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FINAL REPORT OF THE SENATE RECOVERY RESIDENCES STUDY COMMITTEE (SR 311)

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Senator Kay Kirkpatrick
District 32

Senator Brian Strickland
District 42

Senator Kim Jackson
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Senator Josh McLaurin
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Department of Behavioral Health and Developmental Disabilities

Prepared by the Senate Office of Policy and Legislative Analysis, 2025

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STUDY COMMITTEE CREATION, FOCUS, AND DUTIES

Senate Resolution 311 created the Senate Study Committee on Recovery Residences. Recovery residences provide sober housing to people in recovery for individuals to live in a supportive residential environment where vital life skills for sustaining recovery from addiction are learned and continually practiced in a secure home-like setting. Compared to certified treatment centers, recovery residences *do not* provide treatment and *are not* licensed. While recovery residences are a necessary and useful step for many individuals fighting addiction, the lack of oversight creates a myriad of issues including facilities prioritizing financial gain over resident safety, which creates unsafe environments that could lead to death or injury. The Study Committee was tasked with understanding the services recovery residences provide and to recommend possible solutions for improving the safety at recovery residences and the quality of services these residences provide.

Senator Randy Robertson of the 29th served as Chair of the Study Committee. The other Senate members were Senator Kay Kirkpatrick of the 32nd, Senator Brian Strickland of the 42nd, Senator Jackson of the 41st, and Senator McLaurin of the 14th. Additional members appointed to the Study Committee included Assistant Commissioner for Agency Affairs and Chief Legal Officer Monica Patel, Department of Behavioral Health and Developmental Disabilities.

The following legislative staff members were assigned to the Study Committee: Jackson Fuentes, Senate Press Office; Lindsey Hughes, Senate Office of Policy and Legislative Analysis; William Spencer, Office of Senator Randy Robertson; Caroline Hicks, Senate Budget & Evaluation Office; and Christopher Hennessy, Office of Legislative Counsel.

BACKGROUND

Addiction Treatment & Support History

Recovery residences (also referred to as "halfway houses" or "sober living houses") provide *peer-supported*, alcohol-free and drug-free living environments for people transitioning back into mainstream life following their treatment in an alcohol or drug treatment program, upon release from prison, or while on probation or parole.

The earliest recorded recovery residence was established in the 1840s. These pioneering programs offered structured living environments for individuals on recovery journeys. These early residences built the foundation for a compassionate, community-focused approach to addiction recovery. By the mid-1900s, recovery support models significantly expanded. Mutual support groups and Alcoholics Anonymous houses emerged during this time period and heralded a broader understanding of the vital role that social support plays in successful addiction recovery. By the late 20th century, organizations like Oxford House (discussed below) were established and signaled the shift away from an almost-exclusive clinical focus towards a *peer-led, community-based* recovery environment. Because of society's increased understanding of sustained addiction recovery practices, and the emerging opioid crisis, the early 2000s were a period of growth for regional recovery residence organizations.[1]

Georgia Law and Previously Introduced Legislation

Presently, Georgia does not require licensure for recovery residences because these residences are not classified as formal *treatment centers*, which are covered by Georgia's Rules & Regulations Rule 111-8-53-.01 & .23. Recovery residences are not classifed as treatment centers because these residences provide a supportive living environment for individuals in recovery, but do not *offer clinical treatment*.

This lack of regulation allowed some nefarious actors to provide substandard living conditions because their primary goal is to enrich their owners. One illegal practice is *patient brokering*, where owners accept fees or kickbacks for transporting their residents to certain out-patient treatment providers. Sometimes, these situations involve unlawful agreements in which the recovery houses bring their residents to treatment providers, and in exchange, the treatment providers refer clients who completed their in-patient treatment programs to recovery residences.

To address this issue, Georgia passed Senate Bill 4 in 2021. Now codified in law, O.C.G.A. §26-5-80 makes it unlawful for any person to *pay or offer any compensation* (*e.g.,* commission, benefit, bonus, rebate, kickback, or bribe) to engage in any split-fee arrangement in exchange for referral of a person to or from a substance abuse provider. This law also prohibits any person from *soliciting or receiving any compensation* or engaging in any split-fee arrangement for the referral of person to or from a substance abuse provider or in return for treatment from a substance abuse provider. Consumers can report violations of this law to their local district attorney or the AG's Consumer Protection Division.

In 2024, Georgia passed House Bill 1073, repealing the additional hearing and notice requirements imposed on "halfway houses" (*i.e.,* recovery residences), drug rehabilitation centers, or other facilities for the treatment of drug dependency. Typical zoning requests only take between 15 to 45 days, but prior to HB 1073, a recovery residence's zoning application typically took six to nine months to receive a final zoning decision.[2]

Introduced Legislation

During the 2023 legislative session, Chairman Robertson introduced Senate Bill 331. SB 331 prohibits an individual or organization from operating a recovery residence without Department of Community Health (DCH) certification. This bill also classifies recovery residences into four categories based on services offered, the residence's governance systems, and the personnel on-site. The bill requires DCH to conduct at least *biennial inspections* and outlines a

[1] National Association of Recovery Residences (2011).
[2] Georgia Public Broadcast: "New Zoning Law may help prevent stigma against housing for people in addiction recovery."

process for recovery residences to cure deficiencies found during these inspections. Under this bill, DCH must comply with certain reporting requirements and it establishes additional duties and powers for regulating recovery residences. Additionally, the bill requires certified recovery residences to collect outcome data and comply with other reporting requirements. Lastly, the bill requires any state, county, or local zoning ordinance in Georgia to classify a recovery residence as a *residential use* of property. It prohibits any restrictions, prohibitions, or other provisions that are not also applicable to residential uses in similar types of structures in the same zoning district. This bill did not reach final passage.

Voluntary Certification Organizations

While the State of Georgia does not officially license recovery residences and, historically, its regulatory oversight has been minimal, there are organizations that provide voluntary certification processes.

Georgia Association of Recovery Residences (GARR)

In 1987, seven recovery residential recovery programs organized GARR to distinguish their programs by establishing high-quality standards, ethical operating principles, and third-party oversight. GARR is a National Association of Recovery Residences (NARR) affiliate (*see below for NARR discussion).* While Georgia does not require recovery residences to obtain licenses, GARR offers a voluntary certification process. GARR is discussed more in depth below.

NARR

In 2011, NARR was founded as a response to the lack of a nationally recognized best practices or quality oversight in recovery housing operations (despite such residences existing since the mid-19th century). NARR received input from 48 stakeholders across 12 states to create a nomenclature and standards for the range of peer-based housing and recovery residences. Establishing a common recovery residence language and service quality framework enables providers and stakeholders to communicate more effectively and provide better and more accessible recovery-oriented housing and services based on the Social Model of Recovery. GARR is the designated state affiliate for NARR in Georgia and adheres to NARR's Code of Ethics.

Substance Abuse and Mental Health Services Administration (SAMHSA)[3]

In 2018, the federal government signed into the law the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT). Significantly, Subtitle D: Ensuring Access to Quality Sober Living (SEC. 7031) requires the Secretary of Health and Human Services to identify or facilitate "the development of best practices for operating recovery housing." In conjunction with the SUPPORT legislation, SAMHSA, an agency within HHS focusing on behavioral health, identified ten specific guiding principles to assist federal policy makers in qualifying acceptable sober living programs.[4] Additionally, Section 1232 of the Consolidated Appropriations Act (2023), titled "Developing Guidelines for States to Promote the Availability of High-Quality Recovery Housing," requires SAMHSA to publish best practices for recovery residences. These guidelines serve as guidance for states, governing bodies, providers, recovery house operators, and other stakeholders involved in the recovery process. SAMHSA's guidelines reference NARR's four levels of supporting housing depicted above. SAMSHA's best recovery practices are shown in the table below.

[3] The Winding Road to a Recovery Home.
[4] SAMHSA Sober Living Guidelines and Best Practices: Part One.

Table 2. Recovery Housing Best Practices

Best Practice Number	Topic
Best Practice 1	Be Recovery-Centered
Best Practice 2	Promote Person-Centered, Individualized and Strengths-Based Approaches
Best Practice 3	Incorporate the Principles of the Social Model Approach
Best Practice 4	Ensure Quality, Integrity, Resident Safety and Reject Patient Brokering
Best Practice 5	Integrate Co-Occurring and Trauma-Informed Approaches
Best Practice 6	Establish a Clear Operational Definition
Best Practice 7	Establish and Share Written Policies, Procedures and Resident Expectations
Best Practice 8	Importance of Certification
Best Practice 9	Promote the Use of Evidence-Based Practices
Best Practice 10	Evaluate Program Effectiveness

Model Recovery Residence

GARR/NARR and Oxford House are all involved in recovery housing, but they differ in their structure and focus. While NARR is a national addreditation organization and GARR is a state accreditation organization that establishes standards and promotes best practices for recovery residences, Oxford House is a *specific model* of a self-run, democratically managed, and substance-free living environment.

Oxford House[5]

The first Oxford House was opened in 1975 in Silver Spring, Maryland. By 1987, there were 13 Oxford Houses. Bill Spillane, a professor at Catholic University of School of Social Work in Washington D.C., interviewed about 1,200 former Oxford House residents a decade later. About 80 percent of those early Oxford House residents stayed clean and sober after leaving the house. In 1988, Congress passed P.L. 100-690, the "Anti-Drug Abuse Act". One of the act's provisions required all states to establish a revolving loan fund to provide start-up funds for groups wishing to open sober living homes based on the Oxford House model. These $4,000 loans paid the first month's rent and security deposit, which accelerated the rate at which individual recovering people could find affordable housing. In 2011, Oxford Houses received official recognition of its recovery residence model when it was listed on the National Registry of Evidence-based Programs and Practices. By 2022, Oxford House had more than 20,000 residents at more than 3,500 homes across 47 states and numerous foreign counties.

The Oxford House's Nine House Traditions[6] include:

1. Oxford House's primary goal is the provision of housing and rehabilitative support for the alcoholic and drug addict who wants to stop drinking or using and stay stopped;
2. All Oxford Houses are run on a democratic basis. Our officers are but trusted servants serving continuous periods of no longer than six months in any one office;

[5] All of the information provided below is from Oxford House History.
[6] Oxford House Traditions.

3. No Member of an Oxford House is ever asked to leave without cause—a dismissal vote by the membership because of drinking, drug using, or disruptive behavior;
4. Oxford House is not affiliated with Alcoholics Anonymous or Narcotics Anonymous, organizationally or financially, but Oxford House members realize that only active participation in Alcoholics Anonymous and/or Narcotics Anonymous offers assurance of continued sobriety;
5. Each Oxford House should be autonomous except in matters affecting other houses or Oxford House, Inc., as a whole;
6. Each Oxford House should be financially self-supporting although financially secure houses may, with approval or encouragement of Oxford House, Inc., provide new or financially needy houses a loan for a term not to exceed one year;
7. Oxford House should remain forever non-professional, although individual members may be encouraged to utilize outside professionals whenever such utilization is likely to enhance recovery from alcoholism;
8. Propagation of the Oxford House, Inc., concept should always be conceived as public education rather than promotion. Principles should always be placed before personalities; and
9. Members who leave an Oxford House in good standing are encouraged to become associate members and offer friendship, support, and example, to newer members.

