DEPARTMENT OF HUMAN SERVICES

Legislative Report

Sober Homes Situational Analysis

Behavioral Health Division

September 2023

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Contents

Introduction

Through legislation (Minnesota Laws 2021, First Special Session, Chapter 7, Article 11, Section 37) DHS was charged with engaging stakeholders and developing recommendations related to:

- increasing access to sober housing programs
- promoting person-centered practices and cultural responsiveness in sober housing programs
- potential oversight of sober housing programs
- providing consumer protection for individuals in sober housing programs with substance use disorders and individuals with co-occurring mental illnesses.

DHS took a three-pronged approach in responding to the legislative mandate. This included: (1) conducting a review of best practices, current trends, national models, and media coverage of sober homes; (2) stakeholder engagement, public meetings, surveys and group discussions, identification of themes and recommendations; and (3) conducting a situational analysis of the current state of equitable access to sober homes, overall experience and quality of care and desirable changes.

DHS contracted with Genesis Consulting Services, LLC (vendor/researcher) to conduct a situational analysis to assess the state of sober homes. The specific goals of the situational analysis were to determine to what extent sober homes are accessible to everyone, including women, people in rural communities and Minnesotans from marginalized communities including persons who identify as Black, Indigenous or Persons of Color (BIPOC). Research was conducted and a diverse group of stakeholders were surveyed to determine whether a roster of sober homes in Minnesota exists and to identify which homes are associated with Minnesota Association for Sober Homes (MASH) and which are not. For the context of this work, all persons involved in operating, administering or supervising sober homes are referred to as "providers." Providers in this context are entities who deliver care to sober home residents, which include sober homeowners, county officials, counselors, mental health experts and sober home provider organizations.

Interviews were conducted with providers, sober home residents and families of sober home residents to understand their perspectives on sober home services, access, oversight, cultural responsiveness and capacity to serve populations with co-occurring mental health conditions.

Legislation

Minnesota Laws 2021, First Special Session, Chapter 7, Article 11, Section 37:

Sec. 37. **DIRECTION TO THE COMMISSIONER; SOBER HOUSING PROGRAM RECOMMENDATIONS.**

(a) The commissioner of human services, in consultation with stakeholders, must develop recommendations on:

(1) increasing access to sober housing programs;

(2) promoting person-centered practices and cultural responsiveness in sober housing programs;

(3) potential oversight of sober housing programs; and

(4) providing consumer protections for individuals in sober housing programs with substance use disorders and individuals with co-occurring mental illnesses.

(b) Stakeholders include but are not limited to the Minnesota Association of Sober Homes; the Minnesota Association of Resources for Recovery and Chemical Health; Minnesota Recovery Connection; NAMI Minnesota; the National Alliance of Recovery Residencies (NARR); Oxford Houses, Inc.; sober housing programs based in Minnesota that are not members of the Minnesota Association of Sober Homes; a member of Alcoholics Anonymous; and residents and former residents of sober housing programs based in Minnesota. Stakeholders must equitably represent geographic areas of the state and must include individuals in recovery and providers representing Black, Indigenous, people of color, or immigrant communities

(c) The commissioner must complete and submit a report on the recommendations in this section to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance on or before September 1, 2022.

Sober Home Overview

The Substance Abuse and Mental Health Services Administration (SAMHSA) refers to sober homes as "recovery houses." In their words:

> Recovery houses are safe, healthy, family-like substance-free living environments that support individuals in recovery from addiction. While recovery residences vary widely in structure, all are centered in peer support and a connection to services that support long-term recovery. Recovery housing benefits individuals in recovery by reinforcing a substance-free lifestyle and providing direct connections to other peers in recovery, mutual support groups and recovery support services.

In Minnesota, sober homes are often drug and alcohol-free living environments designed to cultivate positive change and progress toward recovery. Many rely on a peer support model, focusing on the power of working toward recovery with other individuals who share the same goal. These homes are not intended to provide treatment or other types of clinical services. Many require, or strongly encourage, participation in 12-step programs, such as Alcoholics Anonymous (AA). Additionally, sober homes ask that residents abide by house rules that may include things such as maintaining abstinence, paying rent, helping with house chores or attending house meetings.

Research methods

Overview

The researcher obtained Institutional Review Board (IRB) approval to assure that appropriate steps were taken to protect the rights and welfare of humans participating as subjects in this research, given the potential

vulnerability of the population served by sober homes. All precautions were taken if past trauma surfaced during engagement with a sober home resident. The researcher reached out to potential participants utilizing a flyer approved by DHS leadership and IRB.

