A Primer on Recovery Residences: FAQs

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The National Association of Recovery Residences
A Primer on Recovery Residences: FAQs

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Introduction

Recovery residences have spread rapidly in the United States in recent decades. In 2011, the National Association of Recovery Residences (NARR) was founded to promote a recovery-oriented continuum of support for those with substance use disorders by credentialing recovery residences that implement empirically based recovery principles and practice standards. NARR currently represents more than 1,900 recovery residences in the United States. The purpose of this document is to answer some of the most frequently asked questions about recovery residences.

Answers to general questions on recovery residences were prepared by George Braucht, Jason Howell, Dave Sheridan and others on the NARR advocacy committee; answers to questions related to research on recovery residences were answered by an independent expert panel that included Leonard A. Jason, PhD, Director, Center for Community Research, DePaul University; Amy A. Mericle, PhD, Research Scientist, Treatment Research Institute; Douglas L. Polcin, EdD, Senior Scientist, Alcohol Research Group; and William L. White, MA, Senior Research Consultant, Chestnut Health Systems. Assistance in reviewing existing research was also provided by Ronald Harvey, MA, and Bronwyn Hunter, MA, DePaul University, and Fried Wittman, Ph.D., Alcohol Research Group.

Fred Way, Executive Director of the Philadelphia Association of Recovery Residences (PARR), served as liaison between the NARR advocacy committee and the expert panel. At the time this primer was first prepared, the following individuals served on the NARR Board of Directors: Tom Bennett, Texas, Ranch at Dove Tree; Susan Blacksher, California, California Association of Addiction Recovery Resources; Eddie Bryant, Michigan, Michigan Association of Recovery Residences; Michelle Adams Byrne, Texas, Recovery Inn; Susan O Binns, Tennessee, YANA, AHHAP; George Braucht, Georgia, Board of Pardons and Paroles; Lori Criss, Ohio, The Ohio Council of Behavioral Health and Family Services Providers; Chris Edrington, Minnesota, Colorado St. Paul Sober Living; Beth Fisher, Georgia, North Carolina, South Carolina, Hope Homes; Trina Frierson, Tennessee, Tennessee Association of Recovery Residences; Carlos Hardy, Maryland, Maryland Recovery Organization Connecting Communities; Tom Hill, Washington, D.C., Faces and Voices of Recovery; Jason Howell, Texas, Soberhood; Curtiss Kolodney, Connecticut, The Connecticut Community for Addiction Recovery; Ted McAllister, Georgia, Haven Homes; Kevin O'Hare, Michigan, Touchstone Recovery; Dave Sheridan, California, Sober Living Network; Susan Smith, Michigan, Network 180; Nancy Steiner, Florida, Sanctuary; Nathan Lee Tate, Carolina, Recovery Residence Association of the Carolinas; and Fred Way, Pennsylvania, Philadelphia Association of Recovery Residences.

1. What is a recovery residence?

"Recovery residence" (RR) is a broad term describing a sober, safe, and healthy living environment that promotes recovery from alcohol and other drug use and associated problems. Many thousands exist in the United States that vary in size, organization, and target population. (The exact number of recovery residences is unknown since many RRs are not regulated by government or independent organizations.) At a minimum, RRs offer peer-to-peer recovery support with some providing professionally delivered clinical services all aimed at promoting abstinence-based, long-term recovery.

Recovery residences are sober living environments, meaning that residents are expected to abstain from alcohol and illegal drug use. Each credentialed recovery residence publishes policies on relapse sanctions and readmission criteria and other rules governing group living. Recovery residences may require abstinence from particular types of medications according to individual policy.

2. What is the primary purpose of a recovery residence?

The purpose of a recovery residence is to provide a safe and healthy living environment to initiate and sustain recovery—defined as abstinence from alcohol and other non-prescribed drug use and improvement in one's physical, mental, spiritual, and social wellbeing. Individuals build resources while living in a recovery residence that will continue to support their recovery as they transition to living independently and productively in the community.

3. What services do recovery residences provide?

Recovery residences are divided into Levels of Support based on the type as well as the intensity and duration of support that they offer. Services provided span from peer-to-peer recovery support (all recovery residences) to medical and counseling services (recovery residences offering higher levels of support). The NARR Standards define minimum services for each Level of Support, but additional services may be provided at each level. Section 5 of the NARR Standards included in the Appendix details the minimum required service elements for each Level of Support.

4. How are recovery residences managed to ensure the safety of the local neighborhood and community?

Recovery residences are guided by the NARR standards that established best practices for maintaining the safety and health of the residents, the local neighborhood, and the larger community. NARR-certified recovery residences meet standards addressing safety from an administrative, operational, property, and good neighbors perspective (see Appendix).

5. How long have recovery residences existed in the United States?

Residences with the mission of providing support for recovery from addiction have existed in the United States since the mid-nineteenth century. The first such residence was a room established in 1841 to support members of the newly formed Washingtonian Temperance Society. In 1857, the Washingtonians opened a "home for the fallen" in Boston, which soon closed but was re-opened in 1863 as the Washingtonian Home of Boston, which evolved into one of the premier addiction treatment programs of the nineteenth century. The Washingtonian Homes in Boston and Chicago were part of a larger network of inebriate homes that existed in tandem with religiously sponsored residential inebriate colonies (e.g., Keswick Colony of Mercy), state-sponsored inebriate asylums (e.g., New York State Inebriate Asylum), and private addiction cure institutes (e.g., Keeley Institutes, Gatlin Institutes, Neal Institutes) that thrived until the passage of state and then national prohibition laws (Baumohl & Room, 1987; White, 1998).

The early inebriate homes were replaced in the opening decades of the twentieth century with private hospitals and sanitaria catering to the affluent and local "jag houses" used for detoxification and respite. These gave way in the 1940s and 1950s to the development of recovery-supportive homes, retreats, and farms associated with Alcoholics Anonymous. One factor precipitating this shift included the increased popularity and expansion of Alcoholics Anonymous. A second factor was the emergence of tighter housing markets after World War II in many metropolitan areas, which made it increasingly difficult for individuals with alcohol and drug problems to find sober living environments that supported abstinence (Wittman, Biderman, & Hughes, 1993). In the city of Los Angeles, recovering AA members opened "twelfth step" houses to address the increased need for alcohol- and drug-free living environments. Managers of these houses either mandated or strongly encouraged attendance at AA meetings. By the 1960s, Los Angeles supported several dozen such houses (Wittman, Biderman, & Hughes, 1993). Growth of the houses expanded to other parts of Southern California over subsequent decades and resulted in the creation of the Sober Living Network in 1995. The Sober Living Network currently represents 550 sober living homes in five Southern California counties.

As more state-sponsored alcoholism programs were started in the 1950s, concerns grew about how to sustain personal recovery in the transition from the institution to the community. This birthed new social institutions—the halfway house and the three-quarter-way house—that provided semi-structured residential support designed to aid community re-entry (Cahn, 1969; Raush & Raush, 1968; Rubington, 1970). Many of these programs closed due to a loss of funding as more formal community-based treatment programs increased in the 1960s and 1970s.

A more formal residential model emerged in the late 1940s and early 1950s at Pioneer House and Hazelden that became known as the "Minnesota Model." This model was subsequently medicalized and widely replicated as a residential alcoholism treatment approach throughout the U.S. and Europe (Cook, 1988; Spicer, 1993). In the 1970s, a model of recovery support akin to early Minnesota Model programs developed in California. Christened "social model programs," these programs provided an alternative to more medicalized models of treatment, but many of these programs fell under the sway

of increased professionalism and evolved into more traditional addiction treatment organizations (Borkman, Kaskutas, Room, Bryan, & Barrows, 1998; Dodd, 1997).

Synanon was founded in 1958 as the first ex-addict-directed therapeutic community in the United States. This residential model of mutual support rapidly expanded in the 1960s and 1970s and was subsequently professionalized as a major addiction treatment modality (De Leon, 2000; Janzen, 2001; White, 1998). In the closing decades of the twentieth century, self-governed, financially self-supported recovery residences rapidly spread in the United States. The largest of these networks of recovery residences is Oxford House that, since its inception in 1975, has grown to 1,521 houses in 45 states with a total resident capacity of more than 12,000 (Oxford House, Inc., 2012).

Recovery residences continued to grow in the opening years of the twenty-first century sparked by both increased need (resulting in part from harsh economic conditions in many cites), the emergence of recovery as an organizing construct for the addictions field, and increased interest in recovery support institutions that could extend the benefits of addiction treatment. The history of recovery residences continues to unfold in the United States.

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6. How are recovery residences internally governed and externally regulated?

6a. How are recovery residences internally governed at the residence level?

Recovery residences' internal governance varies across NARR's Levels of Support (see Appendix). Forms of governance range from democratically run by the residents to oversight by licensed professionals.

6b. How are recovery residences externally regulated?

The regulation of recovery residences vary from state to state, local government to local government, and model to model. In general, states regulate professional services and local governments regulate health and safety standards. Both state and local government regulation must adhere to federal laws and limits, such as the Americans with Disabilities Act and the Fair Housing Act.

6c. What role do non-governmental organizations (NGO) play?

A variety of NGOs exist at the local, regional, and national level. NARR exists at the national level and partners with other organizations at the regional level. Many states/regions have NARR affiliates that maintain policies and procedures for their members that meet the NARR Standard. Identify your local affiliate by going to the NARR website: www.narronline.com.

6d. Are recovery residences regulated by third party payers?

