

The Intersection of Recovery Housing & Housing First— A Dialogue on Collaboration and Partnership

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Realizing Recovery

Policy & Practice Improvement Series

Office of Recovery

Substance Abuse and Mental Health Services Administration

U.S Department of Health and Human Services

This document was developed by SAMHSA’s Office of Recovery, while the content and themes outlined within were identified by participants—including technical experts and those with lived experience—during the Recovery Housing & Housing First Dialogue. Please note that the views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Office of Recovery, the Substance Abuse and Mental Health Services Administration (SAMHSA), or the U.S. Department of Health and Human Services (HHS).

A special thanks to each participant for their time and dedication towards advancing the field of recovery.

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EXECUTIVE SUMMARY

On August 29-30, 2023, the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Office of Recovery hosted the *Intersection of Recovery Housing & Housing First: A Dialogue on Collaboration and Partnership*. This convening brought together over 70 individuals including persons with lived experience with mental health conditions, substance use disorders, and homelessness; their families and allies; housing providers; researchers; technical assistance providers; and federal and state government staff.

The goals of this meeting include 1) bringing national awareness to the intersection of and unique attributes across recovery housing and housing first programs, 2) highlight the critical need for collaboration between the two; and 3) to use these insights to inform the Office of Recovery's efforts to advance recovery across the nation.

Across the two days, speakers in four plenary sessions provided background information across various topics: providing a primer on Recovery Housing and Housing First models; creating a "no wrong door" continuum of care; exploring financing strategies, including Medicaid waivers; and facilitating harm reduction. Attendees also participated in breakout sessions and group dialogue about each of the plenary sessions, as well as on future directions of supportive housing.

Common Themes

The following themes were identified as recurring or common throughout the dialogue:

- **Recovery is fundamentally about an individual's choices, and a continuum of services is required to meet the needs of those on their recovery journey.** Recovery is self-directed, individualized, and personal. Without a full continuum of service types, service delivery methods, and programming, people are unable to make truly autonomous decisions about their recovery process and journey. Further, individuals may need different types of supports at different times along their journeys of recovery. By creating a continuum of recovery services within a community, service providers can meet those in recovery where they are and provide the supports and services that the individual needs and wants.
- **Communities should build a continuum of care where there is "no wrong door" for a person to come into recovery services and housing.** Individuals in recovery come from different backgrounds and come into recovery services and housing in different ways. To create a cohesive continuum of services, providers should network within their communities to know what services are available from which providers and help individuals in recovery navigate the system. In this way, no matter where a person enters the recovery continuum, providers can help the individual navigate the system as a guide and access the types of services they need and want.
- **Despite having different paradigms and programming, Housing First and Recovery Housing are not at odds and can co-exist within a continuum of service options.** Although Recovery Housing typically focuses on abstinence-based recovery, and Housing First focuses on harm reduction pathways into recovery, both programs are fundamentally working towards the same goal which is to help individuals define, create, and travel down a recovery pathway that will be effective for them. It is important for communities to create supportive housing continuums that have both Recovery Housing and Housing First options.
- **An adequate continuum of care will include a range of services as well as a variety of housing types.** Recovery Housing and Housing First programs are philosophically different from one another, and both offer a variety of services. These may include mental health services, substance use treatment services, employment services, social services, and more. However, a continuum also needs to provide various types of housing depending on the circumstances of the individual. Emergency shelters, respites, long-term permanent housing, family housing, and gender specific housing are important components of a supportive housing continuum that can aid individuals on their recovery trajectories.

- **Lack of adequate funding for supportive housing programs creates silos and competition between Housing First and Recovery Housing programs.** Currently, America is in the grips of three simultaneous, reinforcing crises: (1) an affordable housing crisis, (2) an epidemic of deadly drug use, and 3) a mental health crisis including rising rates of suicide. Although the need for supportive housing has grown exponentially across the country, the available funding has not kept pace. HUD’s most recent ‘time in count’ survey revealed a significant increase in people experiencing homelessness [with an estimated 650,000](#) Americans unhoused on a single night in January 2023. Programs that should be collaborating to provide the best supportive housing services, and to help populate a full continuum of services, are too often competing for the same inadequate funding streams.
- **Collaboration between Recovery Housing and Housing First is imperative to enhance housing options, service quality, and better outcomes.** Collaboration between Recovery Housing and Housing First programming can create safer, higher quality services by allowing better matches between program philosophy and individual recovery goals. Collaboration and networking between these programs can increase the ease with which individuals navigate the care continuum. Further, collaboration can create opportunities for both programs to offer referrals and warm handoffs between one another.
- **There is significant work to be done to engage members from under-represented groups in the conversation.** Black, Indigenous people, LGBTQIA+, and rural communities are deeply impacted by substance use, mental health conditions, and homelessness. However, these communities often have difficulty finding and engaging with supportive housing services. Conscious effort must be taken to engage these underrepresented groups in services, supportive housing work, and supportive housing policy creation and revision.
- **Limited funding streams make sustainability a challenge.** Few single funding sources are large enough to support and sustain all the financial needs of a supportive housing provider. Providers often have to seek out multiple sources of funding simultaneously and continuously. This may require writing multiple grants, speaking with multiple stakeholders, and making difficult programming decisions based on budgetary constraints. Because the population of individuals needing services continues to expand, and since grants are often short-term, seeking adequate funding is a resource intensive task.

