Recovery Housing: Best Practices and Suggested Minimum Guidelines

On October 24, 2018 the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities was signed into law by President Trump. Subtitle D, Ensuring Access to Quality Sober Living (SEC. 7031), of this law mandates that the Secretary of Health and Human Services, in consultation with other specified individual stakeholders and entities, shall identify or facilitate the development of best practices for operating recovery housing. These best practices may include model laws for the implementation of suggested minimum standards that:

(1) consider how recovery housing is able to support recovery and prevent relapse, recidivism, and overdose, including by improving access to medication assisted treatment
(2) identify or facilitate the development of common indicators that could be used to pinpoint potentially fraudulent recovery housing operators

The SUPPORT legislation seeks to improve client care for individuals suffering from a substance use disorder who are in need of supportive recovery-oriented transitional housing. The Administration and SAMHSA's Assistant Secretary for Mental Health and Substance Use have dedicated time, attention, and resources to ensuring that individuals with addictions have access to life saving medications, treatments, and services in settings throughout the substance use disorder continuum of care, including recovery housing. As such, the information and suggestions within this document address the areas of concern listed above and should serve as an opportunity for states, governing bodies, treatment providers, recovery house operators, and other interested stakeholders to improve the behavioral health of their citizens.

This report identifies ten specific areas, or guiding principles, that will assist patients, providers, specialists, concerned citizens, and state and federal policy makers in defining and understanding what safe, effective, and legal recovery housing is. There has been significant and valuable work by national organizations to assist in developing polices, practices, and guidance that improves recovery houses as a valuable model of care. The areas defined in this report are not meant to supplant or contradict that good work. In contrast, these areas are meant to provide an overarching framework that can be mutually supportive of the foundational policy and practice work that has successfully guided the development of recovery housing to date. Based on best practices evidence, SAMHSA recommends following these Ten Minimum Standards to guide recovery house operators, stakeholders and states in enacting laws designed to provide the greatest level of client care and safety.

1. Have a clear operational definition
2. Understands that addiction is a chronic condition requiring recovery supports
3. Co-occurring Informed
4. Assesses facility and appropriately matches client needs

5. Administrative acumen and accountability
6. Provides or supports evidence-based practices
7. Ensures quality and client safety
8. Ongoing communication with interested parties and care specialists
9. Culturally Competent
10. Measures performance and success

Background Information:

The disease of addiction is often accompanied by a unique culture and an environment that supports and facilitates the progression of the disease. During active addiction, most people with a substance use disorder have an established informal network of enablers, suppliers, or dealers that all operate to furnish the addicted person with the desired intoxicating chemicals. This informal network can be comprised of a parent who supplies money or pays bills, close friends and using associates, a particular corner or location known for drug dealing, a prescribing physician, stocked medicine cabinet or other unhealthy relationships that exacerbate the desire for self-medication. These unhealthy dynamics create a self-destructive living environment that is both familiar and entrenched as using patterns and addictive behaviors tend to be ritualistic in nature. In addition, cravings to use drugs are often associated with emotional reactions or "triggers" to environmental cues that are most pronounced. For most addicts these environmental and emotional cues are strong and complicate the recovery process. Therefore, it is necessary for people seeking recovery to relocate to another environment to gain a fresh start free of the trappings of a potentially fatal lifestyle. Recovery housing is an intervention that was specifically designed to address the recovering person's need for a safe and healthy living environment while supplying the requisite recovery and peer supports. Given how vital recovery housing is to the continuum of care, the ten best practices and minimum standards are further described within this document.

Best Practices and 10 Minimum Standards:

1. **Recovery House Operational Definition:**

In keeping with the basic premise that recovery houses are important interventions in the continuum of care that are designed to prevent relapse by providing recovery supports to individuals in early recovery; all recovery housing should have a clear operational definition that accurately delineates the type of services offered and to what degree or intensity these services are provided. The SUPPORT legislation defined the term 'recovery housing' to describe a shared living environment free from alcohol and illicit drug use and centered upon peer supports and connection to services that promote sustained recovery from substance use disorders. Noted recovery house researchers Polcin, Korcha, Gupta, Subbaraman, & Mericle (2017) described recovery sober living homes as alcohol and drug free recovery residences that assist individuals with substance use disorders in achieving and maintaining long-term abstinence. Both of these

descriptions highlight the basic concept that recovery house utilize the social model of recovery to help individuals maintain sobriety.

