PLANNING COMMISSION AGENDA REPORT

MEETING DATE: NOVEMBER 14, 2016 **ITEM NUMBER:** PH-10

SUBJECT: **CONDITIONAL USE PERMITS PA 16-41 AND PA 16-44 TO OPERATE A SOBER LIVING FACILITY SERVING 28 PERSONS, INCLUDING AN APPEAL OF DENIAL OF REASONABLE ACCOMMODATION FOR A LAND USE REQUIREMENT, AT 269 AND 271 16TH PLACE.**

DATE: **NOVEMBER 2, 2016**

FROM: **COMMUNITY IMPROVEMENT DIVISION/DEVELOPMENT SERVICES DEPARTMENT**

PRESENTATION BY: **SHERI VANDER DUSSEN, INTERIM ASSISTANT DIRECTOR/COMMUNITY IMPROVEMENT DIVISION**

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PROJECT DESCRIPTION

Planning Applications PA 16-41 and PA 16-44 are Conditional Use Permits (CUPs) filed pursuant to City of Costa Mesa Municipal Code, Title 13 Section 13-323, for a sober living facility housing up to 28 residents in eight units. The subject properties are contiguous and operated as a single facility, so the applicant also submitted a reasonable accommodation request for relief from the zoning requirement that a group home, residential care facility or state licensed drug and alcohol facility is at least 650 feet from another property that contains a similar facility. The request for Reasonable Accommodation was denied. The applicant has appealed that denial to the Planning Commission.

Because these sites are contiguous and operated as a single facility, staff has prepared a single staff report for both applications, and recommends that the Planning Commission consider both applications in a single public hearing. However, staff recommends that the Planning Commission adopt separate resolutions for each application.

APPLICANT/PROPERTY OWNER

The applicant, Casa Capri, LLC. is represented by Melissa Goodmon. The property is owned by Zackary Irani.

ENVIRONMENTAL DETERMINATION

The project is categorically exempt from the provisions of the California Environmental Quality Act (CEQA) under Section 15301, Existing Facilities.

PROCEDURE

The hearing on the CUP application is governed by the procedures set forth in Section 13-29(g) of the Costa Mesa Municipal Code. The appeal of the Director's denial of the reasonable accommodation request is governed by Section 13-200.62(g), which provides that "the standard of review on appeal shall not be de novo and the Planning Commission shall determine whether the findings made by the director are supported by substantial evidence presented during the evidentiary hearing. The planning commission, acting as the appellate body, may sustain, reverse, or modify the decision of the director or remand the matter for further consideration, which remand shall include specific issues to be considered or a direction for a de novo hearing."

The CUP and reasonable accommodation in general have differing review processes and procedures. However, in this matter, the decision on the CUP is linked to the decision on the requested reasonable accommodation. Because of this, staff recommends that these separate items be processed concurrently by the Planning Commission pursuant to Section 13-29(e)(6) and (q), and that the Applicant be afforded the appellate rights of Section 2-309(4) to both the decision on the CUP and the reasonable accommodation request.

RECOMMENDATION

Uphold the Director's denial of the reasonable accommodation request to allow the subject facility to be operated on two contiguous parcels, in effect allowing the facilities to be located within 650 feet of each other; deny CUP PA 16-41; and approve CUP PA 16-44 by adoption of resolutions.

BACKGROUND/ANALYSIS

The subject properties are located on the south side of 16th Place between Westminster Avenue and Santa Ana Avenue in the R3 (Multiple Family Residential) zone. The General Plan designation for the properties is High Density Residential. The adjacent and nearby properties enjoy the same zoning and land use designations.

Casa Capri Recovery operates a sober living facility serving up to 14 residents on each of the subject properties, for a total of 28 beds. Under Section 13-6 of the City's Zoning Code, *an alcoholism or drug abuse recovery or treatment facility* is a type of residential care facility as it is a residential facility licensed by the state where care, services, or treatment are provided to persons living in a community residential setting. Pursuant to Ordinance 15-11, group homes serving more than six residents are required to obtain a CUP, even if they are licensed by the state.

Per Costa Mesa Municipal Code, Title 13 Section 13-321, a "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. This section of the zoning code makes it clear that a sober living home may only occupy a single parcel. The subject facility encompasses two properties. Therefore, the applicant was required to file a separate Conditional Use Permit for each parcel. The applicant requested a reasonable accommodation to allow the facilities on each property to be located next door to each other as all of the units are operated as a single facility.

Conditional Use Permit Requirement for Sober Living Facilities in Multi-Family Residential Zones

On November 17, 2015, the City Council adopted Ordinance 15-11 revising Title 13 of the Costa Mesa Municipal Code to add Chapter XVI which established conditions for granting a CUP to group homes, residential care facilities, and drug and alcohol treatment facilities serving more than six residents in the City's multiple family residential zones. All group homes and residential care facilities currently operating in multi-family zones before the ordinance was adopted must come into compliance with Ordinance 15-11 by December 17, 2016.

Sections 65008(a) and (b) of the California Government Code prohibit discrimination in local governments' zoning and land use actions based on (among other categories) race, sex, lawful occupation, familial status, disability, source of income, or occupancy by low to middle income persons. Section 65008(d)(2) also prevents agencies from imposing different requirements on single-family or multifamily homes because of the familial status, disability, or income of the intended residents. Individuals in recovery from drug and alcohol addiction are defined as disabled under the Fair Housing Act. Therefore, the City is obligated to treat residents of sober living homes like it treats other residents of the City. Conditions of approval must reflect this obligation.

CUP Application Deemed Complete

The applicant submitted all of the CUP application requirements for group homes with seven or more occupants. CUP application requirements include, but are not limited to, the following items:

- Completed Live Scan forms for all owners/operators who have contact with residents, corporate officers with operational responsibilities, house managers and counselors;
- The Group Home's Relapse Policy;
- Written policies directing occupants to be considerate of neighbors, including refraining from engaging in loud, profane or obnoxious behavior that would unduly interfere with a neighbor's use and enjoyment of their dwelling unit;
- Written policy requiring occupants to actively participate in a legitimate recovery program;

- Written policy that prohibits the use of any alcohol or any non-prescription drugs at the sober living home or by any individual in recovery including the house manager if applicable on or off site. House Rules must also include a written policy regarding the possession, use and storage of prescription and over the counter medications, that includes monitoring and oversight by qualified staff; and
- Written policy that precludes any visitors who are under the influence of drugs or alcohol.

Sober Living Homes with Seven or More Occupants Must Obtain an Operator's Permit pursuant to Title 9, Section 374.

In addition to a CUP, an Operator's Permit application is required for group homes with seven or more occupants if the facility is not licensed by the State of California. The applicant submitted a complete application for an Operator's Permit and demonstrated compliance with all of the City's requirements. The facility meets the operational requirements for issuance of an Operator's Permit. The requirements include, but are not limited to, the following:

- The group home is required to have a house manager who resides at the group home or any multiple 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. The facility has identified a resident house manager and has provided contact information as part of the Operator's Permit application packet.

- Occupants must not require, and operators must not provide, "care and supervision" as those terms are defined by Health and Safety Code 1503.5 and Section 80001(c)(3) of title 22, California Code of Regulations. The applicant's description of the facility does not include the provision of "care and supervision" as defined by the State.

- The applicant has indicated that this 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. Summit Coastal Living will make outside referrals to qualified facilities upon request.

- Upon eviction from or involuntary termination of residency in a group home, the operator of the group home shall make available to the occupant transportation to the address listed on the occupant's driver license, state issued identification card, or the permanent address identified in the occupant's application or referral to the group home. The group home may not satisfy this obligation by providing remuneration to the occupant for the cost of transportation. The operator requires that all occupants provide a permanent address as part of the intake paperwork as well as a security deposit to be held by the operator or the signature of a guarantor that has agreed to cover the transportation costs to a detox facility or permanent residence in the event of a relapse.

If a CUP is approved by the Planning Commission, staff will issue the Operator's Permit. Failure to comply with the terms of the Permit could be grounds to revoke the CUP.

Facility Description

The existing sober living facility began operation at this location in July 2011, prior to the enactment of Ordinance 15-11. The facility consists of two parcels, each developed with a single building containing four units. These parcels were developed at the same time as a mirror image and share a common courtyard in the center of the buildings. All units are currently operated as a single facility.

A sober living home is a sub-type of group home. Article 2 of Section 13-6 (Definitions) defines a group home as follows:

> *"A facility that is being used as a supportive living environment for persons who are considered handicapped under state or federal law. A group home operated by a single operator or service provider (whether licensed or unlicensed) constitutes a single facility whether the facility occupies one or more dwelling units."*

The facility includes eight units in two, two-story buildings on two properties. There are four units with fourteen beds on each property. Each unit contains two bedrooms and one bathroom. One bedroom in each building is used for an office. The applicant employs staff members who are on-site 24/7 in lieu of having a resident manager.

Each parcel contains two garage parking spaces and two open parking spaces, for a total of eight spaces. Clients are not permitted to keep cars at the facility. Casa Capri does provide shuttle service in cars and mini-vans. These vehicles are not kept on the subject property. Residents also rely on bicycles and/or public transportation.

Since Casa Capri Recovery began operation of the facility in 2011, Code Enforcement staff has not opened any complaint investigations.

General Plan Conformance

The provision of a variety of housing types, including housing for the disabled, is consistent with the Land Use and Housing Elements of the City's General Plan.

- **Goal LU-1F.1: Land Use and Goal HOU-1.2:** *Protect existing stabilized residential neighborhoods, including mobile home parks (and manufactured housing parks) from the encroachment of incompatible or potentially disruptive land uses and/or activities.*

  Consistency: The City's regulations are intended to preserve the residential character of the City's neighborhoods. This facility has demonstrated its compatibility with the neighborhood over the past two years.

- **Goal HOU-1.8:** *Housing Element: Encourage the development of housing that fulfills specialized needs.*

  Consistency: The proposed request provides for a supportive living environment for persons who are considered disabled under state and federal law.

REQUIRED FINDINGS

Pursuant to Title 13, Chapter XVI and Section 13-29(g) of the Costa Mesa Municipal Code, the Planning Commission must make required findings for the CUP, based on evidence presented in the administrative record. Staff recommends that the Commission uphold the Director's determination to deny this request for reasonable accommodation to allow these contiguous parcels to be operated as a single sober living facility. Upholding the denial of a reasonable accommodation means that one CUP must be denied. Use of one of the parcels for a sober living facility serving fourteen women would be in compliance with the City's regulations.

- *Pursuant to the purpose and intent of the Multi-Family Residential Group Home Ordinance, the sober living facility would provide a comfortable living environment that will enhance the opportunity for disabled persons, including recovering addicts, to be successful in their programs.*

  The facility encompasses two parcels of land. There are two buildings containing eight units on these parcels. There are 16 bedrooms in the eight units. The facility currently houses 28 residents. When Ordinance 15-11 was adopted by the City Council, it specifically included a provision limiting the operation of a sober living facility to a single parcel. The intent of this limitation is to ensure that sober living facilities do not occupy a disproportionate number of homes in any neighborhood, and to avoid overconcentration of sober living units in any area. The City also sought to ensure that disabled persons recovering from addiction have the opportunity to reside in a comfortable residential environment vs. an institutional setting. The City determined that 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 disabled 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 state and federal laws were designed to provide relief from for disabled persons.

  The existing facility occupies two buildings on contiguous parcels, which is a violation of the Costa Mesa Municipal Code. Therefore, this finding can only be made if just one of the CUPs is approved. Operation of a facility four units on this parcel would be compatible with the neighborhood. The use of a single building in the neighborhood as a sober living home will not create an overconcentration of such facilities. The use of four units to accommodate 14 residents will provide a comfortable residential environment. The smaller household size accommodated in each unit allows the residents to live in a more typical household. Parking needs

can be accommodated on-site, and the facility will not share any common walls with neighbors who may be concerned about noise.

- *The sober living facility would further the purposes of the FEHA, the FHAA, and Lanterman Act by limiting the secondary impacts related to noise, traffic, and parking to the extent reasonable.*

  Residents of this facility are not allowed to have cars or park them at the site. The operator does use mini-vans and cars to provide transportation to activities such as school, work and counseling. These vehicles are not stored on-site.

  There are four parking spaces provided on each parcel. The zoning code requires residents of sober living homes to park on-site, or on the street within 500 feet of the facility. There are no parking restrictions, such as permit parking or red curbs, which would interfere with the ability of residents or employees of the facility to secure on-street parking if all on-site parking spaces are occupied. Since residents are not allowed to keep cars on the property, the amount of parking provided on-site will be adequate to accommodate staff and guests. The facility is in compliance with the city's standards.

  Smoking and noise impacts are often cited when sober living homes create problems in neighborhoods. Residents of the facility are required to smoke at the rear of the site, between the garages. The garages abut an alley. There is a fence between the smoking area and the alley. The garages and the fence will help minimize any impacts related to smoking at the subject facility.

- *The sober living facility would be compatible with the residential character of the surrounding neighborhood.*

  The CMMC specifically limits the operation of group homes to a single parcel. The subject site includes two contiguous parcels, allowing the facility to include eight units serving 28 women. This approach results in an overconcentration of sober living units in this neighborhood, detracting from the residential character of the neighborhood. The approval of one multi-family building containing four sober living units would not be inconsistent with the residential character of the neighborhood as it would not create an overconcentration of facilities, as defined by the City's ordinances. The applicant has demonstrated an ability to operate the facility in a manner consistent with the residential character of the neighborhood.

- *The group home is at least 650 feet from any property that contains a group home, sober living home or state licensed drug and alcohol facility, as defined in the code and measured from the property line.*

  In a letter dated June 10, 2016, the City's Director of Economic and Development Services denied Casa Capri's accommodation request to allow this facility to operate on two contiguous parcels.

Section 13-320 of the Costa Mesa Municipal Code establishes criteria for approval of group homes in multi-family zones. Group homes serving disabled persons as defined by state and federal law are not considered to be boardinghouses. Rather, these facilities offer disabled persons the opportunity to live in residential neighborhoods in compliance with state and federal laws. Recovering alcoholics and drug addicts, who are not currently using alcohol or drugs, are considered disabled under state and federal law. Any group home serving six or fewer people must be viewed as a residential use pursuant to state law. Group homes serving more than six residents are subject to local regulation. Standards for large group homes are set forth in the zoning code. The intent of the regulations is preserve the residential character of the City's neighborhoods while providing opportunities for the disabled to live in comfortable residential surroundings.

The City adopted standards for group homes in response to a proliferation of sober living homes in the community. The City found that an overconcentration of sober living homes in the City's residential neighborhoods could be deleterious to the residential character of these neighborhoods and could also lead to the institutionalization of such neighborhoods. Sober living homes generally do not function as a single housekeeping unit because they house extremely transient populations; the residents generally have no established ties to each other when they move in and typically do not mingle with other neighbors; the residents have little to no say about who lives or doesn't live in the home; the residents do not generally share expenses; the residents are often responsible for their own food, laundry and phone; when residents disobey house rules they are often just evicted from the house; and the residents generally do not share the same acquaintances. The City found that the size and makeup of the households in sober living homes 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 addition, all the individuals residing in a sober living facility are generally over the age of 18, while the average household in Costa Mesa has just 2.2 individuals over the age of 18.

Because of their 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. These issues may include the housing of large numbers of unrelated adults 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' properties; neighbors who have little to no idea who does and does not reside in the home; little to no participation by residents in community activities that form and strengthen neighborhood cohesion; 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 residents congregating in the same general area; and the potential influx of individuals with a criminal record.

Nevertheless, the City recognizes that while not in character with residential neighborhoods, when operated responsibly, group homes, including sober living homes, provide a societal benefit by providing disabled persons the opportunity to live in residential neighborhoods. These facilities also provide recovery programs for individuals attempting to overcome their drug and alcohol addictions. 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.

In response to the needs and concerns described above, the City established a minimum separation of 650 feet between group homes, residential care facilities and/or state licensed drug and alcohol facilities. The City found that a separation requirement will still allow for a reasonable market for the purchase and operation of sober living homes within the City. The requirement will still result in preferential treatment for sober living homes in that non-disabled individuals in a similar living situation (i.e., in boardinghouse-style residences) have fewer housing opportunities than the disabled. The City determined that 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 disabled 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 state and federal laws were designed to provide relief from for disabled persons.

The operator of a group home may request reasonable accommodation when compliance with all of the standards is not possible. Section 13-200.62 (f) of the zoning code sets forth the required findings to be used in the determination to approve, conditionally approve, or deny a request for reasonable accommodation. The Code specifies that all findings must be made in order to approve such a request.

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

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

The applicant requested relief from the zoning code's requirement that a group home, residential care facility or state licensed drug and alcohol facility is at least 650 feet from another property that contains a group home, sober living home or state licensed drug and alcohol treatment facility. Based on the limited information provided by applicant, and staff's own research into the issue, the Director denied the reasonable accommodation requested to allow these two contiguous parcels to be operated as a single sober living facility, for the following reasons.

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

  The application established that the requested accommodation (waiver of the 650-foot separation and single lot requirements) may allow a CUP to be granted to enable Casa Capri Recovery to continue to operate in compliance with the Costa Mesa Municipal Code at its current location. In theory, this action would allow one or more individuals who are recovering from drug and alcohol abuse to enjoy the use of one of these dwellings. However, the request is not necessary to allow one or more individuals who are recovering from drug and alcohol abuse to enjoy the use of a dwelling within the City.

- Applicant has not met its burden to show whether the existing supply of facilities of a similar nature and operation in the community is insufficient to provide individuals with a disability an equal opportunity to live in a residential setting.

  Based on the most recent data compiled by City staff, there are approximately 98 sober living homes within Costa Mesa. Of these, 37 are located in single-family neighborhoods and 61 are within multi-family residential zones. Additionally, there are approximately 83 state licensed drug and alcohol residential care facilities in Costa Mesa. Twenty-five are in single-family residential zones, 55 are in multi-family residential zones, and one is in a C1 zone. No evidence has been submitted to indicate that the number of sober living homes and drug and alcohol residential care facilities existing or potentially allowed in compliance with the City's standards is inadequate.

- Applicant has not met its burden to show whether the requested accommodation is consistent with whether or not the residents would constitute a single housekeeping unit.

  According to the City's definition of a sober living home, a sober living home's residents do not constitute a single housing keeping unit. The requested accommodation is for a provision of the Costa Mesa Municipal Code that would not apply to single housekeeping units. Therefore, this finding is not relevant.

- Applicant did not demonstrate that the requested accommodation is necessary to make facilities of a similar nature or operation economically viable in light of the particularities of the relevant market and market participants.

  The applicant did not provide evidence in its application regarding this factor; therefore, City staff was not able to make this finding. As noted above, there is a significant number of sober living facilities in Costa Mesa.

- Applicant was not able to demonstrate that the requested accommodation will not result in a fundamental alteration in the nature of the City's zoning program.

  The City's separation standard of 650 feet was intended to ensure that there would be no more than one group home, residential care facility or state licensed drug and alcohol facility on any block. The City limits the operation of sober living homes to a single parcel to minimize the opportunity for an overconcentration of sober living units to occur in a neighborhood. The subject properties are located adjacent to each other and approval of one CUP will create a separation conflict with the other property.

  The burden to demonstrate necessity remains with the Applicant. Oconomowoc, 300 F.3d at 784, 787. Applicant must show that "without the required accommodation the disabled will be denied the equal opportunity to live in a residential neighborhood." Oconomowoc, 300 F.3d at 784; see also, United States v. California Mobile Home Mgmt Co., 107 F3d 1374, 1380 (9th Cir. 1997) ("without a causal link between defendants' policy and the plaintiff's injury, there can be no obligation on the part of the defendants to make a reasonable accommodation"); Smith & Lee, Inc. v. City of Taylor, Mich., 102 F.3d 781, 795 (6th Cir. 1996) ("plaintiffs must show that, but for the accommodation, they likely will be denied an equal opportunity to enjoy the housing of their choice").

  The Applicant has asserted that the requested accommodation from the 650-foot distance requirement is reasonable. However, a zoning accommodation may be deemed unreasonable if "it is so at odds with the purposes behind the rule that it would be a fundamental and unreasonable change." Oconomowoc, 300 F.3d at 784. The Applicant made no mention of the purpose underlying the City's zoning limitation, or explained how the accommodation requested would not undermine that purpose. In fact, the Director found that such allowance would fundamentally alter the character of this neighborhood and is thus unreasonable.

  Allowing multiple group homes, sober living homes and/or state licensed drug and alcohol treatment facilities to cluster in a residential neighborhood does effect a fundamental change to the residential character of the neighborhood. Allowing facilities to be located on contiguous parcels has a similar effect. The clustering of group homes in close proximity to each other does change the residential character of the neighborhood to one that is far more institutional in nature. This is particularly the case with respect to sober living homes. Both California and

federal courts have recognized that the maintenance of the residential character of neighborhoods is a legitimate governmental interest. The United States Supreme Court long ago acknowledged the legitimacy of "what is really the crux of the more recent zoning legislation, namely, the creation and maintenance of residential districts, from which business and trade of every sort, including hotels and apartment houses, are excluded." Euclid v. Amber Realty Co., 272 U.S. 365, 390 (1926).

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

> It is axiomatic that the welfare, and indeed the very existence of a nation depends upon the character and caliber of its citizenry. The character and quality of manhood and womanhood are in a large measure the result of home environment. The home and its intrinsic influences are the very foundation of good citizenship, and any factor contributing to the establishment of homes and the fostering of home life doubtless tends to the enhancement not only of community life but of the life of the nation as a whole.
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> Miller v. Board of Public Works, 195 Cal. 477, 490, 492-93 (1925).
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> With home ownership comes stability, increased interest in the promotion of public agencies, such as schools and churches, and 'recognition of the individual's responsibility for his share in the safeguarding of the welfare of the community and increased pride in personal achievement which must come from personal participation in projects looking toward community betterment.'
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> Ewing v. City of Carmel-by-the-Sea, 234 Cal. App. 3d 1579, 1590 (1991), *citing* Miller, 195 Cal. at 493.

It is with these purposes in mind that the City of Costa Mesa has created residential zones, including R2 zones for multi-family residences.

The requested accommodation, in these specific circumstances, would result in a fundamental alteration of the City's zoning program, as set forth in Ordinance numbers 14-13 and 15-11, because it would increase and/or contribute to the overconcentration of these types of facilities in this residential neighborhood.

Based on denial of a reasonable accommodation, the facility does not comply with the City's adopted standards for separation between group homes, residential care facilities and state licensed drug and alcohol facilities. Therefore, the findings required by CMMC to approve both CUPs cannot be made, either. However, if one CUP is denied, the other CUP may be approved, since the use of one of these parcels will fully comply with the City's standards.

