

**TESTIMONY  
OF  
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PERSON IN SUSTAINED RECOVERY FROM AN OPIOID USE DISORDER  
RECOVERY ADVOCATE, FACING ADDICTION WITH NCADD**

**BEFORE THE  
SUBCOMMITTEE ON HEALTH  
COMMITTEE ON ENERGY AND COMMERCE  
U.S. HOUSE OF REPRESENTATIVES**

**“Combatting the Opioid Crisis: Prevention and Public Health Solutions.”**

**MARCH 22, 2018**

**Testimony of Ryan Hampton, Facing Addiction with NCADD**

**in Support of H.R. 4684:**

**“Ensuring Access to Quality Sober Living Act”**

U.S. House Energy and Commerce Subcommittee on Health

March 22, 2018

Mr. Chairman, Ranking Member Green, members of the committee: my name is Ryan Hampton and I'd like to thank the committee for inviting me to testify today on H.R. 4684 – the “Ensuring Access to Quality Sober Living Act.” As a person in sustained recovery from an opioid use disorder, an advocate, and a member of the recovery community, it is an honor to speak about the impact that H.R. 4684 will have on Americans with substance use disorder. It's meaningful that you've included people in recovery at policymaking tables, so my testimony today feels empowering.

**A little about me.**

I first became addicted to opioids after a doctor gave me a prescription for painkillers following a hiking injury. I spent a decade struggling with an addiction to heroin. The person you see standing in front of you today is in remission in spite of the broken system we have in place. I have been sober for over three years, yet I tried for much longer to access the limited number of tools available to indigent people with substance use disorder.

For years, when I was in active addiction, I went to free support groups at treatment centers, ate soup and sandwiches at homeless shelters, and put my name on dozens of addiction treatment waiting lists. I had no money, no insurance. No matter where I turned, the answer was usually, “Sorry, we can't do anything for you.” At one program, after I'd broken down in front of the director, begging for help, they finally said they could help me. The director took out a thick ringed binder and opened it: it was the treatment

center's waiting list. He said he could put my name on the list, last, after hundreds of other people. I remember realizing how hopeless my situation was. What if I died before my number came up? What if my phone was disconnected? What if I missed the call? I called addiction programs every day. There were no places for people like me, who lacked money, insurance, and family to fall back on.

I did get some help from the free recovery resources I could find. 12 Step meetings, free meals, and low-income or publicly funded facilities provided me with just enough support to keep trying. Few offered same-day services: most were assessment-only. I knew I was deeply sick, and that I would need medication and professional intervention. Surviving until I got the opportunity to get treatment was crucial for a heroin user like me. Then, after I got into a treatment center, I needed help re-entering everyday life. I needed a long term, safe, sober living situation that facilitated my recovery. I didn't need much to stay sober, but the things I needed were absolutely not negotiable.

I needed housing, medical care, and a supportive peer network, and a low barrier to access those things. I needed help, acceptance, and a path out of my addiction.

Along the way, I learned what *didn't* work. Long waiting lists, abstinence requirements for housing, unscrupulous house managers, and unethical treatment practices all undermined my recovery. Some facilities discriminate against harm reduction measures by refusing to stock naloxone. Others will not allow people who use medication assisted treatment. If you're on methadone, you may be unwelcome. That's a barrier to access, and it kills. I, and many of the people I knew, failed to find a safe place to live, or had a single relapse and were forced back into homelessness. The stigma of addiction was reinforced by the very people who were supposed to be helping us. Many of those people are dead now, because the help they needed was withheld.

Even someone as determined and desperate as me struggled to get help. I went through multiple treatment centers, detoxes, and sober living homes before I was able to finally find sustained recovery. My struggle was the result of trying to navigate a fractured system on my own, with no resources and no guide. I truly wanted to recover, and so did most of the people I knew. Yet, I am here today and many of the people I have met on my journey are still out using, or dead.

- Recovery should not be dependent on luck.

### **Once I knew I needed help, I faced a huge challenge.**

High costs and long waiting lists shut me out of treatment for years. There was no clear path to recovery, that I was aware of. I thought I was supposed to go to treatment, where I would magically be cured of my addiction. I knew nothing about sustaining recovery, or what happened after the standard 28-day treatment.

Yet, those 28-day programs weren't available to me. I was forced to continue in my addiction while I sought help. This was a problem: first, I could have overdosed and died before I ever got the chance to get sober. Second, many places that offered support made it clear that if I couldn't pass a drug test, I wouldn't be welcome. Housing, treatment, and medical care were offered only to people who were "clean." Conditional support made recovery impossible for someone like me, who needed medical detox and inpatient treatment. I explained to more than one gatekeeper that if I'd been able to stop on my own, even for a day, I would have. However, my addiction was in control, and those doors were closed to me.

Third, there were more challenges beyond just stopping my heroin use. I was unemployable in early sobriety. I had some skills, but no idea how to find work or explain to an employer why I hadn't been able

to hold a steady job for the last decade. I had nowhere to live; no car, no bank account, and no credit history. Even when I was sober, I didn't have the tools I needed to re-enter society and contribute in a productive way. I wanted those things, but had no idea how to attain them. I may as well have been wishing for the moon. Again, because there was no clear path for me, I went in circles.

