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TREATMENT · RESEARCH · EDUCATION

OXFORD HOUSES EVALUATION FINDINGS

October 2017

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GREAT HEALTH AND WELLBEING

Acknowledgements

The authors would like to thank the teams at SHARC and Mind for the opportunity to produce this report, which makes a valuable contribution to the limited peer-based recovery literature.

We are also deeply appreciative of the collaborative spirit demonstrated by the staff at SHARC and Mind, and the generosity and cooperation of the residents of Oxford Houses, without whom this evaluation could not have been conducted.

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Published by Turning Point which is a part of Eastern Health.

This project was funded by SHARC through the Commonwealth Department of Health (DoH).

The responsibility for all statements made in this document lies with the authors. The views of the authors do not necessarily reflect the views and position of SHARC or DoH.

The suggested citation for this report is:

Thorn, P. Savic, M., Campbell, S. & Manning, V. (2017) *Oxford Houses evaluation findings*. Turning Point, Eastern Health, Fitzroy.

Abbreviations & Key Terms

Chapter	A collection of a group of Oxford Houses. Houses are grouped into chapters to ensure that each House has the opportunity to share their experiences as a collective and the experiences of individual residents
Chapter meeting	Regular forums that are open to past and present residents. Their principal functions are to engender intra-resident discussion and support, provide feedback to staff, facilitate the establishment of new Houses, and maintain adherence to program principles.
Connectedness	Refers in this report to interpersonal social connectedness, which encompasses a variety of dimensions, including egocentric network size, composition, and density, and the volume of social interaction with and closeness to members of the network
Mind Australia	A community-managed specialist mental health service provider
Mutual aid	Non-clinical and –professional help, typically from peers
Mutual aid groups	Collectives organised for the provision of mutual aid. In lay terms, self-help groups
Oxford Houses	A network of community-based, resident-administered, mutual aid residences for individuals in recovery
Problematic use	A pattern of use characterised by a dosage and/or frequency that has negative implications for the health and wellbeing of the user or people around the user
Recovery capital	Defined by Granfield and Cloud (1999) as “the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery”
SHARC	A Victorian community based, not-for-profit organization established to promote and provide peer-led, mutual-aid approaches to recovery from severe substance related issues for individuals and families
Wellbeing	Operationalised within this report as a the combination of psychological health, physical health, and overall quality of life

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Executive Summary

Background

Completion of alcohol and other drug (AOD) treatment doesn't necessarily guarantee long-term recovery. Relapse is common after treatment ends as individuals are faced with the challenges that use-facilitating environments and networks pose, as well as stigma and unstable housing in the community. Aftercare and support for long-term recovery is needed to maximise gains made in treatment and prevent relapse. However, aftercare is not routinely provided. This report examines the impacts of the Oxford Houses Australia program, which is run by The *Self Help Addiction Resource Centre* (SHARC) and *Mind Australia*, and aims to support long term recovery.

The *Self Help Addiction Resource Centre* (SHARC) is a Victorian community based, not-for-profit organization established to promote and provide peer-led, mutual-aid approaches to recovery from severe substance related issues for individuals and families. SHARC provides a range of services including Residential Peer Programs; Family Drug Help, and the Association of Participating Service Users.

Mind Australia is one of the country's leading community-managed specialist mental health service providers. Mind provides a comprehensive range of programs including; residential rehabilitation, outreach services, drug and alcohol, transition to independent living, transition to stable and secure accommodation, respite for carers, volunteer and mentor programs, individual service packages and programs that foster healthy living, creative expression and participation in employment.

Oxford Houses are residences for individuals in recovery from alcohol and other drugs. With the exception of those houses which allow residents to live with their minor children, they are single-sex dwellings. The houses are 4-6 bedroom rental properties leased by Oxford Houses Australia. They are democratically-administered by the residents, who are required to contribute equally to the upkeep of the Household by paying dues, completing chores, and fulfilling particular roles in the House. Insofar as they conform to these requirements, maintain abstinence, and don't engage in disruptive or unruly behaviour, there is no prescribed length of stay. The remit of Oxford Houses is to provide safe, supportive, and stable living environments in which residents can pursue long-term abstinence. While the effectiveness of Oxford Houses has been established overseas, this evaluation seeks to extend the evidence-base to Australia.

Methods

Commissioned by SHARC and Mind Australia, Turning Point conducted a six-month study of the Oxford Houses program. The purpose of this study was to evaluate key outcomes of the program to inform recommendations about the efficacy and sustainability of the program and areas for potential improvement.

The data presented were generously provided by Oxford Houses residents attending two Chapter meetings separated by six months. Outcomes explored include alcohol and other drug use (AOD) use, recovery capital, engagement in meaningful activity, connectedness, and wellbeing.

Findings

1. *Residents use alcohol and other drugs less frequently*
 - a. With the exception of tobacco, these data indicate a complete cessation of substance use among residents in Oxford Houses. While these results may be somewhat self-selecting—it may be that the Oxford Houses program is extremely effective at detecting and expelling residents who relapse, rather than effective per se in inducing and sustaining abstinence—at the very least they indicate that, so long as they remain in an Oxford House, residents are almost certainly successfully maintaining sobriety. Indeed, residents themselves reported remarkably high commitment to abstinence and to their continuing sobriety.
2. *Residents have increased recovery capital*
 - a. Compared with a population attending treatment as usual community rehabilitation services, Oxford Houses residents reported significantly higher recovery capital. With the caveat that all results require replication, from a clinical standpoint it is apparent that the Oxford Houses program provides an environment that is more conducive to the development of strengths and resources for recovery. Methodological constraints limit our ability to interpret these data longitudinally.
3. *Residents participate in meaningful activity*
 - a. Almost all residents reported active engagement with one or more Household roles and most residents frequently attending their House and Chapter meetings. Compared to their time in active addiction outside of an Oxford House, a higher proportion of residents were steadily employed and furthering their education. The mean number of days they spent engaged in these activities was 165% and 367% higher, respectively. Residents also reported less absenteeism, were less likely to lose or be fired from their jobs, and less likely to drop or fail out of school. One of the more striking results produced by this research regards the proportion of participants who engaged in meaningful volunteer activities. More than 90% of Oxford Houses residents were thusly engaged. This is particularly important given the substantial fiscal cost of funding substance use treatment; depending on the extent and character of residents' volunteering, it may represent a substantial indirect remuneration of their treatment costs.
4. *Residents have more and more-supportive social connections*

- a. These data indicate that Oxford Houses residents are more likely to identify and associate with other individuals in recovery and less likely to identify and associate with active AOD users. Residents reported having larger and more, active, diverse, and supportive social networks generally and, specifically, more people with whom they could discuss sensitive and important issues. Residents also spent more time with their families, and their familial relationships improved compared to their time in active addiction outside of a House. Finally, a high proportion (approximately 94%) of residents reported actively assisting and being assisted by other individuals in recovery through participation in mutual aid activities, such as self-help groups and intra-House provision of social support.
5. *Residents report higher wellbeing*
 - a. Residents reported better psychological health, physical health, and quality of life. Compared to active users, more residents exercised regularly, maintained healthy eating habits, and received medical supervision.
 - b. Residents were less likely to be involved with the criminal justice system in any capacity, and the proportion of residents compared to active users who engaged in antisocial behaviours and were arrested and/or incarcerated for those behaviours was dramatically lower. A minority of residents reported having recently been the victim of violence, but was much lower than the proportion of active users who reported the same.
 - c. Fewer residents had outstanding debts, and more residents reported paying their bills on time and planning for the future.
 6. *Program specific elements are associated with positive outcomes*
 - a. Program-specific elements such as the availability of social support, secure housing, identification with other Housemates, and the number of roles played in the House were positively associated with improved wellbeing in the baseline survey.
 - b. Survey findings seem to confirm our hypothesised model for how the Oxford Houses program functions, underscoring the role of building recovery capital, and facilitating connectedness and meaningful activity

Future directions

This evaluation highlights the many potential benefits and value of the Oxford Houses program. Scaling up the implementation of the program may enable more people to experience the positive impacts reported by residents in this evaluation. Further research is needed to examine the long-term impacts of Oxford Houses in Australia.

1. Introduction

AOD problems are associated with a range of health and social harms which can be difficult to address. While AOD treatment in Australia has been found to be helpful, rates of relapse after treatment can be high. The period immediately following formal AOD treatment is an exceptionally high risk period for relapse, as people typically return to their former using environments and peer networks, with minimal or no support from services (Jason & Ferrari, 2010).

The Oxford Houses program, which is run by SHARC and Mind Australia, provides safe and supportive accommodation for people who have initiated a recovery pathway to build their strengths and resources for long-term recovery maintenance. Specifically, the program aims to provide stable accommodation, opportunities for social reconnection and support for abstinence through a peer-driven support system.

While the Oxford Houses model is well established in the United States, there has been only one formal evaluation of Oxford Houses in Australia to date, which occurred ten years ago (Roberts & Berends, 2005). This project aims to update the evidence base by evaluating the impacts of the Oxford Houses program on key outcomes including AOD use, recovery capital, engagement in meaningful activity (including but not limited to employment and education), connectedness, and wellbeing. The study conducted a survey of current residents at baseline and 6-months later to examine the impacts of the program. Survey data will be analysed statistically. The findings of the project will inform recommendations about the sustainability of the program and areas for potential improvement. This report presents the preliminary findings from the survey.