Solutions and Strategies for Moving Forward

The following solutions and strategies for advancing the field emerged during the dialogue:

- **Increase and create funding streams that are flexible and longer lasting.** For service providers to ensure quality housing and programming, they need adequate, sustainable (long-term) funding options. Funding also needs to be flexible enough that it can be used to adequately meet the needs of the service providers. Foundations, agencies, and organizations providing grant funding should institute longer grant cycles and allow funding to be spent on housing; direct services; employee salaries; physical infrastructure; and program administration.
- **Funding opportunities should treat Recovery Housing and Housing First as different components of the same continuum of services.** Both Recovery Housing and Housing First programs should be part of a healthy and robust supportive housing continuum. Funding organizations should not “penalize” organizations from either paradigm. Funding agencies should treat both modalities as valid, legitimate, and vital components of service continuums.
- **Create connections and networks between Housing First and Recovery Housing programs.** Housing First and Recovery Housing programs need to enhance their collaboration on local and state levels. Each has different services, resources, capacities, and service networks. By pooling these together, Recovery Housing and Housing First can offer higher quality services that are better tailored to individuals. Further, this creates opportunities to: pool funding; submit joint funding proposals; improve coordinated care for individuals and systems; enhance systems and client advocacy and enable individuals to receive flexible and appropriate services.

- **Support staff to reduce workforce turnover.** Working within supportive housing environments and helping individuals on their recovery journeys can be intensely emotional and sometimes exhausting resulting in burnout and staff turnover. Better supports need to be in place for staff wellness. Increased funding can lead to increased wages for direct care staff; increased staff training for staff (including information on self-care); and can help augment benefits within organizations (e.g., personal time off, health benefits) to protect the mental and physical wellness of those engaging in recovery work.
- **Create and support a range of housing for individuals who are in various stages of recovery.** Many programs are at overcapacity with the number of clients they serve. Consider reviewing regulations surrounding supportive housing programs. For example, some organizations, particularly faith organizations, have an extensive history in providing shelter services. However, regulations may make it difficult for these organizations to provide needed services. Similarly, respite housing is an underutilized type of housing that is absent from many service continuums.
- **Engage state policy makers and funders.** Providing supportive housing services is difficult without state-level involvement. This can have long ranging effects including lack of funding; policies and regulation that hamper the ability to work; a lack of investment in programming; and more. Further, state policy makers may make decisions about supportive housing without the appropriate knowledge and experience from providers to guide these decisions.
- **Create or expand an online technical assistance center for people engaged in supportive housing work.** A training and technical assistance center (TTA) or “one stop shop” for both housing first and recovery housing providers could promote collaboration and best practices. This centralized resource could include information on recovery housing and recovery-related resources; create a forum or messaging board that allows housing providers to communicate with one another; create a federal/state funding announcement calendar and forecast; expand resources to include more research and policy, procedures, and protocols associated with recovery housing and housing first.
- **Align system goals and priorities of funding agencies.** Supportive housing sits at a nexus of various issues: substance use, mental health conditions, homelessness, child welfare, criminal justice, poverty, domestic violence, trauma, chronic illness, and more. Services are often an amalgamation of best practices from various fields. Unfortunately, some payers provide funding for direct mental health and substance abuse services only; other provide it for housing services only. By bringing together all agencies that have a stake in helping individuals recover, funding can be made more flexible and tailored for supportive housing needs.

MEETING REPORT

Primer on Recovery Housing and Housing First Models

Housing First Model—Pathways to Housing PA

Christine Simiriglia, President and CEO, Pathways to Housing PA

Ms. Christine Simiriglia established [Pathways to Housing PA | Housing First Ends Homelessness](#) in Philadelphia, Pennsylvania in September of 2008. Pathways currently serves over 625 people who have experienced long-term homelessness and have multiple disabilities in permanent, scattered site housing across the city of Philadelphia. The program has had remarkable results with a population that faces many challenges. Pathways uses a scattered site/harm reduction model to work with people who are unhoused and struggling with opioid/poly-substance use. Pathways houses and provides wrap around services for over 300 people. In 2020, Pathways launched [Housing First University | Pathways to Housing PA](#) for agencies and communities looking to adopt the model. Pathways to Housing PA is known for its innovation in filling the gaps in services that exist for those with multiple needs. Pathways has also co-located with a federally qualified health center (FQHC) for medical care and established an opioid treatment program. Pathways also developed the Philadelphia Furniture Bank to ensure that people moving out of homelessness have what they need to be successful in their new housing.

Housing First programs such as Pathways to Housing PA are identified as evidence-based and fully evaluated models of care. In contrast, some providers may use the term “housing first,” which is a general philosophy of housing that often does not include any other services. Housing First has a 30-year track record of success. Data has shown that after five years, Housing First has an [85-90% retention rate](#) for participants. Additionally, individuals in Housing First programs have a decreased need for more expensive programming and fewer inpatient stays. Participants are also integrated into the community. The goal is for individuals to “be part OF the community, not just IN the community.”

Housing First, as operated by Pathways, has a quick start up time. Pathways leases apartments that already exist within the city, which eliminates wait time and cost of building new units and ultimately reduces incidence of homelessness. Pathways has seven modified Assertive Community Treatment (ACT) teams, one blended case management team, an outreach team, community inclusion services, and partners with an FQHC

The infographic consists of two blue rounded rectangular boxes. The top box features a white icon of a house with a percentage sign inside. To its right, the text reads 'Housing First' followed by a bulleted list: 'Evidence based program', '38 distinct fidelity measures', 'ACT/ICM', and 'Intensive level of services in permanent supportive housing'. The bottom box features a white icon of a simple house outline. To its right, the text reads 'housing first' followed by a bulleted list: '“a philosophy of addressing a person’s homelessness by quickly housing people and ensuring that they have access to housing and some level of supportive services.”' and 'Issues: individuals don’t get services → Not successful → “Housing First is ineffective”'.

