April 12, 2019

Submitted electronically to Recoveryhousing@samhsa.hhs.gov

The Honorable Elinore McCance-Katz
Assistant Secretary for Mental Health and Substance Use
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville, MD 20857

RE: Proposed Recovery Housing Guidelines

Dear Assistant Secretary McCance-Katz:

On behalf of the National Council for Behavioral Health (National Council), thank you for the opportunity to comment on SAMHSA's Proposed Recovery Housing Guidelines. The National Council is the unifying voice of America's health care organizations that deliver mental health and substance use disorder (SUD) treatment services. National Council members frequently interact and collaborate with recovery housing operators. The National Council is dedicated to all Americans having access to comprehensive, high-quality behavioral health services and supports that afford every opportunity for recovery. The National Council, in total, represents 3,000 member organizations serving over 10 million Americans across the country.

Below you will find a summary of our overarching concerns regarding the proposed guidelines. **Most importantly, we believe the proposed guidelines if disseminated as written would produce the following harmful effects:**

1. **Reduce the availability of Level I and II recovery residences**
2. **Undermine national recovery housing quality standards as developed by the National Alliance for Recovery Residences (NARR)**
3. **Disrupt and reverse progress made by states in adopting recovery housing quality standards**

Additionally, we have provided more detailed comments on the proposed text in the accompanying pdf.

Overly Clinical Focus
The document confuses the purpose of recovery housing, including by characterizing recovery housing as a treatment intervention. **Recovery housing is not treatment, it is housing.** The purpose of recovery housing is to provide a safe and supportive place for people to live their recovery from substance use disorders.

The document contains many references to a clinical treatment perspective, using clinical language and clinical assumptions that frequently do not align with recovery housing and recovery community perspectives. While providing a connection to treatment may be a focus of the support recovery homes provide (especially at higher support levels like Levels III and IV), many recovery housing residents are not engaged in any formal treatment services.

To push recovery housing in a more clinical direction would fundamentally alter the current structure of recovery housing, which research has shown to be successful in helping individuals achieve long-term recovery.[1] Again, the purpose of recovery housing is not to provide addiction treatment services. Recovery housing is predicated on providing a direct connection to peer support and the homes are often peer-run.

Much of the fraud involving recovery housing identified in recent years has involved insurance schemes, in which recovery housing operators receive kickbacks for referrals to inappropriate treatment and excessive drug testing. Notably, by confusing the role of recovery residences with clinical treatment, the guidance may actually expose more residents to this kind of fraud and abuse, instead of achieving the directive of H.R. 6 to mitigate these practices.

Describing recovery housing as treatment raises several other risks including: encouraging treatment to be offered by individuals or organizations that are not trained to provide clinical care and placing undue zoning burdens on recovery housing operators (special use allowances for health care facilities, such as treatment programs, as opposed to housing providers), which in turn would enable housing discrimination against people in recovery from substance use disorders.

Finally, focusing the guidance on treatment ignores nonclinical recovery residences (Level I and II), which make up the most affordable and widely available recovery housing models across the U.S. Many of the recommendations contained with the "10 Minimum Standards" could only be met by homes with resources and staffing levels consistent with higher levels of support and thus would be too burdensome for Level I and II residences to comply. As a result, the guidance would likely have the extremely damaging result of decreasing access to Level I and II recovery residences.

Lack of Specificity/Failure to Reference NARR Standards

The guidance should refer to the recovery housing quality standards developed by the National Alliance for Recovery Residences (NARR). The NARR standards outline necessary written policies and procedures that ensure resident safety and appropriate support. However, many of these policies and procedures are not even mentioned in the proposed guidance. The NARR standards should be prominently featured in the document and regarded as the gold standard for operating a recovery residence.

By offering "10 Minimum Standards" that do not directly align with the NARR standards is likely to create confusion for states and operators. Worse yet, this discrepancy could undo the time, effort and financial investment many states have already made to develop and implement certification programs based upon the NARR standards.

Further, H.R. 6 specified that HHS may include reference to "model state laws" as part of its recovery housing guidance. However, the agency offers no guidance on potential legislative or regulatory strategies to help states increase quality recovery housing. We recommend SAMHSA refer to a joint report by the National Council for Behavioral Health and NARR entitled *Building Recovery: State Policy*

[1] Polcin, D. L., Korchia, R. Bond, J. and G. Galloway. *What Did We Learn from Our Study on Sober Living Houses and Where Do We Go from Here?* J Psychoactive Drugs. 2010 Dec; 42(4): 425–433. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3057870/

Guide for Supporting Recovery Housing to identify and disseminate best policy practices developed by states to promote quality recovery housing.

Language and Tone
The language used throughout the document is negatively-based and built upon pathology, deficits, alarmism and stigma. This is not in keeping with the best practices currently being adopted by the field. We have provided recommended replacement language for many of these terms in our accompanying detailed comments.

Evidence-based Practices
The guidance recommends that recovery housing operators provide or support access to evidence-based practices. Evidence-based practice remains aspirational in the treatment field and, more importantly, in the recovery support field. Language that suggests a continuum of promising, best, and evidence-based practices better serves the state of the art of recovery houses.

Need for Resources
Advancing the evidence base for recovery housing and equipping a workforce to comply with these potential new operating standards requires dedicated resources. Without resources for research/evaluation, technical assistance, and training for states and recovery housing operators, the status of these things will remain unchanged.

The National Council appreciates the opportunity to provide comments. We welcome any questions or further discussion about the recommendations described here. Please contact Chuck Ingoglia at chucki@thenationalcouncil.org or 202-684-7457 ext. 249. Thank you for your time and consideration.

Sincerely,

Linda Rosenberg

Linda Rosenberg
President & CEO
National Council for Behavioral Health