

# Substance Use and Housing National Leadership Forum

**Convening Report** | October 6-7, 2014  
Washington, DC



Forum hosted by:



**NATIONAL COUNCIL  
FOR BEHAVIORAL HEALTH**  
STATE ASSOCIATIONS OF ADDICTION SERVICES  
*Stronger Together.*

## **Acknowledgements**

The Substance Use and Housing National Leadership Forum was co-hosted by CSH and the National Council for Behavioral Health. Funding for the convening was generously provided by the Melville Charitable Trust.

This summary report was co-authored by Janette Kawachi, Director of Innovations and Research (CSH), Kevin Irwin, Senior Program Manager (CSH), Peggy Bailey, Director of Health Initiatives (CSH), and Becky Vaughn, Vice President of Addictions (National Council for Behavioral Health). Thanks to Lori Criss, Ed Stellon and Ed Blackburn for their very helpful review and comments on the draft. Also thank you to all the Convening Participants and their agencies for the work they do in their communities and for their contributions at the Convening. Convening Participants and their Agencies are identified in the Appendix to this report.

## **About Melville Charitable Trust**

Since 1990, the Melville Charitable Trust has focused on the singular goal of ending homelessness. Research and the Trust's experience have demonstrated that homelessness is a solvable problem and that safe, accessible and affordable housing is an indispensable part of the solution. For individuals and families with the greatest challenges to housing stability, ensuring access to affordable housing with appropriate services – supportive housing – is smart, humane and cost-effective. The Trust is the largest foundation in the U.S. that is exclusively devoted to supporting solutions to prevent and end homelessness. Since inception, we have invested more than \$120 million to alleviate homelessness by developing supportive housing, community solutions, and a stronger policy environment. Patient, strategic and consistent investment has provided us with a broad view of the field and confidence in what approaches are most effective.

## **About CSH**

CSH transforms how communities use housing solutions to improve the lives of the most vulnerable people. We offer capital, expertise, information and innovation that allow our partners to use supportive housing to achieve stability, strength and success for the people in most need. CSH blends over 20 years of experience and dedication with a practical and entrepreneurial spirit, making us the source for housing solutions. CSH is an industry leader with national influence and deep connections in a growing number of local communities. We are headquartered in New York City with staff stationed in more than 20 locations around the country. Visit [csh.org](http://csh.org) to learn how CSH has and can make a difference where you live.

## **About the National Council for Behavioral Health**

The National Council for Behavioral Health is the unifying voice of America's community mental health and addiction treatment organizations. Together with our 2,500 member organizations employing 750,000 staff, we serve our nation's most vulnerable citizens — more than eight million adults and children living with mental illnesses and addictions. We are committed to ensuring all Americans have access to comprehensive, high-quality care that affords every opportunity for recovery and full participation in community life.

## Introduction

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On October 6 & 7, 2014 CSH and the National Council for Behavioral Health (National Council) assembled a diverse group of leaders from the housing, homeless prevention, Substance Use Disorder (SUD) treatment, health and recovery fields for the **Substance Use and Housing National Leadership Forum**. The Forum was held at the Hall of States Building in Washington, DC and provided a broad-based, national effort to bring practitioners, policy leaders, and researchers together to fuel new thinking and innovation around housing, service approaches and recovery supports for individuals affected by SUDs. By convening a cross-section of experts from across key systems, the aim was to develop a strategic vision and set of concrete actions to be taken to bring promising housing and services integration practices to scale for people with addiction disorders.

The primary goals of the convening were to:

- Facilitate **connection and productive dialogue** among national leaders and practitioners to meet the housing and service needs of individuals and families affected by addiction
- Develop **a vision, a framework and key components** of a comprehensive continuum of housing and service programs that meet the needs of the target population, including special subpopulations (chronically homeless, families, youth, veterans, etc.)
- Learn, share and discuss **emerging/promising practices** for integrating housing and service approaches, with particular attention to cross-system collaboration strategies
- Describe the current available evidence and identify **key research and evaluation** needs to support necessary shifts in policy and practices.
- Identify **key challenges and barriers** - at federal, state and local levels and across policy and practice - to creating integrated housing and service solutions for the target population.
- Develop **policy recommendations, actionable strategies and concrete next steps** to put key elements of a framework into practice at federal, state and local levels

More than ever, behavioral health systems are recognizing that safe and affordable housing in the community is a foundational component of recovery for people with SUDs. The needs of individuals and families are as diverse as the population itself, necessitating a broad array of integrated housing and service options that maximize stability, choice and self-directed change across the life of the recovery process. Much knowledge has been gleaned over the last two decades about effective housing programs and needed system changes and there is still much to learn.

Several factors contribute to the timeliness of initiating a national dialogue around housing and substance use. First, over the past decade, many behavioral health systems across the U.S. have shifted away from a treatment system that focuses on acute care to one of sustained recovery management that embraces a view of recovery as a lifelong process. This shift in the recovery paradigm is gradually chipping away at the long-standing philosophical divide between “harm reduction” and “abstinence-based addiction treatment” approaches that have historically impeded productive dialogue and collaboration in this arena. Second, health reform in the U.S. has begun to favor more integrated, holistic care approaches for people including those with substance use and mental health issues. Recognition of housing as a critical component of health care continues to grow.

