



# **PLANNING COMMISSION AGENDA REPORT**

MEETING DATE: OCTOBER 12, 2015

ITEM NUMBER: PH-2

**SUBJECT: CODE AMENDMENT CO-15-04 TO AMEND, REPEAL AND ADD SECTIONS TO TITLE 13 (PLANNING, ZONING AND DEVELOPMENT), RELATING TO GROUP HOMES, SOBER LIVING HOMES, BOARDING HOUSES, AND RESIDENTIAL CARE FACILITIES OF THE COSTA MESA MUNICIPAL CODE**

**DATE: OCTOBER 7, 2015**

**FROM: DEVELOPMENT SERVICES DEPARTMENT**

**PRESENTATION BY: MEL LEE, AICP, SENIOR PLANNER**

**FOR FURTHER INFORMATION CONTACT: MEL LEE, AICP, SENIOR PLANNER**

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## **DESCRIPTION**

The proposed ordinance for Planning Commission consideration proposes modification to Title 13, of the Costa Mesa Municipal Code with regard to group homes, state licensed facilities and boardinghouses in the Multiple-Family Residential zones and Planned Development zones ("MFR Group Home Ordinance"). The additions to Title 13 would require a Conditional Use Permit ("CUP") to locate a group home or a state licensed alcohol or drug abuse treatment facility that serves seven (7) or more occupants in the designated Multiple-Family Residential Zones. In addition, the ordinance requires that an operator of a group home obtain an operator's permit to operate a group home of seven (7) or more occupants in the designated MFR zones, pursuant to the procedure set forth in Title 9.

## **RECOMMENDATION**

Recommend that City Council approve and give first reading to the Ordinance.

## **BACKGROUND**

The City of Costa Mesa, as well as other California Cities, has seen a rapid increase in the proliferation of group homes in both single-family and multiple-family neighborhoods. In particular, the City has seen a significant increase in the number of multiple-family units being utilized as housing for large numbers of individuals recovering from alcohol and drug addiction. Those facilities that provide only residential services and are not licensed by the state are commonly referred to as sober living homes. While those facilities that are licensed by the State Department of Health Care Services (DHCS) to provide residential, detoxification, and other supportive recovery services are commonly referred to as residential care facilities. Over the past 20 months from January 2014 to September 2015, the City experienced an increase of 25.4% in the number of sober living facilities and residential care facilities in the multiple-family residential zones. Those new facilities resulted in an increase of 142-beds, which is a 20.6% increase in beds since January of 2014. As of September 2015, the City had a total of 84 residential facilities, with 831-beds to treat drug and alcohol addiction located in its multiple-family residential districts.

Currently, in all zones, it is estimated that the City of Costa Mesa is home to 1,586 alcohol and drug recovery beds, divided as follows: 44 licensed residential facilities/certified alcohol and drug programs in residential zones, providing 411 beds; 107 unlicensed sober living homes in residential zones, providing 600 beds. Included in those 107 homes are 41 homes who have submitted applications per the R1 Ordinance providing 252 beds; and 1 State Licensed Facility on two separate parcels, providing 76 beds in a non-residential zone; and 40 nonresidential services facilities, providing support services such as administrative offices, therapy etc. In addition, the City of Costa Mesa is currently home to almost 28.9% of the state licensed residential drug and alcohol treatment facilities in Orange County, while the City holds 3.6% of the County's population, thus it is reasonable to infer that unlicensed sober living homes are locating in the City at a higher concentration than in nearby communities.

In addition to the number of recovery facilities in the City's multiple-family residential zones, current zoning interpretation allows up to 6-persons per unit, without a use permit, regardless of the unit size. This has resulted in overcrowded units with 3 to 6 adults in a single bedroom.

As a result of the increase in these facilities, the City is experiencing problems with overcrowded and/or over-concentrated group homes in multiple-family neighborhoods. The sharp increase in numbers of group homes has generated community outcry and complaints including overcrowding, inordinate amounts of second hand smoke and noise, increased parking demands, and the clustering of group homes in close proximity to each other that has changed the residential character of the neighborhoods to one that is far more institutional in nature. This is particularly the case with respect to sober living homes, as the numbers of these homes has increased exponentially compared to other types of group homes.

The proposed regulation will require group homes and residential care facilities with seven (7) or more occupants, to obtain a Conditional Use Permit to ensure they operate in a manner consistent and compatible with the adjacent land uses and the nature of the surrounding residential neighborhoods in which they are located. The proposed regulations establish development standards for these uses including, but not limited to separation requirements between facilities and maximum occupancy limits.

Strong evidence exists that a supportive living environment in a residential neighborhood provides more effective recovery than an institutional-style environment. The proposed ordinance seeks to regulate group homes in the City of Costa Mesa in general, and in particular seeks to address overconcentration and secondary effects of sober living homes. The goal of the proposed ordinance is to provide the disabled with an equal opportunity to live in the residence of their choice, and the need to maintain the residential character of existing neighborhoods.

## **DISCUSSION/ANALYSIS**

### ***LEGAL BACKGROUND***

Pursuant to state law, the City is required to treat various state-licensed residential care facilities serving six or fewer disabled residents (“Residential Care Facilities”) that are located in residential zones as a single family residential use. Consistent with state law, the City of Costa Mesa’s Municipal Code currently provides that residential care facilities that house six or fewer individuals are permitted by right in all residential zones. Residential Care Facilities serving seven or more persons are currently permitted by right in all Multiple-Family Residential zones and Planned Development zones, subject to the same separation requirement as sober living homes. The Health and Safety Code however, does not regulate group homes. Group home facilities include sober living homes (a subset of group homes), and provide residential services to individuals who are disabled. In the case of sober living homes, these facilities provide residential services to individuals recovering from drug and alcohol addiction. Group home facilities are allowed to locate in a residential zone as long as they are serving six or fewer disabled tenants (a recovering addict is generally considered disabled under state and federal law), and are not providing treatment. Without this interpretation, group home facilities would only be permitted to house a maximum of two individuals in a Multiple-Family Residential or Planned Development neighborhood because they would constitute a boarding house.

Since group home facilities are not regulated by the state, there is no specific state law requiring the City to treat such uses as a family use. However, state and federal laws do require the City to make reasonable accommodations in its zoning laws when such accommodation is reasonably necessary to afford the disabled the opportunity to use and enjoy a dwelling. Based on the makeup and needs of the typical group home facility, the City must make available some form of accommodation in its zoning code. Allowing the operation of group home facilities that house up to six individuals within any Residential zone provides that accommodation.

## **GROUP HOMES**

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 state licensed facilities ("Residential Care Facilities") and do not include single housekeeping units.

## **SOBER LIVING HOMES**

A sober living home is a type of group home, which houses individuals who are recovering from an alcohol or drug addiction. During their stay, tenants of sober living homes are required to be enrolled in some type of drug rehabilitation program such as the 12-Step Recovery, Alcoholics Anonymous, Narcotics Anonymous, etc., which typically lasts 90 days or more. Tenancy in a sober living facility is transient. A study of Oxford House (Attachment 11), a nationwide sober living provider, found that the average stay for their tenant's is 256 days. A 2007 Study (Attachment 12) found that 65-70% of all persons who enter drug treatment programs do not finish. This contributes to the transient nature of the population. Often tenants that fail to complete treatment are evicted from their sober living home without an adequate transitional plan and as a result contributing to a growing homeless population in the City, requiring expensive and staff intensive assistance. Many sober living homes advertise weekly rentals, which speaks to the transient nature of the population. Sober living homes are typically run by an entity or person who does not reside in the residence, further reducing their ties to the community.

The tenants of a sober living home arrive there in a number of ways. They could self-check in. They could be there as a condition of probation, with or without a reference by the County Probation Department. They may be there in lieu of incarceration; pending a court hearing; or trial. Some may be on parole and have parole officers. It is believed that the passage of Proposition 36, the Substance Abuse and Crime Prevention Act (the "Act"), by California voters in 2000 has significantly increased demand for space in sober living homes. The Act mandated that specified first and second time non-violent drug offenders receive treatment in lieu of incarceration. The purpose behind the Act was to decrease the cost of imprisoning non-violent drug offenders and to reduce recidivism. Additionally, the Affordable Care Act has significantly expanded the availability of health care coverage of substance abuse treatment, and this is anticipated to increase the numbers of individuals in supportive housing.

Tenants of sober living homes typically share chores, but do not share costs and are not responsible for any significant maintenance. In some cases it appears that tenants are responsible for their own food. The City has inspected sober living facilities with separate refrigerators, and in some cases locked bedrooms. Rents are generally set by a person or entity that does not reside in the facility. The better run sober living facilities have house rules, curfews and a no tolerance policy for any drug or alcohol use. The rules are not set by the tenants. The tenants have little to no say as to who resides at the facility or who is their roommate.

The cost for residing in a sober living facility varies greatly. Prices on the Sober Living Network's website showed per tenant monthly rental fees ranging from a low of \$410 at a sober living facility in Anaheim to a high of \$6,500 for one in Irvine. Of the 20-homes shown in Costa Mesa, the monthly rents ranged from \$660 to \$1,500. Many recovering addicts are fully employed and some sober living facilities require that their tenants be employed or at least be actively seeking employment

### ***POTENTIAL IMPACT FROM SOBER LIVING HOMES***

Possible impacts from sober living homes are set forth in detail in the ordinance, but in large part are similar to impacts caused by any situation in which large numbers of individual adult tenants reside in a single residential unit or series of residential units. In addition, sober living facilities create additional impacts beyond the normal overcrowding situation which are somewhat unique. Based on complaints from neighbors it appears that such uses create an inordinate amount of second-hand smoke. This has been a common complaint here in Costa Mesa, and also in Orange and Newport Beach. Sober living homes generate secondary impacts including, but not limited to, neighborhood parking shortfalls and overcrowding, which is particularly noticeable in the multiple-family zones where, at this time, operators routinely house up to 6 persons per unit regardless of the number of bedrooms in the unit.

The clustering of sober living facilities in close proximity to each other and the common practice of turning all the units in a multiple-family residential property as one large sober living facility results in neighborhoods dominated by sober living facilities. In these neighborhoods, street life is dominated by large capacity transportation vans, picking-up and dropping-offs residents and staff, serviced providers taking up much of the available on street parking, staff in scrubs carrying medical kits going from unit to unit, vans dropping off prepared meals in large numbers, and frequent Costa Mesa Fire Department deployments in response to medical aid calls. In some neighborhoods Costa Mesa Police Department deployments are a regular occurrence as a result of domestic abuse calls, burglary reports, disturbing the peace calls and parole checks at sober living facilities. Large and often frequent AA or NA meetings are held at some sober living homes. Attendees of these meetings contribute to the lack of available on street parking and neighbors report finding an unusual amount of litter and debris, including beverage containers, condoms and drug paraphernalia in the wake of these meetings.

Transiency is also more pronounced in a sober living home than it is with other types of boarding house uses. The likelihood that a sober living home is housing a convicted criminal is higher than typical residential uses. It has also been the City's experience that sober living facilities often have numerous building code violations and unpermitted additions and often ignore the City's occupancy limits. City staff has spent an inordinate amount of time inspecting these properties just to get them to come into compliance with the building and zoning codes and some take the position that state and federal laws preclude the City from regulating them at all.

## **PROPOSED REGULATIONS**

The proposed ordinance would establish new regulation for Boardinghouses, Group Homes, including Sober Living Homes and Residential Care Facilities in the following Zoning Districts:

- R2-MD – Multiple-Family Residential District
- R2-HD – Multiple-Family Residential District
- R3 - Multiple-Family Residential District
- PDR-LD Planned Development - Low Density (up to 8 DU's/Acre)
- PDR-MD Planned Development - Medium Density (up to 12 DU's/Acre)
- PDR-HD Planned Development - High Density (up to 20 DU's/Acre)
- PDR-NCM Planned Development - North Costa Mesa (up to 25-35 DU's/Acre)
- PDC Planned Development Commercial
- PDI planned Development Industrial
- I&R Institutional and Recreational District

### **GROUP HOME REGULATION**

#### Group homes serving six or fewer residents.

The ordinance would permit group homes, inclusive of sober living homes, serving six or fewer residents to locate in the specified zones. Group homes of six or fewer would be required to obtain a Special Use Permit ("SUP") pursuant to the existing provisions of Chapter XV with a few modifications. State licensed alcohol and drug abuse treatment facilities serving six or fewer residents are exempt from Chapter XV and do not need a SUP.

#### Group homes serving seven or more residents

Group homes serving seven or more residents would be required to obtain a CUP in order to locate in the specified multi-family residential zones. In addition, group homes would be required to obtain an operator's permit in order to operate in the MFR zones. The requirements for issuance of an operator's permit are set forth in a separate ordinance that amends Title 9 (see Attachment 2). These requirements are similar to the requirements for a SUP. City Council will be considering this Ordinance with regard to changes in Title 9.

#### State licensed facilities serving seven or more residents

State licensed facilities would be required to obtain a CUP in order to locate in the MFR zones. These facilities, as they are regulated by the state, would not be required to obtain an operator's permit to operate in the specified multi-family residential zones.

### Reasonable Accommodation

An applicant may seek relief from the strict application of the provisions of the ordinance 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 the existing provisions of section 13-200.60 et seq.

### **ISSUANCE, DENIAL OR REVOCATION**

#### Conditional Use Permit

The general standards for issuance of a CUP of Section 13-29(g) are applicable. In addition, the following standards apply. A CUP may be issued where the group home, residential care facility or state licensed drug and alcohol treatment facility is at least six-hundred fifty feet (650') from any property that operates such the same or similar home or facility as measured from the property line (see radius map attached showing the existing unlicensed facilities within the City – Attachment 5). An applicant for a CUP for a group home or sober living facility must also obtain an operator's permit pursuant to Title 9. The standards for revocation of a CUP are the same as for any CUP issued by the Planning Commission.

#### Special Use Permit

A Special Use Permit shall be issued if the applicant is in compliance with the requirements of existing Chapter XV. A Special Use Permit may be denied, and if already issued, shall be denied or revoked, upon a determination by the director that any of the applicable provisions of Chapter XV have been violated or are not being complied with. An appeal of the director's determination shall be heard by the Planning Commission on a de novo basis.

#### Compliance

Existing group homes with seven or more occupants will have 120 days to obtain an Operator's Permit, and one year to obtain a Conditional Use Permit. Existing state licensed facilities with seven or more occupants shall have one year to obtain a Conditional Use Permit. Existing group homes and state licensed facilities that are obligated by a written lease exceeding one (1) 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.

Group homes with six or fewer occupants that are in existence upon the effective date of this ordinance shall have 90 days to apply for a Special Use Permit, and one year from the effective date of this ordinance to comply with its provisions relating to Special Use Permits. Existing group homes that are 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 to obtain a Special Use Permit pursuant to planning division approval.

## **PUBLIC NOTICE**

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

- Publication of a display ad in the local newspaper (Daily Pilot); and
- Posting of the Planning Commission Agenda 72-hours in advance of the meeting.

## **ENVIRONMENTAL DETERMINATION**

The 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 CEQA because there is no possibility that the proposed amendment to the Zoning Code will have a significant effect on the environment.

## **LEGAL REVIEW**

The draft ordinance has been reviewed by the City Attorney's office.

## **CONCLUSION**

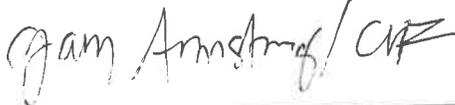
The proposed amendment will provide the regulatory framework to limit the number of people in a group home and to prevent the overconcentration of residential care facilities, group homes and sober living homes in multiple-family residential and planned residential neighborhoods. The regulations require a Conditional Use Permit (CUP) to operate group homes and sober living homes in the Multiple-Family Residential and Planned Development Residential Districts. The CUP will allow the City to review the proposed use on an individual basis, track the location of sober living homes in the effected zones and establish reasonable operating standards through Conditions of Approval on these uses to ensure that they do not generate the type of secondary impact that would be out of character for the neighborhood; while still furthering the purpose of the FEHA, the FHAA and the Lanterman Act, by allowing special accommodation and/or additional accommodation for the handicapped.

## **ALTERNATIVES**

The City could continue to regulate group homes as it does currently. However, this has not worked well as group homes tend to go into residential neighborhoods without notification to the City and often exceed the occupancy limit of the code. There is some tendency for such facilities to locate close together and this type of clustering erodes the residential character of a neighborhood and creates an institutionalized environment that is counterproductive to recovery. With a Conditional Use Permit requirement, the City can

track the location of group homes and help ensure that these homes operate in a manner that is considerate to its neighbors and enhances the chances of recovery for its tenants. The additional requirement that sober living homes and residential care facilities of 7 or more persons, maintain a discrete separation distance from any other sober living home will minimize the secondary impacts created by these facilities, while ensuring recovering addicts and alcoholics access to living in the City's multiple-family residential and planned residential neighborhoods

  
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Distribution: Director of Economic & Development/Deputy CEO  
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File (2)

- Attachments:
- 1) Draft Ordinance Proposed
  - 2) Proposed Operator's Permit Ordinance.
  - 3) Draft Land Use Matrix Revised (Strike-Thru)
  - 4) Draft Land Use Matrix Revised (No Strike-Thru)
  - 5) 650-Foot Radius Map (Multi-Family Zones)
  - 6) Penal Code Section 290 & 3003 & 3003.5
  - 7) Section 10501(a)(6) of title 9, California Code of Regulations
  - 8) U.S. Federal Fair Housing Act - Reasonable Accommodation Code Section
  - 9) Lanterman Act
    - a) Legislative Intent
    - b) Licensed facilities for the developmentally Disabled
  - 10) Health & Safety Code – Excerpts Regarding Alcohol Treatment
  - 11) Oxford House Study
  - 12) *Drugs, Brains and Behavior: The Science of Addiction*, National Institute of Drug Addiction, National Institutes of Health, NIH Pub. No. 14-5605, April 2007 (revised February 2008, August 2010, July 2014); *Recovery Housing: Assessing the Evidence*, Sharon Reif, Ph.D, et al., Psychiatric Services, Vol. 65 No. 3, March 2014.

## ORDINANCE NO. 15-

**AN ORDINANCE OF THE CITY COUNCIL OF THE CITY OF COSTA MESA TO AMEND TITLE 13 OF THE COSTA MESA MUNICIPAL CODE BY ADDING CHAPTER XVI (GROUP HOMES, SOBER LIVING HOMES, AND RESIDENTIAL CARE FACILITIES) IN THE R2-MD, R2-HD AND R3 RESIDENTIAL ZONES AND THE PDR-LD, PDR-MD, PDR-HD, PDR-NCM, PDC, AND PDI (PLANNED DEVELOPMENT ZONES) OF TITLE 13 AND AMENDING SECTION 13-6 (DEFINITIONS) OF ARTICLE 2 (DEFINITIONS) OF CHAPTER I (GENERAL) AND SECTION 13-30 TABLE 13-30 (LAND USE MATRIX) OF CHAPTER IV OF ARTICLE 1 OF CHAPTER V OF TITLE 13**

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

WHEREAS, under the California Constitution, Article XI, Section 7, the City has been granted broad police powers to preserve the residential characteristics of its R2MD, R2HD, and R3 zones; and planned development residential zones, 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, 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 accommodations 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 characteristics of residential neighborhoods and to provide opportunities for the handicapped to reside in such neighborhoods 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- and multi-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 in the number of sober living homes, which has generated secondary impacts including, but not limited to neighborhood parking shortfalls, 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, over the past 20 months from January 2014 to September 2015 the City experienced an increase of 25.4% in the number of sober living facilities and residential care facilities in the multiple-family residential zones. Those new facilities resulted in an increase of 142-beds, which is a 20.6% increase in beds since January of 2014. As of September 2015 the City had a total of 84 residential facilities, with 831-beds to treat drug and alcohol addiction located in its multiple-family residential districts; and

WHEREAS, currently, in all zones, it is estimated that the City of Costa Mesa is home to 1586 alcohol and drug recovery beds, divided as follows: 44 licensed residential facilities/certified alcohol and drug programs in residential zones, providing 411 beds; 107 unlicensed sober living homes in residential zones, providing 600 beds; Included in those 107 homes are 41 homes who have submitted applications per the R1 Ordinance providing 252 beds; and 1 State Licensed Facility on two separate parcels, providing 76 beds in a non-residential zone; and 40 nonresidential services facilities, providing support services such as administrative offices, therapy etc.

