



November 22, 2022

[House Bill \(H.B.\) 707](#), 87th Legislature, Regular Session, 2021, requires the Health and Human Services Commission (HHSC) to conduct a study to evaluate the status of and opportunities, challenges, and needs to expand recovery housing in Texas for people in recovery from substance use disorders. The report on this study is due December 1, 2022, and must include recommendations for legislative or other action, including policy changes and the adoption or implementation of best practices and training and technical assistance resources.

H.B. 707 defines recovery housing as “a shared living environment that promotes sustained recovery from substance use disorders by integrating residents into the surrounding community and providing a setting that connects residents to supports and services promoting sustained recovery from substance use disorders, is centered on peer support, and is free from alcohol and drug use.”

HHSC holds contracts for recovery housing. To eliminate any perception of bias, HHSC contracted with Texas A&M University’s Bush School of Government and Public Service, Department of Public Service and Administration (PSAA) to conduct the study on recovery housing and compile the report.

Consistent with the requirements of H.B. 707, the PSAA research team collected and compiled data using a variety of methods. An extensive literature review identified emerging themes and informed study protocols. A wide variety of stakeholder groups and experts participated in 17 focus groups across the state and over 50 interviews. In total, the researchers visited 43 recovery residences across the state to gain a comprehensive understanding of the landscape of recovery housing in Texas.

The literature review, site visits, focus groups, and interviews conducted by Texas A&M University PSAA researchers yielded evidence that recovery homes are positive resources for people seeking to maintain long-term recovery. Recovery housing was also found to add value to local communities, bringing more benefits than they do costs. Potential policy changes to aid in the expansion of recovery housing have been identified for consideration by the legislature.



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Executive Summary

Pursuant to House Bill (H.B.) 707, 87th Legislature, Regular Session, 2021, the Texas Legislature required the Health and Human Services Commission (HHSC) to conduct a study of recovery residences. H.B. 707 called for the study to explore the opportunities for, challenges of, and need for expansion of recovery residences in the State including recommendations for action, policy changes, best practices, and the need for training and/or technical assistance.

Findings

Through literature review, site visits, focus groups and interviews we found convincing evidence recovery residences increase the odds of successful long-term recovery. Despite needing more recovery housing, especially for underserved populations, operators are reluctant to expand. The main reasons discussed are the high startup costs involved and the difficulty navigating city ordinances and restrictive homeowner associations (HOA).

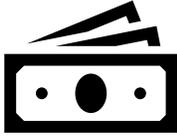
Recommendations

Recommendations begin with establishing a comprehensive definition of recovery residence differentiating it from a boarding home and creating baseline requirements for safety and ethics. These should apply to any recovery residence. Next, implement a voluntary certification process managed either by the State or by third party certifiers (led by people with lived experience in long-term recovery) and make certain State benefits available only to certified recovery residences. The certification process should focus on safety, ethics, and best practices including disclosing potential conflicts of interest and include interim certification for new residences. Ideally, certification would be on-going and include technical assistance as needed. The State benefits that would ease burdens to setup and operation of recovery residences; facilitating expansion are as follows:

-  **Property Damage Protection – Offer properties access to funds that cover tenant damage for property owners who lease to recovery residences.**
-  **Limited Immunity – Provide property owners with immunity of civil and criminal responsibilities related to the selection of tenants in the recovery residence.**
-  **Provide Naloxone – Free Naloxone and related training should be available to all recovery residence tenants and management.**



Work with Texas Department of Criminal Justice – Allow individuals to parole to certified recovery residences.



Revolving Loan – Small revolving loan program to help offset setup costs to new recovery residences



Improving Access – Subsidize costs, particularly for underserved segments of population entering recovery residences.

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Introduction

Pursuant to House Bill (H.B.) 707, 87th Legislature, Regular Session, 2021, the Texas Legislature required HHSC to conduct a study of recovery residences and how they are operating. Further, H.B. 707 called for the study to explore the opportunities for, challenges of, and need for expansion of recovery residences in the state. The Bill seeks recommendations for action, including policy changes, best practices, and the need for training and/or technical assistance.

H.B 707 defines recovery residences as “a shared living environment that promotes sustained recovery from substance use disorders by integrating residents into the surrounding community and providing a setting that connects residents to supports and services promoting sustained recovery from substance use disorders, is centered on peer support, and is free from alcohol and drug use.” Recovery residences provide a safe, supportive and healthy environment for those in recovery to improve their social, mental, physical and spiritual wellbeing (NARR, 2012). The recovery component of recovery residences is just that – a place for those in recovery to continue their journey without the stresses of needing to find housing and with the social/peer support needed to maintain their path to sober and healthy living.

A small but growing body of research supports the effectiveness of recovery residences in sustaining abstinence and promoting gains in a variety of other domains. While the studies are discussed in greater detail later, recovery residences are associated with higher levels of continued recovery, increased income, decreased incarceration, and lower criminal justice costs (L. A. Jason, Olson, Ferrari, & Lo Sasso, 2006; S. S. Martin, Butzin, & Inciardi, 1995). Although critical questions remain regarding recovery residences, research shows recovery residences provide important benefits that promote recovery.

To satisfy the requirements of H.B. 707, HHSC contracted with a group of researchers from the Department of Public Service and Administration (PSAA) at Texas A&M University. The following report addresses the requirements of this Bill.

Background

Overview

The term recovery residence commonly refers to Oxford Houses, sober living houses, therapeutic communities, transitional housing, or sober living facilities. While each name is associated with a different approach to the organization of the residence and the services they provide, they share a common purpose to ensure a safe space for those in recovery to live in a healthy substance free environment (Borkman, Kaskutas, Room, Bryan, & Barrows, 1998; A. A. Mericle, 2014; A. A. Mericle & Miles, 2017; D. L. Polcin, Korcha, Bond, & Galloway, 2010; Wittman, Jee, Polcin, & Henderson, 2014). Because the term recovery residence encapsulates several different approaches, there are varying definitions in laws, regulations, and guidelines across the nation (Bryce et al., 2021; A. A. Mericle, Polcin, Hemberg, & Miles, 2017). Further complicating the matter, the federal government often uses the terms recovery housing and recovery residences interchangeably.

While in other states, recovery residences are sometimes referred to as halfway houses, in Texas it is important to distinguish between these terms as Texas statute define halfway houses as transitional housing for parolees. While halfway homes might serve a similar mission, they do not have the structure or community focus of recovery residences. The utilization of terms interchangeably can perpetuate societal stigma and the association of criminality with substance use disorder (SUD). This may present an obstacle to a person's recovery as well as their inclusion and development in the community (Ashford, Brown, & Curtis, 2018; Livingston, Milne, Fang, & Amari, 2012).

Characteristics

Levels

Four levels and types of recovery residences have been identified by the National Alliance for Recovery Residences (NARR) (NARR, 2012; D. Polcin, Mericle, Howell, Sheridan, & Christensen, 2014). These levels help both those making referrals and potential residents understand the types of supports and/or services a house is

likely to provide. Table 1 below details the various levels, common examples, and an overview.

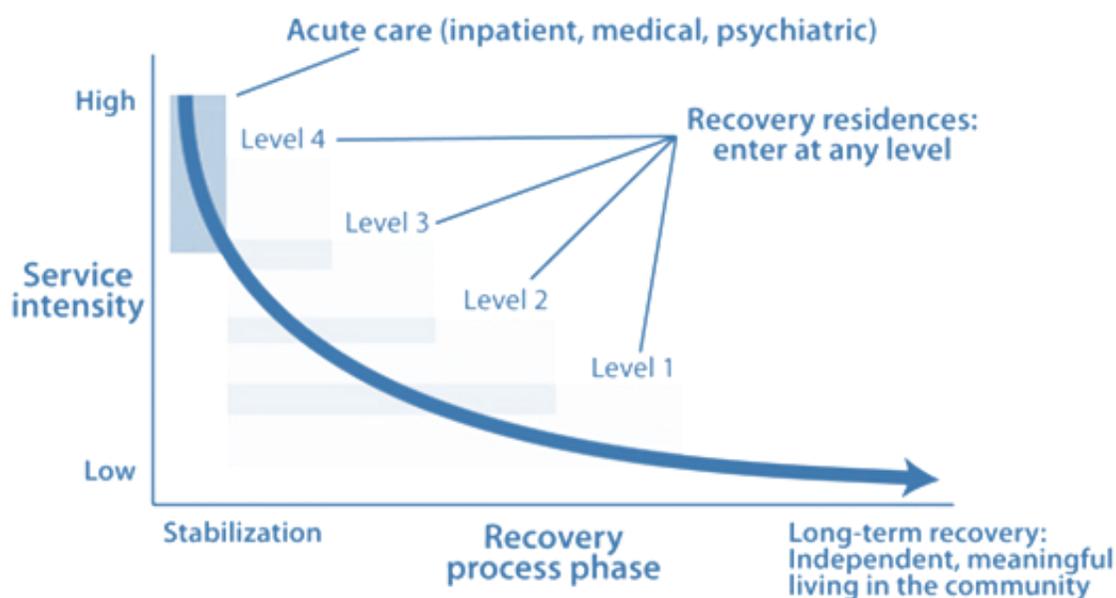
Table 1. NARR Levels, Definitions, and Common Names

NARR Level	Level I	Level II	Level III	Level IV
Common names	Oxford House™	Sober Living Houses	Many names	Therapeutic Communities
Definition	<p>Level I residences are purely peer managed residences located in residential neighborhoods. The residents run the recovery residence on their own utilizing a democratic voting process. At this level, there are no paid staff members or on-site services. A good example of these residences would be Oxford Houses (Oxford House, 2021).</p>	<p>Level II residences are also typically rooted in residential neighborhoods; however, unlike Level I, these residences are not run by the residents but rather a house manager. Sometimes this might be a senior resident who is paid or is given a rent discount or stipend. In these residences, there are typically no services provided on-site and residents attend 12-step recovery groups - this is either strongly encouraged or is a requirement as part of the house rules. The California model - Sober Living Houses are good examples of this Level of residence (D. L. Polcin et al., 2010)</p>	<p>Level III residences exist as private households in residential neighborhoods, while others operate in multifamily, commercial, or other environments. These residences employ paid staff, who provide on-site resources and services. These services can include but are not limited to recovery support groups, community connection, and life skills training. One analysis of these residences concluded that Level III is somewhat of a hybrid program that combines a social model of recovery and more advanced services delivered by trained staff (A. A. Mericle, Miles, & Cacciola, 2015).</p>	<p>Level IV facilities are typically not found in residential neighborhoods. These residences are better defined and distinguished as residential treatment programs. This level of recovery residence is much more structured than level III and provides a variety of on-site clinical services in addition to many of the resources found in a Level III residence. Based on the level of care provided, Level IV's are legally obligated to employ licensed and credentialed professionals who provide clinical and more in-depth services that are regulated by law. Therapeutic communities (TC's) as referenced above are a good example of level IV facilities (De Leon, 2000).</p>

Information provided and adapted with permissions by RecoveryPeople - a 501(c)3 charitable nonprofit incorporated in the state of Texas. – The National Alliance for Recovery Residences (NARR, 2012; D. Polcin et al., 2014).

Figure 1 displays the relationship that exists between the intensity of services and the typical stage of recovery of residents. The general expectation is that people who need more intensive services will choose higher-level residences while retaining the ability to move between residences over time. As indicated, pinpointing the exact level of a residence may prove difficult as the residence may have characteristics of multiple classifications.

Figure 1. Recovery Residences in the Continuum of Recovery



Largely duplicates figure from (The Society For Community, 2013).

Level 1

Level 1 residences do not have paid staff and the house rules are democratically set. Further, they are almost exclusively located in residential neighborhoods. While participation in recovery groups such as 12-step programs is the norm, attendance

is not mandatory. However, most hold a regular house meeting to discuss any issues that may arise. Finally, no supportive services are formally provided on-site (D. Polcin et al., 2014).

The most widely known examples of Level 1 residences are Oxford Houses. There are more recovery residences associated with Oxford House than any other model with over 3,200 homes in the United States (Doogan, Light, Stevens, & Jason, 2019; Oxford House, 2021). Oxford House, Inc. (OHI) serves as an umbrella organization and provides the framework for affiliated residences (Oxford House, 2021).

Level 2

Recovery residences that are classified as Level 2 include a house manager. This manager is either paid and/or may receive free or reduced rent if they live in the house. The main responsibility of most house managers is to hold the residents accountable to the rules of the house. Another key difference between Level 1 and Level 2 homes is that the house rules are set by the house owner/operator rather than by a majority vote of the residents. Like Level 1 homes, they are typically in a residential neighborhood and do not provide services on-site. Participation in recovery groups such as 12-step programs is strongly encouraged and often required (NARR, 2012; D. Polcin et al., 2014).

Sober Living Houses (SLHs) (sometimes referred to as the California Model) are a prominent example of Level 2 recovery residences. SLHs do not have the unifying parent organization that Oxford Houses have. Given this there is more variation in how the model is implemented (D. L. Polcin et al., 2010).

Level 3

Level 3 recovery residences offer on-site services that may include recovery support groups, life skills training, and wellness planning by paid staff. While Level 1 and 2 recovery residences may have an owner or be incorporated, the NARR states all Level 3 residences will have that characteristic. While clinical services are not provided at the home, the residence will likely provide access to third-party clinical providers, an approach frequently called "the Florida Model." Often,

residents will attend an Intensive Outpatient Treatment program outside of the home and return to the recovery residence at the end of their day. These recovery residences may be located in either residential, multi-family, or commercial locations (Amy A Mericle, Miles, Cacciola, & Howell, 2014; NARR, 2011; D. Polcin et al., 2014).

Level 4

Those recovery residences that are characterized as Level 4 provide clinical services on-site. Because of this, they are required to have the appropriate licensure for whatever regulated services they provide. These facilities are rarely located in a neighborhood (NARR, 2011; D. Polcin et al., 2014).