- Every day I spent seeking help could easily have been my last day alive.

**Most importantly, I needed a place to live.**

Finding recovery housing was even more difficult than finding treatment. After I'd gotten a bed in a residential treatment, with financial help plus a "scholarship" to offset the cost of treatment, I was homeless. Everything I owned fit into two garbage bags, which I lugged with me from place to place. The stress and anxiety that I felt from not knowing where I would live was incapacitating. One time, I was able to find sober living shortly after treatment, but the owner was not a trustworthy person. The "sober residence" was essentially a flophouse, with no recovery support, no oversight, and no peer network. At least one of my roommates was actively using heroin. That home's owner was arrested shortly after I moved in, and convicted of a crime. When I relapsed, I quickly went back to my old life. Without safe, sober housing, all my hard-won sobriety fell apart.

The [2016 Surgeon General's Report on Addiction Alcohol, Drugs and Health](#) and the [White House Commission on Opioids Final Report](#) both recommend the use of peer recovery supports and recovery housing<sup>1,2</sup>. A recent study by Harvard's Recovery Research Institute (RRI) found that, "because it can

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<sup>1</sup> U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Washington, DC: HHS, November 2016.

take some time after abstinence has been initiated for the brain systems to recalibrate and to adapt to the absence of drugs, services should be provided in an ongoing way after an acute residential or outpatient treatment.”<sup>3</sup> Providing ethical, safe housing and peer recovery support post clinical services is linked to higher rates of recovery.

I realized, through painful trial and error, that my recovery relied on support that wasn’t there. Guaranteed access to quality sober living would have made an immense difference in my recovery. Instead of facing stigma, rejection, and shame at every turn---instead of being told that I needed to cure myself of my own chronic illness before I could access shelter and medical care---I would have been able to focus on the difficult task of getting healthy again.

Even if you do not believe that access to addiction treatment and recovery supports like housing is the humane thing to do, the economic costs of *not* treating this illness are staggering. In November of 2017, the White House Council of Economic Advisors found that in 2015 alone, the cost of the opioid epidemic was over \$500 billion. Increased costs to state Medicaid programs, emergency room visits, and hospital admissions and readmissions all drove this economic impact, not to mention criminal justice costs.

Some people may say that people with substance use disorder “brought it on themselves,” and that *they* are the problem, not the system. To that, I say that science shows that the adolescent brain doesn’t fully mature until after the age of 25. Many people use substances for the first time, prescription or otherwise, at a very young age. Holding an adult responsible for the uninformed decision they made with an immature adolescent brain doesn’t make sense.

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<sup>2</sup> Office of National Drug Control Policy, President’s Commission Final Report. Washington, DC. Retrieved March 16, 2018 from [https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final\\_Report\\_Draft\\_11-15-2017.pdf](https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-15-2017.pdf)

<sup>3</sup> Recovery Research Institute. Is Residential or Outpatient Treatment Alone Enough to Treat Substance Use Disorders? Retrieved March 16, 2018 from: <https://www.recoveryanswers.org/research-post/is-residential-or-outpatient-treatment-alone-enough-to-treat-substance-use-disorders/>

- Without a place to call home, it is nearly impossible to get sober.

**I made it my mission to work day and night on this public health crisis.**

As I grew in my recovery, I met other people who shared my beliefs about recovery access. Through Facebook, I connected with Greg Williams at Facing Addiction with NCADD. We talked about how people with substance use disorder were underrepresented in the media and in politics. Although the drug epidemic was already claiming 100+ lives every day, it seemed like nobody was talking about recovery, or the thousands of families, friends, and grassroots advocates who were on the front lines, saving lives.

Together, Greg and I made a plan: I'd take a cross-country road trip through America's heartland, talking to people affected by addiction. My best friend Garrett Hade, a small crew, and I piled into the vehicle and we set off. I didn't imagine we'd make history, but here we are. Over the next month, I filmed a series of short interviews. The documentary series, *AddictionXAmerica*, was viewed by over 1 million people and shared thousands of times. I was pleased: a national conversation was happening. People started talking about addiction like a disease, not a moral failing. The drug epidemic was a health crisis, a national emergency that political leaders and policymakers were choosing to ignore. When I came home to California, I felt energized and empowered.

- Raising awareness about addiction, and talking about recovery, is my mission.

**Then my friend Tyler died – and no one was accountable.**

Yet, all the awareness in the world is meaningless if we do not implement meaningful change. I'm here today because my friend Tyler died of a heroin overdose in a sober living home just a few blocks from my apartment. His body was found in the living room. Because there was no naloxone on site, and because the home staff weren't trained to deal with overdoses, my friend lost his life. Not having naloxone in a sober living home is like refusing to put lifeboats on an ocean liner. It doesn't mean that you're planning on a shipwreck: it means that, in case of a disaster, the passengers will make it safely to land.

When I contacted the residence's manager, I was brushed off. Nobody cared that my friend was dead. They didn't care that his death was preventable. They focused on his "choice" to use heroin, which anyone with experience with substance use disorder will tell you is a fallacy. There is no "choice" for people who are struggling with addiction. Our survival should not be conditional: we need help, not judgment and shame.

