAL PLANNING

Regional planning issues play an important role in local-level planning within the City of Costa Mesa. Region-wide issues such as transportation, air quality, growth management, affordable housing, and open space must be integrated into the City's planning efforts in order to effectively address and provide consistency with issues that effect not only Costa Mesa residents, but residents of the region as well.

Traffic congestion and transportation is one of the most important planning problems facing southern California. Recognizing the role that each City plays in regional traffic problems, Costa Mesa has been an active participant in regional Growth Management programs.

Coordination with regional agencies, such as the County of Orange, the Orange County Council of Governments, Southern California Association of Governments, Regional Water Quality Control Board, South Coast Air Quality Management District, and Caltrans, ensures that local-level policies reinforce region-wide goals and programs.

2.5 DESCRIPTION OF LAND USE PLAN

Land use designations indicate the type and nature of development allowed in a given location. While terms like "residential", "commercial", and "industrial" are generally understood, State General Plan law requires a clear and concise description of land use categories that are depicted on Exhibit LU-4, *General Plan Land Use Map*.

The Land Use Element contains 15 land use designations as follows:

- ◆ Low-Density Residential
- ◆ Medium-Density Residential
- ◆ High-Density Residential
- ◆ Commercial – Residential
- ◆ Neighborhood Commercial
- ◆ General Commercial
- ◆ Commercial Center
- ◆ Regional Commercial
- ◆ Urban Center Commercial
- ◆ Cultural Arts Center
- ◆ Industrial Park
- ◆ Light Industry
- ◆ Public/Institutional
- ◆ Golf Course
- ◆ Fairgrounds

These are also shown later in this element in Table LU-9, *General Plan/Zoning Relationships*, along with their corresponding zoning districts.

GENERAL PLAN LAND USE MAP

The General Plan Land Use Map (Exhibit LU-4) indicates the location of the land use designations within the City and its Sphere of Influence. Copies of the General Plan Land Use Map may be obtained from the Planning Division.

LAND USE INTENSITY/DENSITY

State General Plan law requires the Land Use Element to indicate the maximum building intensities/densities allowed in the City. The Land Use Element contains 15 land use designations; each allows certain land uses and establishes corresponding intensity/density standards (refer to Table LU-1 on page LU-3). Table LU-1 also includes the expected overall levels of development within each land use designation.

A number of terms are used to describe the land use designations. The term "intensity" refers to the degree of development based on building characteristics such as height, bulk, floor area ratio, and percent of lot coverage. Intensity is most often used to describe non-residential development levels.

For most non-residential land use categories (commercial, industrial, and public), the "floor area ratio" (FAR) provides the most convenient method of describing levels of development. The FAR is the relationship of total gross floor area of all buildings on a lot to the total land area of the lot expressed as a ratio. For example, a 21,780 square-foot building on a 43,560 square-foot lot (one acre) yields an FAR of 0.50. The FAR describes use intensity on a lot, but not the actual building height, bulk, or lot coverage. These are regulated through the zoning code or specific plans.

Building intensity can also be measured by the impacts generated by a particular development. One critical impact is traffic generation. Because of the scale of major development sites in North Costa Mesa and their potential for significant traffic generation, trip budgets have been established for the major land holdings covered by the North Costa Mesa Specific Plan. These trip budgets are shown on Table LU-7 (see following discussion). Also, the FAR in many of the land use designations is "stepped" in correlation to the traffic-generating characteristics of a particular land use.

The term "density," in a land use context, is a measure of the desired population or residential development capacity of the land. Residential density is described in terms of dwelling units per gross acre (du/ac); thus, the density of a residential development of 100 dwelling units occupying 20 acres of land is 5.0 du/acre. A dwelling unit is a building or a portion of a building used for human habitation and may vary considerably in size (square footage) from small apartments at 400-500 square feet to large single-family homes exceeding 5,000 square feet. For purposes of calculating population, an average number of persons per acre or dwelling unit for all types and sizes of dwelling units is assumed.

Insert Exhibit LU-4, General Plan Land Use Map
11 x 17

TRIP BUDGETS

The concept of regulating development potential in terms of both building intensities and trip generation limits was first used to control major developments within the Regional Commercial and Urban Center Commercial designations in the mid-1980s. The thought behind this concept was to design a combination of freeway access improvements and local arterial improvements and to allocate development rights to the major landholdings in northern Costa Mesa based upon land use intensities which could be accommodated by the planned improvements. These major landholdings include the Industrial Park portion of Segerstrom Home Ranch, Metro Pointe, South Coast Plaza, South Coast Plaza Town Center, South Coast Metro Center and the currently undeveloped portions of Sakioka Farms.

The trip budget is expressed in terms of morning (AM) and afternoon (PM) peak hour traffic volumes. The trip budget for each of the major landholdings is based upon the general office trip rates and office FAR standard as used in the Costa Mesa Traffic Model prepared for this 2000 General Plan; and the Regional Commercial, Urban Center Commercial are described in the Land Use Classifications portion of this element. The trip budget for the Industrial Park portion of Segerstrom Home Ranch are also based on assumptions from the 2000 General Plan Traffic Model.

The allowable floor area ratios and trip budgets shall be applied on a project-planning rather than parcel-specific basis. This approach will allow consideration of multi-phased or multi-lot projects as a whole development rather than individual pieces of the whole. An example would be a commercial condominium subdivided as a planned unit development where each building is located on a separate lot which conforms to its building footprint and where the parking and landscaped areas are located on common lots. In this example, the individual building lots would have a floor area ratio of at least 1.00 FAR, but the overall project (individual building lots and all common lots) would meet the allowable floor area ratio building intensity standard for the given land use classification. However, the rates could be applied at a parcel-specific level if the project is or can be developed on a single lot and not subdivided at a later date.

Subdivisions of existing developments or projects shall not cause the development to become nonconforming or, if already nonconforming, shall not make the development more nonconforming with respect to the density and intensity standards for the land use designation in which the project is located unless binding agreements restricting development of the newly created parcel(s) are recorded as a part of the subdivision.

TRIP BUDGET TRANSFERS

The trip budgets established at the Traffic Analysis Zone (TAZ) level in the Costa Mesa Traffic Model can also be combined or transferred between TAZs in a specified area of the City and under certain conditions to account for large master planned developments which contain multiple TAZs. Likewise, trips can be combined or transferred between individual parcels within single TAZs. Combinations and/or transfers shall only be allowed for projects, which meet the following conditions:

- ◆ The combination and/or transfer of trips shall only be allowed in the area of the City that is north of the I-405 and east of Harbor Boulevard, and shall be limited to parcels within a one mile radius of each other.
- ◆ Trip budget transfers shall be evaluated in the review and approval of a planned development or master plan projects. Sufficient conditions of approval shall be applied to the master plan or development plan to ensure long-range control over subsequent phases of development.
- ◆ The combination and/or transfer of trips shall not result in any greater impacts on the surrounding circulation system than would occur if each Traffic Analysis Zone was developed independently.
- ◆ For the combination and/or transfer of trips between TAZs, such combination and/or transfer of trips shall not exceed the total trip budget of all parcels involved if each were developed independently according to the floor area ratio and trip generation rates provided herein.
- ◆ The combination and/or transfer of trips shall not allow development intensities, which result in abrupt changes in scale or intensity within the project or between the project and surrounding land uses.
- ◆ Approval of the master plan or development plan shall be conditioned to ensure compliance with the above criteria and to preclude future over-development on portions of the project or properties from which trips were transferred.
- ◆ Trip budget transfers shall be recorded against the properties.

DEFINITIONS

The following definitions and interpretations shall be used to implement this portion of the General Plan Land Use Element:

Effective Trip Generation shall mean the AM and PM peak hour traffic volumes generated onto the public streets by a specific project proposal.

Floor Area Ratio shall mean the gross floor area of a building or project divided by the project lot area upon which it is located.

Gross Floor Area shall mean the total building area of all floors within the walls of all structures except elevator and other vertical shafts (including stairwells) and elevator equipment areas. Parking structures shall not be considered building area for the purposes of calculating allowable floor area ratios.

Peak Hour shall mean the hour during the AM peak period (typically 7:00 a.m. – 9:00 a.m.) or the PM peak period (typically 3:00 p.m. – 6:00 p.m.) in which the greatest number of vehicle trips are generated by a given land use or are traveling on a given roadway.

Project Lot Area shall mean the total area of a project after all required dedications or reservations for public improvements, including but not limited to streets, parks, schools, flood control channels, etc., unless otherwise noted in this 2000 General Plan.

Project shall mean a development proposal submitted under a single ownership or control at the time of the initial plan submittal and approval. A project may be subdivided or developed in phases by subsequent multiple owners. However, the initial building intensity established by the initial project approval shall be maintained throughout the development of the entire project.

Trip shall mean a one-way vehicular journey either to or from a site, or it may be a journey totally within the site. The latter is usually referenced to as an internal trip. Each trip will have two trip ends, one at the beginning and the other at the destination.

Trip Budget shall mean the maximum number of AM and PM peak hour trips allocated to a project site. The trip budget shall be derived by multiplying the project area by the allowable floor area ratio and by the AM and PM peak hour trip generation rates for the applicable land use classification.

Trip Rate shall mean the anticipated number of trips to be generated by a specific land use type or land use classification. The trip rate shall be expressed as a given number of trips for a given unit of development intensity (i.e., trip per unit, trip per 1,000 sq.ft., etc.). Trip rates used in the calculation of trip budgets under the provisions of this section of the Land Use Element shall be those rates established by City Council resolution. Trip rates for determining Low, Moderate and High Traffic uses are those contained in the 4th Edition Trip Generation Manual published by the Institute of Transportation Engineers (ITE).

LAND USE DESIGNATIONS

RESIDENTIAL

Costa Mesa's 3,865 residential acres are divided into the Low-, Medium-, and High-Density Residential designations.

Low-Density Residential

Low-Density Residential areas generally are intended to accommodate single-family residences on their own parcels. Other housing types include attached housing that provide a greater portion of recreation or open space than typically found in multi-family developments, and clustered housing which affords the retention of significant open space. Low-Density Residential areas are intended to accommodate family groups and outdoor living activities in open space adjacent to dwellings. In order to avoid land use conflicts, these areas should be located away from or protected from the more intense non-residential areas and major travel corridors. The density for this land use designation shall be up to eight units to the acre. At an average household size of 2.74 persons per dwelling unit, the projected population density within this designation would be up to 21.9 persons per acre.

Costa Mesa contains seven distinct residential neighborhoods: 1) Eastside, 2) Westside, 3) Mesa Verde, 4) College Park, 5) North Costa Mesa/Mesa Del Mar/Halecrest Hall of Fame, 6) Bristol/Paularino, and 7) South Coast/Wimbledon Village. These existing, stable single-family neighborhoods should be preserved and maintained. The establishment of attached or clustered housing through the planned development concept can be allowed in appropriate Low-Density Residential areas as a means to encourage the consolidation of parcels or to make more efficient use of larger parcels.

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As the majority of land for Low-Density Residential use has become fully developed, future large scale single-family tract development is precluded. It can be expected that larger single-family lots will be proposed for subdivision in the future. Planned developments near the maximum density may also become more common, perhaps through combination of parcels and replacement of single-family development.

Non-residential uses that complement and serve the surrounding residential neighborhood are also appropriate within this designation. These uses typically include schools, parks, churches, libraries, and public facilities. Additional uses authorized by State law, such as group residential facilities, accessory apartments, granny flats, and family day care homes are also appropriate.

Compatible zoning districts include R1, PDR-LD, I&R, and I&R-S.

Medium-Density Residential

The Medium-Density Residential designation is intended for single-and multi-family developments with a density of up to 12 units to the acre. The 12 units to the acre standard can be exceeded for legal, non-conforming Medium-Density Residential lots of a certain size that existed as of March 16, 2000. These lots must be less than 7,260 square feet in size, but not less than 6,000 square feet. On lots that have a density calculation fraction equal to or greater than 1.65 units per acre, two units may be constructed.

The 12 dwelling units per acre standard is exceeded by approximately 53 percent of the existing Medium-Density development. Existing non-conforming units, that are voluntarily destroyed, may be rebuilt to the same density, subject to other standards of the zoning code and the following: the allowable density or number of units to be redeveloped is limited to the 2000 General Plan density plus a 25 percent density incentive bonus or the existing number of units, whichever is less.

At an average household size of 2.74 persons per dwelling unit, the projected population density within this designation would be 32.9 persons per acre.

Density bonuses shall be granted by the City when a project is designed to provide housing for individuals and families with specialized requirements (e.g., senior citizens, handicapped, very-low, low-income, and moderate income households with needs not sufficiently accommodated by conventional housing) with needs not sufficiently accommodated by conventional housing) or provide other facilities or land as required by State law. The City may also grant additional incentives or concessions pursuant to State law.

In order to encourage the development of additional residential ownership opportunities in the Westside, City Council may designate an overlay area by adoption of the Mesa West Residential Ownership urban plan. The Mesa West Residential Ownership urban plan may allow residential densities up to 20 units per acre provided that certain development standards are met for encouraging ownership housing. With an average household size of 2.74, the projected population density for the urban plan area would be 54.8 persons per acre.

The type of development in this designation is generally less oriented to outdoor living activities and is thus more tolerant to impacts that might adversely affect low-density residential development. Although still susceptible to the impacts caused by more intense uses and noise, a Medium-Density Residential

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development has greater potential to provide mitigation through visual and acoustical shielding. Areas for Medium-Density Residential use can be established closer to potentially disparate uses than can Low-Density Residential, providing the potential impacts are not of a severity that precludes mitigation.

Because of the location and intensity of development, Medium-Density Residential areas are also appropriate for quasi-residential uses such as convalescent hospitals and group residential homes. Schools, churches, parks, libraries, and related public facilities are also appropriate.

Complementary commercial uses within this designation may be allowed in planned development projects provided that the commercial uses will have floor area ratios that are the same as the Neighborhood Commercial land use designation.

Medium-Density Residential areas are distributed throughout the City. The main concentration is located southeast of Newport Boulevard between Mesa Drive and 19th Street; northwest of Orange Avenue; southeast of Orange Avenue between 16th and 18th Streets; and between Santa Ana and Irvine Avenue north of Santa Isabel.

Compatible zoning districts include R1, R2-MD, PDR-MD, I&R, and I&R-S.

High-Density Residential

Areas designated as High-Density Residential are intended for residential development with a density of up to 20 units to the acre with the exception of Sakioka Lot 1 and The Lakes, both of which are discussed in the following paragraphs. Density bonuses shall be granted by the City when a project is designed to provide housing for individuals and families with specialized requirements (e.g., senior citizens, handicapped, very-low, low-income, and moderate income households with needs not sufficiently accommodated by conventional housing) or provide other facilities or land as required by State law. The City may also grant additional incentives or concessions pursuant to State law.

Sakioka Lot 1, a 41-acre vacant parcel, located in the Town Center area of the City adjacent to Anton Boulevard, has a higher density limit of 25 to 35 units to the acre. The upper limit of 35 units per acre shall include any density bonus.

In 2006, General Plan Amendment (GP-06-02) was approved for a 2-acre portion of the 27-acre The Lakes planned development project located at the northeast corner of Avenue of the Arts and Anton Boulevard. The approval consisted of a site-specific density increase for the 2-acre retail site to 125 units/acre. This equates to a maximum of 250 units on the site with an approximate building height of 26 stories. Additionally, resident-serving commercial/retail use component is permitted provided that minimal traffic-generation characteristics of this retail component can be demonstrated in review and approval of a master plan. Based on an average household size of 2.5, the projected population density for this 2-acre site would be 312.5 persons per acre. Additional development standards for this planned development are contained in the North Costa Mesa Specific Plan.

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In 2007, General Plan Amendment GP-06-03 was approved for a 3-acre property located at 3350 Avenue of the Arts, north of Anton Boulevard along the east side of Avenue of the Arts in The Lakes area (Area 5 of the North Costa Mesa Specific Plan). This approval consisted of: (1) a site-specific density increase to a maximum of 44 units/acre for a mixed-use development comprised of a boutique hotel and high-rise residential building and (2) a maximum nonresidential FAR of 2.12 FAR which includes the hotel use and ancillary commercial uses. The North Costa Mesa Specific Plan contains provisions related to the maximum overall development of dwelling units, hotel rooms, and resident-serving retail/commercial uses. Based on the average household size of 2.5 persons per unit, the projected population density for this 3-acre site would be 110 persons per acre. Additional development standards for this planned development, including maximum allowable building height and mix of dwelling units and hotel rooms, are contained in the North Costa Mesa Specific Plan.

The maximum density of 20 dwelling units per acre is exceeded by approximately 46 percent of existing High-Density development. Existing non-conforming developments, that are voluntarily destroyed, may be rebuilt to the original density subject to other standards of the zoning code and the following: the allowable density or number of units to be redeveloped would be limited to the 2000 General Plan density plus a 50 percent density incentive bonus or the existing number of units, whichever is less.

In order to encourage the development of additional residential ownership opportunities in the Westside, City Council may designate an overlay area by adoption of the Mesa West Residential Ownership urban plan. For existing developments that exceed 20 dwelling units per acre, the Mesa West Residential Ownership urban plan may allow redevelopment of residential projects to existing densities provided that certain development standards are met for encouraging ownership housing.

With an average household size of 2.74, the projected population density within this designation would be 54.8 persons per acre.

High-Density areas should be located in proximity to transportation routes, especially those served by public transit, and also within convenient distances to shopping and employment centers. Although proximity to the above uses and transportation routes often results in a residential development being subject to adverse impacts, High-Density Residential development can be less susceptible to impacts than lower densities if visual and acoustical shielding techniques are incorporated into the project.

In addition to the above locational preferences, viable High-Density development is also dependent upon site characteristics. A site should be of appropriate size and dimension before the higher densities within this designation are allowed.

Because of their location and intensity of development, High-Density Residential areas are also appropriate for quasi-residential uses (e.g., convalescent hospitals, and group residential homes). Schools, churches, parks, libraries, and related public facilities are also appropriate.

Complementary commercial uses within this designation may be allowed in planned development projects provided that the commercial uses will have Floor Area Ratios that are the same as the Neighborhood Commercial land use designation.

Mixed-use development projects are intended to provide additional housing opportunities in the City by combining residential and nonresidential uses in an integrated development. Additionally, this type of development is intended to revitalize areas of the city (such as the Westside) without exceeding the capacity of the General Plan transportation system. Mixed-use developments shall be implemented through an adopted urban plan (such as the 19 West Urban Plan) and shall be identified on the City's Zoning Map by designating either the R2-HD and R-3 base zoning districts with the mixed-use overlay district. The mix of uses can occur in either a vertical or horizontal design, up to four stories in height. Product types shall be identified in the applicable urban plan and may include live/work units and commercial/residential units where the residential uses are located above or adjacent to the nonresidential component. Nonresidential uses may include office, retail, business services, personal service, public spaces and uses, and other community amenities. In conjunction with areas that are designated with the mixed-use zoning overlay district, the maximum FAR is 1.0. An increase to 1.25 FAR may be allowed for mixed-use plans exhibiting design excellence. In a mixed-use overlay district area, this FAR includes both residential and non-residential components, and the maximum number of stories is four.

The mix of residential and nonresidential uses would result in an average employee population of 22 employees per acre in the nonresidential component, and in the residential component, the average number of residents per acre is anticipated 65 persons. The total average population per acre is 87 persons.

Major High-Density neighborhoods are clustered around Orange Coast College; along Mesa Verde Drive East; between Adams and Harbor; around Vanguard University; in the northeast portion of the South Coast Metro area; in the Downtown Redevelopment area; and the southeast portion of the City.

Compatible zoning districts include R2-MD, R2-HD, R3, PDR-HD, PDR-NCM, MU, I&R, and I&R-S.

COMMERCIAL

Seven commercial land use designations are applied throughout the City. These designations vary in location and intensity in order to accommodate the full range of commercial activity present in Costa Mesa. Development "intensity" potential is measured/prescribed using Floor Area Ratios in relation to the amount of traffic expected.

Employment generation for commercial uses varies dependent upon the specific use within the commercial designations. Population density standards range from 1 employee/300 square feet for office uses to 1 employee/500 square feet for retail shopping center uses. Employment generation rates for a variety of commercial uses are provided in Table LU-5.

Commercial Designations

Graduated floor area ratio standards divide commercial uses into four broad categories based upon their traffic generation characteristics. The following table and text lists and describes these standards.

**TABLE LU-4
COMMERCIAL BUILDING INTENSITY STANDARDS**

Land Use Designation	Very Low Traffic FAR	Low Traffic FAR	Moderate Traffic FAR	High Traffic FAR
Commercial –Residential	NA	0.40	0.30	0.20
Neighborhood Commercial ^e	0.75	0.35	0.25	0.15
General Commercial ^e	0.75	0.40	0.30	0.20
Commercial Center ^{d, e}	0.75	0.45	0.35 ^d	0.25
Regional Commercial	a.	a.	a.	a.
Urban Center Commercial	b.	b.	b.	b.
Cultural Arts Center	c.	c.	c.	c.

Notes:

- a. 0.652/0.89 FAR. Refer to Regional Commercial discussion.
- b. 0.50 FAR for Retail, 0.60 FAR for Office, 0.79 FAR for S.C. Metro Center. Refer to Urban Center Commercial discussion and the North Costa Mesa Specific Plan for additional discussion.
- c. 1.77 FAR. Refer to Cultural Arts Center discussion and the North Costa Mesa Specific Plan for additional discussion.
- d. 0.70 Site-Specific FAR for 1901 Newport Boulevard. Refer to Commercial Center discussion.
- e. With application of the mixed-use overlay district, the FAR may range from 1.0 to 1.25. Refer to appropriate land use designation discussion.

The Very-Low Traffic category allows commercial uses with daily trip generation rates of less than 3 trip ends per 1,000 square-feet of floor area. Allowable uses under this standard include mini-warehouse developments.

The Low Traffic category allows commercial uses with daily trip generation rates between 3 and 20 trip ends per 1,000 square-feet of floor area. Allowable uses under this standard include general offices, hospitals, motels, hotels, and furniture stores.

The Moderate Traffic category allows commercial uses with daily trip generation rates of between 20 and 75 trip ends per 1,000 square-feet of floor area. Allowable uses within this standard include general retail uses, car dealers, medical and government offices, auto repair, and dry cleaners.

The High Traffic category allows commercial uses with daily trip generation rates in excess of 75 trip ends per 1,000 square-feet of floor area. Allowable uses in this category include restaurants, convenience markets, service stations, and banks.

**TABLE LU-5
SELECTED EMPLOYMENT GENERATION RATES/POPULATION DENSITY
STANDARDS FOR COMMERCIAL AND INDUSTRIAL USES**

Commercial Uses	Generation Rate/Population Density Standard
General Retail	1 Employee/450 Square Feet ¹
Restaurant	1 Employee/450 Square Feet
Service Uses	1 Employee/333 Square Feet ¹
Corporate Headquarters	1 Employee/337 Square Feet ²
Office	1 Employee/300 Square Feet ²
Retail Shopping Center	1 Employee/500 Square Feet ¹
Hotel	1 Employee/2.5 Rooms
Performing Arts Theatre	1 Employee/2,500 Square Feet
Industrial Uses	Generation Rate/Population Density Standard
Light Industry	1 Employee/470 Square Feet ²
Industrial Park	1 Employee/420 Square Feet ²
Office	1 Employee/300 Square Feet ²
Warehouse	1 Employee/750 Square Feet
Manufacturing	1 Employee/300 Square Feet
Notes: ¹ Accounts for net leasable area (10% discount from gross floor area). ² Accounts for 8% assumed future vacancy rate.	

Commercial-Residential

The Commercial-Residential designation is intended to be applied to a limited area on the eastside of Newport Boulevard between Walnut Street and Mesa Drive. It is the intent of this land use designation to allow a complementary mix of commercial and residential zoning along Newport Boulevard. It is anticipated that individual parcels will be developed as either a commercial or residential use. A mix of both commercial and residential uses on one parcel should only be allowed as a Planned Development.

Residential development is encouraged provided that certain development standards are met pursuant to the adopted Newport Boulevard Specific Plan. Residential Density ranges from 12 units per acre to 17.4 units per acre. Using average household size data from the 1990 census, the projected population density in residential developments would be up to 44 persons per acre. It will be necessary to ensure adequate buffering between the residential development and non-residential uses.

It is also the intent of this land use designation to allow commercial uses, which serve and complement the residential neighborhoods to the east and within the specific plan area. Appropriate uses include markets, drug stores, retail shops, financial institutions, service establishments and support office uses. Restaurants and residency hotels such as single-room occupancy (SRO) hotels may be appropriate if properly located to avoid adverse impacts to the surrounding residential areas.

Population densities in commercial development within the Commercial-Residential designation are largely a factor of the employment-generating ratios of the uses permitted. Table LU-5 identifies the ratios used to estimate employment projections throughout this plan. The standard mix of uses in this

designation would generate an average population density of 27 employees per acre. A development that consisted of office use only would require up to 60 employees per acre. Residency hotels, such as single room occupancy (SROs), may have resident populations of up to 117 persons per acre.

Institutional uses are also appropriate in this designation, provided that land use compatibility and traffic issues have been addressed. Institutional uses would require discretionary approval.

Allowable floor area ratios are 0.20 for high traffic generating uses, 0.30 for moderate traffic generating uses, and 0.40 for low traffic generating uses as shown on Table LU-4.

Residential and non-residential uses may be integrated into a single development through the Planned Development process. Residential densities in planned development projects shall not exceed 17.4 units per acre pursuant to the development standards in the Newport Boulevard Specific Plan. Non-commercial uses would be subject to the same floor area standards as commercial uses in this designation.

Compatible zoning districts include AP, CL, C1, P, PDC, R2-MD, R2-HD, PDR-MD, and PDR-HD.

Neighborhood Commercial

The Neighborhood Commercial designation is intended to serve convenience shopping and service needs of local residents. Appropriate uses include markets, drug stores, retail shops, financial institutions, service establishments and support office uses. Restaurants, hotels and motels, and residency hotels such as single room occupancy (SRO) hotels may be appropriate if properly located, designed, and operated to avoid adverse impacts to surrounding uses. Since Neighborhood Commercial uses are intended to serve nearby residential neighborhoods, the uses permitted should be among the least intense of the commercial uses.

Allowable floor area ratios are 0.15 for high traffic generating uses, 0.25 for moderate traffic generating uses, 0.35 for low traffic generating uses, and 0.75 for very-low traffic generating land uses. See Table LU-4.

Population densities in the Neighborhood Commercial designation are largely a factor of the employment-generating ratios of the uses permitted. Table LU-5 identifies the ratios used to estimate employment projections within this land use designation. Typically, the building intensity range of this designation would generate a corresponding population density of 23 employees per acre for a standard mix of uses. A development that consisted of office use only would require up to 51 employees per acre. SRO hotels would have resident population of up to 105 persons per acre.

In conjunction with areas that are designated with the mixed-use zoning overlay district, the maximum FAR is 1.0. An increase to 1.25 FAR may be allowed for mixed-use plans exhibiting design excellence. In a mixed-use overlay district area, this FAR includes both residential and non-residential components, and the maximum number of stories is four.

Mixed-use development projects are intended to provide additional housing opportunities in the City (such as the Westside) by combining residential and nonresidential uses in an integrated development. Additionally, this type of

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development is intended to revitalize areas of the city, without exceeding the capacity of the General Plan transportation system. Mixed-use developments shall be implemented through an adopted urban plan (such as the 19 West urban plan) and shall be identified on the City's Zoning Map by designating the CL and/or C1 base zoning district with the mixed-use overlay district. The mix of uses can occur in either a vertical or horizontal design, up to four stories in height. Product types shall be identified in the applicable urban plan and may include live/work units and commercial/residential units where the residential uses are located above or adjacent to the nonresidential component. Nonresidential uses may include office, retail, business services, personal service, public spaces and uses, and other community amenities. The mix of residential and nonresidential uses would result in an average employee population of 22 employees per acre in the nonresidential component, and in the residential component, the average number of residents per acre is anticipated 65 persons. The total average population per acre is 87 persons.

The Neighborhood Commercial developments are found at several intersections found throughout the City. The main concentration of these developments are found at the intersections of Baker Street and Fairview Road and Victoria Street and Placentia Avenue.

Compatible zoning districts include CL, C1, AP, MU, and P.

General Commercial

The General Commercial designation is intended to permit a wide range of commercial uses, which serve both local and regional needs. These areas should have exposure and access to major transportation routes since significant traffic can be generated. General Commercial areas should be insulated from the most sensitive land uses, either through buffers of less sensitive uses or on-site mitigation techniques. The most intense commercial uses should be encouraged to locate on sites of adequate size to allow appropriate mitigation. Appropriate uses include those found in the Neighborhood Commercial designation plus junior department stores and retail clothing stores, theaters, restaurants, hotels and motels, and automobile sales and service establishments.

In the General Commercial designation, the allowable floor area ratios (FAR) are 0.20 for high traffic generating uses, 0.30 for moderate traffic generating uses, 0.40 for low traffic generating uses, and 0.75 for very low traffic generating uses (see Table LU-4). Development within this range would typically result in combinations of one- and two-story commercial buildings. Buildings in excess of two stories may be permitted in select areas where the additional height would not impact surrounding uses.

In conjunction with areas that are designated with the mixed-use zoning overlay district, the maximum FAR is 1.0. An increase to 1.25 FAR may be allowed for mixed-use plans exhibiting design excellence. In a mixed-use overlay district area, this FAR includes both residential and non-residential components, and the maximum number of stories is four.

Because of the wider range of uses and more building intensity permitted in the General Commercial designation, the population density within this designation will also be more intense than that found in the Neighborhood Commercial designation. The standard mix of uses in this designation would generate an average population density of 27 employees per acre. A development that

consisted of office use only would require up to 60 employees per acre. Residency hotels such as single room occupancy (SRO) hotels may be located in the General Commercial district. These hotels would have resident populations of up to 117 persons per acre.

Mixed-use development projects are intended to provide additional housing opportunities in the City (such as the Westside) by combining residential and nonresidential uses in an integrated development. Additionally, this type of development is intended to revitalize areas of the city, without exceeding the capacity of the General Plan transportation system. Mixed-use developments shall be implemented through an adopted urban plan (such as the 19 West Urban Plan) and shall be identified on the City's Zoning Map by designating either the CL, C1 and/or C2 base zoning districts with the mixed-use overlay district. The mix of uses can occur in either a vertical or horizontal design, up to four stories in height. Product types shall be identified in the applicable urban plan and may include live/work units and commercial/residential units where the residential uses are located above or adjacent to the nonresidential component. Nonresidential uses may include office, retail, business services, personal service, public spaces and uses, and other community amenities. The mix of residential and nonresidential uses would result in an average employee population of 22 employees per acre in the nonresidential component, and in the residential component, the average number of residents per acre is anticipated 65 persons. The total average population per acre is 87 persons.

Institutional uses are also appropriate in the General Commercial designation, provided that land use compatibility and traffic issues have been addressed. Institutional uses would require a discretionary approval.

As complementary uses, residential and other noncommercial uses may be allowed through the Planned Development process. Residential densities in planned development projects shall not exceed 20 dwelling units per acre. The corresponding population density is up to 50 persons per acre. Noncommercial uses would be subject to the same floor area standards as commercial uses in this designation.

The adoption of General Plan amendment (GP-02-06) established a site-specific FAR of 0.40 and trip budget of 186 AM peak hour trips and 281 PM peak hour trips for the 4.4-acre site located at 1626/1640 Newport Boulevard. These two standards allow the development of medical office uses or similar "moderate-traffic" generating uses provided that the site-specific trip budget is not exceeded.

Facilities that transfer, store, or dispose of hazardous wastes that are generated at another source (off-site) are most appropriately located in the Industrial Park and Light Industry land use designations; however, a facility with a purpose and scale of operation that is compatible with this commercial designation may be allowed pursuant to the issuance of a conditional use permit.

General Commercial developments are mainly located along major arterials such as Harbor Boulevard, East 17th Street and Bristol Street south of the I-405 and SR-55.

Compatible zoning districts include CL, C1, C1-S, C2, PDC, AP, MU, and P.

Commercial Center

The Commercial Center designation is intended for large areas with a concentration of diverse or intense commercial uses serving local and regional needs. Appropriate uses include a wide variety and scale of retail stores, professional offices, restaurants, hotels and theaters. Intense service uses, such as automobile repair and service, should be discouraged. Because of the large service area, direct access to major transportation corridors is essential.

Development within this designation is intended for a variety of intensities ranging from one- to four-story buildings. The allowable floor area ratios are 0.25 for high traffic generating uses, 0.35 for moderate traffic generating uses, 0.45 for low traffic generating uses, and 0.75 for very-low traffic generating uses.

In conjunction with approval of Home Ranch Alternative A, a site-specific FAR of 0.41 was established for the 17.2-acre IKEA site. (IKEA is a large retail/warehouse use.) This property is located at the southeast corner of South Coast Drive and Harbor Boulevard. A trip budget of 43 AM peak hour trips and 431 PM peak hour trips was also adopted for the IKEA site. A maximum allowable FAR of 0.40 for office uses was also established for the remaining 45.4 acres located south of South Coast Drive. The combined trip budget for this site and the 14.5-acre Industrial Park parcel located to the north of South Coast Drive is 1,593 AM peak hour trips and 1,569 PM peak hour trips. The North Costa Mesa Specific Plan provides more FAR, building height, and trip budget information for Segerstrom Home Ranch (Area 1).

In conjunction with areas that are designated with the mixed-use zoning overlay district, the maximum FAR is 1.0. An increase to 1.25 FAR may be allowed for mixed-use plans exhibiting design excellence. In a mixed-use overlay district area, this FAR includes both residential and non-residential components, and the maximum number of stories is four.

Anticipated population density for the standard mix of uses in the Commercial Center designation would be 45 employees per acre. A development that consisted of office use only would require up to 66 employees per acre. Residency hotels such as single room occupancy (SRO) hotels may be located in the Commercial Center district. These hotels would have resident populations of up to 131 persons per acre. Again, these estimates are generalized and should be more refined as specific development proposals are approved.

Mixed-use development projects are intended to provide additional housing opportunities in the City (such as the Westside) by combining residential and nonresidential uses in an integrated development. Additionally, this type of development is intended to revitalize areas of the city, without exceeding the capacity of the General Plan transportation system. Mixed-use developments shall be implemented through an adopted urban plan (such as the 19 West Urban Plan) and shall be identified on the City's Zoning Map by designating either the CL, C1 and/or C2 base zoning districts with the mixed-use overlay district. The mix of uses can occur in either a vertical or horizontal design, up to four stories in height. Product types shall be identified in the applicable urban plan and may include live/work units and commercial/residential units where the residential uses are located above or adjacent to the nonresidential component. Nonresidential uses may include office, retail, business services, personal service, public spaces and uses, and other community amenities. The mix of residential and nonresidential uses would result in an average employee population of 22 employees per acre in the nonresidential component, and in the residential component, the average number of residents per acre is anticipated 65 persons. The total average population per acre is 87 persons.

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Institutional uses are also appropriate in this commercial designation provided that land use compatibility and traffic issues have been addressed. Institutional uses require discretionary approval.

As complementary uses, residential and other noncommercial uses may be allowed through the Planned Development process. Residential densities in planned development projects should not exceed 20 dwelling units per acre. The corresponding population density range is up to 50 persons per acre. A site-specific residential density of 40 du/ac was approved for 1901 Newport Boulevard. The corresponding density range for the project is 100 persons per acre.

The adoption of General Plan amendment (GP-02-04) established a site-specific FAR of 0.70 and a site-specific density of 40 units/acre for the property located at 1901 Newport Boulevard, a 7.79 acre site located on the northwest corner of W. 19th Street and Newport Boulevard. The General Plan amendment recognized the existing development intensity of the 1901 Newport Plaza commercial building (127,500 sq. ft) and allowed additional development of 145 single-family attached condominiums, a five-level parking structure, and two-level subterranean parking structure.

Facilities that transfer, store, or dispose of hazardous wastes that are generated at another source (off-site) are most appropriately located in the Industrial Park and Light Industry land use designations; however, a facility with a purpose and scale of operation that is compatible with this commercial designation may be allowed pursuant to the issuance of a conditional use permit. The Commercial Center designation is applied to major developments in the Downtown Redevelopment Area and is centered around the intersection of Harbor Boulevard and 19th Street. These developments include Triangle Square, 1901 Newport Plaza, the Costa Mesa Courtyards, and Border's Books.

Compatible zoning districts include C1, C2, C1-S, PDC, AP, MU, and P.

Regional Commercial

The Regional Commercial designation is intended to apply to large concentrated shopping centers of regional scale and importance. The intended uses within this designation include major department stores, specialty retail outlets, restaurants, offices, hotel and other complementary uses.

Application of the Regional Commercial designation is limited to the existing South Coast Plaza sites. This includes the original 97-acre site between Bristol and Bear Street and the additional 18-acre site located west of Bear Street. This designation and locational criteria recognizes the evolution of South Coast Plaza as a regionally significant retail trade center served by major regional transportation facilities and services. Population density standards for this designation are projected to be up to 53 employees per acre.

The Costa Mesa 2000 General Plan Traffic Model assigns a trip budget for the original South Coast Plaza site of 1,166 AM peak hour trips and 5,036 PM peak hour trips. The trip budget for the site west of Bear Street is 293 AM peak hour trips and 1,264 PM peak hour trips (see Table LU-6).

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TABLE LU-6: TRIP BUDGETS FOR SOUTH COAST PLAZA

	Maximum Building Square Footage	Floor Area Ratio	A.M. Peak Hour Trip Budget	P.M. Peak Hour Trip Budget
South Coast Plaza (west of Bear Street)	690,350	0.89	293	1,264
South Coast Plaza (east of Bear Street)	2,750,000	0.652	1,166	5,036

Development within this designation is largely characterized by multi-story commercial uses and parking structures. The maximum allowable floor area ratio for the portion of South Coast Plaza west of Bear Street site shall be 0.89 (690,350 sq.ft.) The maximum floor area ratio for the original South Coast Plaza site east of Bear Street is 0.652 (2,750,000 sq.ft.). Future expansion or redevelopment of the South Coast Plaza site is also governed by the trip budgets stated above.

Complementary residential uses within this designation are allowed through the Planned Development process. The maximum allowable residential density shall be 20 dwelling units per acre. The corresponding population density is up to 50 persons per acre.

The compatible zoning district is PDC.

Urban Center Commercial

The Urban Center Commercial designation is intended to allow high intensity mixed commercial development within a limited area. Developments within this designation can range from one- and two-story office and retail buildings to mid- and high-rise buildings of four to approximately 25 stories, provided that the maximum building height in the North Costa Mesa Specific Plan is not exceeded. Appropriate uses include offices, retail shops, restaurants, residential, and hotels.

Allowable floor area ratio (FAR) standards for this designation are 0.50 for retail uses and 0.60 for office uses with the exception of South Coast Metro Center that has a site-specific FAR of 0.79 for combined office and retail uses. See Table LU-7 and discussion for the South Coast Metro Center for further detail.

For mixed-use projects that include separate or distinct components, the non-residential floor area ratio standard and the residential density standard shall apply to each of the respective components, not the entire project site. For mixed-use projects which do not include distinct elements or which include mixed-use buildings, the overall level of intensity shall be governed by the allowable non-residential floor area ratio and the maximum number of residential units identified in this designation for a specific project site. Developments shall also comply with the established trip budget standards and comply with the most restrictive standard.

Complementary residential uses within this designation may be allowed through the Planned Development Zone process. The maximum allowable residential density within this designation shall be 20 dwelling units per acre, unless otherwise specified in Table LU-7.

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The corresponding population density is 2.74 persons per household for residential projects of 20 dwelling units per acre, which equates to 54.8 persons per acre.

Facilities that transfer, store, or dispose of hazardous wastes that are generated at another source (off-site) are most appropriately located in the Industrial Park and Light Industry land use designations; however, a facility with a purpose and scale of operation that is compatible with this commercial designation may be allowed pursuant to the issuance of a conditional use permit. The conditional use permit process shall comply with the procedures and siting criteria established by the Orange County Hazardous Waste Management Plan, the City of Costa Mesa's zoning ordinance provisions for these types of facilities, and other state legislation, as appropriate.

The Urban Center Commercial designation includes the following major developments:

- ◆ Automobile Club of Southern California
- ◆ Metro Pointe
- ◆ South Coast Metro Center/Experian
- ◆ Sakioka Lot 2

In 2000, all of these four properties had development agreements with the City of Costa Mesa that vested maximum development square footages, floor area ratios, trip budgets, and allowed uses. It should be noted that with the adoption of the 2000 General Plan, a new traffic model was developed and approved. This updated traffic model differs in methodology assumptions and trip rates when compared to the 1990 General Plan Traffic Model. Thus the 1990 trip budgets contained in these existing development agreements are not directly comparable to the 2000 trip budgets. The trip budgets contained in existing development agreements will continue to govern these properties with appropriate adjustments made to account for differences in the traffic models when necessary.

Provided in Table LU-7 is a summary of the various land use standards that apply to these major developments.

**TABLE LU-7
MAJOR DEVELOPMENTS
URBAN CENTER COMMERCIAL LAND USE DESIGNATION**

Major Development	Development Agreement Maximum Non-Residential Building Sq.Ft./FAR	Maximum Allowable Residential Units	General Plan Maximum A.M. Peak Hour Trip Budget	General Plan Maximum P.M. Peak Hour Trip Budget	North Costa Mesa Specific Plan Applies
Automobile Club of Southern California* (3333 Fairview Road)	967,000 sq.ft. 0.56 FAR	0	1,190**	1,576**	No
Metro Pointe* (901 South Coast Drive only)	592,281 sq.ft. 0.48 FAR	0	729**	965**	Yes
South Coast Metro Center/Experian* (443-595 Anton Blvd.- odd numbers only)	Residential Option: 1,335,386 sq.ft. 0.69 FAR Non-Residential Option: 1,546,180 sq.ft. 0.79 FAR	Residential Option: 484 high-rise residential units per the location in the North Costa Mesa Specific Plan.	Residential Option: 1,931** Non-Residential Option: 1,886**	Residential Option: 1,976** Non-Residential Option: 1,994**	Yes
Sakioka Lot 2* (325 Anton Blvd.)	863,000 sq.ft. 0.50 retail FAR 0.60 office FAR	0	1,062**	1,407**	Yes

* A development agreement governs this property that specifies the maximum building square footage and floor area ratio.
** Vehicle trips per hour.

Automobile Club of Southern California Processing Center. This 39.2-acre site is comprised of two parcels and is located on the southwest corner of Sunflower Avenue and Fairview Road. The primary site contains 29.5 acres and is located west of Fairview Road, between South Coast Drive and Sunflower Avenue. The second parcel contains approximately 9.7 acres and is located across the adjacent flood control channel to the west, just north of South Coast Drive. As of 2000, the site was developed with 717,000 sq. ft. of office and support service uses. An additional 250,000 sq. ft. of development is allowed pursuant to a development agreement for a total of 967,000 square feet; the resultant maximum FAR is 0.56. Future construction will be developed in phases during the 30-year term of the agreement. The 2000 General Plan Traffic Model establishes a trip budget of 1,190 a.m. peak hour trips and 1,576 p.m. peak hour trips for this site. Based on an expected employment population of 2,574 employees, the population density standard for the site would be approximately 66 employees per acre.

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Metro Pointe. Metro Pointe includes two office building sites located north of South Coast Drive at its intersection with Greenbrook Drive and approximately 28.5 acres of land located south of South Coast Drive along the San Diego Freeway. A development agreement approved in 1994 addresses the site south of South Coast Drive. The development agreement vests the property owner with the ability to construct 592,281 square feet of office and commercial uses with a resultant floor area ratio of 0.48. The 2000 General Plan Traffic Model establishes a trip budget of 729 a.m. peak hour trips and 965 p.m. peak hour trips for Metro Pointe. This property is also located in the North Costa Mesa Specific Plan. Using the employment generation rates in Table LU-5, this results in an allowable population density standard of up to 150 employees per acre.

South Coast Metro Center/Experian. The 44.72-acre South Coast Metro Center/Experian sites were the subjects of a development agreement in 2000. The project is located south of Anton Boulevard and east of Avenue of the Arts. Upon completion, the site will include nearly 1,546,180 square feet of office and commercial development. GP 99-06 created a site-specific FAR of 0.79 for the combined South Coast Metro Center and Experian sites. The 2000 General Plan Traffic Model establishes a trip budget of 1,886 a.m. peak hour trips and 1,994 p.m. peak hour trips. This property is also located in the North Costa Mesa Specific Plan. The anticipated population density standard is up to 90 employees per acre.

In 2006, General Plan Amendment (GP-06-02) was approved, and it consisted of a site-specific residential density increase for a 4.86-acre site portion of this development as an optional development scenario for this property. The maximum density allowed is 100 units/acre with integrated ancillary retail uses. This equates to a maximum density of 484 high-rise units at 100 units/acre. The residential development option results in a corresponding decrease in the maximum allowable floor area ratio and building square footages for non-residential buildings in order to be similar to the a.m. and p.m. trip budgets established for the South Coast Metro Center/Experian sites for strictly a non-residential development. See Table LU-7 for the trip budget and floor area ratio for the residential option. The North Costa Mesa Specific Plan provides further detail for these properties. The anticipated population density standard is 255 residents/employees per acre for this 4.86-acre site.

Sakioka Lot 2. The 33-acre Sakioka Lot 2 is located south and east of Anton Boulevard. This site is undeveloped except for farmhouses and farm operation facilities. Pursuant to a development agreement for the site, the maximum allowable building square footage is 863,000 square feet with a corresponding maximum floor area ratio of 0.50 retail/0.60 office. The 2000 General Plan Traffic Model establishes a trip budget of 1,062 a.m. peak hour trips and 1,407 p.m. peak hour trips. This property is also located in the North Costa Mesa Specific Plan. The anticipated population density standard for Sakioka Lot 2 is up to 90 employees per acre.

The compatible zoning district is PDC.

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Cultural Arts Center

As part of GP-00-02, the Cultural Arts Center designation was applied to the 54 acres that comprise South Coast Plaza Town Center. This area is generally bounded by Sunflower Avenue to the north, Bristol Street to the west, Avenue of the Arts to the east, and the San Diego (I-405) Freeway to the south. This designation is limited to this geographical area, and it is not intended to be applied to other locations in the City.

The Cultural Arts Center designation allows intensely developed mixed commercial and cultural uses within a limited area. The intended uses within this designation include mid- to high-rise offices, hotels, restaurants, retail and cultural uses (theater, art museum or academy, etc.), as well as mid- to high-rise residential units in limited areas that are defined in the North Costa Mesa Specific Plan. It serves as the cultural center of the community and provides a focus to the arts-related uses, with the complement of nearby employment and shopping opportunities.

The overall allowable floor area ratio (FAR) standard for this designation is 1.77. Included in this FAR calculation is the land dedicated or reserved in 2000 for the Avenue of the Arts off-ramp and associated flood control channel improvements. The 1.77 FAR may be exceeded on individual parcels within South Coast Plaza Town Center provided that over the entire 54-acre site the 1.77 FAR is not exceeded. Further delineation of the allocation within South Coast Plaza Town Center of the floor area ratio and trip budget is provided in the North Costa Mesa Specific Plan. Based on the employment generation analysis contained in Final Program EIR No. 1047 prepared for South Coast Plaza Town Center, the anticipated population density is 275 employees per acre.

In 2006, General Plan Amendment (GP-06-02) was approved, and it established a high-rise residential development option for each of the three sub-areas in South Coast Plaza Town Center. The maximum number of residential units allowed in the entire South Coast Plaza Town Center is 535 units, which results in an average residential population density of 25 persons per acre over the entire 54-acre area. The high-rise residential development option is further detailed in the North Costa Mesa Specific Plan. As shown in the following table, this scenario results in a corresponding decrease in the maximum allowable floor area ratio and building square footages for non-residential buildings in order to maintain the a.m. and p.m. trip budgets established for the South Coast Plaza Town Center.

TABLE LU-7A

SOUTH COAST PLAZA TOWN CENTER

	Maximum Allowable Non-Residential FAR	Maximum Non-Residential Building Square Footage	Maximum Allowable Number of High-Rise Residential Units	A.M. Peak Hour Trip Budget	P.M. Peak Hour Trip Budget
Residential Option	1.70 ¹	3,991,008 sq.ft.	535	5,123 ²	6,632
Non-Residential Option ³	1.77 ⁴	4,161,813 sq.ft.	80	5,180	6,632
<ol style="list-style-type: none"> 1. This maximum FAR may be increased to no more than 1.77 in direct relation to the decrease in the maximum number of high-rise residential units. 2. This maximum peak hour trip budget may be increased to no more than 5,180 a.m. peak hour trips in direct relation to the decrease in the maximum number of high-rise residential units. 3. This alternative includes the 80 high-rise residential units associated with the museum site in Segerstrom Center for the Arts; see North Costa Mesa Specific Plan. 4. This maximum FAR may not be increased if the 80-unit residential component is not constructed; see North Costa Mesa Specific Plan. 					

The compatible zoning district is TC.

INDUSTRIAL DESIGNATIONS

Two industrial land use designations are applied to over 1,000 acres in the City. These designations accommodate a variety of industrial and compatible office uses and support some commercial uses. Development “intensity” potential is measured/prescribed using Floor Area Ratios in relation to the amount of the traffic generated.

The graduated floor area ratio standards also divide the industrial uses into four broad categories based upon their traffic generation characteristics. Although the categories are the same as the commercial ones, the thresholds are different because of the lower overall traffic generation characteristics of industrial uses. The following table and text lists and describes these standards:

**TABLE LU-8
INDUSTRIAL BUILDING INTENSITY STANDARDS**

Land Use Designation	Very-Low Traffic FAR	Low Traffic FAR	Moderate Traffic FAR	High Traffic FAR
Light Industry ^a	0.75	0.35	0.25	0.15
Industrial Park	0.75	0.40	0.30	0.20
Notes:				
a. With application of the mixed-use overlay district, the FAR may range from 1.0 to 1.25. Refer to Light Industry discussion.				

The Very-Low Traffic category allows industrial uses with daily trip generation rates of less than 3 trip ends per 1,000 square-feet of floor area. Allowable uses under this standard include mini-warehouse developments.

The Low Traffic category allows industrial uses with daily trip generation rates between 3 and 8 trip ends per 1,000 square-feet of floor area. Allowable uses under this standard include a wide range of manufacturing and assembly uses.

The Moderate Traffic category allows uses with daily trip generation rates between 8 and 15 trip ends per 1,000 square-feet of floor area. Allowable uses under this standard include support of office, research and business park type uses.

The High Traffic category allows uses with daily trip generation rates in excess of 15 trip ends per 1,000 square-feet of floor area. Allowable uses under this standard include support commercial service uses and restaurants.

Industrial Park

The Industrial Park designation is intended to apply to large districts that contain a variety of industrial and compatible office and support commercial uses. Industrial parks are characterized by large parcels and landscaped setbacks, which lend to the creation of a spacious campus-like environment. Industrial parks must have proximity to freeways and other major transportation routes in order to provide the accessibility they require. An internal circulation system consisting of lesser highways is also necessary to accommodate the vehicle demands created. Industrial parks have major physical separations from areas designated for other uses in order to maintain their distinctiveness and avoid potential land use incompatibilities.

Development within this designation would consist of one- and two-story buildings. Additional height may be permitted when compatible with adjacent development and the uses are consistent with other constraints such as height limits near John Wayne Airport. The Industrial Park portion of the Home Ranch site may include buildings up to five stories in height near the center of the development. The North Costa Mesa Specific Plan provides more building height information for Segerstrom Home Ranch (Area 1).

In the Industrial Park designation, the allowable floor area ratios are 0.20 for high traffic generating uses, 0.30 for moderate traffic generating uses, 0.40 for low traffic generating uses, and 0.75 for very low traffic generating uses. The exception to the above standards is the 14.5-acre Segerstrom Home Ranch site. This site is governed by the maximum allowable FAR standard of 0.40, a

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maximum building square footage of 252,648. The combined trip budget for this site and the 45.4-acre Commercial Center parcel located to the south of South Coast Drive is 1,593 AM peak hour trips and 1,569 PM peak hour trips. The North Costa Mesa Specific Plan provides more FAR and trip budget information for Segerstrom Home Ranch (Area 1).

Anticipated population densities are dependent upon the particular mix of the uses within a given project. However, based upon the standards provided in Table LU-6, the population density would be an average of 40 employees per acre. An office development would have a population density of 58 employees per acre.

Commercial uses may be allowed provided that the use is determined to be complementary to the industrial area. Commercial recreational uses may also be appropriate under the same condition. Institutional uses may also be appropriate provided that land use compatibility and traffic issues have been addressed. Institutional uses shall require discretionary approval.

Proposed Industrial development would be analyzed for potential significant impacts to air quality, aesthetics, land use, and other environmental issues. The Planned Development process encourages the approval of industrial development with minimal impacts to the environment; thereby promoting cleaner and environmentally sensitive business. Generally, commercial uses are not compatible with industrial uses. However, ancillary commercial uses that support industrial uses are allowed.

Combinations of residential, institutional, and commercial uses may be allowed through the Planned Development zone process. Floor area ratios and population densities for commercial projects would be similar to the Neighborhood Commercial land use designation. Residential densities in planned development projects shall not exceed 20 dwelling units per acre. The corresponding population density range is up to 50 persons per acre.

Large industrial park developments are located in two areas of the City of Costa Mesa. First, the Airport Industrial Area is located south of the I-405, east of SR-55 and north of SR-73 adjacent to John Wayne Airport. The second is located in the northeast portion of the City north of the I-405 between the Santa Ana River and Fairview Road.

Facilities that transfer, store or dispose of hazardous wastes that are generated at another source (off-site) may be allowed in this land use designation, subject to the issuance of a Conditional Use Permit.

Compatible zoning districts include MP, PDI, and CL.

Light Industry

The Light Industry designation applies to areas intended for a variety of light and general industrial uses. Uses are expected to be small manufacturing and service industries as well as larger industrial operations. Although the uses within Light Industry areas are intended to be less intense than those allowed in Industrial Parks, the frequent lack of a physical separation between Light Industry areas and residential areas necessitates on-site mitigation of impacts. Access to industrial areas should be provided in a manner that directs industrial traffic away from more sensitive uses.

Development within this designation would be characterized by a combination of one- and two-story buildings. Because of the location of Light Industry areas and their proximity to residential uses, higher buildings should be restricted to areas that will not impact the surrounding residential uses. The allowable building intensity standards are floor area ratios (FAR) of 0.15 for high traffic generating land uses, 0.25 for moderate traffic generating land uses, 0.35 for low traffic generating uses, and 0.75 for very-low traffic generating uses. The average population density would be 31 employees per acre, and 53 employees per acre for office uses based on standards provided in Table LU-5.

Mixed-use development projects are intended to provide additional housing opportunities in the City (such as the Westside) by combining residential and nonresidential uses in an integrated development. Additionally, this type of development is intended to revitalize areas of the city, without exceeding the capacity of the General Plan transportation system. Mixed-use developments shall be implemented through an adopted urban plan (such as the 19 West and Mesa West Bluff Urban Plan) and shall be identified on the City's Zoning Map by designating the MG base zoning district with the mixed-use overlay district. The mix of uses can occur in either a vertical or horizontal design, up to four stories in height. Product types shall be identified in the applicable urban plans and may include live/work units and commercial/residential units where the residential uses are located above or adjacent to the nonresidential component. Nonresidential uses may include office, retail, business services, personal service, public spaces and uses, and other community amenities. The mix of residential and nonresidential uses would result in an average employee population of 16 employees per acre in the nonresidential component, and in the residential component, the average number of residents per acre is anticipated to be 24 persons. The total average population per acre is 40 persons. Residential development may be allowed in conjunction with the mixed-use overlay district for Mesa West Bluff Urban Plan area at density that does not exceed 13 units per acre, with a projected population density of 36 persons per acre. The required Mesa West Bluff urban plan shall include development standards to ensure compatibility with surrounding land uses.

Commercial uses may be allowed provided that the commercial use is determined to be complementary to the industrial area. Commercial recreational uses may also be appropriate under the same condition.

Institutional uses may also be appropriate in this industrial designation provided that land use compatibility and traffic issues have been addressed. Institutional uses would require a discretionary review and approval process.

Combinations of residential, institutional and commercial uses may be allowed through the Planned Development zone process. Floor area ratios and population densities for commercial projects would be similar to the Neighborhood Commercial land use designation. Residential densities in

Planned Development projects are not to exceed 20 dwelling units per acre. The corresponding population density range is up to 50 persons per acre.

The largest concentrations of Light Industry land are in the southwest industrial area along Placentia Avenue between 19th and Victoria Streets.

Facilities that transfer, store, or dispose of hazardous wastes that are generated at another source (off-site) may be allowed in this land use designation, subject to the issuance of a Conditional Use Permit.

Compatible zoning districts include MG, PDI, MU, and CL.

INSTITUTIONAL AND OPEN SPACE

Costa Mesa's large portion of land set aside for public, semi-public, and open space type uses is designated under one of three land use designations: Public/Institutional, Golf Course, and Fairgrounds.

Public/Institutional

The Public/Institutional designation is intended for both publicly and privately owned land that provides recreation, open space, health and educational opportunities as well as uses that provide a service to the public.

Since this designation includes many different types of land uses, the land use map has been further labeled to identify the individual uses within this designation.

Areas that are included in this designation are park sites, health care facilities, educational institutions, religious facilities, fairgrounds, and public facilities. As many of the uses in this designation are recreational and open space in nature, levels of building intensity are minimal. The maximum building intensity for this designation is a floor area ratio of 0.25 and a population density of 44 employees per acre.

The adoption of GP-02-5 established a site-specific floor area ratio of 0.35 for the 9.44-acre Civic Center. This General Plan amendment recognized existing development intensity and allowed an expansion to the Police Facility. The Civic Center contains the 5-story City Hall, the 2-story Police Facility, Fire Station Number 5 and the Communications Center.

Compatible zoning districts include I&R, I&R-S, and P.

Golf Course

Three golf courses are located within the City's planning area. Two of these, the City's course and Mesa Verde Country Club, are located within the current City limits. Santa Ana Country Club is in the unincorporated area east of Newport Boulevard. Because of the large area devoted to open space, the building intensity for this designation is a floor area ratio of 0.01.

The compatible zoning district is I&R.

Fairgrounds

The Fairgrounds land use designation is applicable to only one property known as the Orange County Fair and Event Center (OCFEC) in the City of Costa Mesa. The Fairgrounds is a 150-acre site located at 88 Fair Drive. This designation is intended to:

- Ensure continued development of the property as an integrated complex that is composed of recreational, agriculture-related educational institutions, open space, farmland, equestrian, and commercial uses, and
- Promote the continued and sustained use of the property for the annual Orange County Fair in recognition of its value as a regionally significant resource in the City of Costa Mesa.

Home to the annual Orange County Fair since 1949, the site is bounded by Arlington Drive (north boundary), Fair Drive (south), Fairview Road (west), and Newport Boulevard (east). Regional access is primarily provided to the site by State Route 55 (SR-55) at the interchanges of Fair Drive/Del Mar Avenue and 22nd Street/Victoria Street. Access from Interstate 405 (I-405), which is approximately one mile north of the Fairgrounds, is provided via interchanges at Bristol Street, Fairview Road, and Harbor Boulevard.

The site was formerly a portion of the Santa Ana Army Air Base, and in 1949 the California 32nd District Agricultural Association (DAA) acquired the property from the Federal Government. Since that time, the annual Orange County Fair has occurred at this location. Through the years the 32nd DAA has expanded the use of the property into a year-round exhibition, conference, equestrian, activity, and event center; these uses compose collectively the OCFEC.

The 32nd DAA Fair Board adopted the current OCFEC Master Plan in 2003. Given that the 32nd DAA is a state entity for administration of the Orange County Fair, Costa Mesa has limited land use and permitting authority over the property while it is controlled by the State. Therefore, the City of Costa Mesa did not have the authority to adopt the 2003 OCFEC Master Plan.

If in the future, the State no longer controls the property, any proposed new development or change of use shall be subject to review for consistency with the City's General Plan and zoning regulations. The new property owner/operator may continue to operate the Fairgrounds as it existed at the time of sale as a legal nonconforming use and development. The property's legal nonconforming status will remain in effect until such time as the property owner submits and receives approval of a master plan by Costa Mesa.

During the timeframe that General Plan Amendment GP-09-01 for the OCFEC was adopted, Costa Mesa was in the process of preparing a ballot initiative for the June 2010 election. The ballot measure intends to preserve the property for fairground and event center uses by requiring Costa Mesa voter approval of any General Plan amendment in respect to the Fairgrounds designation. Additionally, the City was preparing a Fairgrounds Specific Plan that would further establish land use regulations that reinforce the fairground uses.

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As of 2009, the Fairgrounds site contains a total of 400,000 square feet of buildings, including:

- Pacific Amphitheater
- Arlington Theater
- Grandstand Arena
- Equestrian Center
- Exhibit and Administration Buildings
- Concession and Restaurant Buildings
- Memorial Gardens
- Centennial Farms
- Livestock Barns

Orange County Fair (OC Fair) attendance from 1995 to 2006 ranged from 750,000 to 950,000 visitors during the 4-week long period. From 2006 to 2009, OC Fair attendance exceeded a million visitors. Based on peak attendance of approximately 60,000 visitors per day during the OC Fair event, approximately 48,000 vehicle trips per day is expected (based on average vehicle occupancy of 2.5 persons per vehicle).

Although best known for the annual OC Fair, the site hosts many “non-fair” activities and events year round, including the weekly Orange County Marketplace and Farmer’s market, equestrian events, trade and consumer shows, special vehicle sales events, agricultural events, and cultural festivals. In 2009, the Fairgrounds were also home to the Centennial Farm, Equestrian Center, 4-H Clubs, and All American Boys Chorus. In addition, Orange Coast College used a portion of the parking lot for off-site parking during the school year.

The Fairgrounds designation recognizes the existing fairground and event center uses associated with this site. The 2000 General Plan traffic model does not take into account the trip generation from the annual OC Fair or weeknight/weekend special event uses (i.e. Orange County Marketplace) because peak vehicle trips to the site occur outside normal business timeframes. However, further development of the Fairgrounds will need to be balanced with the development capacity of the City’s transportation system and with the protection of surrounding neighborhoods.

Permitted uses include ancillary office uses, exposition/conference uses, equestrian uses, agricultural/livestock activities, restaurants, temporary specialty retail sales (including vehicle sales), outdoor marketplace, emergency operational uses, and concerts/live entertainment uses. Complementary uses to the fairground and event center uses may include botanical gardens, animal exhibits, museum, art/historical artifacts gallery, and performance art theaters that are supportive of the fairground uses.

Uses that are not supportive of fairground and event center uses are expressly prohibited. Prohibited uses include, but are not limited to, casinos/gambling venues, shopping centers, hotel/motels, residential uses, self-storage facilities, hospitals, and medical uses. In addition, exclusive use or dedicated athletic sports facilities and educational uses that are unrelated to the OCFEC are prohibited.

As a State-owned property, the Fairgrounds is not normally subject to the City’s Noise Ordinance. However, pursuant to a 1990 Court Order (Case Nos. 42 07 28 and 55 65 08), exterior noise standards comparable to the City’s noise

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regulations have been applied to the property. Noise sensitive uses include neighboring residences, Davis Intermediate School, and Costa Mesa High School. The court-ordered noise restrictions apply to the operation of the Pacific Amphitheater.

Development within the Fairgrounds designation is intended for buildings ranging from one- to four-story structures. The maximum allowable floor area ratio for this designation shall be 0.10.

Employment generation for fairground and event center uses vary dependent upon the specific use within this designation. For example, typical employment density standards are 1 employee per 300 square feet of office use, 1 employee per 333 square feet of service uses, and 1 employee per 500 square feet for retail. Because of the limited range of uses and lower building intensity permitted in the Fairgrounds designation compared to other nonresidential land use designations, the standard mix of uses in this designation would generate a population density in the range of 4 to 15 employees per acre. Office development consisting of a maximum buildout of 653,400 square feet at 0.10 FAR would generate up to 14.5 employees per acre, although it is important to note that office uses are ancillary to the primary fair and event center uses.

The compatible zoning district is I&R.

GENERAL PLAN/ZONING RELATIONSHIP

The relationship between the 2000 General Plan land use designations and zoning districts is shown in Table LU-9. This table indicates how properties should be zoned to be consistent with the General Plan Land Use Plan Map. As presented in the table, there are 15 General Plan land use designations and 21 zoning categories.

HOUSING AND EMPLOYMENT PROJECTIONS

Providing a land use arrangement that encourages a correlation of employment and housing opportunities is a local and regional responsibility. Providing sufficient commercial land to support residential development is primarily a local responsibility, although commercial uses, which serve regional needs are provided as well. Sufficient land must also be established to meet the recreational needs of the local community, although regional needs are often accommodated by land within individual cities.

Refer to Table LU-3, *Population, Housing, and Employment*, to review historical data for Costa Mesa's population, number of housing units, and employment opportunities.

**TABLE LU-9
GENERAL PLAN/ZONING RELATIONSHIPS**

General Plan Designation	Description/Discussion	Consistent Zoning Classification
Residential		
Low-Density Residential	Residential development with a density up to 8 units per acre.	R1, PDR-LD, I&R, I&R-S
Medium-Density Residential	Residential development with a density of up to 12 units per acre.	R1, R2-MD, PDR-MD, I&R, I&R-S, MU
High-Density Residential	Residential development with a density of up to 20 units per acre; except the density in the PDR-NCM zone is 25 to 35 units per acre and The Lakes subarea in the North Costa Mesa Specific Plan is a site specific density of 125 units per acre.	R2-MD, R2-HD, R3, PDR-HD, PDR-NCM, MU, I&R, I&R-S
Commercial		
Commercial – Residential	A complementary mix of commercial and residential and zoning along Newport Boulevard. Typically, individual parcels would be developed as commercial or residential. The maximum residential density is 17.4 units/acre.	AP, CL, C1, P, PDC, R2-MD, R2-HD, PDR-MD, PDR-HD
Neighborhood Commercial	Small, well-defined commercial areas designed to serve local convenience and service needs of adjacent residential areas.	CL, C1, AP, P, MU
General Commercial	Large shopping areas along major transportation routes servicing both local and regional markets.	CL, C1, C2, C1-S, PDC, AP, MU, P
General Plan Designation	Description/Discussion	Consistent Zoning Classification
Commercial Center	Major shopping, service, and office facilities designed to serve citywide and regional markets. Complementary residential uses are permitted in the PDC zone.	C1, C2, C1-S, PDC, AP, PDC, P
Regional Commercial Center	Large concentrated shopping centers of a regional scale.	PDC
Urban Center Commercial	Intensely-developed mixed commercial including offices, residential, retail shops, restaurants, and hotels.	PDC
Cultural Arts Center	Intensely-developed mix of commercial, office, residential, and cultural arts uses.	TC
Industrial		
Light Industry	Manufacturing, distribution, and service industries located on small sites.	MG, PDI, CL, MU
Industrial Park	Planned, large site research, manufacturing, office, and industrial development.	MP, PDI, CL
Other		
Golf Course	Public and private golf and country club.	I&R
Public/Institutional	Government offices, hospitals, educational institutions, cemeteries, parks, and other public facilities.	I&R, I&R-S, P
Fairgrounds	Orange County Fairgrounds and Exposition Center.	I&R

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Table LU-10, *General Plan Residential Land Use 2020*, and Table LU-11, *General Plan Non-Residential Land Use 2020*, presents data regarding Costa Mesa's growth by land use category for the year 2020 planning horizon.

**TABLE LU-10
GENERAL PLAN RESIDENTIAL LAND USE 2020¹**

Residential Land Use	Gross Acres	2000 Existing Dwelling Units	2020 Dwelling Units
Single-Family ²	2,167	19,122	19,576
Multi-Family ³	1,842	21,455	22,893
Total	4,009	40,577	42,469

Notes:

¹ Based upon OCP-2000 projections, Center for Demographic Research, California State University, Fullerton.
² Includes Low-Density Residential General Plan land use designation.
³ Includes Medium-Density, High-Density, and Commercial-Residential General Plan land use designations.

