Recovery Housing in the State of Ohio:

Findings and Recommendations from an Environmental Scan

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1 Formerly the National Association of Recovery Residences

Authors' Note

Recovery Housing in the State of Ohio describes various historical, national, state, and local contexts that contribute to the findings and recommendations. As a source for long-term recovery supports and affordable housing—along with several other social, relational, and economic benefits—recovery housing sits at the intersection of several converging systems and ongoing national dialogues. Many of these systems bring their own histories, terminology, and contexts. While these factors will be discussed in various ways, the authors wish to acknowledge several key issues. This report does not attempt to endorse one perspective over another, nor to propose singular solutions. Rather, the findings and recommendations are intended to contribute to an ongoing dialogue and inform future discussions of research, policy, and practice.

Recovery housing is used as a term to frame the environmental scan activities. The concept includes the four levels of recovery residences as defined by the National Alliance for Recovery Residences,[2] while leaving open the possibility of how recovery housing models will be defined and supported in Ohio. Further, the programs and participants represented different personal and professional experiences, which color their understanding of recovery housing. This includes people in recovery, advocates, business leaders, housing and service providers, researchers, and experts in housing, homelessness, criminal justice, addictions treatment, and other systems. These perspectives are included as well.

Findings in this report indicate the need to **foster public awareness** about recovery housing—and the disease of addiction more broadly—at local, state, and national levels. Several programs described difficult experiences in addressing neighborhood concerns that stem from stigma about addiction. In some cases, this opposition was successfully addressed through effective community education and outreach. In fact, as described in this report, the literature points to the positive effects that occur when a recovery home is opened in a neighborhood.

Beyond neighborhoods, additional efforts are needed to **educate stakeholders**. Some misperceptions persist about recovery housing as a narrow, linear continuum of treatment that relies on 12-step models or punitive practices. Rather, the desire among recovery housing advocates is to create a flexible, sustainable range of options, which are made available to individuals at any point in their recovery process.

2 Formerly the National Association of Recovery Residences

Discussions about recovery housing often include debate about **relapse and recovery**. Perceptions about relapse as a potential part of the recovery process vary significantly among peers, advocates, and experts. For many in recovery, relapse does not occur. However, for others, this is not the case. Relapse may occur for various reasons and can lead to overdose, hospitalizations, jail, or death. Recovery housing programs make every effort to support residents and prevent relapse. Most establish responsive and supportive relapse policies, taking into concern the safety, sobriety, and well-being of all residents.

Some participants expressed difficulty in finding a place for recovery housing models within the **continuum of affordable housing**, which includes Permanent Supportive Housing (PSH) as well as Housing First models. These models emphasize client choice, voluntary services, permanency, and harm reduction. This is challenging to recovery housing advocates who recognize the need for some transitional housing options, as well as some housing that requires a clean and sober living environment. The authors talked with various stakeholders who represent PSH and Housing First perspectives, most of whom agreed that recovery housing is an important resource in the affordable housing continuum.

Adding to the challenge of the growing state and national recovery housing initiative is that **not all recovery housing providers view themselves as affordable housing providers** with the primary goal of serving individuals living in poverty, or who are homeless or at risk of homelessness. The way that programs frame their services and seek out residents may affect the types of challenges, funding opportunities, and technical assistance needs that arise. The primary orientation of this report is toward programs that serve individuals and families that struggle with housing and income, and includes findings about potential funding resources and policies that could help to expand recovery housing as a resource for marginalized populations.

These issues represent just a few key challenges that were identified during the environmental scan. Despite the complexity created by different systems and viewpoints, the bottom line is the same: recovery housing represents an important resource to engage people in long-term recovery, and additional resources are necessary to expand recovery housing and support programs in providing high-quality, accessible services. This report is intended to inform and advance these efforts.

Executive Summary

The 2010-2011 National Survey on Drug Use found that on average, 2.78% of individuals over the age of twelve in Ohio reported illicit drug dependence or abuse in the past year. In the same survey, an estimated 7.6% of Ohioans over the age of twelve noted alcohol dependence or abuse in the past year. These numbers amount to an estimated 926,000 individuals in need of substance abuse treatment for alcohol and/or drug dependence (Han, Clinton-Sherrod, Gfroerer, et al., 2011).

Ten years ago, opioid use in Ohio involved primarily heroin and occurred mostly in Ohio's urban counties. In recent years there has been a dramatic shift in the non-medical use of prescription opioids, which has amplified substance use in rural communities (OARP, 2012). Medical Centers, including Cincinnati's Children's Hospital and Grant Medical Center in Columbus, are reporting increases in pregnant women addicted to prescription pain medication and, likewise, increases in the number of infants born drug-affected.

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Although substance use disorders affect people in all economic circumstances, the difficulties faced by people living in poverty may be even more formidable since access to treatment services and supports is lacking. Adults with substance use disorders and mental illnesses are twice as likely to have incomes less than 150% of the poverty level compared to adults without either disorder (SAMHSA, 2010). Part of this population includes individuals who have experienced episodes of homelessness and/or long protracted periods without housing. In 2011, 13,977 people experienced homelessness in Ohio; of those, 2,880 identified as having a chronic substance abuse problem (HUD, 2012).

Among individuals and families facing poverty, housing insecurity, and substance abuse, these issues are compounded by a lack of affordable housing and high rates of unemployment. The National Low Income Housing Coalition (NLIHC) provides a guide for affordability based on income. NLIHC's report "Out of Reach 2013" reports that the average Fair Market Rent for a two-bedroom apartment in Ohio was $717. Yet, individuals who receive Social Security Income (SSI) earn $213 monthly; minimum wage earners earn $408 monthly, and low-income households earn $459 monthly. Even

households representing average renters in Ohio earn $585 monthly, indicating a significant disparity between earnings and housing costs. In addition to the lack of affordable housing, the Ohio unemployment rate remains around seven percent, despite a steady decline in recent years. Further, individuals in recovery may find access to employment challenging, due to criminal history, poor employment history, and limited job training or skills.

Within the criminal justice system, individuals who are incarcerated also experience high rates of addiction; these issues are often untreated upon release from prison (Burke, 2008). The Ohio Department of Alcohol and Drug Addiction Services (ODADAS) in 2011 reported that 70 to 80% of all Ohio Department of Rehabilitation and Correction offenders had a history of substance abuse (Great Lakes Addiction Technology Transfer Center (ATTC), 2012). Others estimate rates as high as 86.6% for men and 85.7% for women. Furthermore, 63.2% of men and 52.3% of women had a history of alcohol abuse, according to the same report (Great Lakes ATTC, 2012). The rate of substance abuse or dependence among adult offenders on probation or parole supervision is more than four times that of the general population (Great Lakes ATTC, 2012).

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Despite these social and economic challenges in Ohio, several factors contribute to the timeliness of exploring and expanding recovery housing. In recent years, increasing attention has been focused on the problem of addiction across Ohio communities. As the widespread availability of prescription drugs has grown, so too has the numbers of individuals facing addictions, including large numbers of young adults. At the same time, Ohio's Departments of Mental Health (ODMH) and Alcohol and Drug Addiction Services (ODADAS) will merge in July 2013. This report represents an initiative undertaken by ODMH to better understand the current status and need for recovery housing across communities. The merge with ODADAS will allow both agencies to be engaged in capital planning for housing resources, and to submit a joint financial plan for the first time. Like many states and systems, mental health and addictions services have operated in parallel with different languages and priorities for decades. Finally, while the question of Medicaid expansion in Ohio remains unanswered and is not a complete solution, many recovery housing providers anticipate the potential benefits of the increased enrollment.

The purpose of this Environmental Scan report is to document current status, needs, opportunities, and challenges for expanding recovery housing approaches throughout Ohio. Findings will inform policy changes, best practices, and training and technical assistance resources, with the goal of increasing recovery housing capacity in the state.

Key activities in the scan included a literature review of peer-reviewed articles and relevant technical assistance manuals, reports, and white papers; a review of state and Federal housing regulations relevant to recovery housing in Ohio; telephone and in-person key informant interviews with national experts and stakeholders; site visits to recovery housing programs representing various models and regional areas in Ohio; and focus groups with community stakeholders. Following these data collection activities, team members reviewed and coded notes, identifying salient themes to be used as the basis for this report. This Executive Summary includes a brief discussion of key findings.

Why Recovery Housing? Why Now?

In recent decades, concerns over the effectiveness of an acute care model of addiction treatment have arisen. The acute care model has been characterized as disconnected from the processes of long-term recovery (Dodd, 1997), being comprised of brief treatment, discharge, and termination of the service relationship. Some have cited reduced access, retention, utilization of evidence-based clinical practices, linkages to communities of recovery, and increases in re-addiction and readmission (Kelly & White, 2011; White, 2008; Laudet & White, 2010; McLellan, McKay, Forman, Cacciola, & Kemp, 2005). The resulting calls to expand the acute care model to one of sustained recovery management (Dennis & Scott, 2007; McLellan, Lewis, O'Brien, & Kleber, 2000) within a broader recovery-oriented system of care (Kelly & White, 2011; White, 2008) have gained traction. This long-term view of recovery by necessity requires the incorporation of recovery supports, including short- and long-term housing, social and peer supports, employment supports, and access to mutual aid groups such as Alcoholics Anonymous and other peer support groups.

Alongside this shift towards a long-term recovery paradigm, health reform in the U.S. has begun to favor a more integrated, holistic care approach for people with substance abuse and mental health issues. Based on a continuum of care model, this concept emphasizes the need for various recovery supports, including housing. Individuals who are in recovery and struggling with housing insecurity have few housing options that are supportive to their recovery needs. This trend is likely to increase as program cuts in managed care settings have led to shorter stays in primary treatment centers (Fisher, 2010). As a result, many programs face the dilemma of how to find supports for someone who has been stabilized during their stay in a primary treatment center, but who may not be ready to maintain their recovery in their prior homes and neighborhoods—thus increasing their likelihood for relapse (Granfield & Cloud, 2001).

Recovery housing approaches provide safe, healthy, environments that support residents in their recovery. The varied models of recovery housing also provide communities where individuals are able to improve their physical, mental, spiritual, and social wellbeing (NARR, 2012). These communities enable individuals to build resources that support their recovery, also known as recovery capital, through peer support and other services and supports. Recovery housing may be particularly important for low-income groups who have the least number of affordable and recovery-oriented housing options (Polcin et al., 2012b).

Although this type of peer support housing has been around since 1846 (White, 1998), recovery housing—also known as recovery residences, sober homes, and sober living—is in the early stages of being defined. Recovery housing represents a range of models that provide varying levels of supports. However, preliminary research on selected models indicates positive outcomes. Studies on peer-run, monitored, and supervised programs document significant longitudinal improvements at 12-, 18-, and/or 24-month follow up (Jason et al., 2007a; Jason et al., 2006; Kaskutas, Zavala, Parthasarathy, & Witbrodt, 2008; Polcin et al., 2010).

Specifically, longitudinal studies of peer-run recovery homes have shown that after 24 months, when compared to individuals who returned to their communities of origin after treatment, peer-run housing residents had significantly better outcomes, including: decreased substance use, decreased rates of incarceration, and increased income (Jason et al., 2007a; Jason et al., 2006). Furthermore, studies have shown that living in recovery housing (when compared to control groups) leads to higher rates of employment, ranging from 79% to 86% (Jason et al., 2007a; Polcin et al., 2010). One study of the Oxford House model—one peer-run model of recovery housing—found that among mothers

who had lost custody of their children as a result of their substance use, over 30% had regained custody two years after entering the home. This is compared to 12.8% of women in the control group (Jason & Ferrari, 2010). Many of these positive outcomes have been attributed to the support individuals receive living in recovery-oriented communities.

In addition to the positive recovery outcomes indicated by research, studies attempting to calculate the economic costs and benefits of establishing recovery homes have overwhelmingly found that the benefits far outweigh the costs. For example, researchers have documented cost savings of $29,000 per person, when comparing residency in a peer-run recovery home to returning to a community without recovery supports. This factors in the cost of substance use, illegal activity, and incarceration that might occur (Lo Sasso et al., 2012).

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Additionally, a cost analysis of the peer-run Oxford house model compared to a traditional, fully staffed halfway house model identified significant cost savings. The study concluded that if the Oxford Houses had been traditional halfway houses, the cost to taxpayers would have been $224.4 million to cover staffing, housing maintenance, facility fees, and other expenses. In comparison, Oxford House, Inc. received only $1.6 million in grants from state and local governments during fiscal year 2007, while residents nationwide spent an additional $47.8 million to pay the operational expenses of the homes that same year (Oxford House, Inc., 2007).

In light of the significant recovery outcomes, cost savings to taxpayers and communities, and opportunities to support employment and families, recovery housing warrants further exploration and consideration.

Key Findings

Discussions with key informants, site visits, and focus groups revealed several salient themes that are informed by the literature and housing reviews, described briefly in this section.

The availability of recovery housing in Ohio is insufficient, especially housing tailored to the special needs of subpopulations.

Men, women, families, young adults, people experiencing or at risk of homelessness, criminal offenders, and individuals with co-occurring mental health and substance use disorders all need and seek out recovery housing. Because this model is in demand by such a broad range of people, different approaches are needed to meet the needs of people at various points in their lives and pathways to recovery. Within the range of recovery housing models, individuals and families may seek programs that represent independent or communal living styles, programs with peer or clinical supports, and varying degrees of recovery services and supports. Additionally, the demographics of communities vary, indicating a need for a tailored response to special populations.

Women and Families The availability of programs for women and families across communities in Ohio is severely lacking. Women and families may need to travel across the state to seek services at programs that provide gender-responsive, child-friendly, family-oriented care. Programs serving two-parent families are even more scarce.

Individuals with Co-Occurring Mental Health Disorders While many people in recovery who have a dual diagnosis of mental illness may be able to manage symptoms and medications without support from peers or staff, others may not. Many peers and staff are not trained to support individuals with dual diagnoses. This can create challenges for an individual seeking recovery supports, especially in communal, peer-run settings.

Individuals with Criminal Justice Histories Recovery housing for people with criminal histories is difficult to find in many communities, and is often cited as the most significant gap. However, the extent to which this was a major problem varied by community. In some cases, only criminal offenders with certain felonies, such as sex offenses, had difficulty finding housing. Resources are typically limited due to program rules, local zoning, and neighborhood concerns related to housing criminal offenders. While many newly released offenders are placed in halfway housing that is monitored by the Ohio Department of Rehabilitation and Corrections, the availability of recovery services and supports vary significantly. Key informants reported that the numbers of people in the community with criminal justice involvement and addiction to drugs or alcohol is also on the rise, due to changes in prosecution and incarceration policies for certain charges. Despite the growing number of offenders in need of recovery services, no additional funding has been allocated to community service agencies.

Current variations in recovery housing definitions, language, and understanding pose challenges to the efforts to advance it as a model.

The concept of recovery housing is in the early stages of being codified and defined. Very few recovery housing providers are familiar with the National Alliance for Recovery Residence's (NARR's)[3] newly developed standards for recovery residences. Additionally, the term "recovery housing" itself is understood in multiple ways. For example, recovery housing providers might frame their programs as sober housing, halfway houses, faith-based housing, transitional housing, recovery supports, or supportive housing. This varies in part due to the different structures and policies across sytems and communities.

One national stakeholder suggested that "recovery" may be the most helpful unifying concept to bring various systems and resources together more effectively. However, even this word raises questions. For example, does recovery mean the same thing as sobriety? Is reduced use over a period of time considered recovery? These questions have implications for research and data collection efforts and funding resources, as well as individual and programmatic differences in understanding the recovery process and the supports that are required.

3 Formerly the National Association of Recovery Residences

The network of recovery housing providers in Ohio lacks the infrastructure, resources, and technical assistance to support growth and quality oversight.

Currently, recovery housing providers in Ohio are loosely connected within and across communities, if at all. There are few opportunities for networking and coalition building, despite the desire expressed by many to do so. Inventories of recovery housing providers are informal at best and often non-existent, creating challenges in making referrals and monitoring program quality. Additionally, no formal system exists to provide quality oversight, infrastructure, or capacity building support to recovery housing providers. Depending on the program, some recovery housing components may carry certifications or monitoring, such as those funded through public housing subsidies or services grants.

Quality Oversight Currently there is no regular mechanism for ensuring quality across recovery housing programs, or for fielding complaints. Some residents and recovery housing providers noted the existence of recovery housing programs that may not be providing adequate services or supports for residents. For example, some individuals start recovery homes with no relevant experience. In these cases, residents describe conditions that are similar to a boarding house rather than a recovery home, with little or no supports to foster long-term recovery.

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Funding Government support is critical to the development and operation of recovery housing for individuals experiencing homelessness and poverty. In addition to providing funding and supporting sustainability, Federal and state leadership fosters the development of collaborations. Most recovery housing providers lack the capacity to pursue capital funds to support the acquisition and maintenance of housing. These funds are essential not only to start up a home, but to ensure that the home can be renovated and repaired to maintain compliance with building codes and housing quality standards. However, smaller homes may be able to become self-sufficient without external funds, depending on program resources and occupancy. Once the home is established, some recovery housing providers may need to seek public funds for ongoing services and recovery support. Overall, most recovery housing providers expressed concerns about connecting to funding resources—partially due to limited funding as well as barriers to collaborating with local systems of care.

Technical Assistance Recovery housing providers—particularly smaller programs that identify as grassroots or community-based organizations (CBOs)—have significant technical assistance needs with few available resources. Many expressed a need for basic assistance with business, accounting, and marketing functions. They regularly face difficult decisions that pit business goals against their singular mission of supporting recovery. Further, certifications are costly and difficult for some recovery housing providers, but may provide eligibility for certain funding streams. Recovery housing providers may also have difficulty navigating zoning and building codes.

Data Collection Recovery housing providers need data to tell the story of their success. Several expressed that they are able to serve people in an effective and culturally competent manner,

especially those who have fallen through the cracks of the broader service system. However, there is no consistent mechanism for collecting and reporting data on recovery housing at national, state, or local levels. Some programs are required to report into other data collection systems based on funding received through federal and state grants; others choose to collect data on their own. Among smaller programs, data collection may be seen as an administrative burden and intrusion of privacy, rather than an opportunity to advocate for expanded resources. Currently, the National Alliance for Recovery Residences (NARR) is beginning to explore national data standards for its members.

Existing models and preliminary standards can be built upon to expand recovery housing in Ohio.

The culture, components, and policies of recovery homes and programs varied significantly, with each cultivating its own atmosphere and identity over time. Screening and intake procedures vary depending on a program's size, structure, and funding sources. However, many recovery housing providers recognized the screening and intake period as an urgent window of opportunity to engage someone in recovery. Day-to-day expectations are often similar, including job searching or employment; attendance at 12-step or other support meetings; participation in house meetings; participation in treatment services (depending on the type of program); continued sobriety; and compliance with house rules and responsibilities.

Rules and Structure Within programs, rules and structure are important to residents, though this is often a difficult transition at first. These rules include requirements for work, attendance at meetings, curfews, visitors, and responsibilities in the home. The rules may become less intensive as individuals spend more time successfully in the home.

Relapse Policies All programs established relapse policies. Many recovery housing programs embrace an abstinence-based policy, while finding ways to support and re-engage someone who has relapsed. A small number of participating programs utilized a zero-tolerance policy. However, even in these cases, the programs attempted to find the right level of care for the resident rather than evicting them into homelessness, and the person was often welcome to return to the house following a period of sobriety. These policies typically recognized that for some people in recovery, relapse may occur. Many programs incorporated strategies to identify the potential for relapse and prevent it before it occurs. In addition to enforcing policies for the health and well-being of the resident who has relapsed, the policies also ensure that any potential triggers to other residents (i.e., drugs, alcohol, or the presence of someone who is using) are removed. In homes that are run partially or fully by peer residents, the rules are typically enforced by the group in a democratic decision-making process.

As the grant cycle closes in 2013, the majority of ATR-funded recovery housing programs are at risk of reductions or closing their doors altogether.

Types of Recovery Housing Recovery housing programs tended to fall into four broad categories or "levels" as defined by the National Alliance for Recovery Residences (NARR). These levels include: fully peer-run homes (Level I), monitored peer-run residences with a dedicated house manager (Level II), supervised residences with paid staff (Level III), and service provider residences with 24/7 staff (Level 4). NARR's standards, along with best

practices that have been adopted by recovery housing programs, represent a preliminary set of guidelines that can be used to expand and provide oversight to programs.

Lessons Learned from Access to Recovery The Access to Recovery (ATR) grant program also provides opportunities to examine lessons learned and best practices as Ohio seeks to expand recovery housing. Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), the ATR program was administered in five counties through Ohio's Department of Alcohol and Drug Addiction Services (ODADAS). ATR supported providers to develop or support existing recovery housing programs, and provided technical assistance and oversight. As the grant cycle closes in 2013, the majority of ATR-funded recovery housing programs are at risk of reductions or closing their doors altogether. This represents an opportunity for the State of Ohio to support sustainability and potential expansion of the ATR-funded recovery housing, as well as to identify model programs and best practices that can be used as a foundation for a statewide expansion effort.

Effective recovery housing requires a range of recovery supports that are often the most difficult to fund.

The mix of services and supports available to residents varies by program—dictated in part by the level of care intended by the program as well as available funding resources. Regardless of the number and type of resources available, programs strived to find ways to meet both the tangible and social support needs of residents. Below is a summary of services and supports identified across sites:

- ✔ Housing
- ✔ Basic case management
- ✔ Wraparound case management
- ✔ Mental health, addictions, and trauma counseling
- ✔ Individual and group therapy
- ✔ Relapse prevention
- ✔ Recovery coaching
- ✔ Peer support
- ✔ Spiritual support
- ✔ Vocational rehabilitation/employment skills training
- ✔ Job searching and coaching
- ✔ Health care
- ✔ Detox services
- ✔ Step-down recovery services
- ✔ Post-detox stabilization/interim housing
- ✔ Family reunification
- ✔ Children's and family counseling and services
- ✔ Education about the disease of addiction
- ✔ Refusal skills
- ✔ Grief support
- ✔ System navigation
- ✔ 12-step meetings
- ✔ Budgeting and savings
- ✔ Grocery shopping
- ✔ Nutrition and healthy cooking
- ✔ Recreation (e.g., parties, sports teams, dance classes, community activities)
- ✔ Volunteer opportunities
- ✔ Applications for income and healthcare benefits
- ✔ Child care (e.g., applying for vouchers)
- ✔ Apartment furnishings (e.g., furniture, dishes, decorations)
- ✔ Personal care items (e.g., personal hygiene, diapers, strollers, towels)
- ✔ Kids' summer camp program
- ✔ Transportation (e.g., rides, bus passes)

Medication Assisted Treatment and Prescriptions Not all recovery homes allow individuals who are using Medication Assisted Treatment (MAT—e.g., buprenorphine, methadone, naltrexone) or other prescriptions. Within homes that do, MAT may create some difficulty in managing and monitoring medications. Some programs instituted high-security lockers and cameras to prevent

theft. Others felt that as a controlled substance, MAT could serve as a trigger to other residents. Across all homes, MAT prescriptions—along with other prescriptions—were closely monitored and safely stored and locked. Recovery housing providers may need support in developing capacity and safety and security procedures to house residents who are using MAT. However, the support offered in some recovery homes also provides an important opportunity for residents to learn effective self-management of medications.

Employment Supports Finding employment is a consistent emphasis across recovery homes. It is not only viewed as an essential step in the personal recovery process, but it is also a business strategy so that residents can earn income and pay rent. Recovery housing providers have developed best practices to support employment among people newly in recovery, including the encouragement of low-demand, entry-level jobs early in the recovery process; coaching about how to frame recovery in terms of skills and personal growth; and the development of formal and informal networks with local employers.

Peer Support A key element to the early stages of engagement is peer support. Alumni networks that are available and accessible to residents have a positive impact and are often used to help engage someone during screening, intake, assessment, and the early days of recovery. This support continues throughout the recovery process, though the frequency and intensity of supports may diminish over time.

Unmet Needs While many programs successfully provide or create linkages to a range of recovery supports, residents also identified unmet needs. For example, people in recovery often need legal aid to address criminal records or debt-related issues. Additionally, several residents expressed a need for more wellness supports, including dental care and sober recreational opportunities.

Various mechanisms exist to support recovery housing. However, the availability of funds and ability to access them varies significantly.

Given the variation in recovery housing models, the needs for funding also vary. Typically, larger programs have a number of different funding sources to support both housing and services. They may have the ability to acquire vouchers or subsidies from the US Department of Housing and Urban Development (HUD) and secure funding for services through grants; yet they may still struggle to sustain these resources. Smaller, independent recovery housing providers (i.e., Levels I and II) may not have the infrastructure, capacity, or the need to apply for any type of public funding. Level I and II homes do not provide formal services beyond housing and peer support; however, they may benefit from funds to support the development and operation of the home, or to support residents who may have a gap in employment or income. Across the board, the difficulties in securing funding to pay for housing and recovery supports are common.

Despite the challenges identified by most recovery housing providers, the environmental scan identified potential funding resources that may be able to support housing development and operation, services, and recovery supports. In order to expand recovery housing in Ohio and create sustainable programs, recovery housing providers will require support in developing awareness of funding resources, creating collaborative relationships with county boards and local systems of care, accessing technical assistance, and building capacity. Stakeholders in community planning will need to work together to create coordinated plans for supporting recovery housing. Additionally, expansion of resources is most urgently needed to fund recovery supports across all levels of programming.

Below is a brief summary of the types of resources currently or potentially available to support recovery housing:

Housing

Capital to Develop, Acquire, or Rehab Housing

- Community Development Block Grant (CDBG)
- Ohio Department of Mental Health's Community Capital for Housing Program
- HOME Program
- Housing Opportunities for People with AIDS (HOPWA)
- Ohio Housing Trust Fund
- National Housing Trust Fund
- Federal Low Income Housing Tax Credits
- Section 202 Supportive Housing for the Elderly
- Section 811 Supportive Housing for Persons with Disabilities
- Section 515 Rural Rental Housing
- Supportive Housing Program
- Tax Exempt Bond Financing
- Community Foundations
- Land Trusts

Rental Assistance

- HOME Program
- Housing Opportunities for People with AIDS (HOPWA)
- Section 8 Housing Choice Voucher Program
- Continuum of Care (CoC) Homeless Assistance Grants
- Veteran's Affairs Supportive Housing

Resident Self-Pay

Services

- Federal Grants (e.g., SAMHSA, ACYF, Department of Labor, Department of Justice, CMS, HRSA)
- State Grants (e.g., ODADAS, ODMH)
- County Alcohol Drug and Mental Health (ADMH) Board Levy Funds
- Medicaid
- Foundations
- Donations
- Resident Self-Pay

Recovery Supports

- SAMHSA's Access to Recovery (ATR)
- County Alcohol Drug and Mental Health (ADMH) Board Levy Funds
- Foundations
- Donations
- Resident Self-Pay

Resident Self-Pay Resident self-payments are also a common form of revenue for programs, across the spectrum of recovery homes. Among communal, peer-run recovery homes, all residents are expected to share an equal amount of the household expenses. Thus, these recovery houses are effectively self-funded. Recovery housing programs that are situated in larger service programs also charge rent, typically 30% of a person's income, or a flat fee ranging from $75-$125 weekly. Smaller programs may be fully reliant on this income while larger programs may have the flexibility to subsidize the rent at times. Additionally, recovery housing has historically been based on a model of self-pay; this is typically viewed as an important cultural value in recovery—being able to pay your own way whenever possible.

Medicaid Payments Among larger service agencies that offer recovery housing, Medicaid may be viewed as an important revenue resource. Although the reimbursement rates are low, this resource can be used to support addiction treatment services, which frees other unrestricted funds that a program may be using to provide basic treatment, supports, or housing for residents. As noted

earlier, the possibility of Medicaid Expansion in Ohio represents a potential source of increased revenue and sustainability for some recovery housing providers. However, smaller programs will require assistance in developing capacity and collaborations to access this resource. In addition to the barriers for smaller recovery homes in billing Medicaid, it is a limited resource overall. While the expansion would help thousands of Ohioans living in poverty, the number of people who would be newly eligible is not sufficient to serve as a complete solution for recovery housing providers. Not all recovery homes primarily or even partially serve individuals who are living at or below 138% of the poverty level, which will be the new eligibility threshold. Additional funding solutions are needed to expand recovery housing for childless adults as well as parents and families who are struggling with addiction.

Recovery housing providers require support in connecting and collaborating with established systems of care rather than creating a parallel system.

Recovery housing providers find themselves at the intersection of several parallel systems, each with their own taxonomy for language, services, and funding. In addition to the variations in publicly funded systems and resources, there are several other divisions that create challenges to a more cohesive statewide or national recovery housing effort. These divisions create barriers for collaborating with funders; local coalitions; county alcohol, drug, and mental health (ADMH) boards; HUD Continuums of Care (CoC); government agencies; and other stakeholders.

Addictions Treatment Systems Within the addictions treatment field, there is often a divide between recovery housing and recovery support providers who are independent of the broader treatment continuum, and treatment providers who offer traditional clinical treatment interventions. Non-traditional recovery support and recovery housing providers may be described as adhering to a "social model," with a focus on peers, 12-step meetings, and group living as pathways to recovery. According to one stakeholder, this group of recovery housing providers is often perceived as being divorced from the mental health and addiction treatment continuums, creating challenges when seeking collaboration, community support, and funding.

Private and Public Markets Within the broad spectrum of recovery housing providers, programs include those seeking private market, self-pay clients as well as those seeking to serve poor, low-income, or homeless individuals who may not be able to pay some or all of the program costs. While some services and supports are consistent across various models, recovery housing providers in the private and public markets will face vastly different sets of challenges to developing, marketing, and sustaining their programs.