Tyler's tragic death was met with indifference. Nobody was held accountable. To my knowledge, the sober residence where he died has not changed their policy. A few weeks after Tyler's death, I contacted local sober livings in Pasadena and offered to do a free naloxone intervention training with clients. All but one told me they weren't interested: they said that naloxone encourages people to use.

- This ignorance and indifference places people in recovery housing at risk of death.



**H.R. 4684 is the result of a community conversation with Congresswoman Judy Chu.**

I was distraught, so I sought a solution in the only place I know to be effective: my Congresswoman's office. Congresswoman Chu agreed to meet with me, and listened to my story about my friend. Together, we discussed some possible solutions to this unaddressed problem. We are here today as a result of her willingness to help, and her support of the recovery community.

One way for policymakers to improve policy is to include people and families with lived experience in recovery from SUD at policymaking tables at the state and federal levels. Congresswoman Chu did that, and as a result, I'm able to give testimony on this meaningful and impactful piece of legislation. Including people from the recovery community could inject new proven successful policy prescriptions to this effort.

- Now, we have an opportunity to save lives by ensuring access to quality sober living.

**H.R. 4684 is important. It's life or death.**

As we are sitting here, someone will die in a sober home because the residence doesn't have naloxone on hand. Someone else will die because they were kicked out after a relapse. We can't let that happen.

Individuals who relapse should be provided other recovery options, rather than being kicked out. They could be moved to another house or referred to treatment: that way, they won't endanger anyone else, and they'll still continue receiving help.

Without ethical measures in place, we'll continue to lose people like Tyler. Millions of people who access treatment and continuing care ask for help in good faith: we need to ensure that their safety net is strong, safe, and ready to catch them.

When a mother or father takes their child to sober living, they should be able to have confidence that they're leaving their child in good hands. Sober residences are a key part of continuing care.

- We should have a standard in place that ensures that these homes are what they say they are, and are equipped to do what they're supposed to do.

**We need national standards for sober housing.**

I'm here today because Congresswoman Chu listened to my concerns, and asked for my support of this critical bill. Thanks to her, the support of Facing Addiction with NCADD, which represents over 800 community organizations across the U.S. and 75 regional affiliates across the U.S., a network now reaching over 35 million Americans, as well as Students for Opioid Solutions (SOS) and the National Alliance of Recovery Residences (NARR), I ask for bipartisan support of H.R. 4684 as a solution. I know it's not a silver bullet, but it will help get best practices in recovery housing implemented across the country so those who don't implement them can be held accountable by their states.

My friend's death was 100% preventable, and H.R. 4684 addresses the changes we need in order to ensure that recovery homes are doing what they're supposed to: saving lives, not endangering Americans. Recovery should not be about luck, and it shouldn't be a guessing game for people who are in desperate need of help. The Betty Ford Institute Consensus Panel defined recovery as "a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship." Similarly, the Substance Abuse and

Mental Health Services Administration (SAMHSA) defines recovery as “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.” Sober housing is a key part of the recovery process, and a vital stepping stone to helping people reach their potential. The NARR Standards for recovery emphasize dignity, choice, and safety.

Quality, access, care, and choice are key parts of the NARR Standards for recovery residences. H.R. 4684 is a step in the right direction that will for the first time develop a national standard that can be disseminated to states and help people---and prevent more tragic overdoses, like the one that killed my friend.

- Quality means defining the essential elements of a properly operated recovery residence that everyone in our communities should demand.
- Access means providing a roadmap for developing the full spectrum of recovery housing to better match needs and a blueprint for housing providers to rise to the occasion.
- Care means evaluating the peer support components of a residence’s recovery environment.
- Choice means empowering informed recovery housing choices with regard to placement and resource allocation.

Recovery should be a peer-based system, and sober living helps build the peer network that is linked with greater success in recovery from substance use disorder. In addition to the cost savings, peer based environments are a model for later in life and teach you how to nurture your recovery. Their effectiveness is supported by evidence in the U.S. Surgeon General’s Report on Alcohol, Drugs, and Health:

*Recovery-oriented Systems of Care (ROSC) embrace the idea that severe substance use disorders are most effectively addressed through a chronic care management model that includes longer term, outpatient care; recovery housing; and recovery coaching and*

*management checkups. Recovery oriented systems are designed to be easy to navigate for people seeking help, transparent in their operations, and responsive to the cultural diversity of the communities they serve.*

*Treatment in recovery-oriented systems is offered as one component in a range of other services, including recovery supports. Treatment professionals act in a partnership/consultation role, drawing upon each person's goals and strengths, family supports, and community resources.*

*On a systems level, outcomes from Connecticut's Department of Mental Health and Addiction Services (DMHAS) ROSC initiative have demonstrated a 46 percent increase in individuals served, with 40 percent using outpatient care at lower costs, resulting in a decrease of 25 percent annual cost per client and a 24 percent decrease in overall treatment expenses.*

- Sober living standards mean lower costs, longer recovery, and healthier communities.