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**TABLE LU-11
GENERAL PLAN NON-RESIDENTIAL LAND USE 2020**

Land Use Designation	Gross Acres	2000 Existing Development (SF)	2020 Development (SF)
Commercial-Residential (commercial uses) ¹	434	588,339	571,007
Neighborhood Commercial	44	424,648	567,371
General Commercial	632	8,344,029	10,607,341
Commercial Center	30	611,227	653,383
Regional Commercial	115	2,926,203	3,440,350
Urban Center Commercial	160	2,126,024	3,914,357
Cultural Arts Center	54	2,801,368	4,161,813
Industrial Park	763	10,028,934	12,207,260
Light Industry	383	4,903,788	5,996,712
Public and Institutional	1,287	1,072,037	3,892,286
Golf Course	560	84,180	243,961
Fairgrounds	146	128,765	427,396
Total	4,608	34,039,542	46,683,237

Source: City of Costa Mesa, Development Services Department, February 2000.

Notes:
¹ Commercial-Residential land use designation acreage was also included in the multi-family residential land use in Table 3-3.
 SF = square feet

2.6 GOALS, OBJECTIVES AND POLICIES

The goals, objectives, and policies that address land use are as follows:

**GOAL LU-1:
LAND USE**

It is the goal of the City of Costa Mesa to provide its citizens with a balanced community of residential, commercial, industrial, recreational, and institutional uses to satisfy the needs of the social and economic segments of the population and to retain the residential character of the City; to meet the competing demands for alternative developments within each land use classification within reasonable land use intensity limits; and, to ensure the long term viability and productivity of the community's natural and man-made environments.

Objective LU-1A. Establish and maintain a balance of land uses throughout the community to preserve the residential character of the City at a level no greater than can be supported by the infrastructure.

- LU-1A.1 Provide for the development of a mix and balance of housing opportunities, commercial goods and services, and employment opportunities in consideration of the needs of the business and residential segments of the community.

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- LU-1A.2 Consider the effects of new employment, particularly in relation to housing impacts, when new commercial or industrial development is proposed.
- LU-1A.3 Locate high-intensity developments or high traffic generating uses away from low-density residential in order to buffer the more sensitive land uses from the potentially adverse impacts of the more intense development or uses.
- LU-1A.4 Strongly encourage the development of low-density residential uses and owner-occupied housing where feasible to improve the balance between rental and ownership housing opportunities.
- LU-1A.5 Provide housing and employment opportunities within planned development areas to the extent feasible.
- LU-1A.6 Aggressively pursue methods to discourage the development of multiple units on long, narrow, single parcels. Possible methods could include a lot combination zoning incentive or the creation of new lower density zoning to be applied to lots with less than a certain minimum frontage.

Objective LU-1B. Ensure the long term productivity and viability of the community's economic base.

- LU-1B.1 Permit adequate quantities and locations of commercial land to serve residential neighborhoods.

Objective LU-1C. Promote land use patterns and development, which contribute to community and neighborhood identity.

- LU-1C.1 Permit the construction of buildings over two stories or 30 feet only when it can be shown that the construction of such structures will not adversely impact surrounding developments and deprive existing land uses of adequate light, air, privacy, and solar access.
- LU-1C.2 Limit building height to four stories above grade south of the I-405 Freeway, except for special purpose housing, such as elderly, affordable, or student housing. An exception is for the Newport Plaza property at 1901 Newport Boulevard where a five-level parking structure is allowed.
- LU-1C.3 Prohibit construction of buildings which would present a hazard to air navigation as determined by the FAA.
- LU-1C.4 Require building setbacks, structure orientation, and the placement of windows to consider the privacy of adjacent residential structures within the same project and on adjacent properties.
- LU-1C.5 Develop incentives for lot combination, or disincentives for development without lot combination. Consider policies such as zoning designations, which fall between zones, or development standards, which tie density to lot width as well as area.

- LU-1C.6 Provide assistance to neighborhoods with excessive noise impacts, such as walls for sound attenuation, development of landscaped greenbelts, etc.

Objective LU-1D. Ensure consideration of utility system capacities in land use planning and development processes.

- LU-1D.1 Include an evaluation of impacts on utility systems and infrastructure in EIRs for all major general plan amendment, rezone, and development applications.

- LU-1D.2 Phase or restrict future development in the City to that which can be accommodated by infrastructure at the time of completion of each phase of a multi-phased project.

Objective LU-1E. Ensure correlation between buildout of the General Plan Land Use Plan Map and the Master Plan of Highways.

- LU-1E.1 Building densities/intensities for proposed new development projects shall not exceed the trip budget for applicable land use classifications, as identified in the Land Use Element. Building intensities for proposed new development projects shall not exceed the applicable floor area standards, except for the following conditions:

- (a) Limited deviations from the graduated floor area ratio standards depicted in Tables LU-4 and LU-8 for the commercial and industrial land use designations may be approved through a discretionary review process. No deviation shall exceed a 0.05 increase in the FAR in the moderate traffic category, and no deviation shall be allowed in the very-low, low, and high traffic categories. Deviations from the FAR standards shall not cause the daily trip generation for the property to be exceeded when compared to the existing daily trip generation for the site without the proposed project or maximum allowable traffic generation for the Moderate Traffic FAR category, whichever is greater.
- (b) Additions to existing nonconforming non-residential developments may be allowed if the additions do not affect the overall traffic generation characteristics of the development, and, if the additions do not substantially affect the existing height and bulk of the development. Additions to non-residential developments shall be limited to those land uses with traffic generation rates based on variables other than building area square footage. Examples of such additions include, but are not limited to: 1) Hotels/Motels: increases in the size of hotel rooms or lobbies where no increase in the total number of rooms is proposed; 2) Theaters: increases to "back-stage" support areas or lobbies where no increase in the total number of seats is proposed.
- (c) In the above conditions, the new development shall be compatible with surrounding land uses. Additional criteria for approving deviations from the FAR standards may be established by policy of the City Council.

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- LU-1E.2 Development Plans shall be required for all phased development and approvals and shall be approved by the Planning and Transportation Services Divisions prior to the issuance of building permits.
- LU-1E.3 Development Plans shall include an overall buildout plan, which can demonstrate the ability of the circulation system to support the proposed level of development.
- LU-1E.4 The City shall continue its annual preparation of the Development Phasing and Performance Monitoring Program. The annual review will specifically address major intersection operations in any mixed-use overlay area.

Objective LU-1F. Establish policies, standards, and procedures to minimize blighting influences and maintain the integrity of stable neighborhoods.

- LU-1F.1 Protect existing stabilized residential neighborhoods, including mobile home parks (and manufactured housing parks) from the encroachment of incompatible or potentially disruptive land uses and/or activities.
- LU-1F.2 Actively enforce existing regulations regarding derelict or abandoned vehicles, outdoor storage, and substandard or illegal buildings and establish regulations to abate weed-filled yards when any of the above are deemed to constitute a health, safety, or fire hazard.
- LU-1F.3 Continue code enforcement as a high priority and provide adequate funding and staffing to support code enforcement programs.
- LU-1F.4 Ensure that residential densities can be supported by the infrastructure and that high-density residential areas are not permitted in areas, which cause incompatibility with existing single-family areas.
- LU-1F.5 Provide opportunities for the development of well planned and designed projects which, through vertical or horizontal integration, provide for the development of compatible residential, commercial, industrial, institutional, or public uses within a single project or neighborhood.

**GOAL LU-2:
DEVELOPMENT**

It is the goal of the City of Costa Mesa to establish development policies that will create and maintain an aesthetically pleasing and functional environment and minimize impacts on existing physical and social resources.

Objective LU-2A. Encourage new development and redevelopment to improve and maintain the quality of the environment.

- LU-2A.1 Use eminent domain in redevelopment project areas when necessary to effect lot combination and to ensure optimum size

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and configuration of parcels experiencing development pressures.

- LU-2A.2 Continue to implement, review, and update the redevelopment plan for the adopted project area.
- LU-2A.3 Prepare a specific plan to ensure that the portion of the Route 55 extension from 19th Street through the Redevelopment Area is compatible with the Redevelopment Area and to review development related issues on the remainder of the alignment.
- LU-2A.4 In the event of damage or destruction, allow any legal conforming use in existence at the time of adoption of the General Plan that is located in a nonconforming development to be rebuilt to its original building intensity, as long as any such rebuilding would not increase the development's nonconformity, and the damage or destruction was in no way brought about by intentional acts of any owner of such use or property.
- LU-2A.5 Develop standards, policies, and other methods to encourage the grouping of individual parcels to eliminate obsolete subdivision patterns and to provide improved living environments while retaining the single-family zoning or single-family character of such areas in the City.
- LU-2A.6 Do not allow "rounding up" when calculating the number of permitted residential units except for lots existing as of March 16, 1992, zoned R2-MD that have less than 7,260 square feet in area, and no less than 6,000 square feet, where density calculation fractions of 1.65 or greater may be rounded up to two units.
- LU-2A.7 Allow creation of parcels without street frontage if sufficient easements are provided for planned developments or common-interest developments.
- LU-2A.8 Encourage increased private market investment in declining or deteriorating neighborhoods.
- LU-2A.9 Pursue maximum use of utility company funds and resources in undergrounding existing overhead lines.
- LU-2A.10 Ensure that appropriate watershed protection activities are applied to all new development and significant redevelopment projects that are subject to the NPDES Stormwater Permit, during the planning, project review, and permitting processes.
- LU-2A.11 Avoid conversion of areas particularly susceptible to erosion and sediment loss (e.g., steep slopes) and/or establish development guidelines that identifies these areas and protects them from erosion and sediment loss.
- LU-2A.12 Preserve or restore areas that provide water quality benefits and/or are necessary to maintain riparian and aquatic biota.

- LU-2A.13 Promote site development that limits impact on and protects the natural integrity of topography, drainage systems, and water bodies.
- LU-2A.14 Promote integration of stormwater quality protection into construction and post-construction activities, as required by the NPDES Stormwater Permit and the City's Local Implementation Plan.

**GOAL LU-3:
SOCIO-ECONOMIC CONSIDERATIONS**

It is the goal of the City of Costa Mesa to respond to the needs of its citizens for housing, public services, community facilities, and safety of persons and property, to the extent possible within budgetary constraints, and when deemed appropriate for local governmental involvement.

Objective LU-3A. Ensure availability of adequate community facilities and provision of the highest level of public services possible, taking into consideration budgetary constraints and effects on the surrounding area.

- LU-3A.1 Pursue annexation of certain areas within the City's Sphere of Influence to control development or uses which may be detrimental to the City.
- LU-3A.2 Strongly encourage protection and preservation of existing, but underutilized, school sites for future recreational, social, or educational uses.
- LU-3A.3 Establish a development impact fee program to fund additional fire and police personnel, facilities, and equipment to meet the demands of additional growth in the City.
- LU-3A.4 Require appropriate site and environmental analysis for future fire and police station site locations or for the relocation or closure of existing fire and police facilities.

Attachment No. 14

California Quick Facts, US Census Bureau

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State & County QuickFacts

California

People QuickFacts	California	USA
Population, 2013 estimate	38,332,521	316,128,839
Population, 2010 (April 1) estimates base	37,253,959	308,747,716
Population, percent change, April 1, 2010 to July 1, 2013	2.9%	2.4%
Population, 2010	37,253,956	308,745,538
Persons under 5 years, percent, 2013	6.5%	6.3%
Persons under 18 years, percent, 2013	23.9%	23.3%
Persons 65 years and over, percent, 2013	12.5%	14.1%
Female persons, percent, 2013	50.3%	50.8%
White alone, percent, 2013 (a)	73.5%	77.7%
Black or African American alone, percent, 2013 (a)	6.6%	13.2%
American Indian and Alaska Native alone, percent, 2013 (a)	1.7%	1.2%
Asian alone, percent, 2013 (a)	14.1%	5.3%
Native Hawaiian and Other Pacific Islander alone, percent, 2013 (a)	0.5%	0.2%
Two or More Races, percent, 2013	3.7%	2.4%
Hispanic or Latino, percent, 2013 (b)	38.4%	17.1%
White alone, not Hispanic or Latino, percent, 2013	39.0%	62.6%
Living in same house 1 year & over, percent, 2008-2012	84.2%	84.8%
Foreign born persons, percent, 2008-2012	27.1%	12.9%
Language other than English spoken at home, pct age 5+, 2008-2012	43.5%	20.5%
High school graduate or higher, percent of persons age 25+, 2008-2012	81.0%	85.7%
Bachelor's degree or higher, percent of persons age 25+, 2008-2012	30.5%	28.5%
Veterans, 2008-2012	1,952,910	21,853,912
Mean travel time to work (minutes), workers age 16+, 2008-2012	27.1	25.4
Housing units, 2013	13,790,495	132,802,859
Homeownership rate, 2008-2012	56.0%	65.5%
Housing units in multi-unit structures, percent, 2008-2012	30.9%	25.9%
Median value of owner-occupied housing units, 2008-2012	\$383,900	\$181,400
Households, 2008-2012	12,466,331	115,226,802
Persons per household, 2008-2012	2.93	2.61
Per capita money income in past 12 months (2012 dollars), 2008-2012	\$29,551	\$28,051
Median household income, 2008-2012	\$61,400	\$53,046
Persons below poverty level, percent, 2008-2012	15.3%	14.9%
Business QuickFacts	California	USA
Private nonfarm establishments, 2012	864,913 ¹	7,431,808
Private nonfarm employment, 2012	12,952,818 ¹	115,938,468
Private nonfarm employment, percent change, 2011-2012	2.0% ¹	2.2%
Nonemployer establishments, 2012	2,926,065	22,735,915
Total number of firms, 2007	3,425,510	27,092,908
Black-owned firms, percent, 2007	4.0%	7.1%
American Indian- and Alaska Native-owned firms, percent, 2007	1.3%	0.9%

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Asian-owned firms, percent, 2007	14.9%	5.7%
Native Hawaiian and Other Pacific Islander-owned firms, percent, 2007	0.3%	0.1%
Hispanic-owned firms, percent, 2007	16.5%	8.3%
Women-owned firms, percent, 2007	30.3%	28.8%

Manufacturers shipments, 2007 (\$1000)	491,372,092	5,319,456,312
Merchant wholesaler sales, 2007 (\$1000)	598,456,486	4,174,286,516
Retail sales, 2007 (\$1000)	455,032,270	3,917,663,456
Retail sales per capita, 2007	\$12,561	\$12,990
Accommodation and food services sales, 2007 (\$1000)	80,852,787	613,795,732
Building permits, 2012	58,549	829,658

Geography QuickFacts**California USA**

Land area in square miles, 2010	155,779.22	3,531,905.43
Persons per square mile, 2010	239.1	87.4
FIPS Code	06	

1: Includes data not distributed by county.

(a) Includes persons reporting only one race.

(b) Hispanics may be of any race, so also are included in applicable race categories.

D: Suppressed to avoid disclosure of confidential information

F: Fewer than 25 firms

FN: Footnote on this item for this area in place of data

NA: Not available

S: Suppressed; does not meet publication standards

X: Not applicable

Z: Value greater than zero but less than half unit of measure shown

Source U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, American Community Survey, Census of Population and Housing, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits
Last Revised: Tuesday, 08-Jul-2014 06:37:34 EDT

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Attachment No. 15

Households and Families: 2010, 2010
Census Briefs

INTRODUCTION

The 2010 Census enumerated 308.7 million people in the United States, a 9.7 percent increase from 281.4 million in Census 2000. Of the total population in 2010, 300.8 million lived in 116.7 million households for an average of 2.58 people per household. This was down from an average of 2.59 in 2000 when 273.6 million people lived in 105.5 million households. The remaining 8.0 million people in 2010 lived in group-quarters arrangements such as school dormitories, nursing homes, or military barracks. This report presents information on the number and types of living arrangements of American households in 2010 derived from the relationship question on the 2010 Census.

HOUSEHOLD RELATIONSHIP QUESTION

The relationship item (Figure 1), a version of which has been on the census since 1880, asks the relationship of each member of the household to the householder or the person designated as the individual who owns or rents the housing unit.¹ This question provides information about individuals as well as the composition of families and households. Three separate categories describe the sons and daughters

¹ In a case of joint ownership, one individual is chosen as the householder. If this choice cannot be made, the first person 15 years and over listed on the form is chosen as the householder.

Figure 1.

Reproduction of the Question on Relationship to Householder From the 2010 Census

2. How is this person related to Person 1? Mark ONE box.

- | | |
|---|--|
| <input type="checkbox"/> Husband or wife | <input type="checkbox"/> Parent-in-law |
| <input type="checkbox"/> Biological son or daughter | <input type="checkbox"/> Son-in-law or daughter-in-law |
| <input type="checkbox"/> Adopted son or daughter | <input type="checkbox"/> Other relative |
| <input type="checkbox"/> Stepson or stepdaughter | <input type="checkbox"/> Roomer or boarder |
| <input type="checkbox"/> Brother or sister | <input type="checkbox"/> Housemate or roommate |
| <input type="checkbox"/> Father or mother | <input type="checkbox"/> Unmarried partner |
| <input type="checkbox"/> Grandchild | <input type="checkbox"/> Other nonrelative |

Source: U.S. Census Bureau, 2010 Census questionnaire.

of the householder in 2010: biological, adopted, or stepchild. Relatives identified in the questionnaire are spouses, brothers, sisters, and parents of the householder, as well as grandchildren, parents-in-law, and sons/daughters-in-law.

Those who live in households but who were not related to the householder were identified as housemates/roommates, roomers or boarders, and unmarried partners of the householder. This latter group includes people who initially identified themselves as being same-sex spouses of the householder. The tables with same-sex couples show these groups in two ways. One estimate shows households as originally reported on the census forms. The second presents improved and preferred estimates of the same-sex household population, accounting for marking errors that inadvertently overestimated that

By
Daphne Lofquist,
Terry Lugaila,
Martin O'Connell,
and
Sarah Feliz

Table 1.

Relationship to Householder by Age: 2010(For information on confidentiality protection, nonsampling errors, and definitions, see www.census.gov/prod/cen2010/doc/sf1.pdf)

Relationship type	Total	Number				
		Under 18 years	18 to 29 years	30 to 44 years	45 to 64 years	65 years and over
Total household population	300,758,215	73,920,881	47,903,506	59,766,531	80,357,019	38,810,278
Householder	116,716,292	28,297	13,862,048	30,758,709	46,247,402	25,819,836
Spouse	56,510,377	8,793	4,863,702	17,524,307	24,935,103	9,178,472
Biological son or daughter	82,582,058	60,466,596	16,007,784	3,941,728	2,093,818	72,132
Adopted son or daughter	2,072,312	1,527,020	403,558	99,376	41,282	1,076
Stepson or stepdaughter	4,165,886	2,784,531	1,100,511	217,220	61,226	2,398
Brother or sister	3,433,951	298,242	1,125,419	848,247	922,338	239,705
Father or mother	3,033,003	(X)	(X)	128,343	1,187,041	1,717,619
Grandchild	7,139,601	5,825,229	1,117,324	180,096	16,926	26
Parent-in-law	925,713	(X)	(X)	10,178	281,266	634,269
Son-in-law or daughter-in-law	1,216,299	25,063	593,674	428,186	158,997	10,379
Other relative	4,662,672	1,631,262	1,268,787	774,403	648,580	339,640
Roomer or boarder	1,526,210	142,899	559,814	376,180	363,573	83,744
Housemate or roommate	5,223,365	42,515	3,163,824	1,084,638	769,490	162,898
Unmarried partner	7,744,711	11,651	2,622,772	2,724,034	2,020,431	365,823
Other nonrelative	3,805,765	1,128,783	1,214,289	670,886	609,546	182,261

(X) Not applicable

Source: U.S. Census Bureau, *2010 Census Summary File 1*.

population's size.² This report uses this set of estimates in the text, as it represents the best set of numbers from the 2010 Census.

People related to the householder

Despite the diversity of households in the United States, three relationship categories made up the majority of people in 2010. The householder, his or her spouse, and his or her sons and daughters comprised 262.0 million people or 87 percent of the population (Table 1). Of the 88.8 million children of householders, 93 percent were biological children. There were approximately twice as many stepchildren (4.2 million) as adopted children (2.1 million).

As expected, most of the children living with their parents were under 18 years old. These three child types exhibit different age distributions. About 73 percent of either biological or adopted

children were under 18, compared with 67 percent of stepchildren. Stepchildren were more likely to be young adults ages 18 to 29 years (26 percent) than either biological or adopted children (19 percent each). Stepchildren were older in general as they reflect the blending of two different families where the spouse already has older children from a prior marriage.

In the same generation as the children of the householder are the sons-in-law and daughters-in-law of the householder. They numbered 1.2 million in 2010, and almost half of them were young adults who depended on their in-laws for housing assistance. Given their age, most were probably recently married. About one-third of all brothers and sisters of the householder (3.4 million) were 18-to-29 years old.

Another 1.1 million young adults were grandchildren of the householder. This age group made up 16 percent of the 7.1 million grandchildren living with their grandparents—the majority of these grandchildren were under 18 (82 percent). At the other end of

the generational continuum were the parents and parents-in-law of the householder, comprising about 3.0 million and 926,000 relatives, respectively. Unlike people in any other relationship category, the majority of these were 65 years and over—57 percent of parents and 69 percent of parents-in-law were this age.

Although not specified by detailed type in the 2010 Census, another 4.7 million were "other relatives" who lived in households. About one-third of them were under 18 and were often nephews and nieces of the householder.³

Nonrelatives of the householder

People who were not related to the householder numbered 18.3 million in 2010 (6.1 percent of the household population), up from 14.6 million in 2000 (5.2 percent of the household population). In fact, 1 out of every 8 homes in

² See Martin O'Connell and Sarah Feliz, "Same-sex Couple Household Statistics From the 2010 Census," SEHSD Working Paper Number 2011-26, September 27, 2011, <www.census.gov/hhes/samesex/data/decennial.html>.

³ There were 845,000 nephews and nieces of the householder under 18 in Census 2000. See Terry Lugaila and Julia Overturf, "Children and the Households They Live In: 2000," *Census 2000 Special Reports*, CENSR-14 (March 2004), Table 1.

UNMARRIED PARTNER HOUSEHOLDS

An "unmarried partner household" consists of a householder and a person living in the household who reports that he or she is (1) an unmarried partner of the householder and of the opposite sex; (2) an unmarried partner of the householder and of the same sex; or (3) a spouse of the householder and of the same sex. Procedures for the 2010 Census edited same-sex spouse households as unmarried partner households, and these households appear as such in published Summary File 1 tabulations. During the review of the data, counts of same-sex spouses appeared inflated due to mismarking errors in the gender item on the census forms. Up to 28 percent of the total number of same-sex unmarried partner households may actually be opposite-sex households: 62 percent of reported same-sex spouses were probably marked in error compared with 7 percent of reported same-sex unmarried partners. This report presents data both for same-sex households as shown in Summary File 1 tabulations and for a set of "preferred estimates" that attempts to remove statistically same-sex households that are likely opposite-sex households.

2010 contained one or more people not related to the householder.⁴ Roomers or boarders comprised 1.5 million individuals who represented a wide array of people such as students, migrants to an area waiting for better accommodations, or people who could not afford

to rent their own home.⁵ About 143,000 (9.4 percent) of roomers and boarders were less than 18 years old, suggesting they might be children of displaced families living in boarding homes. Another 61.3 percent (936,000) were in the prime working ages of 18 to 44 years, compared with 35.8 percent

⁵ A historical perspective and the growth and characteristics of roomers and boarders is presented in Melissa Scopilliti and Martin O'Connell, "Roomers and Boarders: 1880–2005," paper presented at the Annual Meetings of the Population Association of America, New Orleans, LA, April 17–19, 2008, <www.census.gov/population/www/documentation/paa2008/Scopilliti-OConnell-PAA-2008.ppt>.

⁴ Proportion derived from U.S. Census Bureau, *2010 Census Summary File 1*, Table P27.

for the household population as a whole.

Housemates or roommates who were coequals with the householder and who shared maintenance of the housing unit had more economic equality with the householder. Looking at the age structure of these 5.2 million people, 61 percent were young adults ages 18 to 29 who might be sharing living expenses. The percentage declined sharply for the next older age group, 30 to 44 years old (21 percent).

Overall, the unmarried partner population numbered 7.7 million in 2010 and grew 41 percent between 2000 and 2010, four times as fast as the overall household population (10 percent). Unmarried partners were generally older than housemates: 2.6 million (34 percent) were 18 to 29 years old, while 2.7 million (35 percent) were 30 to 44 years old. In addition, 26 percent of unmarried partners were 45-to-64 year olds, compared with 15 percent of housemates. This difference in age profiles reflects the transitions occurring first when a young person shares expenses as a housemate or roommate after leaving the parent's home and later when that person develops a more permanent and personal relationship with an unmarried partner.

HOUSEHOLDS

All of these various relationship types contribute to the formation of households, both family and nonfamily households. Who lives in a household has important consequences for economic resources available to housing units and for access to everyday social support systems such as care for young children or older parents. The following sections show the different types of households in 2010 and their growth over the decade.

The number of households grew by over 11 million since 2000.

The number of households in the United States increased 11 percent, from 105.5 million in 2000 to 116.7 million in 2010. While family households increased 8 percent, from 71.8 million in 2000 to 77.5 million in 2010, nonfamily households increased faster, 16 percent, from 33.6 million in 2000 to 39.2 million in 2010. As a proportion of all households, family households declined from 68 percent in 2000 to 66 percent in 2010, while the proportion of nonfamily households increased from 32 percent to 34 percent, respectively.

Table 2 shows that husband-wife households numbered 56.5 million in 2010 and made up 73 percent of all family households in 2010 (households containing at least one person related to the householder by birth, marriage, or adoption).

HOUSEHOLD DEFINITIONS

A "household" includes all of the people who occupy a housing unit. One person in each household is designated as the "householder." In most cases, this is the person, or one of the people, in whose name the home is owned, being bought, or rented. If there is no such person in the household, any household member 15 years old and over can be designated as the householder.

A family consists of a householder and one or more other people living in the same household who are related to the householder by birth, marriage, or adoption. Biological, adopted, and stepchildren of the householder who are under 18 are the "own children" of the householder. Own children do not include other children present in the household, regardless of the presence or absence of the other children's parents.

A family household may also contain people not related to the householder. A family in which the householder and his or her spouse of the opposite sex are enumerated as members of the same household is a husband-wife household. In this report, husband-wife households only refer to opposite-sex spouses and do not include households that were originally reported as same-sex spouse households. Same-sex spousal households are included in the category, "same-sex unmarried partner households" but may be either a family or nonfamily household depending on the presence of another person who is related to the householder. The remaining types of family households not maintained by a husband-wife couple are designated by the sex of the householder.

A nonfamily household consists of a householder living alone or with nonrelatives only, for example, with roommates or an unmarried partner.

Family households maintained by a female householder with no spouse present numbered 15.3 million, more than twice the number maintained by a male householder with no spouse present (5.8 million). Among nonfamily households, one-person households predominated (31.2 million) and were more than three times as common as

nonfamily households with two or more people (8.0 million). More women than men lived alone (17.2 million and 13.9 million, respectively). A geographic look at one-person households follows later in this report.

Despite increases in both the number of households and of people in the United States since 2000, the

Table 2.

Households by Type: 2000 and 2010(For information on confidentiality protection, nonsampling errors, and definitions, see www.census.gov/prod/cen2010/doc/sf1.pdf)

Household type	2000		2010		Change, 2000 to 2010	
	Number	Percent	Number	Percent	Number	Percent
Total households	105,480,101	100.0	116,716,292	100.0	11,236,191	10.7
Family household.....	71,787,347	68.1	77,538,296	66.4	5,750,949	8.0
Husband-wife households.....	54,493,232	51.7	56,510,377	48.4	2,017,145	3.7
With own children.....	24,835,505	23.5	23,588,268	20.2	-1,247,237	-5.0
Without own children.....	29,657,727	28.1	32,922,109	28.2	3,264,382	11.0
Female householder, no spouse present.....	12,900,103	12.2	15,250,349	13.1	2,350,246	18.2
With own children.....	7,561,874	7.2	8,365,912	7.2	804,038	10.6
Without own children.....	5,338,229	5.1	6,884,437	5.9	1,546,208	29.0
Male householder, no spouse present.....	4,394,012	4.2	5,777,570	5.0	1,383,558	31.5
With own children.....	2,190,989	2.1	2,789,424	2.4	598,435	27.3
Without own children.....	2,203,023	2.1	2,988,146	2.6	785,123	35.6
Nonfamily households.....	33,692,754	31.9	39,177,996	33.6	5,485,242	16.3
Male householder.....	15,556,103	14.7	18,459,253	15.8	2,903,150	18.7
Living alone.....	11,779,106	11.2	13,906,294	11.9	2,127,188	18.1
Not living alone.....	3,776,997	3.6	4,552,959	3.9	775,962	20.5
Female householder.....	18,136,651	17.2	20,718,743	17.8	2,582,092	14.2
Living alone.....	15,450,969	14.6	17,298,615	14.8	1,847,646	12.0
Not living alone.....	2,685,682	2.5	3,420,128	2.9	734,446	27.3
Unmarried couple households ¹	5,475,768	5.2	7,744,711	6.6	2,268,943	41.4
Opposite-sex partners.....	4,881,377	4.6	6,842,714	5.9	1,961,337	40.2
Same-sex partners ²						
Summary File 1 counts.....	594,391	0.6	901,997	0.8	307,606	51.8
Preferred estimates.....	358,390	0.3	646,464	0.6	288,074	80.4
Average household size.....	2.59	(X)	2.58	(X)	- 0.01	(X)
Average family size.....	3.14	(X)	3.14	(X)	0.00	(X)

(X) Not applicable.

¹ Unmarried couple households can be family or nonfamily households depending on the relationship of others in the household to the householder. In this table, it is the sum of opposite-sex partners and same-sex partners from Summary File 1 counts.

² Summary File 1 counts in this table are consistent with Summary File 1 counts shown in American FactFinder.

Sources: U.S. Census Bureau, *Census 2000 Summary File 1* and *2010 Census Summary File 1*.

average household size decreased over the decade, from 2.59 to 2.58, but average family size stayed the same, 3.14.⁶ These indicators show a slowing of the downward trends that have existed since the end of the Baby Boom in the 1960s. In 1960, the average household size was 3.29 people per

⁶ Average family size is the number of family members in the household (persons related to the householder including the householder) per family household. This computation excludes persons not related to the householder.

household, and the average family size was 3.65 people per family.⁷

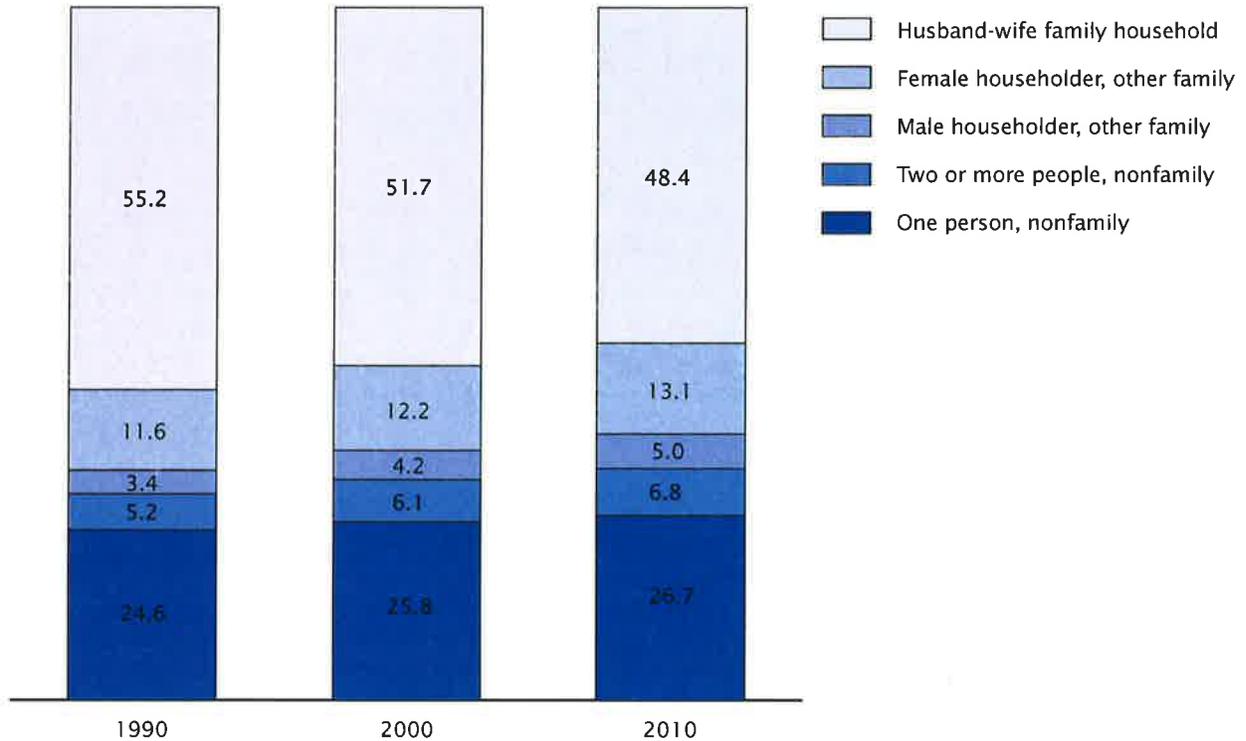
The number of households within each category type increased in the last 10 years, including husband-wife households, which increased

⁷ Average household size for 1960 may be found in Frank Hobbs and Nicole Stoops, "Demographic Trends in the 20th Century," *Census 2000 Special Reports*, CENSUR-4 (November 2002), Figure 5-3. Average family size for 1960 may be found in U.S. Census Bureau, 1960 Census of Population, Supplementary Reports, PC(S1)-38, *Families in the United States: 1960*, Table 280.

by 2.0 million. Figure 2 shows that, despite this increase, in 2010 less than half of all households (48 percent) were husband-wife households, down from 52 percent in 2000 and 55 percent in 1990. This is the first time that husband-wife families fell below 50 percent of all households in the United States since data on families were first

Figure 2.
Households by Type: 1990, 2000, and 2010

(Percent distribution. For information on confidentiality protection, nonsampling error, and definitions, see www.census.gov/prod/cen2010/doc/sf1.pdf)



Sources: U.S. Census Bureau, *Census 2010 Summary File 1*; *Census 2000 Summary File 1*; *1990 Census of Population, Summary Population and Housing Characteristics, United States (1990 CPH-1-1)*.

tabulated in 1940.⁸ For each of the other types of households shown in Figure 2, the percentage share has increased since 1990.

Opposite-sex unmarried partner households increased by 40 percent

⁸ See the Census Bureau's Families and Living Arrangements Web page, Historical Table HH-1, <www.census.gov/population/socdemo/hh-fam/hh1.xls>.

since 2000, almost four times the national average. For same-sex households, the preferred estimates for 2000 and 2010 showed an 80 percent increase. However, same-sex partner households made up less than 1 percent of all households in both 2000 and 2010.

Household types varied by race of householder in 2010.

Two-thirds of all households in the United States were family households (Table 3). This proportion varied considerably by race: 64 percent of non-Hispanic White alone households were family households, compared with 78 percent of Hispanic or Latino households.

DEFINITION OF RACE CATEGORIES USED IN THE 2010 CENSUS

The U.S. Census Bureau collects race and Hispanic origin information following the guidance of the U.S. Office of Management and Budget's (OMB) 1997 *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity*. These federal standards mandate that race and Hispanic origin (ethnicity) are separate and distinct concepts and that when collecting these data via self-identification, two different questions must be used. Individuals who responded to the question on Hispanic origin are classified as either Hispanic or as non-Hispanic.

Individuals who responded to the question on race by indicating only one race are referred to as the race-alone population or the group that reported only one race category (e.g., White alone, Black or African American alone, American Indian and Alaska Native alone, Asian alone, Native Hawaiian and Other Pacific Islander alone, and Some Other Race alone). Individuals who chose more than one of the six race categories are referred to as the Two or More Races population in this report. All respondents who indicated multiple races (more than one race) or races in combination with each other can be collapsed into the Two or More Races population category, which, combined with the six race-alone categories, yields seven mutually exclusive and exhaustive categories. Thus, the six race-alone categories and the Two or More Races category sum to the total population.

As a matter of policy, the Census Bureau does not advocate the use of the alone population over the alone-or-in-combination population or vice versa. The use of the alone population in sections of this report does not imply that it is a preferred method of presenting or analyzing data. The same is true for household and family tables presented in Summary Files 1 or 2 that show the alone-or-in-combination population. Data on race from the 2010 Census can be presented and discussed in a variety of ways.

Households containing husband-wife families varied as well: 29 percent of all Black or African American alone households were husband-wife households, while 60 percent of Asian alone households were husband-wife families.

Three in 10 Black or African American alone households were female householder, no spouse present families, three times as high as White alone households (9.9 percent) and Asian alone households (9.5 percent). The majority of female family households with no spouse present contained own children of the householder, except for Asian alone households. Male family households with no spouse present represented 5 percent of all households. Almost one-half of all of these households contained own children of the householder.

Households containing unmarried couples can be family or nonfamily households, depending on the presence of relatives of the householder. Nationally, 6.6 percent of all households were unmarried partner households. American Indian and Alaska Native alone households reported the largest percentage of unmarried partner households (10.9 percent). Asian alone households had the lowest proportion of unmarried couple households, 3.6 percent. The majority of all

Table 3.

Household Type by Race and Hispanic Origin: 2010(For information on confidentiality protection, nonsampling errors, and definitions, see www.census.gov/prod/cen2010/doc/sf1.pdf)

Household type	Total	White alone	Non-Hispanic White alone	Black or African American alone	American Indian and Alaska Native alone	Asian alone	Native Hawaiian and Pacific Islander alone	Some Other Race alone	Two or more races	Hispanic or Latino of any race
Total households (number)	116,716,292	89,754,352	82,333,080	14,129,983	939,707	4,632,164	143,932	4,916,427	2,199,727	13,461,366
Total households (percent)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Family households	66.4	65.4	64.3	64.9	70.4	73.9	77.0	80.8	67.6	78.4
Husband-wife households	48.4	51.2	51.1	28.5	40.1	59.7	51.3	49.6	41.0	50.1
With own children	20.2	19.9	19.0	12.8	19.4	31.8	29.0	34.2	23.0	31.3
Under 6 years only	4.6	4.5	4.4	2.3	3.6	8.9	6.1	6.9	5.7	6.4
6 to 17 years	4.4	4.1	3.7	3.0	5.1	6.3	8.2	10.8	6.0	9.4
6 to 17 years only	11.3	11.3	10.9	7.5	10.7	16.6	14.7	16.5	11.3	15.5
Without own children	28.2	31.2	32.1	15.7	20.7	27.9	22.2	15.4	18.0	18.8
Female householder, no spouse present	13.1	9.9	9.2	30.1	21.4	9.5	17.0	20.2	19.2	19.2
With own children	7.2	5.2	4.7	17.4	12.3	4.1	9.8	13.6	12.3	12.1
Under 6 years only	1.5	1.1	1.0	3.6	2.6	0.7	2.2	2.6	3.0	2.4
6 to 17 years	1.3	0.8	0.7	3.7	2.8	0.5	2.3	3.4	2.6	2.9
6 to 17 years only	4.4	3.3	3.1	10.1	6.8	2.8	5.3	7.6	6.8	6.9
Without own children	5.9	4.7	4.5	12.7	9.2	5.5	7.2	6.6	6.9	7.1
Male householder, no spouse present	5.0	4.3	4.0	6.3	8.9	4.7	8.7	10.9	7.3	9.1
With own children	2.4	2.1	2.0	2.9	4.6	1.4	4.3	5.7	3.8	4.7
Under 6 years only	0.7	0.6	0.5	0.8	1.3	0.4	1.3	1.8	1.2	1.5
6 to 17 years	0.4	.03	0.2	0.5	0.9	0.2	0.9	1.4	0.7	1.1
6 to 17 years only	1.4	1.3	1.2	1.6	2.3	0.9	2.0	2.5	1.8	2.1
Without own children	2.6	2.2	2.0	3.4	4.3	3.2	4.4	5.3	3.5	4.4
Nonfamily households	33.6	34.6	35.7	35.1	29.6	26.1	23.0	19.2	32.4	21.6
One person	26.7	27.6	28.6	29.7	22.6	19.0	15.7	12.6	23.4	15.2
Two or more people	6.8	7.0	7.1	5.4	7.0	7.2	7.3	6.6	9.0	6.4
Unmarried couple households ¹	6.6	6.4	6.2	7.0	10.9	3.6	9.3	10.2	9.8	9.4
Opposite-sex partner	5.9	5.6	5.4	6.4	10.0	3.1	8.2	9.4	8.8	8.6
With own children	2.3	1.9	1.7	3.3	5.4	1.0	4.3	6.1	4.3	5.2
Without own children	3.6	3.7	3.7	3.1	4.6	2.1	3.9	3.2	4.5	3.3
Same-sex partner—Summary File 1 counts ²	0.8	0.8	0.8	0.6	0.9	0.5	1.1	0.8	1.0	0.8
With own children	0.2	0.2	0.1	0.2	0.3	0.2	0.4	0.4	0.3	0.3
Without own children	0.6	0.7	0.7	0.4	0.6	0.4	0.7	0.4	0.7	0.5
Same-sex partner—Preferred estimates ³	0.6	0.6	0.6	0.4	0.6	0.4	0.9	0.5	0.8	0.5
With own children	0.1	0.1	0.1	0.1	0.2	0.1	0.3	0.2	0.2	0.2
Without own children	0.5	0.5	0.5	0.3	0.5	0.3	0.6	0.3	0.6	0.4

¹ Unmarried couple households can be family or nonfamily households depending on the relationship of others in the household to the householder. In this table it is the sum of opposite-sex partners and same-sex partners from Summary File 1 counts.

² Summary File 1 counts in this table are consistent with Summary File 1 counts shown in American FactFinder.

³ Preferred estimates remove likely numbers of opposite-sex couples included in same-sex tabulations.

Source: U.S. Census Bureau, 2010 Census Summary File 1.

unmarried partner households were opposite-sex partner households.

Also shown in Table 3 are the preferred estimates for same-sex partner households by race and Hispanic or Latino origin. The preferred estimates removed the households that were likely to have been opposite-sex households as judged by inconsistencies between their first names and their responses to the gender item.⁹ This resulted in a reduction of same-sex households as a percentage of all households from 0.8 percent to 0.6 percent. About 0.1 percent of all households in the United States in 2010 were estimated to be same-sex partner households with own children of the householder present, the highest being 0.3 percent for Native Hawaiian and Pacific Islander alone households.

Thirty-one percent of all households were in four states.

Table 4 shows that four states contained 31 percent of all households enumerated in 2010: California (12.6 million), Texas (8.9 million), Florida (7.4 million), and New York

⁹ See O'Connell and Feliz, *op. cit.*, for a detailed discussion of this statistical procedure.

(7.3 million).¹⁰ These states also had the most households in 2000, although Florida, which had the fourth-highest number of households in 2000, was the third highest in 2010, topping New York. Sixteen states had less than 1.0 million households, with Wyoming having the fewest (227,000). Nevada, which had 751,000 households in 2000, had slightly over 1.0 million households in 2010. No state experienced a decline in the number of households in 2010. On a regional basis, more households were located in the South (43.6 million) than any other region in the country.¹¹

The average number of people per household in 2010 ranged from a

¹⁰ These four states (California, Texas, Florida, and New York) also were the states with the largest populations.

¹¹ There were four regions (Northeast, Midwest, South, and West). The Northeast region includes Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont. The Midwest region includes Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin. The South region includes Alabama, Arkansas, Delaware, the District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia. The West region includes Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

low of 2.30 in North Dakota to a high of 3.10 in Utah, the only state in 2010 that averaged more than 3 people per household. The District of Columbia averaged only 2.11 people per household, a decline from 2.16 in 2000. Regionally, the West had the highest average number of people per household (2.74), while the lowest average was in the Midwest (2.49).

Utah had the highest average number of people per family (3.56), followed by California (3.45) and Hawaii (3.42). Ten states averaged less than 3 people per family in 2010: Maine, New Hampshire, and Vermont in the Northeast; West Virginia and Kentucky in the South; Iowa, North Dakota, and Wisconsin in the Midwest; and Montana and Wyoming in the West.

HOUSEHOLD COMPOSITION

Utah had the highest proportion of husband-wife households in 2010.

Sixty-one percent of all households in Utah were married husband-wife couple households, the highest in the country. New York and Louisiana had the lowest proportions of husband-wife households (44 percent). Husband-wife couples

Table 4.
**Households and Families for the United States, Regions, States, and for Puerto Rico:
 2000 and 2010**

(For information on confidentiality protection, nonsampling errors, and definitions, see www.census.gov/prod/cen2010/doc/sf1.pdf)

Area	All households		Percent of households in 2010									Average number of people in 2010	
			Family households						Nonfamily households				
	April 1, 2000		Husband-wife households		Female family households ¹		Male family households ¹		One person		Two or more people	Per household	Per family
			Total	With own children under 18 years	Total	With own children under 18 years	Total	With own children under 18 years	Total	With householder 65 years and over			
United States	105,480,101	116,716,292	48.4	20.2	13.1	7.2	5.0	2.4	26.7	9.4	6.8	2.58	3.14
REGION													
Northeast	20,285,622	21,215,415	46.9	19.5	13.3	6.9	4.7	2.1	28.1	10.7	7.0	2.53	3.12
Midwest	24,734,532	26,215,951	48.8	19.7	11.9	6.9	4.6	2.4	28.1	10.1	6.5	2.49	3.06
South	38,015,214	43,609,929	48.3	19.7	14.2	7.8	4.9	2.3	26.4	9.0	6.3	2.56	3.10
West	22,444,733	25,674,997	49.5	22.1	12.2	6.6	5.6	2.8	24.8	8.4	8.0	2.74	3.30
STATE													
Alabama	1,737,080	1,883,791	47.9	18.5	15.3	8.1	4.6	2.0	27.4	9.8	4.8	2.48	3.02
Alaska	221,600	258,058	49.4	22.7	10.7	6.8	6.0	3.5	25.6	5.4	8.2	2.65	3.21
Arizona	1,901,327	2,380,990	48.1	19.5	12.4	7.1	5.6	3.0	26.1	9.1	7.7	2.63	3.19
Arkansas	1,042,696	1,147,084	49.5	18.9	13.4	7.7	4.7	2.4	27.1	10.1	5.3	2.47	3.00
California	11,502,870	12,577,498	49.4	23.4	13.3	6.8	6.0	2.8	23.3	8.1	8.0	2.90	3.45
Colorado	1,658,238	1,972,868	49.2	21.4	10.1	6.0	4.6	2.5	27.9	7.8	8.1	2.49	3.08
Connecticut	1,301,670	1,371,087	49.0	20.9	12.9	7.1	4.4	1.9	27.3	10.6	6.5	2.52	3.08
Delaware	298,736	342,297	48.3	18.3	14.2	7.6	5.0	2.4	25.6	9.7	7.0	2.55	3.06
District of Columbia	248,338	266,707	22.0	7.9	16.4	7.9	3.9	1.3	44.0	9.7	13.7	2.11	3.01
Florida	6,337,929	7,420,802	46.6	16.6	13.5	7.1	5.0	2.3	27.2	11.1	7.6	2.48	3.01
Georgia	3,006,369	3,585,584	47.8	21.1	15.8	8.9	4.9	2.2	25.4	7.5	6.1	2.63	3.17
Hawaii	403,240	455,338	50.5	20.1	12.6	5.2	5.8	2.4	23.3	8.1	7.7	2.89	3.42
Idaho	469,645	579,408	55.3	24.0	9.6	5.9	4.7	2.8	23.8	8.8	6.6	2.66	3.16
Illinois	4,591,779	4,836,972	48.2	21.0	12.9	6.9	4.7	2.2	27.8	9.7	6.4	2.59	3.20
Indiana	2,336,306	2,502,154	49.6	19.9	12.4	7.3	4.9	2.6	26.9	9.5	6.2	2.52	3.05
Iowa	1,149,276	1,221,576	51.2	20.0	9.3	5.9	4.2	2.5	28.4	11.1	6.9	2.41	2.97
Kansas	1,037,891	1,112,096	51.1	21.3	10.4	6.5	4.5	2.6	27.8	9.9	6.2	2.49	3.06
Kentucky	1,590,647	1,719,965	49.3	19.1	12.7	7.1	4.8	2.4	27.5	9.8	5.6	2.45	2.98
Louisiana	1,656,053	1,728,360	44.4	17.6	17.2	9.3	5.5	2.6	26.9	8.9	6.0	2.55	3.10
Maine	518,200	557,219	48.5	16.7	10.0	6.0	4.5	2.7	28.6	11.3	8.4	2.32	2.83
Maryland	1,980,859	2,156,411	47.6	20.4	14.6	7.6	4.8	2.2	26.1	8.7	6.8	2.61	3.15
Massachusetts	2,443,580	2,547,075	46.3	19.7	12.5	6.8	4.2	1.8	28.7	10.6	8.3	2.48	3.08
Michigan	3,785,661	3,872,508	48.0	18.9	13.2	7.3	4.8	2.4	27.9	10.2	6.2	2.49	3.05
Minnesota	1,895,127	2,087,227	50.8	21.2	9.5	5.9	4.3	2.3	28.0	9.7	7.4	2.48	3.05
Mississippi	1,046,434	1,115,768	45.4	17.8	18.5	10.0	5.2	2.4	26.3	9.5	4.6	2.58	3.11
Missouri	2,194,594	2,375,611	48.4	18.9	12.3	7.1	4.6	2.5	28.3	10.1	6.4	2.45	3.00
Montana	358,667	409,607	49.2	17.8	9.0	5.4	4.5	2.6	29.7	10.7	7.5	2.35	2.91
Nebraska	666,184	721,130	50.8	21.2	9.8	6.2	4.2	2.3	28.7	10.4	6.5	2.46	3.04
Nevada	751,165	1,006,250	46.0	19.6	12.7	7.0	6.6	3.3	25.7	7.9	9.1	2.65	3.20
New Hampshire	474,606	518,973	52.1	20.4	9.7	5.7	4.5	2.5	25.6	9.2	8.0	2.46	2.96
New Jersey	3,064,645	3,214,360	51.1	23.3	13.3	6.6	4.8	2.0	25.2	10.1	5.5	2.68	3.22
New Mexico	677,971	791,395	45.3	17.9	14.0	7.8	6.2	3.4	28.0	9.3	6.5	2.55	3.13
New York	7,056,860	7,317,755	43.6	18.7	14.9	7.5	5.0	2.1	29.1	10.5	7.3	2.57	3.20
North Carolina	3,132,013	3,745,155	48.4	19.6	13.7	7.8	4.6	2.3	27.0	9.1	6.3	2.48	3.01
North Dakota	257,152	281,192	48.6	18.6	8.2	5.2	4.1	2.2	31.5	11.0	7.7	2.30	2.91
Ohio	4,445,773	4,603,435	47.2	18.2	13.1	7.5	4.7	2.4	28.9	10.4	6.2	2.44	3.01
Oklahoma	1,342,293	1,460,450	49.5	19.7	12.3	7.0	5.0	2.7	27.5	9.9	5.8	2.49	3.04
Oregon	1,333,723	1,518,938	48.3	18.7	10.5	6.1	4.7	2.5	27.4	9.7	9.1	2.47	3.00
Pennsylvania	4,777,003	5,018,904	48.2	18.3	12.2	6.5	4.6	2.2	28.6	11.4	6.5	2.45	3.02
Rhode Island	408,424	413,600	44.5	17.6	13.5	7.7	4.8	2.2	29.6	11.3	7.6	2.44	3.04
South Carolina	1,533,854	1,801,181	47.2	17.7	15.6	8.4	4.7	2.2	26.5	9.2	5.9	2.49	3.01
South Dakota	290,245	322,282	50.1	19.7	9.7	6.2	4.4	2.6	29.4	10.9	6.4	2.42	3.00
Tennessee	2,232,905	2,493,552	48.7	18.7	13.9	7.5	4.8	2.3	26.9	9.4	5.7	2.48	3.01
Texas	7,393,354	8,922,933	50.6	23.7	14.1	8.0	5.2	2.5	24.2	7.2	5.9	2.75	3.31
Utah	701,281	877,692	61.0	31.7	9.7	5.5	4.4	2.2	18.7	6.4	6.1	3.10	3.56
Vermont	240,634	256,442	48.5	17.6	9.6	6.0	4.4	2.6	28.2	10.3	9.3	2.34	2.85
Virginia	2,699,173	3,056,058	50.2	21.1	12.4	6.7	4.4	2.0	26.0	8.5	7.0	2.54	3.06
Washington	2,271,398	2,620,076	49.2	20.4	10.5	6.2	4.7	2.5	27.2	8.7	8.4	2.51	3.06
West Virginia	736,481	763,831	49.8	17.0	11.2	5.7	4.8	2.3	28.4	11.6	5.8	2.36	2.88
Wisconsin	2,084,544	2,279,768	49.6	19.4	10.3	6.4	4.5	2.5	28.2	10.2	7.4	2.43	2.99
Wyoming	193,608	226,879	50.9	19.6	8.9	5.6	4.8	2.8	28.0	8.8	7.4	2.42	2.96
Puerto Rico	1,261,325	1,376,531	45.0	18.2	22.6	10.9	5.5	2.2	23.8	9.5	3.1	2.68	3.17

¹ No spouse present in household.

Sources: U.S. Census Bureau, *Census 2000 Summary File 1* and *2010 Census Summary File 1*.

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Table 5.

Top Ten Places of 100,000 or More Population With the Highest Percentage of One-Person Households: 2010

(For information on confidentiality protection, nonsampling errors, and definitions, see www.census.gov/prod/cen2010/doc/sfl.pdf)

Place ¹	Total households	One-person households			
		Number	Percent of total	With householder 65 years and over	
				Number	Percent of one-person households
Atlanta city, Georgia	185,142	81,555	44.0	15,832	19.4
Washington city, District of Columbia	266,707	117,431	44.0	25,913	22.1
Cincinnati city, Ohio	133,420	57,941	43.4	13,230	22.8
Alexandria city, Virginia	68,082	29,564	43.4	4,882	16.5
St. Louis city, Missouri	142,057	60,468	42.6	14,424	23.9
Pittsburgh city, Pennsylvania	136,217	56,823	41.7	16,469	29.0
Arlington CDP, Virginia	98,050	40,516	41.3	6,523	16.1
Seattle city, Washington	283,510	117,054	41.3	24,611	21.0
Cambridge city, Massachusetts	44,032	17,933	40.7	4,242	23.7
Denver city, Colorado	263,107	106,828	40.6	23,686	22.2

¹ The 2010 Census showed 282 places in the United States with 100,000 or more population. They included 273 incorporated places (including 5 city-county consolidations) and 9 census designated places (CDPs) that were not legally incorporated.

Source: U.S. Census Bureau, *2010 Census Summary File 1*.

maintained only 22 percent of households in the District of Columbia. Regional patterns in the proportion of husband-wife households show that the highest percentage was in the West (50 percent) while the lowest percentage was in the Northeast (47 percent).

Over a quarter of households were one-person households.

In 2010, 31.2 million households consisted of one person living alone.¹² This represents a 4.0 million increase in one-person households since 2000. Although this increase from 2000 to 2010 was smaller than the growth experienced between 1990 and 2000 (4.6 million), the proportion of one-person households grew slightly from 26 percent in 2000 to 27 percent in 2010. About one-third of

¹² One-person households are a subset of nonfamily households. In one-person households the householder lives alone.

all one-person households in 2010 had householders who were 65 years and over, compared with 22 percent of all householders (Table 1).

Table 5 shows the top ten places with the highest proportion of one-person households and the percentage of these households maintained by a person 65 and older. In 2010, one-person households were the most common form of household type in Atlanta, Georgia, and Washington, DC (both 44 percent), followed by St. Louis, Missouri; Cincinnati, Ohio; and Alexandria, Virginia, with 43 percent. People over the age of 65 occupied less than 20 percent of one-person households in Atlanta; Arlington, Virginia; and Alexandria. These areas may represent cities inhabited by younger adults who may move in search of job opportunities.

Figures 3a, 3b, and 3c are maps showing the percentage of one-person households and their geographical concentration at the county level.¹³ Figure 3a shows a high percentage of one-person households concentrated along the upper and central Midwest extending down into northeastern New Mexico. Figure 3b shows a much smaller proportion of Midwestern counties with high concentrations of persons living alone for those aged 15 to 64 years. Figure 3c specifically examines one-person households composed of individuals 65 years and older. It shows that the high percentages noted in Figure 3a in the Midwest are the result of the elderly living alone, perhaps staying in or not moving far from homes or towns where

¹³ A reference to state includes states and their statistically equivalent entities. A reference to county includes counties and their statistically equivalent entities.

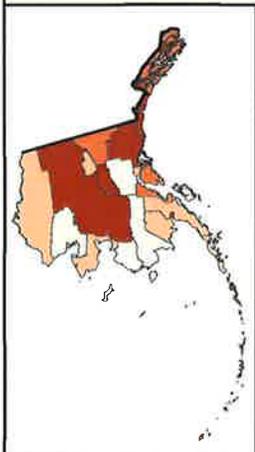
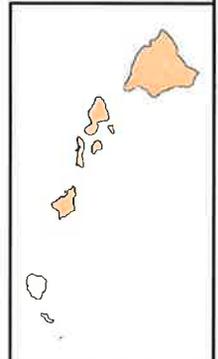
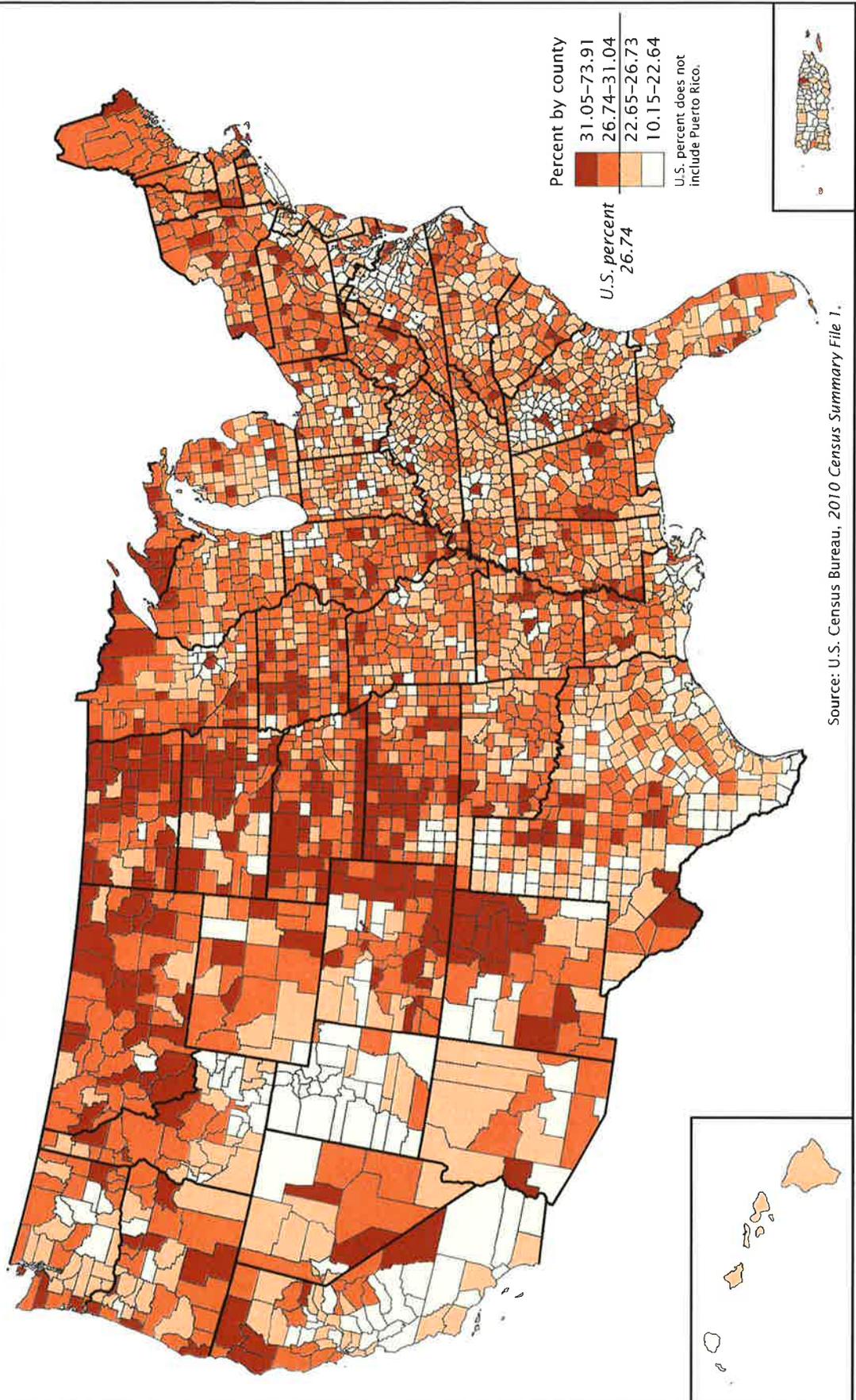
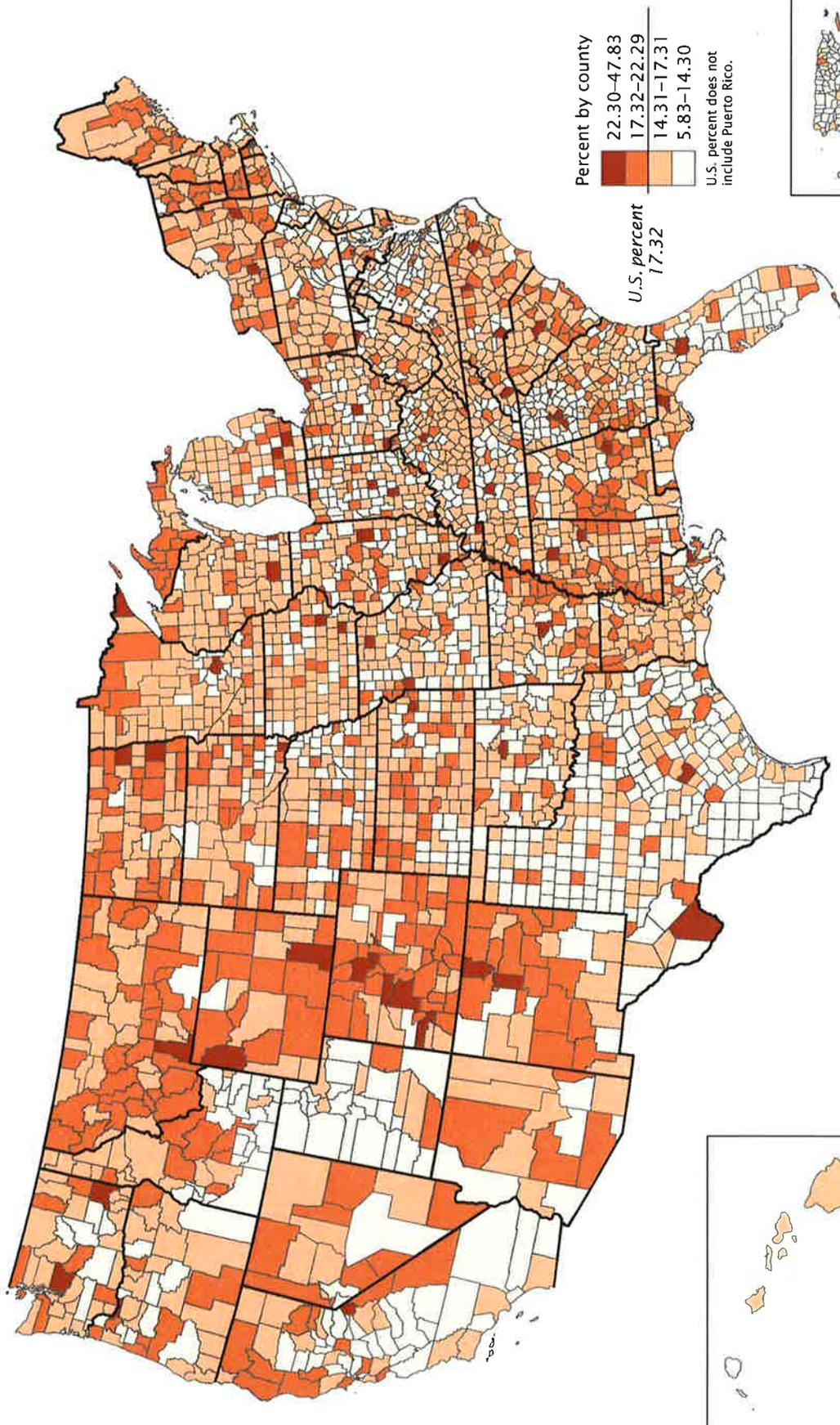


Figure 3a.
Households With Person Living Alone, All Ages: 2010
 For information on confidentiality protection, nonsampling error, and definitions,
 see www.census.gov/prod/cen2010/doc/sfi.pdf.



Source: U.S. Census Bureau, 2010 Census Summary File 1.

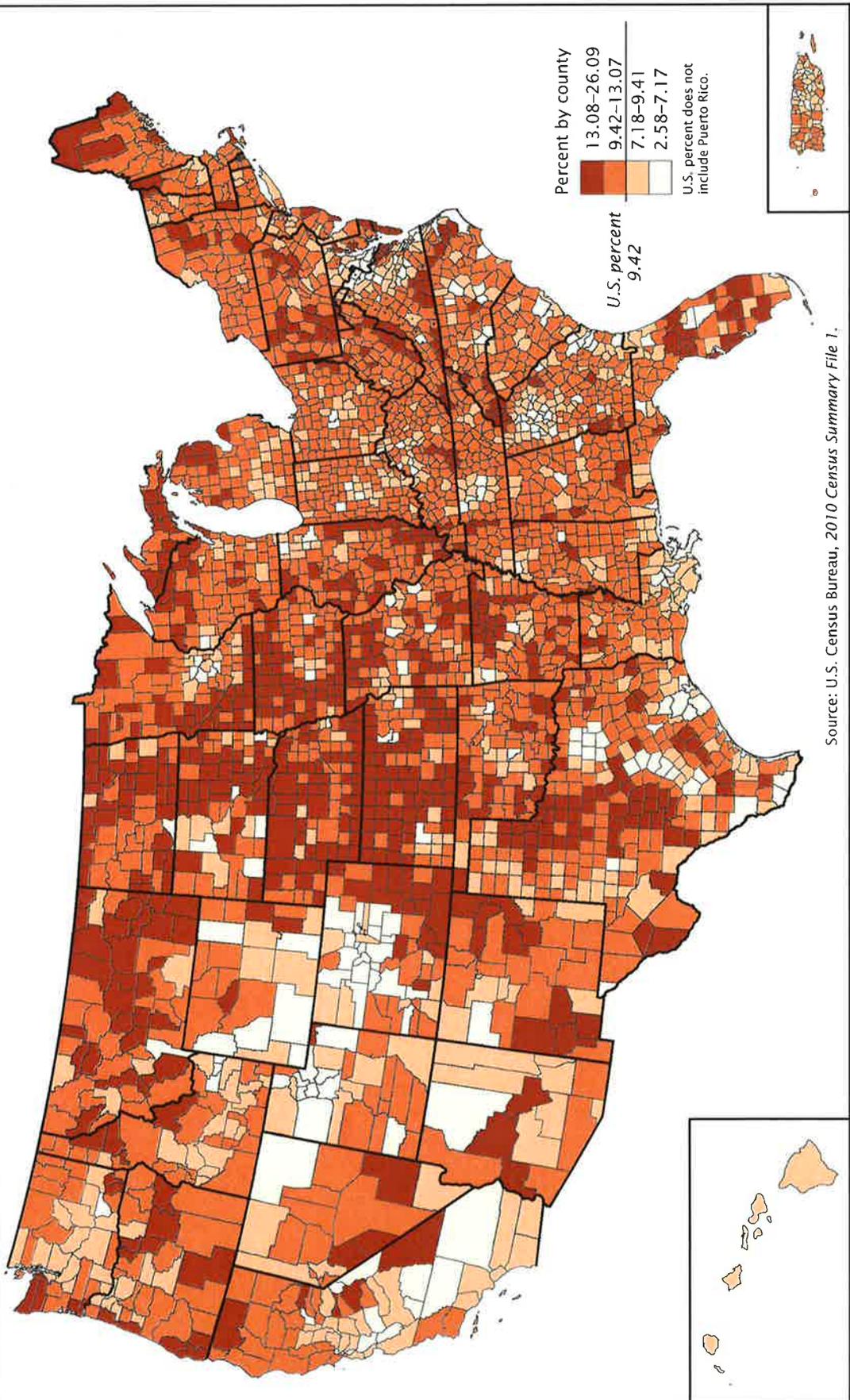
Figure 3b.
Households With Person Living Alone, Ages 15 to 64: 2010
 For information on confidentiality protection, nonsampling error, and definitions, see www.census.gov/prod/cen2010/doc/sf1.pdf.



