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
2010: Conference calls & industry leadership recruitment

May 2011 Meet-up
- Steering committee founded
- Working document: collated regional standards

Weekly discussions and consensus building

Sept. 2011 NARR Summit
- Standard ratified and published

How was the 2011 Standard developed?
Standard draws from 170+ years of wisdom

1840s
• Earliest recorded RR
  • Pioneer House, Hazel’s Den
  • AHHAP

Mid-1900s
• AA Houses

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

Standard draws from 170+ years of wisdom
<table>
<thead>
<tr>
<th></th>
<th>Original Standard Domains</th>
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<tbody>
<tr>
<td>1</td>
<td>Organizational / Administrative Standards</td>
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<tr>
<td>2</td>
<td>Fiscal Management Standards</td>
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<td>3</td>
<td>Operation Standards</td>
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<td>4</td>
<td>Recovery Support Standards</td>
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<td>5</td>
<td>Good Neighbor Standards</td>
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<tr>
<td>6</td>
<td>Property Standards</td>
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</table>
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

**Administrative**
- 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)*
NARR (2015)
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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
- ROSC
- Peers
- Empowerment
- Recovery
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)
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
NARR (2015)
Domains, Core Principles & Standards

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Social Model Philosophy added throughout the revised standard
Empower
Housing Choice / Levels Determination
“What am I paying for?”
“Which is right for me?”
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:
- Service Bundles
Levels differ in:

- Staffing

Staffing Supervision

Levels differ in:

1. Peer elected officers
2. Senior resident / Peer House Manager
3. Staff supervision e.g. ongoing skills development and support
One size does not fit all: Recovery residences a fit? If so, which is right for whom?

Recovery capital
Disease(s) severity & complexity
Stages of development, change & recovery
Person-driven choice
Harsh reality: Local availability & affordability
Measurable Standards
Operate with integrity

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<tbody>
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<td>1</td>
<td>Are guided by a mission and vision</td>
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<td>As evidenced by:</td>
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<td>- A written mission statement that corresponds with NARR principles</td>
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<td>- A vision statement that corresponds with NARR’s core principles as stated in this document</td>
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<td>Adhere to legal and ethical codes</td>
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<td>Are financially honest and forthright</td>
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<td>Collect data for continuous quality improvement</td>
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<td>Operate with prudence</td>
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® Recommended
### Administrative and Operational Domain

#### Uphold resident rights

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<thead>
<tr>
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<th>Description</th>
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<tbody>
<tr>
<td>6</td>
<td>Communicate rights and requirements before agreements are signed</td>
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<tr>
<td>7</td>
<td>Promote self and peer advocacy</td>
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<td>8</td>
<td>Protect privacy</td>
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## Adminstrative and Operational Domain

### Are recovery-oriented

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<td>10</td>
<td>View recovery as a person-driven, holistic and lifelong process</td>
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<td>11</td>
<td>Are culturally responsive, congruent and/or competent</td>
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<td>Administrative and Operational Domain</td>
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<tr>
<td>12</td>
<td>Involve peers in governance in meaningful ways</td>
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<td>13</td>
<td>Use peer staff and resident leaders in meaningful ways</td>
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<td>14</td>
<td>Maintain resident and staff leadership based on recovery principles</td>
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<td>15</td>
<td>Create and sustain an atmosphere of recovery support</td>
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<td>16</td>
<td>Ensure staff are appropriately trained and credentialed</td>
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<td>17</td>
<td>Provide supportive staff supervision</td>
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<td>18</td>
<td>Encourage residents to own their own recovery</td>
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<td>II</td>
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<tr>
<td>19</td>
<td>Inform residents about community-based supports</td>
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<td>II</td>
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<tr>
<td>20</td>
<td>Offer RSS in informal settings</td>
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<td>II</td>
<td>III</td>
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<td>21</td>
<td>Offer RSS in formal settings</td>
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<td>22</td>
<td>Offer life skills development in formal settings</td>
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<td>IV</td>
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<td>23</td>
<td>Offer clinical services in accordance with State law</td>
<td>IV</td>
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## Recovery Support Domain

### Provide a home

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<tbody>
<tr>
<td>24</td>
<td>Are home-like environments</td>
<td>I</td>
<td>II</td>
<td>III</td>
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<tr>
<td>25</td>
<td>Are alcohol and drug-free environments</td>
<td>I</td>
<td>II</td>
<td>III</td>
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<tr>
<td>26</td>
<td>Are cultivated through structure and accountability</td>
<td>I</td>
<td>II</td>
<td>III</td>
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<td>Recovery Support Domain</td>
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<tr>
<td><strong>Inspire purpose</strong></td>
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<tr>
<td>27 Promote meaningful daily activities</td>
<td>I</td>
<td>II</td>
<td>III</td>
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<tr>
<td></td>
<td>Cultivate community</td>
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<td>28</td>
<td>Create a “functionally equivalent family”</td>
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<td>29</td>
<td>Foster ethical, peer-based mutually supportive relationships between residents and/or staff</td>
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<td>30</td>
<td>Connect residents to the local recovery community</td>
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## Property and Architecture Domain

### Promote recovery

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<tbody>
<tr>
<td><strong>31</strong></td>
<td>Create a home-like environment</td>
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<td><strong>32</strong></td>
<td>Promote community</td>
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<td>Property and Architecture Domain</td>
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<td>33</td>
<td>Promote home safety</td>
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<tr>
<td>34</td>
<td>Have an emergency plan</td>
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# Good Neighbor Domain

## Are good neighbors

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<td>35</td>
<td>Are compatible with the neighborhood</td>
<td>I</td>
<td>II</td>
<td>III</td>
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<td>36</td>
<td>Are responsive to neighbor complaints</td>
<td>I</td>
<td>II</td>
<td>III</td>
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<tr>
<td>37</td>
<td>Have courtesy rules</td>
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<td>II</td>
<td>III</td>
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