Additionally, the Substance Abuse and Mental Health Services Administration (SAMHSA) official definition of recovery housing is described below:

> *Recovery houses are safe, healthy, family-like substance-free living environments that support individuals in recovery from addiction. While recovery residences vary widely in structure, all are centered on peer support and a connection to services that promote long-term recovery. Recovery housing benefits individuals in recovery by reinforcing a substance-free lifestyle and providing direct connections to other peers in recovery, mutual support groups and recovery support services. Substance-free does not prohibit prescribed medications taken as directed by a licensed physician, such as Medication Assisted Treatment, and other FDA approved medications.*

For purposes of this document, SAMHSA's official definition will serve as the benchmark from which to ascribe best practices and suggested minimum standards. The utilization of this definition is because it encompasses the basic tenets as set forth in the statute and it stipulates the inclusion of medication assisted treatment and other FDA approved pharmacological interventions.

Within the treatment industry levels of care generally signify the type of services provided and to what intensity these services are provided. To deliver the best care possible, recovery house operators should include to which level of care their facility delivers services to their residents. SAMHSA supports the levels of care, as identified by the National Alliance of Recovery Residences (NARR) and other stakeholder agencies depicted below, as these levels accurately reflect the basic structural blueprint of quality recovery housing.

NARR Level	Typical Resident	On-site Staffing	Governance	On-site Supports
Level 1 **(e.g., Oxford Houses)**	Self-identifies as in recovery, some long-term, with peer-community accountability	No on-site paid staff, peer to peer support	Democratically run	On-site peer support and off-site mutual support groups and, as needed, outside clinical services
Level 2 **(e.g., sober living homes)**	Stable recovery but wish to have a more structured, peer-accountable and supportive living environment	Resident house manager(s) often compensated by free or reduced fees	Residents participate in governance in concert with staff/recovery residence operator	Community/house meetings, peer recovery supports including "buddy systems", outside mutual support groups and clinical services are available and encouraged
Level 3	Those who wish to have a moderately structured daily schedule and life skills supports	Paid house manager, administrative support, certified peer recovery support service provider	Resident participation varies; senior residents participate in residence management decisions; depending on the state, may be licensed; peer recovery support staff are supervised	Community/house meetings, peer recovery supports including "buddy systems". Linked with mutual support groups and clinical services in the community, peer or professional life skills training on-site, peer recovery support services
Level 4 **(e.g., therapeutic community)**	Require clinical oversight or monitoring, stays in these settings are typically briefer than in other levels	Paid, licensed/ credentialed staff and administrative support	Resident participation varies, organization authority hierarchy, clinical supervision	On-site clinical services, on-site mutual support group meetings, life skills training, peer recovery support services

Source: The National Alliance for Recovery Residences

2. Addiction as a chronic condition requiring recovery supports:

The American Society of Addiction Medicine asserts that addiction is characterized by the inability to abstain, impairment in behavioral control, spontaneous cravings, and a diminished capacity to recognize significant problems. In as much, addiction or a substance use disorder resembles other chronic diseases because it includes cycles of relapse and remission, and without interventions, treatment and engagement in recovery-oriented activities premature death is possible. It is therefore envisioned that recovery houses meeting the suggested minimum standards in accordance with best practice guidelines set forth in the SUPPORT legislation will treat addiction as a chronic condition through a system of recovery supports utilizing the social model of recovery. The transition from active addiction into lasting recovery is often a difficult and emotionally trying journey for many addicts. The first 12 months of this transitional period, sometimes referred to early recovery, is a crucial period as people contend with raw core clinical issues such as family of origin problems, unresolved trauma, grief and loss, emotional immaturity, low frustration tolerance, and other triggers that makes them susceptible to relapse. It is in this period of early recovery, usually post inpatient treatment, that recovery houses are uniquely qualified to address.

