MHACBO-NARR Recovery Residence Accreditation Manual

2021

MHACBO-NARR Recovery Residence Accreditation

MHACBO is the Oregon affiliate of the National Alliance of Recovery Residences. Currently, 36 U.S. states utilize the National Alliance of Recovery Residences (NARR) accreditation standards for the credentialing of recovery residences.[1] The NARR accreditation standards have also been adopted by the National Council on Behavioral Health and are featured in the 2021 White House Office of National Drug Control Policy sponsored "Model State Legislation" for recovery residences.[2-3]

Major Points in this manual:

- MHACBO-NARR recovery residence accreditation is for individual residences. Each residence acquires its own separate accreditation.
- To become accredited you must complete an online application on each residence through Certemy at MHACBO.org, and MHACBO staff/agents will complete an on site inspection of the residence.
- The MHACBO-NARR accreditation is based on the NARR 3.0 Standards. Review the standards contained in this manual.
- To open a new application on a particular residence click on the "New Application for MHACBO-NARR Accreditation" button on the MHACBO website. If you have more than one residence, you will need to upload a copy of your Policy & Procedure manual for each residence.
- NARR Accreditation has four levels. You must select the level of accreditation that you are seeking for any particular recovery residence (I-IV). Your application cannot be processed until you select the level of accreditation you are pursuing.

1. National Overview of Recovery Housing Accreditation, Legislation and Licensing Eric Martin, MAC, CADC III, PRC, CPS, Kristi McKinney, B.S., CADC II, Van Burnham, IV, B. Accy., CRM, Michael Razavi, MPH, CADC I, CRM II
2. Building Recovery: State Policy Guide for Supporting Recovery Housing, National Council for Behavioral Health, 2018
3. Model Recovery Residence Certification Act, Legislative Analysis and Public Policy Association sponsored by the White House Office of National Drug Control Policy, 2021

	Level I Peer-run	Level II Monitored	Level III Supervised	Level IV Service Provider
Admin	• No reimbursed staff. • Democratically run, members vote to make decisions. • House manual with pre-established policies that guide the democratically run process.	• Residence is monitored by a House Manager (Senior Resident). • Policy & Procedure Manual implemented by staff and residents.	• Residence has a recognized organizational hierarchy. • House manager. • Administrative oversight for service providers. • Policy & Procedure Manual implemented by staff and residents.	• Overseen organizational hierarchy. (e.g. Board of Directors, OHA, etc.) • Clinical and administrative supervision. • Policy & Procedure Manual implemented by staff and residents.
Services	• Drug screening. • House meetings. • Community self help meeting participation is encouraged.	• House rules provide structure. • Peer run groups. • Drug screening. • House meetings. • Participating in community self help meetings and/or treatment is required.	• Life/recovery skills development is emphasized. • Clinical services are utilized in the outside community, or are delivered to participants in the house. • Drug screening. • House meetings. • Community self help meeting participation is required.	• Life/recovery skills development and training is delivered. • Clinical services are provided in-house. • Drug screening. • House meetings. • Community self help meeting participation is required.
Residence	• Generally single family residences (houses).	• Primarily single family residences. • Possibly apartments or multi-family homes.	• Various types of residential settings.	• Various types of residential settings. • Often a step down phase within a continuum of care of a treatment center. • May be a more institutional environment.
Staff	• No paid positions within the residence. • Perhaps an overseeing officer.	• At least one compensated position.	• Facility manager. • Certified staff, peers or case managers.	• Certified/licensed staff, including addiction counselors and peers.

Instructions

Review the NARR 3.0 Standards in this Manual:

MHACBO-NARR Certification is based on the NARR 3.0 Standards. You must select the level of housing accreditation for which you are applying.

Documents you will need to upload in the application:

1. Copy of Director/Operator's ID.
2. Copy of Oregon Secretary of State Business Registration (save from Oregon Secretary of State website).
3. Mission/vision statement.
4. Current liability insurance certificate.
5. Written consent from property owner to operate a recovery residence.
6. Written description of accounting systems/practices.
7. MHACBO-NARR Code of Ethics signed by all staff members.
8. Policies & Procedures:

    Non-discrimination Policy
    Staff Background Check Policy
    Employment/Contracting with Residents Policy
    Financial Boundaries between Staff Residents
    Ethical Compliance Policy
    Resident Fee Refunds Policy
    Third Party Payments Policy
    P.I. Confidentiality Policy
    Admission Policy
    Grievance Policy
    Length of Stay Policy
    Resident Governance Policy
    Staff Job Descriptions Policy
    Staff Management Policy
    Staff Credentialing Policy
    Priority Placement Policy
    Cultural Responsiveness
    Abstinence Policy
    Contraband Policy
    Drug Testing Policy
    Medication Management Policy
    Community Safety Policy
    Safety Inspections Policy
    Smoke-Free Policy
    Infectious Disease Policy
    Resident Leadership Descriptions Policy
    Good Neighbor Policy
    Preemptive Neighborhood Policy

9. Resident Documents (handouts given to residents)

    Resident Rights, including Grievance Policy
    Resident Rules & Expectations
    Payment/Fees Obligations/Agreements
    Confidentiality Statement
    Relapse Policy
    Eviction Policy
    Preemptive "Good Neighbor & Parking Rules"

Open application on the MHACBO website in Certemy.

Each residence carries its own certification. You must complete an application for each and every separate residence. To simplify this process put all of your policies and procedures into one word/pdf document.

1	Administrative and Operational Domain			LEVELS			
				I	II	III	IV
A.	**Core Principle: Operate with Integrity**						
	1.	**Use mission and vision as guides for decision making**					
		a.	A written mission that reflects a commitment to those served and identifies the population served which, at a minimum, includes persons in recovery from a substance use disorder.	✔	✔	✔	✔
		b.	A vision statement that is consistent with NARR's core principles.	✔	✔	✔	✔
	2.	**Adhere to legal and ethical codes and use best business practices**					
		a.	Documentation of legal business entity (e.g. incorporation, LLC documents or business license).	✔	✔	✔	✔
		b.	Documentation that the owner/operator has current liability coverage and other insurance appropriate to the level of support.	✔	✔	✔	✔
		c.	Written permission from the property owner of record (if the owner is other than the recovery residence operator) to operate a recovery residence on the property.	✔	✔	✔	✔
		d.	A statement attesting to compliance with nondiscriminatory state and federal requirements.	✔	✔	✔	✔
		e.	Operator attests that claims made in marketing materials and advertising will be honest and substantiated and that it does not employ any of the following: • False or misleading statements or unfounded claims or exaggerations; • Testimonials that do not reflect the real opinion of the involved individual; • Price claims that are misleading; • Therapeutic strategies for which licensure and/or counseling certifications are required but not applicable at the site; or • Misleading representation of outcomes.	✔	✔	✔	✔
		f.	Policy and procedures that ensure that appropriate background checks (due diligence practices) are conducted for all staff who will have direct and regular interaction with residents.		R	R	✔
		g.	Policy and procedures that ensure the following conditions are met if the residence provider employs, contracts with or enters into a paid work agreement with residents: • Paid work arrangements are completely voluntary. • Residents do not suffer consequences for declining work. • Residents who accept paid work are not treated more favorably than residents who do not.	✔	✔	✔	✔

