ARKANSAS ALLIANCE OF RECOVERY RESIDENCES

Understanding Recovery Residences.

What recovery residences are, the levels of support, and why certification matters.

OPERATOR TOOLKIT · FOUNDATIONS

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01 · FOUNDATIONS

What is a recovery residence.

A recovery residence is a sober, safe, and healthy living environment that promotes recovery from alcohol and other drug use and the problems that come with it. The term is broad — it covers sober living houses, recovery homes, halfway houses, Oxford Houses, and therapeutic communities. These models vary in size, structure, and intensity of services, but they share a common purpose: providing residents with the stable environment, peer support, and recovery-supportive culture needed to initiate and sustain long-term recovery.

All credentialed recovery residences are abstinence-based environments. This stands in contrast to "wet housing," which permits substance use, and "damp housing," which discourages but does not exclude use. Each residence publishes its own house rules, relapse policies, and readmission criteria.

Recovery residences emerged to fill a critical gap between professionally directed addiction treatment and independent community living. More than half of people who complete addiction treatment resume substance use within 90 days of discharge, and assertive continuing care is rarely a routine part of treatment in the United States. Recovery residences provide a missing bridge: a recovery-oriented physical and social environment where residents practice the skills, relationships, and routines that sustain recovery over time.

02 · CONTEXT

The role recovery residences play.

Modern thinking about recovery from substance use disorders identifies three components: sobriety, improvement in global health (physical, emotional, relational, and spiritual), and citizenship — meaning positive reintegration into community and family life. Recovery residences are designed to support all three, not just abstinence in isolation.

Recovery residences are increasingly recognized as a formal level of care. The American Society of Addiction Medicine (ASAM) Criteria, 4th Edition (2023), incorporates recovery residences into the continuum of care for substance use disorders, and ASAM's 2025 public policy statement explicitly supports their expansion. The Substance Abuse and Mental Health Services Administration (SAMHSA) and the U.S. Department of Housing and Urban Development likewise treat recovery housing as an important part of the response to substance use disorders and homelessness.

For operators, this means recovery residences are not informal arrangements. They are an increasingly recognized part of the recovery system — with corresponding standards, expectations, and responsibilities.

03 · FRAMEWORK

The NARR Levels of Support.

The National Alliance for Recovery Residences (NARR) — established in 2011 — has set the field's most widely adopted framework. NARR defines four Levels of Support, distinguished by the type, intensity, and duration of services provided. All four levels are abstinence-based, peer-supported environments; they differ primarily in structure, staffing, and clinical involvement. AARR applies the NARR Quality Standards 3.0 in certifying recovery residences across Arkansas.

- Level 1 — Peer-Run. Democratically self-governed by residents, with no paid staff. Oxford Houses are the canonical example. Length of stay is open-ended; residents share expenses and house responsibilities.
- Level 2 — Monitored. Operated by a senior resident, house manager, or non-clinical staff. House structure is more formal than Level 1, but support remains peer-based. Most traditional sober living houses fit here.
- Level 3 — Supervised. Run by paid staff, with life-skills programming and recovery-oriented services alongside peer support. Often called "social model" recovery programs.
- Level 4 — Service Provider. Highly structured, professionally staffed, with on-site clinical services. Therapeutic communities are a common example. Length of stay is typically shorter, with residents stepping down to lower levels over time.

Residents may enter at any level depending on need and may step down (or, less commonly, up) as their recovery progresses. The levels are not a quality ranking; they describe service intensity, not effectiveness.

04 · EVIDENCE

What the research shows.

The evidence base for recovery residences has grown substantially over the past two decades, though gaps remain. Operators should understand both the encouraging findings and the limitations.

- Sustained recovery outcomes. Longitudinal studies of Level 1 (Oxford Houses) and Level 2 (sober living houses) consistently show significant improvements in abstinence, employment, income, and reduced incarceration over 18- to 24-month follow-up. In one randomized trial, Oxford House residents had a 31% relapse rate at 24 months versus 65% for individuals in standard aftercare.
- Length of stay matters. Six months is the most consistently cited tipping point. Residents who stay longer than six months in a Level 1 residence have markedly lower relapse rates (around 17%) than those who leave earlier (around 46%). This finding is one of the strongest in the field.
- Active ingredients. The strongest predictors of positive outcomes are sustained mutual-aid (12-step or other) involvement, social networks supportive of abstinence, and adequate length of

stay. Demographic characteristics generally do not predict outcomes, suggesting recovery residences benefit a wide range of residents, including women with children and individuals with co-occurring psychiatric conditions.

- Cost-effectiveness. A randomized study of Oxford House found a net societal benefit averaging approximately $29,000 per person, driven primarily by reduced incarceration and increased employment. Cost-effectiveness research across all levels remains limited but points in a favorable direction.
- Important caveats. Long-term (5–10 year) outcome research is sparse. Most rigorous research has focused on Oxford Houses and a smaller body of California sober living houses; findings may not generalize to every model. Outcomes for residents with serious mental illness or significant co-occurring medical conditions remain understudied.

05 · PRACTICE

Core operating principles.

Effective recovery residences share a set of operating principles drawn from both research and practitioner experience. These principles are also the substance of most certification standards, including the NARR Quality Standards 3.0 that AARR applies.

Abstinence-based environment with humane relapse policies.

Residents are expected to abstain from alcohol and illicit drug use. NARR standards require each residence to publish a clear relapse policy. Best practice is to treat relapse as a signal for immediate intervention and a higher level of care — not as punishment, and not as a normal part of recovery to be tolerated in the residence. The safety of every resident depends on the integrity of the abstinence-based environment.

Support for medications used in recovery.

