Recovery Residences Levels Development and Determination

While addiction is increasingly recognized as a chronic condition necessitating lifestyle change and ongoing care[1,2], most addiction treatment is time-limited and may not include the type of services clients prioritize as being vital to recovery[3]; [4]. Safe and stable housing has been identified by the Substance Use and Mental Health Services Administration[5] as integral to recovery, but studies have found that nearly a third (32%) of individuals entering substance abuse treatment report being marginally housed in the prior 30 days[6]. Moreover, individuals often return from inpatient, outpatient and criminal justice settings to living environments that enable addictive lifestyles.

Recovery residences provide a vital service for initiating and sustaining long-term recovery and many thousands exist in the United States. In 2010, the National Alliance for Recovery Residences (NARR) gathered industry leaders from across the United States. Through consensus building, they create a common nomenclature, identified four types or Levels of Support, defined fidelity standards, and offered an Affiliate certification program. By 2017, NARR has Affiliates and/or Associates in 25 States with several others under development.

Recovery Residence Language

In 2010, recovery housing providers and advocates met at national treatment conferences and discussed the need for a national standard and organization. That discussion quickly grew to include individuals from across the United States who met through weekly conference calls. The need for a common language quickly became apparent. Thought leaders from different regions often talked past each other because state-by-state policies and marketplaces dramatically shape what can organically grow in a region. In a fragmented industry, people only know what they have seen or experienced. They may not even know anything different exists, and

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1 Dennis ML, Foss MA, Scott CK. An eight-year perspective on the relationship between the duration of abstinence and other aspects of recovery. Evaluation Review. 2007;31:585–612. [PubMed]

2 McLellan AT et. all. Drug Dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation. JAMA. 2000 Oct 4;284(13):1689-95.

3 Duffy, P. & Baldwin, H.Recovery post treatment: plans, barriers and motivators, *Substance Abuse Treatment, Prevention, and Policy* 2013 8:6

4 Laudet A, What are your priorities right now? Identifying service needs across recovery stages to inform service development. Journal of Substance Abuse Treatment, Volume 38, Issue 1, Pages 51–59 January 2010.

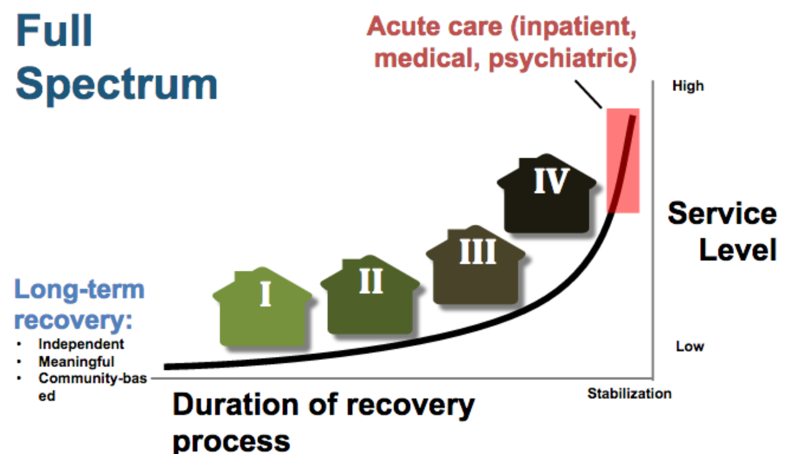
5 https://www.samhsa.gov/recovery

6 KM Eyrich-Garg et al. Individual Characteristics of the Literally Homeless, Marginally Housed, and Impoverished in a US Substance Abuse Treatment-Seeking Sample Soc Psychiatry Psychiatr Epidemiol 43 (10), 831-842. 2008 May 26.

they may make assumptions about what someone else is talking about based on their limited personal knowledge. For example, someone from in Southern California would say, “sober living”, to someone from Pennsylvania who would then wonder if that was the same thing as a “recovery home” in Philadelphia. Then someone from the Southeast would mention the Florida Model, which would leave everyone else scratching their heads. Few could even agree on what constituted a Quarter-, Halfway- andor Three Quarter House. Oxford House ™ and therapeutic communities were both well defined, but they alone inadequate describe the diversity found across the United States. Rather than try and redefine terms that might mean something to someone else, NARR adopted the umbrella term “recovery residences”.