Housing Systems Despite being a model that provides housing, recovery housing providers are not always part of the HUD Continuum of Care (CoC). Yet, many residents have histories of homelessness, or were homeless or at imminent risk of homelessness upon entry into the program. This division may be due to a program's primary orientation (e.g., a housing provider or a treatment provider); definitions and eligibility criteria associated with affordable housing funding streams (e.g., definitions of homelessness, priorities set by local CoCs, definitions of disability); and limited resources and opportunities for collaboration. Additionally, recovery housing providers may experience mistrust and misperceptions about their programs among local housing and homeless service networks. Some housing advocates expressed concern related to a perception that recovery housing residents may not have a choice about the type of model that works best for them.

Additionally, models such as Housing First and Permanent Supportive Housing have been

widely adopted. Despite the prominence of these models in Ohio and nationally, most key informants recognized the value of recovery housing, noting that some people need a clean and sober environment or may benefit from the presence of a peer group as they engage in recovery. Stakeholders emphasized the importance of framing the various models along a flexible continuum of choice, rather than one that requires a linear step-down or "housing readiness" framework.

Definitions and Policies Government funding regulations across systems may not align with the services, populations, and needs of recovery housing programs. For example, funding requirements may specify definitions of homelessness or disability that exclude a portion of the population seeking publicly funded services. Or, policy mandates tied to addiction treatment grants such as zero-tolerance relapse policies create barriers to recovery housing programs that promote a more responsive, supportive approach to relapse. These barriers may require further exploration and policy changes in order to expand effective recovery housing.

Within local service networks, some recovery housing providers experience perceived and actual barriers to collaboration.

Currently, many recovery housing providers feel left out of local community priorities and networks, which often dictate resource allocation. Yet, they provide a service that is consistently described as capable of meeting the needs of hard-to-serve individuals.

Many smaller recovery housing providers—describing themselves as grassroots or community-based organizations (CBOs)—viewed themselves as poorly resourced and excluded from local funding, networking, and decision-making opportunities. These providers felt that they did not receive their fair share of funding resources, which was often none at all if they operated independently of local service provider networks. Many compared themselves to traditional treatment service providers, who were viewed as large service agencies with more resources to provide services as well as the infrastructure and skilled staff to successfully pursue new funding opportunities. Treatment providers who fit this perception of "traditional" were quick to point out the struggles they face regularly in terms of funding and billing, even though they may have a more robust infrastructure.

Individuals receiving services may not be well-informed about the range of recovery housing and supports available, which impacts referrals and treatment decisions.

These larger agencies were also viewed by CBOs as preferred providers of services who regularly receive client referrals. Some recovery housing providers experienced difficulty securing referrals from local agencies and networks, while others consistently had waitlists. Among programs who struggled to secure referrals, the problem was framed more broadly around the divide between large and small programs. Referrals were particularly problematic in counties that received state or federal funding, such as SAMHSA's Access to Recovery (ATR) funds. In these cases, the competition for grant resources was difficult, and often negatively impacted the ability of smaller programs to maintain desired occupancy levels. Smaller recovery housing providers not receiving these funds may not be "on the radar" of referring agencies, or the range and quality of the services and supports being provided is unknown. Additionally, individuals receiving services may not be well-informed about the range of recovery housing and supports available, which impacts referrals and treatment decisions. Notably,

some providers of recovery housing and treatment, as well as homelessness and housing services, were surprised to hear the difficulties with referrals, given the shortage of housing resources across communities.

Some smaller programs prefer to remain independent and did not express a desire to be connected to local networks or CoCs. These programs may choose not to seek public funding so that there are no specific programmatic or regulatory requirements that would change the nature of their program. Additionally, many recovery housing providers view their work as an extension of their own recovery journeys; as a result, some may not want to be told how to provide recovery supports by outsiders.

County and local community contexts influence the development and expansion of recovery housing.

Communities can greatly influence the success of recovery housing residents and programs. Factors that impact recovery housing include: the neighborhood location; stigma and community attitudes; the county alcohol, drug, and mental health (ADMH) board structure; and other networks or Continuums of Care (CoC). Smaller, self-governed programs, particularly peer-run and monitored homes, are the most vulnerable to community dynamics. Support from the communities in which they reside is a crucial element for long-term stability.

Community Outreach and Education Several key informants identified the need to conduct education and outreach to various entities, including neighborhood associations, city or town councils, county boards, and other stakeholders. Legislative support for recovery housing is essential. Gaining this type of support requires marketing, advocacy, and passion on the part of recovery housing providers. If stakeholders are informed about the importance of recovery housing, then it will become a higher priority and resources will be allocated more consistently.

Neighborhood Relationships Once a recovery home is established, program managers set clear rules and guidelines around "good neighbor" policies, to ensure that no issues arise. This includes efforts to keep the houses and grounds well maintained, restrictions on interactions with local neighbors, and opportunities to volunteer and provide community service. These strategies help to combat stigma against addiction as well as any lingering concerns about the location of programs. In fact, well-kept recovery homes can help to turn skeptics into champions for recovery.

County-level Board Interaction Across the state, the role of county-level Alcohol, Drug and Mental Health (ADMH) boards is to provide a structure for planning and administering funds for the provision of mental health and addiction services. This includes treatment, prevention and recovery support services that create opportunities for people with substance use disorders and mental illness. As funding resources are made available through federal, state and local tax levy dollars, the counties contract with a network of providers (mental health and addictions) and then provide oversight and technical assistance. However, addictions services, especially recovery housing, are often underrepresented among state funding through county boards.

County boards are often not fully involved in housing planning in their community, if at all. However, some boards collaborate successfully with their local HUD Continuum of Care (CoC). This collaboration is important, since not all ADMH boards create housing plans. Particularly in the context of recovery housing, it is essential that boards seek to understand the housing needs in their communities and identify how best to address these needs with currently available housing funding.

Boards vary significantly in their ability to work collaboratively and effectively with local service agencies. Several participants noted the importance of engaging and developing rapport with boards

in order to support their programs. County board representatives recommended that recovery housing providers explore the certifications they would need to become eligible for government funding when available, and that they contact other community agencies—including those making referrals—to market their services. In order to create statewide opportunities to explore, standardize, and expand recovery housing, county boards may need to shift how they are engaging and supporting recovery housing providers of all kinds. Additionally, recovery housing providers need support to understand how best to work with counties, CoC, and other stakeholder entities.

Next Steps

Housing and supportive services play a critical role in the recovery process. A growing body of evidence points to the role housing plays as an essential platform for development. As noted by the US Interagency Council on Homelessness, "Stable housing is the foundation upon which people build their lives—absent a safe, decent, affordable place to live, it is next to impossible to achieve good health, positive education outcomes, or reach one's economic potential" (USICH, 2010). Recovery residences provide a safe, stable, community-based alternative for facilitating recovery at all stages of the recovery process. Research has documented positive recovery outcomes, along with significant cost savings.

This environmental scan report represents an initial step in understanding the current state and need for recovery housing in Ohio. Findings will inform funding and policy decisions, as well as provide insights into technical assistance needs. A full summary of recommendations is included in *Section 10*. In addition, next steps include the development of a statewide NARR affiliate association and identification, development, and delivery of technical assistance resources, along with a statewide dissemination and implementation effort.

Objectives and Methodology

Objectives

The purpose of the Environmental Scan is to document the current status, needs, opportunities, and challenges to expanding various recovery housing approaches throughout Ohio. Findings will inform policy changes, best practices, and training and technical assistance resources, with the goal of increasing recovery housing capacity in the State.

Specifically, the environmental scan seeks to:

- ✔ Describe the current state of recovery housing across communities in Ohio;
- ✔ Identify effective models and key elements of recovery housing;
- ✔ Identify the technical expertise, cultural competence, community capacity, infrastructure, and
- ✔ financial capital necessary to develop and operate recovery housing;
- ✔ Document the legal and regulatory considerations for creating policies that align with the goals of recovery housing; and
- ✔ Recommend next steps and identify potential barriers to meeting the need for recovery housing in the State of Ohio.

Methodology

The environmental scan is comprised of several components, including a literature review, a review of housing regulations, key informant interviews (telephone and in-person), site visits, and focus groups. Methods for each component are described below.

Literature Review

In order to better understand the published work on recovery housing and similar housing models, the team began with a literature review in which academic reference databases, peer-reviewed journals and the Internet were searched for relevant articles. This review was conducted first by identifying key search terms, which were devised by the research team and reviewed internally with the Ohio Council of Behavioral Health and Family Services Providers. Reference databases were searched using the defined search terms and Boolean search methods. In addition, key articles were pulled from relevant journals in order to ensure the comprehensiveness of the reference databases.

The *Journal of Groups in Addiction and Recovery* and *Addiction* were searched for recovery housing and findings included one special issue on Oxford Houses. Relevant articles were selected from search results, downloaded, and alongside them citations were formatted and saved. As articles were reviewed, emergent themes were tracked using an excel spreadsheet. These themes were then used to develop content outlines and the full literature review, which was reviewed internally and with the Ohio Council.

Regulations Review

Housing experts at the Center for Social Innovation were counseled prior to defining the scope of the Housing Regulations Review. Several key organizations and leaders in Ohio were identified along with HUD resources and specific regulations of importance. From here, an outline of the review was developed. Development of the regulations review occurred concurrently with the literature review and followed the same iterative process.

Site Visits, Focus Groups, and Interviews

Concurrent with background research, the team began developing an outreach plan. This consisted of creating a prospectus document, identifying organizations for site visits, interview contacts (state and national experts), and protocols and procedures for research activities. The prospectus document described details of the project and was used for email outreach.

In order to access a diverse set of information that captured differences associated with geographic, cultural, and political nuances in Ohio, we collected data from five geographic regions: Northeast, Southeast, Central, Southwest, and Southeast. Within this grouping, we planned to reach rural, Appalachian counties, urban areas, and various recovery housing and recovery support providers ranging from large organizations to small-scale, faith-based, and peer-run organizations.

A spreadsheet was created with contacts in rows and variables of interest in columns. Key contacts were identified as national and state stakeholders. Roles and areas of expertise for national key informants include: academic research, policy maker, national stakeholder group, regional funding, and recovery housing provider in another state. Roles and areas of expertise for local key informants include: administrators, peers, residents, housing developers, advocates and other stakeholders, and policy makers at the State, county, or city level. Organizations were also identified as potential site visit candidates.

Protocols for interviews were developed using previous recovery and housing related project instruments. The protocols began as one comprehensive document with an interview script, glossary, and series of questions with prompts by main topics. This document was reviewed by the team, tested with a recovery housing program, revised, and then split into three separate interview protocols: one for administrators, one for policy makers, and one for residents. Protocols for administrators and policy makers included sections on policy; best practices; recovery housing models; resident needs; community capacity; technical expertise; financial capital; and, legal and regulatory considerations. Resident protocols included information on finding recovery housing, daily activities, services, challenges, and areas of need or recommendations for program improvement.

Site Visits

For site visits, we determined that interviews and meetings with stakeholders representing various viewpoints were critical. This included administrators and staff, residents, and regional and community stakeholders. A tour of facilities was also scheduled at each site.

We developed an outreach plan which guided the use of our key informant spreadsheet to identify contacts, reach out to them, and request one or two day visits that included interviews with administrators, staff, and informal discussions with residents in addition to focus groups with key regional stakeholders and facility tours. Over a period of three weeks, outreach was conducted over email and phone. Outreach emails were sent with the prospectus document and followed up by telephone calls. All regions except one were reached and scheduled within two weeks. In the Northwest region, one selected site was planning to close within a couple of months, and one site declined participation because they did not want any government involvement in their program. After reaching out to several additional key stakeholders, two sites agreed to participate in visits in the northwest region; as a result, two site visits were conducted rather than having a focus group. The participating organizations included The Phoenix House (Canton, OH), Amethyst, Inc. (Columbus, OH), The Counseling Center (Portsmouth, OH), Serenity Recovery (Cincinnati, OH), The Phoenix House (Lima, OH), and Grace TLC (Lima, OH).

Focus Groups

After site visit dates were scheduled, lead contacts at each organization participated in planning meetings with the site visit team to coordinate an agenda, and focus group invitation lists were finalized. Area stakeholders were then contacted by email and follow-up telephone calls. All site visit logistics were tracked in a site visit spreadsheet. The five regions were visited between April 22 and April 25, 2013. Four team members split up into groups of two and traveled to each focus group. A final plan for each focus group was developed as a master list for site visit facilitators.

During site visits and focus groups, one team member led the meetings using administrator, policy maker, and resident protocols, and one team member took notes either by hand or on a laptop computer. After the site visits, team members documented their key themes and then reviewed and cleaned notes, which were then used to code emergent themes used for qualitative analysis.

Key Informant Interviews

Key informant interview contacts were prioritized from the original contact spreadsheet. Aiming to cover a range of Federal, State, and Local policy makers, decision makers, and recovery housing and recovery support providers, 24 interview subjects were selected and then divided among six team members charged with scheduling and conducting interviews. Interview outreach scripts were developed and the prospectus document was used to provide additional detail over email. All interview subjects were asked for their permission to record interviews (when applicable) and for their consent to participate in this research. Using protocols, team members scheduled and conducted interviews between April and early May. All recordings were downloaded and saved in project management software and then sent to a transcriptionist.

Data Analysis

Most telephone interviews were recorded; notes from all were recorded and/or transcribed. Notes were taken at site visit interviews and focus groups, written and entered into NVivo. After all data was collected, the team members held a coding meeting, determining the salient themes to be used as the basis for the report. These themes were grouped and organized into report sections while also being incorporated into NVivo. With all qualitative data entered into NVivo, nodes were created for each code and all data points were reviewed and coded into the various nodes. Supporting evidence was then documented for each theme. Writing was cross checked between team members, and drafts of the report were sent to internal and external experts for review. A summary of the site visit and focus group sample and a list of key informants is included on page 23.

Sample

Site (N=6)	Staff (n=34)	Stakeholders (n=34)	Residents (n=45)	Totals (n=113)
Counseling Center	**(n=8)**	**(n=9)**	**(n=5)**	**(n=22)**
The Phoenix House (Canton)	**(n=4)**	**(n=12)**	**(n=7)**	**(n=23)**
Serenity Recovery House	**(n=2)**	**(n=8)**	**(n=8)**	**(n=18)**
Amethyst, Inc.	**(n=15)**	**(n=5)**	**(n=10)**	**(n=30)**
Phoenix House (Lima)	**(n=2)**	**n/a**	**(n=12)**	**(n=14)**
Grace TLC	**(n=3)**	**n/a**	**(n=3)**	**(n=6)**

Key Informants (N=24)

- Dave Sheridan, NARR and CA Sober Living Network
- Fred Way, Philadelphia Association of Recovery Residences
- Ted McAllister, Georgia Association of Recovery Residences
- Marsha Baker, SAMHSA/CSAT
- John Majer, Oxford Housing Research Team, DePaul University
- Doug Polcin, Alcohol Research Group
- Kathryn Icenhower, Shields for Families
- Sam Tsemberis, Pathways to Housing
- Rob Morrison, NASADAD
- Tom Hill, Faces and Voices of Recovery
- Peter Gaumond, Office of National Drug Control Policy
- Roma Barickman, Ohio Department of Mental Health *IN PERSON
- Doug Bailey, Ohio Department of Mental Health *IN PERSON
- Alisia Clark, Ohio Department of Alcohol and Drug Addiction Services *IN PERSON
- Adreana Tartt, ODADAS * IN PERSON
- Sally Luken, Corporation for Supportive Housing Ohio
- Kara Peterson, Ohio Department of Rehabilitation and Corrections
- Douglas Argue, Coalition for Housing and Homelessness in Ohio *IN PERSON
- Jacqui Buschor, Ohio Development Services Agency *IN PERSON
- Donna Conley, Ohio Citizen Advocates
- Damon Allen, Federal Home Loan Bank of Cincinnati
- Joe Pimmel, Ohio Capital Corporation for Housing
- Dan Faraglia, Coleman Professional Services
- James Cunningham, US Department of Housing and Urban Development (Cincinatti Field Office)
- Peggy Bailey, Corporation for Supportive Housing

Why Recovery Housing? Why Now?

The history and trends of substance use disorder treatment in the United States have been well documented (White, 1998; White, Kelly, & Roth, 2012). Historically, mutual aid groups like the Wellbriety Movement, Women for Sobriety, and Alcoholics Anonymous, have long been a part of the treatment services spectrum (Coyhis & White, 2006; White et al., 2012). However, their penetration into addiction treatment has been varied. Substance use treatment has been dominated by: a philosophy that favors the individual as the primary unit of intervention; a model that follows the example of acute care hospitals with brief treatment, discharge, and termination of the service relationship; and clinical and medical methods of treatment (White et al., 2012). Emphasizing the individual over the family, kinship network, or the larger natural environment in which recovery is sustained can be a challenge for many individuals in recovery. These factors can greatly impact likelihood of relapse (Granfield & Cloud, 2001).

Efforts to merge traditional treatment with mutual aid and support began with the inception of halfway houses in the 1950s (Rubington, 1967). Other models, including the Minnesota Model programs (Spicer, 1993) and the social model of recovery pioneered in California (Borkman, Kaskutas, Room, Bryan, & Barrows, 1998; Shaw & Borkman, 1990/1991) have followed the example of halfway houses. Yet, professionally directed addiction treatment and recovery mutual aid groups have remained distinct institutions that individuals must navigate on their own (White et al., 2012).

An Expanded View of Recovery

The acute care model has been described by some as disconnected from the processes of long-term recovery (Dodd, 1997), which has led to reduced access, retention, use of evidence-based practices, linkages to communities of recovery, and, conversely, increases in re-addiction and readmission (Kelly & White, 2011; White, 2008; Laudet & White, 2010; McLellan, McKay, Forman, Cacciola, & Kemp, 2005). This has also resulted in nonprofessional recovery resources being viewed as ancillary rather than complimentary to recovery (White et al., 2012).

As a result, the field of addictions services is undergoing a shift from the traditional short-term, acute care model focused on abstinence and reducing recidivism, towards a continuum of care model focused on sustained recovery management over an extended period of time (Fisher, 2012; McLellan et al., 2005; Vanderplasschen, et al., 2013). White, Kelly, and Roth (2012) have cited a number of new trends in the expansion of recovery-oriented substance use treatment. These include increased

interests in defining recovery (Betty Ford Institute Consensus Panel, 2007; Center for Substance Abuse Treatment, 2007), evaluating the effects of mutual-aid groups on long-term recovery outcomes (Humphreys et al., 2004; Kelly & Yeterian, 2008) and expanding access to new forms of peer-based recovery support services (White, 2009). The Institute of Medicine, along with leading researchers, has called for a shift away from an acute care model in the treatment of substance use disorders towards a chronic care model (Institute of Medicine, 2006; McLellan et al., 2005; Laudet & White, 2010).

The shift towards a long-term view of recovery has created a gap that is now being filled by recovery support institutions. White et al. (2012) described these institutions as five distinct categories:

1. **Recovery Community Centers** Settings that host support meetings and provide recovery coaching
2. **Recovery Schools** Recovery support provided within the academic environment, such as programs provided at Brown University, Rutgers University, Texas Tech University, and Augsburg College programs
3. **Recovery Industries** Recovery-friendly employers or businesses established by people in recovery to foster employment skill development
4. **Recovery Ministries** Churches, mosques, synagogues, and temples that provide addiction-recovery support services
5. **Recovery Homes** These recovery support institutions are distinct in that they are neither addiction treatment nor mutual-aid groups (such as AA). They seek to focus beyond the individual to create a space where "personal and family recovery can flourish" (White et al., 2012, p. 307)

The impetus behind this momentum is twofold: *First*, the traditional system has provided an opportunity to learn what approaches are most effective. *Second*, health reform in the U.S. has begun to favor more integrated, holistic approaches, thus expanding support for care models that emphasize recovery supports. Newer recovery models have found more effective ways to provide services ensuring continuous quality improvement, and there is increasing awareness of the similarities between substance use disorders and other chronic illnesses (e.g. hypertension, diabetes, and asthma). For example, the medical field has accepted the fact that chronic illnesses do not have a cure; treatment is not time-limited and does not stipulate a fixed amount or intensity of medications and/or services (McLellan et al., 2005).

With a shift in focus to long-term, person-centered care delivery, the influence of stable, supportive housing is a critical factor. There is a need for an expanded concept of housing that supports people to progressively develop their own plans for lifelong recovery. This type of housing must support the person in recovery to define the steps they need to build a life in the community and a life of purpose. Recovery housing helps to fill this need and is in the early stages of being standardized and defined in Ohio and nationally.

National Alliance for Recovery Residences

In recognition of the growing importance of recovery housing and the lack of definitions and standards to support it, the National Alliance for Recovery Residences (NARR)[4] has initiated an effort to define and standardize the provision of recovery residences across the country. Current activities are focused on supporting grassroots affiliate organizations within states. NARR's goal is to identify a lead affiliate for each state, which will serve as the oversight and support for other affiliate organizations. While these efforts are in the early stages, initial publications of a white paper and

4 Formerly the National Association of Recovery Residences

operating standards represent critical steps in codifying recovery residences, ensuring quality oversight, and supporting programs to expand their resources.

Additionally, NARR recently developed a joint policy statement with the Society of Community Research and Action—Community Psychology, Division 27 of the American Psychological Association (Jason, Mericle, Polcin, & White, in press). The policy statement includes recommendations that span funding, research, training, and public awareness, all of which will continue to foster a national, comprehensive, evidence-based effort to standardize and expand recovery housing.

State Initiatives

Like Ohio, many other states are exploring and finding ways to support recovery housing. Most recently, Hawaii commissioned a task force to provide recommendations for sober housing. The report confirmed the need for clean and sober homes as one of many recovery supports needed to support long-term recovery (Altarum Institute, 2012). The report also recommends a voluntary registry of sober homes along with a more in-depth look at standardizing the model.

Massachusetts mandated a study that explored negative perceptions, concerns, and complaints about alcohol and drug-free (ADF) housing. The report found that the state Bureau of Substance Abuse Services (BSAS) may have some discretion in providing oversight of programs that provide treatment services; however, the opportunities to provide broad oversight and regulation of ADF housing is limited due to fair housing concerns (Massachusetts Department of Public Health, 2010). The report also suggested that local governments should be supported in providing minimum oversight and responding to health and safety concerns. Additionally, providers and residents of ADF housing would benefit from training opportunities to improve quality and ensure residents are informed about their rights.

In 2013, the state of Maryland released a request for proposals (RFP) seeking to contract with an agency to establish a Maryland State Recovery Housing Association. The membership Association will be comprised of recovery houses that have met the standards set out by NARR. In addition to forming this agency, the contract also includes the development of a website and resource clearinghouse for best practices (Maryland Department of Health and Mental Hygiene, 2013). These efforts follow those of others like California, Georgia, Texas, Pennsylvania (Philadelphia), and others that have been early leaders in recognizing the value of recovery housing and establishing affiliate organizations through NARR.

Ohio Snapshot: Needs and Opportunities

Needs

The 2010 – 2011 National Survey on Drug Use found that on average, 2.78% of individuals over the age of twelve in Ohio reported illicit drug dependence or abuse in the past year. In the same survey an estimated 7.6% of Ohioans over the age of twelve noted alcohol dependence or abuse in the past year. These numbers amount to an estimated 926,000 individuals in need of substance abuse treatment for alcohol and/or drug dependence (Han, Clinton-Sherrod, Gfroerer, et al., 2011).

In Ohio, the nature of drug abuse has recently shifted. Ten years ago, opioid use in Ohio involved primarily heroin and occurred mostly in urban counties. In recent years, there has been increased use of non-medical prescription opioids, largely in rural communities (OARP, 2012). Women and young adults are noticeably more addicted to opioids. Medical Centers, including Cincinnati's Children's Hospital and Grant Medical Center in Columbus, Ohio, report increases in pregnant women addicted to prescription pain medication and, likewise, increases in the number of infants born drug-affected. These are costly trends, as opioid-affected newborns require extensive stays in hospitals and special medical attention (OWN, 2012).

> Adults with substance use disorders and mental illnesses are twice as likely to have incomes less than 150% of poverty level, compared to adults without either disorder (SAMHSA, 2010).

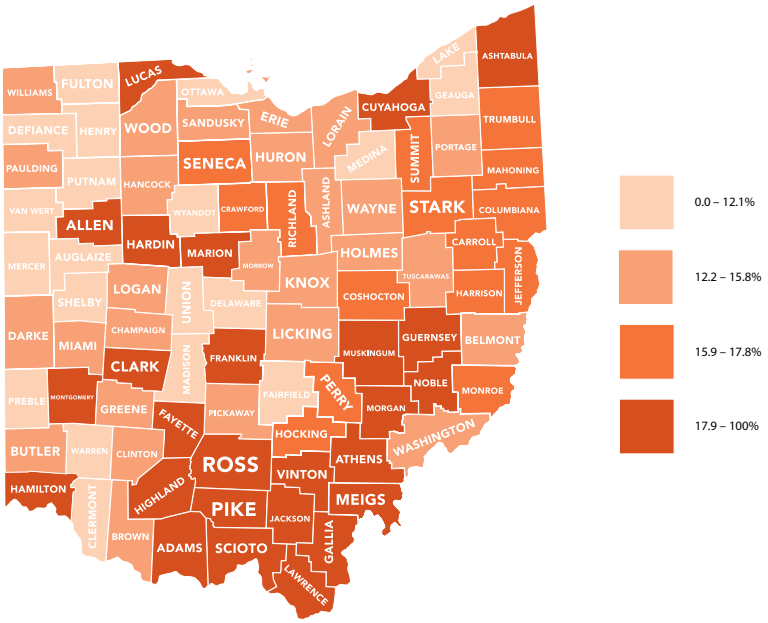
In addition to the high rates of addiction in Ohio, several other socioeconomic factors can impact access to treatment, recovery and stability. The following summary identifies these issues and provides Ohio and national data to describe the current situation.

Poverty

In 2011, there were an estimated 1.7 million Ohioans living in poverty (US Census Bureau, 2013). The highest county poverty rates can be found in the southeastern, Appalachian area of Ohio, while the counties with the largest numbers of people in poverty are located in some of the State's largest urban areas.

Although substance use disorders affect people in all economic circumstances, the difficulties faced by people living in poverty may be even more formidable since access to treatment services and supports is lacking. Based on combined national data from 2006 and 2008, there were 3.7 million persons aged 12 or older living in poverty and in need of substance use treatment in the US. Of these, only 17.9 percent received treatment at a specialty facility during this time period (SAMHSA, 2010). Conversely, adults with substance use disorders and mental illnesses are twice as likely to have incomes less than 150% of poverty level, compared to adults without either disorder (SAMHSA, 2010). Males living in poverty were nearly twice as likely as their female counterparts to have been in need of substance use treatment in the past year (17.1% vs. 8.9%) (SAMHSA, 2010).

Percent of total population in poverty 2011: Ohio (U.S. Census, 2011)



Homelessness

Included in the population living in poverty are Ohioans who have experienced episodes of homelessness and/or protracted periods without housing. In 2011, 13,977 people experienced homelessness in Ohio; of those, 2,880 identified as having a chronic substance abuse problem (HUD, 2012).

Nationally, approximately 38% of people experiencing homelessness struggle with alcohol abuse or dependence, and 26% of people experiencing homelessness abuse drugs other than alcohol (SAMHSA, 2003). Forty-three percent of cities report substance use as one of the top three factors associated with homelessness (United States Conference of Mayors, 2011). Studies have also demonstrated that stable housing is crucial to substance use treatment among people experiencing homelessness (Kraybill & Zerger, 2003).

Lack of Affordable Housing

The National Low Income Housing Coalition (NLIHC) provides a guide for affordability based on income. NLIHC's report "Out of Reach 2013" reports that the Fair Market Rent for a two-bedroom apartment in Ohio was $717. Fair Market Rent (FMR) differs from county to county; a two-bedroom apartment ranges from a low of $615 in rural counties to $787 per month in more urban counties (HUD, 2013). FMR is determined by the Department of Housing and Urban Development and represents an estimate of the average cost of rental housing in a given area based on market conditions.