Model	Key Features
Housing First	<ul style="list-style-type: none">• Evidence based program• 38 distinct fidelity measures• ACT/ICM• Intensive level of services in permanent supportive housing
housing first	<ul style="list-style-type: none">• “a philosophy of addressing a person’s homelessness by quickly housing people and ensuring that they have access to housing and some level of supportive services.”• Issues: individuals don’t get services → Not successful → “Housing First is ineffective”

Recovery Housing Model—The Oxford House Model

Edward Smith, Regional Manager, Oxford House

Mr. Edward Smith is the Regional Manager for Oregon, Colorado, South Dakota, and California for [Oxford House, Inc.](#), a nonprofit network of over 3,600 (internationally) self-help recovery homes. Mr. Smith is responsible for the opening of over 60 houses all throughout the state of Oregon. He is a man in long-term recovery, who has been in recovery since 2003 and has worked with Oxford House since 2004. Mr. Smith is the recipient of the 2015 Oxford House Founders award. At Oxford House, Mr. Smith discovered the power of relational culture. Mr. Smith is an advocate for those in recovery. He has worked in several local and state organizations to remove the stigma of addiction and the ability for those to change their lives.

The Oxford House model is a democratic, self-run recovery housing system. While there is great variety between how each house is run due to the democratic system, there are some commonalities that are required of the model. When new houses are started, Oxford House employees provide training and guidance to establish the peer-run model. Houses are required to be democratically run, self-supporting, and to remove (and refer) individuals who experience a recurrence in use. During their stay, residents must follow the [Oxford manuals](#). Each house has officers who serve six-month terms before new elections are held. Further, even though each house operates autonomously, they each belong to chapters, where all chapter houses meet once a month to discuss any issues. Today, there are 3,600 houses in 47 states serving over 40,000 individuals.

Central City Concern (CCC)—Blended Model

Sean Hubert, Vice President and Strategy Officer, Central City Concern (CCC)

As Vice President and Strategy Officer, Mr. Hubert supports teams that are advancing [Central City Concern \(CCC\)](#)'s core strategy of delivering supported pathways out of homelessness through a client-centered and connected care approach in Portland, Oregon. Mr. Hubert has overseen over \$350 million in real estate development at CCC including more than 1,300 units of housing and 180,000 square feet of clinical facilities created or preserved. CCC's real estate portfolio consists of approximately 2,400 units of affordable housing and several clinical and commercial facilities. CCC's housing and employment teams serve over 4,000 people each year who experience homelessness or at risk of homelessness and provide a diverse range of supportive programs including helping people in recovery from drug or alcohol addiction, unhoused veterans, reentry programs for people exiting the criminal justice system and housing integrated with health care programming.

Central City Concern (CCC), a hybrid between Recovery Housing and Housing First programming, operates under the assumption that homelessness is the result of many intersecting complex factors that compound one another. At the macro level, communities with low affordable housing options are at highest risk of high rates of homelessness. However, at the micro level, the [predictors of homelessness](#) include justice-involvement, SUD, chronic untreated diseases, mental health issues, age, and race. In fact, [20-30% of unhoused individuals](#) report a SUD. To combat homelessness effectively, a community requires a network of organizations working in tandem and the causes of homelessness, together. The CCC model brings together community partners to identify gaps in service continuum, and to create services to fill those gaps. They emphasize individually defined recovery, housing, and employment to combat chronic homelessness. To do this, they offer a wide variety of housing types, including: (1) low barrier stabilization housing (designed for 3- 6 month stays) (2) transitional housing (designed for 6-24 month stays) (3) Integration Housing (4) Permanent Housing.

No Wrong Door: Enhancing Collaboration and Choice

The following themes, strategies, and solutions were identified during a panel and subsequent roundtable discussion on collaboration, choice, and the importance of a 'No Wrong Door' approach.

What are the causes for the lack of collaboration between Recovery Housing and Housing First programs, what are some of the strategies we can employ to reduce this lack of collaboration?

- *Isolation and Competition*
 - Although Recovery Housing and Housing First have similar goals, they often compete for funding.
 - Both Recovery Housing and Housing First want to promote the well-being of residents, help with recovery, and reduce the rate of overdose and other negative outcomes. However, these programs are often also isolated from each other, and the competition for funding can make collaboration difficult.
 - To create advantages in applying for the next notice of funding opportunity (NOFO), programs often forgo creating these relationships.
- *Local, State, and Federal Policies*
 - Government policies and priorities can actively promote or disrupt opportunities for collaboration. For example, in some states, all housing for individuals in recovery is required to be low barrier; however, Recovery Housing requires abstinence from drugs and alcohol, which may “lock out” Recovery Housing as an option for individuals who might need the community support and structure of sober living to sustain their recovery.

The Potluck Metaphor for “No Wrong Door”

“I think of no wrong door like a potluck. Everyone brings their best dish to the potluck, and people can take what they want / what they need. There is good food on the table to choose from. I see my role as increasing the size of the table. I recognize I can’t be an expert on everything; no one can be an expert on everything. We can have all of these people and organizations come together, offer the services and resources that they’re best at, and let the people who need the services come and pick and choose what they need, when they need it.”

