Recovery Housing 101

Thursday, December 17, 2020

David Awadalla: Hello, everyone. My name is David Awadalla and I'm a senior research scientist with ICF. We are going to be talking today about recovery housing and we're going to be kind of talking about the ins and the outs and also talking about the research behind it.

So let's go ahead and get started. So today we're going to start out with some welcome and introduction, both myself and my colleague, Rachel Post from the Technical Assistance Collaborative. We are going to be introducing ourselves.

We're also going to be covering some poll questions and also talking about what recovery housing is, the relationship between HUD and recovery housing and then also discussing the levels of support, the issues and then we're going to be wrapping up on some closing thoughts and questions.

So as I mentioned, I'm a senior research scientist with ICF. I had been working in the house systems policy compliance and public health fields for over eight years with positions ranging from the federal, state and local levels. Prior to joining ICF I served as the project director and as the subject matter expert and consultant for the Michigan Department of Health and Human Services.

I've also worked for the Substance Abuse and Mental Health Services Administration within the U.S. Department of Health and Human Services. So the breadth of my professional experience has been comprised of research, consulting and technical assistance surrounding opioids, opioid use and substance use disorder as well as ethics between treatment and primary prevention of OUD and drug overdose.

So in addition to assisting HUD with the new recovery housing program, I currently work with the Centers for Disease Control on preventions, Division of Overdose Prevention, helping with technical assistance for their overdose data to Action Cooperative Agreement, which funds 66 state and local public health departments for opioid overdose prevention and surveillance.

So I'm excited to be here today to discuss the ins and outs and importance of recovery housing. And with that, I'm going to turn it over to my colleague, Rachel Post, from the Technical Assistance Collaborative.

Rachel Post: Great. Thank you, David. I'm excited to be here with you all today. As David mentioned, my name is Rachel Post. I'm a senior associate at the Technical Assistance Collaborative and I have over 20 years of experience designing and implementing innovative evidence-based nationally recognized programs serving people exiting homelessness and incarceration and those with complex primary and behavioral health conditions.

Prior to joining TAC I served as the public policy director at Central City Concern in Portland, Oregon where I led federal, state and local advocacy efforts, including those to recognize and fund recovery housing, leading to HUD's publication of the recovery housing brief which we'll be talking about shortly.

I also designed and implemented the first evidence-based supported employment program for people in early stages of recovery from substance use disorders and living in recovery housing and I have experience in designing and implementation of chronic homeless Housing First programs in the Portland, Oregon and Denver, Colorado.

Since joining TAC I have provided subject matter expertise to CMS on two SUPPORT Act initiatives that we'll be highlighting shortly related to Medicaid's role in funding housing-related supports for people with substance use disorders. So with that, we'll go to the next slide.

Okay. So today's session learning objectives, as a result of this webinar, we hope that you'll be able to explain what recovery housing is, the populations it serves, how it is different from detox, treatment, clinical programs and the role it plays in substance use disorder treatment and long-term recovery as well as that you'll be able to describe standards, ethics and guiding principles that generally govern recovery housing.

So first, we just want to bring everyone back to sort of the subject at hand here. So as all of you are likely aware, the -- this current recovery housing program is a result of the SUPPORT Act Public Law 115-271, which was enacted on October 24, 2018 to address the opioid epidemic and Section 8071 authorized the program to aid grantees with providing stable, temporary housing to individuals in recovery from substance use disorder.

And the provision required that eligible states and the District of Columbia have age-adjusted rates for drug overdose deaths above the national overdose mortality rate and that the funds would be distributed based on Community Development Block Grant program under Title 1 of the Housing and Community Development Act.

In December, 2019, these funds were appropriated through public law and $25 million of funds were authorized by the SUPPORT Act and the funds were awarded by a formula to 25 eligible grantees. So the 24 states and the District of Columbia that are participating in today's webinar, there may be others.

This content is directed specifically to those 25 eligible grantees. And the formula for the award included unemployment rates, the 15 percent labor force nonparticipation and age-adjusted rates of the drug overdose deaths. Now I'm going to turn the presentation back over to David so that he can do a few polling questions with folks.

David Awadalla: Great. Thank you so much, Rachel. So before we dive into the rest of the webinar, as Rachel mentioned, I want to just take a few minutes to ask you several polling questions. So these questions are really going to help drive our technical assistance for the recovery housing program grants over the next year.

So please make sure you take a few moments to answer each question. So before we begin, I'm just going to hand it off to John Panetti [ph] who's going to provide you with a little bit of background on answering the following poll questions. Great. Thanks, John. Go ahead.

John Panetti: Hi, all. So you should see the poll pop up on the right side of your screen. Just go ahead and select your answer and then there's a second step where you have to -- after you selected, you have to actually submit the answer. So if you go ahead and do that, that would be great.

This data is really, really important to us for informing future webinars. So I'll go ahead and give people a moment to answer the poll. I'll give everybody just a few more seconds to finish answering the poll question. All right. Thank you, everybody, for answering the poll.

