NARR
National Alliance for Recovery Residences

Recovery Residence Standards
(NARR version 2015)

What is a “Standard”?

A noun

1. Something considered by an authority or by general consent as a basis of comparison; an approved model.
2. A rule or principle that is used as a basis for judgment : i.e. *They tried to establish standards for a new philosophical approach*
3. An average or normal requirement, quality, quantity, level, grade, etc.: i.e. *His work this week hasn't been up to his usual standard.*
4. Standards, those morals, ethics, habits, etc., established by authority, custom, or an individual as acceptable: i.e. *He tried to live up to his father’s standards*

Why a national standard?

Unification. Education. Quality Capacity.

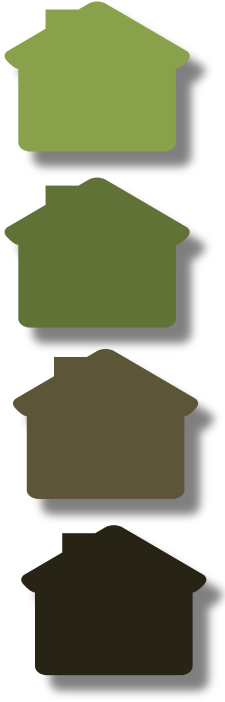
- ✓ Standardized nomenclature allows for more productive & meaningful conversations
- ✓ Translates across states: different & changing laws
- ✓ Inclusive framework:
  - 4 Levels of Support

- ✓ Unites fragmented knowledge base
- ✓ Facilitates the collection and promotion of best practices
- ✓ Offers a blueprint to new capacity & quality capacity
- ✓ Equips researchers with comparative subjects
- ✓ Basis for a certification program

Why a certification?

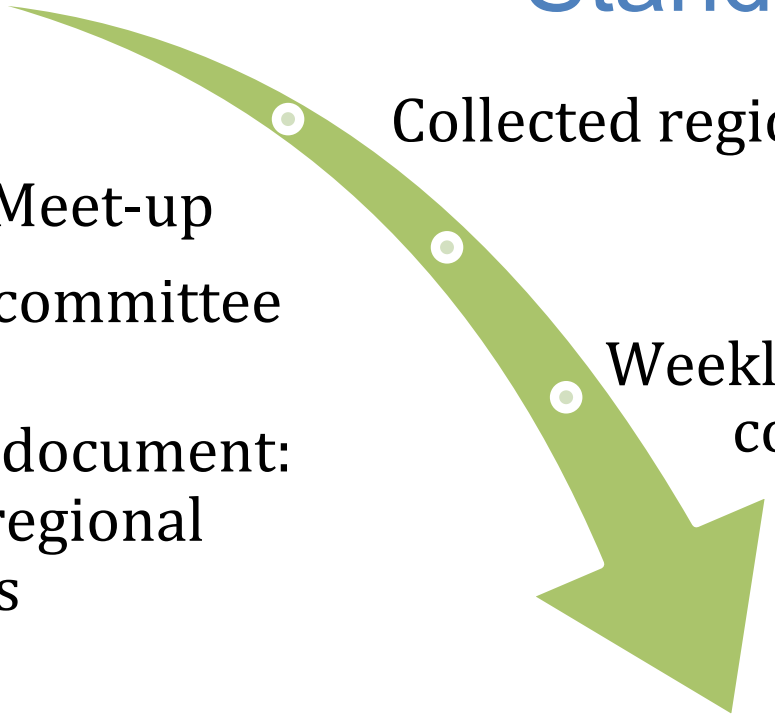
More then just quantity, we need quality

- ✓ Public facing mechanism that empowers choices and instills confidence: consumers, funders, referral agents…
- ✓ Provides consumer protection and a grievance process
- ✓ Incentivizes fidelity to best practices (ideally through support and mentoring) rather than policing compliance ("carrots" over "sticks")
- ✓ Opt-in certification promotes quality without raising impediments to fair housing choice and complements (not replaces) existing regulation
- ✓ Cost effective and flexible over time



How was the 2011 Standard developed?