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			• All qualified residents are given equal opportunity for available work. • Paid work for the operator or staff does not impair participating residents' progress towards their recovery goals. • The paid work is treated the same as any other employment situation. • Wages are commensurate with marketplace value and at least minimum wage. • The arrangements are viewed by a majority of the residents as fair. • Paid work does not confer special privileges on residents doing the work. • Work relationships do not negatively affect the recovery environment or morale of the home. • Unsatisfactory work relationships are terminated without recriminations that can impair recovery.				
		h.	Staff must never become involved in residents' personal financial affairs, including lending or borrowing money, or other transactions involving property or services, except that the operator may make agreements with residents with respect to payment of fees.	✔	✔	✔	✔
		i.	A policy and practice that provider has a code of ethics that is aligned with the NARR code of ethics. There is evidence that this document is read and signed by all those associated with the operation of the recovery residence, to include owners, operators, staff and volunteers.	✔	✔	✔	✔
	3.	**Be financially honest and forthright**					
		a.	Prior to the initial acceptance of any funds, the operator must inform applicants of all fees and charges for which they will be, or could potentially be, responsible. This information needs to be in writing and signed by the applicant.	✔	✔	✔	✔
		b.	Use of an accounting system which documents all resident financial transactions such as fees, payments and deposits. • Ability to produce clear statements of a resident's financial dealings with the operator within reasonable timeframes. • Accurate recording of all resident charges and payments. • Payments made by 3rd party payers are noted	✔	✔	✔	✔
		c.	A policy and practice documenting that a resident is fully informed regarding refund policies prior to the individual entering into a binding agreement.	✔	✔	✔	✔
		d.	A policy and practice that residents be informed of payments from 3rd party payers for any fees paid on their behalf.	✔	✔	✔	✔
	4.	**Collect data for continuous quality improvement**					
		a.	Policies and procedures regarding collection of resident's information. At a minimum data collection will • Protect individual's identity. • Be used for continuous quality improvement and	✔	✔	✔	✔

			• be part of day-to-day operations and regularly reviewed by staff and residents (where appropriate).				
B.	**Core Principle: Uphold Residents' Rights**						
	5.	**Communicate rights and requirements before agreements are signed**					
		a.	Documentation of a process that requires a written agreement prior to committing to terms that includes the following: • Resident rights • Financial obligations, and agreements • Services provided • Recovery goals • Relapse policies • Policies regarding removal of personal property left in the residence	✔	✔	✔	✔
	6.	**Protect resident information**					
		a.	Policies and procedures that keep residents' records secure, with access limited to authorized staff.	✔	✔	✔	✔
		b.	Policies and procedures that comply with applicable confidentiality laws.	✔	✔	✔	✔
		c.	Policies and procedures, including social media, protecting resident and community privacy and confidentiality.	✔	✔	✔	✔
C.	**Core Principle: Create a culture of empowerment where residents engage in governance and leadership**						
	7.	**Involve residents in governance**					
		a.	Evidence that some rules are made by the residents that the residents (not the staff) implement.	✔	✔	R	R
		b.	Grievance policy and procedures, including the right to take unresolved grievances to the operator's oversight organization.	✔	✔	✔	✔
		c.	Verification that written resident's rights and requirements (e.g. residence rules and grievance process) are posted or otherwise available in common areas.	✔	✔	✔	✔
		d.	Policies and procedures that promote resident-driven length of stay.	✔	✔	*	*
		e.	Evidence that residents have opportunities to be heard in the governance of the residence; however, decision making remains with the operator.		✔	✔	✔
	8.	**Promote resident involvement in a developmental approach to recovery**					
		a.	Peer support interactions among residents are facilitated to expand responsibilities for personal and community recovery.		✔	✔	✔
		b.	Written responsibilities, role descriptions, guidelines and/or feedback for residence leaders.	R	✔	✔	✔
		c.	Evidence that residents' recovery progress and challenges are recognized and strengths are celebrated.		✔	✔	✔

D.	Core Principle: Develop Staff Abilities to Apply the Social Model						
	9.	**Staff model and teach recovery skills and behaviors**					
		a.	Evidence that management supports staff members maintaining self-care.		✔	✔	✔
		b.	Evidence that staff are supported in maintaining appropriate boundaries according to a code of conduct.		✔	✔	✔
		c.	Evidence that staff are encouraged to have a network of support.		✔	✔	✔
		d.	Evidence that staff are expected to model genuineness, empathy, respect, support and unconditional positive regard.		✔	✔	✔
	10.	**Ensure potential and current staff are trained or credentialed appropriate to the residence level**					
		a.	Policies that value individuals chosen for leadership roles who are versed and trained in the Social Model of recovery and best practices of the profession.		✔	✔	✔
		b.	Policies and procedures for acceptance and verification of certification(s) when appropriate.		✔	✔	✔
		c.	Staffing plan that demonstrates continuous development for all staff.		R	✔	✔
	11.	**Staff are culturally responsive and competent**					
		a.	Policies and procedures that serve the priority population, which at a minimum include persons in recovery from substance use but may also include other demographic criteria.		✔	✔	✔
		b.	Cultural responsiveness and competence training or certification are provided.		✔	✔	✔
	12.	**All staff positions are guided by written job descriptions that reflect recovery**					
		a.	Job descriptions include position responsibilities and certification/licensure and/or lived experience credential requirements.		✔	✔	✔
		b.	Job descriptions require staff to facilitate access to local community-based resources.		✔	✔	✔
		c.	Job descriptions include staff responsibilities, eligibility, and knowledge, skills and abilities needed to deliver services. Ideally, eligibility to deliver services includes lived experience recovering from substance use disorders and the ability to reflect recovery principles.		✔	✔	✔
	13.	**Provide Social Model-Oriented Supervision of Staff**					
		a.	Policies and procedures for ongoing performance development of staff appropriate to staff roles and residence level.		✔	✔	✔
		b.	Evidence that management and supervisory staff acknowledge staff achievements and professional development.		R	✔	✔
		c.	Evidence that supervisors (including top management) create a positive, productive work environment for staff.		✔	✔	✔

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2.	Physical Environment Domain			LEVELS			
				I	II	III	IV
E.	**Core Principle: Provide a Home-like Environment**						
	14.	**The residence is comfortable, inviting, and meets residents' needs**					
		a.	Verification that the residence is in good repair, clean, and well maintained	✔	✔	✔	✔
		b.	Verification that furnishings are typical of those in single family homes or apartments as opposed to institutional settings.	✔	✔	✔	✔
		c.	Verification that entrances and exits are home-like vs. institutional or clinical.	✔	✔	✔	✔
		d.	Verification of 50+ sq. ft per bed per sleeping room.	✔	✔	✔	✔
		e.	Verification that there is a minimum of one sink, toilet and shower per six residents.	✔	✔	✔	✔
		f.	Verification that each resident has personal item storage.	✔	✔	✔	✔
		g.	Verification that each resident has food storage space.	✔	✔	✔	✔
		h.	Verification that laundry services are accessible to all residents.	✔	✔	✔	✔
		i.	Verification that all appliances are in safe, working condition.	✔	✔	✔	✔
	15.	**The living space is conducive to building community**					
		a.	Verification that a meeting space is large enough to accommodate all residents.	✔	✔	✔	✔
		b.	Verification that a comfortable group area provides space for small group activities and socializing	✔	✔	✔	✔
		c.	Verification that kitchen and dining area(s) are large enough to accommodate all residents sharing meals together.	✔	✔	✔	✔
		d.	Verification that entertainment or recreational areas and/or furnishings promoting social engagement are provided.	✔	✔	✔	✔
F.	**Core Principle: Promote a Safe and Healthy Environment**						
	16.	**Provide an alcohol and illicit drug free environment**					
		a.	Policy prohibits the use of alcohol and/or illicit drug use or seeking.	✔	✔	✔	✔
		b.	Policy lists prohibited items and states procedures for associated searches by staff	✔	✔	✔	✔
		c.	Policy and procedures for drug screening and/or toxicology protocols.	✔	✔	✔	✔
		d.	Policy and procedures that address residents' prescription and non-prescription medication usage and storage consistent with the residence's level and with relevant state law.	✔	✔	✔	✔
		e.	Policies and procedures that encourage residents to take responsibility for their own and other residents' safety and health.	✔	✔	✔	✔