WHEREAS, the City of Costa Mesa is currently home to almost 28.9% of the state licensed residential drug and alcohol treatment facilities in Orange County, while the City holds 3.6% of the County's population, thus it is reasonable to infer that unlicensed sober living homes are locating in the City at a higher concentration than in nearby communities; and

WHEREAS, over the last decade the number of sober living homes in the City of Costa Mesa is rapidly increasing, leading to an overconcentration of sober living homes in certain of the City's residential neighborhoods, which is both deleterious to the residential character of these neighborhoods and may also lead to the institutionalization of such neighborhoods; and

WHEREAS, the number of sober living homes has not increased to the point of overconcentration in certain Planned Development zones; 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 residential 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, in 2008, the U.S. Department of Health and Human Services projected spending on substance abuse recovery to be \$35 billion annually by 2014 (source: *Projections of National Expenditures for Mental Health Services and Substance Abuse Treatment 2004-2014*, U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration, Katharine R. Levit et al., 2008); 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, establishing distance requirements for sober living homes is reasonable and non-discriminatory and not only helps preserve the residential character of the R2MD, R2HD, and R3 zones; as well as the planned development residential neighborhoods, but also furthers the interest of ensuring that the handicapped are not living in overcrowded environments that are counterproductive to their well-being and recover; and

WHEREAS, sober living homes do not function as a single housekeeping unit for the following reasons: (1) they house extremely transient populations (programs are generally about 90 days and as noted, the 2008 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 (2.68 persons per household 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 the 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 and public utility providers utilize federal census data and other information relating to the characteristics of residential neighborhoods to, among other things: (1) determine the design of residential homes, residential neighborhoods, park systems, library systems, transportation systems; (2) determine parking and garage requirements of various (bedroom) sizes and density of units; (3) develop its General Plan and zoning ordinances; (4) determine police and fire staffing; (5) determine impacts to water, sewer and other services; and (5) establish 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 dwelling and the lack of regulations, sober living facilities present problems not typically associated with more traditional residential uses, including but not limited to: the housing of large numbers of unrelated adult who may or may not be supervised; disproportionate numbers of cars associated with a single housing unit, 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 participation in community activities that form and strengthen neighborhood cohesion; a history of

opening facilities in complete disregard of the Costa Mesa Municipal Code and with little regard for impacts to the neighborhood; disproportional impacts from the average dwelling unit to nearly all public 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 variable separation requirement will still allow for a reasonable market for the purchase and operation of sober living homes within the City and still result in preferential treatment for sober living homes in that non-handicapped individuals in a similar living situation (i.e., in boardinghouse-style residences) have fewer housing opportunities than the handicapped; and

WHEREAS, housing inordinately large numbers of unrelated adults in a single dwelling 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 residential neighborhoods, that when operated responsibly, group homes, including sober living homes, provide a societal benefit by providing the handicapped the opportunity to live in residential neighborhoods, as well as providing recovery programs for individuals attempting to overcome their drug and alcohol addictions, and that therefore providing greater access to residential zones to group homes, including sober living homes, than to boardinghouses or any other type of group living 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 an individual home are lessened; and

WHEREAS, in addition to group homes locating in residential 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 these neighborhoods; and

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

WHEREAS, no residential developments of any kind are permitted in the I&R (Institutional and Recreation) zone, and no group homes exist in this zone at the time of the adoption of this ordinance; 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 definition in Section 13-6 (Definitions) of Article 2 (Definitions) of Chapter I (General) of Title 13 (Planning, Zoning and Development) are hereby repealed and replaced with the following:

*Boardinghouse.* A residence or dwelling, other than a hotel, wherein rooms are rented under two (2) 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 (2) or fewer rooms being rented. Boardinghouse, large means three (3) to six (6) rooms being rented. Boardinghouses renting more than 6 rooms are prohibited.

**Section 2:** Chapter XVI (Group homes and residential care facilities in the R2-MD, R2-HD and R3 residential zones and the PDR-LD, PDR-MD, PDR-HD, PDR-NCM, PDC, AND PDI (Planned Development Zones) of Title 13 (Planning, Zoning and Development) is hereby added as follows:

**13-320. - Purpose.**

This chapter is intended to preserve the residential character the City of Costa Mesa's 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 off-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 residential neighborhood; and (4) to provide comfortable living environments that will enhance the opportunity for the handicapped, including recovering addicts to be successful in their programs.

**13-321. - Definitions.**

Property. For purposes of this chapter, property is defined as any single development lot that has been subdivided bearing its own assessor's parcel number or with an approved subdivision map or condominium map.

**13-322. - Group Homes in the R2-MD, R2-HD and R3 residential zones and the PDR-LD, PDR-MD, PDR-HD, PDR-NCM, PDC, AND PDI (Planned Development Zones) Zones with Six or Fewer Occupants.**

(a) A special use permit shall be required for and may be granted to permit the operation of a group home including a sober living home with six or fewer occupants in the R2-MD, R2-HD and R3 residential zones and the PDR-LD, PDR-MD, PDR-HD, PDR-NCM, PDC, AND PDI (Planned Development Zones) Zones) zones subject to the following conditions:

(1) The application complies with subsections (a)(1), (a)(2) and (a)(4) through (a)(9) of Section 13-311.

(2) The application includes a live scan of the house manager and/or operator of the group home.

(3) The group home or sober living home is at least 650 feet from any other property, as defined in Section 13-321, that operates the same or similar home or facility as measured from the property line.

(b) 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.

(c) Notwithstanding any provision of section 13-3119(b) to the contrary, the Development Services Director may revoke or deny a special use permit for a group home subject to this chapter following the director's determination that any of the circumstances set forth in Section 13-311(b)(1) through (7) exist.

**13-323. - Conditional Use Permit Required for Group Homes, Residential Care Facilities and Drug and Alcohol Treatment Facilities in the R2-MD, R2-HD and R3 residential zones and the PDR-LD, PDR-MD, PDR-HD, PDR-NCM, PDC, AND PDI (Planned Development Zones) with 7 or More Occupants.**

A conditional use permit shall be required for and may be granted to allow the operation of a group home, state licensed residential care facility or state licensed drug and alcohol treatment facility with seven (7) or more occupants in **the R2-MD,**

**R2-HD and R3 residential zones and the PDR-LD, PDR-MD, PDR-HD, PDR-NCM, PDC, AND PDI (Planned Development Zones) zones** subject to the following conditions:

(a) The requirements of Chapter III PLANNING APPLICATIONS have been met.

(b) The group home, residential care facility or state licensed drug and alcohol treatment facility is at least six-hundred fifty feet from any property, as defined in Section 13-321, that operates such the same or similar home or facility as measured from the property line.

(c) The applicant obtains an operator's permit as required by Article 23, Chapter 2 of Title 9 except that this requirement shall not apply to any state licensed residential care facility or state licensed drug and alcohol treatment facility.

(d) The findings for granting a conditional use permit in accordance with Section 13-29(g) are met.

**13-324. - Compliance.**

(a) Group homes in the in the R2-MD, R2-HD and R3 residential zones and the PDR-LD, PDR-MD, PDR-HD, PDR-NCM, PDC, AND PDI (Planned Development Zones) Zones with six (6) or fewer occupants that are in existence upon the effective date of this ordinance may continue to operate subject to the following:

1. A complete application for a special use permit is filed within 90 days of the effective date of this ordinance; and
2. The group home is in full compliance with all of the conditions of this ordinance within one (1) year of its effective date. Notwithstanding the foregoing, existing group homes obligated by a written lease exceeding one (1) 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 (1) additional years grace period pursuant to planning division approval.

(b) Group homes, state licensed residential care facilities and state licensed drug and alcohol treatment facilities in the R2-MD, R2-HD and R3 residential zones and the PDR-LD, PDR-MD, PDR-HD, PDR-NCM, PDC, AND PDI (Planned Development Zones) with seven (7) or more occupants that are in existence upon the effective date of this ordinance may continue to operate subject to the following:

1. The operator of a group home obtains an operator's permit pursuant to section 9-445 et seq. within 120 days from the effective date of this ordinance; and
2. The group home, state licensed residential care facility and/or state licensed drug and alcohol treatment facility is in full compliance with all

conditions of this ordinance, including obtaining a conditional use permit, within one (1) year from the effective date of this ordinance. Notwithstanding the foregoing, an existing group home, state licensed residential care facility and/or state licensed drug and alcohol treatment facility obligated by a written lease exceeding one (1) 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 (1) additional years grace period pursuant to planning division approval.

**13-325. - Severability.**

Should any section, subsection, clause, or provision of this chapter 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.

**Section 3:** Subdivisions (4) through (10) of Section 13-30 Table 13-30 of Chapter IV (Citywide Land Use Matrix) of Title 13 (Planning, Zoning and Development) are hereby repealed and replaced with the following:

See Attachment A.

**Section 4:** Footnote 4 to Table 13-30 (Land Use Matrix) of Section 13-30 (Purpose) of Chapter IV (Citywide Land Use Matrix) of Title 13 (Planning, Zoning and Development) is hereby repealed and replaced with the following:

<sup>4</sup> For the purposes of this table, the symbols shall have the following meaning: C—Conditional Use Permit; MC—Minor Conditional Use Permit; P—Permitted; •—Prohibited. S—Special Use Permit.

**Section 5:** Footnotes 6 and 7 and 8 to Table 13-30 (Land Use Matrix) of Section 13-30 (Purpose) of Chapter IV (Citywide Land Use Matrix) of Title 13 (Planning, Zoning and Development) is hereby added as follows:

<sup>6</sup> Subject to the separation requirements set forth in Section 13-322(a)(3).

<sup>7</sup> Small boardinghouses shall locate at least 650 feet from any other small boardinghouse. Large boardinghouses shall be located at least 1,000 feet from any other boardinghouse.

<sup>8</sup> Uses prohibited in the base zoning district of a Mixed-Use Overlay Zone shall also be prohibited in the Overlay Zone.

**Section 6:** 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 7:** 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 8:** 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.

Adopted this \_\_\_\_\_ day of \_\_\_\_\_, 2015

\_\_\_\_\_  
Stephen Mensinger, Mayor

ATTEST:

\_\_\_\_\_  
Brenda Green  
City Clerk of the City of Costa Mesa

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

I, BRENDA GREEN, City Clerk of the City of Costa Mesa, California, do hereby certify that the foregoing Ordinance was introduced at the regular meeting of the City Council held on the \_\_\_\_ day of \_\_\_\_\_, 2015, and thereafter at the regular meeting of said City Council duly held on the \_\_\_\_ day of \_\_\_\_\_, 2015, was duly passed and adopted by the following vote, to wit:

AYES:  
NOES:  
ABSENT:  
ABSTAIN:

\_\_\_\_\_  
Brenda Green  
City Clerk of the City of Costa Mesa

**[DRAFT] ORDINANCE NO. 15-**

**AN ORDINANCE OF THE CITY COUNCIL OF THE CITY OF COSTA MESA TO AMEND TITLE 9 OF THE COSTA MESA MUNICIPAL CODE BY AMENDING SECTIONS 9-116 (ISSUING OFFICER) AND 9-125 (BUSINESSES ETC. REQUIRING PERMIT) OF ARTICLE I OF CHAPTER II OF TITLE 9 AND TO ADD SECTION 131 (BUSINESSES WHERE DEVELOPMENT SERVICES DIRECTOR MAY ISSUE PERMIT) OF ARTICLE I OF CHAPTER II OF TITLE 9 AND ARTICLE XXIII (GROUP HOMES) OF CHAPTER II OF TITLE 9**

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

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

**Section 1:** Sections 9-116 and 9-125 of Article I of Chapter II of Title 9 are amended, and Section 131 of Article I of Chapter II of Title 9 and Article XXIII of Chapter II of Title 9 are hereby added, to read as follows:

**Article I.**

**9-116. - Issuing officer.**

"Issuing officer" shall mean the city council of Costa Mesa, the director of finance, the fire chief, the chief of police, or the development services director.

**9-125. - Businesses, professions, trades and occupations requiring a permit under the provisions of this chapter.**

- (q) Group homes, as defined in section 13-6, that have seven (7) or more occupants.

**9-131. - Businesses where the development services director may issue permit.**

The development services director may issue permits for operation of a group home located in the in the **R2-MD, R2-HD and R3 residential zones and the PDR-LD, PDR-MD, PDR-HD, PDR-NCM, PDC, AND PDI (Planned**

**Development Zones)** zones pursuant to the requirements of Article XXIII of this Chapter.

## **Article XXIII GROUP HOMES**

### **9-443. - Definitions**

The definitions set forth in Title 13 of this Code shall apply to the provisions of this article unless otherwise provided for herein.

### **9-444. - Zoning requirements.**

In addition to the requirements of this article, all group homes subject to this article shall comply with the requirements set forth in Chapter XVI of Title 13 of this Code.

### **9-445. – Operator’s permit required.**

It shall be unlawful for any person to operate, or to permit any person to operate, a group home on any property located within the **R2-MD, R2-HD and R3 residential zones and the PDR-LD, PDR-MD, PDR-HD, PDR-NCM, PDC, AND PDI (Planned Development Zones)**, without a valid permit issued for that group home pursuant to the provisions of this article.

### **9-446. – Exceptions.**

The requirements of this article shall not apply to:

- (a) A group home located in the R-1 zone that has six (6) or fewer occupants, not counting a house manager, and that is in compliance with the provisions of Chapter XV of Title 13 of this code;
- (b) A state licensed *alcoholism or drug abuse recovery or treatment facility*;  
*or*
- (c) A state licensed *residential care facility*.

### **9-447. Requirements for issuance of operator’s permit.**

- (a) The owner/operator shall submit an application to the director that provides the following information:
  - (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.

(b) Requirements for operation of group homes.

- (1) 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 twenty-four-hour basis and who are responsible for the day-to-day operation of the group home.
- (2) 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 five hundred (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.
- (3) 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.
- (4) 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.
- (5) If the group home operator is not the property owner, written approval from the property owner to operate a group home at the property.
- (6) The property must be fully in compliance with all building codes, municipal code and zoning.
- (7) In addition to the regulations outlined above, the following shall also apply to sober living homes:
  - i. 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.

- ii. 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 ninety (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.
  - iii. 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.
  - iv. 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.
  - v. 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.
  - vi. 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.
- (c) 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 Article 15 of Chapter IX of Title 13 of this Code.
- (d) The operator's permit shall be issued by the director if the applicant is in compliance, or, where applicable, has agreed to comply, with the requirements of subsections (a) and (b) above.

- (e) In addition to denying an application for failing to comply, or failing to agree to comply, with subsections (a) and/or (b), an application shall be denied 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 (2) 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 (7) to ten (10) 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 ten (10) years);
    - ii. Arson offenses—Violations of Penal Code Sections 451—455 (last seven (7) years); or
    - iii. Violent felonies, as defined in Penal Code Section 667.5, which involve doing bodily harm to another person (last ten (10) years).
    - iv. The unlawful sale or furnishing of any controlled substances (last seven (7) 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 disabled or handicapped as defined by the FHAA and FEHA.
  - (6) An operator's permit for a sober living home shall also be denied, and if already issued shall be 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 (1) 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.
  - (7) For any other significant and/or repeated violations of this section and/or any other applicable laws and/or regulations.

**9-448. – Transfer of operator’s permit.**

- (a) An operator’s permit shall not be valid for a location other than the property for which it is issued, unless and until the transfer of the permit is approved by the director pursuant to the requirements of section 9-447.
- (b) An operator’s permit may not be transferred to any other person or entity. No operator’s permit issued pursuant to this article shall be transferred or assigned or authorize any person or entity other than the person or entity named in the permit to operate the group home named therein.

**9-449. - Revocation of operator’s permit.**

An operator’s permit may be revoked upon a hearing by the director pursuant to section 9-120 for failing to comply with the terms of the permit and/or for failing to comply with the applicable provisions of section 9-447.

**9-450. – Reapplication after denial or revocation.**

- (a) An applicant for an operator’s permit whose application for such an operator’s permit has been denied may not reapply for such a user’s permit for a period of six (6) months from the date such notice of denial was issued.
- (b) A holder of a operator’s permit that has been cancelled, revoked or otherwise invalidated may not reapply for a user’s permit for a period of six (6) months from the date that such revocation, cancellation or invalidation became final.

**9-451. – Compliance.**

A group home that is subject to the provisions of this article that is in existence as of the effective date of this ordinance shall have 120 days to comply with the provisions of this article.

**Section 2:** 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 3:** 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 4:** 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.

Adopted this \_\_\_\_\_ day of \_\_\_\_\_, 2015

\_\_\_\_\_  
Stephen Mensinger, Mayor

ATTEST:

\_\_\_\_\_  
Brenda Green  
City Clerk of the City of Costa Mesa

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

I, BRENDA GREEN, City Clerk of the City of Costa Mesa, California, do hereby certify that the foregoing Ordinance was introduced at the regular meeting of the City Council held on the \_\_\_\_ day of \_\_\_\_\_, 2015, and thereafter at the regular meeting of said City Council duly held on the \_\_\_\_ day of \_\_\_\_\_, 2015, was duly passed and adopted by the following vote, to wit:

AYES:  
NOES:  
ABSENT:  
ABSTAIN:

\_\_\_\_\_  
Brenda Green  
City Clerk of the City of Costa Mesa

TABLE 13-30  
CITY OF COSTA MESA LAND USE MATRIX

LAND USES	ZONES												
	R 1	R 2	R 3	A P	C L 1	C 2	C 1	T C 1	M G	M P	P R	P D	P I
<b>RESIDENTIAL USES</b>													
1. Single-family dwellings (single housekeeping units)	P <sup>4</sup>	P	P	P	P	P	P	P	P	P	P	P	P
2. Multi-family dwellings	•	P	P	•	•	•	•	•	•	•	•	•	•
2.1 Common interest developments, residential	•	P	P	•	•	•	•	•	•	•	•	•	•
2.2 Small lot subdivisions, residential	•	P	P	•	•	•	•	•	•	•	•	•	•
3. Mobile home parks	•	C	C	•	•	•	•	•	•	•	•	•	•
4. Boardinghouse, small	•	P	P	•	•	•	•	•	•	•	•	•	•
5. Boardinghouse, large	•	C	C	•	•	•	•	•	•	•	•	•	•
6. Residential care facility, 6 or fewer persons (State licensed)	P	P	P	•	•	•	•	•	•	•	•	•	•
7. Group homes, 6 or fewer	S	S	S	•	•	•	•	•	•	•	•	•	•
7.1. Sober living homes, 6 or fewer	S <sup>5</sup>	S <sup>u</sup>	S <sup>u</sup>	•	•	•	•	•	•	•	•	•	•
8. Residential care facility, 7 or more	•	C	C	•	•	•	•	•	•	•	•	•	•
9. Group homes, 7 or more	•	C	C	•	•	•	•	•	•	•	•	•	•
9.1 Sober living homes, 7 or more	•	C <sup>u</sup>	C <sup>u</sup>	•	•	•	•	•	•	•	•	•	•
10. Referral facility (Subject to the requirements of Section 13-32.2 Referral facility)	•	C <sup>2</sup>	C <sup>2</sup>	•	•	•	•	•	•	•	•	•	•

Chapter IV Citywide Land Use Matrix

Revised 1/02 Ordinance 01-30; 3/02 Ordinance 02-4; 2/05 Ordinance 05-2; 7/05 Ordinance 05-11; 2/06 Ordinance 06-2; 02/07 Ordinance 07-2  
Revised 3/98 Ordinance 98-5; 4/00 Ordinance 00-5; Ordinance 201; Ordinance 01-1

Revised 1/02 Ordinance 01-30; 3/02 Ordinance 02-4; 2/05 Ordinance 05-2; 7/05 Ordinance 05-11; 2/06 Ordinance 06-2; 02/07 Ordinance 07-2

1. Uses proposed in this zone are subject to verification of consistency with the adopted master plan. Uses not specified in the master plan, could be allowed, subject to the review process indicated in this matrix, if the proposed use is determined to be compatible with the adopted master plan.
2. This use is subject to the requirements of the referenced Municipal Code article or section.
3. If residential uses exist, accessory uses shall be permitted.
4. For the purposes of this table, the symbols in the non-shaded areas shall have the following meaning: C - Conditional Use Permit; MC - Minor Conditional Use Permit; P - Permitted; • - Prohibited; and S - Special Use Permit

5. Subject to the separation requirements set forth in Section 13-32.2(a)(3).
6. Small boardinghouses shall locate at least 650 feet from any other small boardinghouse. Large boardinghouses shall be located at least 1,000 feet from any other boardinghouse.
7. Uses prohibited in the base zoning district of a mixed-use overlay zone shall also be prohibited in the overlay zone.

