Committee on the Judiciary

Subcommittee on the Constitution and Civil Justice

Examining Sober Living Homes

Written Testimony of Dave Aronberg

The United States is facing an unprecedented opioid epidemic. Provisional data from the Centers for Disease Control and Prevention (CDC) estimate that 136 people now die each day from opioid overdoses. As local, state and federal officials address the issue, far too many lives continue to be lost to a system of health care that is inefficient at best, and corrupt at worst, in its delivery of services to those suffering with Opioid Use Disorder..

One critical area of concern is the lack of decent, peer supported and well run sober living homes. A crucial component of sobriety is a stable, supportive, drug and alcohol free living environment. Although good sober living houses can improve treatment outcomes, flophouses masquerading as sober homes will encourage the opposite: relapse and failure.

Whenever sober living homes are discussed, keep in mind that no clinical treatment is provided in the home. A well run home may offer recovery support services, peer support and other wraparound services that are not clinical in nature. The sober living home is just that: a home.

The question then becomes, how do we encourage or require that a sober living home has standards to protect the recovering addict, and is not merely a warehouse, flophouse, or worse? To encourage effective sober living homes and discourage or eliminate the bad actors in the industry, Congress should review the application of two federal laws: The Americans with Disabilities Act (ADA) and the Fair Housing Act (FHA).

Substance Use Disorder (SUD) is a disease and considered a disability under the ADA. Persons suffering from SUD are protected from discrimination by the ADA. This includes protection related to housing under the FHA. An active drug user, however, is not part of this protected class. Far too often, bad actors in the drug treatment and sober homes industries use the ADA and FHA as shields to prevent local and state governments from scrutinizing their operations. This has led to the proliferation of sober living homes that have no standards, no oversight and no protections for the vulnerable and disabled residents who live in the homes. Because there is no medical or clinical treatment occurring in the homes, there are no licensing requirements that are ordinarily attached to treatment facilities.

A few local jurisdictions in South Florida have adopted ordinances requiring new sober homes to obtain certification or demonstrate recognized standards to receive a reasonable accommodation waiver from zoning limitations on the number of unrelated adults living in the home. In most instances, however, local and state governments are reluctant to impose standards on sober living homes for fear of violating the ADA and FHA. In past years, cities such

as Boca Raton, Florida, and Newport Beach, California, tried to limit sober living homes within their jurisdictions, but were sued and had to pay significant costs, causing a chilling effect in local government oversight.

In 2016, the Department of Justice (DOJ) and the Department of Housing and Urban Development (HUD) issued a Joint Statement attempting to clarify state and local land use laws and practices and the application of the FHA. Unfortunately, the Joint Statement did not address the specific issue of sober living homes and the need for standards to protect the vulnerable class of residents. While there is no need to rewrite the language contained in the Joint Statement's existing 16 questions and answers, this omission can be remedied by simply adding a new question and answer that directly addresses the question of whether local zoning laws can require sober homes and recovery communities to be certified, licensed or otherwise be subject to minimum standards for the protection of the residents.

I recommend that DOJ and HUD re-issue the Joint Statement adding a new 17th question and answer as follows:

Proposed New Question and Answer 17:

17. ***Can a state or local government require group homes, including sober living homes, and recovery communities to be licensed, certified or otherwise be subject to minimum standards?***

Notwithstanding the foregoing, the Fair Housing Act allows state or local governments to require group homes, including sober homes and recovery communities, to be licensed or certified. However, using sober homes and recovery communities as the example, the license or certification requirements must be narrowly tailored to meet the actual needs of the occupants in recovery. The requirements must actually protect this fragile population from continued drug and/or alcohol use, abuse, exploitation, fraud, inadequate support and care, theft of funds or possessions, and homelessness when reentering the community.

In jurisdictions where a license or certification is available from the state or a local jurisdiction, local zoning may require a proposed group home, including sober homes and a proposed recovery community, to apply for and obtain an available license or certification to be allowed as a permitted use under the jurisdiction's land-use code. Such land-use codes should allow for the provisional licensing or certification issued by a licensing or certification entity when a sober home or recovery community first opens and require that the sober home or recovery community obtain its license or certification before the provisional license or certification expires. Failure to be awarded certification or licensing that a zoning code requires is justification for denying zoning approval.

When no licensing or certification is available from the state or a local jurisdiction, local zoning may require the provider to demonstrate through a conditional or special use permit procedure that it will operate the proposed sober home or recovery community in a manner that

protects its occupants from continued drug and/or alcohol use, abuse, exploitation, fraud, inadequate support and care, theft of funds or possessions, and homelessness when reentering the community.