Source: U.S. Census Bureau, 2010 Census Summary File 1.

Figure 3c.
Households With Person Living Alone, Ages 65 and Older: 2010

For information on confidentiality protection, nonsampling error, and definitions, see www.census.gov/prod/cen2010/doc/sf1.pdf.



they were born.¹⁴ Note that in Alaska the reverse is true: relatively high numbers of counties with younger people living alone and very low concentrations of people 65 years and over living alone. This may result from the presence of industries—such as mining and logging—that attract younger people.

Unmarried partner households increased from 2000 to 2010.

The unmarried partner category identifies people with a close and personal relationship to the householder that goes beyond sharing household expenses. Two people may live together as an unmarried couple for a variety of reasons. For young men and women, the arrangement may represent a transitory or trial relationship, while for others it may be a precursor to an eventual marriage. For older couples that have been formerly married, it could represent an alternative lifestyle to the one they previously experienced, especially if they do not anticipate any future childbearing or childrearing activities. Unmarried partners can be either opposite-sex couple households or same-sex couple households.

There were 4.9 million opposite-sex unmarried partner households in 2000, increasing to 6.8 million by 2010 (Table 2). Opposite-sex unmarried partner households accounted for 4.6 percent of all households in 2000, while in 2010 they accounted for 5.9 percent of all households. State-level data in Table 6 show that Maine had the highest percentage of opposite-sex unmarried partner households

¹⁴ Data from the 2010 American Community Survey indicated that the Midwest region had the highest proportion of people living in the state where they were born. See Ping Ren, "Lifetime Mobility in the United States: 2010," *American Community Survey Briefs*, ACSBR/10-07 (November 2011), <www.census.gov/prod/2011pubs/acsbr10-07.pdf>.

(8.4 percent), followed by Vermont (8.1 percent). The only states with less than 5 percent of households reporting as opposite-sex unmarried partner households were Utah and Alabama (3.9 percent and 4.1 percent, respectively). Puerto Rico recorded 5.9 percent of its households as opposite-sex unmarried partner households.

Using the preferred set of estimates for measuring same-sex unmarried partner households shows there were 358,000 same-sex unmarried partner households in 2000, increasing to 646,000 in the 2010 Census (Table 2). In 2000, same-sex unmarried partner households accounted for 0.3 percent of all households, doubling in proportion to 0.6 percent of all households in 2010. Regionally, same-sex unmarried partner households were most common in the West (0.7 percent) and least common in the Midwest (0.4 percent). Of all areas, Washington, DC, had the highest percentage of same-sex unmarried partner households (1.8 percent). Among the states, proportions of 0.8 percent were found only on the east coast (Delaware, Massachusetts, and Vermont) and the west coast (California and Oregon). North Dakota and South Dakota had the lowest percentages (0.2 percent). Puerto Rico reported only 0.3 percent of all households were same-sex partner households.

Multigenerational families numbered 5.1 million in 2010.

A topic of growing interest is that of multigenerational families—family households consisting of three or more generations of relatives, such as a householder living with his or her children and

grandchildren.¹⁵ Multigenerational households may be more likely to reside in areas where new immigrants live with their relatives, in areas where housing shortages or high costs force families to double up their living arrangements, or in areas that have relatively high percentages of children born to unmarried mothers and where unmarried mothers live with their children in their parents' homes.

In 2000, there were 3.9 million multigenerational households; that number increased to 5.1 million in 2010.¹⁶ In 2000, multigenerational households made up 3.7 percent of all households, while in 2010 they made up 4.4 percent of all households. Hawaii had the highest percentage of multigenerational households, which accounted for 8.8 percent of all households in that state. Other states exceeding 5 percent in 2010 tended to be in the West and in the South, including California (6.7 percent), Georgia (5.1 percent), Louisiana (5.2 percent), Maryland (5.1 percent), Mississippi (5.7 percent), Nevada (5.1 percent), and Texas (5.8 percent). The state with the smallest percentage of multigenerational households was North Dakota (1.4 percent), which was also the state with the highest proportion of

¹⁵ The numbers in this report only identify three types of commonly encountered multigenerational households: (1) householder-child-grandchild, (2) parent/parent-in-law of householder-householder-child, and (3) parent/parent-in-law of householder-householder-child-grandchild. These numbers, then, represent a subset of all possible multigenerational households but were the most common combinations; they made up 98.1 percent of all households in 2000 with three or more generations of relatives. See Frank Hobbs, "Examining American Household Composition: 1990 and 2000," *Census 2000 Special Reports*, CENSR-24 (August 2005), Table 7, <www.census.gov/prod/2005pubs/censr-24.pdf>.

¹⁶ The data in this section referring to numbers for 2000 are from Tavia Simmons and Grace O'Neill, "Households and Families: 2000," *Census 2000 Briefs*, C2KBR/01-8 (September 2001). The data for 2010 are from the U.S. Census Bureau, *Census 2010 Summary File 1*.

Table 6.

Household Indicators for the United States, Regions, and States, and for Puerto Rico: 2010(For information on confidentiality protection, nonsampling errors, and definitions, see www.census.gov/prod/cen2010/doc/sf1.pdf)

Area	Percent of all households						
	Unmarried partner households			Multi-generational households	Presence of nonrelatives in the household	With individuals under 18 years	With individuals 65 years and over
	Opposite-sex partners	Same-sex partners					
		Summary File 1 counts ¹	Preferred estimates ²				
United States	5.9	0.8	0.6	4.4	12.1	33.4	24.9
REGION							
Northeast	5.9	0.8	0.6	4.1	11.9	31.5	26.7
Midwest	6.0	0.6	0.4	3.2	11.2	32.0	24.5
South	5.4	0.8	0.5	4.7	11.4	34.0	24.8
West	6.3	0.9	0.7	5.3	14.5	35.4	24.2
STATE							
Alabama	4.1	0.6	0.3	4.4	8.8	33.1	25.5
Alaska	7.8	0.7	0.5	3.7	15.1	36.4	16.0
Arizona	6.9	0.9	0.7	4.9	13.9	33.6	26.4
Arkansas	5.1	0.6	0.4	3.8	9.8	33.0	26.2
California	6.2	1.0	0.8	6.7	15.3	37.5	24.7
Colorado	5.6	0.8	0.6	3.2	12.6	32.7	20.2
Connecticut	5.8	0.8	0.6	3.7	11.2	32.7	26.5
Delaware	6.4	1.0	0.8	4.7	12.8	32.5	27.0
District of Columbia	5.8	1.9	1.8	3.9	18.3	20.7	20.4
Florida	6.5	0.9	0.7	4.6	13.4	29.8	31.4
Georgia	5.1	0.8	0.6	5.1	11.4	36.8	21.2
Hawaii	6.3	0.9	0.7	8.8	15.5	34.3	30.3
Idaho	5.7	0.6	0.4	3.0	11.6	35.7	23.9
Illinois	5.7	0.7	0.5	4.4	11.1	33.5	24.2
Indiana	6.3	0.7	0.4	3.4	11.3	33.3	23.9
Iowa	6.2	0.5	0.3	2.0	11.2	30.6	25.5
Kansas	5.3	0.6	0.4	2.8	10.6	33.2	23.7
Kentucky	5.7	0.7	0.4	3.5	10.3	32.6	24.4
Louisiana	6.1	0.7	0.5	5.2	11.4	34.7	23.7
Maine	8.4	1.0	0.7	2.2	13.9	27.8	27.1
Maryland	5.6	0.8	0.6	5.1	12.6	34.3	23.9
Massachusetts	6.0	1.0	0.8	3.5	12.8	30.8	25.6
Michigan	5.8	0.6	0.4	3.4	10.9	31.6	25.4
Minnesota	6.2	0.7	0.5	2.2	11.9	31.6	22.8
Mississippi	5.1	0.6	0.3	5.7	9.7	35.8	25.1
Missouri	6.1	0.6	0.4	3.2	11.1	31.8	25.0
Montana	6.1	0.6	0.3	2.3	11.8	28.4	25.6
Nebraska	5.5	0.5	0.3	2.2	10.8	32.0	23.9
Nevada	7.7	0.9	0.7	5.1	16.4	33.9	24.0
New Hampshire	7.4	0.9	0.6	2.8	13.1	31.0	24.4
New Jersey	5.2	0.8	0.5	5.0	10.5	35.0	26.9
New Mexico	7.3	1.0	0.7	5.0	12.8	33.7	25.3
New York	5.9	0.9	0.7	4.6	12.7	31.7	26.3
North Carolina	5.2	0.7	0.5	3.8	10.9	33.3	23.9
North Dakota	6.0	0.4	0.2	1.4	11.4	27.9	23.9
Ohio	6.1	0.6	0.4	3.2	10.9	31.3	25.3
Oklahoma	5.3	0.7	0.4	3.7	10.6	33.3	25.0
Oregon	7.1	1.0	0.8	3.0	14.9	30.1	25.3
Pennsylvania	6.0	0.7	0.4	3.5	10.9	29.9	27.9
Rhode Island	6.7	0.9	0.7	3.8	12.7	30.1	26.6
South Carolina	5.3	0.6	0.4	4.6	10.8	32.8	25.5
South Dakota	6.1	0.4	0.2	2.2	10.9	31.1	24.9
Tennessee	5.2	0.7	0.4	4.2	10.4	32.6	24.9
Texas	5.2	0.8	0.5	5.8	11.1	38.9	21.2
Utah	3.9	0.7	0.4	4.6	11.1	43.3	20.0
Vermont	8.1	1.1	0.8	1.9	14.8	28.3	25.4
Virginia	5.0	0.7	0.5	4.0	11.8	33.4	23.3
Washington	6.7	0.9	0.7	3.2	14.1	31.9	22.8
West Virginia	6.0	0.7	0.4	3.2	10.4	28.6	28.5
Wisconsin	6.7	0.6	0.4	2.2	11.8	30.6	24.0
Wyoming	6.6	0.5	0.3	2.4	12.3	30.9	22.0
Puerto Rico	5.9	0.5	0.3	6.6	8.3	37.0	29.6

¹ Summary File 1 counts in this table are consistent with Summary File 1 counts shown in the American FactFinder.² Preferred estimates remove likely numbers of opposite-sex couples included in same-sex tabulations.

Source: U.S. Census Bureau, 2010 Census Summary File 1.

one-person households (31.5 percent, Table 4). Puerto Rico recorded 6.6 percent of households as multi-generational households.

Thirty-three percent of households included people under 18 years, and 25 percent included people 65 years and over.

There were 38 million households in 2000 with individuals under the age of 18, representing 36 percent of all households.¹⁷ By 2010, this number slightly increased to 39 million households, but the proportion of these households declined to 33 percent. Utah, in 2010, had the highest percentage of households with individuals under the age of 18 years, accounting for 43 percent of all households in Utah. States with less than 28 percent of households with individuals under the age of 18 years were Maine and North Dakota, while the District of Columbia recorded 21 percent.

In 2000, 25 million households had individuals aged 65 years and over, which amounted to 23 percent of all households. In 2010, the number of households with people aged 65 and over increased to 29 million, which accounted for 25 percent of households. Only two states had a person aged 65 years and over living in at least 30 percent of the state's households: Florida (31 percent) and Hawaii (30 percent). These areas probably reflect popular retirement destinations. Alaska and Utah had the lowest percentages of households with a person 65 years and over (16 percent and 20 percent, respectively).

¹⁷ See Simmons and O'Neill, op. cit. The data for 2010 are from the U.S. Census Bureau, *Census 2010 Summary File 1*.

Interracial couples were most prevalent in the West.

In 2010, almost 7 percent of married couple households included a householder and spouse of different races (Table 7).¹⁸ Four to 6 percent of married couples in the Midwest, the Northeast, and the South consisted of spouses of different races, compared with 11 percent in the West. Hawaii had the highest proportion (37 percent), followed by Oklahoma and Alaska (both about 17 percent). Because these states have high proportions of native populations (for example, Native Hawaiian and Other Pacific Islanders, and American Indian and Alaska Natives, respectively), these states may have greater potential for the likelihood of interracial marriage.

Unmarried partner households consistently had higher percentages of partners of different races than do married couple households at national and regional levels and for individual states.¹⁹ Nationally, the percentage for both opposite-sex and same-sex couples was 14 percent.²⁰ For opposite-sex unmarried partner households, the

¹⁸ The seven race groups used in this report were White alone; Black or African American alone, American Indian and Alaska Native alone, Asian alone, Native Hawaiian and Other Pacific Islander alone; Some other race alone; and Two or more races. If either spouse or partner was not in the same single race as the other spouse or partner, or if at least one spouse or partner was in a multiple-race group, then the couple was classified as an interracial couple.

¹⁹ Since unmarried partner relationships are often short-term or trial relationships, the partners may be less likely to choose partners with the same characteristics, such as race or ethnicity, as do married couples. See Robert Schoen and Robin M. Weinick, "Partner Choice in Marriage and Cohabitations," *Journal of Marriage and Family*, Vol. 55, No. 2 (1993), pp. 408–414.

²⁰ Data in this section refer to same-sex households using preferred estimates. About 85 percent of the 255,000 misclassified same-sex households in the Summary File 1 counts are estimated to be married opposite-sex households (O'Connell and Feliz, op. cit., Appendix Table 6b).

highest percentage of mixed-race partnerships was in the West (21 percent) while the lowest was in the Midwest (11 percent). Over half (56 percent) of these households in Hawaii had partners of different races, followed by Alaska and Oklahoma (28 percent each).

Regional patterns and levels for same-sex unmarried partner households were similar to those for opposite-sex unmarried partner households. Again, as with opposite-sex unmarried partners, same-sex unmarried partners had the highest percentage of mixed-race partnerships in the West (21 percent) while the lowest was in the Midwest (11 percent). Fifty percent of same-sex unmarried partner households in Hawaii had partners of different races, followed by California, Oklahoma, and Alaska (23 percent each).

Four percent of married couple households had one Hispanic partner and one non-Hispanic partner.

Nationally, 4.3 percent of married couples had partners where one is Hispanic and the other is not of Hispanic origin, compared with 8.2 percent of opposite-sex unmarried partners and 10.4 percent of same-sex unmarried partners (Table 7). Similar to the geographic pattern noted for interracial partners, the highest percentages of Hispanic/non-Hispanic partner households for all three types of households were in the West. New Mexico had twice the national average of the proportion of households having only one Hispanic partner for each household type. West Virginia had the lowest proportions for both opposite-sex married and unmarried partners (0.9 percent and 1.7 percent, respectively), while Mississippi had the lowest

Table 7.

Percent of Households With Partners of a Different Race or Hispanic Origin for the United States, Regions, and States, and for Puerto Rico: 2010

(For information on confidentiality protection, nonsampling errors, and definitions, see www.census.gov/prod/cen2010/doc/sf1.pdf)

Area	Householders with partner of a different race				Householders with partner of a different Hispanic origin				Householders with partner of a different race or origin			
	Husband-wife	Unmarried partner households			Husband-wife	Unmarried partner households			Husband-wife	Unmarried partner households		
		Opposite-sex partners	Same-sex partners			Opposite-sex partners	Same-sex partners			Opposite-sex partners	Same-sex partners	
			Summary File 1 counts ¹	Preferred estimates ²			Summary File 1 counts ¹	Preferred estimates ²			Summary File 1 counts ¹	Preferred estimates ²
United States	6.9	14.2	12.6	14.5	4.3	8.2	8.8	10.4	9.5	18.3	17.7	20.6
REGION												
Northeast	5.3	12.3	11.0	12.8	3.2	7.1	7.3	8.7	7.5	16.0	15.4	18.1
Midwest	4.4	11.1	9.4	11.1	2.4	5.4	5.1	6.1	6.0	13.9	12.4	14.7
South	6.2	12.7	10.5	12.1	3.9	7.2	7.6	9.2	8.8	16.5	15.3	18.1
West	11.6	20.9	19.1	20.9	7.5	13.4	13.9	15.6	15.9	26.8	26.4	29.2
STATE												
Alabama	3.9	9.3	6.6	7.8	1.4	2.8	2.3	2.8	4.8	10.5	8.0	9.4
Alaska	17.1	28.4	22.2	22.9	4.8	6.8	7.8	9.0	19.7	31.3	26.1	27.8
Arizona	9.3	18.0	15.2	16.7	8.3	15.1	14.4	16.3	14.3	25.2	23.1	25.8
Arkansas	4.7	11.0	8.6	10.3	2.0	4.0	3.0	3.5	5.9	12.7	10.3	12.2
California	12.8	22.6	21.3	23.4	8.6	14.9	16.1	17.9	17.6	28.9	29.8	32.9
Colorado	8.8	16.1	14.2	15.2	7.7	13.6	13.5	14.8	13.5	23.2	21.7	23.6
Connecticut	5.5	13.8	10.1	11.5	3.7	9.2	7.3	8.7	8.0	18.2	14.6	16.9
Delaware	5.7	13.3	9.6	10.6	2.7	6.1	4.5	4.7	7.3	16.2	12.2	13.4
District of Columbia	10.6	13.8	18.7	19.1	5.1	6.4	12.1	12.7	14.1	17.6	26.8	27.6
Florida	6.5	12.7	10.2	11.3	5.9	10.0	11.0	12.7	10.9	18.8	18.2	20.6
Georgia	5.2	11.0	9.3	11.0	2.7	4.7	5.2	6.2	6.8	13.2	12.6	14.8
Hawaii	37.2	56.4	47.2	49.7	7.6	14.2	11.8	12.6	39.2	58.9	50.1	52.9
Idaho	6.1	12.3	9.3	10.6	4.2	9.0	7.2	8.6	8.6	16.7	13.0	15.1
Illinois	5.2	11.7	11.7	13.8	3.6	7.5	8.2	9.9	7.6	15.6	16.5	19.7
Indiana	4.0	10.2	8.4	9.8	2.3	4.8	4.0	4.4	5.4	12.5	10.5	12.3
Iowa	3.1	9.6	7.1	8.6	1.8	4.7	4.0	5.0	4.2	12.1	9.4	11.5
Kansas	6.4	15.6	11.3	12.9	3.9	8.7	6.7	8.1	8.8	19.9	15.0	17.6
Kentucky	3.3	9.5	7.0	8.4	1.3	2.9	2.3	2.8	4.1	10.8	8.3	10.0
Louisiana	4.3	9.4	7.8	9.0	2.6	3.8	4.6	5.5	6.1	11.4	10.8	12.7
Maine	3.2	6.5	5.2	5.6	1.1	2.0	2.3	2.9	4.0	7.7	6.7	7.4
Maryland	6.9	12.8	12.3	14.0	2.9	4.5	5.3	6.1	8.8	15.1	15.6	17.8
Massachusetts	5.4	12.3	9.9	11.1	2.4	6.5	5.9	6.8	7.0	15.6	13.6	15.4
Michigan	4.7	11.2	8.9	10.5	2.5	5.5	4.3	5.2	6.3	14.3	11.5	13.6
Minnesota	4.4	12.4	10.2	11.7	1.8	4.4	4.3	5.2	5.5	14.6	12.4	14.5
Mississippi	2.9	7.1	5.3	7.3	1.3	2.2	1.8	2.4	3.7	8.1	6.3	8.5
Missouri	4.5	10.4	9.0	10.6	2.1	4.0	4.4	5.4	5.8	12.5	11.6	13.8
Montana	6.1	11.7	11.0	11.8	2.7	5.4	4.7	5.0	7.8	14.8	13.5	14.2
Nebraska	4.4	12.7	9.5	11.1	2.8	7.3	6.0	6.6	6.0	16.1	12.9	14.9
Nevada	13.3	23.6	20.5	22.4	7.9	13.9	14.1	15.8	17.6	29.5	27.4	30.2
New Hampshire	3.6	6.7	5.7	6.5	1.7	3.4	3.4	4.0	4.7	8.6	8.0	9.2
New Jersey	6.2	14.5	11.6	13.5	4.5	10.0	9.1	10.9	9.3	19.8	17.2	20.3
New Mexico	11.1	19.7	17.2	18.8	13.2	20.2	19.4	21.8	19.4	29.7	28.2	31.3
New York	6.6	14.3	13.7	15.9	4.1	8.5	9.7	11.3	9.3	18.7	19.6	22.7
North Carolina	5.2	12.4	9.1	10.5	2.4	4.6	3.9	4.6	6.6	14.4	11.2	13.1
North Dakota	3.8	10.8	9.6	12.3	1.3	3.6	3.6	4.8	4.6	12.7	11.2	14.8
Ohio	3.8	10.4	8.3	9.7	1.7	3.9	3.5	4.2	4.9	12.4	10.4	12.2
Oklahoma	17.2	28.5	21.1	23.1	3.6	7.6	5.4	6.5	19.1	31.4	23.7	26.2
Oregon	8.8	15.7	13.4	14.2	4.4	8.4	8.2	9.0	11.4	19.8	18.2	19.5
Pennsylvania	3.5	9.9	8.3	10.2	1.9	4.8	4.5	5.7	4.7	12.3	10.9	13.5
Rhode Island	5.7	14.1	10.9	11.8	2.5	6.9	4.7	5.1	7.1	17.1	13.4	14.5
South Carolina	4.1	10.5	7.4	9.2	2.0	3.6	3.1	3.8	5.3	12.2	9.2	11.4
South Dakota	4.3	12.8	9.1	12.6	1.5	4.0	3.2	4.1	5.2	14.6	10.7	14.4
Tennessee	3.8	9.9	7.4	8.6	1.7	3.4	3.2	3.7	4.9	11.5	9.2	10.8
Texas	7.6	15.2	12.8	14.8	7.1	13.3	13.8	16.8	12.2	22.0	21.2	25.2
Utah	6.5	15.4	10.8	12.2	5.0	11.6	9.7	11.4	9.4	20.9	16.0	18.3
Vermont	3.3	5.8	6.1	6.7	1.3	2.2	3.2	3.6	4.3	7.1	8.1	9.0
Virginia	7.2	14.3	11.7	13.4	3.2	5.4	5.6	6.6	9.2	16.9	15.1	17.6
Washington	10.9	19.6	17.0	18.5	4.4	8.5	8.3	9.3	13.4	23.4	21.3	23.3
West Virginia	2.6	7.2	5.4	7.3	0.9	1.7	1.8	2.7	3.2	8.1	6.5	9.1
Wisconsin	3.8	10.6	8.6	10.3	2.1	5.4	5.2	6.3	5.1	13.3	11.6	14.1
Wyoming	5.8	11.0	9.9	12.0	5.1	10.3	7.3	9.0	8.9	16.5	14.2	17.2
Puerto Rico	15.7	20.8	19.7	22.1	1.4	1.5	2.1	2.8	16.7	21.8	21.2	24.0

¹ Summary File 1 counts in this table are consistent with Summary File 1 counts shown in the American FactFinder.

² Preferred estimates remove likely numbers of opposite-sex couples included in same-sex tabulations.

Source: U.S. Census Bureau, 2010 Census Summary File 1.

proportion for same-sex unmarried partners (2.4 percent). This, of course, reflects the below-national proportions of people in these states who are Hispanic or Latino.²¹

Figures 4a, 4b, and 4c summarize state variations in coupled households with partners of either a different race or Hispanic origin for the three types of coupled households.²² The maps show the state variations within each type of coupled household, the similarity in these geographical variations among the types of households, and the differences in the levels of these proportions.

Overall, 10 percent of opposite-sex married couples had partners of a different race or Hispanic origin. States with higher percentages of couples of a different race or Hispanic origin were primarily located in the western and southwestern parts of the country. These areas tend to have a high Hispanic population. Hawaii had the highest percentage of spouses of a different race or Hispanic origin (39 percent). Alaska, New Mexico, and Oklahoma also had about 19 percent of opposite-sex married couples where the partner is of a different race or Hispanic origin than the householder. This reflects the high proportion of American Indian and Alaska Native alone population in Alaska and Oklahoma and the high proportion of Hispanics or Latinos in New Mexico. Another interesting pattern of relatively low percentages (less than 5 percent) emerges in a range of states extending from the Gulf Coast states of Mississippi and Alabama through Appalachia to Ohio and Pennsylvania, and

²¹ Sharon R. Ennis, Merarys Rios-Vargas, and Nora Albert, "The Hispanic Population: 2010," *2010 Census Briefs*, C2010BR-04 (May 2011), Table 2.

²² A reference to state includes states and their statistically equivalent entities. A reference to county includes counties and their statistically equivalent entities.

another cluster emerges among the New England states of Maine, New Hampshire, and Vermont. States in the South had a history of interracial marriage laws that prohibited marriage between Whites and Blacks. These laws were not repealed until 1967 in the Supreme Court decision of *Loving v. Virginia*.²³ The low proportions noted in the New England states likely reflect the small proportions of the population in those states that are either Black or Hispanic (1 percent to 2 percent).²⁴

Although opposite-sex unmarried couples were approximately twice as likely to have partners of a different race or Hispanic origin (18 percent) as opposite-sex married couples (10 percent), they have a similar pattern of state percentages. Figure 4b shows that the states with the highest percentages of opposite-sex unmarried partners of a different race or Hispanic origin were in the western and southwestern United States, including Hawaii and Alaska.²⁵ Diverse populations in terms of both racial and ethnic origins characterize these areas. Along with the areas mentioned earlier, above-average percentages of couples of different racial and ethnic origins were noted in Kansas, Oklahoma, and Texas in the West Central part of the United States, Florida in the South, and New Jersey and New York in the Northeast.

²³ Alabama did not officially remove language prohibiting interracial marriage from its state constitution until 2000. "Alabama removes ban on interracial marriage," *USA Today*, November 7, 2000.

²⁴ See Ennis, Rios-Vargas, and Albert, op. cit., Table 2, and Sonya Rastogi, Tallese D. Johnson, Elizabeth M. Hoeffel, and Malcolm P. Drewery, Jr., "The Black Population: 2010," *2010 Census Briefs*, C2010BR-06 (September 2011), Table 5.

²⁵ The correlation between the percentages of partners of a different race and Hispanic origin between opposite-sex married and unmarried couples for the 50 states and the District of Columbia is 0.980.

The final map (Figure 4c) shows that same-sex unmarried partners with a partner of a different race or Hispanic origin were about 2 percentage points higher than for opposite-sex unmarried partners. However, both household types had similar geographical patterns.²⁶ As with opposite-sex unmarried couples, the states with the highest percentages of different-race same-sex unmarried partners were in the western and southwestern United States, along with Hawaii and Alaska. New Jersey, New York, and the District of Columbia had higher than average percentages on the east coast. The lowest percentages of interracial/ethnic same-sex couples were in a band of states extending from the lower Mississippi Valley through Appalachia and in upper New England.

The striking similarity in state variations among the three household types suggests that the racial and ethnic composition of populations strongly influenced the patterns shown among the states, while the type of household—married or unmarried—was an important factor that affected the proportionate level of mixed race and ethnic partners.

METHODOLOGY AND SOURCES OF DATA

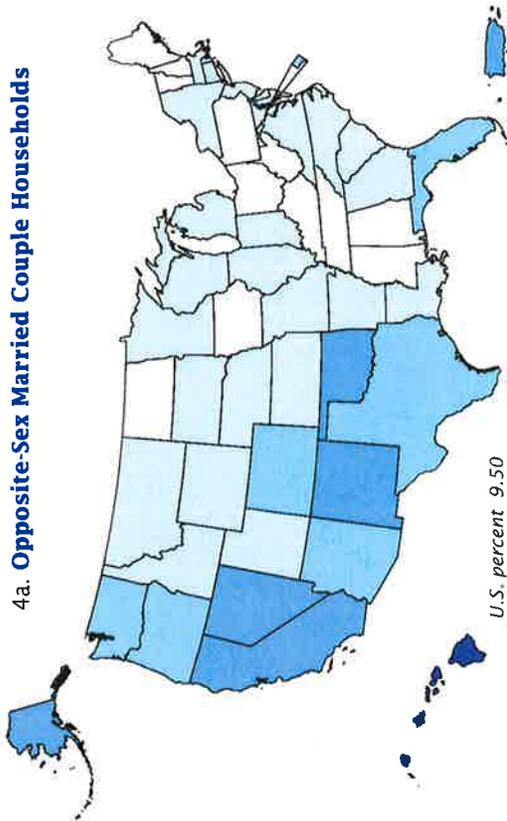
This report uses decennial census data primarily for the years 2000 and 2010. Unrounded data are used to compute all derived values. For readability, most whole numbers in the text are expressed in millions or rounded to the nearest thousand, and most percentages are rounded to the nearest whole percent. In the tables, whole numbers are unrounded, and percentages

²⁶ The correlation between the percentages of partners of a different race and Hispanic origin between opposite-sex and same-sex unmarried couples for the 50 states and the District of Columbia is 0.961.

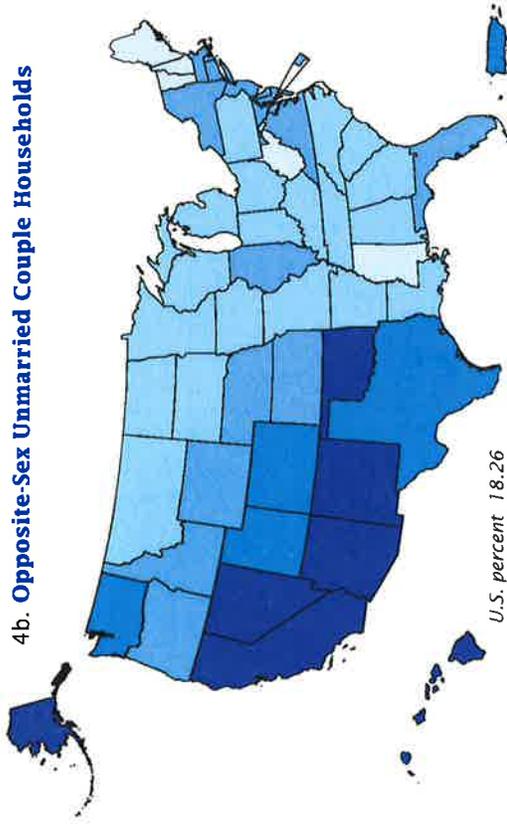
Figures 4a.-4c.

Households With Partners of a Different Race or Hispanic Origin: 2010

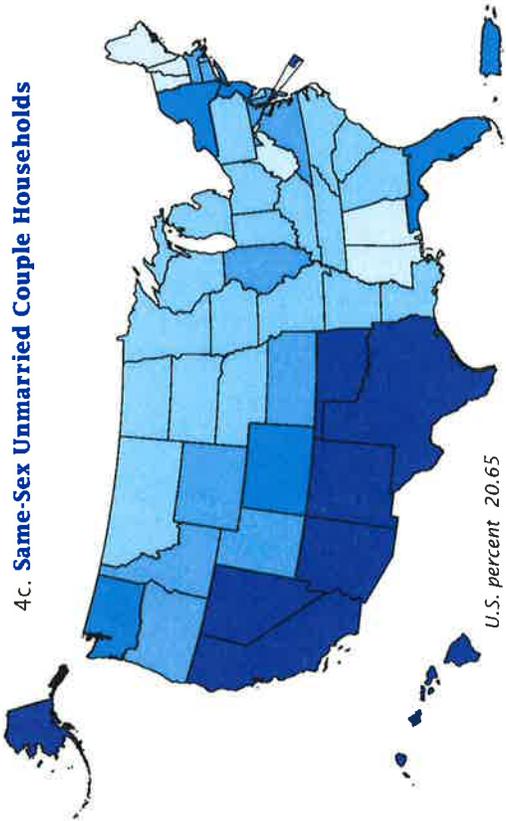
4a. **Opposite-Sex Married Couple Households**



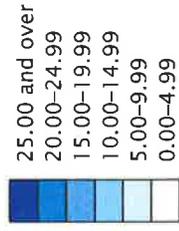
4b. **Opposite-Sex Unmarried Couple Households**



4c. **Same-Sex Unmarried Couple Households**



Percent by state



U.S. percent does not include Puerto Rico.

Sources:
Figures 4a and 4b: U.S. Census Bureau, 2010 Census Summary File 1.
Figure 4c: U.S. Census Bureau, 2010 Census Summary File 1 (Preferred estimates from Table 7 of this report).
For information on confidentiality protection, nonsampling error, and definitions, see www.census.gov/prod/cen2010/doc/sf1.pdf.

are rounded to the nearest tenth. Maps are created using unrounded data.

ABOUT THE 2010 CENSUS

Why was the 2010 Census conducted?

The U.S. Constitution mandates that a census be taken in the United States every 10 years. This is required in order to determine the number of seats each state is to receive in the U.S. House of Representatives. The data collected in the census is used to provide states with the small-area data they need to redraw state legislative districts to distribute over \$400 billion in federal program funding per year and to help a variety of stakeholders in tasks such as planning services for their communities or researching the diversity of their neighborhoods.

Why did we ask the household relationship question?

The relationship question measures the changing composition of families and households in the United States and provides essential information for the planning and carrying out of federal programs

designed to help families and children. The information derived from the relationship item helps to identify, for example, areas that have experienced changes in the number of children, elderly people living alone or with their children, and single-parent households so that government agencies can develop and evaluate programs that assist these populations. Housing agencies and developers use this information to determine community needs for different types of housing, such as multibedroom housing for areas with large household populations or special needs housing for the elderly. Businesses use the data to find potential new markets or to change their product mix in neighborhoods to reflect changes in family structure and associated consumer habits.

FOR MORE INFORMATION

For more information on families and households in the United States and additional 2010 Census tables on interracial spouses and partners, visit the U.S. Census Bureau's Web site at <www.census.gov/hhes/families>. Data on families and households for state and local

areas are available on the Internet at <factfinder2.census.gov>. Information on confidentiality protection, nonsampling error, and definitions is available on the Census Bureau's Web site at <www.census.gov/prod/cen2010/doc/sf1>. Information on other population and housing topics is presented in the 2010 Census Briefs series located on the U.S. Census Bureau's Web site at <www.census.gov/prod/cen2010/>. This series presents information about race, Hispanic origin, age, sex, and housing tenure and type.

If you have questions or need additional information, please call the Customer Services Center at 1-800-923-8282. You can also visit the Census Bureau's Question and Answer Center at <ask.census.gov> to submit your questions online.

Attachment No. 16

Patricia A. Shields, expert witness, resume,
qualifications and references

Patricia Shields

4318 Maryland St. #B, San Diego, CA 92103. (619) 295-1374.

EDUCATION

University of San Diego School of Law

Juris Doctor December, 1999.

*Honors &
Activities*

U.S.D. Community Service Grant. Summer, 1999

Student Bar Association. Fourth Year Representative, 1999.

Adele Gilman Memorial Scholarship. Spring 1998. "Outstanding female evening student who has made significant contributions to the community."

University of Michigan School of Social Work

Master of Social Work

University of San Diego

Bachelor of Arts, English Literature, Minors: Philosophy, American History

EXPERIENCE

University of California - San Diego

Temporary Services. Variety of clinical and administrative assignments pertaining to patient care at UCSD Medical Center. (September, 2000 to present)

Bet Tzedek Legal Services - Los Angeles, CA.

Summer Law Clerk. Nationally recognized program targeting problems of fiduciary and elder abuse. Performed factual investigations, prepared legal documents, conducted legal research, negotiated on behalf of consumers, represented clients at administrative hearings. (Summer, 1999)

San Diego Mediation Center - San Diego, CA.

Volunteer Mediator - Small Claims Court. Mediate disputes between small claim court parties. Received mediation training. Program includes ongoing supervision and training. (April 1998 - December 1998)

*Clinical
Social Work*

The County of San Diego, Health and Human Services - San Diego, CA

Mental Health Program Manager: Middle Manager responsible for the operations of two mental health clinics and community outreach programs with a total monthly census of 1,200 clients. Supervisor, multi-disciplinary staff of 26 providing crisis intervention, evaluation, medication management, and case management to adults and older adults. Responsible for all aspects of operations and personnel management including hiring, training, assigning and evaluating work, performance evaluation, and discipline.

Provide direct clinical services in the form of diagnosis, treatment, referral, and discharge planning for difficult and high profile cases. Assure compliance with State and Federal Regulations covering clinical services. Design specialized programs. Ensure culturally appropriate programming.

San Diego County, Board of Supervisors appointee to advisory committees on HIV Prevention and on Long-Term Care for Older Adults. Field Instructor, San Diego State University School of Social Work. Chair, departmental committee to formulate, implement and oversee confidentiality standards for "managed care" in mental health and public health programs.

Consultant, Los Angeles County Department of Mental Health and U.S. Public Health Services on treatment needs of mentally ill substance abusers. Advisor to community groups such as The United Way on social service needs and planning! (1985-1999 Retired)

The County of San Diego, Department of Social Services - San Diego, CA

Protective Services Worker: investigated and acted upon allegations of elder and child abuse; extensive interaction with Juvenile Court and law enforcement. Duties included psychosocial assessments, crisis intervention, writing court reports, formulating treatment plans. (1979 - 1985)

Presentations U.C. San Diego: *Mental Health and Substance Abuse Treatment in Managed Care.* (1997)
Medical College of Pennsylvania: *Cross-Training as a Workable Strategy for Program Improvement in Substance Abuse and Mental Health Treatment.* (1993)
American Medical Association: *Interdisciplinary Teams in Homeless Outreach.* (1987)

Research Publication Richard Hough, Henry Tarke, Virginia Renker, Patricia Shields, and Jeff Glatstein.
Recruitment and Retention of Homeless Mentally Ill Adult Participants in Research. . J. Cons.and Clin. Psychol. 881. (1996)

LICENSE **Licensed Clinical Social Worker** (California, 1982) #LCS 8838

SPECIAL SKILLS Microsoft Office, PCIS

**Patricia Shields, LCSW
2358 University Ave. #171
San Diego, CA 92104**

November 22, 2014

Elena Q. Gerli, ESQ
3777 N. Harbor Boulevard
Fullerton, CA 92835

Dear Ms. Gerli:

My current resume does not capture the depth of my involvement and interest in the needs of individuals with substance abuse disorders. I am enclosing an earlier one that covers my work in field in greater detail. I am including a letter of recommendation from Areta Crowell Ph.D. I worked under Areta when she was Director of San Diego County Mental Health. I continued to work with her when she became the Director of Los Angeles County Mental Health. In 1994 I decided a law degree would enhance my effectiveness as an advocate so I went to law school. A letter by Figueredo M.D. a Trustee at the University of San Diego supporting my law school application is also enclosed.

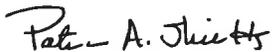
In 1979, as an Adult Protective Services worker, my caseload contained many alcoholics including those who had been treated at State Mental Hospitals. I was quickly aware of the many barriers to treatment and the need for good substance abuse treatment, access to mental health services, and access to safe housing.

In 1985, I became a Mental Health Program Manager. This coincided with the development of the Social Model Recovery system. For many years I was the Dual Diagnosis Coordinator for San Diego County Mental and Drug & Alcohol Services. I was able to apply state-of-the-art theory and observe the results first hand.

From 2005 to 2012, I observed the workings of the recovery system as a Deputy Commissioner for the Board of Parole Hearings

Now after decades of observation, I can attest to the potential in almost every individual for profound change when exposed to "recovery principles."

Sincerely,



Patricia Shields, LCSW

Areta Crowell, Ph.D.
2934 Beachwood Drive,
Hollywood, CA 90068
323-463-7535 (Ph. and FAX)
crcrowell@earthlink.net

Department of Health and Human Services
National Health Service Corps/Loan Repayment Program
Application and Award Branch
5600 Fishers Lane, Room 8A-55
Rockville, MD 20857

Reference for Patricia Shields

I have known Pat Shields since I became Director of Mental Health Services for the County of San Diego in 1988. She was then the manager of a publically funded, multipurpose, culturally competent, multi disciplinary psychiatric community service which included outpatient and case management services for persons with chronic and severe mental illnesses. She also directed an innovative ahead-of-its-time outreach and in-home program for homebound mentally ill elderly persons and an exceptionally effective outreach program for homeless persons with mental illness. She was the most informed leader in the Department in developing better approaches to meeting the needs of persons with addictive disorders as well as mental illnesses. I found her to be a visionary manager who contributed thoughtfully and with great depth of insight into the management of the Mental Health programs under my direction. I became the Director of the Los Angeles County Department of Mental Health in 1992, and retired in 1998 but have remained active in mental health affairs, serving on various boards and committees, including serving currently as the President of the Mental Health Association of California. I have continued to be in contact with Ms. Shields throughout these years because I value her knowledge, experience and insight. She has always had good information to share. Her integrity and dedication to excellent public service for all people is outstanding. She has demonstrated great consistency in her adherence to the values of serving under served populations. She continues to demonstrate her clinical and management skills in the work she is presently performing within the California prison system. I have no reservations in offering my highest regard for the character and professional skills of Patricia Shields.


Areta Crowell

ANITA V. FIGUEREDO, M.D.
417 COAST BOULEVARD,
LA JOLLA, CA 92037

USD SCHOOL OF LAW
OFFICE OF ADMISSIONS
5998 ALCALA PAARK
SAN DIEGO, CA 92110-2492

RE: PATRICIA SHIELDS

This is a recommendation for the admission of Ms. Shields to the first year class of the Law School, in September, 1995.

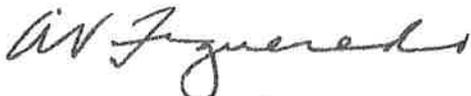
I have known Pat for 15-20 years, when she was involved in the recuperation of a person close to me. I have watched with great interest and admiration her development from that time and have used her expertise in various situations which were very difficult for several of my patients. Her help has been invaluable.

She has great sympathy and empathy for the disadvantaged, especially the mentally ill, the aged, the addicted and the homeless, (frequently combined characteristics). Better than the rest of us who sympathize, Pat works to correct and ameliorate their situations, and has devoted her life through her career, to this end.

Her application contains the information on her skills, work history and accomplishments. I will not enumerate those. I wish particularly to point out that legal training would enhance her ability to accomplish the good that she is already doing, and perhaps to make a greater difference in the lives of the unfortunates with whom she works and to whom she means so much. Further, it seems to me that it would enhance the life experience of her classmates to have a person of Pat's career background and experience in their midst. Her presence in the USD classroom setting would increase the diversity which the University seeks. In addition, Ms. Shields is a most intelligent, dedicated student who will serve as an inspiration to her peers.

I trust that you will consider Pat Shields' application favorably.

Thank you for your attention to this request.



Anita V. Figueredo, M.D.
Faculty, USD School of Law

Attachment No. 17

Letter opinion from Joan Ellen Zweben,
Ph.D.

Joan Ellen Zweben, Ph.D.
714 Spruce Street
Berkeley, California 94707

(510) 526-4442
(510) 527-6842 Fax

Lic. #PSY 4103
E-mail: Joan.Zweben@ucsf.edu

November 24, 2014

To the Planning Commission of the City of Costa Mesa:

I have been asked to provide input on the issue of whether 15 adults living together not as a single housekeeping unit are necessary to provide individuals recovering from alcohol and drug addiction the opportunity to the use and enjoyment of the dwelling of their choice. The basis for the request, as stated in applicants' June 5, 2014, letter, is that persons "recovering from addiction are far more often successful when living in a household with at least eight other persons in recovery, particularly in the early stages of recovery. Barring more than three unrelated individuals from residing together, without regard to the size of the residential unit, interferes with the critical mass of individuals supporting each other in recovery."

No supporting evidence was cited or provided in the letter. I have found no evidence supporting such a claim in the relevant literature, and in my opinion 15 adult individuals recovering from alcohol and drug use is not a necessary number for successful recovery.

Recovery success in supportive housing is not a question of numbers. Problems occur even with six people in residence, but rather, a question of structure. When a group of unrelated adults live together, a system for organizing household chores, shopping, and other basics of daily living is needed, as well a system of accountability. Many households do this for themselves spontaneously, but if this does not occur, or one of the natural leaders moves out, a vacuum is created that can result in a difficult situation. One of the most common problems occurs when a member relapses to alcohol or other drugs and there is no agreed-upon mechanism for handling this. This circumstance is very difficult for peers to address under the best of circumstances, even if there are only six people in the residence. If the recovery home providers minimize regulations, the result does not always benefit the residents.

Six people in supportive housing can provide the necessary support but, as mentioned above, even these have problems. Larger size does not necessarily bring more benefits, especially in a boarding house model. There is no magic number. I reviewed the literature on Sober Living Environments (SLE's)¹ and did not find any studies using size as the key variable. The studies

¹ See, e.g., the following attachments to the agenda report: *Community Context of Sober Living Houses*, Douglas L. Polcin, Ed.D., et al., NIH Public Access Author Manuscript, December 1, 2012 (published in final edited form as *Addict Res Theory*. 2012 December 1; 20(6): 480-491. doi: 10.3109/16066359.2012.665967); *Residential Treatment of Substance Abuse Disorders, Core Therapeutic Elements and Their Relationship to Effectiveness*, Practice Committee Consensus Report, State Association of Addiction Services, April 2013; *Residential Treatment for*

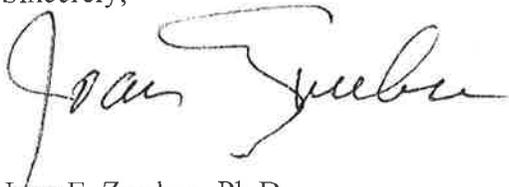
focused on what level of structure was desirable, with tighter structure favoring better outcomes. The housing situations studied were typically tied to particular treatment programs.

Other key elements for recovery include a strong commitment to abstinence, shared by all individuals. This is challenging, because commitment in the individual fluctuates over time. Some staff oversight is required for times when conflict resolution is needed, or issues like relapse need to be handled. Availability of supportive services like psychiatric and other medical resources, transportation, employment specialists, assistance with money management, etc.

Under certain circumstances, 15 people in supportive housing could even be detrimental to recovery. The term "Supportive Housing" usually means specific services are available, mostly through case management, some onsite. These include: counseling, life skills training, employment services, medical/psychiatric services, etc. There should be a staff member designated who can provide case management, structure and accountability. Much depends on the background and training of that person. Being in recovery is a great asset, but it is not a sufficient job qualification. Strong management skills are needed. There should be weekly house meetings with a leader who has clear authority. Having 15 people and minimal structure is a recipe for problems.

My own experience, at East Bay Community Recovery Project and also at the San Francisco VA, is that Sober Living Environments are challenging with any number of residents. Once people are no longer participating in a structured treatment program, the relapse rate increases, particularly during the early stages of the transition.

Sincerely,



Joan E. Zweben, Ph.D.
Executive Director
East Bay Community Recovery Project
Oakland, CA.

Clinical Professor of Psychiatry; University of California, San Francisco

Individuals With Substance Use Disorders: Assessing the Evidence, Sharon Reif, Ph.D. at al., Psychiatric Services, March 2014 Vol. 65 No. 3; *Recovery Housing: Assessing the Evidence*, Sharon Reif, Ph.D. at al., Psychiatric Services, March 2014 Vol. 65 No. 3; *Sober living houses for alcohol and drug dependence: 18-Month outcomes*, Douglas L. Polcin, Ed.D., et al., Journal of Substance Abuse Treatment 38 (2010) 356-365.

Attachment No. 18

Joan Ellen Zweben, Ph.D., *Curriculum Vitae*

CURRICULUM VITAE

Joan Ellen Zweben, Ph.D.
714 Spruce Street
Berkeley, California 94707

October 2014

Phone: 510\526-4442
Fax: 510\527-6842

E-Mail: Joan.Zweben@ucsf.edu

CURRENT ACTIVITIES

Executive Director, East Bay Community Recovery Project (www.ebcpr.org). Outpatient and residential programs, providing psychological, educational and medical services to alcohol and drug dependent clients and their families since 1989.

Clinical Professor; Department of Psychiatry; University of California, San Francisco; 1994 - present.

Staff psychologist (GS 13), Veterans Affairs Medical Center, San Francisco, Ca. (10% time, 1974 - present.)

Teaching and Training: Courses and supervision in assessment and treatment of substance abuse problems to mental health professionals, physicians, and staff in substance abuse treatment settings.

EDUCATION

B.A. (cum laude), Brandeis University, Waltham, Mass., 1963. Major: Sociology

Ph.D., The University of Michigan, Ann Arbor, Michigan, 1971. Area: Psychology (Clinical)

LICENSES & CREDENTIALS

Licensed as a clinical psychologist in the State of California. License # PSY 4103

Certificate of Proficiency in the Treatment of Alcohol and Other Psychoactive Substance Use Disorders (#AD001273); American Psychological Association; APA College of Professional Psychology; 1996 - present.

Certified Addiction Specialist, American Academy of Health Care Providers in the Addictive Disorders; Certificate #B4418, 1989.

National Provider Number: 1548281447

AWARDS & HONORS

Nyswander-Dole Award. National Methadone Conference; November 10, 1992

Department of Veterans Affairs, Service Award; February 1, 1994

Fellow (Division 50), American Psychological Association, 1998

Honored Instructor Award; University of California, Berkeley; 1999

Vernelle Fox Award; California Society of Addiction Medicine; October 10, 2003
Women and Children's Substance Abuse Treatment Innovator Award; Center for Substance Abuse Treatment; August 2, 2004
County Alcohol and Drug Program Administrators Association of California (CADPAAC) – Treatment/Recovery Award; May 26, 2010.
Ruby Award (for work with women), Soroptomist Club of El Cerrito; May 21, 2012
Department of Veterans Affairs, Service Award (40 Years); February 6, 2014

PREVIOUS ADMINISTRATIVE ACTIVITIES

Founder and Executive Director, The 14th Street Clinic & Medical Group, Inc., 1979-2007.
Comprehensive treatment of opioid dependent patients, using medication and psychosocial interventions.

Executive Director, Pacific Institute for Clinical Training, Education and Consultation, Inc. (PICTEC, Inc.) Consultation in organizational development; program monitoring and evaluation; training of professionals and paraprofessionals to work in a variety of mental health and substance abuse settings. (1974-1989)

TEACHING AND TRAINING

Teaching and training activities during the last three years are available in a separate listing.

Contract faculty, Alcohol and Drug Abuse Studies Program, University Extension, University of California at Berkeley. Courses in specialized topics in substance abuse (e.g., cocaine and alcohol; basic issues in substance abuse treatment) for students in the program and professionals in the community. (1984 - 2010.)

Contract faculty, CSPP/Alliant University; San Francisco, Ca. Courses in specialized topics in substance abuse for students in the program and professionals in the community. (1997 - present.)

Staff Trainer, Gestalt Education Network International (GENI). Teaching/supervision of Gestalt therapy, assessment and treatment of addiction, and related skills to European psychotherapists in Germany, Sweden, France (1982-1994)

Graduate faculty, Dominican College, San Rafael, California. Taught courses in group psychotherapy and Gestalt psychotherapy. (1978-1982)

Lecturer in Psychology, The University of California, Berkeley. Seminars and supervision of graduate and post-doctoral students in areas of intensive individual psychotherapy, group psychotherapy, and Gestalt psychotherapy. (1970-1974)

Project Outreach, Department of Psychology, The University of Michigan, Ann Arbor, Michigan. Group Project Coordinator: responsibility for screening and placement of approximately 300 students per quarter in ongoing and weekend human relations training groups. Responsibility for training and supervision of 50 group leaders; designed and implemented training program. Organizational development consultation (1968-1970)

Teaching Fellow, Department of Psychology, The University of Michigan, Ann Arbor, Michigan. Taught courses in personality theory; psychodiagnostic testing (including supervision of clinical psychology graduate students' work with children and adults); the dynamics of planned change (with Ronald Lippitt,

et. al.); a course in organizational change, consultation, and human relations training; introduction to psychology as a social science (honors section) (1965-1970)

AFFILIATIONS, REVIEW BOARDS AND ADDITIONAL CREDENTIALS

Member, Board of Directors, Walden House, Inc., San Francisco, California; 1973 - 1986; President from 1980 - 1985. (Therapeutic community for adolescent and adult substance abuse population.)

Community College Instructor Credential (No. 81140) issued April, 1975 by the California Community Colleges. (Valid for life.)

Member, Advisory Council, Alcohol and Drug Abuse Studies (Certificate Program.) University Extension, University of California; Berkeley, Ca. 94720.

Editorial Review Board, *Journal of Psychoactive Drugs*, 1986 - present.

Advisory Board, American Academy of Health Care Providers in the Addictive Disorders, 1989 - present. Certified Addiction Specialist, 1989.

Consultant, Methadone Treatment Committee, American Society of Addiction Medicine. 1990 - present.

Board Member, California Opioid Maintenance Providers, 1990 - present

Member, The College on Problems of Drug Dependence; 1995 - present.

Co-Editor, *Journal of Maintenance in the Addictions*; Haworth Press; 2000-2007.

Editorial Board, *Journal of Substance Abuse Treatment*. Elsevier Press; 2002-present.

Member, Steering Committee: Clinical Trials Network, National Institute on Drug Abuse; 2002 – 2010. Member, Executive Committee; 2004-2008. Co-Chair, National Steering Committee, Oct 2009 – Oct 2010. Chair, CTP Caucus, Jan 2011 to April 2012. Member, Steering Committee, Western States Node, 2002 – 2013.

PUBLICATIONS

Journal Articles and Book Chapters

Zweben, J.E. and Miller, R.L. (1968). The systems games: teaching, training, psychotherapy. *Psychotherapy: Theory, Research, and Practice*, Vol. 5 (2), pp. 73-76.

Zweben, J.E. and Hammann, K. (1970). Prescribed games: a theoretical perspective on group techniques, *Psychotherapy: Theory, Research, and Practice*, Vol. 7 (1), pp. 22-27.

Zweben, J. E. (1971). *Psychological and Psychosomatic Responses to the Oral Contraceptive*, Doctoral Dissertation, The University of Michigan.

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Deitch, D.A. and Zweben, J.E. (1976). The impact of social change on treating adolescents in therapeutic communities. In *Journal of Psychedelic Drugs*, 8 (3), pp. 199-208.

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Nathan, P.E.; Zweben, J.E., Rawson; Richard R. (2015) Substance Abuse Disorders. In: APA Handbook of Clinical Psychology – Volume IV: Psychopathology and Health.

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In Preparation

Attachment No. 19

Letter opinion from Michael N. Brant-
Zawadzki, M.D., F.A.C.R.

November 21, 2014

To the Planning Commission of the City of Costa Mesa:

I have been asked to provide input on the issue of whether 15 adults living together not as a single housekeeping unit are necessary to provide individuals recovering from alcohol and drug addiction the opportunity to the use and enjoyment of the dwelling of their choice. The basis for the request, as stated in applicants' June 5, 2014, letter, is that persons "recovering from addiction are far more often successful when living in a household with at least eight other persons in recovery, particularly in the early stages of recovery. Barring more than three unrelated individuals from residing together, without regard to the size of the residential unit, interferes with the critical mass of individuals supporting each other in recovery."

No supporting evidence was cited or provided in the letter. I have found no evidence supporting such a claim in the relevant literature, and in my opinion 15 adult individuals recovering from alcohol and drug use is not a necessary number for successful recovery.

A true sober living facility has been defined by the State as a household supportive of a sober life style AFTER treatment. A household with six individuals certainly meets that definition/goal. A boardinghouse-style residential facility with 15 individuals who have no communal relationship, living under individual contracts with an operator for varying short lengths of stay is more of a commercial or institutional setting, one that may be counter-therapeutic to reintegration into a sober living lifestyle.

Treatment facilities are a different story--ones housing a large number of disparate individuals are more like hospitals, and require similar oversight, both medical and regulatory. They require a location providing appropriate privacy, security, and servicing access requirements and compliance with Federal and State laws, not typically found in a single family zoned neighborhood.

No ideal number exists that best supports recovery; the more the living situation resembles a typical residential household where people share expenses, chores and responsibilities, and can develop/maintain interpersonal relationships of a medium or long range nature, the better. This is because the key elements for a sober living home to maximize the likelihood of successful recovery for its residents consist in a

home setting mirroring that of a normal neighborhood, not a campus for those recovering from substance abuse. Access to counseling and medical (psychiatric) treatment facilities/providers on an individual basis (not contracted for by the operator) can be facilitated, as needed, much like in any other family setting.

Additionally, having as many as 15 recovering addicts living together could potentially be detrimental to these individuals' recovery by fostering a "labeling" function, one that unnecessarily creates an "addict" victim mentality, differentiating the so-housed individuals from the other 1 out of 4 Americans who have some type of mental health disorder annually.

Sincerely,



Michael Brant-Zawadzki, MD, FACR
Executive Medical Director, Physician Engagement
The Ron and Sandi Simon Endowed Chair,
Executive Medical Director, Neurosciences
Hoag Memorial Hospital Presbyterian

Attachment No. 20

Michael N. Brant-Zawadzki, M.D., F.A.C.R.,
Curriculum Vitae

CURRICULUM VITAE

Name: Michael Nicholas Brant-Zawadzki, M.D., F.A.C.R

Date of Birth: December 2, 1949

Citizenship: USA

Education:

<u>Dates Attended</u>	<u>Degree, Institution & Location</u>	<u>Title or Status</u>	<u>Major Subject</u>
1967-1971	Stanford Univ., Stanford, CA	1971 B.A.	Biology
1971-1975	Univ. Cincinnati, Cin., OH	1975	M.D.
1975-1976	University Hospital, UCSD San Diego, CA	Intern	Internal Medicine
1976-1979	Stanford University Medical Ctr.	Resident	Diag. Radiology
1979-6/80	Stanford University Medical Ctr.	Fellow	Neuroradiology

Licenses, Boards, Certificates

1975	CA Medical License No. G31971
1979	Certified, American Board of Radiology
1995, 2005	Certified (CAQ), Neuroradiology, American Board of Radiology
2005-2006 (retired)	State of Tennessee, Telemedicine
2013	Certif. in Leadership for Healthcare Transformation, Paul Merage School of Business, UC Irvine

Current Positions

7/2013-Present	Hoag Memorial Hospital Newport Beach, CA	Executive Medical Director Physician Engagement
9/2007-Present	Hoag Memorial Hospital Newport Beach, CA	Executive Medical Director Neurosciences Institute
1990 - Present	Stanford University Stanford, CA	Adjunct Clinical Professor of Diagnostic Radiology

Business Positions Held Previously

1990-1995	Medical Director, Future Diagnostic Imaging, Inc. A California statewide preferred provider radiology network
1995-1996	President - California Managed Imaging Statewide radiology management service organization
1996-2001	Board of Directors-California Managed Imaging
1998-2007	Head, Advisory Board-ONI, Inc. (an MRI manufacturer)
2000-7/2002	Senior Vice President of Medical Affairs- CT Screening Int'l.
6/2005-2007	Board of Directors-Health Management Partners, LLC
2006-2007	Sr. Vice President, Amirsys Inc.

Professional Positions Held Previously

2000-2007	Hoag Memorial Hospital Newport Beach, CA	Medical Director Radiology Department
1986-2007	Hoag Memorial Hospital Newport Beach, CA	Chairman/Vice-Chairman Radiology Department (Position alternates biannually)
1986-2007	Hoag Memorial Hospital Newport Beach, CA	Director of MRI
6/83-6/86	Univ. Calif. San Fran. School of Medicine	Associate Professor in Residence - Radiology, Neurology and Neurosurg. Co-Director, Magnetic

		Resonance Research Laboratory, Dept. of Radiology
7/80-6/83	Univ. Calif. San Fran. School of Medicine	Assistant Professor in Residence - Radiology
7/80-6/83	Univ. California San Francisco General Hosp.	Service Chief, Neuroradiology and Special Procedures Section
1979-1980	Stanford University Stanford, CA	Instructor in Radiology

Concurrent Positions Held Previously

1987-1990	Univ. Calif., San Francisco School of Medicine	Clinical Professor Department of Radiology
1988 - 1991	Loma Linda University	Clinical Professor of Radiology
1997- 2001	University of California Irvine	Clinical Professor of Radiology

Honors and Awards

1975	Stella F. Hoffheimer Award (1st in medical school graduating class)
1974-1975	Alpha Omega Alpha, 3rd and 4th years, University of Cincinnati College of Medicine
1973	Roche Award (Basic Sciences Prize), University of Cincinnati College of Medicine
1986	Memorial Award Paper - Association of University Radiologists (Senior Author)
1989	Fellowship, American College of Radiology
1993	Gold Medal, Society of Magnetic Resonance in Medicine, 7th recipient for outstanding pioneering achievements in magnetic resonance imaging
1996-2004	Selected as one of 100 best physicians in Orange County
1997	International Society for Magnetic Resonance in Medicine - Fellow of the Society
1997	American College of Radiology - Distinguished Commission Service Award
2005-2008	Best Doctors in America
2006-2007	Orange County Medical Association Physician of Excellence
2008	JACR Best of 2008 Articles Award
2011	Southern California Super Doctors
2011	Top Doctor by US News and World Report
2013	Best Doctors in America

PROFESSIONAL SOCIETY ACTIVITIES

Memberships in Professional Organizations

1974-	Alpha Omega Alpha
1980-	American College of Radiology
1980-	Western Neuroradiologic Society
1981-	American Society of Neuroradiology
1982-	Radiologic Society of North America
1982-94	Society of Magnetic Resonance in Medicine
1984-86	Association of University Radiologists
1984-87	American Association for the Advancement of Science
1985-	American Medical Association
1987-	Orange County Radiological Society
1987-94	Society for Magnetic Resonance Imaging
1994-	International Society for Magnetic Resonance in Medicine
1994-	American Society of Spine Radiology
1994-	Society of NeuroInterventional Surgery
1995	Society of Interventional Radiology
1998-	American Heart Association
2007-	American College of Physician Executives

Honorary Memberships

1985	The Pacific Northwest Radiological Society
1985	The Texas Radiological Society
1992	Chicago Radiological Society

Professional Organization Activities

1984	Western Neuroradiological Society	Program Committee
1984	American Society of Neuroradiology	Ad Hoc Com. on MRI

1984	American Society of Neuroradiology	Program Committee
1985	Western Neuroradiological Society	Audit Committee Chairman
1986	American Society of Neuroradiology	Subcommittee on MRI Chairman
1987	American Society of Neuroradiology	Research Overview Committee
1987-88	American College of Radiology	MR Committee
1989-91	Society of Magnetic Resonance Imaging	Board Member Board of Directors
1989-91	American College of Radiology	MR Committee
1991-95	American College of Radiology	Commission on Neuro- radiology and MR
1991-96	American College of Radiology	Committee on Gov't Relations of the Commission on Neuroradiology and MR
1991-96	American College of Radiology	Committee on Human Resources of the Commission on Neuroradiology and MR
1990-91	Western Neuroradiological Society	Secretary-Treasurer
1991-92	Western Neuroradiological Society	President-Elect
1992-93	Western Neuroradiological Society	President
1991-92	Society of MR in Medicine	Executive Committee Board of Trustees
1992-93	California Medical Association	Scientific Advisory Panel on Radiology
1993-94	American Society of Neuroradiology	Executive Committee Chairman - Rules Committee
1994-95	American Society of Neuroradiology	Executive Committee Member at Large
1996	American Board of Radiology	Examiner Neuroradiology CAQ exam
1996	Internat'l Soc for Magnetic Resonance in Medicine	Treasurer
1996	North American Spine Society	Task Force on Clinical Guidelines
1997	Radiological Society of North America	Health Policy and Practice Committee
1997	American College of Radiology	Government and Public Relations of the Commission on Neuroradiology and MR
1997	American College of Radiology	Human Resources of the Commission on Neuroradiology and MR
1997	North American Spine Society	Spinal Imaging Task Force, Committee on Practice Guidelines

1997-98	Internat'l Soc for Magnetic Resonance in Medicine	Treasurer and Chairman, Finance Committee
1997-98	American College of Radiology Neuroradiology and M.R.	Government and Public Relations of the Commission on
1997-00	American College of Radiology	Committee on Managed Care of the Commission on Economics
1998	Cardiovascular Radiology Council	Board Member
1999	Radiological Society of North America	Health Services, Policy and Research Subcommittee
2002	Radiological Society of North America	Program Committee
2002	American Society of Neuroradiology	Program Committee
2003	Radiological Society of North America	Vice Chairman Public Information Committee
2003	Radiological Society of North America	Outreach Subcommittee
2003	American College of Radiology	Screening Technologies Task Force
2004	Radiological Society of North America	Neuroradiology/Head & Neck Subcommittee
2004-2006	Radiological Society of North America	Chairman Public Information Committee
2010-11	Radiological Society of North America	First Vice President
2011	American College of Radiology	Chairman Accountable Care Organization
2013 -Present	American College of Radiology	Head Injury Institute Steering Committee
2014	American College of Radiology	Committee On Finance and IT IR Taskforce
2014	American College of Radiology	Committee On INR Vascular IR Taskforce
2014	American College of Radiology	RIC Radiology Integrated Care

Service to Professional Publications

Neuroradiology (1986-1992)	Editorial Board
Radiology Today	Editorial Board
Journal of Health Care Technology	Editorial Board
Radiology Report	Editorial Board
MRI Decisions	Editorial Board
American Journal of Neuroradiology	Editorial Board
JAMA, American Journal of Radiology	Reviewer
Journal of MRI	Editorial Board
Radiology (1985-1990)	Associate Editor
MAGMA	Editorial Board
Magnetic Resonance Quarterly (1994)	Co-Editor-in-Chief
Topics in Magnetic Resonance Imaging (1996-1998)	Editor
Stroke	Reviewer
Radiology	Reviewer
Journal of the American Medical Association (1996)	Reviewer
American Journal of Neuroradiology (1997-8)	Associate Editor
Seminars in Ultrasound CT and MRI (2003)	Guest Editor
Journal American College of Radiology (2006-6/2012)	Associate Editor
Investigative Radiology	Reviewer

Hospital and Community Service

1986 -1992	Established annual post-graduate course "Symposium on Magnetic Resonance Imaging
1987 -	Founded and established Harbor Radiology Research and Educational Fund (\$250,000 non-profit foundation)
1987-93	Critical Care Committee
1988-93	Continuing Education Committee
1989-91	Acting Director, Hoag Neurological Institute
1991-2002	Executive Committee, Hoag Hospital
1995-Present	Medical Care Improvement Committee, Hoag Hospital
1999-Present	Stroke Pathway Team, Hoag Hospital
1999-Present	Cardiovascular Services Committee, Hoag Hospital
1999-Present	Bylaws Committee, Hoag Hospital
1999-Present	Medical Information Committee
2002-2009	Credentials Committee, Hoag Hospital

SCIENTIFIC AND PROFESSIONAL MEETINGS AND WORKSHOPS ATTENDED

International, national, and regional: see PAPERS PRESENTED section

INVITED LECTURES, PRESENTATIONS not listed previously

Papers Presented

- 1978** National professional societies, 2 presentations. National VA Television Network, guest discussant.
- 1979** National professional society, 1 presentation.
- 1980** National professional society, 2 presentations. 4th Annual National Symposium on Aging, UCSF, guest discussant.
- 1981** Professional societies, 2 presentations. Professional society courses, 7 lectures.
- 1982** International symposia: Toulouse, France, 1 presentation
National professional societies: Boston, MA, 2 presentations; Chicago, IL, 2 presentations.
Postgraduate courses: UCSF, 5 lectures; Stanford, 1 lecture; Salt Lake City, 1 lecture.
Regional professional societies: 3 presentations.
- 1983** International symposia: NMR course, London, England; International Congress of Computed Tomography and NMR, San Francisco, 4 presentations;
Society of Magnetic Resonance in Medicine, San Francisco, 1 poster, 1 presentation;
Basic NMR Course, Dubrovnik, Yugoslavia, 2 presentations;
Radiol Society of North America, 1 refresher course.
National professional societies: Roentgen Ray Society, Atlanta, GA, NMR Refresher Course, 1 presentation;
American Society of Neuroradiology, San Francisco, 1 presentation; Western Neuroradiological Society, invited lecture;
American Academy of Pediatrics, San Francisco, 1 presentation;
Western Angiography Society, Berkeley, 2 presentations.
Postgraduate courses: Tampa, FL, 3 lectures;
Hawaii, 2 lectures;
Advances in Digital Radiography, Chicago, IL, 1 lecture;
NMR Seminar, UCSD; Radiology of Trauma course, UC Irvine, Faculty; Digital Angiography Symposium, Chicago, IL, 3 presentations.
- 1984** International symposia: Roentgen Revisited, Germany/Austria, 5 presentations;
Society of Magnetic Resonance in Medicine, York, 2 presentations, 1 invited presentation;
Royal Australasian College of Radiologists, Canberra, Australia, 5 presentations;
Radiological Society of North America, 1 refresher course.
National professional societies: Federation of Western Societies of Neurological Science, Napa, CA, 1 presentation
American Association of Neurological Surgeons, San Francisco, CA, 1 presentation;
American Roentgen Ray Society, Las Vegas, NV, 1 presentation; Association of University Radiologists, Newport Beach, CA, 1 presentation; American Society of Neuroradiology, Boston, MA, 1 presentation;
American Neurological Association, Baltimore, MD, 1 presentation. Postgraduate courses: American College of Medical Imaging, Los Angeles, CA, 3 presentations,

UCSF, 8 lectures;
University of Wisconsin refresher course, Chicago, Illinois, 3 presentations; Harvard Postgraduate course, Boston, Massachusetts, 2 presentations;
UC San Diego, San Diego, CA 3 presentations.
Visiting professorship: Montefiore Hospital, Albert Einstein School of Medicine, Bronx, NY, 1 presentation.
Regional professional societies: 5 presentations.

