Recovery Housing Webinar Series

Recovery Housing Program Models

Wednesday, February 3, 2021

John Panetti: Hi, everyone. And welcome to today's Recovery Housing Webinar. My name is John Panetti from ICF and I will be your host today. As a reminder for both technical questions and content related questions, please use that Q&A box on the right hand side of your screen.

And with that, I'd like to go ahead and turn it over to my colleague, David Awadalla.

David Awadalla: Hello, everyone. My name is David Awadalla. And I'm a senior research scientist with ICF. I am excited to welcome you to the second webinar in the Recovery Housing Webinar Series. Let's dive right in and take a quick look at today's agenda.

After our welcome and learning objectives, I'm going to provide a brief overview of the SUPPORT Act and CDBG Recovery Housing Program. Next up we will dive into our panelist presentations, followed by a panel discussion, and brief Q&A. Finally we'll wrap up today's webinar with some closing thoughts.

For those of you who may have missed December's Recovery Housing 101 Webinar, my name is David Awadalla, and I'm a senior research scientist from ICF. Co-facilitating today's webinar with me is Rachel Post from the Technical Assistance Collaborative. And finally the best part, I'm excited to announce today's presenters, Dave Sheridan from the National Alliance for Recovery Residences, and Mercedes Elizalde from Central City Concern.

So we have a couple of quick learning objectives for today. So we hope that through attendance you'll be able to identify the components or levels of recovery housing programs and describe the outcomes generated by recovery housing.

As I briefly mentioned, before we hand it off to our presenters, I want to provide a quick overview of the SUPPORT Act and the recovery housing program funding. As many of you are aware, the SUPPORT Act was in response to the opioid crisis. Within the SUPPORT Act, Section 8071 authorized stable temporary housing for up to two years for individuals in recovery from a substance use disorder. Eligible states as well as the District of Columbia have age adjusted rates of drug overdose deaths above the national mortality rate. And finally, the SUPPORT Act for patients and communities act is based on the CDBG program under Title I of the Housing and Community Development Act of 1974.

Next up, I just want to remind you all that the 2020 appropriated amount for the program is $25 million, with funds being awarded by formula to 24 states and the District of Columbia. To determine grantees, the program used a formula that included unemployment rates, labor force nonparticipation, and as I mentioned previously age adjusted drug overdose deaths.

So now for the best part, I am honored to introduce our first presenter for today, Dave Sheridan from the National Alliance for Recovery Residences. Dave Sheridan is the executive director of NARR. He's a national speaker and writer with the primary focus on the development operation of statewide recovery housing systems. His work with NARR includes technical assistance and other work for state addiction agencies related to the establishment of statewide recovery

housing certification and support systems. He's also an advocate and resource on fair housing issues, and has advised on legislation regarding state recovery housing oversight and support.

His professional background is in institutional investments and he brings his corporate experience to bear on challenges facing the recovery housing field. Dave's behavioral health industry experience includes CFO and chief operating officer positions with a prominent Southern California addiction treatment provider. He also serves on the board of the Chandler Lodge Foundation, a men's recovery residence and community center in North Hollywood, California. With that I am excited and honored to turn it over to Dave.

David Sheridan: Well thank you, David. And it's a pleasure to be here. And I'd like to thank you who are attending this webinar for the opportunity to have this discussion. We really welcome your interest in recovery housing, but we don't often get a chance to discuss this with state housing authorities. So the first thing we want to cover today are some of the basics around the process of recovery and where recovery housing fits in that, and then a little bit about what the resource actually is.

[side conversation on how to advance the slides]

So the first set of questions is what do we mean when we talk about recovery, because that is the first word in recovery housing. And I thought we'd start with just a brief overview of really high level of recovery as a process. Along the left right axis as we go from left to right is basically an individual's progression in time from the time they enter recovery until a point some time in the future where they achieve long term stable recovery which we define as independent living and meaningful life in the community. And as you go from the bottom to the top, what's changing in that dimension are the number and intensity of the support services that individuals are receiving in their journey.

So when somebody enters recovery, a lot of times they're coming in in one of the locations in the upper left of the graph. They're entering either through an emergency room, a detox program, some kind of hospitalization. And what sits in those red boxes are what we think of as residential treatment programs, and acute and subacute care. And a lot of the focus in the addiction field is around treatment. The orange dots represent a community based version of treatment called outpatient treatment. And that's delivered in the community, where somebody already has a place to live.

There are other kinds of services that people are receiving as they progress through their recovery journey that could include things like job readiness, job placement, mental health services, family services, a variety of things, but again all received in the community, and varying in intensity depending on individuals' needs and their progress towards stable recovery. And it's that part of the recovery spectrum where recovery housing sits. It's there for people who don't have safe and recovery supported places to life while they're engaging in this part of their recovery.

And there are different support levels, different models of recovery housing, which we'll go into. But they're all designed to cater to different subsets of needs that revolve around an individual

and their circumstances at any point in time. When we talk about recovery, what we're really talking about is a broader range of things than simply abstinence from substances. SAMHSA describes -- SAMHSA is the organization inside the Department of Health and Human Services that really defines a lot of the basics about recovery. And they look at it as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. That's pretty all-encompassing.

But we can simplify it a little bit to say that there are domains in individuals' lives that are important to achieving health, wellness, and that sense of purpose and community. And that's health, home, purpose, community. Lots more of information about this, but the real point is that it's a multi- dimensional process as opposed to some kind of a narrow clinical set of experiences and outcomes.

And in order to support that process of recovery, this resource called recovery housing is developed over the last 50 years. And I should say before we move further that this resource actually predates the dawn of addiction treatment. It's existed for a very, very long time, and existed in all parts of the country. And recovery housing is a fairly unique set of environmental services and recovery supports. And not everybody with a substance use disorder will require recovery housing. Everybody has different requirements. So depending on needs, a lot of the options include things that I think you folks are already very familiar with. There's low cost rental housing, there's housing first or supportive housing, assisted living for people with physical disabilities and more profound mental health challenges. And finally what we're going to talk about today is recovery housing.