Sober home providers, advocates, and treatment facilities readily offered feedback and opinions. In contrast, perspectives from sober home residents and their families, particularly representing the full diversity of Minnesota and the population of sober home residents, proved more difficult to obtain as some residents and family members expressed reluctance to participate.

Background

Virtual interviews with participants took place from March 2022 to May 2022. To protect the anonymity of participants, the research documented all interview responses, stored on a secure server. A thematic analysis of responses began in June 2022 with the initial themes identified and presented during the workgroup sessions.

Limitations

This report is based on qualitative discussions between DHS, Genesis Consulting Services, providers, sober home residents and families. This report is a summary of individual opinions, understanding and experiences of/with sober homes in Minnesota. All data and findings are anonymous. Quantitative data was not used in this report.

Demographics

Interviews included representatives from 13 sober homes, two counties, five treatment facilities and two sober home advocate groups totaling 40 participants. The participants included 25 individuals representing providers and 15 individuals representing recipients or their families. Recognizing that providers were overrepresented, the researcher attempted to identify and recruit additional participants with lived experience, with mixed results.

All groupings focused on adults aged 18 and over and the total number of subjects for both the provider group and sober home resident group ranged from 25 to 40 participants. The contractor sent letters to sober home managers seeking voluntary participation from residents, with an emphasis on underserved populations, including women and the Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and Plus (LGBTQIA+) communities.

Data collection

To gather the qualitative data, the vendor recorded interviewee responses and categorized them using a thematic analysis process, and then used coding to highlight areas of commonality through the entirety of responses from participants.

Of the 13 sober homes participating in the interview, 12 (92%) were private pay with monthly rent ranging from $500 to over $900 per month. Only one participating sober home paid the resident’s rent. Occasionally, families

paid for a resident's rent. Some residents obtained various forms of rental assistance such as payment for the first several months of their lease.

The State of Sober Housing in Minnesota

The goal of the situational analysis was to assess the "state of the state" of sober housing in Minnesota. This included a focus on: the accessibility of sober homes, whether they provide appropriate resources and stakeholder perceptions of sober home oversight. Additionally, the situational analysis focused on:

- Overall experience and quality of services
- Impact of the opioid crisis
- Options available for people who could benefit from the services but cannot pay for them
- Funding mechanisms, including identification of payors and how payments are made

Access to housing

Rogers et al., 2019 and Carnemolla & Skinner, 2021 suggests that lodging affords a person the opportunity to focus on securing a self-sustaining and self-sufficient way of life. These findings align with feedback received from participants in the sober homes study. The workgroup heard a frequent response: "A successful sobriety journey begins not only with a person's commitment, but also with stable housing." This input and comments like it, assisted the vendor in identifying specific solutions. These solutions can be seen in the recommendations listed at the end of this report.

Mental illness

Based on research conducted by Heun-Johnson et al., 2019, Minnesota residents who experience a mental health episode/crisis have a higher prevalence of substance abuse, alcohol and/or illegal drug use within a year of the episode/crisis. The vendor highlighted the perspective of providers/sober homeowners, sober home residents and their families regarding the prevalence of mental illness among sober home residents. A common theme within the study showcased that mental health is a key factor in the recovery journey of those living in sober homes.

Person-Centered practices

Person-centered practices are essential to recovery. Feedback from some workgroup participants indicated that "person-centered practice" was not a term that is commonly used in the sober home community. Participants also stated the active practice of this concept is something embedded in many current sober home models and acknowledged the benefit of sober home providers in engaging in regular professional development in areas of person-centered practices. This was especially true for sober homes with on-site staff.

Given the present state of information about sober homes, DHS and the vendor are not able to confirm the extent to which such settings exist or whether they are scaled at the level needed and preferred by potential residents.

Sober home prevalence

There is no definitive list or central registry for sober homes in Minnesota. As a result, the total number of sober homes in Minnesota is unclear. The Minnesota Association for Sober Homes (MASH) identifies approximately 60 unique sober homes on their online directory. Analysis of the MASH directory and other available information suggests 159 unique sober homes operate in Minnesota. Because of limited data and absence of requirements for sober homes to be identified as such, this estimate may be lower than the actual total number of sober homes (i.e., there may be other sober homes not represented in that figure). This lack of information impedes policymaking and identifying resources needed by sober homes.