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TABLE 13-30  
CITY OF COSTA MESA LAND USE MATRIX

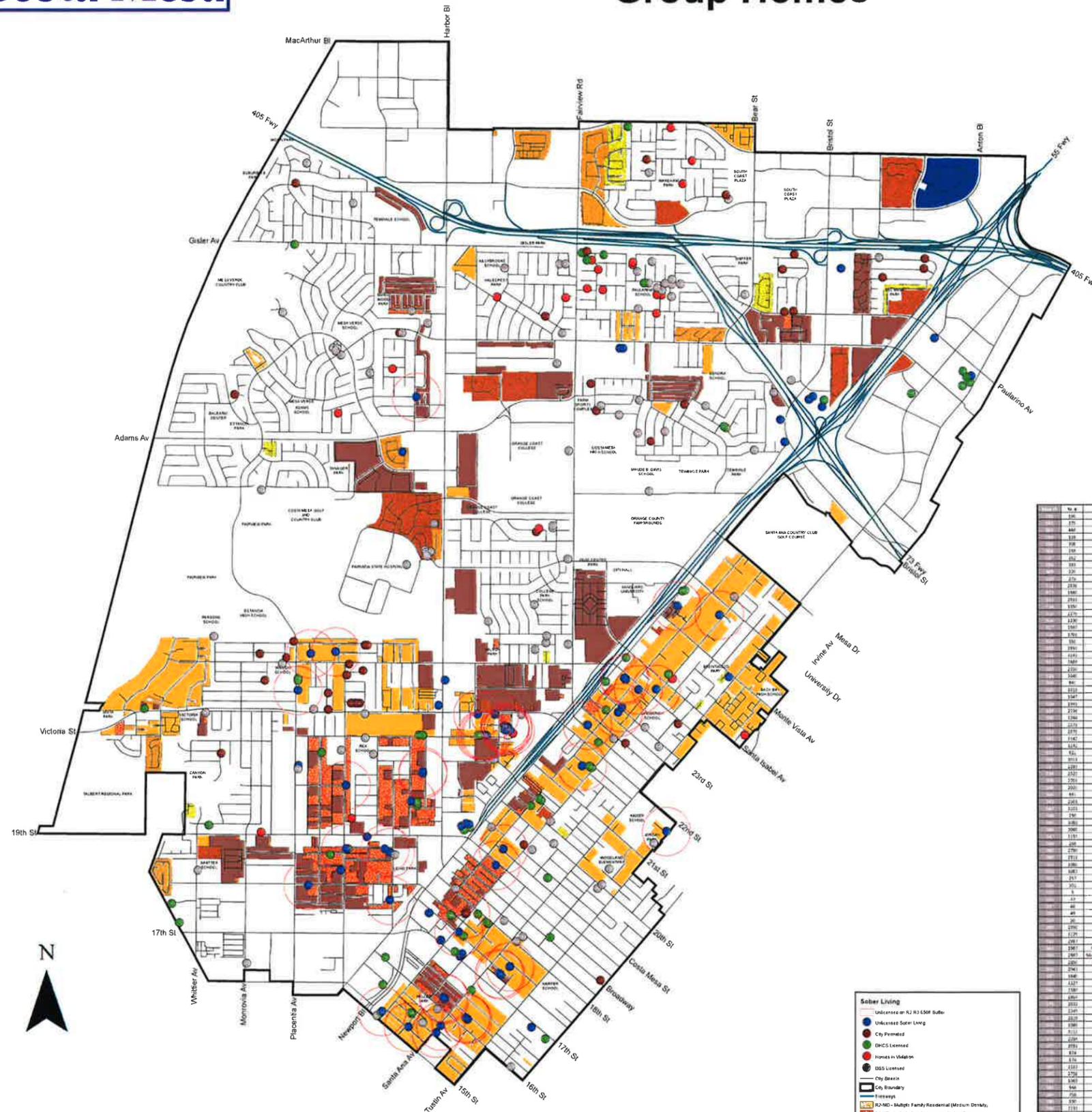
LAND USES	ZONES																					
	R 1	R 2 M D	R 2 H D	R 3	A P	C L 1	C 2	C 1 S <sup>1</sup>	T C <sup>1</sup>	M G P	M P	P D R L D <sub>1</sub>	P D R M D <sub>1</sub>	P D R H D <sub>1</sub>	P D R N C M <sup>1</sup>	P D C <sub>1</sub>	P D I <sup>1</sup>	I & R S <sub>1</sub>	I & R <sup>1</sup>	P		
<b>RESIDENTIAL USES</b>																						
1. Single-family dwellings (single housekeeping units)	P <sup>4</sup>	P	P	P	•	•	•	•	•	•	•	P	P	P	P	P	P	P	•	•	•	•
2. Multi-family dwellings	•	P	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	P	•	•	•	•
2.2 Small lot subdivisions, residential	•	P	P	P	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
3. Mobile home parks	•	C	C	C	•	•	•	•	•	•	•	C	C	C	C	C	C	C	•	•	•	•
4. Boardinghouse, small <sup>7</sup>	•	P	P	P	•	•	•	•	•	•	•	P	P	P	P	P	P	P	•	•	•	•
5. Boardinghouse, large <sup>7</sup>	•	C	C	C	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
6. Residential care facility, 6 or fewer persons (State licensed)	P	P	P	P	•	•	•	•	•	•	•	P	P	P	P	P	P	P	•	•	•	•
7. Group homes, 6 or fewer	S	S	S	S	•	•	•	•	•	•	•	S	S	S	S	S	S	S	•	•	•	•
7.1. Sober living homes, 6 or fewer	S <sup>5</sup>	S <sup>6</sup>	S <sup>6</sup>	S <sup>6</sup>	•	•	•	•	•	•	•	S <sup>6</sup>	S <sup>6</sup>	S <sup>6</sup>	S <sup>6</sup>	S <sup>6</sup>	S <sup>6</sup>	S <sup>6</sup>	•	•	•	•
8. Residential care facility, 7 or more	•	C	C	C	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
9. Group homes, 7 or more	•	C	C	C	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
9.1 Sober living homes, 7 or more	•	C <sup>6</sup>	C <sup>6</sup>	C <sup>6</sup>	•	•	•	•	•	•	•	•	C <sup>6</sup>	C <sup>6</sup>	C <sup>6</sup>	C <sup>6</sup>	C <sup>6</sup>	C <sup>6</sup>	•	•	•	•
10. Referral facility (Subject to the requirements of Section 13-32.2 Referral facility).	•	C <sup>2</sup>	C <sup>2</sup>	C <sup>2</sup>	•	•	•	•	•	•	•	•	C <sup>2</sup>	C <sup>2</sup>	C <sup>2</sup>	C <sup>2</sup>	C <sup>2</sup>	C <sup>2</sup>	•	•	•	•

Chapter IV Citywide Land Use Matrix  
Revised 3/98 Ordinance 98-5; 4/00 Ordinance 00-5; Ordinance 2/01; Ordinance 01-1  
Revised 2/05 Ordinance 05-2; 7/05 Ordinance 05-11; 2/06 Ordinance 06-2; 02/07 Ordinance 07-2

- Uses proposed in this zone are subject to verification of consistency with the adopted master plan. Uses not specified in the master plan, could be allowed, subject to the review process indicated in this matrix, if the proposed use is determined to be compatible with the adopted master plan.
- This use is subject to the requirements of the referenced Municipal Code article or section.
- If residential uses exist, accessory uses shall be permitted.
- For the purposes of this table, the symbols shall have the following meaning: C - Conditional Use Permit; MC - Minor Conditional Use Permit; P - Permitted; • - Prohibited; and S - Special Use Permit
- 650 foot separation required between sober living homes, or from state licensed alcohol or drug abuse recovery or treatment facilities in the R1 zone. CMMC 13-311(a)(10)(i)
- Subject to the separation requirements set forth in Section 13-322(a)(3).
- Small boardinghouses shall locate at least 650 feet from any other small boardinghouse. Large boardinghouses shall be located at least 1,000 feet from any other boardinghouse.
- Uses prohibited in the base zoning district of a mixed-use overlay zone shall also be prohibited in the overlay zone.



# Group Homes



- Sober Living**
- Unlicensed or RJ R1 150F Subo
  - City Permitted
  - DHCS Licensed
  - Homes in Violation
  - DSS Licensed
  - City Boundary
- Zoning**
- R2-MD - Multi-Family Residential (Medium Density)
  - R2-HD - Multi-Family Residential (High Density)
  - R3 - Multi-Family Residential
  - PDR-LD - Planned Development Residential - Low Density
  - PDR-MD - Planned Development Residential - Medium Density
  - PDR-HD - Planned Development Residential - High Density
  - PDR-MC-W - Planned Development Residential - North Costa Mesa

No. #	No. Name	Permitted	Permitted	Radius
100	100th St	Y	Y	0.5
101	101st St	Y	Y	0.5
102	102nd St	Y	Y	0.5
103	103rd St	Y	Y	0.5
104	104th St	Y	Y	0.5
105	105th St	Y	Y	0.5
106	106th St	Y	Y	0.5
107	107th St	Y	Y	0.5
108	108th St	Y	Y	0.5
109	109th St	Y	Y	0.5
110	110th St	Y	Y	0.5
111	111th St	Y	Y	0.5
112	112th St	Y	Y	0.5
113	113th St	Y	Y	0.5
114	114th St	Y	Y	0.5
115	115th St	Y	Y	0.5
116	116th St	Y	Y	0.5
117	117th St	Y	Y	0.5
118	118th St	Y	Y	0.5
119	119th St	Y	Y	0.5
120	120th St	Y	Y	0.5
121	121st St	Y	Y	0.5
122	122nd St	Y	Y	0.5
123	123rd St	Y	Y	0.5
124	124th St	Y	Y	0.5
125	125th St	Y	Y	0.5
126	126th St	Y	Y	0.5
127	127th St	Y	Y	0.5
128	128th St	Y	Y	0.5
129	129th St	Y	Y	0.5
130	130th St	Y	Y	0.5
131	131st St	Y	Y	0.5
132	132nd St	Y	Y	0.5
133	133rd St	Y	Y	0.5
134	134th St	Y	Y	0.5
135	135th St	Y	Y	0.5
136	136th St	Y	Y	0.5
137	137th St	Y	Y	0.5
138	138th St	Y	Y	0.5
139	139th St	Y	Y	0.5
140	140th St	Y	Y	0.5
141	141st St	Y	Y	0.5
142	142nd St	Y	Y	0.5
143	143rd St	Y	Y	0.5
144	144th St	Y	Y	0.5
145	145th St	Y	Y	0.5
146	146th St	Y	Y	0.5
147	147th St	Y	Y	0.5
148	148th St	Y	Y	0.5
149	149th St	Y	Y	0.5
150	150th St	Y	Y	0.5
151	151st St	Y	Y	0.5
152	152nd St	Y	Y	0.5
153	153rd St	Y	Y	0.5
154	154th St	Y	Y	0.5
155	155th St	Y	Y	0.5
156	156th St	Y	Y	0.5
157	157th St	Y	Y	0.5
158	158th St	Y	Y	0.5
159	159th St	Y	Y	0.5
160	160th St	Y	Y	0.5
161	161st St	Y	Y	0.5
162	162nd St	Y	Y	0.5
163	163rd St	Y	Y	0.5
164	164th St	Y	Y	0.5
165	165th St	Y	Y	0.5
166	166th St	Y	Y	0.5
167	167th St	Y	Y	0.5
168	168th St	Y	Y	0.5
169	169th St	Y	Y	0.5
170	170th St	Y	Y	0.5
171	171st St	Y	Y	0.5
172	172nd St	Y	Y	0.5
173	173rd St	Y	Y	0.5
174	174th St	Y	Y	0.5
175	175th St	Y	Y	0.5
176	176th St	Y	Y	0.5
177	177th St	Y	Y	0.5
178	178th St	Y	Y	0.5
179	179th St	Y	Y	0.5
180	180th St	Y	Y	0.5
181	181st St	Y	Y	0.5
182	182nd St	Y	Y	0.5
183	183rd St	Y	Y	0.5
184	184th St	Y	Y	0.5
185	185th St	Y	Y	0.5
186	186th St	Y	Y	0.5
187	187th St	Y	Y	0.5
188	188th St	Y	Y	0.5
189	189th St	Y	Y	0.5
190	190th St	Y	Y	0.5
191	191st St	Y	Y	0.5
192	192nd St	Y	Y	0.5
193	193rd St	Y	Y	0.5
194	194th St	Y	Y	0.5
195	195th St	Y	Y	0.5
196	196th St	Y	Y	0.5
197	197th St	Y	Y	0.5
198	198th St	Y	Y	0.5
199	199th St	Y	Y	0.5
200	200th St	Y	Y	0.5

Map #	St. #	St. Name	Exp. Date	zoning	Radius
100	100	100th St	01/01/2015	Y	0.5
101	101	101st St	01/01/2015	Y	0.5
102	102	102nd St	01/01/2015	Y	0.5
103	103	103rd St	01/01/2015	Y	0.5
104	104	104th St	01/01/2015	Y	0.5
105	105	105th St	01/01/2015	Y	0.5
106	106	106th St	01/01/2015	Y	0.5
107	107	107th St	01/01/2015	Y	0.5
108	108	108th St	01/01/2015	Y	0.5
109	109	109th St	01/01/2015	Y	0.5
110	110	110th St	01/01/2015	Y	0.5
111	111	111th St	01/01/2015	Y	0.5
112	112	112nd St	01/01/2015	Y	0.5
113	113	113rd St	01/01/2015	Y	0.5
114	114	114th St	01/01/2015	Y	0.5
115	115	115th St	01/01/2015	Y	0.5
116	116	116th St	01/01/2015	Y	0.5
117	117	117th St	01/01/2015	Y	0.5
118	118	118th St	01/01/2015	Y	0.5
119	119	119th St	01/01/2015	Y	0.5
120	120	120th St	01/01/2015	Y	0.5
121	121	121st St	01/01/2015	Y	0.5
122	122	122nd St	01/01/2015	Y	0.5
123	123	123rd St	01/01/2015	Y	0.5
124	124	124th St	01/01/2015	Y	0.5
125	125	125th St	01/01/2015	Y	0.5
126	126	126th St	01/01/2015	Y	0.5
127	127	127th St	01/01/2015	Y	0.5
128	128	128th St	01/01/2015	Y	0.5
129	129	129th St	01/01/2015	Y	0.5
130	130	130th St	01/01/2015	Y	0.5
131	131	131st St	01/01/2015	Y	0.5
132	132	132nd St	01/01/2015	Y	0.5
133	133	133rd St	01/01/2015	Y	0.5
134	134	134th St	01/01/2015	Y	0.5
135	135	135th St	01/01/2015	Y	0.5
136	136	136th St	01/01/2015	Y	0.5
137	137	137th St	01/01/2015	Y	0.5
138	138	138th St	01/01/2015	Y	0.5
139	139	139th St	01/01/2015	Y	0.5
140	140	140th St	01/01/2015	Y	0.5
141	141	141st St	01/01/2015	Y	0.5
142	142	142nd St	01/01/2015	Y	0.5
143	143	143rd St	01/01/2015	Y	0.5
144	144	144th St	01/01/2015	Y	0.5
145	145	145th St	01/01/2015	Y	0.5
146	146	146th St	01/01/2015	Y	0.5
147	147	147th St	01/01/2015	Y	0.5
148	148	148th St	01/01/2015	Y	0.5
149	149	149th St	01/01/2015	Y	0.5
150	150	150th St	01/01/2015	Y	0.5
151	151	151st St	01/01/2015	Y	0.5
152	152	152nd St	01/01/2015	Y	0.5
153	153	153rd St	01/01/2015	Y	0.5
154	154	154th St	01/01/2015	Y	0.5
155	155	155th St	01/01/2015	Y	0.5
156	156	156th St	01/01/2015	Y	0.5
157	157	157th St	01/01/2015	Y	0.5
158	158	158th St	01/01/2015	Y	0.5
159	159	159th St	01/01/2015	Y	0.5
160	160	160th St	01/01/2015	Y	0.5
161	161	161st St	01/01/2015	Y	0.5
162	162	162nd St	01/01/2015	Y	0.5
163	163	163rd St	01/01/2015	Y	0.5
164	164	164th St	01/01/2015	Y	0.5
165	165	165th St	01/01/2015	Y	0.5
166	166	166th St	01/01/2015	Y	0.5
167	167	167th St	01/01/2015	Y	0.5
168	168	168th St	01/01/2015	Y	0.5
169	169	169th St	01/01/2015	Y	0.5
170	170	170th St	01/01/2015	Y	0.5
171	171	171st St	01/01/2015	Y	0.5
172	172	172nd St	01/01/2015	Y	0.5
173	173	173rd St	01/01/2015	Y	0.5
174	174	174th St	01/01/2015	Y	0.5
175	175	175th St	01/01/2015	Y	0.5
176	176	176th St	01/01/2015	Y	0.5
177	177	177th St	01/01/2015	Y	0.5
178	178	178th St	01/01/2015	Y	0.5
179	179	179th St	01/01/2015	Y	0.5
180	180	180th St	01/01/2015	Y	0.5
181	181	181st St	01/01/2015	Y	0.5
182	182	182nd St	01/01/2015	Y	0.5
183	183	183rd St	01/01/2015	Y	0.5
184	184	184th St	01/01/2015	Y	0.5
185	185	185th St	01/01/2015	Y	0.5
186	186	186th St	01/01/2015	Y	0.5
187	187	187th St	01/01/2015	Y	0.5
188	188	188th St	01/01/2015	Y	0.5
189	189	189th St	01/01/2015	Y	0.5
190	190	190th St	01/01/2015	Y	0.5
191	191	191st St	01/01/2015	Y	0.5
192	192	192nd St	01/01/2015	Y	0.5
193	193	193rd St	01/01/2015	Y	0.5
194	194	194th St	01/01/2015	Y	0.5
195	195	195th St	01/01/2015	Y	0.5
196	196	196th St	01/01/2015	Y	0.5
197	197	197th St	01/01/2015	Y	0.5
198	198	198th St	01/01/2015	Y	0.5
199	199	199th St	01/01/2015	Y	0.5
200	200	200th St	01/01/2015	Y	0.5

**Cal Pen Code § 290. Sex Offender Registration Act; Persons required to register**

Deering's California Code Annotated

PENAL CODE

Part 3. Of Imprisonment and the Death Penalty

Title 1. Imprisonment of Male Prisoners in State Prisons

Chapter 8. Length of Term of Imprisonment and Paroles

Article 1. General Provisions

(a) Sections 290 to 290.024, inclusive, shall be known and may be cited as the Sex Offender Registration Act. All references to "the Act" in those sections are to the Sex Offender Registration Act.

(b) Every person described in subdivision (c), for the rest of his or her life while residing in California, or while attending school or working in California, as described in Sections 290.002 and 290.01, shall be required to register with the chief of police of the city in which he or she is residing, or the sheriff of the county if he or she is residing in an unincorporated area or city that has no police department, and, additionally, with the chief of police of a campus of the University of California, the California State University, or community college if he or she is residing upon the campus or in any of its facilities, within five working days of coming into, or changing his or her residence within, any city, county, or city and county, or campus in which he or she temporarily resides, and shall be required to register thereafter in accordance with the Act.

(c) The following persons shall be required to register:

Any person who, since July 1, 1944, has been or is hereafter convicted in any court in this state or in any federal or military court of a violation of Section 187 committed in the perpetration, or an attempt to perpetrate, rape or any act punishable under Section 286, 288, 288a, or 289, Section 207 or 209 committed with intent to violate Section 261, 286, 288, 288a, or 289, Section 220, except assault to commit mayhem, subdivision (b) and (c) of Section 236.1, Section 243.4, paragraph (1), (2), (3), (4), or (6) of subdivision (a) of Section 261, paragraph (1) of subdivision (a) of Section 262 involving the use of force or violence for which the person is sentenced to the state prison, Section 264.1, 266, or 266c, subdivision (b) of Section 266h, subdivision (b) of Section 266i, Section 266j, 267, 269, 285, 286, 288, 288a, 288.3, 288.4, 288.5, 288.7, 289, or 311.1, subdivision (b), (c), or (d) of Section 311.2, Section 311.3, 311.4, 311.10, 311.11, or 647.6, former Section 647a, subdivision (c) of Section 653f, subdivision 1 or 2 of Section 314, any offense involving lewd or lascivious conduct under Section 272, or any felony violation of Section 288.2; any statutory predecessor that includes all elements of one of the above-mentioned offenses; or any person who since that date has been or is hereafter convicted of the attempt or conspiracy to commit any of the above-mentioned offenses.

**Cal Pen Code § 3003. Release of parolee to "last legal residence"; When parolee may be returned to another county; Release of information to local law enforcement agencies; Mileage exclusions; Other considerations; Parole to another state; Implementation of Law Enforcement Automated Data System (LEADS)**

Deering's California Code Annotated

PENAL CODE

Part 3. Of Imprisonment and the Death Penalty

Title 1. Imprisonment of Male Prisoners in State Prisons

Chapter 8. Length of Term of Imprisonment and Paroles

Article 1. General Provisions

(a) Except as otherwise provided in this section, an inmate who is released on parole or postrelease supervision as provided by Title 2.05 (commencing with Section 3450) shall be returned to the county that was the last legal residence of the inmate prior to his or her incarceration. For purposes of this subdivision, "last legal residence" shall not be construed to mean the county wherein the inmate committed an offense while confined in a state prison or local jail facility or while confined for treatment in a state hospital.

(b) Notwithstanding subdivision (a), an inmate may be returned to another county if that would be in the best interests of the public. If the Board of Parole Hearings setting the conditions of parole for inmates sentenced pursuant to subdivision (b) of Section 1168, as determined by the parole consideration panel, or the Department of Corrections and Rehabilitation setting the conditions of parole for inmates sentenced pursuant to Section 1170, decides on a return to another county, it shall place its reasons in writing in the parolee's permanent record and include these reasons in the notice to the sheriff or chief of police pursuant to Section 3058.6. In making its decision, the paroling authority shall consider, among others, the following factors, giving the greatest weight to the protection of the victim and the safety of the community:

(1) The need to protect the life or safety of a victim, the parolee, a witness, or any other person.

(2) Public concern that would reduce the chance that the inmate's parole would be successfully completed.

(3) The verified existence of a work offer, or an educational or vocational training program.

(4) The existence of family in another county with whom the inmate has maintained strong ties and whose support would increase the chance that the inmate's parole would be successfully completed.

(5) The lack of necessary outpatient treatment programs for parolees receiving treatment pursuant to Section 2960.

(c) The Department of Corrections and Rehabilitation, in determining an out-of-county commitment, shall give priority to the safety of the community and any witnesses and victims.

(d) In making its decision about an inmate who participated in a joint venture program pursuant to Article 1.5 (commencing with Section 2717.1) of Chapter 5, the paroling authority shall give serious consideration to releasing him or her to the county where the joint venture program employer is located if that employer states to the paroling authority that he or she

intends to employ the inmate upon release.

(e)

(1) The following information, if available, shall be released by the Department of Corrections and Rehabilitation to local law enforcement agencies regarding a paroled inmate or inmate placed on postrelease supervision pursuant to Title 2.05 (commencing with Section 3450) who is released in their jurisdictions:

(A) Last, first, and middle name.

(B) Birth date.

(C) Sex, race, height, weight, and hair and eye color.

(D) Date of parole and discharge.

(E) Registration status, if the inmate is required to register as a result of a controlled substance, sex, or arson offense.

(F) California Criminal Information Number, FBI number, social security number, and driver's license number.

(G) County of commitment.

(H) A description of scars, marks, and tattoos on the inmate.

(I) Offense or offenses for which the inmate was convicted that resulted in parole in this instance.

(J) Address, including all of the following information:

(i) Street name and number. Post office box numbers are not acceptable for purposes of this subparagraph.

(ii) City and ZIP Code.

(iii) Date that the address provided pursuant to this subparagraph was proposed to be effective.

(K) Contact officer and unit, including all of the following information:

(i) Name and telephone number of each contact officer.

(ii) Contact unit type of each contact officer such as units responsible for parole, registration, or county probation.

(L) A digitized image of the photograph and at least a single digit fingerprint of the parolee.

(M) A geographic coordinate for the parolee's residence location for use with a Geographical Information System (GIS) or comparable computer program.