A recovery support network comprised of sober friends, certified peers with lived experience, and if necessary professional treatment providers is essential in helping the

newly sober individual avoid a relapse with potentially dangerous consequences. Community, camaraderie, empathy and guidance are necessary ingredients in helping somebody remain on track as they navigate their way back into life. This is true for individuals recently discharged from inpatient treatment, criminal justice custody, or people seeking an alternative from a living environment that is not conducive to recovery.

To be most effective in breaking the cycle of addiction of remission followed by relapse, recovery housing should support the life building aspect of recovery by generating recovery capital, as opposed to merely treating the acute episodes of addiction. Recovery capital refers to the combination of both internal and external resources that nurture and foster a person's development. It is during this early phase of recovery, especially while living in a recovery house, where a person learns to cope with setbacks and challenges, develops essential life skills, pursues employment or educational opportunities and works through interpersonal relationship difficulties. Recovery houses are uniquely qualified to enhance these important growth areas that assist a person in maintaining lasting recovery.

3. Co-occurring Informed:

In compliance with the SUPPORT legislation's mandate to improve client care within the recovery house system, SAMHSA recommends that all recovery house operators and their designated staff should be informed as co-occurring disorders. According to Polcin, Korcha, Gupta, Subbaraman, & Mericle (2016) the issue of co-occurring mental disorders and substance use disorders is prevalent within American society. Utilizing the National Epidemiological Survey on Alcohol and Related Conditions, Polcin et al (2016) reported that approximately 18% and 20% of individuals with a substance use disorder also met criteria for an anxiety disorder or for at least one mood disorder respectively. Additionally, Compton, Cottler, Jacobs, Ben-Abdallah, & Spitznagel (2003) indicted that for individuals in substance use disorder treatment, especially inpatient residential treatment, the rates for comorbid psychiatric disorders is much higher. Furthermore, the 2017 National Survey on Drug Use and Health (NSDUH) produced by SAMHSA determined that there are 8.5 million adults with a co-occurring mental illness and a substance use disorder, and 3.1 million of these individuals qualified as having a serious mental illness.

Polcin et al (2016) used data from the largest evaluation of sober living houses and examined how living in a recovery house affected the severity of comorbid psychiatric symptoms of individuals with a co-occurring ailment. After controlling for length of stay, Polcin et al (2016) discovered that overall psychological distress and symptoms of depression and anxiety improved. However, Polcin et al (2016) advised caution as these symptoms of psychological distress were associated with decreased rates of abstinence and that psychiatric symptoms represent an increased risk for relapse. These findings seem to support the notion that recovery house operators, staff, and certified peers need to be informed as to how co-occurring disorders and resulting symptomology can contribute to increase a person's susceptibility for relapse.

4. Comprehensive Assessment (assess program and client):

The SUPPORT legislation stated that the Secretary shall consider how recovery housing is able to support recovery, relapse, recidivism, or overdose, by improving access and adherence to treatment including medication assisted treatment. In completing this consideration and in fulfilling this requirement, SAMHSA recommends that all client referrals and placements be predicated upon what gives the client the best chance for success. Therefore, a comprehensive assessment should be a component of these best practice solutions to help recovering individuals achieve the amelioration of relapse and recidivism. Kushner, Abrams, Thuras, Brekke, & Sletten (2005) studied co-occurring patients and determined that a prescreening for comorbid disorders such as depression and anxiety should be conducted to discover potential relapse indictors. Kushner et al. (2005) further asserted that institutions should have knowledge of relapse factors of previous clients or profiles of clients that could aid in determining if a particular setting is appropriate and gives a prospective client the best chance of success. To best achieve these ends, the assessment should involve the prospective facility and the individual client.