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	17.	**Promote Home Safety**					
		a.	Operator will attest that electrical, mechanical, and structural components of the property are functional and free of fire and safety hazards.	✔	✔	✔	✔
		b.	Operator will attest that the residence meets local health and safety codes appropriate to the type of occupancy (e.g. single family or other) OR provide documentation from a government agency or credentialed inspector attesting to the property meeting health and safety standards.	✔	✔	✔	✔
		c.	Verification that the residence has a safety inspection policy requiring periodic verification of • Functional smoke detectors in all bedroom spaces and elsewhere as code demands, • Functional carbon monoxide detectors, if residence has gas HVAC, hot water or appliances • Functional fire extinguishers placed in plain sight and/or clearly marked locations, • Regular, documented inspections of smoke detectors, carbon monoxide detectors and fire extinguishers, • Fire and other emergency evacuation drills take place regularly and are documented (not required for Level I Residences).	✔	✔	✔	✔
	18.	**Promote Health**					
		a.	Policy regarding smoke-free living environment and/or designated smoking area outside of the residence.	✔	✔	✔	✔
		b.	Policy regarding exposure to bodily fluids and contagious disease.	✔	✔	✔	✔
	19.	**Plan for emergencies including intoxication, withdrawal and overdose**					
		a.	Verification that emergency numbers, procedures (including overdose and other emergency responses) and evacuation maps are posted in conspicuous locations.	✔	✔	✔	✔
		b.	Documentation that emergency contact information is collected from residents.	✔	✔	✔	✔
		c.	Documentation that residents are oriented to emergency procedures.	✔	✔	✔	✔
		d.	Verification that Naloxone is accessible at each location, and appropriate individuals are knowledgeable and trained in its use.	✔	✔	✔	✔

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3	Recovery Support Domain			LEVELS			
				I	II	III	IV
G.	**Core Principle: Facilitate Active Recovery and Recovery Community Engagement**						
	20.	**Promote meaningful activities**					
		a.	Documentation that residents are encouraged to do at least one of the following: • Work, go to school, or volunteer outside of the residence (Level 1, 2 and some 3s) • Participate in mutual aid or caregiving (All Levels) • Participate in social, physical or creative activities (All Levels) • Participate in daily or weekly community activities (All Levels) • Participate in daily or weekly programming (Level 3's and 4's)	✔	✔	✔	✔
	21.	**Engage residents in recovery planning and development of recovery capital**					
		a.	Evidence that each resident develops and participates in individualized recovery planning that includes an exit plan/strategy	✔	✔	✔	✔
		b.	Evidence that residents increase recovery capital through such things as recovery support and community service, work/employment, etc.	✔	✔	✔	✔
		c.	Written criteria and guidelines explain expectations for peer leadership and mentoring roles.	✔	✔	✔	✔
	22.	**Promote access to community supports**					
		a.	Resource directories, written or electronic, are made available to residents.	✔	✔	✔	✔
		b.	Staff and/or resident leaders educate residents about local community-based resources.	✔	✔	✔	✔
	23.	**Provide mutually beneficial peer recovery support**					
		a.	A weekly schedule details recovery support services, events and activities.		✔	✔	✔
		b.	Evidence that resident-to resident peer support is facilitated: • Evidence that residents are taught to think of themselves as peer supporters for others in recovery • Evidence that residents are encouraged to practice peer support interactions with other residents.	✔	✔	✔	✔
	24.	**Provide recovery support and life skills development services**					
		a.	Provide structured scheduled, curriculum-driven, and/or otherwise defined support services and life skills development. Trained staff (peer and clinical) provide learning opportunities.			✔	✔
		b.	Ongoing performance support and training are provided for staff.			✔	✔
	25.	**Provide clinical services in accordance with state law**					
		a.	Evidence that the program's weekly schedule includes clinical			*	✔

			services.				
H.	**Core Principle: Model Prosocial Behaviors and Relationship Enhancement Skills**						
	26.	**Maintain a respectful environment**					
		a.	Evidence that staff and residents model genuineness, empathy and positive regard.	R	✔	✔	✔
		b.	Evidence that trauma informed or resilience-promoting practices are a priority.	R	R	✔	✔
		c.	Evidence that mechanisms exist for residents to inform and help guide operations and advocate for community-building.	✔	✔	✔	✔
I.	**Core Principle: Cultivate the Resident's Sense of Belonging and Responsibility for Community**						
	27.	**Sustain a "functionally equivalent family" within the residence by meeting at least 50% of the following:**					
		a.	Residents are involved in food preparation.	✔	✔	✔	✔
		b.	Residents have a voice in determining with whom they live.	✔	✔	✔	✔
		c.	Residents help maintain and clean the home (chores, etc.).	✔	✔	✔	✔
		d.	Residents share in household expenses.	✔	✔	✔	✔
		e.	Community or residence meetings are held at least once a week.	✔	✔	✔	✔
		f.	Residents have access to common areas of the home.	✔	✔	✔	✔
	28.	**Foster ethical, peer-based mutually supportive relationships among residents and staff**					
		a.	Engagement in informal activities is encouraged.	✔	✔	✔	✔
		b.	Engagement in formal activities is required.			✔	✔
		c.	Community gatherings, recreational events and/or other social activities occur periodically.	✔	✔	✔	✔
		d.	Transition (e.g. entry, phase movement and exit) rituals promote residents' sense of belonging and confer progressive status and increasing opportunities within the recovery living environment and community.	✔	✔	✔	✔
	29.	**Connect residents to the local community**					
		a.	Residents are linked to mutual aid, recovery activities and recovery advocacy opportunities.	✔	✔	✔	✔
		b.	Residents find and sustain relationships with one or more recovery mentors or mutual aid sponsors.	R	✔	✔	✔
		c.	Residents attend mutual aid meetings or equivalent support services in the community.	R	✔	✔	✔
		d.	Documentation that residents are formally linked with the community such as job search, education, family services, health and/or housing programs.	R	✔	✔	✔
		e.	Documentation that resident and staff engage in community relations and interactions to promote kinship with other recovery communities and goodwill for recovery services.	R	✔	✔	✔
		f	Residents are encouraged to sustain relationships inside the residence and with others in the external recovery community	✔	✔	✔	✔

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4.	Good Neighbor Domain			LEVELS			
				I	II	III	IV
J.	**Core Principle: Be a Good Neighbor**						
	30.	**Be responsive to neighbor concerns**					
		a.	Policies and procedures provide neighbors with the responsible person's contact information upon request.	✔	✔	✔	✔
		b.	Policies and procedures that require the responsible person(s) to respond to neighbor's concerns.	✔	✔	✔	✔
		c.	Resident and staff orientations include how to greet and interact with neighbors and/or concerned parties.	✔	✔	✔	✔
	31.	**Have courtesy rules**					
		a.	Preemptive policies address common complaints regarding at least: • Smoking • Loitering • Lewd or offensive language • Cleanliness of the property	✔	✔	✔	✔
		b.	Parking courtesy rules are documented.	✔	✔	✔	✔

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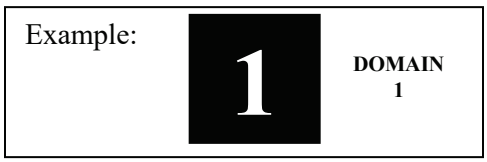
Reference Guide

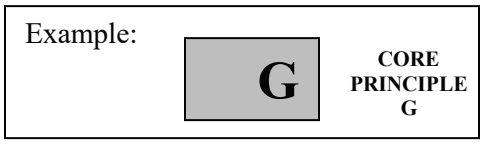
DOMAINS: Notice that there are four (4) **Domains**, the major sections of the document above labeled numerically 1-4: (These are the largest numbers on the document and are in white on a black background)

1. Administrative and Operational Domain
2. Physical Environment Domain
3. Recovery Support Domain
4. Good Neighbor Domain

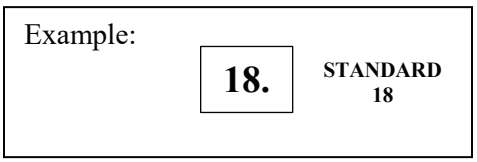


CORE PRINCIPLES: Under each of the **4 Domains** are ten (10) **Core Principles** labeled alphabetically with capital letters, A-J in black type with gray backgrounds:

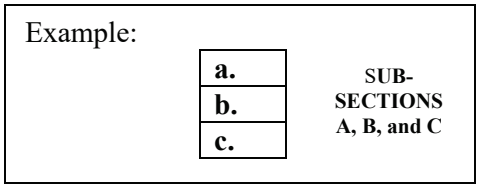
A Operate with Integrity
B Uphold Residents' Rights
C Create a Culture of Empowerment Where Residents Engage in Governance and Leadership
D Develop Staff Abilities to Apply the Social Model
E Provide a Home-like Environment
F Promote a Safe and Healthy Environment
G Facilitate Active Recovery and Recovery Community Engagement
H Model Prosocial Behaviors and Relationship Enhancement Skills
I Cultivate the Resident's Sense of Belonging and Responsibility for Community
J Be a Good Neighbor



STANDARDS: Under each of the **10 Core Principles** are the thirty-one (31) **Standards** labeled numerically from 1-31, in black print with white backgrounds.