The Therapeutic Community (TC) model is a prominent example of a Level 4 approach. TCs are highly structured programs where the bulk of an individual's day is planned for them, including chores. Within the regimented structure, clinical services such as counseling are built in. TCs facilitate a high degree of social interaction with other residents as a therapeutic means towards learning new tools to support recovery. Often key staff in long-term recovery serve as role models for residents. The highly regimented day is designed to reduce boredom in order to distract from preoccupations that were once associated with substance misuse. An additional perceived benefit of the rigorous schedule is to produce satisfaction associated with completing a fulfilling and complete day (De Leon, 1990, 2000). Generally, residents have shorter stays at Level 3 and 4 residences and will either step down to a Level 2 or 1 home or move to independent living.

Medications for Substance Use Disorder

Use of medications for a substance use disorder (MSUD) is a widely used approach for assisting in recovery for those with SUD. This approach combines the use of monitored/regulated prescription medications and behavioral therapy to treat people. The use of certain types of medications has become a central approach to treatment of both opioid and alcohol use disorders (Jerry & Collins, 2013; Robertson et al., 2018; Timko, Schultz, Cucciare, Vittorio, & Garrison-Diehn, 2016).

Despite the positive clinical evidence regarding MSUD and recovery, some residents oppose their use by other residents in their homes (Majer et al., 2018). The attitudes of residents who support a purely medication-free abstinence-based approach argue that MSUD shifts the dependency from one drug to another (Jerry & Collins, 2013; Majer et al., 2018). Thus, some residences do not view MSUD use as “recovery” and consider these medications a banned substance in their residences; while others view using MSUD as an integral tool towards recovery (L. A. Jason, Bobak, O'Brien, & Majer, 2022).

While the rules of some residences prohibit the use of MSUD in their homes, NARR issued a bulletin encouraging recovery residences to reevaluate prohibitions on MSUD (NARR, n.d.). NARR goes on to note that blanket prohibitions can be violations of both the Americans with Disabilities Act (ADA) and the Fair Housing Act (FHA). Persons prescribed medication to treat a SUD are protected by the ADA and the FHA. Given this, recovery residences that deny access to an individual based upon taking medications as prescribed for a SUD may be in violation of the law (Legal Action Center, 2009).

While there is much medical and socio-cultural research detailing the benefits of the use of MSUDs, the important driving factor for purposes of recovery residences is that a division exists between residences that allow taking medications as prescribed for a SUD and those that do not.

Key Components of Recovery Housing

Recovery Component

For many years, the primary line of care for those with SUD was acute treatment care; however, this approach has been mostly categorized as lacking sustainability, out of touch, or ineffective. When looking at long-term recovery results, many times acute treatment alone is associated with an elevated risk of symptom recurrence (L. A. Jason et al., 2006). This approach is also extremely costly when not followed up by a referral to continued services or an action plan, as prescribed for most chronic diseases (McKay, 2009; White, Kelly, & Roth, 2012). Thus, much research has been implemented to find alternative and more adaptable methods of treatment – customized and catered to individual needs to promote long-term recovery and support.

As the mindset shifted to this more holistic approach, the recovery community began looking at persons with SUD as needing long-term recovery supports rather than a one-time treatment. Extended support and resources such as employment, peer support, and housing were recognized as necessary for a person's success in recovery, as opposed to an episodic approach to treatment (McKay, 2009; White et al., 2012). The continuation of care comes from the recognition that SUD, much like other chronic disorders, is an ongoing condition (McKay, 2009). Viewing SUD as a health issue rather than a moral failing allowed recovery specialists to begin questioning how to support people in recovery after their treatment to maintain their recovery in the world beyond the treatment center.

Figure 2. Recovery Residences and Their Pillars of Success



Out of this context of long-term recovery, residences have emerged and are continuing to develop and evolve as a place for those in recovery to access peer support in a home environment. While in some cases management and recovery professionals view recovery residences simply as a housing alternative for people in recovery, many of the housing regulatory entities and medical professionals view recovery residences as “recovery support.”

Housing Component

From a housing perspective, recovery residences have unique characteristics. Unlike market housing, recovery housing is designed for a specific population. In the most basic terms, this population should be limited to persons with a history of SUD, are in recovery, are seeking to continue their recovery, and choose to live in a recovery residence to promote their recovery. Recovery residences provide a shared housing experiences that promote a family-like environment with peer-support, encouraging both accountability and support. They also link residents to support and services within the community that promote recovery and stability.

These residences not only require that people living there be in recovery, but also have eligibility requirements, and “levels” of care based on one's substance misuse history and the structure they may require to support their recovery. Eligibility may be based on any number of factors, but is most commonly based on gender, age, length of sobriety, and/or ability to pay. Additionally, most residences have a set of house rules (e.g., abstinence, curfew, smoking, medication, visitors, etc.). The eligibility and house rules of each recovery residence is dependent on the mission of the house, as well as the structure each individual needs to maintain recovery and a healthy life.

Services and Resources

As discussed in the overview of models, each residence differs in the services and resources it provides. For instance, Level 1 residences, such as Oxford Houses, provide minimal services while Level 4 residences provide clinical services inside the homes. The rest of the facilities exist on a continuum between these extremes. For instance, Level 2 facilities often require residents to participate in recovery support

programs such as 12-step programs while Level 3 residences may provide these services on site.

The variation of the services provided can be viewed as an asset—letting residents identify the housing model that best fits their needs. At a minimum, all recovery residences provide peer-support. However, given the lack of oversight; there are no barriers to opening a home and calling it a recovery residence regardless of the structure or services they may or may not provide. It is important to understand that while NARR provides helpful guidelines and best practices; some recovery residence operators are not even aware of NARR and do not follow any prescribed guidelines; while others may strive to go above and beyond what is expected. This variation in services and resources among recovery residence providers can make it very difficult to determine the best placement for an individual.

Procedures

Consistent with the requirements of H.B. 707, the project team collected data utilizing a multitude of procedures. First, existing scholarly literature was explored to identify emerging themes, controversies, and issues. This extensive review of the literature informed study protocols and methods. Next, we conducted a series of eight focus groups around the State. People from treatment, advocacy, city planning, criminal justice and recovery residence owners were invited to join the focus groups. Additionally, key stakeholders in the recovery field were asked to help identify people to invite to these focus groups. These initial focus groups took place in the following cities: Austin, New Braunfels, Dallas, El Paso, Midland, Laredo, Lufkin, and Abilene. Following this, we visited 43 recovery residences from all areas of Texas. Finally, we conducted an additional nine focus groups to complement our findings. These final focus groups were held in the following cities: Corpus Christi, San Antonio, Fort Worth, Houston, Lubbock, McAllen, Tyler, Beaumont, and Waco. Throughout the project period we conducted over 50 interviews of stakeholders, advocates, academics, and recovery residence owners. Throughout the process, we conducted interviews with stakeholders, state officials, and academics to both

better understand the landscape of recovery residences and to help guide our study approach.

To identify recovery residences to visit, we contacted over one hundred facilities by phone to identify the level of services provided and the extent to which MSUD are allowed. In instances where sites did not know their NARR Level, the project staff asked about their structure and services and assigned them a level based on their answers. The sites were divided into three strata: 1) Urban vs. Rural; 2) MSUD allowed vs. not; 3) Each NARR Level (I-IV). The goal was to visit 3 sites of each subtype. Due to scheduling conflicts, Coronavirus Disease 2019 (COVID-19)-related cancelations, and small numbers of certain facilities in rural areas, we ended with 43 facilities visited. In all, 27 urban and 16 rural recovery residences; 26 facilities that allowed MSUD compared to 17 that did not allow MSUD; and 6 NARR Level I, 14 Level II, 16 Level III, and 7 Level IV residences were visited.

At each site visit, interviews were conducted with the owner and/or residence manager if there was one available. Members of the research team toured the facilities and used a standardized checklist to guide the observation of the recovery residence's safety (e.g., presence of smoke detectors, adequate bathroom facilities). In addition, focus groups were conducted with the residents who also completed a brief survey. Residents who participated in the focus groups received a \$25 shopping gift card for their effort.

As shown in Figure 3, there was a wide range of ages represented by the residents—from 17 to 74, with an average age of 39. Figure 4 shows the gender distribution of recovery residents we visited. Approximately 60% identified as male, 38% identified as female, and 2% identified as another category.

Following each site visit and focus group, team members noted key observations. The team then aggregated these findings to identify common themes. The findings below summarize the key themes that emerged during the interviews/focus group sessions.

Figure 3. Age of Residents

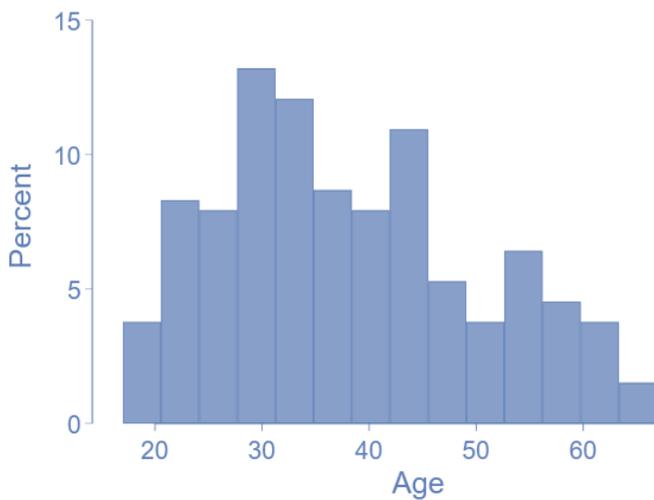
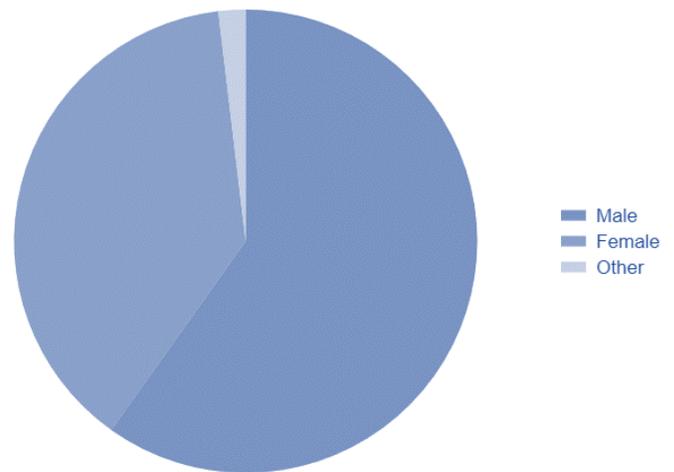


Figure 4. Gender Identity of Residents



Findings

Benefits

Benefits of recovery residences accrue to both the individual resident and to society. Respondents were asked what they thought were the key benefits to both the individual as well as to the community and society of recovery residences. As expected, respondents identified a great many benefits.

Individual

All respondents were quick to point out many benefits from living in a recovery residence. While these benefits are numerous, they all ultimately help residents maintain their recovery. This is consistent with scholarly research that demonstrates an association between recovery residences and improved maintenance of recovery. In a review of parolees, those who participated in a

therapeutic community were found to have lower frequency of substance misuse than non-participants (S. S. Martin et al., 1995). An evaluation of Oxford Houses showed similar findings (L. A. Jason et al., 2007).

In an experimental study of Oxford Houses, residing in a recovery residence more than doubles the likelihood of being in remission at 24 months compared to those who were not provided with a recovery residence model (L. A. Jason et al., 2006). In a follow-up study, residing in an Oxford House significantly increases the likelihood of long-term sustained recovery. Those who lived in an Oxford House for less than 6 months still showed lower rates of substance misuse after 24 months than those randomly assigned to traditional aftercare (L. A. Jason et al., 2007).

The reason(s) for the improved recovery varied by the person. We discuss the most frequently referenced reasons offered below.

Housing

Perhaps the most obvious benefit is having a safe place to stay. Several residents noted that they had no other options for housing other than shelters or living on the street. Many reasons were offered for the lack of options: severed relations with family members; expenses; poor credit; and criminal convictions were the most often discussed reasons. Others indicated the options they did have available would have put them right back in the situation they had been in when they were misusing substances.

The safety of the recovery residence was viewed as a key contributor to the continued recovery of residents. Respondents spoke of safety in terms of location in a safe area of town, free from the threat of physical or emotional assault in the home, and free from triggers that may lead to a return to use. In fact, one individual noted that when he lived on the streets, he would use methamphetamines to stay awake and protect his personal belongings. Several respondents mentioned the safety of the residence was especially comforting having recently left an abusive relationship to enter treatment.

House managers and owners discussed the safety measures they took beyond the basics of having working smoke detectors and working door locks including not

“The connection with people in the house [was] immediate, like [a] social support system...if I was not living here, I would probably have ended up living in like a studio apartment by myself or something. And the isolation is really definitely not good for my recovery.”

Resident

publishing the address of the home to protect the residents from unwanted visitors and regularly monitoring the vicinity to make sure drug dealers were not lingering around. Many homes also provided residents with locking storage areas to store their personal belongings as well. Having the basic need for safety met allowed residents to focus more on their recovery.

By design, recovery residences should be located in a safe neighborhood (Wittman et al., 2014). Many of the facilities we visited were in safe neighborhoods, a fact not lost on the residents. Many residents were intentional about keeping their neighborhoods safe, indicating that they would alert authorities if there were illegal activity occurring in their neighborhoods. This safety was viewed as a valuable component of several residents' recovery. This was contrasted with the experiences many people had before entering their recovery, which often included being unhoused and/or incarcerated. On the other hand, a few of the facilities we visited were in areas where drug use was common—possibly due to the difficulty of finding

“The sober house has been the safest, best place I’ve ever lived in.”

Focus Group Participant

affordable homes to purchase or lease. To help mediate this, some of the houses were gated so residents could go to their cars and leave without being approached by drug dealers.

The safety measures seemed to be working from the residents’ perspectives. Of those whom we visited, 97 percent felt somewhat or very safe in their recovery residences. 90 percent felt somewhat or very safe in the neighborhood their recovery residence was located in.

The recovery residences also provided people the ability to keep a physical distance between themselves and triggers. For instance, some residents were in a completely different city than where their SUD was most pronounced. Others stayed in their home communities but needed to be able to stay away from family members and past acquaintances who served as triggers for them.

