Missouri's Evaluation of Recovery Residences: Findings and Recommendations for the Future

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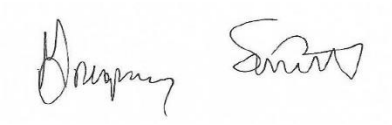
Introduction

Recovery housing can find its roots in Missouri back to the 1960s when much of the available housing was Oxford-style housing or operated by religious organizations. In his 2003 State of the Union address, President George W. Bush announce the creation of the Access to Recovery (ATR) program as a way to enlist the faith community and peer organizations in the nation's war to combat drug use. The Missouri Department of Mental Health (DMH) was successful in obtaining federal ATR grant funds for the full 14 years that the program existed. This program helped to fund recovery housing and other recovery services across the State of Missouri for more than a decade. Even though the program was widely successful, the program expired in its entirety in April 2018.

The end of ATR motivated recovery support service (RSS) providers – including housing providers – throughout the state to come together in an effort to secure funding from the state to replace the expiring ATR funding. As a result, the Missouri Coalition of Recovery Support Providers (MCRSP) was established in 2015 to create a voice and representation for faith, peer and community-based recovery support service providers in Missouri. The coalition exists to identify, unite, mobilize, and empower grassroots recovery support providers that assist individuals in their restoration of self-worth, human dignity, self-respect, life skills, and self-confidence needed for sustained recovery and effective community living.

MCRSP worked with then-Governor Eric Greitens to insert a line-item in his FY2019 state budget to continue RSS funding with state general revenue dollars. Ultimately, the legislature approved $2.625 million for recovery support services funding, and then increase the amount again in the FY2020 budget to $3.76 million. Additional federal funding was also made available to recovery housing through programs like the State Targeted Response (STR) grant to target the opioid epidemic, as well as subsequent State Opioid Response (SOR) grant. The state has also invested other funds in recovery programs through its Justice Reinvestment program to help keep offenders out of prison and in community-based treatment and recovery programs in order to save the state money and to deliver needed services to people suffering from substance use disorders.

In 2018, MCRSP affiliated with the National Alliance of Recovery Residences (NARR) and began to accredit recovery homes throughout the State of Missouri to ensure the programs met the NARR-established accreditation standards. By mid-2020, MCRSP has accredited 28 different housing programs throughout the state that operate 115 recovery homes containing more than 1,150 beds. Eighty-three of these homes have deemed MAT-friendly. Many are working with treatment providers to house clients on MAT treatment regimens. With a little increase in RSS funding, we could easily double the number of recovery houses and beds accredited in the state over the next two years, providing clients with greater options in the types of housing and services available to fit their needs.



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Executive Summary

This report details an evaluation of recovery residences in Missouri that are accredited by the National Alliance of Recovery Residences (NARR) and approved by the State Targeted Response (STR)/State Opioid Response (SOR) grants between March 2019 and August 2019. This report identifies key recovery housing characteristics, provides recommendations for recovery housing stakeholders, and ways to provide supportive and sustainable housing for people seeking long-term recovery. This is the first recovery housing evaluation of its kind in Missouri and provides an overview of the current recovery housing system.

Eligibility and Response Rate

- NARR-accredited and STR/SOR approved houses were eligible to participate in the evaluation (N = 66)
- Data were collected on 95% of eligible houses (N = 64)
- This was a point-in-time environmental scan of recovery houses and their internal and external characteristics

Resident Characteristics

- Collectively, there were over 600 residents served across 64 houses.
- House managers reported that a history of opioid and methamphetamine use was the most common among residents. Histories of injection drug use and opioid overdose were also common among residents (See Resident Substance Use History).
- House managers and residents were predominantly White and men.
- White individuals are overrepresented in the recovery housing population, accounting for 77% of residents relative to their representation in Missouri's overdose deaths, accounting for only 70% of opioid overdose deaths. In contrast, Black individuals are underrepresented in recovery homes at 17%, given they account for 28% of overdose fatalities (See Resident Characteristics).[12]
  Note: These percentages reflect opioid overdoses only, whereas individuals in recovery residences use substances other than opioids.

Geographic and External (e.g., surrounding neighborhood) Recovery Environment

- Houses were predominantly limited to urban areas, with about half located in the St. Louis metropolitan area, and the rest distributed across Kansas City, Springfield, and Southeast Missouri.
- Overall, most house managers' perception of their neighborhood and relationships with community members was quite positive. Very few experiences with crime and substance use were reported whereas community activities (e.g., walking/exercising), access to resources within walking distance, and clean well-kept streets were highly endorsed.

Internal (e.g., homelike culture) Recovery Environment

- There was a mixed endorsement of the domains measuring adherence to the Social Model Philosophy, which is the foundation of NARR standards. Specifically, resident interaction, creating a home-like environment, and engagement with the broader recovery community through mutual aid participation was highly endorsed, but for many houses, residents had limited control over household functioning, residency, and rule enforcement.
- Recovery houses expect people to live there for approximately 9-12 months, and most houses do not have a limit on the length of stay for residents.
- Most houses have a zero-tolerance policy for using substances in the home, violence, sexual misconduct, and repeated theft in the home, while other dischargeable offenses (e.g., using substances outside the home) are determined on a case-by-case basis.

Acceptance of Medications for OUD (MOUD) and Naloxone Access

- Methadone was the least accepted medication; naltrexone was the most accepted medication.

- Over half of house managers indicated that tapering off of MOUDs was encouraged.
- A majority of houses reported having naloxone on-site in the event of an overdose, but a few houses reported not having it on-site nor providing any overdose reversal training to residents.

Staff Training

- Peer support is the most received training reported by house managers but less than half of the houses receive training to enhance cultural competency in any other area.
- Resident data collection varies greatly by housing agency. There is no standard for what type of data and how much data is collected on residents.

Summary of Types of Recommendations for Recovery Stakeholders (See Conclusion for full text)

Below are the broad categories of recommendations that emerged through this evaluation process. More detailed recommendations are provided at the end of this report.

1. Evaluation: Implement resident-level survey evaluations and assess differences in outcomes by race and gender on an ongoing basis.
2. Geographic and racial diversity: Increase the number of accredited, medication-friendly recovery housing providers in rural areas and in areas without accredited recovery housing (e.g., North County/North City, St. Louis) through incentive programs, targeted assistance, and relationship building.
3. Standardized training: Develop and implement standardized training for housing managers with content related to long-term MOUD use, cultural competency, and overdose reversal. Regularly scheduled overdose reversal training for residents should also be implemented.
4. Inclusive policies and practices: Monitor and enforce housing policies and practices designed to create inclusive home environments for transgender/non-binary residents, individuals on long-term treatment medication, and people of color.
5. Length of stay reimbursement: Revisit maximum length of stay funding policies to allow for longer-term reimbursement for residents who cannot self-pay (this does not mean indefinite), potentially using gradual cost-sharing models, and potentially different length of stay models for pregnant persons.
6. Oversight and enforcement: Enact additional requirements for NARR accreditation and re-accreditation to ensure quality maintenance and improvement across housing organizations.

Note: Additional housing recommendations were reported in the Community Based System Dynamics (CBSD) evaluation.

Background

Missouri has been awarded various grants to address the opioid overdose crisis, two of which were large SAMHSA-funded grants. The STR grant began in May 2017 and ended in May 2019. The SOR grant serves as a continuation of the STR grant, and began in October 2018 and will continue through October 2020. These grants were awarded to the Missouri Department of Mental Health (DMH), with elements administered, implemented, and evaluated by the University of Missouri St. Louis - Missouri Institute of Mental Health (UMSL-MIMH). The majority of grant funds went towards direct treatment reimbursement for uninsured and under-insured individuals with opioid use disorder (OUD); however, there were also funds allocated for prevention, recovery, and harm reduction services. Recognizing that stable housing is a crucial factor in maintaining long-term recovery, grant-contracted treatment agencies were encouraged to utilize STR and SOR funding to support clients' housing needs by partnering with local recovery housing operations.

Around the same time the STR grant began, the Missouri Coalition of Recovery Support Providers (MCRSP) adapted standards created by NARR to accredit recovery homes in Missouri. The purpose of the accreditation is to ensure recovery homes provide a stable, clean, and safe environment for people in recovery. To be eligible to be reimbursed for housing individuals through the STR and SOR grants, recovery homes must become both NARR-accredited and deemed "friendly" towards the use of MOUDs through a survey administered by DMH. The purpose of these requirements is twofold; 1) to incentivize recovery homes to become NARR-accredited, assuring a standard in quality across recovery housing environments in Missouri, and 2) to ensure individuals receiving treatment through the STR and SOR grants would not be required to discontinue or taper off their medications or feel stigmatized for using medication in their recovery at their home. Both the NARR-accreditation process and MAT-friendly housing environments are still relatively new to Missouri and have not been without their challenges. Under the STR and SOR grants, grant staff at UMSL-MIMH worked with DMH and MCRSP to develop a robust evaluation of NARR-accredited and STR/SOR approved recovery homes in Missouri.

Research and evaluation of recovery housing can assist with identifying what is and is not working, assessing adherence to established standards, identifying residents and populations with distinct needs, increasing awareness about the necessity of recovery support services, and amplifying the voice of the population being served. The initial impetus for evaluation of recovery homes through the STR/SOR project was driven by recovery home providers interest in collecting data to demonstrate the impact of their services. Thus, in collaboration with recovery housing providers, MCRSP, and DMH, three evaluation projects were developed: a survey on housing characteristics including policies and procedures, and a point-in-time estimate of residents, a resident-level survey to assess resident outcomes, and community-based system dynamics workshops to assess the current functioning of the recovery housing system. The following report details the results from the housing characteristics survey. Please visit nomodeaths.org/findings to view additional details from the community-based system dynamics workshops.

Housing Characteristics Evaluation

Research indicates that housing characteristics matter for positive resident outcomes.[1234] Specifically, the physical, social, and cultural environments that influence both internal and external characteristics of a recovery home can impact a person's recovery and their chance of relapse.[4] For example, some studies suggest that negative, external characteristics such as easy access to illicit substances are linked with higher chances of relapse.[1] Similarly, strong internal, social environments such as ones that build community, provide a sense of home, encourage peer support and mutual aid, and other active residents in recovery reduces the chance of relapse, and are also good predictors of adherence to the Social Model Philosophy.[123] One theory about how practices are working is that the quality of house management and the willingness of the surrounding community can affect recovery housing.[5] Furthermore, stigma related to MOUD has been noted in the research literature as especially prevalent in recovery programs and can serve as a barrier to accessing services and care for people receiving these medications.[6]

Although some recovery housing research supports areas in which housing can promote recovery, there remain large gaps within the research surrounding recovery houses and the factors that promote recovery, which include:

- Lack of information on where the neighborhoods are in which recovery residences that blend peer support and professional support services are located.[3,7]
- The economic information of neighborhoods and other characteristics that could increase the risk for substance use.[1,3]
- Organizational aspects of recovery housing that could affect resident outcomes (e.g., management training)[8]
- The MOUD attitudes and perceptions of residents and manager[9]
- Few evaluations of non-Oxford recovery homes (e.g., NARR-accredited houses)[10]

These evaluation questions are important not only to fill in the gaps within formal research but to identify ways in which recovery housing systems can be strengthened. In Missouri, UMSL-MIMH developed a Housing Characteristics survey to evaluate NARR-accredited homes funded through the STR/SOR program. This survey was designed to give recovery stakeholders an idea of resident demographics at the time of data collection and to contribute to the lack of data collected on who accesses recovery housing services in Missouri. This evaluation aims to fill several gaps in recovery residence research. The goals of this evaluation were too:

1. Compare on the ground practices with NARR Accreditation standards
2. Identify variation across houses (e.g., internal/external characteristics, policies, procedures)
3. Determine acceptance and friendliness of MOUD in houses

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[1] Ferrari, J. R., Groh, D. R., & Jason, L. A. (2009). The Neighborhood Environments of Mutual-Help Recovery Houses: Comparisons by Perceived Socioeconomic Status. *Journal of Groups in Addiction & Recovery*, 4(1-2), 100–109. https://doi.org/10.1080/15560350802712470

[2] Ferrari, J. R., Jason, L. A., Sasser, K. C., Davis, M. I., & Olson, B. D. (2006). Chapter 3 Creating a Home to Promote Recovery: The Physical Environments of Oxford House. *Journal of Prevention & Intervention in the Community*, 31(1-2), 27–40. https://doi.org/10.1300/J005V31N01_03

[3] Mericle, A. A., Polcin, D. L., Hemberg, J., & Miles, J. (2017). Recovery Housing: Evolving Models to Address Resident Needs. *Journal of Psychoactive Drugs*, *49*(4), 352–361. doi: 10.1080/02791072.2017.1342154

[4] White, W.L. (2009) The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment.* 36: 146-158

[5] Wittman, F.D. & Polcin, D. (2014). The evolution of peer run sober housing as a recovery resource for California communities. *Int J Self Help Self Care*. 8 (3): 157-187.

[6] Miles, J., Howell, J., Sheridan, D., Braucht, G., & Mericle, A. (2020) Supporting individuals using medications for opioid use disorder in recovery residences: challenges and opportunities for addressing the opioid epidemic. *The American Journal of Drug and Alcohol Abuse*. 46(3): 266-272.

[7] Jason L.A., Olson B.D., Ferrari J.R., Lo Sasso A.T. (2006) Communal house settings enhance substance abuse recovery. *Am J Public* 96(10):1727-9.

[8] Mericle, A. A., Mahoney, E., Korcha, R., Delucchi, K., & Polcin, D. L. (2019). Sober living house characteristics: A multilevel analyses of factors associated with improved outcomes. *Journal of Substance Abuse Treatment*, *98*, 28–38. doi: 10.1016/j.jsat.2018.12.004

[9] National Association of Recovery Residences (2018). MAT-capable recovery residences: How state policymakers can enhance and expand capacity to adequately support medication-assisted recovery. MAT-capable recovery residences: How state policymakers can enhance and expand capacity to adequately support medication-assisted recovery. Retrieved from https://narronline.org/resources/

[10] National Association of Recovery Residences (2012) Primer on recovery residences: frequently asked questions. Retrieved from https://narronline.org/resources/

4. Establish a point-in-time estimate of residents accessing housing services in Missouri

Survey questions focused on the physical, social, and cultural characteristics of the recovery home. Specific sections of the survey focused on adherence to NARR- accreditation standards (e.g., "do you have naloxone on-site?") and alignment towards the Social Model Philosophy (See Social Model Philosophy Scale for more). Other sections aimed at understanding variations in policies among recovery homes (e.g., discharge policies) and variation across houses (See Internal Characteristics or External Characteristics). We also assessed acceptance of MOUD and other MOUD-related policies because a component of accessing STR/SOR funding involved accepting people on MOUD and not requiring tapering.

Methodology and Data Collection Procedures

The UMSL-MIMH team started collecting data on a rolling basis from March 2019 to August 2019 as new houses were accredited and STR/SOR approved. During this time, there were 29 organizations with 78 homes that were NARR accredited through MCRSP. Out of those 29 organizations, 24 organizations with 68 homes were STR/SOR approved. Two houses were not accepting residents during the data collection process. We had a final total of 66 eligible homes for this evaluation.

Surveys were initially distributed electronically through Qualtrics. House managers received four emailed reminders, after which they received follow-up reminders by phone. In some instances, mailed paper copies with stamped and addressed return envelopes were requested since the electronic version proved inaccessible for some managers. The UMSL-MIMH team followed-up by phone for paper surveys that were returned incomplete and completed the surveys with house managers over the phone.

Recovery homes have different hierarchies, with many of them having live-in house managers. Live-in house managers have a variety of responsibilities, ranging from being in charge of intakes and discharges to only verifying if other residents completed daily/weekly chores. We recruited live-in housing managers so that we could get an on the ground, direct perspective as to how policies are implemented in the homes. If a house did not have a live-in housing manager, the survey was sent to whoever was the most involved with day-to-day activities in the house. There were 16 houses (25%) that did not have a live-in housing manager, so an administrative staff or executive director filled out the survey.

Overall, 64 houses (out of 66) completed the survey which results in a 97% response rate. The total sample size is 64 for all metrics throughout the report unless otherwise noted.

Data Collection and Recruitment Challenges

There were several challenges in our data collection and recruitment of recovery housing organizations:

1. **Lack of trust with the external evaluation team:** Executive directors had quite a few concerns before survey distribution. They were concerned about sharing the housing managers' contact information, in addition to what the survey would be asking and the lack of knowledge of housing managers about the information asked. There was some concern about letting the housing managers represent the agency without the supervision of the executive director. Most concerns were about the results and who the results would be shared with, what would be shared, and if there would be any consequences that could fall back on the agencies. To combat this, the UMSL-MIMH team conducted in-person visits and calls with executive directors to foster buy-in.
2. **Fostering buy-in with house managers:** In addition to fostering buy-in with the executive directors, the UMSL-MIMH team spent a lot of time fostering buy-in with the housing managers to get them on board to complete the survey. In some cases, we would do in-person visits or call into an organization's house meeting to talk with the managers about the survey and what it would be asking so that they were prepared when they received it.
3. **Variability in housing hierarchies:** Each organization has a unique set-up, sometimes without live-in housing managers. This made it difficult to identify the best person to participate in the evaluation – it ended up being the person most involved with the house, which sometimes included executive directors.

4. **Turnover within homes**: UMSL-MIMH sent additional surveys to seven recovery homes due to turnover amongst staff. Two of those cases never hired additional staff during the data collection process, resulting in the two missing responses. In other cases, we contacted the executive director to receive the new manager's contact information.

Characteristics of Housing Managers

Summary

In this section, we focused on the demographics of the house managers/staff that completed the survey. These questions give us an idea of who makes up the majority of the house managers across the state. Demographical information provides insight into underrepresented identities while giving stakeholders and funders a better idea of where resources may be lacking. In general, we found that a majority of house managers were White and male. A variety of age groups are represented among house managers and a majority identified as a person in recovery as well as having Peer Support Specialist Credentials. This supports the **MCRSP Standard 14** that supports having a home staffing/leadership plan in which staff and residents model recovery principles.

Table 1. Reported Gender of House Managers

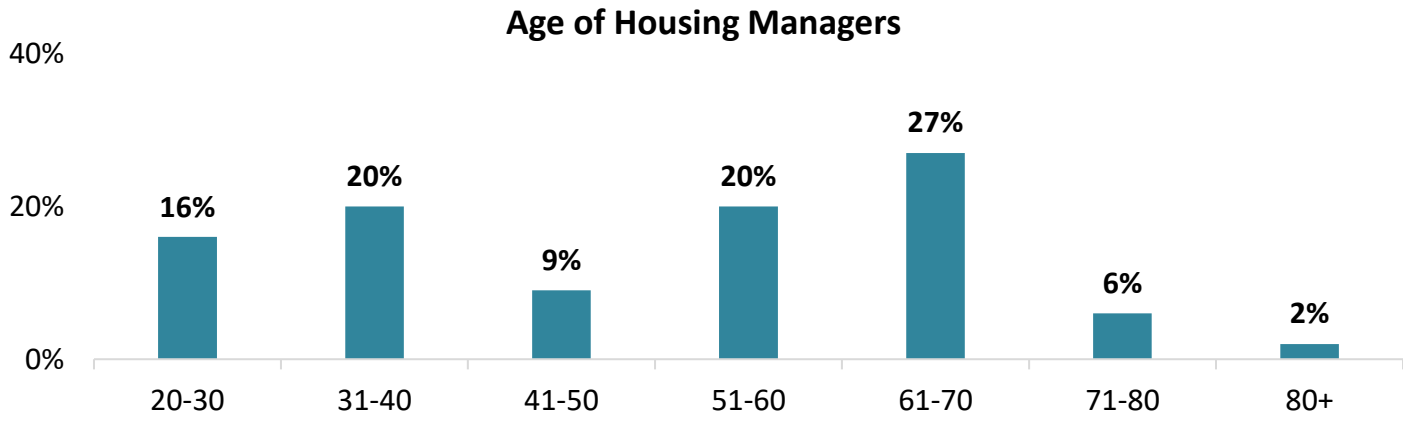
Gender	Percent
Men	**58%**
Women	**41%**
Transgender Man	**1%**

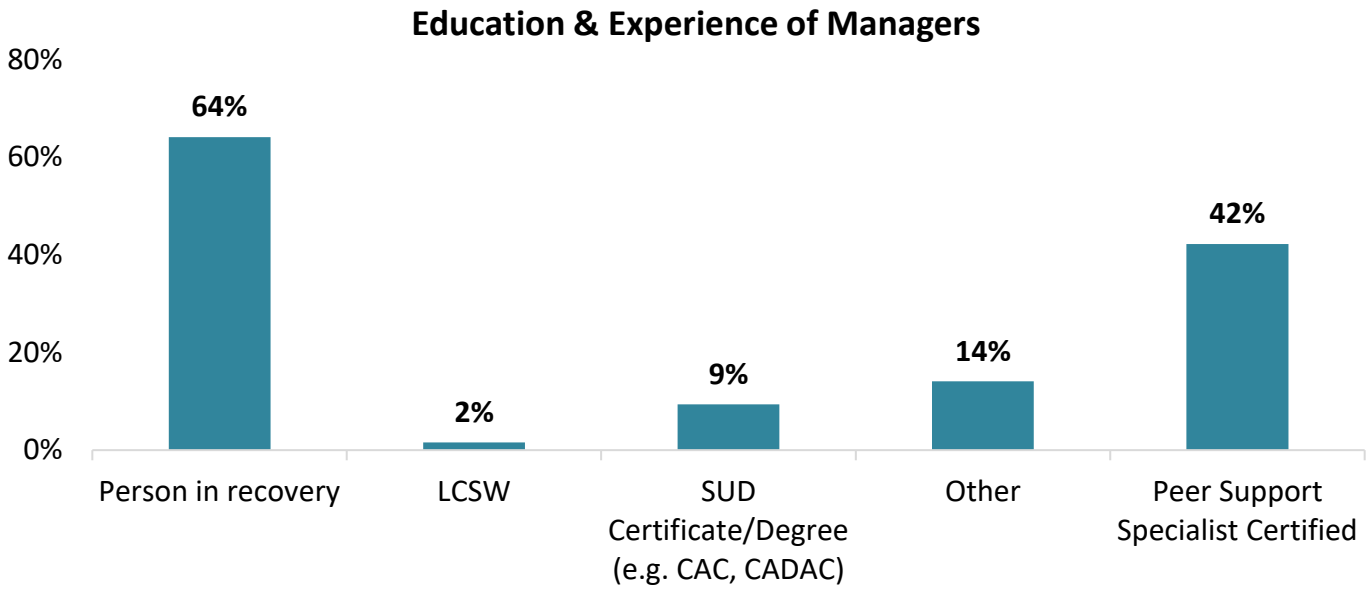
A majority of recovery housing managers were men. A small percentage of managers were transgender.

Table 2. Reported Race of House Managers

Race	Percent
Black	**17%**
White	**80%**
Multi-racial	**3%**

Housing managers were predominately White. Only one person reported being Hispanic/Latinx.





We asked house managers (or the person completing the survey), *"Which of the following [education and experience] applies to you*?" Response options were select all that apply, so responses may add to greater than 100%.

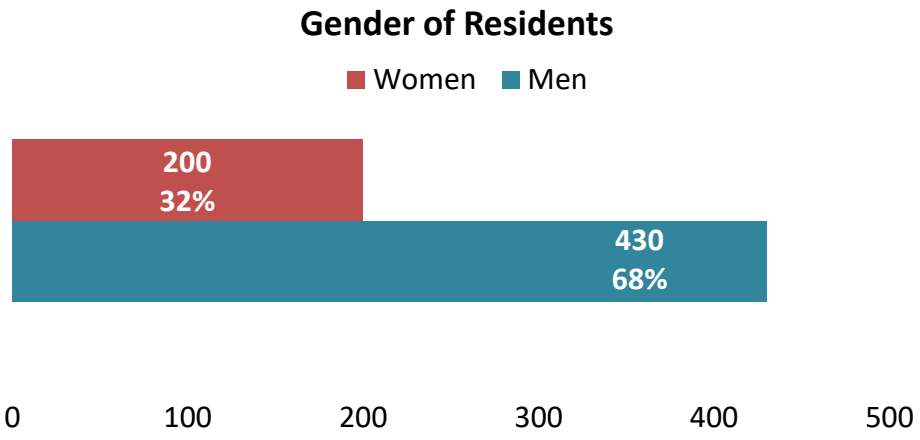
For the "Other" response option, participants were asked to specify. Responses included: program graduate, BA in Biblical Counseling, ministry worker, PREP trained facilitator, and other advanced degrees such as JD and MA in Clinical Psychology.