2. Literature review

While AOD treatment in Australia has been found to be helpful (Teesson et al, 2008, 8, 15; McKetin et al, 2012), it does not guarantee recovery. It is estimated that 20% to 80% of treated individuals will eventually return to their problematic patterns of use (Finney et al., 1999; Jin et al., 1998). A recent review of European therapeutic communities identified relapse rates of up to 70% within eighteen months of treatment cessation (Vanderplasschen et al, 2014). The difficulty inherent to long-term recovery is starkly highlighted by Hser et al. (2001), who found that a quarter of individuals treated for heroin use relapsed after 15 years of abstinence. The period immediately following formal AOD treatment is an exceptionally high risk period for relapse, as people typically return to their using environments and peer networks, with minimal or no aftercare or support from services (Jason & Ferrari, 2010). Substances are also often used as a means of combating the stress and anxiety that comes with housing instability and other forms of instability and uncertainty (Laudet et al., 2004; Pervin, 1988). As acknowledged in the Victorian Alcohol & Drug Association's (2010) submission to the inquiry into Public Housing in Victoria, the housing instability that is common to individuals with AOD problems can further expose them to unsafe or unsustainable living arrangements, AOD

and homeless subcultures, and anti-social behaviours. Subsequently, this has a significant cost to the community and undermines long-term recovery.

Unlike specialist AOD treatment – where the focus is on supporting an individual to abstain or reduce harm from their AOD use – after care and residential services can help individuals recognise that recovery in the long term is more than merely the absence of problematic AOD use. Within a mental health context, recovery means empowering individuals to take ownership of their illness within a strengths-based approach emphasising belonging and engagement (Slade, 2009). Australia’s national framework for recovery-oriented mental health services (Commonwealth of Australia, 2013) defines recovery as ‘being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues’. Similarly, the Betty Ford Institute Consensus Panel (2007) defines recovery from addiction as “voluntarily maintained lifestyle characterised by sobriety, personal health and citizenship” and in the United Kingdom, the Drug Policy Commission Consensus Group (2008) as a process that “maximises health and wellbeing... and involves participation in the rights, roles and responsibilities of society”. Finally, the Substance Abuse and Mental Health Services Administration (2012) identified four major dimensions of recovery – health (overcoming or managing one’s symptoms), home (a safe place to live), purpose (meaningful daily activities) and community (social networks that provide support, friendship, love and hope), all of which are target areas within the Oxford Houses program.

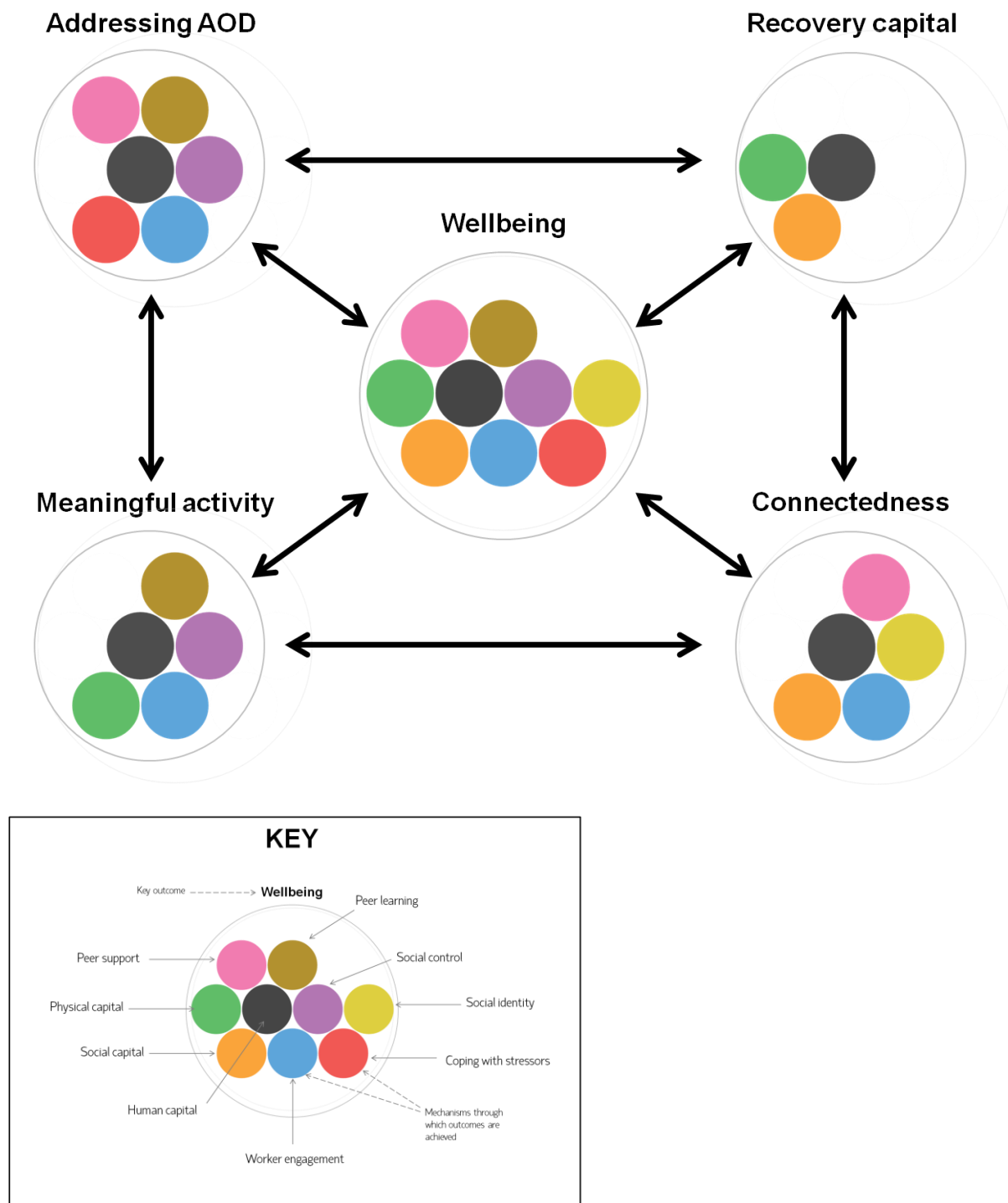
Oxford Houses provide safe, stable, and supportive spaces for people who have initiated a recovery pathway and assists them in developing their strengths and resources for genuine, long-term recovery. The Oxford Houses accommodation model offers a self-help residential programme without time limits that requires abstinence and the abiding of certain key rules (Jason and Ferrari, 2010). Oxford Houses aim to provide opportunities for employment and opportunities for social reconnection through a peer-driven support system. As documented in the SHARC/Mind Oxford Houses resident guidelines (2017), core aims of the program include:

- A secure, affordable and mutually supportive group environment;
- Personal responsibility for managing individual recovery and supporting the recovery of others;
- Commitment to a recovery that embraces abstinence from alcohol and other drugs, and;
- Strong volunteer and role-model input.

In addition to addressing AOD issues, the Oxford Houses program emphasises building recovery capital (personal strengths and resources to facilitate recovery), facilitating

connectedness, encouraging meaningful activity (work, education and volunteering) and enhancing personal wellbeing. As illustrated in Figure 1, these areas are highly interconnected (Laudet, 2011). Per recovery literature and program documentation, there are several key recovery mechanisms that the program draws upon to achieve outcomes in each of these areas (please see Appendix 1; these are also detailed in Figure 1).

Figure 1: Key outcomes and mechanisms through which Oxford Houses work



While the Oxford Houses model is well established in the United States, there has to date been only one formal evaluation of Oxford Houses in Australia. This evaluation was conducted by Turning Point, and it found that Oxford House residents achieved a range of positive AOD and wellbeing outcomes over an eighteen month period as well as an improvement in their connectedness and participation in the broader community (Roberts & Berends, 2005). Stable housing, self-help and peer support were identified as important facilitators. In their summation, Roberts & Berends (2005) concluded that Oxford Houses provides a “valuable adjunct to health services” and a “foundation... for whole of life re-orientation”. Despite this, the landscape surrounding AOD problems and treatments has largely shifted in Australia since 2005 and the stewardship and program at Oxford Houses has since acclimatised. Given this, there is a need to document how the Oxford Houses program currently functions in Australia and to evaluate its impacts.

3. Aims

This project evaluates the impacts of the SHARC/Mind Oxford Houses program in relation to the key outcome areas mentioned (AOD issues, recovery capital, meaningful activity, connectedness and wellbeing).

The specific research questions that this project set out to address include:

1. Do residents use AOD less frequently when they are in Oxford Houses compared to before they entered the program?
2. Do residents have increased recovery capital the longer they are in the program?
3. Do residents participate in meaningful activity (work, education, and volunteering) when they are in Oxford Houses compared to before they entered the program?
4. Do residents have more supportive social connections (e.g., belong to more groups, spend more time with people in recovery etc.) when they are in the Oxford Houses program than before they entered the Oxford Houses program?
5. Do residents report higher wellbeing when they are in the Oxford Houses program compared to before they entered the program?
6. What factors (e.g., age, gender, participation in program activities, length of time in the program) are associated with positive outcomes?