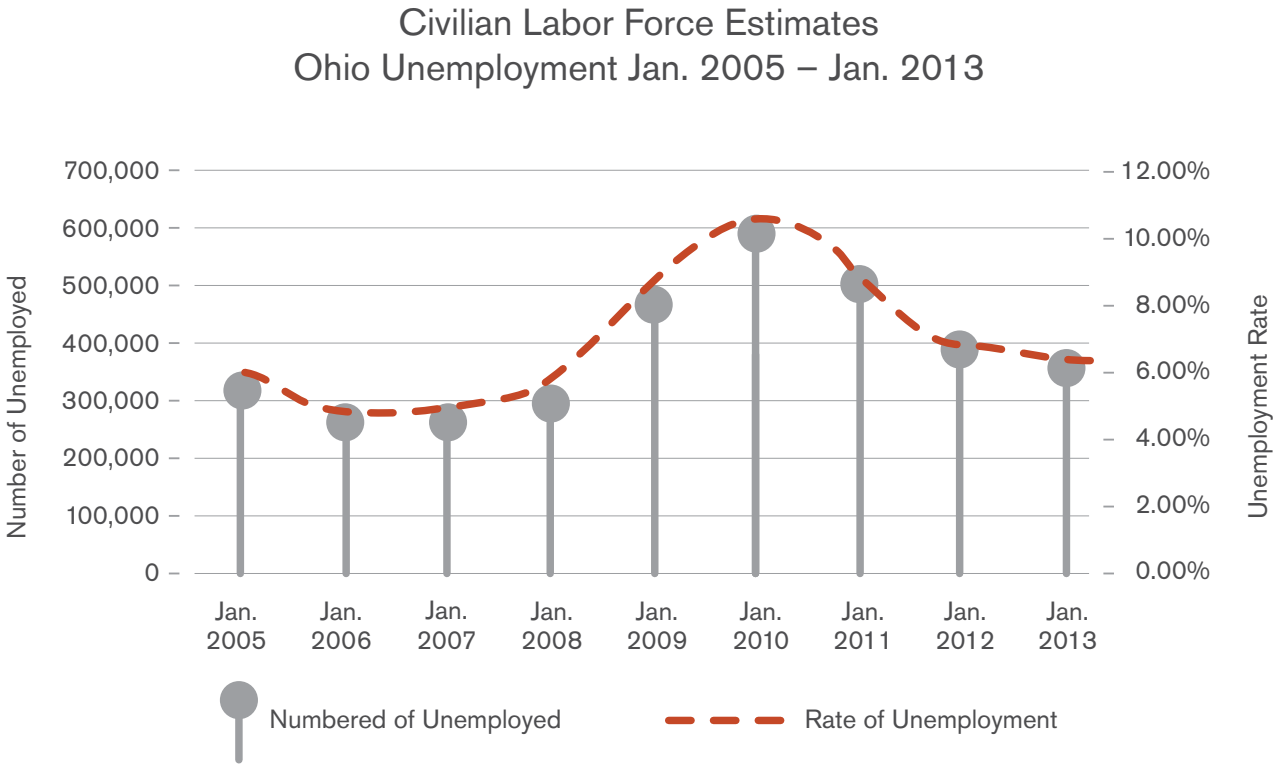
The table below shows the monthly affordable rent for selected income levels. People with the greatest need for housing are likely to have limited income or have limited earning potential.

Monthly Rent Affordable to Selected Income Levels Compared with Two-bedroom FMRs (NLIHC, 2012)

Unemployment

Although the rate of unemployment in Ohio has seen a steady annual decline the last three years, it remains around seven percent. In addition to the difficulties created by the current unemployment rate, people in recovery may find access to employment challenging, due to criminal history, poor employment history, and limited job training or skills.

Number of Unemployed-Ohio (Ohio DJFS, 2013)



Criminal Justice Involvement

It is estimated that 68% of people who are incarcerated nationally meet the criteria for substance abuse or dependence, compared to nine percent of the general population (Solomon et al., 2008). In the State of Ohio, according to the Great Lakes Addiction Technology Transfer Center (2012),

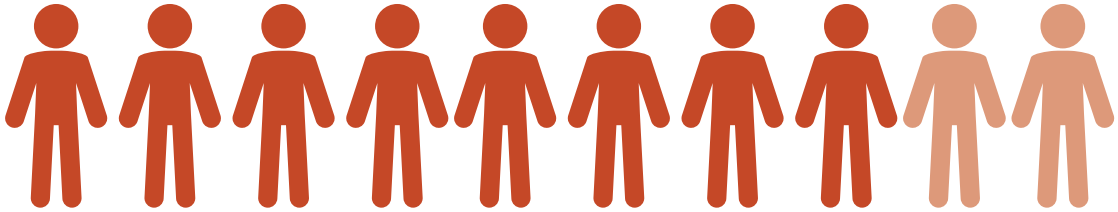
> *"A profile of almost 3,300 inmates entering the Ohio prison system in 2004 found that 86.6% of males and 85.7% of females had a history of drug abuse. Furthermore, 63.2% of males and 52.3% of females had a history of alcohol abuse."*

The Ohio Department of Alcohol and Addiction Services (ODADAS) in 2011 reported that 70 to 80 percent of all Ohio Department of Rehabilitation and Correction offenders had a history of substance abuse (ODADAS, 2012). The rate of substance abuse or dependence among adult offenders on probation or parole supervision is more than four times that of the general population (ODADAS, 2012). Despite these statistics, only about ten percent of prisoners with substance use issues receive treatment while incarcerated (Burke, 2008).

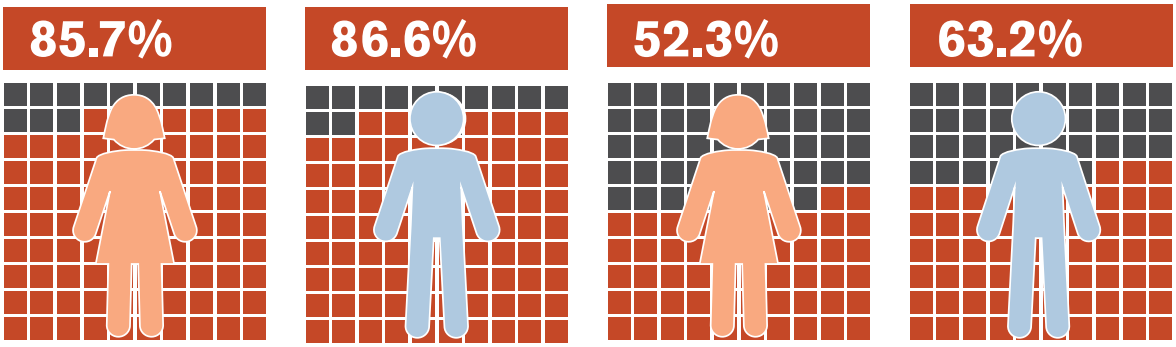
Number of People in Ohio Prisons with History of Substance Abuse

(Great Lakes Addiction Technology Transfer Center, 2012)

8 in 10 People in Ohio Prisons Have a History of Substance Abuse



Profile of 3,330 Inmates Entering the Ohio Prison System in 2004



Co-occurring Disorders

Among individuals with substance use disorders, co-occurring mental health conditions occur with frequency. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), over 8.9 million individuals nationally have co-occurring mental health and substance use disorders, with only 7.4% of people receiving treatment for both conditions. The 2010-2011 National Survey on Drug Use also found that on average 6.4% of Ohioans reported having a serious mental illness.

Opportunities

Despite the current social and economic challenges in Ohio, several factors contribute to the timeliness of exploring and expanding recovery housing. These factors have helped to focus increased attention on the problem of addiction and the need to consider non-traditional models of care that may meet the needs of individuals and families in recovery:

Increase in Opiate Abuse. Ohio is facing an increase in the numbers of people finding access to and abusing prescription drugs. This crisis has effectively changed the face of addiction in some communities. Previously, people seeking addiction services were in their 30s and 40s, and typically had accessed treatment multiple times. Now, the population is younger (18-25 years) and engaging in treatment for the first time. Some programs are serving young adults

that are still primarily living at home with their parents; they require different types of supports than other adults.

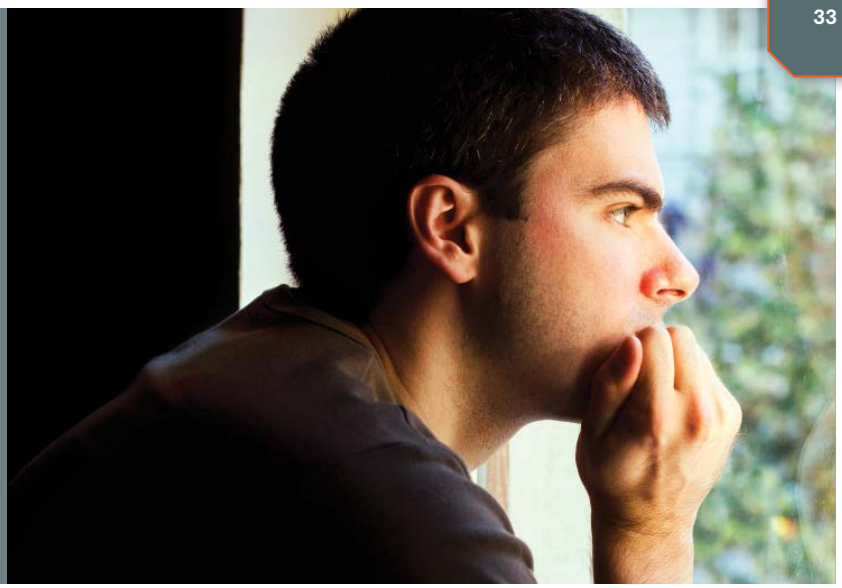
Although questions remain about the shifts in the population seeking addiction recovery services, the growth of the epidemic has helped to sharpen the focus on the need for more treatment and recovery services. Additionally, some advocacy and public education groups are pursuing efforts to foster awareness about addiction and treatment across communities. For example, the Drug Free Action Alliance, as well as national groups like Faces and Voices of Recovery, are providing forums, networks, and resources targeted towards individuals in need of recovery and their families. The work of these groups has been compared to the efforts of the National Alliance on Mental Illness (NAMI), which has led national efforts to support individuals and families facing mental illness for decades.

Consolidation of Ohio's Departments of Alcohol and Drug Addiction Services (ODADAS) and Mental Health (ODMH). As of July 1, 2013, Ohio's Departments of Mental Health (ODMH) and Alcohol and Drug Addiction Services (ODADAS) will consolidate. Some planning and collaborative activities are already underway. This report represents an initiative undertaken by ODMH to better understand the current status and need for recovery housing across communities. The findings in this report will inform decisions for the funding of housing, services, and supports, and the development of standards and guidelines to expand and operate recovery housing. This merger will allow ODADAS to be engaged with ODMH in capital planning and for the two agencies to submit a joint financial plan. Like many states and systems, mental health and addictions services have operated in parallel systems with different languages and priorities for decades.

At the same time that the agencies are merging, shifts in ODMH priorities have helped to spark interest in exploring the expansion of housing models to include recovery housing. The emphasis will be on ensuring a range of choices across the housing spectrum. ODADAS is well positioned to work with ODMH on the expansion of recovery housing, given their role in administering federal Access to Recovery (ATR) funding through SAMHSA. These funds have been used in five counties to support the provision of recovery supports, including recovery housing, and represents the first opportunity that ODADAS has had to engage in housing. The administration of these grants has laid important groundwork for understanding and providing oversight to recovery housing providers, including those representing a smaller, more independent style of program. Lessons learned from the ATR program can be used to inform next steps. ODADAS is already considering policy changes that would better reflect the range of models and operating policies that have been shown to work in the ATR-funded programs.

Possibility of Medicaid Expansion. Finally, the question of Medicaid expansion in Ohio remains unanswered. The majority of recovery housing providers anticipate the potential benefits of expansion in creating revenue for treatment and recovery support services. The expansion would allow for childless adults with incomes at or below 138% of the federal poverty level to become eligible for enrollment. Currently, childless adults are not eligible for Medicaid in Ohio at all (Health Policy Institute of Ohio, 2013). Despite the shift in eligibility, even if the Medicaid expansion happens, many recovery housing providers will continue to face challenges in securing funding for housing as well as the full range of recovery supports needed to support residents. Additionally, not all recovery housing programs serve individuals who are living in poverty or experiencing homelessness; therefore, a Medicaid expansion may not affect all programs equally.

Literature Review: What is Known About Models, Residents, and Outcomes?



Defining Recovery Housing

Recovery housing approaches provide safe, healthy environments that support residents in their recovery. A range of models represent different levels of care that are intended to support individuals at multiple points during their recovery process, as their needs for more or less intensive supports change. Recovery housing fosters communities where individuals are able to improve their physical, mental, spiritual, and social well-being (NARR, 2012). These communities enable individuals to build their resources—also known as recovery capital—by providing additional support as people transition toward independent and productive living. Recovery housing may be particularly important for low-income groups who have the least number of affordable and recovery-oriented housing options (Polcin et al., 2012b). White, Kelly, and Roth (2012) define recovery housing as distinct from addiction treatment by its:

> "*homelike environment, self-determined lengths of stay, democratic self-governance, and their reliance on experiential rather than professional authority—no paid professional staff*" (p.7).

The National Alliance for Recovery Residences (NARR) has begun to define types of recovery housing—referred to as recovery residences—along with standards. NARR defines recovery residences as sober, safe, and healthy living environments dedicated to promoting recovery from alcohol, drugs, and other associated problems (Fisher, 2012; NARR, 2012). The organization has established four levels of recovery residences that offer differing levels of care. Rather than serving as a linear, step-down continuum of services, the models meet the varying needs of people in recovery, allowing them to move in and out of the levels as needed, and as the resources are available. Each tier delineates the services and supports that are available to residents.

While recovery housing may encompass models outside of NARR's four levels of recovery residences, this framework is useful for understanding the research base behind recovery housing. Each level of provides peer-based recovery support with a varying range of structured and peer support services (e.g., case management, employment support, or life skills training) to meet the needs of residents:

Level I. Peer-run recovery residences, the most common being Oxford House, are democratically run by the residents and have no external supervision or oversight. Peer-run recovery residences offer residents the ability to determine which arrangements will most effectively meet their needs. For

example, there are specific peer-run houses that allow children to reside with their parents. These homes are not closed to other residents; however, residents who prefer not to live with children do not have to accept entry into child-friendly homes. Level I homes also have the flexibility to make their own arrangements for medication management. Some may choose to restrict any opioids or prescription medications, limiting entry for individuals using opioid-assisted substance treatment (often referred to as Medication Assisted Treatment or MAT) or certain psychotropic medications. Other homes may specifically cater to people who use these medications (NARR, 2012). In essence, a range of homes meeting the specific needs of different sub-populations exist: homes where specific languages are spoken, gender-specific homes, homes for men with children, homes for individuals of a similar age, homes for individuals with co-occurring disorders, and homes for individuals previously in prison (NARR, 2012). Additionally, some homes welcome a range of residents, creating a more heterogeneous home.

Level II. Monitored residences, often called sober living homes, have one compensated person on staff that serves as a house manager to monitor activities and screen potential residents (NARR, 2011). Sober living homes offer a structured environment with support services, predominantly facilitated by peer providers, for people in recovery to gain access to an interim environment where they can transition from rehabilitation environments to their former lives (Polcin, 2010). Sober living homes have shown favorable outcomes in research on sustained recovery when partnered with 12-Step programs (Polcin, 2010).

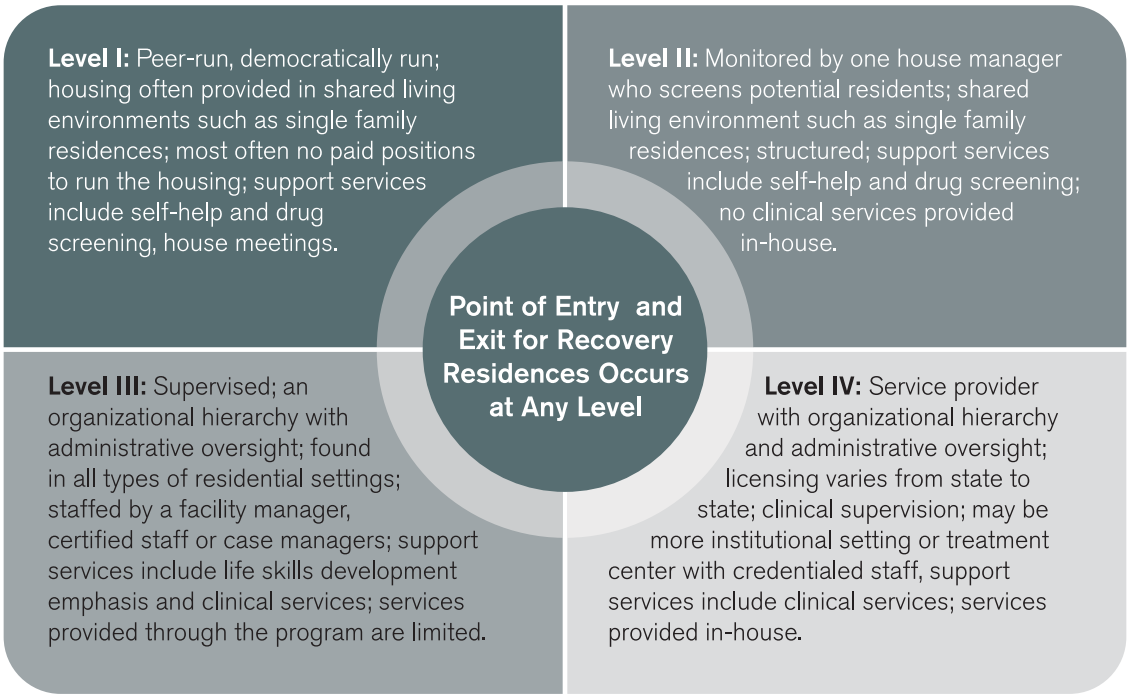
Level III. The next level of recovery residences, **supervised residences**, offers a high level of support, with the goal of eventually transitioning residents to lower levels of support (NARR, 2012), or in some cases, to independent living. These programs have an organizational hierarchy that provides administrative oversight for service providers, which include certified staff and case managers, and a facility manager (NARR, 2011). Services provided in supervised residences are typically met in the outside community, with the exception of clinical services (NARR, 2011). Length of stay in supervised residences tends to be short due to third party payer restrictions. Residents' time is highly structured; therefore it may not be reasonable to require residents to work or volunteer offsite, meaning they are often unable to financially contribute to the residence. Along with Level IV, Level III recovery homes are often referred to as residential treatment.

Level IV. The most structured and supervised level of recovery residences, **service provider residences**, as defined by NARR, also referred to as therapeutic communities, are often not thought to fit under the umbrella of recovery housing. Level IV treatment residences are overseen by an organizational hierarchy, provide primary medical treatment services by credentialed staff, are generally located in a more institutional environment, and are funded through mechanisms other than resident contributions, all of which distinguish Level IV residences from the traditional recovery housing model (NARR, 2011). Despite these differences, NARR has included Level IV in its model, recognizing the value of the services they provide to individuals in recovery. Level IV residences are often the first step people make into recovery housing. In addition to medical services, there is also an emphasis on the development of life skills among residents (NARR, 2011). The services these institutions provide require financial support from outside entities, including federal, state, and private foundations, or through third-party insurance payers (NARR, 2012). Length of stay in these residences tends to be shorter, often due to cost and guidelines set forth by funding sources. Service provider populations often contain a large number of residents who have been referred from the criminal justice system, as an option either requested by the inmate or recommended when the facility in which they are housed is required to make a placement referral (NARR, 2012).

Level I and II residences are often located in residential areas in a single-family home, though not exclusively. These homes have the fewest regulations: residents must adhere to the house rules, which include abstaining from substance use (e.g., alcohol and illegal drugs); they must pay an equal share of the expenses; and their behavior must not be destructive to the structure itself or to the recovery of other residents (Oxford House, Inc., 2008; Polcin et al., 2012a). Individuals who adhere to these rules are most often able to remain in these residences indefinitely (Oxford House, 2008; Polcin et al., 2010). Because both of these levels are self-funded through resident contributions, they encourage employment and are self-sustaining, typically requiring no financial support from outside entities or funding streams for housing and services (Jason & Ferrari, 2010; Polcin et al., 2012a). Entry into monitored or peer-run recovery housing most often involves completing an application and a personal interview. Furthermore, paying either the first week's or first month's fees (depending on residence stipulation) is required (NARR, 2012).

Monitored residences (Level II) are structured in a way that encourages senior residents to become peer leaders—deepening their own recovery, providing mentorship for individuals early in recovery, and ensuring that the home's culture is preserved (NARR, 2012). Although most residents eventually leave to reenter their communities, some transition into the role of house manager. The average length of stay in one peer-run model, Oxford House, is a little over one year. However, many residents opt to stay for over three years (Jason et al., 2006).

Levels of Recovery Residences



Currently, there is no systematic inventory of recovery housing nationwide. More broadly, the National Survey of Substance Abuse Treatment Services (N-SSATS) has completed the most comprehensive list of substance abuse treatment facilities to date, reporting a total of 17,376 facilities nationwide (HHS, 2012). However, many of these resources are primary treatment facilities and cannot be defined as recovery housing. Complicating this documentation is the fact that many recovery residences do not consider themselves to be treatment facilities and are not included in

the count (NARR, 2012). However, some smaller associations have conducted inventories. For example, one peer-run recovery-housing model, Oxford House, Inc., reports 1,500 Oxford Houses, with a total of 11,999 beds in 44 states, Canada, and Australia (Oxford Grape, 2011).

The vast majority of residents in recovery housing report involvement in other recovery support services. There are various abstinence-based pathways to recovery recognized and supported by recovery residences, the most well known being Alcoholics Anonymous and Narcotics Anonymous. Most peer-run or monitored (Level I and II) recovery home residents are involved in these 12-Step groups or secular or religious recovery mutual aid groups. When 12-Step programs are combined with drug treatment, participants have higher rates of abstinence than those who participated only in treatment or in 12-Step programs (Fiorentine & Hillhouse, 2000). Recovery residences support various abstinence-based pathways to recovery, such as cognitive behavioral and motivational enhancement therapy, and each residence focuses on one or more particular pathway. Studies have shown that this type of involvement further increases social support, a sense of self-efficacy, and better recovery outcomes (Majer, Jason, Ferrari, Venable, & Olson, 2002b; Polcin et al., 2010). Additional recovery support services frequently offered in recovery residences include peer support, life skills training, and counseling or counseling referrals. Level II, III and IV recovery residences typically offer job readiness workshops and training, and often have established relationships with employers in their respective communities (NARR, 2012).

Who Resides in Recovery Housing?

According to numerous reports, it is twice as common for an individual residing in recovery housing to be male (Jason et al., 2007a; NARR, 2012; SAMHSA, 2011). A national study of residents in one peer-run recovery house model, Oxford House Inc., shows an average age of 38 years (Jason et al., 2007a), which is consistent with other studies that have found the median age of residents to be in the early thirties, ranging from 25-49 years of age (NARR, 2012). According to SAMHSA (2011), whites represent between 60-65% of recovery housing residents, while African Americans and Hispanics represent 22% and 12%, respectively.

Individuals in residential treatment are unlikely to be married: 60% report they have never been married, while 12-13% report currently being married (SAMHSA, 2011). In comparison, among individuals in less intensive recovery homes, 50% report having never married, while 5% are currently married (Jason et al., 2007a).

Gender-Responsive Recovery Housing for Women

Within the context of recovery housing, the needs of women—with and without families—warrant special attention. Based on findings of a national workgroup effort supported by SAMHSA, which explored gender-responsive recovery housing models for women, key elements of effective programs for women must include the following characteristics:

- ✔ Women-focused and gender-specific
- ✔ A place-based approach
- ✔ Abstinence-based approaches
- ✔ Flexible relapse policies
- ✔ Service linkages
- ✔ A focus on safety
- ✔ Sense of community and supports
- ✔ Outcomes and measures of success
- ✔ Attention to parenting and relationships
- ✔ Considerations for children
- ✔ Employment and the pursuit of purpose
- ✔ Unique program models

Please see Appendix B for a full summary of the key elements and workgroup findings.

SAMHSA (2011) reports that among residents 18 and over, 33% had not graduated from high school, 42% had earned a high school diploma, and 25% had completed some post-secondary education. Individuals in residential treatment, such as therapeutic communities or supervised residences, have more obligations due to the supervised nature of the home, and are therefore limited in their availability to work: 11% are employed either full- or part-time, 35% are unemployed, and 54% are not in the labor force (SAMHSA, 2011). However, residents living in less structured recovery homes, such as monitored or peer-run residences, are responsible for paying their portion of household expenses. Therefore, their employment rates are higher: 69% full-time, 14% part-time, and 12% are looking/unemployed (Jason et al., 2007a). Three out of ten residents report current involvement in the legal system due to treatment referral, probation, or awaiting further legal process (NARR, 2012).

There is little data on how many parents reside in recovery housing. Traditionally, if mothers seek treatment, they are often faced with the prospect of losing their children (Wilke, Kamata, & Cash, 2005; Baker & Carson, 1999; Zlotnick, Franchino, St. Claire, Cox, & St. John, 1996). Concerns about childcare and the possibility of family disruption are major reasons that women either do not enter treatment or leave early (Carlson, 2006; Suchman, Pajulo, DeCoste, & Mayes, 2006; Nelson-Zlupko, Kauffman, & Dore, 1995). Mothers are more likely to enter treatment if they can keep their children (Brady & Ashley, 2005; Miller, 2003; Lundgren, Schilling, Fitzgerald, Davis, & Amodeo, 2003; Wobie, Eyler, Conlon, Clarke, & Behnke, 1997; Klee, Jackson, & Lewis, 2002; McMahon, Winkel, Suchman, & Luthar, 2002). Some recovery housing options allow children to reside with mothers, providing supportive housing with integrated treatment to mothers and their children (Polcin, 2001; d'Arlach, Olson, Jason & Ferrari 2006b).

Residents in any stage of recovery residence are equally likely to have comorbid psychological conditions, which affect 35% to 45% of residents (NARR, 2012). People with psychiatric comorbid substance use disorders are faced with unique stressors that are triggers to relapse into substance use (Laudet, Magura, Vogel, & Knight, 2004). In particular, psychiatric symptoms are often perceived as a reason for substance use among people with comorbid psychiatric disorders (Laudet et al., 2004).

Individuals in recovery represent all races, ethnicities, genders, demographics, and socioeconomic statuses. However, research has shown that minorities with severe substance use disorders often underutilize addiction treatment and mainstream recovery mutual-aid resources, such as 12-Step programs (Chartier & Caetano, 2011). A lack of information regarding minorities in recovery has led to concerns among some in the recovery field as to whether the differing cultural needs of residents are being met in recovery housing settings. While some programs cater to specific religious or ethnic groups, many do not. Alvarez, Jason, Davis, Ferrari, and Olson (2004) found that initial concerns among Hispanic residents about their minority status were unfounded—the overwhelming majority reported positive experiences and that they "blended into the house" within the first couple of weeks. Yet, it is not always the case that each resident will blend well in his or her home. For example, American Indians reported greater disharmony within their recovery home than Caucasians (Kidney, Alvarez, Jason, Ferrari, & Minich, 2009). Cultural competence is a critical component to be considered and practiced by recovery housing providers.

Recovery Outcomes

Overall, results have revealed a few recurring themes affecting recovery outcomes across all levels of recovery housing. Social support, self-efficacy, and length of stay in residence (six months or more) are all key components of recovery housing, directly affecting recovery outcomes, including the

probability of a relapse (Jason et al., 2007a). Additionally, peer support is effective at providing motivation and a sense of responsibility, as reported by the majority of members in recovery housing, including current members and alumni (Jason, Aase, Mueller, & Ferrari, 2009). Laudet and White (2010) have concluded that:

> *"Fostering recovery requires two important pragmatic shifts in service delivery: the adoption of a model of sustained recovery management and a coordinated multi-system approach that integrates services and supports across agencies to best meet an individual's needs given one's recovery stage, recovery path, and resources" (p. 57).*

According to the literature, recovery residences are able to facilitate those shifts in service delivery.

Longitudinal studies of peer-run recovery homes have shown that after 24 months, when compared to individuals who returned to their communities of origin after treatment, peer-run housing residents had significantly better outcomes, including: decreased substance use, decreased rates of incarceration, and increased income (Jason et al., 2007a; Jason et al., 2006). Furthermore, studies have shown that living in recovery housing (when compared to control groups) leads to higher rates of employment, ranging from 79% to 86% (Jason et al., 2007a; Polcin et al., 2010). Many of these positive outcomes have been attributed to the support individuals receive living in recovery-oriented communities. Jason et al. (2007a) found that participants who received the strongest levels of support from social networks developed while in recovery were more likely to remain abstinent and that results were not demographic-specific (Jason et al., 2007a).

"Fostering recovery requires two important pragmatic shifts in service delivery: the adoption of a model of sustained recovery management and a coordinated multi-system approach that integrates services and supports across agencies to best meet an individual's needs given one's recovery stage, recovery path, and resources."

Research on recovery homes have also documented positive effects for children and families. One study of the Oxford House model (a peer-run, Level I home) found that although 87% of women living in Oxford Houses had children, 50% had lost custody as a result of their substance use. Two years after entering the home, over 30% had regained custody of their children compared to 12.8% of women in the control group (Jason & Ferrari, 2010). Another study found that in homes where children were allowed to live in the residence, a positive effect was reported for residents on both substance use and recovery measures (Kim, Davis, Jason, & Ferrari, 2006). d'Arlach, Olson, Jason, and Ferrari (2006b) found that child residents had a positive impact on recovery for both mothers and non-mothers residing in the homes. Many of these positive outcomes have been attributed to the increased responsibility all residents feel when children are present in the homes. Finally, a study of men living in peer-run residences where children were present had the highest rates of long-term recovery, compared to men in peer-run homes without children (Ortiz, Alvarez, Jason, Ferrari, & Groh, 2009).

Longitudinal outcome studies from monitored (Level II) recovery homes have shown two distinct patterns. First, after six months, residents with moderate to severe substance abuse problems made improvements that were maintained through 12- and 18-month follow-up. Second, residents entering with low severity substance abuse problems were able to maintain the low severity throughout the course of the study, and maintain these improvements after leaving the residence (Polcin et al., 2010). This same study showed that the strongest predictor of consistent and positive outcomes for residents was involvement in 12-Step programs and building supportive social networks. In contrast to peer-run homes, studies of monitored homes have found that certain demographic characteristics were strong outcome predictors. Residents in older age categories were twice as likely to remain abstinent when compared to younger residents aged 18-28 years (NARR, 2012). Additionally, residents who had earned a high school diploma were twice as likely to remain abstinent, and less likely to be arrested during the previous six months when compared to residents who did not have a high school diploma (NARR, 2012).