Some recovery residences accept third party payments (e.g., insurance, HUD, Medicaid, etc.). Third party payers define what is reimbursable and the service duration according to mandated standards of quality and practice. Check with your payer to determine the particular coverage that is offered or contact the specific recovery residences being considered.

7. Are there different types of recovery residences?

Yes, there are many different types of recovery residences. Variations are found within and across all four Levels of Support (See Appendix). These levels collectively provide a spectrum of housing to best meet the unique and changing needs of individuals

across the stages of long-term recovery. Recovery residences are also designed for specific/special populations such as language, gender, women with children, age, co-occurring problems, medication status, and prison re-entry.

8. How can I find a local recovery residence that best meets my needs?

NARR has defined four levels of recovery support in part to assist individuals looking for facilities that match their needs. Review these levels to determine the most suitable level of support. Then contact your local/regional recovery residence association or speak to individuals active in the local recovery community for recommendations for that particular level of recovery residence. For professionals, an evidence-based placement tool for recovery residence is not available yet. However, ASAM criteria can be used to guide decisions for referral to professionally directed recovery residences.

Government telephone helplines and associated websites provide information on clinical or treatment resources but links to most recovery residences may not be provided. If you recently had a clinical assessment or were in treatment, ask the clinician for several RR recommendations. You can also search for "recovery residences in (your city or state)" on the internet. Additional sources include the telephone book; local professional organizations, faith communities, social service agencies, and resource manuals; and NARR (www.narr-online.com or email: infor@narr-online.com).

9. How many recovery residences exist in the United States?

To date, there has been no systematic inventory of RRs in the US. The National Survey of Substance Abuse Treatment Services (N-SSATS) represents the most comprehensive resource on facilities providing substance abuse treatment in the US. Many RRs do not consider themselves treatment facilities, and are not on the master list of organized substance abuse treatment facilities known to the Substance Abuse and Mental Health Services Administration (SAMHSA), which consists primarily of licensed, certified, or otherwise state-approved agencies (US Department of Health and Human Services, 2012). Further, even if RRs were on the master list and participated in the N-SSATS survey, it would be difficult to determine how many of the facilities surveyed identified as RRs because this is not queried as a type of service provided.

Some work to inventory RRs has been conducted by smaller regional and national associations. For example, most recent data provided by Oxford House, Inc. indicates that the current number of Oxford houses (NARR Level 1 residences) is over 1,500, having a total of 11,999 recovery beds (Oxford Grape, 2011). Their online directory lists houses currently operating in 44 states in the US (Oxford House, Inc, 2012). The State of California licenses approximately 900 level III and IV residential facilities the California Association for Addiction and Recovery Resources (CAARR) registers more than 250 sober living residences. (Susan Blacksher, California Association of Addiction Recovery Resources, Personal Communication, September 17, 2012; also see Polcin, Korcha, Bond, & Galloway, 2010). A recovery home (homes comparable to NARR Level 1 and Level 2 residences) mapping initiative conducted in Philadelphia identified 271 homes

with a service capacity for approximately 1,850 residents (Johnson, Martin, Sheahan, Way, & White, 2009).

A critical function of NARR is to serve as a national directory of recovery residences. NARR currently represents 14 associations in 14 states, plus one organization (the Association of Halfway House Alcoholism Programs, AHHAP) with national membership. As of June 2012, NARR represents approximately 1,950 residences (18 level 1, 1,265 level 2, 650 level 3, and 16 level 4) with an estimated total resident capacity of over 25,500 persons in recovery (Fred Way, Personal Communication, July 2012).

More knowledge is needed about how RRs are distributed by state or region and what differences in availability exist between urban, suburban, and rural areas. Regarding the availability of recovery residences by community income, we know access to third-party funding increases the access to RRs, and this increase is expected to be bolstered by the Affordable Care Law in 2014.

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10. Where are recovery residences typically located?

As mentioned earlier, RRs can be found in nearly every state in the US. Ideally, houses can be found in residential areas that provide RR residents an opportunity to integrate into the community and provide community members an opportunity to learn about RRs. Unfortunately, RRs often face significant opposition to opening in residential areas and have also been found to be concentrated in poorer residential neighborhoods (Johnson, Martin, Sheahan, & White, 2009).

Fortunately, research conducted to date among community members suggest that negative attitudes toward RRs can be overcome. For example, in interviews with

community members living next to and near to Oxford Houses, Jason, Roberts, & Olson (2005) found that community members reported that Oxford House residents blended well into the neighborhood and made good neighbors. They also found that the majority of Oxford House neighbors interviewed had either gained resources, friendships, or a greater sense of security following contact with the Oxford House residents. Furthermore, they found no evidence of property devaluation in the neighborhoods containing Oxford Houses; community members who knew of the Oxford House actually saw an increase in property value over an average of 3 years. Similar results were found by Polcin, Henderson, Trocki, Evan, & Wittman (in press) who interviewed community members about Sober Living Homes (homes comparable to NARR Level 1 and Level 2 residences) in Northern California; however, these researchers did find that size and density of the house appeared to influence neighborhood perceptions and that larger and more densely populated houses may need to more actively manage their relationships with community members.

Standards developed by NARR (see Appendix X) ensure that member houses (regardless of NARR level) abide by all local building and fire safety codes and that they maintain the interior and exterior of the property in a functional, safe, and clean manner that is compatible with the neighborhood. Moreover, these standards provide guidance on "good neighbor" policies to promote positive community involvement in residential neighborhoods.

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11. Is there a national organization that represents recovery residences in the US?

The National Association of Recovery Residences (NARR), established in 2011, currently represents approximately 1,500 residences through its local organizational affiliates. NARR advocates for recovery residences and their residents at the national and local levels. NARR members maintain standards for recovery residences of all kinds across four NARR levels of support from Level 1 peer-operated residences to Level 4 residences offering a wide variety of treatment and recovery support services. NARR is also positioned to advocate for recovery residences at the national and state level. At the state and regional level, NARR works in conjunction with affiliated recovery residence provider organizations representing individual providers. Affiliates ensure the NARR Standard is met through training and technical assistance.

Three additional recovery residence organizations exist with a national scope. The oldest is the Association of Halfway House Alcoholism Programs (AHHAP), founded in 1958, and now are affiliated with NARR. AHHAP members include all of the NARR levels of support. AHHAP residences operate in accordance with social model recovery principles. Oxford House Inc. was established in 1975 and supports Oxford Houses internationally. Oxford Houses are NARR Level 1 residences, with each residence operated solely by the residents in accordance with Oxford House guidelines. Oxford House Inc. supports and promotes its model for peer-operated recovery residences through training, technical assistance, and access to startup financing. They also advocate for recovery housing rights and provide legal support to Oxford Houses involved in disputes with cities and towns over their right to exist. Treatment Communities of America (formerly Therapeutic Communities of America) represents more than 600 residential addiction treatment programs in the United States.

12. Do recovery residences honor all pathways to recovery or just AA and NA? If so, how do they do that?

Recovery residences support various abstinence-based pathways to recovery, and each residence focuses on one or more particular pathway. People seeking support for a specific, culturally congruent path to recovery should determine what recovery activities are required before accepting a placement. One key to look for is the respect shown for an individual's choices and an environment wherein residents support each other.

13. Are residents expected to work and volunteer?

Working and volunteering are generally considered vital components of recovery (Betty Ford Consensus Panel, 2007; Cloud & Granfield, 2008; White, 2007). Level 1 and 2 residence fees are usually paid by the residents themselves, so they must work onsite and/or offsite to meet their financial obligations. Studies of Oxford House and Sober Living House residents have found that the majority of residents are employed when they enter the residence and that employment outcomes improve over time (Jason, Davis, & Ferrari, 2007; Polcin, Korcha, Bond, & Galloway, 2010). In Level 3 and 4 residences, however, residents' time is more structured and may include numerous recovery activities during the day. In those residences, it may not be reasonable or feasible for residents to also have an outside work or volunteer activity requirement. Still, these residences, as well as Level 1 and 2 residences, may offer job readiness workshops and have relationships with local employers and community organizations to facilitate employment and volunteer involvement among residents.

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Recovery Home Residents

14. How does someone get into a recovery residence?

Entry into a recovery residence usually involves an application/personal interview. Payment of first week's or first month's fees upon acceptance is common. Some residences are closely affiliated with outpatient programs and require concurrent participation in those programs. Other residences draw their residents exclusively from their own addiction treatment or mental health program.

15. Are there stages/tiers of participation in recovery residences?

Many residences define levels of recovery progress within the resident community. These levels are often also called phases and correspond with time in the residence, recovery progress as assessed by peers and/or staff, and the degree to which residence behavioral requirements have been met. Each level or phase is typically accompanied by an increase in privileges, greater personal autonomy, exemption from certain requirements of previous phases, and possibly different physical accommodation choices.

Many residences with this type of system often pair later phase residents with new arrivals in a sort of "buddy system." A blackout period is required in the initial phase of some recovery residences. This is a period in which the new resident is required to break communication with the outside world or with their natural supports in order to stabilize and focus on their recovery. Many residences limit the activities for new residents for a length of time after admission. These restrictions might include always being accompanied by a more senior resident when outside the home, limits to contacts with family or friends, and expectations for a higher degree of involvement in recovery support activities. Durations typically range from one week to one month.

16. What is known about the characteristics of people living within recovery residences?

The national profile of persons residing in all four levels of recovery homes is not presently available. The founding of NARR may provide a means of gathering that data in the future.

