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Substance Abuse and Mental Health Services Plan

2014 Annual Plan Update

Esther Jacobo, Interim Secretary **Rick Scott, Governor**

Substance Abuse and Mental Health Services Plan 2014-2016

2014 Annual Plan Update

Prepared pursuant to s. 394.75, F.S.

Substance Abuse and Mental Health Programs
Department of Children and Families

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I. Introduction

I.A. PLAN PURPOSE

The Department of Children and Families (Department), pursuant to s. 394.75, F.S., is required to develop a triennial master plan for the delivery of publicly funded community based behavioral health services in Florida. In interim years, the Department submits an annual update that outlines progress and any alterations to the plan. This 2014 plan update provides a status report on progress toward meeting those goals.

I.B. ORGANIZATIONAL PROFILE

Florida Statute directs the Department to create the Office of Substance Abuse and Mental Health (SAMH).[1] The Department is the state substance abuse and mental health authority. SAMH develops standards for the provision of services in partnership with other state agencies that also provide behavioral health services. The Department provides other social services, such as child welfare, domestic violence prevention, public benefits, and homeless services

The Department is led by the Secretary of Children and Families, appointed by the Governor.[2] The Secretary appoints an Assistant Secretary for Substance Abuse and Mental Health, who provides leadership and direction for the SAMH Headquarters office, and reports directly to the Secretary.[3] The Assistant Secretary is supported by the Director for Substance Abuse and Mental Health, and the Director for Institutional Services.

The Department's mission is to "Protect the Vulnerable; Promote Strong and Economically Self-Sufficient Families, and Advance Personal and Family Recovery and Resiliency." The priorities identified in the annual update represent the primary areas of focus for SAMH and have been updated since the development of the 2014-2016 Master Plan to better represent the Department's mission, statutory responsibilities, and federal requirements.

The Department does not directly provide any community based behavioral health services, rather contracts for the administration and provision of services. However, the Department has statutory responsibility for the oversight and administration of community substance abuse and mental health services, including contracting, budget, and quality assurance activities. The SAMH regional offices are the Department's representatives to the community for substance abuse and mental health issues. Regional SAMH directors are responsible for administrative functions including implementation of managing entity contracts and licensure of substance abuse programs.

Substance abuse and mental health services are also available through other state agencies including the Department of Education (DOE), Department of Health (DOH), Department of Juvenile Justice (DJJ), Department of Corrections (DOC), Department of Elder Affairs (DOEA), and Agency for Health Care Administration (AHCA). Local partners include consumers of substance abuse and mental health

[1] S. 20.19, F.S.

[2] *Id.*

[3] *Id.*

services, family members of consumers, Community-Based Care agencies, local government, judiciary, law enforcement, advocacy groups, and providers of substance abuse and mental health services.

As of November 2013, the Department has contracts with seven Managing Entities[4] which are nonprofit organizations that administer and manage the delivery of behavioral health services through a contracted system of care. The goal of this service model is to increase access and promote continuity of care through efficient management of services. The Department currently contracts with the following:

- Broward Behavioral Health Coalition,
- Central Florida Cares Health System,
- Lutheran Services of Florida,
- Big Bend Community-Based Care,
- Southeast Florida Behavioral Health Network,
- South Florida Behavioral Health Network, and
- Central Florida Behavioral Health Network.

The Department's SAMH Headquarters office also houses the Statewide Office of Suicide Prevention (SOSP). A statutory duty of the Department is to implement a Suicide Prevention Coordinating Council[5] to develop mechanisms for implementing the *Florida Suicide Prevention Strategy* and to provide oversight, build capacity, create policy, and mobilize communities. The overall goal is to lower the number of suicides and improve quality of life.

[4] The 2001 Florida Legislature enacted Senate Bill 1258 authorizing the Department to implement Behavioral Health Managing Entities.
[5] See s. 14.20195, F.S.

II. Update of Strategic Priorities

II.A. PROGRAMMATIC PRIORITIES FOR SUBSTANCE ABUSE AND MENTAL HEALTH

As a part of constructing the triennial master plan, SAMH identifies statewide trends and conditions that relate to substance abuse and mental health, and the impact that these identified factors may have on service capability, system management, and funding implications. These factors also inform priorities for both the Department and the contractors for behavioral health funding. Florida is a diverse state, not only in terms of reported ethnicity, but also the geographic composition of the state. It is an oft quoted cliché that what is appropriate for Miami-Dade county, is likely not appropriate for Escambia or Duval counties.

It is also important to note that there are several system related conditions that the Department has not previously addressed in planning that inform the update to the 2014-16 Master Plan. In FY12-13, the Department implemented seven statewide managing entity contracts – as noted previously. Although this has existed in statute since 2001, statewide implementation only occurred in FY12-13. In the implementation process, there have been a series of lessons learned by both the Department and the contractors. For the 2014 update to the 2014-16 Master Plan, the Department is refocusing goals related to the managing entities to resolve the implementation issues. The Department will:

- Resolve contract deficiencies with the managing entities to refocus the mission to be the development of community centered system of care that is responsive to regional need.
- Re-develop the administrative framework of the Department to support the managing entity, rather than the prior model, which supported direct provider contracts.
- Re-develop and implement oversight and management control processes to ensure accountability and transparency.

As a recipient of federal block grant funding, there are also a number of requirements that the Department must ensure are met. The implementation of managing entity contracts in FY12-13 did not fully address these requirements, and represent an important omission that will be addressed in this update.

There are several federal issues that have arisen that were not previously addressed in the triennial plan, that are outlined in this update. They include:

- The continued federal budget instability, including the impact of sequestration.
- The implementation and delays in implementation of the Patient Protection and Affordable Care Act (ACA).
- Shifts in federal priorities for the block grants that are divergent to state priorities.

As a requirement of receiving the substance abuse block grant from the federal government, there are a series of assurances that the Department must make to the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). With the expansion of managing entities, the achievement of many of these assurances will require the Department to alter the administrative framework associated with them.

The Department is required to submit goals to SAMHSA for the FFY14-15 block grant application, and the following have been identified:

1. *Substance Abuse Prevention and Treatment Services to Individuals with Communicable Diseases (Tuberculosis and HIV/AIDS)*
   To meet the federal requirements of the substance abuse block grant, the Department will develop and implement a methodology to capture and report early intervention services to SAMHSA.

2. *Substance Abuse Prevention and Treatment Services for Intravenous Drug users (IVDU)*
   Pursuant to the block grant, the Department is required to ensure the provision of services to IDVU, and to manage access with a waiting list and interim services for those on the list.

3. *Substance Abuse Prevention and Treatment Services for Pregnant Women and Women with Dependent Children*
   The Department will identify best practices for prevention and treatment services for Pregnant Women and Women with Dependent Children. In addition to this, as a condition of the block grant, the Department must manage access to services with a waiting list, and interim services for those on the list. In FY13-14, the Department will develop and implement a policy to ensure that families can remain together in treatment.

4. *Evidence-based Prevention and Treatment Services for Adults with Serious Mental Illness (SMI) and Children with Serious Emotional Disturbance (SED)*
   The Department will ensure that providers are trained and receive technical assistance using written Standards of Care for evidence-based practices.

5. *Substance Abuse and Mental Health Prevention and Treatment Services for Youth with SED*
   The Department will continue to implement Community Action Teams (CATs) to increase access to intensive, community based services for children and youth delivered in a team approach.

6. *Services for Adults with SMI and Children with SED*
   The Department will increase access to behavioral health services so that adults, children, and families are active and self-sufficient participants in their communities.

III. 2013 Legislative Session

III.A. BILLS

The Florida Legislature passed the following bills in the 2013 legislative session related to substance abuse and mental health services.

- **HB 215 – Dependent Children**

  The “Nancy C. Detert Common Sense and Compassion Independent Living Act” makes changes to the Independent Living Program for foster care youth. This bill gives children in foster care the option of remaining in foster care until age 21.

- **HB 1355 – Purchase of Firearms by Mentally Ill Persons**

  A clarification in the firearms law that requires data reporting of individuals who sought voluntary commitment for crisis stabilization services in the purchase of firearms.

- **SB 1518 – Department of Children and Families Conforming Bill**

  The Legislature authorized managing entities to carry over up to eight (8) percent of state general revenue from one fiscal year to the next, and to receive an advance payment equivalent to two (2) monthly payments.

III.B. PROVISO

- **SOBER HOUSES**

  This proviso required the Department to develop a plan to determine whether to establish a licensure and registration process relating to Sober Houses. These facilities provide peer-supported substance free environments for persons in recovery from alcohol or drug abuse. (The report is included as Appendix 3 to this update.)

- **COMMUNITY ACTION TEAMS (CATs)**

  Specific Appropriation 352A was distributed to ten (10) Community Action Teams (CATs) in the amount of $6.75 million. The local providers implementing the ten (10) teams are named in the proviso language. The teams are established as pilot projects for children ages 11 to 21 with mental health or co-occurring disorders, who are considered high risk for out-of-home care. The Department is required to develop a report that evaluates the effectiveness of CATs in meeting the goal of offering parents and caregivers a safe option for raising their child at home instead of more costly institutional, foster home, or juvenile justice placements.

- **INFORMED FAMILIES / SUBSTANCE ABUSE PREVENTION SERVICES**

  Specific Appropriation 374 provided $750,000 for a statewide program, called Informed Families of Florida, for the prevention of child and adolescent substance abuse. The Department is required to assess the effectiveness of these prevention efforts with existing resources and services utilized throughout the state.

- **REINVESTMENT GRANTS – "PUBLIC SAFETY, MENTAL HEALTH, AND SUBSTANCE ABUSE LOCAL MATCHING GRANT PROGRAM"**

  Specific Appropriation 352A provides $3 million for Criminal Justice Reinvestment Grants. These Reinvestment Grants have served as a model for the state to partner with communities, and with their Public Safety Councils, to expand access to behavioral health services for individuals with mental illnesses and substance abuse disorders at risk of incarceration.

- **SUBSTANCE ABUSE SERVICES FOR PREGNANT WOMEN AND THEIR CHILDREN**

  Specific Appropriation 375 provided $8.9 million for the expansion of substance abuse services for pregnant women and their affected families. These services include residential and non-residential services and support both the mother and the child, consistent with the recommendations from the Statewide Task Force on Prescription Drug Abuse and Newborns.

- **MANAGING ENTITY ADMINISTRATIVE REDUCTIONS**

  The funds in Specific Appropriations 346 through 380 were reduced by $3.2 million due to the contract savings from the managing entities.

- **COMMUNITY-BASED CARE AGENCIES**

  Specific Appropriation 352A provided $5 million in behavioral health funding for the Community-Based Care agencies to expand services to families with substance abuse issues.

IV. Approved Operating Budget

Table 1 Fiscal Year 2013-2014 Approved Operating Budget – Mental Health Services

Mental Health Services							
Regions	**Adult Community Mental Health**	**Children's Community Mental Health**	**Executive Leadership and Support Services**	**Civil Commitment Program**	**Forensic Commitment Program**	**Sexual Predator Program**	**Total**
Headquarters	$4,202,558	$25,117,292	$5,957,333	$45,997,794	$54,709,037	$29,026,700	**$165,010,714**
Northwest	$27,047,973	$5,756,613	$419,728	0	0	0	**$33,224,314**
Northeast	$42,599,597	$11,913,870	$1,327,375	0	0	0	**$55,840,842**
Suncoast	$94,500,786	$19,361,288	$1,133,473	0	0	0	**$114,995,547**
Central	$26,587,323	$10,535,304	$321,787	0	0	0	**$37,444,414**
Southeast	$49,046,503	$13,174,713	$468,776	0	0	0	**$62,689,992**
Southern	$36,188,139	$11,557,757	$498,856	0	0	0	**$48,244,752**
West Florida Community Care Center	0	0	0	$5,823,880	0	0	**$5,823,880**
Florida State Hospital	$6,130,215	0	0	$48,472,588	$54,754,392	0	**$109,357,195**
Northeast Florida State Hospital	0	0	0	$62,455,842	0	0	**$62,455,842**
North Florida Evaluation and Treatment Center	0	0	0	0	$21,390,556	0	**$21,390,556**
Control[6]	$3,734,310	$239,880	$83,380	0	0	$300,000	**$4,357,570**
Reserve[7]	0	0	$3,773	$127,719	$71,006	0	**$202,498**
Unfunded Budget[8]	1,463,628	175,967	366,345	0	129,709	0	**2,135,649**
Total	**291,501,032**	**97,832,684**	**10,580,826**	**162,877,823**	**131,054,700**	**29,326,700**	**723,173,765**

[6] Control: Identifies budget in the AOB (July 1) pending allocation for Department initiatives later in the fiscal year. This budget is released pending approved project plans or in some cases EOG and Legislative Actions.

[7] Other: During the AOB process, $161,826 was adjusted between Executive Leadership and Support Services and Children's Mental Health related to grant realignment. Also, $2,486,370 was adjusted among the Civil Commitment, Forensic Commitment, and Sexual Predator Program Components related to a vetoed issue. "Reserve (98)" identifies budget earmarked for the Information Technology refresh.