Finally, parity legislation, Medicaid expansion, health homes and other health care innovation initiatives arising out of the Affordable Care Act (ACA) are creating unprecedented opportunities to test and finance integrated models of housing and recovery support services for individuals with SUDs. Importantly, for the first time in many states, provisions of the ACA that expand Medicaid coverage on the basis of income will allow low-income individuals and those experiencing homelessness with SUDs to be eligible for Medicaid.

## Summary of Convening

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The planning committee for the convening included representatives from CSH, the National Council, Melville Charitable Trust and the Hilton Foundation. The meeting was organized with careful attention to representing a broad and balanced range of perspectives, while keeping the participant list small enough (40 attendees) to allow for a roundtable style discussion (see Appendix A for Participant List). The committee recruited experts from across the country, from urban and rural areas, representing different roles and responsibilities (federal policy, research, state systems, national associations, consultants, advocates and providers) and working in different systems (SUD treatment, mental health, recovery communities, Medicaid, homeless services, affordable housing and supportive housing).

Participants intently focused on learning and sharing information, finding common ground, identifying and resolving challenges and developing innovative policy and practice solutions. While the agenda covered a wide spectrum of topics, the conversations generally revolved around three primary themes:

- I. Opportunities and Challenges for Cross-Systems Integration**
- II. Promoting Housing as a Platform for Recovery**
- III. Understanding and Establishing the Evidence**

### **I. Opportunities and Challenges for Cross-Systems Integration**

Shifts in both policy and practice across health and behavioral health in recent years have created new opportunities for improving service delivery, quality and integration among all sectors serving individuals with SUDs. In particular, several provisions of the ACA and their impact were highlighted throughout the discussion including Medicaid expansion for low income single individuals regardless of disability, the extension of federal parity protections for mental health and addiction benefits, the creation of health homes, the shift toward more flexible outcome-based payment models and other health care innovation initiatives.

There are promising trends toward integration at the provider level as well. A number of established Ending Homeless Housing providers - such as Central City Concern, Project Home and the Colorado Coalition for the Homeless –operate both Recovery Housing and Housing First programs and provide an example of what is possible. These programs recognize and celebrate the potential for recovery among this population and provide a flexible, person-centered continuum of housing options that accommodate the changing needs of individuals over the lifetime of recovery. In such programs, housing decisions are fundamentally person-driven, and individuals who choose Recovery Housing are self-initiating their treatment and electing to be part of a community of individuals supporting one another in their choice to abstain from alcohol and other drugs. Many of these individuals have had several prior attempts at housing that they were not able to maintain as a result of behaviors that emerge when living with active addictions. On the flip side, for individuals that are not yet able or interested to stop or reduce their use, these programs offer Housing First units that present an alternative to homelessness and provide a potential platform for future recovery and engagement in services or treatment.

In addition to the health and behavioral health sectors, successfully tackling the problem of housing instability and substance use and moving toward recovery-oriented systems will require broader collaboration with other sectors that touch this population including homeless services, housing, criminal justice, education, vocational rehabilitation, employment, child welfare, schools and youth services programs. The continuum of care must be conceived broadly to include services that address prevention, intervention, treatment, aftercare and long-term recovery supports. Many of these other systems continue to view and treat substance use as a moral failing rather than a health problem, leading to punitive responses toward alcohol or drug use that interfere with an individual's or family's efforts at recovery, health, and wellness. This is most apparent in the criminal justice system and in U.S. drug policy but is also reflected in discriminatory housing practices toward people with current or past use of drugs and some child welfare practices that lack services and support for parents with SUDs and fail to promote the safety and permanency of children in healthy families. New addiction research and recovery advocacy efforts have helped to slowly change these perceptions but stronger outreach and public education efforts are needed to raise awareness around addiction as a public health crisis and engage these other sectors into recovery-focused system transformation efforts.

Despite promising dialogue at the national level and new opportunities and momentum for improving cross-system integration, there is still clearly much work to do – at the federal, state and local levels – to break down longstanding silos and reduce discrimination. Discussions at the national level are so new that they have not yet successfully translated into concrete practice or policy changes at the federal, state, or local levels to achieve these goals. Participants discussed various challenges to integration – including inter-sectoral language barriers, conflicting priorities, siloed funding streams, misaligned performance measures and data sharing barriers – which are summarized below.

### **Finding a Common Language and Vision**

Perhaps one of the most significant challenges to integrating multiple systems into Recovery-Oriented Systems of Care (ROSC)<sup>1</sup> is the different meaning and use of language around recovery. Terms like “treatment”, “supportive housing”, “recovery housing”, “person-centered care”, and “housing choice” are commonly heard within the health, mental health, addiction and housing fields. However, these words often have different meanings within each of these systems. In particular, the term “recovery” remains highly contested between, and sometimes even within, these systems. Participants noted that recovery has taken on a much broader and individualized meaning within the mental health and addiction fields that underscores the significance of quality of life goals (housing, employment, community integration, etc.) and embraces multiple pathways. Yet, for some people and providers in the field, recovery remains analogous to complete and total abstinence from substances. Among supportive housing providers, there exists a tension between providers that see harm reduction and Housing First practices as fundamental quality dimensions of supportive housing and other programs (particularly those serving families) that maintain a “treatment-first” approach and sobriety requirements while in housing. These divergences often go beyond language differences and get to the values

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<sup>1</sup> A ROSC is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems. Read more about ROSC at: [http://www.samhsa.gov/sites/default/files/rosc\\_resource\\_guide\\_book.pdf](http://www.samhsa.gov/sites/default/files/rosc_resource_guide_book.pdf)

underlying the use of these terms. The barrier to collaboration often results from the opinion that one model is superior to another rather than promoting the need for all models to offer person-centered support.