- *The proposed use is substantially compatible with developments in the same general area and would not be materially detrimental to other properties within the area.*

  The introduction of one sober living home in compliance with the City's standards would not be materially detrimental to the area. However, over the last decade, the number of sober living homes in the City of Costa Mesa has rapidly increased, leading to an overconcentration of sober living homes in certain of the City's residential neighborhoods. Overconcentration is both deleterious to the residential character of these neighborhoods and may also lead to the institutionalization of such neighborhoods. The City's establishment of distance requirements for sober living homes is reasonable and non-discriminatory and helps preserve the residential character of the R2MD, R2HD, and R3 zones, as well as the planned development residential neighborhoods. It also furthers the interest of ensuring that disabled persons are not living in overcrowded environments that are counterproductive to their well-being and recovery. The approval of this request to allow this facility to encompass two parcels will contribute to an overconcentration of such facilities in this neighborhood.

- *Granting the CUP will not be materially detrimental to the health, safety and general welfare of the public or otherwise injurious to property or improvements within the immediate neighborhood.*

  As noted above, approval of both CUP applications will result in overconcentration of group homes, residential care facilities and/or state licensed drug and alcohol facilities in this neighborhood. Short-term tenants, such as might be found in homes that provide addiction treatment programs of limited duration, generally have little interest in the welfare of the neighborhoods in which they temporarily reside -- residents "do not participate in local government, coach little league, or join the hospital guild. They do not lead a scout troop, volunteer at the library, or keep an eye on an elderly neighbor. Literally, they are here today and gone tomorrow -- without engaging in the sort of activities that weld and strengthen a community." Ewing, 234 Cal. App. 3d at 1591.

  Strong evidence exists that a supportive living environment in a residential neighborhood provides more effective recovery than an institutional-style environment (see Attachments 5 and 6). The City's zoning regulations address overconcentration and secondary effects of sober living homes. The goal of the regulations is to provide the disabled with an equal opportunity to live in the residence of their choice, and to maintain the residential character of existing neighborhoods.

  The City has found through experience that clustering sober living facilities in close proximity to each other results in neighborhoods dominated by sober living facilities. In these neighborhoods, street life is often characterized by large

capacity vans picking-up and dropping-off residents and staff, service providers taking up much of the available on street parking, staff in scrubs carrying medical kits going from unit to unit, and vans dropping off prepared meals in large numbers. The City has experienced frequent Fire Department deployments in response to medical aid calls. In some neighborhoods, 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 meeting 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. These types of impacts have been identified in other communities as well (see Attachment 7).

- *Granting the conditional use permit will not allow a use which is not in accordance with the general plan designation.*

  The proposed use is consistent with the City's General Plan. However, an overconcentration of group homes, sober living homes and licensed treatment facilities for alcohol and drug addiction is not consistent with the General Plan. The City's regulations are intended to preserve the residential character of the City's neighborhoods. The City Council has determined that an overconcentration of sober living facilities would be detrimental to the residential character of the City's neighborhoods. The denial of one CUP and approval of the other CUP will allow a sober living facility to operate in compliance with the City's regulations.

ALTERNATIVES

A draft resolution denying the appeal of the Director's determination on Reasonable Accommodation and PA 16-41 has been provided. A draft resolution approving PA 16-44 has also been provided. The Planning Commission could choose to approve CUP PA-16-44 instead of PA 16-41. Should the Planning Commission wish to approve the reasonable accommodation request and both CUPs, the hearing should be continued to allow staff to prepare resolutions for consideration at a subsequent meeting.

LEGAL REVIEW

The draft resolution has been reviewed and approved as to form by the City Attorney's Office.

CONCLUSION

The applicant has requested an accommodation to allow a sober living facility at 269 16th Place and 271 16th Place to be operated on two contiguous parcels, resulting in one parcel containing a group home, sober living home or state licensed drug and alcohol treatment facility being within 650 feet of another such facility.. The applicant has failed to demonstrate that all of the required findings can be made. The approval of a sober living facility operated on contiguous properties is not permitted under the CMMC. Staff recommends denial of the appeal to waive this separation requirement, denial of PA 16-41, and approval of PA 16-44.

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Attachments:

1. Vicinity and Zoning Maps
2. Applicant's Request for Reasonable Accommodation dated March 23, 2016
3. Letter from Director dated May 18, 2016, denying Reasonable Accommodation
4. Applicant's Request to Appeal the Denial to the Planning Commission dated May 23, 2016
5. *Recovery Housing: Assessing the Evidence*, Sharon Reif, Ph.D. at al., Psychiatric Services, March 2014 Vol. 65 No. 3
6. *Residential Treatment for Individuals With Substance Use Disorders: Assessing the Evidence*, Sharon Reif, Ph.D. at al., Psychiatric Services, March 2014 Vol. 65 No. 3
7. *Community Context of Sober Living Houses*, Douglas L. Polcin, Ed.D., et al., NIH Public Access Author Manuscript, December 1, 2012 (published in final edited form as *Addict Res Theory*. 2012 December 1; 20(6): 480-491. doi: 0.3109/16066359.2012.665967)
8. Draft Resolution Upholding the Denial of the Reasonable Accommodation Request and PA 16-44
9. Draft Resolution Upholding the Denial of the Reasonable Accommodation Request and Approval of PA 1-41

Distribution: Director of Economic & Development Services/Consultant
Interim Assistant Director, Planning
Interim Assistant Director, Community Improvement

Senior Deputy City Attorney
Public Services Director
City Engineer
Transportation Services Director
Fire Protection Analyst
File (2)

Applicant c/o:
Melissa Goodmon
2801 Bristol Street, Suite 110
Costa Mesa, CA 92626

ATTACHMENT 1

City of Costa Mesa

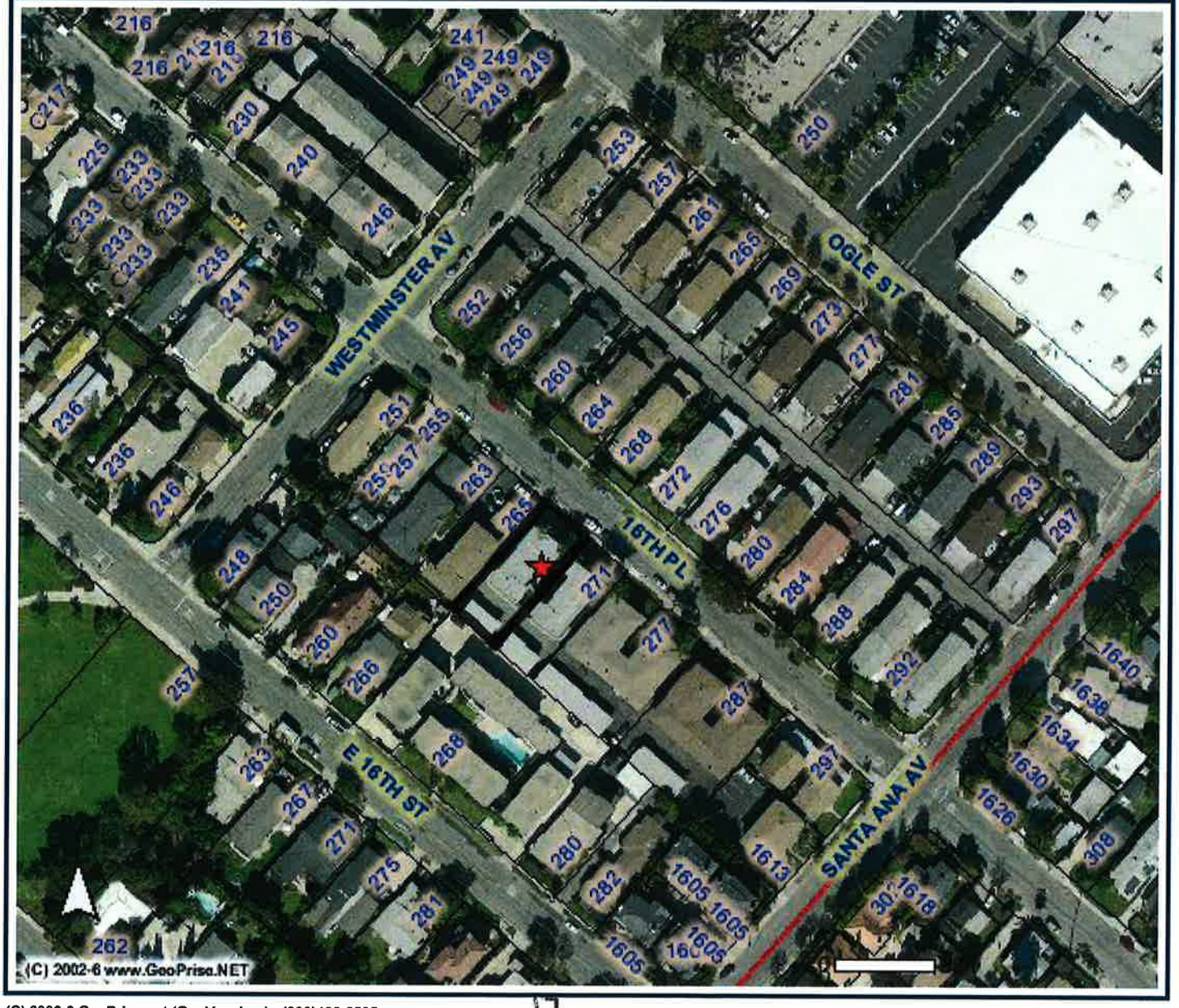
CITY OF COSTA MESA - [Created: 11/2/2016 3:01:37 PM] [Scale: 183.64]

Overview Map

Legend

- Address Medium
- Address Points
- Freeway
- Roads
- Collector (cont)
- Freeway
- Major
- Newport BLVD (cont)
- Primary
- SECONDARY
- Hydrology Channels

Map Display



(C) 2002-6 GeoPrise.net (GeoVec, Inc.) - (866)422-2505

City of Costa Mesa

CITY OF COSTA MESA - [Created: 11/2/2016 2:57:11 PM] [Scale: 183.65] [Page: 8.5 x 11 / Portrait]

Overview Map

Legend

Address Medium

Address Points

Freeway

Roads

Collector (cont)

Freeway

Major

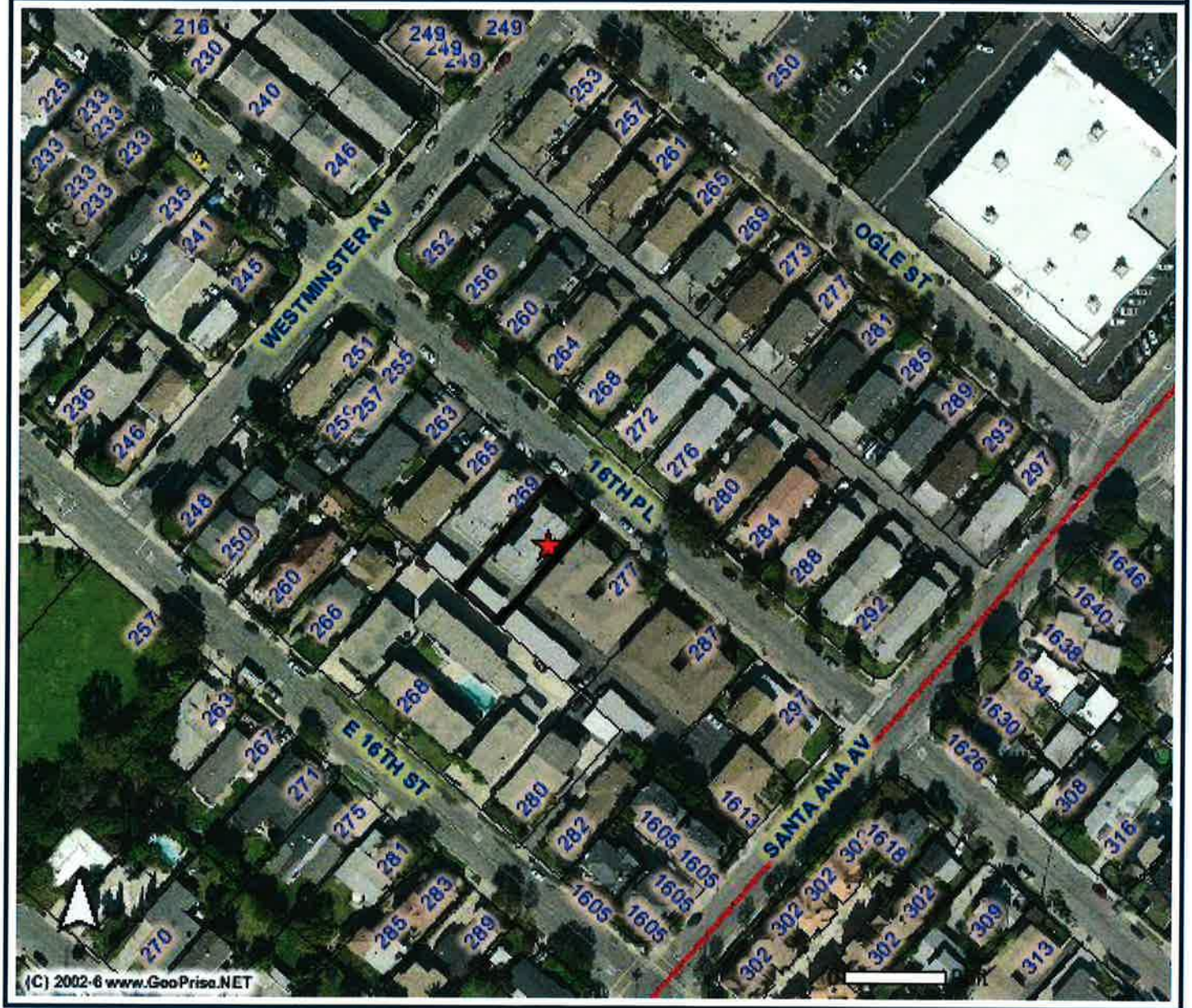
Newport BLVD (cont)

Primary

SECONDARY

Hydrology Channels

Map Display



City of Costa Mesa

CITY OF COSTA MESA - [Created: 11/2/2016 3:00:25 PM] [Scale: 183.65] [Page: 8.5 x 11 / Portrait]

Overview Map

Legend

Address Medium

Address Points

Freeway

Roads

Collector

Freeway

Major (cont)

Newport BLVD

Primary

SECONDARY

Hydrology Channels

Street Names

Street Centerlines

Parcel Lines

Map Display

City of Costa Mesa

CITY OF COSTA MESA - [Created: 11/2/2016 2:58:40 PM] [Scale: 183.64] [Page: 8.5 x 11 / Portrait]

Overview Map

Legend

Address Medium

Address Points

Freeway

Roads

Collector

Freeway

Major (cont)

Newport BLVD

Primary

SECONDARY

Hydrology Channels

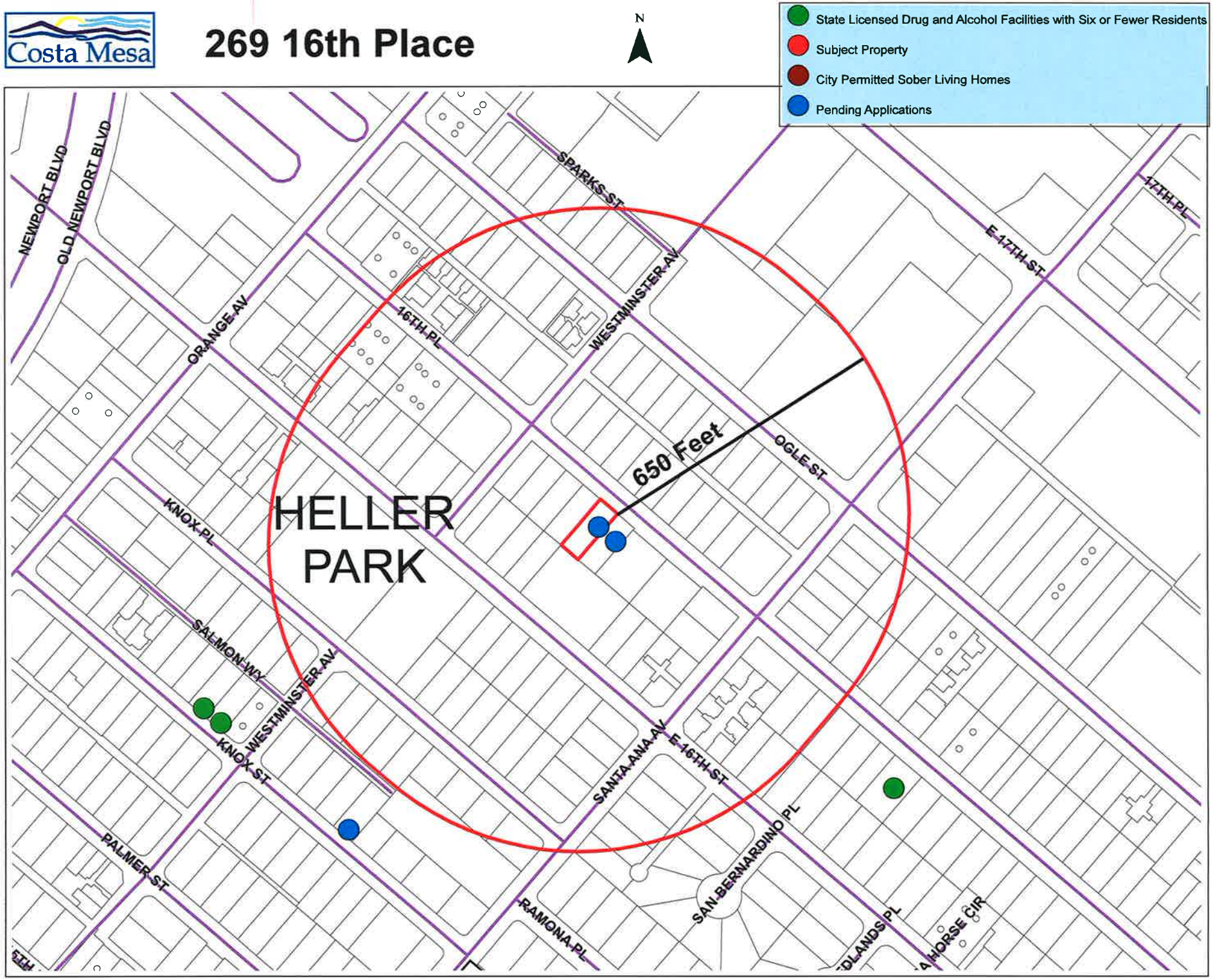
Street Names

Street Centerlines

Parcel Lines

Map Display

269 16th Place



271 16th Place

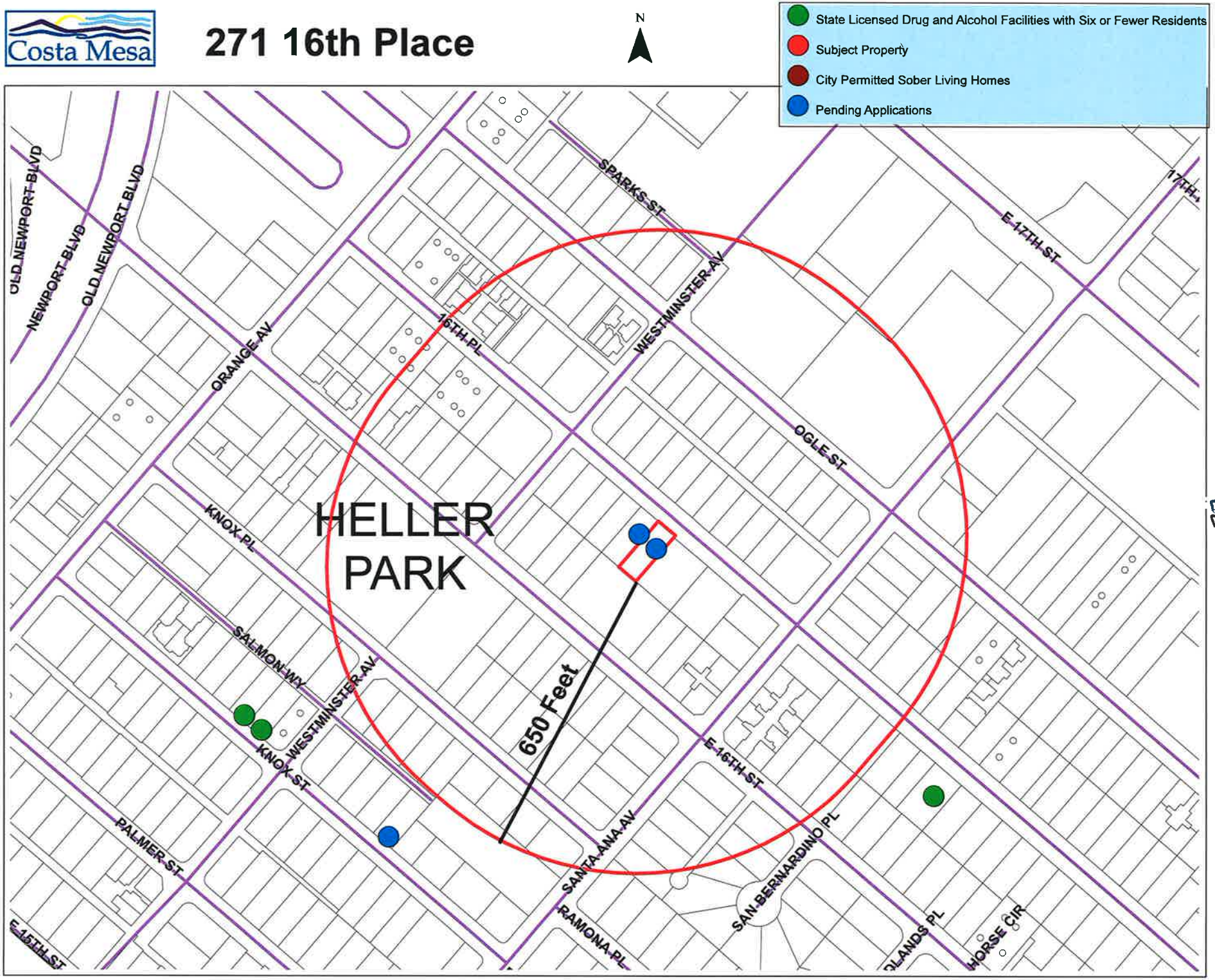


Exhibit C -269 and 271 16th Place

Part 10 Reasonable Accommodations

1.**Please explain which zoning code provisions, regulations, policies or conditions from which the accommodation is being requested.**

RESPONSE:
Reasonable Accommodation is requested from Ordinance No. 15-11, Section 13-322-3.b – "The group home or sober living home is at least 650 feet from any other property, as defined in Section 13-321, that contains a group home, sober living home or state licensed drug and alcohol treatment facility, as measured from the property line"

The properties at 269 and 271 16th Place are adjacent to one another and therefore are technically within 650 feet of each other.

While the Ordinance does provide for the 650' separation, it would be difficult to relocate the existing sober living residences at 269 and 271 16th Place because it is an ideal property with the two adjacent buildings and central common area that provides a safe and secure place for women working to keep sobriety. This specific property provides two structures that maintains a residential appearance with landscaping and curb appeal for residents of surrounding properties, keeps, smoking and laundry areas interior to the site and has sufficient on-site parking for any personnel or visitors so as not to impact any surrounding residents with second hand smoke, noise or on-street parking. The location is also beneficial to the sober living residents by providing an attractive and safe environment that is near the counseling that is required to support sobriety as well as offering pedestrian opportunities as the women embrace sobriety to find employment nearby.