Facility Assessment:
State governing agencies including probation and parole departments and licensing bodies should advise potential referents to recovery housing to be well versed about the prospective program prior to referring a potential client. Relevant information to be considered in determining the most appropriate setting includes:

- House Culture: such as permissiveness of unhealthy behaviors, degree of adherence to outside meeting attendance, is general living environment supportive of recovery, etc.
- Level of Care: the type, nature and intensity of therapeutic services and recovery supports provided, especially for co-occurring clients
- Types of clients or general profiles of clients who have had success and/or failure at facility
- Utilization of certified peers with relevant lived experience
- Geographic area, neighborhood or external surrounding environment of the recovery house
- Current residents: welcoming, committed to sobriety, are they mostly employed, supportive of one another
- Medication Assisted Treatment: does the operator or other house staff support the use of medication assisted treatment, is the use of this medication properly monitored, are the other residents in the house also supportive of MAT, are peers with MAT experience available for clients with severe opioid use disorder (OUD)
- Level of training and professionalism of house staff (e.g., co-occurring disorder, crisis interventions, etc.)
- Reputation regarding ethical business practices, including fraud and abuse of residents
- Relapse policy

- Availability of NARCAN

Client Assessment:
Client assessment is the other integral part of the Comprehensive Assessment that should be performed prior to referral and placement into a recovery house system of care. Whether the referent is a licensed clinician, concerned family member, criminal justice professional, or other stakeholder it is important to know and consider the relevant and pertinent information about a person before making impactful decisions regarding their chances for a successful recovery. Usually a licensed clinician obtains intimate knowledge of their client throughout the therapeutic process. Listed below are some relevant factors to consider when making an appropriate referral to a particular facility or level of care.

- Level of emotional maturity of client
- Severity of substance use disorder
- Clinical diagnoses, co-occurring, etc.
- Treatment history including prior relapses
- Easily swayed by those not committed to recovery
- Level of commitment to sobriety
- Family of origin
- Frustration tolerance
- Level of functioning in outside world
- Criminal history
- Progress made in treatment and/or lack there of
- Promiscuity or engagement in other potentially unhealthy behaviors
- Strengths, weaknesses, and other core issues

5. Provision of or support for Evidence Based Practices:

As previously stated, the SUPPORT legislation instructed the Secretary to consider how recovery housing is able to support recovery, relapse, recidivism, or overdose, by improving access and adherence to treatment including medication assisted treatment. Therefore, one of the 10 minimum standards regarding client care and recovery housing needs to address the usage of and support for evidence-based practices. Evidenced based practices are the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient (Sackett, 1996). Essentially, evidenced based practices represent the intersection of a three-prong process of clinical expertise, client data including values, preferences, concerns and needs, and the best available research evidence into the formulation of treatment decisions. As such the full integration of these components expands the opportunity for improved clinical outcomes including the overall quality of life (Sackett, 1996).

Since client care and improved clinical outcomes form the impetus of this legislation, it is important to ensure that access to these practices are expanded to those seeking services.

In so doing, SAMHSA recommends that recovery houses either offer treatment and recovery services that strongly encourage participation. Polcin (2009) conducted a study on the premise that outpatient clients need an established living environment that supports sobriety to improve treatment outcomes. Polcin (2009) determined that improvements in the number of months using substances, the number of days in the month using substances, the number of arrests, and in rates of employment incurred for those domiciled in sober living. Additionally, 76% of the residents that participated in this study remained domiciled in a recovery house for at least five months. In 1995, the Philadelphia Coordinating Office for Drug and Alcohol Abuse Programs (Office of Addiction Services) established a recovery house system for individuals participating in state-licensed outpatient substance abuse programs. This particular program has grown from the initial five recovery houses to 21 houses encompassing 288 beds in the Philadelphia area. This evidence seems to reinforce the idea that the combination of recovery houses with outpatient treatment is an efficacious model of care.

