

WHITE PAPER ON RECOVERY HOUSING

A PATHWAY TO RECOVERY

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INTRODUCTION

Recovery housing is a valued part of the continuum of care for people struggling with addiction. TAADAS endorses a focus on a recovery oriented system of care that includes a full range of treatment and support. Recognizing that addiction treatment is the long term, management of a chronic disease requires the adoption of interventions that treat the disease at every stage. The value and role of recovery housing is delineated in this paper along with the impact of current housing policy on access to recovery housing. TAADAS has engaged in advocacy to promote funding for addiction treatment since its inception in 1976. What we have come to understand about the nature of addiction, as a long term, chronic disease, is that acute, episodic treatment alone is not generally effective. Acute treatment works for the flu. Addiction is not like the flu. There is no cure. Addiction requires a lifetime commitment to its assessment and management. Learning to live with addiction is very similar to learning to live with any other chronic illness - like diabetes. Diabetes requires constant assessment and evaluation of the need for intervention, such as insulin. Diabetic treatment now often includes case managers that coach those with the illness to manage their diets, exercise and promote overall wellness. Lifestyle changes are necessary for most people with diabetes.

Lifestyle changes are also necessary as part of a treatment plan for those with addictions. Returning to a former neighborhood, living situation, job or stressors often trigger a return to substance use. New choices require new thinking and new alternatives. While treatment can start the process of ‘rewiring the brain’ to promote new thought patterns and choices – whether to treat diabetes or addiction – it is the support and environment that solidifies a new lifestyle and maintains recovery.

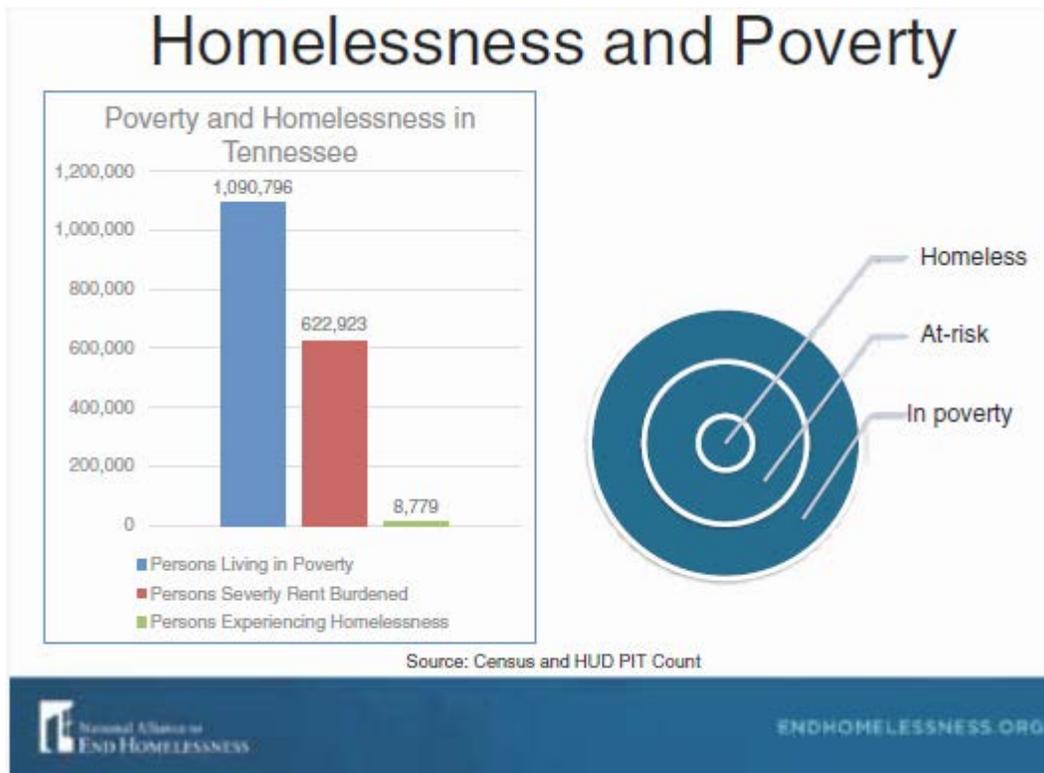
Access to recovery housing can be instrumental for recovery. Access to a place where temptation is not nearby, where those around you reinforce a recovery message and know the signs of relapse, and where new skills can be developed, often provides a needed place of sanctuary for those in recovery. Access to a continuum of care that includes medical detoxification, residential treatment, out-patient treatment, recovery housing and peer support has been widely recognized as cost-effective, evidence-based system of treatment. There is a new emphasis on promoting a recovery-oriented system of care in the addiction treatment literature. At the same time, much emphasis and research has also been occurring to address homelessness. Most homelessness studies have found that a majority of the homeless have a history of or a current issue with addiction. Addiction issues often increase while people live on the streets. The housing that is often available to persons with addiction, who are often starting over in life, is low income housing or homelessness project housing. While the intent of any housing program is to provide a safe environment, for those with addictions the environment itself is key to any successful tenure in the community. The interplay of these two missions, addressing homelessness, and addressing addiction, primarily with Housing First initiatives as this paper goes on to describe, has come into conflict.