While residential treatment facilities and recovery homes serve all types of individuals, on average, the person is twice as likely to be male, which is consistent with SUD prevalence rates (Jason, Davis, & Ferrari, 2007; SAMHSA, 2011). For individuals undergoing residential treatment, the median age is the early thirties; however age groups from 25 to 49 are almost equally represented. The average age for a resident in a national study of Oxford House residents was 38. (Many recovery residences report that this average iage s decreasing.) Whites represent 60 to 65% of individuals in treatment and recovery homes. African Americans and Hispanics comprise 22% and 12% respectively in residential treatment (SAMHSA, 2011), In the national Oxford House Survey, Whites represented 58% of residents and Blacks and Hispanics represented 34% and 3.5% respectively (Jason, Davis & Ferrari, 2007). Existing data would suggest Hispanics are underrepresented in recovery housing when compared to these treatment statistics.

Of those individuals aged 18 or older in residential treatment, 33% had not completed high school, 42% had a high school degree, and 25% had completed some post-secondary education (SAMHSA, 2011). The average educational level for participants in a recovery residence (Oxford House) study was 12.6 years (Jason, Davis & Ferrari, 2007). Only 11% of those in residential treatment are employed either full-time or part-time; 35% are unemployed; and 54% are not in the labor force. (SAMHSA, 2011). Individuals residing in recovery homes are likely to be employed either full-time (69%) or part-time (14%), or looking for work (unemployed = 12%)(Jason, Davis & Ferrari, 2007).

Both those in residential treatment and in recovery homes are unlikely to be married. Sixty percent of the individuals have never been married, and married individuals make up about 12 to 13% of those in residential treatment (SAMHSA, 2011). For recovery home residents, about half have never been married and only 5% are currently married (Jason, Davis & Ferrari, 2007). .

Persons both in residential treatment and recovery houses often suffer from comorbid psychological conditions, which affect approximately 35% to 45% of the individuals. In addition, about 3 in 10 individuals are involved in the legal system—being referred to treatment, on probation, or awaiting legal processes.

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17. What percentage of residents will have completed or still be involved in professional treatment?

Studies to date of RRs reveal that the vast majority of RR residents have a history of inpatient or outpatient addiction treatment.

18. What is the degree of involvement in AA, NA, and other recovery mutual support groups and institutions of persons living in recovery residences?

The vast majority of Oxford House residents are actively involved in 12-step groups like Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), and such involvement is linked to increased social support and self-efficacy for abstinence (Majer, Jason, Ferrari, Venable, & Olson, 2002). Our experiences in working directly with this population, both clinically and as community-based researchers, have informed us that AA and NA members benefit by concurrent involvement in a sober living environment and twelve-step activities. 12-step involvement entails a set of specific behaviors that guide members of 12-Step fellowships in their recovery processes—actions outlined as "suggestions" in the fellowships' basic texts (Alcoholics Anonymous, 2001; Narcotics Anonymous, 2008). These key ingredients for recovery initiation and maintenance have both theoretical and empirical support (Majer, Jason, Aase, Droege, & Ferrari, in press). Similarly, sober living houses in California either strongly encourage or mandate attendance at 12-step groups (Polcin, Korcha, Bond, & Galloway, 2010) and studies of these homes have concluded that a higher level of 12-step involvement predicts better recovery outcomes.

Early therapeutic communities (TCs) of the 1960s and 1970s were not philosophically aligned with AA, NA, or other 12-Step programs (De Leon, 2000; Yablonsky, 1965), but in recent decades, most TCs have integrated or adapted 12-Step concepts and participation in 12-Step groups into their treatment approach (White, 1998). A 1995 survey of TCs in the United States revealed that 90% had 12 Step meetings being held on their premises, with 58% encouraging 12-Step participation by their residents during treatment and 83% encouraging such participation during the aftercare phase of treatment (Troyer, Acompara, O'Connor, & Berry, 1995).

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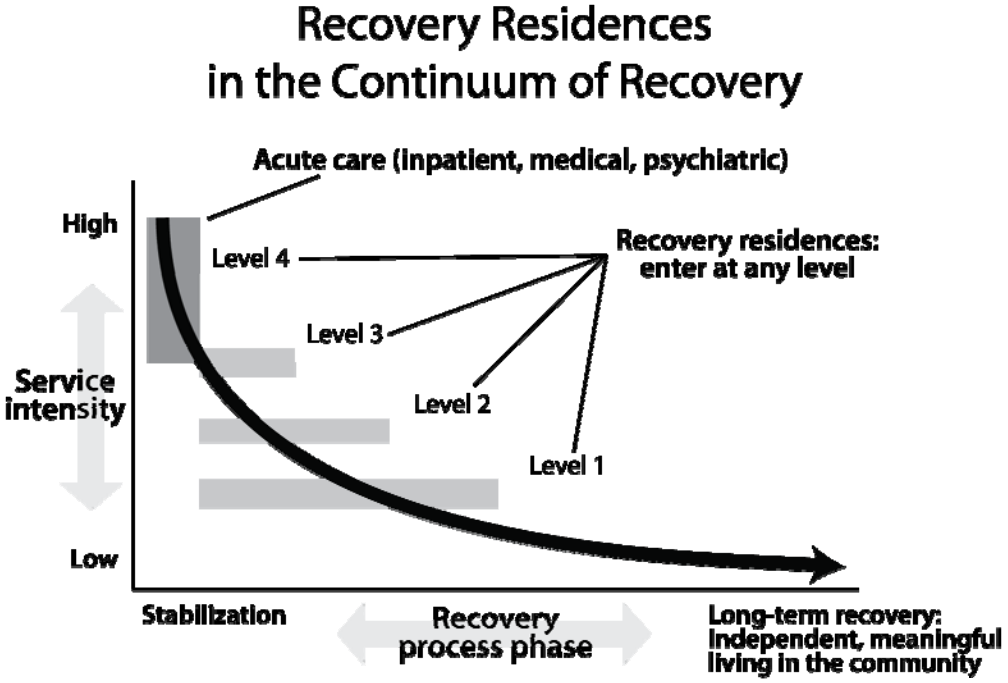
19. How do service needs and the degree of problem severity affect admission decisions to recovery residences?

The role that service needs and problem severity play in admissions decisions varies widely within and across levels of recovery residences (See illustration below).



There are also recovery residences designed specifically for individuals with certain needs (e.g., co-occurring addiction and severe mental illness, veterans, mothers with children); however, some recovery residences may not be equipped to adequately meet these residents' needs. Individuals with specific service needs seeking RRs should ask the provider about how these needs can (or cannot) be addressed within a particular residence.

20. Are people taking medications (e.g., methadone, buprenorphine, other medication-assisted therapies, other prescription medications, or over-the-counter medications) accepted into recovery residences and if so, how are the medications managed?

Yes, but medication policies vary across recovery residences. Some RRs do not accept applicants who are taking specific medications, such as narcotics and psychotropic medications; others accept residents who are being tapered down from specific medications under medical supervision; and still others fully accept persons in medication-assisted addiction treatment. Medications can be self-managed by the resident, managed by a licensed 3rd party provider, or in the case of Level 4 RRs, managed by licensed staff of the facility. Individuals seeking RR who are on medications should ask each provider about the medication policies in order to choose the RR that best fits their needs.

Both over-the-counter (OTC) and prescription medications can be abused and jeopardize an individual's recovery. Moreover, not taking medications as prescribed can undermine one's recovery. NARR requires each recovery residence (RR) to establish and clearly communicate its policy and procedures around both OTC and prescription medications. These policies and procedures are designed to maintain a safe living environment and support the recovery of everyone in the home, including the resident(s) taking medication.

There are 4 different types of RRs, each offering a different Level of Support in both services and staffing. Level 4 RRs offer clinical services whereas Levels 1, 2, and 3 do not. While laws can vary from state to state, they generally restrict the dispensing and managing of medications to licensed professionals, like the ones you would find in a Level 4 RR. That being said, most residents taking medication do not live in a Level 4 RR. Although they cannot provide medication management, Levels 1, 2, and 3 can use policies and procedures around the self-management of medications and the eligibility of individuals taking specific medications to live in the house. These policies and procedures are used to maintain a safe, recovery supportive living environment for a specific population within the scope of service an RR is qualified to provide. For example, the use of methadone, buprenorphine, and other medication-assisted recovery pharmaceuticals are allowed in some RRs, but not in others. This is in part due to the logistics, staffing, and cost of managing these types of medications, but it also may reflect philosophical differences within the recovery community and consumer choices. There is a demand for both RRs designed for individuals using medically assisted products in their recovery and for those that dis-allow medically assisted recovery.

21. How long do people stay in a recovery residence?

Length of stay varies depending on the residents' needs, progress, and willingness to abide by residence guidelines as well as on the payment structure of the residence. Many residences encourage a minimum length of stay or, for Level 3 and 4 residences,

have identified benchmarks set forth for residents to graduate (De Leon, 2000). Level 1 and 2 residences (e.g., Oxford Houses and Sober Living Houses) typically have an open-ended length of stay (Polcin, Korcha, Bond, & Galloway, 2010). For example, in the Oxford House model, residents can stay in the house indefinitely as long as they do not drink alcohol or use drugs and pay an equal share of the house expenses (Oxford House Inc., 2008). On average, residents stay in Oxford Houses a little more than a year, but many residents stay 3 or more years (Jason, Olson, Ferrari, & Lo Sasso, 2006).