3. Survey Methods

This study used a pretest-posttest design involving a baseline and follow-up survey. This is consistent with best-practice and draws on the previous Turning Point evaluation of Oxford Houses (Roberts and Berends, 2005). Before any data were collected, this study was approved by the Eastern Health Human Research and Ethics Committee (HREC; HREC number: E26-2015).

3.1 Recruitment

The recruitment process detailed here was developed in consultation with SHARC/Mind. Researchers invited current residents to complete the baseline survey at the beginning of the April 2016 Chapter meeting and the follow-up survey at the beginning of the October 2016 Chapter meeting.

Prior to survey administration, researchers introduced the overarching aim of the project, provided a brief explanation of its processes and objectives, and obtained informed, written consent. Researchers emphasised that participation was voluntary and that survey responses and any records of participation would be anonymised and kept confidential, barring exceptional circumstances. Researchers were available to provide clarification during the administration of the surveys, and they collected all documentation at the end of the Chapter meeting.

The researchers also provided participant information and consent forms, survey forms and postage paid envelopes to SHARC support workers for distribution to Oxford House residents who were unable to attend the Chapter meeting but were interested in completing the survey.

3.2 Survey

Drawing on an established approach used in various Life in Recovery projects (Best, 2015; Laudet, 2013; Laudet & Hill, 2015), the survey used validated measures to inquire about a range of life experiences relating to health and wellbeing, housing, engagement in meaningful activities, community participation, and citizenship. The survey used standardised tools aimed at eliciting information in relation to the five key outcome areas (please see Table 1).

The survey determined whether these experiences occurred during active addiction and whether these same experiences occurred since they had been in Oxford Houses.

The survey was a self-completed structured questionnaire with five sections:

1. *About you*, which asks about participants' demographic and other characteristics;
2. *Time in active addiction*, using the Life in Recovery questions and approach;
3. *Since you entered Oxford Houses*, which asks about clients experiences in Oxford Houses;
4. *Current perceptions of recovery*, which asks about participants' commitment to recovery and the recovery strengths and resources they possess, and;
5. *Comparing now with before you entered Oxford Houses*, which asks participants about their treatment utilisation, substance use, health and wellbeing before and after entering Oxford Houses.

Table 1. Standardised tools included in survey instrument in relation to key domains

Tools	AOD	Recovery capital	Connectedness	Meaningful activity	Wellbeing
21-item Australian Treatment Outcome Profile, which includes days of drug and alcohol use in the past month (Ryan et al., 2014)	✓	✓		✓	✓
5-item Commitment to Sobriety Scale (Kelly & Greene, 2014)	✓				
Life in Recovery measures on recovery history, treatment history and current situation in relation to finances, family life, social life, health, legal issues, work, and study (Best, 2015)		✓	✓	✓	
50-item Assessment of Recovery Capital scale (Groshkova et al., 2013)		✓			
Social identification items (Doosje et al. 1995)			✓		

3.3 Data Analysis

Descriptive statistics were used to understand the demographic characteristics of the sample, and the mean scores on scales included in the survey. *T*-tests and correlation analyses were performed to analyse relationships between variables. Particular attention was paid to any significant changes in the outcomes specified in research questions 1 to 5 between when participants were in active addiction and their current situation at follow-up.

4. Results

4.1 Participants

A total of 20 and 32 participants completed the baseline active addiction survey and the residential follow-up survey, respectively. This report focuses on the 16 participants who completed both surveys.

4.2 Participant Characteristics

Twelve (70%) participants were male. The sample ranged from 20 to 69 years, with a mean age of 40.00 ($SD = 12.00$). All but one participant was born in Australia. None identified as Aboriginal or Torres Strait Islander.

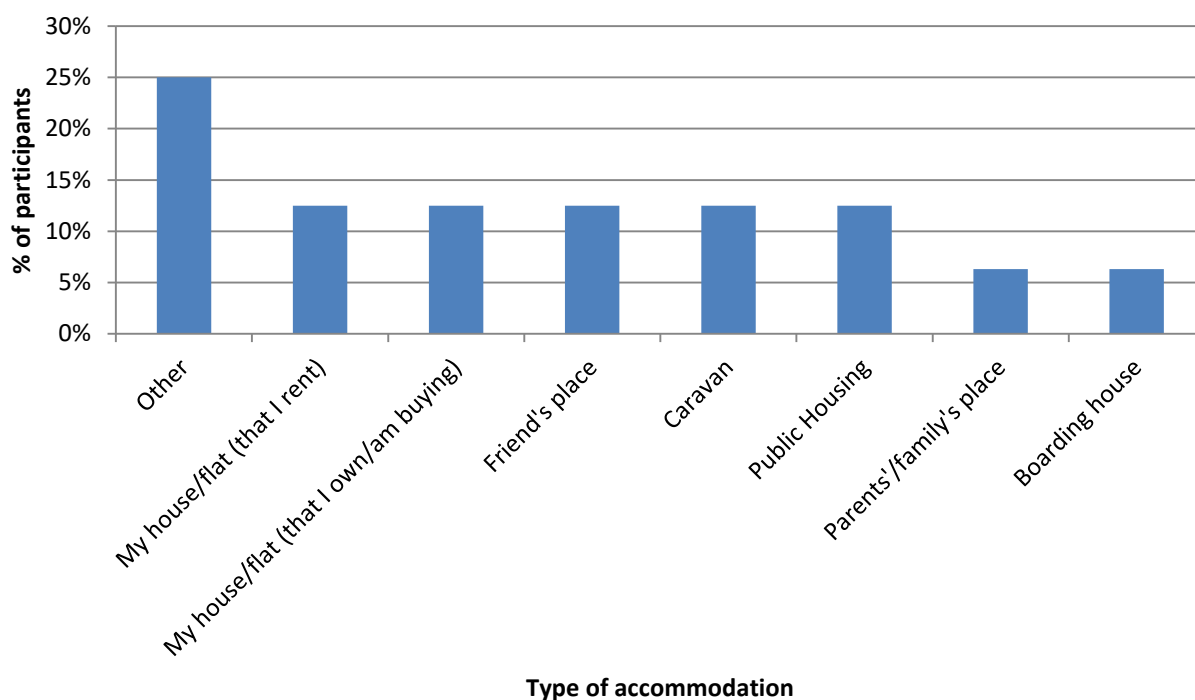
At baseline, nine participants had completed an apprenticeship or TAFE, two had a post-graduate qualification, three were a high school graduate, and two had completed only some high school. Only one participant was employed full-time, two were employed part time, four were studying, two reported that they had a disability, and five were unemployed. Most participants ($n = 13$) reported that they were currently receiving

government benefits: Nine were receiving Newstart Allowance, two student allowance (e.g., Youth Allowance, ABSTUDY, or Austudy), and two a Disability Support Pension.

Most participants (11) were single and had never married, one participant reported being married or in a de facto relationship, and the remaining four were single and divorced, separated, or widowed. Only three participants had dependent children under the age of 18, and all only one child.

The type of accommodation participants lived in prior to Oxford Houses varied across the sample (see Figure 2). Of the four participants who reported they lived in 'other' accommodation prior to Oxford Houses, one lived in an AOD treatment facility, one in a residential rehabilitation centre, one lived in a share house, and one did not clarify.

Figure 2. Participant accommodation prior to Oxford Houses

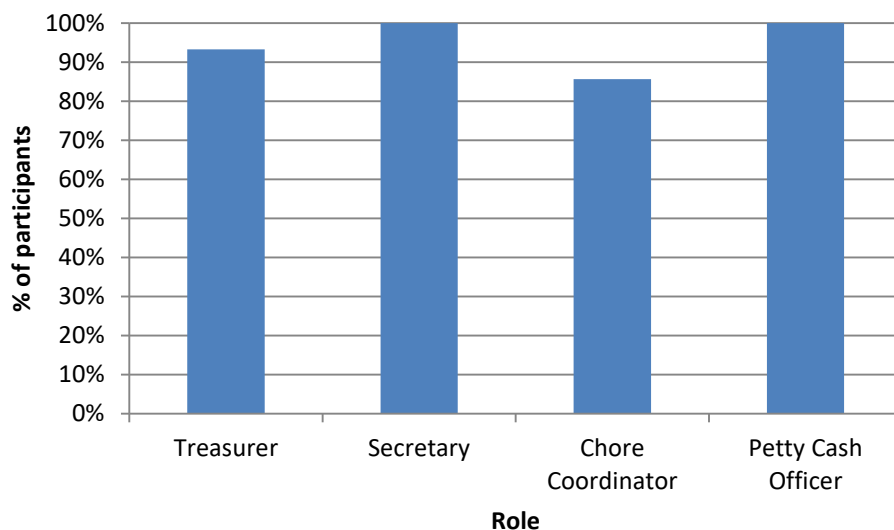


4.3 Oxford Houses

At follow-up, participants had spent between 7 and 72 months ($M = 21.19$, $SD = 16.90$) in Oxford Houses. Approximately four people ($SD = 1.00$) lived in each Oxford House. Participants were asked to indicate on a 7-point Likert-type scale their level of agreement with the statements: "I identify with the people in my House" and "I identify with the people in the Chapter". Response options ranged from *disagree completely* (1) to *agree completely* (7), with higher scores indicating stronger identification. Mean scores suggested that participants strongly identified with both the people in their House ($M = 5.63$, $SD = 1.15$, range = 3 - 7) and the people in the Chapter ($M = 5.06$, $SD = 1.34$, range = 2 - 7).

