April 12, 2019

Substance Abuse and Mental Health Services Administration
Submitted via email

Comments on draft, "Recovery Housing: Best Practices and Suggested Minimum Guidelines"

We appreciate the opportunity to provide feedback regarding the draft of *Recovery Housing: Best Practice and Suggested Minimum Guidelines.* The primary mission of the National Alliance for Recovery Residences (NARR) is to promote and uphold standards for recovery housing, and we value SAMHSA's endeavor to identify best practice guidelines and provide guidance to improve the quality of recovery housing. NARR was founded in 2011 by recovery residence operators, advocates, and established recovery housing organizations from across the country, united in the common purpose of promoting standards and ethics for all levels of recovery housing. The National Quality Standard developed by NARR is currently represented in 32 states. We appreciate the references to our work in this document. SAMHSA's definition of recovery and its four dimensions, *Health, Home, Purpose and Community* were grounding principles in the development of the NARR standard.

The following are areas of concern and suggestions for consideration.

1. ***Clarify language regarding document purpose***

The two primary aspects of a ***standard*** are that it is a basis for quality, and it is measurable. In discussing the ten characteristics desired in standards we suggest they be referred to as 'guidelines' or 'principles,' and that the term 'standard' be reserved for sets of rules that are concrete, measurable, and preferably in current use for the purpose of assessing recovery residences for alignment with industry best practices. For example, the phrasing, "SAMHSA recommends following these Ten Minimum Standards" is misleading because it confuses principles with fully developed and actionable operating rules.

2. ***Clarify the target audience for the document, reorganize by audience to increase clarity***

We are concerned that in the attempt to reach all audiences (most prominently state oversight agencies and individual recovery housing providers), the ability to operationalize the guidelines is compromised. Guidance and further clarification on specific expectations would need to be provided for overseeing state agencies to operationalize these principles. It is not clear how a state agency can create measurable compliance plans based on this document, which in at least one state (CA) will be a requirement. We fear that without appropriate guidance there will be confusion. State agencies and others in the early stages of recognizing and supporting standards-based recovery housing providers may react by ceasing their forward progress. States that have not yet taken concrete steps will not be able to base system development policy on a document

that does not address those issues. Recommendations should be explicit as to the audience, and should be addressed in separate sections of the document.

3. Provide support and guidance to states for building a network of ethical recovery housing providers

State entities are evolving in their implementation of recovery housing standards. Ohio and Florida are two examples of state support and collaboration facilitating a rapid organizational development and ethical, standards-based response and oversight. With support they were able to 'create from scratch' and operationalize standards, guidance and oversight for recovery housing providers in their area. Even these evolved organizations need and request guidance on additional steps they can take to build and support a system of providers and residences that operate with integrity. Guidelines and principles that specifically address organizational stakeholders would be helpful and fill a current void in the field. Specifically, other states need to understand best practices for implementing and supporting standards-based, accessible and supportive recovery housing systems. In our view this is a set of issues on which SAMHSA guidance would be most valuable. A good starting point, and one that we recommend as a citation in a final version of this document, is *Building Recovery: State Policy Guide for Supporting Recovery Housing*, published in 2018 by the National Council for Behavioral Health and NARR.

4. Use consistent, recovery-oriented language that applies to all levels of recovery housing

The language used throughout the document is clinical, and as such does not apply to Level I and II housing that is based in peer principles with minimal staffing. Level I, Level II, and in many states, Level III recovery residences do not provide 'treatment' services of any kind. Rather, the emphasis is on social model-based community support and accessing resources in the greater community. None of the ten guidelines directly addresses the development and maintenance of a recovery-supportive environment around social model principles. Recovery housing operators may feel pressure to act outside their own scope of practice, and closer to the scope of practice for treatment providers, which could place the health and safety of residents at risk. The document needs to be clear that recovery housing is housing, and it is not treatment.

Additionally, recovery residences are not 'transitional' housing as that term is commonly understood, and as it is often defined in state laws. In Levels I, II and III there are no limits on length of stay.

Finally, the document uses stigmatizing language and suggestions about people in recovery. Usage of terms such as "addict" is harmful to SAMHSA's larger efforts to reduce stigma against people in recovery.