2. **Please explain the basis for the claim for which the individuals are considered disabled under state or federal law and why the accommodation is necessary to provide equal opportunity for housing and to make the specific housing available to individuals.**

RESPONSE:
Under the Fair Housing Act, it is a discriminatory practice to refuse to make "a reasonable accommodation in rules, policies, practices, or services when such accommodation may be necessary to afford a handicapped person equal opportunity to use and enjoy a dwelling." Under the FHA,
a handicap is defined as a physical or mental impairment which substantially limits one or more major life activities of a person.

Persons with drug and alcohol addictions are considered disabled under federal and state law and are entitled to normal residential opportunities while seeking treatment.

Casa Capri Recovery has operated a sober living residence for women at the 269 and 271 16th Place locations for over 4 years. Per the property owner and Casa Capri Recovery there has been no history of citations or complaints from the City of Costa Mesa or the Community.

3. **Please identify any other information that the director reasonably determines is necessary for evaluating the request for reasonable accommodation.**

RESPONSE:
Casa Capri Recovery has maintained sober living residences for women at 269 and 271 16th Place for four years. In the four years that the sober living home has been operated there is no history of warnings, citations or complaints from the City of Costa Mesa or surrounding residents of the property. The property is well maintained and an attractive presence in the neighborhood.

Given the House Rules this sober living facility is a good neighbor. Smoking is only permitted in an area behind the two buildings and surrounded by a fence so it is not visible from surrounding residences in order to limit smoke being intrusive to neighbors. Residents are not allowed to have cars but there are 4 spaces on site so that office staff or any visitors have sufficient on-site parking and on-street parking is not needed. Residents are shuttled off site via Casa Capri Recovery vans or cars. No visitors are permitted after 10:00pm and a house manager is on site at all times when residents are on site. This facility is located on a major arterial and is located in a mixed commercial and multi-family neighborhood.

The advantage of these properties is that it provides a sober living environment with house rules for women with drug and alcohol dependencies. The properties are located in an area of Costa Mesa that is within walking distance of commercial areas of the city so that residents can find employment near there sober living residence. Casa Capri Recovery's plan is to have most of the residents on the property for about a 90 day period so that they can live in a sober environment with support.

Jeremy Broderick, an owner of Casa Capri Recovery has operated within the City of Costa Mesa for six years and has served on both the Preserve Our Neighborhood and Improve Our Neighborhood Task Forces at the invitation of past Mayor Jim Righeimer. Casa Capri Recovery provides an important service needed in the community to help women with drug and alcohol dependency and it has a successful record of client treatment with less than a 10% recurrence rate.

4. **Please provide documentation that the applicant is a) an individual with a disability; 2) applying on behalf of one or more individuals with a disability; or c) a developer or provider of housing for one or more individuals with a disability.**

RESPONSE:
As previously stated, Casa Capri Recovery is a provider of housing for persons with disability. It provides treatment for drug and alcohol dependency to women and in addition to the counseling and support provides a sober living residences at 269 and 271 16th Place that is a safe, pleasant and supervised environment to assist in the recovery process.

5. **Please provide the specific exception or modification to the Zoning Code provision, policy or practices request by the applicant.**

RESPONSE:
Casa Capri Recovery is requesting that the 650 foot requirement from other sober living facilities be waived on the grounds that the sober living residences have been operating at 269 and 271 16th Place in Costa Mesa for the last four years with no history of warnings or citations. The residence is primarily located around other multi-family units and is within walking distance of commercial areas to allow for employment for residents. The facility has an excellent record of resident's attaining recovery.

6. **Please provide documentation that the specific exception or modification requested by the applicant is necessary to provide one or more individuals with a disability an equal opportunity to use and enjoy the residence.**

RESPONSE:
As noted, this sober living residence has been in operation at this location for four years and has served as a safe and secure residence for women working to overcome drug and alcohol dependency as a part of the Casa Capri Recovery process. It is necessary to have a sober living residence component to complement the day to day counseling and treatment provided by Casa Capri Recovery. The location of the residence near commercial areas of the City of Costa Mesa allows residents to live in a secure, residential environment while also being near potential employment opportunities as well as needs such as grocery stores, movie theatres and other forms of safe entertainment.

7. **Please provide any other information that the Hearing Officer reasonably concludes is necessary to determine whether the findings required by Section (e)**
can be made, so long as any request for information regarding the disability of the individuals benefited complies with fair housing law protections and the privacy rights of individuals affected.

Windward Way Recovery's operation of a sober living home is compatible and will not be a detriment to the surrounding properties.

RESPONSE:
See response number 3.

CITY OF COSTA MESA

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

June 10, 2016

SENT VIA FEDEX EXPRESS & ELECTRONIC MAIL

Melissa Goodmon
Casa Capri Recovery
2801 Bristol Street, Suite 110
Costa Mesa, CA 92626

EMAIL: melissa@casacaprirecovery.com

Re: Reasonable Accommodation Request for Properties Located at 269 and 271 16th Place

Dear Ms. Goodmon,

This letter will serve to respond to the application that you submitted on April 14, 2016 requesting reasonable accommodation for land use requirements applicable to the operation of state licensed drug and alcohol facilities at 269 and 271 16th Place. You are applying for reasonable accommodation from the provision in the City of Costa Mesa Municipal Code ("CMMC") section 13-323 (b) that stipulates that the group home, residential care facility or state licensed drug and alcohol facility must be at least six hundred and fifty feet from any property, as defined in Section 13-321, that contains a group home, sober living home or state licensed drug and alcohol treatment facility, as measured from the property line.

The CMMC section 13-200.62 (f) sets forth the required findings to be used in the determination to approve, conditionally approve, or deny a request for reasonable accommodation shall be based on the following findings. ***Compliance with all of the findings is required for approval.*** Based on the facts set forth in your request and in your application for a conditional use permit, I am unable to make all of the necessary findings to support this accommodation, as described below.

(1) The requested accommodation is requested by or on the behalf of one (1) or more individuals with a disability protected under the fair housing laws.

I accept for purposes of your request that you are making this request on behalf of individuals who are considered disabled under state and federal law.

(2) The requested accommodation is necessary to provide one (1) or more individuals with a disability an equal opportunity to use and enjoy a dwelling.

As discussed more fully below, I am unable to make this finding.

Community Improvement Division (714) 754-5245
FAX (714) 754-4856 • TDD (714) 754-5244 • www.ci.costa-mesa.ca.us

(3) The requested accommodation will not impose an undue financial or administrative burden on the city, as "undue financial or administrative burden" is defined in fair housing laws and interpretive case law.

While no facts were presented regarding this factor, I do not find that this request would pose an undue financial or administrative burden on the city.

(4) The requested accommodation is consistent with the whether or not the residents would constitute a single housekeeping unit.

No facts were presented in your application regarding this factor. Accordingly, I am unable to make this finding.

(5) The requested accommodation will not, under the specific facts of the case, result in a direct threat to the health or safety of other individuals or substantial physical damage to the property of others.

I have reviewed no facts that would indicate that the requested accommodation would result in a health and/or safety threat.

(6) Whether the requested accommodation is necessary to make facilities of a similar nature or operation economically viable in light of the particularities of the relevant market and market participants.

No evidence was presented in regarding this factor; accordingly, I am unable to make this finding.

(7) Whether the existing supply of facilities of a similar nature and operation in the community is sufficient to provide individuals with a disability an equal opportunity to live in a residential setting.

No evidence was presented that the existing supply of similar facilities in Costa Mesa is insufficient to provide individuals with a disability an equal opportunity to live in a residential setting. Accordingly, and as discussed below, I am unable to make this finding.

(8) The requested accommodation will not result in a fundamental alteration in the nature of the city's zoning program.

As discussed in greater detail below, I am unable to make this finding.

The City's land use requirements pertaining to sober living homes and residential care facilities are intended to preserve the residential character of neighborhoods, to provide housing opportunities to the disabled, and to the extent possible, free the disabled from institutional style living. The 650 foot separation requirement between group homes and residential care facilities to other group homes or state licensed drug and alcohol facilities provides disabled persons with opportunities to live in normal residential settings and to use and enjoy a dwelling in a manner similar to the way a dwelling is enjoyed by the non-disabled.

Your request to waive the 650 foot separation requirement may allow CUPs to be granted to enable Casa Capri Recovery to continue to operate in compliance with the CMMC at the subject properties. While this action might allow one or more disabled persons to enjoy the use of one of these dwellings, I do not find that the request is necessary to allow one or more disabled persons to enjoy the use of a dwelling within the City. Further, no information was presented to indicate that one or more disabled persons who currently reside at the property would still be in residence as of the date the property must come into compliance with City

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ordinances regarding group homes pursuant to 12-324(a)(2), as discussed below. No facts were presented to support a finding that the existing supply of similar facilities in the community is insufficient to provide individuals with a disability an equal opportunity to live in a residential setting.

Similarly, no evidence was presented to indicate that there are no sites for such facilities elsewhere in the City that would comply with the separation requirement. Based on the most recent data compiled by staff, there are approximately 105 sober living homes and 12 of those facilities are female-only facilities. There are also approximately 64 state licensed drug and alcohol residential care facilities in the City and 20 of those facilities serve only females. The subject properties are located within 650 feet of each other.

The requested accommodation in these specific circumstances would result in a fundamental alteration of the Zoning program, as set forth in ordinance numbers 14-13 and 15-11, because it would increase, and/or contribute to the overconcentration of sober living facilities in this residential neighborhood. **Accordingly, the reasonable accommodation request is denied, because I did not receive sufficient evidence to make the findings required by Section 13-200.62(f).**

This determination can be appealed to the Planning Commission by filing an application for appeal with the City Clerk. Any appeal must be filed within seven (7) days of this date of denial, which is June 17, 2016 by 5:00 p.m., pursuant to Sections 2-305(2) and 2-307 of the Costa Mesa Municipal Code. A fee of $690.00 must accompany the application. In your request for an appeal, please summarize the reasons for the appeal. If the application for appeal is not submitted by the deadline, your time to appeal will have expired.

Please be aware that Section 12-324(a)(2) of the Costa Mesa Municipal Code requires group homes or residential care facilities serving more than six residents to have a conditional use permit approved by the City or cease operation by December 17, 2016.

If you have further questions, please do not hesitate to contact Katie Angel at (714) 754-5618.

Sincerely,

Gary Armstrong

Gary Armstrong, AICP
Economic and Development Services Director/Deputy CEO

cc: Tarquin Preziosi, Esq.
Fidel Gamboa, Acting Neighborhood Improvement Manager
Katie Angel, Management Analyst

Community Improvement Division (714) 754-5245
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ATTACHMENT 4

RECEIVED
CITY CLERK

16 JUN 13 PM 2:31

CITY OF COSTA MESA
BY BG

Costa Mesa

City of Costa Mesa

☐ Appeal of Commission Decision - **$1,220.00**
☒ Appeal of Zoning Administrator/Staff Decision - **$690.00**
(FEES MUST BE PAID IN FULL AT TIME OF FILING APPEAL)

APPLICATION FOR APPEAL OR REVIEW

Applicant Name* Melissa Goodmon
Address: 269 & 271 16th Place Costa Mesa CA 92627
Phone: 949-861-0576 **Representing:** Casa Capri, LLC

REQUEST FOR: ☒ **APPEAL** ☐ **REVIEW****

Decision of which appeal or review is requested: (give application number, if applicable, and the date of the decision, if known.)

* See attached

Decision by:

Reasons for requesting appeal or review:

Melissa Goodmon & Jeremy Broderick of Casa Capri disagree with the City of Costa Mesa's denial of our CUP application for 269 & 271 16th place!

Date: 6/13/16 Signature: Melissa R Goodmon

*If you are serving as the agent for another person, please identify the person you represent and provide proof of authorization.
**Review may be requested only by Commissions, Commission Members, City Council, or City Council Members.

For office use only – do not write below this line **REV 9-1-15**

SCHEDULED FOR THE CITY COUNCIL/COMMISSION MEETING OF:

ATTACHMENT 5

Assessing the Evidence Base Series

Recovery Housing: Assessing the Evidence

Sharon Reif, Ph.D.
Preethy George, Ph.D.
Lisa Braude, Ph.D.
Richard H. Dougherty, Ph.D.
Allen S. Daniels, Ed.D.
Sushmita Shoma Ghose, Ph.D.
Miriam E. Delphin-Rittmon, Ph.D.

Objective: **Recovery housing is a direct service with multiple components that provides supervised, short-term housing to individuals with substance use disorders or co-occurring mental and substance use disorders. It commonly is used after inpatient or residential treatment. This article describes recovery housing and assesses the evidence base for the service.** ***Methods:*** **Authors searched PubMed, PsycINFO, Applied Social Sciences Index and Abstracts, Sociological Abstracts, and Social Services Abstracts. They identified six individual articles from 1995 through 2012 that reported on randomized controlled trials or quasi-experimental studies; no reviews or meta-analyses were found. They chose from three levels of evidence (high, moderate, or low) based on benchmarks for the number of studies and quality of their methodology. They also described the evidence of service effectiveness.** ***Results:*** **The level of evidence for recovery housing was moderate. Studies consistently showed positive outcomes, but the results were tempered by research design limitations, such as lack of consistency in defining the program elements and outcome measures, small samples, and single-site evaluations, and by the limited number of studies. Results on the effectiveness of recovery housing suggested positive substance use outcomes and improvements in functioning, including employment and criminal activity.** ***Conclusions:*** **Recovery housing appears to be an important component in the continuum of care for some individuals. However, replication of study findings with greater specificity and in more settings is needed. (*Psychiatric Services* 65:295–300, 2014; doi: 10.1176/appi.ps.201300243)**

Access to stable and supportive housing is recognized in the addictions field as an important component of establishing and maintaining recovery from substance use disorders (1). Research suggests that maintaining recovery gains may be difficult for individuals who are not living in stable housing situations (2), and environmental cues may play a role in triggering relapse (3). There is a need to identify housing settings that promote recovery after the completion of residential treatment or during the receipt of outpatient treatment for substance use disorders. Recovery housing is one example of a type of service used in the field to address the needs of individuals with substance use disorders.

This article reports the results of a literature review that was undertaken as part of the Assessing the Evidence Base (AEB) Series (see box on next page). For purposes of the AEB Series, the Substance Abuse and Mental Health Services Administration (SAMHSA) has defined recovery housing as a direct service with multiple components that provides supervised, short-term housing to individuals with substance use disorders or co-occurring mental and substance use disorders. Recovery housing aims to increase an individual's stability, improve his or her functioning, and move the resident toward a life in the community by supporting abstinence and recovery. Table 1 contains a description of the components of this service.

Policy makers and other leaders in behavioral health care need information about the effectiveness of recovery housing and its value as a service within the continuum of care. The objectives of this review were to describe models of recovery housing for individuals with substance use disorders or co-occurring substance use and mental disorders, rate the level of research evidence (that is, methodological quality),

Dr. Reif is with the Institute for Behavioral Health, Heller School for Social Policy and Management, Brandeis University, Waltham, Massachusetts. Dr. George, Dr. Daniels, and Dr. Ghose are with Westat, Rockville, Maryland. Dr. Braude and Dr. Dougherty are with DMA Health Strategies, Lexington, Massachusetts. Dr. Delphin-Rittmon is with the Office of Policy, Planning, and Innovation, Substance Abuse and Mental Health Services Administration (SAMHSA), Rockville, Maryland. Send correspondence to Dr. George at preethygeorge@westat.com. *This literature review is part of a series that will be published in* Psychiatric Services *over the next several months. The reviews were commissioned by SAMHSA through a contract with Truven Health Analytics. The reviews were conducted by experts in each topic area, who wrote the reviews along with authors from Truven Health Analytics, Westat, DMA Health Strategies, and SAMHSA. Each article in the series was peer reviewed by a special panel of* Psychiatric Services *reviewers.*

About the AEB Series

The Assessing the Evidence Base (AEB) Series presents literature reviews for 13 commonly used, recovery-focused mental health and substance use services. Authors evaluated research articles and reviews specific to each service that were published from 1995 through 2012 or 2013. Each AEB Series article presents ratings of the strength of the evidence for the service, descriptions of service effectiveness, and recommendations for future implementation and research. The target audience includes state mental health and substance use program directors and their senior staff, Medicaid staff, other purchasers of health care services (for example, managed care organizations and commercial insurance), leaders in community health organizations, providers, consumers and family members, and others interested in the empirical evidence base for these services. The research was sponsored by the Substance Abuse and Mental Health Services Administration to help inform decisions about which services should be covered in public and commercially funded plans. Details about the research methodology and bases for the conclusions are included in the introduction to the AEB Series (10).

and describe the effectiveness of the service. To be useful for a broad audience, this article presents an overall assessment of research quality and focuses on key findings of the review.

Recovery housing and the continuum of care

Recovery housing for individuals with substance use disorders generally consists of alcohol- and drug-free residences, such as sober living houses (4,5). Recovery housing is often provided to individuals after they have been in an inpatient or residential treatment program or during their first few months of recovery or sobriety. Recovery housing is not a formal treatment; rather, it is a service that supports recovery during or after treatment. Thus there is guidance about what constitutes recovery housing, but there are no clear standards.

Sober living houses usually are peer-run residences where small- to medium-sized groups of individuals in recovery live in single or shared bedrooms with common living areas. Individuals are expected to work, contribute rent, and participate in the responsibilities of running the household. Abstinence is an expectation, and individuals who relapse may be asked to leave the house because their behavior threatens the recovery of others. Sober living houses generally do not incorporate a structured recovery program, although residents often are required or strongly encouraged to attend a 12-step mutual-help group (6), and they may choose to participate in formal treatment or aftercare. Less common are sober living houses that are affiliated with outpatient treatment facilities and require individuals to attend outpatient treatment (7).

Oxford House is a specific type of recovery home in which members evaluate and vote on candidates who may become residents to help ensure that they will fit in with the current housing members and meet expectations for the residence (4). Oxford Houses have a national network. They do not require individuals to be engaged actively in formal treatment, but residents may choose to participate in self-help groups or outpatient treatment.

The models of recovery housing described above generally are considered part of the continuum of care that spans from outreach through formal treatment and extends into informal treatment, maintenance, and aftercare needs. In this approach, recovery housing is an essential part of preparing for or transitioning to an independent life in the community. Recovery housing frequently facilitates access to support services and treatment utilization, such as case management, therapeutic recreational activities, and peer coaching or support. Often working in partnership with treatment or recovery programs, recovery housing options may provide transportation, in-house counseling, or mentoring.

Recovery housing is often used by individuals who do not or no longer require higher levels of care, such as hospitalization or long-term residential treatment. Individuals who utilize recovery housing may need assistance with activities of daily living (such as managing finances) or reminders and support to attend treatment, take medications, or abstain from alcohol and drug use. For these individuals, recovery housing may be a step on the way to independent living. It should be noted that there is concern that individuals who utilize abstinence-contingent housing may be at risk for housing instability if relapse occurs during the process of recovery.

In summary, recovery housing is a type of service used for individuals with substance use disorders who are stepping down from inpatient or residential care or who are not ready or able to live independently. This literature

Table 1

Description of recovery housing

Feature	Description
Service definition	Recovery housing is a direct service with multiple components that provides individuals with mental and substance use disorders with supervised, short-term housing. Services may include case management, therapeutic recreational activities, and peer coaching or support.
Service goals	Increase the individual's stability; improve the person's functioning; help the individual move toward a life that is integrated into the community
Populations	Individuals with substance use disorders or those with co-occurring mental and substance use disorders
Settings of service delivery	Settings may vary and include sober living houses.

review examined the available research on recovery housing to determine its relative value as a treatment approach.

Methods

Search strategy

To provide a summary of the evidence and effectiveness for recovery housing services, we conducted a survey of major databases: PubMed (U.S. National Library of Medicine and National Institutes of Health), PsycINFO (American Psychological Association), Applied Social Sciences Index and Abstracts, Sociological Abstracts, and Social Services Abstracts. We searched for and reviewed meta-analyses, research reviews, and individual studies from 1995 through 2012. We also examined bibliographies of reviewed studies. We used combinations of the following search terms: recovery housing, sober housing, halfway house, group home, and substance abuse.

Inclusion and exclusion criteria

This review included the following types of articles: randomized controlled trials (RCTs), quasi-experimental studies, single-group repeated-measures design studies, and review articles such as meta-analyses and systematic reviews; U.S. and international studies in English; and studies that focused on recovery housing for individuals with substance use disorders or co-occurring mental and substance use disorders, including abstinence-contingent recovery housing.

Excluded were studies of residential treatment, supportive housing, supported housing, and permanent supportive housing, because these topics are covered in the review of permanent supportive housing in this series (8). Housing First models focus on permanent housing rather than on short-term, recovery-focused housing; they are also discussed in the article on permanent supportive housing and excluded here. Other housing models for individuals with substance use disorders that do not require total abstinence as a requirement for residence (for example, "wet houses" or "damp houses") were excluded from this review because they are associated with Housing First models. Residential treatment and therapeutic communities are covered in a review of research on residential treatment for substance use disorders in this series (9). Also excluded were articles about shelters or other housing-only options without a recovery focus. We excluded studies that used only a pre-post bivariate analysis or a case study approach without comparison groups. Also excluded were studies that solely analyzed costs associated with the service, because our focus was on outcomes associated with clinical effectiveness.

Strength of the evidence

The methodology used to rate the strength of the evidence is described in detail in the introduction to this series (10). We independently examined the research designs of the studies of recovery housing identified during the literature search and chose from three levels of evidence (high, moderate, or low) to indicate the overall research quality of the collection of studies. Ratings were based on predefined benchmarks that considered the number of studies and their methodological quality. In rare instances when ratings were dissimilar, a consensus opinion was reached.

In general, high ratings indicate confidence in the reported outcomes and are based on three or more RCTs with adequate designs or two RCTs plus two quasi-experimental studies with adequate designs. Moderate ratings indicate that there is some adequate research to judge the service, although it is possible that future research could influence reported results. Moderate ratings are based on the following three options: two or more quasi-experimental studies with adequate design; one quasi-experimental study plus one RCT with adequate design; or at least two RCTs with some methodological weaknesses or at least three quasi-experimental studies with some methodological weaknesses. Low ratings indicate that research for this service is not adequate to draw evidence-based conclusions. Low ratings indicate that studies have nonexperimental designs, there are no RCTs, or there is no more than one adequately designed quasi-experimental study.

We accounted for other design factors that could increase or decrease the evidence rating, such as how the service, populations, and interventions were defined; use of statistical methods to account for baseline differences between experimental and comparison groups; identification of moderating or confounding variables with appropriate statistical controls; examination of attrition and follow-up; use of psychometrically sound measures; and indications of potential research bias.

Effectiveness of the service

We described the effectiveness of the service—that is, how well the outcomes of the studies met the goals of recovery housing. We compiled the findings for separate outcome measures and study populations, summarized the results, and noted differences across investigations. We considered the quality of the research design in their conclusions about the strength of the evidence and the effectiveness of the service.