Residents in higher Levels of Support, RR 3s and 4s, typically move to lower Levels of Support. As such, the average length of stay in RR 3s and 4s tend to be shorter than the average length of stay in RR 1s and 2s. Residences that receive payments from third parties may need to conform to guidelines set forth by these payers. For example, residents living in recovery residences that receive funding from the city of Philadelphia must receive approval to stay in the house every three months with payment limited to 90 days per individual per state fiscal year (Fred Way, Personal Communication, July 2012). Similar constraints may exist for residences that receive reimbursements from other private or public insurers.

Individuals who leave a recovery residence move out into the greater recovery community, move to different levels of support, and a few stay on as the next generation of house managers. Within many recovery residences, senior residents are developed as peer leaders and house managers—a process through which they deepen their own recovery, mentor those in early recovery, and maintain the household's recovery culture.

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22. What happens if a resident of a recovery home uses alcohol or drugs?

For the safety of the resident and the community, a relapse is met with immediate appropriate action. In most recovery residences, this involves moving the individual out of the RR and providing access to a level of support that will help them re-initiate recovery. Relapses can be fatal! They endanger the life of the individual and the lives of everyone else in a RR. Most RRs oppose the concept of relapse as an expected and accepted part of the recovery process as a deadly proposition that undermines recovery stabilization and maintenance (White, 2010). Relapse is a manifestation of addiction, not

of recovery; it is a sign for immediate intervention and change. NARR requires each RR to define their relapse policy and to have procedures that do not "punish" an individual for relapsing but protect the health and well-being of that individual and the RR community as a whole. All recovery residences are abstinence-based environments—in contrast to "wet housing" that allows residents to use alcohol or other drugs or "damp housing" that discourages but does not exclude persons for using.

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23. What does it cost to stay in a recovery residence?

The cost of RR varies widely and is correlated with market price of local housing and the level of support provided. Of the 4 Levels of Support identified by NARR, the higher Levels of Support tend to be more expensive because they must meet higher standards for staffing levels and services provided. However, the Levels of Support are NOT a quality rating system. A variety of services within and across Levels of Support are available to meet the recovery support and financial needs of individuals through their recovery process.

Payment terms vary, but residents can expect to pay monthly (or weekly) fees and sign an agreement committing themselves to a minimum length of stay and adhering to clearly stated house rules that support the recovery of the individual and the community. Typically, there is a refundable deposit or a non-refundable administration fee required on or before move-in. There also may be additional fees or fines clearly listed in the agreement for things like extra services or late payments.

24. How are recovery residences financially supported?

Most recovery residences (particularly levels 1 & 2) are self-funded through resident contribution, but recovery residences with higher levels of support, such as a range of clinical services, often receive other forms of federal, state, and private support.

RRs are historically self-funded, eventually become self-sustainable, and utilize community of volunteers. Start-up costs are typically covered by the housing provider, an Angel Investor, or a nonprofit. As a part of their recovery process, residents are expected to work, pay rent, and support the house. In some cases, residents may not be able to fully cover operational costs, so housing providers offer short-term scholarship beds and utilize other financial resources in the community. No RR could financially survive without the use of volunteer staff and peer's cultivating the culture of recovery in homes.

Start-up costs of RRs vary across the 4 Levels of Support. Lower Levels of Support, RR 1s and 2s, typically rent residential houses—a practice that avoids the capital cost of purchasing a property. The cost of capital improvements and fully furnishing a household to accommodate on average 10 residents is the largest start-up

cost. Marketing, maintenance, and utilities are the largest operational expenses for the lower Levels of Support, RR 1s and 2s. Higher Levels of Support, RR 3s and 4s, have higher staffing and administrative expenses as well as higher initial capital outlays.

In general, RRs are NOT very profitable. By the time someone is ready to embrace recovery, they have often lost the financial means to afford to live in an RR at any price. Plus, occupancy rates can be inconsistent, and operational costs can be high. It may take several years for an RR to recoup start-up costs and achieve a positive cash flow. As a result, a single financial challenge, like defining housing rights, can easily cause an RR to close.

Recovery Residences and Recovery Outcomes (2012)

25. Has there been research conducted on recovery residences?

Outcomes have been reported for all four of the levels described in the National Association of Recovery Residences (NARR) Standards for Recovery Services. A selected sample of studies is discussed below on each of the levels. Studies differ in their designs and level of scientific rigor within and across the four levels. Studies that use randomized controlled designs comparing residential recovery versus control or comparison conditions are relatively limited. Most studies consist of baseline measures acquired at intake compared with the same measures administered at follow-up. Other studies use designs comparing different models of residential recovery or residential recovery programs with outpatient treatment. However, some researchers (e.g., De Leon, Inciardi, & Martin, 1995) have pointed out that the nature of long-term residential recovery settings often makes random assignment or even matching designs difficult in terms of feasibility. They suggested that an individual's process of choosing to enter a particular type of recovery residence (i.e., self-selection) was an integral part of the recovery process that should be included in designs rather than eliminated via random assignment. In other words, the sequence of: 1) learning about recovery options from family, friends, professionals, or other sources; 2) considering the pros and cons of different potential programs; and 3) deciding what type of recovery program is the best match is integral to recovery. Instead of controlling extraneous factors that might influence outcome using random assignment to different groups (i.e., recovery residence versus a control condition), they suggested the use of multivariate statistical models for longitudinal designs that can control for a wide variety of factors that might influence outcome. For a full description of these issues, see the paper by DeLeon et al. (1995) published in the *Journal of Psychoactive Drugs*. Studies by Moos (e.g., Moos & Moos, 2006) also offer good examples of nonrandomized longitudinal designs that use complex statistical models that control for extraneous influences.

Level I

Characteristics of Level I residences coincide most closely with Oxford Houses, which have been studied extensively by Jason et al. over the past 20 years. The brief synopsis of this work described below is taken in part from a review of non-professional recovery programs by Polcin and Borkman (2008).

Although there have been a plethora of publications resulting from the study of Oxford Houses at DePaul University, two papers present the major findings depicting longitudinal outcomes (Jason, Davis, Ferrari, & Anderson, 2007; Jason, Olson, Ferrari, & Lo Sasso, 2006). In the earlier study, 150 individuals completing residential treatment programs were randomly assigned to aftercare as usual or residency in an Oxford House. At 24-month follow-up those assigned to the Oxford House condition had significantly better outcomes on measures of substance use, income, and incarceration. Among those assigned to aftercare as usual, 64.8% reported some alcohol or drug use over the previous 6 months versus 31.3% for the individuals assigned to the Oxford House condition. Individuals assigned to the Oxford House condition also reported lower rates of incarceration than treatment as usual, 3% versus 9%. A cost-benefit analysis by Lo Sasso, Byro, Jason, Ferrari, & Olson (2012) showed a net benefit of an Oxford House stay was on average $29,000 per person, which was significantly higher than the comparison group.

One of the limitations of the Jason et al. (2006) study was the limited geographical area from which the sample was drawn (i.e., the state of Illinois). A second limitation was the sample only included individuals completing residential treatment. The second study of Oxford houses (Jason et al., 2007) addressed both of these limitations. The study consisted of a US national sample of Oxford House residents (N=897), a majority of whom had a history of receiving some type of substance abuse treatment. However, unlike the first study, completion of a residential treatment program was not required for inclusion. Study participants were recruited from a variety of sources and interviewed at three subsequent 4-month intervals. During the final interview, only 13.5% of the respondents reported using alcohol or drugs during the previous 90 days. The average number of days participants used substances over the 90-day period was low: 3.7 days for drugs and 5.6 for alcohol. When participants reported having social networks that supported abstinence and discouraged substance use, they were more likely to be abstinent. They were also more likely to be abstinent to the extent they were involved in 12-step groups. The proportion of residents reporting employment throughout the study was high, ranging from 79% to 86%. Importantly, both longitudinal studies of Oxford Houses showed that a wide variety of persons were able to benefit. Improvement was not limited to specific demographic groups or referral sources.

Level II

Sober living houses (SLHs) similar to those that are members of the Sober Living Network (SLN) in Southern California and some houses affiliated with the California Association of Addiction and Recovery Resources (CAARR) are good examples of Level II residences. Like Level I residences, studies on these types of facilities have been limited.

One of the few studies on Level II residences was a recent study of houses in Northern California (Polcin, Korcha, Bond, & Galloway, 2010). Researchers recruited 245 individuals entering Clean and Sober Transitional Living in Sacramento County, which includes 16 recovery homes. The houses were located in a very high methamphetamine (MA) use area and 53% of the participants entered the houses with dependence on MA during the past year. Participants were interviewed within 2 weeks of entering the houses and then at 6-, 12- and 18-month follow-up. Primary outcomes

included measures of alcohol and drug use and Addiction Severity Index (ASI) alcohol and drug scales. Secondary measures consisted of other ASI scales and a variety instruments assessing criminal justice involvement, employment, and psychiatric problems.

Longitudinal analyses revealed two patterns for primary and some secondary outcomes over time. One pattern involved residents entering the SLHs with moderate to high severity of problems, making significant improvements by 6 months, and then maintaining those improvements at 12 and 18 months. Results from measures that assessed alcohol and drug use over a 6-month time period showed this pattern. For example, alcohol and drug abstinence over a 6-month time period increased from 20% at entry into the SLH to 40% at 6-month follow up. Abstinence improved even more at 12-month follow-up (45%) and declined only a bit at 18 months (42%).