(2) Unless the information is unavailable, the Department of Corrections and Rehabilitation shall electronically transmit to the county agency identified in subdivision (a) of Section 3451 the inmate's tuberculosis status, specific medical, mental health, and outpatient clinic needs, and any medical concerns or disabilities for the county to consider as the offender transitions onto postrelease community supervision pursuant to Section 3450, for the purpose of identifying the medical and mental health needs of the individual. All transmissions to the county agency shall be in compliance with applicable provisions of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191), the federal Health Information Technology for Clinical Health Act (HITECH) (Public Law 111-005), and the implementing of privacy and security regulations in Parts 160 and 164 of Title 45 of the Code of Federal Regulations. This paragraph shall not take effect until the Secretary of the United States Department of Health and Human Services, or his or her designee, determines that this provision is not preempted by HIPAA.

(3) Except for the information required by paragraph (2), the information required by this subdivision shall come from the statewide parolee database. The information obtained from each source shall be based on the same timeframe.

(4) All of the information required by this subdivision shall be provided utilizing a computer-to-computer transfer in a format usable by a desktop computer system. The transfer of this information shall be continually available to local law enforcement agencies upon request.

(5) The unauthorized release or receipt of the information described in this subdivision is a violation of Section 11143.

(f) Notwithstanding any other provision of law, an inmate who is released on parole shall not be returned to a location within 35 miles of the actual residence of a victim of, or a witness to, a violent felony as defined in paragraphs (1) to (7), inclusive, and paragraph (16) of subdivision (c) of Section 667.5 or a felony in which the defendant inflicts great bodily injury on any person other than an accomplice that has been charged and proved as provided for in Section 12022.53, 12022.7, or 12022.9, if the victim or witness has requested additional distance in the placement of the inmate on parole, and if the Board of Parole Hearings or the Department of Corrections and Rehabilitation finds that there is a need to protect the life, safety, or well-being of a victim or witness.

(g) Notwithstanding any other law, an inmate who is released on parole for a violation of Section 288 or 288.5 whom the Department of Corrections and Rehabilitation determines poses a high risk to the public shall not be placed or reside, for the duration of his or her parole, within one-half mile of any public or private school including any or all of kindergarten and grades 1 to 12, inclusive.

(h) Notwithstanding any other law, an inmate who is released on parole for an offense involving stalking shall not be returned to a location within 35 miles of the victim's actual residence or place of employment if the victim or witness has requested additional distance in the placement of the inmate on parole, and if the Board of Parole Hearings or the Department of Corrections and Rehabilitation finds that there is a need to protect the life, safety, or well-being of the victim.

(i) The authority shall give consideration to the equitable distribution of parolees and the proportion of out-of-county commitments from a county compared to the number of commitments from that county when making parole decisions.

(j) An inmate may be paroled to another state pursuant to any other law. The Department of Corrections and Rehabilitation shall coordinate with local entities regarding the placement of inmates placed out of state on postrelease supervision pursuant to Title 2.05 (commencing with Section 3450).

(k)

(1) Except as provided in paragraph (2), the Department of Corrections and Rehabilitation shall be the agency primarily responsible for, and shall have control over, the program, resources, and staff implementing the Law Enforcement Automated Data System (LEADS) in conformance with subdivision (e). County agencies supervising inmates released to postrelease

**Cal Pen Code § 3003.5 Restriction on sharing of single family dwelling, by parolee from imprisonment for offense requiring registration as sex offender, with other person required to register as sex offender**

Deering's California Code Annotated  
PENAL CODE  
Part 3. Of Imprisonment and the Death Penalty  
Title 1. Imprisonment of Male Prisoners in State Prisons  
Chapter 8. Length of Term of Imprisonment and Paroles  
Article 1. General Provisions

§ 3003.5.

(a) Notwithstanding any other provision of law, when a person is released on parole after having served a term of imprisonment in state prison for any offense for which registration is required pursuant to Section 290, that person may not, during the period of parole, reside in any single family dwelling with any other person also required to register pursuant to Section 290, unless those persons are legally related by blood, marriage, or adoption. For purposes of this section, "single family dwelling" shall not include a residential facility which serves six or fewer persons.

(b) Notwithstanding any other provision of law, it is unlawful for any person for whom registration is required pursuant to Section 290 to reside within 2000 feet of any public or private school, or park where children regularly gather.

(c) Nothing in this section shall prohibit municipal jurisdictions from enacting local ordinances that further restrict the residency of any person for whom registration is required pursuant to Section 290.

supervision pursuant to Title 2.05 (commencing with Section 3450) shall provide any information requested by the department to ensure the availability of accurate information regarding inmates released from state prison. This information may include the issuance of warrants, revocations, or the termination of postrelease supervision. On or before August 1, 2011, county agencies designated to supervise inmates released to postrelease supervision shall notify the department that the county agencies have been designated as the local entity responsible for providing that supervision.

(2) Notwithstanding paragraph (1), the Department of Justice shall be the agency primarily responsible for the proper release of information under LEADS that relates to fingerprint cards.

(l) In addition to the requirements under subdivision (k), the Department of Corrections and Rehabilitation shall submit to the Department of Justice data to be included in the supervised release file of the California Law Enforcement Telecommunications System (CLETS) so that law enforcement can be advised through CLETS of all persons on postrelease community supervision and the county agency designated to provide supervision. The data required by this subdivision shall be provided via electronic transfer.



**User Name:** Elena Gerli

**Date and Time:** Sep 14, 2014 4:29 p.m. PDT

**Job Number:** 12787306

**Document(1)**

1. 9 CCR 10501

**Client/Matter:** Costa Mesa City Atty

38

## 9 CCR 10501

This document is current through Register 2014, No. 34, August 22, 2014

Barclays Official California Code of Regulations > TITLE 9. REHABILITATIVE AND DEVELOPMENTAL SERVICES > DIVISION 4. DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS > CHAPTER 5. LICENSURE OF RESIDENTIAL ALCOHOLISM OR DRUG ABUSE RECOVERY OR TREATMENT FACILITIES > SUBCHAPTER 1. PURPOSE AND DEFINITIONS > ARTICLE 2. DEFINITIONS

### **§ 10501. Definitions**

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- (a) The following general definitions shall apply to terminology used in Chapter 5, except where specifically noted otherwise:
- (1) "Adolescent" means an individual between fourteen (14) and eighteen (18) years of age, who has not been emancipated pursuant to Part 6 (commencing with Section 7000), Division 11 of the Family Code.
  - (2) "Adult" means a person who is 18 years of age or older or a minor who has been emancipated pursuant to Part 6 (commencing with Section 7000), Division 11 of the Family Code.
  - (3) "Adult Facility" means a residential alcoholism or drug abuse recovery or treatment facility which is designed to serve adults.
  - (4) "Alcoholism or Drug Abuse Recovery or Treatment Planning" means the development of a resident specific goal and a continuum of recovery or treatment objectives. It is the licensee's responsibility to provide the activities to facilitate this process.
  - (5) "Alcoholism or Drug Abuse Recovery or Treatment Service" means a service which is designed to promote treatment and maintain recovery from alcohol or drug problems which includes one or more of the following: detoxification, group sessions, individual sessions, educational sessions, and/or alcoholism or drug abuse recovery or treatment planning.
  - (6) "Alcoholism or Drug Abuse Recovery or Treatment Facility" means any facility, building or group of buildings which is maintained and operated to provide 24-hour residential nonmedical alcoholism or drug abuse recovery or treatment services.
  - (7) "Authorized Representative" means any person or entity authorized by law to act on behalf of any resident of a residential alcoholism or drug abuse recovery or treatment facility. An authorized representative may be a minor's parent, a legal guardian, a conservator, a public placement agency, or a person granted power of attorney by the resident.
  - (8) "Capacity" means the maximum number of residents for whom the facility has been licensed to provide services at any one time.
  - (9) "Conviction" means a final judgment on a verdict or finding of guilty, a plea of guilty, or a plea of nolo contendere.
  - (10) "Day" means calendar day unless otherwise specified.
  - (11) "Detoxification Service" means a service designed to support and to assist an individual

in the alcohol and/or drug withdrawal process and to explore plans for continued service.

- (12) "Department" means the Department of Alcohol and Drug Programs.
- (13) "Director" means the Director of the Department of Alcohol and Drug Programs.
- (14) "Education Session" means a planned, structured, didactic presentation of information related to alcoholism and alcohol or drug abuse.
- (15) "Evaluator" means any agent or employee of the Department who is authorized by the Director to conduct licensing evaluations on behalf of the Department.
- (16) "Facility" means a residential alcoholism or drug abuse recovery or treatment facility.
- (17) "Facility Administrator" means the individual responsible for the overall management of a residential alcoholism or drug abuse recovery or treatment facility.
- (18) "Goal" means a general statement of the applicant's or licensee's purpose in operating an alcoholism or drug recovery or treatment facility.
- (19) "Group Session" means group interaction that encourages residents to identify and resolve alcohol- and/or drug-related problems, to examine personal attitudes and behavior, and provides support for positive changes in life style and recovery from alcoholism and/or drug abuse.
- (20) "Illicit drug" means any substance defined as a drug in Section 11014, Chapter 1, Division 10 of the Health and Safety Code, except:
  - (A) Drugs or medications prescribed by a physician or other person authorized to prescribe drugs, pursuant to Section 4036, Chapter 9, Division 2 of the Business and Professions Code, and used in the dosage and frequency prescribed; or
  - (B) Over-the-counter drugs or medications used in the dosage and frequency described on the box, bottle,; or package insert,
- (21) "Individual Session" means a private interaction between a resident and program staff which focuses on identification and resolution of alcohol- and/or drug-related problems, to examine personal attitudes and behavior and other barriers to recovery.
- (22) "Licensee" means the entity identified on the license(s), issued by the Department of Alcohol and Drug Programs, to provide residential alcoholism or drug abuse recovery or treatment services in accordance with the provisions of Chapter 7.5 (commencing with Section 11834.01), Part 2, Division 10.5 of the Health and Safety Code and the requirements of this chapter.
- (23) "Objective" means a specific, measurable step which can be evaluated to assess the licensee's progress toward the achievement of the stated; goal.
- (24) "Physician" means a person licensed as a physician and surgeon by the Medical Board of California or by the Osteopathic Medical Board of California.
- (25) "Premises" means the land, buildings, or other structures included in the license issued for an alcoholism or drug abuse recovery or treatment facility.

- (26) "Resident" means an individual who resides in and receives services from a residential alcoholism or drug abuse recovery or treatment facility.
- (27) "Residential Alcoholism or Drug Abuse Recovery or Treatment Facility" means any facility, building, or group of buildings which is maintained and operated to provide 24-hour, residential, nonmedical, alcoholism or drug abuse recovery or treatment services.
- (28) "Revocation of License" means a disciplinary action taken by the Department to rescind a license issued pursuant to the provisions of Chapter 7.5 (commencing with Section 11834.01), Part 2, Division 10.5 of the Health and Safety Code and the requirements of this chapter.
- (29) "Substantial Compliance" means the absence of any Class A or Class B deficiencies, as defined in Section 10543.
- (30) "Suspension of License" means a disciplinary action taken by the Department to discontinue program operations, as permitted under the license, for a specified period of time.
- (31) "Volunteer" means uncompensated personnel.

## Statutory Authority

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### AUTHORITY:

Note: Authority cited: Sections 11755, 11834.50 and 11835, Health and Safety Code.  
 Reference: Sections 11834.01, 11834.02 and 11834.50, Health and Safety Code.

## History

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### HISTORY:

1. New section filed 2-7-85 as an emergency; operative 2-7-85 (Register 85, No. 8).
2. Repealed by operation of law 2-1-86. Readoption of section filed 1-24-86 as an emergency; operative 2-1-86 (Register 86, No. 4).
3. Repealed by operation of law 6-2-86. Readoption of section filed 5-30-86 as an emergency; operative 6-1-86 (Register 86, No. 22).
4. Repealed by operation of law 9-29-86. Readoption of section filed 9-26-86 as an emergency; operative 9-29-86 (Register 86, No. 39). A Certificate of Compliance must be transmitted to OAL no later than 1-27-87 or section will be repealed by operation of law (Government Code section 11346.1(g))
5. Readoption of section filed 1-26-87 as an emergency; operative 1-27-87 (Register 87, No. 5). A Certificate of Compliance must be transmitted to OAL no later than 5-26-87 or section will be repealed by operation of law (Government Code section 11346.1(g))
6. Readoption of section filed 5-26-87 as an emergency; operative 5-26-87 (Register 87, No. 22). A Certificate of Compliance must be transmitted to OAL no later than 9-23-87 or section will be repealed by operation of law (Government Code section 11346.1(g)).
7. Repealer and new section transmitted to OAL 9-23-87 and filed 10-23-87; operative 10-23-87

(Register 87, No. 43).

8. Amendment of subsection (a) filed 12-27-89 as an emergency; operative 1-1-90 (Register 90, No. 1). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed by operation of law on 5-1-90.

9. Amendment of subsection (a) refiled 4-30-90 as an emergency; operative 4-30-90 (Register 90, No. 22). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed by operation of law on 8-28-90.

10. Certificate of Compliance as to 4-30-90 order including amendment of NOTE transmitted to OAL 8-27-90 and filed 9-26-90 (Register 90, No. 44).

11. Amendment of section and Note filed 4-18-94; operative 5-18-94 (Register 94, No. 16).

12. Change without regulatory effect adopting new article 2 heading filed 11-17-94 pursuant to section 100, title 1, California Code of Regulations (Register 94, No. 46).

13. Repealer of subsection (a)(2) and subsection renumbering filed 3-18-97; operative 4-17-97 (Register 97, No. 12).

14. Change without regulatory effect amending subsections (a)(1)-(2) filed 6-15-99 pursuant to section 100, title 1, California Code of Regulations (Register 99, No. 25).

15. Change without regulatory effect amending definitions of "Adolescent" and "Adult" filed 6-12-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 24).

BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

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## 42 USCS § 3604

United States Code Service - Titles 1 through 51  
 TITLE 42. THE PUBLIC HEALTH AND WELFARE  
 CHAPTER 45. FAIR HOUSING  
 GENERALLY

## § 3604. Discrimination in the sale or rental of housing and other prohibited practices.

As made applicable by section 803 [42 USCS § 3603] and except as exempted by sections 803(b) and 807 [42 USCS §§ 3603(b), 3607], it shall be unlawful--

(a) To refuse to sell or rent after the making of a bona fide offer, or to refuse to negotiate for the sale or rental of, or otherwise make unavailable or deny, a dwelling to any person because of race, color, religion, sex, familial status, or national origin.

(b) To discriminate against any person in the terms, conditions, or privileges of sale or rental of a dwelling, or in the provision of services or facilities in connection therewith, because of race, color, religion, sex, familial status, or national origin.

(c) To make, print, or publish, or cause to be made, printed, or published any notice, statement, or advertisement, with respect to the sale or rental of a dwelling that indicates any preference, limitation, or discrimination based on race, color, religion, sex, handicap, familial status, or national origin, or an intention to make any such preference, limitation, or discrimination.

(d) To represent to any person because of race, color, religion, sex, handicap, familial status, or national origin that any dwelling is not available for inspection, sale, or rental when such dwelling is in fact so available.

(e) For profit, to induce or attempt to induce any person to sell or rent any dwelling by representations regarding the entry or prospective entry into the neighborhood of a person or persons of a particular race, color, religion, sex, handicap, familial status, or national origin.

(f) (1) To discriminate in the sale or rental, or to otherwise make unavailable or deny, a dwelling to any buyer or renter because of a handicap of--

(A) that buyer or renter, [;]

(B) a person residing in or intending to reside in that dwelling after it is so sold, rented, or made available; or

(C) any person associated with that buyer or renter.

(2) To discriminate against any person in the terms, conditions, or privileges of sale or rental of a dwelling, or in the provision of services or facilities in connection with such dwelling, because of a handicap of--

(A) that person; or

(B) a person residing in or intending to reside in that dwelling after it is so sold, rented, or made available; or

(C) any person associated with that person.

(3) For purposes of this subsection, discrimination includes--

(A) a refusal to permit, at the expense of the handicapped person, reasonable modifications of existing premises occupied or to be occupied by such person if such modifications may be necessary to afford such person full enjoyment of the premises except that,

in the case of a rental, the landlord may where it is reasonable to do so condition permission for a modification on the renter agreeing to restore the interior of the premises to the condition that existed before the modification, reasonable wear and tear excepted.[:]

(B) 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; or

(C) in connection with the design and construction of covered multifamily dwellings for first occupancy after the date that is 30 months after the date of enactment of the Fair Housing Amendments Act of 1988 [enacted Sept. 13, 1988], a failure to design and construct those dwellings in such a manner that--

(i) the public use and common use portions of such dwellings are readily accessible to and usable by handicapped persons;

(ii) all the doors designed to allow passage into and within all premises within such dwellings are sufficiently wide to allow passage by handicapped persons in wheelchairs; and

(iii) all premises within such dwellings contain the following features of adaptive design:

(I) an accessible route into and through the dwelling;

(II) light switches, electrical outlets, thermostats, and other environmental controls in accessible locations;

(III) reinforcements in bathroom walls to allow later installation of grab bars; and

(IV) usable kitchens and bathrooms such that an individual in a wheelchair can maneuver about the space.

(4) Compliance with the appropriate requirements of the American National Standard for buildings and facilities providing accessibility and usability for physically handicapped people (commonly cited as "ANSI A117.1") suffices to satisfy the requirements of paragraph (3)(C)(iii).

(5) (A) If a State or unit of general local government has incorporated into its laws the requirements set forth in paragraph (3)(C), compliance with such laws shall be deemed to satisfy the requirements of that paragraph.

(B) A State or unit of general local government may review and approve newly constructed covered multifamily dwellings for the purpose of making determinations as to whether the design and construction requirements of paragraph (3)(C) are met.

(C) The Secretary shall encourage, but may not require, States and units of local government to include in their existing procedures for the review and approval of newly constructed covered multifamily dwellings, determinations as to whether the design and construction of such dwellings are consistent with paragraph (3)(C), and shall provide technical assistance to States and units of local government and other persons to implement the requirements of paragraph (3)(C).

(D) Nothing in this title shall be construed to require the Secretary to review or approve the plans, designs or construction of all covered multifamily dwellings, to determine whether the design and construction of such dwellings are consistent with the requirements of paragraph 3(C).

(6) (A) Nothing in paragraph (5) shall be construed to affect the authority and responsibility of the Secretary or a State or local public agency certified pursuant to section

810(f)(3) of this Act [42 USCS § 3610(f)(3)] to receive and process complaints or otherwise engage in enforcement activities under this title.

(B) Determinations by a State or a unit of general local government under paragraphs (5)(A) and (B) shall not be conclusive in enforcement proceedings under this title.

(7) As used in this subsection, the term "covered multifamily dwellings" means--

(A) buildings consisting of 4 or more units if such buildings have one or more elevators; and

(B) ground floor units in other buildings consisting of 4 or more units.

(8) Nothing in this title shall be construed to invalidate or limit any law of a State or political subdivision of a State, or other jurisdiction in which this title shall be effective, that requires dwellings to be designed and constructed in a manner that affords handicapped persons greater access than is required by this title.

(9) Nothing in this subsection requires that a dwelling be made available to an individual whose tenancy would constitute a direct threat to the health or safety of other individuals or whose tenancy would result in substantial physical damage to the property of others.



**User Name:** Kelsey Condon

**Date and Time:** Sep 14, 2014 7:38 p.m. EDT

**Job Number:** 12787344

**Document(1)**

1. Cal Wel & Inst Code § 4500.5

**Client/Matter:** Costa Mesa City Atty

46

## Cal Wel & Inst Code § 4500.5

This document is current through Urgency Chapter 314 of the 2014 Regular Session of the 2013-2014 Legislature and Propositions 41 and 42 approved June 2014

Deering's California Code Annotated > WELFARE AND INSTITUTIONS CODE > Division 4.5. Services for the Developmentally Disabled > Chapter 1. General Provisions

### **§ 4500.5. Legislative findings and intent**

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The Legislature makes the following findings regarding the State of California's responsibility to provide services to persons with developmental disabilities, and the right of those individuals to receive services, pursuant to this division:

- (a) Since the enactment of this division in 1977, the number of consumers receiving services under this division has substantially increased and the nature, variety, and types of services necessary to meet the needs of the consumers and their families have also changed. Over the years the concept of service delivery has undergone numerous revisions. Services that were once deemed desirable by consumers and families may now no longer be appropriate, or the means of service delivery may be outdated.
- (b) As a result of the increased demands for services and changes in the methods in which those services are provided to consumers and their families, the value statements and principles contained in this division should be updated.
- (c) It is the intent of the Legislature, in enacting the act that added this section, to update existing law; clarify the role of consumers and their families in determining service needs; and to describe more fully service options available to consumers and their families, pursuant to the individual program plan. Nothing in these provisions shall be construed to expand the existing entitlement to services for persons with developmental disabilities set forth in this division.
- (d) It is the intent of the Legislature that the department monitor regional centers so that an individual consumer eligible for services and supports under this division receive the services and supports identified in his or her individual program plan.

### **History**

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Added Stats 1992 ch 1011 § 2 (SB 1383). Amended Stats 1997 ch 414 § 4 (SB 1039), effective September 22, 1997.

### **Annotations**

### **Notes**

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#### **Amendments:**

#### **1997 Amendment:**

Added subd (d).