Medication Assisted Treatment (MAT) is an evidence based practice that is explicitly noted in the SUPPORT legislation as a specific area of concern. MAT includes the use of FDA-approved medications, in conjunction with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders. According to the National Institute on Drug Abuse, there were approximately 63,632 overdose deaths in 2016 of which 42,249 were attributed to opioids and synthetic opioids such as fentanyl and fentanyl analogs. In 2017, the provisional number of drug overdose deaths climbed to 72,306 with 49,068 of these deaths attributed to the misuse of opioids and related synthetics. The evidence asserting the efficacy of MAT in treating opioid use disorder is substantial. For instance, Mittal, Vashishtha, Sun, Jain, Cuevas-Mota, Garfein, Strathdee & Webb (2017) examined the efficacy of MAT in reducing the frequency of those people who inject drugs. Mittal et al. (2017) referred to MAT as the "gold standard" treatment for opioid use disorder, and they determined MAT's key role in the reduction of drug injectors introducing non-injectors into this form of ingestion. In other words, MAT reduced the frequency of drug injectors and had the added benefit of reducing the number of new future drug injectors. This can be of great benefit for people in early recovery living in close proximity to one another.

Ma, Bao, Wang, Su, Liu, Degenhardt, Farrell, Blow, Ilgen, Shi & Lu (2018) conducted a meta-analysis that those individuals with opioid use disorder not receiving MAT had the a mortality rate that was 8.10 times higher than their MAT receiving counterparts. Additionally, Ma et al. (2018) found that the cessation of MAT tripled (3.09) the risk factor for an overdosed related fatality, and that longer retention time was closely associated with a reduction in mortality rates. Ma et al. (2018) further indicated that increased retention in MAT was not only beneficial for survival, but those individuals who remained in treatment for one year had lower mortality rates. It is important to note that this one year time frame also matches the time period often ascribed to "early recovery," when a person is susceptible to relapse. This evidence validates the Assistant Secretary's continued encouragement for recovery housing to accept MAT patients, and SAMHSA even conducted a technical expert panel on this subject.

Many individuals afflicted with the disease of addiction often suffer in silence to the point where isolation or social isolation can be a clinical issue that is frequently addressed in treatment. Isolation can start as a way a person can use drugs and alcohol without being intervened upon, which inevitably creates feelings of intense loneliness followed by more using. The idea of "fellowship" to intervene on social isolation has been a key component in the philosophy of 12 step support groups and other recovery-oriented support services for years. In addition, Polcin, Mericle, Howell, Sheridan & Christensen (2014) endorse the social model of recovery where social and interpersonal aspects of recovery are emphasized, as opposed to merely an individual focus.

The utilization of peers, recovery coaches, and the recovery-oriented systems of care are other evidence-based practices that model the social and fellowship aspects of recovery, and are fully endorsed by the Assistant Secretary. According to Jack, Oller, Kelly, Magidson, & Wakeman (2017) primary care physicians can provide effective addiction treatment with medications but their patients often lack the necessary psychosocial supports. Recovery coaches have emerged as an efficacious intervention to help alleviate this problem thereby increasing a person's opportunity for success in maintaining sobriety. In these situations, recovery coaches with MAT lived experience can be a valuable addition to a person's recovery plan. Other evidence suggests that peer-delivered recovery support systems resulted in fewer days drinking to intoxication, a reduction in overall alcohol consumption, and those individuals discharged from inpatient treatment that utilized peer support had a sobriety rate of approximately 48% compared to 33% of those without peer-related services (Samuelson et al, 2013; Tracey et al, 2011).

6. Policies, Procedures, Client Expectations, and Administrative Acumen:

To be in comportment with these 10 suggested minimum standards and practice guidelines as mandated in the SUPPORT legislation, recovery house operators should have clearly written and well laid out listing of all standard operating procedures and policies. To avoid ambiguity, it is recommended that during the initial intake process that these standard operating procedures and house policies are explained to the new admit by a staff member or a designated senior peer. Listed below are some key examples of key topics that should be listed and disclosed to the client.

- Day to day operations of the recovery house
- In-House meetings
- Urine analysis / breathalyzer policies
- Client expectations: education or employment activities, outside meeting (support group) attendance, adherence to treatment plan including medication management, sponsor, peer recovery coach, wake up time, video games, interactions with neighbors, sobriety requirements, tobacco policy, etc.
- Therapeutic Duty Assignments: chore, house duties
- House rules: curfew, visitation policies, leaves of absences, potential consequences
- Discharge policies
- Prices, costs, any additional costs such as testing or late penalties

- Medication protocols (administration, storage, documentation, disposal)

In addition to providing a list of client expectations, house rules, and standard operating procedures new clients should also undergo an orientation process. It is recommended that the orientation process also include a brief rundown of the surrounding living environment including potential hot spots or places to avoid, a list of local AA / NA or other support group meetings, and other areas of interest such as prospective employment opportunities.