TAADAS also recently recognized that, with a new found understanding of addiction as a disease and with the addition of many new medical treatments of addiction, the healing process may be overlooked. Recovery does not typically happen with a single episode of treatment in a residential facility and it does not happen with a dose of medication. Recovery is a process. It necessitates a long term approach for the person in recovery and as a result it requires a long term approach for the

system of care. Offering housing may seem like a quick fix for what looks like an acute, immediate issue, but it does not treat or provide support for the ongoing recovery of an individual and as a result, is prone to fail.

HOMELESSNESS

According to the United States Department of Housing and Urban Development (HUD), a person is considered homeless when he/she resides in a place that is not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings, encampments, or on the streets. People in transitional housing are considered homeless.



In a 2016 HUD Continuum of Care Homeless Assistance Programs Survey of homelessness, Tennessee ranked 19th in the United States in terms of the number of homeless at a point in time with 8,779 homeless people statewide. The National Coalition for the Homeless also ranks Tennessee as 19th in the nation for homelessness, but puts the point in time count at 10,532.

According to Didenko and Pankratz (2007), “two-thirds of homeless people report that drugs and/or alcohol were a major reason for their becoming homeless.” A survey by the United States Conference of Mayors found that 68 percent of cities reported that substance abuse was the largest cause of homelessness for single adults. Substance abuse was also reported as one of the top three causes of family homelessness by 12 percent of cities. (National Alliance to end Homelessness, Opioid Abuse and Homelessness, April 5, 2016).

There is an increase in the number of homeless nationwide and in Tennessee in the last 5 years in particular. Two reasons are generally cited. There's less affordable housing, and more very poor people.

According to the National Law Center on Homelessness and Poverty, an eighth of the country's low-income housing has vanished since 2001. HUD saw its budget cut in half, losing 10,000 units of subsidized low-income housing. Since 2008, more than 5 million homes have gone into foreclosure — at one point, one in 10 homes with a mortgage. A 2010 National Housing Conference study found that over a decade, 200,000 subsidized low-income units in the U.S. were demolished rather than being brought up to code. New construction has not matched this.

The rate of addiction nationally is largely unchanged. Use of most drugs other than marijuana has stabilized over the past decade or has declined. In 2013, 6.5 million Americans aged 12 or older (or 2.5 percent) had used prescription drugs non-medically in the past month. Prescription drugs include pain relievers, tranquilizers, stimulants, and sedatives. And 1.3 million Americans (0.5 percent) had used hallucinogens (a category that includes ecstasy and LSD) in the past month. (NIDA)

HOUSING MODELS

Medical research has determined that substance abuse is a disease - a chronic, recurring disease that requires long term management. Housing stability is fundamental to recovery, providing a foundation for other successes, such as job stability, family reunification and health improvements. In addition, communities benefit when residents are in stable recovery situations with decreased emergency room and ambulance use, a stable tax base, fewer arrests and fewer inmates, reduced child custody cases and a stable work force.

“Further, because most federal policy does not classify addiction as a disability, individuals with histories of addiction cannot access the same income, employment, and housing benefits available to people with mental illness or other disabilities. For example, people in addiction recovery cannot access Medicaid coverage through the Aged, Blind, and Disabled category, nor can they access disability income, vocational rehabilitation services, and Section 8 rental assistance.”⁽⁹⁾

Many communities, in addition to the U.S. Housing and Urban Development Department, are taking an approach that homelessness is best addressed with a ‘Housing First’ philosophy. These models do not require abstinence or engagement in services. Engagement with services is only encouraged. Often service engagement is weak because of the multi-dimensional client issues and disenfranchised client population in addition to the lack of funds to provide appropriate levels of treatment and support.