SUBSECTIONS: And, finally, under each of the 31 Standards are indented subsections labeled alphabetically in lower-case letters from "a." to as many letters as were needed for each standard.



For quick references to NARR Standards, you may find abbreviations such as the following helpful, or you may find others using them and want to be sure you are understanding the references:

2, F,16. c.

"2, F,16. c." is just short-hand for saying, "We are referring to the Physical Environment Domain ("2"), Core Principle "F" ("Promote a Safe and Healthy Environment"), Standard "16." ("Provide an alcohol and illicit drug free environment"), and subsection "c." ("Policy and procedures for drug screening and/or toxicology protocols").

* = Standard may be subject to state requirement

✓ = Required
R = Recommended

TEST YOURSELF:

If you see a reference to “4, J,30. b.”, to what is it referring?

Your answer:

NARR
National Alliance for Recovery Residences
Community ▪ Standards ▪ Ethics ▪ Education

National Alliance of Recovery Residences (NARR)

National Standard 3.0
Compendium

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NARR supports people in recovery from addiction by improving access, availability, and quality of recovery housing & services.

NARR is the largest recovery housing organization in the U.S. NARR has affiliates in more than 26 states from coast to coast who collectively support over 25,000 people in addiction recovery living in more than 2,500 certified recovery residences.

Contents

Introduction

Development of the NARR Standard

Recovery residences provide safe, healthy, abstinent living environments based on a social model of recovery. These settings emphasize developing mutual support and skills for people in recovery that will enable them to lead sober, productive lives in communities. In 2011, the National Association of Recovery Residences (NARR) made history by establishing a National Standard for recovery residences. This Standard defines the spectrum of recovery-oriented housing and services and distinguishes four residence types known as "levels" or "levels of support." The Standard was developed with input from major regional and national recovery housing organizations, recovery residence providers from across the nation representing all four levels of support, and nationally recognized recovery support stakeholders.

The NARR Standard provides guidance for certifying effective recovery residences and incorporates the collaborative values of acute care and social models of recovery. The Standard is built on the lived experience of operators and residents, not the decisions of an external accreditation body. Resident wellness and opportunities to enhance recovery are at the forefront of the Standard.

While the core of the Standard has remained consistent since Version 1.0, two revisions have improved its specificity for operationalizing recovery-oriented, abstinence-based community integrated homes. Today, Version 3.0 offers explicit guidance to providers, including metrics for evaluating the peer support components of a residence's recovery environment.

The collaborative grassroots nature of the process that lead to the first Standard acknowledged the essential role and responsibility of residents in contributing to and improving their recovery as well as the safety and health of the other residents. The current Standard expresses a decade-long process of collaboration among a vibrant community of operators with a shared mission. Operators, residents, and other stakeholders are invited to improve upon these standards by sharing comments and recommendations. As they contribute, they become part of a community and have access to community wisdom.

Purpose of the Compendium

Since the inception of the NARR Standard in 2011, affiliates across the country have been certifying safe, ethical, and quality residences. As these standards reach a broader audience, their content has become recognized as industry standard, affiliates are frequently asked a common set of questions: How were the standards developed? Why were they selected? Why should they be met? The purpose of this compendium is to

- provide justification for each of the standards so that operators, affiliates, advocates, and policymakers can better describe the benefits a certified residence can have for an individual and community; and
- help stakeholders understand why the NARR Standard is becoming a nationally recognized quality standard for recovery housing.

Purpose of the Standard

The mission of NARR is to support persons in recovery from substance use disorders by improving their access to quality recovery residences through standards, support services, placement, education, research, and advocacy. Recovery residences are important assets within a community and among recovery-oriented systems of services. Residences that meet and maintain the NARR Standard ensure that this resource continues as a viable asset for the people who need it. Adherence to the NARR Standard preserves the fidelity of this unique resource. Further, certified residences promote a level of consistency across houses that has not been previously seen or understood by communities, decision-makers, funders, and researchers. The consistency of core elements across certified residences can provide peace of mind to residents, families, neighbors, legislators, and funders, without additional oversight.

How to Use the NARR Standard

Promulgation of the NARR Standard includes affiliate organizations, recovery residence operators, and other stakeholders who are responsible for certifying recovery residences. Certification based on the NARR Standard provides a level of assurance to operators, residents, granting agencies, and others that a home meets a certain threshold of professional reliability and accountability. Further, recovery residence certification indicates that the home is a respected and integral part of the continuum of care for individuals seeking recovery from substance use disorders.

NARR recognizes the value of each residence in meeting the needs of residents and communities while supporting flexibility in approaches to building individual recovery capital and goals. The NARR Standard is used to embrace residence and resident diversity while assuring residents and the community at large that certified residences offer effective and safe environments that support each individual's recovery goals.

The NARR Standard has four **domains:**

1. Administrative and Operational
2. Physical Environment
3. Recovery Support
4. Good Neighbor

Each of the domains includes **core principles** that establish the underlying statements of beliefs that drive NARR's expectations for recovery residences. The core principles are followed by **individual standards** that establish the minimum criteria for certification. Depending on the level of the residence, meeting each of the 31 standards across the 10 principles is required for certification.

Foundation of the Standard

For decades, residents of recovery homes have recognized the benefits these residences have had on their recovery journeys. Their anecdotal stories provide the foundation for what has helped and hindered their own outcomes. Theoretical models of recovery and research on sober living environments have provided insight into not only *what* is helpful in supporting recovery goals for residents of these housing environments, but *how* these elements support recovery. While the NARR Standard was developed with practical input from recovery housing organizations, providers, and stakeholders, the foundation is rooted in core theoretical underpinnings: Recovery residences promote **recovery** through **social model recovery** by providing four **supportive dimensions** and upholding core recovery **principles,** thereby increasing **recovery capital.** These theoretical underpinnings are described in detail here.

Recovery While recovery has been defined in multiple ways, the Substance Abuse and Mental Health Services Administration (SAMHSA) has developed a working definition of recovery by engaging key stakeholders in the mental or substance use disorder recovery communities:

Recovery is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.[1]

This definition does not describe recovery as an end state but as a process. Recovery can have many pathways that may include "professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches."[1] SAMHSA has identified **four dimensions** that support a life in recovery:

- **Health**—overcoming or managing one's disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and, for everyone in recovery, making informed, healthy choices that support physical and emotional well-being
- **Home**—having a stable and safe place to live
- **Purpose**—conducting meaningful daily activities, such as a job, school volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society
- **Community**—having relationships and social networks that provide support, friendship, love, and hope[1]

Social Model Recovery The social model approach is at the foundation of all recovery residences. Rather than being an element of the NARR Standard, the social model guides all its domains and principles and helps to define what makes a recovery residence different from other shared living environments. While one might expect other group living houses to be ethically run, provide a safe environment, and be respectful members of a neighborhood (all NARR Standard domains), viewing these attributes through the lens of the social model helps to define how these attributes support and foster recovery as part of community.[2] The NARR Standard, rooted in this theoretical framework, helps operators identify not only how they are building a residence (walls, furniture, policies, and individual residents), but how they are building community.