[8] Unfunded Budget: Budget identified during the AOB process that does not have a fund source. For example, budget authority is appropriated for multi-year grants as recurring, but when the grant period ends the budget authority remains in the Department. Per the grant ending the budget no longer has a fund source and becomes unfunded. The Department will delete this budget authority from its based budget during the Legislative Budget Request Process that will balance the budget with revenues.

Table 2 Fiscal Year 2013-2014 Approved Operating Budget – Substance Abuse Services

Substance Abuse Services				
Regions	**Adult Substance Abuse**	**Children's Substance Abuse**	**Executive Leadership and Support Services**	**Total**
Headquarters	3,154,207	2,024,641	5,137,106	10,315,954
Northwest	10,020,360	6,476,886	302,072	16,799,318
Northeast	25,797,484	13,305,728	275,106	39,378,318
Suncoast	32,703,569	19,324,127	429,868	52,457,564
Central	15,289,678	8,228,647	360,297	23,878,622
Southeast	22,560,591	12,481,341	312,458	35,354,390
Southern	17,780,448	10,552,919	231,759	28,565,126
Control[9]	583,340	85,845	0	669,185
Reserve[10]	0	0	7,279	7,279
Unfunded Budget[11]	598,400		300,000	898,400
Total	**128,488,077**	**72,480,134**	**7,355,945**	**208,324,156**

V. Performance Measurement Overview

The Department requires managing entities to collect and submit client-level data electronically into the Substance and Mental Health Information System (SAMHIS), the state database. The data includes the socio-demographic and clinical characteristics of the persons served, the types and amounts of services provided to each individual, and the outcome of these services. This data is reported on a centralized "Dashboard", which details the levels of performance for each circuit/region and service provider on a continuous basis. The Dashboard is available at http://dcfdashboard.dcf.state.fl.us/.

V.A. LEGISLATIVE STATUS REPORT

The Department is required to submit a report to the Legislature regarding the compliance of contracted providers.[12] In FY 12-13, 89 percent (16 of 18) of statewide performance targets reported in the report were met or exceeded. Managing Entities are responsible for 126 performance outcome targets. The Managing Entities met 85 percent (107 of 126) of their contracted performance expectations. (The report is included as Appendix 1 to this update.)

[9] Control: Identifies budget in the AOB (July 1) pending allocation for Department initiatives later in the fiscal year. This budget is released pending approved project plans or in some cases EOG and Legislative Actions.

[10] Other: "Reserve (98)" identifies budget earmarked for the Information Technology refresh.

[11] Unfunded Budget: Budget identified during the AOB process that does not have a fund source. For example, budget authority is appropriated for multi-year grants as recurring, but when the grant period ends the budget authority remains in the Department. Per the grant ending the budget no longer has a fund source and becomes unfunded. The Department will delete this budget authority from its based budget during the Legislative Budget Request Process that will balance the budget with revenues.

[12] Section 394.745, F.S.

V.B. PERFORMANCE OUTCOMES AND CLIENTS SERVED

Appendix 1 provides a series of tables depicting FY 2012-2013 output (clients served), and outcome data for the Substance Abuse and Mental Health Programs.

VI. Appendix 1: Performance Measures for SAMH

The following tables depict the FY 2012-2013 General Appropriations Act (GAA) measures and clients served data for the Substance Abuse and Mental Health Programs.

Table 3 FY 2012-2013 GAA Measures and Clients Served – Children's Mental Health Services

FY 2012-2013 GAA Measures and Clients Served - Children's Mental Health Services					
			FY 12-13		
Population	MCode	Measure	**Target**	**Actual**	**Target Met**
At Risk of Emotional Disturbance	M0033	Number of children to be served	≥ 4,330	1,946	No
	M0780	Percent of children who live in stable housing environment	≥ 96	93.62	No
Emotionally Disturbed	M0032	Number of children to be served	≥ 21,925	27,000	Yes
	M0377	Percent of children who improve their level of functioning	≥ 64	65.02	Yes
	M0778	Percent of children who live in stable housing environment	≥ 95	98.33	Yes
Juvenile Incompetent to Proceed	M0019	Percent of children with mental illness restored to competency and recommended to proceed with a judicial hearing	≥ 75	85	Yes
	M0020	Percent of children with mental retardation or autism restored to competency and recommended to proceed with a judicial hearing	≥ 50	42	No
	M0030	Number of children served who are incompetent to proceed	≥ 340	404	Yes
Seriously Emotionally Disturbed	M0012	Percent of school days attended	≥ 86	91.9	Yes
	M0031	Number of children to be served	≥ 46,000	33,710	No
	M0378	Percent of children who improve their level of functioning	≥ 65	66.5	Yes
	M0779	Percent of children who live in stable housing environment	≥ 93	98.04	Yes

Table 4 FY 2012-2013 GAA Measures and Clients Served – Adult Community Mental Health Services

FY 2012-2013 GAA Measures and Clients Served - Adult Community Mental Health Services					
			FY12-13		
Population	**MCode**	**Measure**	**Target**	**Actual**	**Target Met**
Forensic Involvement	M0018	Number of adults served	≥ 3,328	3,687	Yes
	M0743	Percent of adults who live in stable housing environment	≥ 67	80.13	Yes
Mental Health Crisis	M0017	Number of adults served	≥ 30,404	27,532	No
	M0744	Percent of adults who live in stable housing environment	≥ 86	92.44	Yes
Serious Mental Illness	M0703	Percent of adults with serious and persistent illness who are competitively employed.	≥ 20	18.43	No
	M0709	Percent of adults readmitted to a civil state hospital within 180 days of discharge	≤ 8	5.93	Yes
	M0777	Percent of adults readmitted to a forensic state treatment facility within 180 days of discharge	≤ 8	3.57	Yes
Severe And Persistent Mental Illness	M0003	Average annual days worked for pay	≥ 40	39.49	No
	M0016	Number of adults in the community served	≥ 136,480	147,558	Yes
	M0742	Percent of adults who live in stable housing environment	≥ 90	93.97	Yes

Table 5 FY 2012-2013 GAA Measures and Clients Served – Adult Mental Health Treatment Facilities

FY 2012-2013 GAA Measures and Clients Served - Adult Mental Health Treatment Facilities					
			FY12-13		
Population	MCode	Measure	Target	Actual	Target Met
Civil	M0372	Number of people served	≥ 1842	1606	No
	M05050	Percent of adults who show an improvement in functional level	≥ 67	79	Yes
Forensic	M0361	Number of people on admission waiting list over 15 days	= 0	0	Yes
	M0373	Number of adults served	≥ 2,320	2,351	Yes
Incompetent To Proceed	M0015	Average number of days to restore competency	≤ 125	103	Yes
Not Guilty By Reason Of Insanity	M05051	Percent of adults who show an improvement in functional level	≥ 40	60	Yes

Table 6 FY 2012-2013 GAA Measures and Clients Served – Sexually Violent Predator Program

FY 2012-2013 GAA Measures and Clients Served – Sexually Violent Predator Program					
			FY12-13		
Population	MCode	Measure	Target	Actual	Target Met
Sexually Violent Predators	M0283	Number assessed	≥ 2,879	3,187	Yes
	M0379	Number served (detention and treatment)	≥ 480	718	Yes
	M0380	Annual number of harmful events per 100 residents in sexually violent predator commitment.	≤ 3	.6	Yes
	M05305	Percent of assessments completed within 180 days of receipt of referral	≥ 85	98	Yes
	M06001	Number of residents receiving mental health treatment	≥ 169	387	Yes

Table 7 FY 2012-2013 GAA Measures and Clients Served – Substance Abuse – Adult Treatment

FY 2012-2013 GAA Measures and Clients Served – Substance Abuse – Adult Treatment					
			FY 12-13		
Population	**MCode**	**Measure**	**Target**	**Actual**	**Target Met**
Adult Treatment	M0063	Number of adults served	≥ 115,000	100,184	No
Adult Treatment	M0753	Percentage change in clients who are employed from admission to discharge	≥ 10	12.81	Yes
Adult Treatment	M0754	Percent change in the number of adults arrested 30 days prior to admission versus 30 days prior to discharge	≥ 14.6	8.31	No
Adult Treatment	M0755	Percent of adults who successfully complete substance abuse treatment services	≥ 51	58.13	Yes
Adult Treatment	M0756	Percent of adults with substance abuse who live in a stable housing environment at the time of discharge	≥ 94	83.98	No

Table 8 FY 2012-2013 GAA Measures and Clients Served – Substance Abuse – Children's Treatment

FY 2012-2013 GAA Measures and Clients Served – Substance Abuse – Children's Treatment					
			FY12-13		
Population	**MCode**	**Measure**	**Target**	**Actual**	**Target Met**
Children's Treatment	M0052	Number of children with substance-abuse problems served	≥ 50,000	42,093	No
Children's Prevention	M0055	Number of at-risk children served in targeted prevention	≥ 4,500	5,261	Yes
Children's Prevention	M0382	Number of at risk children served in prevention services	≥ 150,000	160,261	Yes
Children's Prevention	M05092a	Alcohol usage rate per 1,000 in grades 6-12	≤ 295	246	Yes
Children's Prevention	M05092m	Marijuana usage rate per 1,000 in grades 6-12	≤ 110	124	No
Children's Treatment	M0725	Percent of children who successfully complete substance abuse treatment services	≥ 48	60.91	Yes
Children's Treatment	M0751	Percent change in the number of children arrested 30 days prior to admission versus 30 days prior to discharge	≥ 19.6	19.73	Yes
Children's Treatment	M0752	Percent of children with substance abuse who live in a stable housing environment at the time of discharge	≥ 93	94.86	Yes

VII. Appendix 2: The Assisted Living Facilities Limited Mental Health (ALF-LMH) Licensed Annual Survey

Pursuant to statute, [13] each Department region prepares an annual plan with community input to ensure the provision of behavioral health services to residents in ALF-LMHs. Public input into the annual plans is handled in a variety of ways, including using established stakeholders' forums, councils, and committees, and reaching out to ALF administrators and staff during Department facilitated trainings. SAMH Headquarters office keeps these plans on file.

According to the Agency for Healthcare Administration (AHCA), as of October 2013, there were 1,046 ALF-LMH facilities statewide with 14,779 beds. Of those, 10,807 are Optional State Supplementation (OSS) beds. A directory of facilities is located on AHCA's website.

ALF-LMH staff members who are in direct contact with mental health residents must take a six hour (minimum) training course about "working with individuals with mental health diagnosis" within six months of receiving ALF-LMH license or within six months of employment.[14] This training must be provided and approved by the Department.[15] Currently, training is provided at least every six months via regional managing entity staff or through contracts with community mental health providers. In several urban areas, training is offered every two (2) to three (3) months (e.g., Miami, Broward County, and Tampa). The Department updated this training curriculum in July 2012 after surveying the ALFs and asking for their input and specific needs. The curriculum now includes more information about behavior intervention and trauma-informed care. It also includes components provided by consumers with their experience. The new training is competency-based, requiring a test after each of the six (6) modules.

Through subcontracts with community substance abuse and mental health providers, the managing entities ensure that:

- The ALF-LMH is provided with documentation that the individual meets the definition of a mental health resident;
- The mental health resident has been assessed and determined to be appropriate to reside in an assisted living facility;
- A case manager is assigned for each mental health resident, unless refused by the resident who may also choose a private provider;
- A community living support plan is prepared by the mental health resident and the case manager in consultation with the administrator of the facility that identifies needs and services;
- Each regional administrator develops, with community input, annual plans that demonstrate how the region will ensure the provision of state-funded substance abuse and mental health treatment services to residents of ALF-LMH facilities;
- A cooperative agreement is in place between the mental health provider and the ALF-LMH that outlines procedures to access emergency psychiatric care 24 hours a day, seven days a week; and
- The provider offers psychosocial mental health services, if available.

[13] Section 394.4574, F.S.

[14] 58A-5.0191 F.A.C.

[15] Section 400.4075, F.S.

VIII. Appendix 3: Recovery Residence Report – Fiscal Year 2013-2014 General Appropriations Act

Recovery Residence Report
Fiscal Year 2013-2014 General Appropriations Act

The Office of Substance Abuse and Mental Health

October 1, 2013

I. SUMMARY

The 2013-2014 General Appropriations Act (GAA) directed the Department of Children and Families (Department) to submit a report to the Legislature by October 1, 2013 about recovery residences in the state of Florida.

In summary:

- Studies completed by Connecticut, Massachusetts and Hawaii, found that recovery residences are not treatment providers, instead offering housing services to residents.
- There is not a valid methodology, in Florida or the nation, to estimate the number of recovery residences.
- This has been a litigious issue in federal court, because of the federal Fair Housing Act and the Americans with Disabilities Act.
- Local government officials from South Florida expressed frustration as to the regulation of sober homes in their comments related to public input.
- Public comment included a variety of concerns:
    - The perception and impact of sober homes in their neighborhoods;
    - The risk for the people in recovery; and
    - The lack of governmental oversight.
- Research suggests that sober homes may be a valuable component of a community based recovery maintenance system for substance use disorders.