Results

Level of evidence

A search of the literature revealed very limited research in this area. No meta-analyses or research reviews on recovery housing were found. We identified five articles describing RCTs that compared some version of recovery housing to some control condition (4, 11–14) and one quasi-experimental study with a within-group, repeated-measures design (15). However, four of the five articles describing RCTs reported on the same base study; therefore, only three distinct studies on this topic met the inclusion criteria. All studies were conducted in the United States. Features of the studies and their findings are summarized in Table 2.

The level of evidence for recovery housing was moderate. There were more than two RCTs of specific types of recovery housing models, but they had some methodological limitations. Methodological flaws, such as missing or inconsistent definition of program elements and small sample sizes, were prevalent and influenced the rating. Because of the variability in how recovery housing was defined, fidelity rarely was discussed. The outcome measures varied across research studies and included measures of substance use, quality of life, and other outcomes. This

Table 2

Studies of recovery housing included in the review

Study	Study design and population	Outcomes measured	Summary of findings	Comments
Randomized controlled trials				
Jason et al., 2006[a] (4)	Oxford House versus usual aftercare; no exclusions noted	Substance use, criminal activity, employment	At 24 months, Oxford House group had significantly lower substance use, higher monthly income, and lower incarceration rates.	Brief report with little detail on methods or participant characteristics
Jason et al., 2007[a] (12)	Oxford House versus usual aftercare; no exclusions noted	Substance use, criminal charges, employment	Oxford House group had significantly more positive outcomes for each measure over time (up to 24 months) compared with usual care. Length of stay and age interactions with outcomes were noted.	Statistical controls for demographic and baseline characteristics (no demographic differences reported by group); no information reported on response rates at follow-up
Groh et al., 2009[a] (11)	Oxford House versus usual aftercare; no exclusions noted	Substance use, criminal activity, employment	Abstinence significantly increased for Oxford House group versus usual care for those who had high 12-step involvement. For those with low 12-step involvement, abstinence rates were similar across groups.	No baseline sociodemographic differences; analyses did not control for covariates
Jason et al., 2011[a] (13)	Oxford House versus usual aftercare; no exclusions noted	Substance use, employment, self-regulation	Individuals with posttraumatic stress disorder (PTSD) in usual aftercare had worse self-regulation at 2 years than those without PTSD in either group. For those with no PTSD, employment rates were higher in Oxford House group than in usual aftercare. For those with and without PTSD, relapse rates were higher in usual aftercare than in Oxford House.	Small sample of participants with PTSD; required employment of Oxford House residents led to somewhat biased outcome; only self-regulation analyses included covariates
Tuten et al., 2012 (14)	Three groups: recovery house alone, recovery house plus reinforcement-based treatment, and usual care; participants, 18–60 years old, were opioid dependent and had completed medication-assisted detoxification; study excluded individuals receiving opioid agonist medication, those experiencing acute medical or psychological illness, and pregnant women	Abstinence (opioid and cocaine), consistent abstinence	Abstinence decreased over time for participants in two recovery house conditions and increased over time for those in usual care condition, with significant differences between recovery house groups and usual care at 6 months. Length of stay mediated abstinence.	Inclusion and exclusion criteria limited generalizability; abstinence measured only for opioids and cocaine; urine samples collected to complement self-report
Quasi-experimental study				
Polcin et al., 2010 (15)[b]	Sober living houses associated with outpatient treatment versus freestanding sober living houses; no exclusions noted	Substance use, Addiction Severity Index, psychiatric symptoms	Significant decline in "peak density" of drug use was noted over 6 months in both groups. Low severity of alcohol and drug use at baseline was either maintained or further improved. Employment significantly improved in both groups. 12-month outcomes were similar to 6-month outcomes.	Self-selection into housing and characteristics of clients in two groups differed; some evidence of recovery success required before entry into sober living house; thus some floor effect for outcomes

[a] These articles reported on the same overall study.
[b] Also reported in Polcin et al., 2010 (6)

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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 posttraumatic stress disorder who were randomly assigned to an Oxford House or to treatment as usual, individuals in the treatment-as-usual condition had lower levels of self-regulation compared with those in the Oxford House condition (13). Replication of this study is warranted because it used small samples. Oxford House residence combined with involvement in a 12-step program had a positive effect on self-report of abstinence over a 24-month period (11).

Tuten and colleagues (14) examined drug abstinence outcomes of individuals who were randomly assigned after opioid detoxification to a recovery home with a reinforcement-based outpatient treatment condition, a recovery home only condition, or usual care (that is, aftercare referrals and community-based resources). They found that the groups had significantly 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.

Evidence for the effectiveness of recovery housing: moderate

Areas of improvement suggested by overall positive results:
- Drug and alcohol use
- Employment
- Psychiatric symptoms

Discussion and conclusions

This review found a moderate level of evidence for the effectiveness of recovery housing (see box on this page). Findings in the literature suggest that recovery housing can have positive effects on many aspects of recovery and that this service has an important role to play in supporting individuals with substance use disorders. This recommendation is tempered by the fact that the six articles identified through the literature review represented only three distinct studies. Further, these studies had methodological limitations, including attrition, nonequivalent groups, small samples, single-site evaluations, and lack of statistical controls.

With limited literature, it is difficult to draw conclusions across studies; however, these studies highlight areas of recovery housing that have policy and practice implications. It should be noted that with an abstinence requirement for entering housing, there is often a floor effect. That is, when participants have very low substance use at baseline, it is unlikely that further improvements over time will be found in substance use measures—a traditional outcome in studies of substance use disorders. Rather, outcome measures are likely to reflect maintenance of abstinence or limited substance use over time. Changes in employment and criminal activity instead may be the key outcomes.

Two studies indicated that outcomes were better with longer stays in the recovery house (12,14). In addition, several studies indicated that success in the recovery house may also depend on other client characteristics, such as involvement in a 12-step program, age, or a diagnosis of posttraumatic stress disorder (11–13). These differential effects should be examined further, and it is likely that other variations in outcomes may be identified in additional studies.

The primary recommendation for future research is for methodologically rigorous randomized or nonrandomized controlled trials that are conducted with larger samples and across multiple sites. Further, several of the studies (for example, studies of Oxford House) were conducted by researchers who were collaborators. In most cases, the conditions were not blind to the interviewers or the evaluators. Because these issues may lend themselves to bias, external evaluations would also be an important next step. The research in this area would benefit from more consistent approaches that would facilitate better cross-comparisons and meta-analyses.

We identified other topics for future research, in addition to the need for greater methodological rigor. The effects of recovery housing on long-term recovery in multiple domains of functioning should be examined. For

example, the literature should focus on improvements in psychiatric symptoms and substance use and severity that extend beyond housing and quality-of-life outcomes. Further studies of approaches to recovery housing for individuals with substance use disorders should be undertaken to determine whether models other than the Oxford House approach are valuable. Also, evaluation of which organizational and structural aspects of sober living houses are effective would help with program development and clarity in defining the recovery housing model.

Finally, it is important to assess recovery housing for specific subpopulations (for example, by diagnosis, age, sex, and immigrant status). Most studies described participants' demographic characteristics, and some studies controlled for these characteristics in their analyses. However, few studies specifically analyzed race or ethnicity through interaction terms, stratification, or other approaches. As with any consideration of individual lives and successful recovery, it is essential to consider subgroup differences. This may be important particularly when we consider how people live, interact, or incorporate their cultural beliefs and backgrounds—key concerns when evaluating the role of housing. These characteristics may affect willingness to live independently or in group settings, for example, and they may also affect the roles of staff or residents in managing aspects of recovery. Preliminary research is beginning to examine approaches to adapt features of recovery homes to better meet the cultural needs of specific racial-ethnic populations (16). However, more research is required to explore the effectiveness of these adaptations. We encourage future researchers to evaluate whether certain approaches are as successful for a variety of subgroups as they are for the broader population.

Recovery housing has value as part of the full spectrum of options that support recovery from substance use disorders. However, a key issue for recovery housing as a service is funding. In most cases, recovery housing does not include formal therapeutic treatment; therefore, it is not reimbursable by public or private insurance. Rather, recovery houses are often supported by charitable donations and contributions from the residents. Policy makers, including payers (for example, directors of state mental health and substance use treatment systems, administrators of managed care companies, and county behavioral health administrators), must consider alternative mechanisms that would support recovery housing as they determine how best to incorporate this approach into a full continuum of care. Consumers will benefit from increased access to sober living opportunities as a long-term step toward a life in recovery in the community. Future rigorous research on this service will improve our ability to target the consumers who would receive the most benefit.

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ATTACHMENT 6

Assessing the Evidence Base Series

Residential Treatment for Individuals With Substance Use Disorders: Assessing the Evidence

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Objective: **Residential treatment is a commonly used direct intervention for individuals with substance use or co-occurring mental and substance use disorders who need structured care. Treatment occurs in nonhospital, licensed residential facilities. Models vary, but all provide safe housing and medical care in a 24-hour recovery environment. This article describes residential treatment and assesses the evidence base for this service.** ***Methods:*** **Authors evaluated research reviews and individual studies from 1995 through 2012. They searched major databases: PubMed, PsycINFO, Applied Social Sciences Index and Abstracts, Sociological Abstracts, and Social Services Abstracts. They chose from three levels of evidence (high, moderate, and low) and described the evidence of service effectiveness.** ***Results:*** **On the basis of eight reviews and 21 individual studies not included in prior reviews, the level of evidence for residential treatment for substance use disorders was rated as moderate. A number of randomized controlled trials were identified, but various methodological weaknesses in study designs—primarily the appropriateness of the samples and equivalence of comparison groups—decreased the level of evidence. Results for the effectiveness of residential treatment compared with other types of treatment for substance use disorders were mixed. Findings suggested either an improvement or no difference in treatment outcomes.** ***Conclusions:*** **Residential treatment for substance use disorders shows value and merits ongoing consideration by policy makers for inclusion as a covered benefit in public and commercially funded plans. However, research with greater specificity and consistency is needed. (*Psychiatric Services* 65:301–312, 2014; doi: 10.1176/appi.ps.201300242)**

People with substance use disorders have a wide variety of needs across the range of symptom severity. To address these needs, a continuum of care that includes intensive treatment services is in place. Recognition is growing that safe and stable living environments are important in the recovery process for individuals with substance use disorders who need structured care. Residential treatment is a structured, 24-hour level of care that enables a focus on intensive recovery activities. It aims to help people with substance use disorders and a high level of psychosocial needs become stable in their recovery before engagement in outpatient settings and before return to an unsupervised environment, which may otherwise be detrimental to their recovery process. This article describes residential treatment and assesses the evidence base for this service.

This article reports the results of a literature review that was undertaken as part of the Assessing the Evidence Base Series (see box on next page). For purposes of this series, the Substance Abuse and Mental Health Services Administration (SAMHSA) has described residential treatment for substance use disorders as a direct service with multiple components that is delivered in a licensed facility used to evaluate, diagnose, and treat the symptoms or disabilities associated with an adult's substance use disorder. SAMHSA

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About the AEB Series

The Assessing the Evidence Base (AEB) Series presents literature reviews for 13 commonly used, recovery-focused mental health and substance use services. Authors evaluated research articles and reviews specific to each service that were published from 1995 through 2012 or 2013. Each AEB Series article presents ratings of the strength of the evidence for the service, descriptions of service effectiveness, and recommendations for future implementation and research. The target audience includes state mental health and substance use program directors and their senior staff, Medicaid staff, other purchasers of health care services (for example, managed care organizations and commercial insurance), leaders in community health organizations, providers, consumers and family members, and others interested in the empirical evidence base for these services. The research was sponsored by the Substance Abuse and Mental Health Services Administration to help inform decisions about which services should be covered in public and commercially funded plans. Details about the research methodology and bases for the conclusions are included in the introduction to the AEB Series (8).

has defined three levels of clinically managed residential services. All provide 24-hour care, but they offer treatment with varying intensity and focus depending on the resident's needs. Table 1 presents a description of the components of this service.

Examination of the effectiveness of residential treatment for people with substance use disorders and for various subgroups is challenged by lack of a clear definition of service methods, treatment duration, and treatment standards. The objectives of this review were to describe models and components of residential treatment for substance use disorders, rate and discuss the level of evidence (that is, methodological quality) of existing studies, and describe the effectiveness of the service on the basis of the research literature. We focus on treatment for substance use disorders, although individuals in treatment may also have co-occurring mental disorders. Effectiveness studies primarily compared residential treatment for substance use disorders to other levels of care (for example, intensive outpatient treatment). Outcomes measured included drug and alcohol use, psychiatric symptoms, and other measures of psychosocial functioning.

Description of residential treatment

Residential treatment for substance use disorders is a setting in which services occur, rather than a discrete treatment intervention. A variety of therapeutic interventions may be implemented across different residential treatment settings; however, a common defining characteristic of residential treatment is that it provides housing for individuals who are in need of rehabilitation services.

Residential treatment occurs in nonhospital or freestanding residential facilities. Treatment for substance use disorders typically takes place in facilities that are licensed by each state's Single State Agency for Substance Abuse Services. Residential treatment is part of the primary rehabilitation phase of treatment and may be preceded by detoxification, if warranted. Residential treatment should be followed by less intensive treatment and aftercare services within a continuum of care. A separate article in this series addresses intensive outpatient programs for substance use disorders (1).

Residential treatment for substance use disorders is used for a wide range of populations with a range of sociodemographic characteristics. For example, residential treatment is appropriate for individuals who have co-occurring mental and substance use disorders because of the challenges associated with having multiple disorders and their common need for intensive treatment in a safe environment. Residential treatment is also appropriate for individuals who are homeless, particularly because of the environmental challenges of achieving and maintaining sobriety or other aspects of recovery without stable housing.

The American Society of Addiction Medicine (ASAM) has spearheaded the complex task of developing specifications for addiction treatment at various levels of care and criteria to identify which individuals are most appropriate for which types of services (2,3). The ASAM patient placement criteria (ASAM PPC-2R) (2) consist of six dimensions: intoxication/withdrawal, medical conditions, mental health conditions, stage of change/motivation, recovery/relapse risks, and the recovery environment. Assessments on these dimensions are often used to place people into the level of care that matches their particular needs and provides a framework for treatment planning.

The ASAM PPC-2R (2) states that "the defining characteristic of all [residential] Level III programs is that they serve individuals who need safe and stable living environments in order to develop their recovery skills." Individuals are considered appropriate for residential treatment, in particular, if they demonstrate a need for medical care, safe and stable housing, or a structured 24-hour recovery environment. Residential treatment services include a live-in setting that is housed in or affiliated with a permanent facility; organization and staffing by addiction and mental health personnel; a planned regimen of care with defined policies, procedures, and clinical protocols; and mutual- and self-help group meetings. The ASAM criteria informed the service-level definitions that are presented in Table 1. Residential treatment programs have specific programmatic and staffing requirements from the states in which they are licensed, which frequently (but not always or wholly) coincide with ASAM criteria.

ASAM describes most residential programs as clinically managed, meaning that they have a structured environment with skilled treatment staff but no on-site physician. Individuals are recommended for residential care if their withdrawal and biomedical needs are minimal, meaning that they did not experience acute withdrawal symptoms or they have already concluded the physical withdrawal process and no longer have a health risk related to withdrawal. Residents may have

moderate psychiatric and general medical needs and significant challenges in the areas of treatment readiness, relapse potential, recovery skills, and environmental stability. The length of stay in nonhospital residential treatment has shortened considerably over time; most planned stays now range from weeks to months, depending on the program and the person's needs.

Most studies of residential treatment use an acute care model in which outcomes are evaluated after treatment, rather than a chronic care model in which outcomes are evaluated during ongoing treatment—as is the case for a chronic condition such as hypertension or other medical comorbidity (4). Evaluations of treatment effectiveness for chronic disorders take place during the continuing care phase of treatment while patients are still receiving supportive care (albeit while living in the community), and permanent change is not expected in the absence of ongoing care. A continuum-of-care model for substance use treatment is critical whereby, after completion of residential treatment, participants are engaged continuously in less intensive forms of treatment to promote smooth transitions to self-management in the community (5,6).

Residential treatment models vary widely and have evolved over the years; this evolution presents challenges to efforts to compare research outcomes. The traditional "Minnesota model" was a planned 28-day residential treatment approach that is fairly rare today, as is the traditional hospital inpatient program with which residential treatment frequently has been compared.

A specific type of residential treatment setting is a therapeutic community. Therapeutic communities and other social model programs generally have a consistent approach, in which all aspects of the residential community are used as part of the treatment experience. The National Institute on Drug Abuse defines care within a therapeutic community as provided 24 hours per day in a nonhospital setting, with planned lengths of stay of six to 12 months. Treatment focuses on social and psychological causes and consequences of addiction. Treatment is structured and comprehensive, to "focus on the 're-socialization' of the individual and use the program's entire community—including other residents, staff, and the social context—as active components of treatment . . . [in] developing personal accountability and responsibility as well as socially productive lives" (7). A social model residential approach is similar to a therapeutic community.

Table 1

Description of residential treatment for substance use disorders

Feature	Description
Service definition	Residential treatment for individuals with substance use disorders is a direct service with multiple components delivered in a licensed facility used to evaluate, diagnose, and treat the symptoms or disabilities associated with an adult's substance use disorder.
	Levels of service intensity:
	Low: Clinically managed, low-intensity residential services provide 24-hour supportive care in a structured environment to prevent or minimize a person's risk of relapse or continued substance use. This level of care may include services such as interpersonal and group-living skills training, individual and group therapy, and intensive outpatient treatment.
	Medium: Clinically managed, medium-intensity residential services provide 24-hour care and treatment for persons with co-occurring substance use and mental disorders who also have significant temporary or permanent cognitive deficits. This level of care includes services that are slowly paced and repetitive; services that are focused primarily on preventing relapse, continued problems, or continued substance use; and services that promote reintegration of the person into the community.
	High: Clinically managed, high-intensity residential services provide 24-hour care and treatment. This level of care is designed for persons who have multiple deficits that prevent recovery, such as criminal activity, psychological problems, and impaired functioning. This level of care includes services that reduce the risk of relapse, reinforce prosocial behaviors, assist with healthy reintegration into the community, and provide skill building to address functional deficits.
Service goal	Provide individuals with safe and stable living environments in which to develop their recovery skills and aid in their rehabilitation from substance use disorders
Populations	Individuals with substance use disorders; individuals with co-occurring mental and substance use disorders; individuals who are homeless
Settings for service delivery	Nonhospital residential facilities; therapeutic communities

Leaders in substance abuse and mental health policy arenas need information about the effectiveness of residential treatment for substance use disorders as they determine which interventions should be included as covered benefits in public and commercially funded health plans and as they make policy decisions about treatment interventions. This review aimed to provide state behavioral health directors and their staff, purchasers of health services, policy officials, and community health care administrators with an accessible summary of the evidence for residential treatment for substance use disorders and a discussion of areas needing further research.

Methods

Search strategy

To provide a summary of the evidence for and effectiveness of residential treatment for substance use disorders, we conducted a literature search of

articles published from 1995 through 2012. We searched major databases: PubMed (U.S. National Library of Medicine and National Institutes of Health), PsycINFO (American Psychological Association), Applied Social Sciences Index and Abstracts, Sociological Abstracts, and Social Services Abstracts. We used combinations of the following search terms: residential treatment, substance use, substance abuse, dual diagnosis.

Inclusion and exclusion criteria

The following types of articles were included: randomized controlled trials (RCTs), quasi-experimental studies, and review articles such as meta-analyses and systematic reviews; U.S. and international studies in English; studies that focused on residential treatment for adults with substance use disorders or co-occurring mental health and substance use disorders; and studies that included outcomes such as measures of substance use.

Studies were excluded that examined residential treatment solely with adolescent populations and that examined residential treatment in criminal justice settings. Clients treated within the criminal justice system are likely to have other motivators for success (for example, to remain out of jail or prison), and thus the services and outcomes examined in these studies are not directly comparable to residential treatment services and outcomes examined elsewhere. Also excluded were studies that focused only on cost-effectiveness, did not have a comparison group, measured only length of stay or other effects that occurred during treatment, or used only pre-post analyses without statistical controls for baseline differences.

Existing review articles were given priority in this summary of the evidence. Individual articles are detailed here only if they were not previously included in a published review.

Strength of the evidence

The methodology used to rate the strength of the evidence is described in detail in the introduction to this series (8). The research designs of the identified studies were examined to determine that they met the inclusion criteria. Three levels of evidence (high, moderate, and low) were used to indicate the overall research quality of the collection of studies. Ratings were based on predefined benchmarks that took into account the number of studies and their methodological quality. In rare instances when the ratings were dissimilar, a consensus opinion was reached.

In general, high ratings indicate confidence in the reported outcomes and are based on three or more RCTs with adequate designs or two RCTs plus two quasi-experimental studies with adequate designs. Moderate ratings indicate that there is some adequate research to assess the service, although it is possible that future research could influence reported results. Moderate ratings are based on the following three options: two or more quasi-experimental studies with adequate design; one quasi-experimental study plus one RCT with adequate design; or at least two RCTs with some methodological weaknesses or at least three quasi-experimental studies with some methodological weaknesses. Low ratings indicate that research for this service is not adequate to draw evidence-based conclusions. Low ratings indicate that studies have non-experimental designs, there are no RCTs, or there is no more than one adequately designed quasi-experimental study.

We accounted for other design factors that could increase or decrease the evidence rating, such as how the service, populations, and interventions were defined; use of statistical methods to account for baseline differences between experimental and comparison groups; identification of moderating or confounding variables with appropriate statistical controls; examination of attrition and follow-up; use of psychometrically sound measures; and indications of potential research bias. The evidence was rated as stronger when service and population definitions were clear and appropriate, statistical controls were used to account for baseline differences, and potential confounding variables and research bias (including attrition) were minimized.

Effectiveness of the service

We described the effectiveness of the service—that is, how well the outcomes of the studies met the goals of residential treatment. We compiled the findings for separate outcome measures and study populations, summarized the results, and noted differences across investigations. We evaluated the quality of the research design in our conclusions about the strength of the evidence and the effectiveness of the service. Although meta-analytic techniques would be valuable to assess the evidence across studies, the wide heterogeneity of the studies precluded this approach.

Results and discussion

Overall, we found a moderate level of evidence in the literature for the effectiveness of residential treatment for substance use disorders. Numerous RCTs and quasi-experimental studies were identified, but there were many methodological challenges within these studies. However, on the whole, the reviews and individual studies that were conducted found that residential treatment is an effective service for some types of patients. The level of evidence and the effectiveness of the service are described further below.

Level of evidence

The literature search identified eight research reviews published since 1995 that largely overlapped in the studies they included. The reviewed studies focused on adult participants with co-occurring mental and substance use disorders (9–11), inpatient populations (12,13), and therapeutic communities (14–16). We further evaluated seven individual RCTs that compared some version of residential treatment to a control condition (17–23) and 14 quasi-experimental studies (24–37). Table 2 and Table 3 summarize the features of the studies included in this review and their findings. The level of evidence for residential treatment for substance use disorders was graded as moderate, because this service met the criteria of having two or more RCTs with methodological weaknesses.