Resident Characteristics: Point-in-Time Estimate

Summary

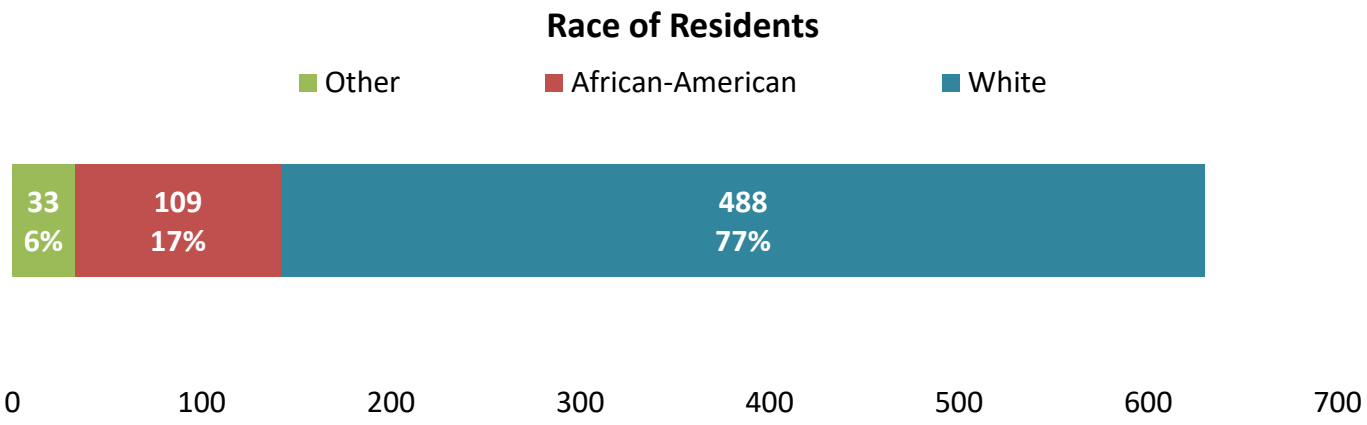
Similar to house manager characteristics, we assessed demographic information of current residents housed during the time of the survey. In addition to demographic characteristics (i.e., race, age, gender, employment status, and veteran status), we asked housing managers/staff about the substance use history of their residents, including their primary substance of choice. As research for positive outcomes in recovery housing grows, the awareness of the need for inclusive and culturally competent support grows as well. Understanding the demographic make-up of current housing residents provides the opportunity to identify groups that may not have equitable access to recovery housing support services and identify the distinct needs and experiences of housing residents. For example, most of the residents are between the ages of 25-44. With individuals aged 25-44 representing 56% of overdose deaths in MO in 2018, the overrepresentation of individuals in this age group in recovery housing aligns with the group age group most heavily impacted by overdose deaths with less than 20% above the age of 45.[11] One highlight is that 60% of residents are employed full-time, which is an important step in a person's path to independence. Although the recovery housing survey was a good first step in collecting and aggregating resident-level data, ongoing data collection from residents will provide the more accurate data and enable the assessment of resident outcomes in addition to resident characteristics.

House managers/staff reported 633 current residents across 64 houses.



Recovery housing residents are primarily men, which reflects the type of recovery housing Missouri offers. Only two residents were reported identifying as transgender. There was missing data for one resident's gender.

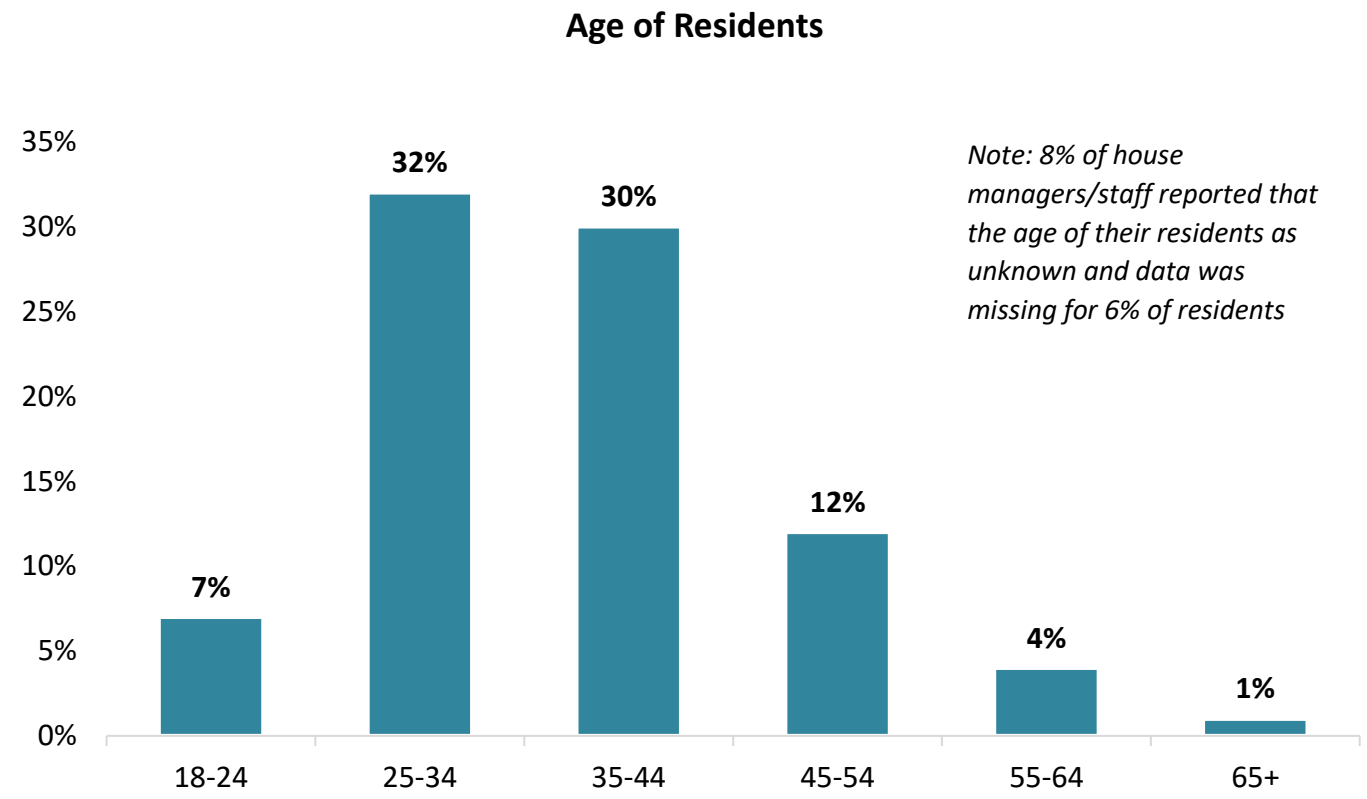
[11] Kaiser Family Foundation (2018) *Opioid overdose deaths by age group*. Retrieved from https://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-age-group



Other races include Native American/Native Alaskan, Asian, Biracial, Hawaiian Islander/Pacific Islander, Jewish, and other (not specified). Other also included unknown or missing data. There was missing data three residents.

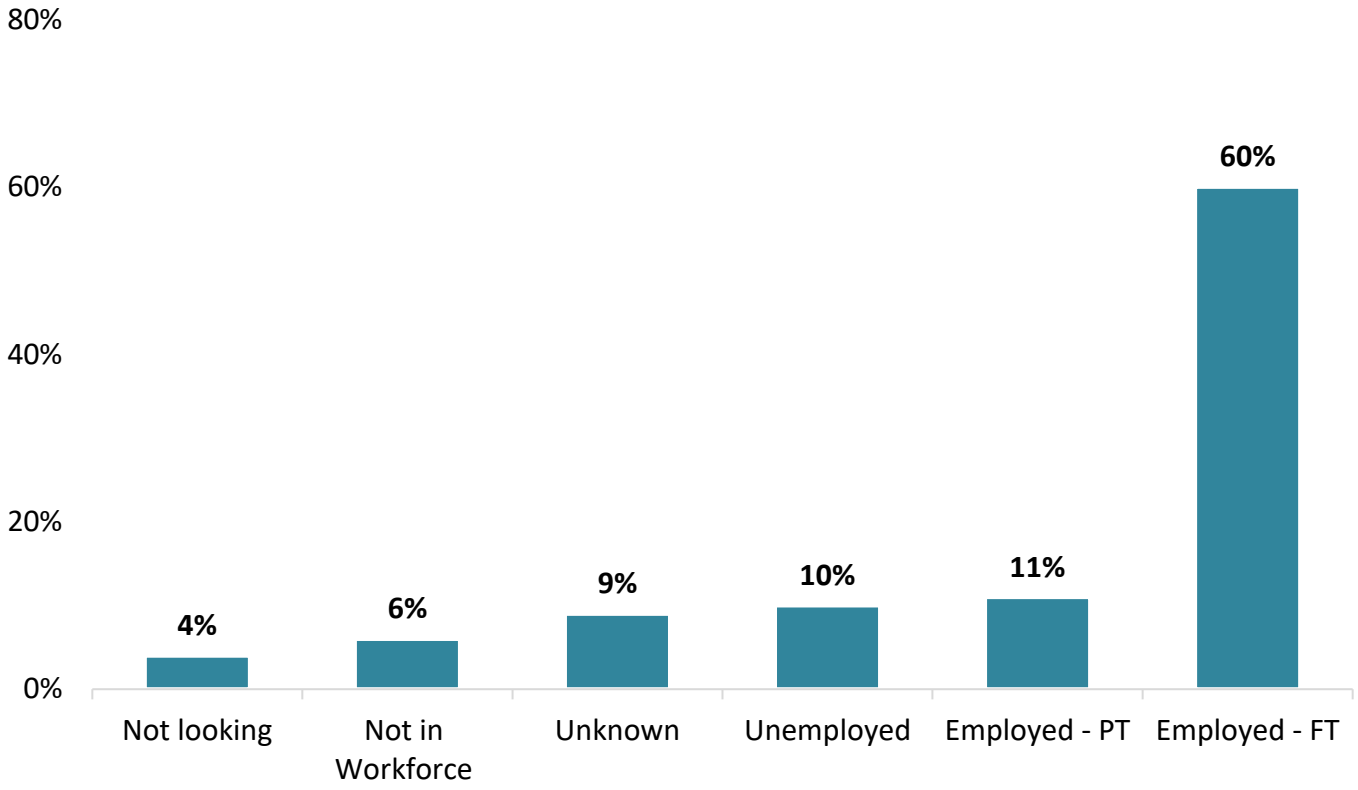
A very small percentage of residents are Hispanic (only 6 out of 633 residents). Please note that housing managers filled out this information, so it could be possible there are more residents who are Hispanic than what the managers reported.

The lack of representation of Black individuals in recovery housing is not surprising. Black individuals (specifically Black males) have a higher rate of overdose deaths compared to White individuals.[12] It is important to note that in these areas that are experiencing high rates of overdoses in the Black community, there are very few housing resources.



[12]Department of Health and Senior Services (2018) Missouri Opioid Information. Retrieved from: https://health.mo.gov/data/opioids/

Resident Employment Status



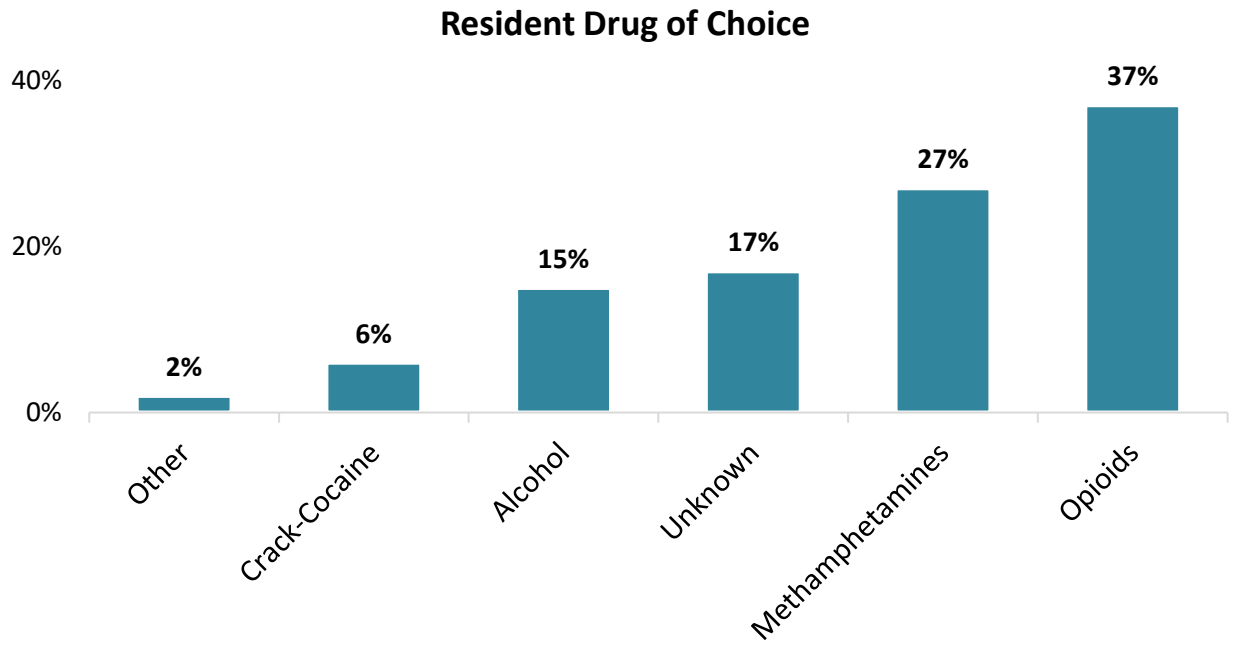
A majority of residents are reported to be employed full time, which, in most houses, is a requirement to live in the house. Only two residents were reported to be a part of the non-competitive workforce or volunteer sector.

Veteran Status

House managers/staff reported that approximately 5% (n = 30) of residents were Veterans. This number reflects the number of residents that are *known* to be veterans. However, because this may not be a data point that is regularly captured in data collection, it is likely that this is an underestimate.

Resident Substance Use History

In an effort to understand whom recovery houses are serving, we asked about the resident's substance use history. This gave us an idea of what drug(s) were previously used among residents. A majority of residents were struggling with opioid use. Missouri has seen an increase of people receiving treatment for methamphetamine use so it is not surprising to see that methamphetamine was the second-highest former drug of choice among residents.[13] Also, we wanted to identify how many residents were formerly IV users, and if managers were aware of residents who have experienced an overdose previously.



Note: Other drugs included marijuana, Xanax, Air duster, PCP

There were six houses that reported higher numbers in the drug of choice compared to the number of residents. This may mean that residents have multiple drugs of choice or are struggling with multiple substances. We are unable to determine what is accurate; therefore, we erred on the side of inclusion, which is why the percentages add up to more than 100%.

IV Users

44%

Housing managers reported being aware that 44% (n = 288) of residents were IV users. Similar to the veteran data point, it is possible that more residents are IV users and it is possible that this is an underestimate as well.

Overdose Experience

30%

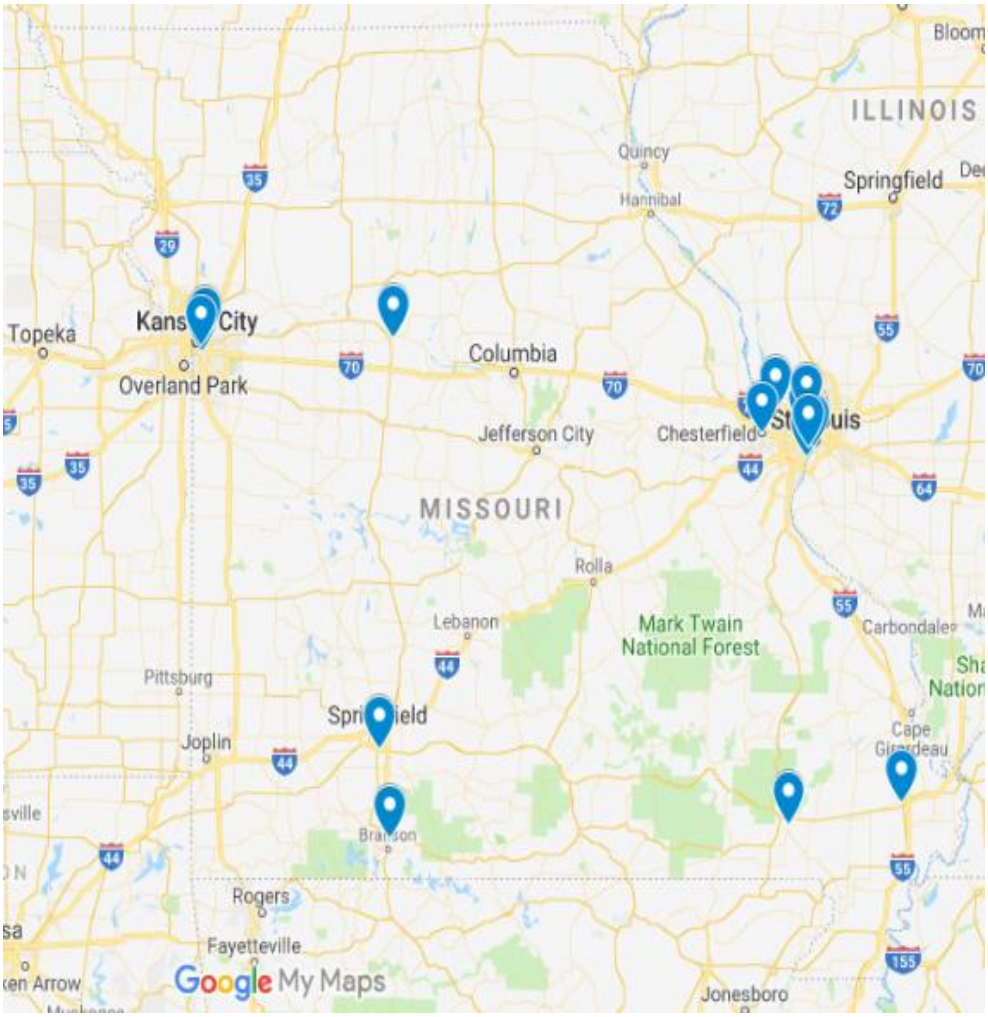
We specifically asked housing managers how many of their residents have experienced an overdose in the past – not how many times a person has overdosed. Housing managers were aware of 30% (n = 191) of residents who had previously experienced an overdose. Again, this means that it is entirely possible more residents had experienced an overdose than was known to managers.

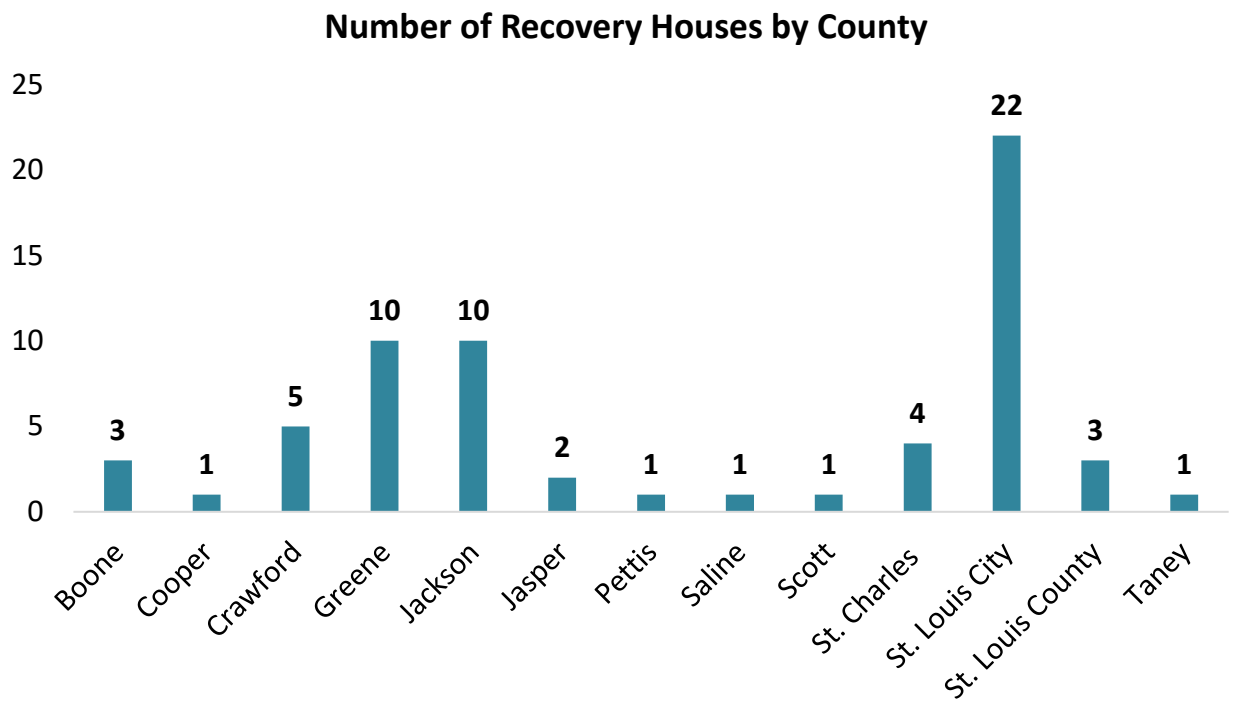
[13] Behavioral Health Epidemiology Workgroup (2020) *Methamphetamine use on the rise*. Retrieved from: https://mcusercontent.com/368aefcfbcfeaff1e0182fb8c/files/e5114bb5-37c7-4ad6-aed1-0b072b02a644/Meth_April_2020.pdf

Geography of NARR-Accredited and STR/SOR-Approved Houses

Most of the NARR-Accredited and STR/SOR-Approved recovery houses are concentrated in the Eastern region of the state (29 STR/SOR approved). The majority of these houses are in the St. Louis City area, with three houses located in St. Louis County and four located in St. Charles County. The Southwest region has 13 houses, with one organization in Springfield providing a large number of houses. The Western region has 12 houses, the Central region has 11, and the Southeast region has one. Two houses were excluded from the survey because of the lack of residents that were located in the St. Louis and Southeast regions. In most regions, there is usually one organization that accounts for a large number of houses. For example, most of the houses in the Kansas City area are under Healing House. In St. Louis, Recovery House has a large majority of the houses; however, there are more agencies representing the St. Louis region compared to other regions. Understanding where the majority of services are provided further equips providers and funders to focus on under-resourced areas

Figure 1. Map of Recovery Houses in Missouri





In addition to a general geographic overview of residences across the state, we measured perceived NARR level of individual houses, to get an understanding of how house staff sees their homes. We found a discrepancy between house managers' reported level of their homes and the MCRSP assigned levels. This could be the result of a communication disconnect between house managers and administrative staff or a lack of understanding of what exactly each level means by housing staff. Descriptions of each level were not provided to house managers; it is possible many housing managers are not even aware of what the different levels signify.

Table 3. Perceived versus Actual NARR-Accreditation Level

NARR & STR/SOR House Level	Perceived	Actual
Level 1-Peer-run	**20%**	**0%**
Level 1.5 (Hybrid)*		**8% (level 1.5)**
Level 2- Monitored	**44%**	**88%**
Level 3- Supervised	**25%**	**5%**
Level 4- Treatment Provider	**5%**	**0%**
Other	**6%**	**-**

*The Hybrid Level 1.5 is not a standard NARR level nationally, but it is used in Missouri. This option was not an option on the survey.