Employment/Education

Many residents noted the extent to which recovery residences helped residents achieve employment; particularly for those in Level 1 and 2 where residents are not attending a more intensive treatment program. This occurred through many avenues. For instance, some houses proactively help people obtain missing identification such as drivers' licenses, birth certificates and Social Security cards. Without these documents, the residents would have difficulty obtaining legitimate employment. One residence even conducts mock job interviews with its residents.

Other recovery residences helped the residents obtain employment through connections with employers in the city. House managers/owners discussed networking with local employers to advocate for their residents as potential good employees despite

"If I were to go home right now, I would have to get a minimum wage job and it would not be helpful for anybody; and with kids especially. It would still be a government funded situation then; it would just be one we couldn't get out of."

Resident

their histories of substance use and possible felonies. Many of the residents noted that being a resident of their house gave them credibility with certain employers in the community that made securing a job easier. One property manager noted that the employee shortage caused by the COVID-19 pandemic allowed his residents to get jobs at places that were once not welcoming to his residents. These employers have reportedly maintained a willingness to hire his residents due to the level of performance prior residents displayed.

At one residence, one-third of the residents worked at the same place—which was especially beneficial for the residents who did not have cars as they were able to

carpool with other tenants. Residents of this property noted that they are often asked if any new people have moved in as the employer was looking for another employee.

Researchers found in an experimental study that residents of Oxford Houses had higher incomes than those who received traditional aftercare (Lo Sasso, Byro, Jason, Ferrari, & Olson, 2012). Other evaluations report similar findings (L. A. Jason et al., 2006; Leonard A. Jason, Olson, & Harvey, 2015). Achieving employment was a source of pride for many people. Having a resident describe their job in great detail with visible satisfaction in the quality of the position regularly occurred during focus group sessions.

Most of the Level 1 and 2 recovery residences we visited had mandatory work, volunteer, or school requirements. Within a set period, typically a month, people must obtain employment or some other productive way to occupy their time (volunteering or continuing their education). In general, recovery residence owners did not want people to have excess time on their hands.

While many residents obtained meaningful employment, others were pursuing their education. Residents discussed the opportunity to earn a GED or begin college classes. This was generally only possible for residents of subsidized recovery residences where the rent was very low. One resident pointed out that having the opportunity to get a higher education and thus a higher paying job was empowering them to one day be free of government assistance.

Criminal Behavior

Residents admitted that without the recovery residence, they would be more likely to return to criminal activity. Scholarly research indicates these statements are supported by data. Those who went to an Oxford House following their time in rehabilitation showed less criminal activity and incarceration compared to those who did not go to a recovery residence following rehabilitation (L. A. Jason et al., 2006; Lo Sasso et al., 2012).

Focus Group participants in the criminal justice field often discussed that they actively pursued relationships with recovery residences so they could refer their clients to them. Recovery residences were held in high regard in that they provided a positive environment for those recently released from prison and/or those on probation; thus, increasing the odds the resident would not recidivate. While this is an important benefit to both the individual as well as to society, it is important to discuss that having a felony conviction continues to be a significant barrier to employment and independent housing in the long-term making it difficult for people to move on and live productive lives.

Pride

Many of the residents expressed pride related to their recovery residence. The focus of the pride was quite varied. For some, they expressed pride in the better person they have become. Several residences had at least a portion of

“Not only do you receive help, but then you want to help others. You know you want to manage it all. And I’m proud of that. I really am because it’s a quality of life that you learn here.”

Resident

their residents who participated in some form of volunteer work, which made many of these residents feel a sense of pride. Others were proud of living in a home as nice as the one they were in—it was a sign that they were worthy. Similarly, one residence had regular visits from an individual of high social standing in the community and the residents felt honored by his presence and saw it as a sign their recovery mattered to important people.

A sizable proportion of residents who we interviewed held their programs in high regard. We often heard statements such as “this place saved my life.” Often these people had lived in other recovery residences in the past, but found the current residence was better able to meet their needs. Residents offered numerous reasons that their recovery residence was successful; examples include: the house manager; the supports; the fellow residents; and the rules in place. This sense of pride was discussed by residents in each of the 4 Levels of recovery residences.

House managers/owners discussed the pride they had in their residence as well. Most took great pains to create a home-like environment and would say they wanted their recovery residence to be a place they themselves would be proud to live in. Several places we visited had impeccable lawns, very clean homes and were happy to show the place off during our tours. The entire set-up was purposeful and clearly conveyed the message that the owner/manager was invested in the success of their residents.

Camaraderie

Most of the participants we spoke to were quick to point towards a feeling of commonality that existed among their fellow residents. Many residents viewed the other members of the house as family— particularly important given the many people who noted they were ostracized from their families. Indeed, having others around you who are in similar circumstances with similar values provides a high level of comfort and security.

A recurring theme was people feeling they could wake up other residents in the middle of the night if they felt they needed to talk about struggles they were facing, especially for matters related to their recovery. A general willingness to help each other emotionally, monetarily, or through providing transportation was regularly reported.

“Having a healthy relationship with women, because I isolated in my addiction, being able to love women back to wholeness. Because in the streets that was my competition.”

Resident-when asked what they were most proud of

Positive peer pressure was also seen as a benefit of recovery residences. Residents reported not wanting to let their housemates down by returning to SUD symptoms. People would go to Alcoholics Anonymous (AA), Celebrate Recovery (CR), or Narcotics Anonymous (NA) meetings due to an invitation from a roommate or participate in a substance-free afterhours activity with another resident. These events were viewed as welcomed occurrences by tenants as they helped them maintain their recovery.

"We are a family here."

Resident

Supportive peer relationships were often a new experience for people in recovery residences. House managers/owners as well as residents discussed how participating in-house meetings helped to improve their communication and interpersonal skills. As conflicts in the house would arise, residents learned to positively communicate and resolve their grievances while maintaining positive relationships with their housemates. One participant noted that before they would get mad at someone and become physical; now, they are learning how to sit down and have a respectful discussion and resolve their issues without yelling or violence.

In addition to the supportive peer camaraderie, many participants discussed the benefit of having a house manager/operator who was in long term recovery as well. Often these individuals, who could relate to what the residents were going through, served as mentors and role models to the residents. In fact, at all Levels (1-4); this was nearly universally mentioned as a key component of a good recovery residence by residents, house managers and stakeholders alike.

"When I came here, I was accepted as part of a sister, you know, part of the family, you know, and this I consider this as my home. Even if I transition into an apartment, I know I can always come back here and I can always, you know, come to the meetings here. And in order for me to stay clean and sober, I know where I can come back to."

Resident

Rules and Structure

Each recovery residence varied in design. Residences in Levels 2-4 had rules determined by the operators, while others had democratically set rules. As one would expect, the higher the level, the more rules and structure were in place. Rules and structure were clearly defined and explained to perspective residents, allowing individuals to determine for themselves if they wanted to accept the expectations or move on. In general, though, residents appreciated the rules being in place and felt they helped them maintain their recovery. Respondents discussed

how the rules and structure contributed to the safety and accountability of the residents to their recovery program and were designed to help rather than control.

Respondents often realized that the structure that was in place in one home may not be a good fit for everyone. For example, residents who lived in homes with restrictions determined by the operators did not think they would be as successful in a democratically run home such as an Oxford House. On the other hand, residents of the democratically run facilities believed that the ability to vote on the rules gave them ownership in the operations of the residence which they valued.

Life Skills

Life skills in this context refer to basic activities that most adults do in their daily lives to be successful. Examples include budgeting, chores, self-care, bill paying, driving, etc. Many respondents noted that people new to recovery are unlikely to have mastered many necessary life skills. Living in a recovery residence gives residents the opportunity to learn and practice essential life skills that they will need to become independent and maintain their recovery.

“What we do is help guys reintegrate back into society without the use drugs and alcohol by, you know, teaching them life skills that the either never had or forgot.”

House Manager

Most recovery residences required residents to take part in household chores. Usually, each resident would be assigned a task to complete each week and would be provided with another rotational task the next week. In addition, most residents were required to clean up after themselves

and keep their sleeping areas tidy and beds made. Residents regularly noted that these chores helped prepare them for living independently—some even noted that they had never done household chores as they left their homes in early adolescence and lived on the streets prior to entering a rehabilitation program. In addition to chores, residents often learned grocery shopping and cooking skills.

Several individuals noted that the structure of the recovery residence helped them learn to create and adhere to a budget. The requirement to pay rent, even if it is highly subsidized, was seen as both developing good budgeting habits, and

fostering a sense of ownership and pride in the residence. Residents discussed how careful budgeting allowed them to save for big purchases like a car or a deposit for an apartment.

Learning to live with other residents was regularly noted as an advantage of living in a recovery residence. However, some believed a barrier to moving into a recovery residence for some individuals was a hesitation to live with others they did not know and

“Living here is a bridge to independence.”

Resident

would be forced to work with. Many residents have lived independently for the bulk of their adult lives. Given this, they reported that they lacked the ability to cooperate with others prior to arriving at the recovery residence. Residents often reported satisfaction with their newfound ability to work with others in a positive fashion.

Many facilities require attendance at weekly meetings. While these meetings routinely covered household matters, they also served as a mechanism to foster camaraderie among residents. Further, residents noted these meetings helped them learn how to resolve conflict in a respectful manner. Practicing these life skills gives residents a further sense of pride and accomplishment in their own abilities to maintain their recovery and live independently in the future.

Resources

Many recovery residences provide individuals with access to resources both in the home and in the community. These resources vary from location to location as well as by the level. Some provided access to services such as financial planning. For example, several of the Level 3 recovery residences provide classes such as money management and job skills training. Other recovery residences encouraged tenants to access recovery coaches and facilitated the connections. Regardless of the level of services, most tenants viewed the recovery residence as helping them connect with resources in the community. Sometimes these resources were provided by the house operator, but often the source was other residents who had more experience in the community and/or in recovery.

Some recovery residences are proactive in linking their residents with community resources. Several facilities regularly linked their residents to social services such as the Supplemental Nutrition Assistance Program (SNAP, Food Stamps), local social services (e.g., mental health resources), and recovery support groups such as AA, NA, and CR. Given that many of the residents are new to the area, these

"It's important for them [people in recovery] to do things on their own. They need resources and help, but you can't do it for them."

House Manager

linkages are especially helpful.

Accountability

The overwhelming majority of recovery residences have both regular and random drug tests. Several facilities also have breathalyzer tests. Residents noted that this knowledge

helped keep them from substance use as they did not want to gamble on a failed test that would get them removed from the recovery residence.

Many residents also noted a desire to not let their roommates down. There was a general consensus that others in the home would be able to tell if they were to begin using substances. Most also said they were on the lookout for

"If you allow me to do whatever when I'm first coming in these places, if you're not watching me or guide me, then I'm going to do the only thing I know best (Drugs, Alcohol)."

Resident

unusual behavior from their peers that would indicate substance use. In addition, house managers, who were almost always in recovery themselves, noted their ability to identify individuals who were on the verge of a return to use and would try to intervene before that occurred.

In addition to accountability for staying sober, respondents discussed the importance of being held accountable for “working a program.” Many residents had to attend a certain number of meetings each week and have a sponsor; both common elements of a successful recovery. Respondents agreed that living in a

“You know, especially I mean, relapse starts way before you actually pick up, but that’s sort of rolling around in your brain for a minute.”

House Manager

recovery residence held residents accountable for meeting these requirements and staying on track.

Societal

There is still considerable stigma associated with SUD. This stigma

often prevents individuals from seeking treatment or entering a recovery residence after treatment. However, while most individuals enter recovery residences to help themselves maintain their recovery, many benefits also accrue to society.

Transformation

Perhaps the most common benefit to society mentioned was the transformation of residents from individuals who experience first-hand the stigma and burden of SUD to engaged community members. In terms of societal costs, many residents mentioned frequent theft in their pasts to acquire substances. Further, many noted the amount of time they spent incarcerated due to either a drug-related arrest or for criminal behavior to acquire substances. After entering recovery, these costs were eliminated. One residence required residents to be current on child support payments. Many residents credited the recovery residence as an invaluable force in maintaining their recovery and eliminating these social costs.

“One of our big things is child support. We need to take care of that. That’s a big thing...so that is something else that we are really adamant about.”

House Manager

The scholarly literature supports the statements from the residents. Recovery residences are linked to lower levels of illegal activity (M. T. French, Sacks, De Leon, Staines, & McKendrick, 1999; L. A. Jason et al., 2006; Lo Sasso et al., 2012; S. S. Martin et al., 1995). One

experimental study shows that individuals randomly assigned to Oxford Houses have 24-month incarceration rates that are two-thirds lower than those assigned to traditional after-care (3% vs. 9%) (L. A. Jason et al., 2006). A two-thirds reduction in incarceration would lead to extensive cost savings related to criminal justice spending.

Ending the costly behavior is a substantive benefit in its own right; however, many residents noted that they were now positive contributors to society. Research has shown treatment of offenders with SUD is more cost effective, than incarceration (Petteruti & Walsh, 2008).

For those who were unemployed, by entering the workforce, residents soon viewed themselves as valuable members of their community. Many residents were especially proud to be taxpayers and viewed this transformation as a clear sign of the positive changes they had made in their lives.

“This place gave me my firsts. I remember when I got to this place, I’ve never been in a relationship. I never had a car, never had my place. Now I have a job, I have insurance, I got a car, I have got a significant other to go.”

Resident

Combining a reduction in social costs with an increase in benefits results in a clear benefit to society. In a cost-benefit analysis, scholars compared the costs of Oxford House (e.g., rent) to the benefits that accrue due to living in the House (e.g., higher employment, lower criminal behavior). They find benefits exceeding costs by an average of nearly \$9,000 per resident over a one-year period (Lo Sasso et al., 2012). A similar study placed the estimate at \$8,000 per resident (L. A. Jason et al., 2006). A study limited to unhoused individuals who also experience mental health challenges in addition to SUD showed therapeutic communities demonstrated benefits that exceed costs of over \$80,000 per resident (Michael T. French, McCollister, Sacks, McKendrick, & De Leon, 2002).

In addition, residents believed they served as an example to others with SUD on how to seek assistance. Their hope is that by demonstrating true change that

“The farm, 100%. I think it’s a big part of the whole process: working in the garden and taking it to markets and then selling it for donations and conveying the message we have here.”