Levels Development

With input from 48 thought leaders from 12 states, the National Alliance for Recovery Residences (NARR) nomenclature and philosophical framework includes the full range of peer-based recovery housing and residential programs that promote recovery. The common recovery residence language enabled providers and stakeholders across the United States to effectively communicate and identify four recovery residence types or Levels of Support.



NARR’s Levels cover a continuum that differentiates programs based on service mission and intensity. Lower levels offer lower services intensity and higher levels offer higher service intensity. <u>One Level is not better than or more desirable than another</u>. The Levels identify choices within a spectrum of options. As recovery is a nonlinear process, individuals enter into and move around the spectrum to cost effectively match evolving needs and levels of support. All recovery residences offer alcohol- and illicit drug-free living environments that use a social model of recovery. Beyond that, significant differences exist in the bundled services, governance and/or staffing.

Levels of Support

Informed by the American Society of Addiction Medicine (ASAM) categorization of different types of treatment programs into the ASAM Levels, a NARR steering committee created a philosophical and operational framework that inclusively defines the range of recovery housing and/or residential programs. NARR first traced the evolution of recovery residences from the 1840s to present. Research conducted in the 1990s by Dr. Thomasita Borkman and Dr. Lee Ann Kaskutas identified the Social Model of Recovery[7]. Through the lens of the social model, NARR was able to see similarities across recovery residences, rather than just the differences. Research done by Drs. George Deleon, Leonard Jason, Doug Polcin, Amy Mericle and others highlighted other elements found across the different recovery residence types. Regional organizations submitted their standards, which further clarified what existed in those areas. Moreover, members of the Association of Halfway Houses and Alcoholic Programs (AHHAP), an organization with roots in the late 1950s,

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[7] Borkman, T. J., Kaskutas, L. A., Room, J., & Barrows, D. (1998). An Historical and Developmental Analysis of Social Model Programs Journal of Substance Abuse Treatment, Vol. 15 No. 1, pp. 7-17, 1998 [B760]

actively contributed to the conversations. In September 2011, NARR released the first version of its Standard defining the four Levels of Support.

NARR Levels Chart by Service and Staffing Model

Levels of Support	I	II	III	IV
Bundled Services				
Alcohol and illicit drug free living environments	x	x	x	x
Social model recovery	x	x	x	x
Peer recovery support services		*	x	x
Life skills development classes			x	x
Treatment services				x
Governance and/or staffing				
Democratically elected leaders	x			
Appointed leaders/managers		x	x	x
Trained and/or credentialed staff			x	x
Supervised staff			x	x

(x) Required; (*) May occur, but not required

In the current form, the NARR levels are "big buckets", meaning much variability exists within each level. Given changing market trends and state laws, "big buckets" allow for diversity, flexibility, and responsiveness in the marketplace while empowering consumer and referral agent choices. In general, the Levels distinguish the services that are provides. An overview of the Levels is below.

Level 4s

Level 4 Recovery Residences integrate the social and medical models using a combination of supervised peer and professional staff. In addition to peer-based recovery support and life skills development, they offer clinical addiction treatment services. While all Level 4s are licensed treatment, not all licensed treatments are Level 4 Recovery Residences. Throughout the 1990s, many treatment programs discontinued their social model elements,[14] a distinct difference from recovery residences. Examples of Level 4s are Social Model Extended Aftercares and Therapeutic Communities as well as the "Florida Model", all of which combine a partial hospitalization/day-long outpatient programs with recovery housing.

Level 3s

Level 3 Recovery Residences provide weekly, structured programming that includes peer-recovery support services (e.g., recovery and resiliency groups or person-centered recovery planning) and life skills development (e.g., job readiness or budgeting). Staff are supervised, trained or credentialed, and are often graduates of the program. Level 3s are designed to support people who need extended lengths of support at a higher level of intensity than what Level 1s and 2s provide. Level 3s go by various names and are licensed in only a few states.