And as David mentioned in the introduction, the scope of the SUPPORT Act is a little vague on what it was that they're directing funding to be toward. What we'd like to see is a heavy emphasis on recovery housing, which is really, really hard to come by for people on limited incomes. And for people that don't have it, there's really no plan B. And when we talk about recovery housing, it really all boils down to a few simple common denominators, even though there's a wide variety of service models and physical footprints.

So it's shared housing. And what that means is it's not single room occupancy units or individual apartments, although a number of individuals living together could share an apartment in this kind of a model. It is housing for people with substance use disorders. So everybody in the household is suffering from substance use disorder regardless of what other challenges they're facing, that that's the one unifying theme of the residents. And they're there to address that substance use disorder.

Recovery housing is abstinence based. And we can talk a little bit about what abstinence means in the discussion. It does embrace medications that are used in the recovery process. But the real secret sauce for recovery housing, as opposed to a lot of other housing that might be available, is what we call peer recovery support, or the social model of recovery. And what peer support is, is it's a set of principles, and guidelines, and backup by training, where individuals learn to face life's challenges without the use of drugs or alcohol, but relying on the experience of other people who have gone through the same situation as they're about to go through. So it's a learning teaching modality that's very flat hierarchically. And it's based on creating a lot of

opportunities for individuals in these homes to interact in healthy ways with each other and with members of the local community.

And the final thing that differentiates recovery housing from a lot of the housing that you're probably more familiar with is each residence operates as a family-like community. It mimics a natural family in a lot of ways. Residents get to know each other pretty well, really well. They share life experiences, they share activities, they go to social events together, they can host events at their home. And it's very, very different than a boarding house situation or a single room occupancy type setup.

And this housing can exist in a lot of different physical footprints. The one most people think about in the recovery field when you think about a recovery residence or a recovery home, is it's a group of people living together in a single family detached dwelling, or duplexes, triplexes, in family neighborhoods. But they can also exist in apartment buildings or blocks of units within a building. A lot of special purpose recovery housing has been built and operates, sometimes converted from other types of housing like nursing homes, or old Catholic convents, or old boarding houses. And some of it's even special purpose. And a few housing authorities that we've had some experience with have some experience of their own helping providers develop that kind of housing.

And recovery housing is also evidence based. What that means is that there's a body of research that supports the fact that this form of housing meaningfully contributes to positive recovery outcomes, meaning lower rates of relapse to substance use, lower rates of incarceration, higher rates of employment, higher earnings, and the kinds of markers that we look for when we look for reintegration.

The kind of people who live in recovery housing can vary a great deal. As I mentioned before, everybody living in a recovery housing is someone suffering from a substance use disorder with or without some other co-occurring disorder or disability. They also have a unique need for that supportive community environment. A lot of people when they enter their recovery journey will not need things like addiction treatment, may not need a recovery housing environment. They possibly have enough social skills, social capital, to engage in a recovery process by interacting with just things like 12 step meetings or a religious path, and don't need any external assistance.

So the people that live in these communities really self-identify as having that need for some kind of social and environmental support. Individuals in these homes need to be able to undertake the activities of daily living, like bathing, eating, dressing, because almost none of these places has any kind of professional nursing or care staff. So these are ally for able bodied people, although physical handicaps and some mental disabilities can mesh really well. But it's basically independent living.

They also have to be looking for and seeking out a recovery path that's free of alcohol and other mood altering substances. And there's lots of different ways that people who enter recovery can move to a state where they're more independent, more able to live on their own, better able to function in society, without having to choose an abstinence path. But thousands, and thousands,

and thousands of people are looking for a drug and alcohol free path to achieve their long term goals.

And they also have to be willing to engage in a personally directed program of recovery. So among the supports that are offered integral to the housing environment, are things like introductions to community based meetings, and mentors, and people who have been in recovery for longer than the individual has who can serve as role models. It's a lot of different ways those things can be put together. And often it's based on the individual. But the easiest way for someone to connect with that suite of services is often in a recovery home.

I mentioned that abstinence has some kind of unique characteristics. It does mean that the resident does not consume alcohol, illicit drugs, or medications taken without a prescription. But there's a number of FDA approved medications that treat substance use disorder. And some of them are controversial in some circles because they do -- they are based on opioids. But taken as prescribed, these are consistent with abstinence. This is often called medication assisted treatment or medication assisted recovery. And they're perfectly consistent with abstinence based recovery housing.

There's typically some form of abstinence verification, usually through drug testing of some kind. And it's not a diagnostic tool in these environments. It's simply used to ensure that people are adhering to the drug and alcohol free requirements, and really for the safety of the community. And the consequences for return to use, meaning someone has ceased being abstinent and is using some substance that's prohibited in some form. It's not the case that someone automatically is asked to leave one of these residences when that occurs. Sometimes it's case by case. But it can also include referrals to more appropriate levels of care. In some cases the instance of a relapse indicates that the individual is really not receiving the kind or amount of support they really need.

And when we talked about footprints, and services, and things like that, I skipped over a lot of detail. What we found when we began to codify standards and levels of service was that there's a variety, a wide variety, of service models in existence across the country. And to simplify a lot of that complexity, what we did at NARR was define four different categories, or what we call levels of support. And these are differentiated by the kind and amount of services that are offered in the particular home.

Now underlying all four, and what differentiates these things from other kinds of housing for people who are suffering from substance use disorders, is first of all they're all alcohol and drug free living environments. And they all have that underlying model of peer based recovery support, which we call the social model. And those don't just happen by accident. And they don't happen just because people who are in recovery are living together. There is in all cases a formal process of making those things available and making them real in each of the homes.

As you go up the levels from one, to two, to three, to four, what's happening is the providers are adding services. So in level three and four, and some level twos, you'll start to see that a house is often described as a program. And what that means is that in addition to the living environment, that there are certain formal programmatic elements that are added. These could be group

activities, one on one activities. And in those three levels they're typically centered on what we call life skills development. And that could be job training, job readiness, healthy eating, how to write a resume, a lot of things that aren't really tied to their addiction narrowly defined, but more how to get engaged with a productive life, and get engaged with community activities.

And only in the highest level, in level four, do you see clinical services. And these places are typically licensed treatment facilities. So they're covered by clinical licensure. And not all clinical programs will consider themselves recovery housing, but the ones that do will combine all of those elements. They're really kind of a small fraction of what you'll see out there. Mostly what you'll see are what we call level two and level three.