Financial Overview

Residents' Financial Responsibilities

Recovery residences typically cost between $500 to $5,000 per month depending on the location, amenities, and support services. Because recovery residences are not classified as formal treatment programs, insurance coverage for these residences is limited under most health insurance plans. Recovery residents are generally expected to take financial responsibility for their stay as a necessary step for fostering independence and accountability. These expenses include rent, utilities, and other living costs. While each home may have different rules and financial expectations, the emphasis on personal responsibility is the common thread.[7]

Recovery Residences Funding

In recent years, recovery residences have become eligible for benefits from government assistance. For example, HUD allocated funds through programs like the Recovery Housing Program (RHP), which the SUPPORT for Patients and Communities Act authorized. RHP eligible activities include:

1. Public facilities and improvements;
2. Acquisition and disposition of real property;
3. Payment of lease, rent, and utilities;
4. Rehabilitation, reconstruction, and construction of both single family, multifamily, and public housing;
5. Clearance and demolition;
6. Relocation; and
7. Administration and technical assistance.

Potential Legal Issues

Housing Discrimination

After the passage of the Anti-Drug Abuse Act of 1988, Oxford Houses proliferated. During the early 1990s, communities in "good neighborhoods" sought to close Oxford Houses because local zoning ordinances restricted the number of unrelated individuals that could live together in a single-family home. In response, Congress amended the Federal Fair Housing Act to include protection against discrimination for disabled individuals. Presently, addiction is recognized as a chronic brain disease affecting major life functions, and individuals in recovery are classified as disabled under 42 U.S.C. § 3604 (f)(1)(B) and 24 C.F.R. § 100.201(a)(2). Because of this classification, recovery house

[7] How Sober Living Homes Are Funded: Key Financial Insights.

residents are protected under the FHA and ADA. Additionally, operators of recovery housing, whether nonprofit or for-profit, are also legally protected under federal law. Discrimination against a recovery housing provider is often considered discrimination against individuals with disabilities.[8]For example, cities **cannot** impose additional occupancy permits or zoning restrictions on recovery housing that are not required for other single-family residences.[9] In Georgia, as discussed above, HB 1073 repealed the additional hearing and notice requirements imposed on halfway houses (*i.e.*, recovery residences), drug rehabilitation centers, or other facilities for the treatment of drug dependency.

Paid Work Agreements
A paid work agreement is where a resident either works for the organization or receives a discount on rent or other form of payment for performing work for the organization. Paid work agreements also apply if the resident performs work for an affiliated organization, or an organization owned or operated by the same owners, employees, or family members. All GARR-certified recovery houses must have a paid work agreement policy. Recovery housing operators must also ensure that any paid work agreements comply with local, state and federal labor, tax, and employment laws.[10]

Privacy and Confidentiality[11]
Privacy and confidentiality are crucial for ensuring that individuals feel safe and protected throughout their addiction treatment journey. Two key regulations that address privacy and confidentiality in the context of addiction recovery are Health Insurance Portability and Accountability Act (HIPPA) regulations and the Confidentiality of Alcohol and Drug Abuse Patient Records.

HIPPA establishes national standards to protect individuals' medical records and other personal health information from unwanted disclosure or use. HIPAA provides federal protections for protected health information (PHI) held by covered entities and gives patients the right to examine their health care records and request corrections. While HIPAA is essential, its standards may be insufficient to protect privacy and confidentiality of information related to substance use conditions. Patients with substance use problems are often worried about the potential illegality of their behaviors, and a breach of privacy can significantly impact their health, employment, insurance, relationships, and rights.

The *Confidentiality of Alcohol and Drug Abuse Patient Records*, also known as *42 C.F.R. Part 2*, is a set of regulations issued in 1975 and revised in 1987. 42 C.F.R. Part 2 is a regulation specific to substance abuse treatment. It imposes additional privacy protections that are more stringent than HIPAA. These protections encourage individuals to seek treatment without the fear of their information being disclosed without their consent. Specifically, substance abuse treatment programs cannot disclose any patient information that would directly or indirectly identify a patient with alcohol or drug abuse problems, unless the patient provides written consent. Violations may result in civil penalties.

Other States' Legislation
Currently, only three states enacted mandatory licensing for recovery residences. In 2014, Utah was the first state to mandate licensing for recovery residences. New Jersey followed in 2018, requiring sober living homes to register for a "Cooperative Sober Living Residence License" with New Jersey's State Department of Community Affairs. Any home found operating without a license is subject to a $5000 fine. In 2020, Arizona began requiring sober living homes to register for licenses.

[8] Vanderburgh House: Rental Housing Discrimination in Recovery Housing: Protections and Legal Rights.
[9] City of Edmonds v. Oxford House, Inc., 514 U.S. 725, 1995.
[10] Oxford House Traditions.
[11] New Horizon Centers: Legal Issues in Addiction Recovery.

For some states where licensing is not mandatory, one common method to incentivize certification is to only allow certified residences to receive state or federal funding. For example, in Ohio, certification is still voluntary, but there are some regulations surrounding sober living. These regulations include:

- Banning sober living homes from placing time limits for residency;
- Requiring sober living homes to accept residents who use MAT as a part of their recovery plan;
- Cutting state-backed funding to any sober living home that desclines to seek optional certification with Ohio Recovery Housing; and
- Creating an optional registry for certified recovery homes, know as the Ohio Recovery Housing Locator.

SUMMARY OF TESTIMONY AND DISCUSSION

SENATE STUDY COMMITTEE ON RECOVERY RESIDENCES MEETING ONE

Date: August 18, 2025
Location: CLOB 307—Atlanta, Georgia
Topic: Introductory Meeting—The Disease of Addiction

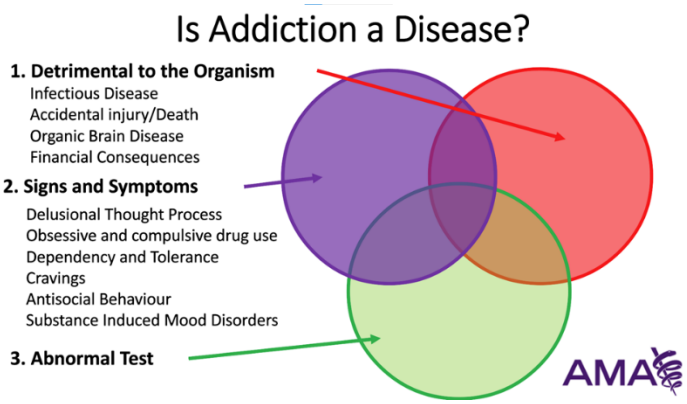
Attendees and Speakers

Members: R. Robertson (Chair); K. Kirkpatrick; K. Jackson; J. McLaurin; M. Patel
Speakers: J. Craig (Highland Rivers Behavioral; North Georgia Recovery Center; Metro Atlanta Recovery Residences)

Summary of Testimony

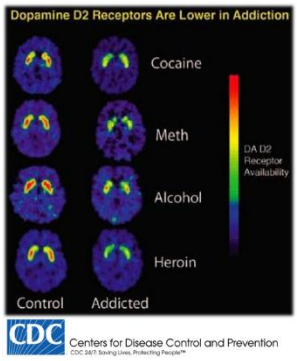
1. Dr. James C. Craig, (Highland Rivers Behavioral; North Georgia Recovery Center; Metro Atlanta Recovery Residences)

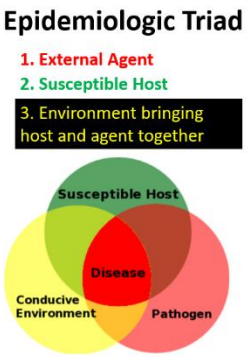
Dr. Craig discussed his medical background and his subspeciality in addictionology. He works with Highland Rivers Behavioral Health, North Georgia Recovery Center, and Metro Atlanta Recovery Residences (MARR). Dr. Craig discussed the organizations' studies that form the basis of his presentation (e.g., SAMHSA, CDC, NIH, NAMI, World Health Organization, HHS, and American Society of Addiction of Medicine (ASAM)).



Dr. Craig defined addiction as a treatable, lifelong, non-curable disease. It involves complex interactions among brain circuits, genetics, the environment, and the individual's life experiences. Why someone starts using drugs or alcohol and why they *can't stop* are not the same thing. Problematic drug use is not the same thing as addiction. One can abuse alcohol without being an alcoholic (e.g., college-age students who drink too much on the weekend, but are not addicted). Dr. Craig discussed the three criteria for classifying or defining a disease. To classify a disease, it must be: (1) detrimental to the organism, (2) possess signs and symptoms, and (3) there must be an abnormal test showing a positive result in a person with the disease and a negative result in a person without the disease. Opiate overdose is the number one cause of accidental injury or death in individuals 19-24 years old.

Dr. Craig discussed the distinct signs and symptoms of addiction (e.g., delusional thought process, obsessive and compulsive drug use, dependency and tolerance, cravings, antisocial behavior, and substance induced mood disorders). With respect to the disease of addiction, the drug of choice is not the most important factor. Ultimately, the drug creates a craving within the individual. A craving is not thinking about drinking or doing drugs. Rather, a craving is very self-limited neurological response that doctors can see on an fMRI. In fact, studies show how doctors can cue a person's craving for an fMRI (e.g., sparking a lighter in the patient's ear).

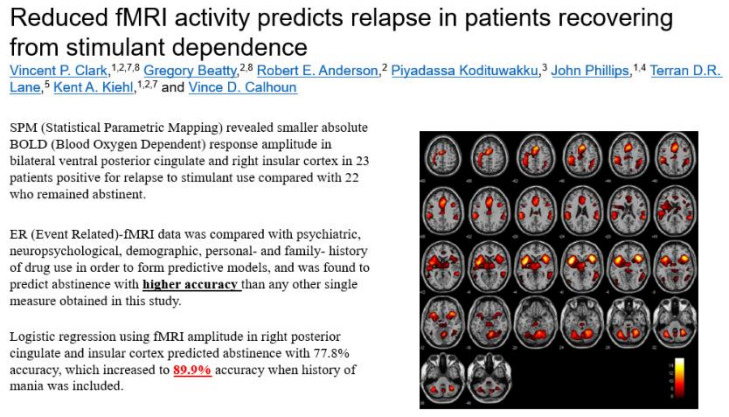




Dr. Craig discussed substance induced mood disorders and how one cannot diagnose a mental illness during substance use and withdrawal because there are too many things occurring, mentally and physiologically, for a proper diagnosis. There is a revolving door effect when doctors prescribe certain medications for "mental illnesses" diagnosed during the substance use and withdrawal stage—that is, when a patient feels discomfort again (caused by the newly prescribed medications), they relapse. Dr. Craig presented PET scan imaging showing various addicts' brains. The scans show brains lacking proper amounts of dopamine—in essence, brains that are overwhelmed with how underwhelming life is. The PET scans show how cocaine, meth, alcohol, and heroin impact these dopamine levels. Dr. Craig stated his patients do not use drugs to party, but to function.

Dr. Craig reviewed a study where individuals with sufficient levels of dopamine reported unpleasant experiences with drugs versus individuals with low levels of dopamine. Genetics impact children's dopamine levels. For example, a child of parents' suffering from addictions typically has naturally lower levels of dopamine. Dr. Craig discussed a series of studies from 2007 showing brain scans from a non-user patient and a patient on cocaine. As drug use continues, dopamine is depleted in the orbitofrontal cortex (OFC), which is why addiction is a progressive disease. The most powerful predictor of relapse is brain-imaging scans. It can predict relapse with 77.8% to 89.9% accuracy.