It looks like most of you chose yes, that you are coordinating or planning to coordinate with your state health authority/single state agency and some of you are also not sure. So I will go ahead and hand it back over to David.

David Awadalla: All right. [inaudible] --

Rachel Post: Okay. Well, it seems that we may have lost David for a moment. But the next question -- let's see, have we moved to the second question? Are you coordinating with your state health authority/single state agency that typically administers -- oh, I'm so sorry, folks.

The next question is did you know that you can coordinate and collaborate with this agency? So the Federal Register Notice encourages collaboration with the state agency or authority that coordinates and distributes federal funding for treatment and recovery support services. So I don't think we actually have a poll with this one.

So I think we'll go to the next slide. This is a polling question. Is your state collaborating with the other types of entities or federally-funded programs listed in the notice, such as we talked about SAMHSA, the U.S. Department of Labor Workforce Innovation and Opportunity Act, HUD Continuum of Care program, HUD Emergency Solutions Grant programs, HUD Housing Opportunities for Persons with AIDS or the U.S. Department of Veterans Affairs.

So if folks could just click all of those that apply, that would be great. You will just get maybe 10 more seconds. Let's close that poll.

John Panetti: All right. So if people are answering still and they haven't submitted, the poll automatically closes in 20 seconds.

Rachel Post: Oh, got it. Thank you. All right. So it looks like folks -- about 13 of 52 of you are partnering with HUD Continuum of Care, 9 of 52, or 17 percent, with the Emergency Solutions Grant and Housing Opportunities for Persons with AIDS, we have 1 person and U.S. Department of Veterans Affairs 1 person. Great. Thank you.

We can go to the next poll. How would you describe your familiarity with substance use disorder treatment and recovery, prevention services in your state? And we have those polling questions up now. So I consider myself an expert, I am somewhat familiar, mostly unfamiliar or completely unfamiliar.

And we're closing that poll. How much longer for that poll before we can get to the results? Great. So it looks like 2 of the 52 folks consider themselves somewhat familiar or consider themselves experts, 2 percent consider themselves somewhat familiar, mostly unfamiliar.

So it looks like the larger class of folks are either mostly unfamiliar or completely unfamiliar with substance use disorder or treatment recovery prevention. Thank you. Next slide. How about -- well, this will be our last poll. How would you describe your familiarity with recovery housing?

And should be near the end of that polling period for this question. This is really helpful information for us to make sure that the future technical assistance we're providing to each of the states is suited to your all's needs.

And so we've got 2 people who consider themselves experts in recovery housing, 6 are somewhat familiar and then we have the remainder of respondents, 16 and 12, who are mostly unfamiliar and completely unfamiliar. So thank you very much for responding. And next slide, please.

David Awadalla: All right. Hey, Rachel, can you hear me?

Rachel Post: Yeah. That's great. Thanks, David.

David Awadalla: Wonderful. Thank you for saving me there. I apologize to everyone, had a little audio difficulty. So I am back on and just in time to talk a little bit about recovery housing. So thank you for your participation in the polls. I just want to acknowledge that recovery housing is an intervention that's designed to address the needs of recovering people.

So it is actually a pretty simple concept. [inaudible] are that it must provide [inaudible] these living environments and also provide the requisite recovery and peer supports. I also want to emphasize that while there are many different types and levels of recovery housing, they all have the same goal guiding their tenants to sustain recovery and having them be contributing members of society.

So recovery housing is an essential part of the substance use disorder treatment and recovery continuum of care. It is typically one of the last stepdowns and you can't see me, but I put that in air quotes, because there are multiple stepdowns or for people who are in this -- the treatment and recovery continuum of care.

As I previously mentioned, it should provide safe, healthy and supportive substance-free living environments and also be centered on the peer support and connection to services that promote that long-term recovery. Finally, recovery housing should also promote connections to mutual support groups and recovery support services to reduce isolation and in turn, relapse.

Mutual support groups typically include Alcoholics Anonymous, Narcotics Anonymous, Celebrate Recovery and SMART Recovery. I also want to mention that many recovery housing programs [inaudible] tenants in some type of mutual support group. So you often see recovery

housing programs have their clients fill out sheets proving that they've been going to mutual support group meetings, because it's such an important part of early recovery.

So I know that many of you perhaps envision Recovery Housing Programs at something specific, however, I do want to acknowledge RHPs do not have one defined look.

Since the only requirement is stay stable and substance-free housing with a peer support [inaudible] they often take the form of shared or congregated single-family homes, [inaudible] apartment buildings or complexes and also individual apartments, it just depends on the program. So with that, I am going to turn it over to Rachel, again, and she's going to talk a little bit about the [inaudible] federal entity programs. Rachel.