Houses that selected "Other" either indicated that they were a Sober Living Home (SLH) or that they were hybrid Levels 1 and 2 homes, the latter of which was not an option on the survey. There were four houses selected the "Other" option. Two houses said they were a SLH, and one house had a missing response. The one house that indicated they were a hybrid Level 1 and level 2 house were included in the row above, as they accurately perceived their house level even though it was not a survey option.

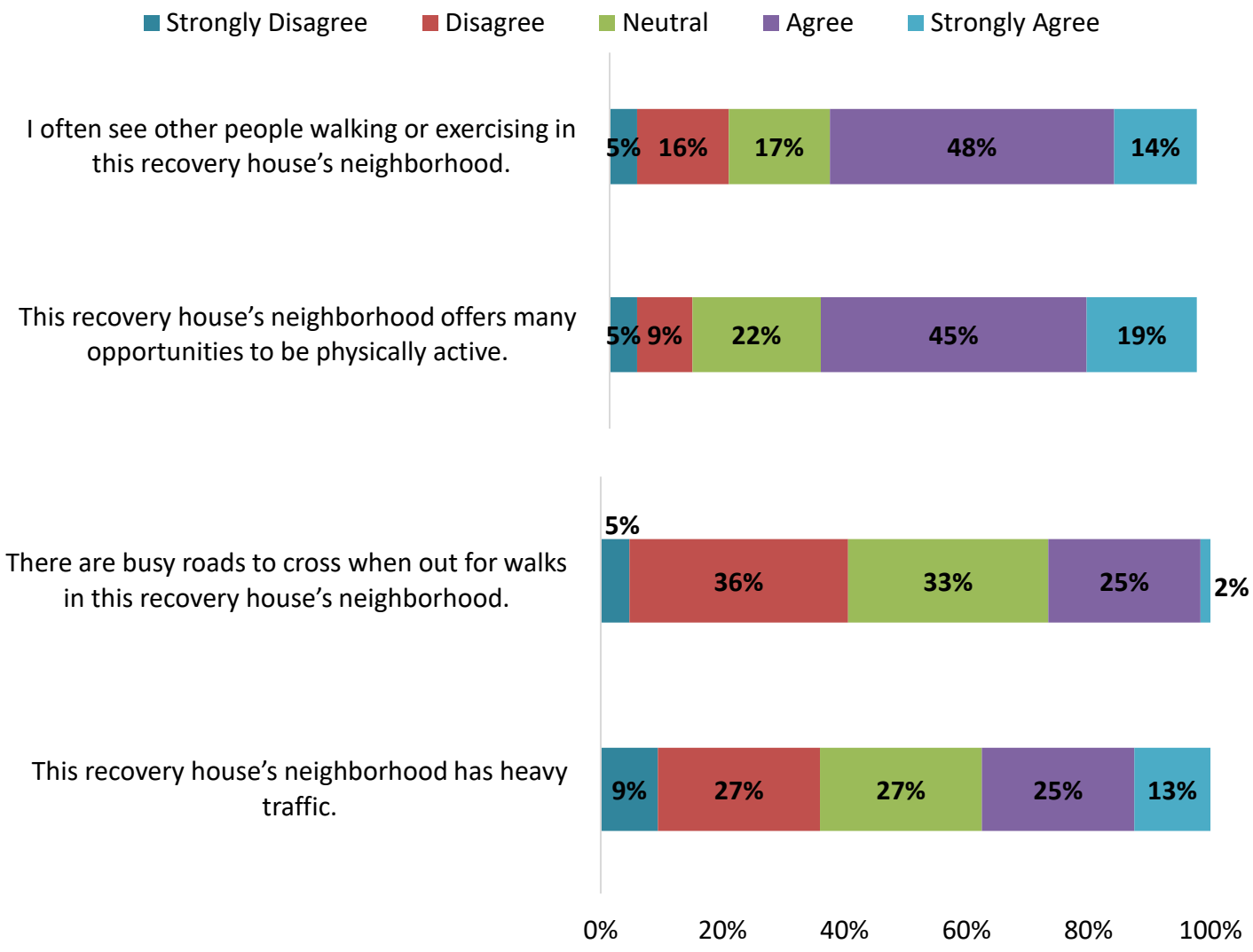
Housing Characteristics (External Environment)

Summary

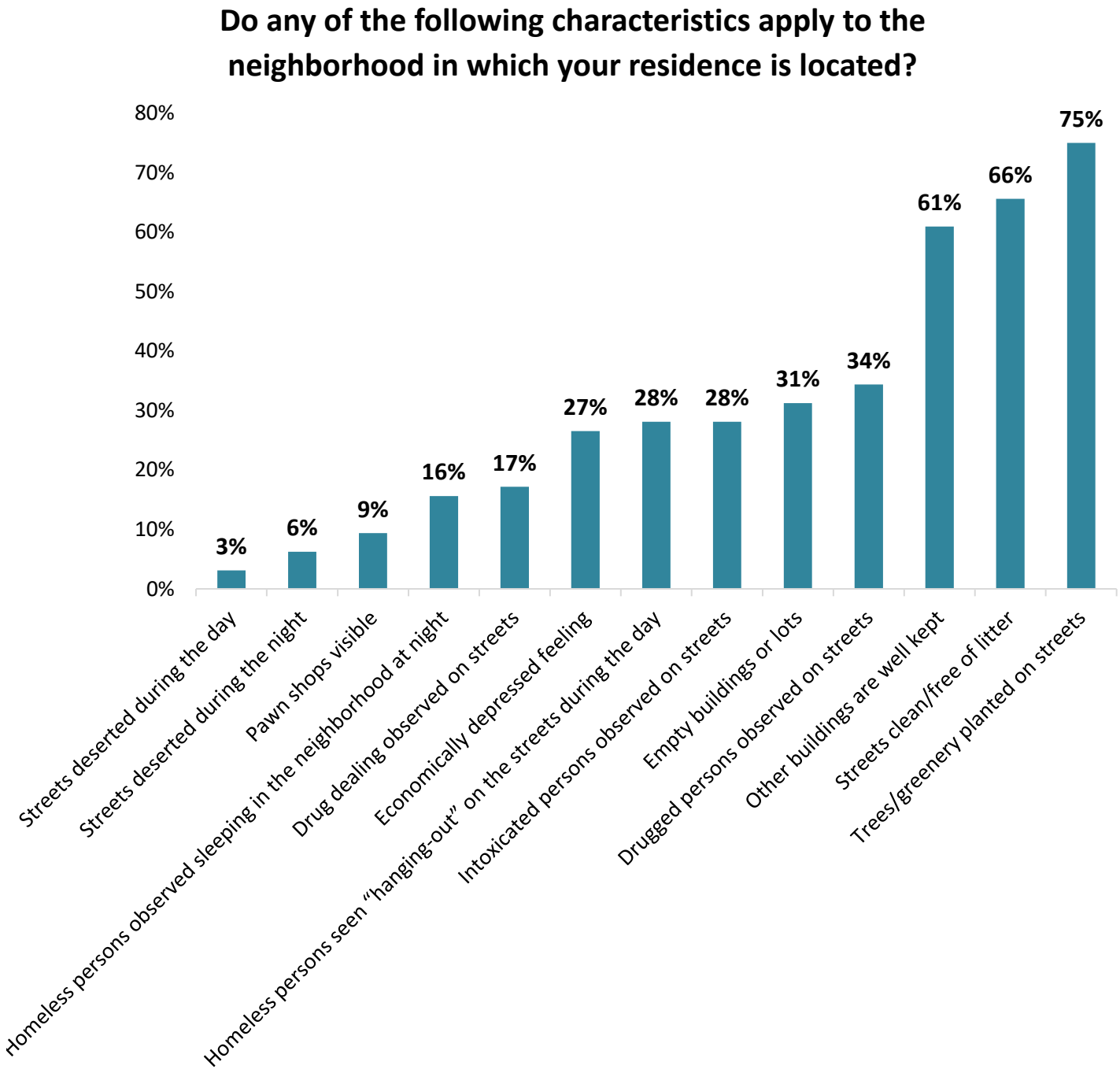
There is research that suggests a recovery house's neighborhood has an impact on the resident's recovery. For example, one study suggested that houses located in low socioeconomic neighborhoods contain more displays of publicly intoxicated persons and easier access to substances. This section looks to identify neighborhood characteristics of SOR recovery houses that could affect resident outcomes. Overall, we see that recovery houses' neighborhoods are perceived by managers to be relatively safe. While crime and substance use is inevitable in any neighborhood, house managers report few issues with it. In contrast, the data below shows that the majority of managers have positive experiences in their surrounding neighborhood, such as community members walking and exercising, useful resources within walking distance, well-kept buildings, well lit and litter-free streets. When it comes to specific aspects of neighborhoods, the data does show the need to address the lack of access to fresh fruit and vegetables.

Physical Characteristics of Neighborhood

This section was to gauge house manager perception of and experience in their surrounding neighborhood. Overall, there seems to positive perception of the physical characteristics.

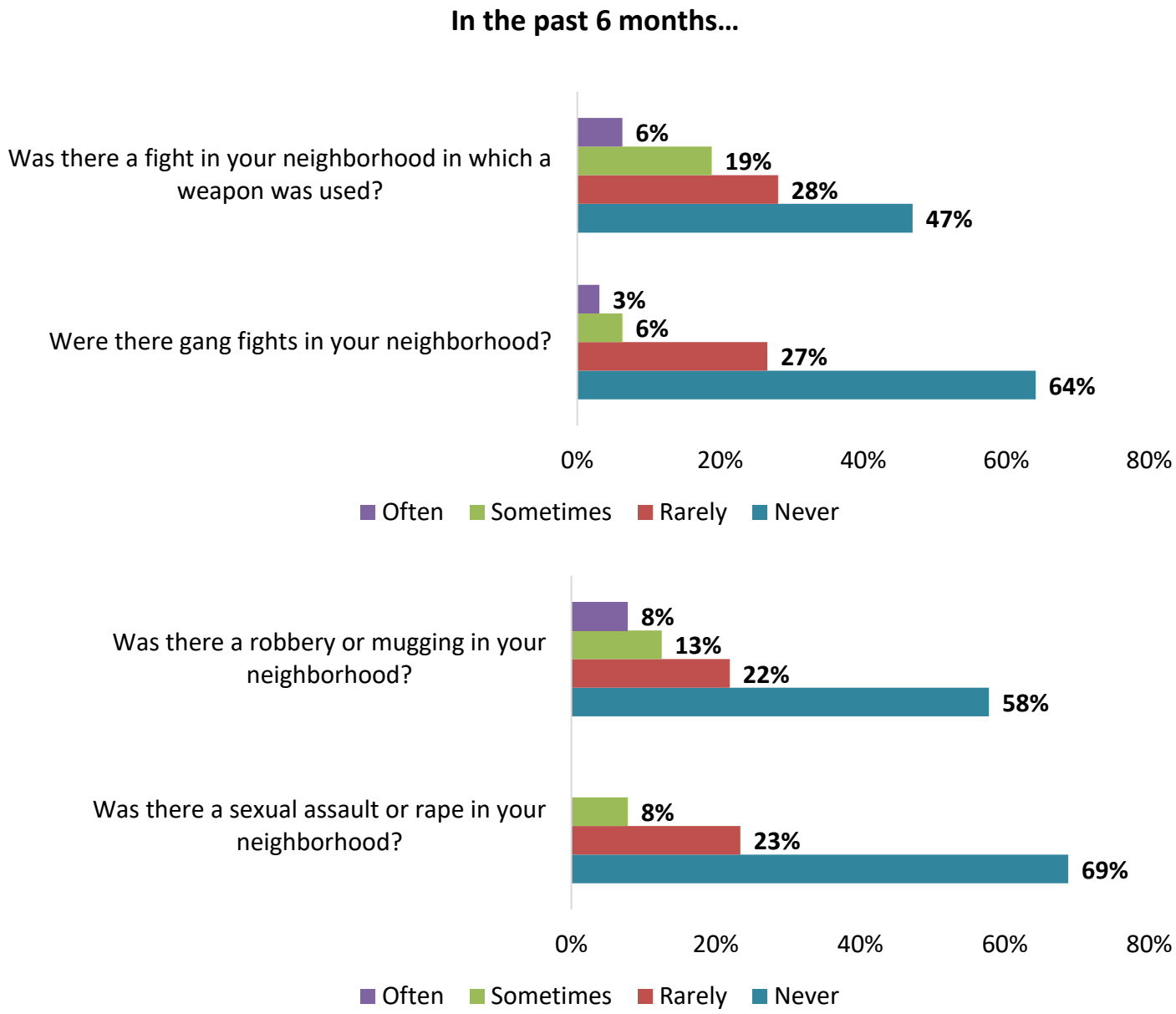



I feel safe walking in this recovery house's neighborhood, day or night.
5%
11%
16%
41%
28%
A large selection of fresh fruits and vegetables is available in this recovery house's neighborhood.
63%
20%
34%
30%
9%
0%
20%
40%
60%
80%
100%
There are many opportunities to purchase fast foods in this recovery house's neighborhood.
3%
16%
16%
56%
9%
Violence is not a problem in this recovery house's neighborhood
8%
9%
28%
23%
31%
0%
20%
40%
60%
80%
100%
This recovery house's neighborhood is safe from crime.
9%
16%
33%
22%
20%
In this recovery house's neighborhood it is easy to walk places.
3%
16%
52%
27%
3%
0%
20%
40%
60%
80%
100%



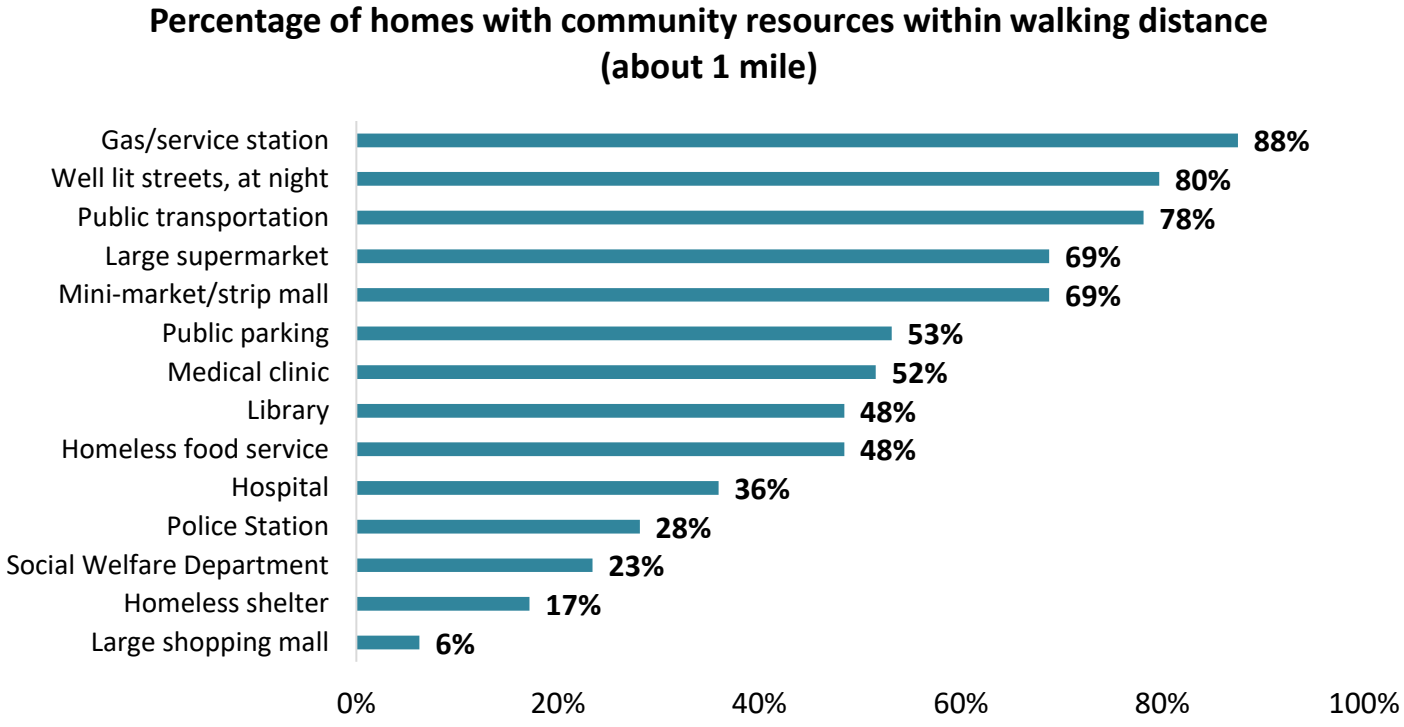
We asked houses to select all of the characteristics that applied to them. Overall, managers reported that their neighborhoods are clean and well maintained with greenery and trees. Less than 50% of houses have people who are intoxicated or drugged visible on the streets, which can be beneficial for people who are trying to maintain their recovery.[1]

The below graphs gauge perceived level of crime in the surrounding neighborhood. The below graphs show that the managers perceive their neighborhoods as safe (no fights, muggings, etc.)



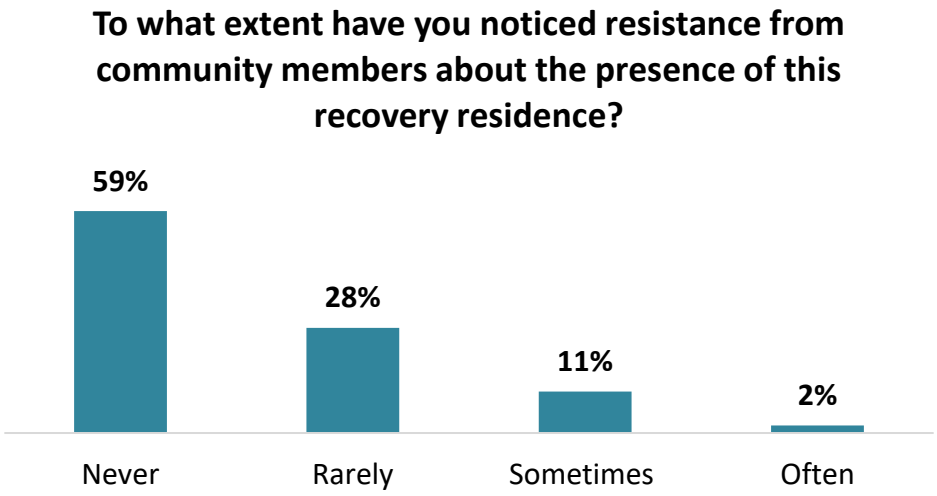
Walkable Community Resources

Access to reliable resources is a key factor in recovery; transportation has been discussed in depth as a major barrier. Whether transportation is unreliable or inaccessible (as we see in urban areas) or just nonexistent (as is the case in many rural communities). Results below show that a majority of houses are within walking distance to a variety of different services and importantly public transportation. However, because of the previous geographical data of recovery houses in Missouri, we know that there is a significant lack of housing in rural areas, which would look vastly different from urban areas in terms of easily accessible resources.

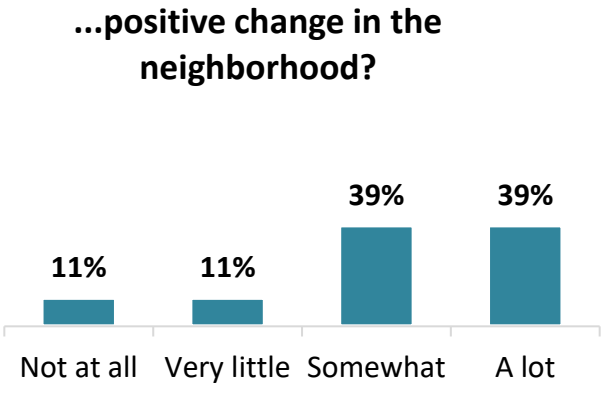


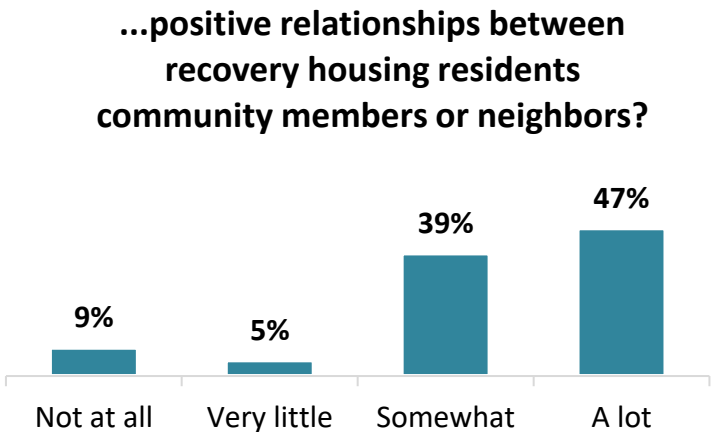
Community Resistance and Good Neighbor Policies

NARR and MCRSP developed accreditation standards to promote positive relationships between the community and recovery housing (see below). The goal of these policies are to ensure recovery housing operators are compatible with the neighborhood and that they are maintaining the home and are responsive to concerns in order to combat the "not in my backyard"(NIMBY) mentality that many houses face. NIMBY is a large contributor to the stigma against recovery housing and can make it very difficult for new houses to get started. MCRSP standards require each house to abide by "courtesy rules" which means residents are made aware of appropriate and acceptable outside activities (i.e. where to smoke or park). Therefore, we assessed the extent to which there was perceived resistance from the community against the recovery house and the role the good neighbor policies play in promoting positive change in the neighborhood and positive relationships with community members. Overall, participants reported minimal resistance from community members and a positive effect of the good neighbor policies.



To what extent have the Good Neighbor Policies promoted…





Housing Characteristics (Internal Environment)

Summary

The NARR standards require houses to create a homelike environment. We wanted to assess the general internal characteristics of the house such as how many residents can live in the house at one time in addition to what amenities that the house offers. More specifically, internal characteristics also include if the house allows transgender individuals to live in the house or if the house allows children. Findings show the majority of housing providers are men-only with only 2% of houses being co-ed. Findings also show that a small proportion of houses allow people who identify as transgender to reside in their homes, and fewer allow children to live with their parents.

Table 4. Maximum Number of Residents

	Percent
1-10	**59%**
11-20	**34%**
21-40	**5%**
> 40	**2%**

Table 5. Number of Residents in Houses

	Percent
1-10	**77%**
11-20	**17%**
21-40	**5%**
> 40	**2%**

A majority of houses have the capacity to house 10 or fewer residents. Very few of the houses hold more than 21 people. Only 6.3% (n = 4) of houses reported having 25 or more residents. Table 4 is a reflection of how many residents were reported living in the houses during the data collection period. We also compared houses maximum resident capacity with the number of residents in each houses. We found that 38% (n = 24) of houses were operating at maximum capacity when the survey was taken. A majority of houses were men only, and very few houses were co-ed. Of the houses that accepted men (i.e., Men only and Co-ed houses), only 34% reported accepting transgender men. Of the houses that accept women, only 27% reported accepting transgender women. The small proportion of houses that accept transgender men and women can create an additional barrier for these individuals in accessing recovery housing.