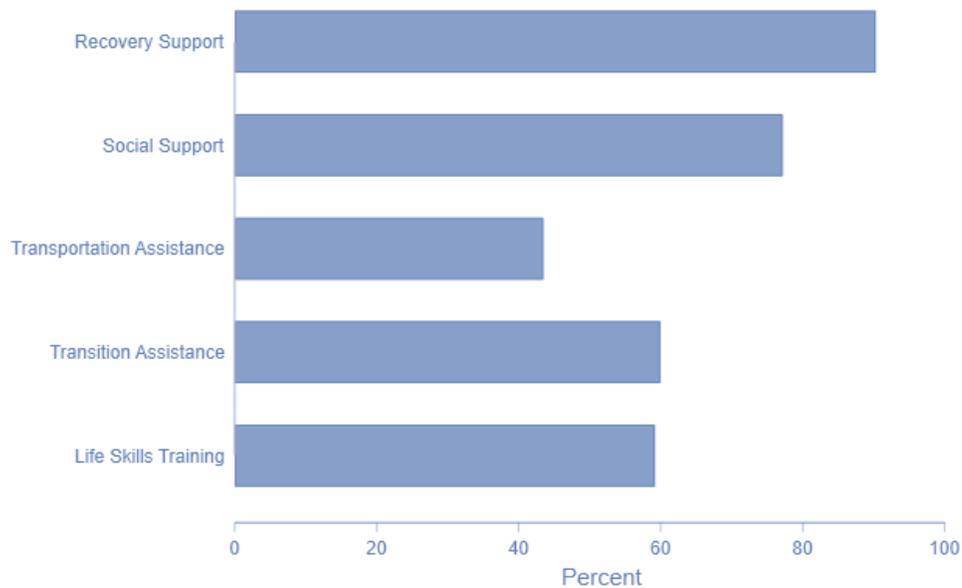
Resident-when asked what they were most proud of

others who knew them prior to recovery will be motivated to pursue recovery as well. Other residents noted that when volunteering in the community they were able to provide information to individuals who

became interested in their residence. This was a source of pride for the individuals reporting such encounters and volunteering was seen as integral to maintaining recovery by multiple residents.

Overall, the project team was able to document several benefits for those who live in recovery residences. The results of the resident survey echo what is reported above. Participants were asked whether they received any of five benefits. The results are shown in Figure 5. The only category below 59% is transportation assistance. Given that some individuals are coming in with their own transportation, this is not surprising. Encouragingly, over 90% reported that the current residence is providing recovery support.

Figure 5. Benefits Received by Residents



Drawbacks

While there was strong agreement recovery residences were positive tools to help individuals maintain their recovery, there were some negatives mentioned by participants. The drawbacks mentioned could be seen as barriers preventing individuals from entering a recovery residence.

Peers Using

One factor mentioned by respondents was the fear that one of the roommates would return to substance use. There was a feeling this could serve as a trigger for the other residents. While individuals have better odds of maintaining recovery in a recovery residence, respondents acknowledged that return to use continues to be a fairly normal occurrence among those in recovery. Most residences we visited had a no tolerance policy for return to use and the individual would be asked to leave immediately. Some had plans in place whereby the individual would be referred to treatment and could apply to return to the residence upon successful completion of treatment. However, many did not. Thus, in most cases, a return to use meant that the person would not be returning to the residence. One individual noted he avoided making deep friendships with fellow residents to prevent being triggered by

a friend's return of symptoms. This likely prevented this person from fully experiencing the positive camaraderie of his residence.

"We all experience pain when someone in the house relapses; it breaks your heart."

House Manager

While all the sites we visited had documented random or regular drug testing procedures, there was some discussion at both the site visits and in the focus groups of residences that would ignore substance use in the house.

"A relapse of a sister here is difficult for all, felt a piece of me die."

Resident

Several examples were provided by many different respondents of places that called themselves recovery residences but were operated by individuals who were

only interested in collecting rent without having any of the essential hallmarks of a recovery residence. Individuals seeking a recovery residence may not have the ability to fully vet the place before moving in. Ending up in a place lacking the very cornerstone of recovery was considered a serious potential drawback.

Cliques

Residents mentioned that cliques can form inside recovery residences. Reportedly, these cliques could lead to alliances forming that promote conflict within the residence. Some residences expressed that in recovery residences that utilize democratic procedures to determine rules and/or determining who can stay in the home, these alliances could lead to unpopular individuals being dismissed from the home. This can lead to individuals avoiding Level I facilities for fear of dismissal.

Family Reunification

Residents reported that visiting family members was difficult. Often individuals live in recovery residences that are not in their hometowns. While this can be beneficial by helping keep residents from their potential triggers, it does make it more difficult to see family members who live some distance away. Many recovery residences do not allow overnight travel, especially in the first few months of moving in. This

often prevents individuals from seeing their families. This seemed particularly problematic for parents who wanted to be reunited with their children as quickly as possible. In response to this, some residences we visited had “family day” on a regular basis where residents could invite family members for a visit. Some even had a family education component to the services they provided whereby families were educated on the science of addiction and how they could best support their loved one in recovery.

While some viewed this as a drawback, it was seen as a positive by some. For those whose family serves as triggers, this serves as a mechanism to avoid interaction with them.

Challenges

While recovery residences have numerous benefits and some drawbacks, they also face several challenges. As discussed here, challenges are factors that apply to the field of recovery residence rather than on the experiences of individuals. Below we discuss many of these challenges.

Availability

A common theme among stakeholders, owners, and residents was that there were not enough good recovery residences in Texas especially for underrepresented populations (discussed below). The only population that seemed well served was males in major metropolitan cities. Some facilities mentioned receiving scores of applications for only a few beds. Overall, there was a belief that if more recovery residences were to open, there would be sufficient demand to keep them occupied.

Cost

Several respondents mentioned that the cost of rent was often a barrier keeping people from recovery residences. Many recovery residences offer low rents compared to other housing options; however, for many who are early in their recovery, even a low rent is difficult to afford. Others demand high rent even when residents are expected to share bedrooms with 2 or more other individuals.

Many of the individuals who are moving into a recovery residence have criminal records, and several did not complete high school. Given this, several residents find their employment options limited to minimum wage positions. For such an individual, a full-time job would yield less than \$1,075 after taxes. Even a comparably low rent of \$600 leaves the resident with less than half of their wages to use for living expenses.

Compounding the issue, some residents have families and another household they are actively maintaining. This leaves little money for them to move into a recovery residence for several months or longer.

To help their residents navigate their limited resources, recovery residence operators sometimes stepped in to assist. For instance, several resident operators help their residents register for SNAP benefits, some collected donated food, while others provided meals. These efforts, though, were not the norm. In addition, several respondents in the bigger urban areas mentioned the availability of “scholarships” that residents could apply for to cover some of their rent. While these scholarships and grants were instrumental in some residents being able to afford the rent, they were not widely available or long term.

Transportation

The overwhelming majority of respondents noted that transportation was one of the key challenges faced by residents. Many residences are in communities without robust public transportation. However, even residences located in urban areas are normally a considerable distance from bus stops due to their location in primarily single-family residential neighborhoods. Residences in rural or suburban areas are often cut off from transportation and residents without a car must beg for rides or walk to get to work or buy groceries. When asked what a particular residence could do to further assist them in the recovery, transportation was frequently mentioned by residents. The only exception was with residents in Level 4 houses where they were either required to stay on property or only had to walk a short distance to their treatment program.

Roommates would often ride to support group meetings (e.g., AA, NA, CR) with a roommate who had a car to get around their own lack of transportation. We also found instances where rides were given to fellow residents for basic needs such as going to work, shopping, and entertainment. Others had to rely on walking or a bicycle. Given the summer heat in Texas, this was viewed as a barrier.

Interestingly, when speaking of these limitations, residents often looked at them as something they are successfully overcoming rather than barriers that would keep them from maintaining their recoveries.

Finding a Fit

For an individual trying to identify a recovery residence to move into, finding a home that fits their specific circumstances is often difficult. Virtually every group (stakeholders, operators, and residents) noted that the model that works for one person may not work at all for another. This can be especially apparent in the distinction between Level I homes such as Oxford Houses where rules are set democratically and other levels where structure is more externally determined. Individuals from each model noted that the other approach would not work for them—with many saying they tried the other model, and it was not a good fit.

Several recovery residences operated under a faith-based model. For many individuals, this was a welcomed approach. Others noted that they were not religious and would not be successful under such a model. House managers often mentioned the vetting process they went through when interviewing potential residents. Each residence had its own unique dynamic and care was often taken to make sure that new residents would be able to adapt and assimilate into the group. Given the high demand for the few beds available, house managers could often afford to be selective about who they admitted.

Underrepresented Groups

Most stakeholders and operators noted there were several groups that were underrepresented in recovery residences. Individuals with spouses and/or children, pregnant people, members of the Lesbian, Gay, Bisexual, Transgender, Queer, and others (LGBTQ+) community, minorities, people with co-morbid conditions, and

people on the sex offender registry were often mentioned as being underrepresented in recovery residences.

Parents were frequently mentioned as underrepresented. Most recovery residences do not allow children. This leaves parents leaving a rehabilitation program in a true quandary: move into a recovery residence and increase the likelihood of maintaining recovery or being reunited with their children. Typically, reuniting with their children is a necessity as they do not have childcare options; unfortunately, this can mean moving back to an environment that may contain many triggers the parent has not learned to deal with yet.

“That’s the only the thing about this house...that I wish I could have my son stay the night here instead of having to pay for a hotel for the weekend.”

Resident

Mothers of young children were mentioned the most; however,

several mentioned that while there are very few options available for mothers that options for fathers were virtually non-existent. Opening a residence for parents can be especially difficult as most recovery residences utilize double occupancy for each bedroom. If a room becomes inhabited by just a parent and child(ren), rent will have to be higher than it would be if non-parents moved in to raise the same level or revenue.

“We want to be better humans while we could still be parents.”

Resident

Expectant mothers face additional challenges. They do not yet qualify for most of the recovery residences for mothers. However, they also will soon be ineligible to live in a traditional recovery residence. Given the many challenges of

pregnancy and early parenthood, this is a population where recovery residences would likely be especially valuable.

Very few options exist for families. While not the norm, we encountered individuals who were married or in a committed relationship who had to live at the recovery residence without their partner. Given that SUD often affect the entire family, having recovery residences where family members can take part in supporting their

loved ones' recovery while working on their own emotions in a supportive environment (similar to Al-Anon) could be helpful.

Members of the LGBTQ+ community were frequently mentioned as underrepresented in recovery residences. There was some mention that this was due to facilities being unwilling to take members of this community; however, many respondents were unable to identify a reason for the underrepresentation. One resident mentioned being asked to leave a recovery residence when they disclosed that they were not heterosexual. In particular, focus group participants and house manager/owners expressed the difficulty in finding an appropriate fit for transgendered individuals, citing a need for more education and acceptance.

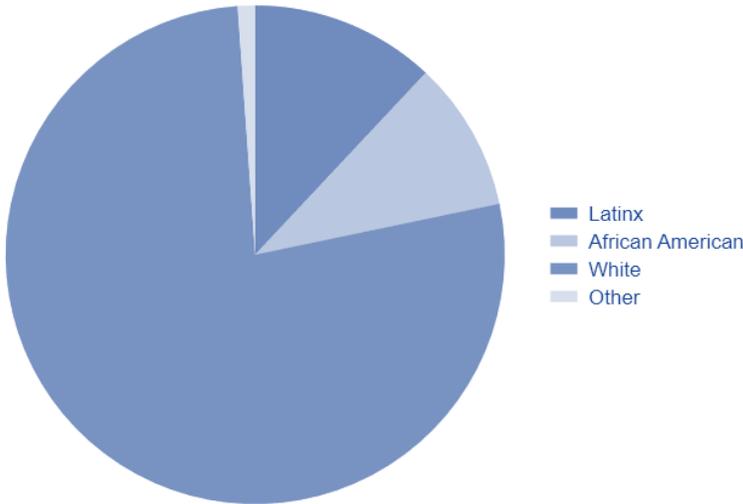
Racial and ethnic minorities were often mentioned as groups that do not utilize recovery residences as much as their population size would predict. African American and Latinx individuals were mentioned most often. Figure 6 supports these reports. 77 percent of the residents we visited were White,

"You don't have to like anybody. You don't have to love anybody here, but you do have to respect them just because they're human beings."

House Manager on LGBTQ+ in the residence

with 12 percent being Latinx and 10 percent African American compared to a statewide racial/ethnic distribution of 40 percent White, 40 percent Hispanic, and 13 percent African American. While African Americans were underrepresented in the facilities we visited, Latinx individuals were dramatically underrepresented. Operators were often perplexed by this and noted they would like to see an increase in the number of minorities in their recovery residences. Given the lack of understanding why these individuals are less likely to access services that improve their chances of maintaining recovery, future research should explore the reasons behind this underrepresentation. One Latinx resident mentioned an appreciation for having Latinx staff members.

Figure 6. Race/Ethnicity of Residents



Relatedly, there was a noted lack of recovery residences along the southern border. This was noted as an additional problem because either potential residents or their family were undocumented and unable to make it past the interior U.S. Border Patrol checkpoints (such as the one in Falfurrias) in

order to travel to the nearest recovery residence. For those in the Rio Grande Valley, the nearest recovery home reported was in Alice or Corpus Christi. Stakeholders in this region believed in the efficacy of recovery residences but felt that the distance prevented many of their residents from utilizing them.

Individuals with a co-occurring mental illness or other issues such as eating disorders, and dementia were also seen as being underrepresented in recovery residences. Feedback on this issue was that their behaviors were often difficult or not a good fit.

One reason offered for the lack of availability for individuals with a mental illness centered upon the importance of taking psychotropic medication to manage their mental illness as prescribed and the negative outcomes associated with stopping taking their medications. Given that most facilities are not licensed to distribute medication, this was seen as outside of their ability to manage. Further, there was concern that residences were not adequately equipped to serve residents who may become violent or who would need additional care/services. In addition, some house managers/owners expressed frustration that individuals with serious mental illness were referred to their house from drug treatment centers knowing they would not be a good fit. Often, there was nowhere else to send these individuals,

and the manager was forced to either accept them or let them leave without housing options.