While the underlying concept of the social model has its roots in sober living environments as early as the 1940s, the model was more formally recognized by the 1970s with 12-step houses or "sober living houses."[2, 3] By then, the term "social model," which emphasized the social and interpersonal aspects of recovery,[2] was used to describe environments that emphasized social/cultural dimensions. This was distinct from other existing recovery supports that had an orientation around individual dimensions, rather than communal ones. Principles of the social model include an emphasis on experiential knowledge gained through recovery experience. Residents draw on their experience as a way to help others. Residents are also peer supporters, both giving and receiving help. The concept of ***psychological sense of community,*** which comes primarily from the field of community psychology, is a similar construct that deals with the feelings of connectedness, group membership, and need fulfillment that members of a community may have toward other members.[4, 5] This concept, like the social model, has been used to define and measure outcomes within sober living environments.[6]

A variety of residential programs have adopted different aspects of the social model into their approaches and studies have shown positive outcomes.[7, 8, 9] As more programs have adopted this approach, The Social Model Philosophy Scale (SMPS), which consists of 33 items, was developed to assess the extent to which programs use a social model approach to recovery.[10] The items within the scale are organized into six program domains:

1. **Physical environment:** the extent to which the program facility offers a homelike environment.
2. **Staff role:** the extent to which staff are seen as recovering peers.
3. **Authority base:** the extent to which experiential knowledge about recovery is valued.
4. **Recovery Orientation (or "view of substance abuse problems"):** the extent to which residents view substance abuse as a disease and are involved in 12-step groups.
5. **Governance:** the extent to which the program empowers residents in decision making.
6. **Community orientation:** the extent to which the program interacts with the surrounding community in a mutually beneficial manner.[2]

Recovery Capital Recovery capital defines the resources that can be drawn on to initiate and sustain recovery.[11, 12] Recovery capital can be organized into three categories:

- **Personal recovery capital** (physical recovery capital such as health, financial assets, safe shelter, clothing, etc. and human recovery capital such as knowledge, educational/ vocational skills, self-esteem, self-efficacy, sense of meaning and purpose in life, etc.)
- **Family/social recovery capital** (intimate relationships, family relationships and social relationships)
- **Community recovery capital** (community attitudes/policies/resources related to substance use issues, such as local recovery role models, treatment and mutual aid resources, recovery residences, etc.)[13]

The amount and quality of recovery capital a person has or can acquire can play a critical role in the success of recovery efforts, both within and outside of professional treatment or a mutual aid support.[13, 14, 15, 16]

Core Principles Certified recovery residences that meet the NARR Standard embody a series of core principles. These are not attributes that can be checked off a list; instead, they are central values that permeate every aspect of recovery residence operation. For example, residences

- view recovery as a complex, holistic, lifelong process requiring in-depth understanding of recovery principles, best practices, and the role of the resident as a collaborator in the process;
- demonstrate that providing a high quality service to people in recovery is their essential priority;
- provide evidence that staff and leadership are prepared to deliver appropriate services and support for the population served, are using best practices based on the social model of recovery, and are engaged in continuous professional development;
- show that residents have significant opportunities and time for interactions with each other, with staff, and/or with other mentors to support their recovery; and
- provide evidence that community-based recovery supports (social, physical, psychological, and spiritual) are readily available.

Standard Analysis

The individual standards contained within the core principles under each of the four domains comprise the NARR Standard. Each of these standards is initially derived from best practices, but reflects the theoretical underpinnings described above. Further, many of them have been demonstrated to be effective at improving recovery outcomes for residents in academic research. This Standard Analysis, which begins on page 7 of this compendium, draws on the anecdotal, theoretical, and research foundations of each domain, principle, and individual standard to provide a rationale for their inclusion in the NARR Standard. Recovery residences that meet the NARR Standard enhance recovery capital by operationalizing the social model. Thus, social model recovery and recovery capital are referenced throughout the Standard Analysis in this compendium. As evidence of how the standards reflect the values of social model recovery, many of them naturally map to the SMPS and are referenced in the analysis. Finally, many of the research studies cited are derived from a common body of recovery residence research literature. For a reference to this literature, see Appendix A.

Domain 1: Administrative Operations

Every recovery residence will have operational features as well as therapeutic features. The principles and individual standards contained within "NARR Standard Domain 1, Administrative Operations" describe the infrastructure of a recovery home. Any recovery residence can promote itself as safe and stable, but a *certified* recovery residence must be able to demonstrate these minimum administrative standards. While operational features may seem separate from those that promote social model recovery, the motivations for these features are rooted in the model's framework and are therefore distinct from other living environments that also employ common sense operational practices. The motivations are described by the following principles.

Principle A. Operate with integrity

While our collective ethical and legal code demands that any private organization operate with integrity, recovery residences have the added motivation to do so to reinforce trust.[4, 17] A core element in fostering a sense of community is the belief that the needs of each member of a group matter to the other members.[6] This belief requires trust—trust that as residents, they are safe in the environment. Further, living with integrity is core to recovery. Recovery residences must model that value to support the recovery of their individual residents. Finally, the standards within this principle can help residence operators navigate questions of policy, resident membership, or procedural changes.

Standard 1: Use mission, and vision as guides for decision making

A residence's mission and vision are the measure by which all activity can be compared. Keeping actions aligned within the mission and vision ensures that the residence's core principles will be maintained even if a specific rule or procedure doesn't dictate how the residence should proceed. Value statements like the mission and vision guide the residence beyond the rules and procedures.

Standard 2: Adhere to legal and ethical codes and use best business practices

This standard addresses the foundational base for all operational practice. Outside of following ethical and legal practices for the preservation of a residence, a solvent business model will help the residence operator make decisions in line with these values, rather than to save money. For example, a residence that is struggling to make payments may decide to cut staff or reduce drug testing, thereby putting their mission and values at risk.

Standard 3: Be financially honest and forthright

This standard outlines an expectation of full disclosure and documentation of any financial transaction. Consistent with the principle under which this standard is contained, it is critical to instill trust to foster a sense of community.[18] The community that facilitates recovery.

Standard 4: Collect data for continuous quality improvement

This standard guides residences in the practice of tracking the population being served. Without collecting performance data, recovery residence operators may be unable to accurately assess whether their mission and values are being met. Collecting and reviewing data on resident demographics, engagement, and outcomes can help inform staff decisions and operational elements. In addition, data can help operators improve the quality of their residences and enhance their communication with potential residents, funders, and community members by allowing for a concrete description of how well the organization is doing.

Principle B. Uphold residents' rights

Recovery residences promote recovery by increasing the recovery capital of its residents. Human recovery capital includes self-esteem and self-efficacy[13]—terms which refer to a person's belief in their own value and self-determination. While there are many examples of resident rights,[19] they reinforce these core values of human recovery capital. It validates residents' agency, shifting previous experiences of complying with an external authority to finding authority within themselves. Resident rights establish an individual's prerogative to be in the community and have grievances and autonomy. Establishing resident rights empowers a population that may be unaware that they have rights as a result of previous experiences with discrimination. Upholding rights helps set the tone of trust between the residence operators, among residents, and within their community. This principle also helps operators know that they are doing the right thing if they must remove a resident who may be infringing on the rights of other residents. The same principle also serves as a guide for upholding the rights of a resident who is being removed.

Standard 5: Communicate rights and requirements before agreements are signed

Communicating rights and requirements up front allows the resident and staff to have clear, transparent communications about mutual expectation from the start. The act of sharing this information is about more than protecting rights

and stating requirements. It validates the strengths and individual agency of the resident and conveys the values of the broader community. The nature and timing of this communication show new residents that they are not seen as consumers but as members of a team. It serves to instill this important social model value: The residence is more than a house—it is a community *(authority base; governance)*.

Standard 6: Protect resident information

It is best practice that residences be guided by HIPPA laws.[20] Many residences are legally required to protect resident information under these laws. However, beyond these requirements, residents who feel safe are better able to participate fully in the community, supporting others and being supported. Thus, all recovery residences, regardless of legal requirements, will have protocols to protect resident information.