And let me go over here, describe these in terms you'll probably see when you start talking to people applying for funds. Level one is pure peer operated. And what that means is there's no notion of an operator of the home or a house manager. Typically the property owner functions strictly as a landlord. And the residents themselves set the house rules, help keep each other on a recovery track, and are responsible for financial and physical upkeep of the house, just like a family would be. They pay their rent to a landlord. And in the case of an Oxford House, which is a trademark name for a wonderful organization that's been around for a long time, they operate under a formal charter from Oxford House Incorporated in Maryland, which is a nonprofit organization similar to NARR in a lot of ways.

Level two, you'll often hear called sober living homes, or sober homes. In a level two, the residents are expected mostly to be working, going to school, looking for a job, maybe attending outpatient programs or other community services. But basically they come and go as they need to, and live just like people in a normal family would. This is true of level one as well. But in a level two, there is a formal operator or service provider that sets the rules, engages the staff which are usually peer managers, and sees to the upkeep of the house in major ways. The residents do the house chores, the day to day cleaning, cooking, gardening. But things like fixing the roof and replacing an air conditioner, you have the property owner and the program operator that takes care of all that stuff.

Level threes are a hybrid between that level one, level two, mostly just living in the community model. But it incorporates some of those services. It goes by a hodgepodge of different names. You may hear them called recovery programs, recovery homes. But it's hard to know based on a label what it is you're looking at when you see an application for funding. You really kind of have to look at what it is they provide. And in a level four, because you're adding clinical services, those will almost always be licensed programs.

So when you're looking to provide funding to these things, the other important thing to realize is that in level three and level four, people are typically not going to live in these environments for a long time. They're probably only there for a number of months while they receive services. In level one and level two, that looks like long term permanent housing. Residents might stay for three months or six months, or they might stay for five years. And there's no way to know when somebody enters one of those living environments, how long they're going to stay. We insist at NARR that the length of stay for a resident be resident-determined. And that means that they're

welcome to stay as long as they are benefitting from the environment and contributing as a sober member of their housing community.

The other thing that's probably a little confusing about all this nomenclature, and this isn't introducing anything new, you can think of a recovery residence or a recovery home as the intersection of three different kinds of services, housing obviously, we talked a little bit about treatment in the case of level four residences, and this whole idea of recovery which is a bundle of services in itself. And where those circles intersect is where recovery housing lives.

One thing we were asked to talk about a little bit are some of the differences between recovery housing and the kind of supportive housing that you're probably more used to funding. And supportive housing you can think of to include recovery housing in some senses, and I'm sure Mercedes is going to talk a little bit about that. But more commonly it's what's usually called housing fist or harm reduction. And they differ a little bit in terms of footprint, but not a terrible amount. Most of the housing first capacity out there is special purpose. It's actually built to suit that population and it's sited in appropriate zoning districts. But there is some scattered site shared housing that qualifies as housing first, harm reduction kind of housing. So it can exist in neighborhoods, in single family homes, it could be apartment based. It's called scattered site.

Recovery residences, the dominant modality is single family residence. But as I mentioned, it also can include multi-unit, mixed use, special purpose construction. So it can vary a great deal, but you'll see a lot more of smaller community based existing footprint kind of housing. The services available in the two differ a bit too. The principle of housing first is that the services need to be available to an individual, but it's the individual who determines what services they want to engage with, and utilize, and when. So they're available, but optional.

Individuals opting to live in a recovery residence are agreeing to take on some responsibilities and engage in some activities as condition of their residence. So they're provided that social model support, but there's also things like house rules, things like you might have to go to three community based activities a week, and engage in regular conversations with a mentor. So it's a mix of self-directed and some programmatic things.

The qualifying disability for housing first, it could be any or none depending on the program. Most of the capacity we know about is designed for people with physical or emotional or mental health disabilities, and substance use disorders. But in a recovery residence as we mentioned, everyone must identify as suffering from and be willing to address a substance use disorder.

The behavioral rules differ. I mentioned that. And housing first, the idea is that someone should have safe housing regardless of what kind of behavior they're willing to engage in, what activities they're willing to engage in. So keep them safe. And so the main behavioral rule is do no harm, that if they're keeping to themselves and aren't a danger to their people that they live near, that's fine. The expectations are a little higher for somebody in a recovery residence. They are expected to get along with their housemates and really live as a family.

Abstinence rules I think are pretty self-explanatory. Most housing first programs don't permit illegal drugs in the unit, but otherwise not regulated. But in recovery residences that's one of the

key differences. There are consequences for return to use, but they vary. Medications, somewhat similar actually. They may be managed, but usually up to the resident. Most recovery residences, except for those clinical level fours, residents are typically in charge of their own medication. Now residences do take steps to mitigate diversion risk for residents that are prescribed medications that are often stolen and abused. There are steps taken to make sure those are secure. But by and large, except for those level fours, residents are expected to be able to manage their own medications.

Costs vary and payers vary between the two. It's almost always third party payment of some kind in the housing first world. But most recovery residences to date are self-pay. Third party payments are increasing a little bit. Several states are using permissions granted to them under Medicaid waivers to offer recovery housing. There are a number of criminal justice programs in the country that utilize recovery housing. So the trend is increasing toward third party payments. But in most places for most of the capacity, residents are expected to meet their own costs of residence.

Lengths of stay can vary. As I mentioned earlier for recovery residences, those higher levels, level three, level four, that are more programmatic, tend to have shorter lengths of stay because the kinds of services offered at some point the resident gets everything they need out of those and it's time to move on to a different environment. The priority populations differ. Housing first typically serves a homeless population, physical disabilities, moderate to severe mental health disabilities. In a recovery residence everyone suffers from an SUD and they're also desirous to engage in that recovery activity.

I thought I'd wrap up a little bit here with a bit about NARR. So we're the National Alliance for Recovery Residences. And we were founded in 2011 by a group of individuals and a few organizations with expertise in recovery housing. But at the time there weren't any national standards, national ethics codes, or any real authoritative compendium of best practices on how to run recovery housing. And so we set about to develop the national standard and a code of ethics. It covers that whole spectrum that we just discussed.