The other outcome pattern showed residents entering the SLHs with low severity of problems at baseline and then maintaining low severity at 6-, 12-, and 18-month follow up. Findings from the ASI alcohol and drug scales were good examples of this pattern. The average score on the ASI alcohol severity at baseline was 0.16 (se=0.02), and for drug severity at baseline, the average was 0.08 (se=0.01). Because ASI values range from 0 to 1, these scores are very low. There was therefore limited room to improve on these measures. Nevertheless, there were significant improvements at 6 months for both alcohol (mean=0.10, se=0.02) and drug (mean=0.05, se=0.01) scales. Those improvements were maintained at 12 and 18 months. Alcohol severity remained at 0.10 at 12 and 18 months, and drug severity also remained essentially unchanged, 0.06 at 12 and 18 months. It should be noted that improvements were maintained at 12 and 18 months despite the fact that most residents had left the SLHs. By 18 months, about 90% of the residents had left, yet there was little regression of the earlier improvements. Thus, the improvements noted were therefore not simply a function of residents being housed in a controlled environment.

The study also examined a variety factors that predicted outcome. These included demographic characteristics and factors related to the philosophy of recovery in SLHs, such as involvement in 12-step groups and developing a social network supportive of abstinence. Generalized Estimating Equations showed that involvement in 12-step groups was the strongest and most consistent predictor of good outcome. As expected, drinking and drug use in the participant's social network predicted worse outcome.

Overall, a wide variety of demographic groups made improvement in the SLHs and only a few demographic characteristics predicted outcome. The most notable exception was the relationship between age and abstinence. Older age categories were over twice as likely to be abstinent than those aged 18-28. Relative to residents who had not completed high school, those with at least a high school diploma were nearly twice as likely to be abstinent over the past 6 months and about half as likely to be arrested.

Level III

A good example of level III residences are "social model" recovery programs, which emphasize experiential learning, peer support, and 12-step recovery principles within a semi-structured group living environment. These programs are more structured than level II residences and include paid counselors who assist residents with case management services and the development of a formal recovery or treatment plan.

Typically, there are various life skills and other types of groups offered at the facility. In many states, such as California, they are licensed by the state to provide treatment services.

As with Phase I and Phase II residences, the outcome studies on Phase III residences have been fairly limited. Studies that have been conducted include the California Drug and Alcohol Treatment Assessment (CALDATA; Gerstein et al., 1994) and studies on social model recovery programs conducted by Kaskutas et al. (2003-2004, 2008) at the Alcohol Research Group.

The CALDATA study examined treatment outcomes among 1,858 clients in California who received methadone treatment, non-methadone outpatient, clinically oriented residential treatment (21 providers), or social model recovery programs (23 providers). The study consisted of follow-up interviews approximately 15 months after leaving treatment. Clinically oriented residential programs included procedures such as psychiatric assessments, individual counseling, and treatment groups (e.g., therapeutic communities). Social model recovery houses were oriented toward peer support, communal living, and practicing 12-step recovery principles. Borkman, Kaskutas, Room, Bryan, & Barrows (1998) compared the two types of residential programs and reported that residents in social model programs had longer stays and incurred lower costs. Costs per treatment episode in the social model programs averaged $2,712, while costs per treatment episode in the clinical residential program averaged $4,405. Overall length of stay was associated with better outcome. Comparison of residents in the two types of residential programs who had comparable lengths of stay showed slightly better outcomes for the clinically oriented programs. For example, residents who remained in treatment 4+ months in the clinically oriented program reduced the number of months they used substances by 63% while social model residents reduced the number of months of substance use by 52%. Reductions in reports of criminal activity were slightly higher in social model programs (80%) than clinically oriented programs (74%).

Studies conducted by Kaskutas et al. (2003-2004, 2008) were stronger designs because they included longitudinal designs that compared measures collected at treatment entry with follow-up measures. The 2003-2004 study consisted of a naturalistic comparison of outcomes for individuals in social model residential programs (N=164) with those in clinically oriented programs N=558). The social model programs were detoxification and residential facilities, and the clinically oriented programs were a mix of inpatient and outpatient. Individuals in the social model programs were more involved in 12-step meetings and reported fewer alcohol and drug problems at one-year follow up, but not problems between the two study conditions in other areas (e.g., family, medical, legal, and psychiatric). The 2008 study randomly assigned clients to receive day hospital program treatment (n=154) or services in social model residential programs (n=139). Although significant improvements were noted at 12 months for both groups, between-group comparisons did not reveal significant differences. Overall, clients tended to remain in the residential programs longer and costs were higher.

Level IV

Relative to other levels, Level IV residences include more structure, paid professional staff, and on-site treatment services. Residential therapeutic communities (TCs) for drug treatment are a good example of Level four residences. Large proportions

of residents in TCs are referred from the criminal justice system, and some are actually located in prisons.

TCs have a long history of participating in research, including large national studies assessing drug treatment outcome. These studies include the Drug Abuse Treatment Outcome Study [DATOS] (Hubbard, Craddock, Flynn, Anderson, & Etheridge, 1997), National Treatment Improvement Evaluation Study [NTIES] (Center for Substance Abuse Treatment, 1996), Treatment Outcome Prospective Study [TOPS] (Hubbard et al., 1984), and Drug Abuse Reporting Problems [DARP] (Simpson & Friend, 1988). Overall, these and other studies on TCs (e.g., Martin, O'Commel, Paternoster, & Bachman, 2011) show that clients make longitudinal improvements on substance use measures, arrests, illegal behaviors and employment.

When TCs have been compared to voluntary, control, or alternative treatment groups, the findings have been encouraging. For example, DeLeon (1988) found that clients referred from the criminal justice system stayed in treatment longer than voluntary clients and had levels of improvement that were similar. Prendergast, Hall, Wexler, Melnick, & Cao (2004) conducted a randomized trial of 715 prisoners randomly assigned to either a therapeutic community program or to a no treatment group. At 5-year follow-up, the TC group had significantly lower *rates* of reincarceration, but not shorter times to first reincarceration. As in most studies of TCs, longer lengths of treatment were associated with better outcome. Martin, Butzin, & Inciardi (1995) studied 457 individuals participating in either an in-prison TC, a TC in the community, both types of TCs, or a no treatment comparison group. Those attending the community-based TC or both types of TC had the best outcome (substance use and re-arrest). The in-prison TC had modestly better outcomes than the no treatment comparison group.

Summary of Outcomes

There is obviously a significant need for additional research on residential recovery homes, especially those characterized by levels 1-3. Studies on level 4 residences are more numerous because of the large number of studies examining outcomes within therapeutic communities. Overall, the available studies across the different levels are encouraging. Longitudinal studies of residents housed within each of the levels show improvements in a range of areas. When comparisons have been made between recovery residences and appropriate alternatives, the results have shown recovery homes yield comparable or better outcomes. Cost and cost-benefit analyses have been limited and to have yielded mixed findings.

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26. Can the research conclusions drawn from studies of the Oxford House network be applied to all recovery residences?

The growing network of Oxford Houses represent one particular level of recovery residence—Level 1—and a particular approach to this level of recovery residence. At present, it is not known the extent to which findings reported from studies of Oxford House can be applied to other levels of care or other Level 1 recovery residences with different policies and practices than Oxford House. Until greater research is conducted on the full spectrum of recovery residences, it is not possible to know how applicable Oxford House research findings are to this broader spectrum of recovery residences.

27. How does living in a recovery residence influence long-term addiction recovery outcomes?

For recovery residences that fall under Levels I to III, there is very little research on long-term recovery outcomes. The primary studies on Oxford Houses (e.g., Jason, Davis, Ferrari, & Anderson, 2007; Jason, Olson, Ferrari, & Lo Sasso, 2006) interviewed residents at 12- and 24-month follow-up. A study of sober living houses in California (Polcin, et al., 2010) interviewed residents at 18-month follow up. While these studies documented significant longitudinal improvements, it is unclear whether improvements continue at 5 or 10 years. Studies of social model residential recovery programs by Kaskutas, Zavala, Parthasarathy, & Witbrodt (2008) reported similar follow-up time frames. There is therefore a significant need for studies tracking residents over longer periods of time.

A few studies of therapeutic communities have reported somewhat longer term outcomes. For example, Prendergast, Hall, Wexler, Melnick, & Cao (2004) conducted a 5-year follow-up of individuals in a therapeutic community and found lower rates of

reincarceration than a comparison group. Large national studies that included residential therapeutic community programs, such as the National Treatment Improvement Evaluation Study (Center for Substance Abuse Treatment, 1996) and the Drug Abuse Treatment Outcome Studies (Hubbard, Craddock & Anderson, 2003) documented improvements in drug use and a variety of other areas that were maintained at 5-year follow-up, although some attrition of improvement was noted along with a variety of study limitations.

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28. What ingredients of the experience living in a recovery residence appear to have the greatest direct effects in elevating recovery outcomes?

Although more research is needed to isolate the specific contributions of different aspects of the RR experience to outcomes, research conducted to date points to the importance of some key factors. For example, in a national study of Oxford House residents, Jason, Davis, & Ferrari (2007) found that social support for abstinence, abstinence self-efficacy, and length of stay (6 months or longer) predicted change in cumulative abstinence, even after controlling for initial time spent in the Oxford House prior to study recruitment, leading these researchers to conclude that receiving sustained abstinence support, guidance, and information from recovery home members may reduce the probability of a relapse. Similarly, in a study of residents of Sober Living Houses in California, Polcin, Korcha, Bond, & Galloway (2010) also found that level of 12-Step involvement and social network characteristics (such as drinking and drug use status of network members) were related to improved outcomes. This is consistent with what

residents themselves say is most helpful to them about living in RRs. In a mixed-methods study of Oxford House residents, Jason, Aase, Mueller, & Ferrari (2009) found that the overwhelming majority of current and alumni members agreed that residents provide support and companionship for each other and that Oxford Houses provide motivation and increase member's sense of responsibility.