- 1985** International symposia: Radiological Society of North America, Chicago, Refresher Course Speaker; Society of Magnetic Resonance in Medicine, London, Invited Speaker; Society of Magnetic Resonance Imaging, San Diego, CA, 2 presentations.
Postgraduate courses: UCSF, 6 lectures.
Regional professional societies: Portland Vascular Society, 1 presentation; Los Angeles Radiological Society, 3 workshops.
Texas Radiological Society, El Paso, TX, 2 presentations;
Washington Imaging Conference, Alexandria, VA, 1 presentation;
Pacific Northwest Radiological Society, Portland, OR, 1 presentation.
National professional societies: American Heart Association, 1 presentation;
American Society of Neuroradiology, New Orleans, LA, 2 presentations; Magnetic Resonance Imaging Contemporary Forums, San Diego, CA, 2 presentations;
American Roentgen Ray Society, Boston, MA, 1 course.
Visiting professorship: D.C. American College of Radiology, George Washington University, Washington, D.C.
- 1986** International symposia: Carvat, Rome, Italy - 3 presentations;
Society Magnetic Resonance, Montreal Moderator.
Post Graduate Courses: UCSF Dept. of Radiology January Course - 3 presentations. March Course - 1 presentation. MRI Course - 3 presentations.
National professional societies: American Society of Neuroradiology, San Diego, CA, - 2 presentations.
American Neurological Association - Guest Speaker. Radiological Society of North America - Refresher Course, Speaker; Chicago.
- 1987** International Symposia: Soc. of Mag. Resonance Imaging, San Antonio, Texas - 1 presentation.
Radiologic Society of North America - Categorical Course Faculty.
Postgraduate Courses: UCSF Department of Radiology. Neuroradiology Course - 3 presentations.
Cedars-Sinai Medical Center (Los Angeles) - MRI Course, 1 presentation.
Barrows Neurol. Institute, Phoenix, Ariz. - Magnetic Resonance Imaging Symposium - 3 presentations.
U.C. San Diego Postgrad. Course on Magnetic Resonance Imaging - 3 presentations. Loma Linda University Postgrad. Course - 2 presentations.
National Professional Societies: American Academy of Neurology, New York - 2 presentations.
1st Annual Symposium on Magnetic Resonance Imaging, Ritz-Carlton, Laguna Niguel, CA - 2 presentations.
- 1988** International symposia Riyadh, Saudi Arabia - 2 presentations Magnetic Resonance Imaging in Paradise: Update 1988, Tahiti - 3 presentations
Postgraduate courses U. C. San Diego School of Medicine, Course of MRI - 2 presentations
University of South Florida, College of Medicine, - 1 presentation
University of New Mexico School of Medicine, Center for Non-Invasive Diagnosis, Short Course in MR 1 presentation
4th Annual Imaging Seminar, University of Vermont, Department of Radiology - 3 presentations
University of Michigan, University Hospitals, Grand Rounds. Resident Noon Conferences - 2 presentations
1988 Harvard Postgraduate Course, Harvard Medical School, Department of Continuing Education, Massachusetts - 2 presentations
UCSF MRI Visiting Fellowship Faculty - 1 presentation
National professional societies 40th Annual Midwinter Radiological Conference, Los Angeles - 1 Presentation
American Roentgen X-ray Society, 88th Annual Meeting, San Francisco - 1 presentation 7th Annual Scientific Meeting and Exhibition - The Society of Magnetic Resonance in Medicine, San Francisco, CA - 2 presentations
1988 Annual Convention of the American College of Osteopathic Radiology, Las Vegas, NV - 2 presentations
Snowmass - 1988, MR & CT of the Head and Spine, Colorado - 4 presentations
2nd Annual Symposium on Magnetic Resonance Imaging, Ritz-Carlton, Laguna Niguel, CA - 2 presentations
6th Conference of Magnetic Resonance Imaging, Los Angeles Huntington Memorial Hospital and Diagnostic Imaging - 3 presentations

Regional professional societies Orange County Academy of Internal Medicine, California - 1 presentation
Los Angeles Radiological Society, Continuing Education Committee, Midwinter Radiological Conference, Universal City, California - 3 presentations
Kaiser Permanente Medical Center - Radiology Symposium, Los Angeles - 2 presentations
Dominican Santa Cruz Hospital, Dominican Neurologic Institute 13th Annual Neurosciences Symposium, California - 2 presentations

1989 International symposia Tissue Characterization in MR Imaging - Wiesbaden, Germany - 1 presentation - 4/89.
Magnetic Resonance Imaging: International Symposium in Venice and Florence, Italy - 5 presentations - 5/89.
Magnetic Resonance Imaging - Eighth Magnetic Resonance Imaging (sponsored by Diagnostic Imaging) - Los Angeles - 4 presentations - 4/13/89
Magnetic Resonance Imaging: Second Annual International Course, Riyadh, Saudi Arabia - 4 presentations - 10/2/89
Postgraduate courses UC San Diego School of Medicine - Neuroradiology Update - 2 presentations - 1/23/89
Medical College of Wisconsin - Intermountain Imaging Conference - Utah - 5 presentations - 2/28/89
UCSF Neuroradiology Visiting Fellowship - 10/23/89
Neuroradiology Harvard Post-Graduate Course - 1 presentation 9/18/89
National professional societies Society for Magnetic Resonance Imaging - Educational Program of the 1989 Annual Meeting - Los Angeles - 1 presentation 2/25/89
American Society of Neuroradiology - Categorical Course and 27th Annual Meeting, Orlando, Florida - 1 presentation 3/18/89
Regional professional societies Hospital of the Good Samaritan - Practical Applications of MRI - 3 presentations - 1/18/89
Los Angeles Radiological Society - Midwinter Radiological Conference - 3 presentations - 1/27/89
Florida Radiological Society - Snowmass 1989: MR and CT of the Head and Spine - 3 presentations - 2/11/89
Los Angeles Radiological Society - General Membership Meeting - 1 presentation - 6/14/89
Western Society of Neuroradiology Symposium - Carmel - 2 presentations - 10/12/89
Los Angeles Radiologic Society Weekend MRI Seminar, Los Angeles - 4 presentations - 9/23/89
Radiology Symposium, Kaiser Permanente - Los Angeles - 2 presentations - 11/4/89

1990 International symposia
Radiologic Society of North America, Chicago, IL - 3 presentations - 11/24/90
Postgraduate courses
Harvard Postgraduate Course - Boston, MA - 3 presentations - 5/23/90
Harvard Postgraduate Course - Boston, MA - 3 presentations - 10/1/90
National professional societies
University of Hawaii at Manoa - MRI Workshop - 1 presentation - 4/8/90
10th Conference on Magnetic Resonance Imaging - Diagnostic Imaging - San Diego, CA - 4 presentations - 4/4/90
4th Annual Conference, Magnetic Resonance Imaging - Barrow Neurological Institute - Arizona - 3 presentations - 3/3/90
Ninth Annual Meeting of the Society of Magnetic Resonance in Medicine - New York, NY - 1 presentation - 8/18/90
Regional professional societies
Greater Kansas City Radiological Society - 2 presentations - 3/7/90
Kaiser Permanente - 1st Annual Neurosurgery Symposium - Costa Mesa, CA - 1 presentation - 1/20/90
5th Annual Palm Beach Magnetic Resonance Imaging Update - Florida - 3 presentations - 2/18/90
4th Annual Symposium on Magnetic Resonance Imaging, Laguna Niguel, CA - 4 presentations - 7/23/90
1990 Annual Scientific Meeting - Western Neuroradiological Society - Santa Fe, New Mexico - 1 presentation - 10/18/90

1991 International symposia
MRI Update - Madrid, Spain - June 24-26
Society of Magnetic Resonance in Medicine - Teaching Program - San Francisco, CA - August 10-11
Radiologic Society of North America - Refresher Course - Chicago - December 1-6
Postgraduate courses
University of California San Diego, Magnetic Resonance Imaging Course, San Diego, CA - 2 presentations - March 5
Breckenridge 1991: MRI in Clinical Practice - Breckenridge, CO - 4 presentations - March 9-16
3rd Annual Snowmass 1991: Practical Magnetic Resonance Imaging, Snowmass, CO - 2 presentations - March 16-23

12th Annual Intermountain Imaging Conference - Steamboat Springs, Colorado - 6 presentations - February 10-15
Harvard Medical School - Clinical MRI: 1991 Update - Cambridge, MA - June 5-8
Neuroradiology in the Rockies - Snowmass, CO - July 7-12
Harvard Postgraduate Course on Basic and Current Concepts in Neuroradiology, Head and Neck Radiology and Neuro-MRI - Boston, MA - September 23-27
Rush-Presbyterian MRI Course - Chicago - October 24 - 3 presentations
National professional societies
Society for Magnetic Resonance in Imaging, Chicago, IL - 2 presentations - April 13-15
Society of Magnetic Resonance in Medicine - Workshop - Napa, CA - May 23-25
Regional professional societies
Los Angeles Radiological Society - 43rd Annual Midwinter Conference - Los Angeles, CA - 6 presentations - February 1-3
Pacific Northwest Radiology Society - Portland, Oregon - 2 presentations - May 3-5
North Bay MRI Tutorials - Fairfield, CA - 3 presentations - April 29-May 3
Hawaii Radiological Society - 8th Annual Mtg - Hawaii - May 25-27
Florida Radiological Society - Practical Magnetic Resonance Imaging 1991 - October 17-20

1992

International symposia

SMRM Scientific Meeting and Exhibition - Berlin, Germany - 1 presentation - August 8-14

Postgraduate courses

14th Conference on MRI - Hawaii - January 8-11

Seminars in MRI - Sponsored by Medical College of Wisconsin - Vail, Colorado - 4 presentations - January 18-25

Florida Radiological Society - Breckenridge 1992 - Clinical MRI - 3 presentations - March 7-14

Snowmass 1992: Practical Magnetic Resonance Imaging - 3 presentations - March 14-21

Magnetic Resonance Imaging 1992: National Symposium - Las Vegas, CA - May 17-20

MRI in Spain and Morocco - 3 presentations - June 28-July 1

1992 Harvard Medical School Postgraduate Course in Neuroradiology, Head and Neck, and Neuro MRI - Boston, MA - 1 presentation - September 21-25

19th Ann. Radiology Symposium- Garden Grove, CA - 1 presentation - October 17

National professional societies

Society for Magnetic Resonance Imaging - 10th Annual Meeting - 1 presentation - April 25-29

American Roentgen Ray Society - Categorical Course - 1 presentation - May 10-15

American Society of Neuroradiology - St. Louis, MO - 1 presentation - June 3-4

Regional professional societies

Los Angeles Radiological Society - 44th Annual Midwinter Radiological Conference - Los Angeles - 6 presentations - January 31-February 2

Portland Vascular Society - 1 presentation - February 4

Chicago Radiological Society - Chicago, Illinois - 1 presentation - February 20

Stanford University School of Medicine - Grand Rounds - February 12

1993

Postgraduate courses

Stanford Neuroradiology Update - Laguna Niguel, CA - 4 presentations - January 18-20

4th Annual Neurosurgery Symposium - Kaiser Permanente - 1 presentation - February 13

Steamboat 1993: 3rd Annual MRI in Clinical Practice by the Florida Radiological Society - Steamboat Springs, CO - 5 presentations - March 6-13.

National Neuroradiology & Pediatric Radiology Review Course: 1993 A Comprehensive Tutorial - Laguna Niguel, CA - 3 presentations - July 28 - 30

National professional societies

Society for Magnetic Resonance Imaging 11th Annual Meeting - San Francisco, CA - 1 presentation - March 27-31

The Society of Magnetic Resonance in Medicine 12th Annual Scientific Meeting and Exhibition - New York, NY - 1 presentation - August 19

American Society of Neuroradiology 1993 Annual Meeting - Vancouver, B.C. - 1 presentation - May 17

Regional professional societies

Los Angeles Radiological Society - 45th Annual Midwinter Radiological Conference - Los Angeles 2 presentations - January 16-January 17

California Medical Association - Annual Session and Western Scientific Assembly - Anaheim, California - February 28

Society of Magnetic Resonance in Medicine 1993 Annual Meeting - 1 presentation - August 19

Visiting professorship

The University of Utah, Salt Lake City, Utah - December 13-14

1994

International symposia

Society for Magnetic Resonance Imaging - 12th Annual Meeting - Dallas, Texas - 1 presentation - March 5

University Hospital of Zurich - Radiology in St. Moritz - St. Moritz, Switzerland - 7 presentations - September 11-18
Riyadh Armed Forces Hospital - The Fourth International MRI Course - Kingdom of Saudi Arabia - 3 presentations - October 2-5
Society of Magnetic Resonance - Second Meeting of the SMR - San Francisco, CA - 1 presentation - August 6-7

Postgraduate courses

Stanford Neuroradiology Update - Laguna Niguel, CA - 4 presentations - January 17-19
University of California San Diego School of Medicine - Postgraduate Magnetic Resonance Imaging Course - San Diego, CA - 3 presentations - February 15
Florida Radiology Radiological Society, Inc - 4th Annual Breckenridge MRI in Clinical Practice - Breckenridge, Colorado - 3 presentations - February 19-26.
University of California, San Diego School of Medicine - Musculoskeletal MR Course - Carlsbad, California - 4 presentations - March 21-25
Johns Hopkins Medical Institution - Principles & Practice of Clinical Magnetic Resonance Imaging - 4 presentations - April 21-24
University of South Florida College of Medicine - 4th Annual Clinical Neuroimaging Plus Seminar - Key West, Florida - 3 presentations - April 20-23
Hoag Memorial Hospital/University of California Irvine - National Neuroradiology & Musculoskeletal Radiology Review Course: 1994 - A Comprehensive Tutorial - Laguna Niguel, CA - 5 presentations - July 24-29

National professional societies

32nd Annual Meeting - American Society of Neuroradiology - Nashville, Tennessee - 2 presentations May 3-7

Radiological Society of North America - Chicago, Illinois - 1 presentation - November 27-December 2

Regional professional societies

Phoenix MR Society - Phoenix, AZ - 1 presentation - January 26
Los Angeles Radiological Society - Los Angeles, CA - 3 presentations - January 28-29
California Radiological Society - Annual Meeting, San Diego, California - 1 presentation - May 20
Memphis Roentgen Society - 2nd Annual Memphis Radiology Meeting - Memphis, Tennessee - 3 presentations - May 28-29
Western Neuroradiological Society - 26th Annual Meeting - Tucson, Arizona - October 6-9, 1994
Los Angeles Society of Neurological Sciences - Los Angeles, California - 1 presentation - Nov 16

Visiting professorships

Department of Radiology - Cornell University Medical Center, New York - November 10-11.

1995

International symposia

Postgraduate courses

Loyola University Chicago - Seminars in MRI - Vail, Colorado - 7 presentations - January 21-28
MR and CT of the Head and Spine - Snowmass, Colorado - 4 presentations - February 11-18
Massachusetts General Hospital and Harvard Medical School - MRI 1995: Clinical Update and Advanced Applications - Maui, Hawaii - 3 presentations - February 26- March 3
University of South Florida - Key West, Florida - 5th Annual Clinical Neuroimaging Plus - 2 presentations - May 10-13
Stanford Neuroimaging Course - Laguna Niguel, CA - 3 presentations - August 13-16
University of Utah - Salt Lake City - Intensive Interactive Head and Neck Imaging - October 26-29

National professional societies

American Society of Neuroradiology, 33rd Annual Meeting - Chicago, Illinois - 1 presentation - April 23-27

American College of Radiology, Intersociety Commission Summit Meeting - Colorado Springs, Colorado - Moderator - July 27-31

Radiological Society of North America - Chicago, Illinois - 2 presentations - November 25-29

Regional professional societies

Los Angeles Radiological Society - Los Angeles, CA - 4 presentations - February 3-5
Western Neuroradiological Society - Victoria, Canada - 2 presentations - October 5-8
San Diego Radiological Society - San Diego - 1 presentation - December 6

1996

International symposia

International Society for MR in Medicine - New York City - 3 presentations - April 26-May 3

Radiological Society of North America, Chicago, Illinois - 1 presentation - Nov 29 - Dec 3

Postgraduate courses

Loyola University Chicago - Snowbird, UT - Diagnostic Imaging Compendium - 6 presentations - February 10-17

University of California San Francisco - Aspen, CO - MRI: Update 1996 - 4 presentations - March 4-8

University of Washington - Hawaii - Masters Radiology Conference - March 11-15

Harvard Medical School/Beth Israel Hospital - MRI 1996: Clinical Update and Advanced Applications - Hawaii 4 presentations - April 9-13

UC San Diego - Coronado, CA - Advanced Imaging of the Spine - 3 presentations - July 23

University of Minnesota - Minneapolis, MN - 59th Course, Radiology 1996, Neuroradiology, Musculoskeletal Radiology, Mammography - 3 presentations - September 11-15
National professional societies
American Society of Neuroradiology, 34th Annual Meeting - Seattle, Washington - 1 presentation - June 21-27
North American Spine Society - 11th Annual Meeting - Vancouver - 1 presentation - October 24
Regional professional societies
Los Angeles Radiological Society - Los Angeles, CA - 4 presentations - January 19-21
Visiting professorships
Department of Radiology, Cleveland Clinic - October 22-23

1997

International symposia
International Society of Magnetic Resonance, Vancouver BC, Invited lecturer, April 12-18.
Postgraduate courses
Jackson Hole Radiology Ski Conference, Jackson Hole, WY - 1 presentation, January 19-22.
8th Annual Neurosurgery Symposium, Kaiser Permanente, Long Beach, CA - 1 presentation, February 1.
Loyola University Medical Center, Diagnostic Imaging Compendium, Vail, CO - 3 presentations, January 25-February 1
The University of British Columbia, Sun Valley Imaging, Sun Valley, ID - 4 presentations, February 25-28
MRI in Clinical Practice, Snowmass, CO - 3 presentations, March 2-7.
Second International Symposium on Musculoskeletal MRI, San Francisco, CA - 3 presentations, June 1-5
University of Utah School of Med, Neuroradiology & Advanced MR, New Mexico, 8 presentations - July 6-11
UC Irvine Medical Center, Neuroradiology Review, Newport Beach, CA, Aug 31 - Sept 4
UC San Francisco, Clinical Magnetic Resonance Imaging, San Francisco, CA - 2 presentations - Oct 6-10.
National professional societies
Regional professional societies
Los Angeles Radiological Society, Los Angeles, CA - 1 presentation - January 18
San Diego Radiological Society, San Diego, CA - 1 presentation - December 10.
Visiting professorships
Stanford University Medical Center, CA, Grand Rounds, 4/24
Partnering and Contracting for Radiology Services Conference, San Diego, CA - 1 presentation, November 18.

1998

International symposia
International Society of Magnetic Resonance, Sydney, Australia, Invited lecturer, April 18-24.
Radiological Society of North America, Chicago, IL - 1 presentation, November 29.
Postgraduate Courses
MRI Clinical Update and Advanced Applications, Kauai, HI - 3 presentations, February 14-21.
Advances in Imaging: 1998, Park City, UT. - 5 presentations, February 22-27.
Clinical Essentials of MRI, Las Vegas, NV - 2 presentations, June 11-12.
Clinical MRI, UCSF - 3 presentations, October 19-23.
Frontiers in Vascular Disease '98, Pebble Beach, CA - 1 presentation, October 15-18.
Neuroradiology for the Practicing Radiologist, Santa Fe, NM - 3 presentations, October 12-15.
Advanced Endovascular Demonstrations, Newport Beach, CA - 1 presentation, October 26.
Neuroradiology Review UCI, Irvine, CA - 4 presentations, October 31.
National professional societies
American Society of Spine Radiology, Practical Spine Imaging Symposium, Cancun, Mexico - 1 presentation, March 18-21.
Society of Neuroradiology, Symposium Neuroradiologicum, Philadelphia, PENN - 1 presentation, May 15-17.
American Heart Association Sunday Morning Program Scientific Sessions, Dallas, TX - 1 presentation, November 8.
Regional professional societies
Los Angeles Radiological Society, Los Angeles, CA - 5 presentations, January 16-18.
Orange County and Inland Neuroradiology Club Meeting, Orange, CA - 1 presentation, March 4.
Visiting professorships
University of California Irvine, CA, Grand Rounds, 1/21

1999

International symposia
Radiology in Beaujolais, Beaujolais, France - 5 presentations, September 20-24.
Radiological Society of North America, Chicago, IL - 2 presentations, November 29-30.
Postgraduate courses
Advances in Imaging: 1999, Park City, UT - 5 presentations, February 14-19.

Intermountain Imaging Conference, Deer Valley, UT – 5 presentations, February 28-March 5.
9th Annual Snowmass 1999: MRI in Clinical Practice, Snowmass, CO–3 presentations, March 14-19
Clinical Essentials of CT & MRI, Atlanta, Georgia – 5 presentations, April 22-25.
MRI 1999 – National Symposium, Las Vegas, NV – 1 presentation, May 6
Clinical Essentials of CT & MRI, Chicago, Illinois – 4 presentations, October 29-31.
CT/MRI Head to Toe, New York, New York – 4 presentations, Dec. 13-18.

National professional societies

American Society of Neuroradiology, San Diego, CA – 2 sessions, 5/25

Regional professional societies

Los Angeles Radiological Society, Pasadena, CA – 4 presentations, January 22-24.

Hoag Imaging - Irvine, CA, Uterine Artery Embolization Educational Lecture, 5/19

Hoag Aliso Viejo – Aliso Viejo, CA, Uterine Artery Embolization Educational Lecture, 10/14

Visiting professorships

Cleveland Clinic, OH, Neuro Board Review, 4/26.

Women's Health Conference – Newport Beach, CA, - 1 presentation, 11/18.

2000

International symposia

STAR Bangkok, Bangkok, Thailand – 4 presentations, January 20-21.

Radiology in Jordan, Amman, Jordan – 5 presentations, May 1-7.

CT Scientific User Conference, Zurich, Germany - 1 presentation, 6/16

Interamerican Congress of Radiology, Buenos Aires, Argentina- 1 presentation, 9/5.

Radiological Society of North America, Chicago, IL- 3 presentations, 11/27, 11/30, 12/1.

Postgraduate courses

Clinical Essential of CT & MRI, Las Vegas, Nevada – 3 presentations, 3/24

Symposium on Vascular Interventions, Las Vegas, Nevada - 3 presentations, Sept. 14-15

Symposium on Vascular Interventions, Las Vegas, NV- 2 presentations, July 14-15.

Clinical Essentials of CT & MRI, Atlanta, GA- 3 presentatoins, 10/27.

National professional societies

American Society of Spine Radiology, Marco Island, Florida – 2 presentations, February 21-23.

American Society of Neuroradiology, Atlanta, Georgia – 1 presentation, April 3-4

Regional professional societies

L.A. Radiological Society Spine Imaging Symposium, Beverly Hills, CA-1 presentation - 11/11

Visiting professorships

New York University, NY Grand Rounds, June 2000

2001

International symposia

Radiological Society of North America, Chicago, IL - 4 presentations - 11/29-30

Postgraduate courses

Practical Radiology at Whistler, Whistler, BC - 2 presentations - 2/15

Harvard MRI 2001 Clinical Updates and Advanced Applications, Kauai, HI - 4 presentations - 2/21

Steamboat 2001: MRI: Basics to Advanced / What You Need to Know, Steamboat Springs, CO - 3 presentations - 3/2

Clinical Essentials of CT & MRI, Las Vegas, NV - 3 presentations - 5/4

Magnetic Resonance Imaging 2001, Las Vegas, NV - 4 presentations - 5/8

Screening CT: Concepts and Strategies, Newport Beach, Ca - 1 presentation - 9/8

Clinical Essentials of CT & MRI, Scottsdale, AZ - 5 presentations - 10/26

CT Screening: The Science; The Business; The Issues, New York, NY - 3 presentations - 12/14-16

Regional professional societies

Western Neuroradiological Society-Santa Barbara, CA - 2 presentations

2002

International symposia

27th Symposium Neuroradiologicum, Paris France, 1 presentation 8/20

Radiological Society of North America, Chicago, IL, 4 presentations 12/1-12/5

Brazilian Radiological Society STAR program, Sao Paulo, Brazil 3 presentations 10/25

Radiological Society of North America, Chicago, IL, 5 presentations 2/3

Postgraduate courses

Advanced MR Imaging Techniques, Las Vegas, NV, presentation 2/10

Barrow Neurological Institute 28th Annual Symposium, Phoenix, AZ 2 presentations 3/2

CT Screening: Concepts and Strategies, Atlanta, GA 4 presentations 3/9-10

Clinical Essentials of CT & MRI, Las Vegas, NV, 2 presentations 4/29-30

Multi-Slice Helical CT: Basics to Advanced, Las Vegas, NV 4 presentations 5/10-11

4th Annual Symposium on Multi-Detector Row CT, San Francisco, CA, 1 presentation 6/23

CT in Early Disease Detection (Screening): Strategy, Efficacy, Technique – 3 presentations - 10/4-6

National professional societies

American Society of Neuroradiology 40th Annual Meeting, Vancouver, CA - 1 presentation - 5/14

Regional professional societies

Orange County Radiological Society, Santa Ana, CA - 1 presentation - 1/31

Hoag Heart & Vascular Institute Endovascular Summit Course -11/8

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2003

Regional Professional Societies

Los Angeles Radiological Society 5th Annual Midwinter Radiology Conference, Los Angeles, CA - 2 presentations 2/1-2/2

San Francisco Bay Radiological Society, San Francisco, Ca, 1 presentation 4/8

Pacific Northwest Radiological Society, Portland, OR 2 presentations, 4/26

California Radiological Society, Newport Beach, Ca 1 presentation, 9/20

Postgraduate courses

3rd Annual Vail Conference: New Advances in MR & CT, Vail, CO-3 presentations 2/6-2/7

Practical Radiology at Whistler, Whistler, BC- 1 presentation 2/12

Wesley Medical Center, Grand Rounds, Wichita Kansas-2 presentations 3/11

California Pacific Medical Center, Grand Rounds, 1 presentation 4/8

Clinical Essentials of CT & MRI, Las Vegas, NV, 3 presentations 4/25

Current Issues of MRI in Orthopedics and Sports Medicine, San Francisco, CA - 3 presentations - 8/26-8/27

National professional societies

American Society of Neuroradiology 41st Annual meeting, Washington, D.C., 2 present 4/28-4/30

2004

Regional Professional Societies

Hoag Heart & Vascular Institute Endovascular Summit, Newport Beach, CA - 2 presentations - 1/15

Beech Street Corporation-Coronary Artery Disease, Lake Forest, CA - 2/18

Hoag Hospital ECU Paramedics lecture - Stroke: Principles of Imaging, Newport Beach, CA - 3/19

Postgraduate courses

Practical Radiology at Whistler. Whistler, BC - 1 presentation - 2/11

Multislice Helical CT: Basics to Advanced, Las Vegas, NV - 4 presentations - 4/16

Clinical Essentials of CT & MRI, Las Vegas, NV - 4 presentations - 5/13

Bare Bones Radiology Conference 6th Annual, Modesto, CA - 2 presentations - 10/23

UCSD Postgraduate Radiology Course 29th Annual, San Diego, CA - 3 presentations - 10/27-10/29

National Tutorial on Stroke, Washington, DC - 3 presentations - 11/12-13

National professional societies

Society of Interventional Radiology 2004 Annual meeting, Phoenix, AZ - 1 presentation - 3/29

American College of Radiology, Arkansas Chapter, Little Rock, AR - 4 presentations - 4/17

American Society of Neuroradiology 42nd Annual meeting, Seattle, WA - 2 presentations - 6/8 & 6/10

International Symposia

Polish Congress of Radiology, Honorary Guest, Warsaw, Poland - 2 presentations - 6/16-19

Radiological Society of North America, Chicago, IL - 5 presentations - 11/27-12/2

Visiting Professorships

Harborview Medical Center Grand Rounds, Seattle, WA - 3/17

2005

Regional Professional Societies

Hoag Heart & Vascular Institute Endovascular Summit, Newport Bch, CA - 4 presentations -1/13-14

Kaiser Permanente Annual Radiology Symposium, Garden Grove, CA - 2 presentations - 10/1

Hoag ACME Education Fall Symposium, Newport Beach, CA - 1 presentation - 10/22

A Review of MRI of the Brain and Spine for Neurologists, Nashville, TN - 2 presentations - 11/5

Postgraduate Courses

Practical Radiology at Whistler, Whistler, BC - 1 presentation - 2/7

Clinical Essentials of CT & MRI, Las Vegas, NV - 3 presentations 4/6-9

Western Stroke symposium: What's New in Prevention, Diagnosis and Therapy, Newport Beach, CA

Course Organizer - 4 presentations - 4/15-17

Issues in Aging Congress, New Orleans, LA - 1 presentation - 7/16

Musculoskeletal & Neuroradiology MR Review, Vancouver, B.C. - 4 presentations - 8/21

UCSD Postgraduate Radiology Course 30th Annual, San Diego, CA - 3 presentations - 10/28

Visiting Professorships

Annenberg Center for Health Sciences at Eisenhower Grand Rounds, Rancho Mirage, CA - 4/21

UCI Medical Center, Dept of Neurology Grand Rounds, Orange, CA - 8/24

International Symposia

CT: Radiology's Powerhouse, Berlin, Germany - 1 presentation - 6/10

Radiological Society of North America, Chicago, IL - 2 presentations - 11/26-12/1

2006

Regional Professional Societies

Orange County Radiological Society, Orange, CA - 2 presentations - 1/31

Hoag Hospital To Your Health Neuroscience Lecture, Newport Beach, CA - 11/15

Postgraduate Courses

Economics Summit: Strategies for Successful Radiology Practices in the 21st Century, Las Vegas,

NV - 4 presentations - 4/21-22

National Tutorial on Stroke, Atlanta, GA - 3 presentations - 5/5-7

Radiology After Five 4th Annual, Las Vegas, NV - 4 presentations - 10/8

Economics of Diagnostic Imaging, National Symposia, Arlington, VA - 3 presentations -

10/27-28
UCSD Postgraduate Radiology Course 31st Annual, San Diego, CA - 8 presentations – 11/2-3
Visiting Professorships
Pomona Valley Hospital Medical Center Grand Rounds, Pomona, CA – 7/25
Torrance Memorial Medical Center Grand Rounds, Torrance, CA – 8/9
San Antonio Community Hospital Grand Rounds, Upland, CA – 11/9
International Symposia
Radiological Society of North America, Chicago, IL - 4 presentations - 11/26-30

2007

International Symposia
European Congress of Radiology, Vienna, Austria – 1 presentation – 3/9
International Society for Magnetic Resonance in Medicine, Berlin, Germany – 1 presentation – 5/20
Radiological Society of North America, Chicago, IL - 3 presentations - 11/24-29
Postgraduate Courses
Clinical Advances in Multi-Slice/Multi-Channel CT & CTA, Las Vegas, NV – 4 presentations – 4/14
Western Stroke Symposium, Newport Beach, CA – 5 presentations – 6/1-3
Radiology After Five 5th Annual, Las Vegas, NV – 4 presentations – 9/8
UCSD 32nd Annual Postgraduate Radiology Course, San Diego, CA – 8 presentations – 10/29
Regional Professional Societies
Hoag 6th Annual Endovascular Summit, Newport Beach, CA - 1 presentation – 5/10
Hoag Community Education Lecture, Newport Beach, CA – 1 presentation – 5/31
Western Neuroradiological Society, Vancouver, BC, Canada – 2 presentations – 10/7
Hoag International Valve symposium, Huntington Beach, CA – 1 presentation – 10/18
National Professional Societies
American Society of Neuroradiology 45th Annual Meeting, Chicago, IL – 1 presentation – 6/13
Visiting Professorships
The Queens Medical Center Grand Rounds, Honolulu, HI – 7/23

2008

Postgraduate Courses
Los Angeles Radiologic Society (LARS), Universal City, CA – 1 presentation – 1/27
CT & MR Imaging Course, Las Vegas, NV – 5 presentations – 4/11
Florida Radiological Society Annual Meeting, Orlando, FL – 1 presentation – 7/12
17th Annual Current Issues in MRI & Sports Medicine, San Francisco, CA – 1 presentation – 8/24
Neuroradiology in Clinical Practice, Las Vegas, NV – 3 presentations – 9/13
UCSD 33rd Annual Postgraduate Radiology Course, San Diego, CA – 6 presentations – 10/30
Visiting Professorships
New York Hospital-Cornell Medical Center Grand Rounds, New York, NY – 1 presentation – 2/4
Regional Professional Societies
Hoag Community Education Lecture, Newport Beach, CA – 1 presentation – 3/19
Patient Lecture: How to Read Your MRI, Laguna Woods, CA – 1 presentation – 3/25
Hoag Community Education Lecture, Newport Beach, CA – 1 presentation – 5/27
Hoag ACME Educational Symposium, Newport Beach, CA – 2 presentations – 6/21
Hoag Annual Endovascular Summit, Newport Beach, CA - 1 presentation – 8/2
Hoag Neuroscience Nursing Conference, Newport Beach, CA 1 presentation – 9/15
California Radiological Society – Newport Beach, CA – 3 presentations – 10/18
International Symposia
International Diagnostic Course in Davos, Switzerland – 10 presentations – 3/31-4/4
Radiological Society of North America, Chicago, IL - 3 presentations - 11/30-12/2
National Professional Societies
American Society of Neuroradiology 46th Annual Meeting, Chicago, IL – 2 presentations – 6/1-4
American College of Radiology Group Practice Leaders' Meeting – Marina del Rey, CA – 1 presentation – 11/2

2009

Postgraduate Courses
Los Angeles Radiologic Society (LARS), Universal City, CA – 3 presentations – 1/24
26th Annual MRI: National Symposium, Las Vegas, NV – 4 presentations – 3/30
Advances in MR & Breast Imaging 2009, Dana Point, CA – 4 presentations – 11/5-6
MRI of the Brain 2009, Austell, GA – 5 presentations – 11/7-8
National Professional Societies
American Society of Neuroradiology 47th Annual Meeting, Vancouver, BC, Canada – 1 presentation – 5/19
American College of Radiology Practice Leaders Meeting, Chicago, IL – 1 presentation – 10/11
ACR-Radiology Business Management Association – Reston, VA – 1 presentation – 11/14
Regional Professional Societies
Patient Lecture: How to Read Your MRI, Laguna Woods, CA – 1 presentation – 5/28
Kaiser Permanente Annual Radiology Symposium, Universal City, CA – 2 presentations - 5/30
Hoag Annual Endovascular Summit, Newport Beach, CA - 1 presentation – 8/7
International Symposia

ISMRM Weekend Case-Based Clinical Educational Course – Los Angeles, CA – 1 presentation 9/13
Radiological Society of North America, Chicago, IL - 4 presentations - 11/29-12/3

2010

Regional Professional Societies

Hoag Neurosciences Symposium, Newport Beach, CA – 1 presentation – 1/16

Lakeview Senior Center Presentation – 4/5

CA Radiological Society Annual Meeting – San Francisco, CA – 1 presentation – 10/2

UCSF Annual Newton Lecture & Grand Rounds – San Francisco, CA – 2 presentations – 10/13

National Professional Societies

American Heart Association Get With the Guidelines Heart & Stroke Workshop, Newport Beach, CA
1 presentation – 1/29

American Society of Neuroradiology 48th Annual Meeting, Boston, MA – 1 presentation – 5/16

Postgraduate Courses

Multislice CT in Clinical Practice, Vail, CO – 4 presentations – 2/8-12

5th Annual Economics Summit: Strategies for Successful Radiology Practices in the 21st Century,
Las Vegas, NV – 3 presentations – 4/16-17

Masters Diagnostic Radiology Symposium, Battery Park, NY – 5 presentations – 4/22-25

Neuroradiology in Clinical Practice, Las Vegas, NV – 4 presentations – 9/24-25

Annual Economics of Diagnostic Imaging – Arlington, VA – 3 presentations – 10/30-31

International Symposia

European Congress of Radiology Wilhelm Conrad Rontgen Honorary Lecture, Vienna, Austria – 1
presentation – 3/5

XIX Symposium Neuroradiologicum – Bologna, Italy – 2 presentations – 10/7-8

Radiological Society of North America, Chicago, IL - 3 presentations - 11/28-12/2

2011

Regional Professional Societies

Hoag Grand Rounds, Newport Beach, CA – 1 presentation – 1/21

Hoag Neurosciences Symposium, Newport Beach, CA – 1 presentation – 3/12

Colorado Radiological Society Leadership Summit, Aurora, CO – 1 presentation – 9/9

Western Neuroradiological Society, Rancho Mirage, CA – 2 presentations – 10/21

Hoag Neuroscience Nursing Conference, Newport Beach, CA 1 presentation – 11/17

International Symposia

ISMRM Weekend Case-Based Clinical Educational Course – Los Angeles, CA – 1 presentation 3/27

15th Annual Advanced MRI Meeting, Graz, Austria – 7 presentations – 5/4-7

Radiological Society of North America, Chicago, IL - 5 presentations - 11/27-12/1

Postgraduate Courses

6th Annual Economics Summit: Strategies for Successful Radiology Practices in the 21st Century,
Las Vegas, NV – 3 presentations – 4/8-9

Masters Diagnostic Radiology Symposium, Battery Park, NY – 5 presentations – 5/19-22

UCSD 36th Annual Postgraduate Radiology Course, Coronado, CA – 7 presentations – 10/26-27

Annual Economics of Diagnostic Imaging – Arlington, VA – 3 presentations – 10/29-30

National Professional Societies

American College of Radiology Intersociety Summer Conference, Sundance, UT

1 presentation – 8/12

ACR-Radiology Business Management Association – Las Vegas – 2 presentations – 10/14

2012

National Professional Societies

ACR Practice Leaders' Meeting – Dallas, Texas – 1 presentation – 1/21

American Heart Association ABC 25th Annual Dr. Walter M Booker, Sr. Memorial Symposium
– 1 presentation – 11/3

Regional Professional Societies

Orange County Radiological Society – Newport Beach, CA - 2 presentations – 3/3

Hoag Neurosciences Symposium, Newport Beach, CA – 2 presentations – 3/10

Speak Up Newport – Newport Beach, CA – 1 presentation 4/11

SoCAL ARIN Conference – Newport Beach, CA – 1 presentation 5/5

Corona del Mar Chamber of Commerce – Corona del Mar, CA 1 presentation – 5/15

Hoag Neurosciences Nursing Conference, Newport Beach, CA – 1 presentation – 11/9

Mindstream Developing and Sustaining a Neuroscience Center of Excellence, Newport Beach, CA
- 1 presentation - 12/6

International Symposia

International Diagnostic Course in Davos, Switzerland – 10 presentations – 3/26-30

Radiological Society of North America, Chicago, IL – 3 presentations - 11/25-28

Postgraduate Courses

29th Annual MRI: National Symposium, Las Vegas, NV – 4 presentations – 5/21

Masters Diagnostic Radiology Symposium, New Orleans, LA – 5 presentations – 5/31-6/3

UCSD 37th Annual Postgraduate Radiology Course, Coronado, CA – 5 presentations – 10/24

Neuroradiology in Clinical Practice, Las Vegas, NV – 3 presentations – 11/2

Stoller Workshop for Orthopedic Imaging, Laguna Beach, CA – 1 presentation – 12/15

2013 Postgraduate Courses
 Masters Diagnostic Radiology Symposium, New Orleans, LA – 4 presentations – 4/4-7
National Professional Societies
 ACR AMCLC Categorical Course – Washington, DC – 1 presentation – 5/4
 PNWRS/WSRS 2013 Advanced Imaging and Problem Solving – Seattle, WA – 2 presentations – 6/2
Regional Professional Societies
 CA Radiological Society-RLI Annual Leadership Meeting – Newport Beach, CA - 2 presentations
 9/21-22
 UCI Osher Lifelong Learning Institute – Newport Beach, CA – 1 presentation – 10/19
 UCSD 38th Annual Postgraduate Radiology Course, Coronado, CA – 5 presentations – 10/30
International Symposia
 Radiological Society of North America, Chicago, IL – 2 presentations – 12/1-5

2014 Postgraduate Courses
 Multi-slice CT in Clinical Practice, Snowmass, CO – 4 presentations – 2/24-25
 Practical Radiology at Whistler, Whistler, Canada – 4 presentations – 3/6-7
 Radiology 2014: Shifting the Paradigm, Las Vegas, NV – 4 presentations – 4/10-12
Regional Professional Societies
 Hoag Neurosciences Symposium, Newport Beach, CA – 1 presentations – 3/29
National Professional Societies
 American Society of Neuroradiology 49th Annual Meeting, Boston, MA – 1 presentation – 5/19
 ACR Forum – Reston, VA – 1 presentation – 5/31

POSTDOCTORAL FELLOWS SUPERVISED

1980 - 1983 (CT-Ultrasound)	Leonora Fung, Margaret Simmons, Cliff Stamler, Geoffrey Chung, & John Rego
1980 - 6/83	Co-director of visiting fellowship in CT scanning at San Francisco General Hospital. Lectures and seminars with fellows (5 hours/week).
1983 - 1984	Steve Ostrov, William Kelly, Paul Badami, Murray Solomon, Lanning Houston, Gary Stimac William Dillon, Jeremy McCreary, & David Haas
1984 - 1985	David Haas, Betsy Holland, Paul Harper, Keith McMurdo, Scott Rosenbloom, Walter Kucharczyk, Luis Lemme-Plaghos, & Isabelle Berry
1985 - 1986	Wallace Peck, Walter Olsen, Keith McMurdo, & Isabelle Berry
6/83 - 6/86	Co-director of visiting Fellowship in Neuroradiology at Moffitt-Long Hospitals. Lectures and seminars with fellows.
6/85 - 6/86	Co-Director of visiting Fellowship in Neuro Magnetic Resonance Imaging/UCSF.
1992-1993	Maureen Jensen
1993-1994	Andrew Kelly
1995-1996	Robin Kates

RESEARCH/GRANTS AND CREATIVE ACTIVITY

RESEARCH PROJECTS (Brief outline)

Funded

2013 - 2016	UniHealth Foundation Grant: \$449,460 Orange County Vital Aging Program: Closing the Gap in Healthcare Need for Maintaining Cognitive Health
2012	Penumbra CLP 4853.A: A randomized, concurrent controlled trial to assess the safety and effectiveness of the Separator 3D as a component of the Penumbra System in the revascularization of large vessel occlusion in acute ischemic stroke. Sub-Investigator, Michael Brant-Zawadzki, MD
2011	Penumbra, Inc: ACE "An <u>A</u> neurysm <u>C</u> oiling <u>E</u> fficiency Study of the Penumbra Coil 400 System". Principal Investigator, Michael Brant-Zawadzki, MD

Bayer GEM-SAV 14607: Gadobutrol-enhanced MRA study of the supra-aortic vessels (GEMSAV) A Multicenter, open-label study to evaluate the safety and efficacy (by blinded reading) of contrast-enhanced magnetic resonance angiography (MRA) after a single intravenous injection of 0.1 mmol/kg gadobutrol in subjects with known or suspected vascular disease of the supra-aortic vessels. Principal Investigator, Michael Brant-Zawadzki, MD

2010 - 2013

UniHealth Foundation Grant: \$772,500
Orange County Vital Aging Program

Bayer GEMMA1 91743: An open-label, multicenter, phase 3 study with corresponding blinded image reading to determine the efficacy and safety of a single intravenous injection of 0.1mmol/kg body weight of gadobutrol 1.0 molar (Gadovist®) in patients with newly diagnosed breast cancer referred for contrast-enhanced breast MRI. Principal Investigator, Michael Brant-Zawadzki, MD

AMAG FER-PAD-001: A Phase II, Open Label, Randomized Multicenter Trial Comparing Noncontrast MRA versus Ferumoxylol Vascular-Enhanced MRI (VE-MRI) for the Detection of Clinically Significant Stenosis or Occlusion of the Aortoiliac and Superficial Femoral Arteries in Subjects with Peripheral Arterial Disease Scheduled for Digital Subtraction Angiography (DSA). Principal Investigator, Michael Brant-Zawadzki, MD

2009

Penumbra, Inc The START Trial (CLP 2480.C): Clinical Outcome in Acute Stroke Treatment after Imaging Guided Patient Selection for Interventional Revascularization Therapy.
Michael Brant-Zawadzki, MD Principal Investigator
Hoag Memorial Hospital Presbyterian, Newport Beach

Interventional Management of Stroke (IMS III): A Phase 3, Randomized, Multi-Center, Open Label, 900 Subject Clinical Trial that will examine whether a combined intravenous (IV) and intra-arterial (IA) approach to recanalization is superior to standard IV rt-PA (Activase®) alone when initiated within three hours of acute ischemic stroke onset. 2009
David Brown, MD Principal Investigator
Michael Brant-Zawadzki, MD Sub-Investigator
Hoag Memorial Hospital Presbyterian, Newport Beach

2008

Siemens FLT101, "A Phase II/III, Open Label, Non-Randomized, Multi - Center Study Of Positron Emission Tomography (PET) Imaging with [F-18]FLT Compared to [F-18] FDG in Cancer Patients for Treatment Evaluation"
Michael Brant-Zawadzki, Principal Investigator
Hoag Memorial Hospital Presbyterian, Newport Beach

Penumbra Imaging Collaborative Study (PICS): A Multicenter Trial to Assess Outcome of Patients Revascularized by the Penumbra System™
Michael Brant-Zawadzki, Principal Investigator
Hoag Memorial Hospital Presbyterian, Newport Beach

CPDS-0701: A PHASE II, MULTICENTER, OPEN-LABEL, IMAGING STUDY INVESTIGATING THE EFFICACY AND SAFETY OF THREE DOSING REGIMENS OF XERECEPT® (CORTICORELIN ACETATE INJECTION): HUMAN CORTICOTROPIN RELEASING FACTOR (hCRF) FOR THE REDUCTION OF PERITUMORAL BRAIN EDEMA (PBE) IN PATIENTS WITH PRIMARY MALIGNANT OR METASTATIC BRAIN TUMORS HUMAN CORTICOTROPIN-RELEASING FACTOR (HCRF).
Christopher Duma, Principal Investigator
Michael Brant-Zawadzki, Sub-Investigator
Hoag Memorial Hospital Presbyterian, Newport Beach

A multicenter, randomized, double-blind, crossover, phase 3 study to determine the safety and efficacy of gadobutrol 1.0 molar (Gadovist®) in patients referred for contrast-enhanced MRI of the central nervous system (CNS).
Michael Brant-Zawadzki, Principal Investigator
Hoag Memorial Hospital Presbyterian, Newport Beach

2002

Beckman Foundation Grant: \$2.5 million
MR Directed Biopsy and In-situ RF Treatment of Breast Tumors
Michael Brant-Zawadzki, Principal Investigator

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- 2000 Autism: A Model of Anomalous Neural Systems Development
Michael Brant-Zawadzki, Co-investigator 2000
Pauline Filipek, Principal Investigator
University of California, Irvine
NIH Grant #HD35458 (\$96,000)
- A Multi-national, Multi-center, Double-blind, Placebo Controlled Study to Evaluate the Efficacy, Tolerability and Safety of Glatiramer Acetate for Injection in Primary Multiple Sclerosis Patients
Michael Brant-Zawadzki, Co-investigator
Gaby Thai, Principal Investigator
University of California, Irvine
NIH Grant #27998
- Novartis Exelon Protocol CENA 713 1A07
Duke University
Michael Brant-Zawadzki, Co-investigator
- 1996-97 The Prospective Multicenter Dose-Ranging Study of Intra-Arterial Thrombolysis in Acute Middle Cerebral Artery Distribution Thromboembolic Stroke
Michael Brant-Zawadzki, Co-investigator
Abbott Laboratories
- The Effects of 500 mg Citicoline on the Evolution of Lesion Volume in Human Stroke Using Diffusion Weighted Magnetic Resonance Imaging.
Michael Brant-Zawadzki, co-investigator
Interneuron Pharmaceuticals, Inc.
- 1992-1993 An Open Phase III Trial of Gadodiamide Injection (Gd-DTPA-3MA) in Contrast Enhanced Magnetic Resonance Angiography of the Head & Neck in Adults.
Michael Brant-Zawadzki, Co- Investigator
Sterling Winthrop Pharmaceuticals
- 1992-1993 An Open Phase III Trial of Gadodiamide Injection (Gd-DTPA-3MA) in Contrast Enhanced Magnetic Resonance Angiography of the Renal and Peripheral Vasculature in Adults.
Michael Brant-Zawadzki, Co- Investigator
Sterling Winthrop Pharmaceuticals
- 1992 Evaluation of High Dose ProHance in Neurological Pathology: Comparison of 0.1 mmol/kg Magnevist to 0.3 mmol/kg ProHance
Michael Brant-Zawadzki, Co-investigator
Squibb Diagnostics
- 1991 Evaluation of Safety and Usefulness of Gadodiamide (0.3 mmol/kg) vs Magnevist (0.1 mmol/kg), Phase III. Michael Brant-Zawadzki, Co-Investigator.
Sterling Research Group (\$137,500)
- 1990 Evaluation of a New Peripherally Positioned Port (Periport) in the Central Venous System for Vascular Access. Michael Brant-Zawadzki, Co-Principal Investigator. Infusaid, Inc., Norwood, MA.
- 1989-1990 Excimer Laser Angioplasty Systems for Treatment of Peripheral Vascular Disease, Phase II/III study. Co-Investigator, Advanced Interventional Systems, Inc.
- Coil Embolization for Neuroradiologic Indications Phase II/III, Co- Investigator, Target Therapeutics
- Coil Embolization for Non-Neuroradiologic Indications, Phase II/III, Co- Investigator, Target Therapeutics
- Multicenter Safety and Efficacy Evaluation of S-041 Injection - A contrast enhancing agent for use in conjunction with MRI of the central nervous system, Phase II/III, Co-Investigator, Salutar, Inc. (\$86,000)
- Embolization with Detachable Silicone Balloons Cerebral Applications, Phase II, Co-Investigator, Interventional Therapeutics Corporation
- Balloon Dilatation of Cerebral Vasospasm, Phase II, Co- Interventional Therapeutics Corporation

Clinical Investigation of ProHance in Patients Suspected of Having Neurological Pathology, Phase III, Co-Investigator. Squibb Diagnostics

(Phase 2) Radiofrequency Hot-Tip wire for peripheral vascular disease, Co-Investigator. Advanced Interventional Systems, Inc

- 1988 - 1989 Open Label Gadolinium DTPA/dimeglumine Protocol 202-13: MRI Enhancement Agent Human Compassionate Use for Brain Lesions and Spinal Cord Tumors. Michael Brant-Zawadzki, Co- Investigator Berlex Laboratories. (\$5000)
- 1987 - 1989 "Chemoembolization of Hepatic Tumors with Angiostat (Collagen Cross-linked) and Cis-Platinum - a Clinical Trial". Target Therapeutics.
"Embolization of Brain Tumors and AVM's with Angiostat - a Clinical Trial". Michael Brant-Zawadzki - Co-Principal Investigator Target Therapeutics.
- 1985 - 1987 "Deep White Matter Lesions: Imaging and Cognitive Studies in the Aged". ROI NIH Grant. Michael Brant-Zawadzki - Co-investigator; 15% time and salary
Fein, G., Van Dyke, C. - Principal Investigators;
submitted July 1985. (\$1,292,510)
Correlation of MR, CT, PET imaging of the aging brain with intellectual measurement.
- 1986 - 1987 "Effects of Calcium Channel Blockers on Cerebral Ischemia: An MRI/MRS Study"
Michael Brant-Zawadzki, Principal Investigator
Syntex Laboratories (\$20,000)
- 1985 - 1986 "Multicenter Study of Gadolinium DTPA as an MRI Contrast Agent"
Michael Brant-Zawadzki, Co- Investigator
Berlex Laboratories (\$100,000.)
- 1985 - 1987 "NMR Metabolic Studies of Regional Brain Ischemia"
Michael Brant-Zawadzki, Co-investigator
P. Weinstein, Principal Investigator
NIH Grant #ROI NS22022-01 (Approx. \$360,000.)
- 1984 - 1986 "NMR Imaging and Spectroscopy in Experimental Edema
Michael Brant-Zawadzki - Co-investigator 15% Time;
Bartkowski, H. - Principal Investigator
NIH Grant #ROI NS20368-01 (\$289,621.)
- 1983 - 1986 "Nitroxide Free-Radical Contrast - Media for NMR Imaging
Michael Brant-Zawadzki - Co-investigator 20% Time;
Brasch, R.C. - Principal Investigator -
NIH Grant #-ROI-AM31937-02 (\$546,000.)
- 1983 - 1984 "NMR and Subsecond CT Monitoring of Tissue Changes and Regional Blood Flow in Cats with Temporary MCA Occlusion"
Michael Brant-Zawadzki - Principal Investigator:
Academic Senate - UCSF Grant 2 - 505164-19900-3
(\$8,969.)
- 1982 -1983 "Brain Edema" Michael Brant-Zawadzki - Co-investigator; Pitts, L. - Principal Investigator
NIH Grant: Clinical Research Center
2-P50-NS14543-045
(Subsection - Brain Edema: Clinical Studies).

Non-funded

Cordis Neurovascular, Inc. Cordis ENTERPRISE Vascular Reconstruction Device and Delivery System. HDE H060001, Principal Investigator 2007

Boston Scientific "Wingspan Stent System and Gateway PTA Balloon Catheter, A Humanitarian Use Device" HDE H050001, Principal Investigator 2006

Boston Scientific "Neuroform™ Microdelivery Stent System, A Humanitarian Use Device" HDE H020002, Principal Investigator 2003

Research and Development of Digital Angiography: Prototype Equipment

Research and Development of NMR imaging and spectroscopy of the central nervous system, acute cerebral ischemia.

Clinical trials of experimental contrast agents for arteriography, myelography, NMR.

Research and Development of Coronary and Cerebrovascular CT Angiography Using Multi-detector CT

PUBLICATIONS

Books

- Federle MP and Brant-Zawadzki MN: Computed Tomography in the Evaluation of Trauma. Baltimore, Williams & Wilkins, 1982; 2nd edition, 1986.
- Moseley M, Berry I, Chew W, Brant-Zawadzki M, James T: Magnetic resonance spectroscopy: Principles and potential applications. Magnetic Resonance in the Central Nervous System, edited by M Brant-Zawadzki, New York, Raven Press, 1987.
- Brant-Zawadzki M: MRI principles: The bare necessities. Magnetic Resonance in the Central Nervous System, edited by M Brant-Zawadzki, New York, Raven Press, 1987.
- Brant-Zawadzki MN and Norman D: Magnetic Resonance Imaging of the Central Nervous System. New York, Raven Press, 1987.
- Lufkin RB, Bradley WG, Brant-Zawadzki, MN - Series Editors. The Raven MRI Teaching File; 10 Volume Series. New York, Raven Press, 1991
- Bradley WG and Brant-Zawadzki MN: MRI of the Brain I. Non-Neoplastic Disease. The Raven MRI Teaching File, Series Editor - Lufkin RB, Bradley WG, Brant-Zawadzki, MN. New York, Raven Press, 1991.
- Brant-Zawadzki MN and Bradley WG: MRI of the Brain II. Non-Neoplastic Disease. The Raven MRI Teaching File, Series Editor - Lufkin RB, Bradley WG, Brant-Zawadzki MN. New York, Raven Press, 1991.
- Bradley WG, Brant-Zawadzki M, Hasso A, Herkens R, Lee JKT, Modic M, Murphy W, Stark D. Magnetic Resonance Test and Syllabus. American College of Radiology. Editor - BA Siegel, 1991.
- Brant-Zawadzki MN, Boyko O, Jensen MC, Gillan G. MRA of the Head and Neck. The Raven Press Teaching File. Raven Press 1993.
- Jeffrey RB, Ralls PW, Leung AN, Brant-Zawadzki M. Emergency Imaging. Lippincott, Williams & Wilkins 1999.
- Lufkin RB, Bradley WG, Brant-Zawadzki MN-Series Editors. MRI of the Spine.
- The Lippincott Williams & Wilkins MRI Teaching File Series. Lippincott Williams & Wilkins, Philadelphia, PA 2000.
- Bradley WG, Brant-Zawadzki M, Cambray-Forker J: MRI of the Brain. The Lippincott Williams & Wilkins MRI Teaching File Series, Series Editors- Lufkin RB, Bradley WG, Brant-Zawadzki M. Lippincott Williams & Wilkins, Philadelphia, PA. 2000.
- Brant-Zawadzki M, Bradley WG, Cambray-Forker J: MRI of the Brain II. The Lippincott Williams & Wilkins MRI Teaching File Series, Series Editors-Lufkin RB, Bradley WG, Brant-Zawadzki M. Lippincott Williams & Wilkins, Philadelphia, PA 2000.
- Brant-Zawadzki M, Chen MZ, Moore KR, Salzman KL, Osborn AG: Spine 100 Top Diagnoses. Pocket Radiologist Series, WB Saunders Company 2002
- Brant-Zawadzki M, Philpotts L: Screening. Radiologic Clinics of North America July 2004: Vol 42;4
- Ross JS, Brant-Zawadzki M, Moore KR, Crim J, Chen MZ, Katzman GL: Diagnostic Imaging Spine. Amirsys 2004

PUBLICATIONS:

Publications (Chapters, Invited Articles, etc.) outside of referred peer-review journals

1978

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1981

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Community Context of Sober Living Houses

Douglas L. Polcin, Ed.D., Diane Henderson, B.A., Karen Trocki, Ph.D., Kristy Evans, B.A., and Fried Wittman, Ph.D.

Alcohol Research Group, Public Health Institute, 6475 Christie Avenue, Suite 400, Emeryville, CA 94608-1010, Phone (510) 597-3440, Fax (510) 985-6459

Douglas L. Polcin: DPolcin@arg.org

Abstract

The success or failure of programs designed to address alcohol and drug problems can be profoundly influenced by the communities where they are located. Support from the community is vital for long term stability and conflict with the community can harm a program's reputation or even result in closure. This study examined the community context of sober living houses (SLHs) in one Northern California community by interviewing key stakeholder groups. SLHs are alcohol and drug free living environments for individuals attempting to abstain from substance use. Previous research on residents of SLHs showed they make long-term improvements on measures of substance use, psychiatric symptoms, arrests, and employment. Interviews were completed with house managers, neighbors, and key informants from local government and community organizations. Overall, stakeholders felt SLHs were necessary and had a positive impact on the community. It was emphasized that SLHs needed to practice a "good neighbor" policy that prohibited substance use and encouraged community service. Size and density of SLHs appeared to influence neighbor perceptions. For small (six residents or less), sparsely populated houses, a strategy of blending in with the neighborhood seemed to work. However, it was clear that larger, densely populated houses need to actively manage relationships with community stakeholders. Strategies for improving relationships with immediate neighbors, decreasing stigma, and broadening the leadership structure are discussed. Implications for a broad array of community based programs are discussed.

Keywords

Sober Living Houses; Residential Treatment; Environmental Influences; Neighborhood; NIMBY

The premise of this paper is that it is insufficient to study the effectiveness of community based services without examining characteristics of the community context in which those services are delivered. How services are perceived by key stakeholder groups will affect whether they are implemented, the level of support they receive, and the types of barriers they encounter (Guydish, et al., 2007; Jason, et al., 2005; Polcin, 2006). As an example, we describe a study of the community context of Sober Living Houses (SLHs), which are alcohol- and drug-free living environments for individuals attempting to achieve sustained abstinence. The study compliments previous research showing that SLH residents make improvements in a variety of areas, including reductions in substance use, arrests, psychiatric severity and unemployment (Polcin et al., 2010). The community context of SLHs is assessed by conducting qualitative interviews with stakeholders, including managers of the houses, neighbors, and local key informants in one Northern California

County. A typology of factors supporting and hindering operations and expansion of SLHs in the community is provided.

Alcohol-and drug-free housing

Few problems in the treatment of addictive disorders have been more challenging than helping clients find long-term, alcohol- and drug-free living environments that support sustained recovery. The progress that clients make in residential treatment programs is often jeopardized by the lack of appropriate housing options when they leave (Braucht, et al., 1995). For clients attending aftercare or outpatient treatment, progress is often jeopardized by their return to destructive living environments at the end of the treatment day (Hitchcock, et al., 1995). These are often the same environments that originally contributed to their addiction. Finding affordable housing has also become more difficult because of tight housing markets in urban areas and the rise in unemployment.

One approach to the need for alcohol- and drug-free living environments has been to refer individuals to residential treatment programs. However, as funding for residential services has decreased over the years it has become an option for very few. Even when clients are admitted to residential services, the length of treatment is typically short, often only a few weeks. Although some programs have developed “half-way” or “step-down” living facilities, these too have maximum lengths of time after which residents must leave regardless of their readiness. Cost is an additional issue for halfway houses because frequently public and private funders are unwilling to pay for services that are not medically oriented. In addition, halfway houses tend to be available only to individuals who have completed rigorous inpatient treatment, which diminishes the potential pool of individuals who might make use of them.

Sober living houses

Polcin et al (2010) suggested sober living houses (SLHs) were an underutilized housing option for a variety of individuals with addictive disorders, including those completing residential treatment, attending outpatient treatment, being released from criminal justice incarceration, and seeking non-treatment alternatives to recovery. SLHs offer an alternative alcohol- and drug-abstinent living environment for individuals attempting to establish or maintain sobriety (Wittman, 1993, 2009). Residents are free to come and go during the day and are not locked into a group schedule, as is typical in most treatment programs. This allows residents to pursue activities vital to recovery such as finding work or attending school. Residents in most SLHs are afforded social support through shared meals, socialization with recovering peers, house meetings, and access to a house manager. To help residents maintain abstinence, SLH's use a peer oriented, mutual-help model of recovery that emphasizes social model recovery principles (Polcin & Borkman, 2008). As such, they emphasize learning about addiction through personal recovery experience and drawing on one's own recovery as a way to help others.

Although management of SLHs varies, some include a residents' council as a way to empower residents in operation of the facility. While SLHs offer no formal counseling or case management, they do either mandate or strongly encourage attendance at self-help groups such as Alcoholics Anonymous or Narcotics Anonymous. Costs of living at the facility are primarily covered by resident fees. Although some residents are able to draw upon entitlement programs or financial help from their families, most must find work to meet house rent and fees. Because SLHs are typically not part of formal treatment systems, they are available to a broad range of individuals provided they follow basic house rules, such as maintaining abstinence from substances, paying rent and fees, attending house meetings and participating in upkeep of the facility.

SLHs are similar to Oxford Houses for recovery, which are widely known in the U.S. and developing in other countries as well (Jason, et al., 2005). Similarities between the two housing models include prohibition of alcohol and drug use, social support for sobriety, encouragement or a requirement to attend 12-step meetings and work a program of recovery, and no limit on how long residents can live in the house. The main difference is that Oxford houses have more regulations for structure, size, density and management of the houses. Similar to our outcome studies of SLHs, which are described below, research on Oxford houses has documented significant improvement of resident functioning over time. For a more complete description of similarities and differences between the two housing models see Polcin and Borkman (2010).

Jason and colleagues (2005) studied neighbor perceptions of Oxford Houses and found very favorable views. However, they did not study other key stakeholders in the community, such as local government officials and criminal justice staff. They also did not aim to understand the impact of regulatory policies on the houses or what various stakeholders felt would improve relationships. Finally, the study was limited to Oxford houses and might not generalize to other types of recovery houses, including SLHs.

Purpose

The purpose of this study was to provide data that depicted the community context where SLHs operate. We wished to understand views about SLHs among key stakeholder groups and ways they support and hinder SLHs. To achieve our aim, we conducted qualitative interviews with key stakeholders in the same geographic area where we conducted a quantitative program evaluation of SLHs, Sacramento County (i.e., Polcin, et al., 2010). We wanted to assess areas where stakeholder groups were in agreement about SLHs as well as areas where they disagreed. The ultimate goal was to create a typology of factors supporting and hindering SLHs within as well as across stakeholder groups.

METHODS

Sample

To assess the community context of SLHs we conducted 43 in-depth qualitative interviews with 1) neighbors of SLHs (N=20); 2) SLH managers (N=17), which included the owner of the houses and the coordinator, and 3) key informants (N=6). Key informants included representatives from the criminal justice system, local government, housing services, and drug and alcohol treatment. The overall sample consisted of 18 women (43%), 3 from the SLH manager group, 4 key informants and 11 neighbors. Eighty six percent of the sample was white and ages ranged from 19 to 70. See Table 1 for a list of characteristics by stakeholder group.

Data collection site

Clean and Sober Transitional Living (CSTL) in Fair Oaks, California was one of our data collection sites for our earlier quantitative study (Polcin et al., 2010). Because the current study was designed to complement our previous work, we interviewed house managers at CSTL and neighbors who resided near one of the 16 CSTL houses. Key informants were recruited from Sacramento County, the county in California where CSTL is located.

CSTL is slightly more structured than some SLHs because the houses are divided into six phase I and ten phase II houses. Phase I houses are adjacent to each other and operate as one unit, which includes shared dining and meeting spaces. These houses are located on a frontage road next to a busy commercial street (i.e., not imbedded within a larger residential area). The close proximity provides residents a sense of community that facilitates their

commitment to the program. Although much less restrictive than residential treatment programs, there is some degree of external control and structure. Phase I residents have a curfew, must sign in and out when they leave and must have five 12-step meetings per week signed by the meeting chairperson. A minimum of 30 days in a phase I house is required before transitioning to phase II. The stability developed in phase I helps residents to be more successful in phase II, which includes increased freedom and autonomy. Phase II houses are conventional single-family homes and are dispersed in residential neighborhoods rather than part of a single complex.