And we also offer a resident certification program. Standards aren't terribly useful unless there's some way to verify that a residence is actually meeting them. And so we have a program that we operate through a network of state affiliate organizations. And we've got about 31 of those right now with another five in development. And we've also developed an operating model for how state governments and state legislatures can support systems of recovery housing in their states. And several of the states that you represent in this audience, I looked at the list of states participating in this program, are states where our affiliate receives active support. So you've got a ready partner in several of the states in this program for identifying good operators and good operations. We also provide training and technical assistance to providers, staff, agencies.

I just got a text from David that I've gotta wrap up. So this is what we look like today. You'll get a copy of these slides. And I will turn it over to Mercedes.

Rachel Post: Perfect. Thanks, Dave. I know I wish we could spend more time talking today. But unfortunately I know people start getting burnt out after about an hour and a half. So with that, I

am excited to turn it over to our next presenter. Her name is Mercedes. And she is joining us from Central City Concern where she's a public policy director. Mercedes works to bridge the gap between direct service and public policy advocacy. As the public policy director, Mercedes collaborates with government agencies and community organizations to advance policy initiatives in support of Central City Concern's mission.

CCC serves about 14,000 people per year through 13 [inaudible] qualified house centers, 2,100 affordable homes, and an employment access center for job seekers. Mercedes is responsible for policy analysis, advocacy, public education, and coalition building efforts to find support and solutions for CCC clients and programs. She brings a unique set of perspectives and knowledge to her work, having experience in direct service as a social worker and program coordinator, a legislative aide to an elected official, and as a community activist.

Mercedes was the first in her family to attend college, and now holds a BA in psychology, with a minor in women and gender studies, with an MA in nonprofit leadership. With that, I am excited to turn it over to Mercedes for our next presentation.

Mercedes Elizalde: Thank you so much. I'm so glad to be here, calling in from Portland, Oregon, for all you folks all over the country. As was said, I work at Central City Concern, which is a nonprofit organization that provides housing, healthcare, employment. And we also have a lot of emerging work in reentry and diversion services for the criminal legal system. Central City Concern focuses on folks who have experienced poverty, homelessness, and complex health issues, with substance use disorder being one of the central tenets of the work that we do. We have just under 1,000 employees. About 45 percent of our employees identify as being in recovery themselves, and 20 percent of our employees were actually once clients of Central City Concern.

We believe in a comprehensive set of solutions. This really mirrors one of the slides that Dave had earlier around the human experience. We try to bring all of these services under our umbrella so that they are accessible and comfortable for folks to engage in. So we provide housing, healthcare, employment, and peer support, in all of our services.

We have been working for a really long time to bridge gaps and pull together our different systems that interface with folks who experience homelessness and poverty and complex health issues. And that led to a fairly large collaboration with several of our health systems here in Portland, Oregon. It resulted in a fairly sizable donation you can see here from our health systems as well as from our government partners and philanthropy. It allowed us to build three new buildings that all have focus on really supporting folks who have struggled in the past to find housing stability.

The Blackburn Center, which was previously called the Eastside Health Center, you can see a little picture there, it has a fully integrated primary and behavioral healthcare clinic on the first two floors, and then recovery housing on top that includes both transitional and permanent housing, as well as a program we call the recuperative care program which is for folks who are being exited from hospital care. The other two projects it helped us build are low income housing that pull from many of our transitional recovery housing programs, but in and of themselves are

very flexible affordable housing buildings since there aren't the same kind of abstinence expectations for those buildings as there are for other recovery housing programs in our portfolio. And I'm going to talk about it in just a minute.

But this is a really important collaboration here, and I think something that many of you are going to be emerging into, is how do you bring housing and health under one umbrella, under one roof literally, to be supporting people who have some of the greatest barriers to have long term housing stability.

So one of the things that we bring into our work is we really believe in housing choice. And we also believe that people need to be able to change their housing situation from time to time depending on how their needs change. We have quite a few recovery housing units. We operate those as I mentioned both as transitional housing programs, but also as permanent housing programs. There are family housing recovery, where families were able to reunite [inaudible] with their children. And then most of the units are single room occupancy apartment buildings for single adults. We also provide housing first and low barrier housing, and permanent supportive housing across our portfolio.

So these are a bit of the details on what our recovery housing programs look like. Many of our clients are coming from a higher level of care. So we also run a withdrawal management program called the Hooper Detox Center. That's where a lot of people might start their journey with Central City Concern, and then being exited from that program into a recovery housing program. But we also have partnerships with organizations that provide inpatient residential treatment and can also refer into a recovery housing program.

About 7 out of 10 people who are leaving the Hooper Detox Center will get a placement in our housing. But that does leave room for improvement. We are still seeing that the need for recovery housing still outpaces the capacity that we have in our community to serve. We are bringing together as many different services as we can. So although the primary consideration is substance use disorder, we also make sure to provide folks with access to both mental health and primary care services. At both the Blackburn Center and at one of our other properties called the Richard Harris, which is also another recovery housing program, it is right next to both of our behavioral health and primary care clinics at that site as well. So really trying to make these spaces very acceptable for folks to get full person care.

We have peer mentors and we also have peer case managers. This also allows for staff to have a variety of responsibilities and grow their own personal careers. We try to keep our ratios comfortable for staff and clients, and we also provide 24/7 front desk support. We provide rental assistance. So this is becoming a bigger part of the work that we're doing and how we're really closing the gaps. I know in Dave's presentation he mentioned that a lot of programs can require folks to pay rent. But we've actually been able to partner with our housing authorities and with HUD's mod rehab program to take the rents down to zero in many cases, especially for folks who are coming straight out of detox or residential, where we really want them to be focusing on their healthcare and not worrying about getting a job right away and paying rent right away.

We do have our employment program connect directly with clients. But again we usually have folks in the residential recovery housing programs for a few months before they actually start engaging with employment. We also have an arm of our organization that does benefits acquisition. So if somebody is not going to be able to engage in traditional employment, we can still make sure that they have access to their own personal income.

And definitely making sure that we're building community in these places. We found that utilizing single room occupancy units gives people both a sense of privacy and independence, but also encourages things like community cooking, and encourage folks to gather in those larger community spaces to build those relationships, knowing that isolation can definitely be a threat to somebody's path of recovery.