Principle C. Create a culture of empowerment where residents engage in governance and leadership

This principle is founded on the importance of building human recovery capital.[13] As residents are empowered through self-governance, their reserves of self-determination, self-confidence, skills, and hope—important factors for recovery[21]—are enhanced. This capital becomes a resource for individuals' ability to maintain their recovery and is essential for any recovery residence. The standards under this principle reflect the Social Model Philosophy Scale (SMPS),[10] which is a useful tool to assess and operationalize a resident-empowered, rather than a hierarchical, community.

Standard 7: Involve residents in governance

This standard addresses protocols for how residents' voices are heard in the community. At all levels of recovery residences, as defined by NARR, residents play a role in house governance. Self-governance, in particular, is a hallmark of Levels I and II. There are a number of theoretical and research-based motivations for this standard: Social model recovery reinforces residence involvement in governance *(staff role, authority base; governance),* and recovery capital literature is grounded in the concepts of hope, self-confidence, and self-determination,[21, 22] all of which are enhanced by this participatory process. The psychological dense of community[4] is also a helpful framework for this standard, as group membership is enhanced through shared leadership. The Oxford House, a model of recovery housing that promotes self-governance and resident leadership, has been evaluated using the Psychological Sense of Community Scale (PSCS)[6] and has demonstrated positive recovery outcomes.[18, 23, 24] Therapeutic communities[25] with community councils also reflect this governance model.

Standard 8: Promote resident involvement in a developmental approach to recovery

This standard addresses protocols for developing recovery capital. To what extent do staff and residents participate in and support the community approach to recovery? What customs are in place to lift resident voice to maintain the health and safety of the community? Reflecting the concepts in social model recovery *(staff role; recovery-orientation)* and recovery capital, examining the staff and resident role in promoting community life is critical for recovery residences.

Principle D. Develop staff abilities to apply the social model

It is important to find the social model reflected in the administration and operations of a recovery residence. Operators prepare staff members to reflect the social model and serve as examples for residents. Formal preparation of staff to exemplify and apply the social model, from tasks outlined in the job description to ongoing training and assessment, are expected to be an operational concern of the residence operator. Staff training and assessment will not only build needed skills, they will reinforce existing skills that are consistent with the model and explain why what's being done is beneficial to residents. In addition, staff trained in the social model become a resource to build the personal and community recovery capital for residents.

Standard 9: Staff model and teach recovery skills and behaviors

Protocols are in place that support staff in practicing self-care, both in and out of the organization. As staff model recovery skills (e.g. self-care, boundaries, support network) and demonstrate genuineness, empathy, respect,

support, and unconditional positive regard, they become a recovery capital resource to residents and reinforce the social model *(staff role; authority base; recovery orientation),* thereby promoting positive recovery outcomes.

Standard 10: Ensure potential and current staff are trained or credentialed appropriate to the residence level

There are currently no mandated training models specific to recovery residence staff, so each residence operator must demonstrate a training approach that incorporates social model abilities *(staff role; authority base).* Protocols for ensuring verification of credentials and ongoing training and education are important for maintaining organizational integrity.

Standard 11: Staff are culturally responsive and competent

Staff are able to understand, embody, and support recovery in line with the social model *(staff role and authority base)* due in part to their experiential knowledge about recovery. Residents are multi-faceted individuals, and race, ethnicity, gender, attraction, history, identity, and other factors play an important role in their recovery experience. Quality recovery residences have policies and practices that are culturally competent, seek staff that are as reflective of the priority population as possible, and pursue training and competencies for culturally congruent recovery support. Such support will enhance human recovery capital.

Standard 12: All staff positions are guided by written job descriptions that reflect recovery

While good organizational practices dictate that hired positions have a written job description, these descriptions in recovery residences have an added purpose in reinforcing the social model (see standards 9 and 10). *(staff role; authority base).* Descriptions include recovery skills and behaviors. Further, a written job description can help define staff roles that are often subject to a lack of clarity as residents move into manager positions. This is also important on occasions when internal house or affiliate disciplinary action is necessary. Clear job descriptions help define what responsibilities, if any, have been violated.

Standard 13: Provide social model-oriented supervision of staff

Beyond licensure requirements for supervision that apply to some recovery residences, the role of supervision and the techniques used are different within the social model. Recovery residence managers, for example, may have an individual development plan for their job as well as an individual recovery plan. While recovery support is an important priority, supervision of residence staff is rooted in the social model, rather than a clinical approach. Supervision is strengths-based *(staff role; authority base),* addresses administrative and performance supports, and addresses recovery only as it supports performance. Recovery residence supervision ties directly to supporting the community of recovery. Operators may consider using the SMPS as a foundation for supervision and incorporate other established resources (see Appendix B).

Domain 2.
Physical Environment

The physical dwelling of a recovery residence provides the platform from which to support recovery, reflecting one of SAMHSA's four dimensions of recovery, Home. The role the physical environment can play for many people's recovery has been well documented with reinforcing literature from the field of trauma-informed care. [26, 27, 28 29] Regarding recovery housing, Wittman et al (2014) explain that, "the setting is the services."[26] The setting can significantly support or hinder residents' recovery and shape the interactions between the recovery home and its neighborhoods. Wittman (1993) defined six architectural considerations for recovery housing that can be helpful as residence operators consider this domain. These include the following:

1. **Location:** The housing is sited in a conventional residential neighborhood with minimal crime that ideally has access to infrastructure: transportation, work, recreation, and social/health services.
2. **Appearance:** The look of the residence conveys a sense of being neighborly rather than reclusive. Ideally, it has a design typical of other houses in the neighborhood, is visible from the street (as opposed to hidden behind a wall), and has an approachable front door.
3. **Design for sociability:** The floor plan has an open design in which kitchen, dining and social spaces follow into each other, strongly encouraging socializing to promote recovery and healthy interactions.
4. **Design for personal space:** The residents typically share rooms but have personal or private space. A balance of shared and private space facilitates both relationship building and personal empowerment.
5. **Facility oversight and security:** The physical design enables easy oversight of the premises as well as personal security that promotes a supportive recovery environment. Space is open and free of physical barriers that would separate or seclude residents.
6. **Care and Upkeep:** High levels of physical maintenance, house-cleaning, and upkeep are vital. [30]

Residences must be home-like, safe, promote abstinence, and cultivate community. These settings reinforce the notion that residents have choice in their living environment and can choose healthy spaces. This empowerment can enhance their human recovery capital. Further, space that is recovery-oriented helps to facilitate compliance with the other standards. Physical environment is the first domain in the social model philosophy scale (SMPS): "the extent to which the program facility offers a homelike environment."[10] The standards in this domain reflect the SMPS.

Principle E. Provide a home-like environment

Foundational to recovery residences is the concept of community. Residences must therefore foster community, in part, through the physical setting. Creating a home-like environment facilitates connectedness and feelings of mutuality among residents, enhancing the psychological sense of community.[4] Many people in recovery have past experiences of hierarchical and authoritarian environments as a result of their institutional engagement. Living arrangements that reflect a family environment support genuineness, empathy, respect, support and unconditional positive regard—essential recovery support attributes. Further, language that

emphasizes "home" and "family" reinforces the role these settings play in the community and helps to provide protection from Fair Housing complaints against "facilities" and "centers" that are not consistent with the recovery residences model. A home-like environment reflects the social model *(physical environment).*

Standard 14: The residence is comfortable, inviting, and meets residents' needs

The role of this standard is to provide a guide for assessment of the physical residence. Many shared living arrangements can provide a safe, substance-free environment without fostering that key element of recovery residences—a home-like environment. A welcoming, comfortable home can foster a sense of safety and belonging and cultivate a sense of community. This standard reflects the Social Model *(physical environment)* and Wittman's consideration that the design allows for personal space and sociability.

Standard 15: The living space is conducive to building community

In addition to providing a comfortable space to meet individual needs, recovery residences must also be conducive to SAMHSA's dimension of community. For example, is ample space allotted for community-wide activities? Does the architecture promote isolation or togetherness? Are the equipment and furnishings suitable for serving a community in a home-like setting? This standard reflects the Social Model *(physical environment)* and Wittman's consideration that the design foster sociability.