Dr. Craig provided a general overview of medication-assisted recovery (MAT). MAT on its own is not sufficient for recovery. There must be behavioral changes as well for the best chances of long-term success. With drugs like psilocybin or ibogaine therapy, it is effectively a control-alt-delete situation on the mesolimbic reward pathway. It resets the pathway, and individuals may remain sober for a period of time, but typically relapse. Dr. Craig discussed the brain's anatomy and how addiction is a dopamine insufficiency where patients seek out solutions to feel normal, including obsessive and compulsive drug use. Ultimately, a patient's dopamine levels can return to the level prior to substance abuse, but it depends on patient's recovery efforts. If recovery is just about removing the substances, then the dopamine levels likely will not return to normal levels. Recovery based in whole life solutions (e.g., seeking dopamine boosts through activities like hiking or meditation) gives patients the best chance to return their dopamine levels to normal.


Reduced fMRI activity predicts relapse in patients recovering from stimulant dependence

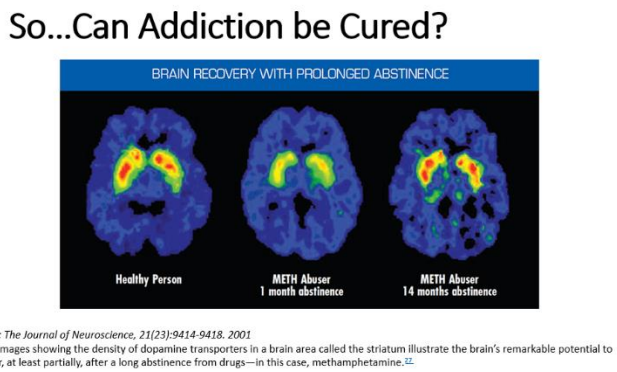
Vincent P. Clark,[1,2,7,8] Gregory Beatty,[2,8] Robert E. Anderson,[2] Piyadassa Kodituwakku,[3] John Phillips,[1,4] Terran D.R. Lane,[5] Kent A. Kiehl,[1,2,7] and Vince D. Calhoun

SPM (Statistical Parametric Mapping) revealed smaller absolute BOLD (Blood Oxygen Dependent) response amplitude in bilateral ventral posterior cingulate and right insular cortex in 23 patients positive for relapse to stimulant use compared with 22 who remained abstinent.

ER (Event Related)-fMRI data was compared with psychiatric, neuropsychological, demographic, personal- and family- history of drug use in order to form predictive models, and was found to predict abstinence with **higher accuracy** than any other single measure obtained in this study.

Logistic regression using fMRI amplitude in right posterior cingulate and insular cortex predicted abstinence with 77.8% accuracy, which increased to **89.9%** accuracy when history of mania was included.

Dr. Craig discussed the "default mode network". The default mode network is comprised of the medial prefrontal cortex and the posterior cingulate cortex. This network is active during passive rest and mind-wandering, which usually involves thinking about others, thinking about one's self, remembering the past, and envisioning the future rather than the task being performed. The default mode network is ego. Dr. Craig stated every quality treatment program is predicated on reducing the ego. Higher default mode network rates are correlated with higher rates of relapse.

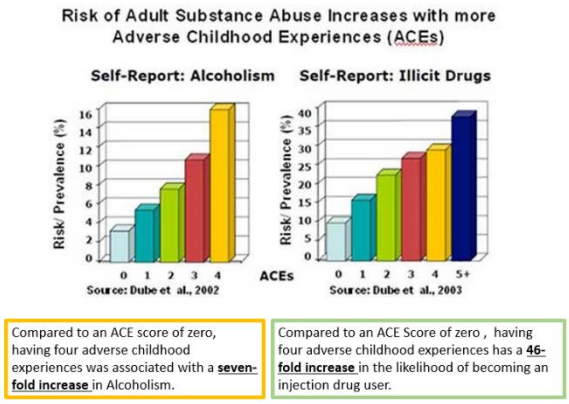


Source: The Journal of Neuroscience, 21(23):9414-9418. 2001
These images showing the density of dopamine transporters in a brain area called the striatum illustrate the brain's remarkable potential to recover, at least partially, after a long abstinence from drugs—in this case, methamphetamine.[57]

Dr. Craig discussed neuroplasticity and a person's brain during recovery. Once an individual is past the dependency stage, their brain's neuroplasticity can return their dopamine levels to a more normal baseline. Dr. Craig discussed the importance of removing all substances (e.g., cigarettes) that cause dopaminergic surges during recovery. Brain scans show a meth user's brain after one-month of abstinence and 14 months of abstinence. After 14 months, the brain showed more normal levels of dopamine. Dr. Craig highlighted how insurance coverage for recovery or rehabilitation centers typically only covers 28 days. He stated this is not a sufficient amount of time and such a scenario sets the patient up for failure.

Understanding genetics for the disease of addiction is important. Addiction is 50% heritable. For comparison, breast cancer is 5% heritable. Knowledgebase for Addiction Related Gene (KARG) mapped 396 genes that cause addiction or making existing addictions worse. Doctors can test for these genetic markers with a blood test at birth. Dr. Craig discussed the OPRM1 receptor and how opioids bind to this receptor. These genes are not specific to only addictions to substances, but can also be indicative of other addictions like gambling and sex addictions.

Dr. Craig discussed the interaction between trauma and addiction. Trauma is defined as adverse childhood experiences (ACEs) for purposes of this discussion. Dr. Craig provided the ACE Score for childhood trauma—10 factors indicative of trauma (e.g., physical abuse by parent, emotional abuse by parent, sexual abuse by anyone, etc.). Such experiences occur prior to the age of 18. 59% of the population has had 0-1 "ACEs". Traumatic events are not causative in addiction, but rather associative. For example, having an ACE score of 4 makes it 46x more likely the person will use opioids. Ultimately, trauma physically changes the brain in a developing child. For example, stress increases cortisol, which is a neuropeptide that can trigger hypervigilance. If constantly triggered, it impacts the brain. In a high cortisol environment, a person experiences cellular change in the hippocampus. Specifically, the amygdala experiences profound changes. Dr. Craig discussed the support models necessary to prevent ACEs.



Dr. Craig discussed addiction treatment options. Because addiction is a complex brain disorder, treatment plans must be individualized to address the unique circumstances within that individual's brain. Dr. Craig referenced ASAM's best practices for treatment and noted that recovery residences are a part of the ASAM continuum. A patient's treatment depends on the patient's stage of addiction. Once a patient abstains from the substances, doctors can then determine if there are any substance induced mood disorders or other existing factors. Then, a doctor can create an individualized, behavioral-based recovery plan (e.g., meditation, exercise, etc.). Regarding the optimal length of treatment, Dr. Craig stated there must be triage system. ASAM criteria parses out severity of illness, which helps determine treatment. Currently, too many patients with a severe addiction receive an inadequate level of care. These programs do not provide enough information or resources for these more severe cases. These bad treatment experiences then leave the individual less likely to return to treatment in the future. Dr. Craig stated some of the

issues in recovery residences are exacerbated by the lax recovery residence environment. It is important to balance housing concerns and stability with an effective recovery residence structure that properly supports an individual's continued recovery.

Further, individuals must receive treatment concurrently for the substance abuse disease and any underlying mental health illnesses. The current treatment crisis is caused by a lack of funding and other resources. A key component of treatment is teaching the underlying brain disorder. Not only do patients not understand the disease, but doctors treating this disease do not fully understand it. Educating the patient helps them understand their brain disorder is not a moral or ethical failure on their part. Dr. Craig stated addiction is the only disease or mental illness that society tries to cure by making the symptoms illegal to have.

Dr. Craig discussed how the criminal justice system impacts individuals struggling with addiction. He stated one cannot treat addiction by penalizing the symptoms. For example, with diabetes, a person does not treat that disease by arresting candy bar manufacturers. For a person struggling with addiction, criminal violations constitute a symptom (i.e., antisocial behavior) that must be addressed, but death or prison should not be the only options. Balancing valid public safety interests (e.g., preventing breaking and entering) with valid public health concerns (i.e., treating addiction is a disease) is critical to implementing effective policies.

Dr. Craig discussed how the War on Drugs exacerbates existing problems and often creates new, worse problems. For example, synthetic marijuana was a response to Delta 9 being illegal. Synthetic marijuana was then legal, but more dangerous, as it was more likely to induce psychosis. Another example is kratom in gas station. Kratom was a response to the opioid crisis, and it is now a legal, dangerous problem. Dr. Craig discussed harm reduction efforts (e.g., SB 6 permitting the use of drug analysis equipment and packaging materials for the specific purpose of detecting whether a controlled substance has been adulterated without classifying the equipment as illegal "drug-related objects"). He supports harm reduction efforts because he prioritizes his patients remaining alive. Ultimately, arrests present an opportunity for substance abuse disorder screening. An arrest can jumpstart an individual's treatment plan. If an individual enters the criminal justice system, Dr. Craig stated arrest, stabilization, and treatment is the optimal path. Therefore, accountability courts mitigate the stigma associated with the criminal consequences of addiction as a disease.

SENATE STUDY COMMITTEE ON RECOVERY RESIDENCES MEETING TWO

Date: September 12, 2025
Location: Capitol 450—Atlanta, Georgia
Topic: Addiction Support Organizations

Attendees and Speakers

Members: R. Robertson (Chair); K. Kirkpatrick; M. Patel (DBHDD);
Speakers: Candice Whittaker (Georgia Association of Recovery Residences "GARR"); Lisa Kugler (Shatterproof Treatment Atlas); Jarrod Windham (El Shaddai Recovery Residence, Georgia Addiction Counselors Association "GACA")

Summary of Testimony

1. Jarrod Windham, Georgia Addiction Counselors Association, El Shaddai Recovery Residence

Mr. Windham described his background as a Certified Addiction Counselor Level 2, who represents Region 5—Middle Georgia—with the Georgia Addiction Counselors Association (GACA). GACA issues addiction-focused credentials for addiction counseling in Georgia:

a. Counselor-In-Training Certification (CCIT) – a temporary, transitional certification for trainees which must be completed within a 3-year period.

b. Certified Addiction Counselor, Level I (CACI) – a certification for addiction counselors who meet the minimum requirements in Georgia.
c. Certified Addiction Counselor, Level II (CACII) – a certification for addiction counselors who hold a Bachelor's degree or higher and meet the level two requirements.
d. Certified Clinical Supervisor (CCS) – a credential for clinicians who supervise addiction counselors and meet the requirements of GACA.
e. Certified Master Addiction Counselor (CMAC) – a **new** certification for addiction counselors who hold a Master's Degree or Higher.

A Certified Addiction Counselor can only diagnose substance abuse disorders, not any other mental health disorders, and cannot prescribe medicine. GACA supports GARR's certification work and continuing education training.

Mr. Windham also runs El Shaddai Refuge, Inc. (ESR), a recovery residence in Laurens County. ESR is a men's recovery residence offering 6 beds. ESR is Christian-based and typically serves previously incarcerated individuals (e.g., currently, ESR houses 4 individuals who were mandated by court to reside at a recovery residence). Such individuals must complete their court-mandated stay at a recovery residence in order to avoid further imprisonment. These residences are an important diversion option available most often through accountability courts.

ESR conducts an intake interview, typically over the phone—especially an individual is still incarcerated. During this intake call, ESR describes the recovery residence, including its more rural location in a log cabin. ESR requires a minimum of 12 months at the residence, with up to 18 months. After the intake interview, an individual receives an acceptance letter that he or she can present to the judge if this is a court-mandated stay. The court then arranges for the individual to be transferred. Often, these individuals remain under the supervision of the court or probation/parole officers.