The studies lacked rigorous experimental design or quasi-experimental methods that controlled for patient characteristics. A focus on selected populations (for example, male veterans) and on a limited number of treatment sites limited the generalizability of several studies. Most effectiveness studies

Table 2

Review articles of residential treatment for substance use disorders included in the review[a]

Study	Focus of review	N of studies reviewed	Main outcomes reported	Summary of findings	Comments
Finney et al., 1996 (12)	Inpatient treatment for alcohol abuse (residential settings)	14 studies: 12 experimental, 2 naturalistic	Drinking, employment	Seven of 14 studies found significant effects for at least 1 drinking variable, but the direction varied; likely moderators are discussed.	Studies had methodological limitations. Inpatient settings were very different from current approaches. Many studies excluded individuals with more severe disorders or those who required housing.
Brunette et al., 2004 (9)[b]	Residential programs for people with co-occurring severe mental and substance use disorders; mostly therapeutic communities	10 studies: 2 RCTs, 8 quasi-experimental	Substance use, housing	Nine of 10 studies supported integrated residential treatment for individuals with co-occurring mental and substance use disorders. Four studies found no differences in substance use outcomes.	Studies had methodological limitations, and settings, services, and populations varied.
Smith et al., 2006 (15)	Therapeutic communities	7 RCTs	Substance use, treatment completion, problem severity	Insufficient evidence was found that therapeutic communities are better than other residential treatment.	Studies had methodological limitations. Variation across studies prevented meta-analysis.
Drake et al., 2008 (11)[b]	Residential treatment for people with dual disorders; mostly integrated programs (review article also addressed other services)	12 studies: 1 RCT, 11 quasi-experimental	Substance use, mental health	Seven of 12 studies showed improvements; longer-term studies showed consistent improvements in substance use and other outcomes; 2 of 10 studies found improved mental health outcomes; 11 of 12 studies found improved outcomes in other areas.	Studies had methodological limitations, and settings, services, and populations varied.
Cleary et al., 2009 (10)[b]	Residential programs for people with co-occurring severe mental illness and substance misuse (review article also addressed other services)	9 studies: 1 RCT, 8 quasi-experimental	Substance use, mental state	Six of 9 studies showed reduced substance use; 4 studies showed improved mental state.	Studies had methodological limitations, and settings, services, and populations varied.
Finney et al., 2009 (13)	Inpatient and residential treatment	Approximately 80 studies overall; number varies by specific topic	Varied by topic and study	Evidence was found to support matching patients to various treatment settings. Evidence supports residential treatment for individuals with few social resources or with a living environment that is a serious impediment to recovery.	Details of most studies were not provided.
De Leon, 2010 (16)	Therapeutic communities	21 studies: 4 field studies, 3 single-site studies, 7 RCTs, 1 quasi-experimental, 6 meta-analyses (8 studies are criminal justice based)	Substance use, criminal justice	A consistent relationship was found between retention in therapeutic communities and outcomes. Improved outcomes were noted in therapeutic communities across RCTs and quasi-experimental studies. Meta-analyses showed mixed findings.	The review was not comprehensive and included criminal justice–based therapeutic communities. Studies without comparison groups were included, and methods, settings, and populations varied widely across studies.
Malivert et al., 2012 (14)	Therapeutic communities	12 studies: 7 RCTs, 2 retrospective, 3 quasi-experimental	Substance use	Substance use decreased during treatment, but relapse was frequent after therapeutic community treatment. Outcomes were better if the participant completed treatment. No impact of psychiatric comorbidities was noted.	Studies had methodological limitations. Variation across studies prevented meta-analysis.

[a] Articles are in chronological order. Abbreviation: RCT, randomized controlled trial

[b] These review articles largely overlapped in the individual studies they included.

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Table 3

Individual studies of residential treatment of substance use disorders included in the review[a]

Study	Design and population	Outcomes measured	Summary of findings	Comments
RCT				
Burnam et al., 1995 (17)	Social model residential versus social model nonresidential versus no intervention; homeless individuals had a dual diagnosis of substance dependence and either schizophrenia or major affective disorder; mostly male	Substance use, severity of mental illness symptoms, housing	At 3-month follow-up, no group differences were found except for housing; residential treatment had a positive effect if the analysis also accounted for services received outside the RCT.	Contamination with outside services was noted, although outside service use was tracked. Differential participation rates and high attrition were also noted.
McKay et al., 1995 (21)	VA inpatient addiction rehabilitation versus VA day treatment; male alcoholic veterans; excluded those with unstable residence, drug dependence, severe medical problems, recent psychosis, schizophrenia	Substance use, other problems	No main effects were found across groups.	The groups were not equivalent despite statistical controls, and many exclusion criteria were used.
Guydish et al., 1998 (20)[b]	Therapeutic community versus therapeutic community model day treatment; excluded homeless individuals, those with severe psychiatric problems, those clinically judged appropriate only for residential treatment	ASI composite scores, psychiatric symptoms, social support	Both groups improved in employment, legal problems, substance use problems, and depressive symptoms. Residential treatment participants also improved in medical and social problems, psychiatric symptoms, and social support.	Exclusions eliminated many individuals likely to be most appropriate for residential treatment. High dropout was noted in the 2 weeks after randomization.
Guydish et al., 1999 (19)[b]	Therapeutic community versus therapeutic community model day treatment; excluded homeless individuals, those with severe psychiatric problems, those clinically judged appropriate only for residential treatment	ASI composite scores, psychiatric symptoms, social support	Both groups improved over time. Those in residential treatment had better ASI social composite scores and fewer psychological symptoms.	Exclusions eliminated many individuals likely to be most appropriate for residential treatment. High dropout was noted in the 2 weeks after randomization.
Rychtarik et al., 2000 (22)	Freestanding residential versus intensive outpatient versus outpatient treatment; participants with alcohol use disorders; excluded homeless individuals, those with addiction treatment in past 30 days, those with serious psychiatric symptoms	Abstinence, substance use	Abstinence improved across groups. Interactions were found for setting for those with higher alcohol involvement and poorer cognitive functioning at baseline; they showed more improvement in a residential setting.	Few differences were noted between groups at baseline. Exclusions eliminated many individuals likely to be most appropriate for residential treatment.
Greenwood et al., 2001 (18)[b]	Therapeutic community versus therapeutic community model day treatment; excluded homeless individuals, those with severe psychiatric problems, those clinically judged appropriate only for residential treatment	Substance use	Abstinence improved in both groups. The day treatment group had a higher relapse rate at 6 months but not at 12 or 18 months.	Exclusions eliminated many individuals likely to be most appropriate for residential treatment. High dropout was noted in the 2 weeks after randomization.
Witbrodt et al., 2007 (23)	Social model residential versus social model day hospital; also examined clients not randomly assigned to each setting; part of health plan system; no random assignment if individual had high environmental risk for relapse or more than minimal medical or psychological problems	Abstinence	Abstinence was noted for about two-thirds of each group at 6 months. No difference was found by setting in adjusted models for either randomly assigned or self-selected (not randomly assigned) clients.	Significant differences were found across groups in various measures of severity. The authors adjusted for these measures in regression models. Differential attrition was noted at follow-up.

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Table 3

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Study	Design and population	Outcomes measured	Summary of findings	Comments
Quasi-experimental				
Moos et al., 1996 (33)	VA community-based residential versus VA hospital-based residential; male veterans discharged from acute inpatient care for substance use disorders	Inpatient readmission (for mental or substance use disorder)	A lower probability of readmission was noted for participants in community residential programs compared with hospital-based programs.	Baseline differences between groups were found for psychiatric diagnosis and inpatient care but not for demographic characteristics. Additional treatment was documented only if received in VA.
Hser et al., 1998 (27)[c]	Short-term inpatient and long-term residential versus outpatient treatment; DATOS study: patients treated in participating community treatment programs	Substance use	Inpatient and residential programs were best for nondaily cocaine and heroin users.	There was no control for baseline patient characteristics aside from pretreatment drug use. Data were collected after 1 week in treatment, which introduced potential bias by excluding early dropouts.
Harrison and Asche, 1999 (26)	Inpatient, mostly Minnesota model, and a few therapeutic communities versus outpatient; excluded those with cognitive impairment that precluded consent	Abstinence	No difference in abstinence was found by group.	Group differences were noted in sociodemographic characteristics. Analyses controlled for many baseline variables, but group placement was based on very different individual characteristics.
Pettinati et al., 1999 (35)	Inpatient versus outpatient; alcohol-dependent but not drug-dependent patients; excluded those with severe withdrawal or serious medical problems	Drinking status	No effect by group was found on return to significant drinking. Survival analysis showed a steeper initial rate of return to drinking for the outpatient group.	Analyses controlled for baseline severity but no other patient characteristics.
Schildhaus et al., 2000 (36)[d]	Residential (mostly therapeutic communities) versus inpatient treatment; SROS study: participants treated in community treatment facilities	Substance use, criminal behavior	No difference in outcomes was found for participants in residential and inpatient settings.	This 5-year follow-up study controlled for many variables before, during, and after treatment using retrospective data.
McKay et al., 2002 (31)	"Full continuum" of residential before outpatient treatment versus "partial continuum" of intensive outpatient treatment as entry point; no exclusions noted	Substance use, ASI composite scores	Both groups improved over time on all outcomes. A significant severity × modality interaction was found, with larger improvements for those with high alcohol severity scores in the full continuum compared with those in the partial continuum.	Baseline differences were noted between groups, including severity scores. Groups had differential issues with recruitment. High attrition was noted.
Mojtabai and Zivin, 2003 (32)[d]	Residential (mostly therapeutic communities) versus inpatient and outpatient; SROS study: participants treated in community treatment facilities	Abstinence, substance use	Overall, no difference was found between residential and outpatient treatment. Some effects were seen with propensity score matching.	This 5-year follow-up study used a propensity score approach to control for baseline characteristics, but control for other characteristics during follow-up, such as additional treatment, was unclear.
Hser et al., 2004 (28)	Residential versus outpatient treatment without methadone; no exclusions noted	Treatment success (includes drug use, ASI drug severity score, criminal activity, residence in community)	Those in residential treatment were more likely to complete treatment and had longer stays, which in turn predicted better outcome.	This study used path analysis with statistical controls. Nearly half of the sample had missing data, and these participants were excluded from analyses.

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Table 3

Continued from previous page

Study	Design and population	Outcomes measured	Summary of findings	Comments
Ilgen et al., 2005 (30)[c]	VA "inpatient" (inpatient, residential, or therapeutic community–like domiciliary) versus "outpatient" (outpatient or intensive outpatient); veterans, no substance abuse treatment in past 90 days; mostly male	Abstinence; suicide attempts; ASI alcohol, drug, and psychological composite scores	At 6 months, inpatient groups had lower alcohol and drug composite scores than outpatient groups. An interaction effect was found such that individuals with a recent suicide attempt were more likely to be abstinent if treated as inpatients.	Analyses controlled only for baseline ASI measures and not for other patient characteristics. Control variables were not specified. "Inpatient" combined several very different types of care.
Brecht et al., 2006 (24)	Residential versus outpatient treatment as usual; methamphetamine users	Methamphetamine use, criminal activity, employment	Reduced methamphetamine use and crime were noted in the residential group. No difference was found for employment.	Data were collected retrospectively.
Ilgen et al., 2007 (29)	Residential versus outpatient community settings; no exclusions noted	Suicidal behavior	The residential setting was associated with fewer suicide attempts during treatment. No difference between groups was found in the year after treatment.	Baseline differences between groups were noted, but analyses used statistical controls. Substance use outcome was not measured.
Tiet et al., 2007 (37)[c]	VA "inpatient" (inpatient, residential, or therapeutic community–like domiciliary treatment) versus "outpatient" treatment (outpatient or intensive outpatient); veterans; mostly male	Substance use severity	No main effect was found for treatment setting. Some small interaction effects were noted: those with a higher severity of substance use at baseline had better outcomes in inpatient and residential than in outpatient settings.	Significant group differences were noted at baseline, but regression models controlled for them. Differential attrition and nonresponse bias were noted.
De Leon et al., 2008 (25)[d]	Long-term residential; matched undertreated and overtreated patients; DATOS study: patients treated in participating community treatment programs	Substance use, arrests	Patients had better outcomes if they were matched to residential treatment than if they were appropriate for residential treatment but undertreated in an outpatient setting. Similar outcomes were noted in residential treatment if patients were matched or overtreated (appropriate for outpatient treatment but treated in a residential setting).	Data were collected after 1 week in treatment, which introduced potential bias by excluding early dropouts.
Morrens et al., 2011 (34)	Integrated treatment for patients with schizophrenia and co-occurring substance use disorder in a residential setting versus treatment as usual; both groups recruited from inpatient psychiatric hospitals and continued with outpatient care; psychotic disorder for at least 2 years and substance use disorder; aged 18–45 years only	Substance use, psychiatric symptoms	At 3 months, the integrated residential group had reduced substance use, improved psychiatric symptoms, and higher quality of life and functioning compared with the treatment-as-usual group.	No baseline differences were noted, but differential dropout limited analyses to 3 months. Some tentative conclusions were drawn for 6- and 12-month follow-ups. Dropout rates varied between groups.

[a] Articles are in chronological order by type of research design. Abbreviations: ASI, Addiction Severity Index; DATOS, Drug Abuse Treatment Outcome Study; RCT, randomized controlled trial; SROS, Services Research Outcomes Study; VA, Veterans Affairs

[b–e] Articles with the same superscript reported some aspects of the same study.

described here evaluated patients who chose or were referred by clinicians to a specific treatment modality. RCTs that evaluated specific treatment modalities for substance use disorders were rare because treatment providers had concerns about randomly assigning individuals in need of treatment to a no-treatment condition or to a lower level of care than was clinically appropriate. Some RCTs were conducted with a large limitation: the researchers required

individuals in the intervention group to be appropriate for the outpatient care that was received by the comparison group, to avoid undertreating individuals who might not be treated safely if randomly assigned to outpatient care. This design created a false comparison, because individuals appropriate for residential treatment (and thus not appropriate for outpatient care) were excluded. Clients with more severe needs (for example, individuals without stable living arrangements or individuals with general medical or psychiatric diagnoses) were often excluded from the intervention group, despite the possibility that they were likely to benefit from residential services.

Many studies that suggested improved outcomes after residential treatment were excluded from this review because they lacked a comparison group or used pre-post measurement without statistical controls. Other methodological concerns in the literature included retrospective data collection, lack of control for the amount of treatment received, and lack of detailed descriptions of the service components. Comparison groups often varied by characteristics of the setting (for example, type of setting or treatment duration) and by treatment content (for example, services or theoretical approach), thereby confounding the comparisons. Each of these limitations influenced the conclusions that could be drawn.

Effectiveness of the service

The effects of residential treatment services were mixed, with some studies indicating positive findings and others showing no significant differences in outcomes between clients in residential treatment settings and those in other types of treatment. For example, the Walden House residential therapeutic community was compared with a therapeutic community model that used a day treatment program (18–20). At six months, both groups had reliable improvement in drug and alcohol use and employment. The Walden House group also had significant improvements in medical and social problems, psychiatric symptoms, and social support. Most outcomes seen at six months were maintained through 18 months (19); the day treatment group had a higher likelihood of relapse at six months but not at 12 or 18 months (18). In quasi-experimental studies, individuals receiving residential treatment had less methamphetamine use and crime (24), higher treatment completion rates and longer treatment stays (28), and reduced suicide attempts during treatment (29) compared with individuals receiving outpatient treatment. Individuals in inpatient residential treatment had lower alcohol and drug severity scores at six months than those in outpatient treatment, after control for baseline severity (30). De Leon and colleagues (25) found some evidence supporting treatment matching; clients matched to long-term residential care had better one-year outcomes than those undertreated in outpatient drug-free settings. Individuals with co-occurring mental and substance use disorders in integrated residential treatment settings had reduced illicit drug and alcohol use, improved psychiatric domains, higher reported quality of life, and improved social and community functioning than those in treatment as usual (9–11,15).

Reflecting the inconsistency in the literature, other studies showed no significant differences between individuals receiving residential treatment and those receiving treatment in comparison conditions on outcomes such as abstinence from drug use, psychosocial variables, reduced drug use, criminal activity, arrest rates, or rates of returning to prison (21–23,26,27,32,35–37). In an RCT, researchers compared treatment in a residential social model and in a nonresidential social model for homeless individuals with co-occurring mental and substance use disorders (17). No significant differences, aside from housing, were found between residential and nonresidential treatment groups at the three-month follow-up. When the analysis controlled for total services accessed, the residential group had significantly fewer days of alcohol use at the three-month follow-up, but no other significant effects were found.

The inconsistency in findings is documented by the literature reviews we examined. Published reviews of residential treatment reported on studies that had serious methodological limitations, resulting in the need for "an RCT with a well-defined population, a standardized program, and a blind assessment of outcomes" (9). Finney and colleagues (12,13) conducted two reviews that summarized the evidence on treatment settings—the first in 1996 and the second in 2009. The 1996 review included research on "inpatient" treatment compared with outpatient treatment or detoxification only (12). Although comprehensive at the time, the review was confounded for our purposes by the inclusion of both hospital inpatient approaches and nonhospital residential approaches and the exclusion of individuals with severe problems or without stable housing. In addition, many approaches described in the review article are no longer commonly used in the field; thus the article is not discussed further here. The 2009 review by Finney and colleagues (13) found evidence supporting the effectiveness of treatment that matched patients to different treatment settings, such as via the ASAM PPC-2R. However, the review provided little information about methods used in the included studies.

Three reviews examined the effects of therapeutic communities on substance use outcomes (14–16). A Cochrane Collaboration review indicated that insufficient evidence exists to state that therapeutic communities are more effective than other levels of care; however, methodological limitations tempered the researchers' conclusions (15). High attrition was a common limitation in the reviewed studies. Some evidence suggested that specific populations, such as homeless individuals with co-occurring mental disorders or individuals in prisons, had better outcomes in therapeutic communities than control groups. The second review found that individuals in therapeutic communities demonstrated improved outcomes compared with individuals in control conditions; however, the findings were limited by various methodological issues, such as overlap between the treatment and comparison conditions and inconsistent program fidelity (16). The third review found significant decreases in substance use

Evidence for the effectiveness of residential treatment for substance use disorders: moderate

Overall mixed results suggest either an improvement or no difference in outcomes such as:

- Drug and alcohol use
- Employment
- Medical and social problems
- Psychiatric symptoms
- Social support

while individuals were in therapeutic communities but indicated that methodological problems tempered the extent to which conclusions could be drawn about the long-term effects of therapeutic communities (14). Similar to other reviews, the third review found that therapeutic communities may provide a better treatment option for individuals with severe psychosocial problems, depending on the length of stay in the program.

Three reviews (9–11) focused on populations with co-occurring mental and substance use disorders. The experimental group usually received integrated residential treatment (for individuals with co-occurring disorders), and control groups received "treatment as usual" with less intense or nonintegrated residential treatment. These reviews found that individuals with co-occurring mental and substance use disorders can be treated successfully in residential settings, whether or not treatment is integrated. At minimum, integrated treatment was equally as effective as standard treatment for this population, and most of the studies found that integrated treatment was more effective than standard treatment in regard to substance use, mental health, and other outcomes.

Conclusions

This review found a moderate level of evidence for the effectiveness of residential treatment (see box on this page). Despite the prevalence of methodological concerns—primarily the appropriateness of the samples and equivalence of comparison groups—some evidence indicates that residential treatment is effective for some types of patients. Further, much of the literature suggests that residential treatment is equally as effective as comparison modalities, and a few studies suggest that it is more effective. However, until research with more rigorous methods is conducted, these conclusions remain tentative.

We echo the call of others for further research to better determine which clients benefit from residential treatment, what duration of treatment confers positive effects, and what types of effective clinical interventions are provided within the program. Further studies should examine the components of residential treatment that might relate to effectiveness, such as types of clinical staff, use of peer support, number of beds, or lengths of stay currently used. To attain ideal outcomes, it is essential for new evaluations of residential treatment for substance use disorders to take a chronic care approach to ensure that a treatment modality is not evaluated in a vacuum and that continuing care is an outcome as well as an essential part of the treatment episode.

Any new research in this area must be methodologically rigorous and use appropriate comparison groups to ensure that conclusions are valid. Systematic, rigorously conducted studies are essential for policy makers to make decisions about the inclusion of residential treatment in health plans and the allocation of resources to residential treatment activities.

Specifically, research needs to identify which individuals respond best to residential treatment programs. Studies should use appropriate control groups. Future research needs to reflect current approaches to residential treatment and examine the role of treatment factors (such as staffing and length of stay) in contemporary approaches to residential treatment. Research must include posttreatment variables, such as mutual-help participation, when evaluating outcomes. Examining effective treatments for individuals with substance use disorders requires furthering our understanding of how to improve treatment retention, length of stay, treatment completion, and participation in aftercare.

Finally, it is important to determine whether treatment services are equally effective for different populations. Given the significance of health disparities in access to and receipt of substance use treatment, implementing effective and culturally responsive care is essential. Most studies described the demographic characteristics of the sample, and some studies controlled for these characteristics in analyses. However, no studies specifically analyzed race or ethnicity through interaction terms, stratification, or other approaches. Examining the effectiveness of treatment across different groups requires analyses comparing outcomes of specific subgroups within and across treatment types. Additional work should analyze the role of culture-specific approaches—for example, multilingual staff. We encourage researchers to incorporate such analyses as we continue to evaluate this treatment modality.

In addition to calling for rigorous research on the current system, we note that the moderate level of evidence for the effectiveness of residential treatment of substance use disorders has relevance for consumers and their families as well as for policy makers. Consumers have a wide range of needs, and they would benefit from a variety of services to address those needs. Residential treatment for substance use disorders fills a niche for consumers who require stable living environments that incorporate therapeutic treatments to help them move toward a life in recovery. Similarly, to reduce the likelihood of treatment failure, policy makers should ensure that a full range of treatments is available to meet consumer needs. With research demonstrating a moderate level of evidence, policy makers can highlight the benefit of including residential treatment as a key service in the continuum of care.

As the treatment system for substance use disorders continues to evolve,

particularly within the current context of broader health care system change, it is essential to understand the role and effectiveness of treatment options. Residential treatment has been used for substance use disorders for many years, and there are clear indications for continuing these services. However, for policy makers and payers (for example, state mental health and substance use directors, managed care companies, and county behavioral health administrators) to be able to make recommendations about which services to cover and include in a treatment continuum, they must be able to evaluate those services as they currently exist. Residential treatment shows value for ongoing inclusion and coverage as part of the continuum of care, but additional rigorous research is necessary to understand how and for whom it best fits.

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Submissions Invited for Column on Integrated Care

The integration of primary care and behavioral health care is a growing research and policy focus. Many people with mental and substance use disorders die decades earlier than other Americans, mostly from preventable chronic medical illnesses. In addition, primary care settings are now the gateway to treatment for behavioral disorders, and primary care providers need to provide screening, treatment, and referral for patients with general medical and behavioral health needs.