-Jen Elder, SAMHSA Homeless and Housing Resource Center

- *Challenging Work, Low Pay, and Limited Funding*
 - Both recovery housing and housing first work can be difficult, exhausting, and challenging.
 - Despite this, the pay is often low due to lack of funding, which leads to high staff turn-over.
 - Many grants do not pay for administrative work even though there are a lot of administrative requirements.
 - Short grant periods (often only two years) mean that organizations are often continuously trying to write grants to attain more funding. Not only is this additional unpaid work, but it also makes long-term strategizing difficult.

Assuming there was enough money, staff, time, etc., in what ways could Recovery Housing and Housing First programs and advocates collaborate more effectively?

- *Strengthen the “No Wrong Door” System*
 - The system needs to truly become a system that works for individuals. No matter where, or how people touch the recovery and housing system, someone can help them navigate; and identify where they need to go to get the services they want.
 - This requires an adequate infrastructure, including a data system that identifies all of the service providers, what services they provide, what populations they serve, what their capacity currently is, etc.
 - While the “no wrong door” approach is critical, the system and providers within need to ensure that getting from one service door to the next is seamless, quick, and easy.
 - The problem is also when the “no wrong door” approach works, but the system isn’t equipped.

- *Finding and using funding sources*
 - There are a variety of funding sources that could be promising. For example, five states are currently piloting the 1115 waivers to use Medicaid funding for housing services.

“No Wrong Door”—A System in Action

“A client who finished detox moved to transitional housing. A few days later, the client told their case manager that they were struggling, and really wanted to use. The case manager walked the client physically to the program’s doctor, who initiated the client on medication assisted treatment. Afterwards, the case manager walked the client back down the hallway to the pharmacy and helped them pick up the medication, and finally back to the housing program and sat with them as they called their sponsor.

When people enter the “wrong door,” they often must then walk back outside to find the next door—and they can encounter triggers, they can encounter additional trauma. Instead of forcing people to leave entirely, wrapping services together or at least making them accessible and low barrier is effective. So, when a person enters the wrong door, they should not have to go back outside.”

- Sarah Holland, Central City Concern (CCC)

What work is happening in rural or specialized communities related to housing? (e.g., LBTQ+, families with children, justice-involved communities)

- *Rural communities*
 - One organization recently received a HRSA grant to [create a center of excellence](#) for rural recovery housing programs.
- *Building a System of Inclusivity*
 - Programs should focus on coordination of care and wrap around services for specialized and underserved populations.
 - Housing First encourages people to self-advocate for what they want and need as too often their voices have not been heard or included.

How do you approach serving individuals with varying challenges related to substance use and/or mental health? How do you navigate the differences in funding, regulations, etc.?

- *Participant:* “We serve those who are experiencing challenges related to SUD and others who are mental health. We try to create multiple continuums to meet the needs of multiple populations. For example, we have a program for formerly incarcerated black men and get them into housing. To meet their needs, we altered the service design to assist them BEFORE they even leave prison and make sure they land softly in the next system.”

Peer support is one of the primary components of recovery housing, and it’s grown in recent years. Is there a common set of guidance?

- There is substantial overlap in the skills needed to be a peer leader in recovery housing and in other recovery services.
- Peers engage in complex, individualized, transformative work. There is a need to identify more ways of support the peer workforce including addressing low wages and burnout.
- Peer work brings lived experience expertise in helping people recover. This expertise should be compensated accordingly.

Innovation & Collaboration

During breakout discussions on strategies for improving innovation and collaboration across Recovery Housing and Housing First, the following questions were posed to participants.

1. What are the barriers to collaboration between Housing First and Recovery Housing programs? (*barriers*)
2. What are some innovations that can help encourage collaboration between Housing First and Recovery Housing programs? (*innovations*)
3. What is needed to make these collaborations happen? (*needs*)

Significant outputs from this discussion are outlined below:

Barriers

- Bureaucracies
- Politics
- Funding barriers for understaffed and grassroots organizations (e.g., NOFO complexities)
- The system is currently housing centered instead of person centered
- Lack of transportation and employment in rural areas
- Insufficient continuum of care
- Co-occurring disorders
- Lack of communication between providers
- Fear, stigma, & misinformation
- Competition for limited funding (available funding does not match the need)
- Limited providers

Innovations

- Peer respite programs
- Co-location of recovery and housing services
- Strengthen or create a more robust continuum of care
- Expand funding to allow for coordination of care (not just direct services)
- ACT teams for SUD (tailor the program for SUD)
- Choice-based screening to help individuals identify the most appropriate program/program type
- Better consent to treat
- Medicaid covered housing
- Use Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) or State Opioid Response (SOR) grant funding to pay per-diem rate for housing
- Navigators
- Respite homes/peer respite
- Innovative referral strategies/linkages to care/warm hand-offs (e.g., two-way referral systems)

- Joint committees and task force
- Lunch and Learns
- American Society of Addiction Medicine (ASAM) criteria
- Diversified boards
- Coordinated access across a system
- Using technology to enhance collaboration
- Federal policy and initiatives to enhance coordination/collaboration across housing system

Needs

- Ensure that nonprofits and housing programs are adequately funded
- Make grants multi-year investments
- Create a dashboard for shared data/communication exchange
- Center for recovery housing and housing first technical assistance
- Expanded career pathways for peers/other people who want to stay in the field and meet their needs with a living wage
- Quality housing
- Listen to the consumer
- Person-driven funding
- State-level licensure for housing
- Family recovery housing
- Making housing part of the healthcare continuum
- Longer-term recovery housing options
- Collaboration
- Local, state, and federal regulations
- Cross-system funding
- Recognizing the unique roles of each program/professional
- Remove silos
- Opportunities to blend substance use and mental health funding
- Local investment
- Better connections between crisis services and housing providers
- Better data on the people coming in, and what they need (qualitative, outcome data, etc.)
- Enforce ADA requirements for non-discrimination of people using Medications for Opioid Use Disorder (MOUD) to push back against programs that won't allow treatment
- Significantly improve oversight regarding sober homes to avoid patient brokers and other illegal and

fraudulent activities.