II. INTRODUCTION

The 2013-2014 General Appropriations Act (GAA) directed the Department of Children and Families (Department) to develop a plan to determine whether sober homes should be licensed or registered:

> From the funds in Specific Appropriations 370 through 380, the department shall develop a plan to determine whether to establish a licensure/registration process relating to residential facilities that provide managed and peer-supported, alcohol-free and drug-free living environments for persons recovering from drug and alcohol addiction, commonly referred to as sober homes. This plan shall identify the number of sober homes operating in Florida, identified benefits and concerns in connection with the operation of sober homes, and the impact of sober homes on effective treatment of alcoholism and on sober house residents and surrounding neighborhoods. The department shall also examine the feasibility, cost, and consequences of licensing, regulating, registering, or certifying sober homes and their operators. The department shall consult with interested parties, including, but not limited to, the Florida Alcohol and Drug Abuse Association, local governments, stakeholders in the chemical abuse treatment community, and operators of sober houses. The plan shall be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by October 1, 2013.[1]

[1] Ch. 2013-040, L.O.F.

III. GENERAL APPROACH

Sober houses are also known by a variety of names, including; sober living homes, community residences, group homes, halfway houses, recovery residences, or alcohol and drug free housing. These terms are considered synonymous and used interchangeably.[2] For the purposes of this report, the Department has used the term recovery residence.

To receive public input, the Department held public meetings and established an online portal to collect public feedback. The Department also consulted with interested parties, including the Florida Alcohol and Drug Abuse Association (FADAA), Florida Association of Recovery Residences (FARR), the Florida League of Cities (FLC), the Florida Association of Counties (FAC), substance abuse treatment providers, local governments, owners and operators of recovery residences, and concerned citizens.

To provide a framework to encourage public response, the Department posed the following questions on its website:

- Should recovery residences be regulated?
- How many recovery residences operate in Florida? What is your methodology for arriving at this number?
- What would be the feasibility, cost and consequence of licensing, regulating, registering, or certifying recovery residences and their operators?
- If there were to be a regulating body, what is the appropriate level of government for it to operate at?
- What should be included in any regulatory framework for a recovery residence?
- Are there any other issues that need to be addressed?

The Department received input from a broad cross section of Florida, including both professional and private individuals. All public comment is included in this report, both in summary and raw form.

[2] When citing other sources, an attempt is made to use the terminology used by the original authors.

IV. What is a Recovery Residence?

There is no universally accepted definition of a recovery residence, and as such is subject to interpretation.[3] However, researchers have proposed the following essential characteristics of a recovery residence:

- An alcohol and drug-free living environment for individuals attempting to establish or maintain abstinence.
- No treatment services offered on site, but attendance at self-help groups such as Alcoholics Anonymous and Narcotics Anonymous may be either mandated or strongly encouraged.
- Compliance with house rules.[4]
- Resident responsibility for paying rent and other costs.
- No limitations on length of stay as long as residents comply with house rules.[5]

These characteristics help distinguish recovery residences from other housing options. For example, unlike most halfway houses, which receive government funding and limit the length of stays, recovery residences are financially self-sustaining through rent and fees paid by residents and there is no limit on length of stay for those who abide by the rules.[6] Furthermore, unlike "wet housing" where residents are allowed to consume alcohol or other drugs and "damp housing" that discourages but does not exclude individuals for consuming, recovery residences are abstinence-based environments where consumption of alcohol or other drugs results in eviction.[7]

Other states undertaking similar studies, attempted to define what a recovery residence is in the context of their respective jurisdictions. A common presentation is the distinction between licensed substance abuse treatment facilities, and a recovery residence as a housing solution for people in recovery.

A 2009 Connecticut study noted the following; "Sober houses do not provide treatment, [they are] just a place where people in similar circumstances can support one another in sobriety. Because they do not provide treatment, they typically are not subject to state regulation."[8]

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[3] *See e.g.,*K. Paquette, N. Greene, L. Sepahi, K. Thom, and L. Winn, *Recovery Housing in the State of Ohio: Findings from an Environmental Scan*, (2013); D. Polcin, R. Korcha, J. Bond, and G. Galloway, *Sober Living Houses for Alcohol and Drug Dependence: 18-Month Outcome,* 38 Journal of Substance Abuse Treatment*,* 356-365 (2010) [hereinafter Polcin et. al., *18 Month Outcomes (2010)*]; D. Polcin, R. Korcha, J. Bond, W. Lapp and G. Galloway, *Recovery from Addiction in Two Types of Sober Living Houses: 12-Month Outcomes,* 18 Addiction Research and Theory, (4), 442-455 (2010) [hereinafter Polcin et. al., *12 Month Outcomes (2010)*].

[4] Such as maintaining abstinence, paying rent and other fees on time, participating in house chores and meetings.

[5] *See,* Polcin et. al., *18 Month Outcomes (2010)*; Polcin et. al., *12 Month Outcomes (2010)*.

[6] *See,* Polcin et. al., *12 Month Outcomes (2010)*, at 442-455; Polcin et. al., *18 Month Outcomes (2010)*,at 352-366.

[7] *See,* L. Jason, A. Mericle, D. Polcin, and W. White, *The Role of Recovery Residences in Promoting Long-term Addiction Recovery,* American Journal of Community Psychology (forthcoming 2013); National Association of Recovery Residences, *A Primer on Recovery Residences: FAQs from the National Association of Recovery Residences* (2012), www.narronline.com/NARR_formation_website/Recovery%20Residence%20Primer%20-%20Long.pdf, site accessed August 14, 2013.

[8] *See,* http://www.cga.ct.gov/2009/rpt/2009-R-0316.htm, site accessed August 18, 2013.

The Alcohol and Drug Abuse Division of Hawaii's Department of Health recommended the following definition in a recent Task Force report; "[A] [c]lean and sober home" means a dwelling that is designed to provide a stable, independent environment of alcohol and drug free living conditions to sustain recovery and that is shared by unrelated adult persons who are attempting to maintain a life of sobriety.[9]

The Massachusetts Department of Public Health's Bureau of Substance Abuse Services (BSAS) has considered Alcohol and Drug Free Housing as a form of group housing that offers an alcohol and drug free living environment for individuals recovering from alcohol or substance use disorders and where, as a condition of occupancy, residents agree not to use alcohol or other substances.[10] More specifically, Alcohol and Drug Free Housing (ADF) refers to:

> [T]he variety of group housing arrangements, however designated or legally structured, that provide an alcohol and drug free living environment for people in recovery from substance use disorders. ADF Housing is also referred to as sober housing, alcohol and substance free housing, clean-and-sober housing, alcohol-free or sober-living environments, three-quarter way houses, re-entry homes and other similar names. ADF Housing includes both transitional and permanent housing models which may be operated by a variety of entities, including state and federal government agencies, licensed mental health and addiction treatment agencies, for-profit and non-profit organizations, the occupants themselves, or private landlords.[11]

[9] State of Hawaii, Department of Health, Alcohol and Drug Abuse Division, *Relating to the Clean and Sober Homes and Halfway Houses Task Force*. Report to the Twenty-Seventh Legislature, State of Hawaii, 2013. Provided via email from Mardelle Gustilo, Hawaii State Department of Health, on June 24, 2013, on file with Department Staff.
[10] Massachusetts Department of Public Health, Bureau of Substance Abuse Services. *Study Regarding Sober (Alcohol and Drug Free) Housing In Response to Chapter 283, Section 10, of the Acts of 2010*, www.mass.gov/eohhs/docs/dph/substance-abuse/adf-housing-study.rtf, site accessed August 14, 2013.
[11] *Id*.

V. Number of Recovery Residences Operating in Florida

Proviso directed the Department to identify the number of recovery residences in the state.

To determine the number, the Department used multiple approaches to obtain a valid estimate of the number of residences in the state. These included:

- Regional Department staff provided an inventory of the facilities known to both them, and the providers they oversee. However, this did not produce a result because the Department did not receive statewide information.
- A request to the major advocacy organizations for local governments in the state, to use their networks to assist the Department to provide an estimate. No information was provided.
- A request to the advocacy organizations for the industry, to use their networks to assist the Department to provide an estimate. The information provided to the Department was incomplete.

A commonly expressed theme has been that the number is currently unknown, given that the operation of a recovery residence has not come under the purview of a regulatory entity. In addition, recovery residences may open or close routinely and the number may vary significantly over short periods of time. It should be noted that this is not a phenomenon unique to Florida; a Massachusetts official noted the Bureau of Substance Abuse Services had been unable to document the number of sober houses, because even voluntary registration has been struck down by courts.[12]

Despite the absence of absolute data, public comment stated that there has been significant growth in the number of recovery residences in Florida.

However, at the time of writing, there is an insufficiently valid method from which to identify the number of recovery residences in the state.

[12] www.salemnews.com/local/x1856220496/Training-proposed-for-sober-house-operators, site accessed September 14, 2013.

VI. Survey of Legal Authority

This section of the report presents federal and state legal authority related to recovery residences.

Florida Authority

Pursuant to Florida Statute, the Department has statutory authority to license substance abuse treatment.[13] This includes both service providers,[14] and the programmatic elements of what constitutes substance abuse treatment.[15] In relation to behavioral health, there is currently no provision in Florida law that contemplates the registration or certification of facilities or providers. As a result, these are undefined terms in the operation of chapters 394, and 397, F.S.

Federal Authority

There are two federal statutes that are particularly relevant to this report. The Fair Housing Amendment Acts of 1988 (FHA),[16] and the Americans with Disabilities Act (ADA).[17] Both of these statutes provide the federal government with enforcement mechanisms to challenge a housing decision made by other governmental or private entities. In a private action, a plaintiff may bring suit for actual damages,[18] which include special damages,[19] and general damages for emotional pain and suffering attributable to the discriminatory practice.[20] Punitive damages may also be awarded.[21] Equitable remedies are also available to the court.[22] In addition to this, the court also has the discretion to award fees and costs.[23]

Specifically, the FHA prohibits discrimination on the basis of disability. This includes people in recovery from substance use disorders.[24] Disability, however, excludes some persons who continue to abuse substances, or has been convicted of manufacture or distribution of a controlled substance.[25]

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[13] *See,* s. 397.321(6), F.S. Note, the statutory provision requires the Department to license and regulate licensable service components, which are defined in s. 397.311(18), F.S. The Department has rule-making authority, as it relates to substance abuse licensing, and has promulgated rules in ch. 65D-30, F.A.C.

[14] Defined pursuant to s.397.311 (17), F.S.

[15] *See*, s. 397.311(18), F.S.

[16] The Fair Housing Act (FHA) was enacted by the Civil Rights Act of 1968, Pub. L. 90-284 (1968), amended by the Fair Housing Amendments Act of 1988, Pub. L. 100-430 (1988), codified at 42 U.S.C. s. 3601, *et. seq.* For the purposes of this report, the Fair Housing Act, and the Fair Housing Amendments Act are referred to as FHA.

[17] Title II of The Americans with Disabilities Act (ADA) prohibits the discrimination by public entities as it relates to housing on the basis of disability. The ADA was enacted by the Americans with Disabilities Act of 1990, Pub. L. 101-336 (1990), amended by the ADA Amendments Act of 2008, Pub. L. 110-325 (2008), codified at 42 U.S.C. s.12101, *et. seq.*

[18] 42 U.S.C. s. 3613(c).

[19] *See e.g., Douglas v. Metro Rental Services, Inc.,* 827 F. 2d 252 (7th Cir. 1987) (Court allowed recovery of expenses to find alternate residence); *Philips v. Hunter Trails Community Ass'n*., 685 F. 2d 184, (7th Cir. 1982) (Court allowed recovery of moving expenses); *Moore v. Townsend,* 577 F. 2d 424, (7th Cir. 1978)(Court allowed recovery of temporary lodgings); *Steele v. Title Realty Co.*, 478 F. 2d 380 (10th Cir. 1973) (Court allowed recovery of telephone charges).

[20] *See e.g., Steele,* 478 F. 2d 380.

[21] *Supra,* note 18.