To stimulate research and discussion in this critical area, *Psychiatric Services* has launched a column on integrated care. The column focuses on service delivery and policy issues encountered on the general medical–psychiatric interface. Submissions are welcomed on topics related to the identification and treatment of (a) common mental disorders in primary care settings in the public and private sectors and (b) general medical problems in public mental health settings. Reviews of policy issues related to the care of comorbid general medical and psychiatric conditions are also welcomed, as are descriptions of current integration efforts at the local, state, or federal level. Submissions that address care integration in settings outside the United States are also encouraged.

Benjamin G. Druss, M.D., M.P.H., is the editor of the Integrated Care column. Prospective authors should contact Dr. Druss to discuss possible submissions (bdruss@emory.edu). Column submissions, including a 100-word abstract and references, should be no more than 2,400 words.

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Community Context of Sober Living Houses

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Abstract

The success or failure of programs designed to address alcohol and drug problems can be profoundly influenced by the communities where they are located. Support from the community is vital for long term stability and conflict with the community can harm a program's reputation or even result in closure. This study examined the community context of sober living houses (SLHs) in one Northern California community by interviewing key stakeholder groups. SLHs are alcohol and drug free living environments for individuals attempting to abstain from substance use. Previous research on residents of SLHs showed they make long-term improvements on measures of substance use, psychiatric symptoms, arrests, and employment. Interviews were completed with house managers, neighbors, and key informants from local government and community organizations. Overall, stakeholders felt SLHs were necessary and had a positive impact on the community. It was emphasized that SLHs needed to practice a "good neighbor" policy that prohibited substance use and encouraged community service. Size and density of SLHs appeared to influence neighbor perceptions. For small (six residents or less), sparsely populated houses, a strategy of blending in with the neighborhood seemed to work. However, it was clear that larger, densely populated houses need to actively manage relationships with community stakeholders. Strategies for improving relationships with immediate neighbors, decreasing stigma, and broadening the leadership structure are discussed. Implications for a broad array of community based programs are discussed.

Keywords

Sober Living Houses; Residential Treatment; Environmental Influences; Neighborhood; NIMBY

The premise of this paper is that it is insufficient to study the effectiveness of community based services without examining characteristics of the community context in which those services are delivered. How services are perceived by key stakeholder groups will affect whether they are implemented, the level of support they receive, and the types of barriers they encounter (Guydish, et al., 2007; Jason, et al., 2005; Polcin, 2006). As an example, we describe a study of the community context of Sober Living Houses (SLHs), which are alcohol- and drug-free living environments for individuals attempting to achieve sustained abstinence. The study compliments previous research showing that SLH residents make improvements in a variety of areas, including reductions in substance use, arrests, psychiatric severity and unemployment (Polcin et al., 2010). The community context of SLHs is assessed by conducting qualitative interviews with stakeholders, including managers of the houses, neighbors, and local key informants in one Northern California

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County. A typology of factors supporting and hindering operations and expansion of SLHs in the community is provided.

Alcohol-and drug-free housing

Few problems in the treatment of addictive disorders have been more challenging than helping clients find long-term, alcohol- and drug-free living environments that support sustained recovery. The progress that clients make in residential treatment programs is often jeopardized by the lack of appropriate housing options when they leave (Braucht, et al., 1995). For clients attending aftercare or outpatient treatment, progress is often jeopardized by their return to destructive living environments at the end of the treatment day (Hitchcock, et al., 1995). These are often the same environments that originally contributed to their addiction. Finding affordable housing has also become more difficult because of tight housing markets in urban areas and the rise in unemployment.

One approach to the need for alcohol- and drug-free living environments has been to refer individuals to residential treatment programs. However, as funding for residential services has decreased over the years it has become an option for very few. Even when clients are admitted to residential services, the length of treatment is typically short, often only a few weeks. Although some programs have developed "half-way" or "step-down" living facilities, these too have maximum lengths of time after which residents must leave regardless of their readiness. Cost is an additional issue for halfway houses because frequently public and private funders are unwilling to pay for services that are not medically oriented. In addition, halfway houses tend to be available only to individuals who have completed rigorous inpatient treatment, which diminishes the potential pool of individuals who might make use of them.

Sober living houses

Polcin et al (2010) suggested sober living houses (SLHs) were an underutilized housing option for a variety of individuals with addictive disorders, including those completing residential treatment, attending outpatient treatment, being released from criminal justice incarceration, and seeking non-treatment alternatives to recovery. SLHs offer an alternative alcohol- and drug-abstinent living environment for individuals attempting to establish or maintain sobriety (Wittman, 1993, 2009). Residents are free to come and go during the day and are not locked into a group schedule, as is typical in most treatment programs. This allows residents to pursue activities vital to recovery such as finding work or attending school. Residents in most SLHs are afforded social support through shared meals, socialization with recovering peers, house meetings, and access to a house manager. To help residents maintain abstinence, SLH's use a peer oriented, mutual-help model of recovery that emphasizes social model recovery principles (Polcin & Borkman, 2008). As such, they emphasize learning about addiction through personal recovery experience and drawing on one's own recovery as a way to help others.

Although management of SLHs varies, some include a residents' council as a way to empower residents in operation of the facility. While SLHs offer no formal counseling or case management, they do either mandate or strongly encourage attendance at self-help groups such as Alcoholics Anonymous or Narcotics Anonymous. Costs of living at the facility are primarily covered by resident fees. Although some residents are able to draw upon entitlement programs or financial help from their families, most must find work to meet house rent and fees. Because SLHs are typically not part of formal treatment systems, they are available to a broad range of individuals provided they follow basic house rules, such as maintaining abstinence from substances, paying rent and fees, attending house meetings and participating in upkeep of the facility.

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SLHs are similar to Oxford Houses for recovery, which are widely known in the U.S. and developing in other countries as well (Jason, et al., 2005). Similarities between the two housing models include prohibition of alcohol and drug use, social support for sobriety, encouragement or a requirement to attend 12-step meetings and work a program of recovery, and no limit on how long residents can live in the house. The main difference is that Oxford houses have more regulations for structure, size, density and management of the houses. Similar to our outcome studies of SLHs, which are described below, research on Oxford houses has documented significant improvement of resident functioning over time. For a more complete description of similarities and differences between the two housing models see Polcin and Borkman (2010).

Jason and colleagues (2005) studied neighbor perceptions of Oxford Houses and found very favorable views. However, they did not study other key stakeholders in the community, such as local government officials and criminal justice staff. They also did not aim to understand the impact of regulatory policies on the houses or what various stakeholders felt would improve relationships. Finally, the study was limited to Oxford houses and might not generalize to other types of recovery houses, including SLHs.

Purpose

The purpose of this study was to provide data that depicted the community context where SLHs operate. We wished to understand views about SLHs among key stakeholder groups and ways they support and hinder SLHs. To achieve our aim, we conducted qualitative interviews with key stakeholders in the same geographic area where we conducted a quantitative program evaluation of SLHs, Sacramento County (i.e., Polcin, et al., 2010). We wanted to assess areas where stakeholder groups were in agreement about SLHs as well areas where they disagreed. The ultimate goal was to create a typology of factors supporting and hindering SLHs within as well as across stakeholder groups.

METHODS

Sample

To assess the community context of SLHs we conducted 43 in-depth qualitative interviews with 1) neighbors of SLHs (N=20); 2) SLH managers (N=17), which included the owner of the houses and the coordinator, and 3) key informants (N=6). Key informants included representatives from the criminal justice system, local government, housing services, and drug and alcohol treatment. The overall sample consisted of 18 women (43%), 3 from the SLH manager group, 4 key informants and 11 neighbors. Eighty six percent of the sample was white and ages ranged from 19 to 70. See Table 1 for a list of characteristics by stakeholder group.

Data collection site

Clean and Sober Transitional Living (CSTL) in Fair Oaks, California was one of our data collection sites for our earlier quantitative study (Polcin et al., 2010). Because the current study was designed to complement our previous work, we interviewed house managers at CSTL and neighbors who resided near one of the 16 CSTL houses. Key informants were recruited from Sacramento County, the county in California where CSTL is located.

CSTL is slightly more structured than some SLHs because the houses are divided into six phase I and ten phase II houses. Phase I houses are adjacent to each other and operate as one unit, which includes shared dining and meeting spaces. These houses are located on a frontage road next to a busy commercial street (i.e., not imbedded within a larger residential area). The close proximity provides residents a sense of community that facilitates their

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commitment to the program. Although much less restrictive than residential treatment programs, there is some degree of external control and structure. Phase I residents have a curfew, must sign in and out when they leave and must have five 12-step meetings per week signed by the meeting chairperson. A minimum of 30 days in a phase I house is required before transitioning to phase II. The stability developed in phase I helps residents to be more successful in phase II, which includes increased freedom and autonomy. Phase II houses are conventional single-family homes and are dispersed in residential neighborhoods rather than part of a single complex.

Although CSTL houses are owned by one individual, there are a number of ways that residents are involved in management and operations. There is a "resident congress" that develops rules for the community, a "judicial committee" committee comprised of residents who enforce rules, and senior peers who monitor the behaviors of residents and bring rule violations to the attention of the judicial committee. In addition, each house also has one designated house manager and residents have an opportunity for input into the operation of CSTL through this person.

CSLT tests for drugs and alcohol at random and may conduct a test at any time if substance use is suspected. A positive test is grounds for dismissal from the house. However, a resident with a positive urine screen may appeal to the judicial committee for reinstatement. Other dischargeable offenses include drug use on the property, acts of violence, and sexual misconduct with other residents. For a more complete description of CSTL see the Polcin and Henderson (2008).

Our quantitative research on 250 CSTL residents who were tracked over an 18-month period showed significant improvement in multiple areas of functioning, including alcohol and drug use, employment, arrests, and psychiatric symptoms (Polcin et al., 2010). Importantly, residents were able to maintain improvements even after they left the SLHs. By 18 months nearly all had left, yet improvements were for the most part maintained. Although individuals with a wide variety of demographic characteristics showed improvement, those who benefited the most were those who were most involved in 12-step groups such as Alcoholics Anonymous and those who had social networks with few or no heavy substance users.

Procedures

All participants taking part in qualitative interviews were contacted by a research interviewer and asked if they were willing to participate. They were informed about the overall purpose of the study and if they agreed to participle they signed an informed consent document. Interviews lasted about one hour and participants were offered $20 for their time. All study procedures were approved by the Public Health Institute Institutional Review Board in Oakland, California.

Content of the Interviews

The overall goal of the qualitative interviews for all three stakeholder groups (i.e., house managers, neighbors and key informants) was to identify areas of strength and weakness for SLHs as well as barriers to expansion. Therefore, there was considerable overlap in the questions asked of the three groups. Examples of questions asked of all three groups included:

> What are the strengths of SLHs? What are the weaknesses? What type of impact have SLHs had on the surrounding neighborhood/community? What are the key barriers to operating and expanding SLHs? How might SLHs be improved?

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Because the three groups had different relationships with SLH facilities, there were also some differences in content of interviews. For example, house managers were asked:

> What types of individual do well in SLHs? What types of individuals need a different environment? How often are residents asked to leave because they cannot pay rent and fees? How do you think management of the houses affects residents' experiences and outcomes? Are there specific local government policies that impact SLHs, such as housing, zoning or health policies? Describe some of the resistance, if any, that was encountered when this house first opened. How were the resistances over come? What actions were not effective? Describe how complaints or concerns from neighbors are handled.

There were also questions that were specific to neighbors. Interviews with neighbors began by asking them whether they knew about SLHs in the neighborhood and when they first became aware of them. If they had no knowledge about SLHs the interviews was terminated. If they were aware of SLHs in the neighborhood they were asked:

> How would you describe them as neighbors? Have you or other neighbors had complaints? Describe any interactions that you have had with SLHs in your neighborhood. Describe any specific ways that you think SLHs impact alcohol and drug problems in your community. What do you think of SLHs compared with other approaches to addiction, such as formal treatment programs or criminal justice consequences?

In addition to general questions asked of all the participants, key informant interviews contained questions designed to elicit information about policies and local laws that might impact SLHs. We queried these officials about their own views about SLHs, the roles SLHs might play in the larger addiction recovery system, and ways they think public policy could be modified to provide more support to SLHs. Examples of questions included:

> What role does housing play for individuals attempting to establish sustained recovery? What is your sense of how well housing needs for individual with alcohol or drug problems are being addressed in your community? How would you describe your department's relationship with SLHs? Describe how SLHs support and hinder the mission of your department. How do local politics affect SLHs in your area?

Analytic plan

A triangulation design (Creswell & Plano-Clark, 2007) was created by drawing on data from the three different stakeholder groups (SLH managers, key informants and neighbors). A preliminary coding list was developed prior to the analysis of the interviews. These codes were based on key research interests, such as factors supporting and hindering SLHs. To analyze the qualitative interviews, we transcribed all sessions and entered text into a qualitative data management program, NVivo, for coding and analysis (Bazeley & Richards 2000; Richards 2002). Team members then coded transcripts independently and met to check coding accuracy and improve coding validity (Carey, Morgan, & Oxtoby, 1996).

RESULTS

The final coding scheme reflecting themes across all three stakeholder groups included codes depicting drug and alcohol problems in the local community, strengths and weaknesses of SLHs, barriers to operation and expansion, perceived impact of SLHs on the surrounding community, views about SLHs in comparison to other approaches to alcohol and drug problems (e.g., more intensive treatment and incarceration), and suggestions for improving SLHs. Some additional codes were applicable to some stakeholder groups but not

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others. For example, codes for neighbors included knowledge about SLHs and interactions with SLHs near them. SLH manager interviews yielded codes depicting views about characteristics of good candidates for SLHs, the extent to which cost functioned as a barrier, the perceived impact of zoning laws and other local policies, SLH relationships with various professionals and local government, and past conflicts with neighbors and how those conflicts were resolved. Codes that were relevant to key informants included ways SLHs support goals of their departments and perceived impact of policies on SLHs.

Knowledge about SLHs

SLH managers provided extensive comments explaining how SLHs work to promote recovery. Typical was this description from a phase I manager.

> ...I believe that it [SLHs] definitely plays a substantial role in that it – I would say the biggest role it plays is it offers relief from isolation and that it can make people aware...That one doesn't have to worry about bills or that everything is inclusive is a very significant role as well.

However, managers were only vaguely aware of problems and challenges the houses faced in relation to the larger community. They noted these issues were handled by the owner of CSTL. Managers offered little information in response to questions addressing the larger context of SLHs, such as the types of relationships CSTL has with local and state government, the effects of regulatory mechanisms (e.g., zoning laws), and how issues such as NIMBY (not in my back yard) were addressed at the community level.

Key informants varied in their perceptions about how much they knew about SLH. Those who felt most familiar with SLHs in general and CSTL specifically were those who worked most closely addressing alcohol and drug problems. Surprisingly, the representative from housing services had very little information about SLHs. When asked how familiar she/he was with SLHs the reply was, "not very." Although other key informants felt they had some general knowledge about SLHs, it was nonetheless limited. For example, one key informant stated, "I don't know that we spend a lot of time hanging out at programs to see what's going on."

Many of the neighbors also had a limited understanding of SLHs. In some cases they had no idea a SLH existed in the neighborhood; it seemed to them like any other house. For those who were aware that there was a SLH in their neighborhood there was often a fairly vague notion of the population served and how the program operated. Without information, some neighbors expressed fears that the residents were mostly parolees or that they included sex offenders. They did not seem to be aware that a minority (about 25%) of CSTL residents was referred from the criminal justice system (i.e., jail or prison) and CSTL does not accept individuals convicted of sex offenses.

Who succeeds and who fails

Many of the respondents, and especially house managers, had very strong ideas about who would be a successful candidate within the sober living environment. Paradoxically, many house manager respondents said that a person had to 'hit bottom' to benefit, yet they also noted potentially successful candidates needed to have enough strength to check themselves into a recovery program and to have the motivation to "push through." Success was viewed as more likely for residents of the SLH who had accepted substance abuse as a disease, one that isn't going away on its own.

> ....[to be successful] they have had to accomplish what we refer to as the first step in the program of AA... that there's no denying of their alcoholism, that they're passed that point; that they're willing to accept that they're an alcoholic, that their

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> lives are unmanageable and they need to do something about it. I think that anybody who comes in these places too soon it's not going to work you.

It was suggested that people who were too young and unmotivated might fail. Such individuals were not as likely to have hit bottom, were often still supported (or 'enabled') by family members and just did not have the long history of failures to motivate them. Prospects for success or failure were also influenced by the right kind of financial support. Most respondents felt that people who paid for their housing themselves from their own earnings did the best as opposed to those who had a family member footing the bill.

> … A lot of the kids around here, the parents just let 'em run amuck and they did whatever they want and now they're in trouble and they're goin' "Mommy help me" and when they screw it up they still get help from mommy. A lot of these kids around here have been through a lot of programs… They're just not ready.

On the other hand, many of the managers, all of whom were in recovery, said that they would never have made it unless the first few months had been paid for by a social agency, the criminal justice system, a family member or some other external form of support. Some felt that more people would be successful if the funds for maintaining themselves at the SLH were more easily available, especially for beginning recovery.

House managers also felt residents who are dual diagnosed with psychiatric disorders were more likely to have a low probability of success. It was felt that such individuals needed many more services than those provided for by the SLH and that some aspects of the housing situation might exacerbate these other problems (e.g. people with social phobia having to come in contact with many strangers on a daily basis or people with paranoia having to share space with other residents). In addition, it was felt that people with more severe mental disorders such as schizophrenia might need skilled personnel to monitor medications.

> Well definitely those with dual diagnosis that we are not prepared to handle – and there are special cases I mean obviously if there is some illness that runs deeper than alcoholism there's no way they can get the help they need here, nor do they pretend that they can offer that sort of help. ..' And it's not like people here don't go see psychiatrists or therapists or whatever because I know there are more than one that do but just if the problems are running much deeper.

People who had been coerced into coming to the SLH were also thought to be unlikely to succeed in the long-term. If an individual had chosen treatment instead of prison or parole, or were forced by the courts, it was thought that they would be less likely to be successful. Such individuals often end up as 'fake it to make it' individuals who try to get by with the bare minimum of effort.

> … they just want to be clean enough just to satisfy the court; once they've got that done they're on their merry way.

Strengths and weaknesses

Virtually all of the house managers and a majority of neighbors and key informants as well mentioned that the strengths of sober living houses are that they provide structure and support for a recovering substance abuser. The role models provided by the longer term residents, the social support and encouragement of staff and residents, the house rules and regulations and the availability of AA meetings all help to keep a person from relapsing. One of the house managers described the importance of social support for abstinence:

> … a lot of people in their usual neighborhoods are family. Like it's not [a good area] for them to get clean 'cause they know a lot of people who they did drugs

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> with. So being like a place where you can live with other people trying to do the same thing and are all about the same thing is really supportive and it helps you stay positively influenced to stay clean and get your life together...

Another house manger emphasized the importance of a supportive community:

> Community, everybody gettin' along, everybody helpin' each other. Everybody's always helpin' each other around here. If they see that you're down and out they'll ask you 'What's wrong?' or start the coffee or whatever and that's what it is people around here care about each other.

On the other hand, the factor of density was mentioned as an area of strength and as a weakness, sometimes by the same respondents. Density of the SLH was viewed as an area of strength for house residents because it allows a range of services to be on hand (including meals, meeting places, AA and other types of classes) as well as a wide range of role models and positive normative pressure. Yet, because there are separate houses, the residents do not have the feeling of being in an institution; with one exception, the houses are approximately family-sized and offer the opportunities to build skills, develop social relationships and offer a degree of privacy. However, there is one neighborhood where there are six adjacent houses together in one complex. Some neighbors experienced this high density arrangement as having a negative impact on the surrounding neighborhood.

Impact on SLH residents and the surrounding community

Participants across all three stakeholder groups generally felt SLHs had a positive impact on the residents who lived in them and the surrounding community. This was particularly evident when respondents considered the consequences of ignoring alcohol and drug problems or alternative approaches to dealing with them, such as criminal justice incarceration. House managers were particularly strong proponents of this view.

> I think we've raised property value. There is no crime going on here. You've got seven houses here and the police don't get called. Cars aren't broken into, there's no burglary you know. I mean the level of integrity of the hundred people that live here is gonna be three times as high as the people living on the street…one over….

Key informants, especially those who worked closely with SLHs and drug treatment, also had positive views about the impact of SLHs. For example, one stated, "I would think that it's just more people that aren't out there drinking and using." Other key informant comments included:

> if they work I think they have a great impact…They're good citizens, neighbors, don't create a nuisance within our community, and I think they have a great impact.

> The more you can be in a home as opposed to an institution or shelter to me that is beneficial to not only the individual but it's actually probably beneficial to the community at large too…

> …if there were a lot of calls for service out there I'd be hearing about it…then we know there are other things going on that we've gotta address but it's usually not been [the case] with CSTL.

A number of neighbors had family members or friends who had a history of addiction problems. Their concern about family and friends who had addiction problems appeared to influence their views about the impact of SLHs.

> Well I don't think that incarcerating people rehabilitates them. You know it's like my daughter if she was in that situation where she could at least was trying to get herself cleaned up and can go to a home, I'd be all for that.

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> …my younger sister had a problem and so she's – so I know she's been in a couple in and out…It's rare you talk to anyone you know honestly that doesn't have a sister or brother, a parent, an uncle, you know what I mean..

> …Yeah they need help you know we have a daughter that's a meth user and so I'm all for anything that will help…Yeah and we've been estranged from her for the last 20 years… .

Although views about the impact of SLHs were generally favorable, concerns were raised about the potential for detrimental impact to residents and the surrounding community if the houses were not well managed. This was the view even among house managers. The owner of CSTL emphasized the importance of standards and integrity.

> We have a class here called Sober Living Specialist and it's a 36-hour class that I put together…. What we're trying to do is create minimum standards and a high level of integrity. And it goes beyond just having a house, I mean you've got recovery integrity, you have fiscal integrity, you have community integrity you know. So we talk about ADA [Americans with Disabilities Act], we talk about FHA [Fair Housing Act]; we talk about structure and management; we talk about how to keep your books and pay taxes and be financially in integrity. We talk about confidentiality and do no harm and a code of ethics.

Phase I and phase II houses—Despite generally positive views about the impact of SLHs on surrounding communities, key informants and some phase I neighbors raised concerns about the impact when houses were too densely located in one neighborhood. One key informant commented:

> Well, it changes the atmosphere; I think that when you walk through, you drive through and there's a group of adults sitting outside you often wonder what's that all about. Is it a halfway house, is it sober living? What's going on is it just about a big family and you know those sorts of things. So it makes you wonder about the neighborhood.

When we looked at the characteristics of the neighbors who had concerns it became clear that they lived in the vicinity of the six phase I houses that were densely located along a two block area in one complex. One neighbor stated, "I hate to say this, but I would say it's been negative. One would've been fine (laughs) but the whole block is too many for this small street." Some complaints of neighbors had to do with nuisance issues such as noise and parking.