Representatives from the Recovery Housing field spoke to the disconnect between the recovery support community and treatment systems. It is important to distinguish “treatment” from “recovery” and not using these terms interchangeably. In the larger national dialogue around ROSC, some treatment professionals have voiced concerns around the “de-professionalization” of the industry and balancing client choice with clinical obligations and medical liability. Recovery Housing providers recognize the increasing need for greater collaboration, integration with mainstream health systems and professionalization of the industry, but there is a general concern about maintaining the importance of the social model of recovery. In the current climate, providers feel the challenge of staying consistent with their missions, identities, and functions, while adapting to major systemic changes that require a broader scope of service and collaboration with other, sometimes much larger, organizations.

While there was agreement on the larger vision of recovery and principles of recovery-oriented care among participants, language barriers and some divergence in priorities were identified. Providers of supportive housing and homeless services were largely focused on the issue of homelessness and the need to increase housing options with harm-reduction focused approaches. Some of these providers voiced their concern that harm reduction approaches are not being used by many traditional treatment systems, reducing options for many chronically homeless individuals who may need services but are pre-contemplative or contemplative in their readiness to change their substance use.

Recovery housing providers serve a much broader target population that includes people who are homeless, at-risk of homelessness, and non-homeless. The primary concern for many of these participants centered on the need for more recovery-oriented housing, peer supports, resources and evidence-based practices that could more broadly meet the needs of individuals with SUDs who are preparing, motivated or already taking action to be alcohol/drug-free and need support to achieve and maintain abstinence.

These language differences present challenges to collaboration in the field and finding common ground would help efforts at improved integration. The task of clarifying diverse understandings and uses of terms towards largely similar goals is in itself an opportunity for affecting a solutions-focused systems change process.

### **Funding Challenges**

It is no surprise that a common challenge, across all sectors, was funding – the insufficiency of current resources, spending limitations set by funders for the types of services and housing delivered, rigid guidelines around the manner/setting in which services can be delivered, and disparate funding streams that do not incentivize the interagency collaboration needed to create holistic, person-centered systems of care. In particular, participants noted that in almost every community, the need for SUD treatment and recovery supports far outstrips the availability, largely due to insufficient funding, payment design, and regulations on service delivery structure. Funding for treatment and recovery supports continues to be a low priority for many policy-makers and is reflected in both public funding levels and coverage for services in private insurance plans, compared to other benefits. Public funding for Recovery Housing is nearly non-existent and most residents are required to pay rent and/or service fees to access this type of housing, which often results in excluding many homeless or very low income individuals. The lack of detox, residential treatment, and inpatient beds and long waiting lists are significant barriers to accessing treatment for this population. Homeless service providers are sometimes forced to send clients to facilities that are several hours away or to

unlicensed and unregulated sober or transitional homes that often prey on vulnerable individuals in need of housing and addiction services<sup>2</sup>.

Most supportive housing and homeless service providers face intense competition for federal, state and local housing resources and homeless service dollars. HUD-mandated homeless program policy changes focused on prevention activities and permanent housing solutions – like Rapid Re-housing or permanent supportive housing – are placing less priority on emergency shelter and transitional housing. As a result, many local Continuum of Care entities are pushing transitional housing programs to convert to permanent housing, significantly increasing competition for permanent supportive housing dollars. Recovery Housing providers that currently receive HUD funding to support their transitional housing programs noted that such changes are making many of them ineligible for future funding despite the on-going need for abstinence-based transitional housing for people experiencing or at risk for homelessness.

In addition to inadequate funding, current funding structures and regulations governing the operation of treatment services have very specific guidelines creating significant obstacles to coordinate and bundle services. Most providers juggle a broad array of contracts and grants to sustain their programs, all of which operate under different funding cycles, rules and reporting requirements. Varying regulatory requirements for the delivery of mental health and addiction services were identified as an important barrier to integrated care. Developing partnerships can be challenging when partners are restricted by regulatory requirements in their approaches to helping the same target population. This issue is particularly prominent for supportive housing providers when they try to work with detox centers and treatment facilities. Many housing providers find that they were able to engage with clinicians during an immediate client crisis, but, like other health systems, found them unable to remain engaged after the client had been discharged from the facility. Most addictions treatment agencies are regulated to operate in an acute care model rather than a chronic disease management model. The result is that once a person is discharged from treatment, providers are no more able to collaborate with a housing provider than an emergency department, hospital, or urgent care center can continue to collaborate once the person is discharged from their care.

Medicaid or insurance-based fee-for-service models that focus on specialized processes and procedures, rather than whole-person quality of care, also challenge integration. There is a need for more flexible risk-based or performance-based payment models that encourage innovation, collaboration and person-centered healthcare. Outreach and case management services – which are critical for individuals with SUDs, especially homeless populations - receive very little, if any, funding through treatment systems creating a significant bias toward site- or clinic-based treatment. Supportive housing providers find it difficult to bring clinical services into a home or community setting that might better meet their tenants' needs. This frustration is, in part, an outgrowth of the practical operating limitations due to the current regulatory, medical liability, and reimbursement policies that restrict where, how much, and by whom clinical services can be delivered. Per some state Medicaid regulations, many clinicians cannot get reimbursed for certain services delivered in home and community based settings increasing the barriers to deliver on-site treatment or recovery supports.