Rachel Post: Great. Thank you, David. Excellent. So I wanted to draw your attention to these resources and we will be sharing these slides on the HUD Exchange Recovery Housing Program website so that you'll be able to open these slides and click into these links.

So these are just various references to documents that recognize the importance of recovery housing and helping people sustain their long-term recovery. So recognizing that treatment by itself really may not be sufficient for a set of individuals who have substance use disorders.

So first, I just wanted to reference the HUD Continuum of Care Recovery Housing Policy Brief from 2015. We'll be diving a little bit deeper into that in just a moment. And then the SAMHSA Recovery Housing: Best Practices and Guidelines from 2018, I'll be talking through quite a bit of that as well.

Additionally, just wanted to note that the surgeon general, in 2016, reported in Facing Addiction in America, the importance of pairing recovery housing and recovery supports with treatment to sustain ongoing recovery. And then we also wanted to include a link here in -- to the SUPPORT Act from 2018 should folks want to peruse that.

And then finally, I wanted to reference this CMS SUPPORT Act Innovative State Initiatives and Strategies for Providing Housing-Related Services and Supports under Sections 1017 and 1018. So I happened to be also working with CMS on technical assistance related to these sections of the SUPPORT Act.

If you go to this link, you will see, just this month, published a report to Congress that highlights five case studies of states who have employed housing-related support services using Medicaid for populations with substance use disorders. Those case studies reference Washington State, California, Arizona, Maryland and Pennsylvania.

They're really great at sort of highlighting how housing resources paired with Medicaid support services are serving individuals in these states and then also in Section 1018, we have just launched a learning collaborative to bring 10 states who are interested in expanding their Medicaid resources to serve individuals with substance use disorders using some care recovery supports, housing-related services with bringing that together with housing resources in their states.

And I just wanted to mention that 6 of the 25 states who have been selected and eligible for the recovery housing program through HUD's CDBG are also participating in the CMS Learning Collaborative and those states are Arizona, the District of Columbia, Kentucky, Louisiana, Ohio and New Mexico.

So for those states, you may want to connect with your state Medicaid agency, if you haven't already, to determine how you go about planning for your recovery housing.

So now I'm going to dive in a little bit deeper into the HUD's Continuum of Care Recovery Housing Policy Brief, which again, from 2015, it -- you know, that is a little dated, but it's written in relationship to the continuum of care but provides guidance for recovery housing programs generally and is still relevant, especially when serving populations of individuals who are experiencing homelessness.

So in this guide, it recognizes that it's important that program participants in recovery housing are those who have self-initiated engagement into treatment or who -- into detox and have identified that they, in fact, do want to live in recovery housing and feel that that will be beneficial in terms of being able to sustain recovery and program participation, as I said, is self-initiated, but, there are minimal barriers to entry.

And so those who have criminal records or eviction history should be served so that there will be few barriers to entry into recovery housing. Housing is single-site or congregate, depending upon whether you work in the housing field or behavioral health to support a recovery oriented community.

We'll talk a little bit more about that when I get to the SAMHSA guidance. Residents have personal privacy and 24/7 access to the housing. That means it's people's homes, they can be there as many hours a day as they want. This is not something that sort of shuts down in the day, people have to go out and then come back in the evening.

And there should be a community space for residents to gather to hold 12-step meetings or other kinds of recovery-oriented activities. And in this kind of programming, that services should be holistic and peer-based. So peer-based recovery supports are those that are offered by people with lived experience.

So people who themselves have recovered from substance use disorder, people who may additionally have exited incarceration or have exited homelessness and that these peer-based recovery supports would be available to everyone who lives in the recovery residence.

Moving on. Additionally, service supports exits to permanent housing and acquisition of income and employment so that if individuals are -- you know, if the housing is temporary, as is the example or at the least the funding source is temporary with these funds, that the program supports individuals in finding and securing permanent housing as well as acquisition of income and employment.

Some people may have a lengthy employment history and may not need a whole lot of support in finding work, others may have a criminal history that makes it difficult for them to find work and keep work. And so there are evidence-based practice approaches to helping and support people in finding and keeping work for this population.

Also, recovery housing, using this approach, would not automatically cause -- would not automatically discharge folks because they have a recurrence of their substance use. So rather than evicting someone immediately, that discharges would only occur when a participant's behavior substantially disrupts or impacts the welfare of the recovery community in which the participants reside.

And then participants may also apply to reenter into the recovery housing program if they express a renewal -- a renewed commitment to living in housing with an emphasis on abstinence and recovery. So people are given second chances if they determine that they're ready to reengage.

And those who are no longer interested in living in recovery housing with an abstinence focus or who are discharged from the program or evicted from the housing are offered assistance in accessing other housing and service options, including options operated with a harm reduction principle.

So onto now the SAMHSA's 2018 Recovery Best Practices. Again, we've included the link here to that document. I think that as states begin to plan how they will design recovery housing using these funds it's a very helpful document to reference.