[22] *Id.*

[23] *Id.*

[24] The ADA defines disability as:

> (A) A physical or mental impairment that substantially limits one or more of the major life activities of such individual;
> (B) A record of such impairment; or

The most significant affirmative obligation for a governmental entity of the FHA and ADA requires that a reasonable accommodation be made, when necessary to allow a person with a qualifying disability, equal opportunity to use and enjoy a dwelling.[26] There is an exception, for the health, safety and property of others. [27]

The FHA provides standing for a person to bring suit if they may be injured by a discriminatory housing practice.[28] Further, a third party may bring suit on behalf of a potential resident in a situation where said resident may be discriminated against.[29] It should be noted that the FHA does not appear require the exhaustion of alternative remedies prior to filing suit in federal court.[30] In addition to judicial action, an administrative complaint may be filed simultaneously with the United States Department of Housing and Urban Development (HUD).[31] HUD may refer cases to the United States Department of Justice (DOJ) to file suit in federal court.[32] The United States Attorney General may also bring an action in situations where a "pattern of discriminatory practice" may exist, and a private party whose interests have, or may be harmed, may petition to intervene.[33]

A violation of the FHA may also constitute a simultaneous violation of the ADA,[34] and the Rehabilitation Act.[35] The ADA also prohibits discrimination on the basis of a substantially limiting impairment.[36] Recovery from a substance use disorder has been considered such an impairment.[37]

(C) Being regarded as having such an impairment. *See*, 42 U.S.C. s. 3602(h).
The FHA defines disability in the same manner. *See,* 42 U.S.C. s. 12102(1). Federal courts have required a case by case inquiry as to the determination of disability. *See*, *Albertson's Inc. v. Kirkingburg*, 527 U.S. 555, (1999).

[25] Note, 28 C.F.R. s. 35.131, limits the extension of non-discriminatory practice to a person who may continue to use illicit substances. This does not include alcohol. A public entity is also permitted to test to verify this.

[26] *See,* 42 U.S.C. s. 3604(f)(3)(B); 42 U.S.C. s. 12131, *et. seq.,* 28 C.F.R. s. 35.130(b)(7). To comply with the reasonable accommodation provisions of the ADA, regulations have been promulgated for public entities (defined by 28 C.F.R. s. 35.104). This includes a self-evaluation plan of current policies and procedures and modify as needed (28 C.F.R. s. 35.105). This is subject to the exclusions of 28 C.F.R. s. 35.150. For interpretation by the judiciary, s*ee, Oxford House Inc., v. Township of Cherry Hill*, 799 F. Supp. 450, (D.N.J. 1992) (Court held that a reasonable accommodation means changing some rule that is generally applicable to everyone so as to make it less burdensome for a protected class).

[27] 42 U.S.C. s. 3604(f)(9).

[28] 42 U.S.C. s. 3602(i).

[29] *See e.g., Brandt v. Vill. of Chebanse, Ill.,* 82 F.3d 172, (7th Cir.1996); *Smith & Lee Assocs., Inc. v. City of Taylor, Mich.,* 102 F.3d 781 (6th Cir.1996). *But see, Kessler Institute for Rehabilitation, Inc. v. Mayor and Council of Borough of Essex Fells,* 876 F. Supp. 641, (D N.J. 1995) (Court held that a non-profit advocacy organization lacked standing to intervene).

[30] *See, e.g*., *Pulcinella v. Ridley Tp.*, 822 F. Supp. 204, (E.D. Pa. 1993); *Oxford House, Inc. v. City of Virginia Beach, Va*., 825 F. Supp. 1251, (E.D. Va. 1993); *Oak Ridge Care Center, Inc. v. Racine County, Wis.*, 896 F. Supp. 867, (E.D. Wis. 1995); *Oliver v. Foster,* 524 F. Supp. 927 (S.D. Tex. 1981); *Concerned Tenants Ass'n of Indian Trails Apartments v. Indian Trails Apartments,* 496 F. Supp. 522 (N.D. Ill. 1980).

[31] 42 U.S.C. s. 3610.

[32] This may occur when HUD refers administrative actions to federal court, 42 U.S.C. s. 3612(a), (o); or in cases that involve challenges to zoning or land use regulations, 42 U.S.C. s. 3610(g).

[33] 42 U.S.C. s. 3614.

[34] In matters of housing discrimination, federal district courts often analyze an alleged violation of the ADA and the FHA as one. *Caron Foundation of Florida, Inc., v. City of Delray Beach*, 879 F. Supp. 2d 1353, (S.D. Fla. 2012) appeal dismissed, (11th Circ. Aug. 16, 2012).

[35] The Rehabilitation Act of 1973 was enacted by the U.S. Rehabilitation Act of 1973, Pub. L. 93-112 (1973), codified at 29 U.S.C. s. 701 *et. seq*.

[36] S. Res. 933, 101st Cong. (1990) (enacted), provided clear direction in the title of the ADA as to Congressional intent: " To establish a clear and comprehensive prohibition of discrimination on the basis of disability."

[37] *See*, 28 C.F.R. s.35.104(4)(1)(B)(ii).

Authority from Other States

At the time of writing, the Department identified Idaho, Illinois, Massachusetts, Oregon, and Tennessee appear to provide a legal basis for the operation of a recovery residence, or an equivalent.[38] There have been a variety of legislative proposals to address regulatory involvement in relation to the operation of a recovery residence.[39]

In 2008, the Massachusetts Bureau of Substance Abuse Services (BSAS) asked sober house operators to voluntarily provide details to a state web-based treatment locator.[40] It should be noted that there does not appear to have been a statutory or regulatory basis for this request. At the time of publication, 50 facilities in the Commonwealth of Massachusetts have provided such information, with BSAS noting that the provision of information on its website does not represent a state license, nor endorsement of the facility.[41]

An alternative statutory construction used in Hawaii, Kansas and Oklahoma, is an explicit prohibition on a local government implementing ordinances or zoning schemes that discriminate against community based housing for people in recovery.[42] Although varying in construction between each state, the general theme has been to define what a recovery residence is, and to statutorily include such as a residence as a single family dwelling.

Case Law

A review of the website for the Civil Rights Division Housing and Civil Enforcement Section at DOJ demonstrates that the FHA and ADA are extensively litigated.[43] For a housing rule, policy or practice to be challenged pursuant to the FHA,[44] federal courts have not required that it be facially discriminatory, but have permitted a challenge on the basis of discriminatory intent, or that it has a disparate impact on people with disabilities.[45] Once a plaintiff has established a prima facie case of housing discrimination,

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[38] *See*, Idaho, IDAHO CODE ANN. 39-302 (11), (2013); Illinois, 20 ILL. COMP. STAT. 301/15-10(f) (2013); Massachusetts, MASS. GEN. LAWS ch. 111B, s. 6A, (2013); Oregon, OR. REV. STAT. s. 430.306(7), (2013); Tennessee, TENN. CODE ANN. S. 33-2-402(2), (2013).

[39] *See e.g.,* State Rep. Hennessey and State Sen. Zeldin of New York proposed A06791 and S04697, 2013-14 Sess. (N.Y. 2013), in the 2013 Legislative Session, a measure which established regulations pertaining to sober living homes. In Hawaii, State Reps. Carroll, Awana, Brower, Coffman, Evans, Kobayashi, Luke, McKelvey, Morikawa, Nakashima, Nishimoto, Woodson, Rhoads and Tokioka introduced H.C.R.200 and H161, 27th Sess. (Haw. 2013) in the 2013 Legislative Session to reconvene a taskforce to examine, among other factors, the impact of criminal justice housing.

[40] www.bostonherald.com/news_opinion/local_coverage/2007/07/health_dept_launches_online_sober_home_list, site accessed September 14, 2013. *See also, supra* note 10.

[41] *See,* www.helpline-online.com/reports/helpline_providers_yftyty3ooxy2yfajlmvcfd55.pdf, site accessed September 14, 2013.

[42] *See,* Hawaii, HAW. REV. STAT. s. 46-4, (2013); Kansas, KAN. STAT. ANN. s. 12-736, (2013); Oklahoma, OKLA. STAT. tit. 43A-3, s. 417.1, (2013).

[43] *See,* www.justice.gov/crt/about/hce/caselist.php , site accessed August 17, 2013.

[44] Specifically, 42 U.S.C. s. 3604(f).

[45] *See e.g., Bangerter v. Orem City Corp.,* 46 F.3d 1491, (10th Cir. 1995) (Plaintiff need not prove malice or discriminatory animus of defendant to make a case of intentional discrimination where the defendant expressly treats someone protected by the statute in a different manner than others); *Thornton v. City of Allegan,* 863 F. Supp. 504, (W.D. Mich. 1993) (Not required that the plaintiff prove discriminatory intent, it is sufficient if the plaintiff proves only that the defendant's action had a discriminatory impact or effect); *Potomac Group Home Corp. v. Montgomery County, Md*., 823 F. Supp. 1285, (D. Md. 1993) (Court held plaintiff may prevail by showing discriminatory intent or by showing discriminatory impact, and that to prove discriminatory intent, the plaintiff need only show that the handicap of a member of a protected group was in some part the basis of the policy being challenged). *But see, Jeffrey O. v. City of Boca Raton*, 511 F. Supp. 2d 1339, 1352, (S.D. Fla. 2007) (Court

federal courts shift the burden to the defendant to demonstrate a legitimate, nondiscriminatory reason, or that the action furthered a legitimate governmental interest, with no alternative.[46] The courts have, however, held that disability does not require a heighted level of scrutiny for governmental action, in the context of the FHA.[47]

The FHA provides justifications for housing restrictions that federal courts have narrowly construed. A governmental entity may act on the basis of protecting the public health and safety of other individuals.[48] However, courts have observed that this justification may not be used as a guise to impose additional restrictions on protected classes under the FHA.[49] Additionally, a threat to the public health and safety, or another's property requires objective evidence that is sufficiently recent to be credible and not unsubstantiated inferences.[50] The action of a governmental entity may also be justified if the restriction is found to be beneficial or benign.[51]

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held that the 11th Circuit had not adopted a standard to determine disparate impact, and did not find the city meet the justifications of *Bangerter*, 46 F.3d 1491).

[46] *See e.g., Tsombandis v. West Haven Fire Dept.,* 180 F. Supp. 2d 262 (D. Conn. 2001), order aff'd in part, rev'd in part on other grounds, 352 F.3d 565, (2d Cir. 2003) (Court held that governmental entity engages in discriminatory practice by refusing to make reasonable accommodations to action); *U.S. v. City of Taylor, MI*., 13 F.3d 920, (6th Cir. 1993), reh'g and suggestion for reh'g en banc denied, (Mar. 11, 1994) and on remand to, 872 F. Supp. 423, (E.D. Mich. 1995), aff'd in part on other grounds, rev'd in part on other grounds, 102 F.3d 781, (6th Cir. 1996) (Court held it is not necessary for plaintiff to prove discriminatory intent motivated by animus); *Human Resource Research and Management Group, Inc. v. County of Suffolk*, 687 F. Supp. 2d 237 (E.D. N.Y. 2010) (Plaintiff can establish discrimination in the form of: (1) disparate treatment or intentional discrimination; (2) disparate impact of a law, practice, or policy on a covered group; or (3) by demonstrating that the defendant failed to make reasonable accommodation to afford people with disabilities an equal opportunity to live in a dwelling).

[47] *See e.g., Familystyle of St. Paul, Inc. v. City of St. Paul, Minn.,* 923 F.2d 91 (8th Cir. 1991), reh'g denied, (Feb. 15, 1991) (Court held that the relevant question is whether legislation is rationally related to legitimate government purpose); *Pulcinella*, 822 F. Supp. 204, (Court held that violation of FHAA would not amount to a Constitutional violation, because disability does not give rise to constitutionally protected class under the Equal Protection or Due Process clause of the Fourteenth Amendment). *But see, Bangerter,* 46 F. 3d 1491, (Court held that the inability to assert a right under the Fourteenth Amendment is not of concern, because the FHA provided a basis to determine the justification of a restriction on housing for the disabled).

[48] 42 U.S.C. s. 3604(f)(9).

[49] *See e.g., Bangerter,* 46 F.3d 1491, (Any requirements placed on housing for a protected class based on the protection of the class must be tailored to needs or abilities associated with particular kinds of disabilities, and must have a necessary correlation to the actual abilities of the persons upon whom they are imposed); *Association for Advancement of the Mentally Handicapped, Inc. v. City of Elizabeth,* 876 F. Supp. 614, (D.N.J. 1994) (Court held state and local governments have the authority to protect safety and health, but that authority may be used to restrict the ability of protected classes to live in the community); *Pulcinella*, 822 F. Supp. 204, (Special conditions may not be imposed under the pretext of health and safety concerns).

[50] *See, Oconomowoc Residential Programs, Inc., v. City of Milwaukee*, 300 F. 3d 775, (7th Cir. 2002) (Denial for a variance due to purported health and safety concerns for the disabled adults could not be based on blanket stereotypes); *Oxford House-Evergreen v. City of Plainfield,* 769 F. Supp. 1329 (D.N.J. 1991) (Generalized assumptions, subjective fears and speculation are insufficient to prove direct threat to others), *Cason v. Rochester Housing Authority,* 748 F. Supp. 1002, (W.D.N.Y. 1990). *But see*, *Roe v. Housing Authority of City of Boulder,* 909 F. Supp. 814, (D. Colo. 1995) (Court held that no reasonable accommodation could be made to house individual with mental illness, and eviction was justified); *Foster v. Tinnea*, 705 So. 2d 782 (La. Ct. App. 1st Cir. 1997) (Court upheld an eviction, on the basis of evidence showing that tenants' son posed a threat to others).