- National strategic approach: both/and for Housing First and Recovery Housing (instead of one or the other)
- Having Coordinated Care organizations sit at the table as well
- Medicaid claims data on costs associated with complications of homelessness/unmanaged SUD and mental health conditions
- Involve more peers and people with lived experience
- Expand housing funding across federal agencies other than HUD

Funding Sources—Local, State, and Federal

Participants were asked to identify funding sources for both ‘housing’ and ‘direct services’ at the federal, state, and local levels. The following table outlines these identified sources:

Local, State, & Federal Funding Sources		
LOCAL		
<ul style="list-style-type: none"> • Departments of Behavioral Health (local) • Private Foundations • Nationwide • United Way • Office of Homeless Services • In-Kind • Continuum of Care/Managed Care • Los Angeles Homeless Services Authority (LAHSA) 	<ul style="list-style-type: none"> • State Housing Authorities • Local Tax Credits • Private Payers/Funding • General Funds • California Work Opportunities and Responsibility to Kids program (CalWorks) Homeless Programs • Revenue Sharing • Public Housing Agency (PHA) Project Based Vouchers • Rental Assistance Donations 	<ul style="list-style-type: none"> • Private Donations • City Liquor Tax • Human Services Block Grant • Providers • Community Reinvestment • Care Portal • Housing Trust Funds • Community Based Organizations • Local Rental Subsidies
STATE		
<ul style="list-style-type: none"> • Reinvestment dollars from Managed Care Savings • California Mental Health Services Act • Texas Targeted Opioid Response • Medicaid • Department of Mental Health • Department of Aging and Disability • Department of Mental Health Managed Care (COC) • SOR (State) • State Medicaid funding • Diversion Funds 	<ul style="list-style-type: none"> • Block Grants • City/State Funding • California Department of Health Care Access and Information (HCAI) • State General Funds • State Housing Trust Fund • State Budget • 1115 Waiver • Arizona Health Care Cost Containment System (AHCCCS) Housing and Health Opportunities (H2O) • Serious Mental Illness (SMI) Housing Trust Fund 	<ul style="list-style-type: none"> • State Department of Corrections • State Health Authority Grants • Department of Human Services • Federal Home Loan Bank (Home 4 Good) • Departments of Behavioral Health (state) • Division of Substance Use Programs • Finance Agencies • New York Connects Housing Options Plus (Program RSS)

FEDERAL & NATIONAL

<ul style="list-style-type: none"> • American Rescue Plan (ARPA) • HRSA Rural Communities Opioid Response Program (RCORP) • National Council on Wellbeing • CDC Overdose Data to Action (OD2A) • U.S Department of Agriculture (USDA) • Centers for Medicare and Medicaid (CMS) • National Housing Trust Fund (NHTF) • National Foundations (e.g., Elton John) 	<ul style="list-style-type: none"> • U.S Department of Housing and Urban Development (HUD) <ul style="list-style-type: none"> - Emergency Solutions Grants Program (ESG) - Public Housing Agency (PHA) Project Based Vouchers - Community Development Block Grants (CDBG) - Continuum of Care • Federal Emergency Management Agency (FEMA) • Blue Cross Blue Shield (BCBS) • Veterans' Health Administration (VHA) • National Equity Fund (NEF) 	<ul style="list-style-type: none"> • Substance Abuse and Mental Health Services Administrating (SAMHSA) <ul style="list-style-type: none"> - Projects for Assistance in Transition from Homelessness (PATH) - Mental Health Block Grant (MHGB) - Building Communities of Recovery (BCOR) • Office of Juvenile Justice (OJJ) • Gilead Focus • Wells Fargo
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Participants discussed current issues in funding gaps. For example, although there can be funding available for direct services, there is very little money available for infrastructure. This is further compounded by the workforce shortages in housing and behavioral healthcare. Funding can be continually appropriated to direct services, but if there are no service providers available, and if there are no physical buildings for these services to be provided in, this funding cannot be used for direct services. Participants also noted that the COVID-19 pandemic relief funding is currently in the process of ending. However, there are still significant deficits that are a result of the pandemic.

Participants also recommended that

- Housing providers seek out healthcare stakeholders.
- Explain how housing can help reduce costs to them and mitigate risk.
- Partnering with private insurance companies to fund pilot programs to divert individuals out of their highest cost systems.
- [From Silos to Collaborations: Building a Health Partner Investment Strategy](#) by NeighborWorks America and Center for Community Investment as a resource to help build these healthcare-housing partnerships.

Housing First programming was described as (often) being tied to HUD resources, and less to direct service resources. However, the Recovery Housing movement has been tied to service resources, and less to housing funding. This is one example of how collaboration across these two different models within a continuum of care can create access points to new funding. By mapping these systems that Recovery Housing and Housing First programs use, there is an opportunity to re-orient the systems and truly cross-pollinate ideas and resources. Participants also recommended that individuals review [Recovery Housing Policy Brief](#) by HUD and [Recovery Housing Best Practices](#) by SAMHSA. An infrastructure with continuums of care to help identify what the housing needs, availability, and capacity are for a community was recommended to scale efforts for reducing homelessness. If systems collaborated, pooled resources, and had an accurate idea of what need and capacity were (and were able to align them in an area), this could have a positive impact on the homelessness crisis across various communities.