Level 2s

Level 2 Recovery Residences, often called sober homes or sober living, are alcohol- and drug-free recovery housing that use house standards, rules and peer accountability to maintain safe, healthy and structured living environments. Senior residents are often appointed as the head of the household, frequently called the House

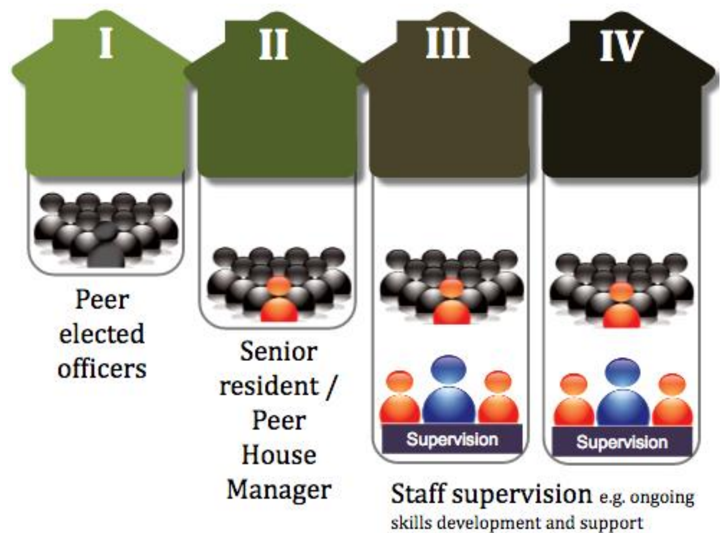
Manager. To serve higher need populations, such as transitional-aged youth with opioid use disorders, some Level 2s add recovery support services and life skills development, but at a lower intensity than Level 3s.

Level 1s

Level 1 Recovery Residences are democratically run alcohol- and drug-free recovery homes. Oxford Houses ™ are the most widely known example and are included in SAMHSA's National Registry of Evidenced-based Programs and Practices (NREBPP). Like Level 2s, Level 1s maintain a recovery culture and community through behavioral standards, house rules and peer accountability. The key difference is that Level 1s are democratically governed.

Staffing and Governance

Different Levels of Support often use different staffing and/or governance models. While all recovery residences are founded on the social model of recovery, variation exists in how peer leadership and governance is operationalized and this is reflected in the NARR Standard. More about social model philosophy is in the "Service" section below.



Democratically Run

A hallmark of Oxford House ™ and other Level 1s is that they are democratically run. The community elects resident leaders and votes on decisions. To a lesser extent, other Levels may choose to empower residents and/or alumni through planning or advisory committees. Sometimes the household votes during house meetings on whether or not a referral is a good match or if a former resident who left can reapply. Whether the community is completely democratically run or empowered within a narrower scope, these are effective means of cultivating social model recovery.

Peer Staffed

Whereas Level 1s elect the House President, Level 2 owners/operators appoint a senior resident to be the Residence Manager (House Manager). The Manager's responsibilities can vary greatly depending on the size of the organization and the division of labor. Compensation ranges from reduced or no rent to a part-time or full-time salaries. Level 3s and 4s typically appoint a Resident Manager.

Supervised Staff

Level 3s and 4s serve people with less recovery capital and/or higher or more complex needs. As such, Level 3s provide workforce performance support or supervision to ensure skill development, role fidelity, quality assurance and outcome improvement, and staff recovery and resiliency support. In addition, Level 3 staffing plans reflect the training and certification required to effectively deliver a range of support services.

Types of Supervision

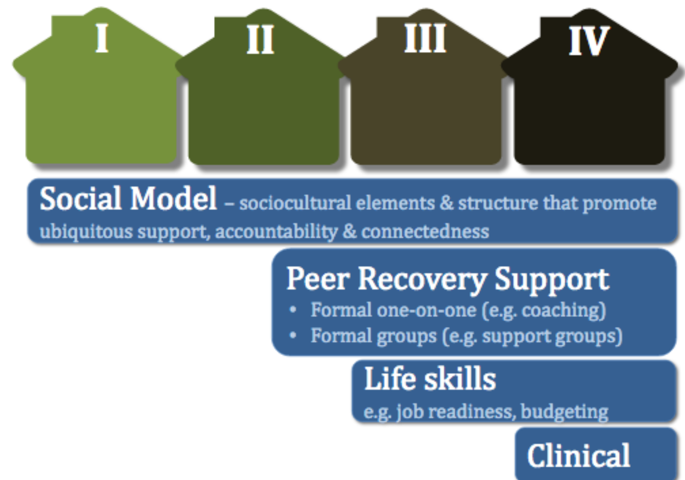
- Administrative – adherence to agency and payor requirements, workflow processes and standard operating procedures.
- Clinical – Focus on peer workers role on the clinical team, if applicable.

Licensed Provider

In addition to formal supervision, Level 4s services are delivered in part

by licensed/certified professionals. However, using staff with clinical credentials does not automatically confer a Level 4 status.