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29. Do outcomes differ for people with co-occurring disorders (mental health, process addictions, major medical issues such as Hep C or HIV) living in recovery residences? Are recovery residences appropriate for these populations?

Little research has been conducted that would provide answers to this question. John Majer and colleagues (2008) conducted a study on the relationship between psychiatric severity and outcomes experienced by Oxford House residents. Those residents with greater psychiatric severity were more likely to use psychiatric medications and participate in outpatient psychiatric treatment while a resident, but there were no differences between those with high and low psychiatric severity on rates of abstinence and duration of residence. While much greater research is needed on this question, preliminary OH study findings would not suggest that persons with substance use and psychiatric co-morbidity are at higher risk of relapse residing in a Level I recovery residence. (also see Majer, Jason, Ferrari, & North, 2002).

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30. What benchmarks are used to evaluate the effectiveness of recovery residences?

A wide variety of indicators have been used to evaluate the effectiveness of RRs, reflecting the multifaceted nature of the recovery process (The Betty Ford Consensus Panel, 2007; Cloud & Granfield, 2008; White, 2007) and how it may affect an individual's quality of life (QOL; Center for Substance Abuse Treatment, 2007). In addition to indicators of sobriety (e.g., alcohol and drug use), researchers studying the outcomes of RR residents have also assessed gains in employment, family and social functioning, psychological and emotional well-being, as well as reductions in criminal involvement (see Jason, Davis, & Ferrari, 2007 and Polcin, Korcha, Bond, & Galloway, 2010 for descriptions of measures used to assess resident outcomes). Measures of QOL have not been used in any published outcome studies of RR residents; however these measures (the WHOQOL-BREF in particular) may be useful indicators of recovery in substance abusing populations (Tracy et al., 2012).

Although clients' outcomes are central to determining the effectiveness of RRs, it is also critical to assess how well RRs may be functioning as service delivery entities and what contributes to their viability and sustainability. Research in this regard will be greatly advanced as RRs adopt the NARR standards, which along with the Oxford House Manual, provide guidelines on structure, administration, staffing, and types of services delivered in different levels of RRs. Some research has been conducted on Oxford Houses in an attempt to examine characteristics of the houses that may contribute to resident outcomes (see Ferrari, Jason, Sasser, Davis, & Olson, 2006 and Jason et al., 2008), but more work needs to be done. This type of research will greatly advance our knowledge about how RRs work as well as about what types of RRs might work best for whom.

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31. Are there differences among types of neighborhoods and communities relative to the sustainability of recovery residences?

Community-based programs such as recovery residences not only require the continued support and participation of their members to ensure the program's sustainability, but also the support of fellow residents of the neighborhoods and communities in which they reside (Jason et al., 2008; Zippay, 2007). Community-based programs consisting of a smaller, self-governed social model program such as the OH system might be more vulnerable to community factors than those of larger, professionally run institutional environments (Borkman et al., 2007; Polcin, 2009). This is because most professionally-run recovery residences are often vetted and licensed businesses or not-for-profit organizations (Archibald, 2007), whereas non-professional OHs require no licensures and are much more subject to the same community dynamics as ordinary housing. Therefore, it is possible that some types of neighborhoods might lead to more positive outcomes for recovery residences like OHs than other types of neighborhoods.

In general, neighborhoods with the following five characteristics should be supportive of positive outcomes for residential recovery homes such as Oxford Houses. First, these neighborhoods must have accessible, affordable rental housing in areas offering amenities for daily life. Most OHs are rental housing in suburban and working-class neighborhoods, which tend to provide stable neighbors, adequate transportation options, and local businesses necessary for daily living, and offer greater flexibility to change locations (Oxford House Inc., 2004). Secondly, Oxford Houses also require individuals in recovery willing to live together in that specific community, and to adhere to OH rules and principles (Oxford House Inc, 2004). Some neighborhoods are overly challenging in maintaining a sober lifestyle because of drug dealing or criminal activity. Third, a supportive neighborhood or community offers opportunities for residents to secure reliable employment and income for the house to become self-supporting (Jason, Olson, Ferrari, & Lo Sasso, 2006). The fourth factor for sustainable OHs consists of institutional support and enforcement of the Fair Housing Act of 1988, which prohibits discrimination against minority housing. The Act has been cited as protection against localities attempting to restrict or close down OHs via targeted zoning laws (Jason et al.,

2008; Miller, 1995). Another institutional support is the Americans with Disabilities Act of 1990, which restricts employers from discriminating against hiring former substance abusers (Zuffoletto, 1992).

The fifth and last requirement for sustainable OHs is community support. Although OH residents and their housing are protected legally, good relations can help combat NIMBY (not in my backyard) attitudes, which can lead to hostile relations between OH residents and the local, non-recovery community (Polcin, Henderson, Trocki, & Evans, 2012; Zippay, 1999). Fortunately, after some initial resistance, community acceptance for therapeutic group homes can improve over time, indicating older houses might have stronger community support (Zippay, 2007). Additional community support includes local 12-step meetings such as Alcoholics Anonymous (Groh, Jason, Ferrari, & Davis, 2009).

Laws around the regulation of addiction treatment and recovery services differ from state to state, and RR Levels of Support range from clinical to nonclinical. The availability of a particular Level of Support is reflective of state law. Even though people in recovery are a protected class under the federal Fair Housing Act and its Amendments, local governments under Not In My Back Yard (NIMBY) political pressure often times illegally discriminate against people in recovery with land use or health and safety ordinances that regulate RR above and beyond housing for individuals without a disability. This discriminatory activity raises barriers for people in recovery to access the housing that many need to live happier healthier lives. With limited resources to navigate the legal system, which can be stigmatizing into itself, RR providers are often bullied out of municipalities, leaving local people in recovery without an important resource.

Harvey, Mortensen, Aase, Jason, & Mueller (under review) found that an impressive 86.9% of Oxford Houses remained open over a period of six years, thus suggesting that OHs are relatively stable systems when they operate in supportive communities. Conversely, Calabra, Beasley, & Jason (2012) found that certain combined community characteristics (based on U.S. Census data), particularly transient communities and low SES, tended to have the greatest number of closings of OH recovery environments. Finally, Ferrari, Groh, & Jason (2009) found no differences in sobriety outcomes among OH recovery homes residents in four socio-economic zones: upper or middle class, urban working or lower class, suburban upper or middle-class, and suburban working or lower class. However, like most complex systems, residential recovery homes likely require multiple levels of neighborhood support to promote positive outcomes (Foster-Fishman, Berkowitz, & Lounsbury, 2001).

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32. Do recovery and family outcomes differ for parents with young children staying in recovery residences?

Many recovery home residents have children; however, few residences allow parents and children to reside in the recovery home together. Although research has recommended further exploration of children's experiences in recovery residences (Polcin, 2001), to date, few studies have examined how recovery and family outcomes differ for parents and young children who live in recovery residences.

The Oxford House model is unique in that there are designated men and children's houses as well as women and children's houses. Oxford House research has explored how children living in Oxford Houses influence aspects of the recovery process. Women who lived in Oxford Houses with children reported getting along with children in the house, that mothers could rely on other house members for babysitting help, and that the children had a positive effect on the household and the women's—both mothers and non-mothers'—recovery processes (d'Arlach, Olsen, Jason, & Ferrari, 2006). Another study compared men and women who lived with children with men and women who did not reside with children in Oxford House. This study found that men who lived with children had more general social support than women who lived with children and men who lived without children (Ortiz, Alvarez, Jason, Ferrari, & Groh, 2009). This finding suggested that women who lived with children might need additional supports and resources compared to men (Ortiz et al., 2009). These findings were similar to a prior study that found that women who had children reported many parenting-related stressors upon entry to Oxford House (Ferrari, Jason, Nelson, & Curtin-Davis, 1999).

It is essential for research to further examine longitudinal outcomes among parents and children who live in recovery residences, including settings that differ from Oxford House. Future research is also needed to explore children's experiences in recovery home settings, and how recovery homes can impact both family and recovery outcomes.

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33. Is there a minimal optimal length of stay in a recovery residence in terms of achieving stable, sustainable recovery?

Systematic evaluations of large-scale treatment programs, such as the Drug Abuse Treatment Outcome Studies (DATOS) carried out in 1991-1993, as well as the earlier Treatment Outcome Prospective Study (TOPS) concluded that the most consistent predictors of positive outcomes in community-based settings are client retention and length of stay (LOS; Etheridge, Craddock, & Dunteman, 1995; Simpson, 2004). Longer LOS predicted higher sobriety rates in both naturalistic, non-experimental studies (Hubbard, Craddock, & Anderson, 2003) and experimental studies with randomly assigned controls or comparison groups (Dearing, Barrick, Dermen, & Walitzer, 2005; Jason et al., 2007). However, earlier research on residential treatment settings indicated that length of stay (LOS) in treatment and aftercare has yielded contradictory results (Moos, Finney, & Cronkite, 1990). For example, McCusker and colleagues (1995) compared four groups in either a 3- or 6-month program in an enhanced TC, or a 6- or 12-month program in a traditional TC. McCusker et al. found that longer LOS in treatment has no beneficial effects than shorter LOS. All groups had the same 6-month post-treatment drug use outcomes ranging from 50% to 56% sobriety rates from drugs (alcohol use was not measured as an outcome).