### **The NARR standards are crucial.**

Requiring a standard of care is not an overreach. We must require sober homes to use evidence-based practices, without turning them into medical facilities. Recovery housing should feel like home: a safe place. It should be free of unlawful drug and alcohol use, a place to connect with community and learn new skills.

The period where someone would live in recovery housing is post-treatment. It may overlap with outpatient care, but it's not the same thing as medical care and shouldn't be put in the same category.

While there are some recovery residences that provide clinical services, they are more expensive and not affordable for most. That's why we should approach sober living as a separate aspect of recovery, not an extension of treatment.

Furthermore, it's important to keep costs low in order to remove barriers to recovery. Many people who need help are like I was: no insurance, no money, and no family to fall back on. To improve access, we need to keep sober living separate from healthcare.

- Evidence shows that, when we invest in recovery supports in the first five years, we are investing in future sobriety. Low costs correlate to long term success: there's no need to increase spending, just raise our standards.

**I'm offering five guiding principles to Members of Congress and other leaders who want to support recovery.**

These are non-partisan guiding principles to help end the greatest public health crisis of our time. There are ways that both parties can help end this health crisis, but I am optimistically looking at a bipartisan goal.

### **1. Humanizing Addiction for Both the Afflicted and the Affected**

People with substance use disorder are smart, caring, compassionate, bright, creative, everyday Americans. We are your neighbors. Our kids go to school with your kids and sleep over at our houses. We live with a chronic disease, and we are responsible for its remission.

We need to be out, loud, and proud so the world sees who we are. We need leaders who sit with us and walk among us; speak with us in town halls; visit recovery night celebrations, and participate in our rallies.

## **2. Suffering From Addiction Is Not a Crime—Reforming Public Safety Responses**

This means not locking up people who are addicted to illegal drugs. It does not mean legalizing dangerous drugs: rather, it means not turning people with substance use disorder into criminals. We need to stop locking people up without treatment, rendering them unemployable, and letting their addiction progress in prison. People who commit nonviolent crimes because of their addiction should have their charges and sentences commuted, once they have achieved successful recovery.

Criminal justice reform is an opportunity for every elected official to make a profound difference in ending the crisis by voting for measures that support recovery.

## **3. Dramatically Expanding Prevention, Screening, and Early Intervention Programs**

So many lives could be saved and repaired if our government funded the evidence-based measures of the White House Opioid Commission. In proportion to the actual need, we need more funding. We may never meet the total need, but we require elected officials to allocate, earmark, designate, and pass deliberate budgetary support to combat addiction. We've got to make treatment universally available. We can't let Congress unanimously pass a parity law and then let it disappear by ignoring its enforcement.

## **4. Promoting Multiple Pathways of Recovery for Individuals and Their Families**

Leaders must support the obvious clinical solutions and expand treatment. More importantly, they must support things like medication-assisted treatment on equal par with abstinence-based programs. Faith-based groups like Catholic Charities and Jewish Family Services that provide addiction care to everyone should receive government grants for their work. We're going to recognize faith as a pathway to recovery.

We're going to show that there isn't one definition of recovery and that there are no absolutes in treatment. Nobody is "less worthy" because of the way they reached remission.

## **5. Mainstreaming Addiction Health Services**

We will treat addiction health services just like every other medical service: with parity and accountability. This means increasing the amount of credit hours about addiction a student is required to take in medical school about addiction. We need standardized screenings and other recovery support tactics, right in your primary care physician's office. We should require sick leave and other employer support for a worker battling addiction. Companies that employ those seeking recovery should receive tax credits. We need to ensure that communities build and nurture adequate treatment availability relative to their population, the same way we expect hospitals to.

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After three years in sustained recovery, I am not only surviving. I'm thriving. I am employed, live in my own apartment, and have an incredible circle of friends and family who love and support one another.

In closing, my path to recovery was long, painful, and blocked by many barriers. Those obstacles, if removed, would create a better quality of life for people in recovery, lower costs for states and the federal government, and healthier communities.

Thank you for including my testimony today. As policymakers continue to make decisions about our nation's addiction crisis, it is meaningful to keep inviting people in recovery and families to the table. I know that, in partnership, we'll continue facing addiction together and end this public health crisis, once and for all.

## **Addendum 1: NARR and National Standards**

### **An Overview From Internal NARR Documents**

#### **NARR Beginnings**

NARR was founded in 2011 by a group of recovery leaders from across the country, all of whom shared a vision for creating a national unifying body dedicated to the support of, and advocacy for, ethical, quality recovery residences, unified in a commitment to best practices. Some leaders came from established state associations such as the Georgia Association of Recovery Residences (GARR), California Association of Addiction Recovery Resources (CAARR, now CCAPP), and Texas Recovery Oriented Housing Network (TROHN). Their initial goals were to codify recovery housing best practices, describe and categorize the many varieties of recovery housing existing across the country, and develop a standardized terminology bridging regional usage variations and permitting a national dialogue based on a shared framework. The group also sought to codify a framework for providing support services and quality assurance to statewide systems of recovery housing, based on the experience of a few long-established state-level organizations.