There is substantial variety in recovery residence models because of Georgia's lack of regulation, which allows nefarious actors to operate. Because of this, ESR received voluntary certification through GARR and is also Transitional Housing for Offender Reentry (THOR) Housing Approved by Georgia. ESR is a flat fee residence that offers basic amenities and provides a regimented schedule to create a safe environment as a means to promote recovery. Upon arrival, ESR prohibits any communication with the outside world for at least 30 days in order to reduce the likelihood of relapse. Once residents complete this introductory period, they may use their phones with the Bark app. Bark can block specific apps and websites—thereby, reducing the potential of relapse from outside influences. Additionally, ESR assists residents with securing employment and promotes personal finance skills.

ESR helps residents attend Alcoholics Anonymous or Narcotics Anonymous meetings as well as other group meetings in the evening that promote evidence-based, behavior modification practices including cognitive behavioral therapy and acceptance and commitment therapy. Upon successfully completing his stay, the resident receives a certificate of completion. ESR keeps residents' files on site, but a resident must ultimately approve of the release of their information. While HIPPA does not apply to resident's files, *Confidentiality of Alcohol and Drug Abuse Patient Records*, also known as *42 CFR Part 2* applies. 42 CFR Part 2 is a regulation specific to substance abuse treatment. It imposes additional privacy protections that are more stringent than HIPAA. These protections are intended to encourage individuals to seek treatment without the fear of their information being disclosed without their consent. Specifically, substance abuse treatment programs cannot disclose any patient information that would directly or indirectly identify a patient with alcohol or drug abuse problems, unless the patient provides written consent. Violations of these regulations can result in civil penalties.

In addition to GARR's voluntary certification, Laurens County required ESR to obtain a Recovery Residence Permit. Laurens County required these permits beginning on January 1, 2021. Specifically, Laurens County requires any

recovery residence in its county to comply with the standards established by GARR. The county's resolution lists standards that recovery residences must follow in its county. These standards include, but are not limited to:

- The residence must be in good repair, clean, and well maintained;
- 50+ square feet per bed per sleeping room;
- A minimum of one sink, toilet, and shower per six residents;
- Each resident has personal item storage;
- Each resident has food storage space;
- That laundry services are accessible to all residents;
- All appliances are in safe, working, condition;
- A meeting space large enough to accommodate all residents;
- A comfortable group area providing space for small groups and socializing;
- Kitchen and dining areas large enough to accommodate all residents;
- A safety inspection;
- A policy regarding smoke-free living environment and/or designated smoking area outside the residence;
- Emergency numbers, procedures (including overdose and other emergency responses) and evacuation maps are posted in conspicuous locations;
- Resident rights, rules, responsibilities, schedules, emergency procedures, emergency numbers, staff contact numbers, and grievance process are posted in the residence; and
- Resource directories, written or electronic, are made available to residents.

2. <u>Candice Whittaker, Georgia Association of Recovery Residences</u>

GARR recognizes that addiction is a chronic brain disease that affects the brain's reward system. Substances alter dopamine levels, the neurotransmitter responsible for pleasure and motivation, causing the brain to crave repeated use. Over time, this disrupts normal brain functioning, making it difficult for individuals to stop using the substances without treatment. Currently, Georgia does not recognize alcoholism as a substance abuse disease or disorder for purposes of treatment center regulations. DBHDD is changing this oversight. Because recovery residences are not treatment centers, Georgia does not regulate these residences.

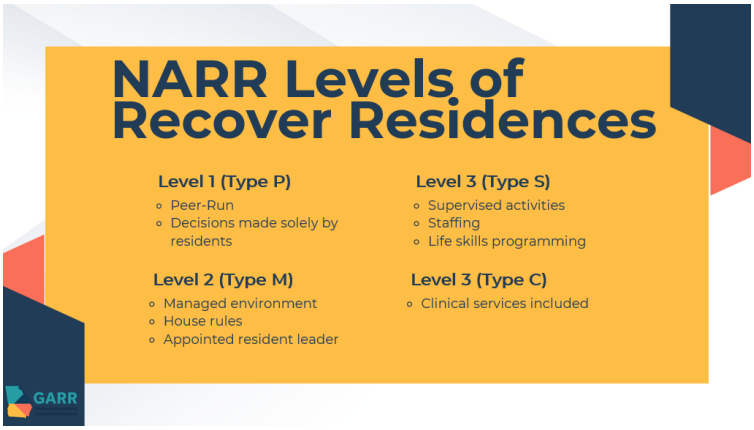
In 1987, seven residential recovery programs organized GARR to distinguish their programs by establishing high-quality standards, ethical operating principles, and third-party oversight. GARR is a National Association of Recovery Residences (NARR) affiliate. In 2011, NARR was founded as a response to the lack of a nationally recognized best practices or quality oversight in recovery housing operations (even though such residences have existed since the mid-19th century). NARR received input from 48 stakeholders across 12 states to create a nomenclature and standards for the range of peer-based housing and recovery residences. Establishing a nationally-recognized, common recovery residence language and service quality framework enables providers and stakeholders to communicate more effectively and provide better and more accessible recovery-oriented housing and services based on the Social Model of Recovery.

GARR believes in the highest quality of care for individuals needing recovery residence services. To achieve this goal, GARR provides it members a framework based upon evidence-based standards, ethics, and education. While Georgia does not require recovery residences to obtain licenses, GARR offers a voluntary certification process. GARR's

certification process includes submitting certain documentation and a site visit. Recovery residences must submit documentation outlining the organization's policies and procedures. GARR classifies an organization's documentation into four categories including administrative documents, resident oriented documents, and Level 3 & 4 Required Policies.

Required administrative documents include, but are not limited to:

- a mission and vision statement;
- a non-discrimination statement permission to operate (i.e., written permission from the property owner of record, if the owner is not the recovery residence operator, to operate a recovery residence on the property);
- a proof of insurance; and
- a code of ethics.



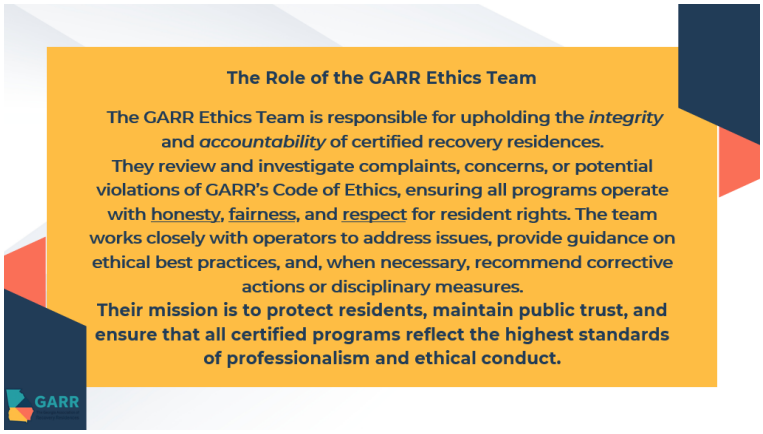
Required "resident oriented documents" include, but are not limited to:

- an admission, discharge, readmission policy;
- a resident agreement (must be signed by the resident and include specific details including information about deposits, monthly or weekly fees, and non-financial information like house rules);
- a statement of resident rights, which must be given to every resident and kept in the residence's common room (as a best practice, this statement should inform residents about their right to non-discrimination, right to fair housing, right to file a grievance in accordance with the residence's policy, and a right to a statement of financial account and to receive receipts);
- a privacy policy;
- medication policy;
- a good neighbor policy (i.e., name and contact information of a person neighbors can contact if they have a concern); and
- a residential financial affairs disclaimer (i.e., a written policy prohibiting staff from becoming involved in the personal financial affairs of residents including loaning money or borrowing money from residents).

Level 3 & 4 Required Policies include, but are not limited to:

- a staffing plan showing how the residents will be appropriately staffed to provide the services and supports listed at the residence; and
- a resident's records secured policy (i.e., a written policy limiting access to resident records to only approved staff).

GARR also requires all full-time recovery residence staff to be CPR, First Aid, and Narcan trained. Narcan must also be accessible in a properly labeled storage space in office and living spaces. When applying for recertification with GARR, a recovery residence must resubmit the information described above and GARR recommends attending at least one recovery residence Zoom workshop. The recovery residence must also submit outcomes from the previous year. Currently, because a lot of recovery residents hire individuals who are in long-term recovery, and may have a criminal history related to his or her substance abuse disorder, GARR does not require its certified residences to complete background checks on its staff. Furthermore, GARR does not review the owner's financials.



GARR-certified recovery residences also typically receive education on other mental health disorders—that is, the operators learn how to identify schizoaffective disorders, but not to diagnose. After identifying individuals with additional mental health disorders, these operators can refer these individuals to additional services. Additionally, GARR offers cultural competency training so recovery residences can better serve a diverse demographic.

GARR does not receive state funding. GARR applied for 501(c)(3) status, which will allow them more access to additional funding. GARR's annual fee for members is based on bed size because inspecting recovery residences with more beds requires more time and resources. Ultimately, demanding more money from recovery residences is passed down to the residents themselves. Often recovery residences waive fees so individuals are not precluded from recovery because of financial issues. Recovery residences and treatment centers are also struggling financially because insurance rates increased.

Currently, in Georgia, there are 110 certified locations totaling over 3,624 beds. There are 24 residences completing the certification process (GARR noticed an increase in voluntary certification requests after Georgia announced this committee). There are still likely thousands of residences and beds uncertified. GARR does not have enforcement power to close unqualified recovery residences. GARR has noticed real estate groups incentivizing people to operate apartment complex style recovery residences without any actual oversight or standards (i.e., a flop house).

Ideally, GARR wants Georgia to regulate recovery residences. Such legislation could designate or recognize GARR as the certification entity (i.e., like Laurens County recovery residence permit resolution). GARR supports legislation like Ohio's recovery residence legislation.

Ohio's legislation states: "Beginning January 1, 2025, no person or government entity may:

1. operate a recovery housing residence unless the residence is accredited or, if newer (in operation for not more than 18 months), actively engaged in efforts to obtain accreditation from one of the organizations specified above; or
2. advertise or represent a residence to be a recovery housing residence, sober living home, or any other alcohol and drug free housing for persons in recovery unless such residence is on the recovery housing residence registry. If either prohibition is violated, the Ohio Mental Health & Addiction Services (OhioMHAS) Director may seek a court order enjoining the prohibited conduct (the prohibition on advertising does not, however, prohibit a halfway house from advertising that it is alcohol and drug free housing for persons recovering from alcohol use disorder or drug addiction).

- No community addiction services provider or community mental health services provider may refer a client to a recovery housing residence unless the residence is on the recovery housing residence registry on the date of the referral. The OhioMHAS Director may refuse to certify services and supports, refuse to renew certification, or revoke the certification of a provider that violates this prohibition".

OhioMHAS recognizes Ohio Recovery Housing's (ORH) certification and Oxford House's charter as appropriate accreditation sources. ORH is a NARR affiliate like GARR. GARR's main concern with potential state regulation is that GARR would not be included as a stakeholder and that state's legislation will shut down the places doing good work.

3. Ian Neubauer, Attorney and Owner/Operator of Second Chance Recovery

Second Chance Recovery Residences is based out of Sandy Springs and provides a variety of structured living environments from apartments to country club housing. Mr. Neubauer is also an attorney who focuses on zoning issues faced by recovery residences. Recovery residences do not fit under a clean umbrella for legal and regulatory purposes. As such, recovery residences often face zoning hurdles from disparate county and municipality zoning requirements. Specifically, different jurisdictions may define single-family residences or group homes in a way that precludes recovery residences from qualifying. Cities and counties may also implement other rules that ultimately prevent recovery residences from operating in the area.