[51] *See e.g.,* Smith & Lee Associates, Inc. v. City of Taylor, Mich., 102 F.3d 781, (6th Cir. 1996) (Court held that unlawful discrimination often takes the form of special rules that are allegedly designed to benefit handicapped persons); *Horizon House Developmental Services, Inc. v. Township of Upper Southampton,* 804 F. Supp. 683 (E.D. Pa. 1992), judgment aff'd without discussion, 995 F.2d 217 (3d Cir. 1993) (Court held that the motives of the drafters of an ordinance which is facially discriminatory, whether benign or evil, are irrelevant to a determination of the lawfulness of the ordinance); *Familystyle of St. Paul, Inc,* 923 F.2d 91, (The court noted that spacing requirement served a valid and legitimate goal of the state and the city by addressing the need to provide services for the mentally disabled in mainstream community settings and by guaranteeing that facilities are located in the community); *Valley Housing LP v. City of Derby*, 802 F. Supp. 2d 359 (D. Conn. 2011) (Court held that claim of non-discriminatory zoning enforcement was a pretext for discrimination); *U.S. v. Borough of Audubon, N.J.,* 797 F. Supp. 353 (D.N.J. 1991), judgment aff'd without discussion, 968 F.2d 14(3d Cir. 1992) (Court held that a municipality applying restrictive zoning classification to preclude the establishment of a group home for recovering alcoholics and drug users cannot avoid a violation by arguing that its actions were merely a response to community sentiment). *But see, Oxford House-C v. City of*

As noted, the FHA does not expressly invalidate the action of a governmental entity in relation to housing, so long as the action grants, guarantees, or protects the same rights.[52] Federal courts have expressed this rationale in case law, noting that an act, ordinance or zoning decision may not single out the disabled, and apply different and unique rules to housing, when compared to the general population.[53]

A Nevada state statute that established a statewide registry for group homes that was intended to be used for police and fire services, and would be made available to the public, was invalidated by the courts.[54] In addition to state law, federal courts have also invalidated a variety of requirements from local governments that would function essentially as a registry of housing for protected classes, finding that the need to know where such facilities are located is, by itself not a legitimate government interest.[55] This has included regulatory devices such as permits, registration requirements, background checks for operators, occupancy restrictions, and inspection requirements.[56]

Federal courts have held that the FHA was intended by Congress to have a broad reach for liability. This includes not only the actors directly involved in a real estate transaction, but also actors that affect the availability of housing.[57] It should also be noted that federal courts have held governmental officials personally liable for decisions that violate the FHA.[58]

In relation to housing for residents in recovery from substance abuse, or mental illness, federal courts have found that halfway houses, group homes, sober houses or other community housing arrangements

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St Louis, 843 F. Supp. 1556, (E.D. Mo. 1994), judgment rev'd on other grounds, 77 F. 3d 249, (8th Cir. 1996), cert. denied, 117 S. Ct. 65, (U.S. 1996) (Court upheld legitimate government interest in decreasing congestion, traffic and noise in residential areas).

[52] 42 U.S.C. s. 3615.

[53] *See e.g., Bangerter,* 46 F. 3d 1491, n. 1., (Invalidating and act and ordinance that facially singles out the handicapped, and applies different and unique rules to them); *Human Resource Research and Management Group,* 687 F. Supp. 2d 237, (It is undisputed that [the ordinance] is discriminatory on its face, in that it imposes restrictions and limitations solely upon a class of disabled individuals); *Potomac Group Home, Inc.,* 823 F. Supp. 1285, (No other county law or regulation imposed any similar requirement on a residence to be occupied by adult persons who do not have disabilities).

[54] *Nevada Fair Housing Center, Inc., v. Clark County, et. al.,* 565 F. Supp. 2d 1178, (D. Nev. 2008) (Invalidating state statute requiring Nevada State Health Department to operate a registry of group homes).

[55] *See, Human Resource Research and Management Group,* 687 F. Supp. 2d 237, (Court held that defendant-city failed to show that the requirement of registration, inspection and background checks was narrowly tailored to support a legitimate government interest); *Community Housing Trust et. al., v. Department of Consumer and Regulatory Affairs et. al.,* 257 F. Supp. 2d 208, (D.C. Cir. 2003) (Court held that the zoning administrators classification of plaintiff-facility, requiring a certificate of occupancy rose to discriminatory practice under FHA).

[56] *See*, e.g., *City of Edmonds v. Oxford House et. al.,* 574 U.S. 725 (1995) (City's restriction on composition of family violated FHAA); *Safe Haven Sober Houses LLC, et. al., v. City of Boston, et. al.,* 517 F. Supp. 2d 557, (D. Mass. 2007); *United States v. City of Chicago Heights*, 161 F. Supp. 2d 819, (N.D. Ill. 2001)(City violated FHA by requiring inspection for protected class housing that was not narrowly tailored to the protection of disabled); *Human Resource Research and Management Group,* 687 F. Supp. 2d 237, (Court held that the city's purported interest in the number of facilities, in relation to the zoning plan, was not a legitimate government interest. Further to this, the court found that there was insufficient evidence to justify action by the city in relation to the protection of this class. The city also failed to justify the requirement for a 24 hour staff member, certified by the New York State Office of Alcoholism and Substance Abuse Services).

[57] *See e.g. Michigan Protection and Advocacy Service, Inc. v. Babin*, 18 F.3d 337, (6th Cir. 1994), *City of Peeskill v. Rehabilitation Support Services, Inc.,* 806 F. Supp. 1147, (S.D.N.Y. 1992) (Court held that city seeking to prevent the acquisition of a building to be used as transitional living violated FHA and state law).

[58] *See e.g. Samaritan Inns. V. District of Columbia,* 114 F. 3d. 1227, (D.C. Cir. 1997) (Court held that officials reversing decision based on public pressure were not entitled to qualified immunity). *But see*, *O'Neal by Boyd v. Alabama Dept. of Public Health*, 926 F. Supp. 1368, (M.D. Ala. 1993) (Court held that state officials are entitled to immunity when conduct does not violate established statutory or constitutional rights that a reasonable person would have known).

used as residences were dwellings, and as such protected by the FHA.[59] As a protected class, federal courts have held that conditions placed on housing for people in recovery from either state or sub-state entities, such as licenses or conditional use permits, may in application be overbroad and result in violations of the FHA and ADA.[60] Further to this, federal courts have enjoined state action that is predicated on discriminatory local government decisions.[61] It should be noted, that in the context of deinstitutionalization[62] for people with mental illness, the Eighth Circuit Court of Appeals held that Congress did not intend for the FHA to contribute to the segregation of the mentally ill from mainstream society.[63] The court further recognized the legitimate and necessary role of the state in licensing services for the mentally ill.[64] However, this recognition was construed within the context of the state's legitimate interest to place mentally ill people in the least restrictive environment available.[65]

In Florida, the most recognized case is that of *Jeffrey O. v. City of Boca Raton.*[66] An ordinance related to the location of treatment facilities of promulgated by the City of Boca Raton, was held to be

[59] *See*, *Connecticut Hosp. v. City of New London,* 129 F. Supp. 2d 123, (D. Conn. 2001).

[60] *See e.g., Oxford House-C,* 843 F. Supp. 1556, (Court held that city singled out plaintiffs for zoning enforcement and inspections, on the basis of disability, plaintiff demonstrated city was ignoring zoning violations from people without disabilities); *Marbrunak v. City of Stow, OH.,* 947 F. 2d 43, (6th Cir. 1992) (Court held conditional use permit requiring health and safety protections was an onerous burden); *U.S. v. City of Baltimore, MD,* 845 F. Supp. 2d. 640 (D. Md. 2012) (Court held that conditional ordinance was overbroad and discriminatory); *Children's Alliance v. City of Bellevue*, 950 F. Supp. 1491, (W.D. Wash. 1997) (Court held zoning scheme establishing classes of facilities was overbroad, and created an undue burden on a protected class); *Oxford House-Evergreen,* 769 F. Supp. 1329, (Court held that refusal to issue permit was based on opposition of neighbors, not on protection of health and safety as claimed); *Potomac Group Home, Inc.,* 823 F. Supp. 1285, (Court held that county requirement for evaluation of program offered at facility at public board. At review board, decisions were based on non-programmatic factors, such as neighbor concerns. Further to this, the court held that the requirement to notify neighboring property and enumerated civic organizations violated the FHA). *But see, U.S. v. Village of Palatine, Ill,* 37 F. 3d 1230, (7th Cir. 1994) (Court held village did not fail to make reasonable accommodation because plaintiff never applied for a special use permit); *Association for* Advancement, 876 F. Supp. 614, (Court dismissed argument that dispersal requirement protected governmental interest in preserving residential character of neighborhood); *Oxford House, Inc. v. City of Virginia Beach, Va.,* 825 F. Supp. 1251, (E.D. Va. 1993) (Court held that public appeal process to denial of permit was reasonable accommodation), *City of St. Joseph v. Preferred Family Healthcare, Inc.,* 859 S.W.2d 723, 2 A.D.D. 1335 (Mo. Ct. App. W.D. 1993), reh'g or transfer denied, (July 27, 1993) and transfer denied, (Sept. 28, 1993) (Court upheld ordinance limiting the number of unrelated people living together, emphasizing ordinance applied equally to all).

[61] *See e.g., Larkin v. State of Mich.* 883 F. Supp. 172, (E.D. Mich. 1994), judgment aff'd 89 F. 3 d 285, (6th Cir. 1996) (Court held there was no rational basis for denial of license on the basis of dispersal requirement, and local government's refusal to permit. The court did find, however, that the city was not a party to the law suit because the state statute did not mandate a variance); *Arc of New Jersey, Inc., v. State of N.J.* 950 F. Supp. 637, D.N.J. 1996) (Court held that municipal land use law, including conditional use, spacing and ceiling quotas violated FHA). *But see, Charter Tp. of Plymouth v. Department of Social Services*, 503 N.W. 2d 449 (Mich. 1993) (Court held statute did not violate FHA because it did not prohibit protected class from obtaining housing); *Familystyle of St. Paul, Inc.* 923 F. 2d 91, (Court upheld state and local action on the basis of deinstitutionalizing protected class). *But see, North Shore-Chicago Rehabilitation Inc. v. Village of Skokie*, 827 F. Supp. 497, (N.D. Ill. 1993) (Court held that municipalities could not rely on the absence of a state licensing scheme to deny an occupancy permit); *Easter Seal Soc. of New Jersey, Inc. v. Township of North Bergen,* 798 F. Supp. 228 (D.N.J. 1992) (Court held that city denial of permit on the basis of failure to obtain state license was due to the city's discriminatory enforcement of zoning enforcement); *Ardmore, Inc. v. City of Akron*, Ohio, 1990 WL 385236 (N.D. Ohio 1990) (Court held granted a preliminary injunction against the enforcement of an ordinance requiring conditional use permit, even though it was applied to everyone, because Congress intended to protect the rights of disabled individuals to obtain housing).

[62] See, *Olmstead v. L.C.,* 527 U.S. 581 (1999) (Court held that unjustified segregation of persons with disabilities constituted violation of the ADA); *Familystyle of St. Paul, Inc.* 923 F. 2d 91, 92.

[63] *Familystyle of St. Paul, Inc.* 923 F. 2d 91*,* at 94.

[64] *Id.*

[65] The court noted that deinstitutionalization of mentally ill adults was of special concern to the state of Minnesota. *Id,* at 92.

[66] 511 F. Supp. 2d 1339, (Note, in this case, the City was held liable for the plaintiff's attorney fees of more than $3 million). There are other sober homes in the state that have been litigated, and have included the imposition of damages for local governments. *See also, Tracey P. et. al. v. Sarasota County et. al.,* 8:05-cv-927-T-27EAJ, (M.D. Fla., 2007) (Settled for $750,000).

discriminatory to people in recovery for substance use disorders.[67] The court, found that the city had not demonstrated that there was no less discriminatory alternative means to further a legitimate government interest.[68] Further to this, the court held that the City did not establish a procedure for a reasonable accommodation to the zoning schema, which pursuant to both the FHA and ADA, it had an affirmative duty to do.[69]

[67] Specifically the court found that the language singled out recovering individuals who would be residing in a substance abuse treatment facility. *Id* at 1349.
[68] The court held that although the city had a legitimate interest in preservation of residential character, however, it did not demonstrate that there was a less discriminatory definition of family. *Id* at 1353.
[69] *Id. See supra* note 26.

VII. Issues Related to Recovery Residences

To identify issues related to recovery residences, this section presents both a research review as well as issues identified by members of the public.