Sober home oversight

Minnesota is one of 23 states that does not regulate sober homes beyond public health-oriented regulations related to board and lodging facilities and local zoning laws. However, MASH indicates that their member sober homes, "have all been inspected and certified as being in compliance with the standards that MASH has established. All member organizations have signed a code of ethics document, and all house managers have completed one or more training sessions" (Minnesota Association for Sober Homes, 2022). Given imperfect estimates of prevalence, that statement might apply to roughly one-third of existing Minnesota sober homes.

Findings and Recommendations

Findings and recommendations have been identified in response to the (1) review of best practices, current trends, national models and media coverage of sober homes; (2) stakeholder engagement, public meetings, surveys and group discussions, identification of themes and recommendations and (3) the situational analysis of the current state of equitable access to sober homes, overall experience and quality of care, desirable changes.

The following section of this report presents findings and recommendations, categorized based on the legislative direction to DHS:

Legislative Focus Area 1: Increasing Access to Sober Housing Programs

Findings

Themes were derived from workgroup participants in workgroups #1-5. These participants identified a total of 10 barriers impacting access for all who need sober housing for healing, especially for individuals who currently experience limited access due to income and/or are part of an underrepresented group (e.g., BIPOC individuals, immigrants and refugees), as follows:

1. **Financial barriers:** Economic factors such as high costs of sober housing, a self-pay model, limited availability of financial supports (deposits, rent) and need for additional public sober housing funding options (e.g., other than Housing Support [formerly known as group residential housing], such as Behavioral Health Fund) impact access to services.
2. **Narrow referral pipeline:** A narrow referral pipeline exists between treatment as a referral resource and access to sober home residences (for example, those in AA or treatment may receive more direct referral support to facilitate connection to sober homes). This narrow referral pipeline limits the availability of referral options and impedes access.

3. **Systemic bias barrier:** There is a lack of opportunities and access to sober homes for people of color, as people of color who could benefit from sober homes may be jailed rather than ordered to participate in treatment programs (at rates that are disproportionate compared with white Minnesotans).
4. **Individual barriers:** Residents experience a variety of individual barriers including the lack of access to emotional supports including pets as emotional support animals, perceived shame and lack of awareness of sober home options and benefits and recovery resources.
5. **Availability of sober homes:** There is limited diversity of housing options including, geographic barriers (rural, diverse urban neighborhoods and others), types of supports and services provided by the sober homes and other barriers that limit the number of sober homes including city government and community "push back" from neighborhood associations. For Indigenous residents who live on reservations, when sober homes are not on the reservation, they must leave the reservation and experience separation from family and community, which leads to challenges and additional triggers when returning home. For women with children and individuals transitioning their gender or gender identity, there are limited sober home opportunities that provide a supportive and affirming environment.
6. **Location and proximity barriers:** Residents need access to grocery stores and public transportation to access employment. In rural areas and specific regions of the state (for example, northern Minnesota), money spent on rideshare/taxis and other forms of non-public transportation significantly cut into limited finances. Location is also a barrier as it relates to proximity to cultural communities, with access to cultural and religious practices and/or dietary needs.
7. **Establish processes to identify sober homes with capacity for working residents with co-occurring mental illness**, such as participation in peer training to support individuals with co-occurring mental illness and/or fulfilling voluntary certification process.
8. **Information barriers for stakeholders:** A lack of centralized, accessible information and knowledge of resources/homes available to people in the recovery ecosystem including people in recovery, families of people in recovery, community organizations who largely serve people of color, county resources, referral centers and treatment centers. The absence of a comprehensive clearinghouse of statewide information on all sober homes in Minnesota for residents looking for recovery opportunities further hinders access to information and resources. A lack of understanding of legal protections for sober home residents by both sober home providers and residents (some individuals may have an ombudsman, but others may not) can contribute to the stability of residents and impact the overall recovery trajectory.
9. **Cultural barriers:** The limited availability of culturally specific and LGBTQIA+ focused homes limits appropriate access and quality services for culturally diverse, underserved populations and geographically diverse regions (rural versus suburban versus urban availability). Some LGBTQAI+ focused homes exist in the state, and feedback from some workgroup participants is that more is needed. Limited availability exists of culturally specific providers including at various levels of care, such as culturally specific house managers and staff. On an individual level, residents are expected to follow established rules that may not be a cultural fit for their personal situation, but due to the scarcity of sober homes, they are required to forego important aspects of their personal recovery in order to access a sober home program. This absence of person-centered practices impacts cultural responsiveness.
10. **Gender barrier:** There is limited availability and access to women-only sober homes. County officials struggle to place women in healthy safe environments that will allow for building a successful sobriety journey. Additionally, there is a lack of resources to support women with children.