Although CSTL houses are owned by one individual, there are a number of ways that residents are involved in management and operations. There is a “resident congress” that develops rules for the community, a “judicial committee” committee comprised of residents who enforce rules, and senior peers who monitor the behaviors of residents and bring rule violations to the attention of the judicial committee. In addition, each house also has one designated house manager and residents have an opportunity for input into the operation of CSTL through this person.

CSLT tests for drugs and alcohol at random and may conduct a test at any time if substance use is suspected. A positive test is grounds for dismissal from the house. However, a resident with a positive urine screen may appeal to the judicial committee for reinstatement. Other dischargeable offenses include drug use on the property, acts of violence, and sexual misconduct with other residents. For a more complete description of CSTL see the Polcin and Henderson (2008).

Our quantitative research on 250 CSTL residents who were tracked over an 18-month period showed significant improvement in multiple areas of functioning, including alcohol and drug use, employment, arrests, and psychiatric symptoms (Polcin et al., 2010). Importantly, residents were able to maintain improvements even after they left the SLHs. By 18 months nearly all had left, yet improvements were for the most part maintained. Although individuals with a wide variety of demographic characteristics showed improvement, those who benefited the most were those who were most involved in 12-step groups such as Alcoholics Anonymous and those who had social networks with few or no heavy substance users.

Procedures

All participants taking part in qualitative interviews were contacted by a research interviewer and asked if they were willing to participate. They were informed about the overall purpose of the study and if they agreed to participate they signed an informed consent document. Interviews lasted about one hour and participants were offered \$20 for their time. All study procedures were approved by the Public Health Institute Institutional Review Board in Oakland, California.

Content of the interviews

The overall goal of the qualitative interviews for all three stakeholder groups (i.e., house managers, neighbors and key informants) was to identify areas of strength and weakness for SLHs as well as barriers to expansion. Therefore, there was considerable overlap in the questions asked of the three groups. Examples of questions asked of all three groups included:

What are the strengths of SLHs? What are the weaknesses? What type of impact have SLHs had on the surrounding neighborhood/community? What are the key barriers to operating and expanding SLHs? How might SLHs be improved?

Because the three groups had different relationships with SLH facilities, there were also some differences in content of interviews. For example, house managers were asked:

What types of individual do well in SLHs? What types of individuals need a different environment? How often are residents asked to leave because they cannot pay rent and fees? How do you think management of the houses affects residents' experiences and outcomes? Are there specific local government policies that impact SLHs, such as housing, zoning or health policies? Describe some of the resistance, if any, that was encountered when this house first opened. How were the resistances over come? What actions were not effective? Describe how complaints or concerns from neighbors are handled.

There were also questions that were specific to neighbors. Interviews with neighbors began by asking them whether they knew about SLHs in the neighborhood and when they first became aware of them. If they had no knowledge about SLHs the interviews was terminated. If they were aware of SLHs in the neighborhood they were asked:

How would you describe them as neighbors? Have you or other neighbors had complaints? Describe any interactions that you have had with SLHs in your neighborhood. Describe any specific ways that you think SLHs impact alcohol and drug problems in your community. What do you think of SLHs compared with other approaches to addiction, such as formal treatment programs or criminal justice consequences?

In addition to general questions asked of all the participants, key informant interviews contained questions designed to elicit information about policies and local laws that might impact SLHs. We queried these officials about their own views about SLHs, the roles SLHs might play in the larger addiction recovery system, and ways they think public policy could be modified to provide more support to SLHs. Examples of questions included:

What role does housing play for individuals attempting to establish sustained recovery? What is your sense of how well housing needs for individual with alcohol or drug problems are being addressed in your community? How would you describe your department's relationship with SLHs? Describe how SLHs support and hinder the mission of your department. How do local politics affect SLHs in your area?

Analytic plan

A triangulation design (Creswell & Plano-Clark, 2007) was created by drawing on data from the three different stakeholder groups (SLH managers, key informants and neighbors). A preliminary coding list was developed prior to the analysis of the interviews. These codes were based on key research interests, such as factors supporting and hindering SLHs. To analyze the qualitative interviews, we transcribed all sessions and entered text into a qualitative data management program, NVivo, for coding and analysis (Bazeley & Richards 2000; Richards 2002). Team members then coded transcripts independently and met to check coding accuracy and improve coding validity (Carey, Morgan, & Oxtoby, 1996).

RESULTS

The final coding scheme reflecting themes across all three stakeholder groups included codes depicting drug and alcohol problems in the local community, strengths and weaknesses of SLHs, barriers to operation and expansion, perceived impact of SLHs on the surrounding community, views about SLHs in comparison to other approaches to alcohol and drug problems (e.g., more intensive treatment and incarceration), and suggestions for improving SLHs. Some additional codes were applicable to some stakeholder groups but not

others. For example, codes for neighbors included knowledge about SLHs and interactions with SLHs near them. SLH manager interviews yielded codes depicting views about characteristics of good candidates for SLHs, the extent to which cost functioned as a barrier, the perceived impact of zoning laws and other local policies, SLH relationships with various professionals and local government, and past conflicts with neighbors and how those conflicts were resolved. Codes that were relevant to key informants included ways SLHs support goals of their departments and perceived impact of policies on SLHs.

Knowledge about SLHs

SLH managers provided extensive comments explaining how SLHs work to promote recovery. Typical was this description from a phase I manager.

...I believe that it [SLHs] definitely plays a substantial role in that it – I would say the biggest role it plays is it offers relief from isolation and that it can make people aware... That one doesn't have to worry about bills or that everything is inclusive is a very significant role as well.

However, managers were only vaguely aware of problems and challenges the houses faced in relation to the larger community. They noted these issues were handled by the owner of CSTL. Managers offered little information in response to questions addressing the larger context of SLHs, such as the types of relationships CSTL has with local and state government, the effects of regulatory mechanisms (e.g., zoning laws), and how issues such as NIMBY (not in my back yard) were addressed at the community level.

Key informants varied in their perceptions about how much they knew about SLH. Those who felt most familiar with SLHs in general and CSTL specifically were those who worked most closely addressing alcohol and drug problems. Surprisingly, the representative from housing services had very little information about SLHs. When asked how familiar she/he was with SLHs the reply was, "not very." Although other key informants felt they had some general knowledge about SLHs, it was nonetheless limited. For example, one key informant stated, "I don't know that we spend a lot of time hanging out at programs to see what's going on."

Many of the neighbors also had a limited understanding of SLHs. In some cases they had no idea a SLH existed in the neighborhood; it seemed to them like any other house. For those who were aware that there was a SLH in their neighborhood there was often a fairly vague notion of the population served and how the program operated. Without information, some neighbors expressed fears that the residents were mostly parolees or that they included sex offenders. They did not seem to be aware that a minority (about 25%) of CSTL residents was referred from the criminal justice system (i.e., jail or prison) and CSTL does not accept individuals convicted of sex offenses.

Who succeeds and who fails

Many of the respondents, and especially house managers, had very strong ideas about who would be a successful candidate within the sober living environment. Paradoxically, many house manager respondents said that a person had to 'hit bottom' to benefit, yet they also noted potentially successful candidates needed to have enough strength to check themselves into a recovery program and to have the motivation to "push through." Success was viewed as more likely for residents of the SLH who had accepted substance abuse as a disease, one that isn't going away on its own.

...[to be successful] they have had to accomplish what we refer to as the first step in the program of AA... that there's no denying of their alcoholism, that they're passed that point; that they're willing to accept that they're an alcoholic, that their

lives are unmanageable and they need to do something about it. I think that anybody who comes in these places too soon it's not going to work you.

It was suggested that people who were too young and unmotivated might fail. Such individuals were not as likely to have hit bottom, were often still supported (or 'enabled') by family members and just did not have the long history of failures to motivate them. Prospects for success or failure were also influenced by the right kind of financial support. Most respondents felt that people who paid for their housing themselves from their own earnings did the best as opposed to those who had a family member footing the bill.

... A lot of the kids around here, the parents just let 'em run amuck and they did whatever they want and now they're in trouble and they're goin' "Mommy help me" and when they screw it up they still get help from mommy. A lot of these kids around here have been through a lot of programs... They're just not ready.

On the other hand, many of the managers, all of whom were in recovery, said that they would never have made it unless the first few months had been paid for by a social agency, the criminal justice system, a family member or some other external form of support. Some felt that more people would be successful if the funds for maintaining themselves at the SLH were more easily available, especially for beginning recovery.

House managers also felt residents who are dual diagnosed with psychiatric disorders were more likely to have a low probability of success. It was felt that such individuals needed many more services than those provided for by the SLH and that some aspects of the housing situation might exacerbate these other problems (e.g. people with social phobia having to come in contact with many strangers on a daily basis or people with paranoia having to share space with other residents). In addition, it was felt that people with more severe mental disorders such as schizophrenia might need skilled personnel to monitor medications.

Well definitely those with dual diagnosis that we are not prepared to handle – and there are special cases I mean obviously if there is some illness that runs deeper than alcoholism there's no way they can get the help they need here, nor do they pretend that they can offer that sort of help. ..' And it's not like people here don't go see psychiatrists or therapists or whatever because I know there are more than one that do but just if the problems are running much deeper.

People who had been coerced into coming to the SLH were also thought to be unlikely to succeed in the long-term. If an individual had chosen treatment instead of prison or parole, or were forced by the courts, it was thought that they would be less likely to be successful. Such individuals often end up as 'fake it to make it' individuals who try to get by with the bare minimum of effort.

... they just want to be clean enough just to satisfy the court; once they've got that done they're on their merry way.

Strengths and weaknesses

Virtually all of the house managers and a majority of neighbors and key informants as well mentioned that the strengths of sober living houses are that they provide structure and support for a recovering substance abuser. The role models provided by the longer term residents, the social support and encouragement of staff and residents, the house rules and regulations and the availability of AA meetings all help to keep a person from relapsing. One of the house managers described the importance of social support for abstinence:

... a lot of people in their usual neighborhoods are family. Like it's not [a good area] for them to get clean 'cause they know a lot of people who they did drugs

with. So being like a place where you can live with other people trying to do the same thing and are all about the same thing is really supportive and it helps you stay positively influenced to stay clean and get your life together...

Another house manager emphasized the importance of a supportive community:

Community, everybody gettin' along, everybody helpin' each other. Everybody's always helpin' each other around here. If they see that you're down and out they'll ask you 'What's wrong?' or start the coffee or whatever and that's what it is people around here care about each other.

On the other hand, the factor of density was mentioned as an area of strength and as a weakness, sometimes by the same respondents. Density of the SLH was viewed as an area of strength for house residents because it allows a range of services to be on hand (including meals, meeting places, AA and other types of classes) as well as a wide range of role models and positive normative pressure. Yet, because there are separate houses, the residents do not have the feeling of being in an institution; with one exception, the houses are approximately family-sized and offer the opportunities to build skills, develop social relationships and offer a degree of privacy. However, there is one neighborhood where there are six adjacent houses together in one complex. Some neighbors experienced this high density arrangement as having a negative impact on the surrounding neighborhood.

Impact on SLH residents and the surrounding community

Participants across all three stakeholder groups generally felt SLHs had a positive impact on the residents who lived in them and the surrounding community. This was particularly evident when respondents considered the consequences of ignoring alcohol and drug problems or alternative approaches to dealing with them, such as criminal justice incarceration. House managers were particularly strong proponents of this view.

I think we've raised property value. There is no crime going on here. You've got seven houses here and the police don't get called. Cars aren't broken into, there's no burglary you know. I mean the level of integrity of the hundred people that live here is gonna be three times as high as the people living on the street...one over...

Key informants, especially those who worked closely with SLHs and drug treatment, also had positive views about the impact of SLHs. For example, one stated, "I would think that it's just more people that aren't out there drinking and using." Other key informant comments included:

if they work I think they have a great impact...They're good citizens, neighbors, don't create a nuisance within our community, and I think they have a great impact.

The more you can be in a home as opposed to an institution or shelter to me that is beneficial to not only the individual but it's actually probably beneficial to the community at large too...

...if there were a lot of calls for service out there I'd be hearing about it...then we know there are other things going on that we've gotta address but it's usually not been [the case] with CSTL.

A number of neighbors had family members or friends who had a history of addiction problems. Their concern about family and friends who had addiction problems appeared to influence their views about the impact of SLHs.

Well I don't think that incarcerating people rehabilitates them. You know it's like my daughter if she was in that situation where she could at least was trying to get herself cleaned up and can go to a home, I'd be all for that.

...my younger sister had a problem and so she's – so I know she's been in a couple in and out...It's rare you talk to anyone you know honestly that doesn't have a sister or brother, a parent, an uncle, you know what I mean..

...Yeah they need help you know we have a daughter that's a meth user and so I'm all for anything that will help... Yeah and we've been estranged from her for the last 20 years...

Although views about the impact of SLHs were generally favorable, concerns were raised about the potential for detrimental impact to residents and the surrounding community if the houses were not well managed. This was the view even among house managers. The owner of CSTL emphasized the importance of standards and integrity.

We have a class here called Sober Living Specialist and it's a 36-hour class that I put together.... What we're trying to do is create minimum standards and a high level of integrity. And it goes beyond just having a house, I mean you've got recovery integrity, you have fiscal integrity, you have community integrity you know. So we talk about ADA [Americans with Disabilities Act], we talk about FHA [Fair Housing Act]; we talk about structure and management; we talk about how to keep your books and pay taxes and be financially in integrity. We talk about confidentiality and do no harm and a code of ethics.

Phase I and phase II houses—Despite generally positive views about the impact of SLHs on surrounding communities, key informants and some phase I neighbors raised concerns about the impact when houses were too densely located in one neighborhood. One key informant commented:

Well, it changes the atmosphere; I think that when you walk through, you drive through and there's a group of adults sitting outside you often wonder what's that all about. Is it a halfway house, is it sober living? What's going on is it just about a big family and you know those sorts of things. So it makes you wonder about the neighborhood.

When we looked at the characteristics of the neighbors who had concerns it became clear that they lived in the vicinity of the six phase I houses that were densely located along a two block area in one complex. One neighbor stated, "I hate to say this, but I would say it's been negative. One would've been fine (laughs) but the whole block is too many for this small street." Some complaints of neighbors had to do with nuisance issues such as noise and parking.

...The only thing that gets people in the neighborhood kind of upset is if you have too many cars and sometimes if there's too many people there, if they have too many guests it'll get the neighbor across the street upset...

...I don't see them as strict enough...I mean they're lifting weights at all hours of the night, there is no – back there is no control of their language at all... every now and then obviously there are screaming and yelling matches and sometimes they are – they're just you know people have lost their cool.

... they [should] cut the size of it and not have so many people over there in so many houses and that they exercise control when they have these large groups and stuff over there. Because these groups have to be coming from more than just those houses because there's been times when I saw hundred or more people there and cars are parked not only up and down the entire street but over in the Safeway parking lot there's so many people there. And I just don't understand why they need that many people at one time.

A few phase I neighbors expressed fears about safety, the potential for an increase in crime, and declining values of houses in the neighborhood. However, when pressed by the interviewer, they had difficulty providing examples of these issues. A phase I neighbor stated she assumed housing values would fall as a result of the SLH in their neighborhood, but did not elaborate or provide examples of declining values. Another neighbor described concerns about crime:

...there were a couple of incidences where in the night...we had a couple of break-ins and you don't know if it was them or not.

Interviewer: So I'm wondering if the break-ins were close to each other and how long ago it was or how recently?

Well, one of them was 5 years ago, the other one was in '89.

The concerns raised by some neighbors of phase I houses were not unanimous. Different points of view from phase I neighbors included:

Well, for me like I say to me it's positive that there's been a positive impact...the crime situation has reduced. I mean we were broken into three times here before... madhouse came.

It seems to be a big success. They have on you know specific nights of the week and specific nights of the month they have a lot of people gathered there in support of the people that are graduating from the program or hopefully successfully moving on from that program. So I have a lot of support for that, I've known several people in my lifetime through friends or employees that have been working for us that had issues with drugs and needed to clean up. And so I think it's a huge benefit to helping people get back on track and finding that support system and other people that are going through the same situations that can be there for each other and be a good support structure for each other.

Another phase I neighbor succinctly summed up the pros and cons of having a large community of phase I houses:

...because you have it the way it is the level of support is incredible as opposed to having the phase 2 houses which are more isolated. But of course you have to work to get that and...having large phase I houses is probably a good thing but if you know it is in a residential neighborhood area and so you create a traffic issue and the streets line up, I mean that's what they have to do. And we were real worried 'cause we thought that whole frontage area was gonna be gone on this latest modification and it was like okay now what are they gonna do? But it isn't, and they are considerate, they do a good job, but it is a lot— they have a lot of people on Sunday night.

Reactions from neighbors of phase II houses were nearly all positive. Neighbors were either unaware that a SLH existed in their neighborhood and when they did know about one they were perceived as good neighbors. One neighbor of a phase II house reported a positive incident with a SLH resident who lived next door. During a violent late night altercation with his wife, he was forced to leave his home. He found refuge and counsel from his next-door neighbor. It was then he learned this was a SLH. In another neighborhood, a single mother reported feeling "safe" because of the SLH residents living across the street. They kept an eye on her house and reported to her when a group of teenagers climbed the fence to her property. She also commented that the SLH residents were good role models for her teenage son.

Residents of phase II houses were viewed as quiet and they maintained their properties well. A few reports suggested there was admiration among neighbors for the changes the residents were attempting to make in their lives:

...I would hope that people would be more observant and respectful to them because they chose to take a different road with their life...they're trying to make a difference for their lives and themselves and their families so I would hope people would respect that.

One phase II SLH manager told a story of a neighbor expressing appreciation for their work recovering from alcohol and drug problems.

...she likes to bake a lot so she brought me like cake, right and she's like 'hi, I'm so and so. I live next door and I just came down here to support you and tell you that I'm so proud of you and I like what you guys are doing here and keep doing the right thing' and I was like "who are you?"...they're like an awesome old couple next door and they have a couple grandchildren and like I said I walk out of the house, they ask me how I'm doing.

Improving the community context

All three stakeholder groups felt the reputation of CSTL in the local community benefited from a variety of volunteer activities in which residents participated. These included involvements in activities such as hosting a Christmas holiday party open to the local community and volunteering to support various events (e.g., parades, Veteran's Day activities and seasonal festivals). One house manager noted:

...so we do stuff like volunteer so that we don't get a [bad] name. Because you know a lot of us we stole a lot, we hurt a lot of people through our actions. So when we give back it shows the community that we're not like that now. We're trying to change. We're still people. We just had problem and we're fixing it now.

Phase I neighbors felt providing more information about SLHs and developing forums for more interaction would be good ways to improve relationships:

"Well maybe if they had more interaction with the community as far as letting the community know what's goin' on, what their goals are, what their success rate is.

Other suggestions from phase I neighbors included distributing brochures about CSTL to local neighbors, inviting them to attend a question and answer meeting at the main facility, and promoting a neighborhood barbeque. One man appeared to be frustrated not having the phone number for whom to call if there were concerns. Another felt intimidated by the residents and feared he would be misunderstood if he raised his concerns. One neighbor suggested CSTL residents get involved in volunteer work, apparently not aware that CSTL residents were already involved in a variety of volunteer activities.

It is important to note that like neighbors of CSTL, house managers also felt increased contact and communication would improve relationships. Managers felt many concerns that neighbors had were based on fear rather than information about the program:

I would challenge the skeptics to come spend a day or two around here and see how the people are; see how these places work; see what they promote, what kind of lifestyle they promote and you know see if their opinion hadn't changed in that period of time.

Another house manager felt similarly:

Like come on in and check it out. Bring a city council member, bring a newspaper reporter, you know bring whoever you'd like and come and see. It's not a cult...its people trying to better themselves.

Finally, like one of the neighbors, the coordinator of CSTL expressed a wish that residents could be involved in more volunteer activities, mentioning breast cancer awareness as an example.

Regulatory impact on SLHs

There is no state or local licensing of SLHs. Because anyone can set up a SLH and operate it as they wish, stakeholders felt there was a need for standards for SLHs. When asked about obstacles to expanding SLHs, several house managers noted that standards were important for both the houses and the operators, "I think there should be more strict guidelines on who can operate these places." One of the key informants noted, "...you know licenses or having somebody in the neighborhood that would involve you know the code of enforcement people." There was a clear sense among all participants that poorly run houses were a threat to all SLHs and they therefore needed to be dealt with "swiftly because they are the ones that make it bad for everybody else." None of the participants mentioned that CSTL was a member of the California Association of Addiction and Recovery Resources (CAARR), which does certify SLHs for compliance with basic safety, health, and operations standards.

There were differences of opinion among stakeholders about the need for a special use zoning permit. A few neighbors and key informants felt that any house containing more than six individuals required a special use permit or it would violate zoning laws. The owner challenged that contention citing the Americans with Disabilities Act and the Fair Housing Act:

...since we are considered disable Americans, which the total public and the whole government want to ignore... we're protected by the Fair Housing Act which says that people with addiction have to be treated like any other family. They can live together; they can have more than six people. Now if the county wants to limit it to six people and then anything over six people you get a use permit then that should apply to every family in Sacramento County as well.

When we asked house managers about the impact of regulatory laws and policies on SLH operations the nearly unanimous response was that these issues that were dealt with exclusively by the owner of CSTL. This individual is active in the local community and also has connections in state government. It is important to note that some of the earlier critics of CSTL now support the program. The owner attributes much of this shift to familiarity; the fact that critics were able to get to know him personally and observe what actually goes on in the houses.

Typology of factors supporting and hindering SLHs

Table 2 shows a summary of factors that support and hinder SLHs from the vantage point of different stakeholders.

DISCUSSION

Overall, there was significant support for SLHs across stakeholder groups. To some extent, our finding that phase II houses were either viewed favorably by neighbors or were not perceived as different from any other house in the neighborhood replicates the study by Jason et al (2005) of Oxford Houses. Even when neighbors or key informant had criticisms of phase I houses, they nevertheless supported the importance of this type of service in the

community and viewed it as preferable to alternative responses to alcohol and drug problems (e.g., criminal justice).

Concerns about phase I houses appeared to center mostly on issues such as the larger size and higher density of these houses in one area, as well as related concerns about noise and traffic. Only a few mentioned issues related to resident behavior, such as offensive language and leaving cigarette butts in the area. It is worth noting that even the most critical phase I neighbors supported the importance of recovery programs and sober housing as a concept. They tended to want the program to have more control over resident behavior and find solutions to the high density of houses and corresponding problems such as limited parking.

CSTL faces a dilemma in that the larger, higher density phase I houses were viewed as helpful to recovery by house managers and even by one of the neighbors. The large complex of adjacent phase I houses creates a sense of independent living blended with extensive support and some degree of structure, both of which are felt to be essential to recovery. The design also allows the owner, coordinator, house managers, and senior peers to monitor the behavior of new residents and address problems promptly. One could argue that the increased oversight and sense of community in phase I prepares residents for success in phase II, and thus leads to stable phase II houses in the community. Given the current scenario, the program might consider collaborating with neighbor about ways to address issues such as parking and traffic congestion. Examples might include holding some meetings off-site or developing alternative places to park when large meetings are held at the facility. Efforts to maintain a “good neighbor” policy by enforcing rules that limit noise, offensive language, cigarette butts, etc. are clearly important.

In a number of areas there was significant agreement among stakeholder groups. Most of the factors supporting and hindering SLHs were identified by participants from at least two groups. For example, the importance of volunteering was mentioned by most of the house managers as well as some neighbors. Size and density were viewed as hindrances by neighbors, especially those who lived near phase I houses, as well as some of the key informants. Both house managers and key informants viewed characteristics and activities of the owner as important to the success of CSTL. Neighbors and managers both felt increased communication and familiarity with SLH operations could help improve relationships. Nuisance problems (e.g., parking) were viewed as a hindrance by neighbors and key informants and all three groups felt that even a limited number of poorly run houses could threaten the viability of all SLHs. Adopting “good neighbor” practices was viewed as essential by nearly all participants.

Communication with neighbors

One of the clearest findings was that both house managers and phase I neighbors felt the need for more communication and interaction. Phase II neighbors, in contrast, were fairly unanimous in their praise of SLHs in their neighborhood and thus felt little need to take action to improve relationships. Given the current stability and successes of phase II houses, the best approach might be to leave well enough alone.

Phase I neighbors and managers proposed specific suggestions for increasing communication that could be readily implemented. These included neighbors attending open houses at the program, the program distributing brochures about CSTL to local neighbors, neighbors spending a day at the program to experience what actually goes on, the program implementing a neighborhood barbeque and developing regular meetings with managers and neighbors to address questions and concerns that arise.

It should be mentioned that the owner of CSTL reported some previous efforts in this regard that were not very successful. One involved going door to door in the neighborhood to introduce the program, which yielded some negative comments and threats. The other involved some ice cream socials that were poorly attended. On at least two occasions letters were sent out to neighbors containing a brief description about CSTL and contact numbers. It is not clear why these efforts were not more successful. It could be that developing a meaningful and sustained impact on the surrounding neighbors will require regular and varied activities, such as regular social events, more substantive forums to address neighborhood issues and problems, and a monthly or quarterly brochure that is distributed to each neighbor.

Although CSTL residents are involved in extensive volunteer work in the local area, there may be a need for more of those activities in the immediate neighborhood. Several immediate neighbors did not appear to be aware of volunteer activities in which CSTL residents participate and they suggested volunteering would improve relationships with the community.

Addressing stigma

House managers believed that stigma plays a strong role in biasing some neighbors against SLHs and their residents. This view was shared by participants in our previous work (e.g., Polcin et al., in press), where addiction counselors and mental health therapists rated stigma as the main obstacle to expanding SLHs. Stigma was rated as a higher obstacle than practical issues such as not have sufficient financial resources to pay for residence in a SLH. In our interviews for this study we found negative assumptions about SLHs when neighbors expressed concerns about increasing crime and decreasing housing values but were not able to support their claims with specific examples.

A good way of addressing stigma was suggested by several house managers. They argued convincingly that the more the local community understood about the day to day operations of CSTL and the residents who lived there the more they would support SLHs in this and other communities. Instead of relying on preconceived biases and notions, they would increasingly base their views on observations about what occurs and interactions with residents. Contact with stigmatized groups as a way to decrease stigma is a strategy supported by a variety of stigma researchers (e.g., Corrigan et al., 2001). It might be particularly helpful to create forums where successful residents could interact with neighbors and share the stories about addiction and recovery. In addition to decreasing negative assumptions about addicts and alcoholics, such interactions might offer hope to families who have a member suffering from a substance use disorder.

Managing community relations

A number of managers and key informants noted how the owner was well connected within the local community (e.g., president of the local chamber of commerce) and used those connections in service of CSTL. A notable limitation of this scenario is that mobilizing community influences in ways that support CSTL was the purview solely of the owner. There is considerable risk that if this individual were not around, the relationships with local and state officials would evaporate. It was striking how little house managers and residents knew about critical issues directly affecting the viability of CSTL, such as zoning laws, the Fair Housing Act, Americans with Disabilities Act, and initiatives at the state level to limit SLHs. Increasing their knowledge of and involvement in these issues would leave the program less vulnerable. This could be accomplished through delegating house managers to attend selected meetings and discussion with the owner about how to best represent the interests of CSTL.

Implications for community based programs

Study findings suggest important considerations, not only for SLHs, but for community based programs more generally. One area where there was nearly unanimous agreement across stakeholder groups was the importance of being good neighbors. Therefore, community based programs need to have policies and resources that ensure upkeep of the facilities to standards consistent with the local neighborhood. Further, there need to be policies in place to contain potentially destructive behaviors, such as drug use and other behaviors that would be experienced as unacceptable (e.g., destruction of property). For example, "Housing First" models for substance use disorders that tolerate alcohol and drug use would not do well in the neighborhoods we studied. To avoid open community resistance, it would seem that these types of harm reduction services would need to be located in areas where substance use is more tolerated. In addition, community based programs need to have mechanisms for handling complaints from neighbors. While CSTL was praised by key informants for responding to complaints promptly, a few phase I neighbors were unsure whom to contact and others felt intimidated and that left them feeling frustrated and more negative toward the program. Phase II neighbors did not express this uncertainty and seemed comfortable approaching residents of phase II houses.

Another consideration is how to handle the issue of anonymity. We found that small, sparsely populated phase II houses were viewed favorably or were unknown to neighbors. One workable option for community programs in such circumstances might be to maintain a relatively low profile and simply blend in with the local community. However, when programs are larger and their presence is obvious, it may be necessary to directly address the concerns of local neighbors, especially to counteract negative assumptions associated with stigma. Such a strategy requires forums for such interaction to occur. Both house managers and neighbors had suggestions in this regard, ranging from neighborhood barbeques to information meetings that describe the program and respond to neighbor questions and concerns.

All of our stakeholder groups emphasized the importance of volunteer work. The specific types of activities that community programs get involved in might be dependent in part on the types of clients served and their capabilities. However, it seems that some very public way of showing involvement in and support for the community is important to garner support. In part, volunteer work might be viewed as important because volunteer work contradicts assumptions associated with the stigma of addiction, such as crime and exploitation of others.

It was clear from our interviews that the owner of CSTL had a long history of successfully managing challenges to CSTL and navigating through the political and regulatory environment. He appeared to persevere using a combination of knowledge about his rights and applicable laws, involvement in local and state politics, and personal relationships that he was able to develop with individuals who were once his adversaries. Such an individual can be invaluable to the development of successful organizations. However, there are serious questions about how the program could maintain its position in the community and its political strength if this individual were not around. CSTL and other community based programs might do well to consider shared models of leadership and responsibility (e.g., Polcin, 1990) for promoting the program's agenda within political and regulatory circles.

Limitations

There are some inherent limitations in our study that are important to note. First, all of the interviews took place in one Northern California County and the issues relative to SLHs there might not generalize to other geographic regions. Second, all of the house managers

were part of CSTL and all of the neighbors resided near CSTL facilities. Although CSTL has implemented the sober living house principles promoted by the California Association of Addiction and Recovery Resources in California, there may be individual factors that are unique to CSTL that limit generalization of results. Other SLHs with different characteristics (e.g., size, management, cost and house rules) might have different issues. Finally, the results are specific to SLHs and might not generalize to other types of housing, such as halfway, step down and Oxford houses.

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Table 1

Sample characteristics by stakeholder group

STAKEHOLDER GROUP	GENDER		RACE				MARITAL STATUS				
	MALE	FEMALE	WHITE	BLACK	HISPANIC	MIXED RACE	SINGLE	MARRIED	DIVORCED	SEPARATED	WIDOW/WIDOWER
House Managers N = 17	14 (82%)	3 (18%)	15 (88%)			2 (12%)	10 (59%)	1 (6%)	4 (23%)	2 (12%)	
Neighbors N = 20	10 (50%)	10 (50%)	18 (90%)	1 (.05%)	1 (.05%)		3 (15%)	13 (65%)	1 (5%)	2 (10%)	1 (5%)
Key Informants N = 6	2 (33%)	4 (67%)	5 (83%)	1 (17%)			1 (17%)	5 (83%)			

Table 2

Factors supporting and hindering sober living houses

	Supporting	Hindering
House Managers	Volunteering Characteristics of Owner Familiarity with SLHs Addressing Complaints Promptly Scope of Addiction Problems Communication	Poorly run houses Stigma Criminal Justice Mandated Dual Diagnosis Finances
Neighbors	Volunteering Familiarity with SLHs Addiction in Family Good Neighbor Behaviors Addressing Complaints Promptly Communication	Poorly run houses Nuisance Problems Perceptions of Crime Perceptions that housing values decline Large houses Densely populated houses
Key Informants	Characteristics of Owner Addressing Complaints Promptly Scope of Addiction Problems	Poorly run houses Nuisance problems Zoning Laws Large houses Densely populated houses Finances

Note: Poorly run houses include factors such as poor appearance and lack of resident accountability.

Nuisance problems include factors such as noise level, parking, offensive language and cigarette butts.

Hindering factors for neighbors primarily refer to Phase I houses.

Attachment No. 22

Residential Treatment of Substance Abuse Disorders, Core Therapeutic Elements and Their Relationship to Effectiveness, Practice Committee Consensus Report, State Association of Addiction Services, April 2013

RESIDENTIAL TREATMENT OF SUBSTANCE USE DISORDERS

Practice Committee Consensus Report

April 2013

SAAS

STATE ASSOCIATIONS OF
ADDICTION SERVICES

*Core Therapeutic
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Executive Summary

The Affordable Care Act (ACA) requires coverage of substance use disorder (SUD) care, identifying SUD services as one of the law's Essential Health Benefits (EHB). As more discretion has been given by the Department of Health and Human Services (HHS) to states to define the EHB, it will be most important to work at the state level to ensure that individuals with mental illness and substance use disorders receive quality care within a full continuum of evidenced-based care.

Addiction is a chronic health condition and can be successfully managed over time like other chronic conditions. Residential treatment is a more intense service within the continuum of care with levels responsive to the conditions of the patient.

The described core elements and therapeutic processes presented in this paper, together with the Patient Placement Criteria developed by the American Society of Addiction Medicine (ASAM) are the basis of the following description of residential treatment:

Residential Treatment is a normative, pervasive environment supporting a 24 hour-per-day culture and milieu of beliefs and ideology, which value respect for the inherent goodness of the individual, the capacity to change, personal responsibility, and the reliance on the treatment community as a therapeutic agent.

Core Elements

1. Structure and stability
2. Safety and separateness
3. Therapeutic conditions and processes

Central to the continuing evolution of residential treatment is a commitment to the principles of self-management of a chronic health condition. Within the normative pervasive environment of the residential setting the community is a therapeutic agent where patients are empowered to manage their health. Disease control and outcomes depend on patients using effective self-management. Support includes acknowledging the patients' role in their care, fostering a sense of responsibility for their health, using proven programs that provide emotional support and strategies for living with chronic illness. Providers and patients work collaboratively to define barriers, set priorities, establish goals, create treatment plans, and solve problems. Goals include sustaining abstinence, preparing for triggers, improving personal health and social functioning, and engaging in continuing care.

Conclusions

1. The effectiveness of residential treatment is embedded in how the core elements of this safe, separate, secure, and stable environment respond to the needs of individuals with deficits in cognitive, social, interpersonal, emotional, and/or coping skills.
2. These individuals come from environments that are unstable, chaotic, abusive, and/or toxic, and need a regimented, supportive, stable environment to "habilitate" or "rehabilitate".
3. Individuals with more severe dysfunctions exhibit impulsivity, deficient anger management, hostile/violent "acting out", and/or resistance/antagonism to limits. They need an environment which manifests respect, capacity to change, and personal responsibility within a communal setting. The communal setting represents a microcosmic representation of the larger society and provides the social context to alter thinking, feelings, and behaviors.
4. Treatment interventions are matched to a person's readiness to change and it is critical that this individualized treatment matching occurs to assure that residential treatment is not under-utilized or over-utilized.

Residential Treatment of Substance Use Disorders

Core Therapeutic Elements and Their Relationship to Effectiveness

Introduction

Alignment with Health Care Reform

The Affordable Care Act (ACA) requires coverage of substance use disorder (SUD) care, identifying SUD services as one of the law's Essential Health Benefits (EHB). With the ACA's strong coverage provisions, millions more Americans will have better access to the SUD care and supports they need to become and remain well. Work to define which services are covered in each of the EHB categories continues at the federal level and in the states. As a field we are moving forward to assure full coverage for mental illness and substance use disorders. We have seen, so far, the strong commitment from the federal Department of Health and Human Services (HHS) to make mental health (MH) and SUD care a top priority. As more discretion has been given by HHS to states to define the EHB, it will be most important to work at the state level to ensure that individuals with mental illness and substance use disorders receive quality care within a full continuum of evidenced based care.

To support this inclusion there is significant evidence of the effectiveness of residential treatment which is compiled by the report *Adult Residential Treatment for Substance Use Disorders: Summary of the Evidence* (Reif et al, Institute for Behavioral Health, Brandies, 2010). There is also support of the effectiveness of residential treatment in the extensive seminal research completed in 1974 by Sells and Simpson (Sells and Simpson 1980) and follow- up studies (Simpson and Sells 1982). There also seems to be, in the professional literature, an identification of the core elements of residential treatment that correlate with its effectiveness. However, it is less clear how and why these core elements are effective and why they need to occur for some individuals in the environment of a residential setting. This report will summarize these core elements and some correlation to their possible therapeutic effectiveness. There is still work to do to support the inclusion of residential treatment in the EHB. It is in this context that the Practice Committee was given the charge to compile a consensus report for SAAS on "the how and why" of residential treatment's effectiveness, which would further support its inclusion as a part of the continuum of care for the treatment of substance use disorders. The intention of this report is to gain a consensus that supports the evidence base of the core set of services and structured activities which have been described in the good and modern adult residential treatment setting (SAMSHA, O'Brien 2010). This report also emphasizes that addiction is a chronic health condition which can be successfully managed over time like other chronic health conditions. Residential treatment is a level of more intense care within the continuum of care with

...the Practice Committee was given the charge to compile a consensus report for SAAS on "the how and why" of residential treatment's effectiveness, which would further support its inclusion as a part of the continuum of care for the treatment of substance use disorders.

levels of intensity responsive to the conditions of the patient. The report will also strongly urge the field to arrive at a consensus in which there is a standardization of the levels of care which balance:

- the need to individualize care to the needs, strengths, severity of brain dysregulation and resulting functional deficits of the individual, their status within the progression and/or remission of the chronic conditions
- the matched intensity and frequency of the essential care services and structured activities (the dosage)
- the required credentials and ratio of staff to the patient population.

The confirmation of evidenced based practices of the core services and the balanced standardization of the levels of care are necessary to support a reasoned and consistent payment structure.

Definitions and Terminology

This report primarily uses the definitions and description of both the ASAM Patient Placement Criteria and the NIDA Principles of Drug Addiction Treatment as sources for defining residential treatment. We limited our focus to ASAM's Level III (non-hospital residential).

"Level III programs offer organized treatment services that feature a planned regimen of care in a 24 hour residential setting. Treatment services adhere to defined policies, procedures, and clinical protocols.... The defining characteristics of all Level III programs is that they serve individuals who, because of their specific functional deficits, need safe and stable living environments in order to develop their recovery skills" (ASAM PPC -2R)

The National Institute of Drug Abuse (NIDA) *Principles of Drug Addiction Treatment* defines residential treatment as follows:

Short-term residential programs provide 24 hour per day intensive but relatively brief treatment typically based on a modified 12-step approach. Long-term residential treatment provides care 24 hours a day, generally in non-hospital settings.... Addiction is viewed in the context of an individual's social and psychological deficits, and treatment focuses on developing personal accountability and responsibility as well as socially productive lives. Treatment is highly structured.... with activities designed to help residents examine damaging beliefs, self-concepts, and destructive patterns of behavior and adopt new, more harmonious and constructive ways to interact with others.

There is significant confusion about the language used to distinguish between clinical residential treatment and other supportive forms of residential housing which provide an important part of the continuum of care supporting some individuals' needs for a stage of their recovery. Some authors have suggested clarifying terminology for clinical residential treatment as "non-hospital inpatient services". This report is concerned that this new terminology will only add further confusion with the mix of another term for clinical residential treatment as distinct from a supportive form of housing. Therefore throughout this study we will continue to use the terminology "residential treatment of substance use disorders".

Scope of Consensus Report and Method of Study

The committee completed a limited survey of the literature to identify the core elements of residential treatment which seem to correlate to its effectiveness. In our survey the core elements are foundational to a residential treatment environment. They are foundational in the sense that they are the necessary and sufficient conditions of the residential environment, which are responsive to the needs and functional deficits identified in the ASAM Patient Placement Criteria for residential levels of care for both adults and adolescents. They are also the necessary and sufficient conditions for the various therapeutic processes and outcomes to occur. Those foundational core elements are: Safety and Separateness, Structure and Stability. The next section summarizes the characteristics of the core elements and the therapeutic process that occur with the environment that these core elements support.

Core Elements

Structure and stability are supported by an environment which includes the following major characteristics:

- Daily regimen of scheduled and structured activities:
 - Group therapy
 - Reflective time
 - Individual therapy
 - Community meetings
 - Didactics
 - Recreational/physical activities
 - Meals
- Defined policies, procedures and clinical protocols
- Specified roles for staff, residents, and family members
- Predictable times to practice recovery and coping skills

Safety and separateness are supported by an environment which provides:

- Safety from:
 - Alcohol and other drugs
 - Dominant drug culture
 - Drug places
 - Chaos
- Safety to:
 - Practice recovery and coping skills
 - Controlled experiential community environment separate from larger society and from the drug using culture to which many patients belong
 - Microcosmic representation of a larger society providing a social and interactive context to alter thinking, feelings, and behaviors

Therapeutic conditions and processes that occur within the residential environment that seem to correlate to its effectiveness include:

- Structures and regimens that support a recovery environment and related behaviors and skills
- Sufficient stability to prevent and minimize relapse
- Treatment and community structure to practice and integrate recovery and coping skills
- Community and treatment settings built upon residents imitative tendencies to learn through reciprocal role modeling by both peers and staff
 - An environment built upon the social nature of persons
 - Encouragement of progress which is dependent on reciprocal interaction in a safe and separate community setting
 - A separate community as a means of personal, and in some cases spiritual, transformation which requires a shift from the self-centeredness of one's personal identity, which is characterized by addiction thinking, feeling, and behaving, to "letting go" to a power greater than oneself
 - Healing not in isolation, but in communion with others

Residential treatment is intended to be individualized though varied levels of care and intensity to the functional deficits identified in the ASAM Patient Placement Criteria. The core elements and therapeutic processes described above are responsive to the functional deficits for patients who meet the ASAM Level III placement criteria. These deficits cumulatively support the need for a safe and separate environment which has structure, stability and a degree of predictability. Throughout a review of these functional deficits are clear indications of the need for a separate environment, stronger and consistent structure to support the application and practice of recovery skills. While all levels of treatment do respond to the dysregulation of brain systems caused by addiction to psychoactive substances, the characteristic of this dysregulation, and resulting functional deficits, is more intense and continual in individuals who need a separate environment to develop and practice their recovery skills. Therefore, in the residential treatment environment an individual's functional cognitive deficits require treatment that is primarily slower paced, more concrete and repetitive in nature. The daily regimens, the structured patterns of activities, are intended to restore cognitive functioning and build behavioral patterns within a community. In addition to cognitive functional deficits this safe and stable environment with the community as a therapeutic agent is also responsive to emotional, social, and interpersonal deficits identified in these criteria. Some of these deficits are the results of trauma which require competencies of trauma informed care in both individual and focused group interventions. Structured group activities and communal living provide the opportunity for learning and practicing new skills in all these areas of significant dysfunction. Social learning within the normative environment occurs through modeling new skills and the practicing of new skills which is responsive to the individual's chaotic environment and often isolated self-centeredness.

In the residential treatment environment an individual's functional cognitive deficits require treatment that is primarily slower paced, more concrete and repetitive in nature.

ASAM Patient Placement Criteria:

Level 111.1 Functional deficits and needs include:

- Problems in the application of recovery skills
- Lack of connectivity to the world of work, education, and family life
- Person in “pre-contemplation” who is living in an environment “too toxic” to permit treatment in an outpatient basis
- Need a supportive environment for receiving “discovery” rather than “recovery” services.

Level III.3 Functional deficits and needs include:

- Person for whom the effects of substance use disorders is so significant that he/she results in a level of impairment for which outpatient services are not feasible or effective
- Functional deficits are primarily cognitive and can be temporary or permanent which require treatment at a slower pace, more concrete and repetitive until cognitive impairment subsides
- Responsive to a person with such severe deficits in interpersonal and coping skills that treatment focuses more on “habilitation” rather than “rehabilitation”

Level III.5 Functional deficits and needs include:

- Person with significant social and psychological problems who can benefit from the treatment community as a therapeutic agent
- Functional deficits: chaotic, often abusive, non supportive interpersonal relationships
- More serious or lengthy criminal history
- Limited or significantly sporadic work and educational history
- Treatment interventions are matched to a person’s readiness to change:
 - For some it is “discovery”
 - For some it may focus on maintaining abstinence and preventing relapse
 - For some it is preventing a return to antisocial behavior
 - For some it is developing a sense of personal responsibility and positive character change
 - For some it is “habilitative”
 - For some it is “rehabilitative”
- Anti-social value systems characterized by:
 - Impulsivity, deficient anger management skills
 - Hostile or violent acting out
 - Resistance and antagonism to limits or problems with authority
 - Hyperactivity and distractibility

(ASAM PPC-2R). (2001)

The above core elements and therapeutic processes lead the committee to the following description of residential treatment:

Residential Treatment is a normative, pervasive environment supporting a 24 hour-per-day culture and milieu of beliefs and ideology, which value respect for the inherent goodness of the individual, the capacity to change, personal responsibility, and the reliance on the treatment community as a therapeutic agent.

Conclusions

5. The effectiveness of residential treatment for both adults and adolescents is embedded in how the very characteristics of core elements of this safe, separate, secure, and stable environment respond to the needs of individuals with significant functional deficits in their cognitive, social and interpersonal, and emotional functioning and coping functions. The functional deficits are identified by ASAM Patient Placement Criteria.
6. These individuals more often come from environments that are unstable, chaotic, abusive and toxic, and therefore they need a regimented, supportive, stable environment in which to learn and practice through interventions that “habilitate” or “rehabilitate”.
7. Individuals with more severe dysfunctions often exhibit impulsivity, deficient anger management, hostile and violent “acting out”, and resistance and antagonism to limits. These individuals need a normative, pervasive environment which manifests respect, the capacity to change and personal responsibility within a communal setting. It is this communal setting that represents a microcosmic representation of the larger society that provides the social context to alter thinking, feelings, and behaviors.
8. Treatment interventions are matched to a person’s readiness to change and it is critical that this individualized treatment matching occurs to assure that residential treatment is not underutilized or over utilized.

This is consistent with *The Six Aims of High-Quality Health Care* from the Institute of Medicine:

- **Safe** - *avoiding injuries* to patients from the care that is intended to help them.
- **Effective** - *providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).*
- **Patient-centered** - providing care that is respectful of and responsive to individual patient preferences, needs, and values and *ensuring that patient values guide all clinical decisions.*
- **Timely** - *reducing waits* and sometimes harmful delays for both those who receive and those who give care.
- **Efficient** - *avoiding waste*, including waste of equipment, supplies, ideas, and energy.
- **Equitable** - *providing care that does not vary in quality* because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

IOM, 2001:5–6.

The duration of care is dependent on the individual progress and any of the following needs of the patient:

- For some it is “discovery”
- For some it may focus on maintaining abstinence and preventing relapse
- For some it is preventing a return to antisocial behavior
- For some it is developing a sense of personal responsibility and positive character change
- For some it is “habilitative”
- For some it is “rehabilitative”

Central to the continuing evolution of residential treatment will be a commitment in practice to the principles of self-management of a chronic health condition. Within the normative pervasive environment of the residential setting the treatment community becomes a therapeutic agent through which patients are empowered and prepared to manage their health and health care. As such, treatment must:

- Emphasize the patient's central role in managing their health
- Use effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow-up
- Organize internal and community resources to provide ongoing self-management support to patients

All patients with chronic illness make decisions and engage in behaviors that affect their health (self-management). Disease control and outcomes depend to a significant degree on the effectiveness of self-management.

Effective self-management support means more than telling patients what to do. It means acknowledging the patients' central role in their care, one that fosters a sense of responsibility for their own health. It includes the use of proven programs that provide basic information, emotional support, and strategies for living with chronic illness. Self-management support can't begin and end with a class. Using a collaborative approach, providers and patients work together to define problems, set priorities, establish goals, create treatment plans and solve problems along the way.

The therapeutic goals are to sustain abstinence, understand and prepare for triggers, improve personal health, improve social functioning, and as needed engage in continuing care as needed in outpatient treatment, recovery housing, recovery management and support services. NIDA in its Principles of Drug Addiction Treatment clearly states the need for integration of care for persons with substance use conditions.

In 2006 the Institute of Medicine (IOM) published the third report of the Quality Chasm Series, *Improving the Quality of Health Care for Mental and Substance Abuse Conditions* (National Academies Press 2006). In this report they strongly recommend the integration of care for mental and substance use problems with other general co-occurring health care conditions and illnesses. The IOM report's recommendation for the coordination and integration of care is foundational to understanding and improving the quality of health care.

- Mental and substance use problems rarely occur in isolation
 - Mental, substance use and general health problems and illnesses are frequently intertwined
 - Coordination of all these types of health care is essential to improved health outcomes, especially for chronic illnesses
- (IOM 2007)

“Effective treatment attends to multiple needs of the individual, not just his or her drug abuse. To be effective, treatment must address the individual's drug abuse and any associated medical, psychological, social, vocational, and legal problems. It is also important that treatment be appropriate to the individual's age, gender, ethnicity, and culture.”

NIDA 2009 Principles of Drug Addiction Treatment: A Research Based Guide

None of the findings of this report are new. They do however strongly support why residential treatment is effective for those who have more severe functional deficits and require a safe and secure environment in which to learn and practice recovery skills.

There is strong evidence that treatment within this level of care can be individualized to the needs, strengths, social supports systems and recovery progress of the patient.

Appendix

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Committee Members

Michael Reagan, Chair, Chief External Relations Officer, Cherry Street Health Services, MI

Susan Blacksher, MSW, MCA, Executive Director CA Association of Addiction Recovery Resources

Charles Bush, Program Manager, Clearview Recovery Center, MS

Cinda Cash, former Executive Director, Connecticut Women's Consortium, Inc.

John Coppola, MSW, Executive Director, NY Association of Alcoholism and Substance Abuse Providers, Inc.

John Daigle, Consultant, FL

Dick Dillon, CEO, Innovaision, LLC, MO

Sheila North, M.A., M.F.T., Executive Director, DePaul Treatment Centers, OR

Constance Peters, MSPA, VP for Addiction Services, Association for Behavioral Health MA

Art Schut, CEO, Arapahoe House Inc., CO

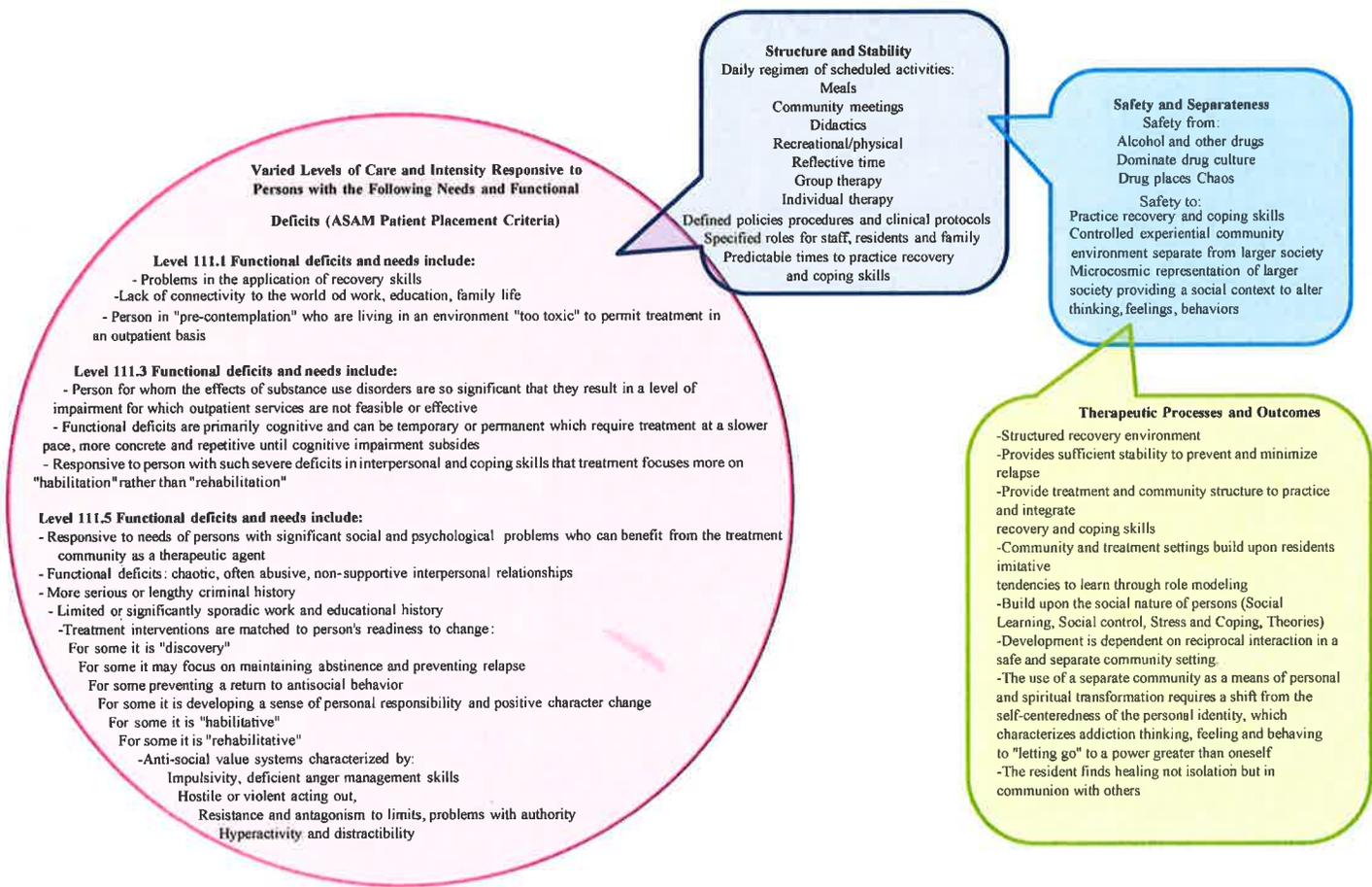
Bill Stauffer, LSW, CADC, Executive Director, PRO-A, PA

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Core Therapeutic Elements of Residential Treatment of Substance Use Disorders

Residential Treatment is a normative pervasive environment supporting a 24 hour-per-day culture and milieu of beliefs and ideology which values respect for the inherent goodness of the individual, the capacity to change, personal responsibility and the reliance on the treatment community as a therapeutic agent. The following four core elements are identified in the literature and correlated with its effectiveness although is less clear how and why they are effective.



Attachment No. 23

Recovery Housing: Assessing the Evidence,
Sharon Reif, Ph.D. et al., *Psychiatric*
Services, March 2014 Vol. 65 No. 3

Recovery Housing: Assessing the Evidence

Sharon Reif, Ph.D.

Preethy George, Ph.D.

Lisa Braude, Ph.D.

Richard H. Dougherty, Ph.D.

Allen S. Daniels, Ed.D.

Sushmita Shoma Ghose, Ph.D.

Miriam E. Delphin-Rittmon, Ph.D.

Objective: Recovery housing is a direct service with multiple components that provides supervised, short-term housing to individuals with substance use disorders or co-occurring mental and substance use disorders. It commonly is used after inpatient or residential treatment. This article describes recovery housing and assesses the evidence base for the service. **Methods:** Authors searched PubMed, PsycINFO, Applied Social Sciences Index and Abstracts, Sociological Abstracts, and Social Services Abstracts. They identified six individual articles from 1995 through 2012 that reported on randomized controlled trials or quasi-experimental studies; no reviews or meta-analyses were found. They chose from three levels of evidence (high, moderate, or low) based on benchmarks for the number of studies and quality of their methodology. They also described the evidence of service effectiveness. **Results:** The level of evidence for recovery housing was moderate. Studies consistently showed positive outcomes, but the results were tempered by research design limitations, such as lack of consistency in defining the program elements and outcome measures, small samples, and single-site evaluations, and by the limited number of studies. Results on the effectiveness of recovery housing suggested positive substance use outcomes and improvements in functioning, including employment and criminal activity. **Conclusions:** Recovery housing appears to be an important component in the continuum of care for some individuals. However, replication of study findings with greater specificity and in more settings is needed. (*Psychiatric Services* 65:295–300, 2014; doi: 10.1176/appi.ps.201300243)

Access to stable and supportive housing is recognized in the addictions field as an important component of establishing and

maintaining recovery from substance use disorders (1). Research suggests that maintaining recovery gains may be difficult for individuals who are not

living in stable housing situations (2), and environmental cues may play a role in triggering relapse (3). There is a need to identify housing settings that promote recovery after the completion of residential treatment or during the receipt of outpatient treatment for substance use disorders. Recovery housing is one example of a type of service used in the field to address the needs of individuals with substance use disorders.

This article reports the results of a literature review that was undertaken as part of the Assessing the Evidence Base (AEB) Series (see box on next page). For purposes of the AEB Series, the Substance Abuse and Mental Health Services Administration (SAMHSA) has defined recovery housing as a direct service with multiple components that provides supervised, short-term housing to individuals with substance use disorders or co-occurring mental and substance use disorders. Recovery housing aims to increase an individual's stability, improve his or her functioning, and move the resident toward a life in the community by supporting abstinence and recovery. Table 1 contains a description of the components of this service.

Policy makers and other leaders in behavioral health care need information about the effectiveness of recovery housing and its value as a service within the continuum of care. The objectives of this review were to describe models of recovery housing for individuals with substance use disorders or co-occurring substance use and mental disorders, rate the level of research evidence (that is, methodological quality),

*Dr. Reif is with the Institute for Behavioral Health, Heller School for Social Policy and Management, Brandeis University, Waltham, Massachusetts. Dr. George, Dr. Daniels, and Dr. Ghose are with Westat, Rockville, Maryland. Dr. Braude and Dr. Dougherty are with DMA Health Strategies, Lexington, Massachusetts. Dr. Delphin-Rittmon is with the Office of Policy, Planning, and Innovation, Substance Abuse and Mental Health Services Administration (SAMHSA), Rockville, Maryland. Send correspondence to Dr. George at preethygeorge@westat.com. This literature review is part of a series that will be published in *Psychiatric Services* over the next several months. The reviews were commissioned by SAMHSA through a contract with Truven Health Analytics. The reviews were conducted by experts in each topic area, who wrote the reviews along with authors from Truven Health Analytics, Westat, DMA Health Strategies, and SAMHSA. Each article in the series was peer reviewed by a special panel of *Psychiatric Services* reviewers.*

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About the AEB Series

The Assessing the Evidence Base (AEB) Series presents literature reviews for 13 commonly used, recovery-focused mental health and substance use services. Authors evaluated research articles and reviews specific to each service that were published from 1995 through 2012 or 2013. Each AEB Series article presents ratings of the strength of the evidence for the service, descriptions of service effectiveness, and recommendations for future implementation and research. The target audience includes state mental health and substance use program directors and their senior staff, Medicaid staff, other purchasers of health care services (for example, managed care organizations and commercial insurance), leaders in community health organizations, providers, consumers and family members, and others interested in the empirical evidence base for these services. The research was sponsored by the Substance Abuse and Mental Health Services Administration to help inform decisions about which services should be covered in public and commercially funded plans. Details about the research methodology and bases for the conclusions are included in the introduction to the AEB Series (10).

and describe the effectiveness of the service. To be useful for a broad audience, this article presents an overall assessment of research quality and focuses on key findings of the review.

Recovery housing and the continuum of care

Recovery housing for individuals with substance use disorders generally consists of alcohol- and drug-free residences, such as sober living houses (4,5). Recovery housing is often provided to individuals after they have been in an inpatient or residential treatment program or during their first few months of recovery or sobriety. Recovery housing is not a formal treatment; rather, it is a service that supports recovery during or after treatment. Thus there is guidance about

what constitutes recovery housing, but there are no clear standards.

Sober living houses usually are peer-run residences where small- to medium-sized groups of individuals in recovery live in single or shared bedrooms with common living areas. Individuals are expected to work, contribute rent, and participate in the responsibilities of running the household. Abstinence is an expectation, and individuals who relapse may be asked to leave the house because their behavior threatens the recovery of others. Sober living houses generally do not incorporate a structured recovery program, although residents often are required or strongly encouraged to attend a 12-step mutual-help group (6), and they may choose to participate in formal

treatment or aftercare. Less common are sober living houses that are affiliated with outpatient treatment facilities and require individuals to attend outpatient treatment (7).

Oxford House is a specific type of recovery home in which members evaluate and vote on candidates who may become residents to help ensure that they will fit in with the current housing members and meet expectations for the residence (4). Oxford Houses have a national network. They do not require individuals to be engaged actively in formal treatment, but residents may choose to participate in self-help groups or outpatient treatment.

The models of recovery housing described above generally are considered part of the continuum of care that spans from outreach through formal treatment and extends into informal treatment, maintenance, and aftercare needs. In this approach, recovery housing is an essential part of preparing for or transitioning to an independent life in the community. Recovery housing frequently facilitates access to support services and treatment utilization, such as case management, therapeutic recreational activities, and peer coaching or support. Often working in partnership with treatment or recovery programs, recovery housing options may provide transportation, in-house counseling, or mentoring.

Recovery housing is often used by individuals who do not or no longer require higher levels of care, such as hospitalization or long-term residential treatment. Individuals who utilize recovery housing may need assistance with activities of daily living (such as managing finances) or reminders and support to attend treatment, take medications, or abstain from alcohol and drug use. For these individuals, recovery housing may be a step on the way to independent living. It should be noted that there is concern that individuals who utilize abstinence-contingent housing may be at risk for housing instability if relapse occurs during the process of recovery.

In summary, recovery housing is a type of service used for individuals with substance use disorders who are stepping down from inpatient or residential care or who are not ready or able to live independently. This literature

Table 1

Description of recovery housing

Feature	Description
Service definition	Recovery housing is a direct service with multiple components that provides individuals with mental and substance use disorders with supervised, short-term housing. Services may include case management, therapeutic recreational activities, and peer coaching or support.
Service goals	Increase the individual's stability; improve the person's functioning; help the individual move toward a life that is integrated into the community
Populations	Individuals with substance use disorders or those with co-occurring mental and substance use disorders
Settings of service delivery	Settings may vary and include sober living houses.

review examined the available research on recovery housing to determine its relative value as a treatment approach.

Methods

Search strategy

To provide a summary of the evidence and effectiveness for recovery housing services, we conducted a survey of major databases: PubMed (U.S. National Library of Medicine and National Institutes of Health), PsycINFO (American Psychological Association), Applied Social Sciences Index and Abstracts, Sociological Abstracts, and Social Services Abstracts. We searched for and reviewed meta-analyses, research reviews, and individual studies from 1995 through 2012. We also examined bibliographies of reviewed studies. We used combinations of the following search terms: recovery housing, sober housing, halfway house, group home, and substance abuse.

Inclusion and exclusion criteria

This review included the following types of articles: randomized controlled trials (RCTs), quasi-experimental studies, single-group repeated-measures design studies, and review articles such as meta-analyses and systematic reviews; U.S. and international studies in English; and studies that focused on recovery housing for individuals with substance use disorders or co-occurring mental and substance use disorders, including abstinence-contingent recovery housing.

Excluded were studies of residential treatment, supportive housing, supported housing, and permanent supportive housing, because these topics are covered in the review of permanent supportive housing in this series (8). Housing First models focus on permanent housing rather than on short-term, recovery-focused housing; they are also discussed in the article on permanent supportive housing and excluded here. Other housing models for individuals with substance use disorders that do not require total abstinence as a requirement for residence (for example, “wet houses” or “damp houses”) were excluded from this review because they are associated with Housing First models. Residential treatment and therapeutic communities are covered in a review of

research on residential treatment for substance use disorders in this series (9). Also excluded were articles about shelters or other housing-only options without a recovery focus. We excluded studies that used only a pre-post bivariate analysis or a case study approach without comparison groups. Also excluded were studies that solely analyzed costs associated with the service, because our focus was on outcomes associated with clinical effectiveness.

Strength of the evidence

The methodology used to rate the strength of the evidence is described in detail in the introduction to this series (10). We independently examined the research designs of the studies of recovery housing identified during the literature search and chose from three levels of evidence (high, moderate, or low) to indicate the overall research quality of the collection of studies. Ratings were based on predefined benchmarks that considered the number of studies and their methodological quality. In rare instances when ratings were dissimilar, a consensus opinion was reached.

In general, high ratings indicate confidence in the reported outcomes and are based on three or more RCTs with adequate designs or two RCTs plus two quasi-experimental studies with adequate designs. Moderate ratings indicate that there is some adequate research to judge the service, although it is possible that future research could influence reported results. Moderate ratings are based on the following three options: two or more quasi-experimental studies with adequate design; one quasi-experimental study plus one RCT with adequate design; or at least two RCTs with some methodological weaknesses or at least three quasi-experimental studies with some methodological weaknesses. Low ratings indicate that research for this service is not adequate to draw evidence-based conclusions. Low ratings indicate that studies have nonexperimental designs, there are no RCTs, or there is no more than one adequately designed quasi-experimental study.

We accounted for other design factors that could increase or decrease the evidence rating, such as how the

service, populations, and interventions were defined; use of statistical methods to account for baseline differences between experimental and comparison groups; identification of moderating or confounding variables with appropriate statistical controls; examination of attrition and follow-up; use of psychometrically sound measures; and indications of potential research bias.

Effectiveness of the service

We described the effectiveness of the service—that is, how well the outcomes of the studies met the goals of recovery housing. We compiled the findings for separate outcome measures and study populations, summarized the results, and noted differences across investigations. We considered the quality of the research design in their conclusions about the strength of the evidence and the effectiveness of the service.

Results

Level of evidence

A search of the literature revealed very limited research in this area. No meta-analyses or research reviews on recovery housing were found. We identified five articles describing RCTs that compared some version of recovery housing to some control condition (4, 11–14) and one quasi-experimental study with a within-group, repeated-measures design (15). However, four of the five articles describing RCTs reported on the same base study; therefore, only three distinct studies on this topic met the inclusion criteria. All studies were conducted in the United States. Features of the studies and their findings are summarized in Table 2.

The level of evidence for recovery housing was moderate. There were more than two RCTs of specific types of recovery housing models, but they had some methodological limitations. Methodological flaws, such as missing or inconsistent definition of program elements and small sample sizes, were prevalent and influenced the rating. Because of the variability in how recovery housing was defined, fidelity rarely was discussed. The outcome measures varied across research studies and included measures of substance use, quality of life, and other outcomes. This

Table 2

Studies of recovery housing included in the review

Study	Study design and population	Outcomes measured	Summary of findings	Comments
Randomized controlled trials				
Jason et al., 2006 ^a (4)	Oxford House versus usual aftercare; no exclusions noted	Substance use, criminal activity, employment	At 24 months, Oxford House group had significantly lower substance use, higher monthly income, and lower incarceration rates.	Brief report with little detail on methods or participant characteristics
Jason et al., 2007 ^a (12)	Oxford House versus usual aftercare; no exclusions noted	Substance use, criminal charges, employment	Oxford House group had significantly more positive outcomes for each measure over time (up to 24 months) compared with usual care. Length of stay and age interactions with outcomes were noted.	Statistical controls for demographic and baseline characteristics (no demographic differences reported by group); no information reported on response rates at follow-up
Groh et al., 2009 ^a (11)	Oxford House versus usual aftercare; no exclusions noted	Substance use, criminal activity, employment	Abstinence significantly increased for Oxford House group versus usual care for those who had high 12-step involvement. For those with low 12-step involvement, abstinence rates were similar across groups.	No baseline sociodemographic differences; analyses did not control for covariates
Jason et al., 2011 ^a (13)	Oxford House versus usual aftercare; no exclusions noted	Substance use, employment, self-regulation	Individuals with posttraumatic stress disorder (PTSD) in usual aftercare had worse self-regulation at 2 years than those without PTSD in either group. For those with no PTSD, employment rates were higher in Oxford House group than in usual aftercare. For those with and without PTSD, relapse rates were higher in usual aftercare than in Oxford House.	Small sample of participants with PTSD; required employment of Oxford House residents led to somewhat biased outcome; only self-regulation analyses included covariates
Tuten et al., 2012 (14)	Three groups: recovery house alone, recovery house plus reinforcement-based treatment, and usual care; participants, 18–60 years old, were opioid dependent and had completed medication-assisted detoxification; study excluded individuals receiving opioid agonist medication, those experiencing acute medical or psychological illness, and pregnant women	Abstinence (opioid and cocaine), consistent abstinence	Abstinence decreased over time for participants in two recovery house conditions and increased over time for those in usual care condition, with significant differences between recovery house groups and usual care at 6 months. Length of stay mediated abstinence.	Inclusion and exclusion criteria limited generalizability; abstinence measured only for opioids and cocaine; urine samples collected to complement self-report
Quasi-experimental study				
Polcin et al., 2010 (15) ^b	Sober living houses associated with outpatient treatment versus freestanding sober living houses; no exclusions noted	Substance use, Addiction Severity Index, psychiatric symptoms	Significant decline in “peak density” of drug use was noted over 6 months in both groups. Low severity of alcohol and drug use at baseline was either maintained or further improved. Employment significantly improved in both groups. 12-month outcomes were similar to 6-month outcomes.	Self-selection into housing and characteristics of clients in two groups differed; some evidence of recovery success required before entry into sober living house; thus some floor effect for outcomes

^a These articles reported on the same overall study.^b Also reported in Polcin et al., 2010 (6)

lack of consistency in models and outcomes made it difficult to assess evidence across programs. Most of the studies did not distinguish among substances used by participants, but the programs required abstinence at the time of entry into housing.