> Recovery homes have been shown to impact gains in employment, increase family and social functioning, improve psychological and emotional well-being, decrease substance use, reduce criminal activity, and increase quality of life measures—a multidimensional construct that includes physical, mental, and social aspects of an individual's life (Jason et al., 2007a; Lo Sasso et al., 2012; Polcin et al., 2010).

Some studies have shown that longer episodes of care in institutions providing higher levels of supervision and support, such as supervised residences, not only encourage active participation and involvement with both mental health and recovery processes (Moos, Pettit, & Gruber, 1995), but that a "tipping point" of six months exists, resulting in a significant decrease in rates of relapse among residents (Jason et al., 2007b). However, more investigation is needed to understand the outcomes of supervised residences.

Additionally, while little research has been conducted to explore the participation in and effectiveness of recovery homes for people with comorbid psychological conditions, some studies suggest recovery housing can foster positive outcomes for these residents. Effective interventions for people with co-occurring psychiatric and substance use disorders are those that engage clients and promote a client-initiated and guided recovery process (Majer et al., 2008). For instance, substance use treatment often promotes self- and mutual-help programs such as those found in 12-Step programs and recovery houses (Humphreys et al., 2004). More participation in self-help settings can result in an increased amount of social support experienced by individuals in recovery (Humphreys, Mankowski, Moos, & Finney, 1999). This support has been associated with better outcomes for both abstinence (Noone, Dua, & Markham, 1999) and psychological functioning (Laudet, Magura, Vogel, & Knight, 2000).

John Majer et al. (2008) conducted a study on the relationship between psychiatric severity and outcomes experienced by residents in one peer-run model, Oxford House. Residents with greater psychiatric severity were more likely to use psychiatric medications and participate in outpatient psychiatric treatment while a resident, but there were no differences between those with high and low psychiatric severity on rates of abstinence and duration of residence (Majer, Jason, Ferrari, & North, 2002a).

Costs and Benefits

Studies attempting to calculate the economic costs and benefits of establishing recovery homes have overwhelmingly found that the benefits far outweigh the costs. Numerous other studies have evaluated other tangible outcomes for individuals living in recovery homes. Recovery homes have been shown to impact gains in employment, increase family and social functioning, improve psychological and emotional well-being, decrease substance use, reduce criminal activity, and increase quality of life measures—a multidimensional construct that includes physical, mental, and social aspects of an individual's life (Jason et al., 2007a; Lo Sasso et al., 2012; Polcin et al., 2010).

Lo Sasso et al. (2012) found that following substance abuse treatment, the average net benefit of residency in a peer-run recovery home, compared to returning to one's original community, is $29,000 per person when the cost of substance use, illegal activity, and incarceration were factored in. Borkman et al. (1998) found that compared to therapeutic community residential treatment centers (Level IV) that provide greater levels of services, supervised homes (Level III) cost considerably less per treatment episode: $4,405 versus $2,712, respectively.

Lo Sasso et al. (2012) found that following substance abuse treatment, the average net benefit of residency in a peer-run recovery home, compared to returning to one's original community, is $29,000 per person when the cost of substance use, illegal activity, and incarceration were factored in.

A study funded by the National Institute of Alcohol Abuse and Alcoholism found that in a sample of 150 participants where half were assigned to a peer-run residence and half returned to their original neighborhoods after treatment, those in the recovery residence earned on average $550 more per month. This is attributed to an expanded social network and access to employment opportunities offered in the recovery residence, which can lead to higher paying jobs (Jason et al., 2006). Over the course of a year, this translated to $494,000 for study participants in the peer-run recovery residence condition (Jason et al., 2006). This same study also found that a decreased rate of incarceration for study participants translated to a savings of $119,000. When productivity and reduced incarceration costs are combined, this yielded a net savings of $613,000 for the recovery residence participants in this study.

Jason and Ferrari (2010) conducted a cost analysis of one peer-run residence model (Oxford House) in 2007 to determine whether the Oxford House model, as opposed to a traditional, fully staffed halfway house model, resulted in cost savings to taxpayers. The study concluded that if the Oxford Houses had been traditional halfway houses, the cost to taxpayers would have been $224.4 million to cover staffing, housing maintenance, facility fees, and other expenses. In comparison, Oxford House, Inc. received only $1.6 million in grants from state and local governments during fiscal year 2007, while residents nationwide spent an additional $47.8 million to pay the operational expenses of the homes that same year (Oxford House, Inc., 2007). The peer-run recovery house model resulted in significant cost savings for taxpayers.

8 Research Findings

Discussions with key informants, site visits, and focus groups revealed several salient themes that are informed by the literature and housing reviews included in this report. This section includes a brief discussion of major themes, as well as recommendations for the State of Ohio, communities, and recovery housing programs.

1. The availability of recovery housing in Ohio is insufficient, especially housing tailored to the special needs of subpopulations.

The availability of recovery housing resources is severely lacking across communities.

There is a nearly universal need for safe, affordable housing that can support recovery. Stakeholders at one program described this need as "almost limitless, there's a need for ten times the amount of housing than we have. It's particularly bad for women." Residents often travel across the state to enroll in recovery homes. This is due to a general lack of recovery housing resources, a lack of specialized resources (such as programs for women and children), or a desire to leave a community that includes triggers such as high rates of drug use or acquaintances who use drugs or alcohol. However, these residents are often not eligible for services because they are from outside the county lines. Suggestions for documenting this need include collaborative agreements with agencies to document and aggregate data including intake numbers and waiting lists:

> *"If all agencies were talking together, we could show a need...additionally, waiting list numbers show need, [and] housing authorities and providers of housing can show need."*

In one county, people have vouchers but no housing resources. Additional limitations come with occupancy standards and restrictions on housing for people with criminal records. Further, the Institutions for Mental Diseases (IMD) rule sets a 16-bed limit, thus preventing

Medicaid from paying for institutional care. While there are mixed opinions about this rule, some see it as a positive change since "it creates more stable housing that is not dependent on treatment." Separating housing from treatment and converting treatment facilities into housing facilities are areas of need for technical assistance.

Recovery housing focused on the needs of single- and two-parent families is scarce.

Programs that are able to house families with children or two parents are limited. Again, residents often travel across the state to seek services in family-oriented recovery housing programs. Even among programs serving people with children, recovery homes in some communities must adhere to policies that limit the number of children per bedroom, or may not allow older children to remain in the housing after a certain age. Programs may have difficulty in serving families with children given the range, size, and cost of housing units that families of different sizes may need. Though rare across the state, The Counseling Center and Amethyst, Inc. both provide recovery housing and support for families.

Among programs that serve families with children, a range of family-oriented services were made available, including counseling, recreational and therapeutic programs, the evidence-based Celebrating Families curriculum, child care vouchers, parenting classes, and tutoring. Some are able to provide family reunification services even if children and spouses are unable to reside in the housing. Often, this is in the form of a linkage to local child and family welfare agencies to develop family reunification plans. Sadly, custody of children has typically been lost before entering recovery housing. In some cases, children are with the departments of children and family services; in other scenarios, they are with family members. One program reported a new grant from Administration for Children and Families that will foster the reunification of the whole family as defined by the client (e.g., husband, significant other, siblings, parents, grandparents, etc.) over three years. The program felt that this was a positive sign of a shift towards keeping families together.

Internally, some programs offer services to help family members understand addiction, treatment plans, and the roles they can play to support recovery. For example, one agency has a family reunification program that runs monthly. It begins with didactic information, followed by a panel discussion with family members. A second level includes conversations about solutions to addictive behaviors. In the end, family members tell each other what they need—something that in many cases has never happened in that family before.

Across programs, the residents' need for family- and child-focused services differed, generally across gender lines. Some men described having limited time with children, but other males described not wanting to have children in their recovery homes: "[It's] hard for some guys though, who don't have kids, they don't want the kids running around…split dads from guys who don't have kids." Most residents at men's programs did not identify visits or reunification with children as a primary concern. In contrast, women tended to celebrate all visitations with other women's children. One woman described her daughter, during her visits, as becoming a part of the house family.

Recovery housing for people with criminal histories is especially difficult to find.

When asked about the types of special populations most in need of recovery housing, many key informants identified housing for people with criminal offenses, especially sex offenders. Some houses do not allow residents with certain offenses, due to house rules or local zoning.

In addition to finding housing, employment is also difficult for people with criminal justice involvement, adding to the challenges of regaining stability.

In Ohio, the Department of Rehabilitation and Corrections monitors a network of close to 2,000 beds in halfway houses, which offer an interim facility in the community for newly released offenders. While many offer recovery supports, the houses do not always provide an atmosphere that is completely recovery focused. Some offenders can be placed in recovery housing upon release, depending on availability and the terms of their parole. Ohio has stopped incarcerating offenders for certain felonies, keeping more people in the community who may need substance use treatment or recovery supports.

Most currently available recovery housing programs are not set up to serve people with co-occurring disorders.

People with co-occurring disorders (COD) often have multiple service needs that require support from skilled staff who understand mental illnesses, symptoms, medications, and interactions with the disease of addiction. Among individuals with COD, mental health concerns may range from mild depression and anxiety to severe mental illness. Participants reported that individuals with mild mental health symptoms may fare well in typical recovery housing. However, individuals with serious psychiatric disorders were more likely to have difficulties. In these cases, it is critical for staff to know how to recognize and assess symptoms, including when someone may be starting to decompensate, or is becoming suicidal. In some programs with higher levels of care, this type of monitoring is likely to happen formally by staff; in lower levels of care, this type of monitoring is important even if it occurs informally. Due to symptoms as well as stigma, individuals with COD may also have difficulty integrating into a peer group and engaging in social support, which could impact their recovery.

Individuals with psychiatric disorders are also likely to require medication. Recovery housing programs may provide some level of monitoring or secure storage for prescription medications. However, the opportunity to reside in recovery housing also provides an opportunity to learn self-management strategies for medication adherence. Particularly in programs representing higher levels of care, this type of support from case managers and other staff was made available. Medication self-management is an important strategy so that an individual minimizes their risk of missing doses, exacerbating symptoms, and potentially having trouble sustaining housing or employment—both in the recovery home and after they move on.

Recovery housing resources for people with COD were rare. Ohio key informants referenced models in California as examples of programs that they knew about. Other key informants referenced programs that utilized a Permanent Supportive Housing (PSH) model. Some stakeholders suggested that recovery housing programs that are intentionally set up to provide these supports are better resources for individuals with COD. However, for the most part, recovery housing providers—especially Level I and II homes—will likely not have the capacity to provide co-occurring services. It is important for recovery housing programs to establish strong connections with mental health service agencies that can serve as resources to residents.

The need for recovery housing for special populations varies by community.

Participants noted that across communities, recovery housing for special populations varies and is reflected in the community demographics. Recovery homes often start up due to a

recognized need in the community and many times are seeking specific types of clients (e.g., certain genders, religions, service needs). When asked about lesbian, gay, bisexual, and transgendered (LGBT)-friendly programs, some key informants indicated that recovery homes are typically LGBT-friendly, but that some LGBT-specific homes also exist. However, participants noted the need for better cultural competency among recovery homes serving residents who identify as LGBT. Additionally, recovery housing for transgender individuals is difficult given the typical gender divides among programs.

Recommendations

1.1. Conduct a more detailed analysis to determine the extent of need for recovery housing.

1.2. Facilitate reciprocity eligibility for recovery support services for residents traveling from outside county lines due to unavailability or need for relocation.

1.3. Identify the extent of unmet recovery needs for families and expand programming that addresses these needs.

1.4. Ensure that programs are providing comprehensive planning that identifies and responds to service needs for individuals and children (when applicable).

1.5. Facilitate partnerships between recovery housing programs and family services agencies.

1.6. Develop partnerships with Ohio's Drug Courts to support recovery housing models, including identifying funding resources to support recovery housing for people participating in drug courts.

1.7. Explore eligibility barriers for people participating in drug courts, who are not considered to be homeless under HUD definitions and therefore may not be eligible to receive housing vouchers for recovery housing programs.

1.8. Collaborate with Ohio Department of Rehabilitation and Corrections and the Division of Parolee and Community Services to support recovery programming in halfway houses, and identify recovery housing resources for offenders. These partnerships are important to ensure that parallel systems of treatment and housing are not being created by jail diversion programs.

1.9. Collaborate with corrections system around discharge planning and developing options for recovery housing prior release.

1.10. Survey communities to understand the unmet need for housing and services for offenders.

1.11. Provide technical assistance to support recovery housing providers in overcoming regulatory and zoning barriers that limit options for people with criminal offenses.

1.12. Support mental health service agencies to develop recovery housing resources for people with co-occurring disorders.

1.13. Provide training on mental health and co-occurring disorders for recovery housing providers.

2. Current variations in recovery housing definitions, language, and understanding pose challenges to the efforts to advance it as a model.

The concept of recovery housing is in the early stages of being codified and defined.

Throughout our site visits and conversations with Ohio stakeholders, very few were familiar with NARR's newly developed standards for recovery residences. The standards were somewhat more familiar among national stakeholders.

Several names are used to describe recovery housing, including:

- ✔ Sober housing
- ✔ Sober living homes
- ✔ Supportive services
- ✔ Wraparound services
- ✔ Recovery support services
- ✔ Recovery housing
- ✔ Recovery residences
- ✔ Halfway houses
- ✔ Faith-based housing
- ✔ Transitional housing

Recovery housing providers and other community stakeholders were more readily able to describe what they know is *not* recovery housing, such as recovery homes that may not provide sufficient recovery supports, or housing that uses a harm reduction approach to substance use.

Beyond language differences that occur at the program and community level, the language also varies across systems and states. This may impact how residents are described by different systems. For example, a recovery housing resident may or may not be deemed "homeless" depending on their circumstances prior to entering housing and the funding stream supporting them. They may also be called a resident, client, peer, or consumer. Additionally, programs are careful about how they present themselves. For example, a program that primarily identifies as a treatment provider will face different regulatory limitations compared to a provider who is primarily oriented as a housing provider. Among recovery homes that did not receive any type of government funding, there were fewer limitations and concerns about how to describe services.

Currently, NARR's efforts are focused on developing affiliate organizations within states. This requires a primary focus on grassroots development, working with programs and coalitions within the states, rather than on facilitating a national dialogue to advance language and standards. However, the group recently published a white paper that is the first step toward a focused national effort (NARR, 2012).

Recommendations

2.1. Sponsor regular regional and state summits for recovery housing providers to meet and learn about other recovery housing efforts in the state and nationally.

2.2. Convene statewide conversations among housing, homeless services, behavioral health, criminal justice, housing developers, faith-based and other related systems of care. This would provide an opportunity for networking and fostering better coordination locally, including efforts to bridge gaps in service systems or pool resources to support recovery housing.

2.3. Establish online learning communities for recovery housing providers in Ohio to share resources and challenges.

2.4. Create a mechanism to define recovery housing models and services consistently across counties and the state.

2.5. Collaborate with NARR to highlight Ohio's efforts nationally and connect with other states taking on similar initiatives.

3. The network of recovery housing providers in Ohio lacks the infrastructure, resources, and technical assistance to support growth and quality oversight.

Ohio recovery housing providers are loosely connected within and across communities, if at all.

Many recovery housing providers described feeling disconnected from other recovery housing resources. They described the opportunity to participate in this project's focus groups as the best networking opportunity they had. Some described being aware of networking opportunities in other communities or counties but not being a part of those groups. Simply having opportunities to come together and share information about their programs and outcomes, to access training, and to meet one another was viewed as valuable.

Simply having opportunities to come together and share information about their programs and outcomes, to access training, and to meet one another was viewed as valuable.

However, other programs—especially large service agencies—intentionally cultivated a broad network of partners. These partners provide resources and referrals, as well as advocacy support within communities. Despite these broad partner networks, recovery housing typically represented a small proportion of the available network of resources.

Organizations that are linked to healthcare or treatment agencies have more access to medical services. Collaborative networks and partnerships are equally important for meeting these needs. Organizations with more resources can offer additional support including job coaching, education, and transportation. As an example, The Counseling Center is supported by its affiliates, Compass Point and Compass Community Health Center. Likewise, The Serenity Recovery Network is supported by the Greater Cincinnati Recovery Resource Collaborative which includes the following provider organizations: Prospect House, Charlie's ¾ Way, Gateway House, and Sober Living. These organizations have expressed interest in building this collaboration beyond Cincinnati with the assumption that participating organizations would support similar philosophies for recovery.

Some communities have taken the initiative to foster local networking. For example, one agency regularly hosts other community agencies to present and network about their

programs and identify referral resources. They aim to include a broad range of agencies, because clients need varied services. Additionally, some agencies had successfully developed formalized local partnerships and collaborations. For example, the Greater Cincinnati Recovery Network described their partnership as helping with "providing the right services to the right people across the continuum." Informal relationships also exist with many community organizations, helping with donations, employment and community service. At the Counseling Center, relationships includes the Salvation Army, The Red Cross, community gardens, private schools and colleges, parks management, and a local horse farm.

Currently, no mechanism exists to ensure quality oversight across recovery housing programs.

Some residents and recovery housing providers shared their experiences or knowledge of homes that may not provide adequate supports to residents. These homes sometimes represent a boarding house rather than a recovery home, and residents might end up sleeping on couches, and receive little or no recovery supports. This might occur when individuals open homes without fully understanding what is needed to run a program. For example, some homes opened when Access to Recovery (ATR) funding became available, with no history of operating homes. Additionally, some of these programs are run by people who have other full-time jobs and therefore do not have the time to dedicate to supporting residents.

People with co-occurring substance abuse and mental health disorders may have particular difficulties in recovery homes that are not well equipped to provide quality care. In these cases, mental health symptoms and medication management may prove challenging. As a result, residents may suffer from untreated or aggravated symptoms, which can impact themselves and other residents negatively.

Inventories of recovery housing providers are informal at best and often non-existent.

Some communities maintain informal lists of recovery housing providers, which can be used to place residents. These lists are not comprehensive and do not exist consistently across communities. This lack of a formal registry inhibits recovery housing providers from marketing their services and securing referrals. The list is managed largely based on word-of-mouth; if service agencies hear negative feedback about recovery homes, they will stop referring clients to those places.

The prospect of creating and maintaining a list of recovery housing is further challenged because some recovery homes prefer to stay fully independent of local networks, government funding, or any type of oversight. This desire appears to be rooted in concerns over the possibility of government regulation that could impact the peer-driven culture of recovery homes or the costs associated with providing this service. Our team was not able to easily reach recovery housing programs that preferred to remain distinct from the local service systems. One program refused to speak with us given the nature of this project and its involvement with state and county entities.

Government support is critical to the development and operation of recovery housing for poor and homeless individuals.

In addition to providing funding and supporting sustainability, Federal and State leadership fosters the development of collaborations. Programs receiving HUD and other government

funding acknowledged how the availability of these resources has helped them to sustain and grow their programs. Several programs noted how federal initiatives such as SAMHSA's Access to Recovery (ATR) and Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) have spurred new collaborations and relationships, in addition to providing funding resources. Many ATR providers developed or expanded housing as a result of this funding resource, and are seeking ways to strengthen their programs and relationships.

Recovery housing providers lack the capacity to pursue capital funds to support the acquisition and maintenance of housing.

Capital funds to purchase or renovate housing are made available through state agencies such as Ohio Department of Development (ODOD). ODMH also provides capital dollars. Given the upcoming consolidation between ODMH and ODADAS, the ODMH capital planning office is seeking to understand the recovery housing needs so that capital dollars might be used to support recovery housing efforts. Notably, ODMH capital dollars do not have to be administered through the county boards; programs would be able to apply directly for the funds. Recovery housing providers could also seek loans through affordable housing development agencies that make loans or grants such as Corporation for Supportive Housing and the Ohio Housing Finance Agency. However, these agencies maintain criteria for lending, such as the use of specific housing models (e.g., Permanent Supportive Housing) or operational capacity. Additionally, some lenders will not lend for 100% of the project cost, which would require additional fundraising for affordable housing projects.

Federal initiatives such as SAMHSA's Access to Recovery (ATR) and Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) have spurred new collaborations and relationships, in addition to providing funding resources.

Recovery housing providers do not always anticipate the costs associated with managing properties, including owning, renovating, repairing, and keeping homes in compliance.

The need for recovery housing providers to seek capital funds in order to purchase or rehabilitate housing for use as a recovery home varies. Some agencies prefer to master-lease apartments or other housing units, rather than own the housing. However, smaller programs would benefit from funds to assist them in securing and preparing homes for use. In some communities in Ohio, the housing market allows for the purchase of homes for as little as $5,000 to $20,000. Often these homes are in areas with high crime and drug use, or may be located far from city centers and therefore important services and supports. In addition to these challenges, some recovery housing providers have purchased homes that are affordable within their budget, only to find during the inspection and permitting process that the home will require upgrades and repairs that could total tens of thousands of dollars. This

is a situation that independent recovery housing providers may not be aware of until it is too late, leaving them in debt and the home uninhabitable. Programs involved in the environmental scan typically provided their own property management—either as a dedicated position in larger programs or as part of a house manager's or owner's role in smaller homes. In the case of master leasing, property managers worked closely with landlords to monitor and address issues.

Certifications are costly and difficult for some recovery housing providers, but provide eligibility for certain funding streams.

Overall, recovery housing as a model does not have a comprehensive mechanism for quality oversight or certification. Depending on the level of recovery housing and the program's goals in seeking public funding, some programs seek certification from one or more agencies (e.g., states, counties). This offers quality control and oversight for certain regulated services, but it is limited in consistency and reach.

Recovery housing providers and stakeholders identified a range of certifications that are required by various agencies, including ODADAS (drug and alcohol services; recovery housing providers through SAMHSA's Access to Recovery grant), ODMH (mental health services), HUD (housing administered through the local Continuum of Care); CARF (Commission on the Accreditation of Rehabilitation Facilities), and others. Some established recovery housing providers have begun to provide consulting services to others who are seeking certification in various areas. The decision to seek certification should be driven by the needs of the program and the community. A new or small-scale recovery home will likely not have the infrastructure or the need to apply for all of the available certifications. Independently run recovery homes that are not seeking government funding are not required to apply for any type of certification.

Some recovery housing programs are developing innovative fundraising and business models, including social enterprise efforts, to generate program revenue.

In recognition of limited public funding resources, some programs are turning to innovative social enterprise models as a means of generating revenue. For example, one recovery housing provider pursued a contract for janitorial services in the community. This contract provides an immediate resource for recovery housing residents needing employment. If a successful business model, it also has the potential to generate revenue to support and grow the program. The contract could be expanded to additional clients or could offer additional services, based on the skills and interests of residents. Another example is a program that developed an innovative model of purchasing and renovating housing, and then selling the homes to residents or alumni. This model also creates jobs for current residents, generates capital through mortgage holdings, and creates long-term housing options for people who are on their path to recovery.

Some programs also engage in fundraising efforts to raise private funds—hosting golf outings, galas, or other events in the community that both raise awareness and engage community members in learning about and supporting the program. Program residents as well as alumni are often involved and can help to broaden the network of people that are looking to support recovery housing.

Recovery housing providers—particularly grassroots or community-based organizations (CBOs)—have significant technical assistance needs with few available resources.

Smaller recovery housing providers may open a home with little experience in operating sustainable programs and delivering effective recovery services. Many indicated that the most significant challenges were related to developing a sustainable business model. These needs include making difficult business decisions, accounting, finding and securing funding, and building infrastructure. As one program noted, when applying for grants, a small program may not have sufficient numbers of skilled staff to win funding; yet, without additional funding, they would not be able to hire and maintain these staff. This program would like support in understanding how to build capacity in situations like this, including how to utilize contingent hires. NARR also identified the need for business and operations training among recovery residences, though resources to do this are not currently available.

Some training and technical assistance (TA) resources are available through county boards or other groups such as the Coalition for Housing and Homelessness in Ohio (COHHIO); Corporation for Supportive Housing (CSH); or the Ohio Association of Nonprofit Organizations. Some TA is also provided through or in conjunction with state agencies (e.g., ODADAS, DMH). However, the resources are limited and in some cases made available only to members, grantees, or treatment providers who are part of existing networks. Many of these groups were cautious about the extent to which they would be able to help a new provider to develop their program, particularly if the program is not already on its way to sustainability. Additionally, some recovery housing providers have begun providing consulting services to others for a fee. This resource is helpful in developing and operating housing.

The most significant challenges were related to developing a sustainable business model.

New recovery housing providers may need basic assistance with business, accounting, and marketing functions.

While some technical assistance is available to support capacity building among community agencies, these resources are limited and often targeted to selected networks. Without this support, recovery housing providers may find themselves unable to pursue and administer funds, out of compliance with accounting regulations, or making uninformed business decisions.

Additionally, marketing the services of a recovery home can be challenging, depending on community attitudes and the openness of local planning and stakeholder entities, as well as the knowledge and experience it takes to market and collaborate successfully.

Some recovery housing programs do this well, and use a range of strategies including:

- brochures
- websites
- radio spots
- public service announcements

- collaborating with other service providers, government social service departments, and community resource centers
- open houses
- community events
- word of mouth through current and former residents
- community outreach in courts, jails, shelters, hospitals, and detox programs

Recovery housing providers face difficult decisions between business/revenue and a singular goal of supporting recovery. All of the recovery housing providers who participated in the environmental scan collected some portion of rent from residents. Some programs allowed a grace period early in the process, before residents would be expected to have income or seek employment. Other programs did not immediately collect rent in these early weeks but charged it as back-rent, due when a resident does secure employment. Typically the rent payments totaled a percentage (e.g., 30%) of someone's income, or a flat rate of approximately $75-$100 per week.

One of the business challenges for recovery housing occurs when providers are faced with the decision to evict a resident for non-payment, or allow them to remain until they are able to get a job and begin paying rent. Most recovery housing providers understand the challenging journey of recovery and what it takes to get back to work in a sustained way, and therefore are not quick to remove people from housing. However, these programs—especially smaller ones—may put themselves into a difficult financial situation if they are unable to collect rent. For these smaller homes, resident payment may be the only source of program income. Larger service provider agencies may be able to generate an unrestricted cash reserve over time, which can be used to pay for these lulls in rent payments, as well as other recovery supports.

Recovery housing providers may have difficulty navigating regulatory mechanisms such as zoning laws and building and administrative codes.

Training and TA Needs

- ✔ Identifying and securing funding
- ✔ Operations and administration
- ✔ Medicaid billing
- ✔ Support navigating city/county/stage regulations, zoning, and codes
- ✔ Motivational interviewing
- ✔ Securing certifications
- ✔ Staffing and staff development strategies
- ✔ Peer support staff training (e.g., understanding "my own issues and triggers," and learning how personal experiences and emotions impact reactions and interpretations)
- ✔ Training in clinical interventions (varies by program)
- ✔ Recovery coaching
- ✔ House managers training/running a recovery house (distinct from case management skills)
- ✔ Navigating service systems
- ✔ Crisis intervention
- ✔ Group facilitation

Training and TA Provided by Programs or Stakeholder Agencies

(These resources are not constantly available but have been offered in recent months or years)

- ✔ Motivational interviewing
- ✔ Trauma-informed care
- ✔ Trauma-based interventions
- ✔ Critical Time Intervention (CTI)
- ✔ Treatment Improvement Protocols (TIPs)
- ✔ Management and operations
- ✔ Support developing certifications
- ✔ Sustainability and capacity building (ATR)
- ✔ Cultural competence
- ✔ Family-driven services
- ✔ Substance use and HIV
- ✔ Person-centered care
- ✔ TA for HUD Continuum of Care housing providers

Recovery homes face administrative barriers to gaining inspections, certificates, and permits. The regulations vary by community, and may require navigating and aligning multiple systems. The process for complying with these regulations can be lengthy, confusing, and costly. The offices that provide inspections and permits are often fragmented and bureaucratic, adding to the difficulties. For example, in one community, a recovery housing provider must apply for a work permit to request an inspection, even if no new construction or repairs are being done.

Recovery housing providers identified the need for certificates of occupancy, safety and fire inspections, and meeting standards for wiring and electricity. In some cases, the upgrades to bring housing up to code are cost-prohibitive. One provider reported the need for a $40,000 fire escape on a house that was purchased for $20,000. In addition to the need for capital to support these repairs, recovery housing providers may need support in understanding and responding to these regulatory issues. This may occur in the form of contractors or by forging alliances with government officials. One stakeholder recommended inviting the county government as a partner to support recovery housing efforts. To initiate this, it would require educating the county about recovery housing and the potential benefits to individuals and communities.

Additionally, municipalities may lack an understanding of fair housing. Often local governments require recovery housing programs to meet excessively high health and safety standards. The resulting barriers to fair housing choice is illegal under federal law. However, the cost of defending fair housing rights is often cost prohibitive *(see Analysis of Federal, State, and Local Regulations and Codes Relevant to Recovery Housing for a more complete discussion of fair housing).*

Recovery housing providers expressed that they are better able to serve people in an effective and culturally competent manner, especially those who have fallen through the cracks of the broader service system.

Recovery housing providers, and particularly more independent programs or community-based organizations (CBOs), frequently view themselves as a default resource when individuals have not succeeded in other treatment programs. These providers often feel that they are more culturally competent and better able to engage people that are considered the hardest to serve by other community agencies.

Regulations vary by community, and may require navigating and aligning multiple systems.

This use of recovery homes as a last stop resource occurred in some communities where Access to Recovery (ATR) funds were available; some residents would continue to be engaged with traditional treatment providers until their ATR funding ran out. At that point, some would get referred back to CBOs for recovery housing or other recovery supports, yet the funding resource would no longer be available. Some CBOs reported that residents left to engage in other programs through their ATR funding, and then returned to the recovery housing setting once the funding ended.