Recommendations:

1. **Create searchable database of Sober Homes in the state.** Improve communication about current sober homes in the state with a searchable database that is updated and maintained to provide detailed

descriptions of populations served, languages spoken, recovery methodologies, geographic locations, etc. This will allow for knowledge of sober homes options that align with individual needs. The database should also be searchable from three different perspectives: 1.) individuals in recovery, 2.) family members and 3.) professional advocates. The database should be neutral and not promote any recovery approaches over types of sober housing and should include proactive equity principles. Accommodations should be provided for people without technological resources to provide access to the database, for example phone contact or 411. Contact information should be provided for language accessibility and organizations that work with individuals looking for sober homes.

2. **Increase person-centered practices and cultural responsiveness in sober housing program by promoting culturally specific providers.** Sober homes should reflect the diversity of Minnesotans who are in recovery. One strategy to encourage diversity in sober homes is to promote and incentivize the development of culturally specific sober housing options. This can be done with start-up funding for new sober home providers from underrepresented communities who may not have access to the capital needed for the down payment of a sober home. This recommendation to increase the number of diverse sober home options is also complementary to Focus Area 2 which specifically promotes person-centered practices and cultural responsiveness in existing sober homes.
3. **Create referral resources for sober homes to establish referral loops and increase referral pipelines within and across programs and services/referral sources.** These referral resources could clearly identify sober homes on a continuum of recovery care in Minnesota and offer flexible opportunities for residents to enter sober homes at different points along a recovery continuum. While a system similar to this does exist, expanding and including more stakeholders in these referral loops will increase access to sober homes. Members highlighted that if a certification process was implemented, that referrals should only be made to those that are certified. Workgroup members highlighted the importance of restricting the use of "fee for referral," ensuring an open network of options for those seeking housing.
4. **Study current funding sources that support sober homes and residents.** Exploring additional funding options and developing advocacy strategies to expand into new sources of funding would ensure individual who need housing would have access to it, regardless of cost. Reducing housing costs would be most impactful for people coming out of treatment. Some workgroup participants indicated that the self-pay model is one aspect of people in recovery developing self-sufficiency, and others advocated that identifying additional funding streams would address financial barriers and facilitate access to sober homes.

Legislative Focus Area 2: Promoting person-centered practices and cultural responsiveness in sober housing programs.

Findings:

Person-centered practices are essential to recovery. Feedback from some workgroup participants indicated that "person-centered practice" was not a term that is commonly used in the sober home community. The concept however is currently embedded in many current sober home models. Many acknowledged a benefit of sober home providers in engaging in regular professional development in areas of person-centered practices. This was especially true for sober homes with on-site staff (Level II, NARR).

Person-Centered Practices

1. **Person-centered practices are individualized personalized practices.** Fundamentally, person-centered practices are respectful and dignified interactions with people with lived experiences on their personal recovery journey, and in practice, this means different things to different people. Often the focus is on the addiction rather than the whole person.

2. **Residents/consumers drive the services regarding cultural, psychological (e.g., trauma), and physical services (e.g., chronic illness) that they need for their recovery.** Specifically, person-centered practices provide autonomy. Those practices should allow for a flexible approach to individual needs and encourage accommodations when necessary.
3. **Person-centered sober homes programming involves a set of intrinsic values, and these can be defined into standards meeting the needs of individuals.** With a common definition and clearly defined key components of person-centered practices, the standards may be used to evaluate and measure the implementation of person-centered practices.
4. **Staffing capacity for intensive sober homes** (e.g., if staff are present, what is their capacity and availability, skills/training and personal/cultural experience). Staffing capacity and level of responsiveness influences the degree of person-centered care they are able to provide (for example, understanding of lived experiences, trauma and cultural background).
5. **High costs, financing scarcity and lack of care coordination influence access to person-centered care.** Sober home care coordination opportunities can impact length of stay. For example, the availability of medicine safes or reducing the number of residents per room can become care standards that impact the perception of care.