The ACA and parity legislation, along with other behavioral health transformation efforts, bring the opportunity to significantly expand the treatment continuum for SUDs. These changes should establish a mainstream funding source for a significant portion of recovery-oriented supports provided by community-based behavioral health providers. However, most homeless and housing services providers have little or no

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<sup>2</sup> See New York Times article on this topic: [www.nytimes.com/2015/05/31/nyregion/three-quarter-housing-a-choice-for-recovering-addicts-or-homelessness.html](http://www.nytimes.com/2015/05/31/nyregion/three-quarter-housing-a-choice-for-recovering-addicts-or-homelessness.html)

experience with Medicaid and need training, credentialing, accreditation and business planning support to ensure adequate capacity to respond to these opportunities. The SAMHSA-funded *BHbusiness* project at the National Council and CSH's *Medicaid Institute* are working with providers to build these necessary business skills.

### **Aligning Goals and Outcomes**

Creating the kind of practice and policy changes at the provider level that lead to holistic, person-centered care will require significant effort on the part of federal, state and local leaders to shift the vision, strategic direction, desired outcomes, culture, resources, and policies that shape the operation of health, behavioral health and housing systems. There is need for a shared sense of accountability between systems for the total health and well-being of the people they serve, rather than compartmentalizing services by particular needs. Ultimately, in order to overcome these challenges, the drivers of systems integration – performance measures, incentive structures, governance structures – must be better aligned in ways that foster stronger collaboration between housing and behavioral health systems.

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On the housing side, this means taking a broader and more intentional approach toward valuing and improving recovery outcomes for tenants with SUDs. To advance supportive housing as a health and recovery-focused solution, beyond ending homelessness, housing systems (including Continuum of Care entities) will need to adopt more recovery- focused goals, policies and performance measures that incentivize better coordination with SUD treatment and recovery support providers. Providers should identify, design and test enhanced models of supportive housing that integrate evidence-based clinical or behavioral health promotion interventions that reduce problematic alcohol and drug use, increase treatment engagement, and improve recovery management behaviors.

Strong incentives for behavioral health systems to make the significant investment of time and resources needed to engage with other sectors are also needed. Currently, many behavioral health reimbursement models are driven by medical necessity and process-driven performance measures (e.g., the number of case management contacts, on-time assessments, re-hospitalizations, etc.) rather than maintenance of housing or family stability, employment or other quality of life measures. While publicly funded treatment systems track many of these larger quality of life goals (for example, through the National Outcome Measures reported by states to SAMHSA), reimbursement structures and policies do not focus on these broader recovery outcomes.

Funders play a significant role and could help with alignment of performance standards. While today's funders are currently asking for integration in practice, they are not yet driving it through their funding streams. Public and philanthropic requests for proposals (RFPs) that outline their own specific outcome measures could be drafted to allow or encourage providers to adapt outcome measures in a way that would facilitate partnership across sectors. Opportunities for federal cross-sector funding demonstrations (e.g., between HUD and



SAMHSA) leading to aligned performance outcomes could provide practical guidance to advance integration of the sectors.

### Data Systems Integration

The ability to share information is essential to enable providers to coordinate care, monitor service delivery and align performance outcomes. Housing and health systems are focused on targeting scarce resources for people with the highest needs/costs so it is critical to know which people cross sectors. In addition, in order to facilitate the kind of inter-agency care coordination necessary to provide holistic care for individuals with multiple complex needs, there must be an infrastructure that allows for this type of real-time information sharing of patient/client data among frontline workers.

Participants raised a number of data sharing challenges including: (1) confusion about the applicability of HIPAA and 42 CFR provisions; (2) uneven implementation of electronic systems adoption and use; (3) lack of interoperability between multiple provider tracking and billing systems, and (4) lack of a shared nomenclature to track individuals within and across providers and sectors. Although regulatory barriers can impede data sharing, innovative communities are finding creative ways to share information (through interagency data sharing agreements and business associate agreements, linked electronic health systems, universal client release forms, etc.) and realizing that HIPAA often acts as more of a cultural barrier than a legal barrier to collaboration. Education and technical assistance around best practices for sharing data between systems and creating feedback loops for decision-making intelligence could help improve collaboration between agencies. Every effort to share, merge and use systems data to drive decision-making and assess impact provides an additional learning opportunity and potentially valuable precedent or tool for subsequent efforts.

## II. Promoting Housing as a Platform for Recovery

Housing is an essential platform for recovery and housing must be recognized and included as a vital part of healthcare and recovery support systems. Recovery – and all that it entails from better health to employment to community re-integration to family reunification to abstinence and beyond – is nearly impossible while homeless or unstably housed.

Recognizing housing as a platform for recovery is not simply about putting a roof over someone’s head to meet basic needs but about providing individuals with a strong foundation for moving beyond stability, regaining hope and achieving long-term wellness and recovery goals. Importantly, participants

noted that this issue was not just about homelessness; not all individuals with an SUD experience homelessness, just as not all homeless people who may use substances necessarily have a diagnosable disorder. Nonetheless, the nature and quality of one’s housing environment is a critical factor impacting the recovery process for all individuals with a mental illness and/or addiction. There continue to be general issues of housing availability and affordability but more attention should be focused on the factors that promote and impede housing choice for this population. Recovery is a highly individualized process that can take many forms, and housing choice does not belong to any one particular model or approach – be it Recovery Housing, Housing First, scattered-site, single-site, sober or transitional housing. Rather, housing choice is about creating well integrated systems that offer a broad and flexible continuum of housing options that meet the diverse needs of people with SUDs,

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wherever they may be on the spectrum of recovery. Abstinence-based and harm reduction approaches to housing do not represent opposing strategies but rather models for engaging different populations and engaging those individuals at different stages of their alcohol and/or drug use.