Effectiveness of the service

Studies examining Oxford House models for individuals with substance use disorders showed positive effects. In an RCT, Jason and colleagues (4,11–13) recruited individuals who were completing residential substance use treatment and randomly assigned them to Oxford House or to treatment as usual (for example, outpatient substance use treatment, aftercare, and mutual help). The researchers, who are long-term collaborators with Oxford Houses, facilitated Oxford House entry by identifying those with openings for new residents and assisting with the application process. Two years after entering the Oxford House, individuals had significantly less substance use, more employment, and higher incomes than those who received usual care. Further, longer stays in an Oxford House were related to better outcomes; this was particularly true for younger Oxford House residents, who had better outcomes if they stayed at least six months. Researchers also found that among individuals with co-occurring post-traumatic stress disorder who were randomly assigned to an Oxford House or to treatment as usual, individuals in the treatment-as-usual condition had lower levels of self-regulation compared with those in the Oxford House condition (13). Replication of this study is warranted because it used small samples. Oxford House residence combined with involvement in a 12-step program had a positive effect on self-report of abstinence over a 24-month period (11).

Tuten and colleagues (14) examined drug abstinence outcomes of individuals who were randomly assigned after opioid detoxification to a recovery home with a reinforcement-based outpatient treatment condition, a recovery home only condition, or usual care (that is, aftercare referrals and community-based resources). They found that the groups had significantly

Evidence for the effectiveness of recovery housing: moderate

Areas of improvement suggested by overall positive results:

- Drug and alcohol use
- Employment
- Psychiatric symptoms

different rates of abstinence at the one- and three-month follow-up assessments; those in the recovery home with reinforcement-based outpatient treatment had the highest rates of abstinence, and those in the usual-care condition had the lowest rates of abstinence. Individuals in the recovery home with reinforcement-based outpatient treatment remained significantly more likely than individuals in the usual-care condition to abstain from opioid and cocaine use at the six-month follow-up assessment. In a single-group, repeated-measures study of individuals receiving outpatient treatment combined with residence in a sober living house, Polcin and colleagues (15) found improvements at six months postbaseline on measures of alcohol and drug use, arrests, and days worked. Significant declines in alcohol and drug use were maintained at 12 months postbaseline, and no significant increases in alcohol or drug use were found at 18 months.

Discussion and conclusions

This review found a moderate level of evidence for the effectiveness of recovery housing (see box on this page). Findings in the literature suggest that recovery housing can have positive effects on many aspects of recovery and that this service has an important role to play in supporting individuals with substance use disorders. This recommendation is tempered by the fact that the six articles identified through the literature review represented only three distinct studies. Further, these studies had methodological limitations, including attrition, nonequivalent groups, small samples, single-site evaluations, and lack of statistical controls.

With limited literature, it is difficult to draw conclusions across studies; however, these studies highlight areas of recovery housing that have policy and practice implications. It should

be noted that with an abstinence requirement for entering housing, there is often a floor effect. That is, when participants have very low substance use at baseline, it is unlikely that further improvements over time will be found in substance use measures—a traditional outcome in studies of substance use disorders. Rather, outcome measures are likely to reflect maintenance of abstinence or limited substance use over time. Changes in employment and criminal activity instead may be the key outcomes.

Two studies indicated that outcomes were better with longer stays in the recovery house (12,14). In addition, several studies indicated that success in the recovery house may also depend on other client characteristics, such as involvement in a 12-step program, age, or a diagnosis of posttraumatic stress disorder (11–13). These differential effects should be examined further, and it is likely that other variations in outcomes may be identified in additional studies.

The primary recommendation for future research is for methodologically rigorous randomized or nonrandomized controlled trials that are conducted with larger samples and across multiple sites. Further, several of the studies (for example, studies of Oxford House) were conducted by researchers who were collaborators. In most cases, the conditions were not blind to the interviewers or the evaluators. Because these issues may lend themselves to bias, external evaluations would also be an important next step. The research in this area would benefit from more consistent approaches that would facilitate better cross-comparisons and meta-analyses.

We identified other topics for future research, in addition to the need for greater methodological rigor. The effects of recovery housing on long-term recovery in multiple domains of functioning should be examined. For

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example, the literature should focus on improvements in psychiatric symptoms and substance use and severity that extend beyond housing and quality-of-life outcomes. Further studies of approaches to recovery housing for individuals with substance use disorders should be undertaken to determine whether models other than the Oxford House approach are valuable. Also, evaluation of which organizational and structural aspects of sober living houses are effective would help with program development and clarity in defining the recovery housing model.

Finally, it is important to assess recovery housing for specific subpopulations (for example, by diagnosis, age, sex, and immigrant status). Most studies described participants' demographic characteristics, and some studies controlled for these characteristics in their analyses. However, few studies specifically analyzed race or ethnicity through interaction terms, stratification, or other approaches. As with any consideration of individual lives and successful recovery, it is essential to consider subgroup differences. This may be important particularly when we consider how people live, interact, or incorporate their cultural beliefs and backgrounds—key concerns when evaluating the role of housing. These characteristics may affect willingness to live independently or in group settings, for example, and they may also affect the roles of staff or residents in managing aspects of recovery. Preliminary research is beginning to examine approaches to adapt features of recovery homes to better meet the cultural needs of specific racial-ethnic populations (16). However, more research is required to explore the effectiveness of these adaptations. We encourage future researchers to evaluate whether certain approaches are as successful for a variety of subgroups as they are for the broader population.

Recovery housing has value as part of the full spectrum of options that support recovery from substance use disorders. However, a key issue for

recovery housing as a service is funding. In most cases, recovery housing does not include formal therapeutic treatment; therefore, it is not reimbursable by public or private insurance. Rather, recovery houses are often supported by charitable donations and contributions from the residents. Policy makers, including payers (for example, directors of state mental health and substance use treatment systems, administrators of managed care companies, and county behavioral health administrators), must consider alternative mechanisms that would support recovery housing as they determine how best to incorporate this approach into a full continuum of care. Consumers will benefit from increased access to sober living opportunities as a long-term step toward a life in recovery in the community. Future rigorous research on this service will improve our ability to target the consumers who would receive the most benefit.

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Attachment No. 24

*Residential Treatment for Individuals With
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No. 3

Residential Treatment for Individuals With Substance Use Disorders: Assessing the Evidence

Sharon Reif, Ph.D.

Preethy George, Ph.D.

Lisa Braude, Ph.D.

Richard H. Dougherty, Ph.D.

Allen S. Daniels, Ed.D.

Sushmita Shoma Ghose, Ph.D.

Miriam E. Delphin-Rittmon, Ph.D.

Objective: Residential treatment is a commonly used direct intervention for individuals with substance use or co-occurring mental and substance use disorders who need structured care. Treatment occurs in nonhospital, licensed residential facilities. Models vary, but all provide safe housing and medical care in a 24-hour recovery environment. This article describes residential treatment and assesses the evidence base for this service.

Methods: Authors evaluated research reviews and individual studies from 1995 through 2012. They searched major databases: PubMed, PsycINFO, Applied Social Sciences Index and Abstracts, Sociological Abstracts, and Social Services Abstracts. They chose from three levels of evidence (high, moderate, and low) and described the evidence of service effectiveness.

Results: On the basis of eight reviews and 21 individual studies not included in prior reviews, the level of evidence for residential treatment for substance use disorders was rated as moderate. A number of randomized controlled trials were identified, but various methodological weaknesses in study designs—primarily the appropriateness of the samples and equivalence of comparison groups—decreased the level of evidence. Results for the effectiveness of residential treatment compared with other types of treatment for substance use disorders were mixed. Findings suggested either an improvement or no difference in treatment outcomes. **Conclusions:** Residential treatment for substance use disorders shows value and merits ongoing consideration by policy makers for inclusion as a covered benefit in public and commercially funded plans. However, research with greater specificity and consistency is needed. (*Psychiatric Services* 65:301–312, 2014; doi: 10.1176/appi.ps.201300242)

Dr. Reif is with the Institute for Behavioral Health, Heller School for Social Policy and Management, Brandeis University, Waltham, Massachusetts. Dr. George, Dr. Daniels, and Dr. Ghose are with Westat, Rockville, Maryland. Dr. Braude and Dr. Dougherty are with DMA Health Strategies, Lexington, Massachusetts. Dr. Delphin-Rittmon is with the Office of Policy, Planning, and Innovation, Substance Abuse and Mental Health Services Administration (SAMHSA), Rockville, Maryland. Send correspondence to Dr. George at preethygeorge@westat.com. This literature review is part of a series that will be published in Psychiatric Services over the next several months. The reviews were commissioned by SAMHSA through a contract with Truven Health Analytics. The reviews were conducted by experts in each topic area, who wrote the reviews along with authors from Truven Health Analytics, Westat, DMA Health Strategies, and SAMHSA. Each article in the series was peer reviewed by a special panel of Psychiatric Services reviewers.

People with substance use disorders have a wide variety of needs across the range of symptom severity. To address these needs, a continuum of care that includes intensive treatment services is in place. Recognition is growing that safe and stable living environments are important in the recovery process for individuals with substance use disorders who need structured care. Residential treatment is a structured, 24-hour level of care that enables a focus on intensive recovery activities. It aims to help people with substance use disorders and a high level of psychosocial needs become stable in their recovery before engagement in outpatient settings and before return to an unsupervised environment, which may otherwise be detrimental to their recovery process. This article describes residential treatment and assesses the evidence base for this service.

This article reports the results of a literature review that was undertaken as part of the Assessing the Evidence Base Series (see box on next page). For purposes of this series, the Substance Abuse and Mental Health Services Administration (SAMHSA) has described residential treatment for substance use disorders as a direct service with multiple components that is delivered in a licensed facility used to evaluate, diagnose, and treat the symptoms or disabilities associated with an adult's substance use disorder. SAMHSA

About the AEB Series

The Assessing the Evidence Base (AEB) Series presents literature reviews for 13 commonly used, recovery-focused mental health and substance use services. Authors evaluated research articles and reviews specific to each service that were published from 1995 through 2012 or 2013. Each AEB Series article presents ratings of the strength of the evidence for the service, descriptions of service effectiveness, and recommendations for future implementation and research. The target audience includes state mental health and substance use program directors and their senior staff, Medicaid staff, other purchasers of health care services (for example, managed care organizations and commercial insurance), leaders in community health organizations, providers, consumers and family members, and others interested in the empirical evidence base for these services. The research was sponsored by the Substance Abuse and Mental Health Services Administration to help inform decisions about which services should be covered in public and commercially funded plans. Details about the research methodology and bases for the conclusions are included in the introduction to the AEB Series (8).

has defined three levels of clinically managed residential services. All provide 24-hour care, but they offer treatment with varying intensity and focus depending on the resident's needs. Table 1 presents a description of the components of this service.

Examination of the effectiveness of residential treatment for people with substance use disorders and for various subgroups is challenged by lack of a clear definition of service methods, treatment duration, and treatment standards. The objectives of this review were to describe models and components of residential treatment for substance use disorders, rate and discuss the level of evidence (that is, methodological quality) of existing studies, and describe the effectiveness of the service on the basis of the research literature. We focus on treatment for substance use disorders, although individuals in treatment may also have co-occurring mental disorders. Effectiveness studies primarily compared residential treatment for substance use disorders to other levels of care (for example, intensive outpatient treatment). Outcomes measured included drug and alcohol use, psychiatric symptoms, and other measures of psychosocial functioning.

Description of residential treatment

Residential treatment for substance use disorders is a setting in which services occur, rather than a discrete treatment

intervention. A variety of therapeutic interventions may be implemented across different residential treatment settings; however, a common defining characteristic of residential treatment is that it provides housing for individuals who are in need of rehabilitation services.

Residential treatment occurs in non-hospital or freestanding residential facilities. Treatment for substance use disorders typically takes place in facilities that are licensed by each state's Single State Agency for Substance Abuse Services. Residential treatment is part of the primary rehabilitation phase of treatment and may be preceded by detoxification, if warranted. Residential treatment should be followed by less intensive treatment and aftercare services within a continuum of care. A separate article in this series addresses intensive outpatient programs for substance use disorders (1).

Residential treatment for substance use disorders is used for a wide range of populations with a range of sociodemographic characteristics. For example, residential treatment is appropriate for individuals who have co-occurring mental and substance use disorders because of the challenges associated with having multiple disorders and their common need for intensive treatment in a safe environment. Residential treatment is also appropriate for individuals who are homeless, particularly because of the environmental challenges of achieving

and maintaining sobriety or other aspects of recovery without stable housing.

The American Society of Addiction Medicine (ASAM) has spearheaded the complex task of developing specifications for addiction treatment at various levels of care and criteria to identify which individuals are most appropriate for which types of services (2,3). The ASAM patient placement criteria (ASAM PPC-2R) (2) consist of six dimensions: intoxication/withdrawal, medical conditions, mental health conditions, stage of change/motivation, recovery/relapse risks, and the recovery environment. Assessments on these dimensions are often used to place people into the level of care that matches their particular needs and provides a framework for treatment planning.

The ASAM PPC-2R (2) states that "the defining characteristic of all [residential] Level III programs is that they serve individuals who need safe and stable living environments in order to develop their recovery skills." Individuals are considered appropriate for residential treatment, in particular, if they demonstrate a need for medical care, safe and stable housing, or a structured 24-hour recovery environment. Residential treatment services include a live-in setting that is housed in or affiliated with a permanent facility; organization and staffing by addiction and mental health personnel; a planned regimen of care with defined policies, procedures, and clinical protocols; and mutual- and self-help group meetings. The ASAM criteria informed the service-level definitions that are presented in Table 1. Residential treatment programs have specific programmatic and staffing requirements from the states in which they are licensed, which frequently (but not always or wholly) coincide with ASAM criteria.

ASAM describes most residential programs as clinically managed, meaning that they have a structured environment with skilled treatment staff but no on-site physician. Individuals are recommended for residential care if their withdrawal and biomedical needs are minimal, meaning that they did not experience acute withdrawal symptoms or they have already concluded the physical withdrawal process and no longer have a health risk related to withdrawal. Residents may have

moderate psychiatric and general medical needs and significant challenges in the areas of treatment readiness, relapse potential, recovery skills, and environmental stability. The length of stay in nonhospital residential treatment has shortened considerably over time; most planned stays now range from weeks to months, depending on the program and the person's needs.

Most studies of residential treatment use an acute care model in which outcomes are evaluated after treatment, rather than a chronic care model in which outcomes are evaluated during ongoing treatment—as is the case for a chronic condition such as hypertension or other medical comorbidity (4). Evaluations of treatment effectiveness for chronic disorders take place during the continuing care phase of treatment while patients are still receiving supportive care (albeit while living in the community), and permanent change is not expected in the absence of ongoing care. A continuum-of-care model for substance use treatment is critical whereby, after completion of residential treatment, participants are engaged continuously in less intensive forms of treatment to promote smooth transitions to self-management in the community (5,6).

Residential treatment models vary widely and have evolved over the years; this evolution presents challenges to efforts to compare research outcomes. The traditional “Minnesota model” was a planned 28-day residential treatment approach that is fairly rare today, as is the traditional hospital inpatient program with which residential treatment frequently has been compared.

A specific type of residential treatment setting is a therapeutic community. Therapeutic communities and other social model programs generally have a consistent approach, in which all aspects of the residential community are used as part of the treatment experience. The National Institute on Drug Abuse defines care within a therapeutic community as provided 24 hours per day in a nonhospital setting, with planned lengths of stay of six to 12 months. Treatment focuses on social and psychological causes and consequences of addiction. Treatment is structured and comprehensive, to “focus on the ‘re-socialization’ of the individual and use the program’s entire

Table 1

Description of residential treatment for substance use disorders

Feature	Description
Service definition	Residential treatment for individuals with substance use disorders is a direct service with multiple components delivered in a licensed facility used to evaluate, diagnose, and treat the symptoms or disabilities associated with an adult's substance use disorder. Levels of service intensity: Low: Clinically managed, low-intensity residential services provide 24-hour supportive care in a structured environment to prevent or minimize a person's risk of relapse or continued substance use. This level of care may include services such as interpersonal and group-living skills training, individual and group therapy, and intensive outpatient treatment. Medium: Clinically managed, medium-intensity residential services provide 24-hour care and treatment for persons with co-occurring substance use and mental disorders who also have significant temporary or permanent cognitive deficits. This level of care includes services that are slowly paced and repetitive; services that are focused primarily on preventing relapse, continued problems, or continued substance use; and services that promote reintegration of the person into the community. High: Clinically managed, high-intensity residential services provide 24-hour care and treatment. This level of care is designed for persons who have multiple deficits that prevent recovery, such as criminal activity, psychological problems, and impaired functioning. This level of care includes services that reduce the risk of relapse, reinforce prosocial behaviors, assist with healthy reintegration into the community, and provide skill building to address functional deficits.
Service goal	Provide individuals with safe and stable living environments in which to develop their recovery skills and aid in their rehabilitation from substance use disorders
Populations	Individuals with substance use disorders; individuals with co-occurring mental and substance use disorders; individuals who are homeless
Settings for service delivery	Nonhospital residential facilities; therapeutic communities

community—including other residents, staff, and the social context—as active components of treatment . . . [in] developing personal accountability and responsibility as well as socially productive lives” (7). A social model residential approach is similar to a therapeutic community.

Leaders in substance abuse and mental health policy arenas need information about the effectiveness of residential treatment for substance use disorders as they determine which interventions should be included as covered benefits in public and commercially funded health plans and as they make policy decisions

about treatment interventions. This review aimed to provide state behavioral health directors and their staff, purchasers of health services, policy officials, and community health care administrators with an accessible summary of the evidence for residential treatment for substance use disorders and a discussion of areas needing further research.

Methods

Search strategy

To provide a summary of the evidence for and effectiveness of residential treatment for substance use disorders, we conducted a literature search of

articles published from 1995 through 2012. We searched major databases: PubMed (U.S. National Library of Medicine and National Institutes of Health), PsycINFO (American Psychological Association), Applied Social Sciences Index and Abstracts, Sociological Abstracts, and Social Services Abstracts. We used combinations of the following search terms: residential treatment, substance use, substance abuse, dual diagnosis.

Inclusion and exclusion criteria

The following types of articles were included: randomized controlled trials (RCTs), quasi-experimental studies, and review articles such as meta-analyses and systematic reviews; U.S. and international studies in English; studies that focused on residential treatment for adults with substance use disorders or co-occurring mental health and substance use disorders; and studies that included outcomes such as measures of substance use.

Studies were excluded that examined residential treatment solely with adolescent populations and that examined residential treatment in criminal justice settings. Clients treated within the criminal justice system are likely to have other motivators for success (for example, to remain out of jail or prison), and thus the services and outcomes examined in these studies are not directly comparable to residential treatment services and outcomes examined elsewhere. Also excluded were studies that focused only on cost-effectiveness, did not have a comparison group, measured only length of stay or other effects that occurred during treatment, or used only pre-post analyses without statistical controls for baseline differences.

Existing review articles were given priority in this summary of the evidence. Individual articles are detailed here only if they were not previously included in a published review.

Strength of the evidence

The methodology used to rate the strength of the evidence is described in detail in the introduction to this series (8). The research designs of the identified studies were examined to determine that they met the inclusion criteria. Three levels of evidence (high,

moderate, and low) were used to indicate the overall research quality of the collection of studies. Ratings were based on predefined benchmarks that took into account the number of studies and their methodological quality. In rare instances when the ratings were dissimilar, a consensus opinion was reached.

In general, high ratings indicate confidence in the reported outcomes and are based on three or more RCTs with adequate designs or two RCTs plus two quasi-experimental studies with adequate designs. Moderate ratings indicate that there is some adequate research to assess the service, although it is possible that future research could influence reported results. Moderate ratings are based on the following three options: two or more quasi-experimental studies with adequate design; one quasi-experimental study plus one RCT with adequate design; or at least two RCTs with some methodological weaknesses or at least three quasi-experimental studies with some methodological weaknesses. Low ratings indicate that research for this service is not adequate to draw evidence-based conclusions. Low ratings indicate that studies have non-experimental designs, there are no RCTs, or there is no more than one adequately designed quasi-experimental study.

We accounted for other design factors that could increase or decrease the evidence rating, such as how the service, populations, and interventions were defined; use of statistical methods to account for baseline differences between experimental and comparison groups; identification of moderating or confounding variables with appropriate statistical controls; examination of attrition and follow-up; use of psychometrically sound measures; and indications of potential research bias. The evidence was rated as stronger when service and population definitions were clear and appropriate, statistical controls were used to account for baseline differences, and potential confounding variables and research bias (including attrition) were minimized.

Effectiveness of the service

We described the effectiveness of the service—that is, how well the outcomes of the studies met the goals of residen-

tial treatment. We compiled the findings for separate outcome measures and study populations, summarized the results, and noted differences across investigations. We evaluated the quality of the research design in our conclusions about the strength of the evidence and the effectiveness of the service. Although meta-analytic techniques would be valuable to assess the evidence across studies, the wide heterogeneity of the studies precluded this approach.

Results and discussion

Overall, we found a moderate level of evidence in the literature for the effectiveness of residential treatment for substance use disorders. Numerous RCTs and quasi-experimental studies were identified, but there were many methodological challenges within these studies. However, on the whole, the reviews and individual studies that were conducted found that residential treatment is an effective service for some types of patients. The level of evidence and the effectiveness of the service are described further below.

Level of evidence

The literature search identified eight research reviews published since 1995 that largely overlapped in the studies they included. The reviewed studies focused on adult participants with co-occurring mental and substance use disorders (9–11), inpatient populations (12,13), and therapeutic communities (14–16). We further evaluated seven individual RCTs that compared some version of residential treatment to a control condition (17–23) and 14 quasi-experimental studies (24–37). Table 2 and Table 3 summarize the features of the studies included in this review and their findings. The level of evidence for residential treatment for substance use disorders was graded as moderate, because this service met the criteria of having two or more RCTs with methodological weaknesses.

The studies lacked rigorous experimental design or quasi-experimental methods that controlled for patient characteristics. A focus on selected populations (for example, male veterans) and on a limited number of treatment sites limited the generalizability of several studies. Most effectiveness studies

Table 2Review articles of residential treatment for substance use disorders included in the review^a

Study	Focus of review	N of studies reviewed	Main outcomes reported	Summary of findings	Comments
Finney et al., 1996 (12)	Inpatient treatment for alcohol abuse (residential settings)	14 studies: 12 experimental, 2 naturalistic	Drinking, employment	Seven of 14 studies found significant effects for at least 1 drinking variable, but the direction varied; likely moderators are discussed.	Studies had methodological limitations. Inpatient settings were very different from current approaches. Many studies excluded individuals with more severe disorders or those who required housing.
Brunette et al., 2004 (9) ^b	Residential programs for people with co-occurring severe mental and substance use disorders; mostly therapeutic communities	10 studies: 2 RCTs, 8 quasi-experimental	Substance use, housing	Nine of 10 studies supported integrated residential treatment for individuals with co-occurring mental and substance use disorders. Four studies found no differences in substance use outcomes.	Studies had methodological limitations, and settings, services, and populations varied.
Smith et al., 2006 (15)	Therapeutic communities	7 RCTs	Substance use, treatment completion, problem severity	Insufficient evidence was found that therapeutic communities are better than other residential treatment.	Studies had methodological limitations. Variation across studies prevented meta-analysis.
Drake et al., 2008 (11) ^b	Residential treatment for people with dual disorders; mostly integrated programs (review article also addressed other services)	12 studies: 1 RCT, 11 quasi-experimental	Substance use, mental health	Seven of 12 studies showed improvements; longer-term studies showed consistent improvements in substance use and other mental health outcomes; 11 of 12 studies found improved outcomes in other areas.	Studies had methodological limitations, and settings, services, and populations varied.
Cleary et al., 2009 (10) ^b	Residential programs for people with co-occurring severe mental illness and substance misuse (review article also addressed other services)	9 studies: 1 RCT, 8 quasi-experimental	Substance use, mental state	Six of 9 studies showed reduced substance use; 4 studies showed improved mental state.	Studies had methodological limitations, and settings, services, and populations varied.
Finney et al., 2009 (13)	Inpatient and residential treatment	Approximately 80 studies overall; number varies by specific topic	Varied by topic and study	Evidence was found to support matching patients to various treatment settings. Evidence supports residential treatment for individuals with few social resources or with a living environment that is a serious impediment to recovery.	Details of most studies were not provided.
De Leon, 2010 (16)	Therapeutic communities	21 studies: 4 field studies, 3 single-site studies, 7 RCTs, 1 quasi-experimental, 6 meta-analyses (8 studies are criminal justice based)	Substance use, criminal justice	A consistent relationship was found between retention in therapeutic communities and outcomes. Improved outcomes were noted in therapeutic communities across RCTs and quasi-experimental studies. Meta-analyses showed mixed findings.	The review was not comprehensive and included criminal justice-based therapeutic communities. Studies without comparison groups were included, and methods, settings, and populations varied widely across studies.
Malivert et al., 2012 (14)	Therapeutic communities	12 studies: 7 RCTs, 2 retrospective, 3 quasi-experimental	Substance use	Substance use decreased during treatment, but relapse was frequent after therapeutic community treatment. Outcomes were better if the participant completed treatment. No impact of psychiatric comorbidities was noted.	Studies had methodological limitations. Variation across studies prevented meta-analysis.

^a Articles are in chronological order. Abbreviation: RCT, randomized controlled trial^b These review articles largely overlapped in the individual studies they included.

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Table 3Individual studies of residential treatment of substance use disorders included in the review^a

Study	Design and population	Outcomes measured	Summary of findings	Comments
RCT				
Burnam et al., 1995 (17)	Social model residential versus social model nonresidential versus no intervention; homeless individuals had a dual diagnosis of substance dependence and either schizophrenia or major affective disorder; mostly male	Substance use, severity of mental illness symptoms, housing	At 3-month follow-up, no group differences were found except for housing; residential treatment had a positive effect if the analysis also accounted for services received outside the RCT.	Contamination with outside services was noted, although outside service use was tracked. Differential participation rates and high attrition were also noted.
McKay et al., 1995 (21)	VA inpatient addiction rehabilitation versus VA day treatment; male alcoholic veterans; excluded those with unstable residence, drug dependence, severe medical problems, recent psychosis, schizophrenia	Substance use, other problems	No main effects were found across groups.	The groups were not equivalent despite statistical controls, and many exclusion criteria were used.
Guydish et al., 1998 (20) ^b	Therapeutic community versus therapeutic community model day treatment; excluded homeless individuals, those with severe psychiatric problems, those clinically judged appropriate only for residential treatment	ASI composite scores, psychiatric symptoms, social support	Both groups improved in employment, legal problems, substance use problems, and depressive symptoms. Residential treatment participants also improved in medical and social problems, psychiatric symptoms, and social support.	Exclusions eliminated many individuals likely to be most appropriate for residential treatment. High dropout was noted in the 2 weeks after randomization.
Guydish et al., 1999 (19) ^b	Therapeutic community versus therapeutic community model day treatment; excluded homeless individuals, those with severe psychiatric problems, those clinically judged appropriate only for residential treatment	ASI composite scores, psychiatric symptoms, social support	Both groups improved over time. Those in residential treatment had better ASI social composite scores and fewer psychological symptoms.	Exclusions eliminated many individuals likely to be most appropriate for residential treatment. High dropout was noted in the 2 weeks after randomization.
Rychtarik et al., 2000 (22)	Freestanding residential versus intensive outpatient versus outpatient treatment; participants with alcohol use disorders; excluded homeless individuals, those with addiction treatment in past 30 days, those with serious psychiatric symptoms	Abstinence, substance use	Abstinence improved across groups. Interactions were found for setting for those with higher alcohol involvement and poorer cognitive functioning at baseline; they showed more improvement in a residential setting.	Few differences were noted between groups at baseline. Exclusions eliminated many individuals likely to be most appropriate for residential treatment.
Greenwood et al., 2001 (18) ^b	Therapeutic community versus therapeutic community model day treatment; excluded homeless individuals, those with severe psychiatric problems, those clinically judged appropriate only for residential treatment	Substance use	Abstinence improved in both groups. The day treatment group had a higher relapse rate at 6 months but not at 12 or 18 months.	Exclusions eliminated many individuals likely to be most appropriate for residential treatment. High dropout was noted in the 2 weeks after randomization.
Witbrodt et al., 2007 (23)	Social model residential versus social model day hospital; also examined clients not randomly assigned to each setting; part of health plan system; no random assignment if individual had high environmental risk for relapse or more than minimal medical or psychological problems	Abstinence	Abstinence was noted for about two-thirds of each group at 6 months. No difference was found by setting in adjusted models for either randomly assigned or self-selected (not randomly assigned) clients.	Significant differences were found across groups in various measures of severity. The authors adjusted for these measures in regression models. Differential attrition was noted at follow-up.

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Table 3*Continued from previous page*

Study	Design and population	Outcomes measured	Summary of findings	Comments
Quasi-experimental				
Moos et al., 1996 (33)	VA community-based residential versus VA hospital-based residential; male veterans discharged from acute inpatient care for substance use disorders	Inpatient readmission (for mental or substance use disorder)	A lower probability of readmission was noted for participants in community residential programs compared with hospital-based programs.	Baseline differences between groups were found for psychiatric diagnosis and inpatient care but not for demographic characteristics. Additional treatment was documented only if received in VA.
Hser et al., 1998 (27) ^c	Short-term inpatient and long-term residential versus outpatient treatment; DATOS study: patients treated in participating community treatment programs	Substance use	Inpatient and residential programs were best for non-daily cocaine and heroin users.	There was no control for baseline patient characteristics aside from pre-treatment drug use. Data were collected after 1 week in treatment, which introduced potential bias by excluding early dropouts.
Harrison and Asche, 1999 (26)	Inpatient, mostly Minnesota model, and a few therapeutic communities versus outpatient; excluded those with cognitive impairment that precluded consent	Abstinence	No difference in abstinence was found by group.	Group differences were noted in sociodemographic characteristics. Analyses controlled for many baseline variables, but group placement was based on very different individual characteristics.
Pettinati et al., 1999 (35)	Inpatient versus outpatient; alcohol-dependent but not drug-dependent patients; excluded those with severe withdrawal or serious medical problems	Drinking status	No effect by group was found on return to significant drinking. Survival analysis showed a steeper initial rate of return to drinking for the outpatient group.	Analyses controlled for baseline severity but no other patient characteristics.
Schildhaus et al., 2000 (36) ^d	Residential (mostly therapeutic communities) versus inpatient treatment; SROS study: participants treated in community treatment facilities	Substance use, criminal behavior	No difference in outcomes was found for participants in residential and inpatient settings.	This 5-year follow-up study controlled for many variables before, during, and after treatment using retrospective data.
McKay et al., 2002 (31)	“Full continuum” of residential before outpatient treatment versus “partial continuum” of intensive outpatient treatment as entry point; no exclusions noted	Substance use, ASI composite scores	Both groups improved over time on all outcomes. A significant severity × modality interaction was found, with larger improvements for those with high alcohol severity scores in the full continuum compared with those in the partial continuum.	Baseline differences were noted between groups, including severity scores. Groups had differential issues with recruitment. High attrition was noted.
Mojtabai and Zivin, 2003 (32) ^d	Residential (mostly therapeutic communities) versus inpatient and outpatient; SROS study: participants treated in community treatment facilities	Abstinence, substance use	Overall, no difference was found between residential and outpatient treatment. Some effects were seen with propensity score matching.	This 5-year follow-up study used a propensity score approach to control for baseline characteristics, but control for other characteristics during follow-up, such as additional treatment, was unclear.
Hser et al., 2004 (28)	Residential versus outpatient treatment without methadone; no exclusions noted	Treatment success (includes drug use, ASI drug severity score, criminal activity, residence in community)	Those in residential treatment were more likely to complete treatment and had longer stays, which in turn predicted better outcome.	This study used path analysis with statistical controls. Nearly half of the sample had missing data, and these participants were excluded from analyses.

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Table 3

Continued from previous page

Study	Design and population	Outcomes measured	Summary of findings	Comments
Ilgén et al., 2005 (30) ^e	VA “inpatient” (inpatient, residential, or therapeutic community–like domiciliary) versus “outpatient” (outpatient or intensive outpatient); veterans, no substance abuse treatment in past 90 days; mostly male	Abstinence; suicide attempts; ASI alcohol, drug, and psychological composite scores	At 6 months, inpatient groups had lower alcohol and drug composite scores than outpatient groups. An interaction effect was found such that individuals with a recent suicide attempt were more likely to be abstinent if treated as inpatients.	Analyses controlled only for baseline ASI measures and not for other patient characteristics. Control variables were not specified. “Inpatient” combined several very different types of care.
Brecht et al., 2006 (24)	Residential versus outpatient treatment as usual; methamphetamine users	Methamphetamine use, criminal activity, employment	Reduced methamphetamine use and crime were noted in the residential group. No difference was found for employment.	Data were collected retrospectively.
Ilgén et al., 2007 (29)	Residential versus outpatient community settings; no exclusions noted	Suicidal behavior	The residential setting was associated with fewer suicide attempts during treatment. No difference between groups was found in the year after treatment.	Baseline differences between groups were noted, but analyses used statistical controls. Substance use outcome was not measured.
Tiet et al., 2007 (37) ^e	VA “inpatient” (inpatient, residential, or therapeutic community–like domiciliary treatment) versus “outpatient” treatment (outpatient or intensive outpatient); veterans; mostly male	Substance use severity	No main effect was found for treatment setting. Some small interaction effects were noted: those with a higher severity of substance use at baseline had better outcomes in inpatient and residential than in outpatient settings.	Significant group differences were noted at baseline, but regression models controlled for them. Differential attrition and nonresponse bias were noted.
De Leon et al., 2008 (25) ^c	Long-term residential; matched undertreated and overtreated patients; DATOS study: patients treated in participating community treatment programs	Substance use, arrests	Patients had better outcomes if they were matched to residential treatment than if they were appropriate for residential treatment but undertreated in an outpatient setting. Similar outcomes were noted in residential treatment if patients were matched or overtreated (appropriate for outpatient treatment but treated in a residential setting).	Data were collected after 1 week in treatment, which introduced potential bias by excluding early dropouts.
Morrens et al., 2011 (34)	Integrated treatment for patients with schizophrenia and co-occurring substance use disorder in a residential setting versus treatment as usual; both groups recruited from inpatient psychiatric hospitals and continued with outpatient care; psychotic disorder for at least 2 years and substance use disorder; aged 18–45 years only	Substance use, psychiatric symptoms	At 3 months, the integrated residential group had reduced substance use, improved psychiatric symptoms, and higher quality of life and functioning compared with the treatment-as-usual group.	No baseline differences were noted, but differential dropout limited analyses to 3 months. Some tentative conclusions were drawn for 6- and 12-month follow-ups. Dropout rates varied between groups.

^a Articles are in chronological order by type of research design. Abbreviations: ASI, Addiction Severity Index; DATOS, Drug Abuse Treatment Outcome Study; RCT, randomized controlled trial; SROS, Services Research Outcomes Study; VA, Veterans Affairs

^{b–e} Articles with the same superscript reported some aspects of the same study.

described here evaluated patients who chose or were referred by clinicians to a specific treatment modality. RCTs that evaluated specific treatment

modalities for substance use disorders were rare because treatment providers had concerns about randomly assigning individuals in need of treatment to a no-

treatment condition or to a lower level of care than was clinically appropriate. Some RCTs were conducted with a large limitation: the researchers required

individuals in the intervention group to be appropriate for the outpatient care that was received by the comparison group, to avoid undertreating individuals who might not be treated safely if randomly assigned to outpatient care. This design created a false comparison, because individuals appropriate for residential treatment (and thus not appropriate for outpatient care) were excluded. Clients with more severe needs (for example, individuals without stable living arrangements or individuals with general medical or psychiatric diagnoses) were often excluded from the intervention group, despite the possibility that they were likely to benefit from residential services.

Many studies that suggested improved outcomes after residential treatment were excluded from this review because they lacked a comparison group or used pre-post measurement without statistical controls. Other methodological concerns in the literature included retrospective data collection, lack of control for the amount of treatment received, and lack of detailed descriptions of the service components. Comparison groups often varied by characteristics of the setting (for example, type of setting or treatment duration) and by treatment content (for example, services or theoretical approach), thereby confounding the comparisons. Each of these limitations influenced the conclusions that could be drawn.

Effectiveness of the service

The effects of residential treatment services were mixed, with some studies indicating positive findings and others showing no significant differences in outcomes between clients in residential treatment settings and those in other types of treatment. For example, the Walden House residential therapeutic community was compared with a therapeutic community model that used a day treatment program (18–20). At six months, both groups had reliable improvement in drug and alcohol use and employment. The Walden House group also had significant improvements in medical and social problems, psychiatric symptoms, and social support. Most outcomes seen at six months

were maintained through 18 months (19); the day treatment group had a higher likelihood of relapse at six months but not at 12 or 18 months (18). In quasi-experimental studies, individuals receiving residential treatment had less methamphetamine use and crime (24), higher treatment completion rates and longer treatment stays (28), and reduced suicide attempts during treatment (29) compared with individuals receiving outpatient treatment. Individuals in inpatient residential treatment had lower alcohol and drug severity scores at six months than those in outpatient treatment, after control for baseline severity (30). De Leon and colleagues (25) found some evidence supporting treatment matching; clients matched to long-term residential care had better one-year outcomes than those undertreated in outpatient drug-free settings. Individuals with co-occurring mental and substance use disorders in integrated residential treatment settings had reduced illicit drug and alcohol use, improved psychiatric domains, higher reported quality of life, and improved social and community functioning than those in treatment as usual (9–11,15).

Reflecting the inconsistency in the literature, other studies showed no significant differences between individuals receiving residential treatment and those receiving treatment in comparison conditions on outcomes such as abstinence from drug use, psychosocial variables, reduced drug use, criminal activity, arrest rates, or rates of returning to prison (21–23,26,27,32,35–37). In an RCT, researchers compared treatment in a residential social model and in a nonresidential social model for homeless individuals with co-occurring mental and substance use disorders (17). No significant differences, aside from housing, were found between residential and nonresidential treatment groups at the three-month follow-up. When the analysis controlled for total services accessed, the residential group had significantly fewer days of alcohol use at the three-month follow-up, but no other significant effects were found.

The inconsistency in findings is documented by the literature reviews we examined. Published reviews of

residential treatment reported on studies that had serious methodological limitations, resulting in the need for “an RCT with a well-defined population, a standardized program, and a blind assessment of outcomes” (9). Finney and colleagues (12,13) conducted two reviews that summarized the evidence on treatment settings—the first in 1996 and the second in 2009. The 1996 review included research on “inpatient” treatment compared with outpatient treatment or detoxification only (12). Although comprehensive at the time, the review was confounded for our purposes by the inclusion of both hospital inpatient approaches and nonhospital residential approaches and the exclusion of individuals with severe problems or without stable housing. In addition, many approaches described in the review article are no longer commonly used in the field; thus the article is not discussed further here. The 2009 review by Finney and colleagues (13) found evidence supporting the effectiveness of treatment that matched patients to different treatment settings, such as via the ASAM PPC-2R. However, the review provided little information about methods used in the included studies.

Three reviews examined the effects of therapeutic communities on substance use outcomes (14–16). A Cochrane Collaboration review indicated that insufficient evidence exists to state that therapeutic communities are more effective than other levels of care; however, methodological limitations tempered the researchers’ conclusions (15). High attrition was a common limitation in the reviewed studies. Some evidence suggested that specific populations, such as homeless individuals with co-occurring mental disorders or individuals in prisons, had better outcomes in therapeutic communities than control groups. The second review found that individuals in therapeutic communities demonstrated improved outcomes compared with individuals in control conditions; however, the findings were limited by various methodological issues, such as overlap between the treatment and comparison conditions and inconsistent program fidelity (16). The third review found significant decreases in substance use

Evidence for the effectiveness of residential treatment for substance use disorders: moderate

Overall mixed results suggest either an improvement or no difference in outcomes such as:

- Drug and alcohol use
- Employment
- Medical and social problems
- Psychiatric symptoms
- Social support

while individuals were in therapeutic communities but indicated that methodological problems tempered the extent to which conclusions could be drawn about the long-term effects of therapeutic communities (14). Similar to other reviews, the third review found that therapeutic communities may provide a better treatment option for individuals with severe psychosocial problems, depending on the length of stay in the program.

Three reviews (9–11) focused on populations with co-occurring mental and substance use disorders. The experimental group usually received integrated residential treatment (for individuals with co-occurring disorders), and control groups received “treatment as usual” with less intense or nonintegrated residential treatment. These reviews found that individuals with co-occurring mental and substance use disorders can be treated successfully in residential settings, whether or not treatment is integrated. At minimum, integrated treatment was equally as effective as standard treatment for this population, and most of the studies found that integrated treatment was more effective than standard treatment in regard to substance use, mental health, and other outcomes.

Conclusions

This review found a moderate level of evidence for the effectiveness of residential treatment (see box on this page). Despite the prevalence of methodological concerns—primarily the appropriateness of the samples and equivalence of comparison groups—some evidence indicates that residential treatment is effective for some types of patients. Further, much of the literature suggests that residential

treatment is equally as effective as comparison modalities, and a few studies suggest that it is more effective. However, until research with more rigorous methods is conducted, these conclusions remain tentative.

We echo the call of others for further research to better determine which clients benefit from residential treatment, what duration of treatment confers positive effects, and what types of effective clinical interventions are provided within the program. Further studies should examine the components of residential treatment that might relate to effectiveness, such as types of clinical staff, use of peer support, number of beds, or lengths of stay currently used. To attain ideal outcomes, it is essential for new evaluations of residential treatment for substance use disorders to take a chronic care approach to ensure that a treatment modality is not evaluated in a vacuum and that continuing care is an outcome as well as an essential part of the treatment episode.

Any new research in this area must be methodologically rigorous and use appropriate comparison groups to ensure that conclusions are valid. Systematic, rigorously conducted studies are essential for policy makers to make decisions about the inclusion of residential treatment in health plans and the allocation of resources to residential treatment activities.

Specifically, research needs to identify which individuals respond best to residential treatment programs. Studies should use appropriate control groups. Future research needs to reflect current approaches to residential treatment and examine the role of treatment factors (such as staffing and length of stay) in contemporary approaches to residential treatment. Research must

include posttreatment variables, such as mutual-help participation, when evaluating outcomes. Examining effective treatments for individuals with substance use disorders requires furthering our understanding of how to improve treatment retention, length of stay, treatment completion, and participation in aftercare.

Finally, it is important to determine whether treatment services are equally effective for different populations. Given the significance of health disparities in access to and receipt of substance use treatment, implementing effective and culturally responsive care is essential. Most studies described the demographic characteristics of the sample, and some studies controlled for these characteristics in analyses. However, no studies specifically analyzed race or ethnicity through interaction terms, stratification, or other approaches. Examining the effectiveness of treatment across different groups requires analyses comparing outcomes of specific subgroups within and across treatment types. Additional work should analyze the role of culture-specific approaches—for example, multilingual staff. We encourage researchers to incorporate such analyses as we continue to evaluate this treatment modality.

In addition to calling for rigorous research on the current system, we note that the moderate level of evidence for the effectiveness of residential treatment of substance use disorders has relevance for consumers and their families as well as for policy makers. Consumers have a wide range of needs, and they would benefit from a variety of services to address those needs. Residential treatment for substance use disorders fills a niche for consumers who require stable living environments that incorporate therapeutic treatments to help them move toward a life in recovery. Similarly, to reduce the likelihood of treatment failure, policy makers should ensure that a full range of treatments is available to meet consumer needs. With research demonstrating a moderate level of evidence, policy makers can highlight the benefit of including residential treatment as a key service in the continuum of care.

As the treatment system for substance use disorders continues to evolve,

particularly within the current context of broader health care system change, it is essential to understand the role and effectiveness of treatment options. Residential treatment has been used for substance use disorders for many years, and there are clear indications for continuing these services. However, for policy makers and payers (for example, state mental health and substance use directors, managed care companies, and county behavioral health administrators) to be able to make recommendations about which services to cover and include in a treatment continuum, they must be able to evaluate those services as they currently exist. Residential treatment shows value for ongoing inclusion and coverage as part of the continuum of care, but additional rigorous research is necessary to understand how and for whom it best fits.

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The authors report no competing interests.

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Submissions Invited for Column on Integrated Care

The integration of primary care and behavioral health care is a growing research and policy focus. Many people with mental and substance use disorders die decades earlier than other Americans, mostly from preventable chronic medical illnesses. In addition, primary care settings are now the gateway to treatment for behavioral disorders, and primary care providers need to provide screening, treatment, and referral for patients with general medical and behavioral health needs.

To stimulate research and discussion in this critical area, *Psychiatric Services* has launched a column on integrated care. The column focuses on service delivery and policy issues encountered on the general medical–psychiatric interface. Submissions are welcomed on topics related to the identification and treatment of (a) common mental disorders in primary care settings in the public and private sectors and (b) general medical problems in public mental health settings. Reviews of policy issues related to the care of comorbid general medical and psychiatric conditions are also welcomed, as are descriptions of current integration efforts at the local, state, or federal level. Submissions that address care integration in settings outside the United States are also encouraged.

Benjamin G. Druss, M.D., M.P.H., is the editor of the Integrated Care column. Prospective authors should contact Dr. Druss to discuss possible submissions (bdruss@emory.edu). Column submissions, including a 100-word abstract and references, should be no more than 2,400 words.

Attachment No. 25

Sober living houses for alcohol and drug dependence: 18-Month outcomes, Douglas L. Polcin, Ed.D., et al., *Journal of Substance Abuse Treatment* 38 (2010) 356-365

Regular article

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

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

^aAlcohol Research Group, Public Health Institute, Emeryville, CA 94608-1010, USA

^bCalifornia Pacific Medical Center, St. Lukes Hospital, San Francisco, CA 94139, USA

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Abstract

Objective: A major challenge facing many individuals attempting to abstain from substances is finding a stable living environment that supports sustained recovery. Sober living houses (SLHs) are alcohol- and drug-free living environments that support abstinence by emphasizing involvement in 12-step groups and social support for recovery. Among a number of advantages, they are financially self-sustaining and residents can stay as long as they wish. Although SLHs can be used as housing referrals after inpatient treatment, while clients attend outpatient treatment, after incarceration, or as an alternative to treatment, they have been understudied and underutilized. **Method:** To describe outcomes of SLH residents, we interviewed 245 individuals within 1 week of entering SLHs and at 6-, 12-, and 18-month follow-up. Eighty-nine percent completed at least one follow-up interview. Outcomes included the Addiction Severity Index (ASI), Brief Symptom Inventory (BSI), and measures of alcohol and drug use. Covariates included demographic characteristics, 12-step involvement, and substance use in the social network. **Results:** Regardless of referral source, improvements were noted on ASI scales (alcohol, drug, and employment), psychiatric severity on the BSI, arrests, and alcohol and drug use. Substance use in the social network predicted nearly all outcome measures. Involvement in 12-step groups predicted fewer arrests and lower alcohol and drug use. **Conclusion:** Residents of SLHs made improvements in a variety of areas. Additional studies should use randomized designs to establish causal effects of SLHs. Results support the importance of key components of the recovery model used by SLHs: (a) involvement in 12-step groups and (b) developing social support systems with fewer alcohol and drug users. © 2010 Elsevier Inc. All rights reserved.

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

1. Introduction

Sober living houses (SLHs) are alcohol- and drug-free living environments for individuals who are attempting to maintain abstinence and develop a recovery-oriented lifestyle (Polcin & Henderson, 2008). Despite research showing that living environments supportive of recovery are associated with better outcome (e.g., Braucht, Reichardt, Geissler, & Bormann, 1995; Hitchcock, Stainback, & Roque, 1995; Schinka, Francis, Hughes, LaLone, & Flynn, 1998), SLHs have been largely overlooked by policymakers and researchers. This article represents a first step toward correcting this

oversight. After reviewing selected studies that show alcohol and drug use is associated with characteristics of social networks and living environments, SLHs are introduced as an underutilized resource for alcohol- and drug-free housing. The article then describes an exploratory investigation of outcomes for 245 individuals entering SLHs along with factors associated with outcome. The primary aim of the study was to provide preliminary data that could be used to support implementation of controlled studies comparing outcomes of residents in SLHs with outcomes of individuals with addictive disorders in other living environments.

1.1. Social networks and living environments

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

* Corresponding author. Alcohol Research Group, Public Health Institute, 6475 Christie Avenue, Suite 400, Emeryville, CA 94608-1010, USA. Tel.: +1 510 597 3440; fax: +1 510 985 6459.

E-mail address: dpolcin@arg.org (D.L. Polcin).

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

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

1.2. Characteristics of SLHs

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

traditional SLHs along with modified SLHs associated with outpatient treatment, see Polcin, Korcha, Bond, Galloway, and Lapp (in press).

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

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

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

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

democratically elected group of residents. SLHs vary in management styles, with some houses emphasizing peer management and leadership of the house and others relying on a strong house manager who is ultimately responsible to the owner/landlord. Third, Oxford houses mandate a range of 6 to 10 members in each house, whereas the numbers of residents in SLHs vary widely depending on the house. Finally, because all Oxford houses fall under the auspices of Oxford House Inc, they tend to be more homogenous than SLHs. Some SLHs are not part of any larger association, and associations that currently exist have different regulations.

1.3. Philosophy of recovery in SLHs

Central to recovery in SLHs is involvement in 12-step self-help groups (Polcin & Henderson, 2008). Residents are usually required to attend meetings and expected to be actively working a 12-step recovery program (e.g., obtain a sponsor, work the 12 steps). However, some houses will allow other types of activities that can substitute for 12-step groups, provided they constitute a strategy for maintaining ongoing abstinence.

Developing a social network that supports ongoing sobriety is also an important component of the recovery model used in SLHs. Residents are encouraged to give and receive support and encouragement for recovery with fellow peers in the house. Residents who have been at the house longest and who have more time in recovery are usually encouraged to provide support to new residents. This type of “giving back” is consistent with a principle of recovery in 12-step groups. Residents are also encouraged to avoid friends and family who might encourage them to use alcohol and drugs, particularly individuals with whom they have used substances in the past.

Although some SLHs use a “strong manager” model where the owner or manager of the house develops and enforces the house rules, contemporary SLH associations such as CAARR and SLN emphasize a “social model approach” to managing houses that empowers residents by providing leadership position and forums where they can have input into decision making (Polcin & Henderson, 2008). Some houses have a “residents’ council,” which functions as a type of government for the house.

1.4. Purpose

To test whether a large, rigorous examination of SLHs is warranted (e.g., randomized clinical trial), this article reports on longitudinal outcomes for 245 SLH residents at 6, 12, and 18 months. Lack of significant improvement over time or exacerbation of alcohol and drug use would suggest that additional study of SLHs was not necessary. However, significant improvement over time would suggest the need to test whether individuals in other living situations made similar improvements or whether improvements were due to the beneficial effects of SLHs.

Our preliminary analyses of a subsample of residents in SLHs suggested they made improvements at 6 and 12 months (Polcin et al., in press). Our primary interest here was to assess outcomes using the full sample over an 18-month period and assess how a variety of covariates were related to outcome. Primary outcomes included severity of drug and alcohol problems. Secondary outcomes included measures of employment, psychiatric, legal, medical, and family problems. We hypothesized that residents who entered the SLHs with high problem severity would improve at 6 months, and those improvements would be maintained at 12 and 18 months. Because some referrals came from controlled environments and some residents had already begun a recovery program before they entered the SLH, we expected that they would enter with lower problem severity and maintain that low severity at 6, 12, and 18 months. Because the philosophy of recovery in SLHs rests on the premise that it is crucial to (a) build a social network that supports abstinence and (b) actively work a 12-step program of recovery, we expected measures of these two factors to correlate with outcomes across time points.

2. Method

2.1. Data collection site

All study participants were recruited from Clean and Sober Transitional Living (CSTL) in Sacramento County California. CSTL operates 16 freestanding SLHs (136-bed capacity) and is structured into two phases. The first (30 to 90 days) is designed to provide more limits and structure (e.g., curfews, mandatory 12-step meeting attendance, shared rooms) to help residents successfully transition into the facility. The second phase allows for more autonomy (e.g., private rooms and fewer requirements for curfews and 12-step attendance). A “Residents Congress” consisting of current residents and alumni help enforce house rules and provide input into the management of the houses. The cost at entry into the house is \$695 per month, which includes family-style meals and utilities. About 90% of the residents use their own financial resources (e.g., employment earnings, savings, family resources, or Social Security Income) to meet housing costs. About 10% of the residents receive financial support from the Substance Abuse Services Coordinating Agency, an agency created for graduates of drug treatment programs in the California Department of Corrections. For a more extensive description of CSTL, see Polcin and Henderson (2008).

2.2. Procedures

Study participants were recruited and interviewed within their first week of entering the houses between January 2004 and July 2006 and interviewed again at 6-, 12-, and 18-month follow-ups. Interviews required about 2 hours, and

participants were paid \$30 for the baseline interview and \$50 for each of the follow-up interviews. All participants signed an informed consent to take part in the study, and all were informed that their responses were confidential. Study procedures were approved by the Public Health Institute Institutional Review Board, and a federal certificate of confidentiality was obtained, adding further protection to confidentiality.

To reach individuals for follow-up interviews, we required them to provide contact information (e.g., phone number, address, e-mail, names of friends who might know whereabouts, family members' phone numbers, health service professions from whom they received services, shelters they frequented, and criminal justice personnel). Among the sample of 245, 89% ($n = 218$) participated in at least one follow-up interview. Follow-up rates for each time point included 72% at 6 months, 71% at 12 months, and 73% at 18 months. To assess whether individuals that we located and interviewed at follow-up differed from those whom we were not able to locate, we conducted baseline comparisons. Separate baseline comparisons were made for individuals interviewed and not interviewed at each time point. On each of these comparisons, we found no differences in terms of demographic characteristics, Addiction Severity Index (ASI) scales (i.e., medical, legal, alcohol, drug, family, and vocational), psychiatric symptoms, and maximum number of days of substance use (alcohol or drugs) per month during the previous 6 months. Thus, the demographic characteristics and problem severity of individuals successfully followed up and lost at follow-up were not significantly different.

2.3. Measures

Several measures were limited to baseline administration and were included as descriptive characteristics:

1. *Demographic characteristics* included standard demographic questions such as age, gender, ethnicity, marital status, and education.
2. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) Checklist for Past 12-Month Alcohol and Drug Dependence* was used to assess substance use disorders over the past 12 months. Items are based on *DSM-IV* diagnostic criteria (American Psychiatric Association, 2000; Forman, Svikis, Montoya, & Blaine, 2004).

Outcome measures included the ASI, which measures severity of problems over the past 30 days. In place of the ASI psychiatric severity scale, we used the Brief Symptom Inventory (BSI). Finally, we used measures that assess the past 6 months in terms of substance use and arrests.

1. *Addiction Severity Index Lite (ASI)*: The ASI is a standardized, structured interview that assesses problem severity in six areas: medical, employment/

support, drug/alcohol, legal, family/social, and psychological. The ASI measures a 30-day period and provides composite scores between 0 and 1 for each problem area. The ASI has demonstrated excellent reliability and validity in numerous studies (McLellan et al., 1992). Although the instrument includes a measure of psychiatric severity as well, we opted to use a more comprehensive measure for psychiatric symptoms, which is described below.

2. *Psychiatric symptoms*: To assess current psychiatric severity, we used the BSI (Derogatis & Melisaratos, 1983). This 53-item measure assesses severity of psychiatric symptoms on nine clinical scales as well as three global indices. Items are rated on a 5-point scale and ask about symptoms over the past 7 days. We used the Global Severity Index (GSI) as an overall measure of psychiatric severity.
3. *Six-month measures of alcohol and drug use*: These measures were taken from Gerstein et al. (1994) and labeled *peak density* and *6-month abstinence*. Peak density is the number of days of any substance use (i.e., any alcohol or drug) during the month of highest use over the past 6 months (coded 0-31). Six-month abstinence was a dichotomous yes/no regarding any use of alcohol or drugs over the past 6 months.
4. *Arrests*: This measure was taken from Gerstein et al. (1994) and was defined as number of arrests over the past 6 months.

Two measures were included as covariates because they assess factors emphasized by as important to recovery in SLHs.

1. *AA Affiliation Scale*: This measure includes nine items and was developed by Humphries, Kaskutas, and Weisner (1998) to measure the strength of an individual's affiliation with AA. The scale includes a number of items beyond attendance at meetings, including questions about sponsorship, spirituality, and volunteer service positions at meetings. An overall scale score ranging from 0 to 9 is generated by summing the items. Measures of internal consistency have been shown to be good across a variety of groups. We included involvement in other 12-step groups in addition to AA, such as Narcotics Anonymous. We therefore refer to "12-step" affiliation throughout the article rather than AA affiliation.
2. *Drinking and drug use status in the social network*: These measures were taken from the Important People Instrument (Zywiak et al., 2002). The instrument allows participants to identify up to 12 important people in his or her network whom they have had contact with in the past 6 months. Information on the type of relationship (e.g., spouse, friend), amount of contact over the past 6 months (e.g., daily, once or twice a week), and drug and alcohol use over the past 6

months (e.g., heavy user, light user, in recovery) was obtained for each person in the social network. The drinking status of the social network was calculated by multiplying the amount of contact by the drinking pattern of each network member, averaged across the network. The same method is applied to obtain the drug status of the network member; the amount of contact is multiplied by the pattern of drug use and averaged across network members.

2.4. Analysis plan

To assess longitudinal changes for each of our outcome measures (ASI scales, GSI, Peak Density, abstinence, and arrests), we used Generalized Estimating Equation (GEE) models (Diggle, Heagerty, Liang, & Zeger, 2002) that compared each follow-up time point (i.e., 6, 12, and 18 months) with baseline. Each outcome measure was entered into a separate model controlling for a variety of baseline demographic covariates (i.e., age, race, education, marital status, and gender). We developed additional GEE models to assess whether factors that are central to the recovery philosophy of SLHs (i.e., involvement in 12-step groups and establishing a social network supportive of abstinence) were related to outcome. A key advantage of the GEE models is that resulting coefficients allow for a longitudinal interpretation of within-individual change in the outcome over time and associations with time-varying covariates of interest. Separate models examined how the 12-step involvement, drinking status of the social network, and drug use status of the social network were related to each outcome. Models controlled for demographic characteristics and time of the interview. Because most of our outcome measures were continuous (ASI, GSI, and peak density), most outcomes are reported as coefficients and standard errors. Those that are dichotomous (abstinent vs. not and arrested vs. not) are reported as odds ratios. GEE analyses were conducted using Stata Version 9 statistical software (Stata Corp, 2005).

3. Results

3.1. Sample

Two hundred forty-five residents of CSTL were recruited into the study during their first week after entering the house. To maximize our ability to generalize results, we employed few inclusion/exclusion criteria: All study participants were age 18 or older and competent to provide informed consent. See Table 1 for a depiction of demographic characteristics of the sample. Most participants were men (77%), White (72.5%), and middle-aged ($M = 38$, $SE = 0.65$). More than three fourths had at least a high school education or GED, and the average income from all sources the month before entering the SLH was \$963 ($SE = \120). About half had never been married, and slightly less (48%) had children

Table 1
Baseline characteristics

Characteristics	<i>N</i> = 245
Demographics (%)	
Male	77
Never Married	50
Children under 18	48
White/Caucasian	73
GED/High School Education	79
Controlled Environment (past 30days)	76
Employed/past 6 months	51
Referral source (%)	
Criminal justice	29
Inpatient	15
Self/Family/Friend	44
Other	12
Continuous measures, <i>M</i> (<i>SE</i>)	
Age	38 (0.65)
Income from all sources	\$963 (120.26)
Length of stay (no. of days)	166 (11.20)

with age less than 18 years. Nearly all the participants had a history of previous treatment (94%), and 60% had been admitted to a residential treatment program within the past 6 months (not shown in the table).

3.2. Baseline characteristics

In addition to demographic characteristics, Table 1 shows referral sources and prebaseline functioning. The most common referral source was self, family, or friend (44%). Although 29% were referred through the criminal justice system, a much higher 42% indicated that they had been arrested at least once over the past 6 months. Thus, having spent some time in a controlled environment before entering the SLH did not necessarily mean that the individual was referred to the SLH from that controlled environment. The most common substances that residents were dependent on during the past year were methamphetamine (53%) and alcohol (49%; not shown in the table). Responses on the ASI for lifetime use of alcohol and drugs was extensive, with 97% of the sample reporting at least 3 years of substance use at baseline. The median number of years of substance use over participants' lifetimes was 18.

Table 2 shows values for study variables at all four time points. Relative to individuals entering treatment in our geographical area (e.g., Polcin & Beattie, 2007; Polcin & Weisner, 1999), residents entered with lower ASI alcohol ($M = 0.16$, $SE = 0.02$), drug ($M = 0.08$, $SE = 0.01$), and legal ($M = 0.11$, $SE = 0.02$) severity. Other baseline measures were of moderate to high severity, which included other ASI scales (family, medical, and vocational) and the GSI. Measures that assessed the previous 6 months before residents entered the SLH revealed more extensive substance use. For example, the average peak density (maximum number of days of substance use per month) over the 6-month period prior to entering the house was 18.81 ($SE = 0.83$) within a potential range of 0 to 31.

Table 2
Outcomes and covariates at each time point

Time point	ASI alcohol	ASI drug	ASI employment	GSI	Peak density	12-step scale	Drinking status of network	Drug status of network	Abstinence	Arrests
	<i>M (SE)</i>	<i>M (SE)</i>	<i>M (SE)</i>	<i>M (SE)</i>	<i>M (SE)</i>	<i>M (SE)</i>	<i>M (SE)</i>	<i>M (SE)</i>	%	%
Baseline	0.16 (0.02)	0.08 (0.01)	0.76 (0.02)	0.83 (0.05)	18.81 (0.83)	5.15 (0.13)	1.32 (0.10)	0.80 (0.10)	17.0	41.9
6-month	0.10 (0.02)	0.05 (0.01)	0.53 (0.02)	0.69 (0.05)	10.35 (0.93)	5.84 (0.14)	1.18 (0.10)	0.51 (0.08)	45.5	26.0
12-month	0.10 (0.01)	0.06 (0.01)	0.54 (0.03)	0.70 (0.05)	9.59 (0.94)	5.47 (0.16)	1.22 (0.11)	0.49 (0.08)	49.1	22.0
18-month	0.10 (0.01)	0.06 (0.01)	0.59 (0.02)	0.72 (0.06)	11.73 (0.97)	5.15 (0.20)	0.96 (0.10)	0.35 (0.05)	43.1	27.6

Note. Drinking status of the social network, drug status of the social network, and AA scale were used as covariates. All other variables were outcome variables.

3.3. Longitudinal outcomes

The average length of stay in the SLHs was over 5 months, but that varied considerably. At the 6-month time point, 42% were still residing in the SLHs. Residency dropped to 18% at 12 months and 16% at 18 months. Table 3 shows significant findings for study outcome variables over the three follow-up time points controlling for demographic factors. The coefficients (continuous variables) and odds ratios (dichotomous variables) show how each outcome measure at each time point compared to baseline. The coefficients and odd ratios showed improvement between baseline and 6 months and then

remarkably little change between at 12 and 18 months. For example, ASI alcohol scores indicated low severity at baseline ($M = 0.16, SE = 0.02$) that nonetheless showed significant improvement at 6 months ($M = 0.10, SE = 0.01$). The improvement noted at 6 months did not decline at 12 or 18 months. In fact, we found the same coefficient at 6-, 12-, and 18-month follow-up ($-0.04 [0.01], p < .01$). Similarly, ASI drug coefficients showed that severity at 6 months ($M = 0.05, SE = 0.01$) declined relative to an already low severity at baseline ($M = 0.08, SE = 0.01$) and then varied by no more than 0.01 at 12 and 18 months. All time points were significant at the .05 or .01 significance level.

Table 3
Outcome measures over time using GEE models

	Continuous measures					Dichotomous measures	
	ASI alcohol	ASI drug	ASI employment	GSI	Peak density	Abstinence	Arrests
	Coefficient (SE)	Coefficient (SE)	Coefficient (SE)	Coefficient (SE)	Coefficient (SE)	OR _{adj} (95% CI)	OR _{adj} (95% CI)
Demographic							
Interview							
Baseline (ref)	–	–	–	–	–	–	–
6-month	–0.04 (0.01)**	–0.03 (0.01)**	–0.15 (0.01)***	–0.16 (0.05)**	–8.6 (1.1)***	2.9 (1.9–4.3)***	0.5 (0.3–0.7)***
12-month	–0.04 (0.01)**	–0.02 (0.01)**	–0.14 (0.01)***	–0.13 (0.05)**	–8.9 (1.1)***	3.8 (2.5–5.7)***	0.4 (0.2–0.6)***
18-month	–0.04 (0.01)**	–0.02 (0.01)*	–0.12 (0.01)***	<i>ns</i>	–7.0 (1.1)***	3.3 (2.2–5.0)***	0.5 (0.3–0.7)***
Age							
18–28 (ref)	–	–	–	–	–	–	–
29–37	–0.05 (0.01)*	<i>ns</i>	<i>ns</i>	<i>ns</i>	<i>ns</i>	2.3 (1.3–4.1)**	<i>ns</i>
38–44	<i>ns</i>	<i>ns</i>	<i>ns</i>	<i>ns</i>	<i>ns</i>	2.2 (1.2–4.0)*	<i>ns</i>
45–71	<i>ns</i>	<i>ns</i>	<i>ns</i>	<i>ns</i>	<i>ns</i>	2.5 (1.4–4.7)**	<i>ns</i>
Race							
Other (ref)	–	–	–	–	–	–	–
White	0.04 (0.02)*	<i>ns</i>	–0.05 (0.02)*	<i>ns</i>	<i>ns</i>	<i>ns</i>	0.6 (0.4–0.9)*
Education							
No high school diploma (ref)	–	–	–	–	–	–	–
High school diploma+	<i>ns</i>	<i>ns</i>	–0.14 (0.03)***	<i>ns</i>	<i>ns</i>	1.8 (1.1, 3.0)*	0.6 (0.4–0.9)*
Marital status							
Married/Divorced/Separated (ref)	–	–	–	–	–	–	–
Never married	<i>ns</i>	<i>ns</i>	<i>ns</i>	<i>ns</i>	<i>ns</i>	<i>ns</i>	1.5 (1.0–2.3)***
Gender							
Female (ref)	–	–	–	–	–	–	–
Male	<i>ns</i>	<i>ns</i>	<i>ns</i>	<i>ns</i>	<i>ns</i>	<i>ns</i>	1.6 (1.0, 2.6)*

Note. OR_{adj} = adjusted odds ratio; CI = confidence interval.