While 47% of the homeless population do not have substance abuse issues and may benefit from a housing first philosophy, a broader discussion of homelessness policy is warranted to successfully address the diverse homelessness and service needs. There are as many types of housing programs to address homelessness as there are types of participants. These models may include:

- **Rapid Re-housing.** Rapid re-housing programs work with landlords to encourage them to rent to homeless people; provide short-term rent subsidy, often the security deposit and the first

two months' rent; and follow up with supports, primarily improving access to employment so that the person will be able to pay the rent once the short-term subsidy expires.

- **Permanent Supportive Housing.** A housing approach for homeless people that have severe disabilities, including mental illness, unchecked addiction, and traumatic brain injury. These individuals often remain homeless for long periods of time. The program consists of rent subsidies, medical care, and support services. Even though relatively expensive, when properly targeted it pays for itself – people who would otherwise go to costly psychiatric emergency rooms, jails, and homeless shelters remain in their housing instead.
- **Recovery Housing** refers to safe, healthy, and substance-free living environments that support individuals in recovery from addiction. While recovery residences vary widely in structure, all are centered on peer support, the social model,¹ and a connection to services that promote long term recovery. Recovery housing benefits individuals in recovery by reinforcing a substance-free lifestyle and providing direct connections to other peers in recovery and recovery services and supports. Recovery Housing can be short term or long term.
- **Transitional housing** is a short term or transitional approach to housing and it focuses supports around a particular issue for residents, such as re-entry from prison, transition from addiction treatment, crisis stabilization, or rehabilitation support. This type of housing can include domestic violence shelters, immigrant programs or halfway houses.
- **Family Housing** can consist of family shelters or long term programs and often add supports such as rental subsidies, case management, child care and screening and programs for social and health services.
- **PATH Programs** connect rural residents to homes and services. PATH provides and coordinates many services and agencies that are often scattered in and around rural environments. This reduces the risk and impact of homelessness. Providers offer outreach, screening and assessment services, referral to community mental health and alcohol or drug treatment services, transportation, case management, and other services that individuals experiencing homelessness or at imminent risk need.

You can see from this short list of models to address homelessness, that a repertoire of housing options and supports are often needed to address homelessness in a single locale.

Sober living programs are traditionally transitional living programs so that people can live in a transitional program temporarily while they learn new sober living skills and then move on – back to their families or perhaps new jobs and homes. This type of living situation was not intended to be permanent, as the goal of recovery is aimed at helping folks gain living skills and resume living in the broader community. HUD and other Housing First proponent's seek to shorten a person's time as homeless (which includes time in transitional housing) to a goal of less than 30 days. While this is an appropriate goal for some, others with an extensive history of chronic relapses, a longer stay may be needed. Stays of up to two years may be critical to internalize recovery lifestyle changes, chronic

¹ In social model settings, the emphasis of recovery is based upon the relationship between the participant and his or her environment (including other participants/residents) whereas in a medical model of treatment, the emphasis of treatment is based upon the partnership of the patient and his or her doctor. ⁽¹⁷⁾

illness management skills and to build the kind of support systems that will stabilize their recovery. Research supports better outcomes with longer engagement in services.

HOMELESS PROGRAMS IN TENNESSEE

Nashville community group How's Nashville, announced an initiative to push for no homelessness in the city by 2016, and many community organizations continue to work toward providing accommodations for the 8,000 to 10,000 estimated homeless in the Nashville area in a given year. This program relies on permanent rapid rehousing.

In Memphis, the implementation of the Mayors' Action Plan to End Homelessness (2011) prompted Memphis/Shelby County to embark upon a strategic mission to pursue evidence-based, data-driven strategies to eradicate homelessness in their community. Significant progress in the reduction in the number of individuals and families who are experiencing homelessness was achieved due to implementing a Coordinated Entry system that focused on permanent, rapid re-housing.

In Knoxville, homeless camps were recently disbanded and the city is trying to address homelessness through existing permanent housing programs. The Knox County Development Corporation is continuously attempting to recruit new landlords to the Section 8 program. One incentive is the Knoxville Extreme Energy Makeover (KEEM) program. Eligible homes receive energy-saving upgrades at no cost to the homeowner. But if the homeowner is a landlord, he or she must accept Section 8 vouchers. So far, KEEM has upgraded 90 units, all of which agreed to have Section 8 tenants in exchange.