And we also keep our housing screening very low barrier. So we want to make sure that folks are not being screened out of this opportunity based on any kind of criminal, past criminal activities, particularly because we know that the way that substance use disorder has been criminalized in our communities means that it's highly likely that somebody will have a record. And so denying housing for somebody based on that is really counterproductive.

So here's a little bit more about our transitional programs. Many people will exit our transitional housing programs into our permanent recovery housing programs, as a way of kind of furthering their stability. One of the benefits of having a transitional program setup is that it gives people an opportunity to determine what their next step is going to be. So if they're ready for getting a job and starting to look at private market housing, then we can help them do that. If they're going to need a little bit more time in a supportive environment where their rent is a bit more controlled or they have ongoing rent assistance, we can do that as well.

You can see that we have some of the numbers here around also return to homelessness that we also recognize, that sometimes people need to come through services more than once to find that stability. And we're always here to take folks if they want to start that journey again. So by and large folks that come through these programs, that 93 percent of folks were still housed and in recovery 12 months later. So we know that this is providing the kind of first steps stability that really maximizes people's long term engagement.

As I mentioned, there's lots of partners involved in how we put these projects together. All these different funding sources come into the organization in different ways to support the recovery housing programs, as well as the additional supportive services that we provide in our community. It's really important to as you're kind of beginning to think about what your recovery housing program is going to look like or what type of partners you're wanting to bring in, is to be thinking about how this fits into the greater strategies that you have for addressing substance use disorder, and really the intersection of substance use disorder and homelessness.

And that's why all these partners come to the table with us, because this is housing that is very -- it's clearly very specific, has a concrete program, it's not meant to serve anybody experiencing homelessness, but really meant to help us engage with folks who have struggled with housing stability and substance use disorder. And we know that those folks show up in lots of different systems, needing support from different partners. And so if we can bring those partners together

at the front end, we can maximize the benefits, and really the cost benefit in supporting those households.

This is a survey of a few nuggets of info we got from a survey that we did with some of our tenants. One of the most important things when developing your recovery housing program is to really listen to the people who are going to be utilizing your services, the folks that you intend to serve. It's really easy to start looking at things like best practices in their own silo, and trying to build a program based on kind of objective measures. But really communities are different. And how issues of substance use disorder show up in your community is going to be different in other places. So you want to base yourself in those best practices, but you also want to grow and learn from your services to make sure that you're providing the kind of supports that really help people.

Many years ago Central City Concern's recovery housing program actually would have been exclusive to things like medication assisted treatment. We would not have considered that to be part of the modality and today we do. So we grow and we learn as we listen to the people that we're serving. The reason that we do primary care, and that we do employment services, and that we started getting into reentry and diversion programs, is because of engagements like this where our clients tell us what it is that they need, and they help us to really change our programs and shift our focus to make sure we're maximizing the benefits for them.

Just a little bit of a cost comparison. It's important to think about, like I said, strategically where does this investment fit into your other investments, but also recognizing that this is a very cost efficient investment to make in your community. We believe at Central City Concern that most people who are looking for support with their substance use disorder do not necessarily need residential treatment. Residential treatment is a high level of care. And just like anything else in our community, not everybody needs the highest level of care. Oftentimes folks need the right kind of support at the right time. And the more we can do that service matching, the better.

And so we've seen that by combining outpatient treatment, peer support environment, supportive services, and stable housing, that we can actually really maximize the benefit for each household without having to necessarily go through higher levels of care right away. Also again because we know the long history of criminalizing folks with substance use disorder, we can see that the cost of continuing to arrest and jail people will ultimately have a higher cost on our system with really no healthcare benefit to follow.

So a big part of this work is helping folks to take that journey. And what we know is that starting recovery is really only the beginning. And what we really want to see are folks being able to make it through a treatment program and have that level of independence and stability about where they want their life to go. But we also want them engaged with primary care for that whole person health. Substance use disorder will really damage folks' health in multitudes of ways, but it's really hard to start working on those other things if you're still struggling with your housing or still struggling with your addiction.

And so what we've seen is that when we provide this service, and when we combine these interventions together, we're not only maximizing where people are getting out of the program at

hand, but we're also maximizing their success in the other programs or other services they might engage in.

And then this last slide here is again just looking at the cost differential of what you're spending when you are investing in recovery housing versus, when you're investing in treatment only, or when your housing and your treatment services are disconnected. So by combining these two things, you maximize the benefit of the treatment overall, and help people to stop cycling through services, but really are able to start to center themselves on what they want to see into the future. And once people start looking at their own lives and their own strengths into the future, what we know is that people are able to stay connected to their treatment programs for longer periods of time. Because they can see themselves in the future, they can see what it's going to look like on the other side.

And that's another component of why peer support is so important, is people being able to see that success in that affinity partner, being able to see that even if it's hard right now, and even if it feels like it's going to take a really long time to get there, that they now have a network of people who have shown them what is possible.

And so looking forward to hearing your questions and providing this group with as much more information as you like, as this is kind of the overall information on how we're providing our program. So thank you very much.

Rachel Post: Mercedes, thank you so much. And Dave as well. That was just really comprehensive content. And I know that the states who are participating in the recovery housing program will benefit greatly from your all expertise and leadership in this field. I also just wanted to note that the Central City Concern model was used as sort of a point of reference for HUD's continuum of care recovery housing policy brief.

So now I'd like to just -- we have some prepared discussion questions for both Dave and Mercedes. And of course we encourage those of you who are listening in to feel free to ask your questions through the Q&A box. I think the way we'll do this is that we'll hear from both Dave and Mercedes first, these discussion questions, and then we'll sort of turn to your questions to them for further information, and then we'll look at other questions that people have for today.

So the first question, and maybe Dave I'll pass this back to you and then come back to Mercedes, is what advice would you offer states as they prepare to deploy these recovery housing program funds?

David Sheridan: Oh, thanks, Rachel. The first piece of advice I'd offer is that if you're not already, you're going to want to develop a relationship with your state's addiction agency. That would be the agency that funds all the addiction services in the state, often licenses treatment providers and professionals. They're going to have the best handle on first of all geographic areas of need, where in the state is the recovery housing really needed but not existing, at least not very good. And they're also going to know the kinds of places that have existing community supports.