## **Research References & Practice Aids**

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### **Hierarchy Notes:**

Deering's California Codes Annotated

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**User Name:** Elena Gerli

**Date and Time:** Sep 15, 2014 11:05 a.m. PDT

**Job Number:** 12807447

**Document(1)**

1. Cal Wel & Inst Code § 4501

**Client/Matter:** Costa Mesa/City Atty

49

## Cal Wel & Inst Code § 4501

This document is current through Urgency Chapter 314 of the 2014 Regular Session of the 2013-2014 Legislature and Propositions 41 and 42 approved June 2014

Deering's California Code Annotated > WELFARE AND INSTITUTIONS CODE > Division 4.5. Services for the Developmentally Disabled > Chapter 1. General Provisions

### **§ 4501. Declaration of policy**

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The State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge. Affecting hundreds of thousands of children and adults directly, and having an important impact on the lives of their families, neighbors, and whole communities, developmental disabilities present social, medical, economic, and legal problems of extreme importance.

The complexities of providing services and supports to persons with developmental disabilities requires the coordination of services of many state departments and community agencies to ensure that no gaps occur in communication or provision of services and supports. A consumer of services and supports, and where appropriate, his or her parents, legal guardian, or conservator, shall have a leadership role in service design.

An array of services and supports should be established which is sufficiently complete to meet the needs and choices of each person with developmental disabilities, regardless of age or degree of disability, and at each stage of life and to support their integration into the mainstream life of the community. To the maximum extent feasible, services and supports should be available throughout the state to prevent the dislocation of persons with developmental disabilities from their home communities.

Services and supports should be available to enable persons with developmental disabilities to approximate the pattern of everyday living available to people without disabilities of the same age. Consumers of services and supports, and where appropriate, their parents, legal guardian, or conservator, should be empowered to make choices in all life areas. These include promoting opportunities for individuals with developmental disabilities to be integrated into the mainstream of life in their home communities, including supported living and other appropriate community living arrangements. In providing these services, consumers and their families, when appropriate, should participate in decisions affecting their own lives, including, but not limited to, where and with whom they live, their relationships with people in their community, the way in which they spend their time, including education, employment, and leisure, the pursuit of their own personal future, and program planning and implementation. The contributions made by parents and family members in support of their children and relatives with developmental disabilities are important and those relationships should also be respected and fostered, to the maximum extent feasible, so that consumers and their families can build circles of support within the community.

The Legislature finds that the mere existence or the delivery of services and supports is, in itself, insufficient evidence of program effectiveness. It is the intent of the Legislature that agencies serving persons with developmental disabilities shall produce evidence that their services have resulted in consumer or family empowerment and in more independent, productive, and normal lives for the persons served. It is further the intent of the Legislature that the Department of

Developmental Services, through appropriate and regular monitoring activities, ensure that regional centers meet their statutory, regulatory, and contractual obligations in providing services to persons with developmental disabilities. The Legislature declares its intent to monitor program results through continued legislative oversight and review of requests for appropriations to support developmental disabilities programs.

## History

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Added Stats 1977 ch 1252 § 550, operative July 1, 1978. Amended *Stats 1992 ch 1011 § 2.5 (SB 1383)*; *Stats 1997 ch 414 § 5 (SB 1039)*, effective September 22, 1997.

### Former Sections:

Former § 4501, relating to medical care, was added Stats 1957 ch 1068 § 1, amended Stats 1959 ch 337 § 1, operative October 1, 1959, Stats 1963 ch 2096 § 7, and repealed Stats 1965 ch 1784 § 4.

### Historical Derivation:

- (a) Former H & S C § 38001, as added Stats 1976 ch 1364 § 2.
- (b) Former H & S C § 38001, as added Stats 1969 ch 1394 § 14, amended Stats 1973 ch 546 § 15, Stats 1975 ch 694 § 3.
- (c) Former § 38000, as added Stats 1965 ch 1244 § 1.

### Annotations

## Notes

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### Amendments:

#### 1992 Amendment:

(1) Substituted "persons with developmental disabilities" for "its developmentally disabled citizens" in the first sentence of the first paragraph, and for "the developmentally disabled" in the second sentence of the fifth paragraph; (2) amended the first sentence in the second paragraph by (a) substituting "and supports to persons with developmental disabilities requires the coordination of" for "to developmentally disabled persons require the coordinated" in the first sentence; and (b) adding "and supports" after "provision of services"; (3) added the second sentence in the second paragraph; (4) amended the third paragraph by (a) substituting the first sentence for the former first and second sentences which read: "Services should be planned and provided as a part of a continuum. A pattern of facilities and services should be established which is sufficiently complete to meet the needs of each person with developmental disabilities, regardless of age or degree of handicap, and at each stage of life."; and (b) adding "and supports" after "feasible, services" in the second sentence; (4) amended the first sentence in the fourth paragraph by (a) adding "and supports" after "Services"; and (b) substituting "people without disabilities" for "nondisabled people" after "available to"; (5) added the second, third, and fourth sentences in the fourth paragraph; (6) amended the fifth paragraph by adding (a) "and supports" after "delivery of services" in the first sentence; and (b) "in consumer or family empowerment and" in the second sentence.

**1997 Amendment:**

Amended the last paragraph by (1) adding the third sentence; and (2) substituting "requests" for "request" in the fourth sentence.

**Case Notes**

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1. Generally
2. Construction

**1. Generally**

Regional center that provided services to developmentally disabled individuals had a nondelegable duty to ensure proper care and services and therefore was vicariously liable for the negligence of its vendor in the death of a disabled adult. Morohoshi v. Pacific Home (2003, Cal App 2d Dist) 112 Cal App 4th 937, 5 Cal Rptr 3d 512, 2003 Cal App LEXIS 1573, rev'd (2004) 34 Cal 4th 482, 20 Cal Rptr 3d 890, 100 P3d 433, 2004 Cal LEXIS 10639.

**2. Construction**

Claims by disabled plaintiffs and their communitybased care providers under the Americans with Disabilities Act, 42 U.S.C.S. § 12132, and § 504 of the Rehabilitation Act, 29 U.S.C.S. § 794(a), which alleged that the State (California) was not employing adequate community based Medicaid services, failed as a matter of law because California was currently operating an acceptable deinstitutionalization plan, W & I C §4501, which (under Olmstead v. L. C. by Zimring (1999) 527 US 581, 119 S Ct 2176, 144 L Ed 2d 540, 1999 US LEXIS 4368 should not be set aside or modified by the courts. Sanchez v Johnson (2005, CA9 Cal) 416 F3d 1051, 2005 US App LEXIS 15821.

**Opinion Notes**

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**Attorney General's Opinions:**

Eligibility of children in resident homes for the retarded for admission to development centers for handicapped pupils. 56 Ops. Cal. Atty. Gen. 235.1.

**Research References & Practice Aids**

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**Collateral References:**

Cal. Forms Pleading & Practice (Matthew Bender(R)) ch 304 "Insane And Other Incompetent Persons".

Cal Jur 3d (Rev) Guardianship and Conservatorship § 404.

**Law Review Articles:**

The regulation of electroconvulsive therapy in California: The impact of recent constitutional interpretations. 18 Golden Gate LR 469.

A proposed consolidated legal capacity standard for California. 27 Santa Clara LR 787.

**Hierarchy Notes:**

Deering's California Codes Annotated

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**User Name:** Elena Gerli

**Date and Time:** Sep 15, 2014 11:11 a.m. PDT

**Job Number:** 12807899

### Documents(7)

1. § 11834.20. Legislative declaration; "Six or fewer persons"  
**Client/Matter:** Costa Mesa/City Atty
2. § 11834.02. Definitions  
**Client/Matter:** Costa Mesa/City Atty
3. § 11834.25. Facilities considered residential use by single family  
**Client/Matter:** Costa Mesa/City Atty
4. § 11834.23. Zoning laws  
**Client/Matter:** Costa Mesa/City Atty
5. § 11834.21. Persons entitled to invoke provisions of article  
**Client/Matter:** Costa Mesa/City Atty
6. § 11834.22. Taxes and fees  
**Client/Matter:** Costa Mesa/City Atty
7. § 11834.24. Fire inspection clearances  
**Client/Matter:** Costa Mesa/City Atty

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## Cal Health & Saf Code § 11834.20

This document is current through Urgency Chapter 314 of the 2014 Regular Session of the 2013-2014 Legislature and Propositions 41 and 42 approved June 2014

Deering's California Code Annotated > HEALTH AND SAFETY CODE > Division 10.5. Alcohol and Drug Programs > Part 2. State Government's Role to Alleviate Problems Related to the Inappropriate Use of Alcoholic Beverages and Other Drug Use > Chapter 7.5. Licensing > Article 2. Local Regulation

### **§ 11834.20. Legislative declaration; "Six or fewer persons"**

---

The Legislature hereby declares that it is the policy of this state that each county and city shall permit and encourage the development of sufficient numbers and types of alcoholism or drug abuse recovery or treatment facilities as are commensurate with local need.

The provisions of this article apply equally to any chartered city, general law city, county, city and county, district, and any other local public entity.

For the purposes of this article, "six or fewer persons" does not include the licensee or members of the licensee's family or persons employed as facility staff.

### **History**

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Added Stats 1984 ch 1667 § 2. Amended Stats 1989 ch 919 § 15.

### **Annotations**

### **Notes**

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#### **Amendments:**

#### **1989 Amendment:**

Substituted "or drug abuse recovery or treatment" for "recovery" after "alcoholism" in the first paragraph.

#### **Editor's Notes**

For adoption of regulations, see the 1989 Note following H & S C § 11830.

### **Research References & Practice Aids**

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#### **Hierarchy Notes:**

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## Cal Health & Saf Code § 11834.02

This document is current through Urgency Chapter 314 of the 2014 Regular Session of the 2013-2014 Legislature and Propositions 41 and 42 approved June 2014

Deering's California Code Annotated > HEALTH AND SAFETY CODE > Division 10.5. Alcohol and Drug Programs > Part 2. State Government's Role to Alleviate Problems Related to the Inappropriate Use of Alcoholic Beverages and Other Drug Use > Chapter 7.5. Licensing > Article 1. General Provisions

### **§ 11834.02. Definitions**

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- (a) As used in this chapter, "alcoholism or drug abuse recovery or treatment facility" or "facility" means any premises, place, or building that provides 24-hour residential nonmedical services to adults who are recovering from problems related to alcohol, drug, or alcohol and drug misuse or abuse, and who need alcohol, drug, or alcohol and drug recovery treatment or detoxification services.
- (b) As used in this chapter, "adults" may include, but is not limited to, all of the following:
  - (1) Mothers over 18 years of age and their children.
  - (2) Emancipated minors, which may include, but is not limited to, mothers under 18 years of age and their children.
- (c) As used in this chapter, "emancipated minors" means persons under 18 years of age who have acquired emancipation status pursuant to Section 7002 of the Family Code.
- (d) Notwithstanding subdivision (a), an alcoholism or drug abuse recovery or treatment facility may serve adolescents upon the issuance of a waiver granted by the department pursuant to regulations adopted under subdivision (c) of Section 11834.50.

### **History**

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Added Stats 1984 ch 1667 § 2, as H & S C § 11834.11. Amended Stats 1988 ch 646 § 1; Stats 1989 ch 919 § 9; Stats 1992 ch 620 § 3 (AB 2460); Stats 1993 ch 219 § 216.1 (AB 1500). Amended and renumbered by Stats 1993 ch 741 § 5 (AB 2160).

### **Annotations**

### **Notes**

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#### **Amendments:**

##### **1988 Amendment:**

Deleted "exclusively for individuals whose involvement in services is related primarily to an alcohol problem" at the end of the section.

##### **1989 Amendment:**

Substituted the section for the former section which read: "As used in this chapter, 'alcoholism recovery facility' means any facility, place, or building which is maintained and operated exclusively to provided 24-hour residential nonmedical alcoholism recovery services."

**1992 Amendment:**

(1) Substituted "that" for "which" after "place, or building" in subd (a); and (2) added subd (c).

**1993 Amendment:**

Substituted the section for the former section which read: "(a) As used in this chapter, alcoholism or drug abuse recovery or treatment facility means any facility, place, or building that provides 24-hour residential nonmedical services in a group setting to adults, which may include, but need not be limited to, mothers over 18 years of age and their children, and emancipated minors, which may include, but need not be limited to, mothers under 18 years of age and their children, who are recovering from alcohol, drug, or drug and alcohol misuse and are currently capable of meeting their life support needs independently, but who temporarily need guidance, counseling, or other alcohol or drug recovery services.

"(b) 'Emancipated minors' as used in this chapter means person under 18 years of age who have acquired emancipation status through one or more of the following methods:

"(1) Declaration of emancipation pursuant to Section 64 of the Civil Code.

"(2) Marriage.

"(3) Service in any of the armed forces of the United States.

"(c) Notwithstanding subdivision (a), an alcoholism or drug abuse recovery or treatment facility may serve adolescents upon the issuance of a waiver granted by the department pursuant to regulations adopted under subdivision (c) of Section 11834.13." (As amended *Stats 1993 ch 741*, compared to the section as it read prior to 1993. This section was also amended by an earlier chapter, ch 219. See *Gov C § 9605*.)

**Editor's Notes**

For adoption of regulations, see the 1989 Note following *H & S C § 11830*.

**Research References & Practice Aids**

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**Cross References:**

Licensure of alcoholism, drug abuse recovery, or treatment facility: *H & S C § 11834.03*.

**Hierarchy Notes:**

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## Cal Health & Saf Code § 11834.25

This document is current through Urgency Chapter 314 of the 2014 Regular Session of the 2013-2014 Legislature and Propositions 41 and 42 approved June 2014

Deering's California Code Annotated > HEALTH AND SAFETY CODE > Division 10.5. Alcohol and Drug Programs > Part 2. State Government's Role to Alleviate Problems Related to the Inappropriate Use of Alcoholic Beverages and Other Drug Use > Chapter 7.5. Licensing > Article 2. Local Regulation

### **§ 11834.25. Facilities considered residential use by single family**

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For the purposes of any contract, deed, or covenant for the transfer of real property executed on or after January 1, 1979, an alcoholism or drug abuse recovery or treatment facility which serves six or fewer persons shall be considered a residential use of property and a use of property by a single family, notwithstanding any disclaimers to the contrary.

#### **History**

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Added Stats 1984 ch 1667 § 2. Amended Stats 1989 ch 919 § 20.

#### **Annotations**

#### **Notes**

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#### **Amendments:**

##### **1989 Amendment:**

Substituted "or drug abuse recovery or treatment" for "recovery" after "alcoholism".

#### **Editor's Notes**

For adoption of regulations, see the 1989 Note following H & S C § 11830.

### **Research References & Practice Aids**

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#### **Hierarchy Notes:**

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## Cal Health & Saf Code § 11834.23

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### **§ 11834.23. Zoning laws**

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Whether or not unrelated persons are living together, an alcoholism or drug abuse recovery or treatment facility which serves six or fewer persons shall be considered a residential use of property for the purposes of this article. In addition, the residents and operators of such a facility shall be considered a family for the purposes of any law or zoning ordinance which relates to the residential use of property pursuant to this article.

For the purpose of all local ordinances, an alcoholism or drug abuse recovery or treatment facility which serves six or fewer persons shall not be included within the definition of a boarding house, rooming house, institution or home for the care of minors, the aged, or the mentally infirm, foster care home, guest home, rest home, sanitarium, mental hygiene home, or other similar term which implies that the alcoholism or drug abuse recovery or treatment home is a business run for profit or differs in any other way from a single-family residence.

This section shall not be construed to forbid any city, county, or other local public entity from placing restrictions on building heights, setback, lot dimensions, or placement of signs of an alcoholism or drug abuse recovery or treatment facility which serves six or fewer persons as long as the restrictions are identical to those applied to other single-family residences.

This section shall not be construed to forbid the application to an alcoholism or drug abuse recovery or treatment facility of any local ordinance which deals with health and safety, building standards, environmental impact standards, or any other matter within the jurisdiction of a local public entity. However, the ordinance shall not distinguish alcoholism or drug abuse recovery or treatment facilities which serve six or fewer persons from other single-family dwellings or distinguish residents of alcoholism or drug abuse recovery or treatment facilities from persons who reside in other single-family dwellings.

No conditional use permit, zoning variance, or other zoning clearance shall be required of an alcoholism or drug abuse recovery or treatment facility which serves six or fewer persons that is not required of a single-family residence in the same zone.

Use of a single-family dwelling for purposes of an alcoholism or drug abuse recovery facility serving six or fewer persons shall not constitute a change of occupancy for purposes of Part 1.5 (commencing with Section 17910) of Division 13 or local building codes. However, nothing in this section is intended to supersede Section 13143 or 13143.6, to the extent those sections are applicable to alcoholism or drug abuse recovery or treatment facilities serving six or fewer residents.

### **History**

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Added Stats 1984 ch 1667 § 2. Amended Stats 1989 ch 919 § 18.

## Annotations

## Notes

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### Amendments:

#### 1989 Amendment:

(1) Substituted "or drug abuse recovery or treatment" for "recovery" after "alcoholism" wherever it appears; and (2) amended the sixth paragraph by (a) adding "or drug abuse" after "alcoholism" in the first sentence; and (b) substituting "or drug abuse recovery or treatment facilities serving" for "recovery facilities providing care for" after "alcoholism" in the second sentence.

### Editor's Notes

For adoption of regulations, see the 1989 Note following H & S C § 11830.

## Research References & Practice Aids

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### Hierarchy Notes:

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## Cal Health & Saf Code § 11834.21

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### **§ 11834.21. Persons entitled to invoke provisions of article**

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Any person licensed under this chapter who operates or proposes to operate an alcoholism or drug abuse recovery or treatment facility, the department or other public agency authorized to license such a facility, or any public or private agency which uses or may use the services of the facility to place its clients, may invoke the provisions of this article.

This section shall not be construed to prohibit any interested party from bringing suit to invoke the provisions of this article.

### **History**

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Added Stats 1984 ch 1667 § 2. Amended Stats 1989 ch 919 § 16.

### **Annotations**

### **Notes**

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#### **Amendments:**

#### **1989 Amendment:**

Substituted "or drug abuse recovery or treatment" for "recovery" after "alcoholism" in the first paragraph.

#### **Editor's Notes**

For adoption of regulations, see the 1989 Note following H & S C § 11830.

### **Research References & Practice Aids**

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#### **Hierarchy Notes:**

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Cal Health & Saf Code § 11834.22

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**§ 11834.22. Taxes and fees**

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An alcoholism or drug abuse recovery or treatment facility which serves six or fewer persons shall not be subject to any business taxes, local registration fees, use permit fees, or other fees to which other single-family dwellings are not likewise subject. Nothing in this section shall be construed to forbid the imposition of local property taxes, fees for water service and garbage collection, fees for inspections not prohibited by Section 11834.23, local bond assessments, and other fees, charges, and assessments to which other single-family dwellings are likewise subject. Neither the State Fire Marshal nor any local public entity shall charge any fee for enforcing fire inspection regulations pursuant to state law or regulation or local ordinance, with respect to alcoholism or drug abuse recovery or treatment facilities which serve six or fewer persons.

**History**

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Added Stats 1984 ch 1667 § 2. Amended Stats 1989 ch 919 § 17.

**Annotations**

**Notes**

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**Amendments:**

**1989 Amendment:**

Substituted (1) "or drug abuse recovery or treatment" for "recovery" after "alcoholism" both times it appears; and (2) "Section 11834.23" for "Section 1834.23".

**Editor's Notes**

For adoption of regulations, see the 1989 Note following H & S C § 11830.

**Research References & Practice Aids**

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**Hierarchy Notes:**

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## Cal Health & Saf Code § 11834.24

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### **§ 11834.24. Fire inspection clearances**

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No fire inspection clearance or other permit, license, clearance, or similar authorization shall be denied to an alcoholism or drug abuse recovery or treatment facility because of a failure to comply with local ordinances from which the facility is exempt under Section 11834.23, if the applicant otherwise qualifies for a fire clearance, license, permit, or similar authorization.

#### **History**

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Added Stats 1984 ch 1667 § 2. Amended Stats 1989 ch 919 § 19.

#### **Annotations**

#### **Notes**

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#### **Amendments:**

##### **1989 Amendment:**

Substituted "or drug abuse recovery or treatment" for "recovery" after "alcoholism".

#### **Editor's Notes**

For adoption of regulations, see the 1989 Note following H & S C § 11830.

### **Research References & Practice Aids**

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# Recovery Housing: Assessing the Evidence

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**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.