Table 6. Sex Restrictions of Houses

	Percent
Men only	**59%**
Women only	**38%**
Co-ed	**3%**

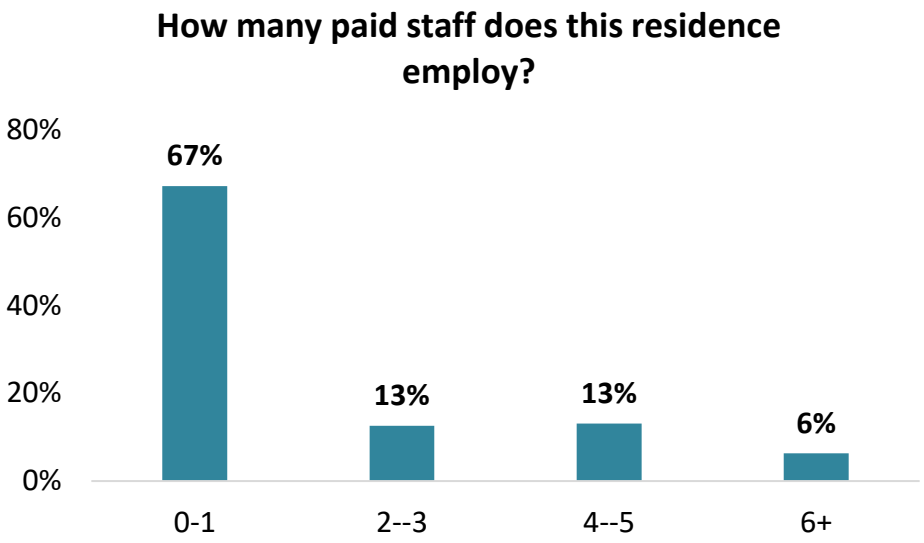
Table 7. Transgender Individuals Allowed in House

	Percent
Transgender men allowed	**34%**
Transgender women allowed	**27%**

Table 8. Proportion of Rooms – Shared vs. Private

Percent	Shared	Private
< 25%	4 houses	33 houses
25-50%	15 houses	19 houses
51-75%	20 houses	9 houses
76-100%	25 houses	3 houses

There are very few houses that have all private rooms - 13 houses have 100% of shared rooms

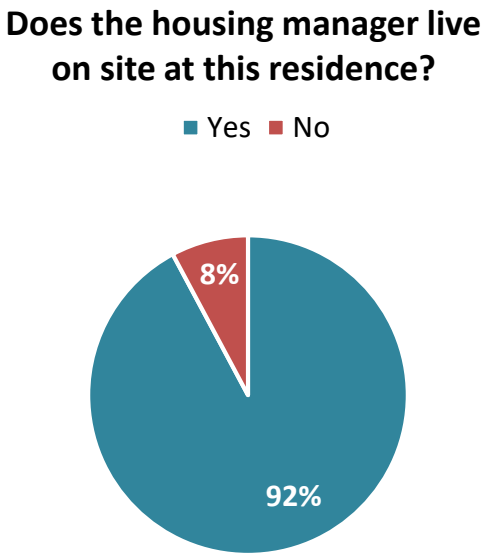


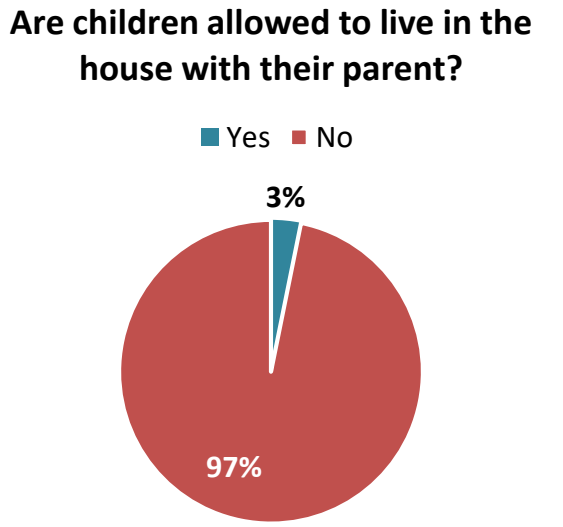
There is a range of paid staffing across the houses. Many of the houses do not have paid staff. One house reported eight paid staff members.

Table 9. Additional Staff Certifications

Staff Certifications	Percent
LCSW	**14%**
Certified Peer Specialist	**48%**
Substance use certificate or degree	**22%**
Identify as a person in recovery	**71%**
Unknown	**10%**

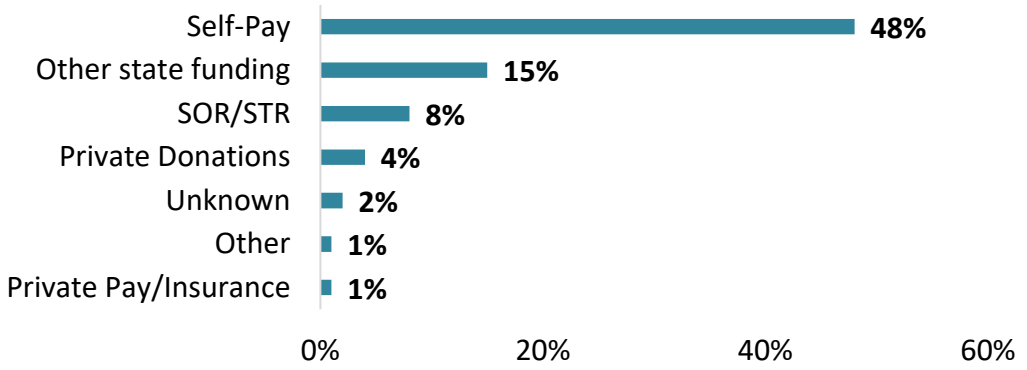
This question was for any of the additional paid staff other than the housing manager. We just asked how many staff had the below certifications. Some staff may have multiple certifications.





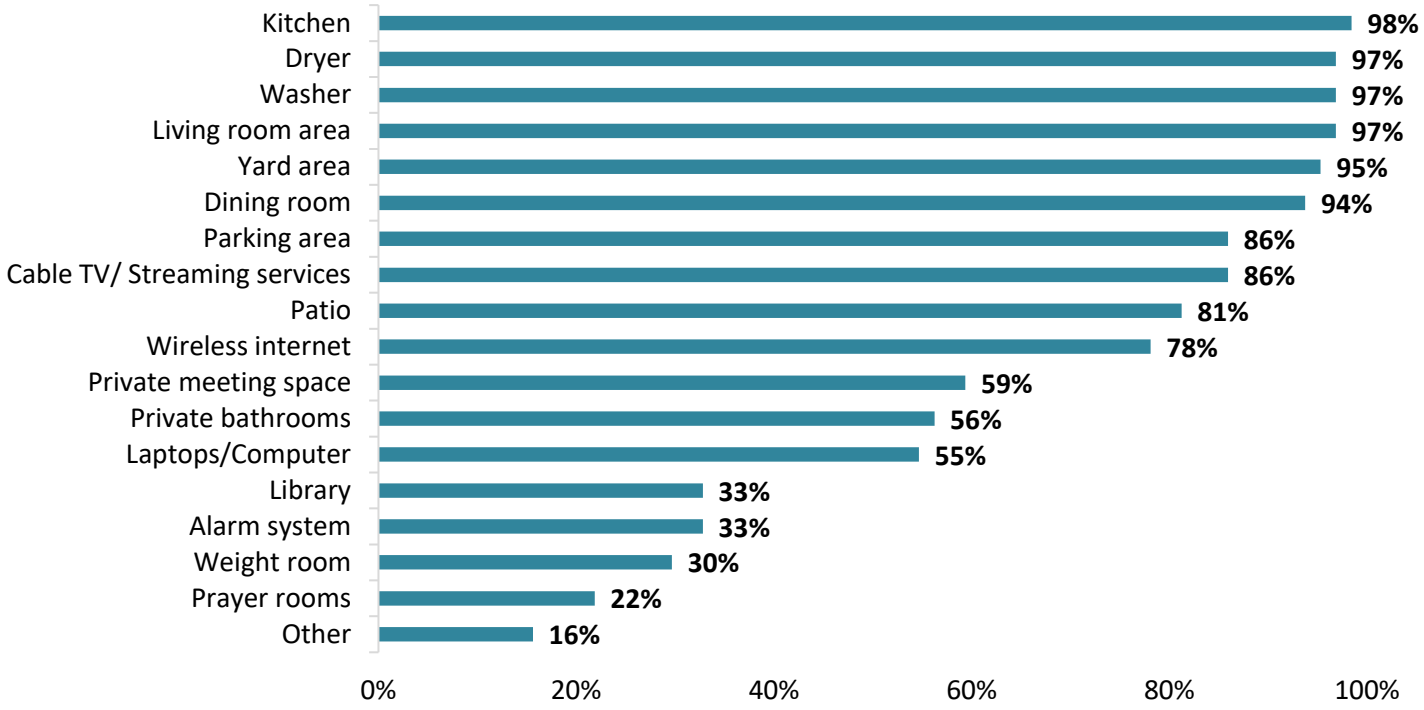
Only eight children were reported living with their parent in a NARR and STR/SOR approved home.

Payer Source



20% of houses either had missing data for the payer source breakdown or we were unable to interpret the data that was entered. The figure to the left represents only 80% of the data collected.

Amenities of Houses



Most houses have the typical set-up – kitchen, washer, dryer, and living room. This aligns with a few of the NARR standards to have a homelike environment for residents. Some houses have additional amenities such as a weight room or library.

Table 10. Other Amenities

Another living room and 1/2 kitchen 2/1/2 bathrooms home phone services donation closet	Playground for children, transportation, Probation & Parole on-site (2)
baby quieting room	Back balcony and garden
Classrooms	controlled entry
Musical instruments	Pool table

Social Model Philosophy Scale (SMPS)

In contrast to medical models of addiction that focus on addressing the underlying biological processes of addiction, recovery housing programs evolved from social models that prioritize experiential services and supports from individuals with lived experience. The Social Model Philosophy focuses on providing residents or clients with a sober social network, culture, and values, usually from peers who are in the same recovery community as them.[14] A scale was developed to measure social model principles in substance use programs.[15] They compared clinical and social model services to identify areas that would be necessary in determining the extent to which a program adhered to the Social Model Philosophy. Then items were narrowed down based on literature dealing with medical/clinical approaches versus the social model approach. The final scale includes six domains with 5-7 questions under each domain. Programs that score higher on the scale are more aligned with a Social Model Philosophy. There are few articles assessing the extent to which recovery houses adhere to the "true" Social Model Philosophy; however, the studies that have been conducted have demonstrated that few recovery homes meet the cutoff score for a true social model program and identified varied endorsement of social model principles across domains.[16]

Research in this area is underdeveloped, but there is some limited support that social model programs play a role in positive outcomes for program participants by increasing individuals' recovery capital (e.g., connecting them with a positive social network and 12-step programs). For example, one study found that residents in recovery homes that have strong 12-step programs and social networks maintained abstinence over an 18-month period in addition to improvements in employment and number of arrests.[17]

Table 11. The Five Domains of the SMPS and Description[18]

Physical Environment	House offers a homelike environment
Staff Role	Staff are seen as recovering peers
Authority Base	Experiential knowledge about recovery is valued
View of Dealing with Alcohol or Drug Problems	Residents view substance use disorders as a disease and are involved in 12-step groups
Governance	House empowers residents in decision-making
Community Orientation	House interactions with the surrounding community in a mutually beneficial manner

Many of the NARR accreditation standards are based out of the Social Model principles. Theoretically, these standards should promote good resident outcomes. The table below gives examples of how NARR/MCRSP standards align with the conceptual domains of the SMPS. There are several NARR/MCRSP standards that align with each domain, but only one example for each was provided for illustrative purposes.

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[14] Kaskutas, L. A., Keller, J. W., & Witbrodt, J. (1999). Measuring social model in California: How much has changed?. *Contemporary drug problems*, *26*(4), 607-631.

[15] Kaskutas, L.A., Greenfield, T.K., Borkman, T.J., & Room, J.A. (1998) Measuring treatment philosophy: a scale for substance abuse recovery programs. *Journal of Substance Abuse Treatment*. 15 (1):27-36

[16] Mericle, A.A., Miles, J., Cacciola, J., Howell, J. (2014) Adherence to the social model approach in Philadelphia recovery homes. *International Journal of Self Help and Self Care*. 8(2):259-275

[17] Polcin, D. L., Korcha, R., Bond, J., & Galloway, G. (2010). What Did We Learn from Our Study on Sober Living Houses and Where Do We Go from Here? *Journal of Psychoactive Drugs.* 42(4), 425-433. doi:10.1080/02791072.2010.10400705

[18] Polcin, D., Mericle, A., Howell, J., Sheridan, D., & Christensen, J. (2014) Maximizing social model principles in residential recovery settings. *Journal of Psychoactive Drugs*. 46(5)436-443. doi: 10.1080/02791072.2014.960112

Table 12. Social Model Domains. This table gives standard examples to each of the five domains:

Social Model Philosophy Domain		NARR/MCRSP Standard
Physical Environment	House offers a homelike environment	29. Create a home-like environment
Staff Role	Staff are seen as recovering peers	13. Use peer staff and leaders in meaningful ways
Authority Base	Experiential knowledge about recovery is valued	14. Maintain resident and staff leadership based on recovery principles
View of Dealing with Alcohol or Drug Problems	Residents view substance use disorders as a disease and are involved in 12-step groups	23. Promote meaning daily (e.g., encourage participation in work, school, mutual aid, etc.)
Governance	House empowers residents in decision-making	12. Involve peers in governance in meaningful ways
Community Orientation	House interactions with the surrounding community in a mutually beneficial manner	26. Connect residents to the local (greater) recovery community.

Overview of SMPS Endorsement among Recovery Houses in Missouri

From our evaluation, we summarized the endorsement of the social model across each of the five domains in the below table. There was a high endorsement of creating a homelike environment. For staff role, there was a high endorsement of mutual activity participation (e.g., eating together) and increased resident responsibility. However, the extent to which residents handle situations independently was not highly endorsed. Authority base had a moderate endorsement of social model orientation for staff positions (e.g., not requiring staff to be credentialed, having alumni on staff or staff who are in recovery themselves) but a high endorsement of peers and alumni involvement (e.g., having people in long-term recovery both living in the house and engaged in activities with the house). The domain measuring the view of dealing with alcohol or drug problems had relatively high endorsement across items. Governance and the extent to which residents make and enforce house rules had very low endorsement across all items. Community orientation resulted in high reports of formal links to the community, vocational training, and support with AA/NA participation. However, there is limited participation by the external recovery community in on-site events. More specific details on each of the five domains below:

Table 13. Domains and Endorsement in Missouri

Social Model Domains	Endorsement of social model orientation in Missouri
Physical Environment	High
Staff Role	Mixed
Authority Base	Mixed
View of Dealing with Alcohol or Drug Problems	High
Governance	Low

Community Orientation	Mixed (mostly high)

Physical Environment

The physical environment subscale for the SMPS measures the extent to which the recover house provides a home-like environment. Overall, responses generally aligned with a social model-oriented response. Results demonstrate that all of the houses provided areas for socializing and a majority reported a lack of environmental factors that would detract from a homelike environment (e.g., reception desk and requiring permission for participants to leave the home).

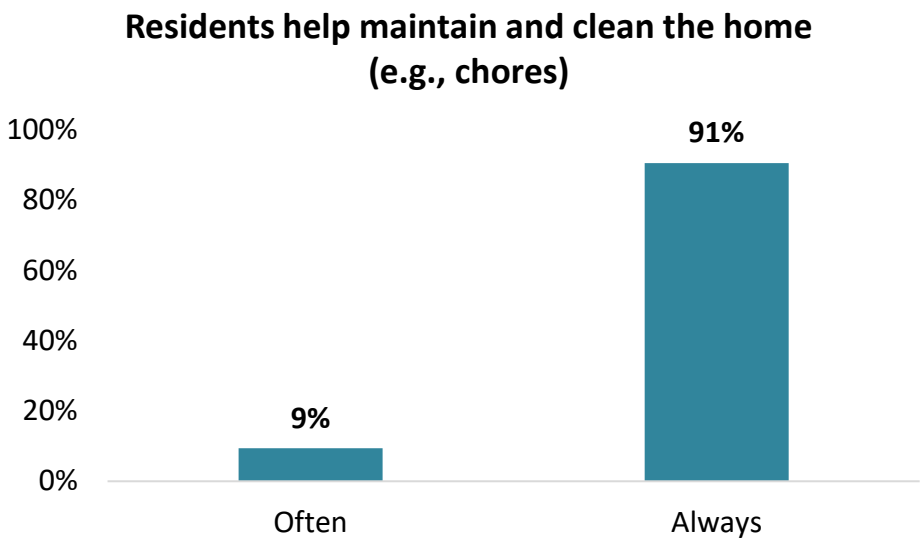
Table 14. Physical Environment

Physical Environment	Social Model-Oriented Response	Count	Percent
Program site is NOT part of a hospital or clinical setting.	No	49	77%
What % of rooms are dedicated to staff offices	Less than 10%	13	20%
Is there a comfortable group area, a living room or sofas, for participant socializing?	Yes	64	100%
Does the site have a reception desk to screen people upon arrival?	No	48	75%
Can participants with a requisite amount of sobriety leave without staff permission?	Yes	55	86%
Are participants involved in food preparation?	Yes	63	98%

The following tables expand on responses presented in the summary table that were not fully captured (i.e., that were summarized or shortened in the summary table).

Rooms Dedicated to Staff Offices

Of houses (21 houses) reported having no rooms dedicated to staff offices. In other words, 100% of their rooms are dedicated to residents.



Response options included: Never, Rarely, and Sometimes but no houses chose these.

This is **NARR Standard 27** and is not an original question on the SMPS, but it aligns with the physical environment domain. Residents helping maintain the home is a part of **MCRSP Standard 24** that requires recovery houses to create a functionally equivalent family within the household.

Staff Role

The staff role of the SMPS measures the extent to which staff are seen as recovering peers. The summary table below demonstrates that respondents answered these questions in ways that both do and do not align with the SMPS. Specifically, there was a moderate-high endorsement of items related to staff spending time with residents and increases in resident responsibility. However, because staff assist in ways that are different from other residents, such as being responsible for handling situations in which residents are under the influence of drugs/alcohol, this can differentiate their role from the perception of another peer in recovery.

Staff Role	Social Model-Oriented Response	Count	Percent
Does the staff eat with the residents?	Yes	61	95%
What is the estimated % of time staff spends out of the office when on-site?	75% or more	34	53%
If staff is not there or in the immediate vicinity and a resident shows up drunk (or on drugs), do residents handle the situation themselves and not involve staff?	Yes	1	2%
Does the staff avoid making appointments for residents outside the house (versus encourage or nearly make all of their appointments)?	Yes	16	25%
Does resident responsibility increase with their length of stay at the program?	Yes	63	98%

The following tables and graphs expand on responses presented in the summary table that were not fully captured (i.e., that were summarized or shortened in the summary table).

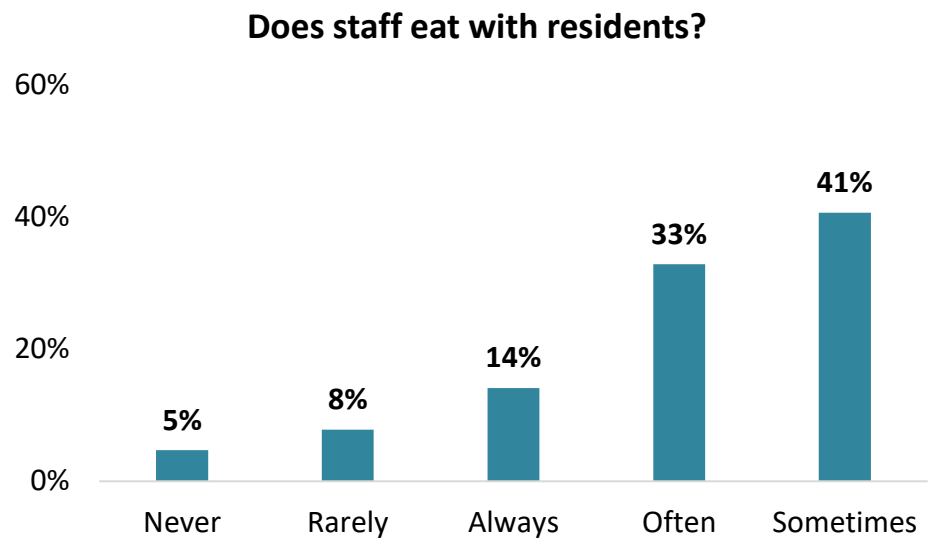
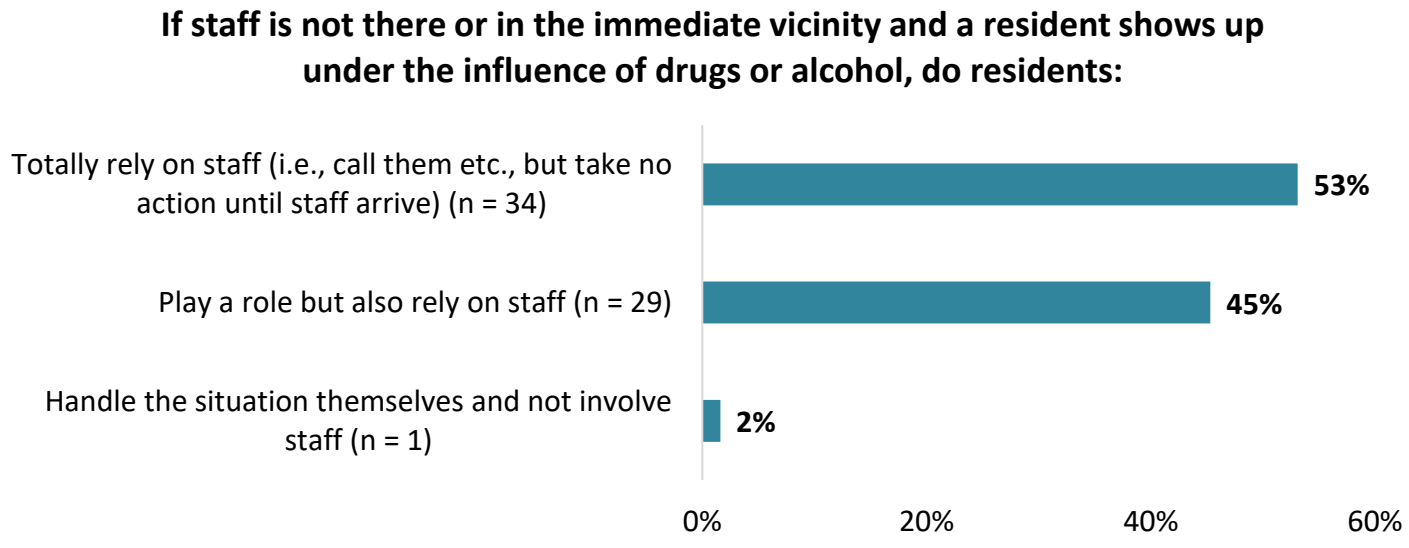
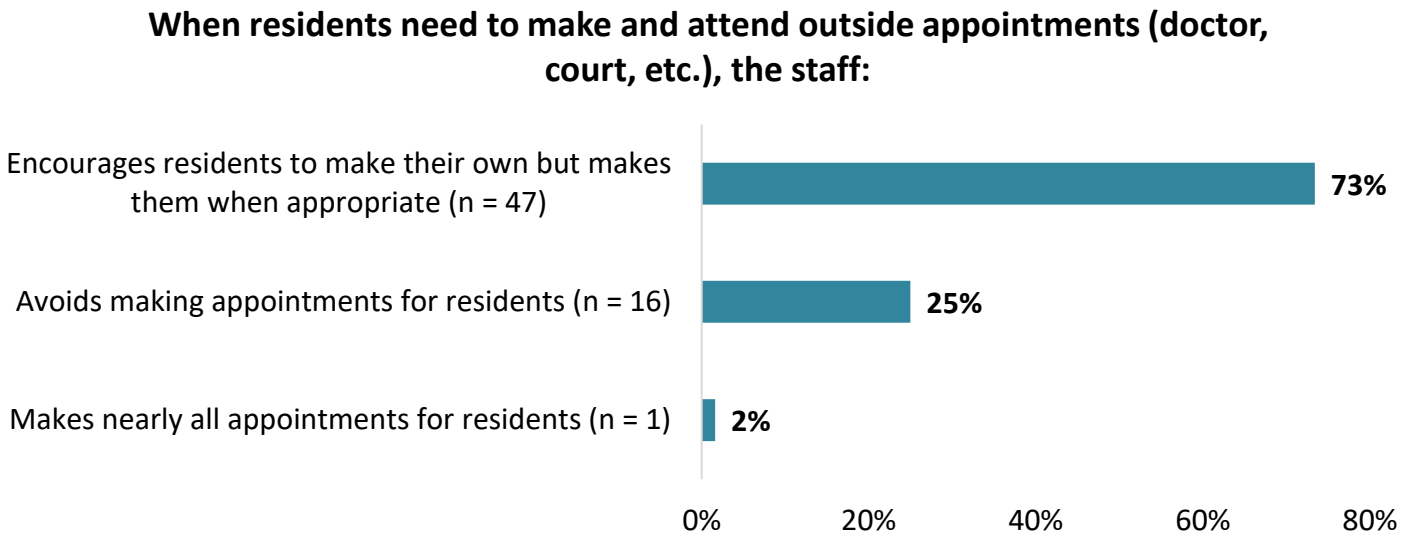
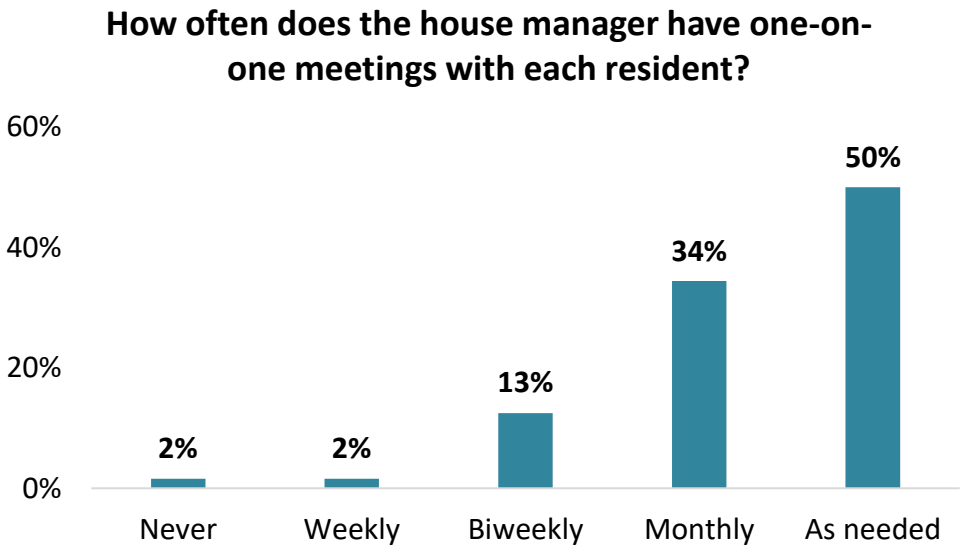


Table 17. Staff time outside the office

Percentage of time of staff spends outside the office when on site	Number of houses
25% or less	**4** houses
26-50%	**14** houses
51-75%	**14** houses
76-100%	**32** houses







This graph highlights that a large proportion of houses conduct regular weekly meetings. From informal conversations with housing managers, we hear that these meetings are a critical component to a person's recovery.