Participants reported attending House meetings ‘all’ ($n = 11$) or ‘most’ ($n = 5$) of the time. They reported attending Chapter meetings somewhat less frequently: Five ‘always’ attended, 11 attended ‘most of the time’, and one only attended ‘sometimes’. Almost all of the participants were actively involved in their House and had performed a number of roles (see Figure 3). Most participants had undertaken each specified role at least once while they had lived in Oxford Houses.

Figure 3. Roles performed by participants in Oxford Houses



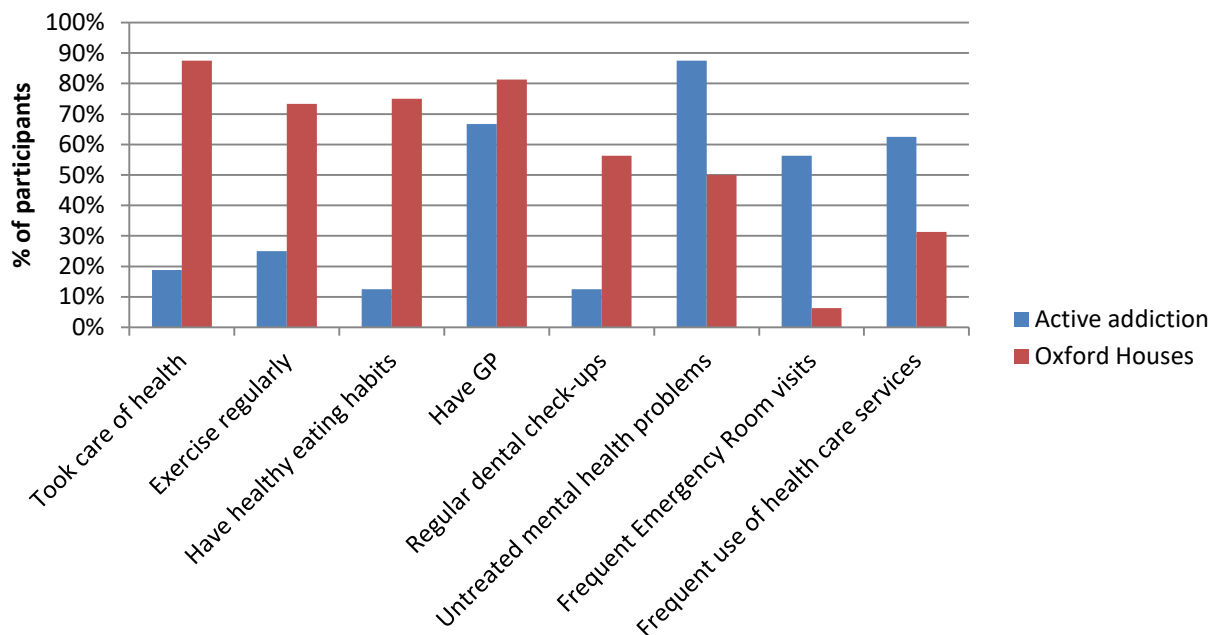
4.4 Experiences in Oxford Houses Compared to Active Addiction

Participants were asked a series of dichotomous yes/no questions about the events and situations they experienced or engaged in prior to and since their residence at an Oxford House. Six life domains of life were measured: health, legal, finances, employment and education and family and friends. Due to missing data, the sample size was not large enough to achieve sufficient statistical power. However, we can nonetheless infer some interesting results from these data.

Health

Participants’ responses indicated that their health improved after entering the Oxford Houses program (see Figure 4). For example, a larger proportion of participants reported they were taking care of their health, exercising regularly, eating a healthy diet, and getting regular dental check-ups, compared to baseline. Concordantly, a smaller proportion of participants reported frequent service use and untreated mental health problems.

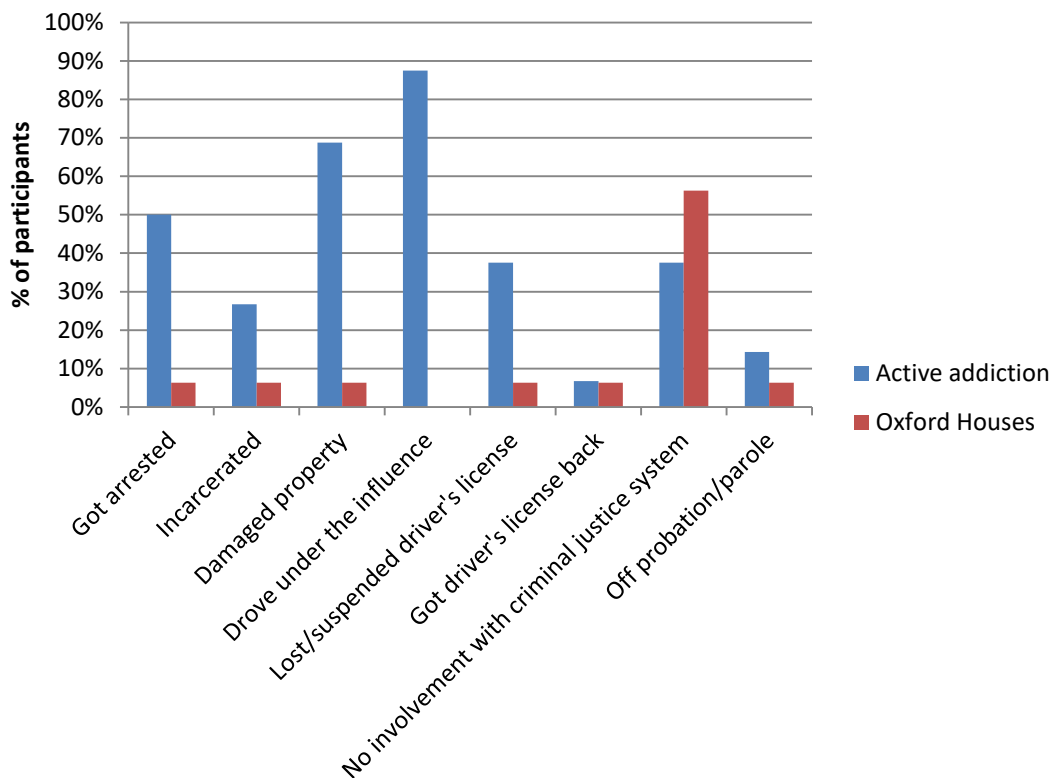
Figure 4. Health – Active addiction vs. Oxford Houses



Legal Issues

The proportion of participants who got arrested, damaged property, lost their driver's licence, were involved with the criminal justice system, or were incarcerated was lower at follow-up compared to baseline (see Figure 5). No incidences of driving under the influence of alcohol or illicit drugs since entering the Oxford Houses program were reported. The slight increase in the proportion of participants reporting engagement with the criminal justice system at follow-up may reflect lag-times in court cases and orders that were pending at baseline.

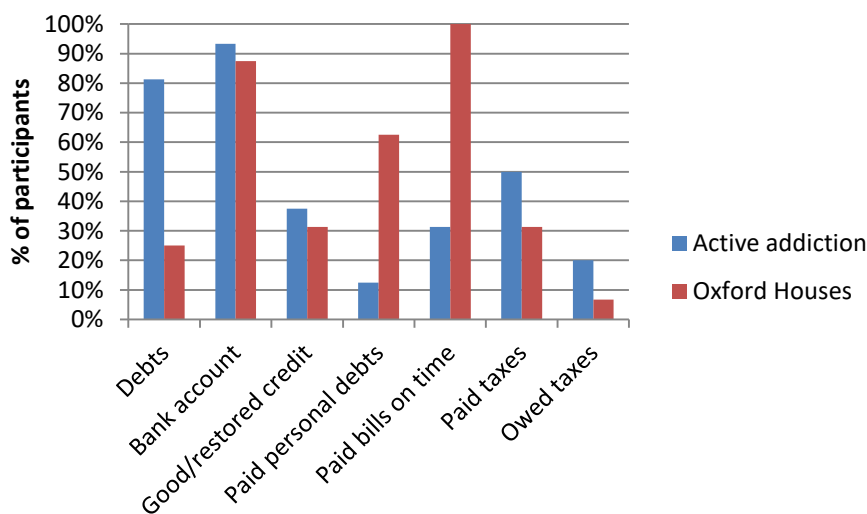
Figure 5. Legal issues - Active addiction vs. Oxford Houses



Finances

As illustrated in Figure 6, the proportion of participants who had outstanding debts and owed taxes was substantially lower at follow-up. All residents of Oxford Houses reported paying their bills on time, and a majority had paid off their personal debts.