And also, I just want to acknowledge that this document recognizes the National Alliance of Recovery Residences levels of care and David's actually going to highlight those levels of care a little bit later. So I won't spend any time on that.

So there are 10 guiding principles in the -- this SAMHSA Recovery Best Practice document and the first one is that programs need to have a clear operational definition of recovery housing so that staff and community understand the intents of the program and the aspects of supports it offers.

And you can see in the link here that there's a definition of recovery housing in this document from SAMHSA. So you can look at that and determine if that's the definition that you intend to use. Second, the recovery residences, recovery housing would recognize that a substance use disorder is a chronic condition requiring a range of supports.

And these supports would include trained recovery housing staff. So people who understand the model, who have had training in it, who have developed competency with it and are capable of running recovery housing with -- to a level -- a standard of care that's recognized.

The peer providers, so again, these peer mentors or peer providers, people with lived experience, will be employed to serve individuals who reside there, assist them in accessing other resources

and supports that they may need or connecting them with 12-step groups and then clinical support.

So for folks who are in need of additional clinical support, such as medication-assisted treatment or outpatient treatment or behavioral health services, that those would be made available and supported by the recovery housing program.

Access to community resources, so that might be to employment supports or to supported education programming or just helping folks find resources, 12-step programming in the community and that it also promotes healthy relationships with people's families and friends.

Moving on to the third principle, which is that it's important for recovery housing and residences to recognize that co-occurring mental disorders often accompanies substance use disorders and that therefore, it's important to ensure that operators of recovery housing and staff have capabilities to be responsive to the needs of individuals and recognize that they need some specific behavioral health training and recognition that symptoms of a mental health condition can also make people more susceptible to recurrence of substance use.

The fourth principle is that it's important to assess recovery housing applicant's needs and interests and to make sure that they are matched to an appropriate level of care and recovery housing environment.

So everyone will need to be assessed for their needs, their strengths, their challenges, place them in housing that has the capacity to meet those needs and that they choose -- and that people may not always choose the program that's available.

And so people need to be able to make decisions about where they live and have say in that and as it says here, included that prospective resident in the assessment and determination and ensure that referral agencies also understand the culture and the nature of recovery residences prior to receiving referrals, because sometimes if, for example, a residential treatment facility doesn't have an understanding about the expectations that if residents will be required to fulfill while living in recovery housing or they don't quite understand the health culture, then they may be not making a referral that is in the best interest of the person who is going to be discharged from residential treatment upon completion of that treatment.

So considerations about the culture of the house could -- you would want to know the degree of permissiveness to engage in unhealthy behaviors in that house, the degree of adherence to outside meeting attendance, as some recovery homes or many would have an expectation, particularly at the beginning stages of someone having completed treatment, that people would attend a 12-step meeting or Narcotics Anonymous meeting every single day.

And also, residents need to understand the type and nature and intensity of the therapeutic services and recovery supports that are offered.

They need to understand if the operator or other house staff support the use of medication-assisted treatment and if use of this medication is properly monitored and if other residents in the

house are supportive of medication-assisted treatment and are any of the peers that are employed and providing supports individuals who have experience with medication-assisted treatment themselves.

So these are the many considerations and there's no way that I can cover them all in this short training, but these are things that it will be important to understand and -- in order to make those referrals and matches be as successful as possible. The fifth principle references promoting the use of evidence-based practices.

And so for folks who may not have as much familiarity with behavioral health and healthcare and many of you may be working within your housing finance agency or whatnot, may not recognize this terminology of evidence-based practice, but really what this means is that the services that are offered have been documented through literature and through studies to be the most effective at producing the best results.

And so it's important to pair recovery housing with evidence-based outpatient treatment. So treatment models that have been documented to be effective at helping to address people's substance use disorders, to provide whole-person care, we're going to talk about that in a later session through providing medication-assisted treatment in conjunction with counseling and behavioral therapies and community recovery supports.

Again, it's not enough to just put somebody in housing where there is abstinence. We have to provide wraparound supports to really promote their optimal success in long-term recovery. And then again, employing peer recovery coaches. Many states have certified peer recovery coaches which have strong training curriculums and certification protocols.

And so it's important to offer this and recovery housing as well. The sixth principle talks about developing and sharing policies and procedures with residents about the expectations.

So reviewing those with folks when they move in to make sure that they understand what the expectations are, share these with referral agencies, clearly explain them to each new resident and provide them with a handbook so that they are able to comply with the house rules and make sure that they're -- they've secure signed document verifying that residents do understand what the expectations are.

The seventh principle references the importance of ensuring quality, integrity and resident safety to promote adherence to ethical principles.

And so it's important -- and David's going to talk a little more about this -- actually, quite a lot more about this in a moment, but it's important to have medication policies that include protocol on locking up medications, administering medications, med counts with staff and residents, increased drug screening when suspected of diversion from medications and communications with partnering stakeholders and releases of information which allow you to exchange information about a resident's participation in their services.