For example, the City of Roswell defines up to three unrelated individuals in one house as family whereas it classifies a group home as six individuals within one dwelling unit (not every county or city provides such a classification). Roswell also requires 3,500 feet of separation between group homes. Roswell defines group homes to include not only recovery residences for individuals with substance abuse disorders, but also group homes for other individuals (e.g., individuals with intellectual disabilities). Ultimately, even though these types of group homes serve different populations and purposes, Roswell still requires 3,500 feet of separation between these homes in order to "maintain the character of the community" (i.e., to not allow the area to become a commercial zone). This regulation impacted Mr. Neubauer and Second Chance last year. Specifically, prior to purchasing another home for its program, Second Chance inquired with the city about whether the house could qualify as a group home and comply with all necessary zoning regulations including the distance requirement. The city official affirmed the new house complied with all the requirements. Second Chance purchased the home. Within a week of its purchase, Roswell informed Second Chance that the new home was 140 feet too close to another group home.

Inconsistency in zoning laws and other building/life safety code requirements for these single-family dwellings often prevent recovery residences from operating in certain jurisdictions. In fact, counties or cities may require recovery residences to complete certain retrofits in order to comply with building/life safety code requirements. These retrofits can cost more than $100,000, which most recovery residences cannot afford—thereby, effectively shutting down the recovery residence overnight. Opposition to recovery residences stems from ignorance about these residences and a "not in my backyard" mentality. Across Georgia, the demand for recovery residences is too high for the state to not regulate this area.

4. Lisa Kugler, Shatterproof Treatment Atlas

Understanding substance abuse disorder (SUD) can be confusing given the nuances within the field. Multiple levels of care exist for services in SUD and often individuals are unsure about which level of care they need. Individuals often face multiple barriers when accessing care (*e.g.*, stigma, limited confidentiality, limited availability of treatment in certain communities, waitlists, insurance challenges, and criminal justice involvement). Additionally, there is no widely accepted standard for clinical quality in SUD care (*i.e.*, there is no standard review or ranking system for recovery residences). Often, the tools comparing SUD treatment options purport to measure quality of care, but do not focus on key clinical indicators.

Shatterproof is a national nonprofit dedicated to reversing the addiction crisis in America, Atlas is a platform operated by Shatterproof that is improving the quality of addiction care nationally by setting clear and transparent expectations and standards. Atlas compares treatment facilities to see which provide high-quality addiction care according to the Shatterproof National Principles of Care (pictured above) and find the treatment one needs based on:

a. Location of the program;
b. Facility protocol to follow best practices;
c. Known information on insurance and alternate methods of payment selected;
d. What groups are served; and
e. The types of treatment services offered.

Atlas relies upon its Principles of Care to assess the quality of addiction treatment providers/facilities. This allows for standardized data gathering and validation processes for all SUD treatment facilities. Shatterproof provides a consumer-friendly needs assessment that is endorsed by ASAM. Shatterproof Atlas developed an assessment tool based upon the American Society of Addiction Medicine (ASAM) standards. The assessment is ten questions related to the severity of the substance use, type of substance use, an individual's clinical needs, etc. The assessment is integrated with a robust facility treatment locator. The dynamic filters guide consumers or case management teams to evidence-based care as indicated for the individual's diagnosis.

To aggregate data, Shatterproof Atlas surveys licensed or credentialed providers. Overall, Shatterproof boasts a 60% survey completion success rate. In Pennsylvania, Shatterproof Atlas has a contract with the Department of Drug and Alcohol Planning for the expansion of Atlas within the state. Because Pennsylvania encourages its SUD treatment providers to share information, Shatterproof has an 80% survey completion success in the state. Atlas does not permit advertisements on its app. The rankings are solely based on the facilities performance under Shatterproof's Principles of Care.

SENATE STUDY COMMITTEE ON RECOVERY RESIDENCES MEETING THREE

Date: October 3, 2025
Location: Capitol 450—Atlanta, Georgia
Topic: Addiction Support Recovery Organizations

Attendees and Speakers

Members: R. Robertson (Chair); K. Kirkpatrick; M. Patel (DBHDD)
Speakers: Sherri Bloodworth & Mary Elliott (Department of Community Supervision "DCS"); Amanda O'Shields & Jack Edwards; Andy Lord; Laurisa Barthen (Georgia Council for Recovery "GCR"); Jeff Breedlove (American Addiction Recovery Association "AARA")

Summary of Testimony

1. Sherri Bloodworth & Mary Elliott, Department of Community Supervision

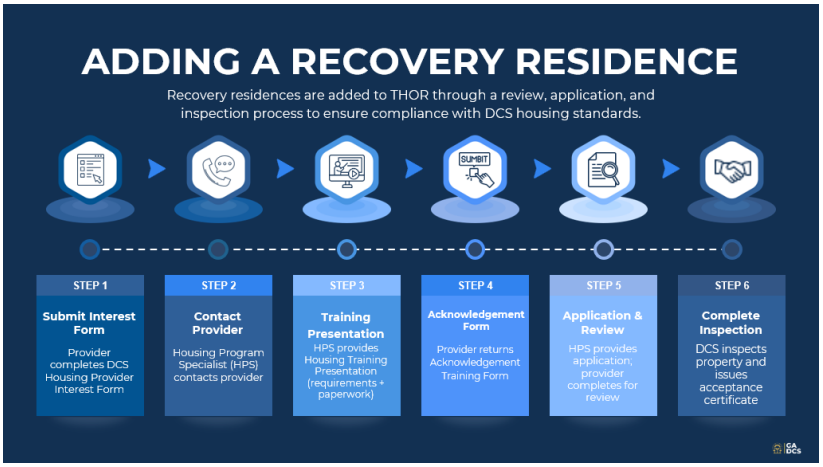
Ms. Bloodworth is the Director of Operations for DCS and Ms. Elliott is the Director of Reentry Services for DCS. DCS monitors and supports individuals under state supervision (*i.e.*, probation or parole). DCS maintains an online directory called the Transitional Housing Opportunities for Reentry (THOR). THOR began as a resource for probation and parole officers to recommend reliable and ethical transitional housing options, but is now accessible online to the public. For facilities included on THOR, DCS must be allowed to enter the premises and conduct their checks as it relates to the individuals under parole or probation. THOR helps staff and supervisees find transitional housing that supports accountability, stability, and successful reentry. THOR classifies facilities into two categories—Structured Housing and Recovery Residence, which are subject to certain inclusion criteria that substantially mirrors the Department of Housing and Urban Development's (HUD) habitability form. There are currently 107 facilities listed on THOR.

In order to be included in THOR, recovery residences must be accredited. However, THOR is not an accreditation authority. Therefore, a recovery residence must be accredited by one of the following agencies: GARR, Department of Community Health (DCH), Commission on Accreditation of Rehabilitation Facilities (CARF), or Joint Commission Accreditation for Healthcare Organizations (JCAHO).

DCH licenses and oversees all drug treatment facilities in Georgia to ensure compliance with state standards. Recovery residences are not regulated by DCH because Georgia law does not classify recovery residences as treatment centers. GARR, discussed above, has certified 110 recovery residences. CARF is an international organization that sets quality standards for health and human service programs by focusing on person-centered care and continuous improvement. Currently, in Georgia, 10 recovery residences are accredited through CARF. CARF mostly includes facilities that take insurance. JCAHO is also an international organization that accredits behavioral health and addiction providers—outpatient, residential, opioid treatment, and medication-assisted therapy. There are currently no facilities in Georgia accredited by JCAHO. Recovery residences typically self-fund any accreditation process. Potential THOR applicants must complete a 20-page application and complete the necessary training and inspections.

THOR defines structured housing as housing only—meaning there is no clinical or treatment component. Of the 107 facilities listed on THOR, 34 are structured houses and 73 are recovery residences. To be classified as a recovery

residence in THOR, the facility must have some treatment component (*e.g.*, outpatient services). In 2021, the General Assembly passed Senate Bill 4, which prohibited any person, including substance abuse providers, to pay or offer or to solicit, or receive, any renumeration for referrals of patients to or from a substance abuse provider. This bill defined recovery residence differently than THOR's definition. Additionally, DCS mostly assists individuals who are court-mandated into a treatment center or a recovery residence.



Sometimes a DCS officer may make referrals for individuals who must complete a court-ordered stay at a recovery residence. Sometimes a family member may seek advice from DCS or consult THOR for recovery residences. If an individual is referred by an accountability court, the individual receives a probated felony sentence and a court-order mandating a stay at a recovery residence. DCS receives all necessary notifications regarding such individuals.

Facilities listed in THOR must maintain open communication with DCS and satisfy all compliance requirements. Specifically, these facilities must grant DCS 24/7 access. The facilities must verify DCS supervised individuals' presence daily. Additionally, THOR approved facilities must submit monthly progress reports for all applicable individuals. DCS is authorized to conduct compliance checks. The facilities must comply with HUD habitability standards to ensure essential standards for safety, security, and quality are met. Even though the HUD habitability standards may not be the gold standard for recovery residences, these standards are a resource available to DCS to establish a baseline.

DCS investigates complaints or concerns regarding THOR approved facilities. A resident, officer, or family may submit complaints. Typically, after receiving detailed information from the complainant, DCS discusses the complaint with the local DCS office, who interacts more frequently with these facilities. Next, DCS conducts an on-site visit where the DCS officer will interview the director, staff, and residents. The DCS officer then complies any other necessary documentation. For example, if the complaint alleges drugs are being brought into the facility, DCS requires the facility to submit proof of its drug testing policy/compliance. After completing these steps, DCS determines if any additional action is needed including suspension or removal from THOR.

Grounds for removal from THOR include: standards and regulations violations; failure to cooperate with DCS staff, site visits, or compliance checks; prohibited acts and practices (i.e., any practice deemed detrimental to resident welfare; staff misconduct; or financial improprieties. DCS may also suspend facilities for minor infractions (e.g., not supplying documents in timely manner). The length of suspension depends on the severity of the infraction and how long it may take a facility to correct the issue. For example, a facility may receive a 90-day suspension if they are in violation of certain habitability standards. Because the facility must coordinate with outside entities to fix the issues (*e.g.*, pest control), DCS provides more time for correction. A total of **1,462** supervisees are currently residing in THOR facilities. Of these, **1,190** are in recovery residences and **272** are in structured housing. For the past two years, THOR facilities suspended or removed from the THOR Directory include:

- **2024**
    - **3** voluntary removals (2 recovery residences, 1 structured housing)[12]; and

[12] A voluntary removal means the provider contacted DCS and requested to be removed from the THOR Directory.

- **1** involuntary removal (a recovery residence who failed to report felony arrest identified during annual background check).

- **2025**
  - **2** involuntary removals (one recovery residence for an unreported felony arrest, one recovery residence for fraudulent SNAP benefit activity); and
  - **2** suspensions (both for unreported staff misdemeanor offenses). Both were Recovery Residences.

2. Amanda O'Shields & Jack Edwards (Private Citizens)

Ms. O'Shields discussed her substance abuse disorder and recovery journey. She spent nearly half her life in active addiction. She attempted sobriety on her own without treatment or other resources initially. Ultimately, she relapsed. She described her next recovery attempt and how she found Valley Rescue Mission, a faith-based recovery residence in Columbus. Ms. O'Shields participated in a nine-month women's recovery program, which included a job at Valley Rescue's thrift store. Valley Rescue provided reliable and safe housing that allowed Ms. O'Shields to regain confidence and rebuild her sense of security.