The founding group provided assistance to other individuals invested in developing new state and regional associations that would collaborate with the national entity, leading to the creation of the Florida Association of Recovery Residences (FARR), Ohio Recovery Housing and a few other organizations. Additionally and importantly, leaders from the Association of Halfway House and Alcoholism Programs (AHHAP) contributed wisdom, intelligence and ultimately merged with NARR to forward the goal of evolving best practices to create and implement a national Standard. <sup>1, 2</sup>



As of this writing NARR recognizes 28 state and regional affiliates, supporting approximately 2,300 recovery residences that provide homes for 25,000 recovering individuals. NARR has become more than an association – it is a movement raising the standard of operation for all recovery residences.

### **About the NARR Standard**

It was clear from discussions leading to the formation of NARR that the most pressing national need was a set of standards that defined best practices for the various recovery housing modalities in existence.

Work on the version 1 standard began in the year before NARR was formally incorporated. The effort drew on experts from around the country, including experienced providers, behavioral health professionals, state government officials and addiction researchers. Although starting with a blank canvas, the standard was developed with a few principles in mind:

- It needed to provide comprehensive guidance about the ethical operation of the full spectrum of recovery residences.
- The standard's primary purpose would be protection of the individual resident, and the individual seeking recovery in a standards-compliant residence.
- The basis of the standard would be the social model of recovery, emphasizing the peer-to-peer nature of the residential recovery experience.
- The standard needed to support a variety of abstinence-based paths to recovery.
- It would support a variety of operating models and recovery philosophies, and would not dictate the programmatic elements of operating a residence.
- The standard would provide comprehensive protection for residents, but would be achievable even by a low-cost residence.

The first version of the standard (2011) achieved those objectives, and was well received by operators, state recovery housing organizations and the professional community. Principal objections were that some

of the rules were more aspirational than concrete, and it was difficult to create rule-based systems for verifying compliance. Version 2 (2015) addressed those concerns with a new structure, and rules designed to be amenable to objective verification procedures. The new standard is also level-specific, since some essential rules are not applicable to all four of NARR's defined levels of recovery support. The new version also more formally incorporates social model principles and metrics. The standard covers these basic areas:

- Health and safety requirements; resident space requirements
- Operational rules including record keeping, financial integrity, staff training and supervision
- Resident rights, including rights to be fully informed about rules, fees and residence expectations affecting the resident; privacy, confidentiality; rights to file unresolved complaints with oversight organization
- Appearance and upkeep of the physical environment (dwelling, furnishings, grounds)
- Good neighbor policies and practices
- Maintenance of a peer-oriented recovery environment; respect for individual choice in recovery engagement; recovery activities and programming; abstinence verification

A Code of Ethics was released in 2016, designed to complement the standard, and applicable to all residence operators and staff.

The current version of the Standard for Recovery Residences and Code of Ethics are available on the NARR website, [narronline.org](http://narronline.org).

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## **Addendum 2: The Role of Recovery Residences in Promoting**

### **Long-term Addiction Recovery**

A Policy Statement from The Society of Community Research and Action – Community Psychology,  
Division 27 of the American Psychological Association

#### **Executive Summary**

Addiction and the larger arena of alcohol and other drug (AOD) abuse and related problems exact an enormous toll on individuals, families, organizations, local neighborhoods, and whole communities in the United States. Although a great number of advances have been made in AOD treatment, far too few individuals who could benefit from treatment receive it, and many who do receive treatment will resume AOD use following their discharge from it. New recovery support institutions are emerging beyond the arenas of traditional addiction treatment to support individuals hoping to initiate and to sustain long term recovery from addiction. One promising mechanism is the recovery residence.

Recovery residences (e.g., sober living houses, recovery homes, and Oxford Houses) are sober, safe, and healthy living environments that promote recovery from AOD use and associated problems. At a minimum, recovery residences offer peer-to-peer recovery support with some providing professionally delivered clinical services all aimed at promoting abstinence based, long-term recovery. Recovery residences are sober living environments, meaning that residents are expected to abstain from alcohol and illegal drug use. Each credentialed recovery residence publishes policies on relapse sanctions and readmission criteria and other rules governing group living. Recovery residences may require abstinence from particular types of medications according to individual policy. Although the exact number is currently unknown, many thousands exist in the United States.

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, and the National Association of Recovery

Residences has developed guidelines to define levels of care and standards to ensure the quality of care received. Yet, despite these advances, recovery residences face innumerable challenges. Critical questions regarding the operations and effects of recovery residence participation remain unanswered, and research scientists wishing to study recovery residences face considerable funding challenges given the prevailing funding emphasis on the neuroscience of addiction. Efforts to establish or relocate recovery residences face challenges with start-up funding and often face considerable neighborhood and political opposition. Also of importance, many health and human professionals are unaware of recovery residences and their benefits on long-term recovery outcomes.

The Society of Community Research and Action (SCRA) has developed, with the executive, advocacy and research committees of the National Association of Recovery Residences (NARR), a policy statement on the value of recovery residences in the United States. This policy statement 1) describes the emergence and rapid growth of recovery residences as a new addiction recovery support institution, 2) highlights research to date on the positive effects of participation in a recovery residence on long-term addiction recovery and related outcomes, 3) champions a research agenda that would address many unanswered questions related to such participation, 4) advocates social policies (laws, regulations and funding guidelines) in which recovery residences can flourish, 5) supports programs of education and training to increase referrals to these new resources by health and human service professionals, and 6) promotes programs to educate local political leaders and the public about the value of recovery residences for individuals, families, and communities in the United States.