2010: Conference calls & industry leadership recruitment



May 2011 Meet-up

- Steering committee founded
- Working document: collated regional standards

Collected regional standards

Weekly discussions and consensus building

Sept. 2011 NARR Summit

- Standard ratified and published

Standard draws from 170+ years of wisdom

1840s

- Earliest recorded RR

Mid-1900s

- AA Houses
- Pioneer House, Hazel's Den
- AHHAP

Late 1900s

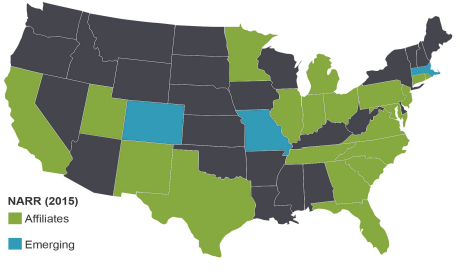
- 70s Oxford House, Inc. formed, regional orgs formed (CAARR, GARR, SLN…), Social Model Philosophy defined

Early 2000s

- More regional orgs formed (MASH, CCAR…), growth in capacity

2011 to present

- NARR – National Alliance for Recovery Residences
- Merged with AHHAP in 2013



Original Standard Domains

1	Organizational / Administrative Standards
2	Fiscal Management Standards
3	Operation Standards
4	Recovery Support Standards
5	Good Neighbor Standards
6	Property Standards

Why review and revise the Standard?

1. Fidelity – Promote. Preserve. Protect.

- Historically, changing markets, policies and funding have corrupted the recovery residence model(e.g. treatment, criminal justice and housing)
- Currently, markets, policies and funding are changing
  - **Health Reform** – ROSC, shift towards outpatient
    - behavioral health & addiction services
  - **Justice Reform** – Jail diversion, re-entry
  - **Housing Choice**

Why review and revise the Standard?

2. **More educational** - what we do & why we do it.

- Make more accessible to wider audiences e.g "outside world"
  - Original NARR standard was written by current providers for current providers. Some common knowledge was taken for granted.
- New entries into the recovery residence marketplace
  - With and with**OUT** lived experience

Why review and revise the Standard?

3. Empower Housing Choice / Levels Determination

- Better distinguish between recovery residence choices within a state and across states

4. Operationalize certification

- Lower barriers to new affiliates implementing the certification program
- Objective, measurable standards reduce confusion and liability

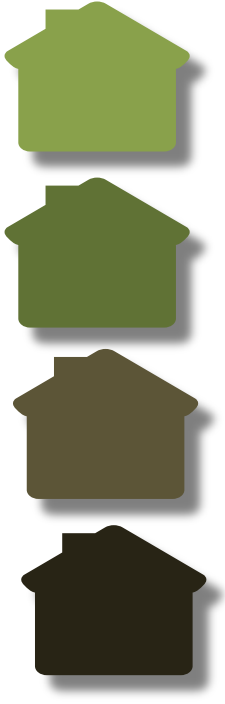
Why review and revise the Standard?

