

National Association of Recovery Residences

A Brief Primer Recovery Residence in the United States:

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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 certifying 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. 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 the 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; Michelle Adams Byrne, Texas, Recovery Inn; Susan O Binns, Tennessee, YANA, AHHAP; George Braucht, Georgia, Board of Pardons and Paroles; Eddie Bryant, Michigan, Michigan Association of Recovery Residences; Lori Criss, Ohio, The Ohio Council of Behavioral Health & 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.

An expanded version of this document with more extensive responses to the questions and research citations is available online at <http://www.narronline.com/>.

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.

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.

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).

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.

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. Such residences include nineteenth century inebriate homes and religiously sponsored inebriate colonies; the development of homes, retreats, and farms associated with Alcoholics Anonymous in the 1940s and 1950s; the halfway house movement of the 1950s; the growth and evolution of residential treatment programs (including 12-Step-oriented Minnesota Model and California social model programs and therapeutic communities in the 1960s and 1970s); and the development of democratically governed, financially self-supported recovery residences like the Oxford House (OH) network in the closing decades of the twentieth century.

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

The governance structure of recovery residences varies from democratic self-governance to onsite professional oversight. External influences on the operation of recovery residences include NARR standards, state and local government regulations, and in some cases, the requirements of external funders.

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. Some work to inventory RRs has been conducted by smaller regional and national associations. This work suggests that RRs can be found in nearly every state in the US, although density may vary from region to region and from city to city. NARR represents more than 1,950 recovery residences in the United States.

10. Where are recovery residences typically located?

RNs can be found in nearly every state in the US. There are significant benefits to RR residents and to community members when RRs are located in residential areas. However, RRs often face opposition to opening in these areas, despite research that finds that community members living near RRs often have favorable attitudes toward them. NARR standards 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.

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

There are four organizations representing recovery residences in the United States: the National Association of Recovery Residences, the Association of Halfway House Alcoholism Programs, Oxford House, Inc., and Therapeutic Communities of America.

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. 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. 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.

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.

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. Smaller studies of residents in residential treatment and recovery residences would suggest primarily White (60-65%), middle aged (25-49), single, or divorced males with slightly more than a high school education and full- or part-time employment.

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 Level 1 and 2 recovery home residents are involved in 12-step groups or secular or religious recovery mutual aid groups. . At a minimum, all NARR certified recovery residences encourage residents to attend recovery mutual aid groups. Early therapeutic communities (TCs) of the 1960s and 1970s were not philosophically aligned with AA, NA, or other 12-Step programs, but in recent decades, most TCs have integrated 12-Step concepts and participation in 12-Step groups into their treatment approach.

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. For example, there are 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 from state to state and across recovery residences. Some RRs do not accept applicants who are taking specific medications, such as narcotics and psychotropics; 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 and some Level 3 RRs, managed by licensed staff at the facility. Individuals seeking an RR who are on medications should ask each provider about the medication policies in order to choose the RR that best fits their needs.

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

Length of stay varies widely from person to person and across recovery residences and levels of support. Recovery residences typically have a minimum length of stay and are less likely to have a maximum length of stay than other forms of residential care or support. Recovery residences are a community and are a part of the community around them.

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, which may involve moving the individual out of the RR and providing access to services that will help him or her re-initiate recovery.

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

The cost of staying in an RR varies widely and is related to the market price of local housing and the level of support provided. Of the four 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.

24. How are recovery residences financially supported?

Most recovery residences (particularly Levels 1 and 2) are self-funded through resident contribution, but recovery residences with higher levels of support often receive other forms of federal, state, and private support.

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. 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 abstinence and related recovery outcomes.

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?

There is very little research on the effects of participation in a recovery residence on long-term (more than five years) recovery outcomes. While shorter-term studies of the effects of living in a recovery residence reveal substantial improvements in outcomes, great research is needed to determine if these improvements extend to successful long-term recovery maintenance.

28. What ingredients of the experience of 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 several key factors: in-house social support for abstinence, enhanced self-efficacy (confidence in one's ability to initiate and sustain recovery), peer-based recovery guidance, enhanced involvement in 12-Step groups, shifts toward an abstinence-based social network, and a length of RR stay of at least six months.

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?

Short Answer

While much greater research is needed on this question, preliminary study findings on the influence of substance use and psychiatric co-morbidity on recovery outcomes of individuals living in an RR do not suggest that persons with substance use and psychiatric co-morbidity are at higher risk of relapse residing in a Level 1 recovery residence.

Extended Answer

Little research has been conducted that would provide answers to this question. John Majer and colleagues 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 1 recovery residence. (also see Majer, Jason, Ferrari, & North, 2002).

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

A variety of indicators have been used to evaluate the effectiveness of RRs. 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, and reductions in criminal involvement. 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. More work needs to be done in this regard. 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.

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

Community characteristics associated with positive RR outcomes and RR sustainability include: 1) accessible, affordable rental housing in areas offering amenities for daily life, 2) neighborhoods that are conducive to a sober, recovery-focused lifestyle, 3) employment opportunities for people in recovery, 4) community enforcement of the Fair Housing Act of 1988 and the Americans with Disabilities Act of 1990, and 5) support from local neighbors and the local recovery community. Research on the stability of RRs (Oxford Houses) reveals a high degree of stability within the community.

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

Few residences allow parents and children to reside in the recovery home together, but the limited studies done on Oxford Houses specifically serving women and children reported positive RR experiences for themselves and their children but also reported these mothers experienced many parenting-related stressors. Research is needed on the experience of children living with their parents in an RR.

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

Research on recovery outcomes in residential addiction treatment settings has reported contradictory results, with some showing longer lengths of stay being predictive of improved outcomes and others reporting no differences between shorter and longer stays. Follow-up studies of Oxford House residents reveal that those staying six months or longer have superior recovery outcomes to those staying less than six months.

34. Do these 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.

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

The prolonged history of harm in the name of help in the history of addiction treatment suggests the need to evaluate the potential of inadvertent harm from all helping interventions offered to individuals seeking recovery support. While the potential for such harm has been investigated for professionally delivered psychosocial interventions for substance use disorders, no studies exist to date that have identified any inadvertent harm to particular populations of people residing in the lower level of recovery residences.

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. Additionally, the societal costs of Oxford House were relatively low when compared to costs for inpatient treatment and incarceration. A more recent study examined costs and benefits from a randomized, controlled study of Oxford House and usual aftercare conditions. 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. Results indicated costs were higher in Oxford House, but the benefits of reduced incarceration, substance use, and illegal activity outweighed those costs.

37. Are government loans available to start recovery residences?

The passage of the 1988 Anti-Drug Abuse Act included provisions to encourage state-level expansion of self-run, self-supported recovery homes, such as Oxford Houses, through

revolving loan funds and technical assistance. Research on Oxford Houses suggests that these policies had an immediate and dramatic effect on the establishment of new houses. Although this Act has since been revised, some states still have these mechanisms in place, but 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.

Recovery Residences and the Community

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

Unfortunately, RRs often face significant “not in my backyard” (NIMBY) opposition to opening in residential neighborhoods or may be forced to open in poorer ones. 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. 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.

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 Levels of Support for various populations (including co-occurring, re-entry with criminal mindsets, etc.) recovering from 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 persons 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 do the Affordable Care Act and other funding and policy changes affect the start-up and sustainability of recovery residences?

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