Another group that was mentioned, though less frequently, were individuals who are on the sex-offender registry. Many recovery residences are located too close to parks, day care center, schools, and other facilities that those on the sex-offender registry are not allowed to live near. It was unclear how many residences allowed individuals on the registry to be a resident and which residences would use that as a disqualifier.

Other groups that were cited as under-represented or difficult to find a good fit for included people with physical disabilities, or who are hard of hearing or visually impaired; the elderly, especially those suffering from dementia or cognitive decline; non-English speakers; and veterans.

General

In addition to the benefits, drawbacks, and challenges discussed above, there were several findings that warrant discussion. These findings tend to center upon the operation and design of recovery residences.

Ideal Management

Respondents frequently discussed the importance of having a house manager who is in recovery as well. These managers are often seen as role models for the residents and they like the fact that the individual both understands what they are experiencing and are also less likely to be able to be deceived by the residents.

While residents prefer managers to be in recovery, that does not mean there is not a place for individuals not in recovery in the world of recovery residences. For instance, one residence was headed by a non-profit board. One board member who does not have a history of a SUD but is well

"We are treated with dignity and respect...makes us feel like we're worth something."

Resident

regarded in the community is highly active in checking in on the state of the

residence and the progress of the residents. Residents felt that the presence of this individual and the care shown to them meant that “they mattered.”

Patient Brokering

Patient brokering occurs when individuals receive compensation from treatment providers for the recruitment or referral of an individual who uses the provider’s services (Government Accountability Office, 2018). A legal scholar paints a concerning picture of “patient brokers” receiving a fee for delivering an individual with a SUD to a short-term treatment facility which then keeps the individual in treatment until their insurance runs out. At this point the treatment facility refers the client to a recovery residence operator. The owner of the recovery residence then charges the individual several months’ rent as a deposit and then evicts him/her quickly for a rule violation (Lieberman, 2018).

According to some participants, patient brokering can occur without nefarious intentions. For example, a recovery residence operator may believe that a certain treatment facility in the community is superior. Because of this, they may require residents to attend that facility for outpatient services. That same facility may unconsciously disproportionately refer patients to the recovery residence due to the frequent interactions with the owner. Neither actor may have pernicious motives; however, the ability of an individual to make their own choices about their health care is restricted. Fortunately, the project team did not encounter evidence of patient brokering at our sites. However, this lack of evidence does not mean that the practice does not occur. Given its prevalence in other states, it warrants continued attention.

Worth noting, this practice is illegal in Texas under Occ. § 102 and Health & Safety § 164, with up to ten years in prison and \$25,000 in fines. The extent to which these laws are being utilized was not discernible. The federal government also made patient brokering illegal in 2018 with the passage of 18 U.S.C. § 220 with a fine of up to \$200,000 and up to ten years in prison per offense.

Conflicts of Interest

Patient brokering often occurs due to conflicts of interest. There are often potential conflicts of interest for owners/operators of recovery residences. For instance, several recovery residences are owned by the same ownership team as a treatment facility. In the facilities we visited, we did not find any evidence of an abuse of the potential conflict of interest—in fact, the rent at these facilities was often low and services high. However, the potential for abuse is present. As an example, in Florida, there were instances of recovery residences being owned by the same individuals who owned medical laboratories. In these cases, urinalyses that residents were required to take were processed through the owner's medical laboratory at a much higher cost than the simple over-the-counter tests many residences utilize (Lieberman, 2018).

That individuals who own rehabilitation facilities would also be interested in running a recovery residence is neither surprising nor necessarily cause for alarm. Some individuals noted starting their recovery residence because they were tired of discharging individuals into environments that challenged their recoveries. Having owners who are also intimately familiar with the recovery process can be an advantage for residents.

Criminal Justice

Many residents we met with had criminal records. They believe that more could be done during incarceration to help those with a SUD find and/or maintain recovery. More prominent, though, were comments regarding the difficulty in paroling into a recovery residency. Several noted mandatory paroling to a formal halfway house and that maintaining their recovery in that environment was difficult. These individuals believe that increasing the number of recovery residences an individual can parole into would be helpful.

Lack of Knowledge

Residents noted that they learned of their recovery residence only after several attempts at recovery. There was a general sense that individuals would access recovery residences earlier if they simply knew they existed and what they offered.

The lack of a directory of recovery residences was also brought up as a barrier to access. Individuals who desired a place like a recovery residence had difficulty locating one as they are often limited to the internet as a resource and many recovery residences do not have websites. In fact, only 13% of residents noted they learned of their recovery residence through the internet. Most indicated they either learned about the residence through family and friends (40%) or through their SUD treatment center (33%).

Medications for Substance Use Disorder

Residents were often silent regarding the use of MSUD. However, when they did speak to it, opinions regarding its legitimacy were mixed. One respondent noted that even though his recovery residence allowed MSUD, he felt peer pressure from fellow residents to stop taking the medication. Another participant noted how difficult it was to find a nice, safe recovery residence for females that allowed MSUD--indicating that these prohibitions likely serve as a barrier to individuals entering into recovery residences. We asked individuals being treated with MSUD to indicate whether they encountered any barriers because of their MSUD prescription.

Figure 7. MSUD-related Barriers Faced by Residents

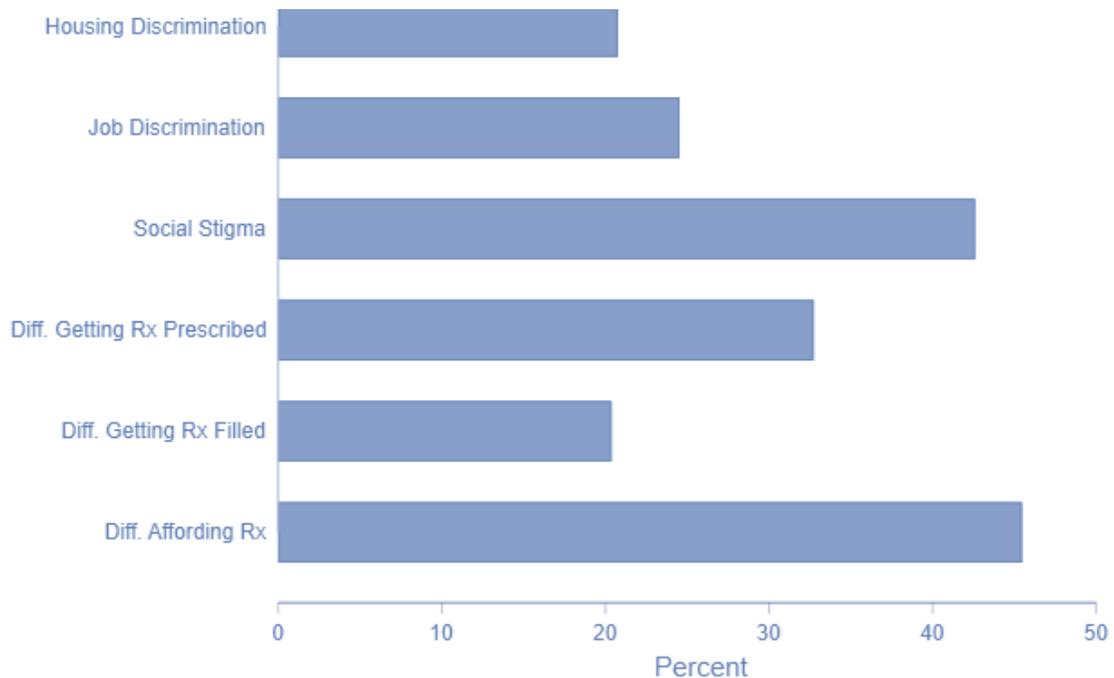


Figure 7 displays their responses. Every barrier offered on the survey was noted by at least 20% of individuals prescribed MSUD, with a high of 45% of respondents noting they had difficulty affording MSUD medications. Also concerning, 43% of people prescribed MSUD indicated they encountered social stigma due to their prescription.

NIMBYism

Despite the overall positive findings regarding recovery residences, the typical public perception of having “group homes” (a term often used for recovery residences by the general public) in one's neighborhood is

“Everybody wants it; they don't want it near them.”

Focus Group Participant

not positive. The common perception from communities and neighborhoods is the common “Not in My Back Yard” (NIMBY) stance—NIMBY typically refers to the sentiment of neighborhoods and communities not wanting crime, lower property values and perceived problems in their neighborhood (Dear, 1992; Kim, 2000).

NIMBYism affects many different industries. Energy production/infrastructure (Carley, Konisky, Atiq, & Land, 2020; Devine-Wright, 2005), prisons (R. Martin & Myers, 2005; Rasmussen, 1992), landfills (Lee, Jones-Lee, & Martin, 1994; Rasmussen, 1992), and affordable housing (Sally, 2013). In Texas, NIMBYism is highlighted as particularly difficult to overcome for recovery residences (TDHCA, 2013).

“Recovery has always had a stigma.”

House Manager

The NIMBY stance raises barriers for people in recovery to access the housing they may need to lead better, healthier, and more stable lives. This is despite many

research studies indicating recovery residences are not only effective at maintaining recovery for people overcoming substance misuse but that most recovery residences are perceived to be good neighbors (Leonard A Jason & Ferrari, 2010; D. L. Polcin, Henderson, Trocki, Evans, & Wittman, 2012).

NARR and Oxford House both advocate for residences to be established in low crime, safe economically stable neighborhoods to minimize opportunities for a return of symptoms, which means the residents also

are generally maintaining positive behaviors and are more vigilant where criminal activity is concerned (NARR, 2012; Oxford House World Services, 2010). Contrary to what one would expect under the NIMBY arguments, recovery residences have very little impact on property values, and the residents are widely considered as good neighbors by those who live nearby (Leonard A. Jason, Roberts, & D.Olson, 2005).

Typically, Level 4 residences are not located in residential neighborhoods, so NIMBYism would not be a barrier like it often is for Level 1, 2 and to some extent Level 3 residences. Some recovery residence operators noted that they received opposition from neighbors when they found out there was a plan to open a recovery residence. Interestingly, most reported that opposition dissipated after the recovery residence operated for some time without causing problems. Several recovery residence operators described hosting “open houses” where they invited neighbors to the house for a meet and greet and to educate them about what was going on at

“A lot of it is just fear and unexplored territory. They don’t know what’s going on in that house, but there’s addicts in there, and it’s gotta be bad.”

Focus Group Participant

“Sober people are good neighbors.”

Focus Group Participant

the residence. These events were described as highly effective in gaining the acceptance of the neighbors. Further, several operators take actions to try and keep a low profile. Nearly all described taking deliberate efforts

to be good neighbors including requiring individuals who wish to sit outside to do so in the backyard when smoking, making sure the lawn stays maintained and keeping noise to a minimum.

Laws

The different levels of recovery residences exist at the intersection of recovery support, clinical services and housing. A recovery residence must adhere to the laws related to these components.

Recovery Support vs. Clinical Services

Often when discussing recovery related services, one assumes clinical services such as those provided by a licensed counselor, nurse, doctor, psychologist, or pharmacist. However, due to the fact that many recovery residences are peer run, the line between clinical treatment and social recovery support may be blurred. Individuals may offer services that should be regulated in an unregulated form while seeking to assist with an individual's recovery. Examples may include providing healthcare (e.g., clinical services, medication administration) or legal advice. Recovery residences may also offer peer-run counseling. It may not be readily apparent to a consumer or an observer whether the peer counselor is a licensed therapist or a fellow resident offering recovery support.

Several residences require strict adherence to any medications prescribed to their tenants. However, due to the operators' lack of medical certifications they are unable to administer medications. A common workaround we observed was to have medications locked up and have the house manager observe the individual take the medication. With this approach they could verify compliance without physically distributing the medications. Other residences would have the individual monitor their adherence to the prescribed schedule but would do audits of how many pills were left compared to what they needed—with too many or too few seen as a violation of house rules.

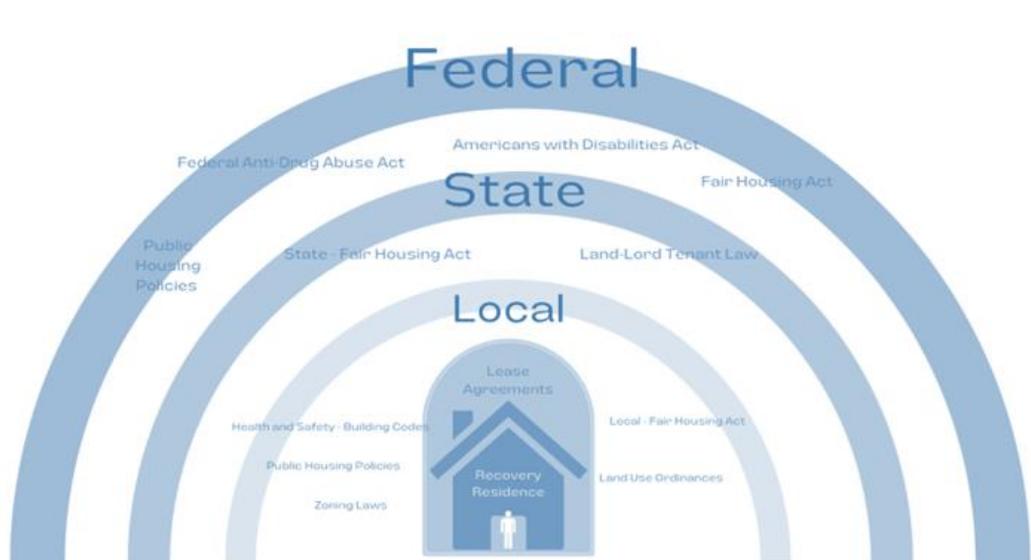
Peer recovery support is one of the key features of recovery residences (D. Polcin et al., 2014). However, the improper delivery of services may jeopardize the credibility of recovery residences (NARR, 2011). Recovery residence leadership must be vigilant in ensuring proper procedures are followed, especially in Level 3 residences—services provided at Level 4 residences should be by licensed clinicians

while Level 1 and 2 residences should not be providing services requiring certifications (D. Polcin et al., 2014).