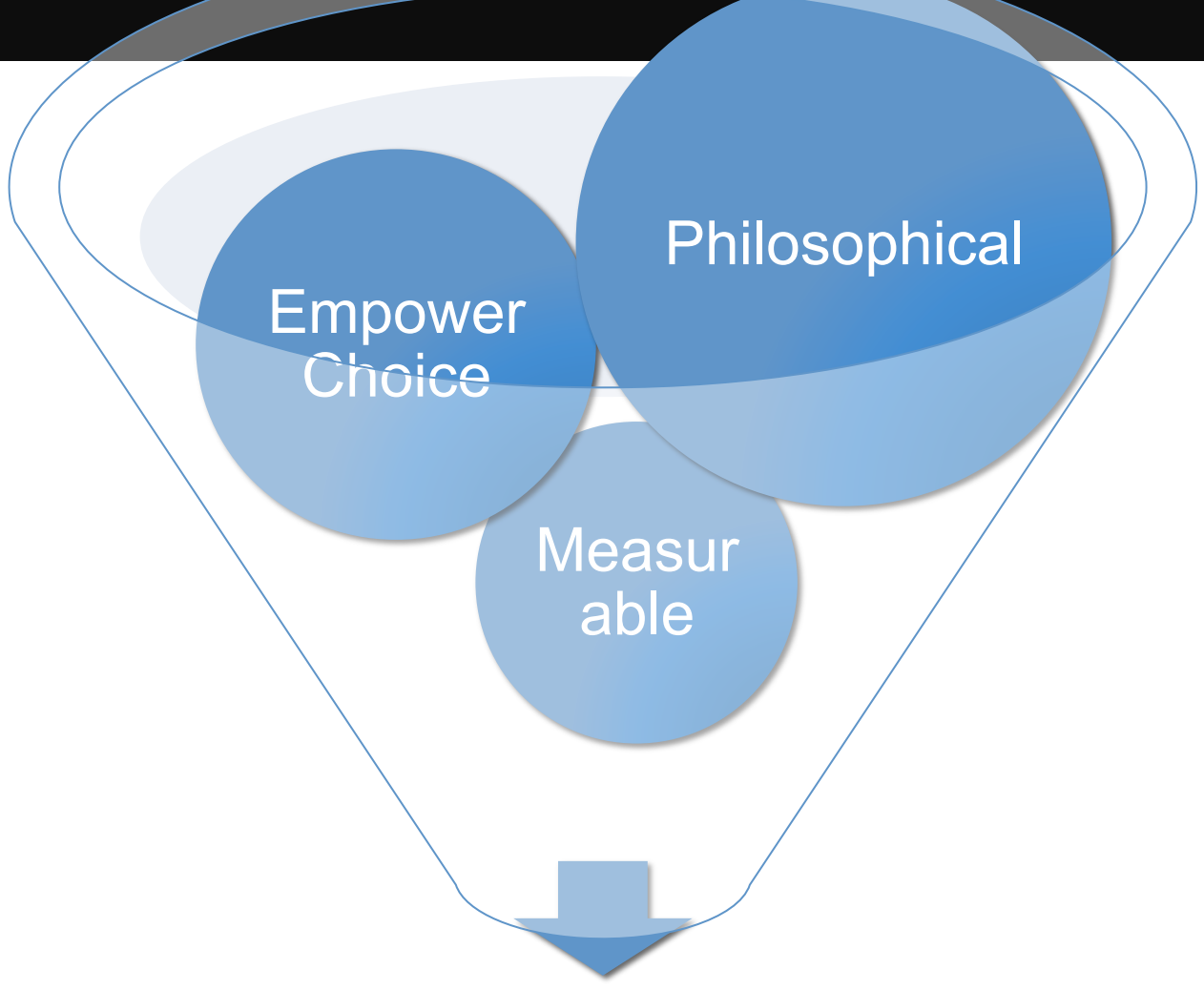
5. Stay relevant

- Incorporate growing body of knowledge
- Periodic reviews and revisions are a best practice

What was the review process?

- Began at the 2014 NARR Best Practices Summit
- Weekly & monthly conference calls
- Identified goals, developed collaborative documents (definitions, cross-walks) and reviewed each standard
- Drafted new format and discussed each item
- Presented draft to NARR Board
- Posted draft for public comment
- Ratification at 2015 Best Practices Summit





2015 NARR Format

NARR (2015)

Domains, Core Principles & Standards

Admin-istrative

- Operate with integrity
- Uphold resident rights
- Are recovery-oriented
- Are peer staffed & governed