Central City Concern is a really unique model. In fact it sets a really high bar for a lot of providers in that they have really assembled a community of supports around their operations. In most of the country those conditions don't exist. And so a lot of times what you're looking for is a provider that's willing and able to expand, is already operating recovery housing if possible, or at least allied services. And if they're operating recovery housing, are they certified by one of our state organizations. If we don't have an affiliate there, that won't be possible. But that will give you an indication of whether or not somebody's operating according to best practices in their other facilities.

Rachel Post: Great. Thank you so much, Dave. Mercedes, how about you? What advice would you offer to our listeners about how to prepare to deploy these funds?

Mercedes Elizalde: I have three things that I would say. One is be strategic, coordinate your funding forces, and invest in capacity building. So being strategic, it's a lot of what Dave just said, think about where geographically do you need it, who are your existing providers, where are the gaps, and how are you using this to really invest in those solutions. Really try to avoid a like best bidder win scenario. You really want to be thinking about this is not just a generic add to your safety net, but this is a strategic investment for a population that has been disinvested in.

When you're coordinated your resources, so as Dave mentioned, Central City is unique in the fact that we are a developer of housing. We also are a property manager. We're also providing the substance use disorder services, the peer support, and the employment. So that means in most places you're going to be looking for a different organization that's providing each one of those. Maybe you have an organization that's providing two or more of those, but you're probably less likely to find an organization like Central City that can do all of them at once.

So you need to be thinking about where is your capital coming from, where your ongoing service dollar is coming from, what's going to pay for those peer supports, those case managers, all that stuff for years to come, and the rental assistance. You really want to be thinking about how you're helping people stay stable in those units, whether that's a heavy operating subsidy so that rent is not as needed, or that you're at least being able to control those rents so that they don't go up when general housing costs go up, and investing in that capacity building. So I mentioned all those partners that you're likely to need. And so you really need to take the time to make sure your providers of these services and your developers of housing are getting to know each other long before you put something up to bid, if you really want to have strong competitive bids.

Rachel Post: All right. Thank you so much, Mercedes. Very thoughtful. The next question, and again Dave we'll start with you, is how has NARR successfully engaged other systems in the operation or support of recovery housing? And which funders and stakeholders are the most important to partner with?

David Sheridan: Oh, that's a great question. I'll try to keep the answer short. As far as stakeholders, what we've found is as we -- we've had a hand in either helping start or helping grow statewide organizations in about 30 states. And the most important partner we've found is that state addiction agency, at least as a starting point. And we've had contracts to assist in Massachusetts, and Oklahoma, Delaware. We were brought in early to help start the systems in

Ohio and in Florida. And we've done a lot of work just on our own with some of the other organizations.

And the biggest catalyst for success is a staff in the public health field in the state that really understands that expansion definition of recovery, that it's more than just treatment and medications, that people entering recovery first of all don't all need treatment, as Mercedes mentioned. But everybody needs something. And recovery housing is a big component of what a lot of people need and a lot of states don't support, certainly don't integrate into their healthcare systems.

So yeah, our success has really been a combined result of agencies with vision, and also groups of operators and stakeholders in usually urban communities to start, but are willing to invest some time and effort into creating an organization that stands for standards and professionalism. And you can find those on our website where our affiliates are. But the states that really stand out in terms of what the states are doing are Ohio, Massachusetts, Indiana, Missouri -- I'm sure I'm leaving some out -- Oklahoma, which is a new effort, they just launched. Great organization in Oregon. Mercedes, you probably know the certification board there. We just chartered them as our affiliate.

So we found a lot of good partners. And as far as funders and stakeholders, criminal justice system has been a huge driver of demand for quality recovery housing. And so get to know people in your state department of corrections, and then find out from them who else you should get to know, because obviously criminal justice systems are more than just state prisons. There's jails, there's local courts. And that's a huge area of need. And you have to really be working in that system to know where those needs are. So they're really important stakeholders.

Rachel Post: [inaudible]

David Sheridan: Yeah. Funders I'm kind of at a loss at. I'll let Mercedes and Rachel take that.

Rachel Post: Thanks, Dave. Mercedes, same questions for you.

Mercedes Elizalde: So I would say begin with the people. I think our strongest and most rewarding partnerships that we've had at Central City and in Oregon is when we're building from a shared understanding of who, quote, the most vulnerable are. That's a term that gets thrown around a lot. But when you dig under the surface, you tend to find that people are talking about different groups of people. So begin with who you're trying to serve. And pull your partners around understanding having that shared understanding. And when we center the people that we care about, it's really easy to start to get out of each other's way and to start to amplify our strengths together.

When it comes to funders or stakeholders, again the people that you seek to serve they need to be front and center. And then you want to think about your tax credit investors, if you're trying to develop something new. I would say you're going to need some sort of capital investment even if you're utilizing existing infrastructure. Because you're going to find that something about the

building or the units aren't exactly what they need to be, so you want to be thinking about where is your capital coming from.

Housing authorities, especially if you have a housing authority that has a move to work waiver where they get a little bit more flexibility in what they can do with some of their funds, you want to have that partner at the table. Property management, you really want to make sure you have a very intentional property management partner who understands what the program is, and what the outcomes and the goals are. You don't want to have a property management company that's managing some of your properties that has like a really heavy hand and doesn't understand the population that they're working with or tries to treat it like market housing.

Your healthcare and human service partners, who are going to be providing those services, and then the next step there, where is your referral network. It's a little bit kind of what Dave was talking about, who gets to fill the unit. And this is going to be particularly important when you're thinking about equitable access. Because who gets to [inaudible] those units is a proxy for then who actually gets care. And when you are building out that referral network, that's when you kind of get back to that, the people you seek to serve, where are they already engaged in your system, or where are they already seeking services and supports, and where have people been disenfranchised in access to existing health and human services, and how are you filling in that gap.

Again long histories of criminalization of folks with substance use disorder means that you may find that a lot of the people who would benefit most from these services have long been excluded from other services.