Housing Laws

Housing laws are layered by the level of government with the federal government having supremacy. State policies must operate within these federal guidelines. Local jurisdictions operate within the constraints placed on them by the state and federal policies. Figure 8 provides a graphical overview of the interaction of laws across levels.

Figure 8. Layers of Housing Laws Relating to Recovery Residences



Housing Laws: Federal

At the Federal level, the Fair Housing Act (FHA), as amended, and the ADA, impact recovery residences. The FHA provides the broadest protections for housing and will thus be discussed here. The FHA makes it illegal to prevent the sale or rental of any housing to an individual based on a variety of factors, including disability (Department of Housing and Urban Development and Department of Justice, 2016). Under case law, it is widely accepted that individuals in recovery from a SUD are considered as persons with a disability under the Act ("Oxford House, Inc. v. Town of Babylon," 1993).

The FHA applies to all types of housing. The law protects persons with a disability from discrimination and ensures they are provided reasonable accommodations to have equal access to housing. The FHA, however, does not preclude landlords/property owners from having tenant selection criteria, so they can deny housing to individuals with prior justice involvement, employment history, poor credit, or past evictions, etc. (Ammann, 2000; Blue & Rosenberg, 2017). This can have a disparate impact on people in recovery as individuals with SUD are overrepresented in unemployment (SAMHSA, 2014), the unhoused (National Coalition for the Homeless, 2009), and the criminal justice system (NIDA, 2020).

When factors are used to prevent housing access correlate with a protected category, they require extra justification. Even without discriminatory intent, decision rules that lead to unfair exclusion are illegal without sufficient rationale (Department of Housing and Urban Development and Department of Justice, 2016). No successful court cases challenging the denial of renting to an individual in recovery from a SUD based on factors such as poor credit history or criminal justice record were found.

Housing Laws: State Level & Local Levels

In 2007, House Bill 216 (TX-86R) amended the Texas Health & Safety Code § 260 (HSC 260) to classify boarding homes as facilities that, among other things, “furnishes, in one or more buildings, lodging to three or more persons with disabilities.” This portion of the code can lead recovery residences to be classified as boarding homes. HSC 260 further allows counties and local jurisdictions to regulate boarding homes and allows for prosecution of a Class B Misdemeanor for operation of a boarding home without registering in compliance with local or county ordinances.

Further, by allowing local governments to regulate recovery residences as boarding homes, HSC 260 provides a mechanism for local decision makers to enact laws that limit the ability of recovery residences to exist. While HSC 260 prohibits municipalities from limiting where a boarding home meeting all local standards can be located, it does provide wide latitude in creating the local standards. However,

HSC 260 includes the qualification that a boarding home provides at least one of several services such as meal preparation or grocery shopping to qualify as a boarding home. The difficulty is in determining what the legal intent of “provides” is. Level 1 and 2 recovery residences will not usually have these services performed by a non-resident. However, if the residents are sharing chores, one could argue the residence is indeed providing the service.

A jurisdiction could make the requirements strict enough to prevent recovery residences from locating in the community at all—either in residential or commercial areas. The Texas Department of Housing & Community Affairs (TDHCA) outlines several alleged instances of restrictive local standards posing significant barriers to recovery residences and limiting their creation (TDHCA, 2013). However, consistent with HSC 260, HHSC has created model boarding house standards (HHSC, 2018). These model standards do not provide apparent roadblocks to recovery houses outside of inspections; however, they do require provision of services that are beyond what a typical Level 1 or 2 recovery residence would provide, such as the provision of three meals a day.

The *Housing Choice Plan* differentiates recovery housing from boarding homes (HHSC Planning Group, 2022). The Housing Choice Plan is a stakeholder-led roadmap for a statewide approach for addressing gaps in housing and support services and policy in the state of Texas. Further, the advocacy organization Recovery People argue that regulation of a recovery residence as a boarding home may violate federal statutes (Savage, 2018). Reports varied widely, depending on where in the State respondents were located, on the topic of being regulated as a boarding home in such a way as to hamper its operation. One example heard in a major metropolitan city was a requirement to include an extensive sprinkler system in the home in order to meet code requirements as a boarding home; thus significantly increasing startup costs.

Even if HSC 260 were amended to exclude recovery residences from boarding home ordinances (or if such regulations were determined to violate federal policy by courts), cities still have another avenue for limiting the presence of recovery

residences. Many local communities enact a maximum number of unrelated individuals that may live in a single-family residence within residential areas (TDHCA, 2013).

Texas Property Code § 92.010 limits statewide the number of adults in a residence to three times the number of bedrooms in most cases. In practice, though, local limits are often much more restrictive. For instance, the cities of Bryan,¹ College Station,² and San Marcos³ limit the number of unrelated adults in a single-family residence to two in at least portions of their communities and many other cities have similar regulations. Most of these ordinances are targeted at limiting the presence of a large number of renters in their neighborhoods (VanHoorelbeke, 1996); however, their effect can be to prevent many recovery residences from freely existing within many communities. If recovery housing is to be available statewide, the ability of local jurisdictions to enact zoning that prevents as few as three unrelated individuals from living together will need to be addressed.

Cities who utilize these unrelated resident ordinances will normally go against established case law. In *Edmonds v. Oxford House, Inc.* (1995), the Supreme Court ruled 6-3 that recovery residences can only be limited in size if the ordinance sets the maximum

numbers of persons who can live in a home regardless of family status. In other words, if single-family residences are

“And so the people up and down the road love us. Our neighbors love us. The city itself seems to be adverse to our growth. They don't want us to grow at all. The problem is, is that we can't do anything but paint our facility without a building permit. So we can't change the tile in the bathroom. We can't fix the showers. We can't do anything without a building permit. And we've had nothing but roadblocks.”

House Manager

1

https://library.municode.com/tx/bryan/codes/code_of_ordinances?nodeId=PTIICOOR_CH13_OZO_ARTIIZODI_S130-31REIGCO

2

https://p1cdn4static.civiclive.com/UserFiles/Servers/Server_12410832/File/Departments/CommServ/ROOHandbook.pdf

³ <https://www.sanmarcostx.gov/DocumentCenter/View/2238/Occupancy-Restrictions-PDF>

limited to nine persons regardless of familial relationship, then recovery residences can be limited to nine residents. However, in this example, a family of ten all related by birth or marriage could not reside in a single-family home (Petrila, 1995).

We did encounter recovery residence operators who noted that cities tried to utilize their limitations on the number of unrelated individuals in a home to shut their property down. However, they noted that referring city officials to the *Edmonds* case was sufficient to halt further action. Further, because we visited operating recovery residences, by definition, we were unable to visit homes that were disallowed by cities through any ordinance and prevented from opening. While clearly the sites we visited were operational; many operators discussed at length the barriers put upon them by their respective city ordinances and/or HOAs that they had to overcome. Focus group participants mentioned city ordinances keeping new facilities from being created.

Federal Funding for Recovery Residences

In 2018 a bipartisan action was signed into law as a form comprehensive opioid legislation known as the "Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act" or the "SUPPORT for Patients and Communities Act" (referred to herein as the "SUPPORT Act"). The SUPPORT Act defined "recovery housing" in federal statute as "a shared living environment free from alcohol and illicit drug use and centered on peer support and connection to services that promote sustained recovery from substance use disorders" ("Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act," 2018).

Using authorization from the SUPPORT Act, the Department of Housing and Urban Development (HUD) is providing funds to 25 states (including the District of Columbia) through the Pilot Recovery Housing Program. The program provides a total of \$25 million per year for up to five years to the participating states on a formula basis to "to provide stable, temporary housing to individuals in recovery from a substance use disorder" for a period of up to two years per individual

(Department of Housing and Urban Development, 2020). Based on the formula outlined in the law, Texas does not receive funds under the program.

Additionally, the SUPPORT Act requires the Secretary of Health and Human Services to develop best practices for recovery housing. The Act provides \$3 million to fund the effort. The Secretary is to work with HUD and other stakeholders and specifically names NARR as a likely stakeholder to consider ("Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act," 2018).

Under the Substance Abuse Prevention and Treatment block grant, the Substance Abuse and Mental Health Services Administration (SAMHSA) provides funds to help prevent and address substance misuse. Under this program, states can provide loans to organizations starting recovery residences. Under the terms of the block grant, Level 1 residences are the ones most likely to be eligible for the loans. Texas has utilized this block grant (in addition to state funds) to provide loans and support to Oxford Houses (Government Accountability Office, 2018).

Important to note that SAMHSA also delineates that "substance-free" does not mean the prohibition of prescribed medications taken appropriately, for treatment of opioid use disorder or other medically related treatments (SAMHSA, 2018).

Licensure/Certification

NARR identifies the four types of residences, as explained previously, and the support services typically provided under each level of residence. While there are federal regulations covering many recovery services—from clinicians to pharmacology recovery residences lack extensive federal regulations beyond those associated with treatments provided by regulated clinicians.

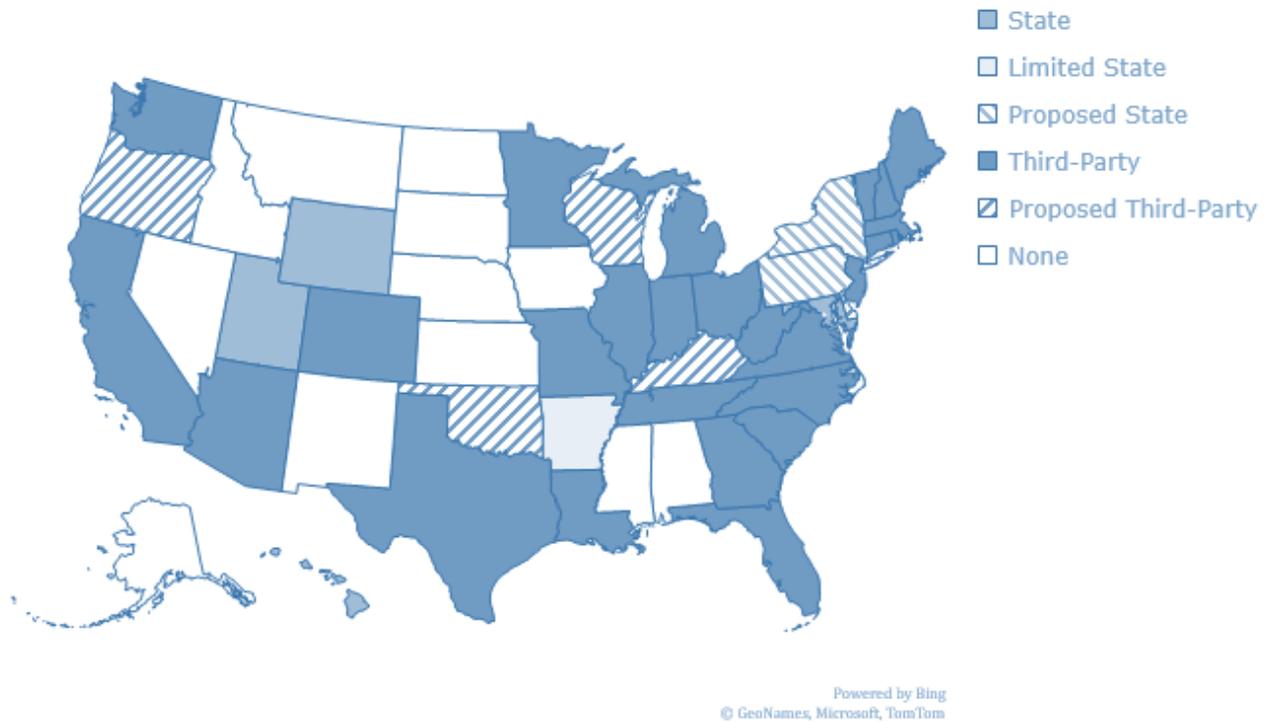
Many states have been slow to require certifications of recovery residences. As shown in Figure 9 only five states have state licensing of recovery residences. However, twenty-six states have third party accreditation of recovery residences available, with the NARR guidelines being the benchmark for standards utilized. NARR guidelines prohibit patient brokering. This leaves recovery residences in

nineteen states without the ability to be licensed or accredited (E. Martin, McKinney, Razavi, & Burnham, 2020).

Even when licensure/accreditation is available, it may not be required for a recovery residence to operate. For instance, in Florida and Massachusetts recovery residences can function without certification; however, a state-funded treatment facility cannot refer an individual to a home that lacks the certification. Indiana, Maryland, Pennsylvania, and Rhode Island have the same regulations as Florida and Massachusetts but also add a restriction that non-certified residences cannot receive state funds. New Jersey and Utah require certification of recovery residences in order to operate (Criss, Molloy, Poliin, Post, & Sheridan, n.d.).

The legal ability of states requiring licensure of recovery residences is debatable. The FHA prohibits practices that limit the ability of individuals with disabilities from accessing housing; the same housing as those without disabilities (Department of Housing and Urban Development and Department of Justice, 2016). Some argue the requirement for a recovery residence to obtain licensing limits this ability (Savage, 2018; Singh, 2018).

Figure 9. Licensure/Certification Policies by State



Created with data from (E. Martin et al., 2020).

When asked their thoughts on state regulation/monitoring of recovery residences; participants often had strong opinions or seemed unsure, often seeming to change course during the discussion. While a few respondents held fast to their belief that there should be absolutely no State oversight, there was agreement among most that basic safety standards should be in place. There was an often-conflicting idea that respondents wanted some kind of standard for a place to be considered a recovery residence; (for example, limiting the number of people in a bedroom, requiring the absence of drugs and alcohol in the house, and making sure residents were not harmed) while at the same time being able to operate the way they wanted to without “interference” from the state. When probed further, many respondents agreed that having a third-party, voluntary licensure such as NARR was a good idea. Finally, the overwhelming

“There should be a black-and-white set of rules like in the military. We need a basic standard of care that everyone follows”

House Manager

majority agreed that if the state were to impose regulation, there should be individuals in recovery included in the decision-making process at every step and that regulation should not put an undue burden in terms of cost or time on the residence operator.