Service Bundles



Housing

Housing offers a safe and secure place to live. Stable housing provides the foundation upon which people build productive lives, improve health and reach their full potential.[8] Housing is a choice, not a clinical placement.[9] Their length of stay is resident-driven rather than programmatically determined. However, the residential component of medical model treatment is generally seen as an ancillary yet contingent program rather than as an independent housing. Concurrently, many non-clinical recovery residences are considered alcohol- and illicit-drug free recovery housing instead of treatment. The Department of Housing and Urban Development (HUD) sub-categorizes recovery housing as either transitional and permanent supportive housing.[10] In either case, alcohol and drug-free recovery housing is an important component in the housing continuum and within a recovery-oriented, person-driven substance use continuum of care. Both social and environmental factors contribute to addiction and recovery.[11] A fundamental risk reduction and resiliency promotion factor is dense and evolving relationships and social networks that provide support, friendship, and hope.[12] Alcohol and illicit drug-free housing is a vital resource. Many return from treatment and/or institutional settings to living in environments that put them at risk for relapse. Some are discharged into homelessness or isolation.

Social Model of Recovery

The social model approach views addiction and recovery as a multifaceted disease shaped by a socialization processes that occur within a sociocultural context that in some way impacts substance use. Recovery, in this framework, involves both the person and their social and physical environments. Although peers in recovery have lived together in mutually supportive communities since the mid-19th century[13], so-defined social model programs emerged out of Alcoholics Anonymous in the 1940s.[14] Drawing from these traditions, social model programs foster the mutual aid-based idea that those in recovery are helped by helping others. Hence, “experiential” knowledge, self-governance, and community, both with respect to the service setting being home-like and developing a network of recovery support in the community, are essential. More explicitly,

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[8] http://www.samhsa.gov/homelessness-housing

[9] https://www.thenationalcouncil.org/BH365/2016/08/23/options-not-opponents-housing-first-recovery-housing/

[10] https://www.hudexchange.info/resources/documents/Recovery-Housing-Policy-Brief.pdf

11 NIDA. "Drugs, Brains, and Behavior: The Science of Addiction." Bethesda, MD, 2007.

12 SAMHSA. "Samhsa’s Working Definition of Recovery." edited by HHS, 2012.

13 W. L. White. Slaying the Dragon: The History of Addiction Treatment and Recovery in America. Bloomington, Ill.: Chestnut Health Systems/Lighthouse Institute, 1998.

14 T. J. Borkman, L. A. Kaskutas, J. Room, K. Bryan, and D. Barrows. "An Historical and Developmental Analysis of Social Model Programs." *J Subst Abuse Treat* 15, no. 1 (1998): 7-17.

Kastukas et. al.'s Social Model Philosophy Scale (SMPS)[15] assesses program adherence to 33 items across six domains:

1. Physical environment: To what degree does the residence feel like a home?
2. Staff role: To what degree do staff interact with residents as peers and role models?
3. Authority base: To what degree is staff authority based on lived experience?
4. View of substance use problems (e.g., Recovery-oriented): To what degree does the program foster residents taking an active role in their recovery?
5. Governance: To what degree are residents involved in making and enforcing rules?
6. Community orientation: To what degree are residents connected and integrated into a wider network of support within the community?

Although aspects of the social model of recovery were crystallized in California during the 1990s, elements of the social model approach can be seen in programs that started well before then and in different parts of the country. SAMHSA's guiding principles for recovery also incorporate social model elements. How and to what degree recovery residences cultivate the social model approach varies, especially across the Levels of Support. Regardless of its Level, a recovery residence fosters a recovery-oriented culture through social norms and covenants, peer leadership, accountability and support, and community engagement.

Social Model vs Medical Model

Adapted from Kaskutas, L.A. et. al.

Domains	Social Model	Medical Model
Physical environment - To what degree does it feel like a home?	Feels home-like. Architecturally promotes recovery supportive interactions among staff, participants, and each other in community spaces like the kitchen, porch, or family room.	Feels institutional. Significant square footage is allocated towards offices and group rooms, rather than community spaces. Entrances and exits are more likely to be gated and guarded.
Staff role - To what degree are staff respected as peers vs. distant superiors?	Staff mingle with residents in community spaces, and activities, e.g., over a meal. As recovery progresses,residents are rewarded with leadership roles and increasing community responsibilities.	Power differentials are enforced among staff and between staff and residents. Minimal opportunities are available for resident leadership development.
Authority base - To what degree is authority based on lived experience?	Many/most employees self-identify as in recovery or alumni. Experiential credentials are valued equally with clinical knowledge	Professional /clinical credentials are required.
Recovery orientation - To what degree is substance	"Resident" or "Participant" and "Recovery Plan": Recovery is	"Client" and "Treatment Plan": Relapse is expected. Provide clinical