The next, number eight, and then we'll just have two more of these to go, talks about making sure that recovery housing programs practice cultural competence. So the -- they provide culturally competent and sensitivity training to all staff working in recovery housing and also to consider staffing that is representative of the resident population's race, ethnicity, gender and sexual orientation.

Obviously -- or I shouldn't say obviously, but individual success in recovery housing and services is frequently dependent upon how well they feel that they are known and understood and supported and part of that cultural competence is very relevant to that. The ninth principle here is maintaining and ongoing communication plan with interested parties and care specialists about any of the following.

So this is important. You know, in the healthcare field, we call this care coordination where when there are multiple systems that are working and to assist an individual who has needs and where services are offered, that there's communication and coordination so that there isn't duplication of service, so there is an understanding with the individual about what they're receiving, from whom, how that's going.

And so these are the various types of communications that can be really beneficial in helping someone be successful in recovery housing. Again, you need release of information signed by that individual in order to be able to share this kind of communication.

And lastly, it's important to evaluate the program effectiveness and resident success by collecting data on measures including abstinence from substance use, employment, criminal justice involvement and social connectedness.

So this data can be used for continuous quality improvement, to improve the program outcomes and also to justify future funding and sustainability of programming from both state level as well as to federal funders.

And there are a lot of -- many of you may have worked with research institutions or university researchers who are really interested in helping you to evaluate the efficacy of the recovery housing program that you are setting up. And so I think with that, I am going to turn this back over to David.

David Awadalla: Great. Thank you so much, Rachel. Hello, again, everyone. So next up we're going to spend a little time discussing the world of peer supports in the substance use disorder treatment and recovery continuum of care, but before we get started, we have one more quick poll question for you all.

So it is how would you describe your familiar with peer-based recovery support programs? A, I consider myself an expert, B, I am somewhat familiar, C, mostly unfamiliar and D, completely unfamiliar. So I'm going to give you guys about 30 seconds to fill that out and provide us your feedback.

All right. It looks like we have the majority of you who have responded, I'm just going to give it another few seconds before we move on. The poll is now closed. Thank you for everyone's feedback. So as I mentioned at the beginning of the webinar. Peer supports play a critical role in recovery housing programs.

Peer-based recovery support is defined as the process of giving and receiving nonprofessional, nonclinical assistance to achieve long-term recovery from severe alcohol and/or drug-related problems. This support is provided by people who are experientially credentialed to assist others in initiating recovery, maintaining recovery and enhancing the quality of personal and family life in long-term recovery.

So you'll see that link at the bottom of the slide, that's actually a recovery research paper authored by a really well-known recovery researcher named William White. I really recommend that everyone check that out after the webinar and it can help you understand the criticalness of peer support programs and not just recovery housing programs, but the entire substance use treatment and prevention and recovery continuum of care.

So while peer supports play a critical role in recovery housing, they are also important, as I mentioned, across the rest of the continuum of care. So peer supports are utilized to support engaging individuals into treatment. They're often used in the emergency department settings as well usually to help link someone to appropriate care following a non-fatal overdose or a substance use disorder-related medical complication.

So let's say someone had an alcohol-related complication and is admitted to the ER due to this complication, maybe it's cirrhosis or some sort of injury from their alcohol use, oftentimes emergency departments work with some of these peer support programs that train peer supports and they will link them up and help them find access to the appropriate level of care in a treatment program.

They're often utilized to assist with treatment completion as well and assist with the necessary transitions to lower levels of care. So peer supports are often used, as I mentioned, through the entire continuum from treatment completion all the way to recovery housing programs.

Even the lowest levels of recovery housing programs are based on peer support. And then finally, they also play a role in the coordination and continuity of care for ongoing physical and/or behavioral health and correctional system requirements.

So parole and probation and pretty much all public safety settings are becoming more in-tuned with the fact that peer supports play such a vital role in helping people find -- sustain recovery and exiting the criminal justice system. So Rachel mentioned, during the first SAMHSA guiding principle, that SAMHSA has worked with the National Alliance for Recovery Residences.

So NARR is a national nonprofit dedicated to expanding the availability of well-operated, ethical and supportive recovery housing. They have developed the most widely-referenced national standard for the operation of recovery residences and work with and support 30 different state affiliate organizations.

Currently, there are over 2,500 NARR-affiliated certified recovery residences throughout the United States. NARR affiliates typically exist at the state level and include organizations, such as Florida Association of Recovery Residences. So NARR actually has four established and federally recognized levels of care in recovery housing.

So before we talk a little bit more about NARR, I just want to ask one more poll question before we finish the poll questions for good. How would you describe your familiarity with the varying levels of support under the NARR Recovery Housing program models? And I'm going to give you guys about 30 seconds to answer this question.

Let's give it a few more seconds and we're going to close one out. Let's go ahead and end this poll and we are going to move on. So as you can see here, there are four different levels of support according to the NARR standards and criteria. So level one, recovery residences, are completely peer run.