Recommendations

Through literature review, site visits, focus groups and interviews we found convincing evidence that recovery residences are positive resources available for individuals seeking to maintain long-term recovery increasing the odds of success significantly. Areas of the law, and by extension administration, that limit the ability of recovery residences to expand in Texas were discussed. Recovery residences were found to be positive institutions within local communities that bring more benefits than they do costs.

The individuals that participated were passionate about the recovery community and many respondents at all levels were individuals in recovery. When asked their thoughts on the most important aspect of a good recovery residence; the most common response was that people in recovery be involved at every level. While there was not a consensus regarding state regulation; there was some agreement that a standard of care needed to be set.

Despite the need for more recovery housing, especially for underserved populations, operators are reluctant to expand, and new operators are few. The main reasons discussed for this lack of supply are the high startup costs involved and the difficulty in navigating unwelcoming city ordinances and restrictive HOAs.

We found that neighbors were often opposed to the opening of recovery residences; however, they normally came to view the residents as a positive fixture of the neighborhood.

Define Recovery Residences

To properly address issues surrounding recovery residences, clarity on what constitutes one is necessary. The definition provided in H.B. 707 serves as a solid

foundation: “shared living environment that promotes sustained recovery from substance use disorders by integrating residents into the surrounding community and providing a setting that connects residents to supports and services promoting sustained recovery from substance use disorders, is centered on peer support, and is free from alcohol and drug use.”

HSC 260 should also be amended to expressly address recovery residences. Given the legal uncertainty of regulating recovery residences as boarding homes under federal law, we recommend that HSC 260 specifically exclude recovery residences from the definition of a boarding home. The ability for communities to classify recovery residences as a boarding home provides an ability to greatly limit the presence of these facilities in their areas and can serve as a serious administrative barrier to the creation of facilities statewide.

Establish Baseline Requirements

The State should set minimum standards for recovery residences. These standards should be focused on safety and ethics. For instance, limits on the number of tenants that can be housed per square foot, and minimum plumbing standards can help protect the residents’ health and safety without limiting the ability of operators to design their programs. Further, basic ethical standards such as prohibitions on patient brokering and assurances of an individual’s ability to leave the residence voluntarily.

To accomplish this, recovery residences need to be clearly defined in statute; in particular, they need to be differentiated from residential rehabilitation facilities and boarding homes. In addition, individuals should have the ability to report violations of state policies to officials.

Implement a Certification Process

Because most recovery residences do not provide clinical services, there have not been any licensing or certification requirements. This lack of credentialing leaves individuals without an objective validation that the residence will be operated in the best interests of the resident as well as the community at large.

Rather than create the specific parameters for certification or creating a new agency for certification purposes, many states have opted to utilize NARR and Oxford House International as third-party certifiers of recovery residences. NARR has an existing set of standards that focus upon the safety of the residence and the ethical operations of the residence (NARR, 2015). OHI also has a published framework for residences operating under the OHI banner (OHI, 2017). Given the uniqueness of Oxford Houses, separate certification procedures are advisable.

Many recovery residence operators suggested they preferred a third-party to certify recovery residences; residents were even stronger in their belief that a third party would be better. Further, residents expressed their belief that having

“Needs to be people with addiction on regulation board.”
Resident

individuals in recovery on whatever governing board used was imperative as they were believed to be able to better understand the needs of people in recovery.

Given the variety of models of recovery residences, the certification process should focus on issues of safety and ethics. Matters related to house rules such as curfews, meeting attendance, and leadership structure should be left to the residence—this was a near unanimous feeling among both operators and residents. Leaving program design to the operators is important unless the State is prepared to have residences either avoid certification or halt operations altogether.

Many states have made certifications of recovery residences optional. In fact, the National Council for Behavioral Health and NARR recommend that states begin with optional certification (Criss et al., n.d.). Having certifications as voluntary was also viewed favorably by most operators and residents we interacted with. Our recommendation is that the certification process be voluntary.

In an environment where there are many recovery residences, those that are certified provide potential residents and their families with assurances that, at a minimum, the residence is safe and run ethically.

The state can incentivize voluntary certification by limiting certain benefits to recovery residences that are certified to encourage certification.

Conflicts of interest

As discussed previously, individuals who own/operate recovery residences often also own/operate other facilities that may pose a conflict of interest. These individuals, though, often open a recovery residence because of their specialized expertise and/or their desire to help individuals achieve and maintain recovery. For residences seeking certification where this is a potential issue, the individuals should disclose to the certification team the potential conflicts and address how they will operate the residences in such a way as to not negatively impact the residents. Whether a residence is certified or not, the operator should note all potential conflicts of interest and provide tenants with the ability to seek clinical services from a provider of their own choosing.

Property Damage Protection

Stakeholders frequently mentioned that finding homes to rent becomes especially difficult once the property owner learns of the intended use. Further, property owners who will rent to recovery residences often charge a substantial premium. Presumably, this is the result of property owners who believe that recovery residences pose too great a risk to their properties and would either believe they must be compensated for the risk or simply wait for other tenants to occupy their properties.

A potentially low-cost mechanism to address this situation is to offer property owners who lease to recovery residences access to property owner property damage protection that cover tenant damage to complement traditional insurance policies, which often have limitations related to damage caused by tenants. If the protection covers replacement value rather than actual (depreciated) value, a primary obstacle to renting to recovery residences is eliminated. The protection can become more attractive by including loss of rental income coverage if the owner is unable to lease the property while repairs are being made.

Limited Immunity

Property owners are legally responsible for some of the behavior of their tenants. For instance, if drugs are dealt from a residence, a property owner may be culpable as well in certain circumstances. When using a property manager, the landlord's legal responsibility does not change (United States Department of Justice, 2021). Given that tenants in a recovery residence are screened by a residence manager, a board, and/or the residents, the property owner does not have the ability to screen tenants (and for them to have that ability would interfere with the design, and likely effectiveness, of recovery residences).

Recovery residences are proactive in policing the behavior of their residents and rarely tolerate socially undesirable behavior, so the actual risk to the property owner is likely minimized; however, owner's preconceived notions about individuals in recovery may still prevent them from renting to recovery residences due to fear they will be more likely to put the owner in legal peril. Given this, some property owners may be hesitant to lease to a recovery residence. This is especially true when dealing with individuals who have biases against individuals in recovery. Providing property owners immunity of civil and criminal responsibilities related to the selection of tenants could ease this concern. Immunity should be limited to certified recovery residences. Of course, the State cannot provide this immunity where the federal government is concerned but can mitigate a substantial portion of risk.

Interim Certification

While certification can prove to be helpful to both the state and facilities, tying access to any benefits offered to certified facilities may prevent new recovery residences from opening due to the inability to earn certifications prior to their opening. To accommodate for this, potential facilities should be able to submit plans to the certifying organization for preliminary approval, which will provide probationary access to appropriate benefits. This interim certification should have an expiration date to prevent the program being used to circumvent the legitimate certification process. Property owners accepting benefits such as insurance offered

because of the preliminary certifications should be able to maintain these benefits for the earlier of a year or the end of the lease.

Providing Naloxone

Naloxone is an opioid antagonist that can help restore normal breathing when slowed due to an overdose of opioids (National Institute on Drug Abuse, 2022). Importantly, Naloxone does not have a negative effect when given to an individual who is not experiencing an opioid overdose. Further, members of the public can be trained to administer Naloxone.

Many individuals living in a recovery residence have opioid use disorder. While the goal of living in the recovery residence is to maintain their recovery, individuals may see a return of symptoms. Given this, recovery residences should be offered free Naloxone and be required to keep an adequate supply on hand. All residents should be trained to administer Naloxone within the first few weeks of moving in.

In February 2022, Texas reached a settlement with Teva Pharmaceuticals over Teva's contribution to the opioid epidemic in the state. As part of the settlement, Teva will provide \$75 million worth of Narcan (a name brand Naloxone) to the state (Larson & Feeley, 2022; Paxton, 2022). Because of this, the state can provide recovery residences with Naloxone without a substantial appropriation of finances.

Work with Texas Department of Criminal Justice (TDCJ)

Often, individuals leaving TDCJ are in recovery from a SUD. Unfortunately, many of these individuals do not have families that are willing and/or able to serve as an address for them to parole too. For these parolees, a halfway house is often the only option they have. As discussed previously, many individuals believe their recovery would have been better supported by living in a recovery residence rather than a halfway house.

HHSC and TDCJ should meet to discuss the merits of allowing individuals to parole to a certified recovery residence. There are a few residences that specialize in housing individuals exiting TDCJ and can serve as examples for both agencies to

explore. Of course, TDCJ should make decisions consistent with public safety; however, the increased use of recovery residences can help reduce the occupancy burden of halfway houses while improving parolees' maintenance of recovery. As recovery is maintained, public safety should also improve as well.

Revolving Loan

Currently, the state operates a revolving loan program to help Oxford Houses form. The loans are quite small (up to \$4,000) and must be repaid within two years. A similar program should be created for non-Oxford House recovery residences seeking to open. Given the loans are both small and required to be repaid, the fiscal impact on the state should be minimal. These loans should also be available to residences that are making modifications to their properties that bring the site up to ADA standards, opening access to individuals with limited mobility.

Technical Assistance

There are many factors to consider when opening a recovery residence. The magnitude of decisions may be enough to keep an individual or organization from opening a recovery residence. To encourage the creation of new recovery residences, technical assistance should be provided at no cost to individuals. Technical assistance would also be of use to existing recovery residences as they encounter issues during operation. This service could either be provided by HHSC or contracted with a third party.

Improving Access

While there is consensus that there is a need for more recovery residences in general; there was agreement among stakeholders that financial barriers exist. One potential solution is to offer short-term scholarships to individuals who do not have the financial resources to move into a recovery residence. This could also be a mechanism to increase access to underserved segments of the population. Special attention should be given to the needs of parents with children as the rent for these facilities must either be subsidized or higher than comparable residences due to the inability to share rooms with another adult.

Conclusion

This report has presented the results of an evaluation of the current status of recovery residences, and the opportunities for expansion, the challenges related to that expansion, and the need to do so. The report identifies regulatory deficiencies at the state and federal level and how they affect recovery housing and, by extension, local governments, and surrounding communities. The discussion is based upon the results of a review of scholarly literature, interviews with stakeholders and experts, site visits, and focus groups. Attention was paid to models of varying design and urbanicity. The report concludes with a series of recommendations for consideration by the Texas Legislature, HHSC, and other relevant actors.

1. Works Cited

- Ammann, J. J. (2000). Housing out the Poor. *St. Louis U. Pub. L. Rev.*, 19, 309.
- Ashford, R. D., Brown, A. M., & Curtis, B. (2018). Substance use, recovery, and linguistics: The impact of word choice on explicit and implicit bias. *Drug and Alcohol Dependence*, 189, 131-138. doi:10.1016/j.drugalcdep.2018.05.005
- Blue, S. C., & Rosenberg, L. (2017). *Recovery Housing Issue Brief: Information for State Policymakers*. Retrieved from Washington, DC:
https://narronline.org/wp-content/uploads/2017/09/Recovery-Housing-Issue-Brief_May-2017.pdf
- Borkman, T. J., Kaskutas, L. A., Room, J., Bryan, K., & Barrows, D. (1998). An historical and developmental analysis of social model programs. *J Subst Abuse Treat*, 15(1), 7-17. doi:10.1016/s0740-5472(97)00244-4
- Bryce, B.-A., Ciancio, A., Gaumond, P., Gibson, K., Howell, J., Johnson, A., . . . Way, F. (2021). *Model Recovery Residence Certification Act*. Retrieved from Washington, DC:
- Carley, S., Konisky, D. M., Atiq, Z., & Land, N. (2020). Energy infrastructure, NIMBYism, and public opinion: a systematic literature review of three decades of empirical survey literature. *Environmental Research Letters*, 15(9), 093007.
- Criss, L., Molloy, P., Poliin, S. G., Post, R., & Sheridan, D. M. (n.d.). *Building Recovery: State Policy Guide for Supporting Recovery Housing*. Retrieved from
https://www.healthvermont.gov/sites/default/files/documents/pdf/State%20policy%20guide%20for%20Recovery%20Housing_0.pdf
- De Leon, G. (1990). The Therapeutic Community and Behavioral Science. *International Journal of the Addictions*, 25(sup12), 1537-1557. doi:10.3109/10826089009088559
- De Leon, G. (2000). The therapeutic community: Theory, model, and method.
- Dear, M. (1992). Understanding and Overcoming the NIMBY Syndrome. *Journal of the American Planning Association*, 58(3), 288-300. doi:10.1080/01944369208975808
- Notice of FY2020 Allocations, Waivers, and Alternative Requirements for the Pilot Recovery Housing Program, (2020).
- Department of Housing and Urban Development and Department of Justice. (2016). *Joint Statement of the Department of Housing and Urban Development and Department of Justice: State and Local Land Use Laws and Practices and the Application of the Fair Housing Act*. Washington, DC Retrieved from
<https://www.justice.gov/opa/file/912366/download>
- Devine-Wright, P. (2005). Beyond NIMBYism: towards an integrated framework for understanding public perceptions of wind energy. *Wind Energy*, 8(2), 125-139. doi:10.1002/we.124
- Doogan, N. J., Light, J. M., Stevens, E. B., & Jason, L. A. (2019). Quality of life as a predictor of social relationships in Oxford House. *Journal of Substance Abuse Treatment*, 101, 79-87. doi:10.1016/j.jsat.2019.03.006
- French, M. T., McCollister, K. E., Sacks, S., McKendrick, K., & De Leon, G. (2002). Benefit-cost analysis of a modified therapeutic community for mentally ill