## **Background**

Addiction and the larger arena of alcohol and other drug (AOD) and related problems exact an enormous toll on individuals, families, organizations, local neighborhoods and whole communities in the United States. Since the mid-twentieth century, an elaborate network of professionally-directed addiction treatment programs has been funded to respond to these problems, but more than half of individuals

treated in these institutions will resume AOD use following their discharge from treatment—most often in the first 90 days following discharge. Assertive continuing care and support is not a routine component of addiction treatment in the United States and only a small percentage of persons treated participate in post-treatment continuing care, which involves post-treatment monitoring and support. There are growing calls to shift acute care models of addiction treatment to models that emphasize sustained, post-treatment recovery management in order to elevate long-term recovery rates and enhance the quality of personal and family life in long-term recovery. Recovery management is a philosophical framework for organizing addiction treatment services to provide long-term recovery maintenance and quality-of-life enhancement for individuals and families affected by severe substance use disorders.

New recovery support institutions are emerging beyond the arenas of addiction treatment and recovery mutual aid societies to achieve these goals. By providing a physical and social world to recover within, these new institutions (e.g., recovery residences, recovery schools, recovery industries, recovery ministries, recovery community centers, recovery cafes, etc.), mark a major milestone in the history of recovery in the United States. One of the earliest to develop and one of the most important of these new institutions is the recovery residence.

Recovery residences (e.g., sober living houses, recovery homes, and Oxford Houses) are sober, safe, and healthy living environments that promote recovery from AOD use and associated problems. The number of recovery residences in the U.S. has grown dramatically in the past 25 years and have helped fill the void of community support between professionally directed addiction treatment and peer-led recovery mutual aid societies. The purpose of a recovery residence is to provide a safe and healthy living environment to initiate and sustain recovery—defined as abstinence from alcohol and other non-prescribed drug use and improvement in one’s physical, mental, spiritual, and social wellbeing.

Individuals build resources while living in a recovery residence that will continue to support their recovery as they transition to living independently and productively in the community. Although recovery is commonly believed to refer to abstinence and a general sense of quality of life, recovery is by no means

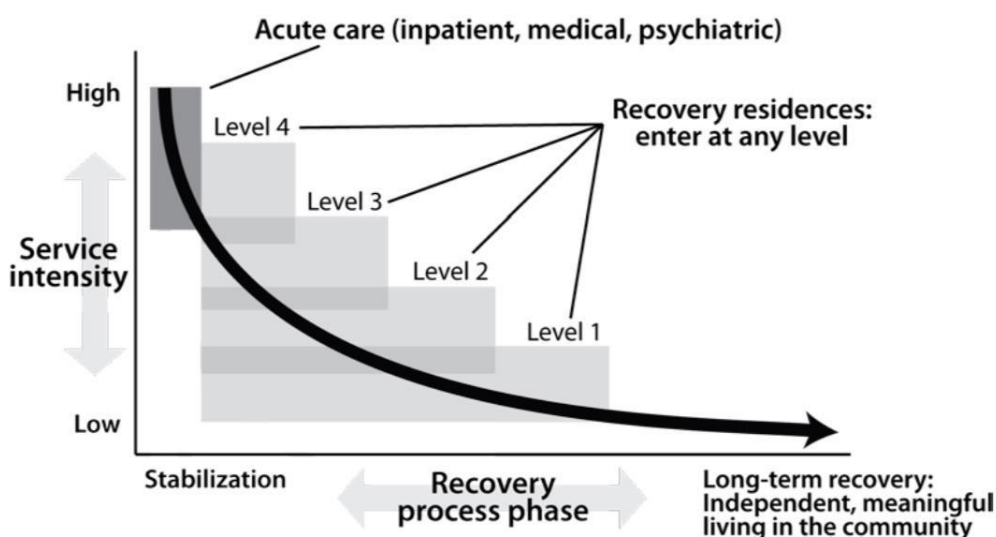
a simple construct that has uniform definition (i.e., some individuals define it as abstinence only from their primary drug; or as use of alcohol, but no drugs; or as no use of “hard drugs” but use of marijuana, or allow for use of “medical marijuana.”)

There is growing consensus that recovery from severe substance use disorders involves three critical components: sobriety, improvement in global (physical, emotional, relational, spiritual) health, and citizenship (positive community reintegration). Recovery residences are abstinence-based environments that provide mutual support for these three elements of recovery -in contrast to "wet housing" that allows residents to use alcohol or other drugs or "damp housing" that discourages but does not exclude persons for using and that do not address these larger recovery processes.