Recovery housing providers need data to tell the story of their success.

Throughout the site visits and discussions with recovery housing providers, several noted exceptional outcomes for residents. One provider stated that their recovery outcomes are "through the roof." However, there are currently no consistent national, state, or local efforts to collect data on recovery housing. As a national stakeholder commented, it is difficult to attract funding for recovery housing since there has been so little research done; yet there is not more research being initiated because there is not significant funding.

While the positive anecdotal evidence is promising, the need to collect and report these data across states and nationally is critical. Particularly if recovery housing programs find themselves advocating for funding and support within their county or at the state level, data about recovery outcomes—as well as cost-effectiveness—are needed. Conversely, some key informants noted that some recovery housing or treatment programs are funded for too long without results. Proper data collection and analysis would help to identify these programs more quickly and either remedy the situation or reallocate the funding elsewhere.

NARR is beginning to assess what questions and domains would be most important to track across national member programs, as well as the best way to go about doing this. As with any data collection effort, attention must be paid to minimizing administrative burdens, using resources effectively, and collecting the most pertinent data. Some recovery housing providers—primarily those located in more traditional treatment settings—may already be using one or several data collection systems such as Homeless Management Information Systems (HMIS), Government Performance and Results Act (GPRA), National Outcomes Measures (NOMS), and others. In addition to the potential administrative burden, some recovery housing providers are reluctant to collect data. This is more common among smaller, independent programs that are passionate about providing an effective recovery housing resource but may not have the desire, infrastructure, or staff to contribute to a broader research effort.

Aside from the logistical and administrative questions surrounding data collection in recovery housing, there are additional methodological questions. For example, one stakeholder noted that most recovery housing programs require a period of sobriety, often 30 or more days, upon entry into the housing. This could skew recovery outcomes when compared to treatment programs that allow entry for detox or immediately post-detox, when the likelihood of recovery is even more tenuous.

Recommendations

3.1. Identify and support the development of a NARR affiliate organization in Ohio.

3.2. Support the lead NARR affiliate organization in Ohio to develop a standard set of definitions and guidelines to describe the range of recovery housing in Ohio. These definitions and guidelines should inform the development of funding opportunities and allocation decisions.

3.3. Hold in-person or virtual meetings with recovery housing providers across the country to inform the development of the Ohio standards.

3.4. Facilitate technical assistance (TA) requests to SAMSHA (e.g., Bringing Recovery Supports to Scale Technical Assistance Center Strategy, Homeless and Housing Resource Network). This could include TA to the Ohio NARR chapter(s) on how best to work with recovery organizations and deliver TA.

3.5. Encourage follow-up with residents graduating from the program.

3.6. Provide technical assistance opportunities to help recovery housing programs to build capacity in business, accounting, and marketing functions.

3.7. Develop a voluntary registry of recovery housing providers at the county and/or state level.

3.8. Create a mechanism for receiving and investigating complaints of recovery housing providers.

3.9. Define benchmarks for recovery success.

3.10. Establish a voluntary data collection system for recovery housing providers that are not connected to county alcohol, drug, and mental health (ADMH) boards. Ensure that this effort is aligned with forthcoming data collection efforts from NARR.

3.11. Hold focus groups with recovery housing providers to identify minimum data points and domains that would effectively tell the story of recovery housing.

3.12. Ensure that funded programs are collecting and reporting data, that quality improvement plans are established if a program is not meeting standards or producing outcomes, and that after quality improvement efforts are exhausted, corrective action is taken when appropriate to remove or modify ineffective programs.

3.13. Provide basic data training for staff in recovery housing programs.

3.14. Publish or identify and disseminate technical assistance tools that guide recovery housing programs in collecting, interpreting, and sharing outcome data with funders, policy makers, and community stakeholders.

3.15. Encourage programs to collaborate with local universities to establish basic metrics that programs can use to collect data in the absence of a more formalized system.

3.16. Develop and promote training and technical assistance opportunities for recovery housing providers in collaboration with community groups such as coalitions, counties, trainers, and model programs.

3.17. Catalog currently available local, state, and federal training and technical assistance resources and promote to recovery housing providers.

4. Existing models and preliminary standards can be built upon to expand recovery housing in Ohio.

Screening, assessment, and intake procedures vary across programs, and represent an urgent window of opportunity to engage someone in recovery.

Intake procedures are sometimes done by house managers (in smaller programs) or by trained clinical staff (in larger service programs). Programs often desire some period of sobriety, many aiming for 30-60 days, before allowing someone to come live in recovery housing. Detox is generally not a resource that is available within the same program that provides recovery housing; however, detox or crisis centers can serve as helpful resources for referring clients into recovery housing for the next phase of sober living.

Beyond the period of sobriety, some programs had very little or no criteria—with the exception of gender—based on the program or house. One recovery housing provider identified itself as one of the only programs that would accept individuals with sex offenses. Another program that aims to serve women who are poor, homeless, and facing addiction looks for various issues such as lack of housing, mental illness, trauma history, traumatic brain injury, loss of children, involvement with criminal justice, lack of social supports, and chronic health issues. This program intentionally seeks women who are unlikely to receive long-term, supportive recovery services and housing elsewhere.

Given the nature of addiction and the tenuous desire to change early in recovery, recovery housing providers want to ensure that they can immediately capitalize on someone's efforts to engage. One program has developed a comprehensive approach to intake, to ensure that individuals applying for the program follow through. This is especially important when the beds are full and someone ends up on a waitlist. In larger programs, the intake process might involve meetings with admissions or treatment teams, all of which can take days or weeks. Throughout the intake process, staff will help a potential resident to identify what type of documentation or medical exams are necessary to apply for the program, and assist in getting this all completed. If the waitlist is still being utilized, the future resident is expected to engage in entry-level groups that include program orientation as well as basic education about addiction, or groups focused on learning about emotions and shame. This helps to sustain engagement until a bed is available, and also helps the person to be fully informed before committing to the program.

One program includes a component called "Shelter from the Storm" where rather than have residents come directly from treatment, they follow a 2-5 week period of sobriety in which they watch inspirational movies and listen to tapes with spiritual messages, complete readings, participate in meetings, and work on their resume. They are not able to leave the house alone. If this time is not completed successfully, the resident leaves and is not considered a member. The implementation of "Shelter from the Storm" has positively impacted the rates of program completion. Prior to beginning the program, 37% left before the first month was completed, now only 15% leave before completing the first month.

The day-to-day structure of activities for residents in recovery housing tends to be similar.

Recovery housing is most often based on a stepped level of care and structure. Within programs, residents typically begin with a more intensive, restrictive schedule (e.g.,

attendance at more meetings, earlier curfew, limited visitors) and over time gain more flexibility and privileges.

Regardless of the level of recovery housing, all programs required some combination of required readings, NA or AA meetings, involvement with the community, employment, or services. Programs that provide staff and services (e.g., Levels III and IV) offer more opportunities for individual and group therapy, case management, and other treatment and recovery services. Among programs providing a less intensive level of support, residents are often busy with work and meetings and spend much of their days away from their house.

Staffing in recovery housing varies by the size of the house and organization.

Peer-run sites have no staffing, but houses with more structure may staff several employees. Staff are often participating in recovery themselves. The requirement for length of recovery necessary to work in recovery housing ranges from 6 months to 2 years. In Level II homes, one or more people typically serve as house managers, and help to enforce rules and structure, while also providing peer support to residents. In Level I homes that are fully peer-run, the residents may rotate roles and responsibilities, though no one is paid or given benefits as a formal staff member. Level III and IV homes tend to have paid staff, including clinically licensed staff as well as case managers, residential managers, and peer support specialists or recovery coaches.

Given the variation in numbers and types of staff, training needs also vary. Due to the large number of peer staff, peer provider training and certifications are often encouraged. Additional training needs include learning about the science of addiction, trauma-informed care, de-escalation and Motivational Interviewing. Chemical Dependency Counseling Assistant (CDCA) certification is also encouraged.

The Importance of Location

The location of recovery housing can help to address many barriers to residential instability. NARR notes that recovery housing should be located in neighborhoods that have accessible, affordable rental housing in areas offering amenities for daily life (NARR, 2012). Ideal neighborhoods for recovery houses are accessible to treatment and social services the residents may be using; are affordable; contain rental housing; and are located near different amenities (e.g. suburban and working class neighborhoods), increasing the opportunity for residents to find gainful employment (Jason et al., 2006; Oxford House Inc., 2004). Residents benefit when recovery homes are accepted into more stable communities with fewer opportunities for relapse, making them more conducive to maintaining sobriety (Jason et al., 2008a). Neighborhoods defined by transient communities and low socioeconomic status (e.g., inner cities) are not ideal locations. These neighborhoods have the greatest number of recovery housing closures (NARR, 2012), which may be due to the lower overall salaries of residents living in these neighborhoods, decreasing their ability to financially support their facility (Jason & Ferrari, 2010). Furthermore, drugs can be more readily available in these neighborhoods, which may make it difficult to maintain sobriety (Jason et al., 2008a; Johnson, Martin, Sheahan, Way, & White, 2009).

Housing Models

At the most basic level housing is provided (regardless of the services and supports provided) using one of two models: 1) ownership or 2) master leasing.

Within each of these options, the resources for developing, acquiring, and operating housing vary. Among programs included in this environmental scan, the type of housing provided varied from single-family homes with single and shared bedrooms, to apartments rented for single, double, or triple occupancy, some in a large multi-unit apartment building dedicated to the program.

Ownership. Purchasing property can provide a permanent source of housing dedicated to recovery. This might occur as the purchase of a single-family or larger home that can host multiple residents (depending on local zoning laws), or the purchase of apartment buildings or scattered site apartment units. Aside from the one-time upfront costs of purchasing property, ownership involves the added responsibility of ownership costs related to regular maintenance, repairs, and property taxes. However, it also offers a great deal of flexibility in creating and implementing recovery housing programs. This type of independence is beneficial for recovery housing providers who may be facing issues of stigma, neighborhood concerns, the need for flexible relapse policies or other internal regulations issues, or the desire to provide housing for people with major criminal offenses.

Master Leasing. Market-rate housing units are leased from for-profit housing owners and then subleased to individuals. The holder of the master lease is typically a local government or non-profit service agency. Master leasing programs are usually initiated for the purpose of providing permanent, affordable, supportive housing. However, master leasing programs can be time-limited.

Under a master leasing arrangement, the housing owner retains long-term ownership of the property and remains responsible for any major improvements, while the lessee takes over day-to-day operation of the house, including tenant screening and selection, regular maintenance, rent collection, and lease enforcement. Any type of market rate housing can be master leased, and can include single-family homes, duplexes, or a number of units in a single building.

Master leasing is very flexible and works effectively for a range of housing types. Since master leasing involves the use of existing housing, projects do not typically need to go through a community planning process. Additionally, these programs often "fly under the radar," as they are integrated into communities and thus not engendering a great deal of community opposition. Master leasing is a good alternative for individuals who would otherwise have difficulty obtaining housing in the private rental market. Since the lessee, rather than the property owner, is responsible for day-to-day property management, the lessee can provide more flexibility and discretion towards individuals who have poor housing history, credit or justice involvement. The lessee can implement policies and practices that are designed to support residents' efforts to sustain their housing and minimize the chance that tenants will be evicted.

Depending on the level and structure of the program, recovery housing providers may provide transitional or permanent supportive housing, in terms of affordable housing provision as defined by HUD.

Providers who are not situated within their local Continuum of Care may not identify their program as offering either of these models; however, the approach has implications for funding and operations.

Transitional Housing. Transitional Housing is "a project that is designed to provide housing and appropriate supportive services to homeless persons to facilitate movement to independent living within 24 months" (HUD, 2013). Transitional housing is one model used for recovery housing in Ohio. There are currently 2,556 transitional housing beds for single adults in Ohio. These units are dedicated to persons who are homeless coming from shelters or places not meant for human habitation (HUD, 2012). The number of beds dedicated specifically for persons in recovery is unknown. As transitional housing program models are time limited, supportive services are provided to help facilitate a move to permanent housing options. Transitional housing models can be created through master leasing, as described above, or through the construction or purchase of units, including single room occupancy (SRO) style housing.

Permanent Supportive Housing. The State of Ohio defines Permanent Supportive Housing (PSH) as community-based housing targeted to extremely low-income households with serious and long-term disabilities (Ohio Interagency Council on Homelessness and Affordable Housing, 2010). According to the State definition, PSH tenants have leases that provide PSH tenants with

all rights under tenant-landlord laws. Generally, PSH provides for continued occupancy with an indefinite length of stay as long as the PSH tenant complies with lease requirements. At a minimum, PSH must meet federal Housing Quality Standards (HQS) for safety, security and housing/neighborhood conditions.

PSH must also comply with federal housing affordability guidelines—meaning that PSH tenants pay no more than 30-40 percent of their monthly income for housing costs (i.e., rent and tenant-paid utilities). Services provided in PSH are voluntary and cannot be mandated as a condition of admission to housing or of ongoing tenancy. PSH tenants are provided access to a comprehensive and flexible array of voluntary services and supports responsive to their needs, accessible where the tenant lives if necessary, and designed to obtain and maintain housing stability. PSH services and supports should be individually tailored, flexible, accessible by the tenant, and provided to the extent possible within a coordinated case plan. As an evidence-based practice, the success of PSH depends on ongoing collaboration between service providers, property managers, and tenants to preserve tenancy and resolve crisis situations that may arise.

Rules and structure are important to residents, though this is often a difficult transition.

Residents praised the "rigid" structure of housing even if admitting that they did not appreciate it at first. Residents and alumni from one program explained that the:

> *"daily schedule is whatever work requires…chores, one of two meditations, and meetings. [We] have to work on steps and have to call our sponsor. [There is] not a whole lot of down time. [The] idea is to make habits that you can leave here with. Then [we] have continued care for the additional support."*

Even among residents who were mandated referrals upon release from criminal justice involvement, the first 30 days are difficult. However, almost all residents or alumni talk about how necessary and helpful this structure was for their path to recovery and independence.

Rules are similar across many recovery houses. The following were described by residents in one program:

> *"All of the rules and guidelines are based in 12-step fellowship…early curfew, no relationships, doing chores, having times for television, not having a vehicle until you have a job and can pay for yourself. [You] have to be honest which teaches [you] accountability. It would be selfish to leave without telling folks where you are. [There is a] strict financial policy. [You] can't have a debit card or check book, [we] even need permission for a back account."*

All programs establish relapse policies, which include abstinence-based and zero-tolerance policies.

All of the programs interviewed enforced a relapse policy of some sort. These policies typically recognized that for some people in recovery, relapse may occur. In addition to enforcing policies for the health and well-being of the resident who has relapsed, the policies also ensure that any potential triggers (i.e., drugs, alcohol, or the presence of someone who is using) are removed for the other residents. This is especially important in communal style homes, typically Levels I and II. In homes that are run partially or fully by peer residents, the rules are typically enforced by the group in a democratic decision-making process.

The majority of programs appeared to support an abstinence-based, flexible relapse policy that recognized that some people in recovery may face a relapse. These policies often included an offer for more intensive services including detox, treatment, or more supportive and structured housing. An important factor in these policies is the intent and honesty of the resident. For example, staff and residents expressed a willingness to support someone who admitted their misstep rather than attempting to hide or deny it.

Many programs also incorporated strategies to help identify the potential for relapse and prevent it before it occurs. For example, in one program, house managers conduct monthly apartment inspections. These inspections help to identify early warning signs—such as an increase in disorganization—which allows the staff to intervene before it occurs. In other homes, peer residents and house managers were able to recognize when a person started to miss meetings or struggle with work or other commitments, and respond with appropriate supports.

While the concept of relapse and its interconnectedness with the recovery process remains a topic of debate within the recovery movement, instances of relapse were typically viewed as an **opportunity to support someone in recommitting to treatment** or 12-Step programs, learning from the experience, and ultimately strengthening their recovery.

A small number of participating programs utilized a zero-tolerance policy. However, even in these cases, the programs often attempted to find the right level of care for the resident rather than evicting them into homelessness, and the person may be welcome to return to the house following a period of sobriety. In other instances, such as the case of selling drugs or violating curfews, residents are discharged. For example, one program promotes a safe and controlled environment with random drug tests:

"If a resident tests positive they have to leave because they were not honest, not because they used."

At another program, after a first time relapse, a resident must attend detox, but most get a second chance to come back to the house. After a second relapse, residents are usually terminated. Having drugs in the house, stealing and fighting are typically grounds for immediate termination.

While the concept of relapse and its interconnectedness with the recovery process remains a topic of debate within the recovery movement, instances of relapse were typically viewed as an opportunity to support someone in recommitting to treatment or 12-Step programs, learning from the experience, and ultimately strengthening their recovery. Additionally, there is some misconception about the use of flexible relapse policies. Some stakeholders expressed concern that these homes allow "wet" or "damp" living, implying that ongoing use of drugs or alcohol is allowed. None of the participating programs represented this type of program. Rather, flexible relapse policies sought to re-engage a resident in recovery and maintain their involvement in the program, if possible. However, if a return to sobriety was not possible, residents would not be allowed to stay.

The National Alliance for Recovery Residences (NARR) standards represent a set of guidelines that can serve as a foundation for expanding the infrastructure for recovery housing in Ohio.

NARR recently published a set of guidelines that are intended for adoption by member programs. These are broad standard criteria that each recovery residence, regardless of level, must adhere to for membership in the alliance. For example, supervised homes have an organizational hierarchy that includes administrative oversight for staff providing services with an established set of policies and procedures (NARR, 2011). Peer-run residences must be democratically run, include drug screenings and encourage self-help meetings, but cannot have paid positions within the residence (NARR, 2011). While medication management policies will vary by residence, to become affiliated with NARR, recovery residences are required to publish explicit policies and procedures surrounding their stance on medication management (e.g., over-the-counter and prescription medication) (NARR, 2012). NARR also requires all residences to define their relapse policies and have procedures in place in the event of resident relapse.

Currently, NARR is developing affiliate organizations across states, with the goal of establishing a single state affiliate as the liaison for other chapters and/or programs in that state. The expectation is that the state affiliate organization will take an oversight role in enforcing the standards. However, NARR recognizes the local realities faced by programs. Programs will retain the flexibility to modify the guidelines as needed to comply with local regulatory or legislative issues.

As the grant cycle closes in 2013, the majority of ATR-funded recovery housing programs are at risk of reductions or closing their doors completely.

Notably, Oxford House, Inc. also offers standard criteria for their peer-run (Level I) homes, which may be useful in establishing standards for recovery housing in Ohio. Their manual outlines policies and procedures specifying how residents should internally regulate themselves by majority rule.

The Access to Recovery (ATR) grant program provides opportunities to examine lessons learned and best practices as Ohio seeks to expand recovery housing.

Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), the Access to Recovery Program (ATR) grants vouchers for substance abuse clinical treatment and recovery support services. The program was administered in five counties through Ohio's Department of Alcohol and Drug Addiction Services (ODADAS). ATR helped some providers to develop or support existing recovery housing programs, and provided technical assistance and oversight. As the grant cycle closes in 2013, the majority of ATR-funded recovery housing programs are at risk of reductions or closing their doors completely. This represents an opportunity for the State of Ohio to support the sustainability and possible expansion of the ATR-funded recovery housing, as well as to identify model programs and best practices that can be used as a foundation for a statewide expansion effort.

The culture of recovery homes and programs varied significantly, with each cultivating its own atmosphere and identity over time.

Despite similarities in program services and goals, the culture and personality of each program differed significantly. For example, some programs exhibited a more communal, home-based feeling, while others allowed for more privacy and independence among residents. Some programs adhered more closely to faith-based or 12-step approaches to recovery, while others did not. Additionally, one program focused on women intentionally cultivated a gender-responsive, trauma-informed environment that focused on the self-growth and empowerment of women.

Recommendations

4.1. Develop a recovery housing manual to support individuals and agencies in developing and operating all levels of recovery housing.

4.2. Provide technical assistance and training opportunities to support recovery housing providers, including capacity building, business management and operations, marketing, coalition building and best practices in service delivery.

4.3. Facilitate technical assistance opportunities between the National Alliance for Recovery Residences and recovery housing providers.

4.4. Seek opportunities to provide training and technical assistance for peer staff.

4.5. Review state policies that require zero-tolerance relapse policies for funded recovery programs.

4.6. Identify and modify policies that inhibit rapid screening and intake (e.g., definitions and eligibility criteria for publicly funded programs).

4.7. Share best practices for developing recovery housing that help to address the barriers to housing stability.

4.8. Explore how lessons learned and preliminary infrastructure from the Access to Recovery (ATR) program may be used to inform the Ohio state recovery housing effort.

4.9. Support current ATR-funded recovery housing providers to ensure sustainability beyond the ATR grant period.

5. Effective recovery housing requires a range of recovery supports that are often the most difficult to fund.

The mix of services and supports available to residents varies by program—dictated in part by the level of care intended by the program as well as available funding resources.

Regardless of the number and type of resources available, programs strived to find ways to meet both the tangible and social support needs of residents. Below is a summary of services and supports identified across sites:

- ✔ Housing
- ✔ Basic case management
- ✔ Wraparound case management
- ✔ Mental health, addictions, and trauma counseling
- ✔ Individual and group therapy
- ✔ Relapse prevention
- ✔ Recovery coaching
- ✔ Peer support
- ✔ Spiritual support
- ✔ Vocational rehabilitation/employment skills training
- ✔ Job searching and coaching
- ✔ Health care
- ✔ Detox services
- ✔ Step-down recovery services
- ✔ Post-detox stabilization/interim housing
- ✔ Family reunification
- ✔ Children's and family counseling and services
- ✔ Education about the disease of addiction
- ✔ Refusal skills
- ✔ Grief support
- ✔ System navigation
- ✔ 12-step meetings
- ✔ Budgeting and savings
- ✔ Grocery shopping
- ✔ Nutrition and healthy cooking
- ✔ Recreation (e.g., parties, sports teams, dance classes, community activities)
- ✔ Volunteer opportunities
- ✔ Applications for income and healthcare benefits
- ✔ Child care (e.g., applying for vouchers)
- ✔ Apartment furnishings (e.g., furniture, dishes, decorations)
- ✔ Personal care items (e.g., personal hygiene, diapers, strollers, towels)
- ✔ Kids' summer camp program
- ✔ Transportation (e.g., rides, bus passes)

Finding employment is a consistent emphasis across recovery homes.

Earnings are most often used for rent, but not always. In some instances, employment or volunteering serve primarily as means of providing life purpose, and are not central sources of revenue for the recovery housing programs. Typically, residents are granted a brief grace period (1-3 weeks) before needing to have a job and begin paying rent. Whenever possible, job supports are made available, including interview training and coaching, resume creation, and access to job banks. Multiple programs use a phased employment strategy that supports new residents as they seek low-threshold, entry-level jobs as a first step when re-entering the workforce. These jobs were called "lily-pad" or "throw-away" jobs. The notion is that these jobs are used as a stepping stone. Though these types of jobs are often low-paid and can create stress, they are less likely to negatively impact a longer-term career path if the position does not work out. While working these jobs, the residents gain skills, confidence, and a renewed sense of responsibility while continuing to look for a more fulfilling (and often better-paying) job. This approach acknowledges the sometimes tenuous sobriety of residents in the early days of recovery, and avoids putting too much pressure on employment too quickly.

Some programs sought to provide a longer upfront period in the program that allowed residents to focus fully on recovery and wellness before considering work. This resource is dependent on the program's financial capacity to support residents who are not contributing to rent payments. This type of period when employment is not yet required may be important to engage residents in services that will help to identify and resolve issues that may impede their ability to find and maintain work (e.g., family of origin issues, unresolved trauma). Additionally, as the population needing recovery services becomes younger, residents may need more intensive job readiness or daily life skills training to help them successfully prepare for employment.

A key element to the recovery housing programs is peer support, especially in the early stages of program engagement.

Peer support is often made available through house managers (who are generally peers and former residents), peers or recovery coaches, and other residents. In the early days of treatment or residence at a recovery home, new residents tend to rely on these supports frequently. This may involve needing help getting to appointments, finding 12-step meetings, or simply grocery shopping. Staff noted that over time, as residents settle into the recovery housing, their need for constant support tapers. As residents move forward in their own recovery, they are also likely to end up serving as a support to others.

As the population needing recovery services becomes younger, residents may need more intensive job readiness or daily life skills training to help them successfully prepare for employment.

Nearby and present alumni networks have a positive impact on residents, and are often used to help engage someone during intake and in the early days of recovery. Alumni can serve as formal or informal staff, participate in meetings, and help newer residents find employment and services. These networks can be the difference in a resident finding employment, and being able to pay rent that keeps them in recovery housing. For example, formal alumni networks exist within Serenity Recovery. A nearby house includes men in recovery who often participate in group activities with current residents. Men at this house also act as informal supervisors at times when the house is not staffed. Additional recovery housing sites explored housing options for alumni support within proximity. After graduating from one participating program, a continued care plan involves weekly meetings for eight months and then recovery dinners every other week for six months.

In addition to informal peer support networks in recovery housing, there is a growing opportunity for peer counselors/peer support specialists or recovery coaches to receive training and certification. One program had a staff person undergo a train-the-trainer program at the Connecticut Community for Addiction Recovery (CCAR). She has since trained five peer mentors, who are now being paid through a grant.

Medication Assisted Treatment (MAT) and other prescription medications may pose challenges in recovery housing programs.

Medication Assisted Treatment (MAT) (e.g., buprenorphine, methadone, naltrexone) may be an effective tool for some people in recovery; additionally, some residents will need psychiatric or other medications related to health or mental health conditions. However, among recovery housing programs that welcome residents who were using MAT or psychiatric medications, some providers reported challenges. Some felt that the presence of residents using MAT could jeopardize the sobriety of other residents, since MATs are controlled substances. For example, in one home, MAT prescriptions were regularly stolen by other residents; in response, the owner installed a security camera. Across all homes, MAT prescriptions—along with other prescriptions—were closely monitored and safely stored and locked. Recovery housing providers may need support in developing capacity and safety and security procedures to house residents who are using MAT.

In addition to MAT, some psychiatric medications may need to be monitored for safety purposes. However, recovery housing also provides opportunities for residents to learn effective self-management of medications. In one program, case managers worked closely with residents to keep track of when they took their medications using a worksheet, which was discussed during case management meetings.

While many programs successfully provide or create linkages to a range of recovery supports, residents identified unmet needs, including:

Legal aid to address criminal records or debt-related issues. Program residents identified the need for legal supports, which are often not available through recovery housing programs. One focus group at the further identified a desire to develop a legal services model that incorporated a partnership between medical and legal entities:

> *"There are only a few models that include mental health and substance use along with legal professionals…There is so much going on in people's lives that can strain recovery and it doesn't stop when they are in recovery housing. Integrating those services could be really helpful."*

Many recovery housing residents may still be dealing with the criminal justice and probation/parole systems while in housing; others may be seeking to seal or expunge records of past offenses. Still others need help facing debts (e.g., credit, student loans) and bankruptcies.

Dental care. While some recovery homes have forged collaborations with health care providers to meet primary health care needs, dental care may be more difficult to find. However, it is important both for health and self-esteem, particularly when seeking employment. One administrator described a woman who was missing her front teeth and unable to get dental care to replace them. The case manager advocated for her, yet they were unable to obtain the needed service, and the woman continued to be challenged with finding employment due, in part, to her physical appearance.

Wellness and recreational supports. Participants expressed a desire for physical exercise opportunities, such as access to community gyms or recreational spaces in recovery homes that are separate from the main living area. Residents also noted the need for sober recreational and social activities, especially since conducting these activities in a sober environment is a new experience for them.

Recommendations

5.1. Link people in recovery to supportive services such as credit repair and legal aid to assist in helping to promote residential stability.

5.2. Ensure that employment is a central focus among recovery housing programs. Additionally, ensure that opportunities to secure income benefits are in place for people who may not be able to work due to a co-occurring disability or mental illness.

5.3. Facilitate employment opportunities available to people in recovery. Develop relationships with employers who are supportive of recovery programs and efforts.

5.4. Explore ways to create employment opportunities for individuals with criminal histories, which may pose barriers. This might include facilitating relationships with employers or reviewing policies that inhibit employment for specific offenses.

5.5. Launch an awareness campaign and/or provide incentives to businesses so that they consider hiring individuals in recovery.

5.6. Encourage providers of Medication Assisted Treatment to link with recovery housing and recovery support services.

6. Various mechanisms exist to support recovery housing. However, the availability of funds and ability to access them varies significantly.

Given the variation in recovery housing models, which range from independent, peer-run homes to scattered site models with staff and supports and residential treatment with 24/7 staff, the needs for funding also vary.

Typically, larger programs have a number of different funding sources to support both housing and services. Smaller, independent recovery housing providers may not have the means to apply for any type of public funding given their status and relationship (or lack thereof) with the local boards and Continuums of Care (CoC). For other programs, they may have the ability to secure funding for services and also some HUD vouchers or subsidies, but they may still struggle to maintain sufficient housing dollars. Across the board, the difficulties in securing funding to pay for housing and recovery supports (e.g., services that are not readily billable through Medicaid or block grants) are common. Additionally, continuous budget cuts in recent years have significantly reduced capacity to provide comprehensive recovery housing and recovery services and supports.

Currently, various funding sources could support recovery housing development and operation, though the degree to which they are available and utilized within communities varies significantly. Below is a summary of the funding resources for housing, and services and supports.