## 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 <sup>a</sup> (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 <sup>a</sup> (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 <sup>a</sup> (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 <sup>a</sup> (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) <sup>b</sup>	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

<sup>a</sup> These articles reported on the same overall study.<sup>b</sup> 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 signifi-

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## **Evidence for the effectiveness of recovery housing: moderate**

Areas of improvement suggested by overall positive results:

- Drug and alcohol use
- Employment
- Psychiatric symptoms

cantly 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 lead 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

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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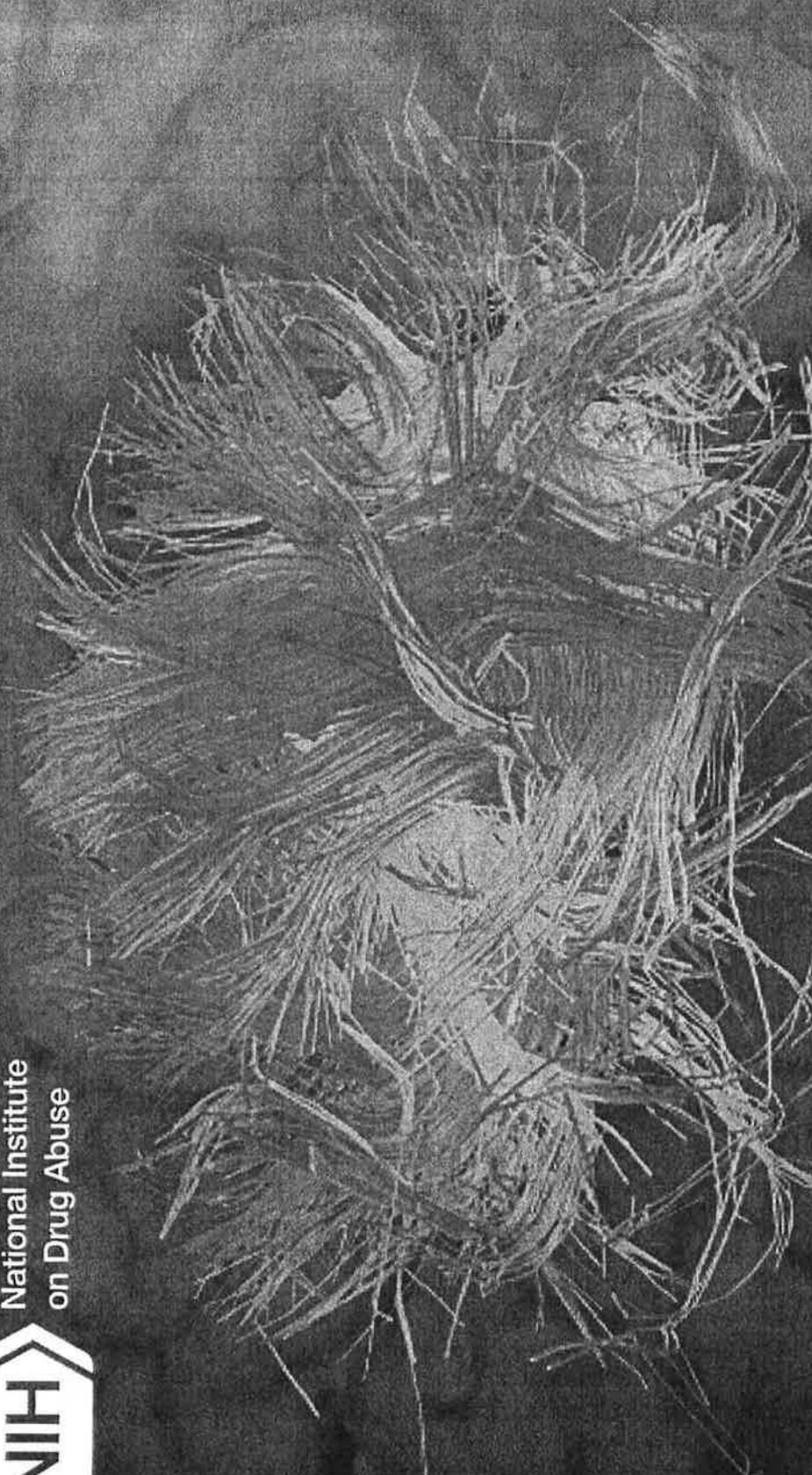
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National Institute  
on Drug Abuse



# *Drugs, Brains, and Behavior* **The Science of Addiction**

Image: White Matter Fibers, Panatier/Aras • www.humanconnectomeproject.org

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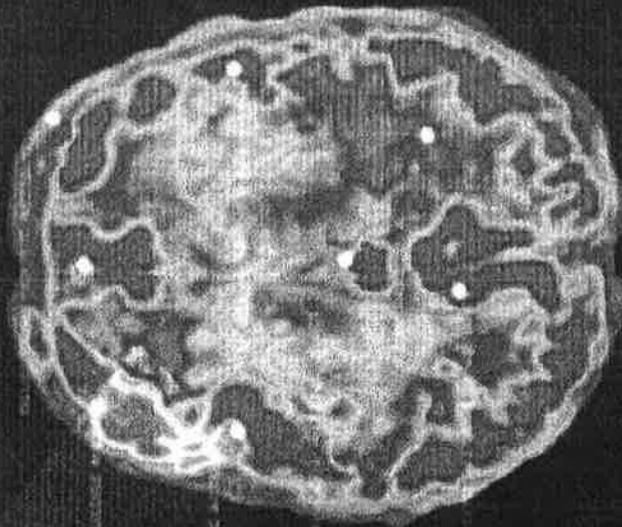
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**HEALTHY** BRAIN ACTIVITY  
INDICATED GLUCOSE METABOLIC ACTIVITY



*“Drug addiction is a brain disease that can be treated.”*

Nora D. Volkow, M.D.  
Director  
National Institute on Drug Abuse

## How Science Has Revolutionized the Understanding of Drug Addiction

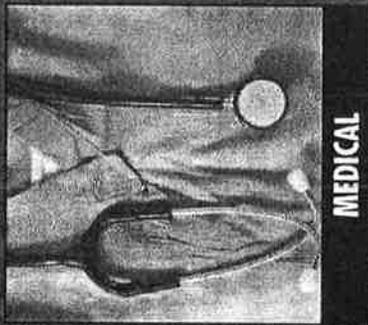
For much of the past century, scientists studying drug abuse labored in the shadows of powerful myths and misconceptions about the nature of addiction. When scientists began to study addictive behavior in the 1930s, people addicted to drugs were thought to be morally flawed and lacking in willpower. Those views shaped society's responses to drug abuse, treating it as a moral failing rather than a health problem, which led to an emphasis on punishment rather than prevention and treatment. Today, thanks to science, our views and our responses to addiction and other substance use disorders have changed dramatically. Groundbreaking discoveries about the brain have revolutionized our understanding of compulsive drug use, enabling us to respond effectively to the problem.

As a result of scientific research, we know that addiction is a disease that affects both the brain and behavior. We have identified many of the biological and environmental factors and are beginning to search for the genetic variations that contribute to the development and progression of the disease. Scientists use this knowledge to develop effective prevention and treatment approaches that reduce the toll drug abuse takes on individuals, families, and communities.

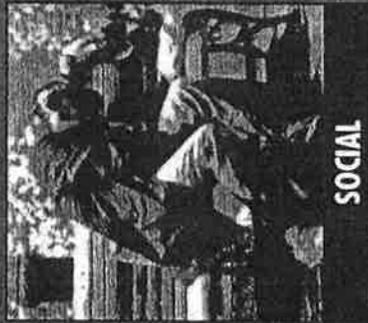
Despite these advances, many people today do not understand why people become addicted to drugs or how drugs change the brain to foster compulsive drug use. This booklet aims to fill that knowledge gap by providing scientific information about the disease of drug addiction, including the many harmful consequences of drug abuse and the basic approaches that have been developed to prevent and treat substance use disorders. At the National Institute on Drug Abuse (NIDA), we believe that increased understanding of the basics of addiction will empower people to make informed choices in their own lives, adopt science-based policies and programs that reduce drug abuse and addiction in their communities, and support scientific research that improves the Nation's well-being.



Nora D. Volkow, M.D.  
Director  
National Institute on Drug Abuse



**MEDICAL**



**SOCIAL**



**ECONOMIC**



**CRIMINAL JUSTICE**

*The consequences of drug abuse are vast and varied  
and affect people of all ages.*

## Why study drug abuse and addiction?

**A** buse of and addiction to alcohol, nicotine, and illicit and prescription drugs cost Americans more than \$700 billion a year in increased health care costs, crime, and lost productivity.<sup>1,2,3</sup> Every year, illicit and prescription drugs and alcohol contribute to the death of more than 90,000 Americans, while tobacco is linked to an estimated 480,000 deaths per year.<sup>4,5</sup> (Hereafter, unless otherwise specified, *drugs* refers to all of these substances.)

**People of all ages suffer the harmful consequences of drug abuse and addiction.**

- **Babies** exposed to drugs in the womb may be born premature and underweight. This exposure can slow the child's intellectual development and affect behavior later in life.<sup>6</sup>
- **Adolescents** who abuse drugs often act out, do poorly academically, and drop out of school. They are at risk for unplanned pregnancies, violence, and infectious diseases.
- **Adults** who abuse drugs often have problems thinking clearly, remembering, and paying attention. They often develop poor social behaviors as a result of their drug abuse, and their work performance and personal relationships suffer.
- **Parents'** drug abuse often means chaotic, stress-filled homes, as well as child abuse and neglect. Such conditions harm the well-being and development of children in the home and may set the stage for drug abuse in the next generation.

## How does science provide solutions for drug abuse and addiction?

Scientists study the effects that drugs have on the brain and on people's behavior. They use this information to develop programs for preventing drug abuse and for helping people recover from addiction. Further research helps transfer these ideas into practice in our communities.



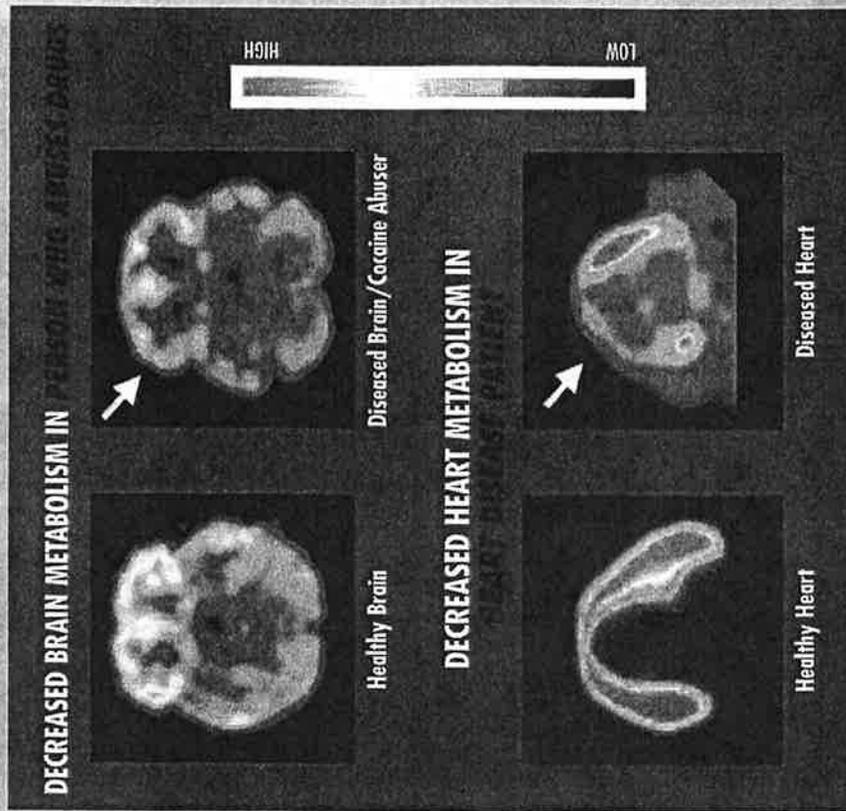
# DRUG ABUSE AND ADDICTION

## What is drug addiction?

**A**ddiction is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences.† It is considered a brain disease because drugs change the brain—they change its structure and how it works. These brain changes can be long-lasting, and can lead to the harmful behaviors seen in people who abuse drugs.

Addiction is a lot like other diseases, such as heart disease. Both disrupt the normal, healthy functioning of the underlying organ, have serious harmful consequences, and are preventable and treatable, but if left untreated, can last a lifetime.

Source: From the laboratories of  
Drs. N. Volkow and H. Schelbert



†The term *addiction* as used in this booklet may be regarded as equivalent to a severe *substance use disorder* as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5, 2013).

## Why do people take drugs?

In general, people begin taking drugs for a variety of reasons:

- **To feel good.** Most abused drugs produce intense feelings of pleasure. This initial sensation of euphoria is followed by other effects, which differ with the type of drug used. For example, with stimulants such as cocaine, the “high” is followed by feelings of power, self-confidence, and increased energy. In contrast, the euphoria caused by opiates such as heroin is followed by feelings of relaxation and satisfaction.
- **To feel better.** Some people who suffer from social anxiety, stress-related disorders, and depression begin abusing drugs in an attempt to lessen feelings of distress. Stress can play a major role in beginning drug use, continuing drug abuse, or relapse in patients recovering from addiction.
- **To do better.** Some people feel pressure to chemically enhance or improve their cognitive or athletic performance, which can play a role in initial experimentation and continued abuse of drugs such as prescription stimulants or anabolic/androgenic steroids.
- **Curiosity and “because others are doing it.”** In this respect adolescents are particularly vulnerable because of the strong influence of peer pressure. Teens are more likely than adults to engage in risky or daring behaviors to impress their friends and express their independence from parental and social rules.

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Courtesy: Vivian Felsen

*No single factor determines whether a person will become addicted to drugs.*

If taking drugs makes people feel good or better, what's the problem?

When they first use a drug, people may perceive what seem to be positive effects; they also may believe that they can control their use. However, drugs can quickly take over a person's life. Over time, if drug use continues, other pleasurable activities become less pleasurable, and taking the drug becomes necessary for the user just to feel "normal." They may then compulsively seek and take drugs even though it causes tremendous problems for themselves and their loved ones. Some people may start to feel the need to take higher or more frequent doses, even in the early stages of their drug use. These are the telltale signs of an addiction.

Even relatively moderate drug use poses dangers. Consider how a social drinker can become intoxicated, get behind the wheel of a car, and quickly turn a pleasurable activity into a tragedy that affects many lives.

Is continued drug abuse a voluntary behavior?

The initial decision to take drugs is typically voluntary. However, with continued use, a person's ability to exert self-control can become seriously impaired; this impairment in self-control is the hallmark of addiction. Brain imaging studies of people with

addiction show physical changes in areas of the brain that are critical to judgment, decision making, learning and memory, and behavior control.<sup>7</sup> Scientists believe that these changes alter the way the brain works and may help explain the compulsive and destructive behaviors of addiction.

Why do some people become addicted to drugs, while others do not?

As with any other disease, vulnerability to addiction differs from person to person, and no single factor determines whether a person will become addicted to drugs. In general, the more *risk factors* a person has, the greater the chance that taking drugs

**RISK AND PROTECTIVE FACTORS FOR DRUG ABUSE AND ADDICTION**

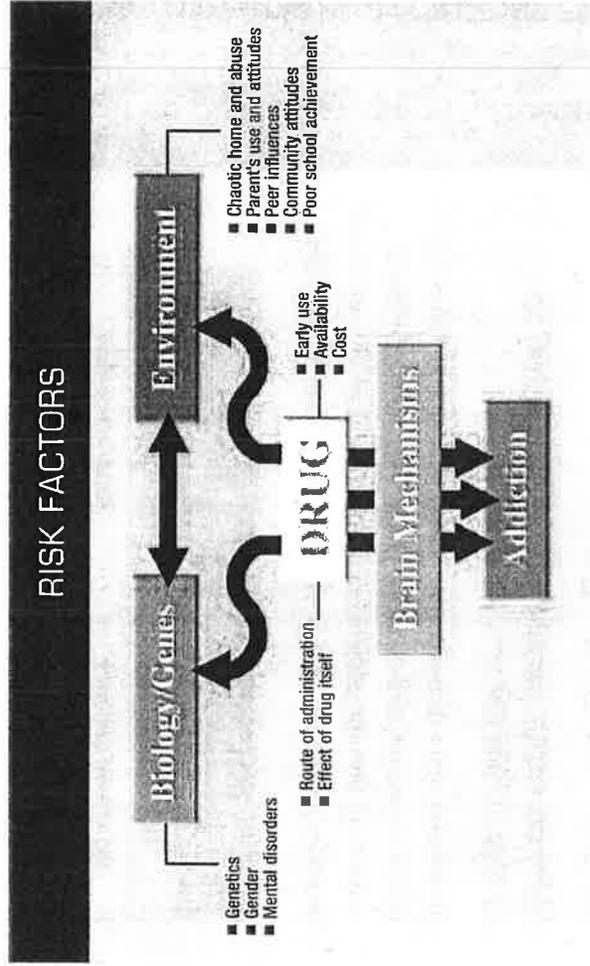
Risk Factors	Protective Factors
Aggressive behavior in childhood	Good self-control
Lack of parental supervision	Parental monitoring and support
Poor social skills	Positive relationships
Drug experimentation	Academic competence
Availability of drugs at school	School anti-drug policies
Community poverty	Neighborhood pride

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will lead to abuse and addiction. *Protective factors*, on the other hand, reduce a person's risk of developing addiction. Risk and protective factors may be either environmental (such as conditions at home, at school, and in the neighborhood) or biological (for instance, a person's genes, their stage of development, and even their gender or ethnicity).

What environmental factors increase the risk of addiction?

- **Home and Family.** The influence of the home environment, especially during childhood, is a very important factor. Parents or older family members who abuse alcohol or drugs, or who engage in criminal behavior, can increase children's risks of developing their own drug problems.
- **Peer and School.** Friends and acquaintances can have an increasingly strong influence during adolescence. Drug-using peers can sway even those without risk factors to try drugs for the first time. Academic failure or poor social skills can put a child at further risk for using or becoming addicted to drugs.



What biological factors increase the risk of addiction?

Scientists estimate that genetic factors account for between 40 and 60 percent of a person's vulnerability to addiction; this includes the effects of environmental factors on the function and expression of a person's genes. A person's stage of development and other medical conditions they may have are also factors. Adolescents and people with mental disorders are at greater risk of drug abuse and addiction than the general population.

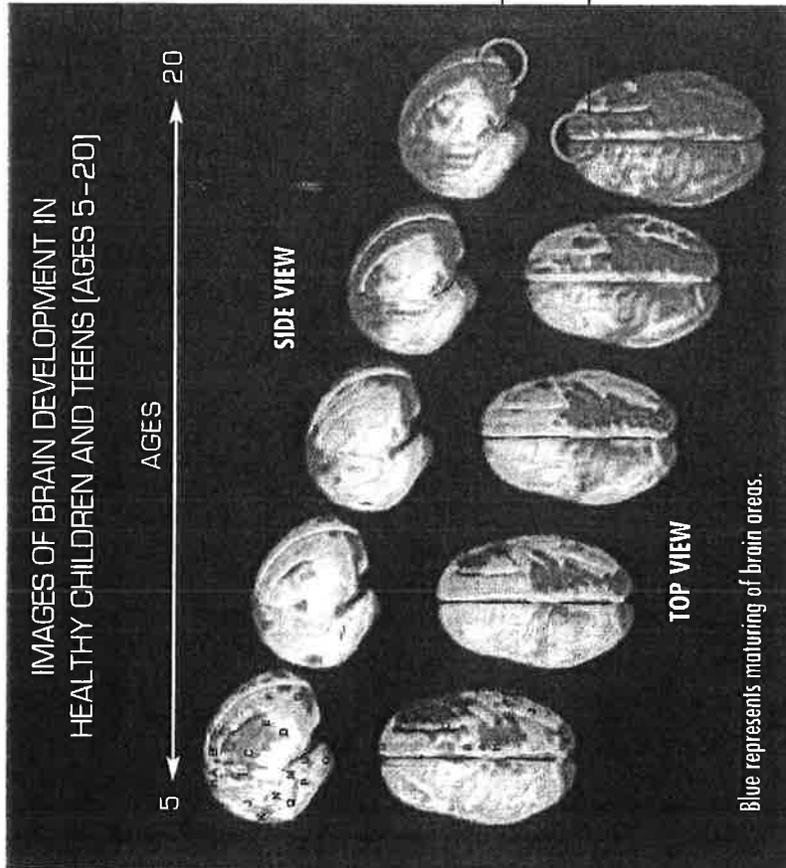
What other factors increase the risk of addiction?

■ **Early Use.** Although taking drugs at any age can lead to addiction, research shows that the earlier a person begins to use drugs, the more likely he or she is to develop serious problems.<sup>8</sup> This may reflect the harmful effect that drugs can have on the developing brain; it also may result from a mix of early social and biological vulnerability factors, including unstable family relationships, exposure to physical or sexual abuse, genetic susceptibility, or mental illness. Still, the fact remains that early use is a strong indicator of problems ahead, including addiction.

■ **Method of Administration.** Smoking a drug or injecting it into a vein increases its addictive potential.<sup>9,10</sup> Both smoked and injected drugs enter the brain within seconds, producing a powerful rush of pleasure. However, this intense "high" can fade within a few minutes, taking the abuser down to lower, more normal levels. Scientists believe this starkly felt contrast drives some people to repeated drug taking in an attempt to recapture the fleeting pleasurable state.



*Addiction is a developmental disease—  
it typically begins in childhood or adolescence.*



The brain continues to develop into adulthood and undergoes dramatic changes during adolescence.

One of the brain areas still maturing during adolescence is the prefrontal cortex—the part of the brain that enables us to assess situations, make sound decisions, and keep our emotions and desires under control.<sup>11</sup> The fact that this critical part of an adolescent's brain is still a work in progress puts them at increased risk for making poor decisions (such as trying drugs or continuing to take them). Also, introducing drugs during this period of development may cause brain changes that have profound and long-lasting consequences.

Source: PNAS 101:8174-8179, 2004.

## Why is adolescence a critical time for preventing drug addiction?

**A**s noted previously, early use of drugs increases a person's chances of developing addiction. Remember, drugs change brains—and this can lead to addiction and other serious problems. So, preventing early use of drugs or alcohol may go a long way in reducing these risks. If we can prevent young people from experimenting with drugs, we can prevent drug addiction.