- chemical abusers. *Evaluation and Program Planning*, 25(2), 137-148.
doi:10.1016/s0149-7189(02)00006-x
- French, M. T., Sacks, S., De Leon, G., Staines, G., & McKendrick, K. (1999). Modified therapeutic community for mentally ill chemical abusers: outcomes and costs. *Eval Health Prof*, 22(1), 60-85.
doi:10.1177/016327879902200104
- Government Accountability Office. (2018). *Substance Use Disorder: Information on Recovery Housing Prevalence, Selected States' Oversight, and Funding*. Retrieved from <https://www.gao.gov/assets/gao-18-315.pdf>
- HHSC. (2018). *Boardng Homes Facilities Report*. Austin, TX Retrieved from <https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2018/hb216-boardng-homes-facilities-dec-2018.pdf>
- HHSC Planning Group. (2022). *Housing Choice Plan*. Retrieved from <https://www.hhs.texas.gov/sites/default/files/documents/housing-choice-plan-report.pdf>
- Jason, L. A., Bobak, T. J., O'Brien, J., & Majer, J. M. (2022). Recovery homes coping with COVID-19. *J Prev Interv Community*, 50(2), 151-162.
doi:10.1080/10852352.2021.1934941
- Jason, L. A., & Ferrari, J. R. (2010). Oxford house recovery homes: Characteristics and effectiveness. *Psychological services*, 7(2), 92.
- Jason, L. A., Olson, B. D., Ferrari, J. R., & Lo Sasso, A. T. (2006). Communal housing settings enhance substance abuse recovery. *Am J Public Health*, 96(10), 1727-1729. doi:10.2105/AJPH.2005.070839
- Jason, L. A., Olson, B. D., Ferrari, J. R., Majer, J. M., Alvarez, J., & Stout, J. (2007). An examination of main and interactive effects of substance abuse recovery housing on multiple indicators of adjustment. *Addiction*, 102(7), 1114-1121. doi:10.1111/j.1360-0443.2007.01846.x
- Jason, L. A., Olson, B. D., & Harvey, R. (2015). Evaluating Alternative Aftercare Models for Ex-Offenders. *Journal of Drug Issues*, 45(1), 53-68.
doi:10.1177/0022042614552019
- Jason, L. A., Roberts, K., & D.Olson, B. (2005). Attitudes toward recovery homes and residents: Does proximity make a difference? *Journal of Community Psychology*, 33(5), 529-535. doi:10.1002/jcop.20073
- Jerry, J. M., & Collins, G. B. (2013). Medication-assisted treatment of opiate dependence is gaining favor. *Cleve Clin J Med*, 80(6), 345-349.
doi:10.3949/ccjm.80a.12181
- Kim, D. S. (2000). Another look at the NIMBY phenomenon. *Health Soc Work*, 25(2), 146-148. doi:10.1093/hsw/25.2.146
- Larson, E., & Feeley, J. (2022). Teva's \$225 Million Opioid Deal With Texas Is Its Biggest. *Bloomberg*. Retrieved from <https://www.bloomberg.com/news/articles/2022-02-07/teva-agrees-to-225-million-texas-opioid-settlement-ag-says>
- Lee, G. F., Jones-Lee, A., & Martin, F. (1994). Landfill NIMBY and Systems Engineering: A Paradigm for Urban Planning. *INCOSE International Symposium*, 4(1), 924-931. doi:10.1002/j.2334-5837.1994.tb01811.x

- Legal Action Center. (2009). Know your rights: Rights for individuals on Medication-assisted Treatment. HHS Publication No.(SMA) 09-4449. Rockville, MD: Center for Substance Abuse Treatment. *Substance Abuse and Mental Health Services Administration*.
- Liberman, D. L. (2018). Not Too Sunny in the Sunshine State: The Need to Improve Florida's Opioid Abuse Treatment Centers to Combat the National Public Health Crisis. *Geo. J. Legal Ethics, 31*, 723.
- Livingston, J. D., Milne, T., Fang, M. L., & Amari, E. (2012). The effectiveness of interventions for reducing stigma related to substance use disorders: a systematic review. *Addiction, 107*(1), 39-50. doi:10.1111/j.1360-0443.2011.03601.x
- Lo Sasso, A. T., Byro, E., Jason, L. A., Ferrari, J. R., & Olson, B. (2012). Benefits and costs associated with mutual-help community-based recovery homes: The Oxford House model. *Eval Program Plann, 35*(1), 47-53. doi:10.1016/j.evalprogplan.2011.06.006
- Majer, J. M., Beasley, C., Stecker, E., Bobak, T. J., Norris, J., Nguyen, H. M., . . . Jason, L. A. (2018). Oxford House Residents' Attitudes Toward Medication Assisted Treatment Use in Fellow Residents. *Community Ment Health J, 54*(5), 571-577. doi:10.1007/s10597-017-0218-4
- Martin, E., McKinney, K., Razavi, M., & Burnham, V. (2020). *National Overview of Recovery Housing Accreditation Legislation and Licensing*. Retrieved from https://mhacbo.org/media/filer_public/2e/fd/2efd1a20-9558-4329-8683-0e2367cbbc2b/nationaloverviewrecoveryhousingjanuary2020.pdf
- Martin, R., & Myers, D. L. (2005). Public response to prison siting: Perceptions of impact on crime and safety. *Criminal Justice and Behavior, 32*(2), 143-171.
- Martin, S. S., Butzin, C. A., & Inciardi, J. A. (1995). Assessment of a Multistage Therapeutic Community for Drug-Involved Offenders. *Journal of Psychoactive Drugs, 27*(1), 109-116. doi:10.1080/02791072.1995.10471679
- McKay, J. R. (2009). Continuing care research: What we have learned and where we are going. *Journal of Substance Abuse Treatment, 36*(2), 131-145. doi:10.1016/j.jsat.2008.10.004
- Mericle, A. A. (2014). The role of social networks in recovery from alcohol and drug abuse. *Am J Drug Alcohol Abuse, 40*(3), 179-180. doi:10.3109/00952990.2013.875553
- Mericle, A. A., & Miles, J. (2017). Quality of life and the complex needs of recovery home residents. *Subst Abus, 38*(3), 309-316. doi:10.1080/08897077.2016.1213780
- Mericle, A. A., Miles, J., & Cacciola, J. (2015). A critical component of the continuum of care for substance use disorders: recovery homes in Philadelphia. *J Psychoactive Drugs, 47*(1), 80-90. doi:10.1080/02791072.2014.976726
- Mericle, A. A., Miles, J., Cacciola, J., & Howell, J. (2014). Adherence to the social model approach in Philadelphia recovery homes. *International Journal of Self-Help & Self-Care, 8*(2).
- Mericle, A. A., Polcin, D. L., Hemberg, J., & Miles, J. (2017). Recovery Housing: Evolving Models to Address Resident Needs. *J Psychoactive Drugs, 49*(4), 352-361. doi:10.1080/02791072.2017.1342154

- NARR. (2011). *An Introduction and Membership Invitation from the National Association of Recovery Residences*. Retrieved from Atlanta, GA: <https://narronline.org/wp-content/uploads/2013/09/NARR-White-Paper-111006-final.pdf>
- NARR. (2012). *A Primer on Recovery Residences*. Retrieved from Atlanta, GA: <https://narronline.org/wp-content/uploads/2014/06/Primer-on-Recovery-Residences-09-20-2012a.pdf>
- NARR. (n.d.). *Helping Recovery Residences Adapt to Support People with Medication-Assisted Recovery*. Retrieved from https://narronline.org/wp-content/uploads/2019/03/NARR-C4-NCBH_MAR-RH-Brief.pdf
- NARR (Ed.) (2015). *Recovery Residence Quality Standards*. St. Paul, Mn: National Alliance for Recovery Residences.
- National Coalition for the Homeless. (2009). *Substance Abuse and Homelessness*. Retrieved from Washington, DC:
- National Institute on Drug Abuse. (2022). *Naloxone DrugFacts*. Washington, DC Retrieved from <https://nida.nih.gov/publications/drugfacts/naloxone>
- NIDA. (2020). Criminal Justice DrugFacts. *DrugFacts*.
- OHI. (2017). *Oxford House Manual*. Retrieved from <https://www.oxfordhouse.org/doc/BasicManual2017.pdf>
- Oxford House, Inc. (2021). *Oxford House, Inc. Annual Report FY2021*. Retrieved from Silver Spring, MD: <https://oxfordhouse.org/doc/ar2021.pdf>
- Oxford House World Services. (2010). *Oxford House-The Model*. Retrieved from Silver Springs, MD: <https://www.oxfordhouse.org/doc/themodel.pdf>
- Oxford House, Inc. v. Town of Babylon, No. CV 91-3591 (E.D.N.Y. 1993).
- Paxton, K. (2022). *Global Opioid Settlement*. Austin, TX Retrieved from <https://www.texasattorneygeneral.gov/globalopioidsettlement>
- Petrila, J. (1995). The Supreme Court's ruling in Edmonds v. Oxford house: implications for group homes. *Psychiatr Serv, 46*(10), 1011-1012. doi:10.1176/ps.46.10.1011
- Petteruti, A., & Walsh, N. (2008). *Jailing communities: The impact of jail expansion and effective public safety strategies*. Washington, DC: Justice Policy Institute.
- Polcin, D., Mericle, A., Howell, J., Sheridan, D., & Christensen, J. (2014). Maximizing social model principles in residential recovery settings. *Journal of Psychoactive Drugs, 46*(5), 436-443. doi:10.1080/02791072.2014.960112
- Polcin, D. L., Henderson, D., Trocki, K., Evans, K., & Wittman, F. (2012). Community Context of Sober Living Houses. *Addict Res Theory, 20*(6), 480-491. doi:10.3109/16066359.2012.665967
- Polcin, D. L., Korcha, R., Bond, J., & Galloway, G. (2010). What did we learn from our study on sober living houses and where do we go from here? *J Psychoactive Drugs, 42*(4), 425-433. doi:10.1080/02791072.2010.10400705
- Rasmussen, T. H. (1992). Not in my backyard: The politics of siting prisons, landfills, and incinerators. *State & Local Government Review, 128-134*.
- Robertson, A. G., Easter, M. M., Lin, H., Frisman, L. K., Swanson, J. W., & Swartz, M. S. (2018). Medication-assisted treatment for alcohol-dependent adults with serious mental illness and criminal justice involvement: effects on

- treatment utilization and outcomes. *American Journal of Psychiatry*, 175(7), 665-673.
- SAMHSA. (2014). *10.8 Million Full-Time Workers Have a Substance Use Disorder*. Retrieved from Washington, DC: <https://www.samhsa.gov/data/sites/default/files/NSDUH-SP132-FullTime-2014/NSDUH-SP132-FullTime-2014.htm>
- SAMHSA. (2018). *Recovery Housing: Best Practices and Suggested Guidelines*. Washington, DC Retrieved from <https://www.samhsa.gov/sites/default/files/housing-best-practices-100819.pdf>
- Savage, K. (2018). *Fair Housing Legal Protections for Recovery Housing*. Retrieved from Austin, TX: <https://recoverypeople.org/wp-content/uploads/2020/07/Fair-Housing-Legal-Protections-For-Recovery-Housing-Savage-2018-.pdf>
- Scally, C. P. (2013). The Nuances of NIMBY. *Urban Affairs Review*, 49(5), 718-747. doi:10.1177/1078087412469341
- Singh, L. (2018). Federal, state sober-living regulations intersect: The Fair Housing Act and Americans with Disabilities Act are two federal laws that prevent discriminatory housing practices. *Behavioral Healthcare Executive*, 38(3), 10-12.
- Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, (2018).
- TDHCA. (2013). *State of Texas Plan for Fair Housing Choice*, . Retrieved from Austin, TX: <https://www.tdhca.state.tx.us/fair-housing/docs/DRAFT-FairHousingChoice-AI-Phase2.pdf>
- The Society For Community, R. (2013). The Role of Recovery Residences in Promoting Long-Term Addiction Recovery. *American Journal of Community Psychology*, 52(3-4), 406-411. doi:10.1007/s10464-013-9602-6
- Timko, C., Schultz, N. R., Cucciare, M. A., Vittorio, L., & Garrison-Diehn, C. (2016). Retention in medication-assisted treatment for opiate dependence: a systematic review. *Journal of addictive diseases*, 35(1), 22-35.
- United States Department of Justice. (2021). *Combating Drug Trafficking in Our Communities: A Landlord's Role*. Retrieved from <https://www.justice.gov/usao-vt/combating-drug-trafficking-our-communities-landlord-s-role>
- VanHoorelbeke, J. (1996). Civil Rights-Zoning and Planning-Zoning Provisions That Govern Areas Zoned for Single-Family Dwellings, Defining Family as Persons Related by Genetics, Adoption, Marriage or a Group of Five or Fewer Unrelated Persons, Describe Those Which May Compose a Family Unit, and are Not Exempt as a Maximum Occupancy Provision under the Fair Housing Act. *U. Det. Mercy L. Rev.*, 74, 135.
- White, W. L., Kelly, J. F., & Roth, J. D. (2012). New addiction-recovery support institutions: Mobilizing support beyond professional addiction treatment and recovery mutual aid. *Journal of Groups in Addiction & Recovery*, 7(2-4), 297-317.
- Wittman, F. D., Jee, B., Polcin, D. L., & Henderson, D. (2014). The Setting is the Service: How the Architecture of Sober Living Residences Supports

Community-Based Recovery. *International Journal of Self Help and Self Care*,
8(2), 189-225. doi:10.2190/sh.8.2.d

List of Acronyms

AA	Alcoholics Anonymous
ADA	Americans with Disabilities Act
COVID-19	Coronavirus Disease 2019
CR	Celebrate Recovery
FHA	Fair Housing Act
GED	General Educational Development tests (aka. High school equivalency tests)
H.B.	House Bill
HOA	Homeowners' Association
HHSC	Health and Human Services Commission
HSC	Health and Safety Code
HUD	United States Department of Housing and Urban Development
LGBTQ+	Lesbian, gay, bisexual, transgender, queer, and others.
MSUD	Medications for substance use disorder
NA	Narcotics Anonymous
NARR	National Alliance for Recovery Residences
NIDA	National Institute on Drug Abuse
NIMBY	Not in My Back Yard
OHI	Oxford House, Inc.
PSAA	Department of Public Service and Administration
SAMHSA	Substance Abuse and Mental Health Services

Administration

SLH Sober Living Houses

SNAP Supplemental Nutrition Assistance Program

SUD Substance Use Disorder

SUPPORT Act Substance Use-Disorder Prevention that Promotes Opioid
Recovery and Treatment for Patients and Communities Act

TC Therapeutic Community

TDCJ Texas Department of Criminal Justice

TDHCA Texas Department of Housing and Community Affairs