

# Demonstrating the Value of Recovery Housing: *Technical Expert Panel Findings*



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# About This Report

In January 2021, the National Council for Mental Wellbeing hosted a technical expert panel (TEP) to explore ways to best demonstrate the value of recovery housing in the United States. The TEP reviewed the current landscape, identified areas for improvement and discussed potential options for improving the system. In partnership with the Opioid Response Network and the American Academy of Addiction Psychiatry, the National Council convened subject matter experts, including recovery housing leaders, researchers, treatment providers, national associations, federal agencies, Single State Agency directors and payers (see Appendix B for full list of participants). Due to the ongoing COVID-19 pandemic, the TEP was convened via video conference over the course of three days.

The panel identified existing strengths and challenges within recovery housing and discussed the following questions to identify solutions for improving the system:

- What is missing from the current recovery housing framework, which encompasses recovery-oriented system of care (ROSC), recovery management, recovery capital and the social model?
- What strategies can be implemented to bridge the cultural divide between the social model (recovery housing) and the medical model (treatment)?
- What are the current opportunities and limitations in the funding of recovery housing?
- What is an ideal funding model for recovery housing and what needs to be in place to adequately fund recovery homes?
- What policies and systems should be implemented to create a more cohesive recovery housing ecosystem?

At the conclusion of the panel, recommendations were identified and next steps proposed to strengthen the system in an effort to build the recovery housing network and demonstrate the value of the service. This report identifies key strategies and recommendations that are informed by recovery housing research and on-the-ground experiences of those participating as part of the TEP.

# Background

In 2019, 20.4 million people above the age of 12 had a substance use disorder in the United States, including 14.5 million people who had an alcohol use disorder and 8.3 million people who had an illicit drug use disorder.<sup>1</sup> In the same year, only 4.2 million people received any substance use treatment, with the majority (2.1 million) seeking treatment through mutual support groups within their communities.<sup>2</sup> Partially due to a lack of recovery supports, more than 60% of people who receive treatment for substance use disorder relapse within one year of leaving treatment.<sup>3</sup>

During the COVID-19 pandemic, substance use has increased significantly and the disparities in access to quality treatment and recovery services have become even more stark. For most, formal treatment is just the beginning of their recovery journey, yet for many, recovery starts at the community level and may not involve any formal treatment services. Regardless of the journey they take, a person seeking long-term recovery should have access to an array of supports, including housing and peer support.

## RECOVERY-ORIENTED SYSTEMS OF CARE

Despite the need and clear evidence of effectiveness, the current health care system is designed to focus on discrete episodes of substance use disorder treatment with little attention to recovery support services that help individuals manage and sustain long-term recovery. In short, the current system is not set up to support the financial sustainability of community-based, peer recovery support services.

The current system is not person-centered and funding of services is largely focused on medical and/or clinical services rendered, not on quality of care and long-term outcomes. Challenges remain in the understanding and recognition of recovery housing as an evidence-based practice that addresses chronic disease management.

Recovery-oriented systems of care (ROSC) is a person-centered approach that values all aspects of recovery, including community and clinical supports. ROSC understands that social determinants of health (SDOH), those conditions in which people are born, grow, live, work and age, shape their overall health and wellbeing.<sup>4</sup> ROSC seeks to wrap services that address these social determinants, including factors such as socioeconomic status, education, employment, social supports and access to health care and housing – many of the elements supported through the ROSC model.



## SERVICE SYSTEM PROGRESSION

### Recovery-oriented System of Care



*In the model, clinical care is viewed as one of many resources needed for successful integration into the community.*

Recovery housing provides stability and structure that directly supports many aspects of the ROSC model – allowing individuals to focus on their community while continuing their recovery journey.

### WHAT IS RECOVERY HOUSING?

Recovery housing is a substance-free living environment that provides a safe and healthy place for individuals who are recovering from addiction. The foundation of every recovery residence is based on the social model for recovery support, which emphasizes:

- The setting as the service.
- Interconnections amongst individuals and with the environment.
- Congruence and culture (reciprocal responsibility and harmony).
- Peer governance, peer leadership, community wisdom.