At the outset, it should be noted that there is no Florida specific published and peer-reviewed research that relates to the operation of recovery residences. However, there is a body of relevant research that has been conducted, that is presented here. These studies are limited by various methodological weaknesses such as small sample sizes or low response rates. Since this report is not intended to provide a methodological critique of all the relevant literature, readers are advised to consult the original source material for more detailed discussions of the strengths or weaknesses of the various research designs. [70]

Research Review

In an explanatory study, researchers studied 132 men from eleven recovery residences in Illinois. Initial interviews were conducted with individuals who had been a resident for at least two weeks, but no more than six weeks. Only forty-eight participants provided data at a second follow-up interview six months later. The following general trends were reported with regard to negative experiences by respondents:

- Around a third reported "personality conflicts."
- Approximately twenty percent reported a "lack of cooperation among members."
- Almost thirteen percent reported "cramped living space."
- Almost thirteen percent reported "personal financial troubles."
- About ten percent reported an "overly structured/authoritarian setting."
- Less than ten percent experienced an "unstructured and poorly governed setting."[71]

Researchers interviewed sixty-four individuals from randomly selected houses in northern Illinois that were in proximity to a recovery residence. Half of the houses were directly next to a recovery residence, and the other half were one block away. They found that residents in almost seventy percent of houses next to recovery residence knew of the existence of it, compared to less than ten percent of people from the houses that were a block away. Qualitative data was collected from the twenty-five residents who knew of its existence. When asked if they had any concerns about its location in their neighborhood, the following responses were obtained:

- Twenty-one said no.[72]
- Four said yes.[73]

[70] An epistemological deconstruction of the framework each researcher has used is for the purposes of this report outside the scope of proviso. *See e.g.,* I. Vasilachis de Gialdino, *Ontological and Epistemological Foundations of Qualitative Research,* 10, Forum: Qualitative Social Research, 2, (2009).

[71] L. Jason, J. Ferrari, B. Smith, P. Marsh, P. Dvorchak, E. Groessl, M. Pechota, M. Curtin, P. Bishop, E. Kot, and B. Bowdin, *Explanatory Study of Male Recovering Substance Abusers Living in a Self-Help, Self-Governed Setting,* 24 Journal of Mental Health Administration (3), (1997), at 332–339.

[72] Neighbors commented, for example: "Guys are friendly."; "They just proved to be good neighbors."; "No trouble from them." L. Jason, K. Roberts, and B. Olson, *Attitudes Toward Recovery Homes and Residents: Does Proximity Make a Difference?* 33 Journal of Community Psychology (5), (2005), at 529-535. [hereinafter, Jason, *Proximity (2005)*].

When these residents were asked if they could see any benefits to having the residence in their neighborhood, they provided the following responses:

- Seventeen responded yes.[74]
- Eight did not know of any benefits.[75]

Researchers physically inspected eleven recovery residences for women and forty-four for men in 2002 in Virginia, Illinois, and Hawaii. An intoxicated or impaired person present was identified near[76] and less than two percent of houses and a drug dealer was identified as "present" near less than four percent of houses. The physical location of bars or pubs nearby occurred in less than a third of houses.[77]

In 2008, researchers contacted ninety recovery residence landlords and solicited their participation in a voluntary and anonymous survey.[78] Responses were received from thirty landlords, including eighteen who rented solely to recovery residences and twelve who rented to both, and other tenants. All landlords indicated that residents paid rent on time and kept the property in good physical condition and that recovery residences appeared to be better maintained compared to others on their blocks. Many of the surveyed landlords indicated that residents built positive relationships with neighbors and those recovery residences had suitable furnishings and window coverings. Additionally, according to landlords who were renting to recovery residences and other renters, excessive noise, rent payment, landlord-tenant communication, and pet problems were less of a problem with them compared to other renters. The most common negative themes mentioned wear and tear on the property and potential problems with the neighbors.[79]

While not directly related to the question of the impact of a recovery residence, Taniguchi[80] concluded in the context of a study of the location of alcohol and drug treatment facilities in Philadelphia, PA, that the answer was at best equivocal.

> These findings may not sit well with people looking for clear cut answers regarding the criminogenic impact of treatment facilities. At best, it is possible to say that treatment providers are not unilaterally bad neighbors and that in certain areas these facilities may be associated with lower crime in the surrounding areas. This must be balanced with the fact that these same facilities may, under certain circumstances, also be criminogenic.

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[73] Neighbors commented, for example: "Sometimes cars block my driveway, only when first opened, no problems now."; "Sometimes a lot of new faces."; "Louder, more people on street." *Id.*

[74] Neighbors commented, for example: "Good lookouts, watch everything."; "Upkeep of outside is good."; "No drugs, no parties going on."; "Take care of property well outside"; "My son plays basketball with guys out in their yard, keeps them out of trouble."; "Glad to see it's being done to rehabilitate women, especially who have children."; "They keep up the yard better than last owner." *Id.*

[75] *Id.*

[76] Near was defined as within half a mile. J. Ferrari, L. Jason, R. Blake, M. Davis, and B. Olson, *"This is My Neighborhood": Comparing United States and Australian Oxford House Neighborhoods,* 31 Journal of Prevention & Intervention in the Community, (1/2), (2006), at 41-49. [hereinafter, Jason, et. al., *Neighborhood (2006)*].

[77] *Id.*

[78] J. Ferrari, D. Aase, D. Mueller, and L. Jason, *Landlords of Self-Governed Recovery Homes: An Initial Exploration of Attitudes, Opinions, and Motivation to Serve Others*, 41 *Journal of Psychoactive Drugs,*(4),(2009), 349-354.

[79] *Id*.

[80] T. Taniguchi, and C. Salvatore, *Exploring the Relationship Between Drug and Alcohol Treatment Facilities and Violent and Property Crime: A Socioeconomic Contingent Relationship,* 25 Security Journal 2, (2012), 95-115.

> Further research would be wise to investigate the dynamics that are underlying these results.[81]

In a 2010 article dealing with the applicability of the FHA to recovery residences, Gorman has noted that the implementation of the sober living home model is inherently diverse, and as a result of this, is easily abused by landlords.[82] In addition to this, the article observes that a local government must balance their response to public outrage at the siting of a residence, and proposed steps to limit the establishment of sober living facilities that do not violate the obligation to maintain adequate affordable housing.[83] Gorman observes that although much has been "fleshed out" in sober living home litigation, however, many questions are still to be answered by judicial interpretation.[84]

In a substantially similar California Bar Journal article, Gorman noted:

> [S]ober living facilities typically involve two competing interests: (1) the interests of individuals recovering from addiction, often represented by landowners or organizations which provide addiction recovery services; versus (2) the interests of residents who seek to preserve the "family-friendly" character of their neighborhoods, often represented by city attorneys, county counsel or other public agency attorneys (or attorneys hired by citizen groups opposed to sober living facilities in their neighborhoods.) These disputes arise after a claimed sober living home is established in a single family residential neighborhood, bringing with it unfamiliar and seemingly unrelated faces living together, congregating on porches and front yards, or wandering nearby streets. Disturbances arise, eventually leading to phone calls to the police, complaints to the local officials, and ultimately demands [to] the city or county to intervene and shut down the sober living home.[85]

In a 2010 report to the General Court of Massachusetts, in a Legislative requirement to study sober houses in the Commonwealth, the Massachusetts Bureau of Substance Abuse Services (BSAS) noted that:

> [The Bureau] is aware of the numerous complaints received regarding ADF Housing operators. These complaints have been lodged by residents of ADF Housing, neighbors and municipal officials. The nature of complaints range from nuisance complaints (noise) to more serious complaints regarding substandard housing conditions, alcohol and drug use on the property, and fatal and non-fatal overdoses of residents. Although BSAS has received frequent complaints about ADF Housing, the majority of complaints are in reference to only a few ADF homes relative to the number of homes that exist in the Commonwealth. In other words, there are many complaints about a few homes and no complaints about the vast majority of others.[86]

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[81] *Id,* at 111.
[82] M. Gorman, A. Marinaccio, and C. Cardinale, *Fair Housing for Sober Living: How the Fair Housing Act Addresses Recovery Homes for Drug and Alcohol Addiction*, 42 The Urban Lawyer 3, (Summer 2010), 607-614, at 608.
[83] *Id,* at 614.
[84] *Id.*
[85] M. Gorman, A. Marinaccio, and C. Cardinale, *Alcoholism, Drug Addiction, and the Right to Fair Housing: How the Fair Housing Act Applies to Sober Living Homes*, 33 The Public Law Journal 2, (Spring 2010), 13-20, at 16.
[86] *Supra*, note 10.

BSAS also noted that it was not possible to comprehensively document or quantify the impact of recovery residences on residents, neighborhoods and local municipalities. This is for two reasons:

- Depending on the nature of the complaint, the avenue for resolution was with various local or state agencies; and
- There is no central repository of substantiated complaints.[87]

Further to this, it was concluded that it was unlikely a state law requiring registration, or tracking the complaints for recovery residences would be permissible pursuant to the FHA.[88]

Florida Public Comment

In public comment directed to the Department, through either email or the website, many of the people responding indicated clearly that they did not want recovery residences in their neighborhoods.[89] From these comments, there were several themes of concern:

- The safety of residents;
- The safety of neighborhoods; and
- The lack of governmental oversight.[90]

At public meetings, participants raised the following concerns:

- Residents being evicted with little or no notice.
- Drug testing might be a necessary part of compliance monitoring.
- Unscrupulous landlords, including an alleged sexual offender who was running a woman's program.
- Recovery residence owned by a bar owner and attached to the bar.
- Residents dying in recovery residences.
- Lack of regulation and harm to neighborhoods
- Whether state agencies have the resources to enforce regulations and adequately regulate these homes.
- Land use problems, and nuisance issues caused by visitors at recovery residences, including issues with trash, noise, fights, petty crimes, substandard maintenance, and parking.
- Mismanagement of resident moneys or medication.
- Treatment providers that will refer people to any recovery residence.
- Lack of security at recovery residences and abuse of residents.
- The need for background checks.
- The number of residents living in some recovery residences and the living conditions in these recovery residences.
- Activities going on in recovery residences that require adherence to medical standards and that treatment services may be provided to clients in recovery residences. This included acupuncture and urine tests.
- Houses being advertised as treatment facilities and marketed as the entry point for treatment rather than as a supportive service for individuals who are exiting treatment.
- False advertising.
- Medical tourism.

[87] *Id.*
[88] *Id.* Refer also to section VI of this report. *See e.g., supra* note, 54.
[89] As an illustration, see Appendix 5.
[90] *See,* Appendix 1.

- The allegation that medical providers capable of ordering medical tests, and billing insurance companies were doing so unlawfully.
- Lack of uniformity in standards.
- Alleged patient brokering, in violation of Florida Statute.[91]

Concerns were also raised in written responses to the Department. Two cities in South Florida that were well represented were Port St. Lucie and Delray Beach. According to the city of Port St. Lucie, regulation or certification is needed to "ensure that operators of the facilities have the adequate training and experience to provide the services which are needed to assist in the recovery process." They also indicated that without regulation or certification "some of them will be nothing more than a boarding house facility."[92]

According to the city of Delray Beach, "we have seen far too many of these residents evicted at all hours, subjected to abusive behavior and worse." They indicate that recovery residences should be required to demonstrate "compliance with life safety standards for the residences and have background check requirements for the operators." They also raised the following concerns:

> The lack of state oversight and regulation has made sober house tenants the target of unscrupulous landlords who prey on tenants/residents by 'flipping' the same bed, insisting on several months' rent up front, and then evicting someone for rules violations, and re-renting the same room/bed. Some owners put "rule-breakers" out on the curb, with no alternative housing, which often leads to an increase in homelessness and crime. Even worse is that there have been situations where the operator is a newly recovered individual who begins using drugs/alcohol again and the whole house ends up in disarray. Further, some operators have criminal backgrounds as sexual offenders...In Delray Beach, we had a problem with women being sexually assaulted by the operator of the house that is supposed to be a safe haven. We also have a sober house attached, owned, and operated by the same owner as the adjacent bar…[I]n Delray Beach we have had people die in sober houses due to lack of state oversight or regulation…There seems to be a lot of insurance fraud occurring within these homes whereby they are charging obscene amounts of money for simple procedures such as urine tests. This is simply another way that the operators abuse their tenants/patients and use this vulnerable population to maximize profits.[93]

[91] *See,* www.dcf.state.fl.us/programs/samh/docs/RRPublicMeetings2013/20130710RecoveryResidencePublicMeetingMinReco.pdf; www.dcf.state.fl.us/programs/samh/docs/RRPublicMeetings2013/20130626RecoveryResidencePublicMeetingMinutes.pdf; http://www.myflfamilies.com/service-programs/substance-abuse/recovery-response-2013, site accessed August 18, 2013. [hereinafter, *Appendices (2013)*].
[92] *See, Port St. Lucie Response,* Appendix 3.
[93] *See, City of Delray Beach Response,* Appendix 3.

VIII. Benefits of Recovery Residences

This section outlines the impact of recovery residences to the treatment of substance use disorders,[94] and neighborhoods.

As noted previously, there appears to be no Florida specific published and peer-reviewed research that relates to recovery residences. However, there is a body of relevant research that has been conducted, that is presented here.

