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RE: Public Comment on SAMHSA's Proposed Recovery Housing Guidelines
https://www.samhsa.gov/proposed-recovery-housing-guidelines

April 9, 2019

As currently written, SAMHSA's *Proposed Recovery Housing Guidelines* will likely have unintended consequences,:

1. **Undermining the accessibility of affordable Level I and Level II recovery residences**
2. **Undermining national best practices developed by the National Alliance for Recovery Residences and Oxford House**
3. **Indirectly, undermining fair housing rights of persons in recovery**

1. Undermining the accessibility of affordable Level I and Level II recovery residences

Historically, recovery housing has been pressured to evolve away from social recovery models towards clinical treatment models. This was documented by Kaskutas, L.A. et. al. (1999) in a study funded by SAMHSA CSAT Contract 270-94-0001.[1] This is also reflected in the spectrum of support defined by the National Alliance for Recovery Residences (NARR) ranging from from non-clinical recovery housing (Level Is, Level IIs and in most states Level IIIs) to licensed residential treatment that integrate social model recovery (Level IVs).

The Guideline's language is written from a clinical perspective and assumes a minimum staffing capacity, which may be appropriate for a Level IV recovery residences and to a lesser extend a Level IIIs. However, it does not reflect Level Is (e.g. Oxford House) and Level IIs (e.g. Sober Livings), which are the most affordable, most available and most researched recovery housing in the nation. Many of the minimum guidelines can not be implemented by Level I and Level II staffing models. Based on economic impact data, specifically productivity and incarceration, Level Is can annually save taxpayers over $8,000 per resident.[2],[3] Multiple longitudinal research

[1] Kaskutas, L.A. et. al. (1999) Measuring Social Model in California: how much has changed? Contemporary Drug Problems 26/Winter 1999 [B861]

[2] Jason LA, Olson BD, Ferrari JR, Lo Sasso AT. Communal housing settings enhance substance abuse recovery. American Journal of Public Health. 2006;91:1727–1729. [PMC free article]
[3] Olson BD1, Viola J, Jason LA, Davis MI, Ferrari JR, Rabin-Belyaev O, Economic costs of Oxford House inpatient treatment and incarceration: a preliminary report. J Prev Interv Community. 2006;31(1-2):63-72

studies reveal that Level Is and Level IIs improve abstinence, psychiatric symptoms, monthly income, employment rates and reduces criminal justice involvement. [4],[5],[6],[7],[8],[9] It is imperative that these Guidelines do not undermine or devalue the proven benefit that Level Is and Level IIs offer to persons in recovery and taxpayers.

Perhaps this is a typo, but the Guidelines goes as far as recommending that recovery housing offer treatment and encourage participation on page 8. Levels I through III do not provide clinical services. While some residents living in Level I, II and III recovery residences may choose to enroll in outpatient services, the President's Commission on Combating Drug Addiction and the Opioid Crisis appropriately highlights that others may choose recovery housing in lue of treatment:[10]

> "Recovery housing can play a critical role for individuals in outpatient treatment, those exiting residential treatment, homeless individuals in early recovery, those involved in drug courts, those returning to the community from incarceration, and those who may not require residential treatment if they have a living environment that is supportive of recovery, outpatient treatment and/or mutual aid groups. Many who cannot return to a home where there is active drug use or a community where they used drugs find a safe haven in a recovery residence. Importantly, like peer recovery support services generally, recovery residences can help maximize the public and private investments in treatment by ensuring better long-term outcomes, by sometimes making a lower, less costly level of care possible and, in some instances, by making treatment unnecessary."

Understandably, the Guidelines highlight the Polcin (2009) study, which looks at recovery housing in combination with outpatient services, but it ignores Dr. Polcin's greater body of work which studies the outcomes of Level II recovery residences (sober livings). This exclusion further demonstrates the Guidelines' bias towards treatment and against non-clinical recovery housing models that are evidenced-based and promising practices.