Cultural-responsiveness

1. **Cultural-responsiveness is an individualized approach that is not a one-size-fits all.** This approach identifies the values, lived experiences and principles of cultural responsiveness and promote the development of diverse approaches tailored to meet the needs of specific populations.
2. **The physical and social environment in sober homes should be culturally responsive** in that they respect the dignity and support the diversity and culture of all its residents.
3. **Culturally specific sober homes that reflect cultural values are needed** for LGBTQIA+ women who have experienced intimate partner violence. Motivational interviewing, cultural and linguistic standards (CLAS) and dialectical behavioral therapy create cultural responsiveness within Minnesota's sober homes.

Recommendations:

1. **Develop or adopt a standardized training program for all sober home operators in Minnesota.** The training curriculum may include standards for person-centered practices and cultural-responsive standards. This training will require a clear commitment to understanding and embracing culture during recovery (including but not limited to cultural humility, implicit bias, microaggressions and others).
2. **Develop or adopt standard definitions and components for person-centered practices**. This would include a focus on an individual's recovery journey and meeting individual needs, providing consumer protections for residents related to person-centered needs and ensuring programs have physical, psychological and emotional supports.
3. **Develop or adopt a common definition of cultural responsiveness.** A definition that meets a minimum standard using CLAS (Culturally and Linguistic Appropriate Services) standards and defines the values and principles of person-centered care in the context of sober homes. These standards can be used to evaluate and measure the implementation of the cultural responsiveness standard in sober homes. This could be one aspect of a sober home certification process, if one is developed.
4. **Create learning cohorts or communities of practice (CoP) for sober home managers and owners.** Learning cohorts or CoPs could provide opportunities to network, share learnings and offer opportunities to participate in training together. Similarly, a network of peer educators with training in standards and practices for sober homes, including person-centered practices and cultural

responsiveness, could be developed. Both networks could be avenues for engaging underrepresented groups in sober homes recovery work.

5. **Develop training and formal resources for sober home providers when residents experience a mental health crisis.**
   Sober homes typically do not provide mental health or substance use services. At the same time, sober home residents may experience mental health crises while in residence. Training for providers would increase the availability of strategies for staff and promote successful responses for the individual in crisis and other members of the home. Resource lists should be centralized and available to all sober homes. This list should be inclusive of programs, providers and other resources who can support an individual with mental health care.
6. **Grow sober home infrastructure for supporting person-centered practices and cultural responsiveness (could be accompanied modest incentives for sober homes participating).**
   Creating sober housing availability locally with 24-hour staff availability. Train peer support specialists and/or staff on how to care for residents with trauma-informed care, person-centered services/planning and with respect for specific communities/life experiences. Offer flexible and diverse options for recovery activities in or near the sober home (schedules, classes, support groups). Standardize orientation processes at sober homes for residents, including roles and responsibilities for sober home providers and residents, and consequences and conflict resolution processes available to both parties by a third party.

Legislative Focus Area 3: Potential oversight of sober housing programs

Findings:

Currently, in Minnesota, there is not a uniform process in place for certifying sober homes or a set of basic standards that all sober homes must meet. Furthermore, there is no clear pathway for sober home residents to report alleged mistreatment and/or concerns.

Considerations in determining whether and how to move forward with oversight of sober homes in Minnesota can be informed by learnings from the national landscape (including an assessment of the policy environment and best practices conducted by Katie Burns, 10,000 Lakes Consulting) and the local landscape (insights from the legislative sober homes workgroup participants). The nine considerations described below can inform or guide a decision for Minnesota.

The following considerations reflect the state of sober housing oversight at the national level.

A set of national standards for sober homes exists. The National Association of Recovery Residences (NARR) developed and has updated a set of standards related to four levels of recovery residences.

1. There are 31 standards organized into four domains, including administrative operations, physical environment, recovery support and good neighbor policies. The standards are tailored to each level of recovery residence. These standards have been endorsed as best practices by the Substance Abuse and Mental Health Services Administration, an agency within the U.S. Department of Health and Human Services. Please note Level III of the NARR standards relate to some providers that are already eligible for payment from the behavioral health fund for some residents and certain standards must be met to receive this payment. Level IV of the NARR standards are programs that are required to be licensed in Minnesota as residential substance use disorder treatment programs. These provider types (Levels III and IV) are not in the scope of these sober homes recommendations and no changes are being proposed to those billing and licensing requirements.