15 L. A. Kaskutas, T. K. Greenfield, T. J. Borkman, and J. A. Room. "Measuring Treatment Philosophy: A Scale for Substance Abuse Recovery Programs." *J Subst Abuse Treat* 15, no. 1 (1998): 27-36.

abuse problems viewed as the problem?	expected as a person-driven, lifelong and holistic process. Promote life skills development.	treatment that focuses on disease and associated problem amelioration.
Governance - To what degree does accountability involve peers?	Meaningful peer governance promotes resident accountability to one another.	Staff hold clients accountable to policies set by administrative/clinical leadership.
Community orientation - To what degree is the community viewed as a resource?	Link with personal and social recovery capital e.g., employment and other, culturally-congruent recovery resources, or family services. Residents connect and maintain relationships with mentors/sponsors, host recovery meetings, and attend recovery supportive social events and contribute to the community in meaningful ways.	Focus on connecting with community treatment resources and "aftercare" activities.

Peer Recovery Support Services

Peer Recovery Support Services (PRSS), also known as peer-based recovery services, are non-clinical services that promote long-term recovery. They are distinguished from both professional treatment and mutual aid services[16]. In contrast to professionally delivered services, PRSS are peer developed and delivered, and in contrast to 12 Step and other forms of mutual aid, PRSS are delivered through formal structures and via specialized roles[17]. Many incorporate evidenced-based and promising practices delivered in a one-on-one,

16 E. Burden, T. Hill, and T. Zastowny. "Developing an Accreditation System for Organizations and Programs Providing Peer Recovery Support Services." *Washington, DC: Faces & Voices of Recovery, Accessed on November* 8 (2012): 2012.

17 W. L. White. *Peer-Based Addiction Recovery Support: History, Theory, Practice, and Scientific Evaluation*. Great Lakes Addiction Technology Transfer Center {and} Philadelphia Department of Behavioral health and Mental Retardation Services, 2009.

group and/or electronic settings, e.g., Motivational Interviewing, Wellness Recovery Action Planning, Whole Health Action Management, Partners for Change Outcome Management System, , Back to Basics, Making Alcoholics Anonymous Easier), or telephonically (e.g. Recovery Check-ins. PRSS interventions are typically delivered by a trained, and ideally certified and appropriately supervised individuals.

PRSS typically reflect a shift in focus from the pathology of addiction to each individual's assets and strengths for initiating and sustaining long-term recovery. These internal and external resources, commonly known as recovery capital, are available to initiate and sustain long-term recovery. Recovery capital includes a person's skills and attributes, family and social connections, physical and mental health, safe places to live and play, employment and education, and community affiliations. Cloud and Granfield[18] identified four components, summarized below.

Components of Recovery Capital

Human Capital Personal attributes, strengths, and skills that support your recovery. This includes your mental and physical health along with your sense of purpose, hope, self-awareness and self-efficacy. It also includes your "street smarts", knowledge, experience and interpersonal skills.	**Physical Capital** Tangible assets such as property and money that increase your recovery options. For example, transportation to a job, enough savings to move to a more recovery-conducive environment or health insurance to access services.
Cultural Capital Social norms, values, beliefs, attitudes and self-identity that emerge and reflect your membership in a culture of recovery or recovery-oriented community.	**Social Capital** Resources that you have as a result of recovery supportive relationships. This includes benefits from receiving as well as providing support to family, friends and fellowship members.

Life Skills Development Classes

For various reasons, persons in early recovery often lack or have poorly developed life skills that are keys to success. Common offerings include employment skills and job readiness classes and education around budgeting, nutrition, relationships, and time management. NARR recognizes life skills development delivered by qualified subject matter experts following formalized curricula. While household chores cultivate social recovery roles and a functionally equivalent family, chores unto themselves are not formalized life skills development.