Authority Base

The authority base subsection focuses on the extent to which experiential recovery knowledge (versus clinical training in recovery) is valued. This subsection assesses the training requirements and personal recovery of staff members as well as the involvement/prevalence of individuals and residents in long-term recovery. There was a somewhat mixed endorsement of the items assessing the authority base; however, the argument could be made that items with only moderate endorsement are not a great measure of the extent to which experiential recovery knowledge is valued. Most of all houses endorsed the presence and involvement of individuals in long-term recovery. The measurement of the original scale suggests that required certificates, degrees, or professional trainings are inconsistent with valuing experiential authority base. However, the required training for staff positions (e.g., naloxone administration, cultural competency, and medication-assisted recovery) does not necessarily negate the value placed on staff and residents' personal recovery experiences.

Table 18. Authority Base

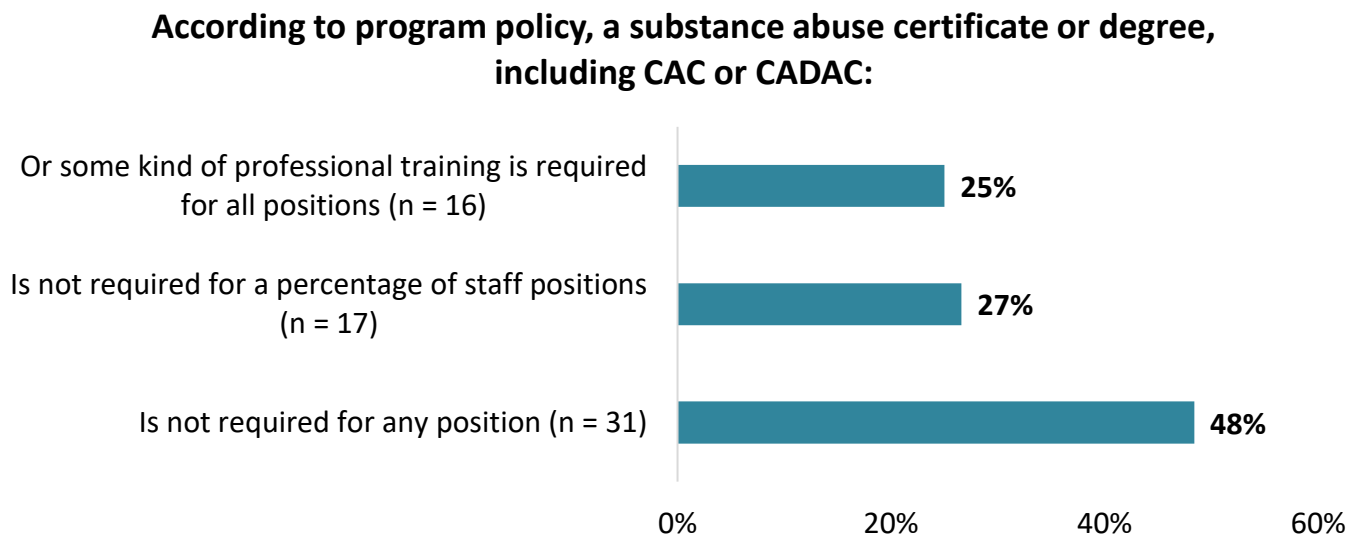
Authority Base	Social Model-Oriented Response	Count	Percent
Are any alumni on staff?	Yes	37	58%
Percentage of staff in recovery (more than 51%)	Yes	41	64%
A certificate, degree, or some kind of professional training is required for any position	No	31	48%
Over a normal week, 50% or more of the participants been clean and sober for 4 weeks or longer?	Yes	52	81%
Are people with long-term sobriety on-site at the program, often getting actively involved with residents?	Yes	64	100%

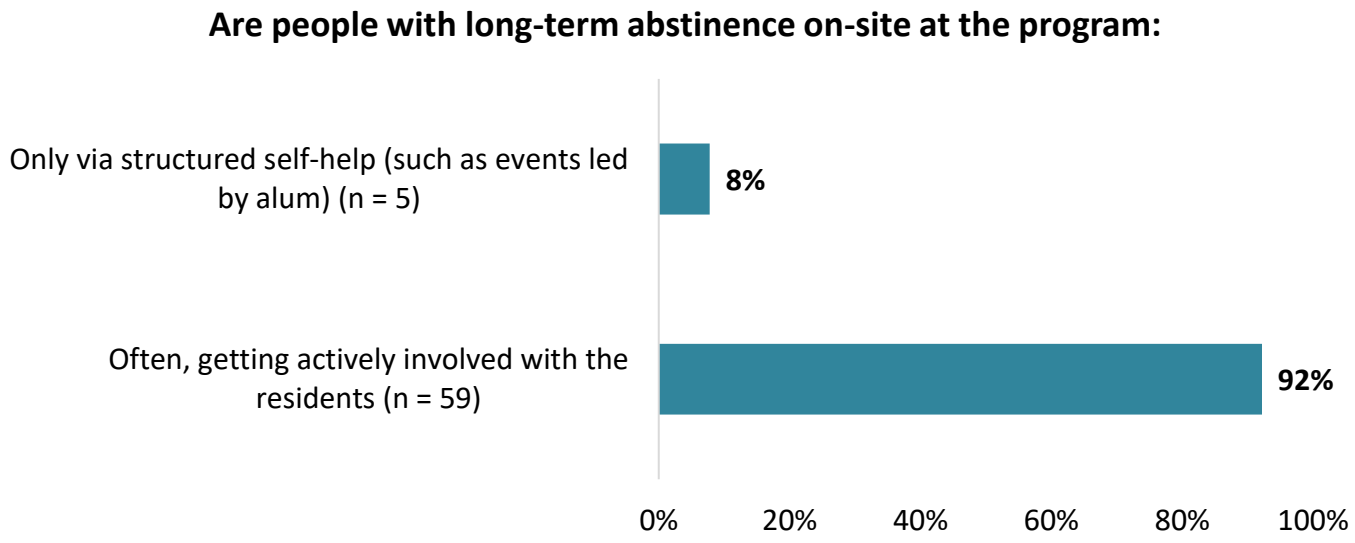
The following tables expand on responses presented in the summary table that were not fully captured (i.e., that were summarized or shortened in the summary table).

Table 19. Percentage of Staff in recovery

Most houses have staff that are in recovery.

Percentage of staff in recovery	
25% or less	**6** houses
26-50%	**7** houses
51-75%	**4** houses
76-100%	**47** houses





View of Dealing with Alcohol or Drug Problems

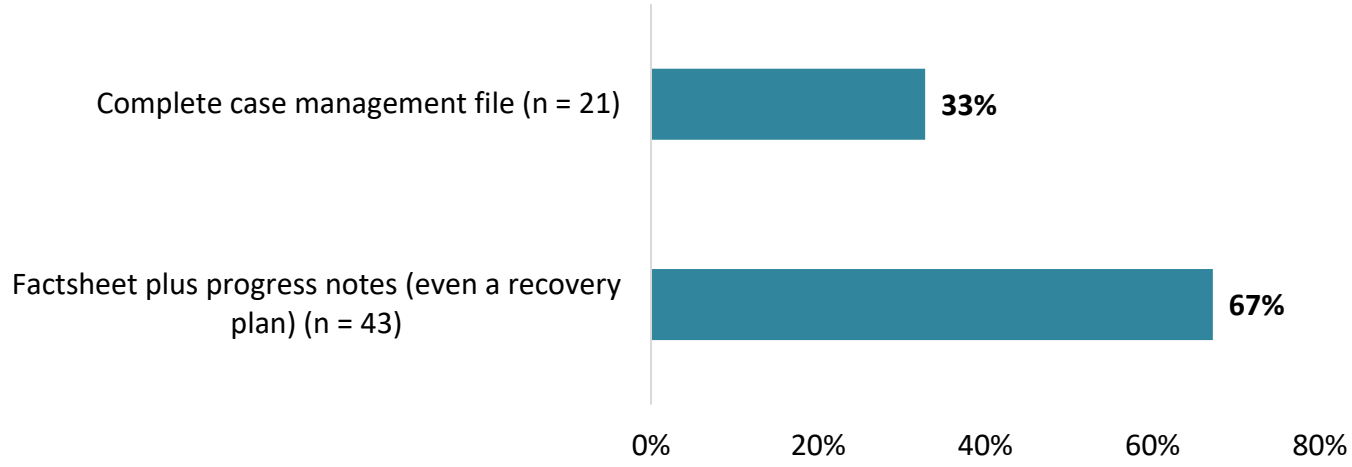
This section focuses on if residents view substance use as a disease and whether they are involved in 12-steps[17]. Consistent with other research on recovery homes, there was a high endorsement of this domain. The responses clearly indicate a recovery-oriented home rather than a clinical/treatment-oriented (e.g., identifying as a recovery program, referring to individuals as "resident" rather than "clients" or "patients", not referring to staff as "counselors" or "therapists") A few houses indicated they were a treatment program (rather than a recovery program), but we suspect the wording of the original scale item could have caused some confusion.[15]

Table 20. View of Dealing with Alcohol or Drugs

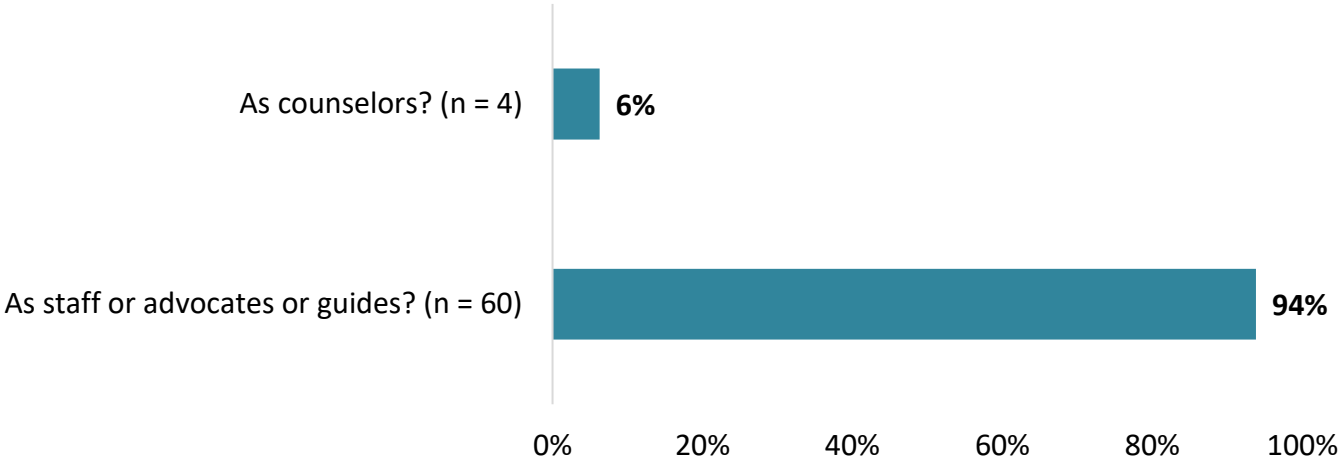
View of Dealing with Alcohol or Drug Problems	Social Model-Oriented Response	Count	Percent
Is this a recovery program (versus treatment program)?	Yes	60	94%
Are less than 50% of participants mandated by some external institution or agency?	Yes	43	67%
Are records kept on each resident (e.g., recovery plan)?	Yes	64	100%
Are participants ever referred to by staff as residents or participants (versus clients or patients)?	Yes	44	69%
Are staff ever referred to by participants as staff, advocates or guides (versus counselors or therapists)?	Yes	60	94%
Does the program provide vocational or academic training?	Yes	50	78%
Are participants encouraged to engage one another in informal activities and conversation?	Yes	63	98%

The following tables expand on responses presented in the summary table that were not fully captured (i.e., that were summarized or shortened in the summary table).

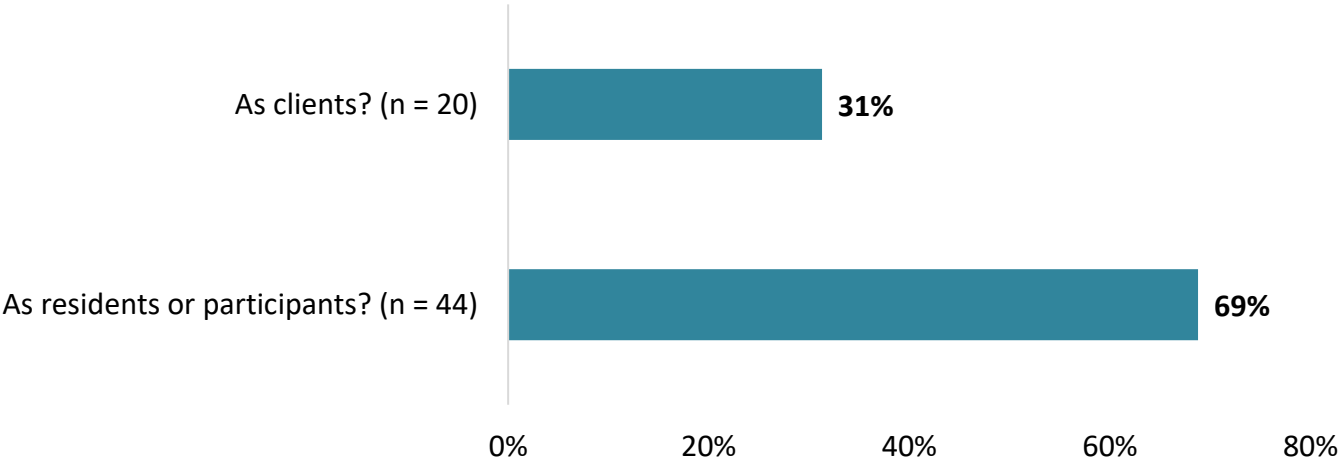
In terms of record keeping, for each participant, the program keeps a:

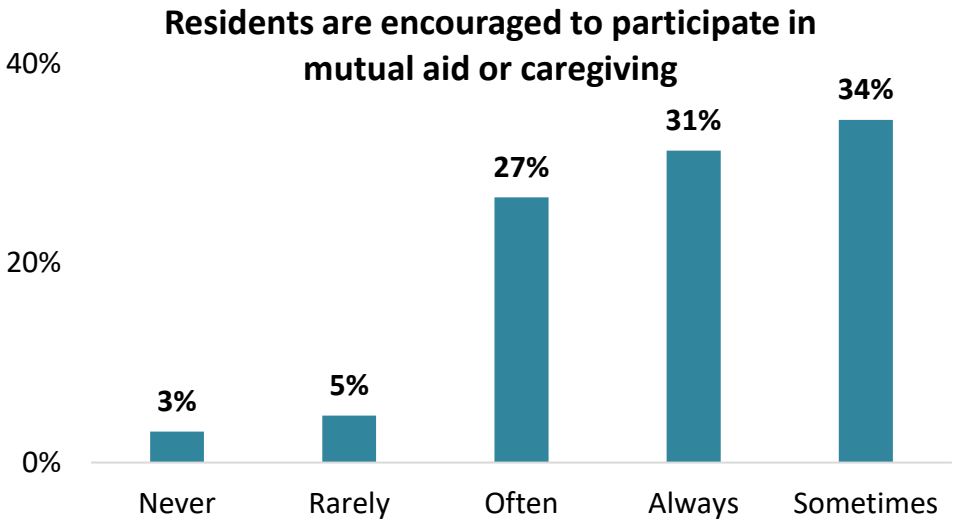


Are staff ever referred to by participants:



Are participants ever referred to by staff:





This question is not part of the original SMPS but it falls under this domain, and is a part of **MCRSP Standard 25.**

Governance

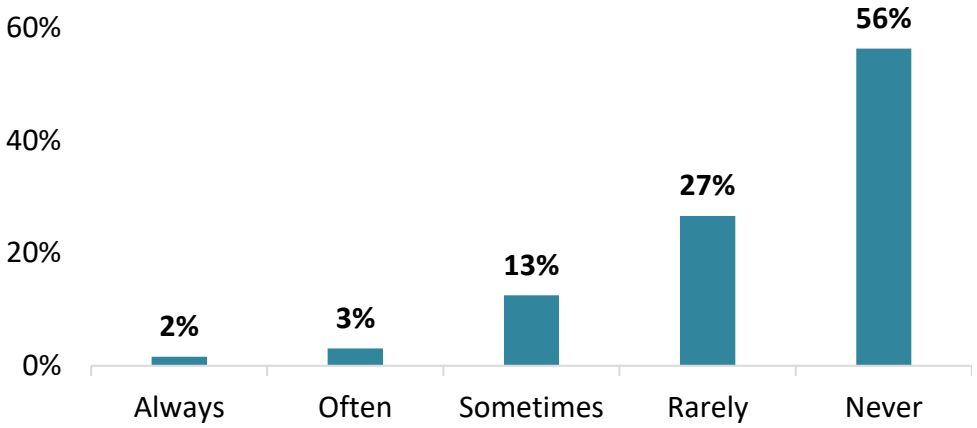
This section focuses on the extent to which residents have a formal role in the governance and decision-making in the recovery home. This includes having a resident's council and resident input when accepting someone into the home or when to end someone's residency. **MCRSP Standard 12** requires homes to involve peers in governance. Consistent with previous research on recovery homes, peer/resident governance shows relatively low endorsement. Only 29 recovery homes reported having a resident's council, and responses indicate that residents have relatively limited power over the governance of the home.

Table 21. Governance

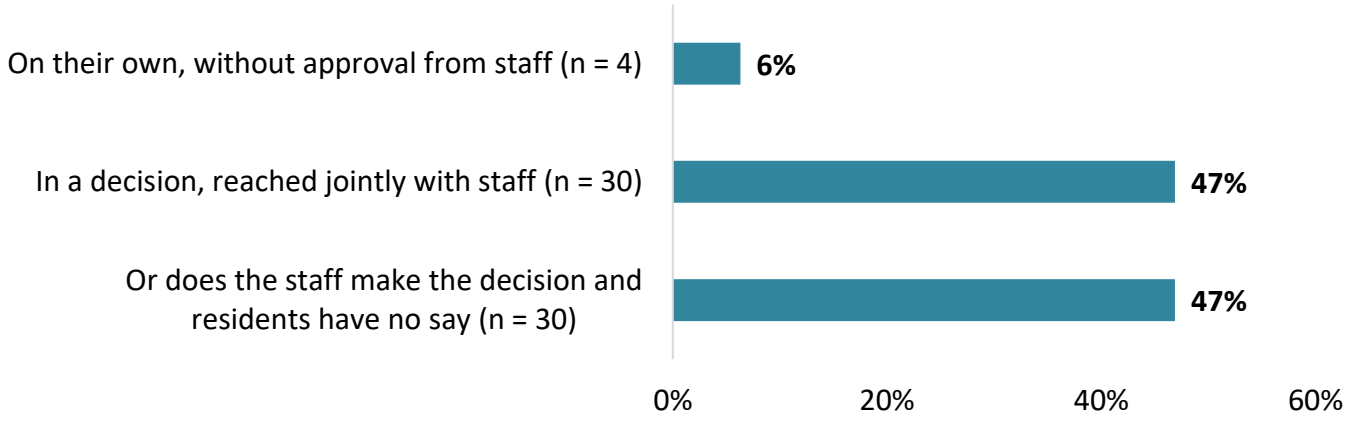
Governance	Social Model-Oriented Response	Count	Percent
Are there rules made by the residents that the residents (not staff) enforce?	Yes	18	28%
Is there a resident's council?	Yes	29	45%
Do the residents or council have the authority to punish or demote residents?	Yes	28	44%
Do the residents or council have the power to end a participant's residency on their own (i.e. without approval from staff)?	Yes	4	6%

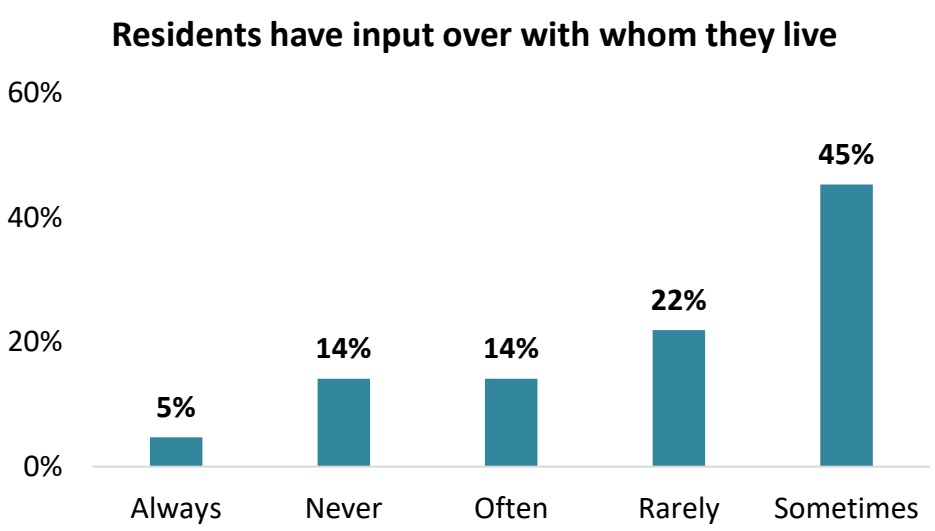
The following tables expand on responses presented in the summary table that were not fully captured (i.e., that were summarized or shortened in the summary table).

Do residents or resident's council has the authority to punish or demote other residents?