The Guidelines view recovery housing as time limited treatment interventions rather than housing that can provide ongoing recovery support. Most recovery housing is a form of permanent supportive housing, rather than the assertion on Page 1 that frames recovery housing as "supportive recovery-oriented transitional housing". In "permanent housing" residents determine their maximum length of stay. In "transitional housing", the maximum length of stay is determined by funding or program policies. Most recovery homes require a minimum length of stay, not a maximum. In recovery housing, especially in Level Is and Level IIs, residents may choose to stay for 3 months or for several years. The key factor is that they choose to stay as long

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[4] Aase DM, Jason LA, Ferrari JR, Groh DR, Alvarez J, Olson BD, Davis MI. Anxiety symptoms and alcohol use: A longitudinal analysis of length-of-time in mutual help recovery homes. International Journal of Self Help & Self Care. 2006–2007;4:19–33. [Google Scholar]
[5] Aase DM, Jason LA, Olson BD, Majer JM, Ferrari JR, Davis MI, Virtue SM. A longitudinal analysis of criminal and aggressive behaviors among a national sample of adults in mutual-help recovery homes. Journal of Groups in Addiction & Recovery. 2009;4:82–91. [PMC free article]
[6] Jason LA, Davis MI, Joseph R, Ferrari JR, Anderson E. The need for substance abuse after-care: Longitudinal analysis of Oxford House. Addictive Behaviors. 2007;32:803–818. [PubMed]
[7] Majer JM, Jason LA, North CS, Ferrari JR, Porter NS, Olson BD, Davis MI, Aase D, Molloy JP. A longitudinal analysis of psychiatric severity upon outcomes among substance abusers residing in self-help settings. American Journal of Community Psychology. 2008;42:145–153
[8] Polcin D. What about sober living houses for parolees? Criminal Justice Studies. 2006;19:291–300
[9] Polcin DL, Korcha R, Bond J, Galloway GP. Sober Living Houses for Alcohol and Drug Dependence: 18-Month Outcomes. Journal of Substance Abuse Treatment. 2010;38(4):356–365.[PMC free article]
[10] White House (2018) https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf

as they are meeting their requirements. Granted, the needs of residents in Level IIIs and Level IVs are expected to decrease overtime and as a result, they often move to a lower Level of Support. However, that does not inherently classify recovery residences as "transitional".

2. Undermining national standards developed by the National Alliance for Recovery Residences

The SUPPORT Act directs SAMHSA to identify or facilitate the development of best practices. Rather than identifying best practices from the national standards developed by the field, SAMHSA chose to internally develop a separate set of standards with minimal input from subject matter experts in the field. On page 1, the Guidelines read, "not meant to supplant or contradict that good work (the national standards)". Yet, it goes on to frame the Guidelines as "Ten Minimum Standards" and "Best Practices and 10 Minimum Standards". This does not align with the spirit and intent of the SUPPORT Act, and undermines the existing national standards.

3. Indirectly, undermining fair housing rights of persons in recovery

While the SUPPORT Act says HHS may include model laws, the driving force behind Subtitle D. Ensuring Access to Quality Sober Living was the concern around unethical business practices, which were highlighted in a GAO Report.[11] Understandably, states are interested in legislation to address these issues, but behind a lack of funding, fair housing discrimination is the biggest barrier to individuals accessing recovery housing. Systemic fair housing discrimination is caused by inappropriate and over regulation that result in barriers to housing choice.

Fortunately, a growing number of states have identified policy approaches that promote quality and ethically operated recovery housing while furthering residents' fair housing rights. This was summarized in the National Council on Behavioral Health's Policy Brief: *Building Recovery: State Policy Guide for Supporting Recovery Housing.*[12]

SAMHSA has an opportunity through this report to identify emerging state models that navigate this complex policy landscape.

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[11] https://www.gao.gov/assets/700/690831.pdf
[12] https://www.thenationalcouncil.org/wp-content/uploads/2018/05/18_Recovery-Housing-Toolkit_5.3.2018.pdf