JAN 10 2012

The Honorable Martin O’Malley
Governor
100 State Circle
Annapolis, MD 21401-1925

The Honorable Thomas V. Mike Miller, Jr.
Senate President
State House, H-107
Annapolis, MD 21401 – 1991

The Honorable Michael E. Busch
House Speaker
State House, H-101
Annapolis, MD 21401 – 1991


Dear Governor O’Malley, President Miller, and Speaker Busch:

Pursuant to Senate Bill 562, the Department of Health and Mental Hygiene respectfully submits this report in response to legislation passed in 2011 that required the Department of Health and Mental Hygiene to identify and report its findings regarding standards for best practices for recovery homes.

I hope the attached information is useful. If you have any questions regarding this report, please contact Ms. Marie Grant, Director of the Office of Governmental Affairs at (410) 767-6481.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

Enclosure

cc: Renata J. Henry
Thomas Cargiulo
Marie Grant
Recovery Homes – Best Practices

In response to Senate Bill 562, Chapter 255 of the Acts of 2011, the Department of Health and Mental Hygiene (DHMH) was charged with identifying standards for best practices on recovery homes and reporting its findings to the Governor and the General Assembly.

History:

Recovery residences serve as a critical support to initiating and sustaining long-term recovery, and have been central to the evolution of community-based addiction recovery services. Beginning with Washingtonian Homes in the 1800s, “inebriate homes” and “farms” emerged as the addiction treatment intervention of choice. Improved understanding of the nature of addiction led to the provision of supportive living, borrowing from the “halfway house” model, for those seeking an alternative to institutionalization. Therapeutic communities gained prominence in the 1960s and 1970s, and a peer-run residential model was created in 1975, made popular by Oxford House, Inc. These historical models are in evidence today in the residential continuum of services. Recovering individuals may receive services in a residence ranging from the peer-run sober home to a residential program that also provides treatment.

A healthy stable community of peer support and an extended period of time to establish and practice healthy routines in a supportive environment remain the essential qualities common to all recovery residences. Recovery housing is the basic service provided by recovery residences that includes, at a minimum, recovery peer supports.¹

Regulatory Issues:

Residential modalities of treatment, including medically monitored intensive inpatient treatment, clinically managed high intensity, medium intensity, and low intensity treatment (halfway houses), are regulated within the Code of Maryland Regulations (COMAR). Recovery housing is not regulated, as it is defined as a supportive living arrangement that does not include clinical services.

The Fair Housing Act, as amended in 1988, prohibits housing discrimination on the basis of race, color, religion, sex, disability, familial status, and national origin. Its coverage includes private housing, housing that receives federal financial assistance, and State and local government housing. It is unlawful to discriminate in any aspect of selling or renting housing or to deny a dwelling to a buyer or renter because of the disability of that individual, an individual associated with the buyer or renter, or an individual who intends to live in the residence. Section 36.209 of the Americans with Disabilities Act (ADA) states that individuals who are in treatment or have completed treatment are protected by the ADA.

¹ Adapted from An Introduction and Invitation from the National Association of Recovery Residences, September 12, 2011. www.narronline.org
DHMH does not intend to regulate recovery housing, as regulation would mean that added housing requirements are being placed on individuals protected by the Fair Housing Act, in potential violation of the law.

However, DHMH is encouraging the purchase of recovery housing with public funds; therefore, housing standards governing this service have been developed so that purchasers can monitor quality, effectiveness, and efficiency.

**Housing Standards:**

The Recovery Housing Standards workgroup was formed as a workgroup of the Alcohol and Drug Abuse Administration (ADAA) Recovery Oriented Systems of Care Steering Committee, Standards Subcommittee. The goal of the workgroup was to develop a set of standards for two levels of Housing, Supportive (staffed) and Recovery (peer operated). ADAA’s plan was to allow jurisdictions to use grant dollars to include supportive and recovery housing as part of an overall continuum of care, as well as to encourage creation of supportive and recovery housing in anticipation of new funding for housing through the SAMHSA Access To Recovery Grant dollars.

The workgroup met from January through July of 2010. There were a total of 18 participants representing clinical treatment providers, consumers, current supportive housing providers, and recovery housing providers. The workgroup voted to accept the Baltimore Area Association of Supportive Housing providers’ voluntary standards (which were modeled after COMAR) as a starting point for their task. The draft standards were reviewed by stakeholders, including addiction treatment providers and the ADAA Steering Committee. They were posted on the ADAA website for comment from June 1 to June 24, 2011. Following the comment period, they were forwarded to the Office of the Attorney General and approved for legal sufficiency. The ADAA Standards for Supportive and Recovery Housing (http://www.dhmh.maryland.gov/adaa/) are currently being used to monitor recovery housing providers receiving ADAA funding.

**Best Practices:**

The National Association of Recovery Residences (NARR) formed in 2010 to address the needs of behavioral and somatic healthcare systems across the country to identify evidence-based practices in the area of recovery residences. Organizational policies and accreditation standards were developed and published by NARR in September 2011 (www.narronline.org). DHMH intends to support the development of a housing association whose role would be to affiliate with the NARR, adopt the national standards created by NARR, encourage recovery residences across the State to become members, provide a membership approval process, and monitor members’ adherence to the standards. Housing provider membership in the association would be voluntary; a recovery housing provider would not, therefore, be subject to mandatory regulations. However, DHMH and other purchasers of recovery housing would still be free to condition funding upon a provider’s membership in the association. DHMH intends to condition
federal and State funding through ADAA to be contingent upon a provider’s membership in the association.

**Next Steps:**

DHMH intends to develop a Request for Proposals (RFP) to support the establishment of a statewide housing association that would become an affiliate of NARR, adopt NARR’s standards, encourage recovery houses Statewide to become members, provide an approval process, and monitor their member houses according to the policies of NARR. DHMH anticipates that the RFP will be released by March 31, 2012, awarded by June 2012 and services implemented by July 1, 2012.