2. **Applying existing national standards for all Level I and Level II sober homes in Minnesota could help improve quality and establish clear expectations for sober home living environments.** A more centralized minimum statewide standard would provide more consistent quality, access and standard of living across the homes. Local zoning laws vary across the state related to the presence and safety standards of sober homes in certain communities. Level I sober homes are essentially self-governed living situations for individuals working toward recovery. Level I sober homes do not have staff in the home. Conversely, Level II sober homes have at least a head resident and/or paid staff on site. A thoughtful approach to oversight standards needs to take this distinction into between Level I and Level II homes into account.
3. **Some other states have taken more active approaches to overseeing sober homes.** Those active approaches vary across states. State have developed voluntary certification, generally using the NARR standards as the basis of the certification process. (Though the certification in this option is voluntary, it is often required for a sober home to be listed in a statewide registry of sober homes or to receive referrals from publicly funded organizations.) Other states also have more targeted consumer protections related to processes removing residents from the home, prohibition of resident brokering and medication assisted therapy (MAT).
4. **In other states that have optional or required certification, states vary in their approaches as to whether a public or designated private entity should carry out the certification process.** If Minnesota were to certify or license sober homes, policy makers would need to designate what entity would be responsible for these new oversight responsibilities. It would require funding and time to implement a certification process and inform providers about these new processes.

Minnesota Landscape Considerations

The following five considerations were identified by workgroup participants.

1. **Some providers have expressed concern that oversight – if designed too aggressively – would undermine the community-oriented nature of sober homes**, particularly Level I. Several other states have chosen to focus their oversight activities on Level II sober homes, in part because there is at least a resident manager or staff member for the home. This is an important distinction because a regulated sober home needs to have a person who can be responsible for carrying out requirements of certification.
2. **Creation and implementation of a complaint resolution process takes time.** However, other public agencies in Minnesota already have complaint processes for other populations and the state can borrow from what works and doesn't work across other processes. In particular, the Ombudsman's office already has a complaint process that could be leveraged as the basis for accepting concerns about sober homes. Care needs to be taken that the process is not overly burdensome for those filing complaints.
3. **The entity providing the oversight needs to consider the lived experience of sober home residents while implementing a certification process.** Education/training would be needed.
4. **Oversight will not automatically result in better living conditions.** A meaningful certification process would need to be adequately staffed and well implemented in order to improve living conditions in those sober homes where improvement is needed.
5. **Oversight structures should not increase costs for sober home providers or residents.** Oversight that raises costs significantly for sober home providers may make it challenging for them to stay in business. Sober homes are in short supply and stakeholders are concerned about maintaining capacity that exists today. Funds could be made available for sober homes to remain open while implementing staff training and establishing new standards and other resources. Establishing oversight should not add cost to residents either given their financial circumstances. Costs due to establishing and implementing oversight should be paid for by public or private sources.

Recommendations

Feedback from all sources of input and workgroup feedback included establishing state-wide oversight focused on three major mutually supportive components. Please note Level III and Level IV providers as defined by NARR standards are not within scope of these recommendations.

1. **Establish a voluntary certification process for sober homes based on National Association of Recovery Residences (NARR standards) for Level II sober homes and/or Oxford House criteria or applicable NARR criteria for Level I Sober Homes.** The certification process could be managed by a state agency or a designated independent third-party private entity. The standards and administration of these standards may include one or more of the following:
   - Although sober homes could operate in the state without being certified, certification could be required for entities to be listed in the registry proposed to be established under the "Access" recommendations.
   - Entities receiving public funding could be required to refer clients only to certified sober home providers.
   - Develop standardized intake procedures for sober homes in the state, including required disclosure about whether the sober home is certified and what level of support is offered to residents (including whether the sober home has any staff on site), signed consents, resident rights and responsibilities, clear and standard involuntary discharge practices and clarification of processes for residents involved in the criminal justice system.
   - Review of physical conditions of the home (including fire safety) and the living conditions for residents.
   - All sober homes would need to be trained in the use of Narcan.
   - Develop standardized training, and perhaps voluntary certification, for Peer Recovery Specialists, who receive basic training and regularly in-service training to be certified.
2. **Workgroup preferences for voluntary certification with or without incentives:** During workgroup #6 in small groups workgroup participants were asked to indicate their preference for a voluntary certification with incentives or without incentives. Feedback received identified the following:
   1) Regarding voluntary certification for sober home providers, approximately two-thirds of the work group participants supported that voluntary certification to some degree, while approximately one-third of the workgroup participants abstained from voting, demonstrating no support for voluntary certification. Some workgroup members abstained from voting because there were limited details regarding the certification focus areas and specific processes of voluntary certification.
   2) Two-thirds of those indicating support for voluntary certification said that incentives would be desirable, while one-third of the respondents said no incentives would be preferable. Comments from workgroup participants indicated that their votes may have been different if the process for voluntary certification were clearly stated and/or specific incentives (rather than examples) were listed. Some workgroup members expressed opposition to linking voluntary certification to referrals from publicly funded entities.
3. **Create a process to accept, investigate and resolve complaints from sober home residents and family members.** Ensure transparency of tracking and reporting complaints so that data is available on the prevalence of problem, reasonable response time, addressing known problems such as resident brokering and separation from real or perceived financial and other potential conflicts of interest. Define the role of the Ombudsman's office in managing complaints or interfacing with oversight structures.
4. **Create communities of practice or learning cohorts for stakeholders involved with sober homes** with the goals to create connections between different stakeholder groups (for example, create connections between mental health professionals and sober home providers) or to bring individuals who do similar work together to share their experiences and learn as a community (e.g., sober home providers, peer