Recovery Support

- Promote health
- Provide a home
- Inspire purpose
- Cultivate community

Architecture

- Promote recovery
- Promote health & safety

Good Neighbor

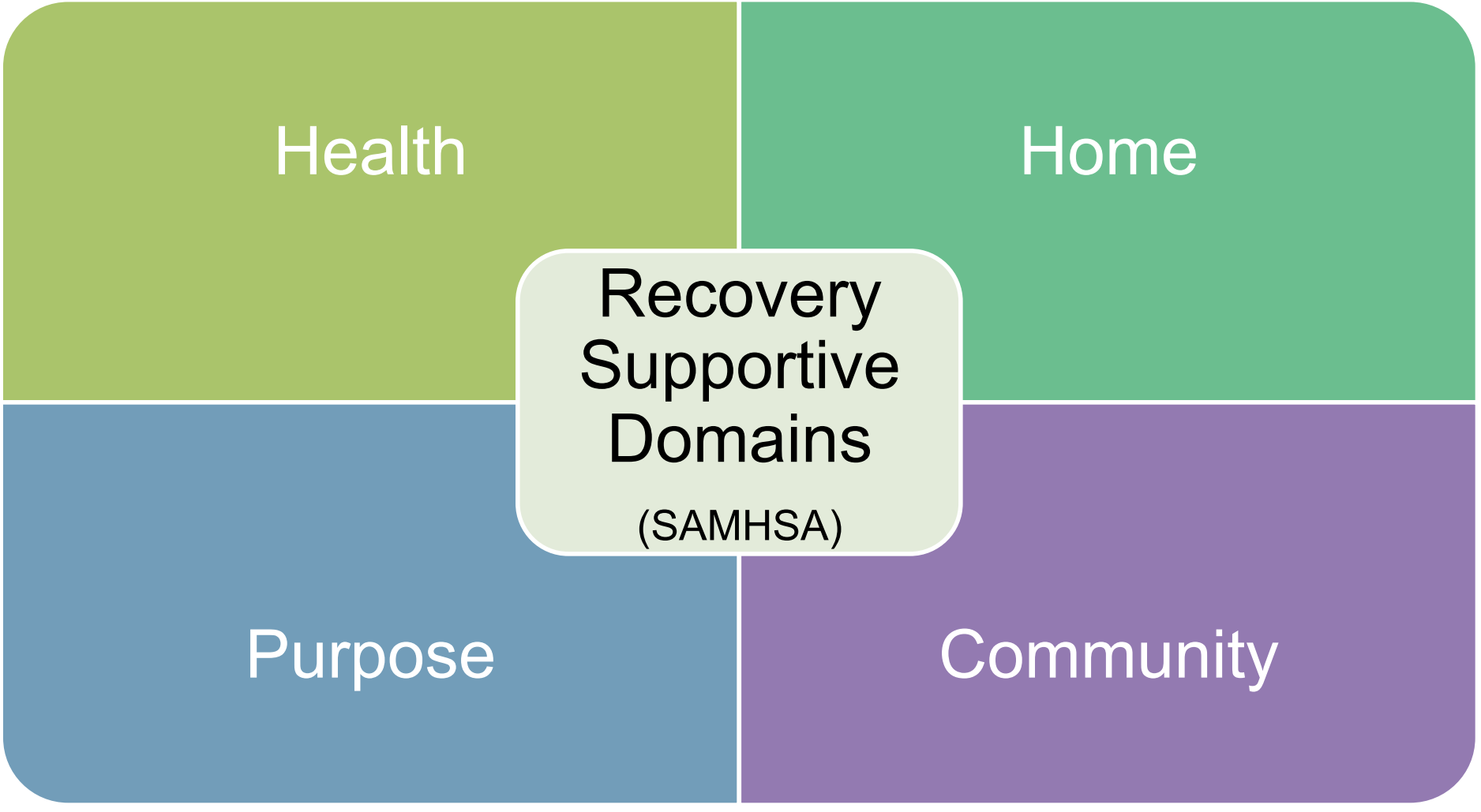
- Are good neighbors

37 Standards
across the domains

How do recovery residence “work”? What we do and why we do it?

Incorporating philosophy into the NARR Standard:

- **Recovery Supportive Domains** (SAMHSA)
- **Social Model Recovery** (Borkman & Kaskutas)


Health
Home
Recovery Supportive Domains
(SAMHSA)
Purpose
Community

NARR (2015)

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- Are good neighbors

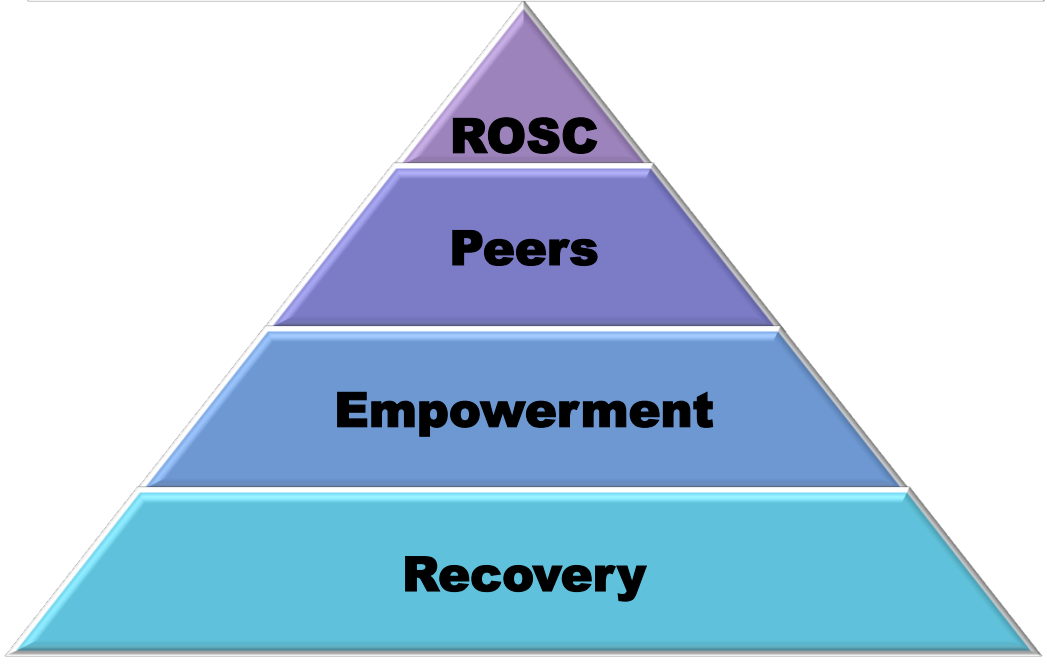
SAMHSA's Supportive Domains of Recovery used to frame principles

What is Social Model Recovery?

A recovery-oriented, chronic care approach:

- ✓ Philosophy and practices are different than medical/ clinical based treatment models
- ✓ Emphasizes social and interpersonal aspects of recovery using recovery as the common bond
- ✓ Values experiential knowledge and mutual support
- ✓ Views recovery as a person-driven, life-long and holistic process

Community = Social Model



KEY ELEMENTS

Where did the Social Model come from?