Mr. Edwards described his nearly twenty years in active addiction. He spent six years in and out of county jails. He described how probation did not provide substantive help for his addiction. Ultimately, a court ordered Mr. Edwards into a recovery program for twelve to eighteen months. Mr. Edwards described his six month wait to get into a THOR approved program. He eventually entered Valley Rescue Mission's Men's Recovery Program. In fact, he only learned about Valley Rescue because of another inmate—not because of any state-provided resources. Mr. Edwards described how the program provided stability and, ultimately, new opportunities that further increased his confidence and ability to integrate back into the community. Specifically, Mr. Edwards benefited from various workshops and jobs like those provided by Valley Rescue's thrift store.

3. Andy Lord (Private Citizen)

Mr. Lord discussed his career background with mental health treatment facilities. As such, he considers himself well-versed regarding mental health treatment options. During COVID, his child's struggle with addiction intensified after she lost her job and experienced several other big transitions. To help his child, Mr. Lord contacted his insurance company to explore treatment options. The insurance company did not help. Ultimately, the company sent a list of five treatment centers—3 of which were for treatment facilities for eating disorders. He stated that this haphazard resource further complicated his efforts to find a qualified treatment facility. Mr. Lord stated this experience felt like the Wild West. In fact, one North Georgia treatment facility tried to advise Mr. Lord about how to circumvent his insurance company's deductible requirement. Because of this chaos, Mr. Lord's child chose an out-of-state treatment facility.

His child chose a Georgia facility for her second in-patient treatment, but only stayed one month because the facility did not provide satisfactory treatment. For her third in-patient treatment stay, Mr. Lord's child entered into an out-of-state program again. Even with a relatively more privileged background including his prior career and connections, Mr. Lord did not have a reference point for quality or cost in Georgia. Understanding these options is crucial. However, in Georgia, Mr. Lord stated this understanding is dependent on connections (*e.g.*, Mr. Lord knew Jeff Breedlove who assisted him). When dealing with addiction, individuals are often making life or death decisions. Mr. Lord emphasized that these decisions are made even harder by the lack of readily available and reliable resources. While examining potential treatment facilities, Mr. Lord felt that the facilities were constantly reiterating their sales pitch like they were pitching a timeshare condominium.

4. Laurisa Barthen, Executive Director of the Georgia Council for Recovery (GCR)

As a person in long-term recovery, Ms. Barthen recounted how difficult it was to find reliable treatment and recovery residence options. During her 28-day stay in a state-funded treatment program, she only met with a counselor once. Ms. Barthen received a three-page list of recovery residences as she planned to continue her recovery within a more accountable environment. However, she still struggled to find a spot at a reliable recovery residence. Ultimately, what helped her recovery the most during her nine-month stay at the recovery residence was her connection with other individuals in recovery.

National Institute on Drug Abuse (NIDA)

Ms. Barthen stated that the recovery community is its own ecosystem that should be regulated in a way that understands and appreciates this ecosystem. Community involvement reduces the risk of relapse, increases social capital, and fosters a sense of belonging. There is a high need for a cost-effective, community-based support programs to improve public well-being. Community support aligns with Georgia's public safety, workforce development, and family stability priorities.

GCR estimates over 50 Recovery Community Organizations (RCOs) across Georgia actively providing support and recovery services. These organizations are independently operated and, often, led by people who are in long-term recovery themselves. RCOs strengthen collaboration through its network functions premised on shared goals to support recovery across the state. RCOs regularly collaborate, share resources, and mentor one another to strengthen their recovery efforts. For example, if a new RCO is struggling with zoning issues, the new RCO can call a more experienced RCO and learn strategies. Collaboration among RCOs also provide a strong, unified advocacy voice at the state-level and ensures advocacy aligns with broader community needs. Currently, Georgia boasts one of the nation's largest peer-led recovery networks with significant community impact.

Georgia's RCOs frequently form effective initiatives. For example, GCR hosts a bus tour with three types of stops: proclamation, policy, and celebration. During a proclamation stop, local leaders present a National Recovery Month Proclamation in support of people living in recovery and families impacted by addiction. A policy stop is when local stakeholders have a diverse community conversation on how addiction and recovery impacts communities. Finally, a celebration stop is a community-based celebration with free food, entertainment, and fellowship celebrating the hope and joy of recovery where hundreds of community members join together to show that Recovery Happens in Communities. Celebration stops highlight local peers in recovery, families impacted by addiction, and allies who support recovery.

Other effective initiatives include local partnerships with organizations like the Kiwanis club, rotary clubs, and local businesses. Cross county partnerships include rural recovery rallies, the bus tour (described above), recovery month events, and community celebrations. RCOs also often provide assistance on a range of issues including peer support in the criminal justice system, reliable transportation, etc. Peer-led programs demonstrate higher engagement and longer retention than clinical-only models because residents trust peer leaders who have experienced

similar challenges firsthand. This personal experience often enhances a program's credibility. Lived experience brings valuable insights that make systems more relevant and compassionate. Integrating lived experience ensures policies and practices are practical and effective.

5. Jeff Breedlove, American Addiction Recovery Association

Due to the nature of the disease, it is dangerous to claim there is only one concept or method for treating addiction. Mr. Breedlove stated it is helpful to think of SUDs treatment and recovery residence regulation in baseball terms. A baseball field establishes what is inbounds and out of bounds. Georgia is the umpire, who should provide some governance by establishing what is inbounds and what is out of bounds, but any state regulations should not be too restrictive to the point of promoting only one treatment model. Preferably, government oversight should be balanced with experienced substance abuse treatment professionals' recommendations (*e.g.*, GARR).

Addiction is a cunning, baffling, and deadly disease with multiple pathways to addiction and to recovery. People must understand that addiction is a disease that needs informed treatment. Stigma is the most dangerous part of the disease. There are 3 types of stigmas: an internal (personal) stigma, an individual's community stigma, and a broader general public stigma. Zoning laws and other regulatory decisions can often reflect this general public stigma—that is, municipalities may deny zoning permits for recovery residences or treatment facilities based on this preexisting stigma. These municipalities weaponize zoning laws to discriminate against constituents.

Mr. Breedlove noted that after Florida implemented more regulations for recovery residences, those bad actors left the state and relocated to states like Georgia that lack proper regulations and allow these actors to operate in the shadows. In fact, he stated that in Georgia, it is harder to become a hair stylist than to become a recovery residence operator. Unintentional injuries, including opioid overdoses, are a leading cause of death for individuals 18 to 45 years old. This issue impacts the heart of Georgia's workforce and the future of Georgia.

SENATE STUDY COMMITTEE ON RECOVERY RESIDENCES MEETING FOUR

Date: October 17, 2025
Location: Capitol 450—Atlanta, Georgia
Topic: Zoning for Recovery Residences

Attendees and Speakers

Members: R. Robertson (Chair); K. Jackson
Speakers: Daniel Lauber (American Institute of Certified Planners "AICP", Attorney/City Planner) and Ian Neubauer

Summary of Testimony

Chairman Robertson introduced the topic of zoning stating that the "not in my backyard mentality" does not help communities. While maintaining the integrity of your neighborhood or city is important, providing resources for individuals in need does not necessarily mean someone is negatively impacting the integrity of the neighborhood.

1. Daniel Lauber, American Institute of Certified Planners

Since 1974, Mr. Daniel Lauber has worked on zoning for community residences (group homes, sober homes, and small halfway houses) and recovery communities. He drafted zoning amendments for Prescott, Arizona; Delray Beach. Florida; and Pompano Beach, Florida that allow for community residences including sober homes and recovery communities. He also guided countless community residences through the zoning process, served as an expert witness in zoning cases and lawsuits, and helped revise the zoning of over 100 cities and counties across the country to comply with the Fair Housing Act.

In Georgia, prior to 1957, local governments did not possess zoning powers. In 1957, the Georgia General Assembly enacted the Zoning Enabling Act, which was then incorporated into the Georgia Constitution. Specifically, Art. 9, §2, Para. IV states, "the governing authority of each county and of each municipality may adopt plans and may exercise the power of zoning. This authorization shall not prohibit the general assembly from enacting general laws establishing procedures for the exercise of such power." Mr. Lauber stated that local zoning laws frequently contain flaws that can be addressed by properly drawn state legislation. In fact, 39 states recaptured their power over zoning to more fairly apply zoning laws.

In addition to state and local zoning laws, recovery residences like other community residences (*i.e.*, homes for individuals with developmental, mental, or substance abuse related disabilities) are covered by the Fair Housing Act (FHA). As such, zoning laws must apply to all community residences for people with disabilities—meaning any modifications to zoning laws cannot just apply to recovery residences. Any changes in zoning laws must be principled and fairly applied.

The basic legal principle from zoning case law is that any zoning law that treats a group of people with disabilities differently than the same sized group of people without disabilities is prima facie discrimination. If a zoning code does not define "family" or "household", then the zoning code cannot regulate a community residence for people with disabilities because they constitute a family. If a zoning code's definition of "family" or "household" allows any number of unrelated individuals to live together as a single housekeeping unit, zoning *cannot* regulate community residences for people with disabilities because they constitute a "family". However, if zoning places a cap on the number of unrelated individuals that constitutes a "family" or "household", zoning can regulate *only* those community residences that *exceed* that cap on the number of unrelated individuals.

Unfortunately, despite multiple studies' confirmation that allowing community residences does not negatively impact a neighborhood's value or the integrity of the community, many cities and counties remain reluctant to allow community residences in their jurisdictions. These reluctant cities and counties impose zoning restrictions on recovery residences and other community residences that comply with the jurisdiction's zoning definition of "family" or "household"—thereby undermining these residences' ability to serve their residents.

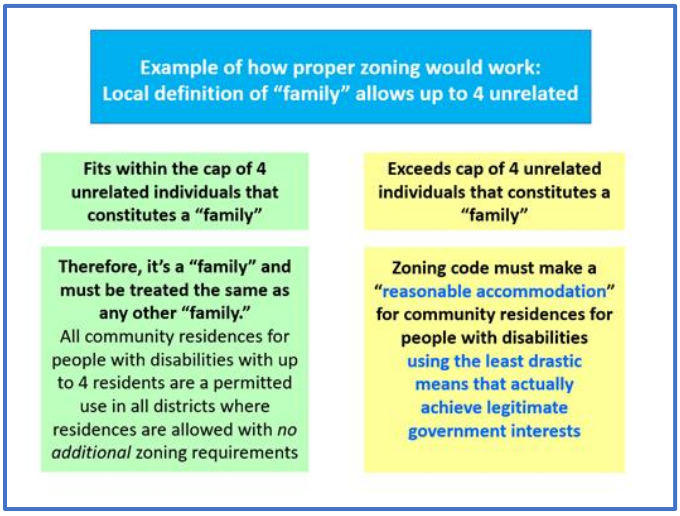
Cities and counties may use their zoning code to prohibit community residences. For example, some jurisdictions exclude recovery residences and other community residences from the zoning code's definition of "family". Some counties and cities treat recovery residences differently than other community residences for people with disabilities, which likely violates existing housing case law (*i.e.*, all community residences must be treated the same). Other cities and counties fail to make the necessary reasonable accommodations to allow community residences that exceed the cap on unrelated individuals in the jurisdiction's zoning code definition of "family" as permitted uses when (1) outside rational spacing distance, (2) licensed/certified, and (3) to more than 12 residents. At times, cities and counties exclude all recovery residences and other community residences from single-family zoning districts to "protect the value or integrity of the community." Similarly, jurisdictions may impose unjustifiable or illegal spacing distances to preclude community residences (*e.g.*, John's Creek imposed a 1-mile spacing requirement, Roswell imposed a 3,500 spacing requirement, Atlanta imposed a 2,000 feet spacing requirement, etc.)