In addition to various housing models, participants mentioned the important role that architecture and the built environment – from neighborhood to housing design - can play in promoting healing and recovery. For example, housing for individuals in recovery should not look or feel anything like exclusion. The physical spaces within a house or complex should be intentionally designed to encourage connection with peers and community engagement and involvement, a therapeutic process that does not resemble a hospital or institutional environment. Lighting, color, shading, movement and landscaping are aspects of architectural design that contribute to a therapeutic environment. In the same way, the physical location of a house or building should reflect the larger goal of societal re-integration such as placement in residential neighborhoods rather in desolate areas away from civilization.

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Individuals with substance use problems face many barriers in trying to access appropriate housing. Some of the main challenges include:

- Punitive responses to substance use and general discrimination against persons living with addiction that limit access to housing but also to treatment, employment opportunities, public assistance and many community-based services.
  - Federal regulations allow housing authorities to consider drug use and convictions of people and/or their family members when making decisions to evict or deny access to federally subsidized housing.
  - Many landlords require past references, credit checks and criminal background checks, employment history, and/or past evictions—all creating additional barriers.
  - Those with criminal histories face significant challenges to finding employment or accessing income supports to obtain or maintain housing.
- Lack of affordable housing in almost every community
- Lack of housing choice – permanent, transitional, affordable housing - for individuals with SUDs
  - Limited recovery housing options available for special populations including women, single and two-parent families with children, transition-aged youth, LGBT individuals, individuals with co-occurring mental health and SUDs, and people with criminal histories - especially sex offenders.
- Challenges related to developing housing for this population as a result of zoning ordinances, land use regulations, NIMBY-ism and inadequate funding sources.
- Lack of expertise, partnerships and experience in housing development among Recovery Housing providers, limiting access to public/private capital to develop housing
- Lack of consistency in standards of care and housing quality among Recovery Housing providers due to little or no oversight and regulation

- In response to these concerns, the National Alliance for Recovery Residences (NARR) released their [national standards](#) for recovery residences in 2011 and launched a certification program.

### III. Understanding and Establishing the Evidence

The final thematic thread that ran throughout the convening was the critical role of evidence. Not surprisingly, representatives from different sectors and disciplinary orientations sometimes access, read, consider and implement evidence in a diverse and segmented manner. The convening conversation raised questions including:

- What is the evidence for the effectiveness of all the varied housing and service models?
- What are the characteristics and service needs of individuals and families affected by substance use?
- What are the primary outcomes of interest?
- How are these outcomes conceived, operationalized and measured?
- What are the most appropriate methods and assessment tools for targeting interventions and resources?
- How do federal policies shape funding?
- How has the availability of funding shaped or incentivized our understanding of evidence?
- What advocacy is needed to cultivate funding for research and evaluation in under-represented areas?
- How does evidence get translated into practice and policy?

#### Availability and Accessibility of Evidence

Availability and accessibility to evidence of the full range of housing, treatment, and recovery oriented service models is lacking. While the evidence base for supportive housing has burgeoned over the past two decades, there has been less investment in research on recovery housing. The historical concentration of funding for controlled trials and clinical treatment interventions in addictions policy and Housing First in HUD policy have led to a biased understanding of the field that has excluded and underrepresented other models and approaches, the most obvious example being those along the continuum of Recovery Housing and chronic disease management of addiction. A targeted advocacy effort, is required to ensure the representation of the full range of models of housing and services for people with SUDs, especially those that are less clinical and more peer and community based.

A comprehensive and objective understanding of the evidence across the various models, how they fit together, areas of convergence/divergence and the identification of potential gaps is also lacking. Just as troubling is the need for more cross-cutting meta-analytic studies that concisely synthesize existing evidence on the efficacy of different housing models (permanent supportive housing, Recovery Housing, transitional housing, etc.) and service interventions (medication-assisted therapies, trauma informed care, harm reduction, etc.) for different populations (chronically homeless, unstably housed, youth, families, dual-diagnosed, etc.) and across various settings (urban/ suburban/rural, scattered-site/single-site). In addition, there is a need for “environmental scans” to assess the existing inventory of housing models across different communities as well as the size, characteristics and needs of the target populations. This information should be considered essential for determining resource allocations and designing proper targeting strategies.

It is clear that “big picture” systems are critical, yet there is little research and evaluation at this level. As the ROSC movement is still in early stages of scaling, communities across the country are embarking on systems-level planning and transformation without clear evidence on the most effective methods for creating and implementing this infrastructure. ROSC reflects a type of system approach that is not predicated on simply scaling one type or forcing standardized interventions together but rather one that is adaptive and responsive to the complexities of peoples’ lives in the context of their communities. Developing such a flexible and dynamic system across various community settings will inevitably generate important systems-level research questions needed to help inform design, planning, and implementation efforts.

### **Defining, Measuring and Operationalizing Key Outcomes**

A critical obstacle to discerning the efficacy of various housing and service interventions is the lack of consistency in how “success” is measured and operationalized across studies. The primary outcomes of interest in evaluations emerging out of the addictions field tend to focus on traditional measures related to achievement/maintenance of sobriety, treatment engagement, participation in social support networks (e.g., 12-step), employment, psychological functioning and other clinical indicators. While more recent community-based research on Recovery Housing and sober living homes is steadily shifting the focus toward more quality-of-life indicators (family reunification, community integration, residential stability, etc.)<sup>3 4</sup>, these studies remain limited.