Financing Strategies – Raising Capital and Access to Services

David Johnson, MSW, ACSW, Chief Executive Officer, Fletcher Group

Mr. David Johnson joined the Fletcher Group in 2017 as the CEO to promote programs and services for individuals experiencing a substance use disorder. With a career spanning over 40 years, he brings a broad perspective on addressing children, families, communities, and system needs. Throughout his tenure, he has led efforts to improve human services practices and policies to boost positive results and give voice to those in need. Mr. Johnson began by discussing the Fletcher Group broadly, and three of their programs: (1) Recovery,

Hope, Opportunity, and Resiliency (RHOAR); (2) The Capital Funding for Rural Recovery Housing Project; and (3) the Women's Addiction Recovery Center. The Fletcher Group began under former Kentucky Governor Ernie Fletcher, and it uses the [Social Recovery Model](#). The Fletcher group provides training, research, and technical assistance in building capacity in programming and evaluation services, and help beginning pilot programs. Currently, the Fletcher group is present in 44 states.

To fund their current programs, the Fletcher Group has utilized a variety of unique funding sources, including Supplemental Nutrition Assistance Program (SNAP), housing vouchers including section 8 housing choice vouchers, and contracts with the KY Department of Corrections. The Fletcher Group also uses strategic partnerships to maximize their funding. For example, a local university donated the land that for the Capital Funding for Rural Recovery Housing Complex. They make sure that programming is holistic and comprehensive and that their campuses are welcoming and integrated. The Fletcher Group has had several successes. For example, the Women's Addiction Recovery Center has been around for 20 years and provides comprehensive services by using blended funding streams. Additionally, their Department of Corrections contract saves money by moving individuals with SUD out of jails/prisons (\$70/day per person) into treatment (\$35/day per person) and provides more appropriate treatment alternatives.

Merna Leisure-Eppick, President, Missouri Coalition of Recovery Support Providers

Ms. Merna Eppick started her career in the non-profit community as a volunteer, active in education and youth advocacy organizations. Ms. Eppick has worked in the field of addiction, treatment, and recovery for over thirty years. Currently, Ms. Eppick is the President of Dynamic New Visions providing addiction recovery, peer support, and mental health services as well as oversight of a newly funded peer respite care facility. She serves on the Board of Directors for the Missouri Coalition of Recovery Support Providers (MCRSP) and is the Housing Task Force Chair. She is the President and Founding member of the Recovery Coalition of the Ozarks, a MCRSP affiliate.

Ms. Eppick explained the recovery movement and coalition created in Missouri to provide housing services for individuals with SUD. The Missouri Coalition of Recovery Support Providers (MCRSP) is less than 10 years old but has already had extraordinary success. In partnership with the MO Department of Mental Health, the MCRS has (1) created the "Director of Recovery" position and (2) gotten a line-item in the state budget for *recovery* services. Over 80% of this line-item budget goes directly to housing support / Recovery Housing / Housing First programming, and of this between 30-40% is used in rural communities. To date, MCRSP operates 25 Recovery Homes and 242 National Alliances for Recovery Residence houses, develops robust partnerships with the department of corrections, has hosted five regional conferences, administers a \$3.67-million-line item in the state budget for recovery services, and conducts extensive recovery events across the state. Further, they received national attention by winning [Faces and Voices of Recovery](#) National Recovery Organization of the Year in 2022.

Medicaid 1115 Waivers

Elizabeth da Costa, Director of Housing, Arizona Health Care Cost Containment System (AHCCCS)

Ms. Elizabeth da Costa serves as AHCCCS Housing Program Administrator. In this role she oversees the contract for the Statewide Housing Administrator which provides rental subsidies to nearly 2,500 members across the state of Arizona. She also assists the team with oversight of the Serious Mental Illness (SMI) Housing Trust Fund, distributing capital dollars to financially support new housing development designed to serve members with a SMI. Ms. da Costa recently came to AHCCCS in October of 2022 having worked for a local non-profit for 13 years. In her prior role, she was the Senior Director of Housing and Community Integration and has experience overseeing multiple grants that span across the housing continuum from outreach and shelter to rapid rehousing and permanent supportive housing programs. Ms. da Costa has direct experience serving vulnerable populations, including experience serving as a Clinical Coordinator for a Forensic Assertive Community Treatment team in Maricopa County. Ms. da Costa has lived experience with poverty, homelessness, and addiction, and uses her recovery and lived and work experience to advocate and drive system improvements.

Ms. da Costa presented the Arizona Health Care Cost Containment System's (AHCCCS) work with 1115 Medicaid waivers. For an individual to be eligible for these services, they must have an SMI diagnosis. Although having a SUD cannot qualify an individual on its own, many of those with SMI have a co-occurring SUD. Currently, \$27 million is available to the state, per year, for state-wide housing programs for Medicaid members. Additionally, the state has an unclaimed property program which contributes approximately an additional \$2 million to the Medicaid system. This is separate from other public housing funding. With this funding, AHCCCS can fund communal living with on-site support services. The Medicaid funding also funds peer-respite services, and six permanent supportive housing teams. Currently, this project is in proof-of-concept stage with CMS, which means that AHCCCS must choose a particular population to target for this intervention. Currently, they are focusing on "high cost, high need" individuals who have chronic health conditions that are overrepresented in unhoused populations. The goal is to identify people at risk of homelessness, before they experience homelessness, to divert them out of high-cost systems and services.