- * $p < .05$.
- ** $p < .01$.
- *** $p < .001$.

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Other outcome variables also showed significant levels of improvement by 6 months that did not decline at 12 and 18 months, including peak density ($p < .001$), abstinence ($p < .001$), ASI employment ($p < .001$), and arrests ($p < .001$). See Table 3 for the coefficients and odds ratios at each time point. At baseline, we found that 19% of the sample had been abstinent from alcohol and drugs for 6 months. At the 6-month time point, that proportion increased to 39%, and by 18 months, it was 42% reporting complete abstinence. Peak density (maximum number of days/month of alcohol or drug use) declined from a mean of 18.81 (0.83) days per month at baseline to 10.35 (0.93) at 6 months. This improvement continued to the 18-month time point ($M = 11.73$, $SE = 0.97$). We found the same pattern for ASI employment, with a mean of 0.76 (0.02) at baseline, 0.53 (0.2) at 6 months, and 0.59 (0.02) at 18 months. For proportion arrested, there were 42% who had been arrested at least once in the 6 months before entering the SLH. That proportion decreased to 26% at 6 months and was 28% at 18 months.

Although GSI showed significant improvement between baseline and 6 months (-0.16 , $SE = 0.05$, $p < .01$) and baseline and 12 months (-0.14 , $SE = 0.05$, $p < .01$), the difference between baseline and 18 months was not statistically significant. Nevertheless, we continued to see a statistical trend at 18 months ($p = .058$), which reflects some degree of ongoing improvement relative to baseline, despite a decline from 12 months.

ASI and substance use outcomes at 12 and 18 months changed very little despite the lower number of individuals still residing in SLHs. Although 42% of the sample were still living in the SLHs at 6 months, that declined to 18% at 12 months and 9% at 18 months. When we used linear and logistic regression models to examine whether length of time in the SLH was associated with primary outcomes (ASI drug, ASI alcohol, peak density, and abstinence) at 18 months, we found no significant relationships.

Outcomes that were assessed and not found to improve significantly over time included ASI legal, family, and medical scales. However, there was a trend for improvement at the 12-month time point for family severity, and all time points indicated less severity relative to baseline. As described below, we did find that several factors significantly impacted these variables despite their lack of improvement over time. Potential reasons for the lack of improvement are reviewed in the Discussion section.

3.4. 12-Step and social network predictors of outcome

In addition to tracking longitudinal changes over time, we were interested in factors that were associated with areas showing improvement (e.g., ASI scales, alcohol and drug use, GSI, and arrests). Longitudinal models assessed how data collection time points were associated with outcome variables controlling for a variety of demographic factors. In general, few demographic characteristics were related to outcomes (see Table 3). However, the notable exception was

the relationship between age and abstinence. Older age categories were over twice as likely to be abstinent than those age 18–28. Not surprising, residents with at least a high school diploma had lower ASI employment severity. However, they also were nearly twice as likely to be abstinent over the past 6 months and about half as likely to be arrested.

Because involvement in 12-step recovery groups and developing a social network supportive of abstinence are central to the recovery philosophy of SLHs, we wanted to see how these factors related to outcome measures. 12-Step involvement was relatively high across all four time points (>5 on a scale of 0 to 9), although there was an increase from baseline ($M = 5.1$, $SE = 0.13$) to 6 months ($M = 5.8$, $SE = 0.14$) that was largely maintained at 12 months (5.5 , $SE = 0.15$). There were similar patterns for alcohol- and drug-related social support. Across all time points, large majorities reported having no heavy drinkers or drug users in their social network. At baseline, 24% reported having at least one heavy drinker in their social network and that declined to 16% at 6 months. At 12 and 18 months, it was 20% and 14%, respectively. For heavy drug users, 22% of the participants reported having at least one heavy drug user in their social network at baseline. That was nearly cut in half by 6 months (12%) and stayed about the same at 12 months (12%) and 18 months (11%).

Table 4 shows how involvement in 12-step groups and characteristics of the social network (drinking and drug use within the social network) predict outcome. These analyses show associations that include all four time points. Thus, Table 4 builds on the outcomes exhibited in Table 3 by adding an additional covariate to each model. Involvement in 12-step groups was strongly associated with outcome measures that assessed a 6-month period (peak density, abstinence, and arrests). In contrast, the social network variables were significant not only for these variables measuring a 6-month period but also with nearly all of our other outcome measures that showed improvement as well (i.e., ASI alcohol, drug, and employment scales; psychiatric severity on the GSI). The only two nonsignificant associations for social network factors and outcomes were (a) drug use in the social network did not predict ASI employment and (b) drinking in the social network did not predict GSI or arrests.

4. Limitations

There are several limitations that are inherent in the study. First, although we conducted longitudinal comparisons within participants, we did not compare outcomes of SLH residents with any type of comparison or control group. We therefore cannot necessarily conclude that SLHs caused the improvements. Individuals self-selected themselves into the SLHs, and the characteristics of these individuals may have at least in part accounted for the longitudinal improvements.

Table 4
Covariates predicting outcome measures using GEE models

Covariates	Continuous measures					Dichotomous measures	
	ASI alcohol Coefficient (SE)	ASI drug Coefficient (SE)	ASI employment Coefficient (SE)	GSI Coefficient (SE)	Peak density Coefficient (SE)	Abstinence OR _{adj} (95% CI)	Arrests OR _{adj} (95% CI)
12-Step involvement scale	<i>ns</i>	<i>ns</i>	<i>ns</i>	<i>ns</i>	−1.20 (0.24)***	1.2 (1.1–1.4)***	0.9 (0.8–1.0)**
Drinking status of social network	0.05 (0.01)***	0.02 (0.01)***	−0.04 (0.01)**	<i>ns</i>	4.81 (0.87)***	0.5 (0.4–0.7)***	<i>ns</i>
Drug status of social network	0.03 (0.01)**	0.04 (0.01)***	<i>ns</i>	0.13 (0.04)**	6.77 (0.90)***	0.4 (0.2–0.5)***	1.4 (1.0–2.0)*

Note. Coefficients and odds ratios have been adjusted for time of interview, age, race, education, marital status, and gender. OR_{adj} = adjusted odds ratio; CI = confidence interval.

* $p < .05$.

** $p < .01$.

*** $p < .001$.

Second, on measures that assess a 6-month period, the improvements noted may have been a function of “regression toward the mean.” This concept suggests that extreme scores drift toward the mean over time. There is the potential that during the 6 months prior to entering the SLHs, participants exhibited extremes in problem behaviors that improved at subsequent time points due to regression toward the mean. However, regression toward the mean would not apply to ASI alcohol and drug scales because those scores were very low at baseline. A third limitation is that we were not able to locate some participants at follow-up time points, and these individuals might have had worse outcomes. Although individual time points had follow-up rates ranging from 71% to 73%, 89% of the participants completed at least one follow up interview. In addition, as noted in the Procedures section above, when we conducted baseline comparisons of participants who were contacted for follow-up interviews with those lost at follow-up, we did not find any difference in terms of severity of ASI scores or alcohol and drug use. Finally, our sample was largely White and male, and participants with different demographic characteristics might respond differently to residence in SLHs.

5. Discussion

Overall, the findings support the need for further studies on SLHs that examine their effectiveness relative to outcomes of individuals in other living situations. Longitudinal, within individual comparisons of participant functioning over time showed that significant improvements were made between baseline and 6 months on all primary outcomes and some secondary outcomes as well. It is noteworthy that the improvements were generally maintained at 12 and 18 months. In addition, analyses reported here used GEE models to show that theoretically relevant covariates (i.e., characteristics of the social network and 12-step involvement) were associated with outcome.

In the discussion below, we first consider in more detail findings for outcome variables measuring a 6-month period (i.e., 6-month abstinence, peak density, days of

employment, and number of arrests). We then address findings for variables measuring shorter periods, such as the ASI scales. We end with an analysis of how our findings support previous research emphasizing the importance of social factors in recovery and considerations for additional research.

5.1. Findings for variables measuring 6 months

Variables that measured a 6-month period showed large improvements between the baseline interview and all follow-up time points. These included measures of alcohol and drug abstinence, peak density of substance use (days of use per month during the month of highest use), days of employment, and arrests. Overall, the 6-month period before entering the houses showed that residents were experiencing significant problems. For example, most (81%) reported some alcohol or drug use, and peak density of substance use was on average 19 days per month. About half had not been employed at all during the 6-month period, and 42% had been arrested. Because these problem areas were high at baseline, there was room for improvement on these measures during subsequent assessments. When we examined demographic factors as covariates of these outcomes across all four data collection time points, it was clear that improvements were being made by a variety of demographic groups. An exception included young age groups (18–28) having smaller proportions reporting abstinence over a 6-month period. One reason could be that the older age groups might have had more unsuccessful attempts to control their use and thus opted for a goal of complete abstinence. If younger residents did have fewer failed attempts to control their use, they may be more likely than older residents to feel that controlled use is an attainable goal.

5.2. ASI and BSI

Measures that assessed a shorter period, such as the ASI (1 month) and BSI (7 days), showed more variability. For example, legal severity was relatively low at entry into the

houses and did not change to any significant extent at 12 or 18 months.

Although some individuals entering the houses did not have any legal issues and thus had low ASI legal severity scores, others had legal requirements to abstain from alcohol and drugs. More than a quarter of the sample was referred from the criminal justice system. However, by the time these individuals were entering SLHs, their legal status may have been less concerning because the most important decisions about their legal status were already decided. Typically, if they complied with SLH rules, such as abstinence, their legal issues were resolved.

Two ASI scales that showed relatively low severity at entry into the houses (i.e., alcohol and drug and scales) nonetheless showed significant improvement between baseline and 6 months that was maintained at 12 and 18 months. The fact that residents had relatively low alcohol and drug severity at baseline is not surprising given that entry into the houses required some demonstrated motivation for recovery to be accepted as a resident. Many residents had already started attending 12-step meetings or had come from controlled environments where access to substances would have been difficult (e.g., residential treatment or incarceration).

On two scales measuring relatively short periods (ASI employment and the GSI from the BSI), we found residents entered with high severity that improved at 6 months and was maintained at 12 months. For employment, significant improvement also persisted through the 18-month follow-up point. For the GSI, the level of psychiatric symptoms was no longer statistically significant (compared to baseline), but it nonetheless continued as a clear statistical trend only slightly beyond the .05 level of significance.

It is not surprising that employment severity was relatively high at prebaseline given the demographic finding that more than three quarters of the sample spent some period in a controlled environment during the 30 days before they entered the facility. Whether the controlled environment was incarceration, residential treatment, or some other facility, it would have detracted from employment stability. In addition, given that residents were expected to pay for rent and other fees, it was not surprising that employment severity improved.

It was interesting that the improvements seen at 6 months were maintained at 12 and 18 months despite the fact that most residents had left the residence at 18 months. At 18 months, there was no relationship between outcome and length of stay in the SLHs. Some of this may be due to residents having on average about a 5-month length of stay, well beyond the minimum 3-month length of stay recommended for residential treatment by National Institute on Drug Abuse (1999). Although SLHs are not residential treatment, they have enough similarities with it that one might expect that the amount of time necessary to maximize effects would be similar. Thus, with a 5-month length of stay, a majority of residents

might have maximized their benefit by the time they left. However, it was also interesting that the relationship between social network variables (12-step involvement and drug and alcohol use in the social network) continued across all follow-up time points. The consistency of outcomes across time points and the ongoing associations between social support variables and outcome suggest the possibility that many residents were able to develop and maintain social support for abstinence even after they had left the residence.

There were few demographic characteristics that predicted ASI and GSI scales. The few significant predictors that were found revealed no pattern of subgroups that benefited more than others. This finding supports the contention that a variety of individuals are able to use SLHs to make improvements in these areas.

5.3. Social support influences

The findings that level of involvement in 12-step groups and characteristics of the social network were related to outcome supports a growing body of literature emphasizing these factors in addiction outcome. For example, Bond et al. (2003) studied a sample of individuals entering alcohol treatment and found that fewer numbers of heavy drinkers in the social network and higher level of involvement in 12-step groups were associated with better drinking outcome at 1- and 3-year follow-up. Moos and Moos (2006) found similar results in a sample of treated and untreated individuals with alcohol use disorders who were followed up over 16 years. They found involvement in AA and access to more social support resources were associated with less drinking. In a review of outcome research in the drug and alcohol field Moos (2007) emphasized a number social support factors, all of which are relevant to AA, as important in recovery from addiction: (a) social bonds that shield one from substance use, (b) social rewards for prosocial behaviors that are inconsistent with substance use, and (c) social learning theory that involves individuals learning how to cope with stress and get needs met without alcohol and drug use.

In addition to supporting previous research on the social factors influencing recovery, the study findings also support the purported mechanisms of how SLHs are helpful (Polcin & Henderson, 2008). Central to the philosophy of recovery in SLHs is the notion that persons with substance use disorders need a sustained living environment (i.e., longer than that typically offered by inpatient treatment) that is free of alcohol and drugs and offers social support for sobriety. Results confirmed that to the extent individuals had more alcohol and drug users in their social networks, they were more likely to have worse outcomes on most of our study variables. Also central to the recovery philosophy of SLHs is the notion that involvement in self-help groups is important. Study results showed that greater involvement in 12-step groups resulted in better outcome.

6. Conclusion

SLHs offer an alcohol- and drug-abstinent living environment and social support for recovery for individuals attempting to abstain from alcohol and drug use. Strengths of the SLH model include the following: (a) they are financially self-sustained through resident fees and (b) residents can stay as long as they wish. The SLHs studied here served as referral sources for a wide variety of individuals with substance use disorders, including those completing inpatient treatment, attending outpatient programs, leaving incarceration, and voluntarily seeking help outside the context of formal treatment. Examination of longitudinal outcomes showed that residents in SLHs made significant improvements in a variety of areas, including alcohol and drug use, employment, psychiatric severity, and arrests. However, causality cannot necessarily be attributed to SLHs because study participants were not randomly assigned to different study conditions. As expected, residents who had social networks that contained less alcohol and drug use and those with higher involvement in 12-step groups had better outcome. The results reported here support the need for larger, controlled trials that compare outcomes of residents in SLHs with outcomes of individual in other living environments. The important mechanisms of 12-step group involvement and alcohol and drug use in the social network warrant further investigation in SLHs and other places where individuals seeking recovery reside.

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STEVEN G. POLIN, ESQ.
Attorney At Law
Admitted to DC & MD

3034 TENNYSON ST. N.W.
WASHINGTON, D.C. 20015

TEL (202) 331-5848
FAX (202) 331-5849
SPOLIN2@EARTHLINK.NET

December 7, 2014

SENT VIA ELECTRONIC MEANS

Jim Fitzpatrick, Chairman
Costa Mesa Planning Commission
77 Fair Drive
Costa Mesa, CA 92626

Re: Appeal of denial of Reasonable Accommodation Request
Yellowstone Recovery
3132 Boston Way

Dear Chairman Fitzpatrick:

On December 3, 2014, my office received a copy of the Planning Department's staff report with attachments and exhibits. As you are aware, this is a package of more than 300 pages and contains new pieces of information, such as statements from individuals purporting to express "expert opinions" concerning the efficacy of Yellowstone's appeal. The timing of the disclosure of the Staff Report and its volume has resulted in the late filing of this response. It is my hope that you understand that the timing of our response is a result of the late disclosure of the Staff Report and the attachments. Hopefully, this has not caused any inconvenience.

This letter and attachments represent Yellowstone's response to the Staff Report and the reasons why the recommendation of denying the appeal is wrong as a matter of fact and law.

I. FACTUAL BACKGROUND

In 2001, Yellowstone began using 3132 Boston Way as a residence for its clients, men in recovery from addiction and alcoholism. Prior to its use by Yellowstone, 3132 Boston Way, was used as a home for recovering alcoholics and substance abusers by another program which had a maximum of 17 residents. The housing provider, Positive Directions, had used 3132 Boston Way for housing recovering alcoholics and substance abusers for approximately ten (10) years.

After Yellowstone began using the Boston Way address as a sober living facility, it was the target of a hate crime. The nature of the crime was highly publicized and covered by the local television stations. It was the subject of a criminal investigation. Notwithstanding the odious nature of the crime, the details must be recounted to provide a flavor of the animus a housing program such as Yellowstone faces. In 2001 it was raced based. Today, Yellowstone faces another type of discrimination: an animus towards persons in recovery from alcoholism and drug addiction. In

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2001, the Boston Way house was vandalized and spray painted with the message: "All niggers here will die." Honey Thames, the Executive Director of Yellowstone, had her car vandalized with the spray painted message: "Rich White Trash."

Yellowstone's is licensed by the State of California to provide recovery services at Boston Way for a maximum of 15 men. The City of Costa Mesa has been aware of its use, the maximum number of residents and its licensed status since 2001. The use of Boston Way by Yellowstone has been open and known to all in the neighborhood and City officials since that date. The City of Costa Mesa's Fire Department has inspected Boston Way approximately seven (7) times since 2001 for fire inspection purposes. Yellowstone's Boston Way house has at all time been listed on the California Department of Health's Website "Department of Health Care Services Licensing and Certification Branch Status Report " The website contains information concerning the City, the organization and the number of beds for which it is license.

Yellowstone has existed without incident at Boston Way since 2001. Notwithstanding this record of being a good neighbor, City Code Enforcement Officer, Mike Tucker, felt it was necessary to gain entry into the Boston Way house to count the beds earlier in 2014. Ostensibly, this was the result of the City's Neighborhood Improvement Task Force and the Mayor's Preserve Our Neighborhood initiative to aggressively enforce the City's newly amended nuisance ordinance. With the approval of the City's Assistant CEO, Rick Francis, he enlisted the assistance of the Costa Mesa Police Department to conduct a warrantless "parole search" of the residence. The search took place on March 12, 2014, while no one was at home. In a letter dated March 28, 2014 to Dr. Thames, Mr. Tucker wrote:

The City of Costa Mesa has a citywide Code Enforcement Program addressing Municipal Code violations. On March 12, 2014, **Costa Mesa Police Officers informed me** that they had found 15 beds, inoperable smoke alarms, and a possible illegal room addition at the above referenced address. As a result of this report and further investigation of City documents, I have determined that the property is in violation of the following sections of the Costa Mesa Municipal Code, the International Property Maintenance Code, and the California Health and Safety Code: (emphasis added)

- 1. CMMC Sec. 13-30.** Residential Service Facility serving 7 or more prohibited in a R1 zone
- 2. IPMC Sec. 704.1.** All systems, devices and equipment to detect a fire, actuate an alarm, or suppress or control a fire or any combination thereof shall be maintained in an operable condition at all times in accordance with the international Fire Code.

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3. Sec. 20-12. Conditions or uses qualifying as a public nuisance.

Conditions which qualify as a public nuisance, include, but are not limited to, the following:

(z) All structures, or portions thereof, occupied for cooking, dining, living, or sleeping, that were not designed or intended to be used for occupancy.

On June 5, 2014, Yellowstone and Dr. Thames requested pursuant to the federal Fair Housing Act, 42 U.S.C. §3604(f)(3)(b) that the City of Costa Mesa treat the residents of 3132 Boston Way as a family and deem the residents of 3132 Boston Way as a single housekeeping unit, and treat the use of dwelling as a single family use.

The letter requested that the City of Costa Mesa pursuant to 42 U.S.C. 3604(f)(3)(B) as a reasonable accommodation treat the use of 3132 Boston Way as a "single housekeeping unit." The City defines a "single housekeeping unit" as *"the occupants of a dwelling unit have established ties and familiarity with each other, jointly use common areas, interact with each other, share meals, household activities, lease agreement or ownership of the property, expenses and responsibilities; membership in the single housekeeping unit is fairly stable as opposed to transient, and members have some control over who becomes a member of the single housekeeping unit."*

In a letter dated August 19, 2014, the City denied the reasonable accommodation request.

Yellowstone filed a timely notice of appeal.¹

II. THE YELLOWSTONE CONCEPT

Yellowstone Recovery is a housing provider for recovering alcoholics and drug addicts. The dwelling located at 3132 Boston Way presently can provide housing for up to 15 unrelated persons and staff in recovery from alcoholism and substance abuse, residing together as the functional equivalent of a family. The City does not impose any numerical limitation on the number of persons who have reside together who are related by blood or marriage. This household function as the equivalent of a family and a single housekeeping unit and allows the recovering persons to provide one another with continual mutual support as well as mutual monitoring to prevent relapse.

¹The Staff Report appears to imply that Yellowstone is not entitled to a reasonable accommodation because it is licensed by the state, and as such is classified by the City as a residential care facility. As will be explained the Fair Housing Act does not make a distinction between licensed and unlicensed facilities, as each is entitled to seek a reasonable accommodation on its own merits.

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Many persons in recovery cannot maintain the traditional family organization that the City's ordinance dictates. Treating the use of 3132 Boston Way as something other than a single family use, therefore, discriminates against groups of disabled persons, such as the residents residing there, which do not meet the City's definition of family and single housekeeping unit. In addition to the actual discrimination against the residents of 3132 Boston Way by the proposed enforcement of the City's zoning code, the ordinance also has a disparate impact on them by preventing them from living together in drug and alcohol free housing units. The potential recovery of people who are handicapped or disabled by reason of alcoholism or drug abuse is greatly enhanced by the mutual support and mutual monitoring provided by living with other recovering persons. Further, it is often critical that a person in the early and middle stages of recovery shares a bedroom with another recovering addict for mutual support and monitoring. The City's restrictions on groups of disabled persons that do not meet its definition of family effectively prohibit this type of living arrangement in single family dwellings, even though no similar restrictions apply to other groups of unrelated, non disabled persons, or to persons related by biology.

The residents of 3132 Boston Way are considered to be the "functional equivalent" of a family for several reasons. The residents have access to the entire house. The residents also participate equally in the housekeeping functions of the house. The quality and nature of the relationship among the residents are akin to that of a family. The emotional and mutual support and bonding given each resident in support of his recovery from drug addiction and alcoholism is the equivalent of the type of love and support received in a traditional family. The need of groups of unrelated recovering alcoholics and substance abusers to live in a structured, safe and therapeutic environment is necessary to the recovery process. It has been found that individuals who decide to live in sober housing programs, such as that offered by Yellowstone Recovery, are allowed to engage in the process of recovery from alcoholism and substance abuse, at their own pace. By living with other persons who are in recovery, the residents should never have to face an alcoholic's or addict's deadliest enemy: loneliness and isolation.

In addition, the residents live in at 3132 Boston Way by choice. The choice is usually motivated by the individual's desire not to relapse into drug and/or alcohol use again after that individual has bottomed out, *i.e.*, lost jobs, home or family. It is also motivated by the desire that one must change their lifestyle, the manner in which they conduct their affairs, and the need to become a responsible, productive member of society.

III. REASONABLE ACCOMMODATION REQUEST TO BE TREATED AS A SINGLE HOUSEKEEPING UNIT

The Fair Housing Act ("FHA") "is worded as a broad mandate to eliminate discrimination against and equalize housing opportunities for disabled individuals." *Bronk v. Ineichen*, 54 F.3d 425, 428 (7th Cir. 1995). The FHA makes it unlawful to discriminate "against any person in the terms, conditions, or privileges of sale or rental of dwelling, or in the provision of services or facilities in

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connection with such dwelling, because of a handicap. . . ." 42 U.S.C. § 3604(f)(1). Discrimination includes "a refusal to make reasonable accommodations in rules, policies, practices, or services, when such accommodations may be necessary to afford such person equal opportunity to use and enjoy a dwelling." 42 U.S.C. § 3604(f)(3)(B). Under the FHA, a handicap is defined as "(1) a physical or mental impairment which substantially limits one or more of such person's major life activities, (2) a record of having such impairment, or (3) being regarded as having such an impairment." 42 U.S.C. § 3602(h). However, "such term does not include current, illegal use of or addiction to a controlled substance." *Id.*

24 C.F.R. § 100.70(b) provides that it shall be unlawful, because of race, color, religion, sex, handicap, familial status, or national origin, to engage in any conduct relating to the provision of housing or of services and facilities in connection therewith that otherwise makes unavailable or denies dwellings to persons. 24 C.F.R. § 100.70(d)(4) states that prohibited activities relating to dwellings under 24 C.F.R. § 100.70(b) include, but are not limited to refusing to provide municipal services or property or hazard insurance for dwellings or providing such services or insurance differently because of race, color, religion, sex, handicap, familial status, or national origin.

Application of zoning, building, housing and fire codes that affect housing for persons with disabilities and that may be utilized to impose terms, conditions and requirements that may result in the denial of housing are subject to challenge under the Fair Housing. All of these code requirements are also subjects to the reasonable accommodation provision of the Act. *See, Gallagher v. Magner*, 619 F.3d 823, 829 (8th Cir. 2010)(application of property maintenance and housing codes are subject to disparate impact analysis under the Fair Housing Act); *New Jersey Coalition of Rooming & Boarding House Owners v. Mayor of Asbury Park*, 152 F.3d 217, 221 (3d Cir.1998)(compliance with building, housing, health and safety code regulations for licensing purposes in determining intentional discrimination against housing for disabled persons); *Wis. Cmty. Servs. v. City of Milwaukee*, 413 F.3d 642, 646 (7th Cir. 2005)(If a zoning or building-code rule bears more heavily on disabled than on other persons, the city must change the rules to the extent necessary to redress the adverse effect); *Tsombanidis v. W. Haven Fire Dep't*, 352 F.3d 565, 571 (2d Cir. 2003)(The Fair Housing Act and the Americans with Disabilities act apply to zoning regulations, property maintenance codes, state building code, and the state fire code); *Marbrunak, Inc. v. City of Stowe*, 974 F.2d 43,47 (6th Cir. 1992)(safety requirements for groups of disabled persons contained in City's zoning code subject to review under the Fair Housing Act); *Alliance for the Mentally Ill v. City of Naperville*, 923 F. Supp 1057. 1074 (N.D. Ill 1996)(under the Federal Fair Housing Act, a municipality may impose special requirements on a Residential Board and Care Occupancy only if such requirements are 'warranted by the unique and specific needs and abilities of those handicapped persons"; *Provisio Ass'n v. Village of Westchester*, 914 F. Supp. 1555, 1562 (N.D. Ill 1995) (municipality refusal to waive sprinkler requirement as a reasonable accommodation which was required by the Life Safety Code found to have violated the Federal Fair Housing Act).

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The residents of Yellowstone Recovery are considered "handicapped" under the 1988 amendments to the Federal Fair Housing Act, unlike those other groups of unrelated, non-disabled persons. See 42 U.S.C. 3600 *et seq.* Recovering addicts and alcoholics are specifically included within the definition of "handicapped individual." See, 42 U.S.C. 3602(h) and 24 C.F.R. 100.201(a)(2).

As members of a protected class under the Federal Fair Housing Act, the issue of whether the use of 3132 Boston Way as a "sober living home" is in violation of the City's zoning ordinances is not relevant to the question of there is a violation of the Federal Fair Housing Act.² *United States v. Borough of Audubon*, 797 F. Supp. 353 (D. N.J.), *aff'd* 968 F.2d 14 (3d Cir. 1992). Thus, any allegation that the use of 3132 Boston Way as a "sober living home" constitutes a violation of a local zoning ordinance does not abrogate its rights in claiming discrimination under the Federal Fair Housing Act. It is well established that the Federal Fair Housing Act prohibits discriminatory land use decision by municipalities, when such decisions are ostensibly authorized by local ordinance. *Association of Relative and Friends of AIDS patients v. Regulation and Permits Administration*, 740 F.Supp. 95 (D.P.R. 1990)(government agency's denial of land use permit to open AIDS hospice violated Fair Housing Act); *Baxter v. City of Belleville*, 720 F.Supp. 720 (S.D. Ill 1989)(on motion for preliminary injunction: city's refusal to issue special use permit under zoning law to develop to remodel building into residence for persons with AIDS violated Fair Housing Act). See also 42 U.S.C. Section 3615 ("any law of a State, a political subdivision, or other jurisdiction that purports to require or permit any action that would be a discriminatory housing practice under this subchapter shall to that extent be invalid [under the Fair Housing Act]").

The legislative history to the Fair Housing Amendments Act of 1988 ("House Judiciary Report") is explicit as to the effect of the amendments on state and local land use practices, regulations or decisions which would have the effect of discriminating against individuals with handicaps. The amendments prohibit the discriminatory enforcement of land use law to congregate living arrangements among non-related persons with disabilities when these requirements are not imposed on families.

[Section 804(f)] would also apply to state or local land use and health and safety laws, regulations, practices or decisions which discriminate against individuals with handicaps. While state and local governments have authority to protect safety and health, and to regulate

²The language of the FHAA itself manifests a clear congressional intent to vitiate the application of any state law that would permit discrimination based on physical handicap. See 42 U.S.C. § 3615 (expressly commanding that "any law of a State . . . that purports to require or permit any action that would be a discriminatory housing practice under this subchapter shall to that extent be invalid") *Astralis Condo. Ass'n v. Sec'y, United States Dep't of Hous. & Urban Dev.*, 620 F.3d 62, 70 (1st Cir. 2010)

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use of land, that authority has sometimes been sued to restrict the ability of individuals with handicaps to live in communities. This has been accomplished by such as the enactment or imposition of health, safety or land-use requirements on congregate living arrangements among non-related persons with disabilities. Since these requirements are not imposed on families and groups of similar size of unrelated people, these requirements have the effect of discriminating against persons with disabilities.

House Report, p. 24 (footnote omitted). Based on this clear expression of legislative intent, the courts have enjoined the application and enforcement of zoning and health and safety regulations which have a discriminatory impact on group homes for persons with disabilities. *Oxford House, Inc. v. Township of Cherry Hill*, 799 F. Supp. 450, 462 (D.N.J. 1992); *Oxford House, Inc. v. Town of Babylon*, 819 F. Supp 1179 (E.D.N.Y. 1993); *Marbrunak, Inc. v. City of Stowe*, 974 F.2d 43 (6th Cir. 1992).

The mutual support that the residents receive from each other is critical to substance recovery. Persons recovering from addiction are far more often successful when living in a household with at least eight other persons in recovery, particularly in the early stages of recovery. Failure to treat the Boston Way residents as a single housekeeping unit, without regard to the size of the residential unit, interferes with the critical mass of individuals supporting each other in recovery.

The reasonable accommodation requirement of the Fair Housing Act draws no distinction between "rules," "policies," and "practices" that are embodied in zoning ordinances and those that emanate from other sources. All are subject to the "reasonable accommodation" requirement. Thus, when a municipality refuses to make a reasonable accommodation in its zoning "rules," "policies," or "practices," and such an accommodation may be necessary to afford handicapped persons an equal opportunity to use and enjoy a dwelling, it violates the reasonable accommodation provision of the act, 42 U.S.C. 3604(f)(3)(B). See *United States v. Village of Marshall*, 787 F. Supp. 872, 877 (W.D. Wisc. 1991)(Congress in enacting the Fair Housing Amendments Act "anticipated that there were rules and regulations encompassing zoning regulations and governmental decision about land use").

Reasonable accommodation has been interpreted by the Courts in cases involving zoning ordinances to mean that a municipality must change some rule that is generally applicable to everyone so as to make its burden less onerous on the person with disabilities. *Township of Cherry Hill* at 465, ft. 25. See, *Casa Marie, Inc. v. Superior Court of Puerto Rico for the District of Arecibo*, 752 F. Supp 1152, 1169 (D.P.R.1990), *rev'd on other grounds*, 988 F.2d 252 (1st Cir. 1993)(noting that a court hearing a reasonable accommodation claim under the Fair Housing Act may "adjudge whether compliance with the zoning ordinances may be 'waived'"); *Horizon House Development Services v. Township of Upper Southampton*, 804 F.Supp. 683, 699-700 (E.D. Pa. 1992), *aff'd mem.*, 995 F.2d 217 (3d Cir. 1993)("affirmative steps are required to change rules or practices if they are necessary to allow a person with a disability to live in a community"). A request

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for a reasonable accommodation may even encompass as request for non enforcement of a zoning ordinance. *Proviso Association of Retarded Citizens v. Village of Westchester*, 914 F. Supp 1555, 1561-62 (N. D. Ill. 1996).

One of the purposes of the reasonable accommodations provision is to address individual needs and respond to individual circumstances. In this regard, courts have held that municipalities that municipalities must change, waive, or make exception to their zoning rules to afford people with disabilities the same access to housing as those who are without disabilities. *Town of Babylon*, 819 F. Supp at 1192; *Horizon House*, 804 F. Supp. at 699; *Township of Cherry Hill* 799 F. Supp at 461-63; *Village of Marshall*, 787 F. Supp at 878; *Commonwealth of Puerto Rico*, 764 F. Supp. at 224.

III. YELLOWSTONE'S REQUEST TO BE TREATED AS A SINGLE HOUSEKEEPING UNIT IS REASONABLE

Here, accommodating the use of 3132 Boston Way as a "single housekeeping unit" would not cause the City any undue financial or administrative burdens nor would it undermine the purpose which the requirement seeks to achieve in preserving the single family nature of the neighborhood. Waiver of the strict requirements contained within the definition of the City's definition of a single housekeeping is consistent with the City's duty of providing a reasonable accommodation. *See, Village of Marshall*, supra at 877-78 (accommodation is unreasonable if it "undermine[s] the basic purpose which the requirement seeks to achieve"). The Fair Housing Act places an affirmative duty on the municipality to accommodate the needs of persons with disabilities. The Act demands that municipalities such as the City of Costa Mesa to change the manner in which its zoning ordinances are applied to afford the disabled the same opportunity to housing as those who are not disabled. *City of Plainfield*, 769 F. Supp at 1344 (accommodation reasonable where it "would not cause undue financial burden to the City").

The Staff report asserts that the reasonable accommodation is not reasonable because Yellowstone "it is so at odds with the purposes behind the rule that it would be a fundamental and unreasonable change," citing *Oconomowoc Residential Programs, Inc. v. City of Milwaukee*, 300 F.3d 775, 784 (7th Cir. 2002). The selective quoting of *Oconomowoc* does not further this discussion, nor does it accurately reflect the holding of the case. *Oconomowoc* is a zoning case wherein the 7th Circuit laid out the analysis for evaluating a request for a reasonable accommodation, which held that the City of Milwaukee failed to accommodate *Oconomowoc* in the application of its zoning ordinance.

First and foremost, the request by Yellowstone to be treated as a "single housekeeping unit" is not unreasonable request. A request to waive or change any zoning law or condition is not unreasonable. The question whether a particular accommodation is reasonable "depends on the individual circumstances of each case" and "requires a fact-specific, individualized analysis of the disabled individual's circumstances and the accommodations that might allow him to meet the

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program's standards." *Wong v. Regents of the Univ. of Cal.*, 192 F.3d 807, 818 (9th Cir. 1999). *Vinson v. Thomas*, 288 F.3d 1145, 1154 (9th Cir. 2002); *Oxford House, Inc. v. City of Baton Rouge*, 932 F. Supp. 2d 683, 689 (M.D. La. 2013). The Staff Report does not conduct a fact-specific, individualized analysis, and instead relies upon generalized, unsupported opinions by its "expert" witnesses. *McGary v. City of Portland*, 386 F.3d 1259, 1264 (9th Cir. 2004); *Hovsons, Inc. v. Township of Brick*, 89 F.3d 1096, 1104 (3d Cir. N.J. 1996)

A reasonable accommodation request only becomes unreasonable if it causes an undue burden financially or administratively or financially, which the city is not claiming, or if it causes a fundamental alteration to its zoning scheme. The City cannot in good faith claim a fundamental alteration to its zoning scheme since by its own admission 3132 Boston Way has been used as sober living since 1998

The Staff Report fails to make highly fact-specific inquiry the law requires as to why Yellowstone needs the requested accommodation. In this regard the City complains that all Yellowstone did was to request an accommodation for 15 persons and did not provide any information on the need for the requested number. This argument is a red herring since the City never stated or requested that Yellowstone provide additional information as to why it was necessary to have 15 persons. This represents a departure as to how the City has handled other reasonable accommodation requests from other sober house providers. For instance, in processing the reasonable accommodation request for 3116 Van Buren Avenue in 2011 to allow up to 13 person residing in a sober house to be treated as a single housekeeping unit, (See attached Exhibit 1) In a letter dated September 30, 2011, City staff stated:

While there is no exact formula that would automatically result in the granting of your Request, the following types of information have been helpful in assisting us in the past:

- Description of the day-to-day operations of the household (e.g., any distribution of household chores).
- Nature of leasing arrangements with tenants (e.g., the average length of stay of a tenant).
- Residency history of tenants.
- Rules of the sober living environment..

This action assertion by the City constitutes a change in policy: one from following the law on evaluating reasonable accommodation requests on a case by cases to one which reflects a strategy of imposing discriminatory obstacles to obtaining housing accommodations. Such a practice was rejected in *Pac. Shores Props., LLC v. City of Newport Beach*, 730 F.3d 1142, 1165 n. 30 (9th Cir. 2013).

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The City erroneously states at page 4 of the Staff Report that "there is no indication in the case law, nor in professional papers that the Director has been able to locate, that 15 individuals in a single family home is necessary for recovering individuals to the use and enjoyment of the housing of their choice." This statement is without a factual foundation. See *Turning Point Found. v. DeStefano*, 2008 U.S. Dist. LEXIS 38616 (D. Conn. May 12, 2008)(Accommodation requested for 15-16 sober house residents.)³; *Connecticut Hosp. v. City of New London*, 129 F. Supp. 2d 123, 127 n. 8 (D. Conn. 2001)(accommodation to be treated as a family for housing related to a state licensed facility treatment facility for up to 16 residents.); *Parish of Jefferson v. Allied Health Care, Inc.*, 1992 U.S. Dist. LEXIS 9124, 1-3 (E.D. La. June 10, 1992)(Failure to accommodate housing provider concerning a duplex with a maximum of eight residents in each unit with a common passageway connecting the properties for a state licensed facility for developmentally disabled persons.); *Tracy P. v. Sarasota County*, Case No. 8:05-CV-927-T-27EAJ (M.D. Fla)(County violated Fair Housing Act by failing to make accommodation to treat residents as a family for housing provider with six houses with six residents at the end of a cul-de-sac).(See attached settlement agreement, Exhibit 2 See "Counteracting 'Jason, Not in My Backyard': The Positive Effects of Greater Occupancy within Mutual-help Recovery Homes" J Community Psychol. 2008 September 1 (Exhibit 3)

In addition, Oxford House has two houses in the District of Columbia with 13 and 15 residents. See http://www.oxfordhouse.org/directory_listing.php.

IV. THE CITY'S RELIANCE OF EXPERT OPINIONS IS MISPLACED AND FAILS TO EVALUATE SINCE IT IS NECESSARY TO HAVE 15 RESIDENTS TO AMELIORATE THE EFFECTS OF SUBSTANCE ABUSE

The Staff Report seeks to convince its readers that the experts in the field of recovery and sober housing have opined that six residents in the optimal number for the recovery process. Unfortunately for the City there is not any legal determination that six or fewer persons in recovery living together are presumptively to be treated as a family. The number six (6) for unlicensed sober living is an urban myth. The State of California has declared that as a matter of law those licensed treatment facilities that provides non medical treatment and that has six (6) or fewer must be treated as single family uses for zoning purposes. Cal. Health & Safety Code § 11834.23.

The only question to be resolved is whether it is necessary that 15 residents living together at 3132 Boston Way provide a therapeutic benefit to each other which has the effect of ameliorating the effects of the disease of alcoholism and drug addiction. [T]he statute requires only accommodations necessary to ameliorate the effect of the plaintiff's disability so that she may compete equally with the non-disabled in the housing market.") *Schwarz v. City of Treasure Island*,

³This case was settled with the City of New Haven agreeing to allow 16 residents to reside together as a family.

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544 F.3d 1201, 1226 (11th Cir. Fla. 2008). Group homes such as the one at issue here is a "dwelling" under 42 U.S.C. § 3602(b), and therefore the FHA prohibits discriminatory actions that adversely affect the availability of such group homes. *See, e.g., Pac. Shores Props., LLC v. City of Newport Beach* at 1157 *Schwarz v. City of Treasure Island* at 1213-16; *Lakeside Resort Enters., LP v. Bd. of Superiors of Palmyra Twp.*, 455 F.3d 154, 160 (3d Cir. 2006); *Larkin v. State of Mich. Dep't of Social Servs.*, 89 F.3d 285, 289, n. 1 (6th Cir. 1996).

Yellowstone need only show that 15 residents living together under the Yellowstone concept is necessary to receive a therapeutic benefit, and that without the accommodation is would adversely affect one or more major life activities. The Yellowstone residents' status as persons in recovery from alcoholism and/or substance abuse require them to live at Yellowstone because their disabilities limits one or more major life activities as that term is defined under both the Fair Housing Act, 42 U.S.C. § 3602(h), and the Americans with Disabilities Act, 42 U.S.C. § 12102(2). Without the accommodation they will not be able to live independently. Major life activities have been limited because they are unable to live independently without the fear of relapse; that they need to live in a structured sober living environment; their inability to reside with their families or significant others leads to the risk of relapse; their lack of knowledge and ability to live without the use of drugs and alcohol; the lack of a stable living environment; the possibility of becoming homeless or incarcerated; and, the need to be surrounded with other women who are learning to live productively without the use of drugs or alcohol. *See, Oxford House, Inc. v. City of Baton Rouge*, 932 F. Supp. 2d 683, 689 (M.D. La. 2013); *Reg'l Econ. Cmty. Action Program v. City of Middletown*, 294 F.3d 35, 47-48 (2d Cir. 2002); *McKivitz v. Twp. of Stowe*, 769 F. Supp. 2d 803, 821-822 (W.D. Pa. 2010)

The Staff Report relies on a letter from Dr. Joan Zweben for the proposition she believe that 15 persons living together does not have a benefit in their recovery because it is actually detrimental to their recovery. She states: "I have found no evidence supporting such a claim in the relevant literature, and in my opinion 15 adult individuals recovering from alcohol and drug use is not a necessary number for successful recovery." This opinion is clearly without a factual foundation or supported by any studies. Experts in the filed of recovery housing who have studies this issue have opined there are no support to the opinion rendered by Dr. Zweben. Doug Polcin, whose study she relies upon, rejects this opinion. He reviewed Dr. Zweben's letter, and has provided a written response. (See Exhibit 4) His response in part reads: "To the best of my knowledge there is no research to support the contention that larger size houses result in worse resident outcomes or more neighborhood problems. In fact, there exists a study by Jason et al (2008) on recovery homes known as Oxford Houses that found the opposite."

Dr. Zweben, and ostensibly the other two experts presented by the City in the Staff report also opine on the detrimental effects of having 15 recovery alcoholics and substance abuser living together. These opinions are also rebutted by two other experts in field, Andrew Wainwright (See Exhibit 5) and Fried Whitman (Exhibit 6). Dr. Zweben's opinion does not address the key in analyzing whether 15 residents is necessary to ameliorate the effects of alcoholism and substance

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abuser which is whether "The variable in this analysis is not the number of people, but how the program, how the house is run."

The only accurate measure of whether a resident living in a household with 15 recovering alcoholics and substance abusers receives a therapeutic benefit is to ask that person. (See attached letters from current and former Boston Way residents.) "The affidavits of the residents show that prior to living in Oxford House, their prospects for recovery were bleak and the residents were unable to function. However, after moving into Oxford House, the residents are able to care for themselves, hold employment, and pay bills. The residents all stated that the supportive structure of Oxford House has enabled them to turn their lives around. (Pt. Ex. P, Q, and R). Thus, the requested accommodation "may be necessary" under the FHA." *Oxford House, Inc. v. City of Baton Rouge* at 693-694.

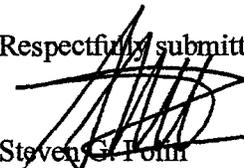
CONCLUSION

The requested accommodation of treating the residents of 3132 Boston Way as a single housekeeping unit is necessary because Yellowstone has demonstrated that having 15 residents is necessary to ameliorate the effects of alcoholism and substance abuse. What goes on in the house have many of the hallmarks of what goes on in a family especially in since we live in a day and age when there are many different types of "non traditional families" or single housekeeping units.

Various studies show that recovering drug or alcohol addicts are aided by a supportive environment. The key to ameliorating the effects of alcoholism and substance abuse is avoiding loneliness and isolation, which can trigger relapses.

When a Yellowstone resident is having one of those bad days, and when there are 15 people living in the home, striving to do the same thing, there's virtually a guarantee that there will be someone there, at any given time, whom that resident can talk and instead of taking a drink or getting high. The process of learning to become a responsible, productive, member of society, to deal with life on life's terms without the use of drugs and alcohol is grounded in the habits and lessons of living with 14 other residents striving to accomplish the same thing: learning to live sober.

Respectfully submitted



Steven G. Polin

cc: Elena Gerli, Deputy City Attorney
Yellowstone Recovery

EXHIBIT 1



CITY OF COSTA MESA

P.O. BOX 1200 • 77 FAIR DRIVE • CALIFORNIA 92628-1200

DEVELOPMENT SERVICES DEPARTMENT

October 31, 2011

Patricia Bintliff
3116 Van Buren Avenue
Costa Mesa, CA 92626

**SUBJECT: REASONABLE ACCOMMODATION REQUEST
MINOR MODIFICATION MM-11-16
3116 VAN BUREN AVENUE, COSTA MESA**

Dear Ms. Bintliff:

The City has reviewed your request for reasonable accommodation to allow up to 13 persons in a sober living facility operated by you at 3116 Van Buren Avenue in an R1 (Single Family Residential) zone. Currently, the Zoning Code permits a maximum of six people in this type of facility in the R1 zone (termed as a "residential service facility"). Additionally, the definition of "residential service facility" excludes "single housekeeping units." Thus, the maximum occupancy limit for residential service facilities does not apply if the occupants of the facility operate as a "single housekeeping unit." The Zoning Code defines single housekeeping units in the following manner:

"The functional equivalent of a traditional family, whose members are a nontransient interactive group of persons jointly occupying a single dwelling unit, including the joint use of common areas and sharing household activities and responsibilities such as meals, chores, and expenses."

Your attorney, Steven G. Polin, provided responses in letters dated August 9, 2011 and September 25, 2011 indicating that the residents of your facility should be considered a single housekeeping unit as defined by code based on the following information:

- The residents have access to the entire house and participate equally in the housekeeping functions of the house.
- The relationships between the residents are functionally equivalent to a traditional family.

It is noted for the record that the evidence provided did not include responses to the City's specific request for information related to the average duration of stay of the residents as highlighted in the attached letter. Nevertheless, based on the information gathered and provided by you and your attorney, the City has concluded at this point that your use can be considered a "single housekeeping unit". Therefore, because "single housekeeping

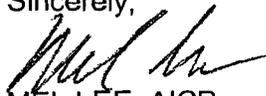
units” are excluded from occupancy limits that are applicable to residential service facilities, it is not necessary to apply for reasonable accommodation to modify the occupancy limit. Your application has been withdrawn.

On a similar note, we understand that you have filed a discrimination complaint against the City with the Department of Fair Housing and Employment. We are not clear as to the basis of your complaint given that there has not been a Code Enforcement action taken by the City to require any changes to your use. Moreover, no changes in your use were required pending the processing of your reasonable accommodation request. That being said, we therefore consider all disputes and complaints as they relate to your use to be amicably resolved or, ultimately, mooted by our findings.

As it is with every case, please note that if future contradictory evidence is presented that may conflict with this determination, the City may need to re-evaluate your use for zoning compliance.

If you have any questions, please contact me at (714) 754-5611 or via email at mel.lee@costamesaca.gov. Thank you again for your cooperation.

Sincerely,



MEL LEE, AICP
Senior Planner

Attachment

cc: Claire Flynn, Acting Asst. Development Services Director
Willa Bouwens-Killeen, Chief of Code Enforcement
Ron Johnson, Code Enforcement Officer

✓ Steven G. Polin
3034 Tennyson St. N.W.
Washington, D.C. 20015

Robert Khuu
Jones & Mayer
3777 North Harbor Boulevard
Fullerton, CA 92835



CITY OF COSTA MESA

P.O. BOX 1200 • 77 FAIR DRIVE • CALIFORNIA 92628-1200

DEVELOPMENT SERVICES DEPARTMENT

October 4, 2011

Steven G. Polin
3034 Tennyson St. N.W.
Washington, D.C. 20015

**SUBJECT: REASONABLE ACCOMMODATION REQUEST
MINOR MODIFICATION MM-11-16
3116 VAN BUREN AVENUE, COSTA MESA**

Dear Mr. Polin:

This letter has been prepared in response to your letter dated September 25, 2011. We appreciate the information regarding the use that you provided in the letter; however, we still require additional information as to the nature of leasing arrangements with tenants (e.g. the average length of stay of a tenant). This was the second bullet point identified in our letter dated September 1, 2011 (see attached).

For example, in your letter dated September 25, 2011, you state that there is no limit to the length of residency for the tenants; however, you also stated that their residency can be terminated if they violate the house rules. How often does this occur? Are they allowed to return at a certain point? Can you provide us with how many tenants "turnover" on a monthly or annual basis? Any information that you can provide in regard to the number and length of tenancy will be helpful in order for us to properly analyze and process the request for reasonable accommodation.

If you have any questions, please contact me at (714) 754-5611 or via email at mel.lee@costamesaca.gov. Thank you for your prompt attention to this matter.

Sincerely,

MEL LEE, AICP
Senior Planner

Attachment

cc: Claire Flynn, Acting Asst. Development Services Director
Willia Bouwens-Killeen, Chief of Code Enforcement
Ron Johnson, Code Enforcement Officer



CITY OF COSTA MESA

P.O. BOX 1200 • 77 FAIR DRIVE • CALIFORNIA 92628-1200

DEVELOPMENT SERVICES DEPARTMENT

September 1, 2011

Patricia Bintliff
3116 Van Buren Avenue
Costa Mesa, CA 92626

**SUBJECT: REASONABLE ACCOMMODATION REQUEST
MINOR MODIFICATION MM-11-16
3116 VAN BUREN AVENUE, COSTA MESA**

Dear Ms. Bintliff:

In accordance with State law, the City of Costa Mesa has 30 days to review a minor modification application ("Request") to determine if it is complete. After reviewing your application submittal, we have determined your application to be incomplete. As submitted, your application lacks information that would fully assist us in reviewing your Request and providing an accurate determination. To that end, we request that you submit additional information. While there is no exact formula that would automatically result in the granting of your Request, the following types of information have been helpful in assisting us in the past:

- Description of the day-to-day operations of the household (e.g. any distribution of household chores).
- * • Nature of leasing arrangements with tenants (e.g. the average length of stay of a tenant).
- Residency history of tenants.
- Rules of the sober living environment.

Moreover, if you are amenable to allow us to conduct a walkthrough of the premises, that would also be helpful to us. Of course, a walkthrough is not required.

Until additional information is provided, the application will be considered incomplete and cannot be processed. Once provided, the City will review the additional information and again determine whether the application is complete and processing can continue.

If you have any questions, please contact me at (714) 754-5611 or via email at mlee@ci.costa-mesa.ca.us. Thank you for your prompt attention to this matter.

er 1, 2011

Bintliff

Sincerely,



MEL LEE, AICP
Senior Planner

cc: Claire Flynn, Acting Asst. Development Services Director
Willia Bouwens-Killeen, Chief of Code Enforcement
Ron Johnson, Code Enforcement Officer

Steven G. Polin
3034 Tennyson St. N.W.
Washington, D.C. 20015

Robert Khuu
Jones & Mayer
3777 North Harbor Boulevard
Fullerton, CA 92835

EXHIBIT 2

**UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
Tampa Division**

**TRACEY P., RICHARD A.,
GERARD O., RENAISSANCE MANOR, INC.,**

Plaintiffs,

vs.

Consolidated Case No. 8:05-CV-927-T-27EAJ

**SARASOTA COUNTY,
JOSEPH and MARIA SERNA,**

Defendants.

Consolidated with

UNITED STATES OF AMERICA,

Plaintiff,

and

COASTAL BEHAVIORAL HEALTHCARE, INC.,

Plaintiff-Intervenor,

vs.

SARASOTA COUNTY, FLORIDA,

Defendant.

SETTLEMENT AGREEMENT AND RELEASE
BETWEEN PRIVATE PLAINTIFFS AND SARASOTA COUNTY

This Settlement Agreement and General Release is entered into as of this 24th day of October, 2007 between Tracey P., Richard A., Gerard O., Renaissance Manor, Inc. and Coastal Behavioral Healthcare, Inc. ("Private Plaintiffs"), Sarasota County (the "County") and Coastal Renaissance Behavioral Health Services, Inc. (collectively, the "Parties").

WHEREAS, Tracey P., Richard A., Gerard O., and Renaissance Manor, Inc filed suit

against the County under the Fair Housing Act and Americans With Disabilities Act in the United States District Court for the Middle District of Florida on or about May 16, 2005, in a case captioned Tracey P., et al. v. Sarasota County, et al., Case No. 8:05-CV-927-T-27EAJ ;

WHEREAS, Coastal Behavioral Healthcare, Inc. joined in a separate suit against the County in the United States District Court for the Middle District of Florida on or about September 14, 2006, in a case captioned United States, et al. v. Sarasota County, Case No. 8:06-CV-01221-JDW-EAJ;

WHEREAS, the United States District Court for the Middle District of Florida consolidated Case No. 8:05-CV-927-T-27EAJ and Case No. 8:06-CV-01221-JDW-EAJ (collectively, the "Litigation");

WHEREAS, the Litigation related to a dispute regarding the zoning of six houses known as "Tammi House" located at 403 Sevilla Street, 405 Sevilla Street, 410 Sevilla Street, 413 Sevilla Street, 414 Sevilla Street, and 417 Sevilla Street in North Port, Florida (collectively, the "Sevilla Street Houses").

WHEREAS, the Parties desire to avoid costly and protracted litigation and have voluntarily agreed to settle all of the claims and differences between them fully and finally on an amicable basis and without a trial or adjudication of any issues of fact or law;

WHEREAS, the Parties agree that this Settlement Agreement is entered into to serve the residents of Sarasota County and for the benefit persons in recovery from substance abuse and alcohol addiction and individuals with mental illness;

WHEREAS, the Parties agree that this Settlement Agreement does not constitute an admission that the County violated the Fair Housing Act, Americans with Disabilities Act, or intentionally discriminated in any manner;

WHEREAS, the Parties agree that they knowingly and voluntarily executed this Settlement Agreement after having the opportunity to secure the advice of competent legal counsel of their choosing;

WHEREAS, the effective date of this Settlement Agreement is October 25, 2007 ("Effective Date");

NOW THEREFORE, in consideration of the foregoing and of the mutual understandings set forth below, the receipt and sufficiency of which are hereby acknowledged, the Parties agree as follows:

1. MONETARY PROVISIONS

The County agrees to provide Renaissance Manor, Inc., Coastal Behavioral Healthcare, Inc., and Coastal Renaissance Behavioral Health Services, Inc. with a monetary contribution to be used to benefit persons in recovery from substance abuse and alcohol addiction and persons with mental illness. This monetary contribution will be in the total amount of Seven Hundred and Fifty Thousand Dollars (\$750,000) and will be paid as follows:

(a) By November 5, 2007, the County will pay Three Hundred Thousand United States Dollars (\$300,000);

(b) By January 5, 2008, the County will pay an additional Two Hundred and Fifty

Thousand United States Dollars (\$250,000);

(c) By October 10, 2008, the County will pay an additional Two Hundred Thousand United States Dollars (\$200,000).

The above payments shall be wired to the Private Plaintiffs to the following bank account: Wachovia Bank, ABA # 063000021, A/N 2155001124388.

2. USE OF THE SEVILLA STREET HOUSES

The Parties agree that, by January 4, 2008, Renaissance Manor, Inc. (including it and all of its predecessors, successors, parents, subsidiaries, heirs, and assigns, and all of the past, present, and future officers, directors, stockholders, agents, attorneys, insurers, servants, representatives, employees, affiliates, and partners) (hereinafter collectively, "Renaissance Manor"), Coastal Behavioral Healthcare, Inc. (including it and all of its predecessors, successors, parents, subsidiaries, heirs, and assigns, and all of the past, present, and future officers, directors, stockholders, agents, attorneys, insurers, co-insurers, representatives, employees, affiliates, and partners) (hereinafter collectively, "Coastal Behavioral") and Coastal Renaissance Behavioral Health Services, Inc. (including it and all of its predecessors, successors, parents, subsidiaries, heirs, and assigns, and all of the past, present, and future officers, directors, stockholders, agents, attorneys, insurers, co-insurers, representatives, employees, affiliates, and partners) (hereinafter collectively, "Coastal Renaissance") will take all necessary steps to effectuate the following terms such that the Sevilla Street Houses may be used as sober housing for persons with disabilities including those in recovery from substance abuse and alcohol addiction and individuals with mental illness as follows:

- a. The collection of six Sevilla Street Houses operating together as one unit known as the "Tammi House" will cease all current operations.
- b. Each of the Sevilla Street Houses will be independent of one another and will be used for residential purposes only.
- c. The structures and facilities of any one of the Sevilla Street Houses will not be used by or made available to residents of any of the other Sevilla Street Houses for functions, events, or gatherings organized by Renaissance Manor, Coastal Behavioral, or Coastal Renaissance for the benefit of the residents of the Sevilla Street Houses.
- d. Renaissance Manor will move and maintain its offices off-site from the Sevilla Street Houses and will not have offices at the Sevilla Street Houses.

3. SERVICES TO THE RESIDENTS OF THE SEVILLA STREET HOUSES

The Parties agree that, by January 4, 2008, Renaissance Manor, Coastal Behavioral and Coastal Renaissance will further take all necessary steps to effectuate the following terms:

- a. Renaissance Manor will provide leasing and property maintenance services to the six Sevilla Street Houses. The duties Renaissance Manor may perform to serve as a lessor or leasing agent include collecting rent, performing property maintenance and property management, and conducting property inspections as necessary.
- b. As part of the responsibilities set forth in Paragraph 3(a), Renaissance Manor may establish rules of tenancy common to all of the residents of the Sevilla Street

Houses in its leases (e.g., (i) no drinking, (ii) no use of drugs, and (iii) no gambling).

- c. The residents of each one of the Sevilla Street Houses may independently impose and enforce rules for sober living for each of their respective homes that are consistent with common rules of tenancy established by Renaissance Manor. Only the residents may impose and enforce these rules and not Renaissance Manor.
- d. The residents of each of the Sevilla Street Houses may select one of the residents of their Sevilla Street House to serve as the house manager for their independent house. Any selected house manager of the Sevilla Street Houses may provide life skills and case management services to the residents on-site in their respective homes if requested to do so by the other residents of that Sevilla Street House.
- e. Renaissance Manor is permitted to continually train and meet with any house managers at a location off-site. Nothing shall preclude Renaissance Manor from inquiring with a house manager about problems developing in any of the Sevilla Street Houses. The selected house managers will not be agents or employees of Renaissance Manor, Coastal Behavioral, or Coastal Renaissance.
- f. There will be no lock-outs of residents of the Sevilla Street Houses, except for situations where the residents' health or safety is compromised.
- g. Renaissance Manor may provide transportation to the residents of the Sevilla Street Houses.

- h. Except as set forth herein, Renaissance Manor, Coastal Behavioral and Coastal Renaissance will not provide any oversight of the residents of the individual Sevilla Street Houses. For example, Renaissance Manor, Coastal Behavioral and Coastal Renaissance will not provide any on-site drug testing of any of the residents, or on-site dispensation of medication to the residents of the Sevilla Street Houses.
- i. Renaissance Manor, Coastal Behavioral and Coastal Renaissance will not provide or facilitate any group substance abuse education or counseling on-site at any of the Sevilla Street Houses.
- j. Renaissance Manor, Coastal Behavioral and Coastal Renaissance will not provide or facilitate any individual substance abuse education or counseling on-site at any of the Sevilla Street Houses, except as set forth below in subparagraphs (l) and (m) below.
- k. Renaissance Manor, Coastal Behavioral and Coastal Renaissance will not provide any life skills services on-site at any of the Sevilla Street Houses.
- l. Renaissance Manor, Coastal Behavioral and Coastal Renaissance will not provide any case management services on-site at the Sevilla Street Houses except as follows: (i) Renaissance Manor may provide training in case management services to each house manager off-site from the Sevilla Street Houses as set forth in Paragraph 3(e) above and (ii) Coastal Behavioral may provide FACT team case management services to FACT team clients as required by an existing State or

Federal obligation.

- m. Renaissance Manor, Coastal Behavioral, and Coastal Renaissance will not provide any psychiatric or mental health services on-site for residents of the Sevilla Street Houses, except for residents who are clients of the FACT team as required by an existing State or Federal obligation.
- n. The residents of the independent Sevilla Street Houses are permitted to hold Alcoholics Anonymous and Narcotics Anonymous meetings on-site. Any such on-site Alcoholics Anonymous and Narcotics Anonymous meetings may not be advertised to the general public but residents of any of the Sevilla Street Houses may attend Alcoholics Anonymous or Narcotics Anonymous meetings at another of the Sevilla Street Houses. While these meetings are not open to the general public, residents of the Sevilla Street Houses are permitted to invite (i) guests on an intermittent basis and (ii) their AA or NA sponsors.
- o. Renaissance Manor, Coastal Behavioral and Coastal Renaissance will not organize or facilitate any of the on-site Alcoholics Anonymous and Narcotics Anonymous meetings described in Paragraph 3(n) above.
- p. The residents of the independent Sevilla Street Houses may choose to have speakers at their on-site Alcoholics Anonymous and Narcotics Anonymous meetings. Renaissance Manor employees (including Sharon Mays Tremain) may attend in that capacity as long as the employee is not serving as a counselor, therapist, or provider of substance abuse or addiction services, is not facilitating

the meetings, and is not compensated for the employee's attendance at, or participation in, the meetings.

- q. Renaissance Manor, Coastal Behavioral and Coastal Renaissance will not rely on the experience or qualifications of Sharon Mays Tremain in any application for federal, state, or county grant funding for the Sevilla Street Houses.

4. NO EXPANSION OF OPERATION

Renaissance Manor, Coastal Behavioral and Coastal Renaissance shall not expand or add another sober house to the Sevilla Street Houses on Sevilla Street or expand the clustered house model to other sites in Sarasota County.

5. RECORD KEEPING AND REPORTING

Renaissance Manor, Coastal Behavioral and Coastal Renaissance agree to provide semi-annual written reports to the County verifying that (a) each resident of the Sevilla Street Houses has entered into at least a month-to-month tenancy agreement and (b) each resident of the Sevilla Street Houses occupied by more than four (4) unrelated persons is a person with a disability as defined in the Fair Housing Act. Renaissance Manor, Coastal Behavioral and Coastal Renaissance will submit their first report within sixty (60) days of the Effective Date of this Settlement Agreement, and subsequent reports every six (6) months thereafter.

6. COMPLIANCE WITH ZONING

(a) If the terms of this Settlement Agreement are complied with and Plaintiffs submit a satisfactory first report as set forth in Paragraph 5 above, within thirty (30) days after receipt of that satisfactory first report, the County will provide a letter to Renaissance Manor, Coastal

Behavioral and Coastal Renaissance that the use of the Sevilla Street Houses as set forth in this Settlement Agreement is permitted and that the Sevilla Street Houses are currently in compliance with the County's Zoning Ordinance. The County thereafter shall issue similar zoning letters to Renaissance Manor and/or Coastal Behavioral upon request and continued compliance with the terms of this Settlement Agreement.

(b) If Paragraphs 2, 3, 4 and 5 of this Settlement Agreement are complied with, the County agrees that the use of the Sevilla Street Houses for sober housing will be regarded as a permitted accommodation for purposes of zoning, and will take no action to shut down the Sevilla Street Houses because they are being so used.

7. FUTURE CONDUCT TOWARD THE PARTIES

(a) The Parties agree not to make malicious or defamatory statements to one another and will refrain from making any malicious or defamatory statements to any third party, including the press, about one another.

(b) The County agrees to treat the Private Plaintiffs within the grant process fairly and equally to all other grant applicants. The County will not take any action to interfere, harass, retaliate, or intimidate a Party to this Settlement Agreement.

8. ATTORNEYS' FEES AND COSTS

Each party is to bear its own attorneys' fees and costs arising from the Litigation.

9. COURT APPROVAL AND DISMISSAL

(a) Within five (5) days of Effective Date of this Settlement Agreement, the Parties shall file with the United States District Court for the Middle District of Florida a Joint Motion to

Approve the Settlement Agreement and Release between Private Plaintiffs and Sarasota County. This Settlement Agreement only becomes effective upon judicial approval of both this Settlement Agreement and the Settlement Agreement with the United States referenced in Paragraph 25 below.

(b) Upon judicial approval of this Settlement Agreement, the Court will dismiss the case with prejudice. The Court shall retain jurisdiction as set forth in Paragraph 19 for the purpose of enforcing the provisions and terms of the Settlement Agreement.

(c) Within ten (10) days of the Court's granting the Joint Motion to Approve the Settlement Agreement and Release, Renaissance Manor and Coastal Behavioral, by and through their counsel, shall file with the Circuit Court of the Twelfth Judicial Circuit in and for Sarasota County, Florida a Notice of Voluntary Dismissal with Prejudice as to all of matters relating to Case No. 2004-CA-010745-NC.

10. RELEASE

a. Release of the County. Private Plaintiffs and Coastal Renaissance, for good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, by and with the advice of counsel, do hereby release, remise, discharge, and forever acquit the County, its agents, directors, employees, officers, managers, contractors, representatives, and attorneys from any and all known claims, causes of action, suits, debts, sums of money, accounts, bills, liabilities, invoices, contracts, controversies, agreements, damages, attorneys' fees, and obligations of any nature whatsoever, that Private Plaintiffs may have had against the County from the beginning of time to the date of execution of this Settlement Agreement.

b. Release of Private Plaintiffs. The County, for good and valuable

consideration, the receipt and sufficiency of which is hereby acknowledged, by and with the advice of counsel, do hereby release, remise, discharge, and forever acquit Private Plaintiffs and Coastal Renaissance, their partners, trustees, beneficiaries, employees, sureties, contractors, representatives, successors, assigns, agents and attorneys from any and all known claims, causes of action, suits, debts, sums of money, accounts, bills, liabilities, invoices, contracts, controversies, agreements, damages, attorneys' fees, and obligations of any nature whatsoever, that the County may have had against the Private Plaintiffs from the beginning of time to the date of execution of this Settlement Agreement.

11. WAIVER OF STATUTORY OR COMMON LAW RIGHTS

The Parties hereby knowingly waive the benefits of any statutory or common law provision that provides, in sum or substance, that a settlement or release does not or cannot extend to claims or disputes of which a party does not know.

12. SURVIVAL OF SETTLEMENT AGREEMENT

Notwithstanding the Parties' respective releases, all agreements, representations, warranties, rights, and obligations of the Parties under this Settlement Agreement shall survive the execution and delivery of this Settlement Agreement and are not released by this Settlement Agreement.

13. NO ADMISSION OF LIABILITY

Nothing contained in this Settlement Agreement shall be construed as an admission of liability or as an admission against interest by either of the Parties.

14. AUTHORITY

The Parties hereby expressly represent and warrant to each other that they have entered into this Settlement Agreement voluntarily and with proper authority. The Parties acknowledge that the only consideration for this Settlement Agreement is expressly set forth within this Settlement Agreement and no further inducements or representations have been exchanged in connection herewith. The Parties further hereby acknowledge that each Party has had adequate time to reflect upon, consider, and consult with legal counsel concerning the terms of this Settlement Agreement. The Parties further agree that this Settlement Agreement is not the result of fraud, duress, coercion, or undue influence on the part of either Party or its counsel.