> …The only thing that gets people in the neighborhood kind of upset is if you have too many cars and sometimes if there's too many people there, if they have too many guests it'll get the neighbor across the street upset…

> …I don't see them as strict enough…I mean they're lifting weights at all hours of the night, there is no – back there is no control of their language at all… every now and then obviously there are screaming and yelling matches and sometimes they are – they're just you know people have lost their cool.

> … they [should] cut the size of it and not have so many people over there in so many houses and that they exercise control when they have these large groups and stuff over there. Because these groups have to be coming from more than just those houses because there's been times when I saw hundred or more people there and cars are parked not only up and down the entire street but over in the Safeway parking lot there's so many people there. And I just don't understand why they need that many people at one time.

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A few phase I neighbors expressed fears about safety, the potential for an increase in crime, and declining values of houses in the neighborhood. However, when pressed by the interviewer, they had difficultly providing examples of these issues. A phase I neighbor stated she assumed housing values would fall as a result of the SLH in their neighborhood, but did not elaborate or provide examples of declining values. Another neighbor described concerns about crime:

> …there were a couple of incidences where in the night…we had a couple of break-ins and you don't know if it was them or not.
>
> Interviewer: So I'm wondering if the break-ins were close to each other and how long ago it was or how recently?
>
> Well, one of them was 5 years ago, the other one was in '89.

The concerns raised by some neighbors of phase I houses were not unanimous. Different points of view from phase I neighbors included:

> Well, for me like I say to me it's positive that there's been a positive impact…the crime situation has reduced. I mean we were broken into three times here before… madhouse came.
>
> It seems to be a big success. They have on you know specific nights of the week and specific nights of the month they have a lot of people gathered there in support of the people that are graduating from the program or hopefully successfully moving on from that program. So I have a lot of support for that, I've known several people in my lifetime through friends or employees that have been working for us that had issues with drugs and needed to clean up. And so I think it's a huge benefit to helping people get back on track and finding that support system and other people that are going through the same situations that can be there for each other and be a good support structure for each other.

Another phase I neighbor succinctly summed up the pros and cons of having a large community of phase I houses:

> …because you have it the way it is the level of support is incredible as opposed to having the phase 2 houses which are more isolated. But of course you have to work to get that and…having large phase I houses is probably a good thing but it you know it is in a residential neighborhood area and so you create a traffic issue and the streets line up, I mean that's what they have to do. And we were real worried 'cause we thought that whole frontage area was gonna be gone on this latest modification and it was like okay now what are they gonna do? But it isn't, and they are considerate, they do a good job, but it is a lot– they have a lot of people on Sunday night.

Reactions from neighbors of phase II houses were nearly all positive. Neighbors were either unaware that a SLH existed in their neighborhood and when they did know about one they were perceived as good neighbors. One neighbor of a phase II house reported a positive incident with a SLH resident who lived next door. During a violent late night altercation with his wife, he was forced to leave his home. He found refuge and counsel from his next-door neighbor. It was then he learned this was a SLH. In another neighborhood, a single mother reported feeling "safe" because of the SLH residents living across the street. They kept an eye on her house and reported to her when a group of teenagers climbed the fence to her property. She also commented that the SLH residents were good role models for her teenage son.

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Residents of phase II houses were viewed as quiet and they maintained their properties well. A few reports suggested there was admiration among neighbors for the changes the residents were attempting to make in their lives:

> ...I would hope that people would be more observant and respectful to them because they chose to take a different road with their life...they're trying to make a difference for their lives and themselves and their families so I would hope people would respect that.

One phase II SLH manager told a story of a neighbor expressing appreciation for their work recovering from alcohol and drug problems.

> ...she likes to bake a lot so she brought me like cake, right and she's like 'hi, I'm so and so. I live next door and I just came down here to support you and tell you that I'm so proud of you and I like what you guys are doing here and keep doing the right thing' and I was like "who are you?"...they're like an awesome old couple next door and they have a couple grandchildren and like I said I walk out of the house, they ask me how I'm doing.

Improving the community context

All three stakeholder groups felt the reputation of CSTL in the local community benefited from a variety of volunteer activities in which residents participated. These included involvements in activities such as hosting a Christmas holiday party open to the local community and volunteering to support various events (e.g., parades, Veteran's Day activities and seasonal festivals). One house manager noted:

> ...so we do stuff like volunteer so that we don't get a [bad] name. Because you know a lot of us we stole a lot, we hurt a lot of people through our actions. So when we give back it shows the community that we're not like that now. We're trying to change. We're still people. We just had problem and we're fixing it now.

Phase I neighbors felt providing more information about SLHs and developing forums for more interaction would be good ways to improve relationships:

> "Well maybe if they had more interaction with the community as far as letting the community know what's goin' on, what their goals are, what their success rate is.

Other suggestions from phase I neighbors included distributing brochures about CSTL to local neighbors, inviting them to attend a question and answer meeting at the main facility, and promoting a neighborhood barbeque. One man appeared to be frustrated not having the phone number for whom to call if there were concerns. Another felt intimidated by the residents and feared he would be misunderstood if he raised his concerns. One neighbor suggested CSTL residents get involved in volunteer work, apparently not aware that CSTL residents were already involved in a variety of volunteer activities.

It is important to note that like neighbors of CSTL, house managers also felt increased contact and communication would improve relationships. Managers felt many concerns that neighbors had were based on fear rather than information about the program:

> I would challenge the skeptics to come spend a day or two around here and see how the people are; see how these places work; see what they promote, what kind of lifestyle they promote and you know see if their opinion hadn't changed in that period of time.

Another house manager felt similarly:

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> Like come on in and check it out. Bring a city council member, bring a newspaper reporter, you know bring whoever you'd like and come and see. It's not a cult....its people trying to better themselves.

Finally, like one of the neighbors, the coordinator of CSTL expressed a wish that residents could be involved in more volunteer activities, mentioning breast cancer awareness as an example.

Regulatory impact on SLHs

There is no state or local licensing of SLHs. Because anyone can set up a SLH and operate it as they wish, stakeholders felt there was a need for standards for SLHs. When asked about obstacles to expanding SLHs, several house managers noted that standards were important for both the houses and the operators, "I think there should be more strict guidelines on who can operate these places." One of the key informants noted, "...you know licenses or having somebody in the neighborhood that would involve you know the code of enforcement people." There was a clear sense among all participants that poorly run houses were a threat to all SLHs and they therefore needed to be dealt with "swiftly because they are the ones that make it bad for everybody else." None of the participants mentioned that CSTL was a member of the California Association of Addiction and Recovery Resources (CAARR), which does certify SLHs for compliance with basic safety, health, and operations standards.

There were differences of opinion among stakeholders about the need for a special use zoning permit. A few neighbors and key informants felt that any house containing more than six individuals required a special use permit or it would violate zoning laws. The owner challenged that contention citing the Americans with Disabilities Act and the Fair Housing Act:

> ...since we are considered disable Americans, which the total public and the whole government want to ignore... we're protected by the Fair Housing Act which says that people with addiction have to be treated like any other family. They can live together; they can have more than six people. Now if the county wants to limit it to six people and then anything over six people you get a use permit then that should apply to every family in Sacramento County as well.

When we asked house managers about the impact of regulatory laws and policies on SLH operations the nearly unanimous response was that these issues that were dealt with exclusively by the owner of CSTL. This individual is active in the local community and also has connections in state government. It is important to note that some of the earlier critics of CSTL now support the program. The owner attributes much of this shift to familiarity; the fact that critics were able to get to know him personally and observe what actually goes on in the houses.

Typology of factors supporting and hindering SLHs

Table 2 shows a summary of factors that support and hinder SLHs from the vantage point of different stakeholders.

DISCUSSION

Overall, there was significant support for SLHs across stakeholder groups. To some extent, our finding that phase II houses were either viewed favora by neighbors or were not perceived as different from any other house in the neighborhood replicates the study by Jason et al (2005) of Oxford Houses. Even when neighbors or key informant had criticisms of phase I houses, they nevertheless supported the importance of this type of service in the

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community and viewed it as preferable to alternative responses to alcohol and drug problems (e.g., criminal justice).

Concerns about phase I houses appeared to center mostly on issues such as the larger size and higher density of these houses in one area, as well as related concerns about noise and traffic. Only a few mentioned issues related to resident behavior, such as offensive language and leaving cigarette butts in the area. It is worth noting that even the most critical phase I neighbors supported the importance of recovery programs and sober housing as a concept. They tended to want the program to have more control over resident behavior and find solutions to the high density of houses and corresponding problems such as limited parking.

CSTL faces a dilemma in that the larger, higher density phase I houses were viewed as helpful to recovery by house managers and even by one of the neighbors. The large complex of adjacent phase I houses creates a sense of independent living blended with extensive support and some degree of structure, both of which are felt to be essential to recovery. The design also allows the owner, coordinator, house managers, and senior peers to monitor the behavior of new residents and address problems promptly. One could argue that the increased oversight and sense of community in phase I prepares residents for success in phase II, and thus leads to stable phase II houses in the community. Given the current scenario, the program might consider collaborating with neighbor about ways to address issues such as parking and traffic congestion. Examples might include holding some meetings off-site or developing alternative places to park when large meetings are held at the facility. Efforts to maintain a "good neighbor" policy by enforcing rules that limit noise, offensive language, cigarette butts, etc. are clearly important.

In a number of areas there was significant agreement among stakeholder groups. Most of the factors supporting and hindering SLHs were identified by participants from at least two groups. For example, the importance of volunteering was mentioned by most of the house managers as well as some neighbors. Size and density were viewed as hindrances by neighbors, especially those who lived near phase I houses, as well as some of the key informants. Both house managers and key informants viewed characteristics and activities of the owner as important to the success of CSTL. Neighbors and managers both felt increased communication and familiarity with SLH operations could help improve relationships. Nuisance problems (e.g., parking) were viewed as a hindrance by neighbors and key informants and all three groups felt that even a limited number of poorly run houses could threaten the viability of all SLHs. Adopting "good neighbor" practices was viewed as essential by nearly all participants.

Communication with neighbors

One of the clearest findings was that both house managers and phase I neighbors felt the need for more communication and interaction. Phase II neighbors, in contrast, were fairly unanimous in their praise of SLHs in their neighborhood and thus felt little need to take action to improve relationships. Given the current stability and successes of phase II houses, the best approach might be to leave well enough alone.

Phase I neighbors and managers proposed specific suggestions for increasing communication that could be readily implemented. These included neighbors attending open houses at the program, the program distributing brochures about CSTL to local neighbors, neighbors spending a day at the program to experience what actually goes on, the program implementing a neighborhood barbeque and developing regular meetings with managers and neighbors to address questions and concerns that arise.

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It should be mentioned that the owner of CSTL reported some previous efforts in this regard that were not very successful. One involved going door to door in the neighborhood to introduce the program, which yielded some negative comments and threats. The other involved some ice cream socials that were poorly attended. On at least two occasions letters were sent out to neighbors containing a brief description about CSTL and contact numbers. It is not clear why these efforts were not more successful. It could be that developing a meaningful and sustained impact on the surrounding neighbors will require regular and varied activities, such as regular social events, more substantive forums to address neighborhood issues and problems, and a monthly or quarterly brochure that is distributed to each neighbor.

Although CSTL residents are involved in extensive volunteer work in the local area, there may be a need for more of those activities in the immediate neighborhood. Several immediate neighbors did not appear to be aware of volunteer activities in which CSTL residents participate and they suggested volunteering would improve relationships with the community.

Addressing stigma

House managers believed that stigma plays a strong role in biasing some neighbors against SLHs and their residents. This view was shared by participants in our previous work (e.g., Polcin et al., in press), where addiction counselors and mental health therapists rated stigma as the main obstacle to expanding SLHs. Stigma was rated as a higher obstacle than practical issues such as not have sufficient financial resources to pay for residence in a SLH. In our interviews for this study we found negative assumptions about SLHs when neighbors expressed concerns about increasing crime and decreasing housing values but were not able to support their claims with specific examples.

A good way of addressing stigma was suggested by several house managers. They argued convincingly that the more the local community understood about the day to day operations of CSTL and the residents who lived there the more they would support SLHs in this and other communities. Instead of relying on preconceived biases and notions, they would increasingly base their views on observations about what occurs and interactions with residents. Contact with stigmatized groups as a way to decrease stigma is a strategy supported by a variety of stigma researchers (e.g., Corrigan et al., 2001). It might be particularly helpful to create forums where successful residents could interact with neighbors and share the stories about addiction and recovery. In addition to decreasing negative assumptions about addicts and alcoholics, such interactions might offer hope to families who have a member suffering from a substance use disorder.

Managing community relations

A number of managers and key informants noted how the owner was well connected within the local community (e.g., president of the local chamber of commerce) and used those connections in service of CSTL. A notable limitation of this scenario is that mobilizing community influences in ways that support CSTL was the purview solely of the owner. There is considerable risk that if this individual were not around, the relationships with local and state officials would evaporate. It was striking how little house managers and residents knew about critical issues directly affecting the viability of CSTL, such as zoning laws, the Fair Housing Act, Americans with Disabilities Act, and initiatives at the state level to limit SLHs. Increasing their knowledge of and involvement in these issues would leave the program less vulnerable. This could be accomplished through delegating house managers to attend selected meetings and discussion with the owner about how to best represent the interests of CSTL.

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Implications for community based programs

Study findings suggest important considerations, not only for SLHs, but for community based programs more generally. One area where there was nearly unanimous agreement across stakeholder groups was the importance of being good neighbors. Therefore, community based programs need to have policies and resources that ensure upkeep of the facilities to standards consistent with the local neighborhood. Further, there need to be policies in place to contain potentially destructive behaviors, such as drug use and other behaviors that would be experienced as unacceptable (e.g., destruction of property). For example, "Housing First" models for substance use disorders that tolerate alcohol and drug use would not do well in the neighborhoods we studied. To avoid open community resistance, it would seem that these types of harm reduction services would need to be located in areas where substance use is more tolerated. In addition, community based programs need to have mechanisms for handling complaints from neighbors. While CSTL was praised by key informants for responding to complaints promptly, a few phase I neighbors were unsure whom to contact and others felt intimidated and that left them feeling frustrated and more negative toward the program. Phase II neighbors did not express this uncertainty and seemed comfortable approaching residents of phase II houses.

Another consideration is how to handle the issue of anonymity. We found that small, sparsely populated phase II houses were viewed favorably or were unknown to neighbors. One workable option for community programs in such circumstances might be to maintain a relatively low profile and simply blend in with the local community. However, when programs are larger and their presence is obvious, it may be necessary to directly address the concerns of local neighbors, especially to counteract negative assumptions associated with stigma. Such a strategy requires forums for such interaction to occur. Both house managers and neighbors had suggestions in this regard, ranging from neighborhood barbeques to information meetings that describe the program and respond to neighbor questions and concerns.

All of our stakeholder groups emphasized the importance of volunteer work. The specific types of activities that community programs get involved in might be dependent in part on the types of clients served and their capabilities. However, it seems that some very public way of showing involvement in and support for the community is important to garner support. In part, volunteer work might be viewed as important because volunteer work contradicts assumptions associated with the stigma of addiction, such as crime and exploitation of others.

It was clear from our interviews that the owner of CSTL had a long history of successfully managing challenges to CSTL and navigating through the political and regulatory environment. He appeared to persevere using a combination of knowledge about his rights and applicable laws, involvement in local and state politics, and personal relationships that he was able to develop with individuals who were once his adversaries. Such an individual can be invaluable to the development of successful organizations. However, there are serious questions about how the program could maintain its position in the community and its political strength if this individual were not around. CSTL and other community based programs might do well to consider shared models of leadership and responsibility (e.g., Polcin, 1990) for promoting the program's agenda within political and regulatory circles.

Limitations

There are some inherent limitations in our study that are important to note. First, all of the interviews took place in one Northern California County and the issues relative to SLHs there might not generalize to other geographic regions. Second, all of the house managers

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were part of CSTL and all of the neighbors resided near CSTL facilities. Although CSTL has implemented the sober living house principles promoted by the California Association of Addiction and Recovery Resources in California, there may be individual factors that are unique to CSTL that limit generalization of results. Other SLHs with different characteristics (e.g., size, management, cost and house rules) might have different issues. Finally, the results are specific to SLHs and might not generalize to other types of housing, such as halfway, step down and Oxford houses.

Acknowledgments

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Table 1

Sample characteristics by stakeholder group

STAKE-HOLDER GROUP	GENDER		RACE				MARITAL STATUS				
	MALE	FEMALE	WHITE	BLACK	HISPNIC	MIXED RACE	SINGLE	MARRIED	DIVORCED	SEPARATED	WIDOW/ WIDOWER
House Managers N = 17	14 (82%)	3 (18%)	15 (88%)			2 (12%)	10 (59%)	1 (6%)	4 (23%)	2 (12%)	
Neighbors N = 20	10 (50%)	10 (50%)	18 (90%)	1 (.05%)	1 (.05%)		3 (15%)	13 (65%)	1 (5%)	2 (10%)	1 (5%)
Key Informants N = 6	2 (33%)	4 (67%)	5 (83%)	1 (17%)			1 (17%)	5 (83%)			

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Table 2

Factors supporting and hindering sober living houses

	Supporting	Hindering
House Managers	Volunteering Characteristics of Owner Familiarity with SLHs Addressing Complaints Promptly Scope of Addiction Problems Communication	Poorly run houses Stigma Criminal Justice Mandated Dual Diagnosis Finances
Neighbors	Volunteering Familiarity with SLHs Addiction in Family Good Neighbor Behaviors Addressing Complaints Promptly Communication	Poorly run houses Nuisance Problems Perceptions of Crime Perceptions that housing values decline Large houses Densely populated houses
Key Informants	Characteristics of Owner Addressing Complaints Promptly Scope of Addiction Problems	Poorly run houses Nuisance problems Zoning Laws Large houses Densely populated houses Finances

Note: Poorly run houses include factors such as poor appearance and lack of resident accountability.

Nuisance problems include factors such a noise level, parking, offensive language and cigarette butts.

Hindering factors for neighbors primarily refer to Phase I houses.

RESOLUTION NO. PC-16-

A RESOLUTION OF THE PLANNING COMMISSION OF THE CITY OF COSTA MESA APPROVING PLANNING APPLICATION PA-16-44 FOR A SOBER LIVING FACILITY OPERATED BY CASA CAPRI RECOVERY HOUSING 14 WOMEN WITHIN 4 EXISTING UNITS ON PROPERTY LOCATED AT 269 E. 16TH PLACE

THE PLANNING COMMISSION OF THE CITY OF COSTA MESA HEREBY RESOLVES AS FOLLOWS:

WHEREAS, an application was filed by Casa Capri Recovery, requesting approval of ***Planning Application PA-16-44,*** a Conditional Use Permit for a Sober Living Facility housing 14 women within four existing attached units;

WHEREAS, the project has been reviewed for compliance with the California Environmental Quality Act (CEQA), the CEQA Guidelines, and the City of Costa Mesa Environmental Guidelines, and has been found to be categorically exempt from CEQA under Section 15301 for Existing Facilities.

WHEREAS, the CEQA categorical exemption for this project reflects the independent judgment of the City of Costa Mesa.

WHEREAS, a duly noticed public hearing was held by the Planning Commission on November 14, 2016 with all persons having the opportunity to speak for and against the proposal.

BE IT RESOLVED that, based on the evidence in the record and the findings contained in Exhibit A, and subject to the conditions of approval contained within Exhibit B, the Planning Commission hereby **APPROVES** Planning Application PA-16-41.

BE IT FURTHER RESOLVED that the Costa Mesa Planning Commission does hereby find and determine that adoption of this Resolution is expressly predicated upon the activity as described in the staff report for Planning Application PA-16-41 and upon the applicant's compliance with each and all of the conditions in Exhibit B and compliance of all applicable federal, state, and local laws. Any approval granted by this resolution shall be subject to review, modification or revocation if there is a material change that occurs in the operation, or if the applicant fails to comply with any of the conditions of approval.

BE IT FURTHER RESOLVED that if any section, division, sentence, clause, phrase or portion of this resolution, or the documents in the record in support of this resolution, are for any reason held to be invalid or unconstitutional by a decision of any court of competent jurisdiction, such decision shall not affect the validity of the remaining provisions.

PASSED AND ADOPTED this 14th day of November, 2016.

Robert L. Dickson Jr., Chair
Costa Mesa Planning Commission

STATE OF CALIFORNIA)
)ss
COUNTY OF ORANGE)

I, Jay Trevino, Secretary to the Planning Commission of the City of Costa Mesa, do hereby certify that the foregoing Resolution was passed and adopted at a meeting of the City of Costa Mesa Planning Commission held on November 14, 2016 by the following votes:

AYES: COMMISSIONERS

NOES: COMMISSIONERS

ABSENT: COMMISSIONERS

ABSTAIN: COMMISSIONERS

_____
Jay Trevino, Acting Secretary
Costa Mesa Planning Commission

EXHIBIT A

FINDINGS FOR APPROVAL

A. The application presented substantially complies with Costa Mesa Municipal Code Section 13-29(g)(2) in that:

Finding: The proposed development or use is substantially compatible with developments in the same general area and would not be materially detrimental to other properties within the area.

Facts in Support of Findings: A sober living home is a supportive living environment for persons who are recovering from drug and/or alcohol addiction. Since the Planning Commission has denied the applicant's request to operate a sober living home on the adjoining property at 269 16th Place (PA-16-41), the subject property is not within 650 feet of any other state licensed drug and alcohol facility or sober living home that is currently permitted pursuant to City of Costa Mesa land use requirements. This separation helps to preserve the residential character of neighborhoods and facilitates General Plan Land Use Element Goal LU-1F.1 and Housing Element Goal HOU-1.2 in that it protects existing stabilized residential neighborhoods, including mobile home parks (and manufactured housing parks) from the encroachment of incompatible or potentially disruptive land uses and/or activities. The configuration of the buildings and the site's proximity to an alley on the easterly property line help mitigate potential impacts.

The sober living home has operated at this location for more than five years. During that time, the City has not received any complaints from surrounding residents regarding the operation of the facility. The facility has not generated excessive requests for emergency services. The property is well maintained. The applicant has demonstrated that this facility is operated in a manner that does not conflict with the residential character of the neighborhood. There will be no more than two occupants per bedroom. Residents are not allowed to keep vehicles at the facility; shuttle service is provided. There is adequate space to accommodate vehicles belonging to the staff and visitors on the driveway and on the street.

Finding: Granting the conditional use permit will not be materially detrimental to the health, safety and general welfare of the public or otherwise injurious to property or improvements within the immediate neighborhood.

Facts in Support of Findings: As part of the application process, the sober living operator was required to Live Scan all owners/operators who have contact with residents, corporate officers with operational responsibilities and house managers. Additionally, the applicant submitted a copy of the House Rules, Relapse Policy and all forms distributed to residents. These documents demonstrate that the facility will be operated in a manner consistent with the provisions of the Costa Mesa Municipal Code. There have

not been any code enforcement complaints since Casa Capri Recovery began operating at the property more than five years ago. Further, the facility has not generated calls for emergency services in excess of those commonly generated by residences in the area.