Figure 6. Finances – Active addiction vs. Oxford Houses



Work and Education

At follow-up, a larger proportion of participants were steadily employed, receiving positive performance reviews, and furthering their education or training, compared to baseline (see Figure 7). The proportion of participants who reported frequently missing school or work and who were fired or suspended was reduced at follow-up. The mean number of days participants reported being engaged in employment, education, or training at follow-up was higher than at baseline (see Table 2). The lack of statistically-significant changes (see Table 2) is likely due to insufficient power resulting from the small sample size.

Figure 7. Work and education - Active addiction vs. Oxford Houses

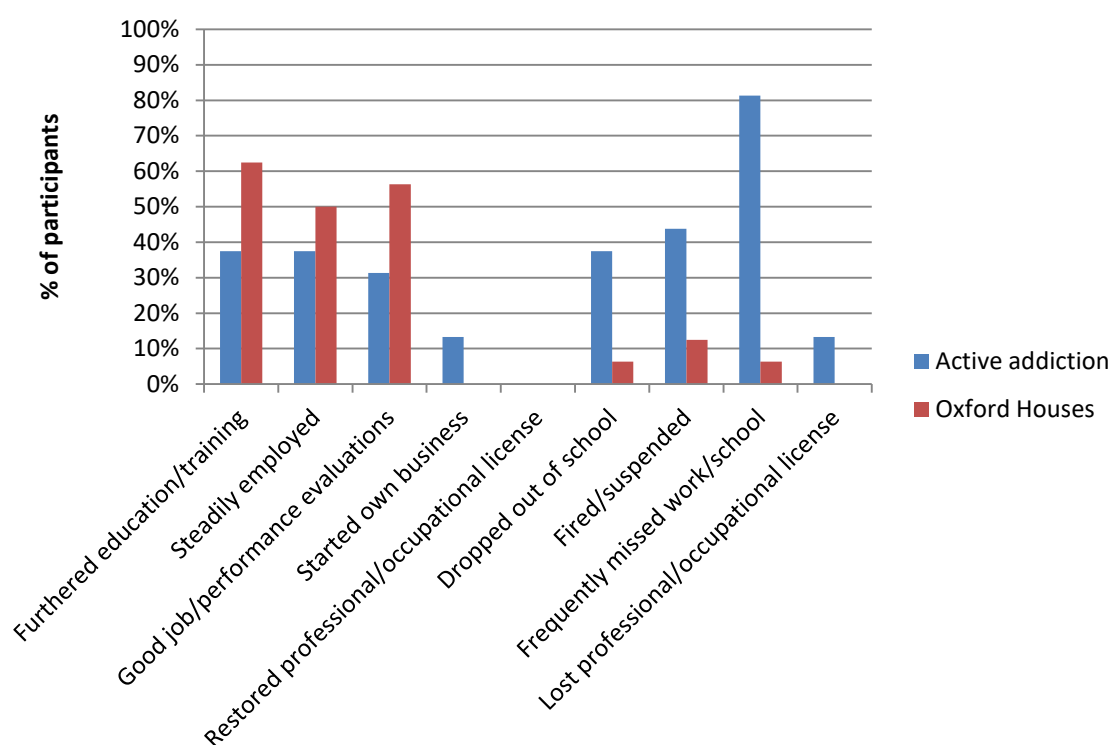


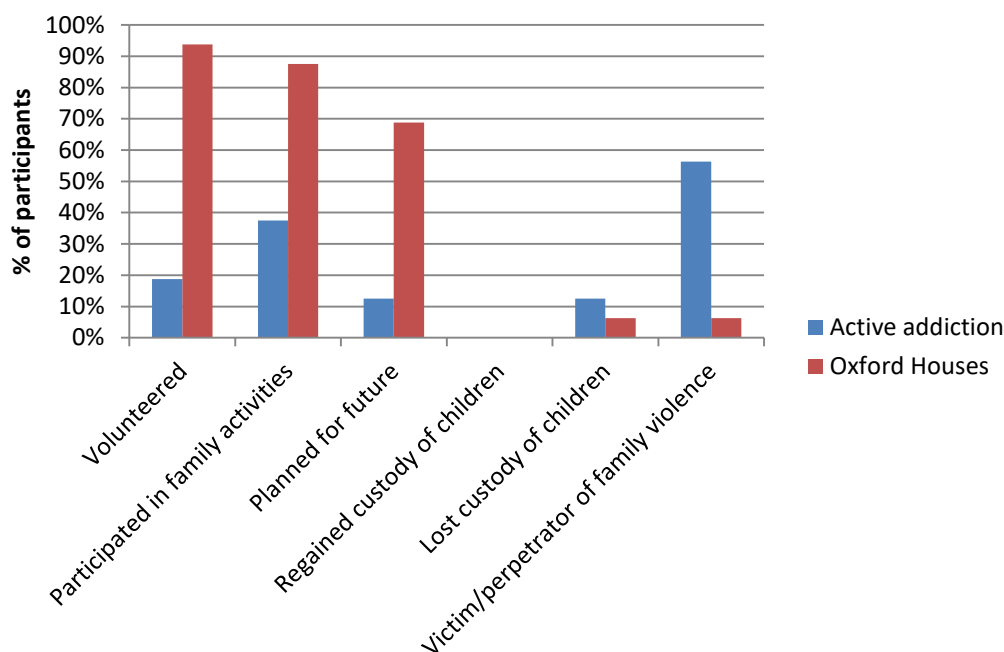
Table 2. Mean number of paid work and education or training days in the four weeks prior to entering Oxford Houses vs. the past four weeks whilst in Oxford Houses

	Active addiction <i>M (SD)</i>	Oxford Houses <i>M (SD)</i>	Paired samples t-test
How many days of paid work have you had in the past four weeks?	5.07 (10.63)	8.38 (9.39)	$t(14) = -1.42, p = 0.18$
How many days of school, tertiary education, or vocational training have you had in the past four weeks?	1.33 (3.83)	4.88 (8.16)	$t(14) = -1.25, p = 0.23$

Family and Social

Participants reported more active social lives and greater familial engagement during their residency at Oxford Houses, compared to baseline. For example there was a substantial increase in the proportion who were engaging in meaningful activities e.g., volunteering, participating in family activities and planning for the future and a substantial reduction in the proportion who were victim or perpetrators of family violence.

Figure 8. Family and social - Active addiction vs. Oxford Houses



4.5 Social Network and Social Identity

At follow-up, participants reported having more social support and people that they could discuss important things with, relative to their situation before Oxford Houses (see Figure 9). They also reported a reduction in the proportion of AOD users (see Figure 10) in their social network and there was an increase in the proportion of individuals in recovery (see Figure 11).

Figure 9. Number of people with which participants discussed important topics – Active addiction vs. Oxford Houses

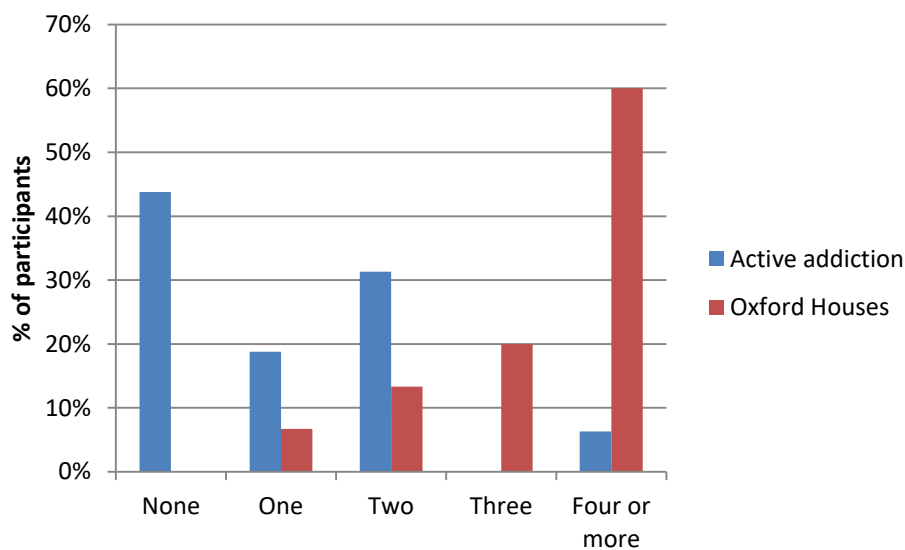


Figure 10. Proportion of participants' social network who were active AOD users – Active addiction vs. Oxford Houses