5. Ensure the document considers fair housing considerations for people in recovery

States and local governments need to be mindful of obligations under the Fair Housing Act, Americans with Disabilities Act and related laws protecting the rights of individuals with SUD in their access to supportive housing. This document does not consider or address the fair housing rights of people in recovery. In our eight years of experience, we have witnessed many attempts by state and/or local governments to restrict the ability of people in recovery to live in their own communities. The current draft of this document could potentially be used to encourage more state and local governments to take similar action, severely limiting the housing choice of people in recovery. We would encourage identifying model laws in states that have successfully implemented legislation and policy that promote ethical recovery housing without over regulating. *Building Recovery: State Policy Guide for Supporting Recovery Housing* provides a useful summary. DOJ and HUD have relevant guidance, which is often ignored in developing legislation affecting disabled populations. Language in this document could be construed to suggest that states make compliance with certain provisions mandatory for any housing for recovering individuals. Attempts to do that have caused great harm, and have been found to violate federal civil rights laws.

6. Clarify language regarding assessments of residents

The draft recommends clinical assessments but does not consider that Level I and Level II recovery housing options do not have staff qualified to perform such assessments. Level I and Level II recovery residences that follow the NARR standards do perform evaluations of residents to ensure that the home is able to meet the level of support appropriate for the resident, but these evaluations are recovery and recovery capital oriented, and not clinical in nature. If a state were to require clinical assessments without identifying responsibility for who should perform them, and without addressing cost and availability of qualified staff, it would create significant access barriers through either higher cost, limited availability of assessment resources, or both.

7. Outcomes and service metrics

Goals of measurement and data-driven process improvement are legitimate but come with a cost. Data collection systems, staff training, and additional staff time for the work are required. This is a barrier for many providers. NARR state affiliates assist individual operators to gather demographic and outcome data, but comprehensive efforts fall short of ideals due to lack of resources. This was discussed at SAMHSA's August 2018 Recovery Research and Evaluation Technical Expert Panel.

With respect to resident assessments and outcome/service metrics, drafters seemed to lose sight of the fact that, unlike addiction treatment, the vast majority of recovery residence expenses are borne personally by the residents. Third party payments are a rarity. As a result any requirements that increase costs will increase barriers to access, no matter how desirable those requirements may be. We would like to see evidence that drafters of proposed regulations have formally

assessed these tradeoffs. We would encourage SAMHSA to consider the practices already in place, and to develop funding and implementation guidelines in consultation with stakeholders that will be utilizing these systems. NARR is willing to support and collaborate in this endeavor.

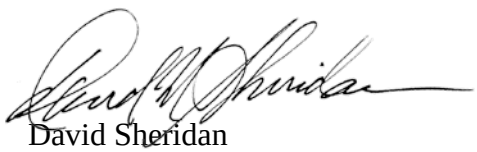
8. ***Increase collaboration with recovery housing experts to identify and implement best practices***

NARR is concerned about the confusion that could be incurred with the release of a SAMHSA 'standard' of recovery residence operation. We encourage SAMHSA to consider the body of knowledge and practice that is successful and in use, without seeking to duplicate what already exists i.e. 'reinventing the wheel'. We would welcome collaboration and offer our assistance in implementing the directive of the SUPPORT Act, which is to identify and facilitate the development of best practices. NARR has a wide knowledge base in our constituency and can provide direction and many examples of successful implementation of standards and best practices from both the systemic and individual provider perspective.

9. ***Extend the deadline for feedback on the SAMHSA: Proposed Recovery Housing Guidelines***

NARR has had innumerable communications this week from our affiliates, individual operators and even outside press entities requesting responses as well as requests that NARR seek additional response time. Our constituents are deeply concerned about the potential impact of the guidance you propose if delivered as written. The short time period allowed for responses is not in alignment with the far-reaching implications the guidelines could have on the field of recovery housing. SAMHSA convened two expert panels last year on very narrow aspects of recovery housing, and similar care should be taken with this much more significant guidance. We know from conversations with the author of the SUPPORT Act language (to which these guidelines are a response) that the intention of the Act's $3 million allocation was in part to fund a thorough approach to the development effort. We respectfully request that the feedback communication period be extended to allow all interested parties and organizations ample time to offer a considered response.

Respectfully submitted,



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