There are two private sector and nationally recognized programs that either certify or charter sober living homes throughout the United States: the National Alliance of Recovery Residences (NARR) and Oxford House, Inc. (OHI). These programs provide models for supportive sober living and have been subject to numerous peer reviewed studies. They have been instrumental in improving outcomes for persons with SUD both during and after treatment. Although some states have recognized the benefits of these programs, no state has imposed mandatory certification, charter requirements or any other similar standards for sober living homes.

Founded in 2011, the National Alliance of Recovery Residences (NARR) is a 501(c)(3) nonprofit recovery community organization that currently serves 30 regional affiliate organizations who collectively support more than 30,000 persons in recovery living in over 3,500 certified recovery residences throughout the United States. Through its certification process, NARR affiliates have been at the forefront in establishing effective nationally recognized standards for sober living homes. This not only serves to protect the vulnerable disabled adults living in the homes, but also serves to protect communities from destructive flophouses masquerading as legitimate sober homes. NARR's stated mission is to support persons in recovery from addiction by improving their access to quality recovery residences through standards, support services, placement, education, research and advocacy.

In 2015, the Florida legislature tasked its drug treatment licensing agency, the Department of Children and Families (DCF), to establish a certifying entity to impose standards on the sober home industry. DCF chose Florida's NARR affiliate, the Florida Association of Recovery Residences (FARR), an independent 501(c)(6) organization, to certify sober homes using NARR standards. The legislature, however, did not make the certification of sober homes mandatory. Instead, certification was only required if a treatment provider referred a patient to a specific home. In 2017, Florida's state certification requirement was expanded to cover both the referral from the facility, as well as the acceptance of a referral from the sober home. Sanctions for violating the certification statute only applied to the treatment provider, since the sober living homes were unlicensed and unregulated. By including only official referrals to or from homes, the certification process achieved just a partial success, as many sober living homes continue to exist under the radar, referring and receiving referrals under the table. Unfortunately, there is no practical way to police those houses that covertly use the referral process without the required certification.

There are 37 NARR standards, 169 sub-standards and 37 ethical codes adopted by both local NARR affiliates and independent state organizations. These standards not only create a

supportive environment for sobriety,, they also protect residential communities by including good neighbor policies. The FARR certification process incorporates the following six distinct stages that include both NARR standards and additional statutory requirements:

1- Submission of an application and execution of a certification and compliance agreement;
2- Submission of policy and procedure documentation and disclosures of proof of insurance and a staffing plan;
3- FARR review of the application data and documentation to ascertain compliance with the NARR quality standards;
4- An onsite visit by a FARR field assessor to ensure that the properties a) are safe, dignified, and alcohol and illicit drug free, b) are implementing NARR policies and procedures, c) maintain a peer environment that is supportive of recovery from addiction and is compatible with NARR Good Neighbor Standards, d) maintain an enrollment process, peer community activities and discharge protocols, and e) establish that objectives are achieved through interviews with staff, peer leaders and residents.
5- Confirmation that the applicant's program maintains a Certified Recovery Residence Administrator (CRRA) for every three locations operated by the applicant. The CRRA is a Florida requirement and is not one of the 37 NARR standards.
6- A grievance resolution protocol, with compliance audits and annual assessments mandated by state statute.

In June, 2018, the U.S. House passed H.R. 4684, the *Ensuring Access to Quality Sober Living Act of 2018*, and its provisions were included in two pending Senate bills, S. 2678, *the Ensuring Access to Quality Recovery Living Act of 2018,* and S. 2680, otherwise known as the *CARA 2.0 Comprehensive Supplementary Funding Bill*.

H.R. 4684 directs the Secretary of Health and Human Services to develop best practices for sober living homes, which may include model laws for implementing minimum standards. The bill specifically references NARR among the stakeholders to be consulted in identifying and developing the best practices and model laws..

Another House bill would create a nationwide recovery home certification and grant program. H.R. 5100, *the Recovery Home Certification Act of 2018*, introduced by Reps. Knight and Eshoo, directs SAMHSA to establish model criteria for recovery homes and award grants to States that establish and operate recovery homes based on such model criteria. The criteria include minimum staffing of recovery support specialists and other staff, qualifications for employees, and policies to support a resident's recovery efforts. The bill also recognizes the inherent economic nexus between sober living and treatment facilities by including recommendations for States to clarify and enforce relationships among health care providers, recovery homes and recovery support providers.