Principle F. Promote a safe and healthy environment

An element of recovery residences and a foundational value of NARR is the provision of an environment that is supportive of sober living. Settings that promote abstinence are critical to enhancing the physical recovery capital for people with substance use disorders, and these housing options provide choice for individuals who seek supportive housing. This principle fosters an abstinence-based environment and promotes safety within the physical structure of the home through formal written policies and practices.

Standard 16: Provide an alcohol and illicit drug free environment

For many people in recovery, a stable and safe place to live (SAMHSA's dimension of Home) requires an environment of abstinence. This standard also provides guidance for creating a community of accountability and fostering a sober environment. This standard reflects the social model (physical environment) and should be communicated to residence operators via written policies and procedures. (See Appendix C for the NARR Position Statement on Medication-assisted Treatment.)

Standard 17: Promote home safety

For many, the feeling of safety is a precursor to sustained recovery. Residents who feel safe are more able to support others, be supported, and fully participate in the community. Residence operators demonstrate safety protocols and resources that are in place in the certification process (e.g., checklists, inspection reports, etc.). This standard reflects the social model *(physical environment),* recovery capital literature *(physical recovery capital),* and Wittman's consideration of facility oversight and security.

Standard 18: Promote health

SAMHSA's recovery dimension of Health underscores the need to support individuals in making healthy choices for their well-being. This includes decisions beyond managing substance use disorders. A healthy environment that is smoke-free and sanitary enhances feelings of security and promotes a home-like, comfortable setting, building personal recovery capital.[31]

Standard 19: Plan for emergencies including intoxication, withdrawal, and overdose

When all members of a family or community prepare for emergencies together, their feeling of connectedness increases. The same is true for recovery house residents. Emergency preparedness protects the health and safety of residents *(physical environment)* and solidifies community *(authority base; recovery orientation).*

Domain 3. Recovery Support

If the physical home is the "heart" of the recovery residence, the recovery support offered there is the "soul." While Domain 1: Administrative Operations and Domain 2: Physical Environment provide the foundation for recovery support through the internal policies and structure of the setting, Domain 3: Recovery Support specifies the recovery-oriented standards a recovery residence must meet. The standards outlined in this domain address many of the theoretical concepts described throughout this compendium. For example, each of the social model program domains—physical environment; staff role; authority base; recovery orientation; governance; community orientation—are reflected in Domain 3, and SAMHSA's dimensions of recovery feature heavily. These will be referenced throughout this Domain. In many ways, the standards describe unique elements that foster positive recovery outcomes for residents of recovery housing.[32, 33, 34]

Principle G. Facilitate active recovery and recovery community engagement

This principle is the defining feature that separates recovery housing from boarding houses or other shared living environments. While the social model is implicit in many of the standards described previously, Principle G operationalizes the social model concretely and directly.

Standard 20: Promote meaningful activities

All people need purpose, defined in SAMHSA's dimensions of recovery as "meaningful daily activities, such as a job, school, volunteer work, or creative endeavors; and, increased ability to lead a self-directed life; and meaningful engagement in society." While the activities under this standard will vary depending on level, residents will engage in meaningful activities individually and as part of their shared community. Participating in meaningful activities includes mutual aid engagement and reflects social model recovery *(recovery orientation),* thereby enhancing personal and community recovery capital. There are many ways a residence can meet this standard, and operators are asked to document that residents do participate in meaningful activities.

Standard 21: Engage residents in recovery planning and development of recovery capital

Two concepts—pathway and agency—are helpful when describing the motivation for this standard. Snyder et al (1991) first discussed these dual concepts together as "global hope."[35] Global hope occurs when an individual has a goal, conceives of a pathway (such as a Recovery Plan) to that goal, and believes that they have the agency to execute the pathway toward the goal. Research suggests that an increase in one's global hope is predictive of drug abstinence.[22] The concept of self-regulation can also help illustrate the important relationship between pathway and agency and how it relates to this standard. Both pathway and agency are strongly associated with self-regulation,[36] which is an individual's ability to realize a personal health issue and understand the factors involved in that issue. As a person better understands the issue, he or she must decide upon an action plan (pathway) for resolving the issue and execute the plan (agency).[37] Further, agency is strongly associated with self-esteem,[36] an important element in personal recovery capital. As they develop their recovery plans and foster agency to execute them, residents are developing their recovery capital. This standard is seated in the social model *(recovery orientation; governance)* as residents take charge of their own decision making and reflects SAMHSA's dimension, Health.

Standard 22: Promote access to community supports

Promoting access to community supports goes beyond posting mutual aid directories. As described in the social model program domain of community orientation, this standard assesses the extent to which the program interacts with the surrounding community in a mutually beneficial manner. Connection to a broader community enhances community recovery capital. While there are a number of ways a residence can promote access to community supports, asset mapping of supports that are vetted and promoted by residents is a common activity that falls within this standard.

Standard 23: Provide mutually beneficial peer recovery support

Mutual aid has been a long-established resource for people in treatment and recovery from substance use issues.[38] Mutually beneficial peer-to-peer support within the household is found across all residence levels. Residents are also linked to mutual aid outside of the residence as well. Common across all levels is social model support *(staff role; authority base)* where lived experience is a valued qualification for support, and interaction with amongst residents and with community facilitates peer support. Residents have a role to play in the recovery of their fellow house members. A core element to fostering a psychological sense of community[4] is the belief that the needs of each member of a group matter to the others.[6] Peer support factors heavily in this shared community.

Standard 24: Provide recovery support and life skills development services

Rather than focusing on substance use disorders as an issue to be treated, social model recovery looks to a more holistic approach to wellness that includes skills development and formal social support *(recovery orientation).* Peer-based recovery support, a service for which positive evidence continues to emerge, is an essential recovery support. [39, 40] Delivered through formal structures and specialized roles, peer-based recovery supports are nonprofessional services delivered across a range of domains to support long-term recovery.[41] These services are provided by peers who have lived experience and training to assist others in initiating and maintaining recovery and in enhancing their quality of life.[3] The formalized nature of peer support, among other features, makes peer support distinct from mutual aid.[39]

Life skills help individuals positively adapt to effectively deal with the demands and challenges of everyday life.[42] Life skills development, such as employment readiness or budgeting, provides essential informational social support.[43] By providing peer-based recovery support and life skills development services delivered by trained and supervised staff, Level III and Level IV recovery residences enhance human recovery capital as well as community recovery capital. This approach also addresses SAMHSA's recovery dimension, Health. Residence operators will demonstrate structured support for skill development for residents and staff.

Standard 25: Provide clinical services in accordance with state law

This standard is applicable to Level IVs and some Level IIIs, depending on state requirements. For residences where this standard applies, operators must demonstrate that the weekly schedule includes clinical services.

Principle H. Model prosocial behaviors and relationship enhancement skills

Persons with substance use disorders may have lacked or lost natural supports and relationship role models. Within recovery residences, social model cultivates and leverages prosocial values and behaviors characterized by concern for the rights, feelings, and welfare of others and by the desire to support others. Moreover, it helps individuals learn how to develop and sustain healthy, supportive relationships within a recovery family.

Standard 26: Maintain a respectful environment

At its most basic level, maintaining a respectful environment is fostering a family-like environment, reflecting the psychological sense of community[4] and social model *(physical environment; authority base; staff role).* The community culture is positive, recovery-oriented, and strengths-based. Residents move from thinking about the individual to supporting one another in their needs. This extends from staff interactions with residents, resident's interactions with leadership and staff, and resident interactions with one another. Additionally, operator knowledge about trauma-informed care and promoting resiliency provides a toolkit to facilitate a respectful, safe environment.[44]

Principle I. Cultivate the resident's sense of belonging and responsibility for community

Being in relationship with others is a concept referenced throughout the Standard. This is described as community, particularity in the context of community recovery capital and the psychological sense of community.[4] Other times, it's discussed as a family-like relationship as it relates to the concepts of home. These concepts point to a process where the individual in the recovery residence moves from isolation to meaningful engagement with others. This principle focuses on enhancing relationship and prosocial skills for the recovery benefit of both the individual and the broader house community.