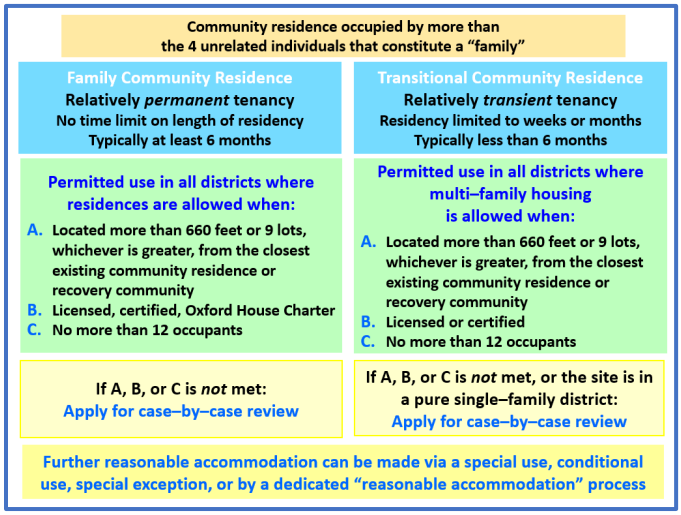
Another way some cities and counties preclude community residences is by *always* requiring case-by-case review for community residences and recovery communities to locate in residential zoning districts. Conversely, some cities and counties preclude community residences by failing to provide a case-by-case review process to make a reasonable accommodation to: (1) allow these uses to locate within the applicable spacing distance required to be a permitted use; (2) allow a community residence for which no license or certification is available; or (3) allow more than 12 occupants in a community residence (i.e., courts ruled that cities and counties must allow more people in a community residence if it is needed to ensure therapeutic and/or financial viability).

Additionally, cities and counties fail to use narrowly-tailored standards based on the reasons why individual review is required and instead apply the same standards for deciding *all* special uses. Some jurisdictions completely exclude transitional community residences from strict single-family districts or categorize zoning treatment of community residences by the number of residents rather than categorizing these residences as a family and transitional community residences.

A potential solution to address these zoning issues would be to reinforce the underlying principle from the FHA case law. The FHA requires state (and local) zoning regulations to make *reasonable accommodations*. Zoning regulations must be: fact-based, *intended to achieve* a legitimate government interest, *actually accomplish* that legitimate government interest, and constitute the *least drastic means* needed to actually attain that legitimate government interest.

Mr. Lauber provided various examples for how proper zoning could work for community residences (*see below*).





Mr. Lauber stated that zoning is based on how performance—meaning zoning decisions should be made on how the property's use performs. The bottom line regarding maximum occupancy for residential areas is that the local property maintenance code, minimum housing code, building code, etc. typically includes a formula to prevent overcrowding that applies to *all* residences. Typically, if there is one individual per sleeping area, then there must be at least 70 square feet excluding closet space. If there is more than one individual per sleeping area, then the residence needs 50 square feet per occupant. For example, if a residence has two roommates per bedroom, then that sleeping area must be 100 square feet. For three roommates per bedroom, the sleeping area must 150 square feet.

1. Ian Neubauer, Attorney and Owner-Operator of Second Chance Recovery

Mr. Neubauer reiterated that if a group of individuals constitutes a family under applicable zoning laws, then cities and counties cannot tell a recovery residence operator that they cannot locate their recovery residence within the jurisdiction's residential area. That is, the jurisdiction cannot issue an outright bar these residences.

Most often, the problem with defining family is the definition is too small in terms of unrelated individuals. Mr. Neubauer would define family as a group of related or unrelated individuals who function as a housekeeping unit. For example, in these residences, the individuals are regularly interacting with one another, share the common spaces, and are responsible for their chores. Mr. Neubauer discussed how Tennessee addressed this issue regarding recovery residences and single-family residences. TN Code § 13-24-102 (2024) states, "for the purposes of any zoning law in

Tennessee, the classification 'single family residence' includes any home in which eight (8) or fewer unrelated persons with disabilities reside, and may include three (3) additional persons acting as support staff or guardians, who need not be related to each other or to any of the persons with disabilities residing in the home."

When defining "family" for zoning purposes, it is important to draft a definition that prohibits "bad actors" from taking advantage (e.g., a biker club that claims it is a family, but in reality, is not functioning as discussed above). An important distinction is that recovery residences are comprised of individuals with disabilities. Therefore, the FHA applies to recovery residences, but a biker club or any other similar club is not a protected class under the FHA. Because individuals in recovery are classified as disabled, which is a protected class, jurisdictions must make reasonable accommodations. Mr. Neubauer stated that ideally a recovery residence has between eight to twelve individuals.

On behalf of Mr. Neubauer, Mr. Lauber discussed why allowing more than four individuals to live in a recovery residence is important. Eight to twelve individuals in a recovery residence increases the clinical efficaciousness of these environments. Allowing more than four individuals enhances mutual support and decreases the likelihood an individual may be left home alone, which is not ideal for individuals in recovery or for individuals with other mental or physical disabilities. Conversely, allowing more than 12 individuals in a single recovery is not advisable as more than twelve individuals loses its "family feel" (the twelve individuals include three full-time staff).

Mr. Lauber then discussed spacing requirements for single-family recovery and community residences. Enforcing spacing requirements is a legitimate concern for jurisdictions. Clustering of community residences reduces the likelihood that individuals in recovery will interact with neighbors who are not in recovery. These interactions are important because these neighbors can serve as role models for individuals in recovery. Ultimately, clustering of recovery residences would change the character of the neighborhood by creating a more institutional atmosphere versus a residential atmosphere. These concerns must be fairly balanced against all the interests described herein. Additionally, jurisdictions must distinguish between clustering of single-family residences and the multi-family recovery residence model (*e.g.*, the apartment complex model, which is in compliance with Georgia law because three to four individuals can live within an apartment and remain classified as a single-family residence).

Mr. Neubauer resumed his testimony stating that recovery residences also often need more than four individuals within the residence for financial viability. Mr. Neubauer outlined the expenses for one of his recovery residences. He estimated that the residence has $8,500 to $9,000 in operating expenses per month. If that residence was limited to four individuals, he would need to charge nearly $2,500 per resident. That price would be unjustifiable to potential residents. Ultimately, individuals in the deep throes of addiction usually cannot keep full-time jobs. Individuals seeking out a recovery residence after treatment often cannot afford an expensive residence. These individuals still need an opportunity for stability and accountability. Recovery residences provide this opportunity and should be financially accessible. Courts often consider financial viability when determining whether reasonable accommodations were provided.

Similarly, it is important for cities and counties to protect other citizens interests including their property values. It is important to balance the needs of individuals in recovery with communities' concerns about their property values declining while property taxes increase. Mr. Neubauer stated that regulating recovery residences will serve multiple purposes. First, it will eliminate the nefarious actors within the recovery residence industry. For example, regulations could prohibit recovery residences from receiving referrals if they are not certified. Similarly, if a recovery residence is not certified, then that residence would not be exempted from the family definition cap (i.e., the number of unrelated individuals permitted in a single-family residence). Regulating recovery residences will also reassure the community-at-large that recovery residences will not negatively impact their neighborhood—that is, the actual character of the neighborhood and the property values.

Senator Jackson discussed the importance of a grace period when introducing certification requirement so that "good" operators are not negatively impacted. Chairman Robertson stated the current issue with GARR certification is that it is voluntary. While Georgia has a strong interest in regulating recovery residences, the regulations should be efficient and serve a purpose. Ultimately, Georgia should ensure that recovery residences are providing a safe place for individuals in recovery while also maintaining the integrity of the community.

Mr. Neubauer stated some jurisdictions zoning laws and enforcement present substantive due process issues because they are categorically denying these residences without a hearing. These jurisdictions are also likely in violation of the FHA. For example, Mr. Neubauer discussed a recent issue within the City of College Park. Specifically, the City emailed Kai Thorup a "Notice of Zoning Violations Regarding Property Located at 2041 English Lane, College Park, Georgia 30337" in regards to his "Halycon House" even though the residence is not out of compliance because it has not opened—meaning more than three people do not currently reside there in violation of the zoning law. The Notice threatens fines of $1,000 per day for every day the residence is not in compliance.

Mr. Neubauer stated the College Park situation presents a substantive due process issue and noted the FHA applies to this residence. Mr. Neubauer stated the city's notice and enforcement efforts are based on speculation. Specifically, if Halycon House only allowed four people in the recovery residence, they would be in compliance with College Park's zoning requirements. In support of Mr. Neubauer's testimony, Mr. Lauber reiterated the legal standard for these situations.

Senator Jackson expressed concerns about preempting local zoning laws, but also noted there are concerns about 159 different zoning laws and 500+ city zoning laws. Ultimately, Georgia also has an interest in ensuring recovery residences can reasonably and fairly operate across Georgia and serve a range of demographics. It would also help individuals more readily find options closer to home, so they do not have to drive across the state (or out-of-state) for safe and reliable options.

Mr. Neubauer described how his recovery residence in Roswell is in compliance with maximum capacity laws and group home spacing requirements, but if he tried to open the same residence in Macon-Bibb County he would not be in compliance because their cap on unrelated individuals living together is lower. Mr. Neubauer described how some cities and counties preemptively created special use permits for recovery residences. However, in reality, there are concerns that these jurisdictions are not actually granting these permits for recovery residences.

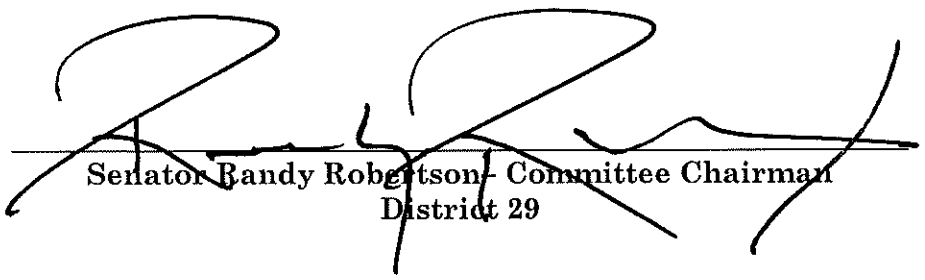
FINDINGS AND RECOMMENDATIONS

Based on the testimony and research presented, the Study Committee on Recovery Residences recommends that the General Assembly:

1. Establish a comprehensive state licensure or certification system for recovery residences with the Department of Behavioral Health & Developmental Disabilities as the licensing authority. (*See* Appendix A for DBHDD's proposed timeline, budget, and other objectives. *See Appendix B* for recommended legislative language.)
2. Authorize DBHDD to adopt standards for recovery residences.
3. Prohibit referrals to unlicensed or uncertified recovery residences.
4. Expand public awareness campaigns and resources regarding different levels of SUD care including recovery residences.
5. Standardize quality indices for recovery residences that incorporate clinical standards and best practices.
6. Maintain a regularly updated registry of licensed or certified recovery residences.
7. Increase transparency among recovery residences and other SUD treatment providers to reduce the proliferation of confusing and potentially misleading information so that Georgians can more easily assess providers' services.
8. Study zoning issues impacting recovery residences, including clarifying the definition of recovery residences.