Clinical Services

State-by-state statutes define what are considered clinical services or treatment. At the risk of oversimplifying, clinical services are delivered by certified or licensed addiction professionals. Any clinical services provided as a standard or advertised component of a residence's services requires that the residence be licensed as a

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18 W. Cloud, and R. Granfield. "Conceptualizing Recovery Capital: Expansion of a Theoretical Construct." *Subst Use Misuse* 43, no. 12-13 (2008): 1971-86.

treatment provider organization. Residential treatment centers could be Level 4s, and in some states 3s even if they also provide the required social model, peer recovery, and life skills support.

Outpatient Plus Recovery Housing: Trends, Classifications and Considerations

It is common for some residents of a NARR Level 1, 2 or 3 recovery residences to enroll in an outpatient treatment program, but a growing trend in programming is to require all the residents of a house to attend the same outpatient treatment program as a condition of their continued residency. These model bundles a outpatient treatment component and recovery housing component into one program. Longitudinal research of this model has revealed improved recovery outcomes[19], but corruption headlines and convictions, point to the ethical and legal complexity of the model and the potential for exploiting consumers and insurance benefits.

"Florida Model": ASAM 2.5 + NARR Level 2 or 3

"Florida Model" programs require all the residents of a house to attend the same outpatient treatment program as a condition of their continued residency. While this model gain popularity in Florida, the model can now be found in many states. The lack of choice as to which program they can choose is more philosophically aligned with treatment and is less aligned with person-driven recovery or housing choice. The Florida Model explicitly or implicitly combines a recovery house and an ASAM 3.5 Partial Hospitalization Program, a "day treatment program". From a service intensity perspective, the "Florida Model" is arguably residential treatment and perhaps should be licensed as such. Florida Models, like residential treatment programs, can be evaluated as a NARR Level 4, if they provide the required social model, peer recovery, and life skills development support.

ASAM 2.1 + NARR Level 2 or 3

A similar trend has emerged that combines a less intensive outpatient programs with a recovery housing component. Again, if residents are not allowed to choose which outpatient program they can attend as a condition of their continued residency, this, like the Florida Model, looks less like housing and more like treatment. But, combining intensive outpatient program (IOP) or supportive outpatient programs (SOP) services with recovery housing may not meet the requirements of a Level 4. This combination could be more accurately evaluated as either a Level 2 or Level 3 based plus ASAM 2.1.

Legal and Ethical Consideration

The combination of outpatient treatment with a recovery housing component into an all-in-one service is complex and riddled with pitfalls, which are often misunderstood. Treatment and recovery housing providers pursuing these business practices are encouraged to seek legal council and ethical guidance. The National Alliance for Recovery Residences (NARR) published a Code of Ethics in 2016. Plus, RecoveryPeople launched workforce development trainings in 2017.

While there are many providers who are ethically offering the outpatient-housing combination, news headlines continue to report on kickbacks, brokering, coercion and other forms of corruption surrounding this combination. Several were indicted in July 2017, as a part of the largest health care fraud enforcement sweep in the Department of Justice's history. [20] A growing number of states, like Florida, have recently passed

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[19] Eighteen Month Outcomes for Clients Receiving Combined Outpatient Treatment and Sober Living Houses (J. Substance Use) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3008818/Outpatient Treatment and Sober Living Houses

[20] https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-charges-against-over-412-individuals-responsible

legislation to combat corruption and support the development of a NARR state affiliate. At the federal level, Senators Warren (D-MA), Hatch (R-PA) and Rubio (R-FL) submitted a bipartisan requested to the U.S. Government Accountability Office (GAO) for a report on recovery housing, which is due Spring 2018. Moreover, the President's Commission on Combating Drug Addiction and the Opioid Crisis[21] published its recommendations in November 2017 that encourages government agencies and stakeholders to work with the National Alliance for Recovery Residences to establish and promote best practices, and in December, the Ensuring Access to Quality Sober Living Act of 2017 was filed , which would allocate funds to promote national best practices.[22].

Exercise:

Identify which Level of Support the following scenarios describe by checking the most appropriate column to the right using the Level Determination Flowcharts found on the following pages.