Treatment

A common theme from the definition of recovery residences in other states, and the research, is that they do not provide substance abuse services on site. As such, this report examines the efficacy of recovery residences as a component of a continuum to support abstinence and recovery from substance use disorders. National research has demonstrated that a variety of psychosocial interventions and medications can effectively treat substance use disorders and reduce use.[95]

Jason, Davis, and Ferrari collected baseline data on 897 people from 169 Oxford Houses.[96] They also collected three subsequent waves of data at four month intervals. Only 607 participants from the initial measurement wave remained in the study at wave four. Of this group, around fourteen percent reported having used either drugs or alcohol at the final assessment. The average number of days they used alcohol was less than four and the number of days they used other drugs was less than six. Self-

[94] Note, the proviso directed the report to examine alcoholism, however, the Diagnostic and Statistical Manual, Fifth Edition (DSM-5) of the American Psychiatric Association classifies alcohol as a substance in the broader diagnostic cluster of substance related disorders. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders,* (5th. Ed., 2013).

[95] *See e.g.,* R. Miller, and P. Wilbourne, *Mesa Grande: A Methodological Analysis of Clinical Trials of Treatments for Alcohol Use Disorders,* 97 Addiction (3), (2002) 265-277; A. McRae, A. Budney, and K. Brady, *Treatment of Marijuana Dependence: A Review of the Literature,* 24 Journal of Substance Abuse Treatment, (2003) 369-376; M. Prendergast, D. Podus, E. Chang, and D. Urada, *The Effectiveness of Drug Abuse Treatment: A Meta-Analysis of a Comparison Group Studies,* 67 Drug and Alcohol Dependence, (2002), 53-72; D. Lai, K. Cahill, Y. Qin, and J. Tang, *Motivational Interviewing for Smoking Cessation*, 1 Cochrane Database of Systematic Reviews, (2010); E. Whitlock, M. Polen, C. Green, T. Orleans, and J. Klein, *Behavioral Counseling Interventions in Primary Care to Reduce Risky/Harmful Alcohol Use by Adults: A Summary of the Evidence for the U.S. Preventive Services Task Force,* 140 Annals of Internal Medicine(7), (2004), 557-568; L Amato, S. Minozzi, M. Davoli, S. Vecchi, M. Ferri, and S. Mayet, *Psychosocial and Pharmacological Treatments Versus Pharmacological Treatments for Opioid Detoxification,* 4 Cochrane Database of Systematic Reviews, (2009); O. Mitchell, D. Wilson, and D. MacKenzie, *The Effectiveness of Incarceration-Based Drug Treatment on Criminal Behavior*, 11 Campbell Systematic Review, (2006); M. Ojmarrh, D. Wilson, and D. MacKenzie, *Does Incarceration-Based Drug Treatment Reduce Recidivism? A Meta-Analytic Synthesis of the Research,* 3 Journal of Experimental Criminology, (2007), 353-375; M. Prendergast, D. Podus, J. Finney, L. Greenwell, and J. Roll, *Contingency Management for Treatment of Substance Use Disorders: A Meta-Analysis,* 101 Addiction, (2006), 1546-1560; J. Irvin, C. Bowers, M. Dunn, and M. Wang, *Efficacy of Relapse Prevention: A Meta-Analytic Review*, 67 Journal of Consulting and Clinical Psychology (4), (1999), 563-570; J. Hettema, J. Steele, and W. Miller, *Motivational Interviewing,* 1 Annual Review of Clinical Psychology, (2005), 91-111; N. Egli, M. Pina, P. Christensen, M. Aebi, and M. Killias, *Effects of Drug Substitution Programs on Offending Among Drug-Addicts*, 3 Campbell Systematic Reviews, (2009); R. Mattick, C. Breen, J. Kimber, and M. Davoli, *Methadone Maintenance Versus No Opioid Replacement Therapy for Opioid Dependence*. 2 Cochrane Database of Systematic Reviews, (2009); M. Gossop, J. Marsden, D. Stewart, and T. Kidd, *The National Treatment Outcome Research Study (NTORS): 4-5 Year Follow-Up Results*, 98 Addiction, (2003), 291-303.

[96] L. Jason, M. Davis, and J. Ferrari, *The Need for Substance Abuse Aftercare: Longitudinal Analysis of Oxford House,* 32 Addictive Behaviors (4), (2007), at 803-818.

efficacy for remaining abstinent from alcohol and other drugs and the percent of participants' social network members who were abstinent or in recovery increased significantly. Additional models controlling for a variety of factors found that length of residency in Oxford House was a significant predictor of abstinence and abstinence self-efficacy. Abstinence self-efficacy was a significant predictor of abstinence. It should be noted that less than a third of the sample remained in an Oxford House throughout the entire study. The remainder left by waves two, three, or four. Compared to participants who stayed in Oxford House across all four waves, individuals who left earlier had higher rates of any substance use over the last ninety days at wave four. This means that over eighty percent of those who left the house and were interviewed at the final wave remained consistently abstinent.[97]

Outcomes Across Wave 1 Through 4				
	Wave 1	Wave 2	Wave 3	Wave 4
% who used alcohol or other drugs	15.7	10.5	9.7	13.5
% who used alcohol	10.1	5.0	7.7	10.3
% who used other drugs	13.3	9.0	7.0	9.8
Days consumed alcohol	2.2	1.4	1.8	3.7**
Days used other drugs	5.5	3.7	2.3	5.6**
Days paid for work	42.0	49.8	50.5	48.4**
Employment income	794.0			941.9**
Total monthly income	981.8			1133.7**
Alcohol abstinence self-efficacy	80.7	80.4	79.3	84.6**
Drug abstinence self-efficacy	80.4	80.8	81.1	84.6**
% of social network abstinent/in recovery for alcohol use	75.0	79.0	79.0	77.0**
% of social network abstinent/in recovery for drug use	90.%	94.0%	94.0%	93.0%**

** $p \leq 0.01$, two-tailed, based on repeated measures analyses[98]

In an Illinois study, researchers noted:

> [T]hose in the Oxford Houses… had significantly lower substance use (31.3% vs. 64.8%), significantly higher monthly income ($989.40 vs. $440.00), and significantly lower incarceration rates (3% vs. 9%). Oxford House participants, by month 24, earned roughly

[97] *Id.*
[98] *Id.*

> $550 more per month than participants in the usual-care group. In a single year, the income difference for the entire Oxford House sample corresponds to approximately $494,000 in additional production. In 2002, the state of Illinois spent an average of $23,812 per year to incarcerate each drug offender. The lower rate of incarceration among Oxford House versus usual-care participants at 24 months (3% vs. 9%) corresponds to an annual saving of roughly $119,000 for Illinois. Together, the productivity and incarceration benefits yield an estimated $613,000 in savings per year, or an average of $8,173 per Oxford House member.[99]

Borkman, Kaskutas, Room, Bryan, and Barrows presented findings from two outcome studies that specifically included social model programs.[100] Both of these studies were published as government reports. One report examined eighteen-month follow-up data on 198 social model program clients in San Diego and found that clients who used only the recovery home were the most likely to be abstaining at follow-up. The other study looked at outcomes among 1,826 clients at social model and nonsocial model residential programs in California. At the fifteen-month post-treatment follow-up, program graduates from both models reduced the number and frequency of substances used. There was also a relationship between length of stay in social model programs and reductions in substance abuse. For social model program stays of less than thirty days, there was a thirty-six percent reduction in substance abuse. For longer stays, there was a fifty-two percent reduction in post-treatment substance abuse.[101]

A longitudinal analysis conducted with a national sample of recovering substance abusers living in Oxford Houses found that persons with psychiatric comorbid substance use disorders, compared to those who do not have co-occurring mental illnesses, are not at higher risk for relapse when they reside in self-help residential settings like Oxford House. Furthermore, residents with high psychiatric severity reported decreased psychiatric outpatient treatment utilization over the course of the study.[102]

Kaskutas, Ammon, and Weisner conducted a naturalistic, longitudinal comparison of outcomes for individuals in social model programs and clinical programs.[103] Researchers obtained twelve-month follow-up data with 164 social model clients from two public detoxification programs and two public residential recovery homes and 558 clinical model clients from a mix of inpatient and outpatient programs. After controlling for demographics and baseline problem severity, social model program clients were less likely than clinical model clients to report alcohol and other drug problems at the one-year follow-up. More specifically, fifty-seven percent of social model clients reported no alcohol problems, compared to forty-nine percent of clinical model clients, and fifty-nine percent of social model clients reported having no drug problems, compared to fifty-one percent of clinical model clients.[104]

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[99] L. Jason, B. Olson, J., Ferrari, and A. Lo Sasso, *Communal Housing Settings Enhance Substance Abuse Recovery,* 96 American Journal of Public Health (10), (2006), at 1727-1729.
[100] T. Borkman, L. Kaskutas, J. Room, K. Bryan, and D. Barrows, *An Historical and Developmental Analysis of Social Model Programs,* 15 Journal of Substance Abuse Treatment (1), (1998), at 7-17.
[101] *Id.*
[102] J. Majer, L. Jason, C. North, J. Ferrari, N. Porter, B. Olson, M. Davis, D. Aase, and J. Molloy, *A Longitudinal Analysis of Psychiatric Severity upon Outcomes Among Substance Abusers Residing in Self-Help Settings,* 42 American Journal of Community Psychology, (2008), at 145-153.
[103] L. Kaskutas, L. Ammon, and C. Weisner, *A Naturalistic Comparison of Outcomes at Social and Clinical Model Substance Abuse Treatment Programs,* 2 International Journal of Self Help and Self Care (2), (2003-2004), at 111-133.
[104] *Id.*

Data from a randomized controlled study was used to conduct a cost–benefit analysis. Economic cost measures were derived from length of stay at an Oxford House residence, and derived from self-reported measures of inpatient and outpatient treatment utilization. Economic benefit measures were derived from self-reported information on monthly income, days participating in illegal activities, alcohol and drug use, and incarceration.[105]

> While treatment costs were roughly $3000 higher for the OH group, benefits differed substantially between groups. Relative to usual care, OH enrollees exhibited a mean net benefit of $29,022 per person. The result suggests that the additional costs associated with OH treatment, roughly $3000, are returned nearly tenfold in the form of reduced criminal activity, incarceration, and drug and alcohol use as well as increases in earning from employment… even under the most conservative assumption, we find a statistically significant and economically meaningful net benefit to Oxford House of $17,800 per enrollee over two years.[106]

Polcin, Korcha, Bond, and Galloway have undertaken comprehensive studies in California, focusing on Sacramento County and Berkley. In Berkley, fifty-five individuals entering four different sober living homes, operated by a specific provider were reviewed.[107] These houses were different from free-standing sober living houses because all clients are required to attend outpatient treatment in order to be admitted. However, residents can remain at these houses after they complete treatment for as long as they want as long as they follow the house rules. All participants were interviewed during their first week of entering the houses between January 2004 and July 2006.[108]

Polcin et. al., used generalized estimating equations models in order to include all participants in their analyses even if they missed follow-up interviews. In the year before entering the program, the most common substances residents were dependent on were cocaine, alcohol, cannabis, heroin, and amphetamines. Residents entered the homes with relatively low average Alcohol Severity Index[109] scores that were generally maintained at follow-up time points.[110] According to the researchers, it is important to note that residents were able to retain their improvements even after leaving the residence.[111]

As a result of the review, Polcin et. al., found that:

- Residents at six months were sixteen times more likely to report being abstinent.
- Residents at twelve months were fifteen times more likely to report being abstinent.
- Residents at eighteen months were six times more likely to report being abstinent.[112]

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[105] A. Lo Sasso, E. Byro, L. Jason, J. Ferrari, and B. Olson, *Benefits and Costs Associated with Mutual-Help Community-Based Recovery Homes: The Oxford House Model*, 35 Evaluation and Program Planning (1), (2012), at 47-53.
[106] *Id.*
[107] Polcin et. al., *18 Month Outcomes (2010),* at 352-366.
[108] They were interviewed again six-months, twelve-months, and eighteen-months, with follow-up rates of 86%, 76%, and 71%, respectively.
[109] The Addiction Severity Index Lite (ASI) is a standardized, structured interview that assesses problem severity in six areas: medical, employment/ support, drug/alcohol, legal, family/social, and psychological. The ASI measures a 30-day period and provides composite scores between 0 and 1 for each problem area. *Id.*
[110] 0.07 (baseline), 0.06 (6 months), 0.5 (12 months), and 0.11 (18 months). The same pattern was observed for drug severity: 0.05 (baseline), 0.03 (6 months), 0.05 (12 months), and 0.11 (18 months). *Id.*
[111] Among the residents contacted for follow up interviews seventy-one percent had left the residence at twelve months and eighty-six percent had left at eighteen months. *Id.*
[112] *Id.*

In Sacramento County, 245 individuals entering sixteen sober living homes were reviewed.[113] Participants were recruited and interviewed during their first week of entering the houses between January 2004 and July 2006.[114] Among the total sample of 245, almost ninety percent participated in at least one follow-up interview. Polcin et. al., used the same methodology as with the prior Berkley study. In the year before entering the program, the most common substances residents were dependent on were methamphetamine and alcohol. Residents entered the homes with low average ASI alcohol scores that showed significant improvement at six months and then were generally maintained at subsequent follow-up time points.[115]