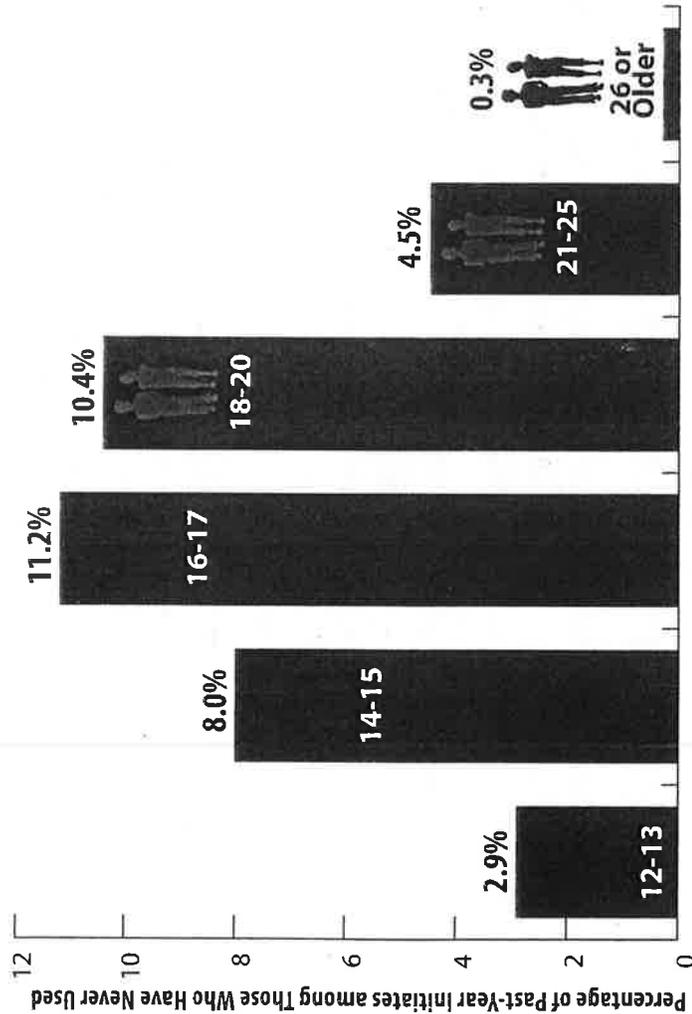
Risk of drug abuse increases greatly during times of transition. For an adult, a divorce or loss of a job may lead to drug abuse; for a teenager, risky times include moving or changing schools.<sup>12</sup> In early adolescence, when children advance from elementary through middle school, they face new and challenging social and academic situations. Often during this period, children are exposed to abusable substances such as cigarettes and alcohol for the first time. When they enter high school, teens may encounter greater availability of drugs, drug use by older teens, and social activities where drugs are used.

At the same time, many behaviors that are a normal aspect of their development, such as the desire to try new things or take greater risks, may increase teen tendencies to experiment with drugs. Some teens may give in to the urging of drug-using friends to share the experience with them. Others may think that taking drugs (such as steroids) will improve their appearance or their athletic performance or that abusing substances such as alcohol or MDMA (ecstasy or "Molly") will ease their anxiety in social situations. A growing number of teens are abusing prescription ADHD stimulants such as Adderall® to help them study or lose weight. Teens' still-developing judgment and decision-making skills may limit their ability to accurately assess the risks of all of these forms of drug use.

Using abusable substances at this age can disrupt brain function in areas critical to motivation, memory, learning, judgment, and behavior control.<sup>7</sup> So, it is not surprising that teens who use alcohol and other drugs often have family and social problems, poor academic performance, health-related problems (including mental health), and involvement with the juvenile justice system.

National drug use surveys indicate some children are already using drugs by age 12 or 13.

### The Drug Danger Zone: Most Illicit Drug Use Starts in the Teenage Years



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2011 and 2012.

Can research-based programs prevent drug addiction in youth?

Yes. The term "research-based" means that these programs have been rationally designed based on current scientific evidence, rigorously tested, and shown to produce positive results. Scientists have developed a broad range of programs that positively alter the balance between risk and protective factors for drug abuse in families, schools, and communities. Studies have shown that research-based programs, such as those described in NIDA's *Preventing Drug Use among Children and Adolescents: A Research-Based Guide for Parents, Educators, and Community Leaders*, can significantly reduce early use of tobacco, alcohol, and illicit drugs.<sup>15</sup>

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## How do research-based prevention programs work?

These prevention programs work to boost protective factors and eliminate or reduce risk factors for drug use. The programs are designed for various ages and can be designed for individual or group settings, such as the school and home. There are three types of programs:

- **Universal programs** address risk and protective factors common to all children in a given setting, such as a school or community.
- **Selective programs** target groups of children and teens who have factors that put them at increased risk of drug use.
- **Indicated programs** are designed for youth who have already begun using drugs.

## Are all prevention programs effective in reducing drug abuse?

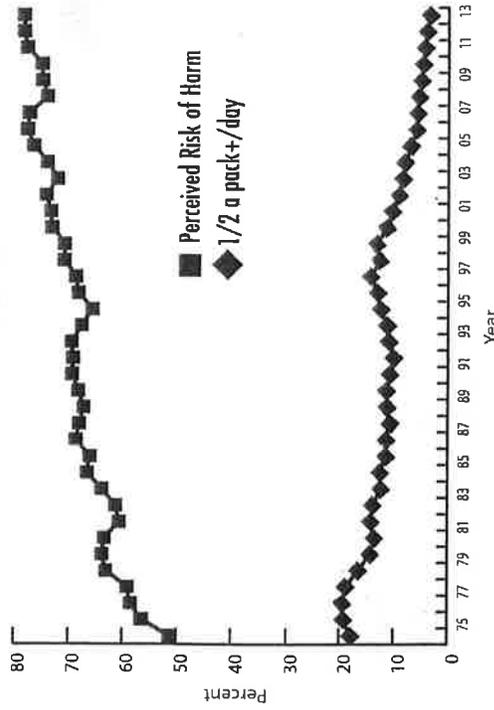
When research-based substance use prevention programs are properly implemented by schools and communities, use of alcohol, tobacco, and illegal drugs is reduced. Such programs help teachers, parents, and health care professionals shape youths' perceptions about the risks of substance use. While many social and cultural factors affect drug use trends, when young people perceive drug use as harmful, they reduce their level of use.<sup>14</sup>

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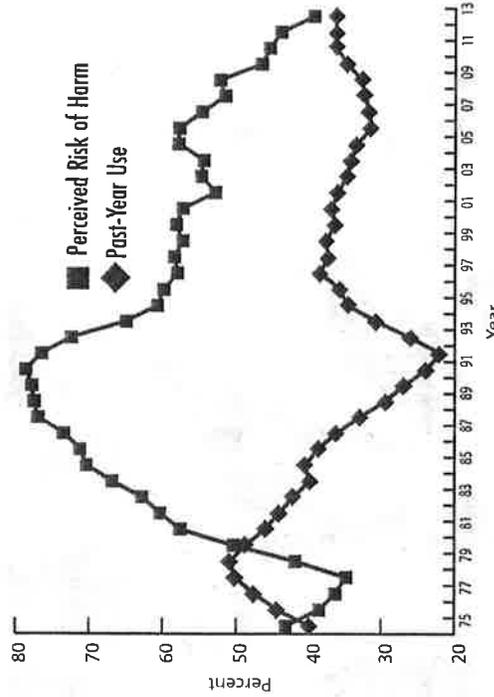


DRUG USE DECREASES WHEN DRUGS ARE PERCEIVED AS HARMFUL, AND VICE VERSA

12TH-GRADE STUDENTS REPORTING PAST-MONTH CIGARETTE USE AND PERCEPTION OF HARM, 1975 TO 2013



12TH-GRADE STUDENTS REPORTING PAST-MONTH MARIJUANA USE AND PERCEPTION OF HARM, 1975 TO 2013



Cigarette smoking among teens is at its lowest point since NIDA began tracking it in 1975. But marijuana use has increased over the past several years as perception of its risks has declined.

Source: 2013 Monitoring the Future survey. University of Michigan, with funding from the National Institute on Drug Abuse.

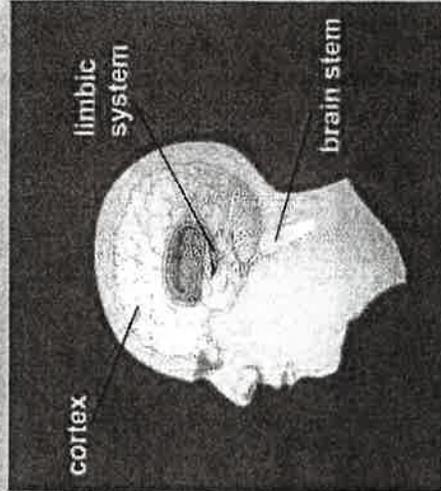
For more information on prevention, see NIDA's most recent edition of *Preventing Drug Use among Children and Adolescents: A Research-Based Guide for Parents, Educators, and Community Leaders* at [www.drugabuse.gov/Prevention/Prevopen.html](http://www.drugabuse.gov/Prevention/Prevopen.html).

## Introducing the Human Brain

**T**he human brain is the most complex organ in the body. This three-pound mass of gray and white matter sits at the center of all human activity—you need it to drive a car, to enjoy a meal, to breathe, to create an artistic masterpiece, and to enjoy everyday activities. In brief, the brain regulates your body's basic functions; enables you to interpret and respond to everything you experience; and shapes your thoughts, emotions, and behavior.

The brain is made up of many parts that all work together as a team. Different parts of the brain are responsible for coordinating and performing specific functions. Drugs can alter important brain areas that are necessary for life-sustaining functions and can drive the compulsive drug abuse that marks addiction. Brain areas affected by drug abuse include:

- **The brain stem**, which controls basic functions critical to life, such as heart rate, breathing, and sleeping.
- **The cerebral cortex**, which is divided into areas that control specific functions. Different areas process information from our senses, enabling us to see, feel, hear, and taste. The front part of the cortex, the frontal cortex or forebrain, is the thinking center of the brain; it powers our ability to think, plan, solve problems, and make decisions.
- **The limbic system**, which contains the brain's reward circuit. It links together a number of brain structures that control and regulate our ability to feel pleasure. Feeling pleasure motivates us to repeat behaviors that are critical to our existence. The limbic system is activated by healthy, life-sustaining activities such as eating and socializing—but it is also activated by drugs of abuse. In addition, the limbic system is responsible for our perception of other emotions, both positive and negative, which explains the mood-altering properties of many drugs.



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### How do the parts of the brain communicate?

The brain is a communications center consisting of billions of neurons, or nerve cells. Networks of neurons pass messages back and forth among different structures within the brain, the spinal cord, and nerves in the rest of the body (the peripheral nervous system). These nerve networks coordinate and regulate everything we feel, think, and do.

#### ■ Neuron to Neuron

Each nerve cell in the brain sends and receives messages in the form of electrical and chemical signals. Once a cell receives and processes a message, it sends it on to other neurons.

#### ■ Neurotransmitters—The Brain's Chemical Messengers

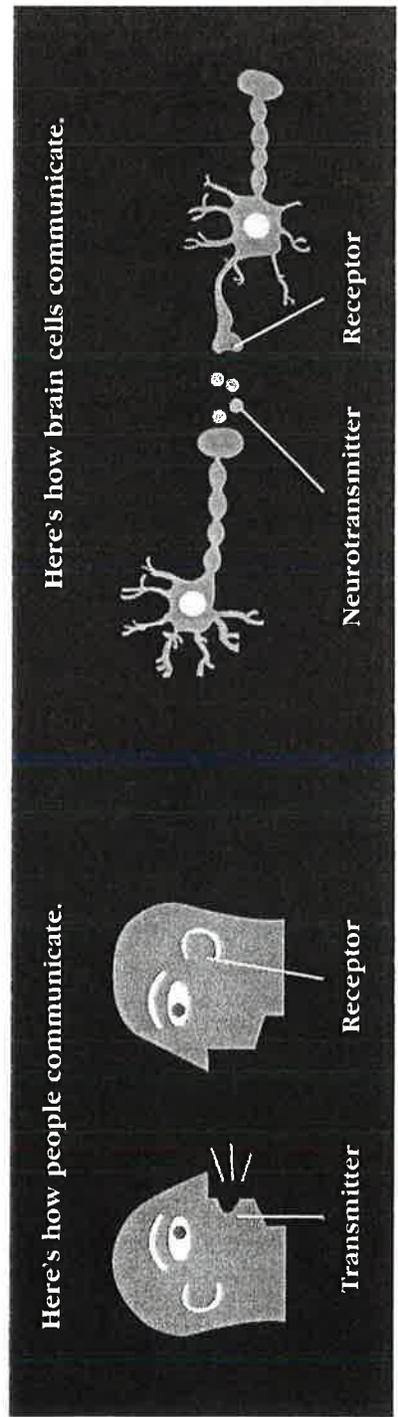
The messages are typically carried between neurons by chemicals called neurotransmitters.

#### ■ Receptors—The Brain's Chemical Receivers

The neurotransmitter attaches to a specialized site on the receiving neuron called a receptor. A neurotransmitter and its receptor operate like a "key and lock," an exquisitely specific mechanism that ensures that each receptor will forward the appropriate message only after interacting with the right kind of neurotransmitter.

#### ■ Transporters—The Brain's Chemical Recyclers

Located on the neuron that releases the neurotransmitter, transporters recycle these neurotransmitters (that is, bring them back into the neuron that released them), thereby shutting off the signal between neurons.



To send a message, a brain cell (neuron) releases a chemical (neurotransmitter) into the space (synapse) between it and the next cell. The neurotransmitter crosses the synapse and attaches to proteins (receptors) on the receiving brain cell. This causes changes in the receiving cell—the message is delivered.

Concept courtesy: B.K. Madras

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*Most drugs of abuse target the brain's reward system by flooding it with dopamine.*

## How do drugs work in the brain?

Drugs are chemicals that affect the brain by tapping into its communication system and interfering with the way neurons normally send, receive, and process information. Some drugs, such as marijuana and heroin, can activate neurons because their chemical structure mimics that of a natural neurotransmitter. This similarity in structure "fools" receptors and allows the drugs to attach onto and activate the neurons. Although these drugs mimic the brain's own chemicals, they don't activate neurons in the same way as a natural neurotransmitter, and they lead to abnormal messages being transmitted through the network.

Other drugs, such as amphetamine or cocaine, can cause the neurons to release abnormally large amounts of natural neurotransmitters or prevent the normal recycling of these brain chemicals. This disruption produces a greatly amplified message, ultimately disrupting communication channels.

## How do drugs work in the brain to produce pleasure?

Most drugs of abuse directly or indirectly target the brain's reward system by flooding the circuit with dopamine. Dopamine is a neurotransmitter present in regions of the brain that regulate movement, emotion, motivation, and feelings of pleasure. When activated at normal levels, this system rewards our natural behaviors. Overstimulating the system with drugs, however, produces euphoric effects, which strongly reinforce the behavior of drug use—teaching the user to repeat it.

How does stimulation of the brain's pleasure circuit teach us to keep taking drugs?

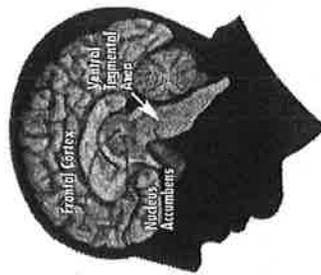
Our brains are wired to ensure that we will repeat life-sustaining activities by associating those activities with pleasure or reward. Whenever this reward circuit is activated, the brain notes that something important is happening that needs to be remembered, and teaches us to do it again and again without thinking about it. Because drugs of abuse stimulate the same circuit, we learn to abuse drugs in the same way.

Why are drugs more addictive than natural rewards?

When some drugs of abuse are taken, they can release 2 to 10 times the amount of dopamine that natural rewards such as eating and sex do.<sup>15</sup> In some cases, this occurs almost immediately (as when drugs are smoked or injected), and the effects can last much longer than those produced by natural rewards. The resulting effects on the brain's pleasure circuit dwarf those produced by naturally rewarding behaviors.<sup>16,17</sup> The effect of such a powerful reward strongly motivates people to take drugs again and again.

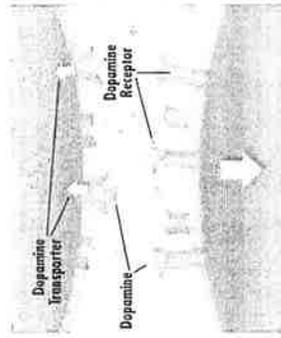
### DRUGS OF ABUSE TARGET THE BRAIN'S PLEASURE CENTER

Brain reward (dopamine) pathways



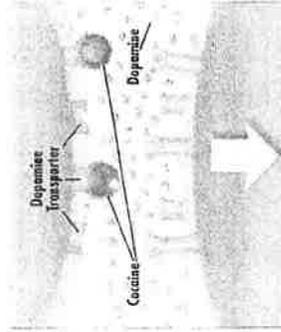
These brain circuits are important for natural rewards such as food, music, and sex.

Drugs of abuse increase dopamine



WHILE EATING FOOD

Typically, dopamine increases in response to natural rewards such as food. When cocaine is taken, dopamine increases are exaggerated, and communication is altered.



WHILE USING COCAINE

This is why scientists sometimes say that drug abuse is something we learn to do very, very well.

### What happens to your brain if you keep taking drugs?

For the brain, the difference between normal rewards and drug rewards can be described as the difference between someone whispering into your ear and someone shouting into a microphone. Just as we turn down the volume on a radio that is too loud, the brain adjusts to the overwhelm-

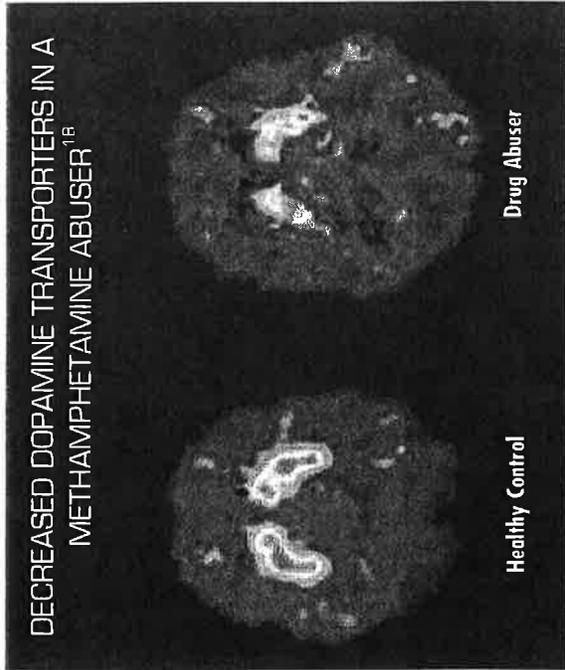
ing surges in dopamine (and other neurotransmitters) by producing less dopamine or by reducing the number of receptors that can receive signals. As a result, dopamine's impact on the reward circuit of the brain of someone who abuses drugs can become abnormally low, and that person's ability to experience *any* pleasure is reduced.

This is why a person who abuses drugs eventually feels flat, lifeless, and depressed, and is unable to enjoy things that were previously pleasurable. Now, the person needs to keep taking drugs again and again just to try and bring his or her dopamine function back up to normal—which only makes the problem worse, like a vicious cycle. Also, the person will often need to take larger amounts of the drug to produce the familiar dopamine high—an effect known as tolerance.

### How does long-term drug taking affect brain circuits?

We know that the same sort of mechanisms involved in the development of tolerance can eventually lead to profound changes in neurons and brain circuits, with the potential to severely compromise the long-term health of the brain. For

DECREASED DOPAMINE TRANSPORTERS IN A METHAMPHETAMINE ABUSER<sup>18</sup>



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example, glutamate is another neurotransmitter that influences the reward circuit and the ability to learn. When the optimal concentration of glutamate is altered by drug abuse, the brain attempts to compensate for this change, which can cause impairment in cognitive function. Similarly, long-term drug abuse can trigger adaptations in habit or non-conscious memory systems. Conditioning is one example of this type of learning, in which cues in a person's daily routine or environment become associated with the drug experience and can trigger uncontrollable cravings whenever the person is exposed to these cues, even if the drug itself is not available. This learned "reflex" is extremely durable and can affect a person who once used drugs even after many years of abstinence.

### What other brain changes occur with drug abuse?

Chronic exposure to drugs of abuse disrupts the way critical brain structures interact to control and inhibit behaviors related to drug use. Just as continued abuse may lead to tolerance or the need for higher drug dosages to produce an effect, it may also lead to addiction, which can drive a user to seek out and take drugs compulsively. Drug addiction erodes a person's self-control and ability to make sound decisions, while producing intense impulses to take drugs.

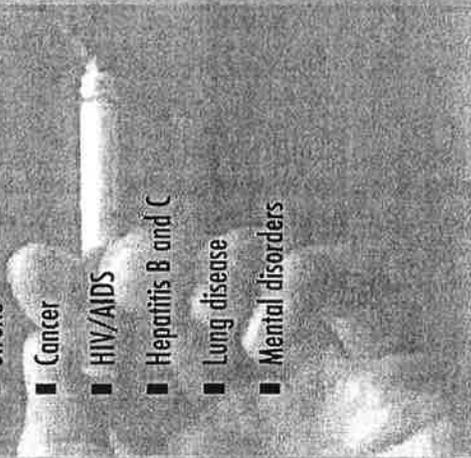
**For more information on drugs and the brain**, order NIDA's Teaching Packets CD-ROM series or the *Mind Over Matter* series at [www.drugabuse.gov/parent-teacher.html](http://www.drugabuse.gov/parent-teacher.html). These items and others are available to the public free of charge.

### What are the medical consequences of drug addiction?

People who suffer from addiction often have one or more accompanying medical issues, which may include lung or cardiovascular disease, stroke, cancer, and mental disorders. Imaging scans, chest X-rays, and blood tests show the damaging effects of long-term drug abuse throughout the body. For example, research has shown that tobacco smoke causes cancer of the mouth, throat, larynx, blood, lungs, stomach, pancreas, kidney, bladder, and cervix.<sup>19</sup> In addition, some drugs of abuse, such as inhalants, are toxic to nerve cells and may damage or destroy them either in the brain or the peripheral nervous system.

### THE IMPACT OF ADDICTION CAN BE FAR-REACHING

- Cardiovascular disease
- Stroke
- Cancer
- HIV/AIDS
- Hepatitis B and C
- Lung disease
- Mental disorders



### Does drug abuse cause mental disorders, or vice versa?

Drug abuse and mental illness often co-exist. In some cases, mental disorders such as anxiety, depression, or schizophrenia may precede addiction; in other cases, drug abuse may trigger or exacerbate those mental disorders, particularly in people with specific vulnerabilities.