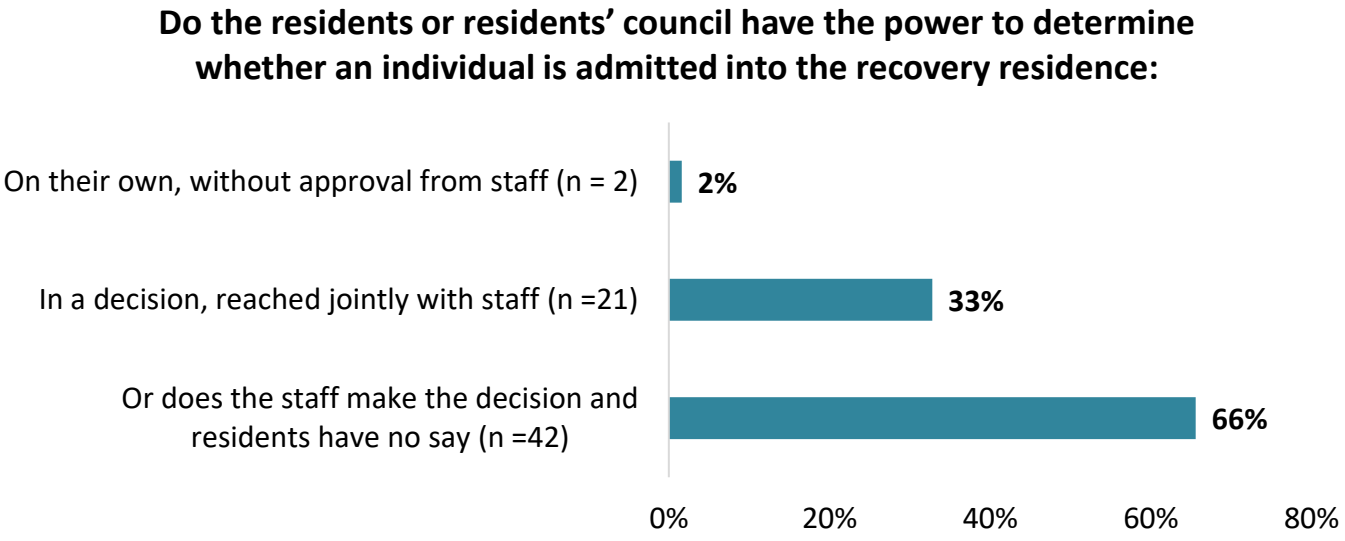


Do the residents or residents' council have the power to end a participant's residency:





The last two questions are not part of the original SMPS but they fall under this domain as they are still relevant to the idea of a resident's council. In addition, **MCRSP Standard 8** supports current residents having a voice in the acceptance of new members.



Community Orientation

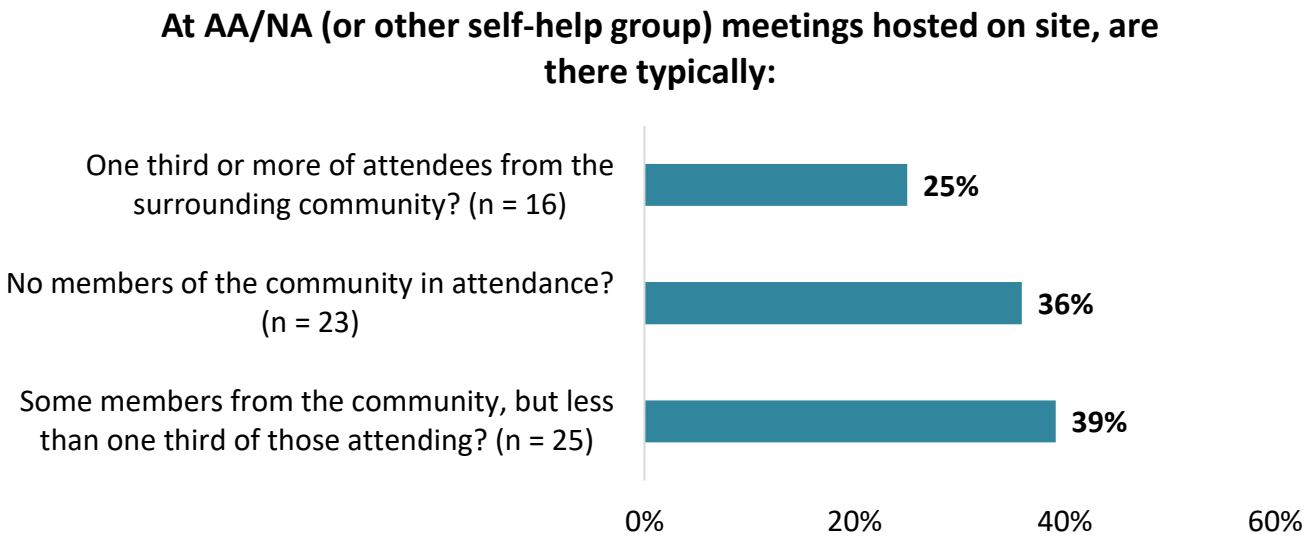
The community orientation subscale assesses the extent to which there are formal links with the greater recovery community and the involvement of the recovery community within a recovery home. There is a mixed endorsement of this domain, but overall it is mostly high – all 64 recovery homes reported that they help formally link residents and encourage engagement in the community, and have regularly scheduled "clean and sober social events." Although many residents find sponsors before leaving a recovery home, there is substantial variation across houses in the extent to which this happens.

Table 22. Community Orientation

Community Orientation	Social Model-Oriented Response	Count	Percent
At AA (or NA) meetings hosted on-site, there are typically 1/3 or more of attendees from the surrounding community	Yes	16	25%

This program helps participants find a sponsor if they are having trouble finding one	Yes	63	98%
What percent of participants find sponsors before leaving the program?	90% or more	17	27%
Are there formal links with the community such as job search, education, family services, health and/or housing programs that participants may easily use?	Yes	64	100%
Do participants engage in community relations and interactions?	Yes	64	100%
Are clean and sober social events "regularly" scheduled?	Yes	64	100%

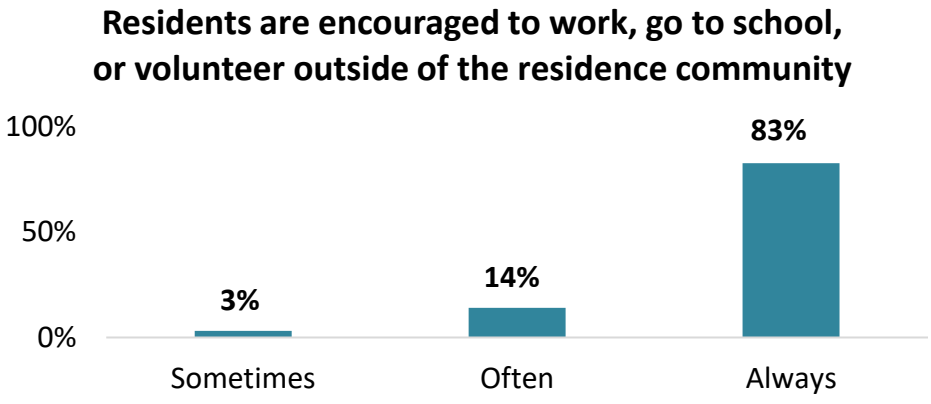
The following tables expand on responses presented in the summary table that were not fully captured (i.e., that were summarized or shortened in the summary table).

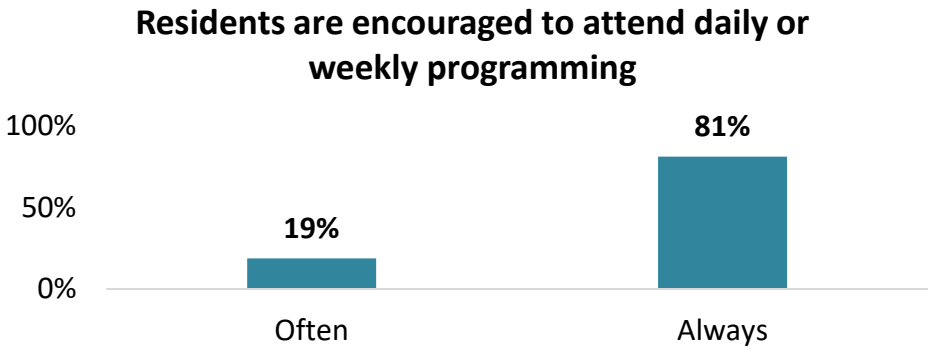


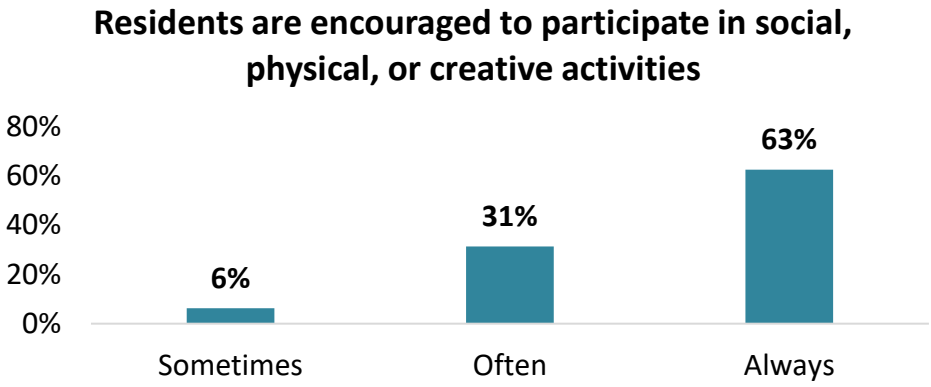
The Social Model Philosophy emphasizes strong connections with the recovery community, and thus assesses the extent to which individuals in recovery who are not current residents participate in activities and meetings hosted by a recovery home. Theoretically, participation by non-residents in house activities can help build the recovery capital of current residents.

Table 23. Participants and Sponsors

What percentage of participants have or find sponsors among AA/NA (or other mutual support groups) members before leaving the program?	
25% or less	**7** houses
26-50%	**13** houses
51-75%	**21** houses
76-100%	**23** houses







Response options also included “Never” and “Rarely”, but no houses chose these.

Residents participating in activities outside the home is a part **MCRSP Standard 23** but not a part of the original SMPS.

Methodological Concerns with the SMPS

There are quite a few issues with using the original SMPS scale. The original wording of the questions were confusing and often required that the evaluation team follow-up on participant responses or discussions with survey-takers to assist them with understanding and answering the questions. For example, the question "Program site is NOT part of a hospital or clinical setting" was a consistently confusing one during follow-ups. Questions in the original scale were primarily dichotomous (yes/no) which limits variability for questions that may be important (e.g., "Do staff eat with residents every day or once a month?"; "How much authority do residents have relative to staff?"). Therefore, we expanded scale responses for many items to better capture the variability across houses.

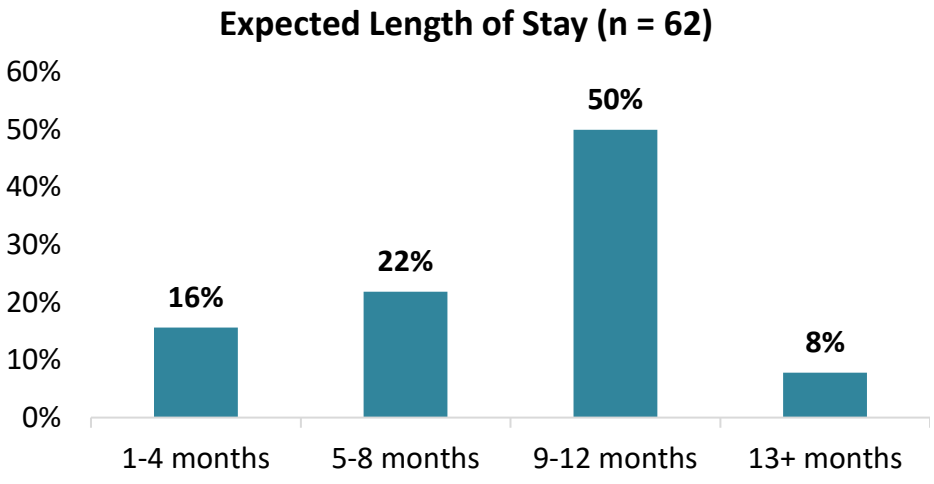
There was stigmatizing language we tried to avoid as well. For example, we changed the question "Are clean-and-sober events "regularly" scheduled?" to "[Are] Mutual aid meetings are hosted on-site…" Concerning MOUDs, there is a lack of clarity of what abstinence means and where MOUDs fits into that. Since the SMPS is rooted in 12-step traditions, popular 12-step, abstinence-based support groups like Narcotics Anonymous, still consider MOUDs as not being abstinent[14].

If this philosophy is important then we need a better measure. We need to update question wording and provide other response formats other than yes/no. Most importantly, we should be keeping up with evolving definitions of recovery and recovery language. Therefore, to improve our research on the impact of the social model on client outcomes, we need better measures.

Policies and Procedures

Summary

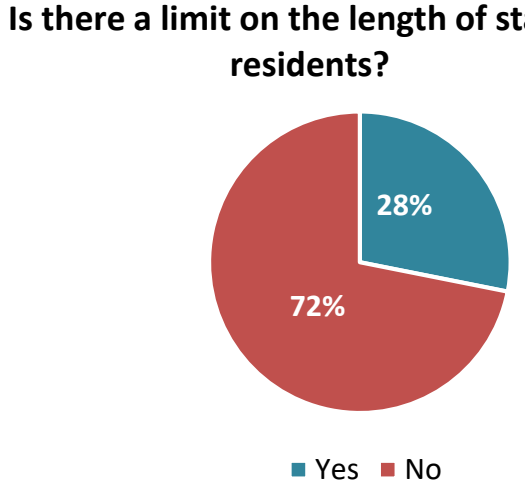
There are specific policies and procedures that are required for NARR accreditation. These policies and procedures focus on many aspects of the house, including expectations for residents and staff. NARR accreditation standards were developed based on the Social Model Philosophy and research that correlated housing policies and procedures with positive outcomes in long-term recovery[10]. For example, the extent to which the program empowers residents in making decisions about the home. Additionally, differences in policies and procedures were highlighted by executive directors during preliminary discussions as possibly playing a role in differential outcomes for residents across housing organizations. For example, executive directors highlighted that houses with fewer initial requirements for admission (e.g., sobriety length) might demonstrate shorter resident stays or less positive outcomes due to accepting people with greater needs and in earlier stages of recovery. Though this evaluation did not correlate any specific policy with outcomes, the responses provide a general baseline for how agencies approach their organization and what expectations they set for their residents. The results below highlight the extent to which housing policies align with and adhere to NARR standards. In general, results demonstrate high alignment with NARR standards although there was variation across houses. Furthermore, practices identified as important by house managers through the Community Based Systems Dynamics workshops and discussions with the MIMH Recovery Team include regular one-on-one meetings between the house manager and residents, and discretion in discharge practices for people who experience a reoccurrence in the house demonstrated high endorsement. More details are presented below.



Note: One house reported 7 days while two houses were missing data

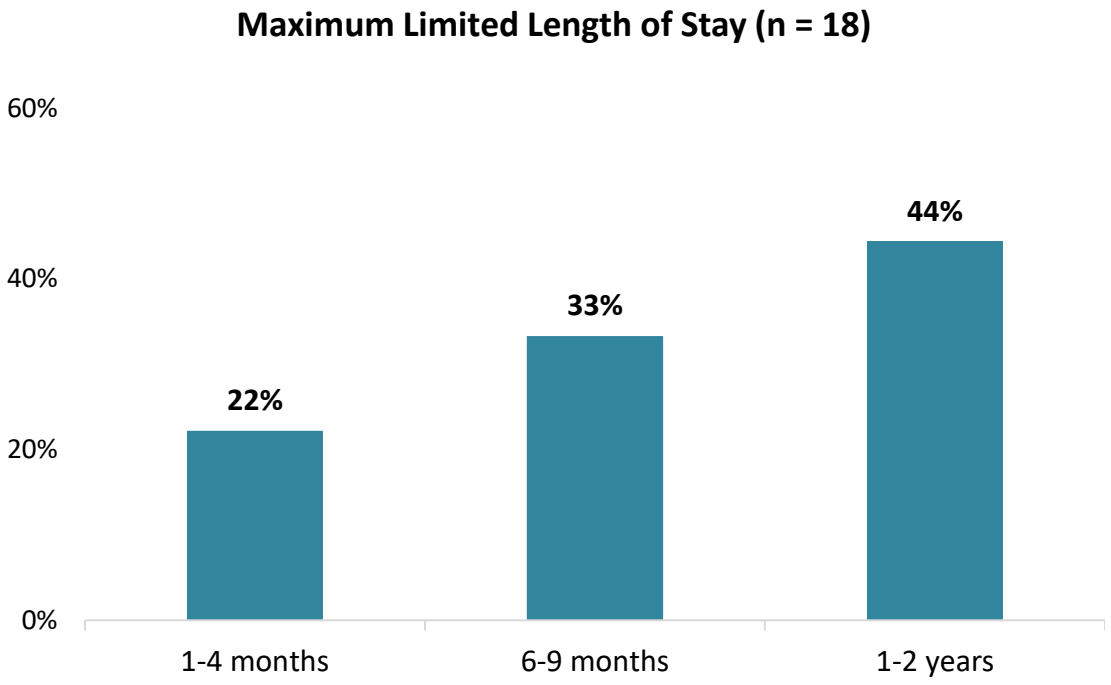
Most houses expect residents stay about a year. There is an understanding that this is temporary housing and the goal is to stabilize to become more independent.

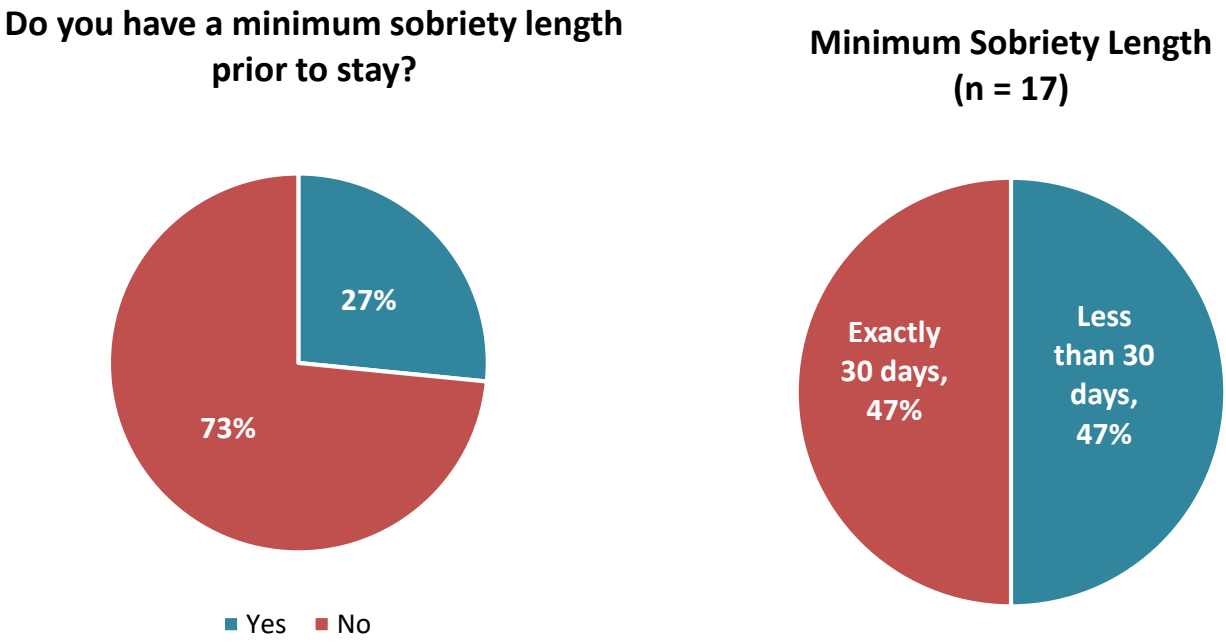
Some housing organizations are structured to move people through the program. For example, there may be an intake house, and residents will move to outer houses as they become more independent and hit certain goals.



A majority of houses do not set a limit on how long residents can remain housed. Of those who do set a limit (n = 18), the reported maximum length a resident can stay is shown below.

It is interesting to note that **MCRSP Standard 8.02** states that policies and procedures should promote resident-driven length of stay.

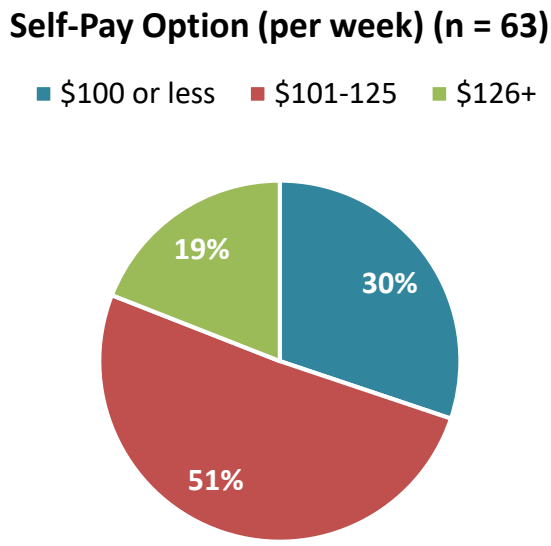


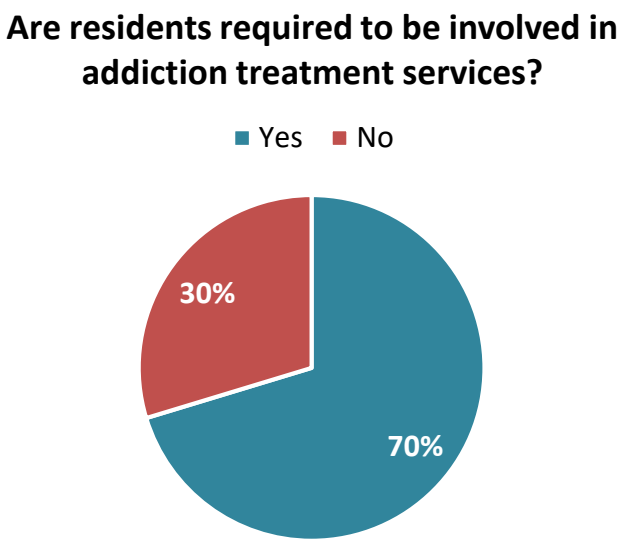


Of the 17 houses that reported a minimum sobriety length, a majority 16 reported requirements of one month or less. However, about half (n = 8) reported a full month of sobriety as a requirement, which is huge barrier to accessing housing. **One house (6%) reported one full year as a minimum sobriety length.**

Only five houses responded yes to both items – so these generally are not the same houses endorsing these two different kinds of limits.

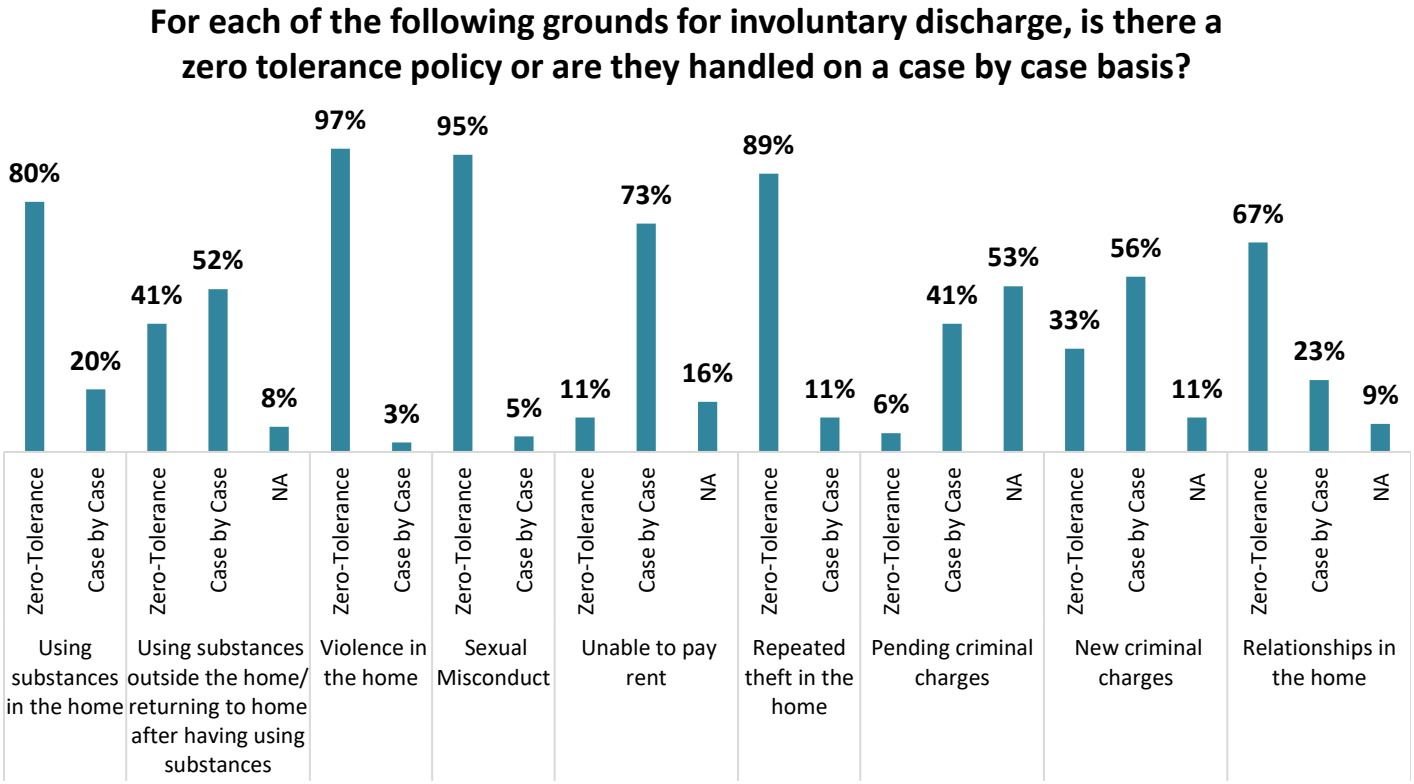
There are many regional differences, for example, Kansas City are more likely to have maximum stay restrictions while other regions are more likely to have a minimum. Houses in St. Louis are more likely to have a sobriety length required.