A recent publication, *A Primer on Recovery Residences in the United States* (Jason, Mericle, Polcin, White, & the National Association of Recovery Residences, 2012), released by the National Association of Recovery Residences based on a review of all materials published on recovery residences to date found that:

- Although the exact number of recovery residences is currently unknown, there are many thousands of such residences operating in nearly every state across the nation;
- Recovery residences in the U.S. span from low to high service intensity and meet the needs of residents at various stages of recovery (see figure below):

## Recovery Residences in the Continuum of Recovery



- Most individuals in recovery residences have past or current involvement in addiction treatment and participate in 12-Step or other recovery mutual aid organizations during their time in the recovery residence.
- Participation in a recovery residence decreases in-treatment and post-treatment relapse rates and significantly increases recovery outcomes (using such recovery measures as sustained abstinence rates, improvements in global health and social functioning—e.g., high rates of employment) at up to two-years of follow-up. Longer-term (5-10 years) follow-up studies have not yet been conducted.
- These benefits extend to women, women with children, African-Americans, and persons with co-occurring psychiatric diagnoses.
- These benefits are contingent on adequate lengths of stay (more than 6 months in level I recovery residences) and a supportive community environment.



- The cost-effectiveness of recovery residences has not yet been rigorously investigated. However, some recovery residences, such as Oxford and California Sober Living Houses, are self-financed primarily through resident fees.
- Research to date generally finds that recovery residences do not negatively affect neighborhoods and may even provide benefits to the communities in which they are located.

Some recovery residences are designed specifically for individuals with certain needs (e.g., co-occurring addiction and severe mental illness, veterans, mothers with children); however, some recovery residences may not be equipped to adequately meet these residents' needs. Individuals with specific service needs seeking recovery residences should ask the provider about how these needs can (or cannot) be addressed within a particular residence. It is still unclear if outcomes differ for people with co-occurring disorders (mental health, process addictions, major medical issues such as Hepatitis C or HIV) living in recovery residences.

Recovery residences are divided into Levels of Support based on the type as well as the intensity and duration of support that they offer. Services provided span from peer-to-peer recovery support (all recovery residences) to medical and counseling services (recovery residences offering higher levels of support). The National Association of Recovery Residence Standards defines minimum services for each Level of Support, but additional services may be provided at each level. Section 5 of the National Association of Recovery Residences Standards, included in *A Primer on Recovery Residences in the United States*, details the minimum required service elements for each Level of Support. National Association of Recovery Residence-certified recovery residences meet standards addressing safety from an administrative, operational, property, and good neighbors' perspective. Recovery residences' internal governance varies across National Association of Recovery Residence Levels of Support. Forms of governance range from democratically run by the residents to oversight by licensed professionals. The regulation of recovery residences vary from state to state, local government to local government, and

model to model. In general, states regulate professional services and local governments regulate health and safety standards. Both state and local government regulation must adhere to federal laws and limits, such as the Americans with Disabilities Act and the Fair Housing Act.

The National Association of Recovery Residences, established in 2011, currently represents approximately 1,500 residences through its local organizational affiliates. The National Association of Recovery Residences advocates for recovery residences and their residents at the national and local levels. Members of the National Association of Recovery Residence maintain standards for recovery residences of all kinds across the four National Association of Recovery Residence Levels of Support, from Level 1 peer-operated residences to Level 4 residences offering a wide variety of treatment and recovery support services. Three additional recovery residence organizations exist with a national scope. The oldest is the Association of Halfway House Alcoholism Programs, founded in 1958, and all are now affiliated with the National Association of Recovery Residences. The members of the Association of Halfway House Alcoholism Program include all of the National Association of Recovery Residences Levels of Support. The Association of Halfway House Alcoholism Program's residences operate in accordance with social model recovery principles. Oxford House Inc. was established in 1975 and supports Oxford Houses internationally. Oxford Houses are National Association of Recovery Residence Level 1, with each residence operated solely by the residents in accordance with Oxford House guidelines. Oxford House Inc. supports and promotes its model for peer operated recovery residences through training, technical assistance, and access to startup financing. They also advocate for recovery housing rights and provide legal support to Oxford Houses involved in disputes with cities and towns over their right to exist. Treatment Communities of America (formerly Therapeutic Communities of America) represents more than 600 residential addiction treatment programs in the United States.

Recovery residences face innumerable challenges in spite of their rapid growth and positive findings on their effects on recovery outcomes. Critical questions regarding the operations and effects of recovery residence participation remain unanswered, and research scientists wishing to study recovery residences

face considerable funding challenges given the prevailing funding emphasis on the neuroscience of addiction. Efforts to establish or relocate recovery residences face challenges with start-up funding and often face considerable neighborhood and political opposition. Also of importance, many health and human professionals are unaware of recovery residences and their benefits on long-term recovery outcomes.

## **Recommendations**

In light of these findings and circumstances, the Society of Community Research and Action (SCRA):

1) Recommends that national, state, and local agencies support local networks of recovery residences.

Specially, the SCRA calls upon:

- The Substance Abuse and Mental Health Services Administration to develop funding mechanisms to support the development, sustainment, and expansion of recovery support services specific to housing.
- The Department of Housing and Urban Development to develop funding mechanisms to support the development, sustainment, and expansion of housing services specifically for individuals in recovery from behavioral health disorders.
- The National Association of Recovery Residences to disseminate national standards for recovery residences and to provide technical assistance for local organizations to meet these standards as a means of improving the quality of local recovery residences in the United States. This is of particular importance in order to deal with a perception by some that relapse is common among residents in recovery homes, they are often in unsafe neighborhoods, and many are disorganized and even exploitive of residents.
- Single State Authorities on alcohol and other drug problems to establish loan funds and other mechanisms that will support the development of recovery residences where the need for such resources has been established.