Funding for Housing

Funding sources for housing can be grouped into two major categories: capital funding and rental assistance. This does not cover any costs for services or recovery supports. The funding sources below summarize resources to support the cost of developing and acquiring new housing, as well as resources to support ongoing costs through rental assistance. There are unique opportunities for funding based on the type of model adopted.

Capital to Develop, Acquire, or Rehab Housing

Capital funding is any funding related to the development, acquisition and/or rehabilitation of a housing project. New construction projects require capital funding to get off the ground; often this requires a number of blended funding sources to break ground on a project. Examples are below:

- ✔ Community Development Block Grant (CDBG)
- ✔ Ohio Department of Mental Health's Community Capital for Housing Program
- ✔ HOME program
- ✔ Housing Opportunities for People with AIDS (HOPWA)
- ✔ Ohio Housing Trust Fund
- ✔ National Housing Trust Fund
- ✔ Federal Low Income Housing Tax Credits
- ✔ Section 202 Supportive Housing for the Elderly
- ✔ Section 811 Supportive Housing for Persons with Disabilities
- ✔ Section 515 Rural Rental Housing
- ✔ Supportive Housing Program
- ✔ Tax Exempt Bond Financing
- ✔ Community Development Financial Institutions
- ✔ Community Development Corporations
- ✔ Community Foundations
- ✔ Land Trusts

While many potential mechanisms for accessing capital funds exists, these resources can be difficult to access. They often require complex application processes and support from attorneys. Additionally, the various funds carry different time limits, ranging from five to fifteen or more years. Programs that successfully secure capital funds may need to seek additional funding to support operating costs or services—costs that would typically not be covered by these funds.

Rental Assistance

Rental assistance is any funding related to the cost of provision of housing, typically limited only to the cost of rent. It is not inclusive of utilities or living expenses. Rental assistance programs are made available either as project-based or tenant-based subsidies. These programs allow tenants with vouchers to rent at a reduced rate (typically 30% of their income) in the private market. However, some rental assistance programs may also be tied to a program or unit commonly referred to as project-based rental assistance. Project-based rental assistance can be a good funding match for recovery residences as the funding subsidizes the costs of the units and the subsidy remains with the unit, unlike tenant-based assistance, which follows the tenant. However, persons occupying the units may be required to meet income qualifications. Brief descriptions of both types of rental assistance subsidies are below:

Tenant-Based Rental Assistance (TBRA). Tenant-based rental assistance programs represent the majority of affordable housing in the U.S. This includes programs such as the Housing Choice Voucher Program (Section 8) and the Continuum of Care Supportive Housing program

(Shelter Plus Care Program). Tenants in these programs select and rent in the private market, and pay 30% of their income towards rent. These programs are administered by Public Housing Authorities, which pay the balance, up to a maximum fair market rent established by HUD. There is no time limit on assistance and tenants may continue to receive subsidies as long as they comply with program rules and remain income-eligible. Tenant-based vouchers are a good housing alternative for persons who require some form of subsidized housing. For recovery housing residents, access to tenant-based rental programs may present an opportunity to move to more permanent affordable housing.

Tenant-based subsidy programs are helpful because they can be used to rent anywhere in the private market, providing a great deal of client choice. Additionally, development of these programs typically do not raise community opposition as they rely on existing rental market housing. However, some stigma can be associated with voucher-holders, and landlords often will not accept vouchers, especially in tight rental markets. This challenge can be compounded by individuals who have poor credit or criminal histories.

Despite the importance of TBRA, vouchers are typically difficult to obtain, since many communities have long waiting lists for people seeking these subsidies.

Project-Based Rental Assistance. Project-based rental assistance, often provided through Public Housing Authorities (PHAs), provides subsidies that are committed to a specific unit in a building through

Ohio Administrative Codes that Support Funding for Housing

Ohio Code 3793.19 Revolving loans for recovery homes fund. This funding source is available to create small-scale recovery residences. Up to $4,000 per residence for security deposits and start-up costs is available in loans to be repaid within two years of the loan disbursement. The revolving loan fund is for the provision of housing for at least four individuals recovering from alcohol or drug abuse.

Ohio Code 2967.14 Halfway houses or community residential centers. Under the Code, the Director of Rehabilitation and Corrections shall adopt rules providing for the use of no more than fifteen percent of the amount appropriated to the Department each fiscal year for the halfway house, re-entry center, and community residential center program to pay for contracts with licensed halfway houses for nonresidential services for offenders under the supervision of the adult parole authority. As discussed earlier, funding can be utilized to provide recovery residences for adult offenders.

Ohio Code 3793.20 State participation in construction or renovation of community residential treatment and outpatient facilities for alcohol and drug addiction services. Under this code, the State of Ohio can provide funding to government entities or private nonprofit agencies to provide alcohol and drug addiction services. This includes funding for the construction or renovation of community residential treatment and outpatient facilities for alcohol and drug addiction services. This funding may be approved as per the following guidelines to the extent funds are available:

The Director of Alcohol and Drug Addiction services may approve the provision of up to 80% of the total project cost where circumstances warrant.

The Director may, where circumstances warrant, use the value of existing facilities or other in-kind match for the local share of the communities' share of the cost.

Upon recommendation of the Director, for services of the highest priority of the Department of Alcohol and Drug Addiction Services, state participation may be approved by the controlling board in amounts that exceed the amount authorized under the Code.

a contract between the owner and the agency administering the subsidy. In project-based rental assistance, the rental subsidy is tied to a particular unit and remains with that unit. In order to qualify, tenants must represent extremely low- and very low-income households with incomes that do not exceed 50 percent of the median income for the area. As eligible tenants move into the unit, they typically pay 30% of their income for rent and the project-based rental assistance covers the difference between the tenant portion of rent and the approved monthly rental charge for that unit (TAC, 2002). Project-based rental assistance is a useful tool to support the creation of new affordable housing units by providing a permanent subsidized funding source for the creation of units. Access to project-based rental assistance can be limited and requires coordination with local PHAs.

Common sources of rental assistance include:

- ✔ HOME program
- ✔ Housing Opportunities for People with AIDS (HOPWA)
- ✔ Section 8 Housing Choice Voucher program
- ✔ Continuum of Care (CoC) Homeless Assistance Grants
- ✔ Veteran's Affairs Supportive Housing

Funding for Recovery Services and Supports

Among programs that provide higher levels of care, especially Level III and IV homes, the provision of services requires resources that are typically outside of the scope of resident self-payments or rental assistance programs. This includes addiction and mental health counseling, trauma counseling, and other health-related services. Among recovery residents in the private mainstream market, residents may be able to use private insurance to cover these services. However, among programs serving low-income, poor, or homeless populations, the most common resources are through government and foundation funding.

Recovery supports appear to be the most difficult piece to support, across the range of recovery housing models. Often these supports are less formal and include non-clinical, non-billable services such as peer support, transportation, purchase of personal and children's items, clothing, etc. Despite the lack of funding, many recovery housing stakeholders identified these wraparound supports as the key ingredients that help recovery homes to succeed. It is these activities that extend beyond traditionally funded services that help people to regain recovery and stability. The mix of recovery supports needed is different for every person. However, finding dollars to support these flexible, personal supports is extremely difficult.

Among large service agencies that have the capacity to bill for Medicaid, this is viewed as an important revenue resource. Although the reimbursement rates are low, Medicaid can be used to support addiction treatment services, which frees other unrestricted funds that a program may be using to provide basic treatment and supports for residents. These funds often come from foundations or private contributions; county levy dollars can also be used as a more flexible source of funds. However, the more that these unrestricted dollars are used to pay for treatment that could otherwise be billed through Medicaid or other insurers, the less these resources are available to fund recovery supports, which are urgently needed to help people in recovery to regain stability. Given the complexity of billing Medicaid, it is difficult for smaller grassroots recovery housing providers to become eligible to do this.

In addition to the barriers for smaller recovery homes in billing Medicaid, it is a limited resource overall. Currently, Ohio's decision to expand Medicaid coverage is pending. While the expansion would help thousands of Ohioans living in poverty, the number of people who

COMPARISON OF HOUSING MODELS FOR RECOVERY HOUSING

Type	Cost Factors	Potential Funding Sources	Benefits
Master-Leasing	▪ Rental costs ▪ Maintenance ▪ Utilities ▪ Repairs/damages ▪ Insurance ▪ Supportive services ▪ Household goods	▪ CoC Homeless Assistance Grants, ▪ HOME Grants ▪ City/County General Funds ▪ Foundations ▪ Charitable Giving ▪ Can be partially funded by resident contributions*	▪ Housing can be procured quickly ▪ Fairly low cost depending on market ▪ Can be supported by resident contributions ▪ Reduce chance of community opposition ▪ Typically does not require local zoning permitting[5]
Tenant-Based Rental Assistance	▪ Supportive services (optional) ▪ Resident typically responsible for household items, everyday maintenance, utilities	▪ Section 8 ▪ VASH ▪ HOPWA ▪ CoC Homeless Assistance Grants ▪ HOME Grants ▪ City/County General Funds ▪ Foundations ▪ Charitable Giving ▪ Can be partially funded by resident contributions*	▪ Permanent subsidized housing ▪ Cost of housing is responsibility of the tenant ▪ Reduce chance of community opposition ▪ Once tenant has voucher housing can typically be obtained quickly (depending on housing market)
Ownership	▪ Capital investment ▪ Mortgage ▪ Insurance ▪ Taxes ▪ Capital repairs ▪ Rental costs ▪ Maintenance ▪ Utilities ▪ Repairs/damages ▪ Insurance ▪ Supportive services ▪ Household goods	▪ CDBG ▪ HOME ▪ Foundations ▪ Charitable Giving ▪ Housing/Land Trusts ▪ City/County General Funds ▪ Can be partially funded by resident contributions*	▪ Permanent recovery housing resource ▪ Can be supported in part by resident contributions ▪ May not require local zoning permitting ▪ Flexibility in leasing
Project-Based Rental Assistance	▪ Supportive services ▪ Capital costs if purchasing/new construction ▪ Household goods (furniture) ▪ Insurance ▪ Maintenance ▪ Utilities ▪ Repairs/damages	▪ PHAs-Section 8 ▪ HOPWA ▪ Can be partially funded by resident contributions*	▪ Can help to subsidize housing and supportive services ▪ Permanent housing ▪ Good source of funding for new developments
Transitional Housing	▪ Rental costs ▪ Maintenance ▪ Utilities ▪ Repairs/damages ▪ Insurance ▪ Supportive services ▪ Household goods(furniture)	▪ HOME ▪ CoC grants ▪ Can be partially funded by resident contributions*	▪ Can be operated through masterleasing

COMPARISON OF HOUSING MODELS FOR RECOVERY HOUSING

Type	Cost Factors	Potential Funding Sources	Benefits
Permanent Supportive Housing	▪ Supportive services ▪ Operating costs ▪ Capital costs if purchasing/new construction ▪ Mortgage ▪ Insurance ▪ Taxes ▪ Capital repairs ▪ Maintenance ▪ Utilities ▪ Repairs/damages ▪ Household goods	▪ Section 8 ▪ VASH ▪ HOPWA ▪ CoC Homeless Assistance Grants, ▪ HOME Grants ▪ City/County General Funds ▪ Foundations ▪ Charitable Giving ▪ Can be partially funded by resident contributions*	▪ Permanent recovery housing resource ▪ Can be supported in part by resident contributions ▪ May not require permitting ▪ Flexibility in leasing

* Resident contributions are typically capped at no more than 30% of resident's income

5 Permitting may be required if number of occupants per house exceeds that permitted by local ordinances

would be newly eligible is not sufficient to serve as a complete solution for recovery housing providers. Not all recovery homes primarily or even partially serve individuals who are living at or below 138% of the poverty level. Additionally, homes that offer lower levels of services do not provide services that would be eligible for Medicaid billing. Additional funding solutions are needed to ensure that all childless adults as well as parents and families who are struggling with addiction will have access to recovery housing.

Commonly used resources to fund services include:

- ✔ Federal Grants (e.g., SAMHSA, ACYF, Department of Labor, Department of Justice, CMS, HRSA)
- ✔ State Grants (e.g., ODADAS, ODMH)
- ✔ County Alcohol Drug and Mental Health (ADMH) Board Levy Funds
- ✔ Medicaid
- ✔ Foundations
- ✔ Donations
- ✔ Resident Self-Payments

Resources identified to fund recovery supports include:

- ✔ SAMHSA's Access to Recovery (ATR)
- ✔ County Alcohol Drug and Mental Health (ADMH) Board Levy Funds
- ✔ Foundations
- ✔ Donations
- ✔ Resident Self-Payments

Resident self-payments are a common form of revenue for programs across the spectrum of recovery homes, particularly Levels I-III.

Among communal, peer-run recovery homes, all residents are expected to share an equal amount of the household expenses. Thus, these recovery houses are effectively self-funded. Over time these homes become self-sustainable, which leads to greater stability for residents because they are not vulnerable to government budget cuts (Polcin et al., 2012a). Recovery

housing programs that are situated in larger service programs also charge rent, typically 30% of a person's income, or a flat fee ranging from $75-$125 weekly. Smaller programs may be fully reliant on this income; larger programs have the flexibility to subsidize the rent at times. Additionally, residents' ability to pay some or all of their rent costs has historically been an important cultural value in the context of recovery. In the event that someone is unable to work due to a physical or mental disability, they are often expected to volunteer or work part-time in some capacity, in an effort to pursue purposeful activities.

Recommendations

6.1. Consider voucher set-asides or preferences for disabled/recovery populations.

6.2. Evaluate the success of the revolving loan program in creating recovery housing.

6.3. Use the revolving loan program as a model for creating a funding stream to support development of new recovery residences. Adapt the model as needed to allow for varying recovery housing models.

6.4. Explore ways to create a funding resource that will provide short-term rental assistance to people newly in recovery.

6.5. Explore opportunities for funding to subsidize recovery housing to ensure it is affordable for persons with limited or no income supports.

6.6. Establish a revolving loan fund to support the upgrade of facilities to meet building codes.

6.7. Create a funding stream for non-Medicaid recovery support services, similar to the Access to Recovery program.

6.8. Explore tax credits for recovery housing providers that primarily serve poor, low-income or homeless populations.

6.9. Educate recovery housing providers about sources of capital funds and funding streams and strategies for successful applications.

6.10. Consider a set-aside of capital funds available through the consolidation of ODMH/ODADAS to develop or upgrade recovery housing.

6.11. Support small recovery home programs to connect with larger organizations to support Medicaid billing functions.

6.12. Encourage the development of housing models which provide alternatives to market rate housing.

6.13. Partner with Public Housing Authorities to link them to recovery housing efforts.

6.14. Consider how all levels of recovery housing may be prioritized in funding opportunities.

6.15. Explore how other states (e.g., Texas, Connecticut, Pennsylvania) have supported recovery community organizations in providing reimbursements for recovery coaching and recovery support services.

6.16. Explore how Medicaid may be used as a resource to fund peer recovery coaches in recovery homes.

7. Recovery housing providers require support in connecting and collaborating with established systems of care rather than creating a parallel system.

Recovery housing providers find themselves at the intersection of several parallel systems, each with their own taxonomy for language, services, and funding.

In addition to variations in publicly funded systems and resources, there are several other divisions that create challenges to a more cohesive statewide or national recovery housing effort, including differences within the recovery housing movement, viewpoints on the delivery of addictions services, and connection to other systems of care. This creates barriers for collaborating with funders, local coalitions and Continuums of Care (CoC), government agencies, and other stakeholders. Individuals who reside in and provide recovery housing may come from various systems or experiences that span public and private housing, treatment and 12-step services, criminal justice, and others.

One national stakeholder suggested that "recovery" may be the most helpful unifying concept to bring various systems and resources together more effectively. However, even this word raises questions. For example, does recovery mean the same thing as sobriety? Is reduced use over a period of time considered recovery? These questions have implications for research and data collection efforts, funding resources, as well as individual and programmatic differences in understanding the recovery process and the supports that are required.

Recovery housing providers span clinical and socially based models.

Within the addiction treatment world, there is often a divide between recovery housing providers who are independent of the broader treatment continuum and treatment providers who offer traditional clinical treatment interventions. Non-traditional recovery support providers may be described as adhering to a "social model," with a focus on peers, 12-step meetings, and group living as pathways to recovery. According to one national stakeholder, this group of recovery housing providers may be perceived as being completely divorced from the mental health and addiction treatment continuums, creating challenges when seeking collaboration, community support, and funding.

Despite a model that provides housing, recovery housing programs do not always identify as part of the HUD Continuum of Care (CoC).

While many residents in recovery housing programs may have histories of homelessness, or were homeless or at imminent risk of homelessness upon entry into the program, the programs are not always connected to or aligned with local housing and homeless service systems. At times, this is because a recovery housing provider may not be seeking or receiving public dollars, which are often administered through local boards or Continuums of Care (CoC). However, some differences appear to be due to the primary orientation of program services. For example, a recovery housing or treatment provider may view their program as primarily providing treatment or recovery supports rather than housing. Particularly among level III and IV recovery residences, these programs are more often viewed as transitional or inpatient settings, rather than as any sort of long-term housing resource. Some community stakeholders agree with this view, and would opt not to include programs representing these

higher levels of care under the framework of housing. In some ways, the shelter aspects appeared secondary to the recovery-oriented goals of the program. In contrast, within the homeless services system, the focus is most often oriented towards housing units, vouchers, and subsidies, with the availability of and connection to clinical and supportive services varying.

Within the context of the HUD CoC, there may also be some resistance to recognizing recovery housing as a viable model that should be funded through homelessness programs. Across the state, communities are tasked with prioritizing the local needs of the homeless population and administering funding resources, typically through the CoC. In areas where street homelessness or chronic homelessness is an urgent need, the majority or total funding available may be targeted to this population. This might impact how someone in recovery—whose housing may be tenuous or non-existent—will seek and be eligible for services. This is especially problematic among women and families, or others who tend to couch-surf among friends and family members, or may be exiting detox or short-term treatment programs. In these instances, local supportive housing resources (some of which may be addiction/recovery-focused) may not be available to them if they are not showing up or qualifying as a homeless person according to local priorities. Beyond these issues of definitions and eligibility, CoCs and communities may be understandably guarding the limited resources they have to operate their own programs or enforce funding priorities.

Definitions of recovery housing remain unclear, which may contribute to confusion and misperception about the potential benefits of the model.

Notably, several recovery housing residents discussed their movements in and out of homelessness at various points in their lives, while not framing housing as a primary need that led them to recovery housing programs. This may indicate one's identity related to addiction; it may also indicate a lack of involvement with housing and homeless services systems.

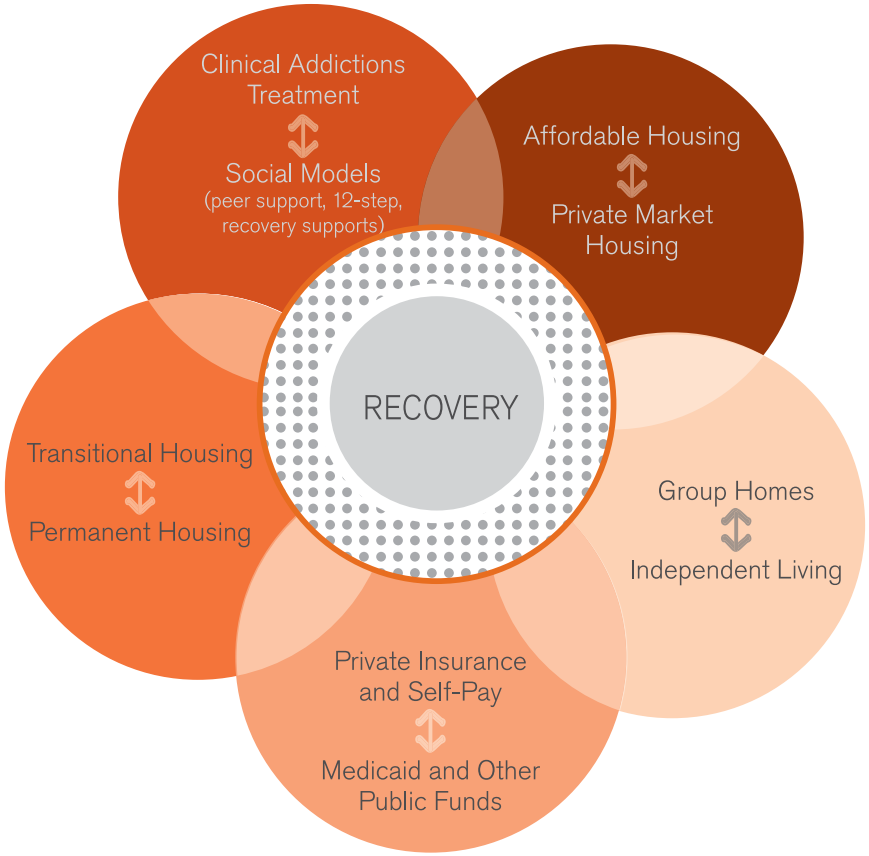
Affordable housing stakeholders recognize that recovery housing is an important choice within the housing continuum for some individuals and families.

Among recovery housing advocates, some have expressed concern that there is no room for recovery housing in the current continuum of affordable housing options. This is due to national shifts in policy towards a permanent housing framework, which has reduced transitional housing options. Additionally, models such as Housing First and Permanent Supportive Housing have been widely adopted. Housing First promotes the immediate placement of individuals into housing, based on the belief that a person will be better able to stabilize other areas of his or her life (e.g., addiction, mental illness) once their basic need for housing is met. Housing First also includes harm reduction principles, which may mean that a person is currently engaging in substance use or other risky behaviors while in housing, with an anticipation that these risk behaviors will improve as the person remains in housing. Permanent Supportive Housing has been a primary means of housing people with histories of chronic homelessness in Ohio. It emphasizes client choice, voluntary participation in services, various supports, and permanent—rather than transitional—

housing. Both models also promote independent living, often in individual or shared apartments and scattered site housing units.

Despite the prominence of these models in Ohio and nationally, most key informants recognized the value of recovery housing, noting that some people need a clean and sober environment or may benefit from the presence of a communal peer group as they engage in recovery. Stakeholders emphasized the importance of framing the various models along a flexible continuum of choice, rather than one that requires a linear step-down or "housing readiness" framework. Several noted that definitions of recovery housing remain unclear, which may contribute to confusion and misperception about the potential benefits of the model.

Multiple Systems and Contexts that Intersect with Recovery



The funding and technical assistance needs of recovery housing providers seeking to serve poor and low-income populations will differ from those targeting a private market.

Some recovery housing providers choose to target their programming towards populations who would otherwise have no access to services—those who are low-income or experiencing poverty and homelessness. However, many programs cater to individuals who have the personal or family resources available to fund their stays in treatment and/or recovery homes. These resources may be through private insurance or self-pay. Among programs currently affiliated with NARR, the organization estimates that the majority of recovery residences use a fully "self-pay" model without any publicly funded supports. This variation among recovery housing providers may create challenges in standardizing guidelines.

Recovery housing programs that are able to operate without public dollars will maintain more flexibility. Among those who currently use or wish to pursue public funding, they will need support in developing the capacity to secure and administer these funds, and they may find themselves needing to align and comply with regulations and standards set by multiple government agencies. Additionally, providers in a private market will approach marketing, outreach, location, and rental costs differently. These differences may impact how NARR and other supporting agencies prioritize and provide technical assistance, facilitate a dialogue, and develop affiliate organizations in Ohio.

Government funding regulations do not always align with recovery housing programs, populations, and needs.

Currently, some government funding resources that could potentially support recovery housing may pose barriers to providing programming that support people in recovery from addictions. For example, some HUD funding carries requirements related to minimum occupancy rates. This creates difficulties in recovery housing programs where residents are newly in recovery and the likelihood of them leaving the program is high. Particularly in light of the opiate crisis in Ohio, the changing face of the population is such that individuals are younger and more often experiencing their first time in a treatment program or sober living environment. This may add to their desire not to stay in a recovery-focused environment the first time. If a funded program falls below the occupancy requirements—or if they violate any other HUD regulations, the CoC can withdraw funding.

Disability is also defined differently across systems. For example, the federal Fair Housing Act includes substance abuse as a disability. However, social security benefits do not. This could create a situation where individuals and recovery housing providers should not face discrimination for recovery-focused housing; however, there will remain challenges in securing income benefits for people with a primary disability of addiction.

Recommendations

7.1. Survey recovery housing providers to identify policy barriers that inhibit them from seeking currently available public funding streams.

7.2. Modify policies and regulations to align with the populations, needs, and housing situations of people seeking recovery housing and recovery support services.

7.3. Recovery housing providers and NARR affiliates should build relationships with local HUD Continuum of Care leaders.

7.4. Provide technical assistance to recovery housing providers on how to work with public funders to address potential policy barriers while maintaining compliance with grant requirements.

7.5. Encourage treatment providers that receive block grants and other public funds to educate clients about recovery supports outside of treatment that promote and sustain long-term recovery.

7.6. Consider policies that would encourage recovery housing referrals and linkages for people who have received treatment multiple times.

8. Within local service networks, some recovery housing providers experience perceived and actual barriers to collaboration.

Recovery housing is often left out of local community priorities, which dictate resource allocation.

In local community planning, recovery housing is generally not deemed a priority model of housing or services. As a result, funding is limited or non-existent, or the population to be served by recovery housing is not considered eligible. The availability of HUD funding for affordable housing is dictated by how the local Continuum of Care (CoC) decides to target resources. Among HUD's various eligible categories of homelessness (e.g., people living on the streets, people at imminent risk of homelessness, disadvantaged youth, and people experiencing domestic violence), a local CoC will decide where to target funds. In one community, all HUD dollars are being targeted to street homelessness, which creates difficulties for recovery housing programs that are serving women and families, who are more likely to be invisibly homeless or at imminent risk of homelessness (e.g., couch-surfing, living in an abusive relationship) than living on the streets.

Grassroots or community-based organizations (CBOs) tended to view themselves as poorly resourced, and excluded from local funding, networking, and decision-making opportunities.

Among smaller, more independent recovery housing and recovery support programs, there is a perception that they are excluded from decision-making tables and local networks of service providers. Most felt that they did not receive their fair share of funding resources, and often none at all if they operated independently of the local service provider networks. Many referred to themselves as community-based or grassroots organizations (CBOs), and compared themselves to traditional treatment providers. In some communities, this divide was framed as treatment providers vs. post-treatment providers (e.g., housing or other recovery supports).

The perception is that the traditional treatment provider agencies have more resources to provide services as well as the infrastructure and skilled staff to successfully pursue new funding opportunities and enhance programming. These treatment providers are viewed as preferred and therefore able to receive many more client referrals. Individuals representing more traditional treatment provider agencies were quick to point out the struggles they also face regularly in terms of funding and billing, even though they may have a more robust infrastructure. Administering grants and contracts to provide services requires specific certifications, staffing levels, training, and use of evidence-based practices. These requirements increase the cost of delivering programming.

Faith-based organizations seemed to be grouped alongside community-based or grassroots organizations. While the degree to which spirituality or specific religions impacted the housing varied, faith-based organizations were viewed as less business-oriented and consequently less sustainable. These programs tend to be driven by donations and staffed fully or partially by volunteers.

The real and perceived barriers for grassroots or community-based organizations (CBOs) to develop sustainable recovery housing are significant.

CBOs are often viewed as having developed recovery housing based on personal experience and passion for recovery. Conversely, traditional providers did not want to be viewed as lacking passion simply because they have successfully developed infrastructure and funding resources. CBOs noted that the lived experience, passion, and peer support are essential to effectively operating recovery housing. However, some CBOs felt the need to reframe how they are viewed among other community agencies. Being viewed as "passionate" could be misinterpreted as lacking skills in business and service delivery, or operating programs without rules, standards, or best practices.

The decision of whether to support someone while they have no income is challenging and pits business operations against the resident's pathway to recovery.

Despite concern, the experience of opening a program without a sound business plan was common. Recovery housing providers often risk their own money. As one person noted, "we pay for our education" by learning difficult lessons. These challenges come up when beds are not filled or when residents are unable to contribute rent due to unemployment or illness. The decision of whether to support someone while they have no income is challenging and pits business operations against the resident's pathway to recovery. These challenges are more difficult among recovery housing providers who have no sources of program revenue other than residents' rent payments. Organizations that are able to access other resources (e.g., block grants, Medicaid, county levy funds) can more readily develop a cash reserve that provides flexibility in supporting residents over time. Overall, the recovery housing providers noted that there is no manual for setting up recovery housing and that a resource of this type would be useful.

Some recovery housing providers experience difficulty securing referrals from local agencies and networks.

Some CBOs in Ohio (as well as other states as noted by key informants) experienced challenges in getting community referrals into their program. Larger, well-established treatment centers appeared to be better able to secure referrals, which allowed them to keep their beds fuller and generating revenue. While some referrals may be made due to a person's treatment needs (e.g., detox or residential treatment vs. recovery housing); the problem seemed broader. Competition for referrals was particularly problematic when state or federal funding was available, as in some counties that received Access to Recovery (ATR) funds. Beyond the competition for available dollars, smaller recovery housing providers are either not "on the radar" of referring agencies, or these agencies may not know enough about the range or quality of the services and supports being provided. Some noted that they have pushed for years to get connected and "play nice" with other programs, without success. One provider of a women's recovery home had not been able to get anyone into her program since she opened. Other programs had beds and even whole homes that remained empty.

The county boards are perceived in some communities as preferring to fund traditional detox and residential treatment services, rather than recovery housing and other recovery supports. These relationships were sometimes referred to as monopolies, given the manner in which the majority of resources were targeted. One stakeholder noted that this type of diversion of referrals is typical when public funds are available to support people who would be eligible and interested in recovery housing. In some communities, there are restrictions or rules in place that require assessment agencies to refer to selected treatment providers.