The lowest level of support, level one typically includes models such as Oxford homes and are usually entirely peer driven and democratically run. This level is often found in single-family homes. Level two are considered monitored as this level often has a housing manager and are sometimes associated with treatment services or programs as the last stepdown.

This level is what many consider as a typical sober living model and I put that in air quotes, which you obviously can't see because I'm not on camera, but there's a lot of kind of news as to what correct sober living model looks like, however, the most typical that we think of, or at least I think of in my head when I envision a sober living program, would correspond with a level two.

And like I mentioned, those usually involve some sort of house manager and it's usually a moderate level of oversight. So next we have level three programs which are supervised in structure and clients are typically earlier on in their recovery. This level often requires some outside care and some states require licensing depending on the involvement of outside clinical services.

And then finally, level four residence is how to engrain clinical services and are considered the highest level of care out of all the NARR models. So whenever there is a clinical service that is engrained into a level four recovery residence, it almost always requires a state licensure as well typically, by that state's behavioral health licensing board and this is probably the most institutional environment and is often the highest level of care.

So oftentimes, people move directly into level four recovery homes after either a detox or an inpatient treatment. So next up I'm going to talk a little bit about voluntary certification and the role that plays. So this is what NARR and its affiliates currently use across the United States.

So apart from a state business license and typical zoning requirements, only voluntary certification of this in most states with RHPs that do not have the engrained clinical services that I mentioned for level four recovery residences. Voluntary certification through a NARR affiliate includes document compliance, onsite compliance and continuum compliance.

Additionally, NARR, as Rachel mentioned, has partnered with SAMHSA and you can find many similarities between SAMHSA's guiding principles and the voluntary certification process and NARR affiliates. So I now want to spend a few minutes discussing some of the issues in recovery housing.

Patient brokering is something that can occur between your recovery housing program, a clinical service or IOP, outpatient or residential program and then laboratory-based drug testing. It is all centered around the insurance reimbursement for urine drug testing.

So kind of the what is, recovery homes are largely unregulated which has led to the inconsistencies and quality of care, fraud and substandard housing and basically, what happened was about 10 years ago some of the treatment providers realized that they could bill private treatment -- or private insurance companies upwards of $5,000 for a urinalysis test.

Obviously, that placed a monetary incentive for billing insurance companies for urine drug testing which resulted in profits being put before people.

This issue is everywhere, but it especially got press and attention in Southern Florida and then also Southern California and there's a lot of articles out there and there's been actually a lot of consequences as a result of this and that's one of the reasons why I want to talk a little bit about why this is so important.

I also want to acknowledge that while this is an issue in the field the vast majority of recovery housing operators are ethical providers that offer outstanding services and vital services to their communities. And additionally, to read more about patient brokering issues, you can check out the resource slide at the very end of the presentation.

So as I mentioned, there are some pretty important consequences that I want to discuss that have happened as a result of patient brokering. So first off, there's been a decrease in the quality of care amongst a lot of the recovery housing operators. That's resulted in higher overdose rates because of the incentive to keep patients sick.

There's also been an increased hesitance to send loved ones to treatment programs and recovery housing programs and it's really increased the nimby attitudes that were already present in a lot of these communities when it came to recovery housing operators and treatment programs.

Finally, there's also been monetary consequences for ethical programs, because a lot of these ethical programs can't compete with the body brokering that is occurring, because when an unethical providers comes and tries to lure a patient over an unethical provider and they're offering him gift cards or cigarettes or even sometimes money and trying to convince them to change insurance plans so that organization can reimburse at a higher rate, it's hard to compete with that and as a result, a lot of the really ethical and well-known providers and some communities have had to shut down because they have lost their patients.

And then finally, and I really encourage you to check out the link that is on this slide as well, insurance companies have literally pulled out of marketplaces because of this issue. For example, in 2015, Cigna pulled completely out of the Florida marketplace citing the [inaudible] analysis fraud that was occurring in that state.

So I just want to reiterate while this is a big issue the vast majority of recovery housing operators are incredible and ethical and they're places where I would send my family members, however, there are some operators who are unethical as well. So next up I want to take a few minutes to acknowledge that the recovery housing landscape has changed since the pandemic began in March.

With a major recession in recovery-related resources, sustained recovery has become much more challenging for many individuals with substance use disorder.

If you actually look at some of the CDC data that has come out recently, a lot of states have seen fatal overdose rates increase since the pandemic began, not surprisingly and that's because many mutual support groups have either temporarily halted or transitioned to a virtual environment and a lot of people in early recovery do not have access to things like laptops.

Some don't even have smartphones. So -- and then also, many individuals in early recovery work service jobs. And so as we all know, the restaurant industry has really taken a hit during the pandemic and has resulted in many tenants not being able to pay rent. So NARR has been acknowledging this and working on this and actually developed Covid-19 guidance for recovery residences that addresses all these issues.