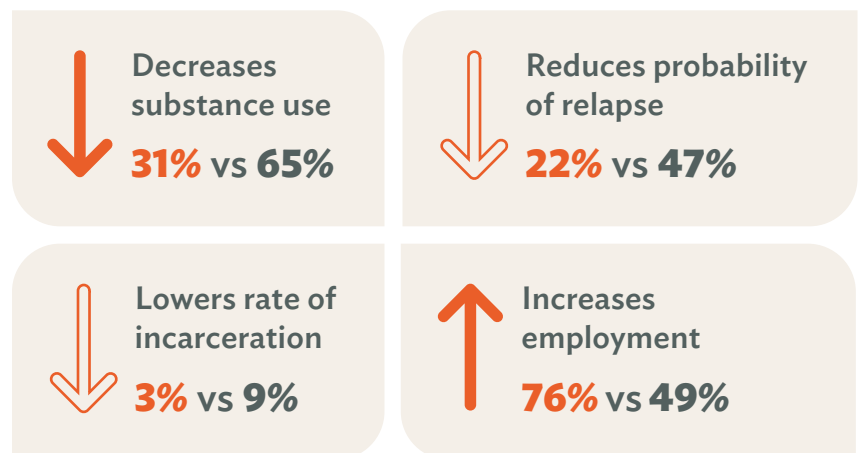
There are many different types of recovery housing structures, but many fall under the Oxford House Charter or the National Alliance for Recovery Residences (NARR) Standard.<sup>5</sup> While Oxford Houses are based on a peer-run model, NARR-accredited houses can fall under four different levels of support.<sup>6</sup>

Oxford House	National Alliance of Recovery Residences
All Houses: Peer-run	Level One: Peer-run
	Level Two: Monitored
	Level Three: Supervised
	Level Four: Clinical Service Provider

***“It’s our hope that recovery housing will be recognized in its own right for the value it brings to people with substance use disorder. It should not be forced to operate in some other framework for housing or service models. Instead, recovery housing should be financed to sustainably coexist with other models to best meet the needs of individuals and communities.”***

— Lori Criss, Director of the Ohio Department of Mental Health and Addiction Services

According to research, recovery housing contributes to improved outcomes and addresses upstream determinants of health compared to usual care.<sup>7</sup> Recovery housing:



Despite its effectiveness as a recovery support and significant interest in recovery housing services among those in or seeking recovery, it is not reimbursable or covered within the traditional medical system. The misunderstanding of what recovery housing is and the supports it provides has led to stigma and discrimination from all levels of society, including state/local governments, medical communities, legal professions and the public.

# Challenges and Recommendations

The following identified challenges and recommendations were informed by our TEP, which included recovery housing experts, recovery researchers, addiction specialists and public policy specialists. This information highlights opportunities for stakeholders to advance health policy and strengthen ROSC to support recovery housing within the broader health care system.

## 1. FINANCING

The current health care system is primarily based on a fee-for-service model, which supports payment and reimbursement for the volume of services provided instead of focusing on quality, outcomes and cost-efficiency. The fee-for-service model also values the individual therapeutic services provided by a single provider compared to placing value on the setting (e.g., housing) as the service. Currently, recovery housing can only be considered a health benefit when clinical services are delivered onsite and operators are precluded from billing for room and board. This has resulted in recovery support services being siloed from treatment, including within existing payment models and other funding opportunities. Ultimately, recovery housing is underutilized as a resource for people leaving substance use treatment, partially because recovery housing lacks a sustainable funding model. This lack of a sustainable funding model can lead to fraud and abusive practices within the current system.

Operating in a health care system that does not value recovery services means that most recovery houses are constrained by limited budgets. The following are potential payment models and strategies that can better improve funding for recovery housing until a value-based system is established to support an independent recovery housing finance model.