Standard 27: Sustain a "functionally equivalent family" within the residence

Living arrangements that reflect a family environment support genuineness, empathy, respect, support, and unconditional positive regard—essential recovery support attributes. Members of a family all pitch in by making food, maintaining the home, and living life with one another. A home-like environment reflects the SMPS *(physical environment),* fostering personal and social recovery capital. The more closely a residence resembles a family household, the more strongly it upholds the characteristics of a single-family neighborhood and the more easily the residents can defend their right to live in residential zoning.

Standard 28: Foster ethical, peer-based mutually supportive relationships among residents and staff

Recovery housing operators are set apart from other helping professions. While appropriate ethical boundaries remain important, it's acceptable for operators and managers to be more informal in their engagement and support. These relationships enhance the community and social recovery capital of residents and address social model recovery *(staff role; authority base).*

Standard 29: Connect residents to the local community

This standard reflects a program domain of social model recovery, which is community orientation. Community recovery capital refers, in part, to the local recovery role models, treatment and mutual aid resources, and recovery homes available to the individual to draw upon as needed to support recovery. This standard emphasizes the role of the residence organization to facilitate that capital.

Domain 4.
Good Neighbor

Principle J. Be a Good Neighbor

A well-run recovery residence is a "family" in a neighborhood. While new families have no requirement to engage with their new community, good neighbors take on that responsibility. Recovery residence operators are expected to function as good neighbors and pursue positive respectful outreach. This engagement is reinforced by the Social Model Recovery program domain, *community orientation.* Modeling good neighbor skills develops these assets for personal recovery capital. The standards in this domain also build on many of the six architectural considerations for recovery housing defined in Wittman (1993): location, appearance, facility oversight and security, and care and upkeep.[26, 30]

Standard 30: Be responsive to neighbor concerns

Just as new residents are joining a community and must work to integrate with and care for the other residents, recovery residence communities can model this behavior by integrating with the neighborhood they are part of. In residential zoning, this includes blending in as a single-family home, not posting signage, and maintaining a pleasant residence. This reinforces the goal that the house is part of a neighborhood, not an island unto itself. This can also help reduce discrimination toward residents who are working to integrate themselves into the community.

Standard 31: Have courtesy rules

As with being responsive to neighbor concerns, having rules of courtesy helps model the good neighbor skills that have become a resource in other aspects of residents' lives. These skills reinforce mutual respect, self-regulation, and a community-orientation over self. Operators can work with residents to help them appropriately engage with the greater community.

Appendix A: Selected Research

Existing research has established recovery housing as a model that supports long-term recovery.[45, 46] Depending on the level of support, length of stay, and model type, recovery housing has been associated with these and other positive outcomes:

- Decreased substance use[7, 8, 47]
- Reduced probability of relapse/reoccurrence[7]
- Lower rates of incarceration[8, 47]
- Higher income[8]
- Increased employment rates[47]

Specifically, there are a few well-researched models and communities contributing to the overall evidence base for such models.

- **Oxford House**™ recovery homes are characterized as democratically run, self-supporting, and drug-free homes and are more effective in reducing substance abuse than referral to usual aftercare options following treatment.[7, 8] Further, the costs of running these homes are low[48] and are offset by the associated benefits, such as reduced illegal activity, incarceration, and substance use.[49] There are more than 2,400 houses utilizing the Oxford House model.[50]
- **Sober Living Houses** are drug-free homes that mandate participation in 12-step meetings. They have been widely studied in California, where more than 300 individual houses are members of the Sober Living Network in Southern California alone.[46, 47, 51] Research conducted in sober living houses in Northern California found improvements in substance use, psychiatric symptoms, employment, and arrests.[33, 47, 52]
- **Philadelphia Recovery Homes** are sober living arrangements often used in conjunction with outpatient treatment, self-help, and other community-based services. Qualitative research has shown operators of these homes see their roles as bigger than just helping residents remain abstinent—a view that is likely to stem from being in recovery themselves or from being a recipient of the benefits of living in a recovery home.[46, 53]
- **Therapeutic Communities** are residential treatment settings that are recovery-oriented, comprehensive, and use active participation in group living and activities to drive individual change. These settings would be considered NARR Level IV. Systematic reviews of the literature on therapeutic communities show better substance use outcomes and legal and employment outcomes as well as psychological functioning.[54]
- **Recovery Housing in Ohio** can vary across the spectrum of recovery residence levels of support. Recent qualitative research has shown that although recovery housing has not been integrated into many housing and treatment continuums in the state, there is growing consensus about its importance and need for various subpopulations.[55]

A common predictor of positive outcomes across recovery housing types is the support individuals receive in recovery-oriented communities.[8] This is consistent with the broader research suggesting that the availability of recovery capital is one factor that affects the success of treatment. Recovery capital includes the economic and social resources necessary to access help, initiate abstinence, and maintain a recovery lifestyle.[56] Social support, such as that provided through 12-step program participation and social network support for sobriety, is a key component of recovery housing and has been shown to directly affect recovery outcomes, including reducing the probability of relapse.[2, 7, 57, 58]

Appendix B: Resources

NARR Code of Ethics

https://narronline.org/wp-content/uploads/2016/08/NARR_Ethics_Code_final_July-2016.pdf
National Alliance for Recovery Residences

All persons working in NARR affiliate organizations, (recovery residence owners, operators, staff, and volunteers) are expected to adhere to a common NARR Code of Ethics. It is the obligation of all recovery residence owners/operators and staff to value and respect each resident and to put each individual's recovery and needs at the forefront of all decision making.

A Primer on Recovery Residences

http://narronline.org/wp-content/uploads/2014/06/Primer-on-Recovery-Residences-09-20-2012a.pdf
National Alliance for Recovery Residences

The purpose of this document is to answer some of the most frequently asked questions about recovery residences.

The Recovery Bill of Rights

https://facesandvoicesofrecovery.org/file_download/inline/158d9cc1-9d1b-4fbc-b24a-963d1478ef73
Faces and Voices of Recovery

This printable poster is a statement of the principle that all Americans have a right to recover from addiction to alcohol and other drugs. All recovery residences must have a resident bill of rights.

Substance Use Disorder Peer Supervision Competencies

http://www.williamwhitepapers.com/pr/dlm_uploads/Peer-Supervision-Competencies-2017.pdf
The Regional Facilitation Center

Peer workers and peer recovery support services have become increasingly central to people's ability to live with or recover from substance use disorders. This peer supervision competency analysis is designed for in-person training.

Core Competencies for Peer Workers in Behavioral Health Services

https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/core-competencies.pdf
Substance Abuse and Mental Health Services Administration (SAMHSA)

Learn about fundamental and essential core competencies required by a range of peer workers. This resource can support peer supervision in recovery residences.

Appendix C: NARR Position Statement on Medication-assisted Treatment

NARR Position Statement on Medication-assisted Treatment—DRAFT*

1. Medication-assisted treatment (MAT) is one of many viable recovery tools. Research shows that MAT, when used along with other recovery support services, improves engagement and outcomes.
2. Recovery residence owners/operators cannot legally deny admission solely on the basis of an applicant's current use of physician-prescribed medications. See Know your rights: Rights for individuals on medication-assisted treatment (2009)[59]
    a. Recovery residences may decline referrals of individuals who use certain medications because the recovery residence does not provide pertinent staff or services. In those cases, referrals should be made to alternative facilities that may be available.
3. Consistent with a recently-approved NARR standard, recovery residences are encouraged to maintain a supply of naloxone and ensure staff are trained periodically in overdose reversal procedures.
4. Based on the NARR Standard, certified recovery residences maintain accommodations for residents to store drugs securely and take their medications following the prescriptions. See standard #16, The NARR Standard (2018).

**This draft position statement was developed at the 2016 NARR Conference and can be found on the Learning Center page of the NARR website. The statement has been updated for this appendix to reflect the standard numbers used in Version 3.0.*

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