Rachel Post: That's great. Thank you so much, Mercedes and Dave. A lot to think about and a lot of great advice as to sort of how to start thinking about who to partner with, and the different funders, and stakeholders, and systems, and the importance of really centering first and foremost the people who programs are intending to serve. The next question, are there any particular challenges or lessons learned that you care to share with our audience? I'm sure there are lots of lessons learned that are sort of to be kept within an organization's growing process. But are there any that you'd like to share with this audience? And Dave, I'll start with you.

David Sheridan: One thing that I would focus on, and Mercedes already touched on, is that the community that has the need is really the center. And often that's identified by agencies, or governmental entities, or nonprofit entities, that maybe don't provide housing. But it's really important to look for those unmet needs. And who are the stakeholders that represent those unmet needs. We've had situations where somebody's come to us for help. They want to open a fairly ambitious recovery housing project. But they want to put it in an area that doesn't really have an acute demand for that service.

And sometimes when we tell them what we know about that particular location and the demand for services in that area, they want to be there because it's a nice place. And typically those things don't do well. And they don't serve the kind of populations that are really missing out. So the lesson learned is really a little bit about what I touched on and a lot of what Mercedes touched on, is those communities are really important, where the residents are going to come from, what

services they're currently getting, and who is being left behind. Because this program I think is a small opportunity, but it's an important opportunity to help change that.

Rachel Post: Great. Thank you, Dave. And Mercedes, so same question to you.

Mercedes Elizalde: Yeah. So again I would say be strategic, and keep your funding timelines aligned, and maintain shared goals. Those are my two biggest pieces of advice. So again looking at how you're being strategic is really thinking about how is this part of the overall safety net that is attempting to serve people with substance use disorder. That means really getting to know, as Dave has said before, who's doing that work, where are the gaps in their services, or where do they see that's being able to leverage the most benefit, and really being strategic about building partnerships to achieve that end.

Keeping your funding timelines aligned, again because you're going to be thinking about what are all the services you're trying to kind of pull into here, who are all the different partners who might be able to bring benefits here. You want to make sure that you're keeping an eye on the outcome. Because if you don't, if housing resources and the support work, like the support dollars, those ongoing support dollars, become unstable in the long run, you're going to see real inconsistency in the outcomes that you can achieve with your properties.

And once example that I'll give is one of our programs where we were building it as a recovery housing program. And we had a partner identified that was going to help to fill some of the units. Towards the end of the road we started getting some pushback from one of our public funders who was helping us subsidize the unit. But they wanted us to pull from our coordinate entry system instead of pulling from our outpatient services partner that we had identified. And this outpatient service organization is providing service to folks who identify as Native American. And so it was really looking at filling that gap for a community that had been long disinvested in. And they wanted us to pull from coordinated entry.

And then coordinated entry in our community is about 80 percent white. And so it means we would be having this partner on site who has this great cultural perspective for how they're going to support the community from their outpatient programs coming into housing. But then one funder, just one, has to pull from a completely different system, which would really change the type of services we were providing because coordinated entry is mostly focused on chronic homelessness.

And so now we had to go back to our partners at the table and say, so what are you actually trying to achieve? Do you want us to focus on chronic homelessness and folks who have substance use disorder? Or do you want us to focus on equity and just community that has been long disinvested, because you can't ask us to do both because they are literally opposing -- there's conflicting data here that we're pulling or conflicting partners that would require us to achieve both, which means we can't. And that was a conversation that then the funders had to have with each other about what they were actually asking us to accomplish.

So it's really important to keep those things aligned, otherwise you're going to see your outcomes either not achieved or you're going to see your partners who are trying to do this on the ground really struggle to give you the outcomes that you said you wanted.

Rachel Post: Mercedes, thanks so much. And I think that just further highlights that we are all operating in an environment where there's a scarcity of affordable housing with support services for all populations. And I think that ensuring that, as you all have suggested, aligning this resource with communities, and locales, and stakeholders where it's needed, just helps to further address some of the unmet needs in an effective and efficient manner. Hopefully one day we'll be doing this presentation to an audience where there isn't a scarcity, and we don't have to choose between populations who need affordable housing. But as you noted, Mercedes, there's a huge gap, and I'm sure Dave as well, in the number of available recovery residences or recovery supportive housing units compared to what's needed.

The last question, formal question that we have, and again I'd encourage folks if you have questions to go ahead and put those into the Q&A chat box. But this one relates to sort of NIMBYism, so not in my backyard. And I know you both probably have a tremendous amount of expertise in how to address that when you're looking to site or develop recovery residences, recovery housing. And so Dave, any words of wisdom to the audience about how to address that?

David Sheridan: Well Rachel, you knew how to ask for about this one. As we mentioned earlier, a stigma that is directed toward people in recovery is real. And the predominant way if manifests is in discrimination. And often that's neighborhoods not wanting any recovery or services anywhere near them. Everybody seems to be in favor of people getting their lives back together, just don't do it near us.

And where this particularly is an issue is with new construction and with housing that's integrated into neighborhoods. So in a lot of cases things that you fund are probably or often special purpose, and the zoning is taken care of in advance of a project moving forward, that you know it's in a zone that you're not going to get neighborhood pushback. But even then, I'm sure you'd run into some surprises. Low income housing has run into it for a long time. But recovery housing is a particularly big issue.

And the coping mechanisms, the strategic things are first of all trying to find sites that both serve excluded communities, and also are least likely to raise the hackles of neighbors. We run into this a lot in Southern California because property is so expensive, and people are very defensive of their property values. And it doesn't even matter what the politics are. People just don't want this sort of thing near them. So a lot of times you want to exercise some care in your partners and the kind of relationships they have with their communities already. The other thing you want to do is become familiar with the housing rights organizations, the stability rights organizations in your states. They can be tremendous allies.

Rachel Post: Great. Thank you so much, Dave. Mercedes, I apologize, but I am wanting to move along because I know we have a number of Q&As in the inbox here. But one thing I can say from the years that I was privileged to work at Central City Concern is you could never start

thinking about that too soon, and the work of working with the community neighborhood associations, etc.

But with that, I'd like to go ahead and open this up to respond to our other questions that have been submitted. I know that we have a couple of questions I think that HUD is going to be responding to. Carrie, I'm going to ask you to join and identify which questions that we had for HUD.