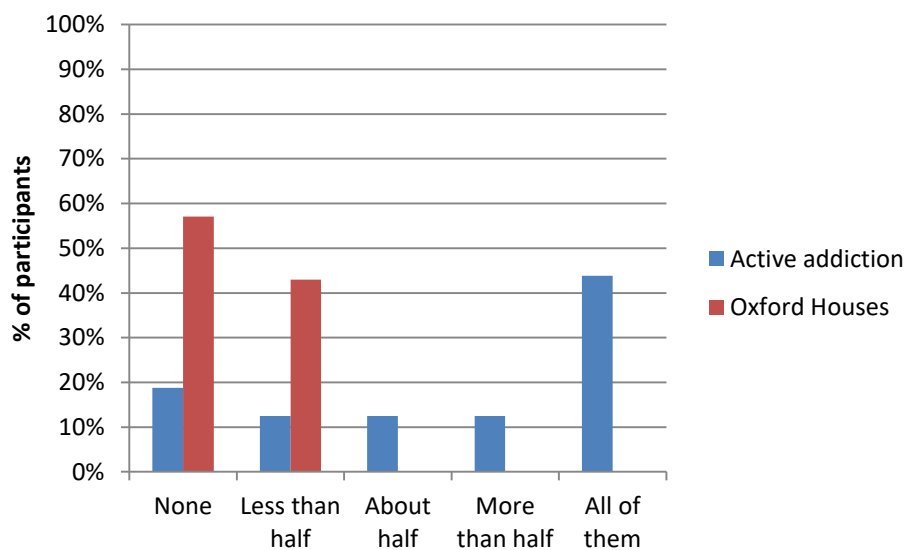
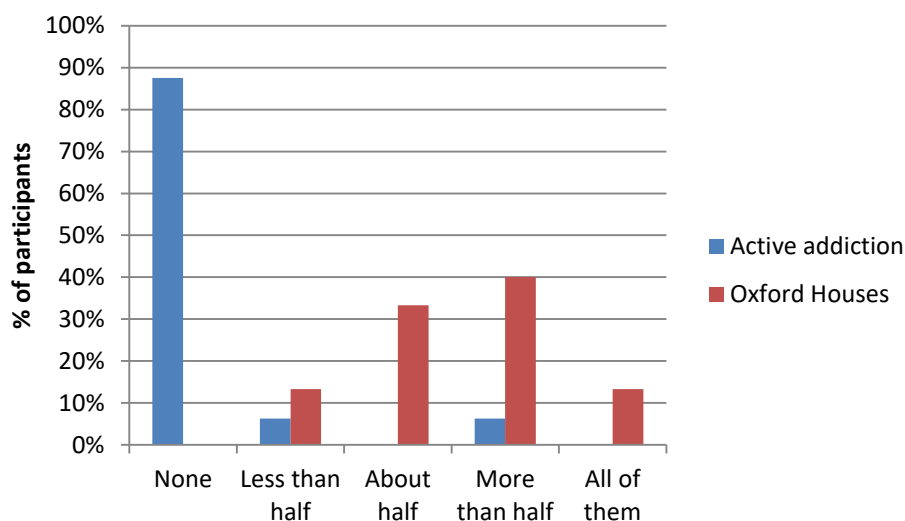


Figure 11. Proportion of participants' social network in recovery – Active addiction vs. Oxford Houses



The change in participants' social networks composition was accompanied by a statistically significant decrease in participants' identification with other AOD users and a statistically significant increase in their identification with people in recovery since entering Oxford Houses (see Table 3). Participants were also significantly more likely to be members of more diverse social groups after being in the Oxford Houses program (see Table 3). These variables were measured on a 7-point Likert-type scale, with response options ranging from *disagree completely* (1) to *agree completely* (7), with higher scores indicating a stronger agreement with each statement (see 'Item' column in Table 3).

Responses to the four items were summed to provide a total positive social connections and identity score. Higher total scores indicate that participants had a more positive social identity and more variety in their social network. Since entering the Oxford Houses program, participants had achieved a more positive social identity and a larger and more diverse supportive social network (see Table 3).

Table 3. Social connections and identity – Active addiction vs. Oxford Houses

Item	Active addiction <i>M (SD)</i>	Oxford Houses <i>M (SD)</i>	Paired samples <i>t</i> -test
Positive social connections and identity	9.31 (1.18)	18.75 (4.28)	$t(15) = -5.86, p < 0.05$
Identify with other people who use alcohol and/or drugs	5.69 (1.96)	3.44 (1.50)	$t(15) = 3.31, p < 0.05$
Identify with other people in recovery	1.69 (1.14)	5.94 (0.93)	$t(15) = -11.83, p < 0.05$
Member of lots of different social groups	2.25 (1.81)	3.94 (1.61)	$t(15) = -3.23, p < 0.05$
Have friends who are in lots of different social groups	3.06 (1.98)	4.31 (1.4)	$t(15) = -2.77, p < 0.05$

4.6 Recovery Capital

The 50-item Assessment of Recovery Capital instrument (ARC; Groshkova, Best & White, 2013) was used to assess recovery strengths and individual progress across 10 domains: substance use and sobriety, psychological health, physical health, community involvement, social support, meaningful activities, housing and safety, risk taking, coping and life functioning, and recovery experience. Participants were asked to indicate whether they agreed or disagreed with each of the 50 ARC items. The 10 ARC domains (henceforth subscales) were grouped into two areas of recovery capital: personal or social capital and lifestyle capital. The overall ARC score was calculated by summing the total scores of the 10 subscales. Higher scores indicate greater recovery capital.

Recruited participants' ARC total mean scores were compared against ARC total mean scores derived from a treatment population in Scotland where the ARC had been previously tested (see Figure 12 and 13). This treatment sample comprised 142 individuals attending one of four Scotch community rehabilitation services between February and July 2010 (Groshkova et al., 2013). Mean ARC total scores in the Oxford Houses participants ($M = 44.79$, $SD = 11.54$) were higher than the treatment population mean score of 31.25 ($SD = 11.54$), $t(13) = 7.90$, $p < 0.05$, indicating that participants in the Oxford Houses program had a greater depth and breadth of internal and external resources that they could draw on to sustain their recovery than the AOD treatment population.

Figure 12. ARC personal recovery domains – Treatment population vs. Oxford Houses

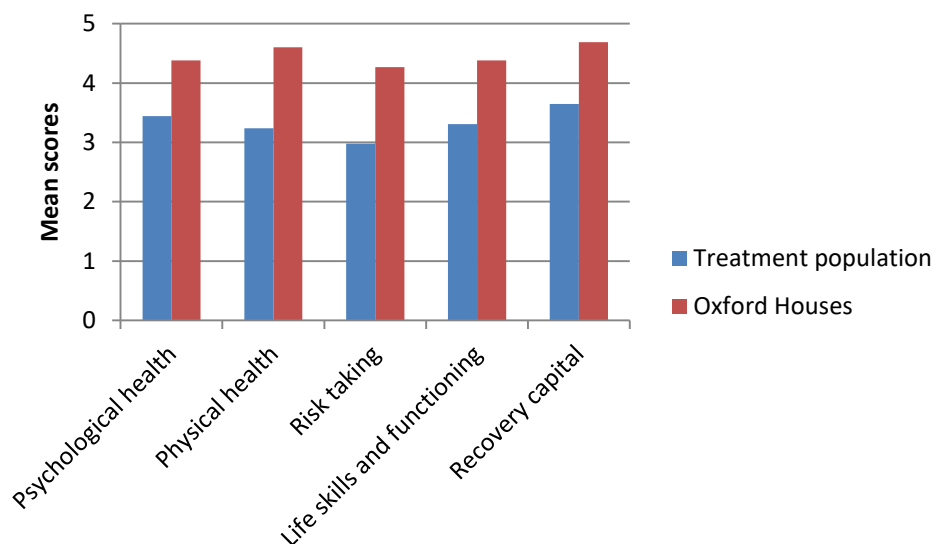
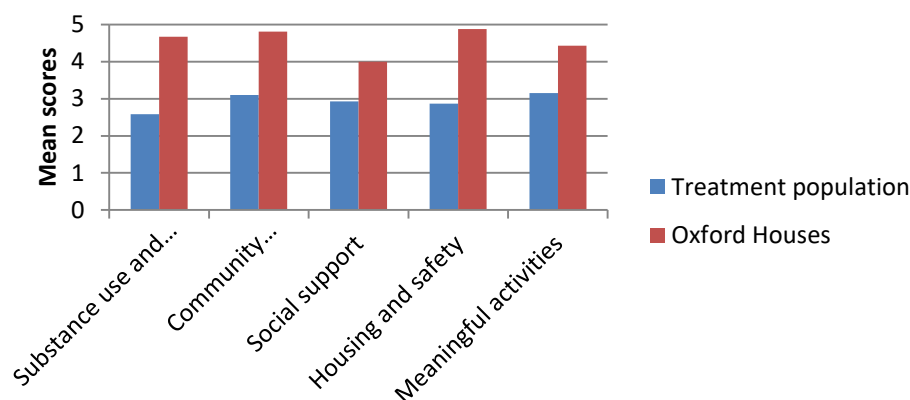


Figure 13. ARC social and lifestyle recovery domains – Treatment population vs. Oxford Houses



4.7 Service Use

Participants were asked to report if they had been engaged with a range of drug and alcohol, health, and other services in the four weeks prior to entering Oxford Houses, and the past four weeks while in Oxford Houses. As seen in Table 4, participants at follow-up reported less use of all services – but particularly acute services such as emergency department and ambulance use – than at baseline. The only exception was the use of a general practitioner, which did not change.