15. MUTUAL DRAFTING

The Parties agree that: (1) each Party to this Settlement Agreement has reviewed and revised this Settlement Agreement and, accordingly, the normal rule of construction (to the effect that any ambiguities are to be resolved against the drafting Party) will not be employed in any interpretation of this Settlement Agreement; (2) if any part, term, or provision of this Settlement Agreement shall to any extent be declared unenforceable or illegal by a court of competent jurisdiction, the remainder of this Settlement Agreement shall not be affected thereby, and each part, term, or provision of this Settlement Agreement (including, but not limited to, any enforceable and legal portion of the challenged part, term, or provision) shall be valid and enforceable to the fullest extent permitted by law; and (3) to the extent that a court of competent jurisdiction determines that one or more provisions of the Settlement Agreement are vague, ambiguous, or conflict, the Parties agree that the Court should construe or apply the provisions so as to carry out the Parties' intent of resolving all of their disputes and liabilities.

16. BINDING ON PARTIES IN INTEREST

The Parties agree that this Settlement Agreement, including all releases, shall be binding upon and/or inure to the benefit of the Parties, their successors, predecessors, alter-egos, agents, affiliates, parent corporations, subsidiaries, officers, shareholders, and assigns and any third party claiming any right through a Party.

17. ASSIGNMENT

Neither Private Plaintiffs nor Coastal Renaissance nor the County may assign or transfer any obligation or duty under this Settlement Agreement to any other person or entity except upon the prior written consent of all other parties to this Settlement Agreement.

18. AMENDMENT

This Settlement Agreement may be amended or modified only by a written agreement signed by all Parties, but any such amendment or modification shall not be deemed a waiver of any prior or subsequent breach of this Settlement Agreement unless so specified.

19. JURISDICTION AND SCOPE OF SETTLEMENT AGREEMENT

(a) The Parties stipulate that the United States District Court for the Middle District of Florida has personal jurisdiction over the Private Plaintiffs and the County for purposes of this Settlement Agreement.

(b) The Parties stipulate that the Court shall retain jurisdiction over the action for a period of four (4) years for the purpose of enforcing its provisions and terms. Thereafter, the Settlement Agreement shall remain in full force and effect.

(c) The Parties shall endeavor in good faith to resolve informally any differences

regarding interpretation of and compliance with this Settlement Agreement before bringing such matters to the Court for resolution. However, in the event of a failure by either party to perform in a timely manner any act required by this Settlement Agreement, or otherwise to act in conformance with any provision thereof, the complying party may move this Court to impose any remedy authorized by law or equity, including, but not limited to, an order requiring performance of such act or deeming such act to have been performed, and an award of any damages, costs, and reasonable attorneys' fees which may have been occasioned by the violation or failure to perform. Such remedies shall be within the discretion of the Court and are not mandatory.

20. ENTIRE AGREEMENT

This Settlement Agreement embodies the entire agreement and understanding of the Parties with respect to the subject matter hereof. This Settlement Agreement supersedes all prior agreements and understandings between the Parties with respect to the specific claims contemplated by this Settlement Agreement.

21. COUNTERPARTS

This Settlement Agreement may be executed in two or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. The Parties agree that signatures obtained by facsimile or electronic transmission will be enforceable as original signatures.

22. HEADINGS

The headings used in this Settlement Agreement are for convenience only and shall not limit or expand the meaning of the Settlement Agreement's provisions.

23. NOTICES AND CORRESPONDENCE

All notices and correspondence shall be sent by either Party to the other in all matters dealing with this Settlement Agreement, by certified mail or overnight courier, at the following addresses:

- (a) For Renaissance Manor, Tracey P., Richard A., and Gerard O.:

Julian Scott Eller
Renaissance Manor, Inc.
1401 16th Street
Sarasota, Florida 34236

- (b) For Coastal Behavioral:

Jerry Thompson
Coastal Behavioral Healthcare, Inc.,
1565 State Street
Sarasota, Florida 34236

- (c) For Coastal Renaissance:

Jerry Thompson
Coastal Behavioral Healthcare, Inc.,
1565 State Street
Sarasota, Florida 34236

- (d) For Sarasota County:

County Administrator
Sarasota County Administration Building
1660 Ringling Blvd.
Second Floor
Sarasota, FL 34236

or any other address timely provided by written notice to the other Party.

24. FLORIDA LAW TO APPLY

This Settlement Agreement shall be construed and enforced pursuant to the laws of the State of Florida (excluding its choice of law rules).

25. SETTLEMENT WITH THE UNITED STATES

The United States has reached a mutually satisfactory resolution of its dispute with the County as set forth in the Settlement Agreement between the United States and the County.

IN WITNESS WHEREOF, the Parties, through their respective authorized representatives, set their hands to this Settlement Agreement on the dates indicated below.

RENAISSANCE MANOR, INC.

By: _____ (Seal)
Julian Scott Eller, Executive Director and
Chief Executive Officer

Date: _____

Witness: _____ (Seal)

COASTAL BEHAVIORAL HEALTHCARE, INC.

By: _____ (Seal)
Jerry Thompson, Chief Executive Officer

Date: _____

Witness: _____ (Seal)

COASTAL RENAISSANCE BEHAVIORAL
HEALTH SERVICES, INC.

By: _____ (Seal)
Jerry Thompson, Chief Operating Officer

Date: _____

Witness: _____ (Seal)

Tracey P.

Date: _____

Witness: _____ (Seal)

_____(Seal)
Richard A.

Date: _____

Witness: _____(Seal)

_____(Seal)
Gerard O.

Date: _____

Witness: _____(Seal)

SARASOTA COUNTY

By: _____(Seal)
Nora Patterson, Chairman of the
Board of County Commissioners

Date: _____

Witness: _____(Seal)

4865377_v4

EXHIBIT 3

EXHIBIT 3



Published in final edited form as:

J Community Psychol. 2008 September 1; 36(7): 947–958. doi:10.1002/jcop.20259.

Counteracting ‘Not in My Backyard’: The Positive Effects of Greater Occupancy within Mutual-help Recovery Homes

Leonard A. Jason, David R. Groh, Megan Durocher, Josefina Alvarez, Darrin M. Aase, and Joseph R. Ferrari
DePaul University

Abstract

Group homes sometimes face significant neighborhood opposition, and municipalities frequently use maximum occupancy laws to close down these homes. This study examined how the number of residents in Oxford House recovery homes impacted residents’ outcomes. Larger homes (i.e., 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; additionally, length of abstinence was a partial mediator in these relationships. These findings have been used in court cases to argue against closing down larger Oxford Houses. 125 words

Keywords

Oxford Houses; group homes; ‘Not in My Backyard’; substance abuse recovery

Group Homes and ‘NIMBY’

Since the 1960’s, many institutional settings have been replaced with community-based programs for persons with mental illnesses, developmental disabilities, and substance abuse disorders (Michelson & Tepperman, 2003). An example of a community-based, mutual-aid recovery home for individuals dealing with substance abuse problems is Oxford House (OH; Jason, Ferrari, Davis, & Olson, 2006a). Oxford House has grown since 1975 to over 1,200 homes across the U.S., 30 in Canada, and eight in Australia. All homes are single-sex (i.e., men or women-only), and some women Houses allow residents’ minor children. Individuals are typically referred to Oxford Houses by treatment facilities or through word of mouth, and new residents are admitted based on an 80% House vote. Regarding the operation and maintenance of Oxford Houses, no professional staff is involved, enabling residents to create their own rules for communal governance (Oxford House, 2002). Residents are held accountable to abstain from substance use or disruptive behavior; find and maintain a job; complete chores; and pay for rent, food, and utilities. Failure to comply with these rules along with any disruptive/criminal behavior or substance use is grounds for expulsion, and all rules are enforced by the house residents; as long as rules are followed, residents are allowed to stay indefinitely. In addition, residents are required to hold house positions (e.g., president or treasurer) elected for six-month intervals by 80% majority vote. A randomized study found that at two-year follow up, the Oxford House participants had lower substance use (31% vs. 65%, respectively), higher monthly income (\$989 vs. \$440), and lower

incarceration rates (3% vs. 9%) compared to usual-aftercare participants (Jason, Olson, Ferrari, & Lo Sasso, 2006b).

There are numerous theoretical reasons why group homes such as Oxford Houses should be located in residential areas (Seymour, no date). For example, group homes in residential communities may allow for community integration, an active ingredient in the treatment of substance abuse and many other disorders. Group homes might also serve to educate the community about stigmatized populations (e.g., people with substance abuse problems, developmental disabilities, or mental illnesses). Finally, group homes can be a deterrent to crime because residents are generally required to maintain positive behaviors (e.g., sobriety) and are often vigilant. The Oxford House national organization dictates that new Houses be established in safe, low crime, economically stable neighborhoods with minimal opportunities for relapse (Oxford House, 2002). Regardless of geographic location, Oxford Houses are typically situated in low-drug, low-crime communities in which residents have access to resources and amenities that enable autonomy and substance-free lifestyles (Ferrari, Jason, Blake, Davis, & Olson; 2006a; Ferrari, Groh, Jason, & Olson, 2007).

Nonetheless, group homes in residential areas sometimes face significant opposition (Zippay, 1997), with neighbors' concerns relating to property values, traffic, noise, inappropriate behavior (Cook, 1997), and safety (Schwartz & Rabinovitz, 2001; Solomon & Davis, 1984). This phenomenon is commonly referred to as the 'Not in My Backyard' syndrome (NIMBY; e.g., Dear, 1992; Kim, 2000; Low, 1993). Oxford Houses are certainly not immune to NIMBY; for instance, a North Carolina Oxford House was protested and vandalized by neighbors before it opened. In addition to neighborhood opposition, municipalities employ several techniques to legally regulate, restrict, or even close down group homes (Gathe, 1997). To start out with, cities sometimes decline to provide the required license to prevent the opening of a recovery home. Other regulatory tactics involve density limitations, which may include the Fair Housing Act and Landlord-Tenant Laws (e.g., group homes cannot remove substance-using or disruptive residents without a court order), prohibiting more than one recovery home within a certain radius, and maximum occupancy rules, the focus of the current investigation (i.e., too many unrelated people living in the same dwelling).

Despite the resistance faced by these homes, group homes actually have very little impact on their surrounding neighborhoods and generally blend into the community (Cook, 1997). Community members frequently expect to have more problems with group homes than really occur (Cook; McConkey et al., 1993), and residential facilities do not tend to negatively affect public safety (Center for Community Corrections, 2002). In fact, contrary to popular fears, literature reviews suggest that these settings may actually increase property values in their neighborhoods (Aamodt & Chiglinksy, 1989; Center for Community Corrections). Similar patterns have been demonstrated for Oxford House recovery homes. Local communities reported Oxford House residents blended well into the neighborhood and made good neighbors (Jason, Roberts, & Olson, 2005). The majority of Oxford House neighbors interviewed had either gained resources, friendships, or a greater sense of security following contact with the Oxford House residents. Furthermore, no evidence of property devaluation was found for neighborhoods containing Oxford Houses; community members who knew of the Oxford House actually saw an increase in property value over an average of 3 years.

Several studies investigated factors that influence the reception of group homes in residential areas. The Center for Community Corrections (2002) interviewed community members and found that neighbor acceptance of community justice facilities and halfway homes was enhanced by an engaged public, a well-run program with access to substance

abuse treatment and job development, community input and continuing involvement, discernible contributions to the community, and a careful assessment of the community prior to entry. Additionally, the more a facility resembles the neighborhood in which it resides and the more autonomous the facility residents, the more likely residents will integrate into the community (Makas, 1993). Further, research indicates that closer proximity (Gale, Ng, & Rosenblood, 1988) and increased contact (Butterfield, 1983) between community members and group home residents has a positive effect on the reception of the homes. Jason and colleagues (2005) revealed that residents who lived adjacent to an Oxford House, as opposed to a block away, had significantly more positive attitudes towards the need to provide a supportive community environment for those in recovery, allow substance abusers in a residential community, and the willingness to have a self-run home on their block.

In attempt to reduce the amount and level of concern related to Oxford Houses and other group homes, educational efforts might be developed such as documenting the effects of group homes on property values, having facility residents maintain friendly rapport with neighbors, and residents becoming more familiar with their surroundings in order to address neighbors' fears (Cook, 1997). For example, staff at a residential facility implemented educational measures to inform the neighborhood about the opening of the home (Schwartz & Rabinovitz, 2001). Significant interactions were found between neighbors visiting these facilities and decreases in dissatisfaction. Finally, it has been suggested that researchers should focus on developing ways that the public can become more familiar with halfway houses and other group homes (Center for Community Corrections, 2002).

Group Home Size

In order to implement educational efforts, this research study focused on one NIMBY threat to group homes: house size. While very little research exists on this topic, one study (Segal & Darwin, 1996) found that within sheltered care facilities for individuals with mental illness, although home size did not relate to levels of management, larger homes were less restrictive in their rules and procedures. Larger homes also spent more on program activities for their residents, and their residents were more involved in facility-based activities. It is possible that these greater occupancy facilities were able to provide more of an opportunity for residents to develop a sense of community. However, this type of sheltered care facility is fairly different from Oxford House recovery homes.

It is suggested that a sufficient number of residents in each home might be a necessary component in the effectiveness of Oxford House through the mechanism of social support. Individuals recovering from addictions should be surrounded by a community in which they feel they belong and are able to obtain sobriety goals (Jason & Kobayashi, 1995). Oxford House residents rated "fellowship with similar peers" the most important aspect of living in an Oxford House (Jason, Ferrari, Dvorchak, Groessler, & Malloy, 1997). The Oxford House experience also provides residents with abstinence-specific social support networks consisting of other residents in recovery (Flynn, Alvarez, Jason, Olson, Ferrari, & Davis, 2006). Individuals who spent more time in an Oxford House had a greater sense of community with others in recovery, less support for substance use (Davis & Jason, 2005), and more support for abstinence (Majer, Jason, Ferrari, Venable, & Olson, 2002). Oxford Houses with more residents might have greater opportunities for members to provide and receive these vital social resources. It is believed that larger Houses will promote recovery through their ability to promote larger (Zywiak, Longabaugh, & Wirtz, 2002), more supportive social networks (MacDonald, 1987) that include sober others in recovery (Hawkins & Fraser, 1987; Zywiak et al.), constructs linked to sober living.

In addition to increased levels of social support, there are other hypothesized benefits to larger Oxford Houses. For instance, rent may be lower in larger homes because residents can

split the costs. Additionally, having more residents allows members to learn from each other and increases opportunities for diversity. In this study, we examined the effects of House size on criminal and aggressive behaviors among Oxford House residents, two areas of significant concern to communities containing group homes (Cook; Schwartz & Rabinovitz, 2001; Solomon & Davis, 1984). Oxford House has been found to promote positive outcomes regarding both criminal activity (Jason et al., 2006b; Jason, Davis, Ferrari, & Anderson, 2007a; Jason, Olson, Ferrari, Majer, Alvarez, & Stout, 2007b) and self-regulation (Jason et al., 2007b), which relates to aggression. Therefore, it was hypothesized in the present study that residents of larger Houses (with 8 or more members) would exhibit fewer criminal and aggressive behaviors as measured by the *Global Appraisal of Individual Needs-Quick Screen* than residents of smaller Houses.

Method

Procedure

Data included in the present study were from the baseline data collection (completed between December 2001 and April 2002) of a community evaluation of residents living in one of 213 U.S. Oxford Houses (see Jason et al., 2007a for details). Participants from this Institutional Review Board-approved study were recruited and surveyed using two strategies. The majority of participants ($n = 797$) were recruited through an announcement published in the monthly Oxford House newsletter that provided contact information for the study. We then contacted Oxford Houses via letters to House Presidents, conducted follow-up phone calls to the Houses, and where possible, members of the research team arranged to visit Houses. Of the 189 Oxford Houses that were approached, 169 (89.4%) had at least one individual who agreed to participate in the study, and the average number of individuals per House choosing to participate in the study was 4.7. For the second method, 100 individuals were randomly selected to fill out the baseline questionnaires at an annual Oxford House Convention attended by 300. Analyses revealed no difference in demographic or outcome variables between the two recruitment groups.

In each case, the nature, purpose, and goals of the study were explained to the potential participants. As part of the consent process, staff members explained that participation was entirely voluntary and that withdrawal from the study was possible at any time. Fifteen dollar payments were made to participants following the survey. These data were gathered by research staff who primarily administered questionnaires in person to the participants. Some data were collected by telephone, which was often the case for those who had left Oxford House. No significant differences were found based on data collection method.

In addition, an environmental survey (assessing House size) was mailed to the House Presidents of all 213 Oxford Houses. No identifiable information about any House resident was requested, and confidentially was maintained for all data. Most often the survey was completed by the House President (60.2%) or another House officer (31.6%), such as the Secretary or Treasurer. The survey then was returned by mail, and a small package of coffee was subsequently sent to the House for participation. Pilot testing indicated that it would take less than 20 minutes to complete and mail the survey, which were collected over a four month period.

Participants

For this investigation, we only included participants from the 154 Houses for which we had data on House size, representing 72.3% of Houses in the larger study. On average, Houses had about 7 total members ($M = 7.1$, $SD = 2.0$, $Median = 7$), and Houses in this study ranged in size from 3–18 residents. Regarding geographic region within the U.S., 27.7% of Houses

were located in the West, 18.4% were in the Midwest and Texas, 28.3% were in the Northeast, and 25.7% were in the Southeast.

This present baseline sample consisted of 643 Oxford House residents, including 227 females (35.3%) and 416 males (64.7%). The sample was ethnically diverse, with 62.5% European American, 29.2% African American, 3.9% Hispanic/Latino, and 4.4% others. At baseline, the average age of the sample was 38.3 ($SD = 9.2$), and the average education level was 12.7 years ($SD = 2.0$). Regarding marital status, 50.4% were single or never married, 45.4% were divorced/widowed/separated, and 4.2% were married. With respect to employment, 67.4% reported being employed full-time, 14.2% part-time, 13.3% unemployed, and 5.1% retired or disabled, and the average monthly income of the sample was \$965 ($SD = 840$). The average participant had stayed in an Oxford House for 1.0 years ($SD = 1.4$). The mean length of sobriety was 1.7 years ($SD = 2.4$) for alcohol and 1.9 years ($SD = 3.2$) for illicit drugs. Regarding recent substance use, participants on average consumed alcohol on 2.3 days ($SD = 9.1$) and drugs on 5.1 days ($SD = 18.3$) in the past 90 days. Concerning legal status, 30% of participants were currently on probation, and 14% claimed that their entry into OH was prompted by the law. Regarding lifetime data, the average participant was charged with a crime 9.9 times ($SD = 14.0$) and were incarcerated a total of 15.9 months ($SD = 36.8$).

Measures

Baseline demographic information (e.g., gender, race, substance disorder typology) was obtained from items on the 5th Edition of the *Addiction Severity Index-lite* (*ASI*; McLellan et al., 1992). The *ASI* assesses common problems related to substance abuse: medical status, drug use, alcohol use, illegal activity, family relations, and psychiatric condition. The *ASI* has been used in a number of alcohol and drug use studies over the past 15 years and has been shown to have excellent predictive and concurrent validity (McLellan et al.).

The *Form-90* (Miller & Del Boca, 1994) was administered to obtain a continuous record of alcohol and drug consumption and intensity within a 90-day time span. This measure gathers information related to employment, health care utilization, incarceration, and alcohol and other drug use over a 90-day retrospective (which provides a reliable time frame for abstinence assessment; Miller & Del Boca).

The number of residents per Oxford House was determined using a brief version of a reliable environmental audit developed and utilized by Ferrari and colleagues (Ferrari et al., 2006a; Ferrari, Jason, Davis, Olson, & Alvarez, 2004; Ferrari, Jason, Sasser, Davis, & Olson, 2006b) for use with group recovery settings. This survey requested responses to forced choice and frequency items in a number of domains, including information about the House setting such as the percentage of residents in recovery from alcohol, drugs, and poly-substances, along with the number of inhabitants within a House. Other sections of this audit gathered information on the interior and immediate exterior House characteristics, amenities found within a 2-block radius of the House, and characteristics of the surrounding neighborhood.

The *Global Appraisal of Individual Needs-Quick Screen* (*GAIN-QS*; Dennis & Titus, 2000) is a self-report, clinical screening tool examining whether or not a psychological or substance abuse symptom has occurred in the past 12 months similar to the DMV-IV Axis I criteria. While the *GAIN-QS* is not a diagnostic tool, it has been utilized within clinical screening contexts to identify problem areas and psychological symptoms that warrant further explanation. For the purposes of this study, 2 indices from the *GAIN-QS* were used as the outcome variables measuring aggressive and criminal behaviors: *Conduct Disorder/*

Aggression Index (6 items; *Cronbach's alpha* = .78, *Mean Score* = 1.34) and *General Crime Index* (4 items; *Cronbach's alpha* = .69; *Mean Score* = .29).

Results

House Size and GAIN-QS Subscales

The average House size in this study was about 7 members ($M = 7.1$, *median* = 7), and because a pending court case attempted to make it illegal for Oxford Houses to house 8 or more residents, we decided to compare 7 or fewer members in a House (i.e., smaller Houses) with 8 or more residents of an Oxford House (i.e., larger Houses). *Regression analyses*¹ determined that this dichotomized House size variable significantly predicted the *GAIN-QS* subscales of *Conduct Disorder/Aggression*, $\beta = -.10$, $t(632) = -2.52$, $p = .01$, and *General Crime Index*, $\beta = -.10$, $t(634) = -2.44$, $p = .02$. House size accounted for 0.8% of the variance in *General Crime Index* scores and 1.9% of the variance in *Conduct Disorder/Aggression* scores. Larger Houses had fewer problems related to conduct disorder/aggression, and criminal activity. Smaller Houses had a *General Crime Index* mean score of 0.34 and a *Conduct Disorder/Aggression Index* mean score of 1.43, whereas the respective scores for larger Houses were 0.21 and 1.16 (lower scores indicate fewer problem symptoms in each area).

House Size and Demographic Analyses

Next, *one-way ANOVA* and *chi-square* analyses were run to determine whether large and small Houses (7 or less vs. 8 or more) differed on demographic variables. Results indicated that the groups only differed on one key demographic variable: larger House residents had been abstinent from drugs and alcohol longer than individual from smaller Houses, $F(1,637) = 4.42$, $p = .04$. Residents in smaller Houses had 298.1 ($SD = 458.6$) cumulative days of abstinence on average, compared to 379.5 ($SD = 476.5$) days for residents of larger Houses. This indicates that individual living in larger Houses maintained abstinence for about 81 days longer. Since larger Houses had significantly longer lengths of cumulative abstinence, we ran correlations to determine if this variable also related to the *GAIN-QS* subscale scores. Among participants for whom we have House size data, cumulative days sober did significantly and negatively correlate with the *GAIN-QS* subscales of *Conduct Disorder/Aggression*, $r(633) = -.26$, $p = .000$, and *General Crime Index*, $r(631) = -.30$, $p = .000$.

Mediational Analyses

We next examined whether the variables in the House size and *GAIN-QS* subscore regression analyses were only significant because individuals in larger Houses had been sober for longer periods of time. In order to evaluate this possibility, we utilized Baron & Kenny's (1986) framework for testing of mediation. In Baron & Kenny's model, the influence of variable A (the initial variable) on variable B (the outcome) may be explained by a third variable known as variable C (the process variable). Complete mediation occurs when variable A no longer affects B after C has been controlled. Partial mediation occurs when the path from variables A to B (the total effect) is diminished in total size but still different from zero after the mediating variable is controlled. The mediational model is a causal one; therefore, the mediator is presumed to bring about the outcome and not vice versa.

¹Although participants were nested within Oxford Houses, we decided not to focus on Hierarchical Linear Modeling results because we wanted to test for mediation, which can be done using regression but not HLM. However, we did run HLM analyses and found that House size (as a level 2 group variable) significantly predicted individually-assessed level 1 *General Crime Index* scores ($t[144] = -2.18$, $p = .03$) but not level 1 *Conduct Disorder/Aggression* scores ($t[144] = -1.17$, $p = .25$).

We used Baron & Kenney's (1986) framework to determine whether cumulative days sober mediated the relationship between House size and *Conduct Disorder/Aggression* (A = House size [7 or less vs. 8 or more], B = cumulative days sober, and C = *Conduct Disorder/Aggression*). As demonstrated earlier with linear regression analyses, House size significantly predicted *Conduct Disorder/Aggression*. House size also significantly predicted cumulative days sober (A→B; $\beta = .08$, $t[637] = 2.10$, $p = .04$; $r^2 = .007$), and cumulative days sober predicted *Conduct Disorder/Aggression* (B→C; $\beta = -.30$, $t[630] = -7.86$, $p = .000$; $r^2 = .089$). Finally, when both House size and cumulative days sober were put in the model predicting *Conduct Disorder/Aggression* (A and B→C), House size maintained significance, but less than earlier (House size: $\beta = -.08$, $t[628] = -2.11$, $p = .04$; cumulative days sober: $\beta = -.29$, $t[628] = -7.69$, $p = .000$; $r^2 = .096$). Therefore, House size is related to *Conduct Disorder/Aggression*, and cumulative abstinence is a partial mediator in this association. These two variables (i.e., House size and cumulative abstinence) explained almost 10% of the variance in *Conduct Disorder/Aggression* scores.

We again employed Baron & Kenney's (1986) framework to determine whether cumulative days sober mediated the relation between House size and *General Crime Index* (A = House size [7 or less vs. 8 or more], B = cumulative days sober, and C = *General Crime Index*). As reported earlier, House Size was a significant predictor of *General Crime Index*, and House Size significantly predicted cumulative days sober. Regarding new analyses, cumulative days sober predicted *General Crime Index* (B→C; $\beta = -.26$, $t[631] = -6.77$, $p = .000$; $r^2 = .068$). Finally, with both House size and cumulative days sober as predictors of *General Crime Index* (A and B→C), House size retained significance but less so than before (House Size: $\beta = -.08$, $t[630] = -2.04$, $p = .04$; cumulative days sober: $\beta = -.25$, $t[630] = -6.60$, $p = .000$; $r^2 = .074$). Thus, House size is related to *General Crime Index* scores, and cumulative sobriety is a partial mediator in this relationship. These two variables (i.e., House size and cumulative abstinence) explained more than 7% of the variance in *General Crime Index* scores.

Discussion

The objective of the present investigation was to examine how the number of residents in an Oxford House impacted outcomes related to aggression and crime among residents. Regression analyses supported our hypotheses that larger House size (i.e., 8 or more residents) would predict less criminal and aggressive behavior. However, an unexpected result was that length of abstinence was a significant mediator in these relationships. House size lost a fair amount of significance when the mediator of cumulative days sober was entered into the models predicting *GAIN* subscale scores, and the addition of cumulative sobriety to the models greatly increased the amount of variance explained. Cumulative sobriety partially explained the relationships between House size and *General Crime Index* and House size and *Conduct Disorder/Aggression*. Thus, greater House size leads to greater cumulative abstinence, which in turn leads to less criminal activity and aggression; however, House size does have some independent impact of its own on these outcomes. It is clear that having more residents in a House is beneficial to residents' recovery from alcohol and drug abuse.

These findings have important policy implications regarding the future of recovery homes. It is argued that local governments allow Oxford Houses immunity from maximum occupancy regulations due to the great need in many communities for these settings. It is very difficult for individuals lacking stable living environments to maintain a sober lifestyle following residential treatment (Milby, Schumacher, Wallace, Feedman, & Vuchinich, 1996). As the cost of housing continues to rise, many individuals leaving inpatient facilities are unable to find affordable housing. Without Oxford House or other recovery home options, former

addicts frequently have no choice but to return to their old negative environments and fall back into their pre-treatment habits, which frequently include antisocial activities such as substance use and criminal activity. Regardless of how successful a client has been in treatment, this progress can be reversed through residence in an environment that promotes crime and drug use (Polcin, Galloway, Taylor & Benowitz-Fredericks, 2004). As demonstrated in this study, a sufficient number of House residents is a factor in the ability of Oxford House to promote these outcomes that benefit local communities.

Furthermore, it is suggested that maximum occupancy regulations that apply to recovery homes are often based on false beliefs and fears. Neighbors often oppose recovery homes because they fear increased crime and violence (Cook, 1997; Schwartz & Rabinovitz, 2001; Solomon & Davis, 1984; Zippay, 1997), and in order to appease these residents, cities frequently use maximum occupancy laws to close the group homes (Gathe, 1997). This pattern is quite ironic given that the Houses being closed (i.e., larger homes) should actually give neighbors less reason for concern. It seems obvious that laws based on these misconceptions should be eliminated. Overall, Oxford Houses have positive (not negative) effects on local communities (Jason et al., 2005), and residents of larger Houses appear to be highly desirable community members (i.e., who engage in less criminal and aggressive behaviors).

This investigation provides one more step in the movement to improve the reception of Oxford Houses and other group homes in local communities. While second-order change alters the systems that cause the problems (Dalton, Elias, & Wanderman, 2001), 'Not in My Backyard' typically serves to inhibit this type of change. Changing the attitudes of mental health professionals, community members, and policy makers may break down the barriers to second-order change (Olson et al., 2002). Educational efforts along with successes in the court room may promote a more positive social climate and set legal precedents. Finally, researchers have argued that social scientists should explore ways that the public can become more familiar with residential facilities (Center for Community Corrections, 2002). We hope that these efforts and the efforts of other researchers, individuals in recovery, treatment providers, lawyers, and political activists are successful in reducing the opposition to group homes in residential areas.

Concerning limitations, our findings might not apply to other group homes or residential facilities, which can vary greatly in focus, procedures, setting, and size. For instance, a "large" Oxford House setting (i.e., greater than 7 members) might be very small in comparison to other residential settings, which may accommodate several dozen residents. It is actually possible in these cases that somewhat smaller settings are more effective. In addition, we were typically not able to collect data from all members within a House; thus, some Houses have more representation than others in this sample. Future studies in this area should acquire information from all members of a House if possible. Furthermore, data analyzed in this study were self-report; therefore, it may have been useful to obtain House size estimates using data from other sources such as Oxford House Inc., the national body that oversees Oxford Houses. Also, alcohol and drug use had little variability within this sample because all participants were recruited from Oxford Houses instead of treatment or detoxification centers (suggesting a later stage in recovery), and because residents caught using can be evicted. Perhaps future research assessing occupancy levels of recovery homes should consider a sample with more variability with regards to substance use. A final limitation is our use of regression analyses as opposed to Hierarchical Linear Modeling due to the tested nature of the data; however, we wanted to test the mediational model, which can be done using regression but not HLM. Nonetheless, future researchers assessing group home size may want to seriously consider the use of HLM.

In order to improve the reception of Oxford Houses in local communities and counteract the NIMBY syndrome, the Oxford House Research Team has provided expert testimony in court cases, sent information to legislators, disseminated research findings with policy implications, collaborated with community partners and state-level agencies, and worked with the media to change the image of recovery homes (see Jason, Davis, Ferrari, & Bishop, 2001). In particular, the DePaul University research team has been involved in several court cases over past several years on the behalf of Oxford Houses. Most recently, municipalities located in Kansas, Iowa, and North Carolina have attempted to close down Oxford Houses or similar recovery homes due to too many unrelated individuals living in one dwelling. Findings from the present study were used in these court cases, and at the present time, the Oxford House organization has won every court case.

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EXHIBIT 4

December 3, 2014

Steven G. Polin
Law Office of Steven G. Polin
3034 Tennyson Street, NW
Washington, DC 20015
202-331-5848
202-331-5849 (fax)
spolin2@earthlink.net

Dear Mr. Polin,

I am writing in response to questions being raised by the Costa Mesa Planning Commission about whether larger sized sober living recovery residences result in worse outcomes for the residents who live there or more problems for communities where they are located. As you know, I have been studying sober living in houses in northern California for the past decade and recently have begun studying houses in Los Angeles. Our research has shown that residents make significant improvement over an 18-month time period on measures of substance use, employment, and arrests. Importantly, improvements are maintained even after residents leave the sober living homes. The sizes of the houses that we studied were not associated outcomes. Interviews with neighbors of sober living houses revealed an absence of serious problems such as complaints about substance use, crime, or declining housing values.

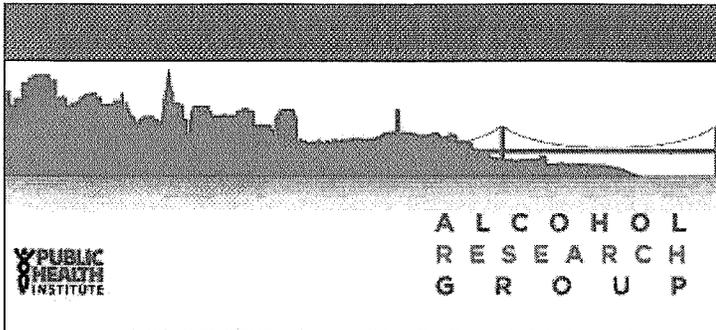
To the best of my knowledge there is no research to support the contention that larger size houses result in worse resident outcomes or more neighborhood problems. In fact, there exists a study by Jason et al (2008) on recovery homes known as Oxford Houses that found the opposite.¹ In their study of 643 residents residing in 154 houses, they found homes with eight or more residents had less criminal and aggressive behavior. The results from this research have been used in court proceedings to argue against closing down larger Oxford Houses.

My view is that the critical question is not the size of the facility but the quality of the operations. Organizations such as the Sober Living Network are available to train and help sober living facilities deal with important issues such as admission requirements, procedures for handling residents who relapse, referrals to more intensive levels of care, and procedures for maintaining a "good neighbor" standing in the community.

Sincerely,



¹Jason, L. A., Groh, D. R., Durocher, M., Alvarez, J., Aase, D. M., & Ferrari, J. R. (2008). Counteracting "Not in My Backyard": The Positive Effects of Greater Occupancy within Mutual-help Recovery Homes. *Journal of Community Psychology*, 36(7), 947-958. doi:10.1002/jcop.20259.



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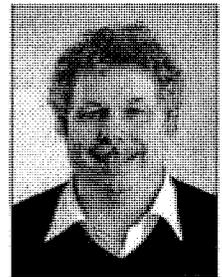
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Douglas L. Polcin, Ed.D
Senior Scientist
Email: dpolcin@arg.org
Phone: 510-597-3440



Education:

Ed.D. Counseling Psychology, Boston's Northeastern University
M.S. Clinical Psychology, San Francisco State University

Primary Research Area:

Peer helping, motivational enhancement therapy, criminal justice mandated treatment, the roles of coercion and confrontation in treatment outcome, bridging treatment and research, and spirituality.

Current Projects:

- ▣ [Capacity Building Initiative for Substance Abuse and HIV Prevention Services for At-Risk Racial/Ethnic Minority Young Adults](#) (Co-Investigator)
- ▣ [Enhancing Engagement and Retention in Quality HIV Care for Transgender Women of Color in Oakland, Alameda County](#) (Co-Investigator)
- ▣ [Intensive Motivational Interviewing for Methamphetamine Dependence](#) (Principal Investigator)
- ▣ [Moderators of Motivation to Maintain Sobriety Over 18 Months](#) (Principal Investigator)
- ▣ [Randomized Trial of Intensive MI to Improve Drinking Outcomes among Women](#) (Principle Investigator)
- ▣ [Reducing Offenders HIV Risk: MI Enhanced Case Management with Drug-Free Housing](#) (Principal Investigator)

Recently/Selected Completed Projects:

- ▣ [An Evaluation of Sober Living Houses](#) (Principal Investigator)
- ▣ [Coercion to enter Treatment from Probation Officers.](#)(Principal Investigator)
NIAAA R03 AA12358

The goal of this study was to investigate probation officers' use of coercion as a means of improving alcohol treatment utilization among individuals on probation. The study also identified individual and organizational factors that predicted the use of coercion to enter treatment. The design used a cross-sectional self-administered survey.

- ▣ [Community Impact on Adoption of Sober Living Houses](#) (Principal Investigator)
- ▣ [Measuring Confrontation During Recovery](#) (Principal Investigator)
- ▣ [When Does Pressure Facilitate Help Seeking? 25 Year Trends and Correlates](#) (Principal Investigator)

Awards & Activities:

- ▣ Adjunct faculty member at John F. Kennedy University (2002 - 2011)
- ▣ Adjunct Faculty at the Pacific Graduate School of Psychology (2008 - 2010)
- ▣ NIAAA Training Program Post-doctoral Fellow, Alcohol Research Group and UC Berkeley SPH (1996 - 1998)

Selected Research Publications:

Polcin D.L., Korcha R., Bond J. (In Press) Interaction of motivation and psychiatric symptoms on substance abuse outcomes in Sober Living Houses.

Polcin D.L., Mericle A., Howell J., Sheridan D., Christensen J. (In Press) Maximizing social model principles in residential recovery settings.. *Journal of Psychoactive Drugs*.

Polcin DL, Sterling J, Brown T, Brown M, Buscemi R, Korcha R (In Press) Client and therapist views about intensive and standard motivational interviewing. *Journal of Contemporary Psychotherapy*.

Polcin, D.L., Bond, J., Korcha, R., Nayak, M.B., Galloway, G.P., Evans, K. (In Press) Randomized trial of intensive Motivational Interviewing for methamphetamine dependence. *Journal of Addictive Diseases*.

Jason, L.A., Mericle, A.A., Polcin, D.L., & White, W.L. (2013) The role of recovery residences in promoting long-term addiction recovery. *American Journal of Community Psychology*, 52, 406-411.

Polcin, D. L., Mulia, N., & Jones, L. (2012) Substance Users' Perspectives on Helpful and Unhelpful Confrontation: Implications for Recovery. *Journal of Psychoactive Drugs*, 44(2), 144-152.

Polcin, D. L., Korcha, R., Greenfield, T. K., Bond, J., & Kerr, W. (2012) Twenty-one year trends and correlates of pressure to change drinking. *Alcoholism: Clinical and Experimental Research*, 36(4), 705-715.

Polcin, D.L., Henderson, D., Trocki, K., Evans, K., Wittman, F. (2012) Community context of sober living houses. *Addiction Research & Theory*, 20(6), 490-491.

Polcin, D.L., Korcha, R.A., Bond, J., & Galloway, G (2010) Sober living houses for alcohol and drug dependence: 18-month outcomes. *Journal of Substance Abuse Treatment*, 38(4), 356-365.

Polcin, D.L., Korcha, R.A., Bond, J., & Galloway, G (2010) Eighteen month outcomes for clients receiving combined outpatient treatment and sober living houses.. *Journal of Substance Use*, 15, 352-366.

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Polcin, D. L., Beattie, M (2007) Relationship and institutional pressure to enter treatment: differences by demographics, problem severity, and motivation. *Journal of Studies on Alcohol and Drugs*, 68(3), 428-36.

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Polcin, D.L., and Zemore, S.E. (2004) How psychiatric severity is related to helping, spirituality, and achievement in Alcoholics Anonymous. *American Journal of Drug and Alcohol Abuse*, 30, 577-592.

For a full listing of Douglas L. Polcin's publications, [click here](#).

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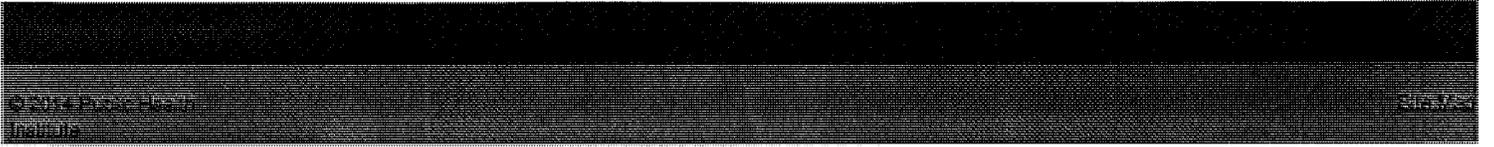


EXHIBIT 5



Improving Lives Together

400 Selby Avenue, Suite D
Saint Paul, MN 55102
Phone: (651) 222-6740
Fax: (651) 222-6743

December 4, 2014

Steven G. Polin
Law Office of Steven G. Polin
3034 Tennyson Street, NW
Washington, DC 20015

Dear Mr. Polin,

I am writing in response to the questions being raised by Costa Mesa Planning Commission about whether a larger sized sober living recovery residence results in worse outcomes or causes more problems within the community. For the purposes of this letter, a sober living residence is any residence with eight to fifteen individuals living in a stable, structured drug and alcohol free environment. The goal of a sober living home is to teach residents how to become responsible, productive members of society, without the use of drugs and alcohol. Recovery of an addicted individual benefits not only that individual's health and mental wellbeing, but their community as well through lower arrests, fewer hospitalizations and the ability to maintain employment.

I am well versed on the subject of addiction, recovery and sober living. I am the CEO and owner of a behavioral health consulting company whose purpose is to assist families and individuals in the process of making decisions regarding treatment and post-treatment options. Many of these individuals require input on whether an individual would benefit from living in a sober house type setting. In addition, I am a recovering addict myself, with 18 years in recovery. I have experienced life as an active addict, as a resident in a primary treatment center, and as a resident in a sober living house.

It has been my experience that as the number of individuals in the recovery home drops, so do the rates of recovery. The concept of one alcoholic or addict helping another, which is found in such programs as AA or NA is carried into sober living homes by their need to have up to 10 residents. Both AA and NA have as a basic foundation that the act of talking to another alcoholic or addict, who is engaged in the recovery process, can actually ameliorate the desires to drink or use drugs when stressful events occur. The efficacy of group support in mental health and drug addiction has been understood for more than 50 years; as has the understanding that such groups function best with between 10-14 participants. One reason for this efficacy is that groups intrinsically have many rewarding benefits—such as reducing isolation and enabling members to witness the recovery of others—and these qualities draw clients into a culture of recovery. Another reason groups work so well is that they are suitable especially for treating problems that commonly accompany substance abuse, such as depression, isolation, and shame.

ANDREW T. WAINWRIGHT

EXPERT WITNESS

400 Selby Avenue, Suite D - Saint Paul, MN 55102
p (651) 222-6740 f (651) 222-6743
awainwright@a-i-r.com

Available to provide court testimony on:

- The efficacy of Sober Living
- The Oxford House model
- The impact of NIMBY laws and discrimination
- 12 Step Recovery
- The history and practice of Alcoholics Anonymous

SOBER LIVING EXPERTISE

- Expert witness for *Water's Edge Recovery vs. City of Stuart; January 2014*
- Expert witness for *Intervention911 in Intervention911 v. City of Palm Springs in the United States District Court for the Central District of California*
- Expert witness in the United States District Court for the District of Colorado for landmark Federal Sober Living case; *December 2012*
 - Expert witness for *St. Paul Sober Living, LLC v. Board of County Commissions, Garfield County, Colorado; December 2012*
- Advised sober house owners and treatment providers nationally on programing, marketing, sales and mission; *2002 - 2012*
- Senior Consultant to St. Paul Sober Living (SPSL) in St. Paul, MN
 - Advised SPSL senior staff on policy, clinical program development and national marketing strategy; *2002 - 2012*
- RAP was implemented by SPSL as the Plus Program in 2012 to provide an expanded level of care; *2009*
- Developed the Recovery Assistance Program (RAP) to help fully implement prescribed behavioral health continuing care plans.
- Advised founders of the Minnesota Association of Sober Housing on program development, implementation of programs and the need for local self-governance; *2007-2008*

SPECIAL QUALIFICATIONS

- Nationally recognized addictions consultant
- 17 years of experience in the behavioral healthcare field
- Consultant to Sober Living/NIMBY attorney Steven Polin; Washington, DC
- Consultant to Sober Living/NIMBY attorney Fabian Hoffner; Minneapolis, MN
- Author, *It's Not OK to be a Cannibal*; Hazelden Press, 2008
- CNN Morning Show Addictions Expert 2008 - 2010

Formatted: Font: Bold, Not Italic

ANDREW T. WAINWRIGHT

EXPERT WITNESS

400 Selby Avenue, Suite D - Saint Paul, MN 55102
p (651) 222-6740 f (651) 222-6743
awainwright@a-i-r.com

PROFESSIONAL EXPERIENCE

- 2009-2014 Assistance in Recovery (AiR), *Chief Executive Officer* St. Paul, MN
Responsible for business operations for the nation's leading behavioral health crisis consulting company.
Responsible for developing a strategic plan to advance the company's mission and objectives and to promote revenue, profitability and growth as an organization.
- 2002-2009 Addiction Intervention Resources, *Executive Director* St. Paul, MN
In charge of creating and managing a national crisis consulting service with offices in St. Paul, MN; Charlotte, NC; Chicago, IL; and Washington DC.
Responsible for training interventionists and coordinating all crisis interventions.
Responsible for coordinating continuing care plans for clients returning home across the United States
- 1999-2002 National Counseling Intervention Services, *Interventionist* Minneapolis, MN
Employed as the lead national drug and alcohol interventionist for Dr. James Fearing.
Traveled throughout the United States working with individuals and families in behavioral health crisis.
- 1999-2000 Hazelden Foundation, *Unit Specialist, Fellowship Club, St. Paul* St. Paul, MN
Managed and cared for 55 recovering persons in a halfway house for chemically dependent adults
Handled dispensing of medications, discipline, counseling sessions, and education on all aspects of day-to-day sober living skills.
- 1997-1998 Chiron Foundation, *Executive Director* St. Paul, MN
Conceived and built a nonprofit foundation to better serve the interests of the community by expanding understanding of recovery from the disease of alcohol and drug addiction.

EDUCATION

- 1993-1994 Catholic University Washington, DC
M.A. studies in English Literature.
- 1992-1993 Georgetown University Washington, DC
M.A. studies in English Literature
- 1987-1992 St. Mary's College of Maryland St. Mary's City, MD
B.A., English Literature
- 1990-1991 Keble College, Oxford University Oxford, England

ANDREW T. WAINWRIGHT

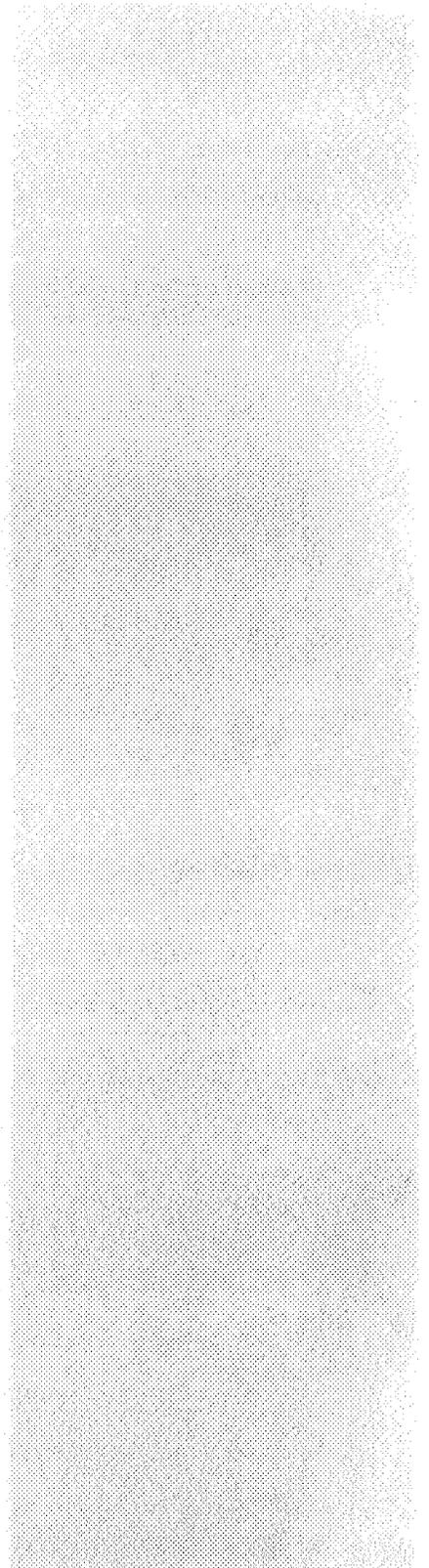
EXPERT WITNESS

400 Selby Avenue, Suite D_- Saint Paul, MN 55102

p (651) 222-6740 f (651) 222-6743

awainwright@a-l-r.com

Fellowship in Medieval and Renaissance Literature





Improving Lives Together

400 Selby Avenue, Suite D
Saint Paul, MN 55102
Phone: (651) 222-6740
Fax: (651) 222-6743

The letter from Joan Ellen Zweben, PhD suggests that recovery homes may actually be harmful to those trying to recover and that the increased size of the residence has a negative impact on recovery rates for individuals. However, research done on the Clean and Sober Transitional Living program in California showed very different results. The CSLT homes have houses that range from 11 to 22 residence per home. Findings found that resident of both Phase 1 and Phase 2 of the sober living program had positive outcomes, with an improved abstinence rate from 11 % at baseline to 68% after 6-12 months in the recovery home. In addition, it was found that residents were able to maintain improvements even after they left the sober living homes. The ability to maintain sobriety outside of the sober living environment plays a significant role in decreased arrests, hospitalizations, and the improved ability for that individual to become a productive member of their community.

In closing, it is my belief that the lack of a stable, drug free environment for those individuals attempting to recover from alcohol or drug addiction is a serious obstacle to achieve any kind of recovery. Recovery benefits the individual, their family and their community. A sober living facility is the most effective way for those transitioning to a sober lifestyle to achieve this goal, and a sober living home is most effective when it is able to utilize a group function with at least 10 individuals in the home.

Sincerely,

A handwritten signature in black ink that reads 'Andrew T. Wainwright'.

Andrew T. Wainwright
CEO
Assistance in Recovery, Inc.

Polcin, Douglas, Ed.D, Korcha, Rachel, MA, Bond, Jason, PhD., Galloway, Gantt, Pharm D. (2010). What Did We Learn from our Study on Sober Living Houses and Where Do We Go From Here. Journal of Psychoactive Drugs, 42(4): 425-433. doi: 10.1080/02791072.2010.10400705

EXHIBIT 6

MEMORANDUM

Re: Yellowstone reasonable accommodation appeal
From: Fried Wittman, President, CLEW Associates
To: Dave Sheridan, Sober Living Network
Dt: December 3, 2014

I agree with Dr. Zweben there are no “magic numbers” regarding the impact of house size (number of residents) on recovery. There is some practice experience as noted below, but this is an area that needs to be explored systematically. At this time, we agree one cannot predict with confidence what will be the effect of any particular size for a sober living household on residents’ recovery experiences and outcomes.

I also agree with her emphasis on the importance of household management to assure that the house functions smoothly and that sobriety is maintained. However, she overlooks the importance of house design as a factor in recovery experiences, and she has a narrow definition of “management” that does not take into account peer-based self-management of sober housing. She is focusing only on “supportive housing” which is not the same as “sober housing” as described below. She ends up being inconsistent with her “no magic numbers” comment and is misleading with respect to sober housing in her assertion in her next-to-last paragraph that “having 15 people and minimal structure is a recipe for problems.” She is talking here about “supportive housing” with a certain kind of professional management structure that is not the same kind of self-managed structure found in sober housing.

(1) Architectural design. Architectural design is a critical aspect of the house’s ability to function as a trouble-free sober environment. House design supports the recovery experience by encouraging positive contacts among the resident group through open-plan circulation systems and easy access to all areas of the house. Supportive house design also provides adequate personal space for residents to feel welcome and to participate comfortably in the household. This type of design is relatively easy to supervise and problem-behaviors quickly come to light; houses designed according to these principles report very few problems with residents and neighbors (Wittman, Jee, Polcin and Henderson, 2014). Many types of housing of all sizes can serve these functions. Housing types range from single-family homes, to small apartment houses, to converted hotels and motels (Wittman & Madden, 1998).

Local officials should be asking about the details for sober housing design to make sure there is adequate social space, appropriate circulation, and adequate space and accommodation for individual residents. This is especially critical to avoid overcrowding (too many beds per room, not enough space for social activities, not enough utility space – bathrooms, kitchen, laundry, storage). This is a general concern for family housing of all types, and codes to avoid overcrowding must apply to all types of residential occupancy. Failure of the local jurisdiction to deal effectively with over-crowding issues and other aspects of poor property management generally cannot be compensated by trying to restrict number of housing occupants in a sober-living residence on the indefensible grounds that such occupancy

is not “therapeutic.” The real issues here (as you suggest) are overcrowding, poor property management, and effective nuisance abatement when problems occur.

(2) Social management for sober living. Sober-living houses have their own self-governance dedicated to maintaining sobriety. When such groups are operating effectively, a number of sober living houses of varying size can operate in a satellite system effectively without problems with neighbors or residents regarding relapse issues and related behavioral matters (Polcin, Henderson, et al., 2012; and Wittman, Jee et al. 2014). At this point to my knowledge there is some case-study research but no systematic research at the community level or the sober housing-type level (Oxford Houses, Social model alcohol recovery homes, free-standing sober living houses). One case study example is the Clean and Sober Transitional Living housing service in Fair Oaks, California; see Wittman, Jee et al., 2014.

Dr. Zweben does not recognize the potential effectiveness of sober living houses developed under a peer-based social model of recovery (Wittman & Polcin, 2014). Dr. Zweben narrowly equates housing “structure” with clinical oversight and professional management of a “supportive housing” facility which offers professional and clinical activities similar to those found in a residential treatment facility. She overlooks the utility of domestic management arrangements for peer-based households where the residents are responsible to each other for maintaining both individual and house-sobriety in the recovery experience, rather than to a professional case-manager or a trained house-supervisor. An alternative management paradigm that shows the linkages between “sober living” and “supportive housing” approaches in a community context is shown in Wittman (1993). Dr. Zweben overlooks sober living residences to focus only on harm-reduction residences.

(3) Differences between Sober Living Residences and Harm Reduction Residences. There are two major differences. First, sober living residences maintain strict sobriety at all times. This emphasis on sobriety is expressed throughout the design and operation of the house. Harm reduction residences have a contingent and equivocal perspective on sobriety, as discussed below.

Second, sober living residences are governed and managed primarily by the residents themselves, and residents are responsible for seeking out needed human services on their own from the health/mental health/social/vocational resources available in the surrounding community. Harm reduction residences are managed by specialized staff and residents are individually encouraged and assisted to use human service programs through case-managers and other trained staff.

Sober living residences. Sober Living Residences are dedicated to maintaining sobriety both for the household as a whole, and to support each resident’s personal daily quest for sobriety. Sobriety is the primary value of an SLR household. Residents who cannot stay sober vacate the premises immediately. Under these circumstances, peer-model household management works well to maintain sobriety.

Harm Reduction residences. “Supportive housing” and “Housing First” residences are dedicated to helping residents deal with multiple personal problems, including alcohol/drug dependency, health/mental health issues, and social/vocational/educational disabilities. Harm Reduction residences take an equivocal, contingent view of sobriety among the residents. Relapses and slips do not necessarily result in an immediate departure from the residence. Instead, residents are engaged by staff to address complex problems that combine AOD dependency with other problems; sobriety does not need to be the first priority for these residents. Under these circumstances staff (not residents themselves) carry the burden of maintaining household sobriety and managing related behavior problems (e.g., on-site use of alcohol/drugs, dealer entry into the facility, withdrawal and isolation rather than participatory social behavior) along with consequent neighborhood fallout. Dr. Zweben’s comments about the need for “more structure” for a greater number of residents apply to these Harm Reduction residences rather than to Sober Living residences.

Local officials should have no problems with well-designed, well-manged Sober Living Residences (they don’t cause trouble), and in any case local officials have little leverage to control SLRs given federal protections of the Fair Housing Amendments Act and the Americans with Disabilities Act. The local-control situation is different for harm-reduction housing. To the extent HR housing provides on-site professional services, and to the extent occupancy of the house is not based on a standard rental agreement or a short-term residency agreement (for example, is contingent on time-limited enrollment in an off-site treatment program), the HR facility may be subject to state licensing and local conditional use permits for a residential treatment facility.

In either case, whether the proposed use is a sober living residence or harm reduction residence, the sponsor should be able to describe clearly how the housing environment will be designed and be managed – how the house will function – to provide a safe and supportive environment, and how potential problems will be prevented and addressed as they occur. Well-designed and well-operated houses of both types perform well to support positive outcomes for recovery (Polcin, Korcha et al., 2010).

What is the situation in Costa Mesa? Since it is clear that housing size (number of residents) per se is not really the issue, what’s the problem beyond a generalized NIMBY concern? What specific harms are being done or threatened?

References

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- Wittman, F.D. (1993). Affordable Housing for People with Alcohol and Other Drug Problems, *Contemporary Drug Problems*, 20(3) (Fall 1993) pp. 541-609.
- Wittman, F. D., Lifchez, R., Crowell, C., Johnson, T., Post, H., & Stoltz, N. (1976). Environmental design for social model alcoholism programs: Department of Architecture, College of Environmental Design, University of California Berkeley.
- Wittman, F. D., & Madden, P. A. (1988). *Alcohol recovery programs for homeless people: a survey of current programs in the U.S.* Rockville, MD: National Institute on Alcohol Abuse and Alcoholism.
- Wittman, F.D., & Polcin, D.L. (2014), The evolution of peer-run sober housing as a recovery resource for California communities, *International Journal of Self-Help & Self-Care*, Vol 8(2) pp. 157-187.
- Wittman, F.D., Jee, B., Polcin, D.L. & Henderson, D., The setting is the service: How the architecture of of sober-living residences supports community-based recovery, *International Journal of Self-Help & Self-Care*, Vol 8(2) pp. 189-225.

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Director's Bio

Project Director

Fried Wittman

wittman@uclink4.berkeley.edu

Friedner D. Wittman, Ph.D., M. Arch., has over thirty years' experience in community planning for health and social services, environmental design, and architectural programming. In addition to his role as Program Director for the Community Prevention Planning Program (CPPP), Dr. Wittman is a Research Specialist at the [Institute for Study of Social Change \(ISSC\)](#), University of California, Berkeley. Prevention by Design is a project of the CPPP, a nationally-recognized program that focuses on training and research in outcome-based planning, and on application of environmental planning approaches to prevent problems related to the retail, public, and social availability of alcoholic beverages, tobacco, and other drugs. Dr. Wittman is also the President of CLEW Associates, a consulting firm that specializes in environmental planning and community planning for health and social services.

Dr. Wittman entered the prevention field as a Commissioned Officer in the U.S. Public Health Service, 1967-1972, assigned to the Community Mental Health Centers Construction Grant Program of the National Institute of Mental Health. From 1973-1988, he maintained a private practice as an architectural program consultant primarily for alcohol, drug abuse, and mental health facilities. From 1978-1988, he was a Research Specialist with the Alcohol Research Group in Berkeley, California. His work includes ten years with two National Alcohol Research Centers funded by the National Institute on Alcohol Abuse and Alcoholism (NIAAA). He also served on several NIAAA review committees since 1972 and was a program consultant to NIAAA's research demonstration grant program on homelessness from 1985-1994. From 1983-1988, he was a Project Director at the Prevention Research Center in Berkeley, California. Dr. Wittman joined the ISSC in and founded CLEW Associates in 1988. He also acted as a consultant to the Prevention Enhancement Protocols program of the Center for Substance Abuse Prevention, US Department of Health and Human Services from 1994-1998.

Dr. Wittman has written over 100 papers, reports, monographs, and published articles. His subjects include (1) environmental approaches to preventing community-level problems of alcohol/drug availability, and (2) policies, practices, and design of facilities for alcohol/other drug recovery as well as treatment of mental health disabilities. His education includes a Ph.D. from the University of California, Berkeley College of



Environmental Design (1983); an M. Arch. from the University of Pennsylvania Graduate School of Fine Arts in Philadelphia (1967); and a B.A. in Philosophy from Swarthmore College, Swarthmore, Pennsylvania (1964). Dr. Wittman and his wife Ruth Ann Henderson Wittman reside in Berkeley, California. They have two children.

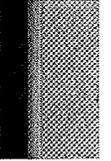


EXHIBIT 7

To The Members of City Council,

My name is Ben, and I am a recovering alcoholic. My sobriety date is 9/20/2012. Without a strong fellowship of men, there is no way that I would have been able to maintain my sobriety date. Since I got sober, I have been a part of the fellowship at the Boston house, and have seen all of these men take steps toward becoming assets to the community, rather than liabilities. These are men who are willing to take responsibility for their past mistakes, and use that experience to help the newcomer coming through the front door do the same.

The courage and the bonding that takes place at this house are nothing short of miraculous. This house is a home for all these men who break down cultural and personal barriers for the common goal of recovery. They are a part of the solution to drug addiction and alcoholism. The Boston house is grounded by the principle of one alcoholic helping another. Without a strong fellowship of sober men to rely on, the newcomer does not stand a chance to get sober and stay sober.

There is a better way to live life than where most of these men came from in their past, myself included. We were all experts in taking what we could get from others. The Boston house shows men how to give of themselves, and to work together towards the common goal of recovery. If the number of sober men in that house was to diminish, there would be less men who might not get a chance to get sober, a chance that I received and am eternally grateful for.

There is not enough time in the day to begin to tell all of the success stories that began at the Boston house. Lost men have found hope. Sick men have recovered. Where some have never been given the gift of a fellowship of strong sober men, the Boston house has always granted that privilege to the men who have lived there. Please do not take away another man's chance to recover, and to show others how to do the same.

Sincerely,

Ben

To whom it may concern-

My name is Casey Hunter, and I am an alumni of Yellowstone Recovery, a graduate of their house on Boston Way. Before I entered treatment, I was homeless, unemployable and on the verge of death due to my drug and alcohol problems. It's because of Yellowstone and the house on Boston Way that I am able to be a productive part of society again. Today I am employable, go to college, and am able to be fully self-supporting. The tools I learned while residing at the Boston house have allowed me to reintegrate into society and live a happy and productive life. More than anything, I enjoyed the camaraderie and the feeling of being a part of that the Boston house portrayed from the very moment I moved in. Being able to live with and learn from an eclectic group of individuals had an indispensable effect on my recovery- it allowed me to learn from people from all different walks of life and taught me to open my mind to ideas and ways of thinking that had been beyond me in the past. In closing, if it weren't for the Boston house and the experience I had there, I am sure I wouldn't be the person that I am today, and that I wouldn't be able to enjoy the amazing life I have today.

Thank You,

-Casey Hunter

To whom ever it may concern

My name is Jason Q I am a Yellowstone client, a resident at the Boston house. I am also new to recovery and Yellowstone is my first program and I am grateful.

The Boston house. Houses men like me and I found this group of men a great part of my recovery. I learned we all share the same illness and although our stories are similar they are not the same and I strongly believe that having all these men in this home with me is a great benefit to my recovery, because my recovery is stronger because of bonding with these men.

I learned this first hand. They have all helped me.

Sincerely,

Jason Quezada

To whom it may concern

I am Jhovany G. I am a fellow brothered patient at Yellowstone. Currently I am at 3rd step sober living I once was a resident at the Boston House I recieved a lot of help with my recovery due group of men house of me. I was able to connect with with several men which in return allowed me to see that I was not alone in my abuse. I helped me better understand my illness through my story and the story of this men. I felt accepted right away, so I was able to open up and share my feeling without a problem. This connection was strong. We gave each other a hand in anyway we can. We were like family that really wanted the best for each other cause we cared. They cheer my me when I was feeling down, give me advice when I wasn't doing good and most important made me realize there a better live then the one was living. If it wasn't for them I would be somewhere where I don't want to go back.

Thank you

Sincerely Jhovany G.

To whom it may concern-

My name is Ken McCracken, and I am an alumni of Yellowstone Recovery, a graduate of their house on Boston Way. Before I entered treatment, I was homeless, unemployable and on the verge of death due to my drug and alcohol problems. It's because of Yellowstone and the house on Boston Way that I am able to be a productive part of society again. Today I am employable, and am able to be fully self-supporting. The tools I learned while residing at the Boston house have allowed me to reintegrate into society and live a happy and productive life. More than anything, I enjoyed the camaraderie and the feeling of being a part of that the Boston house portrayed from the very moment I moved in. Being able to live with and learn from an eclectic group of individuals had an indispensable effect on my recovery- it allowed me to learn from people from all different walks of life and taught me to open my mind to ideas and ways of thinking that had been beyond me in the past. In closing, if it weren't for the Boston house and the experience I had there, I am sure I wouldn't be the person that I am today, and that I wouldn't be able to enjoy the amazing life I have today.

Thank You,

-Ken McCracken

To whom it may concern-

My name is Matthew Mock and I am a current parolee and a SASCA graduate of their six month program. I attended and genuinely participated in all aspects of the program, learning and growing while living at the Boston House. I followed up my time at the Boston house by doing aftercare for another 90 days, where I carried the tools I learned at the Boston house in to everyday life. I still reside at Yellowstone 14 months later and carry the message I so freely received back to the men at the Boston house. Men who are in the same position I was when I got here, men who have seemingly no hope of recovering but are given a second chance at life, just like I was.

Sincerely,

Matthew Mock

To whom it may concern

My name is Mike R. McCracken. I have struggled with Drug and Alcohol addiction most of my adult life. I have been in several different treatment centers over the years and created a great deal of trouble in my life as a result of not taking my addiction problems seriously.

Yellowstone and Boston House have proven to be the last house on the block for me. Although it has taken a lot to adjust to this environment, I truly believe that the diverse dynamic of the Boston House clients coupled with the methods of Yellowstone's recovery have helped me to take a better look at myself and to make the necessary changes that are vital, and conducive to long term sobriety.

I am grateful to Yellowstone's Boston House and think that many other men could benefit immensely from what it has to offer.

Sincerely,

Mike R. McCracken

To whom it may concern-

My name is Omar, and I am an alumni of Yellowstone Recovery I have 26 months sober. Before I entered treatment, I was unemployable and on the verge of death due to my drug and alcohol problems. It's because of Yellowstone that have become a productive part of society again. Today I am employable, and am able to be fully self-supporting. I sponsor men at the Boston house and try to give back what was freely given to me, and I help them live a happy and productive life. More than anything, I enjoy the camaraderie and the feeling of being a part of what the Boston house is trying to do for men. Being able to work with and learn from an sober group of individuals has had an indispensable effect on my recovery- it allowed me to learn from people just like me and taught me to open my mind to ideas and ways of thinking that have been beyond me in the past. In closing, if it weren't for the the men I sponsor at Boston house and the experiences I have there, I am sure I wouldn't be the person that I am today.

Thank You,

-Omar

I have over 124 days sober at Yellowstone and a friend to many of the men at Boston House. All my adult life I have suffered from alcoholism. The difference for me today is learning how to stay sober. Men in the Boston House have helped me stay sober by just being available when I needed fellowship, someone to talk to, and new guys I could help. I needed the opportunity given me at the Boston house and the Boston House staff. They taught me how to build a foundation so I can be self sufficient. Today I have a savings account of over \$500 because of working and help from Yellowstone when I could not pay my rent. My next move will be to a place of my own. Yellowstone has also helped us financially and given scholarships for many of us. People here at Yellowstone have become my friends in spite of my past mistakes. I need to be around men who are working from hard times to a better life. I don't know who to choose which men to eliminate at the Boston House because of some rules which say the city can do that. Please don't eliminate our opportunities, our men at the Boston House

To whom it may concern,

I am writing this letter in support of the Boston House. This house played a significant role in saving my life and turning me into an active member of society. I have also seen this house, and the people who facilitate it, help countless others overcome their past lifestyle. The Boston House helps people in various ways which include laying down a solid foundation on which to grow from, basic life skills, building a safe, healthy network and how to live life on life's terms. If it weren't for the Boston House, I would not have the life I have today. In the program of Alcoholics Anonymous, it's said that if you follow the right path, you will have a life beyond your wildest dreams. Thanks to the Boston House I am now able to be a corporate employee, a son to my mother, a husband to my wife and a father to my son. I would love to see the Boston House continue to help men start a new way of life as it so graciously did for me. I would like to thank the members of this council for their time and consideration on this matter.

Best Regards,

Raymond Conrad

My name is Robert and I am very grateful

1. that I was given a chance to get sober at the Boston House.

I have been at Yellowstone for 20 months and learned
the most from the men at Boston.

Having a bond with so many good men gave me strength
and hope. The energy surrounding this safe place made a
big difference and helped me move forward.

Today I have a job and responsibilities and I am sober and clean.

It would be a shame to leave some of the Boston men behind.

It would be worse if most of the beds for them were gone.

They would not get the opportunity I got to be in an
outstanding program.

Thank you for helping the Boston House men.