- ✓ Social Model Programs emerged out of AA in the 1940s and continued to evolve to include a range of recovery residences and non-residential community centers (Borkman)
- ✓ Predecessor to today's addiction treatment
- ✓ Modern recovery movement is stimulating a Social Model renaissance and further evolving the model

Why the Social Model?

- ✓ Addiction is a chronic illness in need of a chronic care approach
- ✓ Acute, episodic treatment approach results in 50 to 69% relapse within 12 months
- ✓ Most return from treatment/institutions to a living environment that enables addictive lifestyle
- ✓ Social Model programs are cost effective means of improving recovery outcomes

How is it measured?

Social Model Philosophy Scale (SMPS)

Assessment tool used to capture treatment program philosophies over time

33 items across 6 domains:

1. Physical environment
2. Staff role
3. Authority base
4. Recovery orientation*
5. Governance
6. Community orientation

(Kaskutas et. al. 1998)

SMPS: Physical Environment

The physical space of a social model program is vital. It must promote interaction between staff and participants and each other. Social model environments feel more like homes rather than clinical settings

To what degree does it feel like a home?

- Architecturally and functionally homelike
- Community space (%)
- "Welcome mat"
- Everyone pitches in as a family, e.g. food prep or house chores

SMPS: Staff Role

Social model programs encourage staff to mingle with participants. Some of the best insight, feedback and interactions happen in an informal or community setting.

To what degree are staff respected peers vs. distant superiors?

- Share community meals
- Staff's time is spent amongst the residents
- Resident progress is rewarded with more responsibility

SMPS: Authority Base

Social model programs by enlarge employ persons in recovery (often alumni), believing recovery imparts experiential knowledge, an invaluable resource. Professional knowledge is not valued over experiential knowledge

To what degree is authority based on lived experience?

- Staff that are alumni and/or in recovery
- Key roles that don't require professional credentials
- Mutual aid / social support is encourage

SMPS: Recovery-orientation

Social models programs have a recovery-oriented view and approach understanding that recovery is person-driven, lifelong and a "whole-person" process. Plus, alcohol and drugs are only a part of the problem.

To what degree is the program recovery-oriented?

- Called recovery programs, residences or centers
- Called residents or participants
- Have recovery plans

SMPS: Governance

Social model programs utilizes peers to establish and enforce program rules in a significant way. Participants will feel more invested in the program and their own recovery and get to develop skills.

To what degree does accountability involve peers?

- Residents are expected/ encouraged to hold each other accountable
- Residents/councils have influence

SMPS: Community-oriented

Social model program recognize that individuals must learn how to reach out and connect with a web of support in the community including friends, mentors, social activities, employments.

To what degree is the community viewed as a resource?

- Recovery community is invited in
- Residents have mentor/ Sponsor
- Link residents to outside services
- Host recovery events