7. Ensures quality, integrity and client safety:

As mentioned previously in this document, the SUPPORT legislation seeks to improve client care for individuals suffering from a substance use disorder who are in need of supportive recovery-oriented transitional housing. Improved client care and increasing each person's chances for success in recovery are also chief concerns for the Assistant Secretary. It is important to note that most recovery house operators and treatment providers are ethical professional who only want the best for their clients. However, unscrupulous providers do exist and the SUPPORT legislation explicitly addresses the need for the remediation of fraud, particularly in the urine analysis drug testing processes. Listed below are some recommended strategies to improve client care, address fraud, and enhance safety for recovery house residents.

Addressing Unethical Practices:
It is standard clinical protocol for all treatment centers and recovery houses to require patients and residents to submit random urine analyses and breathalyzers. This practice is conducted to ensure the safety of the individual by monitoring sobriety and to ascertain if other interventions are necessary. In other situations, clients may be required to submit additional samples if suspected of using or returning to the residence after spending time in a potentially using type of environment.

In May 2018, SAMHSA conducted a technical expert panel on patient brokering, which also examined the role of fraudulent laboratory billing for urine analyses. Our expert panelists noted that this ethical standard clinical practice has been exploited for financial gain by unscrupulous providers. For instance, Fair Health (2016) examined claims data based on Current Procedural Terminology (CPT) codes and discovered that costs associated with laboratory testing has increased more than 900% between 2011 and 2014. Testing for quantitative levels on negative samples, charging exorbitant amounts that are over and above standard costs for lab test, and excessive drug testing during residential treatments and recovery houses are three main areas of fraudulent activities.

To help alleviate these fraudulent activities and the potential abuse of clients, recovery house operators should have a clearly written set of policies and protocols that describe their urine analysis process complete with all associated costs. In testing situations, clients are generally required to sign a sheet of paper that documents the date and time, and that this is their sample. Listed below are several recommended strategies to curtail this type of fraud in the system:

- Disallow the ordering of additional laboratory testing on negative samples (i.e., additional tests are usually only ordered on positive UA results to determine the amount of a drug present in a person's system)
- Document in client records, and on the order sheet the exact reason a person is being tested (e.g., random, returning from a leave of absence, suspicion for using)
- The price of the urine analysis test needs to be presented to the client for signature and all associated costs should be posted in the tech office or common area including costs of the standard panel of drugs tested, costs for additional levels testing, and costs for ordering a special test to detect the presence of other drugs such as Kratom
- The signed UA document including the price, reason for testing, and the exact tests order should be sent to the client's referent or concerned stakeholder. This should be a standard practice as it can help alleviate collusion between an unscrupulous operator and a complicit client, and it notifies the referent as to the client's progress or need for further intervention.

Given the chronic nature of the disease, relapses happen and with great regularity in the early recovery period. Therefore, it is incumbent on recovery house operators to have clearly defined and established policies, protocols and procedures describing how they address relapsed residents, especially since all relapses can potentially lead to devastating consequences. The Assistant Secretary recognizes that in addition to a set of clearly defined policies regarding relapses, some recovery house operators and treatment providers may choose to address specific relapses on an individual case-by-case basis, as it is difficult to accurately anticipate and account for the full breadth of human behavior and individual circumstances. However, all decisions regarding relapse should be guided by the best interest of the client, and on the safety of the house and recovery environment. Patient brokering is a potentially life threatening form of fraud that involves treating vulnerable people with a substance use disorder as a pawn or commodity to be traded to an unscrupulous treatment center in return for a cash payment or another type of valuable kickback. In some cases, the reimbursed services are never provided to brokered clients. It is standard clinical practice for many individuals to be referred to a step-down continuing care facility such as a sober house after completing inpatient substance abuse treatment. This referral to the step down level of care is done under the auspices to help ensure that the newly sober individual remains committed to recovery and maintains sobriety. However in patient brokering situations, many of these individuals once in sober living facilities, are incentivized with free drugs or other inducements to relapse, thereby restarting another use cycle that requires another referral back to treatment. The sober house operator or another brokering merchant refers this individual back to treatment for another fee and this process of treatment followed by an incentivized relapsed is started all over again.