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Studies on supportive housing and Housing First/harm reduction approaches have examined various outcomes relating to homelessness, jail/prison recidivism, health service utilization, avoidance of costly crisis services, improved physical health/behavioral health, employment, family reunification, reduced drug/alcohol use and community participation. However, the primary emphasis (or value) is placed on housing stability, which is perceived as the platform for success in these other dimensions<sup>5 6</sup>.

To some extent, these differences in outcomes or “success” measures reflect differences in target populations for these housing interventions. While supportive housing has recently expanded to serve a much broader population, it originated as a solution to end chronic homelessness and promote recovery from all the social, economic, physical and psychological ills associated with this condition. On the other hand, recovery housing emerged as an intervention broadly targeted at individuals with SUDs – of varying socioeconomic backgrounds - seeking a safe, healthy place to live that provides them with a community of support for initiating and sustaining long-term recovery from addiction. In order to evaluate the efficacy of these models, more

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<sup>3</sup> Jason, L. A. & Ferrari, J. R. (2010). Oxford House recovery homes: Characteristics and effectiveness. *Psychological Services*, 7(2), 92-102. doi:10.1037/a0017932.

<sup>4</sup> Jason, L.A., Mericle, A.A., Polcin, D.L., & White, W.L. (in press, 2013). The role of recovery residences in promoting long-term addiction recovery. *American Journal of Community Psychology*. Retrieved from [http://www.facesandvoicesofrecovery.org/pdf/Publications/2013\\_Recovery\\_Residences\\_Long-term\\_Recovery.pdf](http://www.facesandvoicesofrecovery.org/pdf/Publications/2013_Recovery_Residences_Long-term_Recovery.pdf)

<sup>5</sup> Sadowski, L., Kee, R, VanderWeele T, Buchanan, D 2009. “Effect of a Housing Case Management Program on Emergency Department Visits and Hospitalizations among Chronically Ill Homeless Adults.” *Journal of the American Medical Association*. Vol 301(17):1771-1778

<sup>6</sup> Massachusetts Housing and Shelter Alliance, 2014. *Home and Healthy for Good June 2014 Progress Report*. Available at: <http://www.mhsa.net/matriarch/documents/June%202014%20HHG%20Report.pdf>

comparative research is needed to assess the effectiveness of different housing models in promoting these various outcomes for individuals at varying stages of substance use and recovery from addiction.

While the coordination of research efforts is needed, it is also important to strategically align research and performance measures with the “whole-health” or “triple-aim” (improve health outcomes, experience of care and per capita costs) focus of current national health reform efforts. The “housing is health care” proposition has recently gained traction in the health field creating a strong demand for cost-benefit analyses to support the business case. New research demonstrating the cost-effectiveness of supportive housing for improving health and reducing costs for frequent users of crisis services has helped the industry leverage millions in service dollars through mainstream health financing streams (e.g., Medicaid and managed care organizations) and has recently propelled the model prominently into the social impact financing scene. While there is good reason to expect that Recovery Housing would also help to promote a high-value health system, more data and research is needed to understand its specific impacts.

While cost-benefit analyses are critical, more research is needed that emphasizes the multiple benefits to individuals, families, neighborhoods, communities, and public systems that are not fundamentally economic. These efforts are also key to battling the stigma and discrimination toward those living with addictions and educating the public about the manifold benefits of using housing as a platform for recovery to achieve a larger social good. Moreover, the current dialogue around building person-centered care and systems needs to be reinforced by equally person-centered research that incorporates the values and quality-of-life goals of those in recovery.

### **Applicability and Meaningful Community Involvement in Research**

Regardless of the strength and rigor of existing and new research, it will only be as impactful as the ability to translate and disseminate evidence that is understandable and resonates across diverse audiences of researchers, policy makers, practitioners, community leaders, and the lay public. It is absolutely essential to ensure meaningful and integral community involvement in every phase of the research and evaluation process, from conceptualization to design to implementation, ensuring that the right questions are asked and that results apply and translate into meaningful changes in practice and policy. In addition, greater effort is needed to incorporate the voice of study subjects - individuals in recovery – into evaluation activities to ensure that our research goals work toward promoting the needs, desires and values the target populations.

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*“People in recovery have goals just like you and me – they want a home, they want a job, they seek friends and intimacy, they want better health, they want to feel respected again. I don’t recall a time when a client mentioned lowering their cost to Medicaid or other public systems as a primary goal in their service plan.” - Convening participant*

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## Recommendations: Working Toward a Comprehensive Continuum of Housing and Services to Promote Long-term Recovery among Individuals with Substance Use Disorders

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### **Systems Change: promote integration of housing, treatment and recovery support systems at the federal, state and local levels**