- The National Conference of State Legislatures, the United State Conference of Mayors, and the National League of Cities to develop policy documents and host webinars and conferences related to the issues surrounding the development of supportive housing for recovering individuals in local communities.

2) Recommends enhanced funding for critical research related to recovery residences. The SCRA calls upon:

- The National Institutes of Health (the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse) to fund research related to recovery residences, including randomized clinical trials, long term outcome studies, cost-effectiveness studies, and studies that isolate the most potent ingredients of the recovery residence model of recovery support.

We need recovery outcome and cost savings data across the Levels of Support for various populations (including co-occurring, re-entry with criminal mindsets, etc.) recovering from a diversity of chemical substances in comparison to or in combination with alternative approaches. Without published research and evidence-based practice designations, licensed professionals and policymakers will continue to question the legitimacy of recovery residences and peer-based recovery.

- The Substance Abuse and Mental Health Administration’s Center for Substance Abuse Treatment to fund evaluations studies related to the integration of recovery residences and related recovery support institutions (e.g., recovery community centers, recovery schools, recovery industries, recovery ministries) within the network of health care initiatives being launched by state and federal government.

Federal, state, and local funding sources to prioritize recovery residence research studies that address 1) the effects of participation in a recovery residence on treatment retention/completion and post-treatment relapse and recovery rates as well as measures of global health and social functioning—e.g., high rates of employment) at longer-term (5-10 years) intervals, 2) the degree of benefits living within recovery residences extends to women, women with children, African-Americans, and persons with co-occurring

psychiatric diagnoses, 3) the degree to which benefits are contingent on adequate lengths of stay (more than 6 months in level I recovery residences) and a supportive community environment, 4) the relative cost-effectiveness of recovery residences, and 5) the effects of recovery residences on neighborhoods and communities in which they are located. These are all high priority areas for research that is needed to develop a more solid basis for our understanding of recovery residences and their impacts on residents and communities.

- National Association of Recovery Residences to increase their presence at key national conferences (National Association of Addiction Treatment Providers, the American Society of Addiction Medicine, and the American Association for the Treatment of Opioid Dependence) to engage the research community on the need for research on recovery residences.
- Editors of addiction-related professional and trade journals to continue to publish studies and reviews and special issues on the effects of participation in a recovery residence on long-term recovery outcomes.

3) Recommends strategies to educate and train addiction treatment professionals and allied health and human services professionals on the value of recovery homes. The SCRA calls upon:

- The APA to disseminate this policy document to all APA members as well as to other major related professional associations (e.g., the American Psychiatric Association, the National Association of Social Workers) with the recommendation that the latter develop and disseminate policy statements on recovery residences and related recovery support institutions.
- College and university addiction studies programs, independent addiction counselor training programs, and educational and training programs for psychiatrists, psychologists, and social workers to integrate information on recovery residences within their respective curricula.
- The national network of Addiction Technology Transfer Centers to disseminate information on recovery residences, including assertive referral procedures that can be used to access such resources and how

recovery residences can be integrated into a continuum of care supporting long-term personal and family recovery from substance use disorders.

- The major addiction professional certification bodies [including NAADAC: The Association of Addiction Professionals, the International Certification & Reciprocity Consortium (IC&RC), the American Board of Addiction Medicine, and state addictions counselor certification boards] to integrate questions related to recovery residences into certification exams and their respective continuing education programs.
- The American Society of Addiction Medicine to formally recognize recovery residences as a level of care within its Patient Placement Criteria.

4) Recommends public education strategies that will address the stigma and misconceptions often attached to recovery homes and their residents. The SCRA calls upon:

- The National Association of Recovery Residences to develop a public education campaign on recovery residences aimed at state and local civic leaders and media representatives.
- The National Association of Recovery Residences' regional and state recovery residence consortia to collaborate with leading recovery advocacy organizations to incorporate issues related to recovery housing within larger recovery advocacy and anti-stigma campaigns.
- The Legal Action Center to develop a kit for local recovery residences on how to respond to NIMBY hysteria and discrimination related to recovery housing regulations and their enforcement.
- The Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Association of Recovery Residences co-develop a recovery residence press kit and a webinar that could be incorporated into SAMSHA's 2013 Recovery Month activities.

Having reviewed the available scientific evidence on recovery residences, we believe these actions will play a significant role in elevating long-term addiction recovery outcomes in the United States and contribute to the quality of life of individuals, families and communities throughout the country.

The proposed policy statement was written by the National Association of Recovery Residences (NARR) research committee and approved by the NARR executive committee before submission to the SCRA.

The NARR research members include Leonard A. Jason, PhD, Director, Center for Community Research, DePaul University; Amy A. Mericle, PhD, Research Scientist, Treatment Research Institute; Douglas L. Polcin, EdD, Senior Scientist, Alcohol Research Group; and William L. White, MA, Senior Research Consultant, Chestnut Health Systems.

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