Importantly, H.R. 5100 includes a prohibition against unlawful payments for referrals to recovery homes and clinical treatment facilities, otherwise known as patient brokering. The significance of this provision is that it gives DOJ jurisdiction to prosecute unlawful kickbacks in the drug treatment industry through interstate and foreign commerce. Currently, DOJ only has jurisdiction to prosecute health care kickbacks involving federal programs such as Medicare or Medicaid. Much of the current fraud and abuse in the sober living and treatment industries involves private insurance and is beyond the reach of federal prosecutors. A similar bill, S. 3254, extending the jurisdiction of DOJ to go after the private pay bad actors has been introduced in the Senate by Sens. Rubio and Klobuchar.

A second nationally recognized program is Oxford house, Inc. (OHI). OHI is a non-profit 501(c)(3) organization, founded in 1975 to assist persons with SUD to live a sober lifestyle with like-minded individuals. OHI is currently operating in 44 states and 531 cities, with a network of 2,435 individual houses and over 19,000 available beds, having served a total of 37,852 residents during the past year. Instead of the NARR standards, which require significant oversight of the housing by recovery residence administrators, and include standards for recovery supports and ancillary non-clinical services, the Oxford model is a democratically run, peer-supported group home that encourages the development of leadership skills and self-sufficiency. Each Oxford House is a rented single-family dwelling and receives a no-cost charter from OHI. Residents govern themselves, electing house officers, holding regular house meetings and following disciplined parliamentary procedures. Residents work and pay rent and share household expenses. Intake into the house is by application, interview and approval of 80% of the existing residents. As such, Oxford House is more attuned to those who have already completed intensive forms of outpatient treatment, are currently in the work force or job ready, and relatively self-sufficient. There are no time limits on residency at an Oxford House. By contrast, residency in most sober homes operating with NARR standards coincides with the length of intensive outpatient treatment; residents usually are week to week and leave after treatment is complete.

As the umbrella organization, OHI does not own property, and issues a charter to each home with the following three conditions: First, the group must be democratically self-run following the Oxford House manual. Second, the group must be financially self-supporting, and lastly, the group must immediately expel any member who returns to using alcohol or illicit drugs. OHI has been the subject of numerous academic studies and have been found to have remarkable success. The National Institute of Drug Abuse (NIDA) funded a study by DePaul University Researchers who followed 897 residents in 219 Oxford Houses nationwide for 27 months, finding that only 13% of the residents relapsed. In 2016, only 16.7% of the 35,000 individuals living in Oxford Houses were asked to leave because they had returned to active addiction. SAMSHA has listed Oxford House on the National Registry of Evidence-Based Programs and Practices (NREPP), and in November, 2016, the U.S. Surgeon General's Report, Facing Addiction in America, highlighted the success of the Oxford House program.

Regardless of the nature of the sober living home, national standards and best practices are crucial to prevent bad actors from running patient warehouses or flophouses and exploiting vulnerable, disabled residents. In the private insurance sector, nefarious marketers from around the country run deceptive ads and specifically target persons with SUD who have access to insurance to seek out-of-network programs, enticing them with false claims to warm-weather destinations such as Florida, Arizona and Orange County California. Insurance companies favor short bursts of treatment that are generally ineffective and result in local marketers who poach or "body snatch" addicts from one facility to another, oftentimes luring their victims with offers of free rent at a sober home, scooters, manicures, gift cards, cash and other "stuff."

The one common denominator in the fraudulent marketing and exploitation of SUD patients is the sober living home. This is especially true in the private pay, insurance-driven recovery industry. Insurance is billed by the facility (not the sober living home), with a brief detox or inpatient stay followed by a few weeks of intensive out-patient treatment (IOP). The corrupted providers will pay sober home owners to send their residents for treatment at their facility, which in turn results in free or reduced rent at the sober home. After insurance benefits are exhausted, the patient is discharged and the sober home will either evict the resident, charge rent and eliminate other benefits, or encourage the resident to take drugs because relapse begins a new series of treatments. Since there are no longer exclusions for pre-existing conditions and no yearly or lifetime limits on rehab benefits, a relapse is fully covered.

Thus, the economic model of short term, ineffective treatment favors relapse. Sobriety is no longer profitable, and relapse and recycle means more income. Many unregulated, uncertified sober homes are operated by convicted felons, allow co-ed housing and drug use, and engage in patient brokering with rogue treatment providers. Requiring businesses that house persons, especially those receiving intensive out-patient treatment, to adopt nationally recognized standards for sober living homes would save lives and directly address a part of the opioid epidemic that is fueled by a corrupt recycling of addiction.