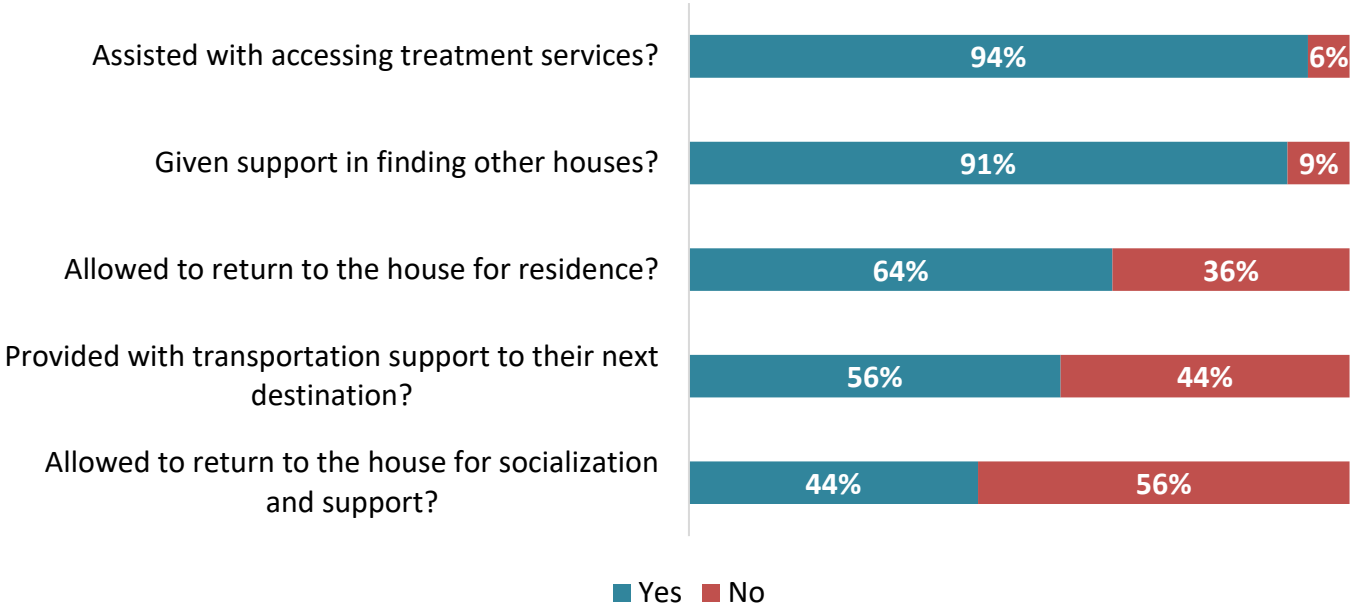
Note: One house was missing information for their self-pay option.

Discharge Policies



There are not specific guidelines for discharge policies in recovery homes. Questions were asked to identify variation in discharge policies across homes. Results show that most houses have a zero tolerance policy for using substances, violence, sexual misconduct, and repeated theft within the home. Many houses also have a zero tolerance policy for relationships in the home. Case by case discharges were common in situations relating to criminal charges and using substances outside the home.

Are residents who have been involuntary discharged:

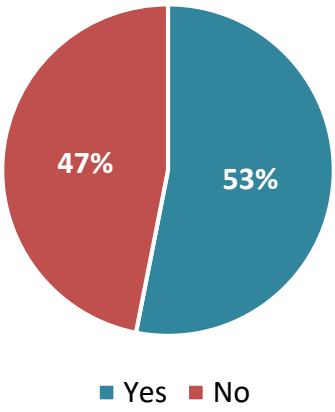


Each housing organization determines the amount of support given when a resident is involuntarily discharged. By asking what support is given also shows variation in across housing policies.

For residents that are involuntary discharged, a majority of houses provide assistance accessing treatment and finding other houses to live. Most houses do allow residents to return for residence but it is not specified what the criteria is that allows them to return. Some houses provide transportation to next destination, while a low percentage of houses allow previous residents to return for groups and socialization.

In the CBSD workshops, housing managers expressed the struggle of supporting their residents without enabling them. Residents getting involuntarily discharged is an unfortunate reality of recovery homes, but results show that managers still try to support residents despite being kicked out. This shows the dedication of housing managers and the willingness to go above and beyond for their residents.

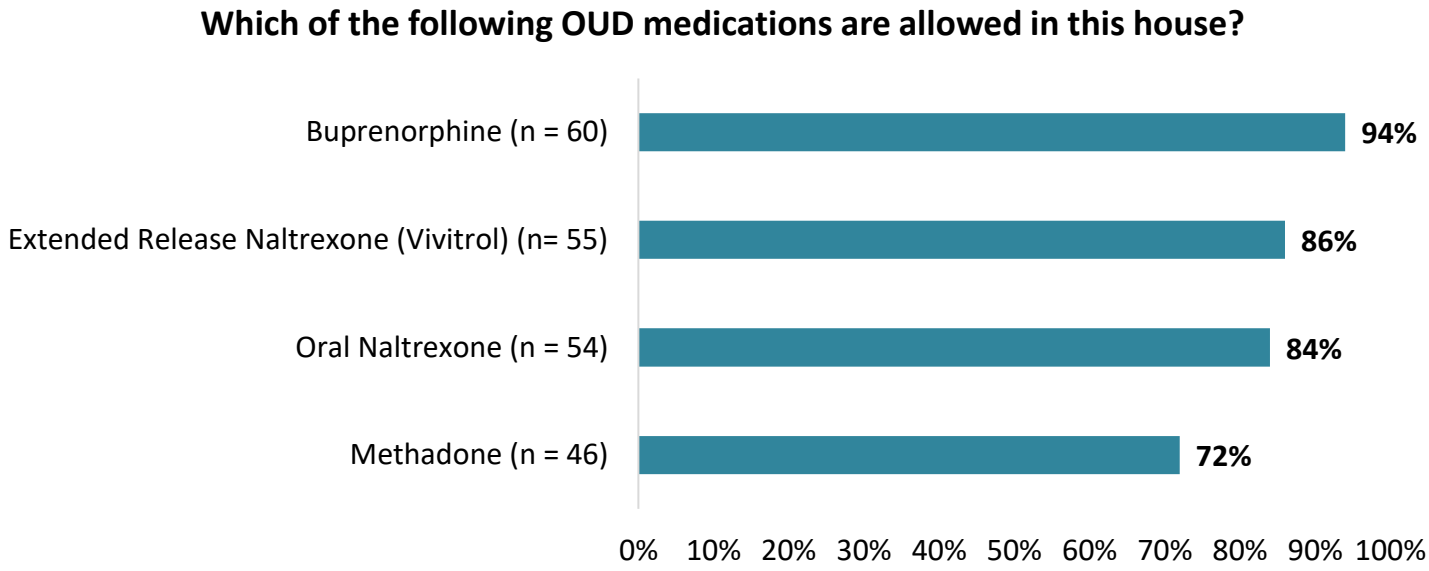
Are former residents contacted on a regular basis for follow up?



Medications for OUD Treatment (Allowance, Policies, and Acceptance)

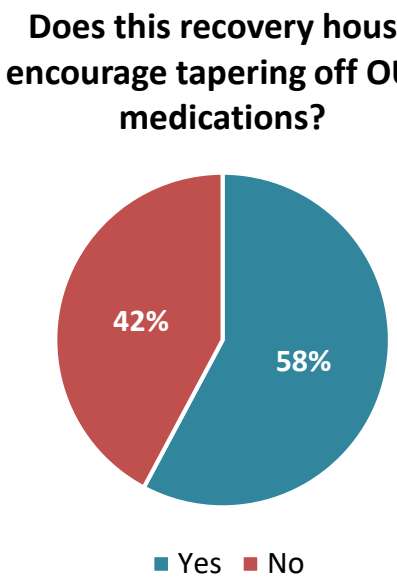
Summary

To access STR/SOR funds, recovery house executives completed a survey indicating that they accepted individuals on MOUD and did not require individuals to taper off their medications to comply with the Missouri Department of Behavioral has a health policy that states *"All Opioid STR program housing must accept people no matter their medication status and place no requirements for step-down dosing or medication tapering."* We asked house managers/staff several questions about the use of and acceptance of MOUDs in the home as they are often more closely involved with residents and may have a different perspective than the homes' executive directors. Perceptions of MOUD and the long-term use of these medications evolved differently in treatment and recovery settings. Whereas treatment settings have historically endorsed medical models of treatment (consistent with MOUD), recovery settings have evolved from social models which are sometimes at odds with the use of MOUD as part of OUD recovery. Additionally, although we were not expressly measuring adherence to the DMH policy and STR/SOR funding requirements, we wanted to assess the extent to which tapering off MOUD medications was *encouraged*, even if it was not a requirement for residency. In general, we found that approximately 58% of houses encourage tapering off MOUD, albeit implicitly through sharing personal experiences and recovery paths, and that methadone was least well received. Methadone was allowed in recovery homes to a lesser extent than other medications and was also less accepted by house managers/staff and "residents" (house managers' perceptions of resident attitudes) alike. Our finding that methadone is less accepted is consistent with studies on different medications in other settings as well (e.g., treatment, judicial).

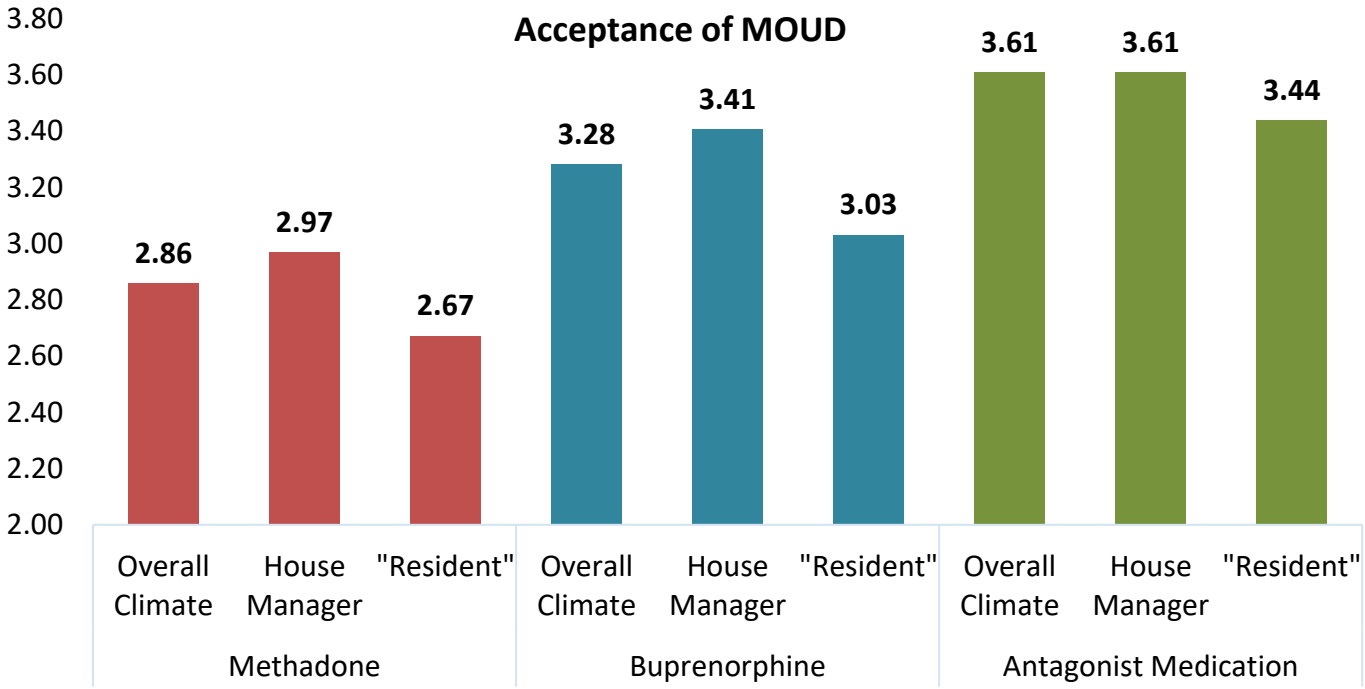


Most houses allow buprenorphine, but there was more variation for the other medications. Methadone was the least endorsed. There was one house indicated that no medications are allowed, although this could have been a misunderstanding of the manager who filled out. Not allowing certain medications is not aligned with STR/SOR funding requirements and may limit housing options for people using them.

There were three houses who chose the "Other" option and wrote in "all" or one of the above medications - these options were added into the graph.



Although per the requirements to access funding, houses were required to allow people using MOUD treatment in to their homes, and NOT ***require*** tapering, we asked respondents about the extent to which tapering was ***encouraged***. Approximately 58% (n = 37) of respondents indicated that tapering on MAT was encouraged within the recovery house. However, due to concerns about the interpretation of this question, we conducted follow-up phone calls with a random sample of nine house managers who endorsed this item. The follow up conversations resulted in the conclusion that housing managers were not explicitly encouraging tapering, but implicitly. For example, if a resident asks the manager for their experience on MOUD the manager may say something like, "I only used medication to stabilize, but then I tapered" which could cause the resident to feel like they must taper as well.



Differences in the overall climate surrounding the long-term use of methadone, buprenorphine, and oral/extended release naltrexone were assessed which indicated that the overall climate for the long-term use of methadone was less accepting relative to the overall climate for the long-term use of either buprenorphine or antagonist medications. Similarly, the reported overall climate for long-term use of buprenorphine was less accepting than the overall climate for the long-term use of antagonist medications.

We next assessed the extent to which MOUD acceptance varied for house managers own acceptance and their perception of residents' acceptance by medication type. Relative to the overall climate of medication acceptance, a similar pattern of results was observed for both housing managers/staff and "residents". Specifically, both housing managers/staff and residents were less accepting of long-term use of methadone relative to long-term use of buprenorphine or antagonist medications. There was also less housing managers/staff and resident acceptance of buprenorphine relative to antagonist.

Finally, house managers perceived themselves as more accepting of each medication than they perceived residents.

Medication Storage

A majority of houses either indicated providing residents with a private lockbox to store medications. Some houses allow residents to keep the lockboxes themselves or the lockbox must be stored in the manager's room or office area. Many of these are diversion techniques to avoid people sharing or selling medications.

Table 11. Participant responses to the question *"Please describe the process for storing and providing access to psychoactive medications."*

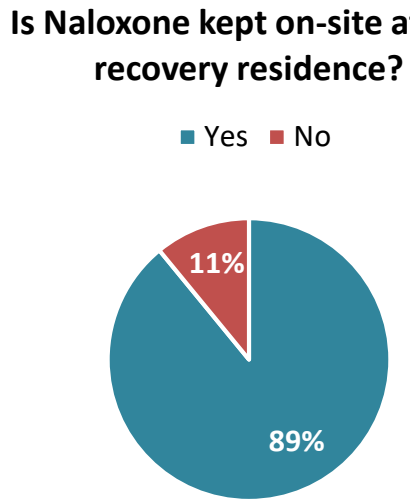
In a designated locked cabinet behind a locked office door taken watched by staff & logged	Each resident provided small lock box with their own lock fastened to their dresser.
Each resident is responsible for their own medication & lock boxes are provided for each individual.	all medication that are psychoactive are stored in personnel lock boxes or locked in managers room
All residents medication is locked in their medicine lock boxes. That way it is safe from being harmful to others. If I need to check them I am able to do so.	Clients have their own lock box with their own key stored in the managers' room. They get own meds, show manager how many they took & sign out for their dose for the day.
All medications are in individual lockers which are in the office with a coded door lock. Weekly residents put pills in to a pill separator box & lock up as stated above. Medication boxes are passed out by staff as prescribed & resident's takes medication in front of staff.	Everyone has a locker with own lock (client has only key). Client responsible for taking their medications. I or house Manager when there is a live in, can count their meds with them present but do not distribute.
All medications are stored behind 3 locks. All are clearly labeled with the client's name. Clients are given one weeks' worth of medications at a time & can be stored in the lock box in their room.	Each client has a lockbox with his own key locked in the manager's room. At night they come in & get their meds under supervision of manager or assistant manager
All of our medications are kept locked in a safe & are distributed daily to the resident according to their daily doses	Personal lock box where resident is responsible for key or code & med counts weekly for accountability
all psychoactive meds are double locked by manager	All prescribed medications are stored in a lock box for each resident. Each resident buys a lock box upon move in. The resident is the only person with a code or key for their box.
all psychoactive meds are locked up in lock boxes in managers office	Each resident has a lockbox to keep medications in.
Each resident is assigned their own locker & given a combination lock, & all meds are required to be locked up in those lockers at all times	They get them from the DR & are kept locked up by the house manager in a lock box in their room.
All medication is stored in a safe & keys are locked up.	Lock box
Assigned a private lockbox & key	lock box in locked & video monitored office
Residents have each their own lock box. The Program Manager, who is offsite, has the combinations to the lock boxes. The lock boxes are also locked in an office & the office is opened twice a day for residents to get medications	Residents are allowed to keep medications on their person typically. Medications are counted at one-on-one sessions & occasionally throughout the week. If there are issues with medications, (like buprenorphine products, stimulants, or benzodiazepines) we can encourage the resident to have their medications held to help them take them appropriately. Medications are never stored, discontinued or disposed of without consent of resident &/or consultation with medication provider.
Medications are kept in a locked cabinet in a locked office.	Lock boxes are provided in each residents living area.

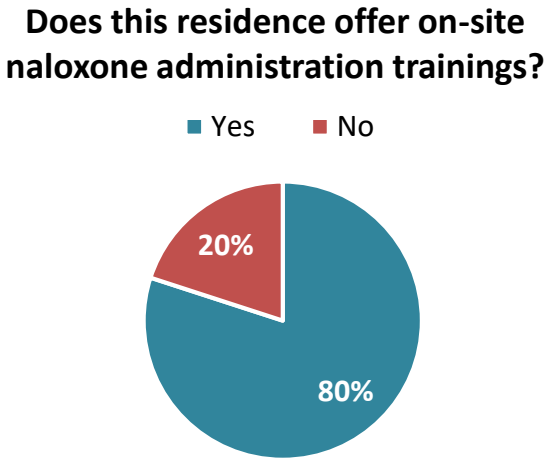
If any prescriptions are controlled substances, the meds are kept in the house manager's locked safe, & are dispensed according to the medication's instructions. A record sheet, that documents the original amount, (& the amount of medication dispensed), is also signed by the client & house manager & kept in the safe as well.	Clients have access to their medication, as needed. Staff track prescriptions, observe clients counting pills out & in, & record pill counts. If clients need medication when staff are not available, clients are allowed to take these dosages with them.
keep their own meds, residents have med box, monitored when new Rx, if there is an issue then will do med counts regular 1x a week	Locked in a closet & dispensed daily under supervision of house manager.
Locked medication room with individual storage for each client's meds.	Giving residents lock boxes with keys or personal lockers to store their meds
Locked up & given by authorized staff	Medications are locked under two keys
There is a lockbox for each client in manager's office	lock boxes in our office
medicine lock boxes	clients keep their medications
Lock box system	Put in lock box with residents
psychoactive meds are locked away in boxes	Each resident has a lock box
We are in the process of installing medication lockboxes in every room that residents will keep their medications locked up in. Only the resident & staff will have a key to the box	Residents have their own locker with a combination lock that residents can put their medication in. House manager & resident are the only people with the combination.
residents have their own lock boxes	residents keep own meds in lock box or locked room
kept by resident in lock box	The Residents have their own lockboxes that only they have key to The boxes are on well in Managers room. When manager is present they are allowed to open & get the meds they need.
Suboxone secured in manager room in lockbox	
Staff provides lockboxes & the residents are responsible for their own medication	Medications are kept in lock boxes & are counted randomly at least once a week
storage lockers	They are locked into personal lockers & counted weekly
They are locked in a safe by staff & when the client needs them he ask for them	We provide lock boxes for the residents with medication & the residents are responsible for their own medication. residents keep own meds in locked box/room
They are secured in agency safe	We have lockers & lock boxes
We keep them locked in a safe & manager & director of program only able to get in the safe. We count sign & date meds along with clients signing at time they are given meds	They are stored in lockboxes in a locked office & only the participant has a key & the second or spare key is held offsite at our corporate office.

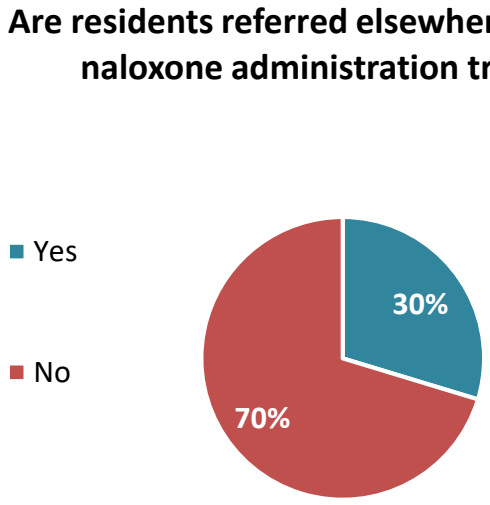
Naloxone

Summary

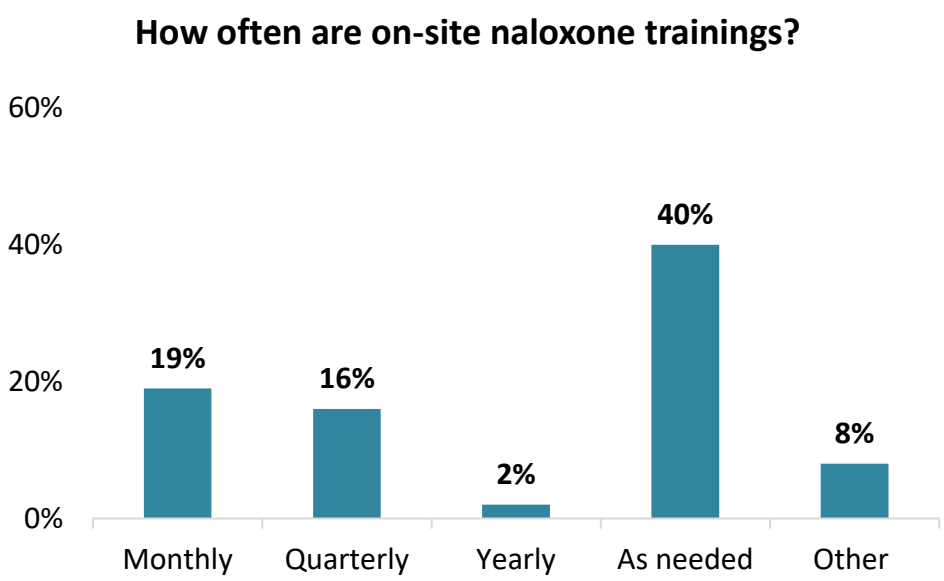
This section of the data focused on the opioid overdose reversal agent, naloxone. The presence of naloxone has a history of controversy in many recovery settings, as it is believed to encourage substance use due to reducing the risk of death. However, **MCRSP Standard 31** states that all houses are required to have "Naloxone is available and accessible; evidence that staff and residents are trained in its use." The following results measure compliance with this standard. There was quite a bit of variability in how often naloxone administration training was provided. Most respondents indicated regular training options or training as needed. Three of the houses indicated that naloxone training was part of the intake process for residents. Most (49%) houses reporting providing training as needed.