Individuals in the criminal justice system may also be required to receive an assessment at particular locations, based on the mandate of the court system. These individuals are often not allowed to use any other type of services than those that were recommended, even if he or she is not successful in this program one or more times. One stakeholder noted that these systems often do not understand the concept of recovery, nor how an effective recovery housing program might reduce recidivism.

Notably, some participants were surprised to hear the difficulties with referrals, given the shortage of housing resources across communities. In some areas, the waitlists posed more problems than the need to secure referrals and fill beds. This discrepancy may highlight the vast differences from county to county, as well as the different experiences with parallel yet overlapping service systems.

Individuals receiving services are often not well-informed about the range of recovery housing and supports available, which impacts referrals and treatment decisions.

Some recovery housing providers described the county-based service provider networks as closed systems that do not suggest recovery housing as a resource for clients that are seeking support. Additionally, some people are not well informed about available community resources and do not know enough to ask for a recovery housing placement. Regarding those who have sought recovery housing, some recovery housing providers shared stories of these clients being linked to larger housing programs with treatment services that are part of a county board network rather than being given a choice among a range of options including smaller or private recovery housing in the same community.

Recovery housing providers need support to understand how best to work with counties and other networks of service providers.

Some newer or smaller recovery housing providers may lack an understanding of how their local service network or CoC works, as well as the broader context of community priorities. Some boards express support for recovery housing as well as a desire to find ways to support smaller grassroots recovery housing and recovery support programs. However, many of these programs approach boards seeking funding and this is often not feasible given a limitation of funding for addictions services, shrinking budgets more generally, and lack of needed certifications or infrastructure to receive and manage funds.

County board representatives recommended that recovery housing providers explore the certifications they would need to become eligible for government funding when available, and that they contact other community agencies—including those making referrals—to market their services. Counties may also need to set up contracts with agencies in order to begin making referrals. Without this mechanism in place, recovery housing providers may not be able to secure referrals. One CBO shared their experience in requesting referrals through a

service grant and being told by the county board representative that "he had no contract for referrals." This experience is reflected by other national stakeholders. In some recovery programs, peer staff are seeking credentials as case managers so that they can participate in making referrals. However, this is not always a desire for peer-run programs that may wish to remain independent rather than compete for public funds, especially if the funds would require specific practices or structures that would change the nature of the home.

Recommendations

8.1. Build networks among recovery organizations and related service providers within communities and counties.

8.2. Identify Housing Specialists working in homeless services systems and develop collaborations that support referrals.

8.3. Encourage county boards to invite recovery housing providers to key meetings and to allow space for presenting about recovery housing issues, needs, programs, and outcomes.

8.4. Encourage programs receiving county funds to establish and demonstrate partnerships with recovery housing providers.

8.5. Explore ways to incorporate recovery housing resources into criminal justice referrals.

8.6. Conduct outreach to county administrators, and stakeholders from criminal justice and other related systems to share information about recovery, and the potential benefits of recovery housing and recovery supports.

8.7. Support county ADMH boards to include recovery housing providers in community planning processes and identify strategies for integrating recovery housing providers in local service networks. This might include conducting outreach to recovery housing providers and inviting them to join planning meetings and share information about their programs with other community agencies and stakeholders.

8.8. Explore ways that existing certification mechanism might be applied or modified to communal recovery housing settings.

9. County and local community contexts influence the development and expansion of recovery housing.

Support from legislators and other local stakeholders is essential to support recovery housing.

During one focus group, it was stated that legislators should know that:

> *"Recovery is an investment in the community. You are funding professionals to work with citizens in need. These are your constituents. This is a statewide problem, so every county needs to think about this."*

Additionally, stakeholders should know that:

> *"Recovery works, and people in recovery work. It benefits society in general, and spills into economy and workforce."*

Another provider described the effect of one person's recovery as "touching many in their life." Recovery supports working together were described as "some services planting the seeds, and others bringing the fertilizer."

When informed, local stakeholder groups may be supportive of recovery housing. Several key informants identified the need to conduct education and outreach to various entities, including neighborhood associations, city or town councils, county boards, and other stakeholders. They believe that if stakeholders are informed about the importance of recovery housing, that it will become a higher priority and resources will be allocated more consistently. When faced with a hearing about the possibility of a new recovery home, advocates must be prepared to offer evidence-based information about addiction, the benefits of recovery housing, savings to the local community and service systems, and how grievances would be handled. One provider earned a favorable city council decision by presenting information on the outcomes of recovery housing, integrating his personal story of recovery, and identifying himself as the responsible owner and manager of the property.

However, the openness of neighborhood associations is not uniform. Some communities have expressed concern with the prospect of siting facilities that house people with criminal backgrounds. This opposition can completely stop development, depending on the local political influence.

Marketing to policymakers and the community involves passion and getting buy-in. Key elements for effective leadership include good communication and transparency, along with clear demonstrations of success. One key informant described the process of opening recovery housing (rented from the housing authority) with outpatient Medication Assisted Treatment (MAT). He described a process

> "Recovery is an investment in the community. You are funding professionals to work with citizens in need. These are your constituents. This is a statewide problem, so **every county needs to think about this."**

that included community engagement through connections with the housing consortium and the HUD Continuum of Care (CoC). Before opening the house, this recovery housing provider held a community meeting with the housing authority, neighborhood association, and hospitals. At the opening of the house, a kick-off was held with a ribbon cutting ceremony.

One stakeholder noted that the Corporation for Supportive Housing offers a helpful toolkit called the "Six Steps to Building Community Support" (2006). Recovery housing providers may be able to draw useful lessons from this document and apply them to recovery housing.

Efforts to offer community service, maintain homes and yards, and act as good neighbors forge positive relationships and buffer against stigma.

Some founded community concerns are increases in traffic, volume, and parked cars, but recovery housing programs have minimized these concerns with rules against clustering outside, creating privacy with fencing, and by talking with neighbors about ways they can help with needs, like mowing lawns. Further, maintaining homes well can turn skeptics into champions for recovery housing. As described during one focus group,

> *"Their housing is often better than the housing around (which is very depressed), it is well kept. They stay in areas that are rental, mixed zones, to overly affluent, which helps. Towns have really become accepting and are now offering up housing."*

CASE STUDY: THE RECOVERY CENTER, LANCASTER, OHIO

Pearl House-Permanent Supportive Housing Project

Pearl House is a permanent supportive housing project for people in recovery. Trisha Saunders the CEO of the Recovery House described the journey the Center took in developing this new construction project. "We were seeing a high rate of relapse for people who we sent outside of the community for residential treatment…they just weren't able to sustain recovery." The purpose of developing Pearl House is to provide a safe, stable place for individuals in recovery—close to community supports and the Recovery Center's outpatient treatment services.

The proposed development aimed to provide 36 units of permanent housing. However, during the process of developing Pearl House the project was confronted with a number of barriers that threatened to halt the development.

The project experienced an overwhelming response from an organized group in opposition to the project. Some local residents brought concerns to the city council regarding the nature of the project even though no city council action was required. In addition, the group challenged the local zoning board by filing a grievance against the development. This created negative publicity and resulted in legal action in hopes to stifle attempts to locate the project in the downtown. The city and the developer incurred significant legal fees in a Board of Zoning process that resulted in the denial of zoning variances and the reduction in the size of the project.

Due to strident opposition by a small group of citizens, the strictest interpretations of local zoning laws were applied to the project. Because of the tone and voracity of the opposition, the local zoning board did not grant variances to this project as they had to others. This resulted in the developer changing the project from 36 to 21 units.

Trisha notes that the Recovery Center has learned a lot from the process, particularly the importance of planning for how to respond to community opposition and how to dispel myths and misconceptions about recovery housing.

Pearl House is continuing to address barriers created by budget reductions and hopes to open its doors soon, to provide a much needed resource to the City of Lancaster.

For more information on the Recovery Center visit http://therecoverycenter.org.

Addictions services, and especially recovery housing, are often underrepresented among county boards and through state funding.

Across the state, the role of county-level Alcohol Drug and Mental Health (ADMH) boards is to provide a structure for planning and administering funds for the provision of mental health and addiction services. This includes treatment, prevention and recovery support services that create opportunities for persons with substance use disorders and mental illness. As funding resources are made available through federal, state and local tax levy dollars, the counties contract with a network and then provide oversight, technical assistance, and support.

Though historically separate, alcohol and drug boards are now commonly merged with mental health boards. Across all counties in Ohio, very few remain separate. With boards that have recently merged, the alcohol and drug addiction treatment stakeholders are sometimes marginalized. The share of funding for mental health services greatly outweighs the funding for addictions services across the state. At the county level, this impacts funding for addictions treatment, recovery housing, and other recovery supports, as well as the ways in which recovery advocates are invited to participate in funding opportunities, planning, or decision-making.

The operations, policies, and political priorities of boards vary significantly. Some boards are funding recovery housing efforts, but advocates in other counties expressed concern about the lack of priority given to addictions services. Participants reported that more education and advocacy was needed.

Stigma in Communities

The greatest barrier to neighborhood acceptance is social stigma due to bias and negative judgments towards people with substance use disorders (Keyes et al., 2010). This stigma often results in the phenomenon referred to as "Not In My Backyard" or NIMBY-ism, the opposition by residents to a proposal for a new development because it is close to them, even if those residents believe that the developments are needed in society overall. This phenomenon can at times lead to hostile relations with the outside community (Polcin et al., 2012b; Zippay, 1999). Often, "local governments with NIMBY political pressure… illegally discriminate with land use or health/safety ordinances" (see NARR, 2012, p.31). Recovery residences are often either harassed out of municipalities or unable to become established in the first place. Stigma against people struggling with addiction also occurs among community stakeholders. Within the broader network of social services, the priority given to individuals whose primary need is related to drug and alcohol addiction is typically low. This bias is especially strong toward single adult males, who may be viewed as the least deserving of public assistance. Additionally, people in recovery housing may have criminal histories, which can create discrimination and stigma on multiple fronts.

However, many of the negative assumptions about recovery housing (e.g., fear of increased crime rates) are unfounded. Studies have shown that 86.9% of the peer-run Oxford House Inc. remain open after six years, meaning that these homes are in fact relatively stable over time (Jason & Ferrari, 2010). Other studies have shown Oxford Houses not only blend well in neighborhoods, but residents make good neighbors for a number of reasons: their homes are well-maintained, they are less likely to commit crimes than the average resident, landlords report fewer problems with tenants than regular renters, and property values have been shown to increase in neighborhoods where recovery homes are established (Ferrari, Aase, Meuller, & Jason, 2009a; Ferrari, Groh, & Jason, 2009b; Jason, Roberts, & Olson, 2005; Lauber, 1986). Although the size and density of the homes influences perceptions, studies have shown a correlation between larger house size and decreased rates of criminal and aggressive behaviors among residents.. These findings have been argued in court, successfully preventing multiple municipalities from closing recovery homes due to maximum-occupancy laws (Jason & Ferrari, 2010). One study found that on average, residents in recovery homes spend 10.6 hours per month volunteering in their communities (Jason & Ferrari, 2010; Jason, Schober, & Olson, 2008b).

Boards vary significantly in working collaboratively and effectively with local service agencies.

Some boards work very well with service provider agencies and peers. A range of governing styles of boards were described, including boards who have little interaction with providers and people in recovery to boards that create processes that fully engage providers and peers in planning and prioritizing resources for community needs.

Several participants noted the importance of engaging and "becoming friendly" with boards. This includes taking active steps to become known by the boards and share information about their programs. In some states, it has been important for grassroots groups to set aside some of their own emotions and frustrations about the challenges of gaining support for recovery housing, so that they could forge productive relationships with the boards. This included compromising on issues so that recovery housing providers and the boards could pursue legislative changes. Some key informants noted that recovery housing providers who held previous relationships with boards have more success and support for recovery housing when they start developing and operating it.

County boards are often not fully involved in housing planning in their community.

Some county ADMH boards collaborate successfully with their local HUD Continuum of Care (CoC). This collaboration is important, since not all ADMH boards create housing plans. Particularly in the context of recovery housing, it is essential that boards seek to understand the housing needs in their communities and identify how best to address these needs with currently available housing funding. Conversely, some CoCs may form subgroups that identify the mental health and addictions treatment needs in their communities as a means of informing housing priorities. Ideally, someone from the ADMH boards would be represented on the local CoC. However, some boards do not engage with the CoC at all. This limits their ability to effectively support local recovery housing efforts.

Recommendations

9.1. Establish pathways for county ADMH boards to contract with recovery housing providers that represent all NARR levels.

9.2. Support the HUD Continuum of Care (CoC) to explore the possibility of counting recovery housing units as part of the COC housing inventory, for those recovery housing providers serving people experiencing homelessness.

9.3. Conduct reviews of how referrals are being provided within counties and to what extent recovery housing resources are considered. Identify how referrals can be made in a manner that best meets the need of the client, to promote recovery and use resources in an efficient and cost-effective manner.

9.4. Create opportunities to raise public awareness of the benefits of recovery housing to dispel misconceptions and counter stigma. Identify a public figure in recovery who can become a champion for recovery housing. Ask the person to host an event to show the documentary "The Anonymous People" developed to engage communities to rethink the culture of anonymity that can unintentionally perpetuate stigma against people in recovery.

9.5. Encourge recovery housing providers to host open forums with neighbors and community stakeholders to provide education about the disease of addiction.

9.6. Utilize advocacy organizations to support recovery projects and address community opposition.

9.7. Support recovery housing projects to develop "good neighbor" policies to promote positive community involvement in residential neighborhoods.

9.8. Explore ways that the county ADMH boards might support the expansion of recovery housing options.

9.9. Create opportunities for community stakeholders to visit and tour successful recovery housing programs, as a means of fostering education and acceptance.

Analysis of Federal, State, and Local Regulations and Codes Relevant to Recovery Housing

Federal, State, and local regulations comprise a wide range of laws and codes that are relevant to housing construction, rehabilitation, ownership, leasing, use of property, and the intended purpose of facilities. Housing laws and regulations will apply to any housing project in which a tenant holds a lease, with some exceptions for private landlords.[6] Local zoning and regulatory issues vary significantly by community; providing an inventory of local zoning laws are beyond the scope of this report. These laws often include limitations on the number of people who can reside in a housing unit, public notice requirements, and the intended purpose of the facility—all of which may pose fair housing concerns.

This summary includes a brief discussion of the following codes and regulations, as well as the key benefits and challenges of each:

- ✔ Fair Housing Act (Federal)
- ✔ Fair Housing Law (Ohio)
- ✔ Americans with Disabilities Act (Federal)
- ✔ Landlord-Tenant Law (Ohio Administrative Code)
- ✔ Public Housing Policies (Public Housing Authorities)

Case Example (HUD, 2004)

A landlord requires all persons applying to rent an apartment to complete an application that includes information on the applicant's current place of residence. On her application to rent an apartment, a woman notes that she currently resides in Cambridge House. The manager of the apartment knows that Cambridge House is a group home for women receiving treatment for alcoholism. Based on this information alone and his personal belief that alcoholics are likely to cause disturbances and damage property, the manager rejects the applicant. The rejection is unlawful because it is based on a stereotype related to a disability rather than an individualized assessment of any threat to other persons or the property based on reliable, objective evidence about the applicant's recent past conduct.

The landlord may not treat this applicant differently than other applicants based on his subjective perceptions of the potential problems posed by her alcoholism by requiring additional documents, imposing different lease terms, or requiring a higher security deposit. "However, the manager could have checked this applicant's references to the same extent and in the same manner as he would have checked any other applicant's references. If such a reference check revealed objective evidence showing that this applicant had posed a direct threat to persons or property in the recent past and the direct threat had not been eliminated, the manager could then have rejected the applicant based on direct threat."

6 Landlords who live in their own buildings with four or fewer apartments are not covered under the Fair Housing Act.

- ✔ Federal Anti-Drug Abuse Act of 1988
- ✔ Notice and Permit Requirements (Local Zoning)
- ✔ Occupancy Maximums (Local Zoning)
- ✔ Dispersal Requirements (Local Zoning)
- ✔ Requirement for Permanent Residency (Local Zoning)
- ✔ Residential Treatment (Ohio Code)
- ✔ Institutions for Mental Disease (Ohio Administrative Code)
- ✔ Halfway Houses and Community Residential Centers (Ohio Administrative Code)

Fair Housing Act (Federal), Ohio State Fair Housing Law, and the Americans with Disabilities Act (Federal)

The Fair Housing Act (FHA) offers protections from discrimination in housing for persons with a disability including persons with a mental or physical impairment which may include conditions such as blindness, hearing impairment, mobility impairment, HIV infection, mental retardation, alcoholism, drug addiction, chronic fatigue, learning disability, head injury, and mental illness (DOJ, 2013).

The Ohio Fair Housing Law gives all persons in the protected classes as described above the right to live wherever they can afford to buy a home or rent an apartment. It is unlawful, on the basis of race, color, religion, sex, national origin, ancestry, military status, disability, or familial status to:

- ✔ Refuse to rent, sell, finance, or insure housing accommodations or residential property
- ✔ Represent to any person that housing accommodations are not available for inspection, sale, rental, or lease
- ✔ Refuse to lend money for the purchase, construction, repair, rehabilitation, or maintenance of housing accommodations or rental property
- ✔ Discriminate against any person in the purchase, renewal, or terms and conditions of fire, extended coverage, of homeowners or renter's insurance
- ✔ Refuse to consider without prejudice the combined income of both spouses
- ✔ Print, publish, or circulate any statement or advertisement which would indicate a preference or limitation
- ✔ Deny any person membership in any multiple listing services or real estate broker's organization

There is a range of fair housing advocacy support for recovery residences. Fair housing groups can offer support and legal advice. Ohio has a number of fair housing organizations including the Columbus Fair Housing Center, which has jurisdiction in Ohio and Indiana ensuring fair housing protections in the general housing market and in HUD funded programs. Additional resources include Oxford Houses, Inc. which provides legal support to Oxford Houses involved in disputes with cities and towns and the Treatment Communities of America, which represents more than 600 treatment programs in the United States.

The more support a recovery home can leverage from these regulations, the more it can protect against restrictions and closings due to zoning laws (Jason et al., 2008a). Links to additional fair housing advocacy organizations can be found at: http://portal.hud.gov/hudportal/HUD?src=/states/ohio/working/fheo/fhagencies

Challenges

The **Fair Housing Act (FHA) and Ohio State Fair Housing Law** protect people recovering from drug and/or alcohol abuse from housing discrimination because these individuals are considered to be people with disabilities. However, neither the FHA nor Ohio Fair Housing Law covers current illegal drug users. While individuals who are in recovery and living in a recovery residence enjoy fair housing protections, those who continue to abuse substances, regardless of where they live, do not (Malkin, 1995). This has potential implications for relapse and the protections extended to individuals in recovery housing who begin actively using.

Despite fair housing laws, renting in the private rental market can be challenging. Private landlords can deny a lease based on poor credit or lack of credit; previous evictions; lack of a housing history (i.e., no previous permanent residence); criminal history (felonies and misdemeanors). Landlords can also deny housing based on the perception of whether the individual poses a direct threat, based on reliable, objective evidence.[7]

Housing providers also need to consider the requirements to make "reasonable accommodations" as outlined under the FHA. "Reasonable accommodations" are changes, exceptions, or adjustments to a rule, policy, practice, or service that may be necessary for a person with a disability to have an equal opportunity to use and enjoy a dwelling, including public and common use spaces:

> *"Since rules, policies, practices, and services may have a different effect on persons with disabilities than on other persons, treating persons with disabilities exactly the same as others will sometimes deny them an equal opportunity to use and enjoy a dwelling. The Act makes it unlawful to refuse to make reasonable accommodations to rules, policies, practices, or services when such accommodations may be necessary to afford persons with disabilities an equal opportunity to use and enjoy a dwelling" (HUD, 2004).*

The **Americans with Disabilities Act (ADA)** prohibits discrimination and/or unfair or unequal treatment based on disability status. The Act also requires that programs be administered in the most integrated setting appropriate to the needs of the individual. This requirement was reinforced as part of the Olmstead vs L.C. Supreme Court decision, which requires States to administer programs in the most integrated settings. The Olmstead ruling provides important clarification for how States comply with the ADA Title II requirements for ensuring "reasonable accommodation" and integration for people with disabilities. For people in recovery, this will equate to having options for treatment that are integrated into the community. This decision applies to all public entities and to the use of public funding and has implications for publicly funded Medicaid services for people with disabilities. Olmstead seeks to ensure people with disabilities have options for housing and are accommodated in the most integrated setting possible. For many States, this will require an exploration of how to ensure people in Medicaid-funded long-term care settings are accommodated to comply with the Act.

7 "A determination that an individual poses a direct threat must rely on an individualized assessment that is based on reliable objective evidence (e.g., current conduct, or a recent history of overt acts). The assessment must consider: (1) the nature, duration, and severity of the risk of injury; (2) the probability that injury will actually occur; and (3) whether there are any reasonable accommodations that will eliminate the direct threat. Consequently, in evaluating a recent history of overt acts, a provider must take into account whether the individual has received intervening treatment or medication that has eliminated the direct threat (i.e., a significant risk of substantial harm)." (HUD, 2004)

Benefits

The ADA and FHA offer a number of protections for people with disabilities. Under the ADA, housing and services must afford people with disabilities an equal opportunity to obtain the same result, or gain the same benefit as that provided to people without disabilities. In addition, the overall design of housing programs and services must ensure that individuals with disabilities have a similar and complete range of housing choices available to them regardless of disability.

The ADA also includes rights of privacy and liberty, which protect individuals against intrusion, meaning, among other things, that an individual cannot be forced to receive medical or therapeutic treatment without their consent. These same principles recognize that an individual holds a property interest in his or her home. That interest cannot be diminished or terminated without appropriate legal process.

The FHA has been used as a tool for supporting recovery housing resources by counteracting local ordinances and community backlash against recovery housing. The FHA covers both privately owned housing and public housing programs and applies to property owners, landlords, housing managers, real estate agents, brokerage service agencies and banks.

The ADA prohibits land use policies or actions that treat groups of people with disabilities less favorably than groups of non-disabled people. An example would be an ordinance prohibiting housing for people in recovery from locating in a particular area, while allowing other groups of unrelated individuals to live together in that area.
The ADA also provides protections for groups poised to develop new housing. Obtaining the necessary permits to develop and locate housing can be fraught with opposition whether from neighborhoods or local officials. Action cannot be taken against—or a permit denied—for a home because of the disability of individuals who live or would live there.

Risk Mitigation Pool City of Portland, Oregon

The City of Portland established a risk mitigation pool for owners of Permanent Supportive Housing (PSH) projects—recognizing that PSH providers face unique financial risk related to the provision of housing—the likelihood of property damage or individuals failing behind on rent. Events, which can add up quickly, could prove financially devastating to a housing project. The City in response set up a Risk Mitigation Pool. The Pool serves 20 PSH providers with 720 housing units and reimburses project owners for unusual property repair and maintenance costs associated with PSH. Since its establishment, the Pool has processed 26 claims, helping to ease property owners' financial distress while keeping critical housing resources in service.

Ohio Administrative Codes: Landlord-Tenant Law

New recovery housing can be created by purchasing or leasing units in the private market. Most often a non-profit or government entity leases or purchases a property and sub-leases to residents. In this instance, the organization providing the housing is required to abide by Ohio State landlord-tenant laws. This includes following appropriate procedures for terminating leases and maintenance of the property. Not all recovery residences may be organized in this way. Some programs that provide temporary housing or residential treatment may have residents sign participation agreements outlining program requirements but do not oblige programs to follow tenancy laws.

Challenge

The laws are designed to protect both landlords and tenants. A provider who takes on the role as landlord assumes the responsibilities outlined under Ohio Code-Landlord-Tenant Law, which includes property management (e.g., the upkeep and regular maintenance of housing). This can require time and resources that may not be readily available for some recovery housing providers. Additionally, when a lease is terminated prematurely, programs must abide by Ohio State Administrative codes, which require a three-day notice period before an eviction can be pursued and filed with the courts. These requirements may pose new administrative, financial, and property management burdens on individuals or organizations newly serving as landlords.

Benefits

Programs providing housing that take on the role of landlord are able to offer various benefits to people in recovery. The benefits of the landlord-tenant relationship are that housing providers are able to provide greater flexibility to individuals who may otherwise have difficulty accessing market rate housing. As discussed earlier, obtaining market rate housing can be difficult in the event an individual has a criminal history, poor credit, or poor housing history. Programs providing recovery housing tend not to consider factors such as criminal history or credit as a pre-requisite for housing; more often prerequisites focus on the individual's commitment to sobriety and ability to live in a shared housing environment.

Programs also have the flexibility to set house rules which help to promote stability and identify ways to prevent and respond to a potential relapse. This flexibility translates into housing which may be able to provide more flexible supports in the case of relapse, rather than termination or eviction. As an example, market rate housing may terminate a lease based on drug or alcohol use[8], whereas a housing provider acting as a landlord may provide more leniencies towards such infractions without automatically terminating a lease.

Recovery residences utilizing market rate housing may benefit from programs that incentivize market rate landlords to rent to people in recovery and/or programs. A "risk mitigation pool" or "landlord guarantee fund" is one way to encourage landlords to house potential renters who may have poor housing history (i.e., poor credit, past evictions). This type of program provides a pool of funds that landlords can access in the event of damages caused by the client to the property. This pool can also be used to either offset the cost of a security deposit or in lieu of a security deposit. This program can also be beneficial for programs that provide housing such as permanent supportive housing.

Public Housing Policies

Public Housing Authorities (PHAs) are often the primary provider of low-income subsidized housing in communities. PHAs operate federal housing programs including Section 8 and permanent supportive housing (Shelter Plus Care Program) through tenant-based rental assistance vouchers.

Challenges

Similar to market rate housing, PHA policies can be restrictive and access may be limited for people with criminal histories, including those related to substance abuse. The current statute

outlines two explicit bans on: 1) occupancy based on criminal activity related to production of methamphetamine on the premises of federally assisted housing, and 2) sex offenders subject to lifetime registration requirements under a State sex offender registration program. PHAs cannot make any exception in these instances. However, PHAs may show flexibility when establishing housing admission standards.

PHA standards may prohibit occupancy of any household member currently engaged in illegal drug use, alcohol use or pattern of drug or alcohol use that may threaten the safety, health or enjoyment of other residents. Admission may also be prohibited for an applicant for three years from the date of eviction if a household member has been convicted of drug-related criminal activity. In this case, PHAs may consider admitting individuals if the PHA determines that the household member has successfully completed a supervised drug rehabilitation program.

Benefits

Beyond the restrictions described above, PHAs have broad discretion to set admission and termination policies.

This can help (and also hurt) efforts to expand local recovery housing efforts. It bears noting that even if an applicant is initially rejected from a PHA waiting list, they may appeal. For example, a person may be rejected due to a criminal background. Typically with assistance from an advocate, this person would appeal the decision. Grounds for an appeal might be that the criminal conviction was related to their untreated substance abuse but that their circumstances have changed significantly (e.g., they have been clean/sober for a period of time, they are in a program and receiving services, they are working with an agency, they are taking medication, etc.).

PHAs are also a good resource for permanent tenant-based subsidized housing. PHAs oversee a number of Federal programs providing permanent housing assistance to many vulnerable Ohio residents. These programs can serve as a vital resource for people moving on from temporary or transitional recovery housing to more permanent stable housing options. Project-based rental assistance can also be used to help support the development of new housing units dedicated to recovery.

The Federal Anti-Drug Abuse Act of 1988

In 1988, Congress enacted the **Anti-Drug Abuse Act**. The Act included a provision that required all states to establish a revolving loan fund to provide start-up funds for groups wishing to open sober living environments based on the Oxford House model. This mandate was changed to a permissive provision in 2000, no longer requiring states to enact this mandate for states that continue to use funds under the Act for this purpose, funds must subscribe to the provision of the Act as outlined below. Models would need to follow these basic tenets:

(A) the use of alcohol or any illegal drug in the housing provided by the program will be prohibited;
(B) any resident of the housing who violates such prohibition will be expelled from the housing;
(C) the costs of the housing, including fees for rent and utilities, will be paid by the residents of the housing; and
(D) the residents of the housing will, through a majority vote of the residents, otherwise establish policies governing residence in the housing, including the manner in which applications for residence in the housing are approved.

Ohio State code 3793.19 establishes a revolving loan fund to meet the requirements of the Act. Despite the move to a permissive mandate this code has not been repealed by the State. The code provides funds for the purpose of establishing programs that will provide housing in which individuals recovering from alcohol or drug abuse may reside in groups of not less than four individuals. Loans made from the revolving fund do not exceed $4,000. Each loan is repaid to the revolving fund by the residents of the housing involved not later than two years after the date on which the loan is made.

Benefits

A key benefit is the fund is specifically created to establish new recovery residences.

Challenges

This program may be too restrictive for programs seeking to establish recovery homes that have flexible policies with regard to relapse. This program requires a strict "abstinence-only" recovery model in order to receive funding. Funding is also limited to $4,000 and repayment is required within two years. This level of funding may be inadequate to start a new recovery residence. However, it can be a resource to be used along with additional funding sources to create small-scale recovery residences.

Local Zoning and Regulations

Local zoning and regulatory issues vary significantly by community. They often include limitations on the number of people who can reside in a housing unit, public notice requirements, and the intended purpose of the facility. Recovery housing providers may require assistance in understanding, navigating, and responding to these regulations.