It is unclear what duration and retention rates in a setting constitutes an effective LOS, and what client characteristics influence this relationship (Condelli & Hubbard, 1994; Finney, Moos, & Chan, 1981). Moos, Pettit, & Gruber (1995) found that patients (N = 5,176, mostly males) who entered a long-term aftercare facility after acute or short-term AOD treatment had ended had lower treatment readmission rates after 6 months and 1 year than treated men (N = 5,176) who were released back into the community, often returning to their homes. The men who entered the aftercare facility also used outpatient mental health care services significantly more than men who were released into the community. Moos et al. (1995) suggested that longer episodes of care tend to encourage active participation and involvement with mental health and recovery processes, such as more frequent office visits and meeting with recovery counselors.

Other factors undoubtedly interact with LOS. High turnover within a treatment environment might be a key component to extending resident LOS and subsequent benefits of longer treatment. In the McCusker et al. (1995) study, they found that retention rates decreased over time, ranging from 55.6% for the 3-month program to only 20.7% for the 12-month program, i.e., the longest episodes of treatment had the lowest completion rates. The low retention rates and similar use outcomes underscore the concept that length of contact with peers, rather than program length alone, is necessary for differential outcomes. It is likely that LOS cannot be equated with the intensity or "dosage" of treatment. In an evaluation of five different inpatient AOD treatment programs, Moos et al. (1990) found that client participation and involvement in the treatment milieu was at least as important as LOS. This suggests that longer stays are effective only if it permits opportunities for people recovering from AOD problems to activate the protective benefits from Moos' theoretical ingredients (Moos, 2008). Length of stay contributes to the "activation" of the theoretical ingredients because many of these processes are time based, i.e., a 6-month program offers more opportunities to learn from peers, or to form protective bonds, than a 30-day program.

OH research indicated a tipping point of six months of residency; at a 24-month follow-up, OH residents who stayed more than six months had relapse rates of 16.6%, compared to relapse rates of 45.7% for residents staying less than six months (Jason et al., 2007). Greater LOS of six months or more may allow individuals to stabilize and adapt to their post-treatment circumstances at a self-defined pace (DiClemente, Schlundt, & Gemmell, 2004; Jason et al., 1997). Other studies have also noted that treatment durations of 6 months or more tend to produce better outcomes in residential settings (Dennis, Scott, & Foss, 2003; Hubbard et al., 2003; Johnson, Finney, & Moos, 2005). Also supporting this contention are studies comparing programs lasting from 14 to 90 days, which found no differences in sobriety outcomes based on LOS (Etheridge et al., 1995).

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34. Do recovery residence outcomes differ by resident characteristics, e.g., age, gender, ethnicity, co-occurring disorders, different amounts and kinds of recovery capital?

The existing literature suggests that a wide variety of individuals are able to benefit from living in a recovery residence. When differences have been found in terms of the characteristics of the types of individuals who benefit most, results have been inconsistent across studies. For example, in a study of sober living houses, Korcha, Polcin, Bond, & Galloway (2010) found higher severity of psychiatric symptoms predicted worse alcohol and drug outcomes. This finding is consistent with numerous alcohol and drug treatment studies that show co-occurring mental health disorders are common among individuals with addictive disorders, and higher psychiatric severity predicts worse outcome (e.g., Broome, Flynn, & Simpson, 1999; Compton, Cottler, Jacobs, Ben-Abdallah, & Spitznagel, 2003; McLellan, Luborsky, Woody, O'Brien, & Druley, 1983; Ritsher, McKeller, Finney, Otilingam, & Moos, 2002). However, a number of studies examining outcomes of individuals in recovery residences did not find psychiatric severity to predict outcome. In a study of 52 Oxford House residents, Majer, Jason, Ferrari, & North (2002) found high co-occurrence of antisocial personality (58%), post-traumatic stress (35%), and affective (38%) disorders. Despite the high incidence of co-occurring disorders, 69% of the residents at 6-month follow up were still residing in the Oxford House or had left the house under favorable conditions. In a subsequent study of Oxford houses, Jason et al. (2007b) did not find mood or anxiety disorders to predict substance use outcomes among 75 residents of Oxford Houses.

Studies of therapeutic community residences (TCs) have also yielded mixed findings. DeLeon (1989) noted that therapeutic communities (TCs) have historically had some difficultly succeeding with clients who have co-occurring disorders. However, he outlined a series of modifications TCs have made to be more responsive to this

population, including decreased confrontation, increased flexibility, and incorporation on mental health professionals as part of the treatment team. In a recent TC study of retention, Darke, Campell, & Popple, (2012) studied 191 individuals entering a TC and did not find worse retention associated with higher psychopathology. However, Mulder, Frampton, Peka, Hampton, & Marsters (2009) studied 3-month retention among 107 individuals enrolled in a TC and found those remaining in treatment had lower mental health problems on the Short Form Health Survey (SF-36), but a higher history of lifetime depression. Samuel, LaPaglia, Maccarelli, Moore, & Ball (2011) studied how 10 different personality disorders were associated with retention in a TC. They found borderline personality disorder was associated with worse overall retention. Antisocial personality and histrionic disorders were related to very early attrition, but not overall retention.

Studies assessing demographic characteristics of individuals entering recovery residences have also yielded little that is consistent across studies. Jason, Davis, Ferrari, & Anderson (2007a) studied 897 men and women in Oxford Houses and did not find associations between demographic variables such as age, sex, and race and 90-day alcohol use. Remaining in the Oxford House for at least 6 months was a strong predictor of alcohol sobriety. However, Polcin, Korcha, Bond, & Galloway (2010a) studied sober living houses in California and found 6-month abstinence from alcohol and drugs was less common among younger individuals age 18-28 than other age groups. No differences were found by sex and race. When associations between demographic variables were examined in relation to Addiction Severity Index (ASI) alcohol and drug scales, the findings were different. There were no significant differences on the ASI drug severity scale by sex, race, or age. In addition, most comparisons on the ASI alcohol scale were also not significant, although whites and those aged 29 – 37 had somewhat lower severity. At 18-month follow-up, length of time in the sober living house did not predict outcome.

Demographic factors and how they relate to outcome have also been examined within the context of TCs. Messina, Wish, & Nemes (2000) examined a variety of predictors of outcome in TCs among women and men separately. Analysis considered a variety of demographic factors, including age, education, and marital status. For men, the only variable predicting substance use at 12 months was treatment completion predicting a negative drug screen. For women, predictors included treatment completion predicting a negative screen and a history of physical abuse predicting a positive screen. Completion of treatment was also associated with employment and avoiding arrests for both men and women. Even for residents who did not complete treatment, longer lengths of treatment were associated with better outcome, especially for women.

Examination of the role that recovery capital plays in influencing outcomes in residential recovery settings has been limited. Recovery capital refers to factors that support establishment and maintenance of recovery, such as social support, 12-step affiliation, spirituality, religiousness, and life meaning (Laudet & White, 2008). Most of these concepts are understudied among persons recovering in residential recovery homes. However, there has been some examination of social support and 12-step affiliation in Oxford and sober living houses. Polcin et al. (2010a) found higher involvement in 12-step groups and fewer heavy alcohol and drug users in the social network predicted better alcohol and drug outcomes among sober living house residents. Similar results were

found in a study of 55 individuals residing in sober living houses affiliated with an outpatient treatment program (Polcin, Korcha, Bond, & Galloway, 2010b). Groh, Jason, Ferrari, & Davis (2009) studied 12-step involvement in Oxford Houses and found high involvement in 12-step groups combined with residence in an Oxford House was associated with higher abstinence. Groh, Jason, Davis, Olson, & Ferrari (2007) found social support from family and friends predicted better alcohol outcomes for residents of Oxford Houses, but alcohol specific social support did not.

Historically, TCs have not integrated 12-step groups into the recovery process, but they have emphasized social support for recovery as an important goal. However, TCs have recently begun to modify their approach to incorporate 12-step involvement. Research by Aromin, Galanter, Solhkhah, Bunt, & Dermatis (2006) of 322 clients in TCs suggested there is increasing support for integrating 12-step groups into the TC modality. Although social support is emphasized in TCs it has been understudied as a predictor of outcome. However, in a recent study Mandell, Edelen, Wenzel, Dahl, & Ebener (2008) documented that social support capital developed early in TC treatment was associated with longer retention, and longer retention was in turn associated with better post-treatment outcomes.

Summary: There is little in the existing literature to suggest that residential recovery programs are not appropriate for specific types of individuals. When significant predictors have been found, they have not been consistent across studies. Two consistent predictors of outcome with implications for operation of recovery residences are involvement in 12-step groups and social support for recovery. Additional research is needed on predictors of outcome, especially the role of recovery capital.

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35. Are there persons for whom recovery residences are not appropriate?

Posing this question to those with expertise in recovery residences generates a number of anecdotal observations on populations that may not do well in this type of recovery support structure (e.g., persons with serious mental illness, persons with a past history of sexual crimes, persons with a high level of personal resources, etc.), but little research has been done on this question. There is evidence from studies of level 1 recovery residences of characteristics associated with better outcomes (e.g., persons who are older, African-American, 12-step involvement, social networks with fewer substance users and who remain in residence more than six months) (Jason, et al, 1997; 2007; Groh, et al, 2009; Polcin et al, 2010).