RECOVERY HOUSING PROGRAMS

Research on recovery housing is limited, but the literature does show that recovery housing improves the success rate for those who access it. Existing studies show reduction in the rates of incarceration and substance abuse, while increasing employment and income, including the ones below:

Jason & Ferrari, 2010⁽³⁾, explored the outcomes of mothers in Oxford Houses compared to women in a control group. Over 30% in recovery housing regained custody of children compared to 13% of the control group.

Research completed by Jason et al., 2007⁽³⁾ and Jason et al., 2006⁽²⁾, compared individuals in a peer-run recovery home to peers who returned to their own community of origin after exiting treatment. After 24 months, the recovery housing group showed decreased substance use, decreased incarceration rates, and increased income.

Multiple studies show that recovery housing leads to higher rates of employment (79-86%).⁽¹⁾⁽³⁾

Recovery residences for families have a multi-generational impact and address long term changes that can provide the resilience children need to live drug free lives. Research also indicates that recovery housing provides individuals with substance use disorders a greater chance at achieving long term recovery than those who do not live in recovery-oriented environments.⁽⁷⁾⁽¹¹⁾⁽¹⁴⁾⁽¹⁷⁾⁽¹⁹⁾

Recovery housing is predominantly transitional housing. The National Alliance for Recovery Residences (NARR) has sought to define recovery housing so that funders and policy makers could evaluate and support appropriate programs and so that providers could measure and evaluate success. Recovery housing was often unregulated and many policy makers wanted assurances that these homes were not just “flop houses” and were reputable. NARR has identified four levels of recovery housing that many states are using to further define and regulate sober living, recovery housing options. The full grid that defines each level of care is Appendix item A.

	RECOVERY RESIDENCE LEVELS OF SUPPORT			
	LEVEL I Peer-Run	LEVEL II Monitored	LEVEL III Supervised	LEVEL IV Service Provider

NARR made history in 2011 by publishing a national standard for recovery residences. This standard defines the spectrum of recovery oriented housing and services and defines the four different types listed above, which are known as “levels” or “levels of support.” These standards were developed through a strength-based and collaborative approach that solicited input from all major regional and national recovery housing organizations. Guidance for the standard was also received from recovery residence providers (some with decades of experience) from across the nation representing all four levels of support and nationally recognized recovery support stakeholders. NARR standards are voluntary and state affiliate-driven. Not all these levels of recovery housing provide services that need oversight or regulation. Most peer run or peer monitored sober living is not regulated. The type of recovery oriented transitional housing that has been traditionally funded through HUD has had programmatic components (Level 2, 3 & 4 programs). These standards can be used to define the nature of a recovery housing program and its compliance with standards of care, supervision and administration. NARR publishes a full list of standards at: <http://narronline.org/affiliate-services/standards-and-certification-program/>. Tennessee has a NARR affiliate, TNARR that has 25 member agencies or affiliate programs statewide. Currently 13 of those affiliates have been inspected and approved. TNARR stands ready to assist any recovery housing program in Tennessee become a Certified Recovery Housing program. Certification shows the professional commitment of the housing provider as well as the quality of the program and can help communities appreciate that professionalism.

Multiple studies show that recovery housing leads to higher rates of employment (79-86%).^{(1) (3)}

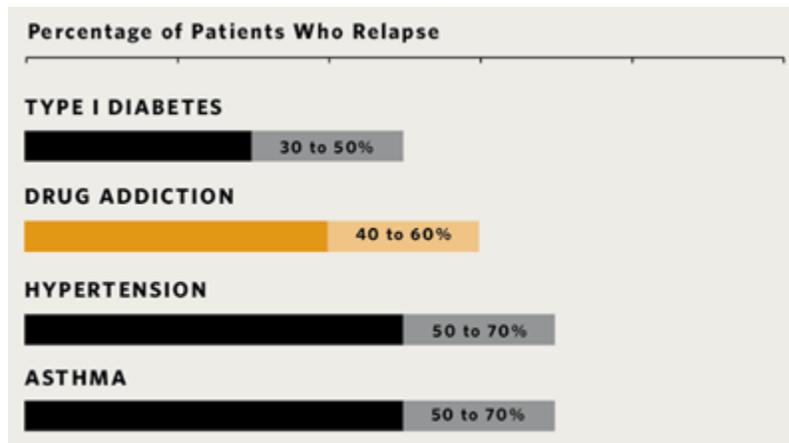
The disease of addiction is one that requires long term management and support – in the same way that we provide long term management for other rehabilitation issues. Post stroke or head injury patients go to a nursing home to recover and participate in rehabilitative treatment. Post heart attack patients receive rehab