Carrie: Thanks, Rachel. Okay, we had a couple of questions that came in that are probably best for HUD to answer. The first one is, we have identified an operator, and what are the competition requirements? Do they have to release an RFP?

Cory Schwartz: Hi, Carrie. This is Cory Schwartz. This is a good question. I was actually just responding to this question in writing through a different source, so it may be the same questioner. But I'm sure a lot of grantees have this kind of same question or a similar question. So our notice, our regulations require RHP grantees to comply with 570 [inaudible] G, that's that the state has to establish and then follow requirements for a procurement policy and procedures based on full and open competition. So it doesn't necessarily -- it doesn't state an RFP. It just requires a state to establish and follow policies and procedures.

One thing to note here is that if a state has identified an operator, depending on what activities they're going to carry out, they may not necessarily need to contract with the entity. They can still use an entity as a subrecipient to carry out that activity under the subrecipient requirements. And the question of whether the entity is a contractor or a subrecipient is something they'll have to look in the uniform administrative requirements, so that's 2 CFR 200.331, that it'll help grantees kind of differentiate what that entity, what service, or what activity that entity is providing.

And that is a way that grantees that have identified a single operator may be able to avoid having to go through full procurement requirements. But obviously there are details that I don't know. If there are more specific questions, we can handle those at a later time. But follow the notice, follow the regs. One other kind of caveat in there is that the SUPPORT Act, and this is in the notice that we reiterated, was that grantees have to distribute funds by giving prior authority to entities with the greatest need, and its ability to deliver effective assistance in a timely manner.

So those are two important things. And this is something that grantees have to include in their use of funds in their action plans, is how they're going to prioritize those entities. So if there is a -- if a grantee did want to provide funds to its subrecipients based on having identified an operator that it wants to use, it still has to ensure that it's prioritizing an entity that meets those requirements, even if it's not going to a full RFP or through the procurement process. That's something important for grantees to note.

Maybe just piggybacking on the procurement question, as I said, the state has to follow the notice, follow the regulations. I do have to include a perfunctory disclaimer, thank you to Dave and Mercedes, when grantees are determining who they want to carry out their programs, of

course this webinar is not serving as an endorsement of NARR affiliates or CCC, although HUD is endorsing their wisdom and their experience. So thank you to Dave and Mercedes.

Rachel Post: Great. Thank you, Cory. Carrie, do we have any other questions?

Carrie: We do have probably two more for HUD. One is these two models presented are very different. And the HUD allocations are relatively small. Can we focus on what works for our community as long as we stay within the RHP and CDBG rules?

Cory Schwartz: Short answer is, yes, of course. That is what the program is designed for. Of course a lot of what Dave and Mercedes have been talking about, and what ICF has talked about and will talk about even more, is these programs are going to require a number of different funding sources and stakeholders that are going to carry out a lot of different activities. And RHP is intended to be a piece of that. And that's the housing component. But there are -- you can't treat people in need by just providing one piece, by just providing housing. There are lots of other players, treatment services that are going to be required, to really address the needs of the people that grantees are trying to serve.

So to reiterate, this is a piece grantees should of course focus on what works for their community, to take what pieces they can from these webinars, from working with our TA provider, on designing programs that address a specific need in their community.

Carrie: Great. That's a great segue to the last question that came up. And that's family versus individuals. So Mercedes mentioned that CCC operates some family oriented recovery housing in support of family reunification. But the RFP notice is very focused on the word individual, is what you see. And that's the intent of the program. So from HUD's perspective, and I'd be curious about NARR as well, are multi-person households eligible? So should a provider [inaudible] single parent in recovery that has children?

Cory Schwartz: So the notice is silent on that. I don't think that we address in here whether persons living with other members of the household that are not in recovery would be excluded from receiving the RFP funds. So I'll leave that as my vague response. But it's something maybe that we will put out with further guidance to make it more clear for grantees, if that would work as an activity.

David Sheridan: From NARR's perspective, we do support models that it's almost exclusively one or the other parent with children. It's a difficult model to operate because the population has virtually no resources usually and they need everything. But there's a lot of good successful long running programs that are part of NARR, including all of our board members, that they do operate that way.

Rachel Post: All right. Thank you. So I know -- do we have any other questions? If not, Carrie, I know we have a few closing remarks. Or anyone else want to submit a question in the Q&A box?

Carrie: I don't see any others. I did just want to point out that I posted in the answer box the website, the link to NARR's website, as well as Central City Concern. So if folks want to take a look or do a little more research on their own, that's there for them. That's all the for the questions for now.

Rachel Post: Great. Thank you so much. And I think, Cory, you were going to share just a brief announcement about upcoming technical assistance available to the grantees?

Cory Schwartz: Sure. So I know a lot of grantees have been asking about on call TA with ICF. We are just finalizing just a few minor details on making that available. But for now grantees can start to request assistance, can start to request on call TA, so at least get those queued up because shortly ICF will be able to start providing those. And ICF will provide some further details through the RFP listserv on how to do that.

Rachel Post: Great. Thank you so much. Well I see that we are about five minutes near the end of this presentation. I do want to -- I so appreciate Dave Sheridan, all the incredible years of service that you have contributed to the evolution of recovery residences and the availability, and Mercedes, so much for the work that you and Central City Concern is doing in this realm. I know that we talked quite a bit today, and I think Cory referenced that using these funds in a way that brings together other stakeholders and systems to help sort of build a whole person approach will be required.

And our next webinar which is scheduled for February -- I think it's the 24th, if I'm correct, and you all should have received as part of the registration for this webinar -- we'll be talking about cross sector partnerships. And so we'll do a deeper dive into the various different systems and partners that you can be working with to develop your particular approach and interventions. So I look forward to us all coming back together and sharing more suggestions and ideas about how to build your system with other partners who also may be other funders as well.

And is there anything else that we we need to -- any other loose ends we need to tie up? David or Carrie? No? I think that's a no. I know that this webinar and the PowerPoint are being recorded. They'll be available on the HUD recovery housing program page. And thank you all so much for taking time out of your busy schedules to learn a little bit more about this recovery housing program. And thanks to our speakers.

(END)