Challenges

When seeking to develop or expand recovery housing, programs may encounter discriminatory zoning laws and policies aimed at preventing or obstructing established recovery housing in communities.

The Department of Justice's enforcement of the Fair Housing Act (FHA) helps to insure zoning and other regulations concerning land use are not employed to hinder the residential choices of individuals, including unnecessarily restricting communal, or congregate, residential arrangements, such as recovery group homes. The Act applies to municipalities and other local government entities and prohibits them from making zoning or land use decisions or implementing land use policies that exclude or otherwise discriminate against protected persons, including individuals with disabilities. However, a local government may generally restrict the ability of groups of unrelated persons to live together as long as the restrictions are imposed on all such groups.

Further analysis is needed to identify jurisdictions in Ohio where local zoning and ordinances present as restrictive barriers to recovery housing efforts. The following summary of zoning limitations and requirements represent examples of zoning restrictions that have been deliberated in the courts nationally.

Notice and Permit Requirements (Mirra, 1998). Programs that operate "group" housing settings may encounter zoning and/or regulations that require program operators to register with municipal authorities or to notify neighbors. Courts have struck down such requirements in a number of cases, judging such rules to be discriminatory (e.g., Stewart B. McKinney v. Town Plan and Zoning Commission, (neighbor notification); Potomac Group Home Corp. v. Montgomery County, Maryland

(hearing and notification requirement); Larkin v. State of Michigan, (notification of neighbors requirements). Given the number of local municipalities in Ohio, further analysis is needed to identify if this requirement currently exists in any Ohio jurisdictions.

Occupancy Maximums (Mirra, 1998)**.** It is common for local zoning municipalities to restrict the number of residents allowed in group home settings. These restrictions often appear in various forms with some applying specifically to group homes and other restrictions applying to all households of unrelated persons. Each of these instances raises questions of direct or indirect discrimination. The FHA allows "any reasonable local, State, or Federal restrictions regarding the maximum number of occupants permitted to occupy a dwelling." This exemption applies only if the maximums apply to everyone in a dwelling, generally for the purpose of avoiding overcrowding.

In the case of the City of Edmonds, Washington vs. Oxford House, Inc., Oxford House opened a group home for 10-12 adults recovering from drug or alcohol addiction. The City of Edmonds promulgated a definition of family, for purposes of single-family zoning. The definition only allowed fewer than five unrelated persons to live together, while any number of related persons could live together (Casebriefs, 2013). The court ruled in favor of Oxford Housing noting the city did not comply with the FHA in making reasonable accommodations. The City of East Cleveland, Ohio in a similar case attempted to define "family" as a "nuclear family." This zoning law was also ruled as unconstitutional. Attempts to define "families" to restrict the make-up of persons in a household have been found to discriminate against residents of group homes.

Dispersal Requirements (Mirra, 1998)**.** Some municipalities may restrict the number of facilities and group homes by requiring them to maintain minimum distances or separation requirements from other sites. As an example, the City of Lancaster, Ohio requires group homes or similar facilities to be located no more than 1,000 feet from similar residences. These regulations often require group homes of any nature to be dispersed to avoid a concentration in a single area. There are many reasons for these ordinances, with some related to the desire to retain the character of the neighborhood (e.g., single-family residential, business zones), and some directly related to community opposition. For every group home that is successfully established, experts estimate that another closes or never opens because of community opposition (Malkin, 1995). With some exceptions the courts have struck down regulations requiring such dispersal requirements. Dispersal requirements alone may not necessarily represent a significant barrier for recovery residences. However, when coupled with other exclusionary zoning, housing programs may find that the only option to provide housing is in those areas where similar types of housing has been already established.

Requirement for Permanent Residency (Mirra, 1998). Zoning and regulations may also place restrictions on the length of time individuals may reside in a group home. Courts have determined such restrictions unconstitutional. The court in North Shore-Chicago Rehab. v. Village of Skokie, IL struck down a requirement that group home residents be "permanent." Similarly, the court in Oxford House, Inc. v. Township of Cherry Hill, NJ barred enforcement of a requirement that all households of unrelated persons meet a standard of "permanency and stability." Oxford House, Inc. v. Town of Babylon, TX barred the town's eviction of the group home "due to the size or transient nature of plaintiffs' group living arrangement."

Benefits

Despite the potential challenges described above, there are any number of ways that zoning changes can help promote the development of housing that is affordable and accessible for persons in

recovery. The majority of these focuses primarily on the development of affordable housing and will help particularly for projects aiming to develop new construction.

Affordable housing options can be created through inclusionary zoning which requires all new housing construction to include a set percentage of affordable units. These measures help to counteract exclusionary zoning practices, which may exclude low-cost housing in certain areas. Inclusionary zoning helps to create a wider range of housing options for people at all economic levels. This also can help to create housing options, that are located close to recovery supports and services, mental health services, employment opportunities, and transportation. The drawback of this approach is that the number of units developed is dependent on the number of new market-rate construction projects in the pipeline.

Regulatory changes that can promote affordable housing include allowing residential development in mixed use zones. This may include redevelopment of commercial premises to residential as well as use of former industrial properties. Local ordinances may also place restrictions on the density of housing (e.g., the number of units permitted in a per-acre area). As an example, if a program seeking to develop a new housing project with 50 new units was gifted a one-acre site for development of recovery housing, but the site is located in a low-density residential area allowing for no more than 30 units per acre, this creates a regulatory barrier. In this instance, the program would be faced with the dilemma of reducing the number of units, which may have an impact on the affordability of the project, or abandoning the project entirely. Relaxing zoning density and/or providing flexibility in the permitting process is one way to support new development.

Additionally, zoning restrictions could create more flexibility for the creation of "in-law" or second units, as well as provide various mechanisms for streamlining application and permitting processes.

Residential Treatment Ohio State Code

The **Ohio State Code 3793** outlines regulations for the provision of drug and alcohol services including the certification of treatment facilities. The purpose of the Code is to define alcohol and drug addiction treatment services, and to identify who can deliver and supervise treatment services.

The provisions of the Code are applicable to all Ohio alcohol and drug addiction programs public or private—regardless of whether they receive any public funds that originate and/or pass through the Ohio Department of Alcohol and Drug Addiction services (ODADAS). Recovery residences providing treatment services will require certification from ODADAS or must demonstrate the residence has received appropriate accreditation.

Recovery residences providing treatment along with housing will need to consider the Ohio code, which specifies people qualified to deliver treatment services. This applies to non-medical community residential treatment. The Code defines this as a 24-hour rehabilitation facility, without 24-hour/day medical/nursing monitoring, where a planned program of professionally directed evaluation, care and treatment for the restoration of functioning for persons with alcohol and other drug problems and/or addiction occurs. Certification from ODADAS may be required.

Ohio State Administrative Code-Institutions for Mental Disease (IMD) Rule

The **Ohio State Code** establishes a rule based on the **Federal Code of Regulations (42 CFR 435.1010)** related to **Institutions for Mental Disease (IMD)**. This rule may have an adverse impact on large-scale recovery residences with over sixteen beds. The impact is directly related to Medicaid

reimbursement for the cost of services provided. Under this rule, if an individual resides in an IMD, the states are not permitted to claim Medicaid reimbursement for otherwise allowable services. Residential facilities may be at risk of being classified as an IMD if the overall character of the residence is to treat individuals with mental or behavioral health disorders and the residence has over sixteen beds.

The Ohio code recognizes an IMD to mean a hospital, nursing facility, or other institution of more than sixteen beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services.

A recovery residence may be at risk of IMD classification if the residence is (any one of the following):

(1) Licensed as a mental nursing home;

(2) The residence was identified as an at-risk facility during a prior IMD review; or

(3) Forty-five per cent or more of the residents have been determined to need specialized services for serious mental illness by the Ohio department of mental health.

Recovery residences that are at-risk or have been classified as an IMD may take steps to meet the law's exclusion criteria, such as reducing the total number of beds in a program to sixteen or fewer.

Ohio State Administrative Code-Halfway Houses and Community Residential Centers

The **Ohio Division of Parolee and Community Services** under the Ohio code may license a halfway house, re-entry center, or community residential center as a suitable facility for the care and treatment of adult offenders. Services provided in these settings may include but are not limited to, treatment for substance abuse and mental health counseling. The Code—although limited to adult offenders—mandates the Division to set aside funding for the development of halfway houses and community residential centers. Many halfway houses and community residential centers licensed by the Division operate similarly to recovery housing and provide a range of support often found in Level III recovery residences (including credentialed staff, case management, substance abuse treatment, life skills, AA/NA).

Community residential centers are voluntary housing placements providing some case management and monitoring for offenders. They require licensure from the Division. The Department of Rehabilitation and Corrections created residential centers as part of a transitional housing initiative in 2004. The Department will pay for up to 90 days in one of these facilities for eligible offenders.

Halfway houses provide housing, food, case management services, residential programming and in some cases, intensive treatment services. Placement in a halfway house is mandatory and the program is responsible for monitoring residents' program compliance. Halfway houses are required to obtain and continuously maintain American Correctional Association (ACA) accreditation in addition to licensure from the Division.

The Division of Parole and Community services may enter into agreements with any public or private agency that operates a halfway house, re-entry center, or community residential center that has been licensed by the Division. Agreements outline the number of beds to be provided for use by the Division and levels of occupancy, as well as the scope of services for all eligible offenders to be provided.

The Division of Parolee and Community Services and the Department of Rehabilitation and Corrections present one possible avenue for exploring and expanding recovery residences targeted toward adult offenders.

Recommendations

A.1. Provide technical assistance on converting housing and managing local permits and zoning considerations, and grant writing

A.2. Create tools for programs to self-evaluate for risk of IMD classification and create strategies for mitigating risk.

A.3. Promote awareness of the FHA, ADA, and the Ohio State Fair Housing Law among recovery housing providers.

A.4. Assist recovery housing providers to develop policies and program rules, which utilize the due process afforded by the tenant landlord law.

A.5. Consider the benefits of implementing a "risk mitigation pool" to support recovery housing providers and/or to support access to market rate housing for persons in recovery.

A.6. Communicate the appeals process to affected applicants and relevant advocate and service organizations.

A.7. Encourage PHAs to implement discretionary policies that allow individuals who have completed and those who are participating in a supervised drug rehabilitation program to access public housing.

A.8. Provide technical assistance to PHAs and other recovery housing providers about the opportunities for PHAs to use discretion related to exclusionary housing criteria (e.g., income eligibility, sex offenses, past history of damaging property).

A.9. Support local jurisdictions in creating flexibility in permitting processes for development of new housing.

A.10. Encourage local jurisdictions to implement inclusionary zoning ordinances to encourage development of affordable housing.

A.11. Encourage mixed use zoning that supports social enterprise efforts within recovery homes.

A.12. Consider restrictions related to Ohio Code where treatment is provided along with housing (Requirements for certification and qualified staff to deliver treatment services).

A.13. Conduct an analysis of Ohio jurisdictions, identifying jurisdictions with restrictive zoning ordinances that present as barriers to developing recovery housing.

Summary of Recommendations

1. The availability of recovery housing in Ohio is insufficient, especially housing tailored to the special needs of subpopulations.

1.1. Conduct a more detailed analysis to determine the extent of need for recovery housing.

1.2. Facilitate reciprocity eligibility for recovery support services for residents traveling from outside county lines due to unavailability or need for relocation.

1.3. Identify the extent of unmet recovery needs for families and expand programming that addresses these needs.

1.4. Ensure that programs are providing comprehensive planning that identifies and responds to service needs for individuals and children (when applicable).

1.5. Facilitate partnerships between recovery housing programs and family services agencies.

1.6. Develop partnerships with Ohio's Drug Courts to support recovery housing models, including identifying funding resources to support recovery housing for people participating in drug courts.

1.7. Explore eligibility barriers for people participating in drug courts, who are not considered to be homeless under HUD definitions and therefore may not be eligible to receive housing vouchers for recovery housing programs.

1.8. Collaborate with Ohio Department of Rehabilitation and Corrections and the Division of Parolee and Community Services to support recovery programming in halfway houses, and identify recovery housing resources for offenders. These partnerships are important to ensure that parallel systems of treatment and housing are not being created by jail diversion programs.

1.9. Collaborate with corrections system around discharge planning and developing options for recovery housing prior release.

1.10. Survey communities to understand the unmet need for housing and services for offenders.

1.11. Provide technical assistance to support recovery housing providers in overcoming regulatory and zoning barriers that limit options for people with criminal offenses.

1.12. Support mental health service agencies to develop recovery housing resources for people with co-occurring disorders.

1.13. Provide training on mental health and co-occurring disorders for recovery housing providers.

2. Current variations in recovery housing definitions, language, and understanding pose challenges to the efforts to advance it as a model.

2.1. Sponsor regular regional and state summits for recovery housing providers to meet and learn about other recovery housing efforts in the state and nationally.

2.2. Convene statewide conversations among housing, homeless services, behavioral health, criminal justice, housing developers, faith-based and other related systems of care. This would provide an opportunity for networking and fostering better coordination locally, including efforts to bridge gaps in service systems or pool resources to support recovery housing.

2.3. Establish online learning communities for recovery housing providers in Ohio to share resources and challenges.

2.4. Create a mechanism to define recovery housing models and services consistently across counties and the state.

2.5. Collaborate with NARR to highlight Ohio's efforts nationally and connect with other states taking on similar initiatives.

3. The network of recovery housing providers in Ohio lacks the infrastructure, resources, and technical assistance to support growth and quality oversight.

3.1. Identify and support the development of a NARR affiliate organization in Ohio.

3.2. Support the lead NARR affiliate organization in Ohio to develop a standard set of definitions and guidelines to describe the range of recovery housing in Ohio. These definitions and guidelines should inform the development of funding opportunities and allocation decisions.

3.3. Hold in-person or virtual meetings with recovery housing providers across the country to inform the development of the Ohio standards.

3.4. Facilitate technical assistance (TA) requests to SAMSHA (e.g., Bringing Recovery Supports to Scale Technical Assistance Center Strategy, Homeless and Housing Resource Network). This could include TA to the Ohio NARR chapter(s) on how best to work with recovery organizations and deliver TA.

3.5. Encourage follow-up with residents graduating from the program.

3.6. Provide technical assistance opportunities to help recovery housing programs to build capacity in business, accounting, and marketing functions.

3.7. Develop a voluntary registry of recovery housing providers at the county and/or state level.

3.8. Create a mechanism for receiving and investigating complaints of recovery housing providers.

3.9. Define benchmarks for recovery success.

3.10. Establish a voluntary data collection system for recovery housing providers that are not connected to county alcohol, drug, and mental health (ADMH) boards. Ensure that this effort is aligned with forthcoming data collection efforts from NARR.

3.11. Hold focus groups with recovery housing providers to identify minimum data points and domains that would effectively tell the story of recovery housing.

3.12. Ensure that funded programs are collecting and reporting data, that quality improvement plans are established if a program is not meeting standards or producing outcomes, and that after quality improvement efforts are exhausted, corrective action is taken when appropriate to remove or modify ineffective programs.

3.13. Provide basic data training for staff in recovery housing programs.

3.14. Publish or identify and disseminate technical assistance tools that guide recovery housing programs in collecting, interpreting, and sharing outcome data with funders, policy makers, and community stakeholders.

3.15. Encourage programs to collaborate with local universities to establish basic metrics that programs can use to collect data in the absence of a more formalized system.

3.16. Develop and promote training and technical assistance opportunities for recovery housing providers in collaboration with community groups such as coalitions, counties, trainers, and model programs.

3.17. Catalog currently available local, state, and federal training and technical assistance resources and promote to recovery housing providers.

4. Existing models and preliminary standards can be built upon to expand recovery housing in Ohio.

4.1. Develop a recovery housing manual to support individuals and agencies in developing and operating all levels of recovery housing.

4.2. Provide technical assistance and training opportunities to support recovery housing providers, including capacity building, business management and operations, marketing, coalition building and best practices in service delivery.

4.3. Facilitate technical assistance opportunities between the National Alliance for Recovery Residences and recovery housing providers.

4.4. Seek opportunities to provide training and technical assistance for peer staff.

4.5. Review state policies that require zero-tolerance relapse policies for funded recovery programs.

4.6. Identify and modify policies that inhibit rapid screening and intake (e.g., definitions and eligibility criteria for publicly funded programs).

4.7. Share best practices for developing recovery housing that help to address the barriers to housing stability.

4.8. Explore how lessons learned and preliminary infrastructure from the Access to Recovery (ATR) program may be used to inform the Ohio state recovery housing effort.

4.9. Support current ATR-funded recovery housing providers to ensure sustainability beyond the ATR grant period.

5. Effective recovery housing requires a range of recovery supports that are often the most difficult to fund.

5.1. Link people in recovery to supportive services such as credit repair and legal aid to assist in helping to promote residential stability.

5.2. Ensure that employment is a central focus among recovery housing programs. Additionally, ensure that opportunities to secure income benefits are in place for people who may not be able to work due to a co-occurring disability or mental illness.

5.3. Facilitate employment opportunities available to people in recovery. Develop relationships with employers who are supportive of recovery programs and efforts.

5.4. Explore ways to create employment opportunities for individuals with criminal histories, which may pose barriers. This might include facilitating relationships with employers or reviewing policies that inhibit employment for specific offenses.

5.5. Launch an awareness campaign and/or provide incentives to businesses so that they consider hiring individuals in recovery.

5.6. Encourage providers of Medication Assisted Treatment to link with recovery housing and recovery support services.

6. Various mechanisms exist to support recovery housing. However, the availability of funds and ability to access them varies significantly.

6.1. Consider voucher set-asides or preferences for disabled/recovery populations.

6.2. Evaluate the success of the revolving loan program in creating recovery housing.

6.3. Use the revolving loan program as a model for creating a funding stream to support development of new recovery residences. Adapt the model as needed to allow for varying recovery housing models.

6.4. Explore ways to create a funding resource that will provide short-term rental assistance to people newly in recovery.

6.5. Explore opportunities for funding to subsidize recovery housing to ensure it is affordable for persons with limited or no income supports.

6.6. Establish a revolving loan fund to support the upgrade of facilities to meet building codes.

6.7. Create a funding stream for non-Medicaid recovery support services, similar to the Access to Recovery program.

6.8. Explore tax credits for recovery housing providers that primarily serve poor, low-income or homeless populations.

6.9. Educate recovery housing providers about sources of capital funds and funding streams and strategies for successful applications.

6.10. Consider a set-aside of capital funds available through the consolidation of ODMH/ODADAS to develop or upgrade recovery housing.

6.11. Support small recovery home programs to connect with larger organizations to support Medicaid billing functions.

6.12. Encourage the development of housing models which provide alternatives to market rate housing.

6.13. Partner with Public Housing Authorities to link them to recovery housing efforts.

6.14. Consider how all levels of recovery housing may be prioritized in funding opportunities.

6.15. Explore how other states (e.g., Texas, Connecticut, Pennsylvania) have supported recovery community organizations in providing reimbursements for recovery coaching and recovery support services.

6.16. Explore how Medicaid may be used as a resource to fund peer recovery coaches in recovery homes.

7. Recovery housing providers require support in connecting and collaborating with established systems of care rather than creating a parallel system.

7.1. Survey recovery housing providers to identify policy barriers that inhibit them from seeking currently available public funding streams.

7.2. Modify policies and regulations to align with the populations, needs, and housing situations of people seeking recovery housing and recovery support services.

7.3. Recovery housing providers and NARR affiliates should build relationships with local HUD Continuum of Care leaders.

7.4. Provide technical assistance to recovery housing providers on how to work with public funders to address potential policy barriers while maintaining compliance with grant requirements.

7.5. Encourage treatment providers that receive block grants and other public funds to educate clients about recovery supports outside of treatment that promote and sustain long-term recovery.

7.6. Consider policies that would encourage recovery housing referrals and linkages for people who have received treatment multiple times.

8. Within local service networks, some recovery housing providers experience perceived and actual barriers to collaboration.

8.1. Build networks among recovery organizations and related service providers within communities and counties.

8.2. Identify Housing Specialists working in homeless services systems and develop collaborations that support referrals.

8.3. Encourage county boards to invite recovery housing providers to key meetings and to allow space for presenting about recovery housing issues, needs, programs, and outcomes.

8.4. Encourage programs receiving county funds to establish and demonstrate partnerships with recovery housing providers.

8.5. Explore ways to incorporate recovery housing resources into criminal justice referrals.

8.6. Conduct outreach to county administrators, and stakeholders from criminal justice and other related systems to share information about recovery, and the potential benefits of recovery housing and recovery supports.

8.7. Support county ADMH boards to include recovery housing providers in community planning processes and identify strategies for integrating recovery housing providers in local service networks. This might include conducting outreach to recovery housing providers and inviting them to join planning meetings and share information about their programs with other community agencies and stakeholders.

8.8. Explore ways that existing certification mechanisms might be applied or modified to communal recovery housing settings.

9. County and local community contexts influence the development and expansion of recovery housing.

9.1. Establish pathways for county ADMH boards to contract with recovery housing providers that represent all NARR levels.

9.2. Support the HUD Continuum of Care (CoC) to explore the possibility of counting recovery housing units as part of the COC housing inventory, for those recovery housing providers serving people experiencing homelessness.

9.3. Conduct reviews of how referrals are being provided within counties and to what extent recovery housing resources are considered. Identify how referrals can be made in a manner that best meets the need of the client, to promote recovery and use resources in an efficient and cost-effective manner.

9.4. Create opportunities to raise public awareness of the benefits of recovery housing to dispel misconceptions and counter stigma. Identify a public figure in recovery who can become a champion for recovery housing. Ask the person to host an event to show the documentary "The Anonymous People" developed to engage communities to rethink the culture of anonymity that can unintentionally perpetuate stigma against people in recovery.

9.5. Encourage recovery housing providers to host open forums with neighbors and community stakeholders to provide education about the disease of addiction.

9.6. Utilize advocacy organizations to support recovery projects and address community opposition.

9.7. Support recovery housing projects to develop "good neighbor" policies to promote positive community involvement in residential neighborhoods.

9.8. Explore ways that the county ADMH boards might support the expansion of recovery housing options.

9.9. Create opportunities for community stakeholders to visit and tour successful recovery housing programs, as a means of fostering education and acceptance.

Analysis of Federal, State, and Local Regulations and Codes Relevant to Recovery Housing

A.1. Provide technical assistance on converting housing and managing local permits and zoning considerations, and grant writing

A.2. Create tools for programs to self-evaluate for risk of IMD classification and create strategies for mitigating risk.

A.3. Promote awareness of the FHA, ADA, and the Ohio State Fair Housing Law among recovery housing providers.

A.4. Assist recovery housing providers to develop policies and program rules, which utilize the due process afforded by the tenant landlord law.

A.5. Consider the benefits of implementing a "risk mitigation pool" to support recovery housing providers and/or to support access to market rate housing for persons in recovery.

A.6. Communicate the appeals process to affected applicants and relevant advocate and service organizations.

A.7. Encourage PHAs to implement discretionary policies that allow individuals who have completed and those who are participating in a supervised drug rehabilitation program to access public housing.

A.8. A.8. Provide technical assistance to PHAs and other recovery housing providers about the opportunities for PHAs to use discretion related to exclusionary housing criteria (e.g., income eligibility, sex offenses, past history of damaging property).

A.9. Support local jurisdictions in creating flexibility in permitting processes for development of new housing.

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A.13. Conduct an analysis of Ohio jurisdictions, identifying jurisdictions with restrictive zoning ordinances that present as barriers to developing recovery housing.

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Appendix A: Glossary of Terms

Behavioral Health This term encompasses both mental health and substance use/addiction related issues, conditions, and services.

Continuum of Care When used in the proper form and capitalized, this term refers to the HUD Continuum of Care (CoC) structures, which exist across counties and states and administer and oversee HUD funding to local programs. The more general terms "continuum" or "continuum of care" may also be used. In this case the terms refer to the concept of a broad, comprehensive spectrum of services and service models that meet the various needs of individuals and families over time (e.g., housing, behavioral health and health service continuums).

Provider This term includes both clinical and non-clinical staff and leaders of various types of recovery housing and behavioral health organizations. The report specifies "recovery housing providers," which includes individuals working in recovery housing programs across all levels, including peers, peer staff, and program and clinical staff. The term may also be used to describe clinical staff and other representatives from service agencies that provide behavioral health and primary health care services.

Recovery Housing This term is used as an organizing framework that encompasses all currently operating models of recovery housing in the State of Ohio. Given the work being undertaken by the National Alliance for Recovery Residences (NARR), the term "recovery residence" is sometimes used interchangeably with recovery housing, especially when drawing on findings from the academic literature that examined one or more levels of recovery residences as defined by NARR. Key informants and other participants expressed various other terms that they use to describe recovery housing, including sober housing, sober living, halfway houses, and others.

Recovery Supports Recovery supports foster health, resiliency, and recovery from mental and substance use disorders. Recovery supports assist individuals seeking and in recovery to remove barriers, navigate systems, stay engaged in the recovery process, and reintegrate into their communities. Some examples include community education on mental and substance use disorders to combat discrimination and to promote social inclusion; emotional support and assistance in setting recovery goals and developing recovery plans; coordination of services and supports to aid recovery; supported employment and supported housing programs; accessible transportation; readily available resource lists and options; and individual alliances and community networks that foster greater quality of life.

Treatment This term refers to evidence-based inpatient or outpatient services that address addiction and/or mental health conditions, and are delivered in clinical settings and/or by clinically trained staff. Participants in the environmental scan often distinguished between this type of treatment (sometimes referred to as traditional), and non-clinical recovery supports and services that include recovery housing, peer support, and other recovery supports as defined in this glossary.

Appendix B: SAMHSA Workgroup on Women, Sober Housing, and Treatment—Activities and Preliminary Findings

Background

In 2009, SAMHSA's Homelessness Resource Center (HRC) received a technical assistance request from an agency that provides housing and addictions treatment to women experiencing homelessness with substance use issues. The program, Amethyst, Inc., asked HRC to help connect similar programs to share best practices. In response, HRC formed the Women and Sober Housing Workgroup.

This workgroup is exploring programs and practices serving women who are homeless and have substance use issues, particularly best practices in providing sober housing and treatment. An important goal of the workgroup is to begin to foster a national dialogue about these services, as this is an interest expressed by ***all*** of the participating programs. Workgroup activities have been supported by SAMHSA's Homelessness Resource Center and the Women, Children, and Families Technical Assistance Program.

What is Sober Housing?

As the workgroup learned during discussions with programs, sober housing is an abstinence-based, sobriety-focused service model. The programs included in this workgroup provide combined housing and treatment services for formerly homeless women along a continuum, allowing for a typically flexible and supportive response to women who relapse. Sober housing in this context is ***NOT*** a zero-tolerance or punitive environment.

What We've Learned

The following elements are core components of these programs. The Workgroup elicited these themes during initial structured discussions with nine programs, followed by multiple group discussions among these and other programs to review and validate the items, culminating in a Dialogue Session in May 2011.

1. **Women-Focused and Gender-Specific**
   Programs are women-focused and identify as offering gender-responsive services. Many sober housing programs serve women with their children, some include fathers or significant others, and some serve only women and do not include children in their housing component.

2. **A Place-Based Approach**
   Essential to any sober housing and treatment model is safe, affordable, and supportive housing. Stable housing is critical for recovery, and programs use multiple approaches to provide housing both during and after treatment.

3. **Abstinence-Based Approaches**
   Programs operate on an abstinence-based model with sobriety-focused policies and procedures that expect participants to remain clean and sober. Programs feel that an abstinence-based model tends to work better and is safer for women and their families.

4. **Flexible Relapse Policies**
   Sober housing programs have recovery-oriented, flexible relapse policies. Most of the programs offer a continuum of treatment and housing services, which tends to impact how flexibly a program can respond to women's relapse needs. Client input about these policies is important and helps to ensure more responsive policies and positive outcomes.

5. **Service Linkages**
   The programs all coordinate within and among service systems. This includes partnerships with community substance use treatment and mental health programs, criminal justice systems, employment and income support systems, schools, child welfare systems, and others.

6. **A Focus on Safety**
   Programs share a primary purpose of providing safety. This often occurs in the context of gender-responsiveness and trauma-informed services and environments.

7. **Community**
   Developing a sense of community is critical. Since many women are estranged from their families, this is an important element in recovery. The services create a recovery family and natural supports for women.

8. **Outcomes and Measures of Success**
   Typical outcomes or measures of success include: maintenance of stable housing; employment; increased income; occupying a meaningful social role(s); and a clean and sober lifestyle. A key to this approach is identifying and meeting women's own functional goals, whether they are employment, education, or improved parenting skills.

9. **Attention to Parenting and Relationships**
   Developing the ability to function in healthy relationships and cultivate positive identities as parents are particularly critical outcomes. Parenting is more than a social role; it is central to women's identities.

10. **Considerations for Children**
    Child and family well-being is a critical priority. Including a safety net for children to remain unified with their family is important for both mothers and children. It is essential that relapse protocols protect these relationships, in partnership with early intervention policies, trauma-informed housing, and additional supports for mothers to learn to care for themselves and their children. This also includes finding ways to strengthen non-traditional family and social support networks, including fathers and partners.

11. **Employment and the Pursuit of Purpose**
    Inherent in this approach is the "pursuit of purpose" orientation in which participants are expected to move toward self-sufficiency. The pursuit of purpose for many women is dependent on economic independence, emphasizing education, employment, and entitlement benefits. Programs work with women from the start to achieve self-sufficiency goals.

12. **Unique Program Model**
    Programs that combine housing, treatment, and gender-specific services are unique. They are often the only programs of their kind within communities.