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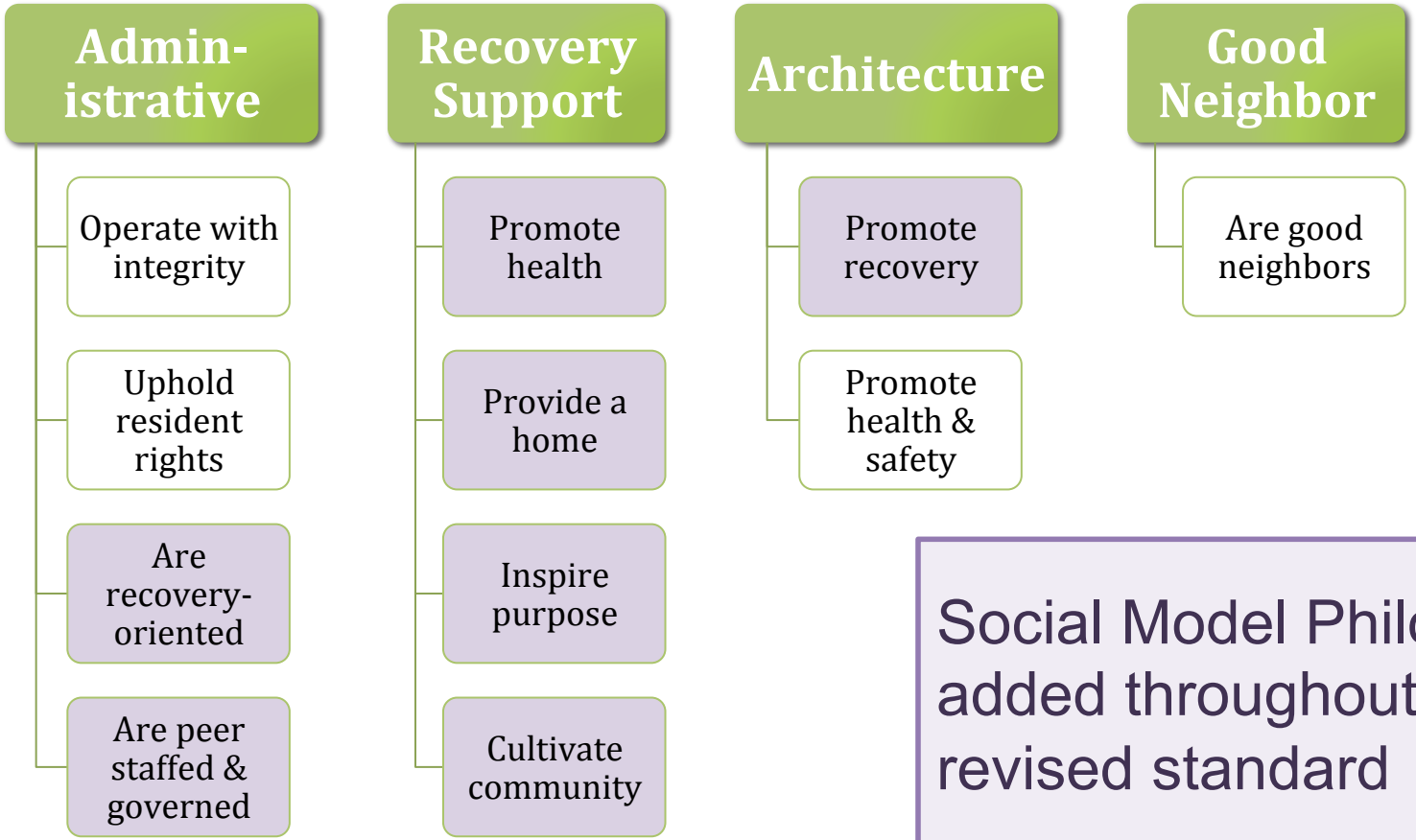
Domains, Core Principles & Standards



Social Model Philosophy added throughout the revised standard

Empower Housing Choice / Levels Determination

Inclusive framework
Recovery Residences
4 Levels of Support

"What am I paying for?"
"Which is right for me?"

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Levels differ in: Service Bundles

Housing – safe, stable housing that is recovery supportive

Social Model – sociocultural elements & structure that promote ubiquitous support, accountability & connectedness

Peer Recovery Support
- Formal one-on-one (e.g. coaching)
- Formal groups (e.g. support groups)