The [AHCCCS H2O](#) funding program will offer enhanced shelter access, rental assistance, or both. The enhanced shelter is emergency housing and offers access to permanent supportive living programming. The rental assistance can also help individuals get into permanent housing up to six months quicker than long-term section 8 housing. Further, to provide health and supportive SMI and SUD services, AHCCCS is working with local community providers to translate their service billing data into Medicaid billing codes through a crosswalk to reimburse these local organizations for their services. To do this, they will be hiring a 3rd party administrator.

The Intersection of Harm Reduction & Recovery

David Awadalla, MSW, BSHP from SAMHSA's Office of Recovery, presented and facilitated a dialogue on the intersection of harm reduction and recovery, and provided an overview of the draft version of SAMHSA's [Harm Reduction Framework \(samhsa.gov\)](#). The Six Pillars of Harm Reduction have many parallels with the guiding principles of recovery and are designed to empower a person to make choices that can result in positive change. The six pillars also acknowledge the importance of including the voices of individuals who use drugs (PWUD) in response efforts. Harm reduction encourages safer practices (syringe exchange, overdose education, fentanyl test strips), safer settings (day centers that are low barrier, access to safe and secure housing), safer access to healthcare (low-barrier opioid treatment services, non-punitive care that is non-stigmatizing), safer transitions to care (warm hand off, medication for opioid use disorder access and treatment on demand), sustainable workforce field (organizational leadership from people with lived experiences, living wages), and sustainable infrastructure (promote education about harm reduction services, hire PWUD to inform policy).

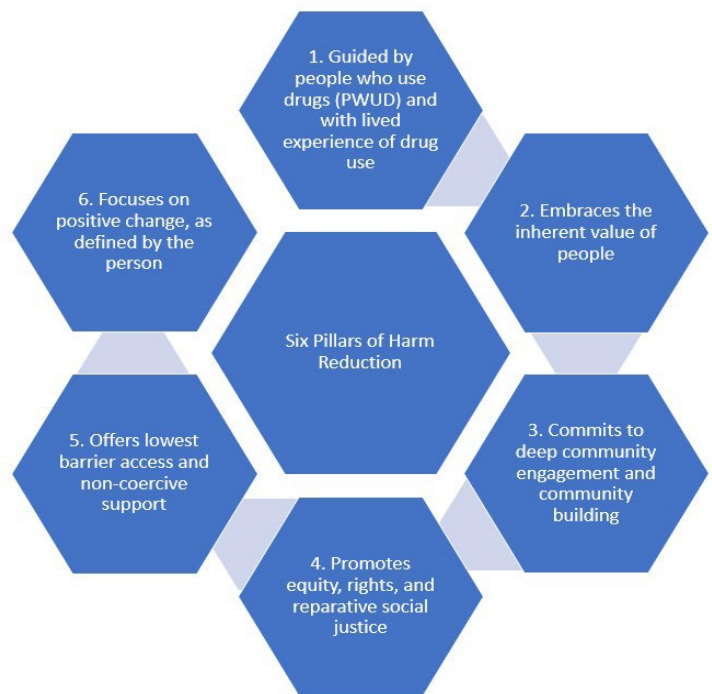
The six pillars are supported and reinforced by 12 core principles that guide harm reduction work. These supporting principles are imperative for programs to incorporate into programming to stay true to the spirit of harm reduction.

Twelve (12) Principles of Harm Reduction:

1. Respect autonomy
2. Practice acceptance and hospitality
3. Provide support
4. Connect family (biological or chosen)
5. Provide many pathways to wellbeing across the continuum of health and social care
6. Value practice-based evidence and on-the-ground experience

7. Cultivate relationships
8. Assist, not direct
9. Promote safety
10. Engage first
11. Prioritize listening
12. Work toward systems change

SAMHSA has a harm reduction grant which, for the first time, is also allowing the purchase of syringes, and offers training and technical assistance across various TTA centers. Participants then discussed ways that Housing First programs and Recovery Housing (which has a sobriety requirement for housing) can incorporate harm reduction approaches into their programming.



The following strategies/activities were identified during this discussion:

- A crisis team that operates on the streets between 5:00pm and 1:00am to hand out fentanyl test strips to individuals. These teams consist of a peer and a nurse and uses a RV in order to transport interested individuals to the diversion center.
- Providing a “shower trailer,” which offers unhoused individuals a shower, clean clothes, faith-based services (if the individual is interested), and food.
- Most programs described having naloxone available in multiple locations in their housing programs.
- Providing free naloxone use trainings to house members.
- Checking overdose reversal supplies multiple times a day to ensure they are available, and that individuals can take them anonymously.
- Offering fentanyl and xylazine testing strips to their clients in case of relapse.
- Offering overdose prevention plans and intensive case management services.
- Encouraging individuals who use drugs to create “health directives,” where the individual creates a plan on what should happen in the event of an overdose.

Conclusion

In the closing minutes of the dialogue, participants revisited some of the solutions and strategies that are outlined above. It was noted that some of these solutions may require significant changes to policy or funding, while others may be achieved through collaborative, actionable, and achievable steps. Particularly, it is these solutions that are intended to guide not just SAMHSA and the Office of Recovery’s housing efforts, but also the Recovery Housing and Housing First programs that provide these crucial services to their communities. Further, the need and responsibility to utilize these strategies and solutions was noted as being integral to promoting collaboration across the continuum of care.