supports at home as well as lifestyle coaching and case management – typically also supported by dietary changes. Asthma patients receive case management, lifestyle coaching and pulmonary rehab at home. Post addiction treatment and rehab often provides lifestyle support, peer coaching and mentoring, case management and rehab in a drug free recovery housing environment that supports the adaptations necessary to live drug free.

The rehabilitative needs of someone with addiction can be provided in sober, recovery housing programs. Addiction rehab requires work to ‘retrain the brain’ and provide skills that can prevent relapse. Different substances have slightly different effects on the brain. But all types of addiction stem from an effect in the survival center of the brain.⁽⁴⁾ Substances essentially reprogram that part of the brain or ‘hijack it’ so that the person wants more and more of the substance, causing them to believe they need it to survive. Addiction disrupts the survival center in the brain so it disrupts self-preservation. Brain chemistry is altered not just when using the substance but for long periods afterwards. Opiates in particular destroy the pleasure cells which leads to an increasing need for more opiates to feel anything or to recreate the ‘high’ that first occurred. Because these cells are destroyed a user will keep using in an attempt to feel better, even though the ‘high’ is never recreated. It can take at least a year of abstinence for a person’s brain to recover enough to be at baseline – essentially fully functioning, able to feel emotions and sensations again and regain resiliency to successfully maintain a drug free life. Recovery housing programs may not provide services directly, but they all provide a supportive environment where skills are recognized and reinforced by sober living neighbors and peers. They also provide an environment where the negative effects (triggers) for substance use is mitigated.

People recovering from addiction can return to their substance use at any point in their recovery process. This is often called relapse. Relapse rates vary among chronic illnesses, but relapse is a commonality for all chronic illnesses.

Comparison of Relapse Rates Between Drug Addiction and Other Chronic Illnesses



Relapse rates for drug-addicted patients are compared with those suffering from diabetes, hypertension, and asthma. Relapse is common and similar across these illnesses (as is adherence to medication). Thus, drug addiction should be treated like any other chronic illness, with relapse serving as a trigger for renewed intervention.⁽⁷⁾

Relapse is one of the most perplexing aspects of addiction. Millions of Americans who want to stop using addictive substances suffer tremendously from the blame and shame of relapse. Relapses can be enormously discouraging. It can take 2-3 years after stopping substance use for most cravings to subside – though they are never eliminated. Relapse can occur at any time. Support of rehabilitative goals for recovery are most essential for the first few years post treatment but continue to need

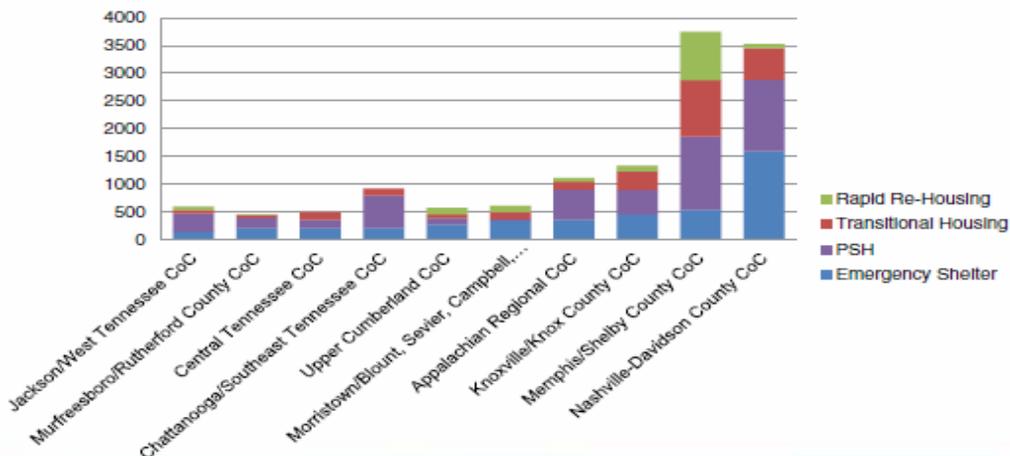
evaluation and reinforcement through a lifetime. Sober living environments that have access to services and peers can be instrumental in helping the newly sober recognize their triggers for use and immediately address any urges to use. Just as stroke recovery can take years, requiring long term maintenance and support, addiction recovery requires long term support. For some, this may take longer stays in order for people to eventually make a transition to an independent living environment.