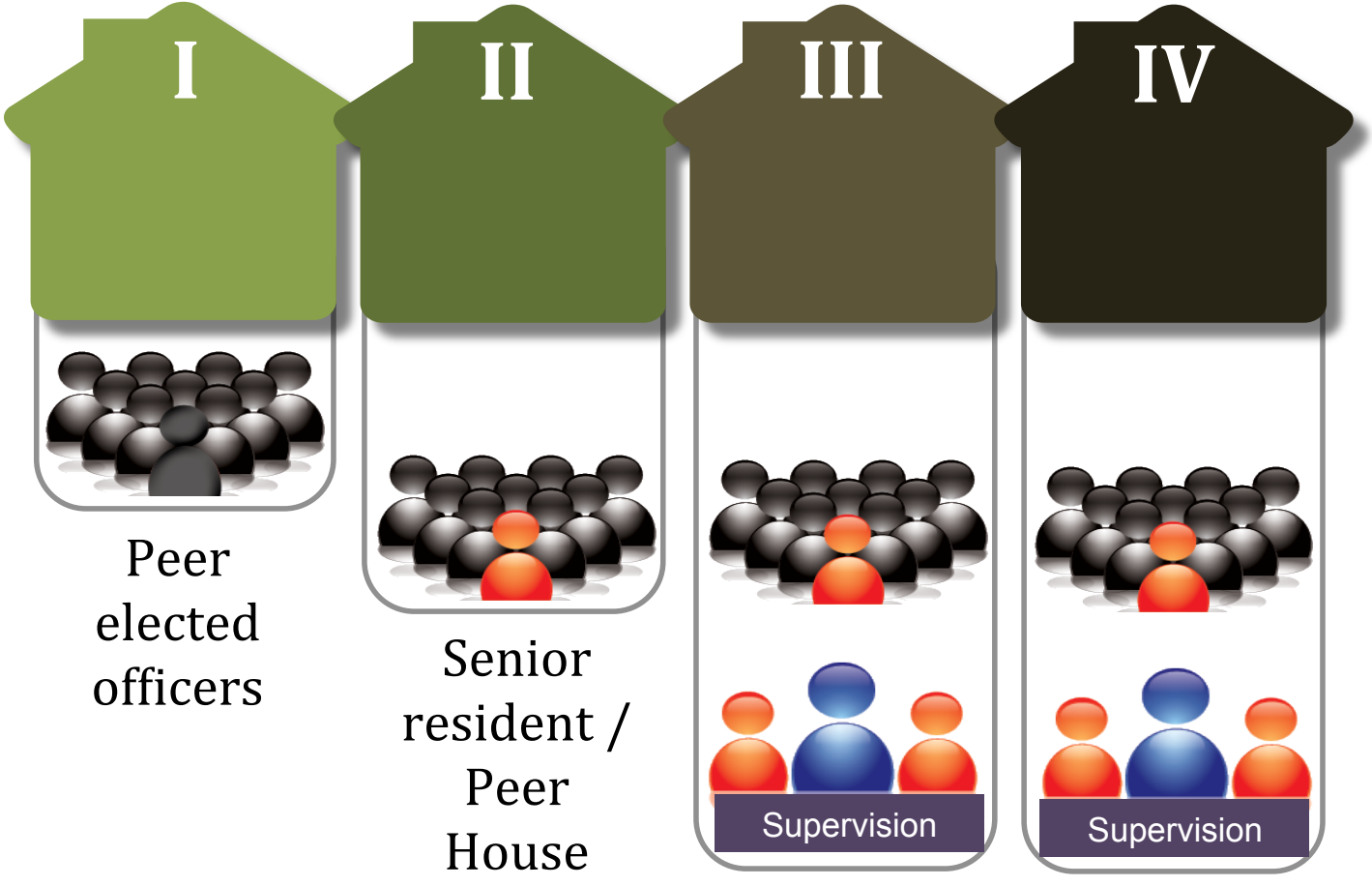
Life skills
e.g. job readiness, budgeting

Trend: IOP/PHP + RR

Clinical

Levels differ in:

Staffing



Peer elected officers

Senior resident / Peer House Manager

Staff supervision e.g. ongoing skills development and support

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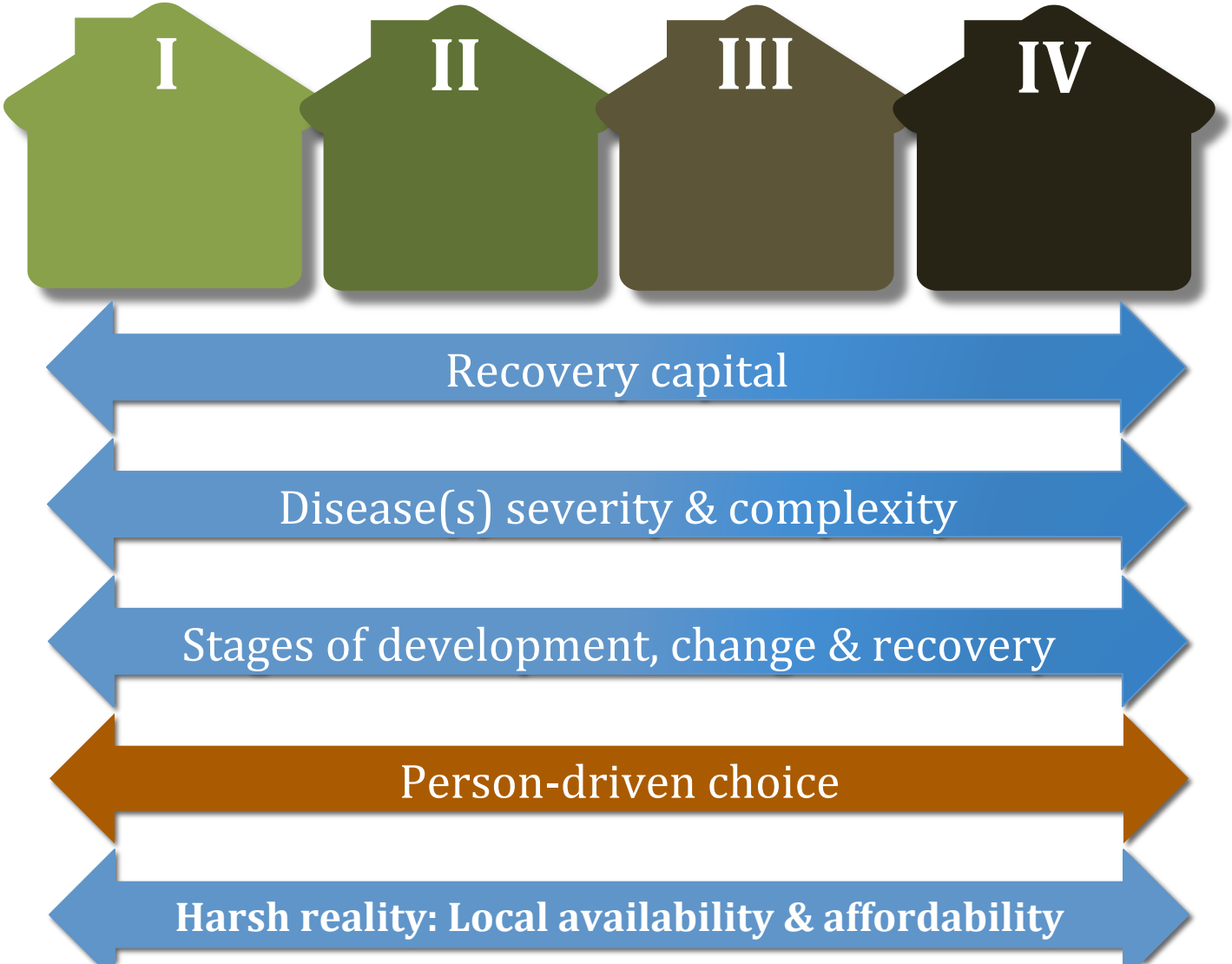
One size does not fit all:

Recovery residences a fit? If so, which is right for whom?



Measurable Standards

Adminstrative and Operational Domain

Operate with integrity

1	Are guided by a mission and vision	I	II	III	IV
	As evidenced by: ❑ A written mission statement that corresponds with NARR principles ❑ A vision statement that corresponds with NARR's core principles as stated in this document				
2	Adhere to legal and ethical codes				IV
3	Are financially honest and forthright	I	II		V
4	Collect data for continuous quality improvement	®	®	III	IV

Philosophical

Measurable

Adminstrative and Operational Domain

Operate with integrity

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2	Adhere to legal and ethical codes	I	II	III	IV
3	Are financially honest and forthright	I	II	III	IV
4	Collect data for continuous quality improvement	®	®	III	IV
5	Operate with prudence	®	®	III	IV

® Recommended

Adminstrative and Operational Domain

Uphold resident rights

6	Communicate rights and requirements before agreements are signed	I	II	III	IV
7	Promote self and peer advocacy	I	II	III	IV
8	Protect privacy	I	II	III	IV

Adminstrative and Operational Domain

Are recovery-oriented

10	View recovery as a person-driven, holistic and lifelong process	I	II	III	IV
11	Are culturally responsive, congruent and/ or competent	I	II	III	IV

Adminstrative and Operational Domain

Are peer staffed and governed					
12	Involve peers in governance in meaningful ways	I	II	III	IV
13	Use peer staff and resident leaders in meaningful ways	I	II	III	IV
14	Maintain resident and staff leadership based on recovery principles	I	II	III	IV
15	Create and sustain an atmosphere of recovery support	I	II	III	IV
16	Ensure staff are appropriately trained and credentialed			III	IV
17	Provide supportive staff supervision			III	IV

Recovery Support Domain

Promote health

18	Encourage residents to own their own recovery	I	II	III	IV
19	Inform residents about community-based supports	I	II	III	IV
20	Offer RSS in informal settings	I	II	III	IV
21	Offer RSS in formal settings			III	IV
22	Offer life skills development in formal settings			III	IV
23	Offer clinical services in accordance with State law				IV

Recovery Support Domain

Provide a home

24	Are home-like environments	I	II	III	IV
25	Are alcohol and drug-free environments	I	II	III	IV
26	Are cultivated through structure and accountability	I	II	III	IV

Recovery Support Domain

Inspire purpose

27	Promote meaningful daily activities	I	II	III	IV

Recovery Support Domain

Cultivate community

28	Create a “functionally equivalent family”	I	II	III	IV
29	Foster ethical, peer-based mutually supportive relationships between residents and/or staff	I	II	III	IV
30	Connect residents to the local recovery community	I	II	III	IV

Property and Architecture Domain

Promote recovery

31	Create a home-like environment	I	II	III	IV
32	Promote community	I	II	III	IV

Property and Architecture Domain

Promote health and safety

33	Promote home safety	I	II	III	IV
34	Have an emergency plan	I	II	III	IV

Good Neighbor Domain

Are good neighbors

35	Are compatible with the neighborhood	I	II	III	IV
36	Are responsive to neighbor complaints	I	II	III	IV
37	Have courtesy rules	I	II	III	IV

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