SAMHSA's May 2018 technical expert on panel patient brokering examined how unscrupulous recovery house operators and colluding treatment providers exploit the phenomena of relapse for financial gain. These experts found that some solutions may include a focus on a value-based payment system for addiction treatment centers, more accountability and audits, and certifications by an independent agency.

Program Certification:
SAMHSA recommends that each recovery house should undergo a certification process by an independent agency. By submitting to an independent certification process recovery housing could witness improved client care and an upgrade in their day to day operations. An examination of relapse policies and a thorough investigation of how clients pass through the system are valuable services to be provided. For instance, an independent third party certifying agency can investigate how many clients continue to repetitively cycle back through the recovery house and treatment center without making any progress. A process such as this can also examine drug testing records and to ensure that the proper policies and procedures documenting client care are in place. A system of certification can assist in the identification of fraudulent operators and curtail abusive business practices.

Medication Policy:
According the NSDUH (2017) the intentional misuse of buprenorphine increased over 30%, making it the fastest growing abused prescription opioid in the country. There are still other prescription opioids that are intentionally misused or abused more than buprenorphine, but this drug has witnessed the largest percentage uptick in popularity. In July 2018, SAMHSA conducted a technical expert panel on the inclusion of MAT into the recovery model of care. Our expert panelists described the diversion of mood-altering (partial and full agonist) MAT drugs as the act of diverting an appropriate prescribed medication from the intended recipient to another recipient. Also equally problematic is the intentional abuse of these medications such as mixing with other drugs or alcohol and/or injecting medications for the sole purpose of achieving intoxication. Since the abuse of mood-altering substances can have detrimental effects on other people's sobriety living in close quarters such as a recovery house, our experts recommended several courses of action listed below to help ensure client safety.

- Medication counts with staff and client
- Increase drug testing (if suspected of diversion)
- Communication between stakeholders, providers & staff (releases of information)
- Distribution of lock boxes
- Maintain proper documentation
- Monitor specific residents
- Open discussion of medications (e.g., group topic, potential triggers, etc.)

Trauma-Informed care:
It is important to note that many individuals who receive substance use disorder treatment, especially those requiring residential treatment, have been adversely affected by trauma. According to McHugh, Gratz, & Tull (2017) approximately 95% of patients with a substance use disorder report a history of being exposed to trauma events. Additionally, those individuals with co-occurring post-traumatic stress disorder (PTSD) or who have been exposed to significant trauma are more susceptible to relapse, suicidal and self-injurious behaviors, higher levels of risk taking behaviors, and have lower incidents of treatment completion (McHugh, 2017). Given these significant statistics, it is

strongly recommended for recovery house operators to try to create a living environment that is considered trauma informed.

SAMHSA suggests that trauma informed care involves an environment that understands, recognizes and responds to the effects of trauma. As such, SAMHSA subscribes to a set of six key principles in providing a trauma informed approach to ensure client wellbeing and to improve quality of care. These concepts listed below can be modified to curtail with the unique model of recovery houses.

- Safety
- Trustworthiness and transparency
- Collaboration and mutuality
- Client empowerment
- Cultural, historical, and gender-related issues

8. Cultural Competency:

Cultural competence means to be respectful and responsive to the health beliefs and practices, and cultural and linguistic needs, of diverse population groups. Cultural competency furthermore describes a person's capability to understand, appreciate, communicate and interact with persons from another culture or who holds an entirely different set of beliefs. The concept of cultural competency is of extreme importance, as the disease of addiction does not discriminate along racial, cultural or social economic lines as people from all walks of life can be affected. Furthermore, the disease of addiction can do tremendous harm to healthy relationships resulting in social isolation and the formation of unhealthy alliances. Recovery that occurs within a recovery house is predicated on peer-to-peer relationships, the restoration of healthy relationships, and for those in treatment the therapeutic relationship between patient and provider. Since recovery housing is grounded upon relationships and the social model of recovery that emphasizes "we" and a strong sense of community, it is strongly recommended that recovery houses adhere to establishing a cultural competent living environment.