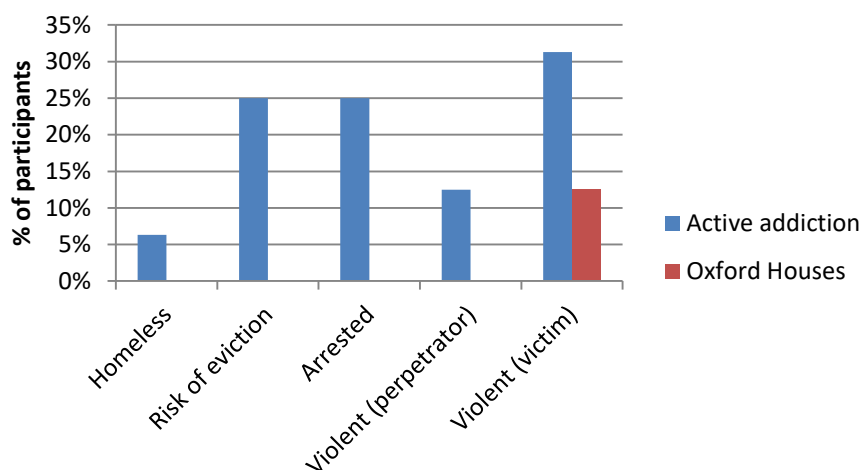
Table 4. Service use – Active addiction vs. Oxford Houses

	Active addiction	Oxford Houses
Drug and alcohol services		
Rehabilitation	81%	6%
Withdrawal service	63%	6%
Counselling	63%	31%
Pharmacotherapy	38%	0%
Telephone or online support or information	38%	13%
Health services		
Mental health professional	75%	44%
GP	88%	88%
Hospital emergency department	63%	13%
Ambulance	56%	13%
Other services		
Education/training	19%	50%
Employment services	56%	50%
Housing services	38%	13%
Legal services	25%	19%

4.8. Homelessness and Violence

No participants reported that they had been homeless, at risk of eviction, arrested, or been a perpetrator of violence at follow-up (see Figure 14). A minority of participants did report that they had been a victim of violence in the past four weeks. Encouragingly, this was still a reduction relative to the proportion that had experienced victimisation before Oxford Houses.

Figure 14. Life complexity issues – four weeks before Oxford Houses vs. past four weeks in Oxford Houses



4.9 Substance Use

Participants were asked to report if and how frequently they had used specific substances in the four weeks prior to entering the Oxford Houses program, and the past four weeks whilst in the program. Table 5 displays the changes in the proportion of participants using at each time point, as well as the mean days of use. Tobacco use remained stable. As expected, all of the participants who used alcohol, cannabis, prescribed benzodiazepines, prescribed opioids, and/or non-prescribed opioids four weeks prior to entering the Oxford Houses program had completely ceased their use of these substances after entering the Oxford Houses program.

Table 5. Substance use – Active addiction vs. Oxford Houses

Substance	Active addiction		Oxford Houses	
	Proportion of users (%)	<i>M (SD)</i> days of use	Proportion of users (%)	<i>M (SD)</i> days of use
Tobacco	75%	25.83 (5.49)	75%	24.58 (8.45)
Alcohol	19%	18.67 (13.65)	0%	0.00
Cannabis	7%	25.00 (0.00)	0%	0.00
Amphetamine type substances	0%	0.00	0%	0.00
Prescribed benzodiazepines	13%	17.00 (15.56)	0%	0.00
Non-prescribed benzodiazepines	0%	0.00	0%	0.00
Prescribed opioids	7%	28.00 (0.00)	0%	0.00
Non-prescribed opioids	7%	5.00 (0.00)	0%	0.00
Cocaine	0%	0.00	0%	0.00

4.10 Commitment to Sobriety

Commitment to AOD use cessation and continued abstinence was assessed using the 5-item Commitment to Sobriety Scale (CSS; Kelly & Greene, 2014). Participants were asked to rate their level of agreement with each CCS item on a 6-point Likert-type scale ranging from *strongly disagree* (1) to *strongly agree* (6). Responses were summed to provide a total score. Higher total scores indicate a stronger commitment to sobriety. The mean CCS score was 28.00, ($SD = 2.83$, range = 20 - 30), indicating that participants were highly committed to maintaining their abstinence and continued sobriety.

4.11 Use of Mutual Aid Groups

Participants were asked to report if they had attended any mutual aid groups over the year prior to entering Oxford Houses and the past six months whilst in the Oxford Houses program. The proportion of participants who attended mutual aid groups increased from 71% in the year prior to entering Oxford Houses to 94% in the past six months in the Oxford Houses program. As in Table 6, Alcoholics Anonymous attendance was identical. The proportion of participants attending Narcotics Anonymous meetings since entering the Oxford Houses program was slightly higher than at baseline. The proportion of participants attending Cocaine Anonymous, Gamblers Anonymous, and SMART Recovery meetings since entering the Oxford Houses program was slightly lower than at baseline.

Table 6. Mutual Aid group use – Active addiction vs. Oxford Houses

Mutual Aid group	Active addiction	Oxford Houses
Alcoholics Anonymous	80%	80%
Narcotics Anonymous	60%	67%
Cocaine Anonymous	10%	0%
Gamblers Anonymous	10%	7%
Alanon	0%	0%
SMART Recovery	10%	7%
LifeRing	0%	0%
Rational Recovery	0%	0%
Any	71%	94%

4.11 Wellbeing

Wellbeing was assessed using the three quality of life items from the Australian Treatment Outcome Profile (ATOP; Ryan et al., 2014). Participants were instructed to rate their psychological health, physical health, and their overall quality of life over four weeks prior to baseline and follow-up on a 10-point Likert-type scale, with '0' representing *poor* and '10' representing *good*.

Paired-samples t-tests revealed participants' psychological health, physical health, and overall quality of life significantly improved since being in the Oxford Houses program, compared to four weeks prior to entering the Oxford Houses program (see Table 7).

Table 7. Wellbeing – Active addiction vs. Oxford Houses

ATOP item	Active addiction <i>M (SD)</i>	Oxford Houses <i>M (SD)</i>	Paired samples t-test
Psychological health	4.25 (2.67)	7.13 (1.78)	$t(15) = -2.93, p = < 0.05$
Physical health	4.94 (3.15)	7.13 (1.60)	$t(14) = -2.40, p = < 0.05$
Quality of life	4.00 (3.20)	7.80 (1.52)	$t(14) = -3.82, p = < 0.05$

The ATOP items (psychological health, physical health, and quality of life) were summed to provide a total current wellbeing score. Higher scores indicate greater overall wellbeing. We then explored the relationships between overall wellbeing and other factors. Table 8 presents the associations between participants' overall wellbeing, the two Oxford Houses program-specific elements (highlighted in blue), and antecedent measures of recovery capital and commitment to sobriety (CSS). As shown in Table 8, there are strong, significant positive correlations between participant wellbeing (as measured on the ATOP) and ARC total scores, ARC subscores, CSS scores, and participants' self-reported identification with their chapter-fellows and the extent of their positive social connections and identity.

Table 8. Statistically significant Pearson Product-moment correlation coefficients between overall wellbeing and other variables

Variable	<i>r</i>
ARC total scale	0.75**
Social support (ARC subscale)	0.54*
Meaningful activities (ARC subscale)	0.83**
Coping and life functioning (ARC subscale)	0.66**
Recovery experience (ARC subscale)	0.58*
Community involvement (ARC subscale)	0.57*
Psychological health (ARC subscale)	0.79***
Identification with people in the Chapter	0.57*
Positive social connections and identity	0.57*
Commitment to sobriety (CSS)	0.54*

Note. * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.

5. Conclusion

This study sought to evaluate the effect of the SHARC/Mind Oxford Houses program in relation to participant AOD use, recovery capital, engagement in meaningful activities, social connectedness, and wellbeing. Its methodology involved the use of a repeated measures pre-post design, with a survey assessing residents when in ‘active addiction’ as the baseline, against which the follow-up survey was compared after residing in Oxford Houses. Twenty participants completed the baseline survey and 32 participants completed the follow-up survey. These final data were drawn from a sample of 16 participants who completed both. The sample had an average residency time in an Oxford House at the time of follow-up of 21 months. Compared to their time in active addiction, clients experienced considerable improvements in a range of wellbeing and life areas after entering the Oxford Houses program – including in health, finances, legal issues, meaningful activities and family and social connectedness. Not only did they report improved wellbeing, they also reported decreased substance use and decreased usage of costly acute health care services and the criminal justice system.

The outcomes described here are similar to those reported by large-scale analyses of Oxford Houses in the United States and the earlier evaluation of Oxford Houses, Melbourne (Roberts & Berends, 2005). Oxford Houses residents tend to have high rates of abstinence. In a national U.S. sample of approximately 900 participants, only 13.5% reported substance use after 12 months of residency (Jason, Davis, Ferrari, & Anderson, 2007). The present sample reported total abstinence for all drugs other than tobacco at follow-up.

Approximately 50% of the current sample reported active employment at follow-up which is higher than the 33% of participants in the patient pathways study, who reported working at least one day in the 90 days, at the one-year follow-up after

treatment (Lubman et al, 2014). In addition, a high proportion of Oxford Houses residents reported active engagement in education and volunteering. The finding that over 90% of the sample volunteered is particularly remarkable and may foster significant benefit to local communities. The volunteer work of residents may substantially, albeit indirectly, offset public funds allocated to their recovery (Australian Bureau of Statistics, 2015; Jason, Schober, & Olson, 2008; Roberts & Berends, 2005).