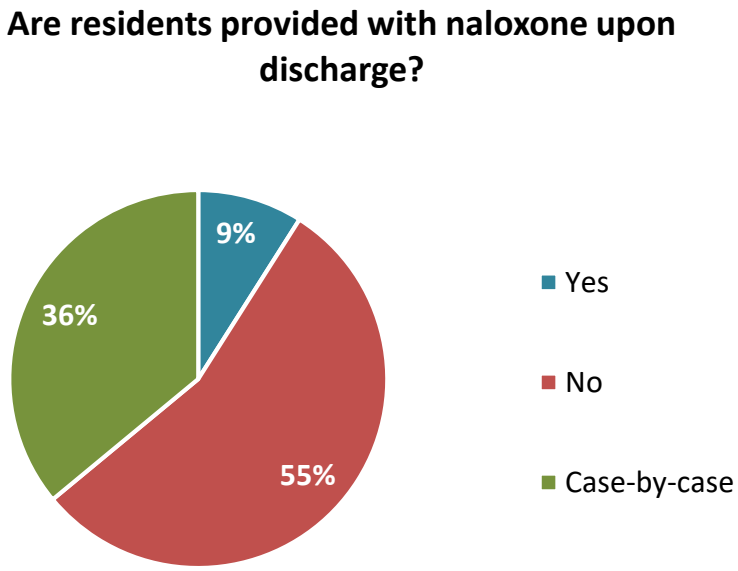
This question was asked regardless if houses responded "Yes" or "No" to if they have onsite naloxone administration training.



"Other" answers included:

- Also at resident intake
- At orientation for each resident
- Haven't set that
- Monthly and as needed
- Upon orientation

Note: This question was only asked of those who responded that naloxone administration trainings were conducted on-site (n = 51).

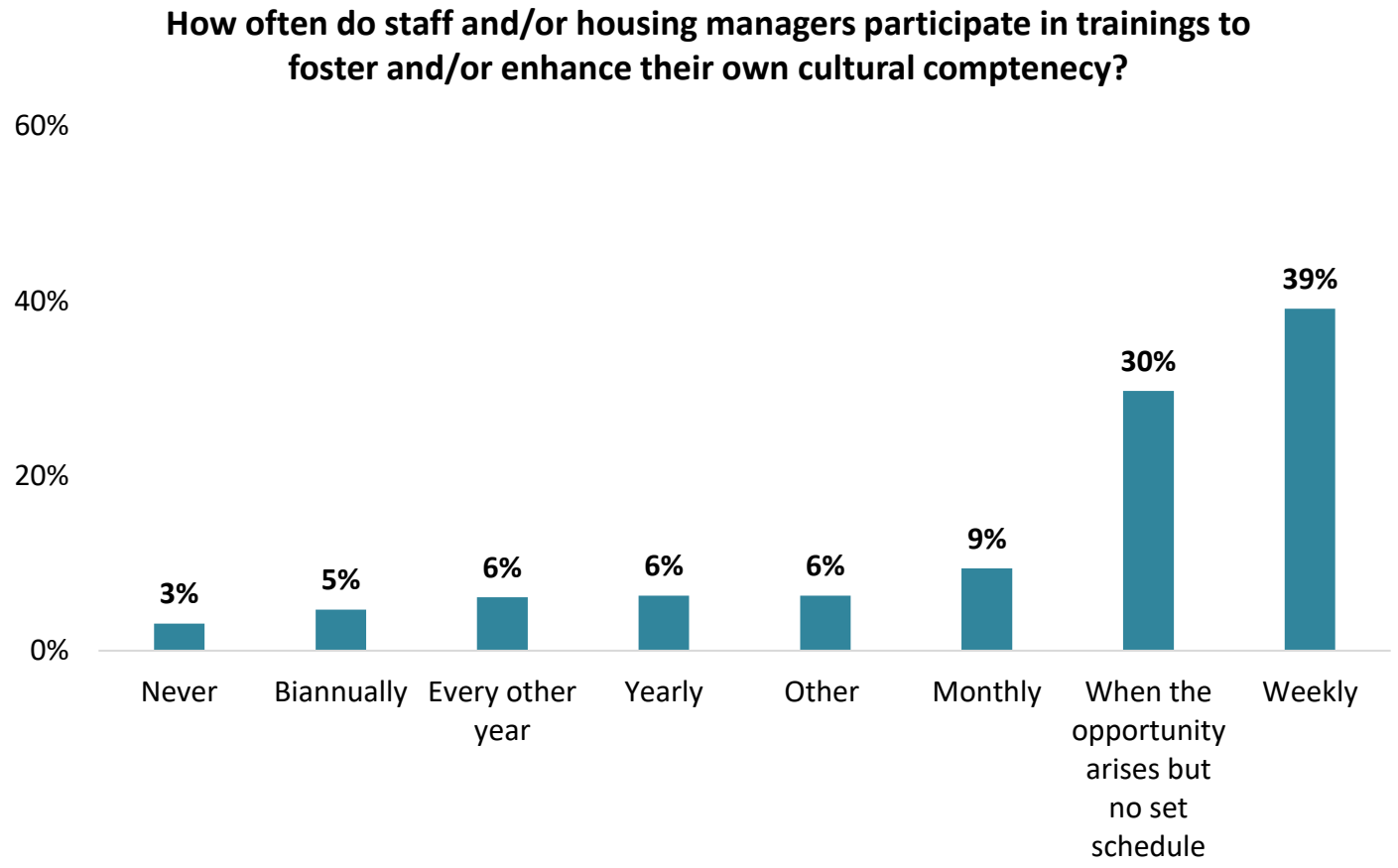


Only 9% of houses reported providing naloxone to residents upon discharge whether it is voluntary or involuntarily and 36% (n = 23) of respondents reported that decisions were made on a case-by-cases basis. Providing naloxone upon discharge could be an important point of intervention, particularly for individuals who are involuntarily discharged. Given that many opioid overdose reversals are done by peers (Hanson et al., 2020), ensuring that individuals with OUD have naloxone before leaving a recovery home is important.

Staff Training

Summary

House managers are expected to maintain their recovery, support residents in their recovery, handle household issues such as maintenance and community complaints, oversee resident compliance to house rules (completing chores, securing employment, appropriate use of medication) and may have an outside job on top of their responsibilities as a house manager. Few housing agencies have the funds to compensate their managers let alone provide regular training. Though **MCRSP Standards 11.03 and 15** require staff to be appropriately trained in cultural competency and appropriate to their level, there are no specifics as to what trainings nor how often these trainings should occur. As shown below, there is a range of frequency and type of trainings offered. While peer support is the most received training less than half of the houses receive training to enhance cultural competency in any other area. This role requires managers to be able to support residents with various backgrounds and needs, and connect them to resources – therefore, sufficient training is necessary to ensure house managers can do this effectively.



There were three houses that chose “Other” in which they responded:

- As needed, CEUs
- It depends on the training being offered
- Sunday manager meetings, with supervision with executive director

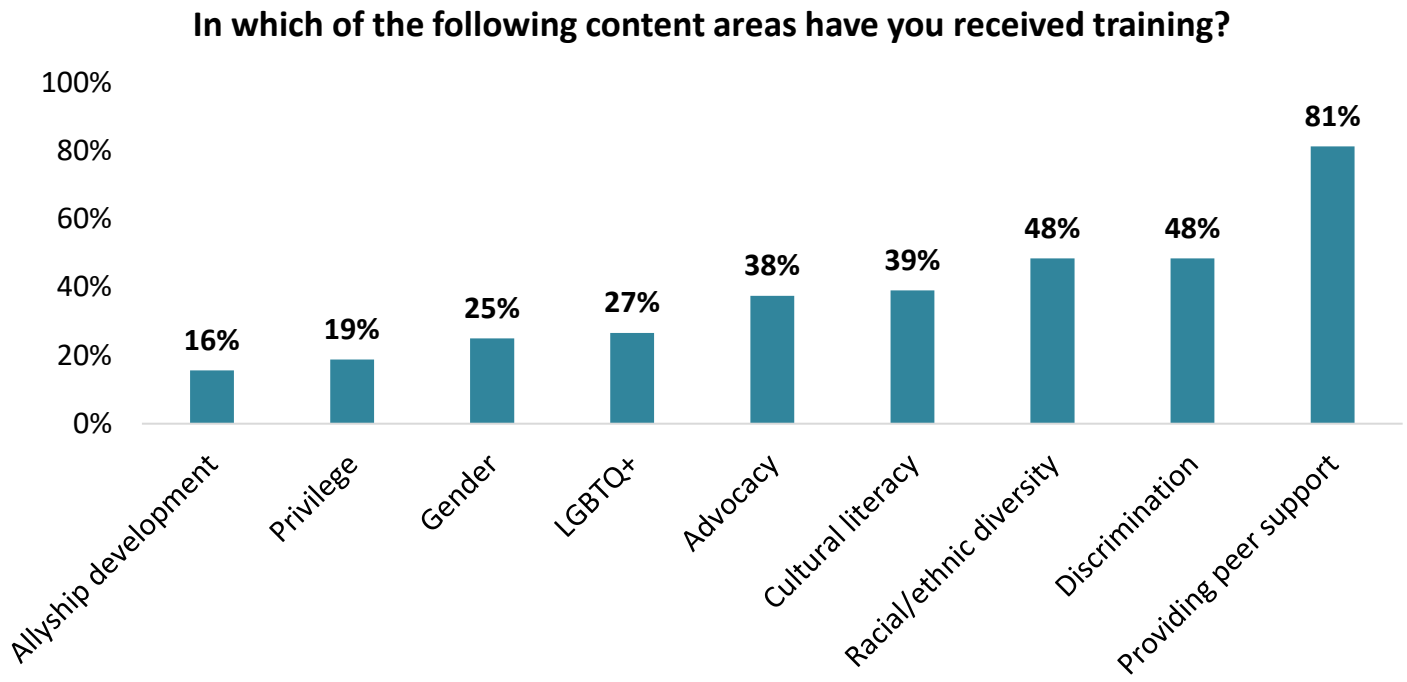


Table 12. Additional Staff Trainings

Other trainings that managers have had:

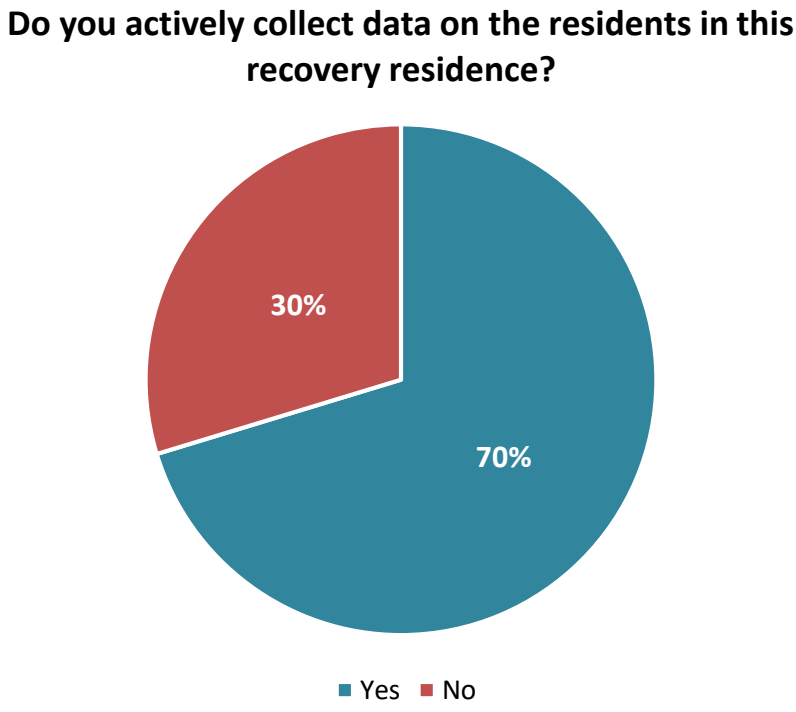
CPR/first air, trauma informed care, Narcan	Missouri Associate Alcohol Drug Counselor II	trauma informed care, motivational interviewing
Ethics	finance	leadership course
leadership training (2)	Narcan	Narcan, CPR, first aid
trauma informed care, first aid, CPR		trauma informed care, Narcan, CPR (2)

Note: One housing manager reported that they had no training.

Data Collection and Quality Improvement Processes in Recovery Homes

Summary

The following questions were meant to measure adherence to the NARR and **MCRSP Standard 4** that all houses "Collect data for continuous quality improvement". NARR discuses in more detail than MCRSP the minimum requirements of data collection include demographic and emergency contact information as well as, for higher-level houses, procedures that can evaluate and report outcome data. We found that the majority of houses do collect data for improvement purposes; however, the process for data collection has not been standardized across providers. This data could potentially allow houses to see what processes are promoting positive outcomes in resident recovery. Recovery houses conducting their data collections have some benefits – their data can demonstrate the impact that they are having which not only creates funding opportunities but also can measure functional outcomes for residents. Standardizing data and outcomes across houses can provide house-to-house support to improve each other. It can also help identify which policies and procedures are linked to positive outcomes.



Of the 70% of housing managers who responded that they collect data, 100% of them report that all data collected is used for quality improvement (See **Table 13** for overall summary of processes and data metrics). However, we found that there is no standardized data collection process for recovery housing.

Examples of processes and metrics:

- Sign-in/sign-out sheets
- Intake process surveys (basic demographics)
- Recovery plans
- Weekly activity sheets
- Community meeting involvement
- Cleaning time
- Medication counts/UDS

Table 13. Data Collection Methods

For those who responded "yes" to actively collecting data, we followed up with *"Please describe the process for collecting data and any specific metrics you use."* The following table summarizes manager's responses:

Series of questions, weekly & monthly reports, mentor reports	activity sheets to make sure all requirements are met	application enrollment weekly reviews & assessments
1 on1 meetings	Excel Spread sheet	I use combat connections system
Application forms, recovery plan, count days of abstinence. We don't have a computer program that captures the data.	Exchange of information with said treatment ctr., Probation & Parole. Peer Support & Pastoral Counseling.	House Manager collects drug screens treatment meetings things like that. [redacted] collects other data & outcomes
Data is collected from beginning of stay through our various computer software, until a person transitions.	Each client has an activity sheet to keep track of recovery meetings & program fees	By format they are provided to us & make sure they keep up with their goals
Clients fill out a weekly activity sheet with a record of classes / sobriety meetings	Information is taken during 1 on 1s, typically recovery plan & comfort or discomfort writhing the house is rated	Life satisfaction, program satisfaction, drug testing, employment, admission/discharge dates,
Weekly sheets	intake & discharge	intake & during counseling
intake paperwork/discharge	send to support	Surveys (2)
One on one talks to get to know the person.	me one on one meetings probation & parole	medication counts urine analysis drops
We collect data through application forms, intake forms, & case management notes. We maintain data in a case management database & track metrics through the database & excel. Specific metrics include: demographics, sobriety, employment, recidivism, & length of stay.	We keep copies of any/all forms filled out by staff & then send them to our head office (SRCC), at least once a month. These forms encompass everything from clients' Weekly Activity Sheets, The Sign-In/Out Sheets, 24-Hour Pass Requests, to Incident Reports & The Weekly Business (House Meeting) Reports.	Weekly random drug testing is provided & properly documented & kept in every resident's folder Every house meeting I make notes of everything that needs to be talked about & review it every week to see if the situation turned itself out.
The intake process involves multiple forms & questionnaires. This data is used to determine courses of actions to serve the resident. The same forms & questionnaires are revisited quarterly to track progress.	We have personal files for each resident & it includes their med charts, meeting attendance, phase up forms & weekly reports.	sobriety time, employment, pay rate increases, counselor/ cps mentor team, counseling notes, G.E.D. testing
	Upon intake, demographics are collected for grants	weekly house meetings & AA NA sponsorship spiritual
Length of stay, access to treatment, type of MAT services used while in the house, employment, court appointments, comfort level within the house,	We just keep a copy of everything in their file. We host weekly meetings among all house managers & staff to discuss data	weekly communication meetings what step each person is on, if they're employed, who is their sponsor, how much clean time they have
We use one on one sheet to encourage residents to improve, & to help shape recovery plans.	We have sign/in out sheet. Activity sheets to be signed but treatment & any meetings	weekly community meeting collecting sponsorship, meetings, spiritual activities, jobs, etc.
weekly community meeting data collecting (stats) clean time job (meetings) etc.	weekly community meeting, sponsorship, clean time & jobs	weekly follow up, monthly, etc.

Conclusion

The UMSL-MIMH State Opioid Response grant team conducted an evaluation of recovery residences in Missouri to gain on-the-ground insight and knowledge about key characteristics of housing organizations and the residents they serve. Individual-level examination of the role of recovery housing in each residents' personal recovery journey is still in the beginning stages and will be carried forward by MCRSP. This will be accomplished through statewide implementation of resident surveys at resident intake and discharge of a recovery housing. Though this future work is necessary, some overall conclusions about the functionality and purpose of the recovery housing system may still be generated from the broader housing-level evaluation presented here. Below are key outcomes and recommendations based on our findings.

Key Outcomes

- Houses were predominantly limited to urban areas, with about half located in the St. Louis metropolitan area, and the rest distributed across Kansas City, Springfield, and Southeast Missouri. At the time of this survey, there was a reported lack of access to recovery housing in rural areas.
- Recovery housing residents and managers are predominately White and male, with Black individuals underrepresented in recovery housing compared to their representation in the population dying of drug overdose in Missouri. Given the disproportionate impact of the opioid crisis Black men in Missouri, ensuring equitable access to recovery housing services is imperative.
- 64% of managers identify as a person in recovery.
- Opioids and methamphetamines are the primary substances used by residents prior to their entry into recovery housing.
- Overall, most house managers' perception of their neighborhood and relationships with community members was quite positive. Very few experiences with crime and substance use were reported and community activities (e.g., walking/exercising), access to resources within walking distance, and clean well-kept streets were the norm.
- 34% of men-only recovery houses are accepting of transgender men living in their homes, while 27% of women-only recovery houses accept transgender women.
- There is a lack of recovery housing for parents. Few houses accept children to live with their parents.
- Recovery housing directors/managers expect people to reside in their homes for approximately 9-12 months, on average. Most houses do not have a limit on the length of stay for residents.
- Most houses have a zero-tolerance policy for using substances in the home, violence, sexual misconduct, and repeated theft in the home, while other dischargeable offenses (e.g., using substances outside the home) are determined on a case-by-case basis.
- Some recovery residences reported that the overall climate in their home was not accepting of certain forms of medication for OUD. This was based on the manager's own perception and their perception of residents' acceptance. Naltrexone was the most widely accepted and methadone was the least accepted.
- 58% of homes reportedly encourage tapering off of OUD treatment medications. Through follow-up phone interviews, we gathered this encouragement to be more implicit than explicit and based on the personal experience of peers in recovery.
- Most houses have naloxone on-site, in accordance with MCRSP standards, and 80% of houses offer in-home trainings.
- For the houses that collect data, they do so for quality improvement. This data can be used to show outcomes and impacts, which can assist with future funding opportunities.
- Accredited recovery houses are required to have staff appropriately trained in cultural competency as well as training appropriate to the level of their house. However, there are no agreed-upon details as to what these trainings must include nor how often they should occur. Therefore, trainings across providers vary in both content and frequency. Less than half of recovery housing managers reported receiving cultural competency or anti-discrimination training.

Recommendations

The recommendations below are not exhaustive and will require intentional involvement from each group making up the recovery system. Many of these recommendations necessitate increased funding for recovery housing, and/or revisiting policies that create additional barriers to accessing housing at the federal, state, and local levels.

- MCRSP implements the resident-level survey developed by the UMSL-MIMH team to assess differences in engagement rates, length of stay, and reason for discharge by race and gender. Review this data on an ongoing basis (at least annually), identify which houses tend to have the most and least favorable outcomes, and provide targeted assistance for improvement and/or restrictive action.
- Increase access to NARR-accredited recovery housing in rural areas by providing capacity-building opportunities and targeted assistance to existing unaccredited housing providers or partners who have previously expressed interest in establishing recovery housing programs. Host virtual and in-person information sessions for individuals involved in the recovery community who may be interested in becoming a housing provider.
- Increase access to NARR-accredited recovery housing owned and operated by people from underrepresented racial groups by providing them capacity-building opportunities and targeted assistance to navigate the accreditation process. Host virtual and in-person information sessions for individuals involved in the recovery community who may be interested in becoming a housing provider.
- Conduct semi-structured interviews with housing managers and residents and ask specifically about their efforts to ensure equity and eliminate racial bias in their homes. Require documented participation in cultural competency efforts for re-accreditation.
- Include questions and statements about equity, non-discrimination, and eliminating racial and gender bias in housing accreditation applications and site visits. Reinforce these as priority values of MCRSP and DMH by referencing them in multiple places and modes of communication.
- Incorporate trans-inclusive policies into NARR standards, and provide specific guidance to recovery home operators on how to foster a nonbinary and trans-inclusive recovery home. Incorporate trans-inclusive policies into MCRSP standards, and provide specific guidance to recovery home operators on how to foster a non-binary and trans-inclusive recovery home (see Ohio Recovery Housing's document for example).
- Develop and disseminate standardized training documents, videos, and in-person workshops offering guidance on inclusive practices and cultural competency and responsiveness.
- Develop and disseminate standardized training documents, videos, and in-person workshops offering clinical guidance on how best to support people pursuing different recovery pathways – through medication, faith, moderation management, etc. – especially when that pathway differs from the established norm of the house.
- Ensure housing directors and managers are connected to entities providing naloxone and overdose education training. Monitor their training engagement. Require documented naloxone training and provision policies and procedures for re-accreditation.
- Establish a NARR policy stating that naloxone should be available to all residents upon discharge.
- Encourage increased resident-level involvement within recovery homes to improve residents' sense of community and shared governance.
- Explore new funding rules for housing support to assist individuals who spend the average length of time (9-12 months) in recovery housing, such as covering decreasing percentages of costs over time to allow for stabilization and establishment of income (for example, 100% of rent covered for six weeks, followed by 50% covered for the following six weeks, followed by 25%...)

Future Questions

Below are additional questions to be addressed in future program development and evaluation efforts:

- How do various characteristics of recovery homes impact residents' recovery outcomes?

- What is the best way to define and measure positive long-term recovery?
- How important is the Social Model Philosophy Scale in determining positive recovery?
- What specific in-house supports are missing for members of the LGBTQ+ community?
- What specific in-house supports are missing for Black and Brown people in recovery housing?
- How does the level of "medication friendliness" within a house impact the length of stay among individuals who take medication as part of their recovery path? How does this impact their dose and course of medical treatment?
- What is the impact of the lack of standardized trainings for recovery managers on the environment within each home? How could additional training on nuanced topics (e.g., cultural responsiveness, openness to long-term medical treatment, personal and professional boundaries) influence the cohesiveness and morale within homes?

Acting upon the above recommendations and addressing the noted future questions about recovery housing will require strong and ongoing collaboration between all stakeholders in the recovery housing system. Though this report highlights many of the positive attributes endorsed by housing directors and managers across Missouri, future evaluations, such as surveys completed by residents themselves throughout the course of their stay within these living environments, are critical to shedding light on the true impact of recovery housing on those who are served by this system.