The Costa Mesa Municipal Code and the conditions of approval require the owner to operate the facility in a manner that will allow the quiet enjoyment of the surrounding neighborhood. Existing mature landscaping and fences provide a buffer from adjacent properties and the adjoining street and sidewalk, helping to minimize impacts to the surrounding neighborhood. The operator will provide contact information to neighbors if there are any concerns regarding operation of the facility. The sober living home is subject to a City inspection of the interior and/or exterior of the facility to verify that the approved use has not been altered and that the property complies with all applicable code(s) upon 24 hours written notice (or up to 48 hours under special circumstances).

The operator is an active member of The Sober Living Network, a non-profit organization that sets the most comprehensive standards for sober living homes in the nation. This organization conducts annual inspections to insure member facilities are in compliance. The standards promulgated by this organization can be found at www.soberhousing.net. These standards reinforce the City's regulations.

The facility will house up to 14 residents in four attached units. Combined, these units include eight bedrooms and four bathrooms. There are also four kitchens, four indoor living areas, and an outdoor living area. The project complies with the City's parking standards. The proposed occupancy of the facility is reasonable. The owner has demonstrated an ability to operate the facility in a manner that is compatible with the neighborhood.

Finding: Granting the conditional use permit will not allow a use, density or intensity which is not in accordance with the general plan designation and any applicable specific plan for the property.

Facts in Support of Findings: The use is consistent with Housing Element Goal HOU-1.8 of the General Plan, which encourages the development of housing that fulfills specialized needs by providing living opportunities for disabled individuals. The facility provides an accommodation for the disabled that is reasonable and actually resembles the opportunities afforded non-disabled individuals to use and enjoy a dwelling unit in a residential neighborhood. The facility offers a comfortable living environment that will enhance opportunities for the disabled, including recovering addicts, to be successful in their programs.

The subject property contains four existing units on a single parcel. The proposed use is consistent with the general plan designation.

B. The project has been reviewed for compliance with the California Environmental Quality Act (CEQA), the CEQA Guidelines, and the City's environmental procedures. The project is categorically exempt from the provisions of the California Environmental Quality Act (CEQA) under Section 15301 for Existing Facilities.

C. The project is exempt from Chapter XII, Article 3 Transportation System Management, of Title 13 of the Costa Mesa Municipal Code.

EXHIBIT B

CONDITIONS OF APPROVAL

Plng.

1. Once issued by the City, the owner shall maintain in good standing, an operator's permit as required by Article 23, Chapter 2 of Title 9.

2. The total number of occupants in the sober living home shall be no more than 14.

3. The use shall be limited to the type of operation described in the staff report and applicant's project description submitted with the application on May 9, 2016, subject to conditions. Any change in the operational characteristics including, but not limited to, home rules and regulations, intake procedures or relapse policy, shall be subject to Community Improvement Division review and may require an amendment to the conditional use permit, subject to either Zoning Administrator or Planning Commission approval, depending on the nature of the proposed change. The applicant is reminded that Code allows the Planning Commission to modify or revoke any planning application based on findings related to public nuisance and/or noncompliance with conditions of approval [Title 13, Section 13-29(o)].

4. Applicant shall defend, with the attorney of City choosing, and shall indemnify and hold harmless the City, its officials and employees, against all legal actions filed challenging City's approval of the applicant's project and/or challenging any related City actions supporting the approval.

5. A copy of the conditions of approval for the conditional use permit must be kept on premises and presented by the house manager to any authorized City official upon request. New business/property owners shall be notified of conditions of approval upon transfer of the business or ownership of land.

6. The project is subject to compliance with all applicable Federal, State, and local laws.

7. All vehicles associated with the residence, including residents and staff, shall be limited to parking on the property and/or on the street within 500 feet of the property.

8. It shall be the applicant's responsibility to maintain current information on file with the City regarding the name, address and telephone number of the property manager and/or owner.

9. The property shall be maintained in accordance with landscape maintenance requirements contained in Costa Mesa Municipal Code Section 13-108.

10. Each dwelling unit shall be limited to one mailbox and one meter for each utility.

11. The facility shall operate at all times in a manner that will allow the quiet enjoyment of the surrounding neighborhood consistent with Title 20 of the Costa Mesa Municipal Code. The applicant and/or manager shall institute whatever measures are necessary to comply with this requirement.

12. If any building alterations are proposed, the applicant shall comply with requirements of the California Building Code as to design and construction.

13. The applicant shall obtain a fire clearance from the Costa Mesa Fire Department pursuant to the requirements of the current version of the California Fire Code within 30 days of the date of approval of this Permit.

14. Applicant shall provide neighbors with the telephone number of the on-site manager and/or property owner, for the purposes of allowing neighbors to lodge complaints or describe concerns about the operation of the facility.

15. 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; education counseling; individual or group counseling sessions; and treatment recovery or planning.

CID 16. The applicant is responsible to ensure that occupants, if any, who are subject to the requirements of Health & Safety Code section 11590 et seq. (Registration of Controlled Substance Offenders), Penal Code section 290 et seq. (Sex Offender Registration Act), and/or any condition of probation or parole, are in compliance with any applicable requirements and conditions of their registration, probation and/or parole while they are occupants or residents of the subject property.

17. Vehicles picking up or dropping off passengers at the facility shall not block traffic or create hazardous conditions and shall comply with all applicable provisions of the California Vehicle Code and Title X of the Costa Mesa Municipal Code.

18. The applicant shall comply with any and all water conservation measures adopted by the Mesa Water District that apply to multi-family residences and/or properties.

19. The applicant shall post a copy of the Good Neighbor Policy in at least one highly visible location inside the facility and in at least one highly visible location in all side and rear yards.

20. Operator shall ensure that no trash and debris generated by tenants is deposited onto the City's rights of way pursuant to Section 8-32 of the Costa Mesa Municipal Code.

21. The applicant shall comply with reservation procedures implemented by the City's Parks and Community Services Department to reserve park shelters or picnic areas for special events.

22. This CUP is subject to review if the applicant fails to comply with any of the conditions of approval listed in this resolution and/or the facility creates an excessive amount of calls for City services.

23. Pursuant to Section 9-374 of the Costa Mesa Municipal Code, upon eviction from or involuntary termination of residency in a group home, the operator of the group home shall make available to the occupant transportation to the address listed on the occupant's driver's license, state issued identification card, or the permanent address identified in the occupant's application or referral to the group home. The group home may not satisfy this obligation by providing remuneration to the occupant for the cost of transportation.

CODE REQUIREMENTS

The following list of federal, state and local laws applicable to the project has been compiled by staff for the applicant's reference. Any reference to "City" pertains to the City of Costa Mesa.

Plng. 1. Use shall comply with all requirements of Chapter XVI of the Costa Mesa Municipal Code relating to development standards for sober living homes in multi-family residential zones.

Bldg. 2. At the time of plan submittal or permit issuance, the applicant shall comply with the requirements of the California Code of Regulations, also known as the California Building Standards Code, as amended by the City of Costa Mesa, including, as applicable, the adopted California Building Code, California Electrical Code, California Mechanical Code, California Plumbing Code, California Green Building Standards Code and California Energy Code.

RESOLUTION NO. PC-16-

A RESOLUTION OF THE PLANNING COMMISSION OF THE CITY OF COSTA MESA UPHOLDING THE DIRECTOR'S DENIAL OF CASA CAPRI RECOVERY'S REASONABLE ACCOMMODATION REQUEST TO ALLOW THE OPERATION OF A GROUP HOME, RESIDENTIAL CARE FACILITY OR STATE LICENSED DRUG AND ALCOHOL TREATMENT FACILITY ON TWO CONTIGUOUS PROPERTIES AT 269 AND 271 16th PLACE; AND DENYING CONDITIONAL USE PERMIT PA-16-41 TO ALLOW A SOBER LIVING FACILITY SERVING UP TO 14 WOMEN AT 269 16TH PLACE.

WHEREAS, Case Capri Recovery (the "Applicant") operates a sober living facility at 269 16th Place, Costa Mesa; and

WHEREAS, an application was filed by the Applicant requesting approval of **Planning Application PA-16-41,** a Conditional Use Permit to allow the subject facility to serve up to 14 women within four existing units; and a request for a reasonable accommodation to allow this facility to be located within 650 feet of another property that contains a group home, sober living home or state licensed druag and alcohol treatment faciltity, allowing the units on these contiguous parcels to operate as a single facility; and

WHEREAS, the City of Costa Mesa recognizes that while not in character with residential neighborhoods, when operated responsibly, group homes, including sober living homes, provide a societal benefit by providing disabled persons as defined by state and federal law 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, the City of Costa Mesa has adopted standards for the operation of group homes, residential care facilities and state licensed drug and alcohol facilities that are intended to provide opportunities for disabled persons as defined by state and federal law to enjoy comfortable accommodations in a residential setting; and

WHEREAS, the City of Costa Mesa has found that congregating sober living homes in close proximity to each other does not provide disabled persons as defined in state and federal law 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 disabled, and which no reasonable person could contend provides a life in a normal residential surrounding; and

WHEREAS, the City of Costa Mesa has determined that a separation requirement for such facilities 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-disabled individuals in a similar living situation (i.e., in boardinghouse-style residences) have fewer housing opportunities than disabled persons; and

WHEREAS, Casa Capri Recovery filed an application with the City's Director of Economic and Development Services/Deputy CEO (the "Director") requesting an accommodation from the Costa Mesa Municipal Code's requirement that a group home, residential care facility or state licensed drug and alcohol facility is at least 650 feet from another property that contains a group home, sober living home or state licensed drug and alcohol treatment facility, as measured from the property line (the "Application"); and

WHEREAS, the applications were processed in the time and manner prescribed by federal, state and local laws, and the Director denied the request for the reasonable accommodation; and

WHEREAS, Casa Capri Recovery appealed the denial of the reasonable accommodation request in a timely manner; and

WHEREAS, a duly noticed public hearing was scheduled for November 14, 2016, before the Planning Commission to hear the appeal and the conditional use perimit; and

WHEREAS, on November 14, 2016, the Planning Commission conducted a duly noticed public hearing, at which time interested persons had an opportunity to testify either in support of or in opposition to the applications and determined by a X-X vote to deny the Application.

NOW THEREFORE, the Planning Commission of the City of Costa Mesa finds and resolves as follows:

BE IT RESOLVED, therefore, that based on the evidence in the record and the findings contained in this resolution, the Planning Commission hereby **UPHOLDS THE DIRECTOR'S DENIAL** of Casa Capri, LLC's reasonable accommodation request to allow the operation of a group home, residential care facility or state licensed drug and alcohol treatment facility on contiguous properties; and **DENIES** Conditional Use Permit PA-16-41.

The Secretary of the Commission shall attest to the adoption of this resolution and shall forward a copy to the applicant, and any person requesting the same.

PASSED AND ADOPTED this 14th day of November, 2016.

Robert L. Dickson Jr., Chair
Costa Mesa Planning Commission

STATE OF CALIFORNIA)
)ss
COUNTY OF ORANGE)

I, Jay Trevino, Secretary to the Planning Commission of the City of Costa Mesa, do hereby certify that the foregoing Resolution was passed and adopted at a meeting of the City of Costa Mesa Planning Commission held on November 14, 2016 by the following votes:

AYES: COMMISSIONERS

NOES: COMMISSIONERS

ABSENT: COMMISSIONERS

ABSTAIN: COMMISSIONERS

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Jay Trevino, Acting Secretary
Costa Mesa Planning Commission

EXHIBIT A

FINDINGS FOR DENIAL

The City's evidence

The City's evidence consists of a staff report with attachments. The staff report provided the factual background, legal analysis and the City's analysis supporting the denial of Casa Capri, LLC's reasonable accommodation request, based on the Applicant not meeting its burden to demonstrate compliance with all required findings per the Costa Mesa Municipal Code.

A. The Applicant has not met its burden to show that the Application meets the following findings for approval of Reasonable Accommodation:

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

  The application established that the requested accommodation (waiver of the 650-foot separation requirement) may allow a CUP to be granted to enable Casa Capri, LLC, to continue to operate in compliance with the Costa Mesa Municipal Code at its current location. In theory, this action would allow one or more individuals who are recovering from drug and alcohol abuse to enjoy the use of this dwelling. However, approval of the request is not necessary to allow one or more individuals who are recovering from drug and alcohol abuse to enjoy the use of a dwelling within the City.

- Applicant has not met its burden to show whether the existing supply of facilities of a similar nature and operation in the community is insufficient to provide individuals with a disability an equal opportunity to live in a residential setting.

  Based on the most recent data compiled by City staff, there are approximately 98 sober living homes within Costa Mesa. Of these, 37 are located in single-family neighborhoods and 61 are within multi-family residential zones. Additionally, there are approximately 81 state licensed drug and alcohol residential care facilities in Costa Mesa. Twenty-five are in single-family residential zones, 55 are in multi-family residential zones and one is in a C1 zone. No evidence has been submitted to indicate that the number of sober living homes and drug and alcohol residential care facilities existing or potentially allowed in compliance with the City's standards is inadequate.

- Applicant has not met its burden to show whether the requested accommodation is consistent with whether or not the residents would constitute a single housekeeping unit.

According to the City's definition of a sober living home, a sober living home's residents do not constitute a single housing keeping unit. The requested accommodation is for a provision of the Costa Mesa Municipal Code that would not apply to single housekeeping units. Therefore, this finding is not relevant.

- Applicant did not demonstrate that the requested accommodation is necessary to make facilities of a similar nature or operation economically viable in light of the particularities of the relevant market and market participants.

  The applicant did not provide evidence in its application regarding this factor; therefore, City staff was not able to make this finding. As noted above, there is a significant number of sober living facilities in Costa Mesa.

- Applicant was not able to demonstrate that the requested accommodation will not result in a fundamental alteration in the nature of the City's zoning program.

  The City's separation standard of 650 feet was intended to ensure that there would be no more than one group home, residential care facility or state licensed drug and alcohol facility on any block. In addition, the Municipal Code limits the operation of any sober living facility to a single parcel, again to prevent overconcentration of sober living units. Therefore, approval of the accommodation request will result in a fundamental alteration of the City's zoning program, as set forth in Ordinance numbers 14-13 and 15-11, because it would contribute to the overconcentration of these types of facilities in this residential neighborhood.

  The burden to demonstrate necessity remains with the Applicant. Oconomowoc, 300 F.3d at 784, 787. Applicant must show that "without the required accommodation the disabled will be denied the equal opportunity to live in a residential neighborhood." Oconomowoc, 300 F.3d at 784; see also, United States v. California Mobile Home Mgmt Co., 107 F3d 1374, 1380 (9th Cir. 1997) ("without a causal link between defendants' policy and the plaintiff's injury, there can be no obligation on the part of the defendants to make a reasonable accommodation"); Smith & Lee, Inc. v. City of Taylor, Mich., 102 F.3d 781, 795 (6th Cir. 1996) ("plaintiffs must show that, but for the accommodation, they likely will be denied an equal opportunity to enjoy the housing of their choice").

  The Applicant has asserted that the requested accommodation from the 650-foot distance requirement is reasonable. However, a zoning accommodation may be deemed unreasonable if "it is so at odds with the purposes behind the rule that it would be a fundamental and unreasonable change." Oconomowoc, 300 F.3d at 784. The Applicant made no mention of the purpose underlying the City's zoning limitation, or explained how the accommodation requested would not undermine that purpose. In fact, the Director found that such allowance would fundamentally alter the character of this neighborhood and is thus unreasonable.

Allowing multiple group homes, sober living homes and/or state licensed drug and alcohol treatment facilities to cluster in a residential neighborhood does effect a fundamental change to the residential character of the neighborhood. The clustering of group homes in close proximity to each other does change the residential character of the neighborhood to one that is far more institutional in nature. This is particularly the case with respect to sober living homes. Both California and federal courts have recognized that the maintenance of the residential character of neighborhoods is a legitimate governmental interest. The United States Supreme Court long ago acknowledged the legitimacy of "what is really the crux of the more recent zoning legislation, namely, the creation and maintenance of residential districts, from which business and trade of every sort, including hotels and apartment houses, are excluded." Euclid v. Amber Realty Co., 272 U.S. 365, 390 (1926).

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

> It is axiomatic that the welfare, and indeed the very existence of a nation depends upon the character and caliber of its citizenry. The character and quality of manhood and womanhood are in a large measure the result of home environment. The home and its intrinsic influences are the very foundation of good citizenship, and any factor contributing to the establishment of homes and the fostering of home life doubtless tends to the enhancement not only of community life but of the life of the nation as a whole.

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

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

Ewing v. City of Carmel-by-the-Sea, 234 Cal. App. 3d 1579, 1590 (1991), *citing* Miller, 195 Cal. at 493. It is with these purposes in mind that the City of Costa Mesa has created residential zones, including R2 zones for multi-family residences.

The requested accommodation, in these specific circumstances, would result in a fundamental alteration of the City's zoning program, as set forth in Ordinance numbers 14-13 and 15-11, because it would increase and/or contribute to the overconcentration of these types of facilities in this residential neighborhood.

B. The Application does not meet the findings required by the Costa Mesa Municipal Code for approval of a Conditional Use Permit:

- *The proposed use is substantially compatible with developments in the same general area and would not be materially detrimental to other properties within the area.*

  The introduction of one sober living home in compliance with the City's standards would not be materially detrimental to the area. However, over the last decade, the number of sober living homes in the City of Costa Mesa has rapidly increased, leading to an overconcentration of sober living homes in certain of the City's residential neighborhoods. Overconcentration is both deleterious to the residential character of these neighborhoods and may also lead to the institutionalization of such neighborhoods. The City's establishment of distance requirements for sober living homes is reasonable and non-discriminatory and helps preserve the residential character of the R2MD, R2HD, and R3 zones, as well as the planned development residential neighborhoods. It but also furthers the interest of ensuring that the handicapped are not living in overcrowded environments that are counterproductive to their well-being and recovery. Allowing a single facility to operate on two parcels would contribute to an overconcentration of such facilities in this neighborhood.

- *Granting the CUP will not be materially detrimental to the health, safety and general welfare of the public or otherwise injurious to property or improvements within the immediate neighborhood.*

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

  Strong evidence exists that a supportive living environment in a residential neighborhood provides more effective recovery than an institutional-style environment (see Attachments 5 and 6 to the staff report). The City's zoning regulations address overconcentration and secondary effects of sober living homes. The goal of the regulations is to provide the disabled with an equal opportunity to live in the residence of their choice, and to maintain the residential character of existing neighborhoods.

  The City has found through experience that clustering sober living facilities in close proximity to each other results in neighborhoods dominated by sober living

facilities. In these neighborhoods, street life is often characterized by large capacity vans picking-up and dropping-off residents and staff, service providers taking up much of the available on street parking, staff in scrubs carrying medical kits going from unit to unit, and vans dropping off prepared meals in large numbers. The City has experienced frequent Fire Department deployments in response to medical aid calls. In some neighborhoods, 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 meeting 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. These types of impacts have been identified in other communities as well (see Attachment 7 to the staff report).

- *Granting the conditional use permit will not allow a use which is not in accordance with the general plan designation.*

  The proposed use is consistent with the City's General Plan if it complies with the City's criteria. However, an overconcentration of group homes, sober living homes and licensed treatment facilities for alcohol and drug addiction is not consistent with the General Plan. The City's regulations are intended to preserve the residential character of the City's neighborhoods. The City Council has determined that an overconcentration of sober living facilities would be detrimental to the residential character of the City's neighborhoods.

C. The Costa Mesa Planning Commission has denied Conditional Use Permit PA-16-15. Pursuant to Public Resources Code Section 21080(b) and CEQA Guidelines Section 15270(a), CEQA does not apply to this project because it has been rejected and will not be carried out.

D. The project is exempt from Chapter IX, Article 11, Transportation System Management, of Title 13 of the Costa Mesa Municipal Code.

PH-1D

CURT A. HERBERTS, II
Owner of affected property at
268 E. 16th Street, Costa Mesa
DBA Pacifica Townhomes
234 E. 17th Street, Suite 118
Costa Mesa, California 92627

November 7, 2016

Katie Angel
Katie.Angel@costamesaca.gov

Re: 269 & 271 16th Place, Notice of Public Hearing
Your ref: Application No. PA-16-41 and PA-16-44

Dear Katie,

Upon receipt of the notice requesting feedback in regards to the proposed issuance of the conditional use permit for a sober living facility, operated by Casa Capri, LLC, at 269 and 271 16th Place, Costa Mesa, I would request the planning commission and/or the city council deny the request for the following reasons:

First, we request you to please deny due to the lack of compliance with the required statutory separation between two properties being less than 650 feet from each other.

Second, we request denial because in the past we have had issues with excessive noise from a sober living facility and complaints from our tenants.

Third, the issue with excessive smoking invading the neighboring properties causes complaints and disturbances in the neighborhood and with our tenants.

Lastly, the proposed 28 occupants for this facility, not including staff, would be wholly under parked for the approximate 10-12 parking spaces that the two 4-plexes currently have available.

For these reasons and others to become more apparent as we are aware that the subject property has been a sober living facility for some time, we would request that you deny Casa Capri, LLC, or any other entity which would request this property for sober living use.

Please feel free to contact me with any questions or concerns. Thank you for your consideration of the issues and the concerns of the neighboring property owners.

Sincerely,

Curt A. Herberts, II
949.631.6004
Herberts.pcrg@sbcglobal.net

PH-1D

11/14/2016

Bob Malanga
1630 Santa Ana Ave
Costa Mesa, CA 92627

Planning Division
City of Costa Mesa

Re: Zoning Decision Application **No. PA-16-41** and **PA-16-44**

I am writing regarding the proposed conditional use permit for Casa Capri LLC. I strongly believe that the Economic Development Services Director made the correct decision to deny Casa Capri LLC's request for Reasonable Accommodation to obtain relief from Title 13, Chapter XVI (Group Homes) of the Costa Mesa Zoning Code.

This Costa Mesa Zoning Code was put into place for very valid concerns over the extremely transient populations creating problems in our residential neighborhoods that are not typically associated with traditional residential populations.

Over the last several years the transient population in our neighborhood created by sober living facilities has caused an increase in trash, public drug use, and homelessness. My typical morning for many years has involved me cleaning broken alcohol bottles and cigarette butts off the sidewalk in front of my house. We have seen an increase of publicly intoxicated and homeless groups sitting in front of and sometimes sleeping at Circle K as well as the surrounding parks. This creates a very unsafe environment for the children traveling to and from Newport Heights Elementary School.

Since Costa Mesa's settlement with Solid Landings Behavioral Health there has been a reduction of sober living facilities in our neighborhood and we are already starting to see progress. The trash in front of my house has reduced and I have not seen the group of homeless that were sleeping next to Circle K in over 2 months. Although the conditions of our city are moving in the correct direction we still have a long way to go.

Continuing to hold sober living facilities, group homes, and drug/alcohol treatment facilities to the Costa Mesa Zoning Codes will help keep our city on the right track.

Thank You,

Bob Malanga
949-466-0410

Received
City of Costa Mesa
Development Services Department

NOV 14 2016