The present results suggest improvements to resident health in a relatively short space of time. Methodological constraints prevent direct comparison with other studies, but improvements to physical and mental health are commonly reported by Oxford Houses residents in the U.S (Jason & Ferrari, 2010). The earlier evaluation report includes a wealth of resident commentary, including anecdotes about healthier eating, improved sleep, and greater self-confidence (Roberts & Berends, 2005). As might be expected given the improvements to resident health noted here and elsewhere, residents reported a diminished need for and use of services during their occupancy at an Oxford House. In particular, residents reported dramatically reduced use of expensive acute services such as ambulance call-outs and emergency department visits. The lack of longitudinal data in this report means that we cannot draw conclusions on the long-term impact of Oxford Houses residency on the use of rehabilitation and withdrawal services, but other studies have noted reduced recidivism among Oxford Houses residents compared to 'usual care' participants (Jason, Olson, Ferrari, & Lo Sasso, 2006).

Socially, this sample followed a similar pattern to that identified in the earlier evaluation (Roberts & Berends, 2005). Between baseline and follow-up, residents bolstered their social network by increasing their number of friends and contacts and associating with a greater proportion of 'positive influences', such as other abstinent and more socially-varied individuals. Given the role of supportive social networks in recovery (Best et al., 2016), this may promote the maintenance of recovery in the longer-term.

Given the small sample size, and the fact that this is a survey of a relatively brief period of time (as opposed to longitudinal data), it is not possible to determine causality or attribute the observed positive impacts solely to the Oxford Houses program. However, the baseline survey does provide an indication that program-specific elements such as the availability of social support, secure housing, identification with other Housemates, and the number of roles played in the House are positively associated with improved wellbeing. Indeed, survey findings seem to confirm our hypothesised model for how the Oxford Houses program functions, underscoring the role of building recovery capital, and facilitating connectedness and meaningful activity. Further research is needed to examine the long-term impacts of Oxford Houses in Australia. Furthermore, qualitative research might examine the role of House-level dynamics and interpersonal factors in the noted impacts, as well as residents' experiences and perceptions of the quality of the program, and any improvements that could be made.

There are some methodological limitations that must be considered when interpreting these results. The evaluation was reliant on self-reported substance use and no objective measures were used. Despite being an anonymous survey, participants may have been concerned about the program ramifications if they were to disclose any substance use and therefore under-reported any substance use. However, self-report measures such as these are generally reliable when confidentiality is guaranteed and when reporting to an independent researcher (Napper et al., 2010). Another limitation is the restricted number of residents who completed both the baseline and follow-up survey which resulted in reduced statistical power to detect significant changes over time.

Despite these considerations, this report details the characteristics and impact of Oxford Houses in Australia. It describes a model that, in addition to being economical and practicable, is, insofar as these data suggest, highly effective. Substance abuse affects millions of Australians and exacts an annual economic cost of billions of dollars (AIHW, 2016; Collins & Lapsley, 2008). The care and support offered to persons with addiction is all too often inadequate. People with AOD problems enter into a broader healthcare system characterised by periods of engagement and disengagement and where treatment gains are often short-lived. Treatment success secures a pathway to recovery with sufficient internal resources combined with a supportive social environment and engagement in meaningful activities, which is what residency in an Oxford House appears to offer.

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5. Appendices

Appendix 1: Program logic overview

PROBLEM STATEMENT What is it that Oxford Houses address?	STRATEGIES What are the broad ways in which Oxford Houses address problems?	ACTIVITIES What are the specific activities that contribute to addressing problems?	OUTCOMES What is it that the program hopes to achieve?
Rates of relapse after treatment can be high, which can impact on the chances of sustained recovery in the longer term.	Provide a home environment in which abstinence is required and supported.	<ul style="list-style-type: none"> • Rule that residents must be abstinent • Mutual aid group attendance (e.g. 12-Step, SMART) • Peer monitoring (risk of relapse) and AOD taking behaviour • Sharing time at weekly house meeting • Regular review of personal recovery plans by peers • Education provided at chapter meetings • Referral by support worker to individual counselling or group therapy (e.g. ACT). • Development of an individual recovery plan with support worker • Support worker checking minutes of weekly house meetings to see if any residents who may be at risk of relapse and who need to be followed up 	Residents will: <ul style="list-style-type: none"> • Increase their commitment to sobriety the longer they have lived in the house. • Increase their likelihood of remaining abstinent from AOD throughout and beyond their stay in Oxford house.
People who have had histories of AOD problems may have depleted recovery capital, which makes maintaining recovery difficult.	Oxford houses aims to build recovery capital through providing a safe supportive environment in which people have opportunities for personal development.	<ul style="list-style-type: none"> • Attendance at weekly house meetings • Attending chapter meetings • Mutual aid group attendance. • Provision of day to day social support by peers within Oxford Houses. • Ability to have visitors attends the house. 	On average, residents will increase their recovery capital the longer they have been in the house.

		<ul style="list-style-type: none"> • Provision of safe and secure housing • Advocacy and assistance from support workers to help residents secure appropriate housing as they are about to leave the program. • System of self-governance instituted by each house, which means that residents are accountable to the house • Learning how to manage conflict by being a member of the house group and discussing issues at house meetings • Developing and strengthening essential life skills and a sense of responsibility by performing roles in the house (e.g. treasurer, secretary, chore coordinator, petty cash officer etc.) • Education and personal development provided at chapter meetings. • Developing spiritual, meditation and Yoga practices 	
<p>People who have had histories of AOD problems may have become disconnected from the community and sources of social support. Disconnectedness can contribute to high rates of relapse, and can limit opportunities for meaningful activity.</p>	<p>Encourage residents to manage their household as a group with decreasing support from SHARC/Mind</p> <p>Develop a culture of peer support and engagement</p> <p>Facilitate development of social capital and social skills</p>	<ul style="list-style-type: none"> • Attendance at weekly house meetings • Attending chapter meeting • System of self-governance instituted by each house. • Learning how to manage conflict by being a member of the house group and discussing issues at house meetings. • Mutual aid group attendance. • Provision of day to day social support by peers within Oxford Houses. • Ability to have visitors attend the house. 	<ul style="list-style-type: none"> • Increased social and community connectedness • Increased ability to build relationships and live with others. • Repairing and maintaining relationships with family and friends outside of Oxford House • It is likely that residents will report greater social

		<ul style="list-style-type: none"> • Support worker can link family members into family drug help programs and other groups (e.g. sporting clubs) and sources of support in the community. • Support worker checking minutes of weekly house meetings to see if any residents who may be at risk of being isolated and who need to be followed up • Encouraging participation in pro-recovery groups (e.g. Mutual aid, the house, the community of Oxford house residents, Oxford Houses alumni (who are encouraged to attend events)). 	<p>skills the longer they are in the program.</p> <ul style="list-style-type: none"> • It is likely that residents will report higher levels of social support the longer they are in the program. • It is likely residents will belong to more (pro-recovery) social groups (comprising a greater proportion of non-using peers) the longer they have been in the house. • It is likely that residents will report stronger identification with a recovery identity, the longer they are in the house. • It is likely residents will rate their satisfaction with their personal relationships higher the longer they are in the program.
<p>Absence of meaningful activity (e.g. volunteering, employment, education etc.) is a risk factor for</p>	<p>Provide an environment and culture that is supportive of employment, education and other forms of meaningful activity.</p>	<ul style="list-style-type: none"> • Attendance at weekly house meetings • Peer support • Peer monitoring and intolerance of inactivity 	<p>Residents will have increased their successful engagement in meaningful activity. The ultimate goal is to see</p>

<p>relapse, and can negatively impact on quality of life.</p>		<ul style="list-style-type: none"> • Recovery plan • Mutual aid group attendance • Developing skills and a sense of responsibility by performing roles in the house (e.g. treasurer, secretary, chore coordinator, petty cash officer etc.) • Support worker to assist in advocacy and linking people in to meaningful activity. • Support worker assists with job applications and CVs. • Support worker links residents to financial advice and education, employment and training opportunities. 	<p>individuals gainfully employed and contributing to economic... (words from SHARC/Mind). For some residents, however, a shorter term goal of achieving a qualification or certificate, or engaging in volunteer activity is more realistic.</p>
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<p>The physical, psychological and overall quality of life of people who have histories of AOD problems can be poor but wellbeing has been shown to increase the longer people are in recovery.</p>	<p>Oxford houses attempt to provide a safe and supportive environment where residents are encouraged to manage and regulate mood and emotions, self-monitor their mental wellbeing, foster healthy life choices in terms of diet, exercise, sleep and seek help as needed as well as supporting peers to identify risky situations.</p> <p>Facilitate the development of skills to support health and wellbeing, and facilitate independent living including household financial management, shopping, cooking, etc.</p>	<p>All of the above</p>	<p>It is anticipated that the program will lead to improvements in psychological, physical and overall quality of life of residents with the goal that on average, residents will report higher wellbeing as their time in the program increases.</p>
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