This is one of the most important and most updated areas of practice. SAMHSA's Best Practices for Recovery Housing (2023) and the ASAM 2025 policy statement explicitly affirm that recovery residences should support residents who are prescribed FDA-approved medications for opioid use disorder (such as buprenorphine and methadone), alcohol use disorder, mental health conditions, and other physical health needs. Excluding residents based on the use of such medications may violate the Americans with Disabilities Act, the Rehabilitation Act, and the Fair Housing Act, and the U.S. Department of Justice has signaled increased enforcement in this area.

Operators should establish clear, written medication policies covering prescribed medications, over-the-counter medications, and storage — protecting both individual residents and the household.

Naloxone on-site and overdose preparedness.

Federal policy increasingly recommends — and some states require — that overdose-reversal medication (naloxone) be available on-site, with staff and residents trained in opioid overdose response. Operators should plan for this from day one.

Peer support and mutual aid.
Active involvement in 12-step or other recovery mutual-aid groups is among the most consistent predictors of positive outcomes. Residences should not impose a single pathway, but should make participation accessible, expected, and culturally relevant for the population they serve.

Work, contribution, and routine.
In Levels 1 and 2, residents typically pay their own fees through employment. Studies of Oxford Houses and sober living houses find that the majority of residents are employed during their stay and that employment outcomes improve over time. Levels 3 and 4 may use more structured daytime programming, with employment expectations introduced as residents progress.

Good-neighbor practices.
Research consistently finds that recovery residences do not negatively affect neighborhoods and may even improve them. Studies of Oxford House neighbors report that residents make good neighbors, and there is no evidence of property devaluation. Maintaining the property, managing house density, and engaging neighbors proactively all support long-term sustainability.

Resident governance and clear written policies.
From peer-run councils in Level 1 to resident handbooks and grievance procedures in Levels 3 and 4, transparent governance reinforces accountability and protects residents. Written policies on admissions, fees, medications, relapse, and grievances are essential — both as good practice and as evidence in any certification or legal matter.

06 · LAW

Legal protections and responsibilities.

People in recovery from substance use disorder are a protected class under the federal Fair Housing Act and its amendments. The Americans with Disabilities Act and the Rehabilitation Act provide additional protections. These laws prohibit discriminatory zoning, occupancy restrictions, and other policies that target recovery residences specifically. Many operators have successfully used these laws to defend the right of a residence to exist in a residential neighborhood.

These protections are paired with responsibilities. Operators must comply with all applicable building, fire, and safety codes. They must accommodate residents using prescribed medications for substance use disorder. And they must not exploit residents — fraud and abuse in poorly regulated recovery housing has prompted federal prosecutions and tightened state oversight in recent years.

07 · CERTIFICATION

Why certification matters.

Historically, recovery residences operated in a regulatory gap — leading to inconsistent quality and, in some cases, real harm to residents. That landscape is changing rapidly. As of 2025, certification through a NARR-affiliated body, state licensure, or accreditation is increasingly required for:

- Access to public funding — including state opioid response grants, opioid settlement dollars, Medicaid waivers, and SAMHSA block grants.
- Receiving referrals from state-funded or licensed treatment providers.
- Inclusion in state or local recovery-housing directories.
- Participation in many private insurance and managed-care arrangements.

Certification signals to residents, families, referral partners, and funders that a residence meets defined quality standards across administration, operations, property, good-neighbor practices, life safety, and resident rights. The SAMHSA Best Practices for Recovery Housing document and the NARR Standard form the practical baseline for AARR certification.

For operators, certification is also a form of risk management. It provides a framework of written policies, staff training, and resident-protection practices that reduce legal and reputational exposure as state and federal scrutiny continues to increase.

08 · NEXT STEPS

What prospective operators should consider.

Opening or operating a recovery residence is a significant undertaking. The following questions are worth working through before applying for AARR certification or starting operations:

- Who will you serve? Recovery residences are often designed for specific populations — men, women, women with children, veterans, individuals re-entering from incarceration, or individuals on medication-assisted treatment. The population shapes the level of support, staffing, and policies required.
- Which level of support? Levels 1 and 2 typically rent existing residential properties and rely on resident fees; Levels 3 and 4 require more capital, professional staffing, and clinical infrastructure.
- What are your funding sources? Most recovery residences are not highly profitable. Lower levels are often self-funded through resident fees; higher levels may rely on insurance, public funding, or grants. Plan for several years before reaching positive cash flow.
- What are your written policies? Relapse, medication, admissions, grievances, fees, and good-neighbor policies should be drafted, reviewed, and consistent with current best practices and legal requirements before opening.

- What is your community-engagement plan? Proactive engagement with neighbors, local officials, and referral partners reduces friction and builds the support that sustainable residences depend on.

09 · SOURCES

A note on sources.

This guide synthesizes information from three primary sources: the National Alliance for Recovery Residences and Society of Community Research and Action Primer on Recovery Residences in the United States (2012); the SCRA / APA Division 27 policy statement The Role of Recovery Residences in Promoting Long-Term Addiction Recovery (Jason, Mericle, Polcin, & White, 2013); and the American Society of Addiction Medicine Public Policy Statement on Housing's Role in Addressing Substance Use and Facilitating Recovery (ASAM, 2025). It also reflects SAMHSA's Best Practices for Recovery Housing (2023) and the ASAM Criteria, 4th Edition (2023). Specific findings cited above derive from peer-reviewed studies referenced in those source documents.

Recovery residence research, policy, and certification standards continue to evolve. Operators should rely on current SAMHSA, NARR, AARR, and Arkansas Department of Human Services guidance for the most up-to-date standards and requirements.