	Scenarios	Level			
		I	II	III	IV
1	House of Light is an eight bed recovery residence. At last night's house meeting, Linda was unanimously voted House Treasurer. In her new role, she is responsible for collecting rent and paying bills.				
2	Tranquility House is a 10 bed (including the House Manager) women's recovery residence. Annie, a new resident, was told before admission that she has to attend morning meditation, five AA meetings a week, and complete weekly house chores. A senior resident has been assigned by the House Manager to help Annie write a resume and get a job.				
3	A Way Up Recovery is a row of five houses serving individuals who have a history of chronic homelessness and both mental health and substance use issues. One of the houses is a community center where the residents host community meetings, meet with their recovery coach, or attend Back to Basics recovery meetings. The week is full of regularly scheduled activities: cooking and meal planning classes, and computer and resume writing classes. Tonight, the residents are attending the alumni advisory council meeting to help plan the 10th year anniversary of A Way Up Recovery.				
4	Hope Extended Aftercare is a long-term women with children program that provides a wide range of support services. One of the recovery coaches is meeting with the clinical director to discuss concerns about a resident's change in behavior. As the meeting ends, the clinical director asks her about the new supervisor who has all the peer staff developing their personal recovery and resiliency plans.				

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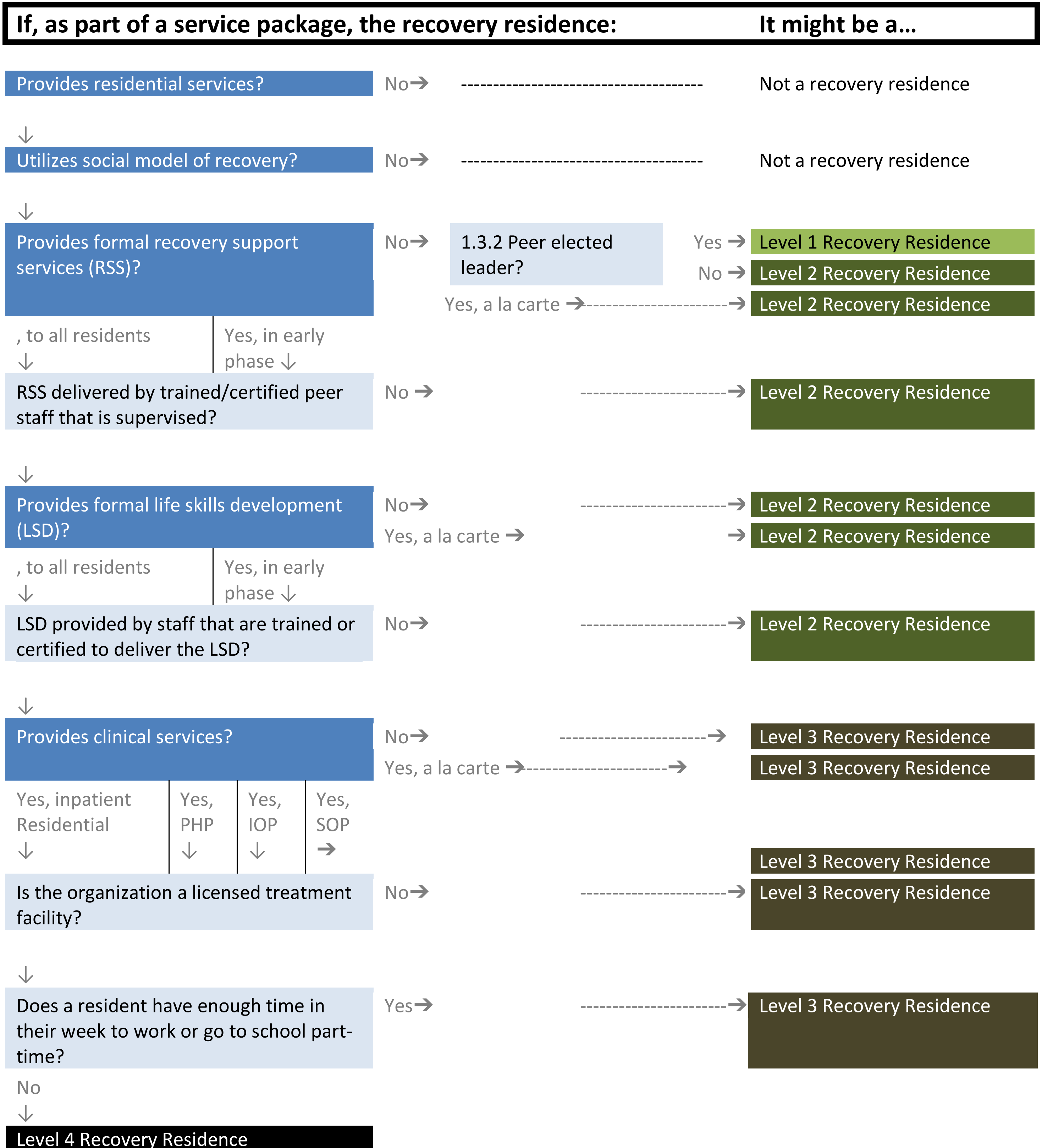
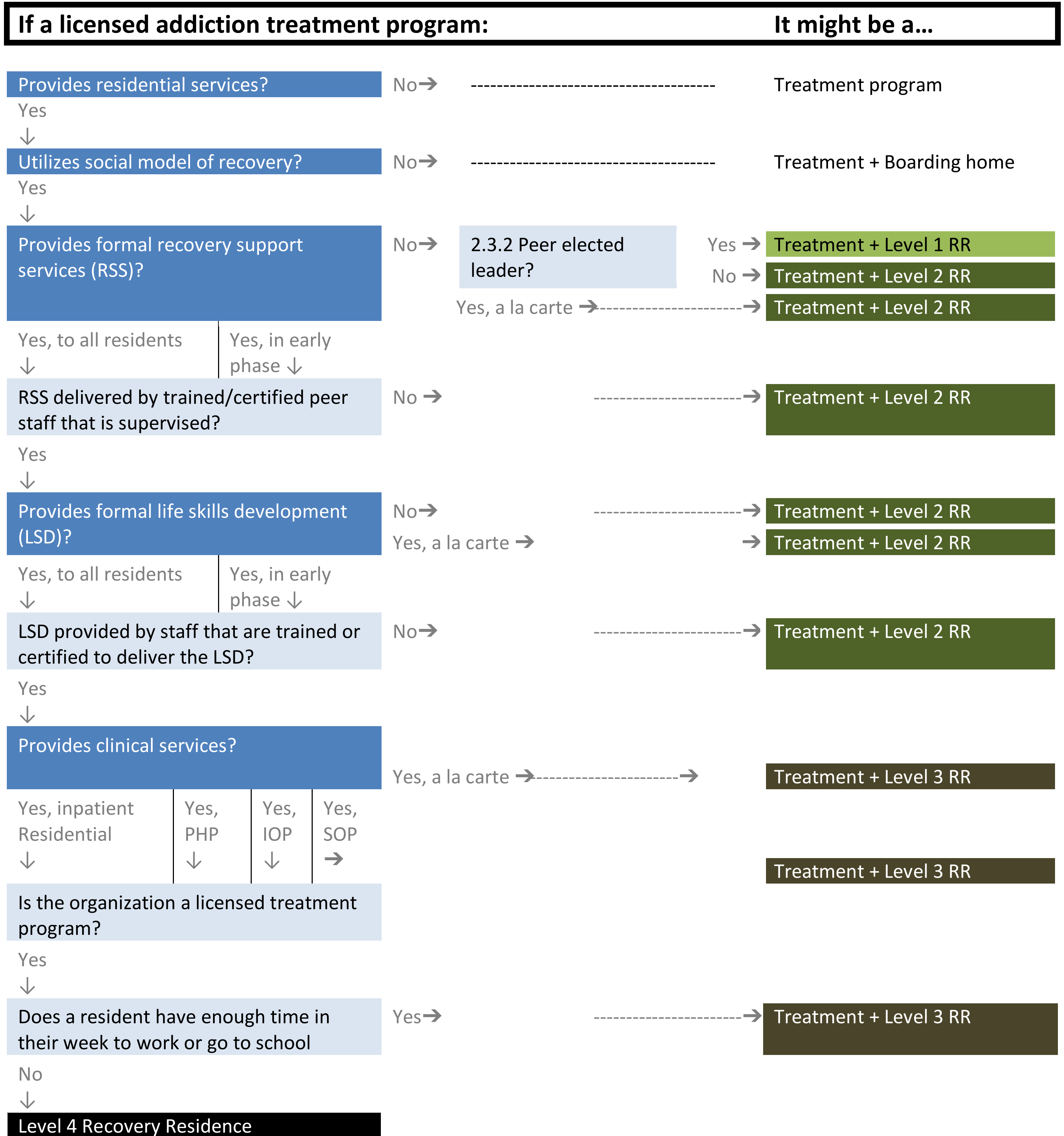
[21] https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf

[22] https://chu.house.gov/sites/chu.house.gov/files/documents/Ensuring%20Access%20to%20Quality%20Sober%20Living%20Act.pdf

Level Determination Flowchart



Level Determination Flowchart-2



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