And whether they're a NARR-certified recovery resident or not, this is applicable and I think this is a challenge that we have to acknowledge is going to be there, especially as you all, as states, move forward with this funding. So with that, we are actually going to wrap it up and open the floor for some Q&A for everyone. Olga [ph], have any questions come in through the chat box?

Olga: [inaudible] and I'll actually take this part. So I don't think we've had too many questions come in yet, but I wanted to ask -- this maybe is for Rachel, but David, please feel free to weigh in as well.

If say you were in the position of these states, right, and you've been given this -- you have this funding coming because you have a higher than average overdose death rate in your state, we now know a little bit about the eligible uses of funds and have some education on what recovery housing is, where would you begin -- Rachel, as someone who's designed programs before, where would you go from here to kind of start to get your head around what to do with this funding?

Rachel Post: Yeah. That's a great question. And we hope to be able to offer some webinar on collaborative partnerships to bring to the table.

So where I would start is I would want to seek out my -- the state Medicaid agency and the single-state agency that administers SAMHSA Block Grant and the SAMHSA Block Grant

funds flow to states to help pay for mental health services as well as substance treatment services and I would want to perhaps start there to see if there is existing recovery housing programming in my state that I may be able to connect with, because if there's already recovery housing that has been established and is working well, perhaps I want to explore expanding upon that capacity.

I also would want to check with the state Medicaid and behavioral health agencies to identify how we're going to target the use of these funds. So within their Medicaid information system, they may have capacity to do data runs to look for people who are frequent users of the hospital and emergency service system who have substance use disorder diagnoses.

I would also want to reach out to -- in some cases, there's an interagency council on homelessness and a state housing homeless management information system platform whereas in other states, the local continuums of care, the HUD continuum of care funds that serve homeless individuals with supportive housing and I would -- I might want to see how we could build a partnership with those systems as well.

So those might be some of the initial places to start. Also, the state behavioral health agencies that administer the SAMHSA Center for Substance Abuse Treatment Block Grants will likely also have the State Opioid Response Grants and those grants can also be used to pay for recovery housing.

So those are some of the initial steps I would take. I also think just making clear to us as your technical assistance providers, what kind of TA supports you need in order to begin examining that partnership and building up recovery housing, I understand, will be available to work with you on some level.

Olga: Great. Thanks. David, did you have anything to add?

David Awadalla: No. That was very well said. Thank you, Rachel. Yeah. Just partnerships, communication and collaboration and definitely reach out to those state agencies that have experience administering this type of funding.

Olga: Okay. Great. Another question that we had come in was that harm reductions seem to be discussed separately from recovery housing. Can you clarify how each model or approach might work together or maybe they don't at all?

David Awadalla: Sure. I can answer this first and then Rachel, you can give your take and answer as well. So harm reduction is -- it's a vital part of the substance use continuum of care. It is a separate -- you know, harm reduction agencies are typically run separately from recovery housing programs.

Having said that, they are -- they play a role with each other in a sense that a lot of people in -- that are engaged in harm reduction and benefit from harm reduction end up at a recovery housing program. I guess, the only barrier or issue there is a lot of recovery housing programs do require

abstinence from addictive substances and I'm not referring to medication-assisted treatment at all.

But specifically, for -- like the approach for harm reduction obviously is save the life first, which is like the most important thing we can do, however, further on when someone's ready to enter sustained recovery and no longer wants to use substances, that's usually when they enter a recovery housing program.

And there has been kind of a heated disconnected and I will say that I've seen some tension between recovery housing programs and the harm reduction community. You know, I wish that wasn't the case and they would work a little bit closer together, because they're both vital, but I will say they're separate.

But I know Rachel had some experience in clearance working with harm reduction agencies out of Oregon. Rachel, what's your take on that?

Rachel Post: Yeah. I think -- so first, let me just define harm reduction, because some of you folks on the line may not be familiar with this concept. So harm reduction is -- it's an engagement approach, a therapeutic approach used to help individuals who are active in their substance use to --

If they're not ready and saying I want to stop, I want treatment, to help them use in a way that's less harmful. So for example, if somebody is an injection drug user and you have street outreach workers who are developing a relationship with that person, you might talk with them about the types of hygiene practices they can use in order to reduce the risks of infection.

You might talk with them about when they use and with whom they use so that there is someone that is with them in the event that they have an overdose event who can contact 9-1-1. You might supply that individual with an opiate antagonist like Narcan to reverse an overdose in the event that they are using, they're not ready to quit but we want to prevent them from dying.

The importance of pairing the recovery housing with other supportive services and providers and healthcare is to optimize the opportunities that somebody who currently is being served through a harm reduction approach will at some point be ready to engage in treatment and come in to recovery housing.

Also, in the presentation, I referenced it as if somebody's in recovery housing and they do have a recurrence of their substance use and it's no longer a suitable setting for them but they need to be housed, we don't want to discharge them to homelessness, to have relationships with housing providers who do offer supportive housing using harm reduction approaches that are called Housing First where you can help facilitate them accessing housing.