A RR is not appropriate for an individual:

- if they are not an eligible population. RRs are designed only for people in recovery from substance use and/or co-occurring issues. Often they are designed for an even more specific population in recovery (e.g., gender, sexual orientation, age).
- if they are unwilling or unable to support the recovery culture of the RR by adhering and upholding the house rules for themselves and others.
- if their needs exceed the scope of service provide. RR's 4 Levels of Support offer a wide range of choices, but even still, there are needs that go beyond what an RR can provide.
- if they pose a threat to themselves, others, or property.
- if they are engaged in criminal activity.

The prolonged history of harm in the name of help in the history of addiction treatment and recovery in the United States suggests the need to evaluate the potential of inadvertent harm from all helping interventions offered to individuals seeking recovery support (White, 1998; White & Kleber, 2008; White & Miller, 2007). While the potential for such harm has been explored for professionally delivered psychosocial interventions for substance use disorders (Ilgen & Moos, 2005, 2006; Moos, 2005), no studies exist to date that have identified any inadvertent harm to particular populations of people residing in the Level I-II recovery residences.

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36. Are recovery residences cost-effective?

Research has not thoroughly investigated the cost-effectiveness of recovery residences. The few studies that exist have compared Oxford House and alternative aftercare models. For example, an exploratory study on the societal costs of Oxford House estimated low annual societal costs per person in Oxford House based on federal and resident data (Olson et al., 2006). Additionally, the societal costs of Oxford House were relatively low when compared to costs for inpatient treatment and incarceration (Olson et al., 2006). A more recent study examined costs and benefits from a randomized, controlled study of Oxford House and usual aftercare conditions (LoSasso, Byro, Jason, Ferrari, & Olson, 2012). Economic costs included length of residency in Oxford House as well as inpatient and outpatient treatment utilization, while economic benefits encompassed monthly income, days engaged in illegal activity, substance use, and incarceration rates (LoSasso et al., 2012). Results indicated costs were higher in Oxford House, but the benefits of reduced incarceration, substance use, and illegal activity outweighed those costs (LoSasso et al., 2012).

Given the limited data on the costs and benefits of recovery residences, additional research to compare recovery residences and other types of housing arrangements is warranted. For example, future research should compare recovery residences with

government-supported housing, permanent supportive housing, transitional housing, incarceration, homelessness, safe havens, and shelters, as well as long-term residential treatment programs. Furthermore, additional data are needed to examine the combined cost savings related to criminal justice and incarceration, hospitalization and medical costs, substance use-related costs, and other social costs for recovery residences. This would include cost savings calculations for parents and families involved in child welfare systems, babies being born drug-free, and promoting intact families. Finally, it is important to incorporate the benefits of recovery residences, including residents' employment, earning incomes, pursuit of purpose, volunteer activities, and improved citizenship behaviors and how these activities impact the societal costs of these settings.

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37. Are government loans available to start recovery residences?

In 1988, Congress passed an "Anti-Drug Abuse Act" that included a provision to encourage state-level expansion of self-run, self-supported recovery homes, such as Oxford Houses. In early 1989, the U.S. Alcohol, Drug Abuse, and Mental Health Administration issued guidelines to all states requiring the establishment of *revolving loan funds* in which each state would set aside $100,000 from their available state funds for the expansion of these homes. Individuals were able to borrow up to $4,000 from this state loan fund to help with initial month's rent, a security deposit, and to purchase furniture and other items necessary to establish a house. Some states also provided separate financial assistance for the hiring of outreach workers or recruiters to facilitate the opening of Oxford Houses.

In a study of thirteen states that had both a revolving loan fund program and recruiters, Oxford House researchers found an increase in the opening of new houses after the introduction of these policies—a total of 559 new Oxford Houses were opened between 1988 and 2002 in these states, in contrast to no new houses being opened in the 10 years prior, suggesting that federal policy and the provision of state-level resources can affect the expansion of recovery residences (Jason, Braciszewski, Olson, & Ferrari, 2005). When the Anti-Drug Abuse Act was revised in 1999, not all states were required to offer loan funds (Braciszewski, Olson, Jason, & Ferrari, 2006). Currently, only the following locations maintain recovery home revolving loan funds: New Jersey, Illinois, Oklahoma, Nebraska, North Carolina, Washington State, Oregon, Delaware, Virginia, Kansas, Hawaii, Wyoming, New Mexico, West Virginia, and District of Columbia.

Oxford Houses across the U.S. also contribute about $300,000 a year that is used to support the development of new Oxford Houses (P. Molloy, personal communication, 21 June 2012).

More research is needed to investigate the status, effects, and implementation of these policies, particularly how they may have affected other non-Oxford House recovery residences.

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Recovery Residences and the Community

38. How do Recovery Residences affect the neighborhoods in which they are located?

The American Planning Association's *Policy Guide on Community Residences* (1997) reviewed more than 50 studies and concluded that **c**ommunity residences such as group homes and halfway houses do not have an effect on the value of neighboring properties. Reviews also note that community residences are often the best maintained homes on their block and that many neighbors were not even aware there was such a residence in the neighborhood (also see Council of Planning Librarians, 1990). Other reviews have found no negative effects on neighborhood safety and that residents of group homes are much less likely to commit a crime of any sort than the average resident (Lauber, 1986).

There are numerous reasons why RRs *should be* located in residential neighborhoods. Establishment of RRs in these areas facilitates the integration of persons in recovery back into the community and also may serve to educate the community about stigmatized populations (e.g., people with substance abuse problems, developmental disabilities, or mental illnesses). Indeed, Oxford House, Inc. advises that new houses be established in safe, low crime, economically stable neighborhoods with minimal opportunities for relapse (Oxford House, 2002), and research on Oxford Houses indicates that they are typically located in these types of neighborhoods (Ferrari, Jason, Blake, Davis, & Olson, 2006; Ferrari et al., 2009).

Despite these reasons and federal law protecting persons in recovery as a protected class under the federal Fair Housing Act and its amendments (see 42 U.S.C. §§ 3601-3619), RRs often face significant "not in my backyard" (NIMBY) opposition to opening in residential neighborhoods (Jason et al., 2008) or may be forced to open in poorer ones. For example, a study conducted in Philadelphia found that over 50% of RRs in that city were located within only 4 of the 49 city zip codes and that 26 zip codes did not have any recovery homes in them whatsoever (Johnson et al., 2009).

This sort of opposition is unfortunate, because research conducted to date generally finds that RRs do not negatively affect neighborhoods and may even provide benefits to the communities in which they are located. Interviewing landlords of Oxford Houses, Ferrari, Aase, Mueller, & Jason (2009) found that landlords reported that things such as excessive noise, rent payment, landlord tenant communication, and pet problems were less of a problem with Oxford House renters than with other renters, and many had positive comments about renting to Oxford House tenants. Studies of neighbors and community members have found similarly encouraging findings. In interviews with neighbors of Oxford Houses, Jason, Roberts, & Olson (2005) found Oxford House residents blended well into the neighborhood and made good neighbors. They also found that the majority of Oxford House neighbors interviewed had either gained resources, friendships, or a greater sense of security following contact with the Oxford House residents. Furthermore, they found no evidence of property devaluation in the neighborhoods containing Oxford Houses; community members who knew of the Oxford House actually saw an increase in property value over an average of 3 years.

Similar results were found by Polcin, Henderson, Trocki, Evan, & Wittman (in press) who interviewed community members about Sober Living Homes (homes comparable to NARR Level 1 and Level 2 residences) in Northern California; however, these researchers found that size and density of the house appeared to influence neighborhood perceptions. Certainly more research on community members' experiences with RRs and the factors that influence community attitudes will be useful in developing strategies to overcome NIMBY opposition to locating RRs in residential neighborhoods conducive to recovery.

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Future Research on Recovery Residences

39. What are the most important questions about recovery residences that have not yet been studied?

First and foremost, we need recovery outcome and cost savings data across the Level of Support for various populations (including co-occurring, re-entry with criminal mindsets, etc.) recovering form a diversity of chemical substances in comparison to or in combination with alternative approaches. Without published research and evidence-based practice designations, licensed professionals and policymakers will continue to question the legitimacy of recovery residences and peer-based recovery.

Other critical research questions on recovery residences include:

- How many recovery residences exist in the U.S. by level of support?
- What is the geographic distribution of recovery residences in the U.S.?
- More knowledge is needed about how RRs are distributed by state or region and what differences in availability exist between urban, suburban, and rural areas.
- What factors promote the viability and sustainability of recovery residences?
- How do different characteristics of residents interact with different types of homes in different settings?
- What are the long-term effects (5 years or longer) of participation in a recovery residence?
- What are the physical, organizational, and social characteristics of the houses that are associated with the best recovery outcomes, e.g., the influence of such factors as size, architectural design, use of space, social climate within the houses, leadership, and operations?
- What are the essential components or “active ingredients” of RRs?
- How do neighborhood factors affect outcome, e.g., such factors as economic status, crime, availability of 12-step houses, and access to other services?
- How do neighborhood factors affect the start-up and sustainability of recovery residences?
- What are the major sources of referral to recovery residences?

- Are there populations for whom RRs are an alternative to addiction treatment (as opposed to an adjunct to addiction treatment)?
- How do Oxford Houses compare to other types of residences in terms of social climate and cost, e.g., the demographic and clinical characteristics of person in residence?
- What percentage of persons in RRs are continuing to participate in addiction treatment or other treatment/counseling?
- How do recovery houses and harm reduction houses differ in terms of goals, structure, outcomes, and relationships with neighbors and local government? What types of neighborhoods are a good fit for each?
- How does the ACA and other funding and policy changes affect the start-up and sustainability of recovery residences?

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