CHALLENGES WITH HOUSING FIRST IN TENNESSEE

Transitional housing, used as sober living, has been affected by the Federal Government’s emphasis on Housing First. In 2012, Tennessee had a total of 3581 HUD funded transitional housing beds. In 2017, Tennessee had a total of 2359 HUD funded beds. That is a loss of over a third of the housing that could be accessible as transitional housing, including sober living programs. It is true that the overall amount of homeless housing across the state has been reduced. However, the total amount of available beds of all types in 2012 was 6492 and the total amount available in 2017 was 6326 – a drop of less than 3 % compared to a drop of 35% in transitional housing alone. As a state, from 2009 to 2016, we have eliminated funding for transitional housing by 85%. The majority of those programs had substance use disorder programs as a major component of the housing. Some continuums in Tennessee over the same period have eliminated all HUD funding for Transitional Housing. Davidson County uses 1% of funding for Transitional Housing. Since 2009, total HUD Continuum of Care (CoC) funding to TN has increased 18% (\$3,083,692) but Transitional Housing funding has decreased by 85% (\$6,087,412). This is most directly attributed to a Housing First approach.

The following graph shows the type of housing available by regional housing collaboratives or Continuums of Care (CoC) across Tennessee in 2016:

2016 Housing Inventory Chart by CoC



Some recovery housing programs in Tennessee were not only discontinued as previously cited, but many have not been able to grow as a result of HUD Housing First policies. Since HUD was a major funder for recovery housing, providers who were funded by HUD in any way had to close or reduce programs as they could not be sustained solely with non-HUD funds. Park Center, a program in Nashville, TN sold their transitional housing site because the program could not be sustained given the loss of HUD funds. Additionally Park Center withdrew a proposal for additional funding because funding for transitional housing was not supported. For Welcome Home Ministries, another Middle TN Recovery Housing provider, the loss of funds has slowed overall growth because of a \$92,000 loss of funding across three HUD funded projects. Welcome Home was forced to use any funding gains that could have been realized for growth to offset HUD funding losses. While Welcome Home Ministries was fortunate not to have to eliminate any programs, they have had to restructure and it has hampered their ability to expand and offer more services to the community. In 2016, Mending Hearts, a recovery housing program in Nashville, TN, had two programs defunded by HUD. These recovery housing programs had been successful and sustained over a number of years. One program served ‘Moms with Kids’ to help single moms and their children affected by addiction. Funds were diverted to this program from other areas of the organization in order to sustain any level of services. This growing reduction in recovery housing access has undoubtedly lowered the success rate of many people in recovery.

The effects of the HUD Housing First policy implementation in Tennessee has been dramatic in reducing the number of sober living beds in the HUD Housing continuum.

Getting people off the streets and in safer places often does save lives. But long term housing stability and safety is often undermined by these rapid housing and permanent housing programs when recovery supports are not in place. Transitional housing that is recovery housing, provides environments that can improve success for those with addictions. When a housing program is unsuccessful, people are often ‘marked’ (i.e. evictions or other notations) and cannot return – creating another barrier to their recovery. The person is marked as unsuccessful rather than the program.

In 2016, the Journal of Dual Diagnosis published a paper by Kristen Paquette and Laura Pannella Winn that discussed the role of recovery housing in the current continuum of housing for the homeless and, in particular, how the Department of Housing and Urban Development’s (HUD) approach called ‘Housing First’ was affecting access to recovery housing. The article begins by citing studies of

It can take 2-3 years after stopping substance use for most cravings to subside – though they are never eliminated.

homelessness and the rate of substance abuse in the homeless which is disproportionately higher – 53% of the homeless population have been found to have a substance use disorder.⁽¹⁵⁾ Some studies have found as high as 2/3 of the homeless population have a substance abuse problem. In comparison, 20% of the homeless have been found to have a serious mental illness.⁽¹⁰⁾ Addiction is clearly a key issue that may have affected how these people became

homeless, affects their choices for housing and affects their stability in housing. Homelessness often means people have less opportunities to find recovery support. The literature they cite found that Housing First programs that were successful, focused on finding homes for families and for those who

were marginally employed, not for those with addictions. Meanwhile cities like New York City are putting new emphasis on supportive housing to address this need.⁽¹⁹⁾

Housing helps a person with the stability to access treatment and recovery support, but it alone does not provide the supports needed for most people to live a drug free life long term. Housing First provides a rapid placement in permanent housing. It does not require participation in programs or any preconditions for acceptance. Many housing assessments have become housing entry assessments alone, and the need to include clinical assessments to enable appropriate referrals and clinical support may be overlooked.