## How can addiction harm other people?

Beyond the harmful consequences for the person with the addiction, drug abuse can cause serious health problems for others. Three of the more devastating and troubling consequences of addiction are:

### ■ *Negative effects of prenatal drug exposure on infants and children*

A mother's abuse of heroin or prescription opioids during pregnancy can cause a withdrawal syndrome (called neonatal abstinence syndrome, or NAS) in her infant. It is also likely that some drug-exposed children will need educational support in the classroom to help them overcome what may be subtle deficits in developmental areas such as behavior, attention, and thinking. Ongoing research is investigating whether the effects of prenatal drug exposure on the brain and behavior extend into adolescence to cause developmental problems during that time period.

### ■ *Negative effects of secondhand smoke*

Secondhand tobacco smoke, also called environmental tobacco smoke (ETS), is a significant source of exposure to a large number of substances known to be hazardous to human health, particularly to children. According to the Surgeon General's 2006 Report, *The Health Consequences of Involuntary Exposure to Tobacco Smoke*, involuntary exposure to secondhand smoke increases the risks of heart disease and lung cancer in people who have never smoked by 25–30 percent and 20–30 percent, respectively.<sup>20</sup>

### ■ *Increased spread of infectious diseases*

Injection of drugs such as heroin, cocaine, and methamphetamine currently accounts for about 12 percent of new AIDS cases.<sup>21</sup> Injection drug use is also a major factor in the spread of hepatitis C, a serious, potentially fatal liver disease. Injection drug use is not the only way that drug abuse contributes to the spread of infectious diseases. All drugs of abuse cause some form of intoxication, which interferes with judgment and increases the likelihood of risky sexual behaviors. This, in turn, contributes to the spread of HIV/AIDS, hepatitis B and C, and other sexually transmitted diseases.

1 OUT OF 3 U.S. AIDS DEATHS ARE  
RELATED TO DRUG ABUSE<sup>22</sup>



Tobacco use is responsible for an estimated 5 million deaths worldwide each year.

### What are some effects of specific abused substances?

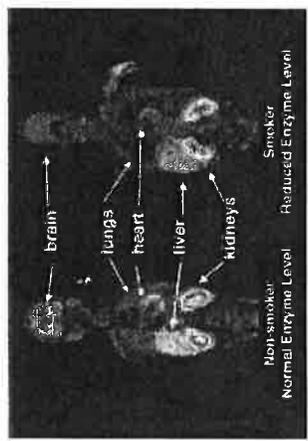
- **Nicotine** is an addictive stimulant found in cigarettes and other forms of tobacco. Tobacco smoke increases a user's risk of cancer, emphysema, bronchial disorders, and cardiovascular disease. The mortality rate associated with tobacco addiction is staggering. Tobacco use killed approximately 100 million people during the 20th century, and, if current smoking trends continue, the cumulative death toll for this century has been projected to reach 1 billion.<sup>24</sup>

- **Alcohol** consumption can damage the brain and most body organs. Areas of the brain that are especially vulnerable to alcohol-related damage are the cerebral cortex (largely responsible for our higher brain functions, including problem solving and decision making), the hippocampus (important for memory and learning), and the cerebellum (important for movement coordination).

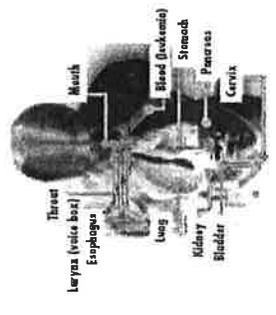
- **Marijuana** is the most commonly abused illegal substance. This drug impairs short-term memory and learning, the ability to focus attention, and coordination. It also increases heart rate, can harm the lungs, and can increase the risk of psychosis in those with an underlying vulnerability.

### TOBACCO SMOKE AFFECTS THE WHOLE BODY

**Monoamine Oxidase B<sup>25</sup>**



**Smoking causes cancer throughout the body.<sup>26</sup>**



- **Prescription medications**, including opioid pain relievers (such as OxyContin<sup>®</sup> and Vicodin<sup>®</sup>), anti-anxiety sedatives (such as Valium<sup>®</sup> and Xanax<sup>®</sup>), and ADHD stimulants (such as Adderall<sup>®</sup> and Ritalin<sup>®</sup>), are commonly misused to self-treat for medical problems or abused for purposes of getting high or (especially with stimulants) improving performance. However, misuse or abuse of these drugs (that is, taking them other than exactly as instructed by a doctor and for the purposes prescribed) can lead to addiction and even, in some cases, death. Opioid pain relievers, for instance, are frequently abused by being crushed and injected or snorted, greatly raising the risk of addiction and overdose. Unfortunately, there is a common misperception that because medications are prescribed by physicians, they are safe even when used illegally or by another person than they were prescribed for.

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- **Inhalants** are volatile substances found in many household products, such as oven cleaners, gasoline, spray paints, and other aerosols, that induce mind-altering effects; they are frequently the first drugs tried by children or young teens. Inhalants are extremely toxic and can damage the heart, kidneys, lungs, and brain. Even a healthy person can suffer heart failure and death within minutes of a single session of prolonged sniffing of an inhalant.
- **Cocaine** is a short-acting stimulant, which can lead users to take the drug many times in a single session (known as a “binge”). Cocaine use can lead to severe medical consequences related to the heart and the respiratory, nervous, and digestive systems.
- **Amphetamines**, including methamphetamine, are powerful stimulants that can produce feelings of euphoria and alertness. Methamphetamine’s effects are particularly long-lasting and harmful to the brain. Amphetamines can cause high body temperature and can lead to serious heart problems and seizures.
- **MDMA (Ecstasy or “Molly”)** produces both stimulant and mind-altering effects. It can increase body temperature, heart rate, blood pressure, and heart-wall stress. MDMA may also be toxic to nerve cells.
- **LSD** is one of the most potent hallucinogenic, or perception-altering, drugs. Its effects are unpredictable, and abusers may see vivid colors and images, hear sounds, and feel sensations that seem real

**For more information on the nature and extent of common drugs of abuse and their health consequences, go to NIDA’s Web site ([www.drugabuse.gov](http://www.drugabuse.gov)) to view the popular Research Reports ([www.drugabuse.gov/ResearchReports/ResearchIndex.html](http://www.drugabuse.gov/ResearchReports/ResearchIndex.html)), DrugFacts fact sheets and other publications.**

but do not exist. Users also may have traumatic experiences and emotions that can last for many hours.

- **Heroin** is a powerful opioid drug that produces euphoria and feelings of relaxation. It slows respiration, and its use is linked to an increased risk of serious infectious diseases, especially when taken intravenously. People who become addicted to opioid pain relievers sometimes switch to heroin instead, because it produces similar effects and may be cheaper or easier to obtain.
- **Steroids**, which can also be prescribed for certain medical conditions, are abused to increase muscle mass and to improve athletic performance or physical appearance. Serious consequences of abuse can include severe acne, heart disease, liver problems, stroke, infectious diseases, depression, and suicide.
- **Drug combinations.** A particularly dangerous and common practice is the combining of two or more drugs. The practice ranges from the co-administration of legal drugs, like alcohol and nicotine, to the dangerous mixing of prescription drugs, to the deadly combination of heroin or cocaine with fentanyl (an opioid pain medication). Whatever the context, it is critical to realize that because of drug–drug interactions, such practices often pose significantly higher risks than the already harmful individual drugs.



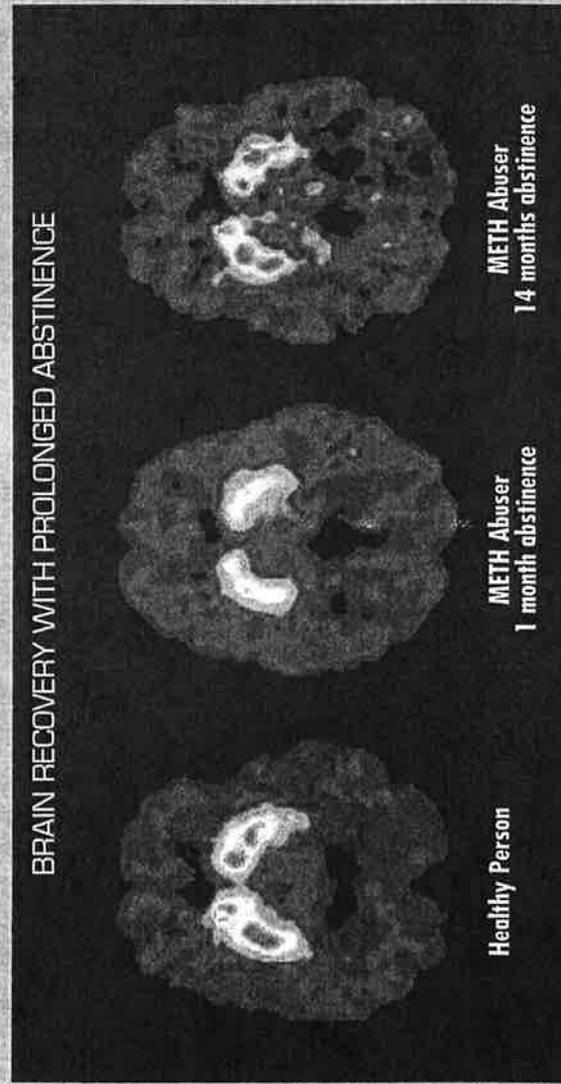
## V. TREATMENT AND RECOVERY

Can addiction be treated successfully?

**YES** • Addiction is a treatable disease. Research in the science of addiction and the treatment of substance use disorders has led to the development of evidence-based interventions that help people stop abusing drugs and resume productive lives.

Can addiction be cured?

Not always—but like other chronic diseases, addiction can be managed successfully. Treatment enables people to counteract addiction's powerful disruptive effects on their brain and behavior and regain control of their lives.



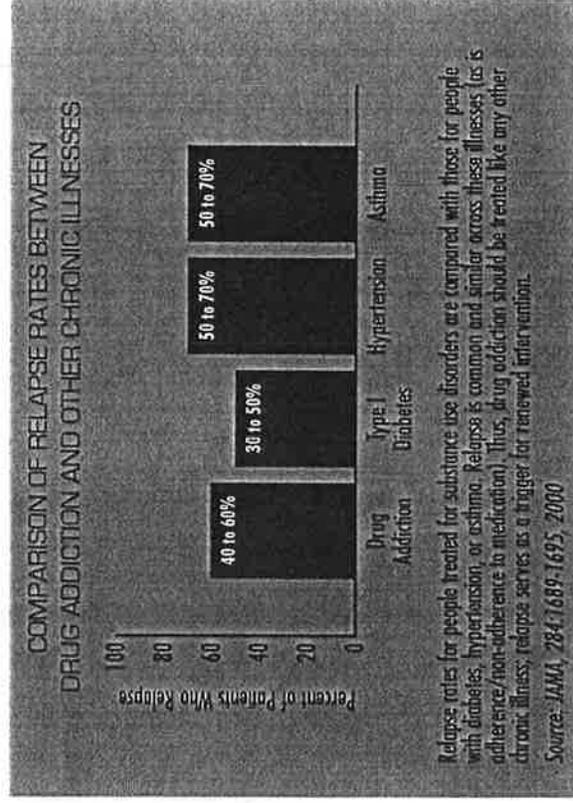
These images showing the density of dopamine transporters in a brain area called the striatum illustrate the brain's remarkable potential to recover, at least partially, after a long abstinence from drugs—in this case, methamphetamine.<sup>27</sup>

## Does relapse to drug abuse mean treatment has failed?

No. The chronic nature of the disease means that relapsing to drug abuse at some point is not only possible, but likely. Relapse rates (i.e., how often symptoms recur) for people with addiction and other substance use disorders are similar to relapse rates for other well-understood chronic medical illnesses such as diabetes, hypertension, and asthma, which also have both physiological and behavioral components. Treatment of chronic diseases involves changing deeply imbedded behaviors, and relapse does not mean treatment has failed. For a person recovering from addiction, lapsing back to drug use indicates that treatment needs to be reinstated or adjusted or that another treatment should be tried.<sup>28</sup>

## What are the principles of effective substance use disorder treatment?

Research shows that combining treatment medications (where available) with behavioral therapy is the best way to ensure success for most patients. Treatment approaches must be tailored to address each patient's drug use patterns and drug-related medical, psychiatric, and social problems.



## How can medications help treat drug addiction?

Different types of medications may be useful at different stages of treatment to help a patient stop abusing drugs, stay in treatment, and avoid relapse.

- **Treating Withdrawal.** When patients first stop using drugs, they can experience a variety of physical and emotional symptoms, including depression, anxiety, and other mood disorders, as well as

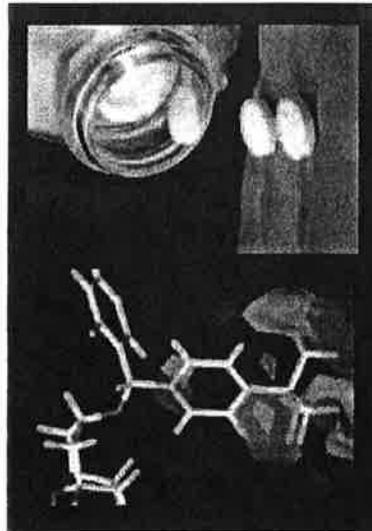
restlessness or sleeplessness. Certain treatment medications are designed to reduce these symptoms, which makes it easier to stop the drug use.

■ **Staying in Treatment.** Some treatment medications are used to help the brain adapt gradually to the absence of the abused drug. These medications act slowly to stave off drug cravings and have a calming effect on body systems. They can help patients focus on counseling and other psychotherapies related to their drug treatment.

■ **Preventing Relapse.** Science has taught us that stress, cues linked to the drug experience (such as people, places, things, and moods), and exposure to drugs are the most common triggers for relapse. Medications are being developed to interfere with these triggers to help patients sustain recovery.

### How do behavioral therapies treat drug addiction?

Behavioral treatments help engage people in substance use disorder treatment, modifying their attitudes and behaviors related to drug use and increasing their life skills to handle stressful circumstances and environmental cues that may trigger intense craving for drugs and prompt another cycle of compulsive use. Behavioral therapies can also enhance the effectiveness of medications and help people remain in treatment longer.



Discoveries in science lead to advances in drug abuse treatment.

### MEDICATIONS USED TO TREAT DRUG ADDICTION

- **Tobacco Addiction**
  - **Nicotine replacement therapies** (available as a patch, inhaler, or gum)
  - **Bupropion**
  - **Varenicline**
- **Opioid Addiction**
  - **Methadone**
  - **Buprenorphine**
  - **Naltrexone**
- **Alcohol and Drug Addiction**
  - **Naltrexone**
  - **Disulfiram**
  - **Acamprosate**



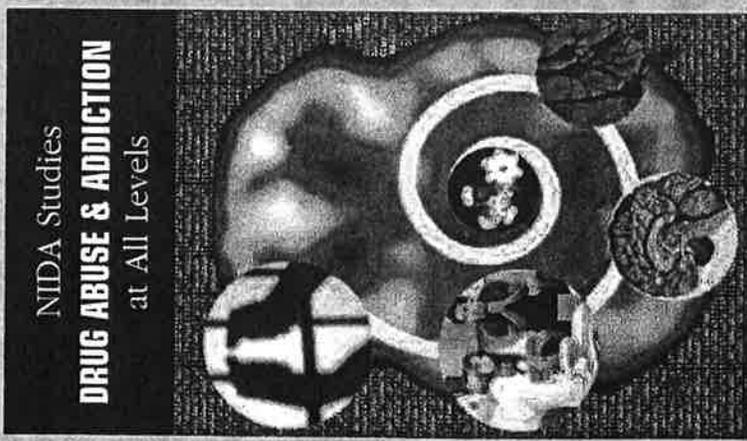
- **Cognitive Behavioral Therapy** seeks to help patients recognize, avoid, and cope with the situations in which they are most likely to abuse drugs.
- **Contingency Management** uses positive reinforcement such as providing rewards or privileges for remaining drug free, for attending and participating in counseling sessions, or for taking treatment medications as prescribed.
- **Motivational Enhancement Therapy** uses strategies to evoke rapid and internally motivated behavior change to stop drug use and facilitate treatment entry.
- **Family Therapy (especially for youth)** approaches a person's drug problems in the context of family interactions and dynamics that may contribute to drug use and other risky behaviors.

## How do the best treatment programs help patients recover from the pervasive effects of addiction?

Gaining the ability to stop abusing drugs is just one part of a long and complex recovery process. When people enter treatment for a substance use disorder, addiction has often taken over their lives. The compulsion to get drugs, take drugs, and experience the effects of drugs has dominated their every waking moment, and abusing drugs has taken the place of all the things they used to enjoy doing. It has disrupted how they function in their family lives, at work, and in the community, and has made them more likely to suffer from other serious illnesses. Because addiction can affect so many aspects of a person's life, treatment must address the needs of the whole person to be successful. This is why the best programs incorporate a variety of rehabilitative services into their comprehensive treatment regimens.

Treatment counselors may select from a menu of services for meeting the specific medical, psychological, social, vocational, and legal needs of their patients to foster their recovery from addiction.

**For more information on substance use disorder treatment,** see *Principles of Drug Addiction Treatment: A Research-Based Guide* ([www.drugabuse.gov/PODAT/PODATIndex.html](http://www.drugabuse.gov/PODAT/PODATIndex.html)) and *Principles of Adolescent Substance Use Disorder Treatment: A Research-Based Guide* ([www.drugabuse.gov/publications/principles-adolescent-substance-use-disorder-treatment-research-based-guide](http://www.drugabuse.gov/publications/principles-adolescent-substance-use-disorder-treatment-research-based-guide)).



### Leading the Search for Scientific Solutions

To address all aspects of drug abuse and its harmful consequences, NIDA's research program ranges from basic studies of the addicted brain and behavior to health services research. NIDA's research program develops prevention and treatment approaches and ensures they work in real-world settings. In this context, NIDA is strongly committed to developing a research portfolio that addresses the special vulnerabilities and health disparities that exist among ethnic minorities or that derive from gender differences.

### Bringing Science to Real-World Settings

- **Clinical Trials Network (CTN)**  
CTN "road tests" research-based drug abuse treatments in community treatment programs around the country.
- **Criminal Justice Drug Abuse Treatment Studies (CJ-DATS)**  
Led by NIDA, CJ-DATS is a network of research centers, in partnership with criminal justice professionals, drug abuse treatment providers, and Federal agencies responsible for developing integrated treatment approaches for criminal justice offenders and testing them at multiple sites throughout the Nation.
- **Juvenile Justice Translational Research on Interventions in the Legal System (JJ-TRIALS)**  
JJ-TRIALS is a seven-site cooperative research program designed to identify and test strategies for improving the delivery of evidence-based substance abuse and HIV prevention and treatment services for justice-involved youth.

### Sharing Free Information With the Public

NIDA further increases the impact of its research on the problems of addiction by sharing free information about its findings with professional audiences and the general public. Special initiatives target students and teachers as well as designated populations and ethnic groups.

## NIDA's Special Initiatives for Students, Teachers, and Parents

**HEADS UP REAL NEWS ABOUT DRUGS AND YOUR BODY**  
**Heads Up: Real News About Drugs and Your Body**—A drug education series created by NIDA and SCHOLASTIC INC. for students in grades 6 to 12.  
[headsup.scholastic.com](http://headsup.scholastic.com)

**NIDA for Teens: The Science Behind Drug Abuse**—An interactive Web site geared specifically to teens, with age-appropriate facts on drugs.  
[www.teens.drugabuse.gov](http://www.teens.drugabuse.gov)

**Drug Facts Chat Day**—A Web chat between NIDA scientists and teens, held through school computer labs once a year during National Drug Facts Week (below).  
[www.drugabuse.gov/chat](http://www.drugabuse.gov/chat)

**National Drug Facts Week**—A week-long observance that encourages community-based events and dialogue between teens and scientists during National Drug Facts Week (below).  
[www.drugfactsweek.drugabuse.gov/](http://www.drugfactsweek.drugabuse.gov/)

## Special Initiative for Clinicians NIDAMED

**NIDAMED**—Tools and resources to increase awareness of the impact of substance use on patients' overall health and help clinicians and those in training identify patient drug use early and prevent it from escalating to abuse or addiction.

## Publications on Prevention and Treatment Principles

**Preventing Drug Use among Children and Adolescents: A Research-Based Guide for Parents, Educators, and Community**

**Leaders**—NIDA's research-based guide for preventing drug abuse among children and adolescents provides 16 principles derived from effective drug-prevention research and includes answers to questions on risk and protective factors as well as on community planning and implementation.

**Principles of Drug Addiction Treatment: A Research-Based Guide**—This guide summarizes the 13 principles of effective treatment, answers common questions, and describes types of treatment, providing examples of scientifically based and tested treatment components.

**Principles of Adolescent Substance Use Disorder Treatment: A Research-Based Guide**—This guide discusses the urgency of treating addictions and other substance use disorders in teenagers, answers common questions about how young people are treated for drug problems, and describes effective treatment approaches supported by scientific evidence.

**Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide**—NIDA's

research-based guide for treating people with addiction who are involved with the criminal justice system provides 13 essential treatment principles, and includes answers to frequently asked questions and resource information.

### For more information:

All NIDA publications are available at [www.drugabuse.gov](http://www.drugabuse.gov). Some publications are also available in print, free of charge. To order print copies call the DRUGPubs Research Dissemination Center at 1-877-NIH-NIDA or go to [drugpubs.drugabuse.gov](http://drugpubs.drugabuse.gov). Watch NIDA videos (NIDA TV) at: [www.drugabuse.gov/nida-tv](http://www.drugabuse.gov/nida-tv).

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