- Host regional or state-wide summits to bring together housing and treatment systems to develop strategies for improving access to housing, treatment and recovery supports for individuals with SUDs; Provide technical assistance to engage stakeholders in an intensive planning process to jumpstart the creation and implementation of a local systems change plan
- Produce a guiding document on relevant terminology that establishes a common language around recovery concepts and principles for funding, policy, practice, etc.
- Educate and engage the supportive housing community around the national recovery conversation, ROSC scaling efforts, innovations in cross-system collaboration and integrating evidence-based recovery supports into core services
- Take advantage of opportunities arising out of the Affordable Care and Parity Act and other health/behavioral health reform initiatives:
  - Advocate to include housing-based support services - including case management, recovery supports, peer support services, health care navigation, etc. – in state Medicaid and private insurance plans
  - Create policies that shift SUD services and supports from an acute care delivery model to a model that fosters quality of life and wellness
  - Change public and private health/behavioral health financing practices to adopt reimbursement strategies that emphasize “whole-person” health and incentivize collaborative care approaches (e.g., bundled rates, global capitation and pay-for-performance models)
- Clearly articulate the role housing plays across the spectrum of recovery and explore opportunities to work with SAMHSA to increase the role of housing systems in ROSC scaling efforts across communities
- Establish national and local campaigns to raise awareness about addiction and recovery and reduce stigma, punitive responses and discrimination toward individuals living with addictions and those in recovery
- Hold regular SUHLF-like convenings to bring together experts, practitioners and policy leaders to continue the dialogue at the national level and advance state and federal policies that address barriers to housing choice for individuals with SUDs
- Build relationships between HUD, local Continuum of Care, recovery housing providers and other stakeholders to explore opportunities for accessing HUD housing dollars and including recovery housing units serving people experiencing homelessness as part of the COC housing inventory

### **Cultivate and Disseminate Knowledge: Build the evidence base around housing models and best practices for serving individuals/families with substance use disorders and work with partners to disseminate knowledge broadly**

- Develop a cross-cutting meta-analysis that provides a review of evidence on housing models across the spectrum for serving individuals with SUDs (supportive housing, housing first, harm reduction, recovery housing, Oxford house, etc.);
- Form a diverse advisory committee that includes experts in supportive housing, recovery housing, SUD treatment and housing policy to develop a research agenda around housing and service approaches for promoting recovery among individuals with SUDs; use this agenda to inform federal/state demonstration projects and evaluation activities
  - Create a mechanism for people in recovery to be involved in the process of defining outcome measures for recovery
- Conduct environmental scans in select communities across the country to assess the current state of and need for supportive housing, recovery housing and other types of housing to serve individuals with SUDs
- Survey Supportive Housing providers to identify the need for treatment and recovery supports among residents and the main barriers to accessing these services in the community
- Increase federal and philanthropic funding to support rigorous research on Recovery Housing to better understand its impact on various recovery outcomes for individuals, the benefits to other systems of care, and the costs associated with operations/service delivery
- Improve data collection practices among recovery housing providers and provide basic data training to staff; Hold focus groups with recovery housing providers to identify minimum data points and domains that would effectively tell the story of recovery housing
- Highlight data sharing best practices and support the development of new integrated data systems which facilitate concurrent monitoring and data collection across systems

***Improve Practice: Build the capacity of supportive housing and recovery housing providers to integrate best practices at the nexus of housing and services for individuals with substance use disorders***

- Explore ways to integrate and synchronize “front-end” intake and assessment processes across systems to facilitate person-centered care and enhance the effectiveness and efficiency of housing and health systems to serve this population
- Provide technical assistance to build the capacity of supportive housing providers to incorporate evidence-based recovery supports into core services (e.g., supported employment, wellness self-management, peer-operated services, recovery coaching, etc.)
- Provide technical assistance to build the capacity of treatment providers and recovery support specialists to use evidence-based practices for effectively engaging individuals experiencing homelessness that are actively using (e.g., motivational interviewing, trauma-informed care, etc.)
- Provide technical assistance opportunities to help recovery housing providers build capacity in the areas of housing development, best practices in service delivery, business, accounting, marketing, data collection and coalition building
- Produce concrete implementation guides/resources for delivering services and supports for individuals with SUDs living in supportive housing
  - Develop a comprehensive practice manual on effectively serving individuals with SUDs in SH (harm reduction, recovery supports, employment, wellness self-management, peer supports, etc.);

- Produce and disseminate assessment tools/strategies, recovery-oriented action planning guides, sample training materials, etc.
- Define recovery and recovery-orientation and create provider tools or guidelines around how to assess and modify current workforce policies and practices to ensure recovery concepts are incorporated into all levels of the system
- Aggressively promote the use of evidence-based practices in supportive housing services through CSH's national Dimensions of Quality certification process
- Create a peer-to-peer learning collaborative among supportive housing providers, treatment providers and recovery housing providers to facilitate information sharing on innovative programmatic and system-level strategies for expanding and improving care for individuals with SUDs

## Conclusion

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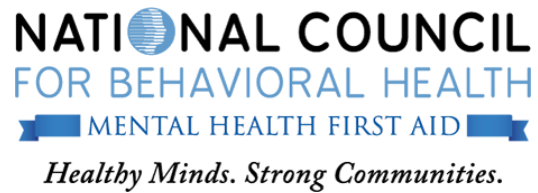
For two days, representatives with varied, unique and occasionally conflicting approaches to addressing SUDs in the context of homelessness and housing came together for a candid and solutions-focused dialogue. The proceedings demonstrated that participants shared far greater areas of convergence than divergence, as the values, goals, missions, and challenges underpinning their efforts were highly aligned. In almost every sector and every jurisdiction the capacity does not match the complexity or severity of need. Yet overall, there was optimism that movement is in the right direction and that meaningful systems change can happen to support self-defined recovery for people who are living with SUDs.