The effects of the HUD Housing First policy implementation in Tennessee has been dramatic in reducing the number of sober living beds in the HUD Housing continuum. COC scoring mechanisms to approve HUD housing programs have in most cases exclusively focused on permanent housing approaches that excluded sober living programs. All types of sober living facilities have been affected, impacting the number of recovery houses and a lack of growth of this model. While intentions are often noble in our collaborative efforts to end homelessness throughout the United States, local, state and federal housing agencies should consider the importance of embracing a philosophy of providing “a choice” of *diverse housing options* for individuals experiencing homelessness. Just as there is not one solitary cause for homelessness that can be identified, there should not be a solitary housing modality offered to resolve homelessness. If we could eliminate the *causes* of homelessness, then the problem of homelessness could be solved.

This growing reduction in recovery housing access has undoubtedly lowered the success rate of many people in recovery.

In a letter to Ben Carson, Secretary of HUD, Linda Rosenberg, CEO of the National Council of Behavioral Health wrote, “HUD's guidance indicates that it can be a part of a larger community approach grounded in choice for people who are experiencing homelessness and have a substance use disorder.” The guidance further states that Recovery Housing should be offered in proportion to client need and desire for such option within the community. It makes the specific recommendation that communities should ensure their housing programs accept and serve people at all stages of addiction and recovery.

However, the current scoring criteria does not align with this guidance and limits the ability of local communities to respond to the range of housing needs of people recovering from addiction. TAADAS urges HUD to review and change its current policies and procedures so that CoCs can prioritize Recovery Housing when the community demonstrates that it has adopted a Housing First approach and that there is a demonstrated need for Recovery Housing options for homeless individuals who may choose this model of housing.”

The National Alliance to End Homelessness agrees as well, stating, “Many communities still operate congregate transitional housing programs – defined as facility-based programs that offer housing and services for up to two years to individuals and families experiencing homelessness. While many people who have traditionally been assisted in long term congregate transitional housing may be served more efficiently in other program models, this model may be appropriate for some people, including: Certain individuals and heads of households struggling with a substance use disorder; Individuals in early

recovery from a substance use disorder who may desire more intensive support to achieve their recovery goals...”.⁽¹²⁾

Housing First was introduced by HUD as a philosophy to provide access to housing. It was not intended as a funding model. Because CoCs are embracing this philosophy and making it the sole basis of their funding decisions – a range of housing models that meet people’s needs have been lost in many communities. Housing choice for participants is lost. According to Ann Oliva, Deputy Assistant Secretary for Special Needs at the U.S. Department of Housing and Urban Development, “HUD does not advocate the wholesale removal of one type of homeless resource in a community (like emergency

shelter or transitional housing) with the replacement of another (like rapid re-housing). That would be short-sighted, and does not take into account the specific needs of communities... Transitional housing is an eligible component of the Continuum of Care (CoC) Program and can be a necessary part of a CoC’s homeless assistance portfolio... Transitional housing should be reserved for those populations that most need that type of intervention – programs that serve domestic violence survivors and youth and those that provide substance abuse treatment...”.⁽¹⁴⁾ Defining the needed housing in each

As our country has tried to address homelessness, program decisions have been made that are detrimental to recovery housing providers and have resulted in a huge loss of recovery housing resources.

community should translate to target populations and housing programs that meet that need.

“The progress clients make in treatment frequently is undermined by the lack of an alcohol and drug free living environment supporting sustained recovery... When clients are released from residential programs into economically deprived neighborhoods that do not actively support abstinence, the recovery they established in treatment may be lost. Outpatient providers face a similar dilemma. *Even if clients are engaged in outpatient treatment, motivated for change, and making improvement, their progress may be mitigated if they reside in a destructive living environment that triggers relapse.*”⁽¹⁸⁾

Access to recovery housing is access to long term recovery success for many. Our current Opioid crisis and overdose death rate in Tennessee require systemic approaches that use housing resources efficiently and appropriately to meet a myriad of housing needs including for those in recovery from addiction. Housing First programs are appropriate for many, especially to address family homelessness. Housing choice is needed to meet the needs of all those facing homelessness.