There was a statistically significant decrease in the number of months they used drugs or alcohol, from about three out of the six months before entering the sober living houses to about one and a half months on average. Even among the almost eighty individuals who relapsed, there was a significant reduction in the intensity of substance use. The number of days of substance use during the month of heaviest use decreased from an average of twenty-three days at baseline to sixteen days at the six-month follow up. Furthermore, there were significance improvements in the number of days worked, the percent arrested, and the severity of psychiatric symptoms.[116]

Impact on Surrounding Neighborhoods

The American Planning Association's 1997 Policy Guide on Community Residences reviewed more than fifty studies and concluded that community residences such as group homes and halfway houses do not have an effect on the value of neighboring properties. Reviews also note that community residences are often the best maintained homes on their block and that many neighbors were not even aware there was such a residence in the neighborhood. Other reviews have found no negative effects on neighborhood safety and that residents of group homes are much less likely to commit a crime of any sort than the average resident.[117]

> Community residences have no effect on neighborhood safety. A handful of studies have also looked at whether community residences compromise neighborhood safety. The most thorough study, conducted for the State of Illinois, concluded that the residents of group homes are much less likely to commit a crime of any sort than the average resident of Illinois. Community residences do not generate adverse impacts on the surrounding community. Other studies have found that group homes and halfway houses for persons with disabilities do not generate undue amounts of traffic, noise, parking demand, or any other adverse impacts. [118]

[113] D. Polcin, R. Korcha, J. Bond, and G. Galloway, *Sober Living Houses for Alcohol and Drug Dependence: 18 Month Outcomes,* 38 Journal of Substance Abuse Treatment, (2010), at 356-365.
[114] They were interviewed again at 6-months, 12-months, and 18-months, with follow-up rates of 72%, 71%, and 73%, respectively. *Id.*
[115] 0.16 (baseline), 0.10 (6 months), 0.10 (12 months), and 0.10 (18 months). The same pattern was observed for drug severity: 0.08 (baseline), 0.05 (6 months), 0.06 (12 months), and 0.06 (18 months). *Id.*
[116] D. Polcin, and D. Hendersen, *A Clean and Sober Place to Live: Philosophy, Structure, and Purported Therapeutic Factors in Sober Living House,* 40 Journal of Psychoactive Drugs (2), (2008), at 153–159.
[117] *See,* www.planning.org/policy/guides/pdf/communityresidences.pdf, site accessed August 18, 2013.
[118] *Id.*

Researchers reported that, knowledge of the existence of an Oxford House led to improved attitudes toward those in substance abuse recovery and self-run substance abuse recovery homes. They summarized the major findings as follows:

> The study's major finding was that residents who lived next to an Oxford House versus those who lived a block away had significantly more positive attitudes concerning the need to provide a supportive environment to those in recovery, the importance of allowing those in substance abuse recovery to live in residential neighborhoods, the need for recovery homes, and the willingness to have a self-run recovery home on their own block…Another important finding was that there were no significant perceived differences in housing prices for those next to and those a block away from the Oxford Houses. In addition, among those interviewees who knew of the existence of the self-run recovery home, the values of their houses had actually increased over a mean of 3 years. These findings suggest that the presence of the Oxford Houses did not lead to reduced values for houses in these communities.[119]

In 2005, researchers surveyed individuals at an annual Oxford House World Convention. Greater than eighty percent of participants indicated that they thought living in the Oxford House increased their likelihood of involvement in their neighborhood. Respondents reported around eleven hours of community participation each month, in the following activities:

- Informing or advising agencies or local leaders
- Involvement in community anti-drug campaigns
- Working with youth
- Fundraising
- Attending community meetings
- Volunteering time with community organizations
- Attending public hearings and forums
- Speaking at political events [120]

In a mixed-methods study of Oxford House residents, Jason et al., found that the overwhelming majority of current and alumni members agreed that residents provide support and companionship for each other and that Oxford Houses provide motivation and increase member's sense of responsibility.[121]

> Both alumni and current residents also reported a variety of formal and informal helping activities in their community outside of Oxford House. Both groups were also similarly likely to respond that they were involved in formal volunteer work in the community and also engaged in informal neighborhood helping such as cleanups… In the current study, alumni and current residents both tended to spend considerable time each week in neighborhood-helping activities, suggesting that these habits may form earlier in recovery and continue once residents move on to another location. Results from the current study also suggest that alumni and current residents are engaging in processes of change, such as helping relationships (via mutual-help involvement) and

[119] Jason, *Proximity (2005),* at 529-535.
[120] L. Jason, D. Schober, and B. Olson, *Community Involvement Among Residents of Second-Order Change Recovery Homes,* 20 The Australian Community Psychologist (1), (2008), at 73-83.
[121] *Jason, et. al., Neighborhood (2006)*.

> social liberation (via ongoing advocacy and community involvement) that are outlined in the transtheoretical model of change for addictive behaviors.[122]

Researchers compared crime rates, from 2005, within a two-block radius of forty-two Oxford Houses and forty-two control houses within the city limits of Portland, Oregon. There were no significant differences between Oxford Houses and control houses with regard to the amount of any of the tested crimes - including assault, arson, burglary, larceny, robbery, homicide, and vehicle theft.[123]

Researchers conducted in-depth qualitative interviews with neighbors living near one of the Clean and Sober Transitional Living houses in Fair Oaks, California. They found that:

> Many of the neighbors also had a limited understanding of SLHs. In some cases, they had no idea a SLH existed in the neighborhood; it seemed to them like any other house. For those who were aware that there was a SLH in their neighborhood, there was often a fairly vague notion of the population served and how the program operated. Without information, some neighbors expressed fears that the residents were mostly parolees or that they included sex offenders. They did not seem to be aware that a minority (about 25%) of residents was referred from the criminal justice system (i.e., jail or prison) and does not accept individuals convicted of sex offenses.[124]

Neighbors who expressed concerns lived in the vicinity of six houses that were densely located along a two-block area in one complex. Some complaints related to noise and parking. Furthermore, a few neighbors expressed fears about safety, the potential for an increase in crime, and declining values of houses in the neighborhood. However, when pressed by the interviewer, they had difficulty providing examples of these issues.[125]

Concerns about houses appeared to center mostly on issues such as the size and higher density of these houses in one area, as well as related concerns about noise and traffic. Only a few mentioned issues related to resident behavior, such as offensive language and leaving cigarette butts in the area. [126]

[122] L. Jason, D. Aase, D. Mueller, and J. Ferrari, *Current and Previous Residents of Self-Governed Recovery Homes: Characteristics of Long-Term Recovery*, 27 Alcoholism Treatment Quarterly (4), (2009), at 442-452.
[123] J. Deaner, L. Jason, D. Aase, and D. Mueller, *The Relationship Between Neighborhood Criminal Behavior and Oxford Houses*, 30 Therapeutic Communities(1), (2009), at 89-94.
[124] D. Polcin, D. Henderson, K. Trocki, K. Evans, and F. Wittman, *Community Context of Sober Living Houses*, 20 Addiction Research &Theory (6), (2012), 490-491.
[125] *Id.*
[126] *Id.*

IX. Conclusions

This section discusses the feasibility, and consequence of action. As noted in section VI., of this report, the intersection of governmental housing action and the operation of the Fair Housing Amendment Acts (FHA) have resulted in litigation. This observation was made repeatedly during the collection of information for this report. This is not a unique phenomenon to Florida, as it has been observed by the Connecticut Office of Legal Research, noting that:

> Because people with substance abuse disorders are covered by the Americans with Disabilities Act and the federal Fair Housing Act, state and local zoning and other requirements meant to regulate them are subject to challenge.[127]

In a 2010 report in response to Legislative requirement to study sober houses in the Commonwealth, the Massachusetts Bureau of Substance Abuse Services (BSAS) noted that:

> The [FHA] limits the Commonwealth's and BSAS' authority to implement mandatory licensure, regulation, registration or certification requirements directed specifically at ADF Housing providers and residents. Federal courts have repeatedly rejected state and local efforts to regulate ADF Housing.[128]
>
> In sum, the FHAA imposes a significant complication to local or state governments seeking to impose licensure, regulatory, registration or certification requirements on ADF Housing. The Commonwealth and BSAS would need to prove with reliable evidence or studies that any proposed mandatory licensure, certification or registration requirement (1) benefits the residents of ADF Housing, or responds to legitimate safety concerns in the community, (2) is narrowly tailored, and (3) that a nondiscriminatory alternative means of achieving those goals is not available.[129]

In public comment, a common thread running through what was presented was that there were bad actors that needed to be regulated or closed down. The following was presented to the Department, as it relates to potential action:

- The Department is an appropriate agency to regulate and operate the licensure of recovery residences in the State of Florida. There are processes and procedures in place for the regulation of other similar uses of homes in residential neighborhoods and similar types of services being provided in the home setting environment. The fees for licensure and registrations could also be similar to fees currently being charged to other community residential homes.[130]

[127] *Supra,* note 8.
[128] *Supra*, note 10.
[129] *Id.*
[130] *See, Port St. Lucie Response,* Appendix 3.

- The State of Florida cannot regulate a relationship between individuals who have a common interest in being sober, agree to live together and share rent. If this is truly the case, people should not be discriminated against for this. The cost of any license/registration fee should cover the cost of licensing/registering by DCF. [131]
- A certificate of need equivalent for new substance abuse treatment providers was proposed.[132]
- That the Department licensed substance abuse providers should be restricted to referring clients to recovery residences that are not voluntarily certified.[133]
- Concern about whether state agencies have the resources to enforce regulations.
- There needed to be a market driven solution instead of focusing on a governmental solution, as has been done in other states.[134]

In relation to the cost of any government action, an industry advocacy organization, the National Association for Recovery Residences (NARR), of which the Florida Association for Recovery Residences is a member, has observed:

> Most recovery residences (particularly levels 1 & 2) are self-funded through resident contribution, but recovery residences with higher levels of support, such as a range of clinical services, often receive other forms of federal, state, and private support. RRs are historically self-funded, eventually become self-sustainable, and utilize community of volunteers. Start-up costs are typically covered by the housing provider, an Angel Investor, or a nonprofit. As a part of their recovery process, residents are expected to work, pay rent, and support the house. In some cases, residents may not be able to fully cover operational costs, so housing providers offer short-term scholarship beds and utilize other financial resources in the community. No RR could financially survive without the use of volunteer staff and peer's cultivating the culture of recovery in homes. Start-up costs of RRs vary across the 4 Levels of Support. Lower Levels of Support, RR 1s and 2s, typically rent residential houses—a practice that avoids the capital cost of purchasing a property. The cost of capital improvements and fully furnishing a household to accommodate on average 10 residents is the largest start-up cost. Marketing, maintenance, and utilities are the largest operational expenses for the lower Levels of Support, RR 1s and 2s. Higher Levels of Support, RR 3s and 4s, have higher staffing and administrative expenses as well as higher initial capital outlays. In general, RRs are NOT very profitable. By the time someone is ready to embrace recovery, they have often lost the financial means to afford to live in an RR at any price. Plus, occupancy rates can be inconsistent, and operational costs can be high. It may take several years for an RR to recoup start-up costs and achieve a positive cash flow. As a result, a single financial challenge, like defining housing rights, can easily cause an RR to close.[135]

[131] *See*, City of Delray Beach, Appendix 3.
[132] *See, Alan Stevens,* Appendix 3.
[133] *See,* FARR, Appendix 3.
[134] *Appendices* (2013).
[135] *See,* National Association of Recovery Residences. (2012). A Primer on Recovery Residences: FAQs from the National Association of Recovery Residences www.narronline.com/NARR_formation_website/Recovery%20Residence%20Primer%20-%20Long.pdf

The 2010 Massachusetts Bureau of Substance Abuse Services (BSAS) report is instructive to Florida. Noting in relation to the impact of BSAS not licensing alcohol and drug free homes (ADF) in Massachusetts:

> BSAS has determined that all complaints about ADF homes fall into specific categories and have existing avenues for resolution. For example:
>
> - All nuisance complaints (such as noise), disruptive behavior of residents, and drug use complaints are typically handled by the local police;
> - Complaints regarding occupancy and substandard living conditions are typically handled by municipal Building and Fire Departments;
> - Complaints regarding unlicensed substance treatment programs are typically handled by the [Mass.] Department of Public Health, specifically BSAS;
> - Complaints regarding unfair housing practices, including eviction practices, are typically handled in… court; and
> - Complaints regarding unscrupulous ADF Housing operators are typically handled through the [Mass.] Attorney General's Consumer Protection Division within the Consumer Protection and Advocacy Bureau.[136]

Until additional independent research is conducted on the outcomes from recovery residences, that is sufficient to conclude which organizational structure is effective, and under what circumstances, the Department is unable to determine the extent to which they contribute to addressing substance use treatment. Absent this determination recovery residences are an issue of community concern similar to other issues related to land use, neighborhood character and, economic impact.

[136] *Supra,* note 10.

IX. Table of Tables