While systems change can and must be imagined and informed at the macro level, practically and functionally systems change occurs locally. State and federal policies are relevant, and it is essential to identify current macro-system features (i.e. federal funding rules) that enable or constrain services and housing for people in recovery. While significant progress has been made at the national level to engender a more productive dialogue around promoting a broader, long-term model of recovery, more must be done at the federal policy level and local efforts must be supported to build the capacity of communities to implement the vision of Recovery Oriented Systems of Care. Participants were unwavering in their insistence that systems must not simply promote an ethic of person-centeredness, but that it must be the central organizing principle that is woven into the very fabric of new systems to ensure support of people as their own agents of change, pursuing self-defined goals, and building upon their own personal assets/capital. These examples must inform and facilitate the dissemination of knowledge and insights about the features, practices and strategies that have been effective.

SUHLF participants were tasked with bringing their expertise, experience and creativity to the tall task of imagining systems that maximize options and create flexible access to and mobility between housing and services that are responsive to the needs of people living with SUDs. The themes that emerged from the conversations are not mutually exclusive, but rather represent processes and efforts that will inform each other in identifying and building solutions to a common challenge. Important barriers to building person-centered systems, coordinating care and improving housing choice for this population were identified and concrete recommendations for stimulating successful change were offered. Most importantly, this diverse group of experts and practitioners, whose service philosophies have often conflicted, thoughtfully and tirelessly worked through difficult issues to reach consensus on several issues and resolved to work together to advance a collective vision.



## Appendix A: Participant List



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## Appendix B: Meeting Agenda



### Substance Use and Housing National Leadership Forum

October 6 - 7, 2014  
Washington, DC  
Hall of the States

#### Convening Agenda

##### Monday, October 6, 2014

Day 1 Objective: Identify key factors supporting and impeding integration of housing and services for individuals experiencing homelessness and affected by substance use; Develop vision and key components of a comprehensive continuum of housing and service programs that meet the needs of the target population; Share emerging/promising practices, with particular attention to cross-system strategies;

- 10:00am – 10:15am: Registration**  
Coffee and light breakfast included
- 10:15am – 10:30am: Welcome and Opening Remarks**  
Deb DeSantis, President & CEO, CSH  
Becky Vaughn, Vice President of Addictions, National Council
- 10:30am – 10:45am: Setting the Stage: Purpose and Goals of Convening**  
Janette Kawachi, Director of Innovations and Research, CSH
- 10:45am – 11:15am: Introductions**
- 11:15am – 12:30pm: Identifying the Issues and Priorities**  
Facilitator: Ryan Moser, Eastern Region Director, CSH  
*Large group discussion to explore areas of consensus and differences surrounding housing and service approaches/philosophies for this population; identify key barriers to collaboration and coordination between housing and SUD treatment systems at federal, state and local levels; and discuss strategic opportunities and challenges to implementation. Through this*

*discussion, the group will collectively identify the top five priority issues, which will be discussed in greater depth during the three afternoon sessions.*

- 12:30pm – 1:30pm: Lunch**  
Presentation on Philadelphia’s Recovery-Oriented-Systems of Care Initiative  
Dr. Marcella A. Maguire  
Director of DBH Homeless Service, City of Philadelphia
- 1:30pm – 2:35pm: First Priority Topic**  
Large Group Discussion  
Facilitator: Ryan Moser
- 2:35pm – 3:40pm: Second Priority Topic**  
Large Group Discussion  
Facilitator: Ryan Moser
- 3:40pm – 3:50pm: Break**
- 3:50pm – 4:50pm: Third, Fourth and Fifth Priority Topics**  
Break-out Groups (assigned seating)  
Facilitators: CSH Staff
- 4:50pm – 5:00pm: Closing Session and Adjournment**  
Ryan Moser
- 6:30pm: Networking Dinner**  
District Chophouse: 509 7th St NW, Washington, DC 20004

## **Tuesday, October 7, 2014**

**Day 2 Objective: Develop policy recommendations and actionable strategies to achieving system-change goals at the state and federal level; identify concrete next steps for addressing identified challenges and putting key components of vision into operation across state/local systems of care; build a research agenda to help advance our collective work**

- 8:30am – 9:00am: Breakfast**
- 9:00am – 9:15am: Review of Day 1 and Charge**  
Peggy Bailey, Senior Policy Advisor, CSH
- 9:15am – 10:15am: Strategy Session: Policy Priorities**  
*Large Group Discussion focused on identifying key policy levers and opportunities at the federal and state levels to expand housing opportunities for the target population(s) and promote better integration between housing and SUD treatment systems within communities*  
Facilitator: Peggy Bailey

- 10:15am – 11:15am: Strategy Session: Improving Practice and Provider Capacity**  
*Large Group Discussion focused on strategies to identify and promote best practices in the field for integrating housing and recovery support services for target population; identify key technical assistance needs and capacity building strategies for providers and communities seeking to implement systems/practice changes*  
Facilitator: Janette Kawachi
- 11:15am – 11:25am: Break**
- 11:25am – 12:25pm: Strategy Session: Building a Research Agenda**  
*Large group discussion focused on identifying a list of prioritized research questions aimed at improving knowledge about the characteristics and needs of the target population, effectiveness of various housing/service interventions, and methods for creating and implementing the infrastructure necessary to support systems integration*  
Facilitator: Kevin Irwin, Senior Program Manager, CSH
- 12:25pm – 1:00pm: Lunch: Closing and Future Directions for Advancing Systems Change**  
Janette Kawachi