SUMMARY AND RECOMMENDATIONS

Developing and funding a full complement of housing options to address homelessness and addiction is necessary because they affect so many other community issues such as our economy and the cost of healthcare, workforce retention, school resources, policing, emergency room utilization, and children's welfare services. Access to housing for those with addictions is even more complicated and affects even more community systems. As our country has tried to address homelessness, program decisions have been made that are detrimental to recovery housing providers and have resulted in a huge loss of recovery housing resources. This loss affects the long term prognosis of those in recovery from addiction. It also effects the long term success of many housing programs. While analyzing the effect of this loss to our state, it should be noted that we are facing an addiction and overdose crisis. Addressing addiction as a long term, chronic illness with a full continuum of care that includes rehabilitative and support services, such as recovery housing, is needed as part of our public health and public service strategies. The following recommendations are offered based on our research:

- Funding for a full continuum of care to treat addiction is needed to ensure long term recovery success. This continuum should include treatment services, such as detoxification and residential treatment, as well as recovery supports, such as peer services and recovery housing.
 - Recovery Housing that contains programmatic elements can be certified through standards such as those developed by NARR and funded through TDMHSAS addiction treatment services as well as through a modified TennCare waiver program.
 - Communities and Continuums of Care should evaluate and revise their funding strategies for HUD housing to include funds for housing that meets the needs of their specific community. Housing choices need to address the need for supportive housing as well as permanent housing, providing a mix of opportunities to benefit their community.
- Housing programs should be encouraged, and where appropriate, funded to provide data relative to the housing needs of those with addictions separately from that of other populations. Housing outcomes for subpopulations, like those with addictions, are often affected by issues differently.
- The Bureau of TennCare funds supportive housing for those with mental health issues and does not fund any supportive living environments for persons with addictions. Equitable funding for such a rehabilitative approach to addictions in the TennCare program is needed.
- Housing First programs as well as other like initiatives should develop strong, comprehensive service referral processes and policies to refer housing participants to other more appropriate housing programs as well as related services when needed and without endangering the participant's current or future participation in housing.

APPENDIX - A

		RECOVERY RESIDENCE LEVELS OF SUPPORT			
		LEVEL I Peer-Run	LEVEL II Monitored	LEVEL III Supervised	LEVEL IV Service Provider
STANDARDS CRITERIA	ADMINISTRATION	<ul style="list-style-type: none"> • Democratically run • Manual or P&P 	<ul style="list-style-type: none"> • House manager or senior resident • Policy and Procedures 	<ul style="list-style-type: none"> • Organizational hierarchy • Administrative oversight for service providers • Policy and Procedures • Licensing varies from state to state 	<ul style="list-style-type: none"> • Overseen organizational hierarchy • Clinical and administrative supervision • Policy and Procedures • Licensing varies from state to state
	SERVICES	<ul style="list-style-type: none"> • Drug Screening • House meetings • Self help meetings encouraged 	<ul style="list-style-type: none"> • House rules provide structure • Peer run groups • Drug Screening • House meetings • Involvement in self help and/or treatment services 	<ul style="list-style-type: none"> • Life skill development emphasis • Clinical services utilized in outside community • Service hours provided in house 	<ul style="list-style-type: none"> • Clinical services and programming are provided in house • Life skill development
	RESIDENCE	<ul style="list-style-type: none"> • Generally single family residences 	<ul style="list-style-type: none"> • Primarily single family residences • Possibly apartments or other dwelling types 	<ul style="list-style-type: none"> • Varies – all types of residential settings 	<ul style="list-style-type: none"> • All types – often a step down phase within care continuum of a treatment center • May be a more institutional in environment
	STAFF	<ul style="list-style-type: none"> • No paid positions within the residence • Perhaps an overseeing officer 	<ul style="list-style-type: none"> • At least 1 compensated position 	<ul style="list-style-type: none"> • Facility manager • Certified staff or case managers 	<ul style="list-style-type: none"> • Credentialed staff

NARR standards for recovery residences can be found at:

<http://narronline.org/affiliate-services/standards-and-certification-program/>



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