Respectfully Submitted,

FINAL REPORT OF THE SENATE RECOVERY RESIDENCES STUDY COMMITTEE (SR 311)



Senator Randy Robertson - Committee Chairman
District 29

APPENDIX A

Georgia Department of Behavioral Health & Developmental Disabilities

Kevin Tanner, Commissioner

Office of the Commissioner

Senate Study Committee on Recovery Residences Agency Member Recommendations

The Problem

Recovery residences in Georgia currently operate without state regulation, creating risks for vulnerable residents who may be court-mandated to these facilities. The state lacks insight into the number, location, or quality of homes, and residents have limited recourse when facilities fail to meet basic safety or ethical standards.

Recommendation

Establish a comprehensive state licensure system for recovery residences by December 31, 2028, with DBHDD as the licensing authority and GARR serving as both an enhanced certifier, and advisory partner.

Proposed Implementation Timeline

Phase	Timeline	Key Activities
Phase 1: Assessment	July-Dec 2026 (6 months)	Network inventory, stakeholder engagement, best practices analysis, resource planning
Phase 2: Legislative Action	Jan-July 2027 (7 months)	Report to legislature, bill passage, funding appropriation
Phase 3: System Development	July-Dec 2027 (6 months)	Rule promulgation, IT development, staff hiring, training programs
Phase 4: Implementation	Jan-Dec 2028 (12 months)	License applications, inspections, technical assistance, full operations

Grace Period: Existing facilities have 18 months from effective date to obtain license

Key Elements

Dual-Track System:

- **DBHDD Licensing**: Mandatory baseline safety and operational standards for all facilities
- **GARR Certification**: Voluntary "gold standard" exceeding minimum requirements. Support of critical functions with DBHDD's oversight including initial grievance review, training and technical assistance as requested by DBHDD. Residences that are already certified are grandfathered into licensed status.

Comprehensive Oversight, overseen by DBHDD and supported by GARR:

- Periodic inspections and compliance monitoring
- Training and technical assistance framework
- Multi-tiered grievance system with resident protections
- Progressive enforcement from warnings to license revocation
- Public registry of licensed facilities

Benefits

For Residents:

- Enhanced safety through consistent minimum standards
- Clear rights and grievance procedures
- Protection from exploitation and fraud
- Informed choice via public registry

For Quality Operators:

- Level playing field and professional credibility
- Access to training and technical assistance
- Market advantage through demonstrated compliance
- Protection from unfair competition

For the State:

- Accountability for court-mandated placements
- Data-driven policy and resource decisions
- Reduced recidivism and associated costs
- Public safety and consumer protection

Legislation Risks & Mitigation

Risk	**Mitigation Strategy**
Industry resistance / facility closures	Extended 18-month transition period; extensive technical assistance; graduated fees; quality improvement support
Reduced bed capacity	Early engagement with operators; support for compliance achievement; phased implementation
Difficulty identifying unlicensed facilities	Complaint-driven investigations; partnerships with courts and local authorities; public education

Estimated Resource Requirements

- **Network Assessment and Ramp Up**: Consultant study and director
- **First-Year Budget:** Personnel, IT system, training development, inspections, communications
- **Ongoing Staffing:** Director, licensing specialists, compliance officers, grievance coordinator, support staff
- **GARR:** Development of contractual framework to support gold-standard review and supportive services
- **Revenue Sources:** Licensing fees and state appropriation

Success Factors

- Strong partnerships with GARR and recovery community
- Adequate funding and staffing from outset
- Clear, practical standards based on national best practices
- Balanced approach protecting residents without over-regulating
- Quality improvement focus supporting - rather than solely punishing - facilities

Recommended Actions

1. **Immediately:** Secure funding for Director of Recovery Residences and Phase 1 assessment to include stakeholder engagement, statewide report, resource assessment ($600,000)
2. **July 2026 – December 2026:** Complete comprehensive assessment and stakeholder engagement; develop legislative proposal and budget request
3. **January 2027 – July 2027** Present findings to legislature; pass enabling legislation with appropriations
4. **July 2027 – December 2027:** Promulgate rules; build systems; hire staff; develop training programs
5. **2028:** Launch licensing; provide technical assistance; achieve full implementation by December 31

Conclusion

This initiative provides a balanced, evidence-based framework that protects residents while supporting quality operators and preserving the peer-support model that makes recovery housing effective. With proper planning, adequate resources, and strong partnerships, Georgia can establish a licensure system that serves as a national model for consumer protection and quality assurance in recovery housing

APPENDIX B

Senator Jackson's Recommendation

(Please note, a summary of zoning key concepts is included at the end, however a full recommendation of zoning has been developed by Ian Neubauer and available upon request)

Addiction is a major health problem that affects multiple service systems and leads to profound harm to the individuals suffering from this disorder and their families, including: impairment, death, chronic addiction, vehicular casualties, acute and chronic diseases resulting in increased health care costs, loss of employment, disruption in educational attainment, ruined credit, housing instability and homelessness, divorce, separation of parents and children, crime, and overcrowded prisons and jails. Addiction is a disease impacting the whole family and the whole society and requires a system of care that includes prevention, intervention, clinical treatment, and recovery services that support and strengthen the individual, families, and the community at large. Recognizing that recovery is a long-term process and requires a broader approach, this section is designed to address the regulation of recovery housing in the state of Georgia

Definition:

Recovery housing is housing that provides a living environment free from alcohol and illicit drug use and centered on peer support and connection to services that promote sustained recovery including: continued sobriety, improved individual health, residential stability, and positive community involvement.

Definition and Standards: "Recovery housing" means housing for individuals recovering from substance use disorders that provides an alcohol- and drug-free living environment, peer support, assistance with obtaining drug addiction services, other addiction recovery assistance, and is certified to ensure adherence to nationally recognized standards.

Standards: As such, the Department of Behavioral Health and Developmental Disabilities, shall develop standards for services provided by residential care and supported housing for people with substance use disorders, when used as a recovery residence, to be certified through an entity approved by the division to ensure adherence to standards determined by the National Alliance for Recovery Residences (NARR) meet other standards established by the division.

Enforcement of recovery housing quality standards by making the receipt of referrals dependent upon meeting recovery housing quality standards:

State agency or vendor with a statewide contract that is providing treatment or services to a person or a state agency or officer setting terms and conditions for the release, parole, or discharge of a person from custody or treatment, shall not refer that person to recovery housing and shall not otherwise include in such terms and conditions a referral to recovery housing unless the recovery housing is certified pursuant to this

section. Support for NARR affiliate organization to operationalize the recovery housing quality certification process:

The state of Georgia shall allocate $500,000-$750,000 to The Georgia Association of Recovery Residences (GARR) to maintain and track the recovery housing quality certification process and provide technical assistance and training for recovery housing operators in their continuous quality improvement efforts to meet the national standards. GARR shall provide an annual report to the Department of Behavioral Health and Developmental Disabilities, and will report quarterly on any newly certified homes or homes that no longer meet the standards.

Data Collection Requirements:

As part of the certification process of recovery homes, GARR shall collect outcome data as specified to meet the National Outcome Measures (NOMs) as required by the Substance Abuse and Mental Health Services Administration (SAMHSA). The Department of Behavioral Health and Developmental Disabilities shall use its discretion on which measures should apply to recovery housing.

Requirements to make a regularly updated registry of NARR certified recovery housing available to the public:

The bureau shall prepare, publish, and disseminate a registry of alcohol and drug-free housing certified pursuant to this section; provided, however, that the registry shall be updated at least bimonthly. The registry shall be disseminated to the director of each state agency or vendor with a statewide contract that provides substance use disorder treatment services. The bureau may also establish an active, searchable database that can be updated in real-time. The commissioner of probation shall inform all district and superior court probation officers and the chief justice of the trial court shall inform all district and superior court judges how to access the registry. The registry shall also be posted on the website and shall maintain the privacy of the residences and their residents.

Zoning Key Concepts:

1. Distinction Between Family and Transitional Community Residences

- **Family Community Residence**
    - **Purpose:** Provides a *relatively permanent* living arrangement—typically **exceeding one month**—for unrelated individuals with disabilities living together as a single, functional family.
- **Zoning:** Permitted as of right in all districts where residential uses are allowed (including single family dwellings), subject to spacing (minimum **660 feet**) in single-family districts and occupancy limits (**12 individuals or two per bedroom**, whichever is less). **Transitional Community Residence:**
    - **Purpose:** Provides a *short-term or temporary* living arrangement—generally **less than one**

month—for unrelated individuals with disabilities living together as a single, functional family.
    - **Zoning:** Permitted as of right in multifamily and higher-density residential zones (duplex, triplex, and multi-unit districts).
    - **Single-Family Placement:** May be sited in single-family zones **through reasonable accommodation** upon showing that the use is compatible and family-like.

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2. Express Carveouts for Residences that Qualify as a "Family" or "Household"

- The legislation would explicitly **exempt** community residences that already fall within a local government's definition of "family," "household," or equivalent term.
- When a city or county defines "family" as a group of unrelated individuals up to a certain number (e.g., four, five, or six), any community residence that complies with that definition is treated *no differently than any other household* and is **not subject to spacing, occupancy, or certification requirements.**
- This ensures that small, family-scale recovery homes or other community residences that already comply with local definitions remain entirely outside the scope of regulation, thereby preventing duplicative or discriminatory oversight.
- In jurisdictions that do **not** define "family," the same exemption applies—protecting smaller, family-like homes by default and deferring to federal housing protections.

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3. Uniform Zoning, Spacing, and Licensing Standards

- Family and transitional community residences are recognized as **residential uses** permitted by right in specified zones with no additional building, fire or life safety requirements that are not otherwise imposed upon single families occupying like dwelling units.
- Applies a **660-foot spacing standard** between community residences and other community residences/congregate living facilities **in single-family districts**.
- Subject to universal overcrowding ordinances, limits occupancy to **12 individuals or two per bedroom**, whichever is less, consistent with normal residential code provisions.
- Requires valid **licensure, certification, or charter** to operate as a matter of right, and a reasonable accommodation if unlicensed/certified/chartered.

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4. Reasonable Accommodation Process

- Mandates local governments to grant reasonable accommodations when strict compliance (spacing, occupancy, or licensing) would otherwise deny equal housing opportunity.Criteria for approval require the applicant to show the residence (amongst other prescribed criteria):
    - Operates in a manner equivalent to a licensed or certified program;
    - Possesses rules and practices governing the operation of the community to protect the residents from abuse, exploitation, fraud, theft, neglect, insufficient support, use of illegal

drugs or alcohol, and misuse of prescription medications;
    - Emulates a family household, not an institutional setting;
    - Maintains a safe, drug- and alcohol-free environment.
- Allows transitional residences to seek accommodation for siting in single-family zones where compatible.

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5. Procedural Safeguards and Transparency

- Local governments must respond **within 10 business days** to verify spacing compliance.
- If a spacing conflict exists, the municipality must provide detailed written documentation within **20 business days**, including addresses, disability types served, and distance calculations.
- Promotes transparency and prevents arbitrary or pretextual denials.

Conclusion

This legislation would modernize Georgia's treatment of community and recovery residences by:

- Providing **federal-law-aligned definitions and zoning standards** that municipalities can implement uniformly statewide;
- Ensuring **non-discriminatory residential uses** for people with disabilities while maintaining clear local spacing and licensing authority;
- Closing the current regulatory vacuum that enables **arbitrary enforcement and litigation exposure**;
- **Shifting the onus onto counties and municipalities** to tighten their own "family" or "household" definitions if they wish to prevent operators from utilizing the unrelated-person allowance as a loophole—thereby returning control to local governments while preserving federal compliance; and
- Ultimately protecting both fair housing rights and neighborhood integrity through a rational, lawful, and transparent statewide framework.