Olga: Great. Thank you. And this one, I think, is -- can be a big issue when it comes to sort of having populations that multiple agencies serve and that is for the Medicaid data, would we need to put in place a data sharing agreement or how do we get there being able to share information and protect it?

Rachel Post: Yeah. That's a great question. So I'm sorry, I just answered that in the box. So there are a lot of communities, states that are -- have entered into data use agreements with continuums of care.

There are examples of hospital systems and managed care organizations that have entered into data use agreements with homeless management information systems operated by the continuum of care to be able to identify and target services to those who have the greatest need.

And so you may want to explore when you are developing your partnership with your state Medicaid agency, whether there are examples of other data use agreements that they have with partners in the community that could be used to develop an agreement or again, that may be an area where some technical assistance can be offered.

For those states that I identified at the beginning who are participating in the state Medicaid Floridian Collaborative, there may be some technical assistance offered through that opportunity to those states on how to develop data use agreements with the behavioral health system and with the housing sector.

Olga: Okay. And then another one I think we sort of talked a little bit about, partnerships and that we may have a webinar in the future on cross-sector partnerships, but someone asked about how to access those partnerships. So how would you kind of approach these partners that maybe you haven't worked with that much before?

Rachel Post: Yeah. So that's a great question and I'll tell you as someone who worked for 20 years within 2 different federally-qualified health clinics that were healthcare for homeless clinics and within HUD continuums of care that provide supportive housing, rental assistance and services to populations of people who are homeless and many of whom have substance use disorders, they are desperate, as hospitals are as well, for any housing resources.

And you all now have up to two years' worth of temporary recovery housing that you can bring to that discussion. I think that every community right now in states with trying to identify resources, to make that whole package of housing and services for populations, particularly populations who have substance use disorders.

And so I would -- in terms of developing a partnership, you may want to look at is there a staff position within either of your respective agencies who can sort of take on a project management role to start to build out that partnership. Again, I think that in the cross-sector partnership, if we do TA in that area or if you ask for TA in that area, we can work with you on sort of the planning process to facilitate that.

Olga: Okay. And this question, I think, is for HUD. Is there guidance on cross-cutting issues between SAMHSA and HUD's CDBG regulations and policies?

Robert Peterson: This is Robert Peterson. I'm the director of the state CDBG division and we're also responsible for the administration of the recovery housing program as well. So with regards

to cross-cutting, typically we think of cross-cutting requirements as the things that apply sort of across the board, environmental review and those types of things.

And the use of RHP funds specifically, they do have those same cross-cutting requirements, however, SAMHSA doesn't have any like cross-cutting requirement that you would trigger necessarily by just doing recovery housing, however, if you are using their funding, then you would have to follow as a nonprofit or whoever it is that's running the recovery housing program.

If they're also funded for the services side of things by SAMHSA, then they would have to follow those rules, but they're not automatically cross-cutting and I think it's mentioned in the webinar as well, and David can probably explain this a little bit better, but it seems like it's an area that's largely unregulated.

So it's not like there's -- there may be state certifications or state licensures for operation of recovery housing, but there's not -- by the nature of having a recovery home. I don't think there's a single cross-cutting federal requirement per se that would touch every program that might do that type of work.

David Awadalla: Hi. This is David. That's correct, Robert. So it would vary state by state. You know, each state has their own -- and there are some recovery housing programs that are funded through a few HCs and state Medicaid and they would just be abiding by the rules and regulations for that particular state.

Olga: Okay. Thank you. So I don't see any other questions. Do any -- do either David or Rachel or Robert have anything else to add?

David Awadalla: Nothing from me. Rachel?

Rachel Post: Nothing other than I think this is a really exciting opportunity. You know, I think there is a huge -- a large deficit of recovery housing available in the United States and this -- it's exciting to see this pilot underway.

Olga: Fantastic.

Robert Peterson: Yeah. Thank you. I want to thank you guys, too. This was a great webinar. I hope to really better understand the field of recovery housing. I noticed in the polls a lot of people are kind of new to this and that's okay, because as you can see, there are people that are working in the field using other funding, of course, but they're working in the field and providing lots of services to support recovery.

So there's a wealth of community to tap into and I'm sure you can -- especially to meet those requirements related to the development of your action plan, to find an entity that is able to deliver the assistance in a timely manner and has need. You know, you can see that -- you can see there'll be an opportunity that's happening to those types of partnerships I'm sure. So I just want to thank everybody, again, and pass it back to the host to close us out.

Olga: Okay. Great. Thanks. I hope everyone has wonderful holidays. And there's a resources page here that the links will be live when the webinar is posted online. Thank you, everyone, for joining us.

David Awadalla: Great. Thank you so much. Bye, everyone.

Rachel Post: Bye.

(END)