recovery specialists, etc.). These learning cohorts and communities of practice may serve as opportunities to engage representation from persons of color and other underrepresented communities in Minnesota's sober home community. A subgroup of this committee could be with residents and sober home providers to provide conflict resolution for homes that experience conflicts between providers and residents. These communities of practice may also identify and advocate for funding sources to support sober home provide quality supports and improve access to sober home for residents.

Legislative Focus Area 4: Providing consumer protections for individuals in sober housing programs with substance use disorders and individuals with co-occurring mental illnesses

Findings:

While this area of legislative charge refers specifically to individuals with substance use and co-occurring mental illnesses, basic consumer protection practices need to be established for all residents, including individuals with substance use and co-occurring mental illnesses. Emerging themes were derived from workgroup participants in workgroups #1-5.

Considerations for people with substance use disorder and co-occurring mental illnesses:

1. **Communication and collaboration among sober homes and mental health providers**. Streamline communications among mental health professionals, sober home providers and recovery community organizations to facilitate mental health treatment and other ongoing support in the recovery process, including those who are unable to live independently.
2. **Create diverse housing options supportive of the recovery of people with co-occurring mental illness**. Create housing options to reflect the full continuum of care and related mental health needs (e.g., single vs. shared rooms) and diverse recovery approaches. Evaluate existing options within the housing recovery support system.
3. **Communicate which sober homes have the capacity to serve the needs of individuals with co-occurring mental illness.** This information could be incorporated into the statewide registry recommended to be established under the "Access" recommendations and a component of required disclosure to family members, when possible, at the point of admission to a sober home.
4. **Create emergency housing/shelters for sober home residents upon a mental health crisis and/or relapse**. Sober home residents lack a safe place to go during a mental health crises or relapse. Often residents are taken to the emergency room.

Recommendations:

1. **Application of sober home resident's Bill of Rights which outlines resident's protections and their responsibilities as sober home residents with Minnesota sober homes.** A sober home resident's Bill of Rights may be developed from existing resources. Ideally, any bill of rights implemented in the state would permit input from all stakeholders, including providers, before being finalized and widely accessible to residents, providers and the public. A Bill of Rights would clarify and build on national practices for sober homes residents.
2. **Clarify sober homes residents' legal relationships with sober home providers** (e.g., shared living spaces, landlord/tenant relationship) and the legal implications (e.g., rights and responsibilities of both residents and sober home providers) for removing non-compliant residents from sober homes, financial implications and others. Define policies to support protections. Some sober homes have lodging agreements but there is currently no statewide standard that applies to all sober homes.

3. **Clarify the legal process for removing non-compliant sober homes residents** and ensure that clients are not discharged to the street abruptly without having an option for a safe place to go.
4. **Clarify the process of financial relationships between residents and sober home providers** that provide protections for sober home residents.
5. **Clarify policies that 1) protect the rights of individuals who relapse while in a sober home, and 2) the rights of those who live in a home of an individual who has experienced relapse.** Develop compassionate responses to people who relapse.
6. **Develop a "resident's bill of rights" for sober home residents** that specifically addresses process for removing non-compliant residents from sober homes. Currently processes are lengthy, and when second chances are given to residents it becomes a vulnerability for them.
7. **Provide crisis counselor or other mental health supports** and de-escalation training for house managers all in support of residents in crisis.

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