As the Office of Recovery’s efforts strengthen recovery support services continues, so will the inherent need for

collaboration between our partners. As such, the strategies and solutions outlined above are intended for all people and organizations seeking to advance recovery across the nation.

About the Realizing Recovery Series

To advance recovery across the nation, the Office of Recovery (OR) forges partnerships to support all people, families, and communities impacted by mental health and/or substance use conditions to pursue recovery, build resilience, and achieve wellness. With this goal in mind, the OR initiated a series of (in-person, virtual, or hybrid) dialogue, technical expert panel, and summit-style convenings, beginning in February of 2023 with SAMHSA’s Technical Expert Panel on Peer Support Certification.

The themes across these convenings, which range from strengthening the peer workforce to advancing recovery across tribal and justice-involved communities, each align with an objective, strategy, or priority within [SAMHSA’s National Recovery Agenda](#). All convenings, both past and present, reinforce efforts to forge new partnerships while strengthening old. Further, each convening and associated report serves not only as a foundation and guiding light for the Office of Recovery moving into 2024, 2025, and beyond; but also provides SAMHSA, the OR, and our federal, state, local, tribal, and territorial partners with the information that is needed to advance recovery across the nation.

To access materials and publications related to recovery—including other reports within the Realizing Recovery Series, please visit <https://www.samhsa.gov/find-help/recovery>.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation.

Appendix A – Participant List

FACILITATOR

Andrew Spiers. Director of Training & Technical Assistance Housing First University, Pathways to Housing PA

PARTICIPANTS

Alex Araica. Community Supports Coordinator, The Wildflower Alliance

Angie Arthur. Executive Director, Homeward Iowa

Pamela Baker. Deputy Director of Homelessness Services, Collaborative Support Programs of New Jersey

Lauryn Berner-Davis. Assistant Director of Implementation Research, National Health Care for the Homeless Council

Anita Bradley. President and Chief Executive Officer, Northern Ohio Recovery Association

Kelly Clark. President, Addiction Crisis Solutions

Haley Coles. Executive Director, Sonoran Prevention Works

Jonathan Cox. Director of Housing Solutions, C4 Innovations

Lori Criss. Director, Ohio Department of Mental Health and Addiction Services

Elizabeth da Costa. Director of Housing, Arizona Health Care Cost Containment System

Barry Decker. Division Director, Pennsylvania Department of Human Services Office of Mental Health and Substance Abuse Services

Kyle Duvall. Deputy Executive Director, Welcome Home Ministries

Will Eberle. Executive Director, Vermont Association of Mental Health and Addiction Recovery

Chris Edrington. Vice President, National Association for Recovery Residences

Jen Elder. Director of SAMHSA's Homeless and Housing Resource Center, Policy Research Inc.

Christina Fidanza. Vice President of Supportive Housing Operations, Project HOME

Victor Fitz. Clinical Care Manager, Crossover Recovery Center, Substance Abuse Center of Kansas

Mollee Flores. Wellness Empowerment Coach, Amethyst Place

Jillian Fox. Director, Corporation for Supportive Housing

Tony Greco. Chief Executive Officer, GET HELP

Anthony Grimes. Executive Director, Virginia Association of Recovery Residences

Brenda Harris-Collins. Director, Recovery Bureau, New York State Office of Addiction Services and Supports

Marsha Hawkins-Hourd. Executive Director, Child and Family Empowerment Center

Elizabeth Henry. Director of Policy, RecoveryPeople

Sarah Holland. Senior Director of Supportive Housing and Employment. Central City Concern

Sean Hubert. Vice President and Strategy Officer, Central City Concern

Dave Johnson. Chief Executive Officer, David Johnson

Cameo Jones. Executive Director, LIV Recovery

Matthew Kelly. Lead Housing Liaison, Mercy Care

Ryland "Riley" Kirkpatrick. Executive Director, Access Point of Georgia, Inc.

Katie League. Behavioral Health Manager, National Health Care for the Homeless Council

Merna Leisure-Eppick. President, Missouri Coalition of Recovery Support Providers

Andy Mendenhall. President and Chief Executive Officer, Central City Concern

Stephanie Meyer. Special Assistant to the Secretary, Pennsylvania Department of Human Services

Darrell Mitchell. Executive Director, Progress House

Jonathan Pendergrass. Housing and Employment Benefits Program Manager, Kansas Department for Aging and Disability Services

Rachel Post. Senior Associate, Technical Assistance Collaborative

Sean Read. Vice President of Regional Programs, Friendship Place

Lauren Reed. Special Project Manager (SABG), Mercy Care

Jason Robison. Chief Program Officer, Emotional Health Association/SHARE! (Self- Help and Recovery Exchange)

Christopher Ronquest. Director of Re-Entry Services, The McShin Foundation

Fred Rottnek. Director of Community Medicine, Program Director of Addiction Medicine Fellowship, Saint Louis University and Assisted Recovery Centers of America

Elizabeth Salisbury-Afshar. Associate Professor, University of Wisconsin

Michelle Sambrano. Director of Prevention Services, Southwest Behavioral and Health Services

Tony Sanchez. Owner, Creative Collaborative Solutions

Michael Santillo. Chief Operating Officer, Prevention Links

Jenna Sheldon Neasbitt. Co-Director, MARS Inc.

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Aaron Williams. Senior Advisor, The National Council for Mental Wellbeing

Nisha Wilson. Chief Clinical Strategy Officer, Oklahoma Department of Mental Health and Substance Abuse Services

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