The SUPPORT legislation explicitly mentions the recovery and supportive housing needs of the Native American community. According to Tipps, Buzzard, & McDougall (2018) the opioid overdose rate among American Indians has risen over the years from 2.9 deaths per 100,000 people in 199 to 13.9 deaths per 100,000 people in 2016. In Minnesota, a state with a large Native American population, the overdose death rate was 47.6 compared to the non-Hispanic white rate of 7.3 per 100,000. Additionally, the urban Native American population within the city of Minneapolis was also high with a death rate of 42.4% in the 1999-2016 time period (Tipps, et al., 2018). A multitude of tribes are now incorporating the use of naloxone, medication assisted treatment and Wellness Courts as interventions to address these difficult circumstances.

However, according to the Urban Indian Health Knowledge Resource Center (2018) the Native American population still has concerns regarding the cultural competency of some evidence-based practices, as these programs fail to accurately account for cultural

differences. As such, they are starting to embrace the concept of Practice Based Evidence as means to addressing their difficulties through their own unique cultural framework. Tipps et al. (2018) stated that several tribal communities have adopted the recovery house model that is also linked to outpatient treatment centers. Therefore, SAMHSA is encouraging the use of cultural competent recovery houses that offer a recovery-oriented living environment for Native Americans with a substance use disorder.

9. Ongoing Communication:

Ongoing communication is another important aspect of clinical practice that recovery houses should implement as part of their operating procedures. Provided there is a signed release of confidential information, ongoing communication between the client's referent, concerned loved one, treatment provider, former treatment provider, certified peer recovery coach and criminal justice professional, if involved, is essential to helping the client stay on track with recovery. In certain vocational type programs, it could also be advantageous to maintain contact with the person's place of employment. In addition, ongoing communication between the recovery house, treatment providers, case managers, and probation officers is a standard of care implemented by the Philadelphia Coordinating Office for Drug and Alcohol Abuse Programs. Listed below are some topics areas that could be covered during communication between stakeholders to improve the quality of client care.

- Level of program adherence
- Client behavior – potential relapse indictors
- Attendance concerns at treatment
- MAT dosage changes, take home doses
- Progress reports
- Psychotropic medication changes
- Employment status
- Referral decisions (especially following a relapse to help alleviate any brokering type activities)
- Drug testing
- Discharge planning
- Any social network concerns
- Relapse history

10. Performance Measurement:

SAMHSA recognizes and understands the difficulties some recovery houses will have with accurately gaging performance. This is especially true for the Level 1 type houses that are more democratically managed by the peer community. However, as recovery houses become recognized more and more as vital components in the continuum of care, it is important to properly assess how each house is ultimately performing in delivering quality client care. SAMHSA utilizes a set of National Outcome Measures (NOMs)

which consists of 10 variables that encompass mental health, substance abuse treatment and prevention metrics.

Even though recovery houses may struggle to obtain such a wide array of data, especially once a client has discharged from their facility, they may still be able to tabulate client performance as they remain domiciled at their facility. Nonetheless, collection of performance data, both client characteristics and utilization of evidenced based services, will provide federal, state, and local policy makers with the information they need to further the advancement of recovery housing. This process could become less complicated as recovery houses move towards independent certification, as the certification process aids in record keeping functions and can help operators implement a system that can be managed by nonprofessional staff. SAMHSA recommends that recovery houses work towards implementing a performance measurement system, especially if such entities are going to seek third party reimbursements.

References

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Fighting Opioid Abuse in Indian Country

Introduction to Evidence-Based Practice : Overview

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A Safe Transition to Wellness

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