### *An Independent Recovery Payment Model*

The TEP identified that an independent recovery payment model will not look like any payment model in use today – it will value recovery housing in its own right. It is recommended that the recovery payment model be informed by the American Society of Addiction Medicine (ASAM) Criteria but tailored to the non-clinical nature of recovery housing. The model should cover the continuum of care from treatment through recovery but can also cover treatment and/or recovery independently.

As recovery housing can be the entry point to recovery for many individuals, this payment model should not require a medical diagnosis for recovery housing services. It is important that all levels of recovery housing are incorporated into the model and that it places value on workforce expertise, quality of services and outcomes associated with the service. Furthermore, the model should be evidence-based. For example, research indicates that self-efficacy increases after six months of residency, which should serve as a baseline for coverage in the payment model.<sup>8</sup>

## State Spotlight: Kentucky

Kentucky has a unique setup that relies on several strategic partnerships throughout the state's government bodies, nonprofit sector and private entities all working to improve access to recovery supports. Recovery Kentucky was established in 2005 by three government agencies: The Kentucky Department for Local Government (DLG), the Kentucky Department of Corrections (DOC) and the Kentucky Housing Corporation (KHC). Today the program maintains 14 Recovery Kentucky centers, including the men's and women's programs of The Healing Place in Louisville and the Hope Center in Lexington, for a total of 18 programs providing safe housing and effective recovery services for more than 2,100 individuals at any given time.

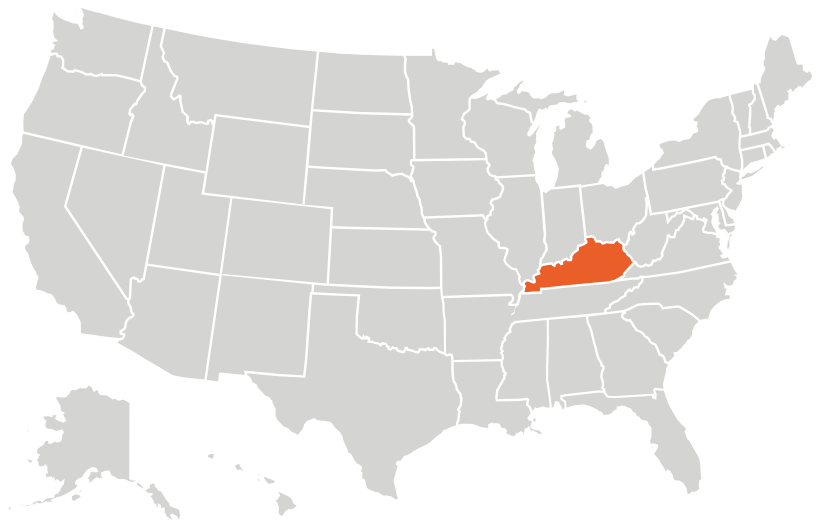
Each of Recovery Kentucky's centers utilize the social model of care in an effort to build recovery capital for people participating in the recovery program. The University of Kentucky conducts annual outcomes assessments of the program, which continuously shows the effectiveness of the program.

**Financing:** The Recovery Kentucky program utilizes a unique financing model that pulls from both public and private resources to achieve financial stability. Starting with construction of each facility, Recovery Kentucky strategically utilizes tax credits through the Kentucky Housing Corporation and generous funding from partners, like the Federal Home Loan Bank of Cincinnati and local community organizations, to ensure each facility is fully paid at completion, without a mortgage. This keeps costs low for operators and for those entering into the program. Operating costs are also kept low through government funding between DLG, the Supplemental Nutrition Assistance Program (SNAP), the Housing Authority Section 8, the Community Development Block Grant and referrals from DOC.

***“In 2005, the Fletcher Administration witnessed too many Kentuckians homeless and incarcerated due to their substance use disorder, and Governor Fletcher directed his administration to create an innovative funding model to serve the underserved.”***

— Tony White, The Fletcher Group

Recovery Kentucky does not currently use State Targeted Response (STR) or State Opioid Response (SOR) funding and has successfully developed financial sustainability for recovery services in the state. This funding model is unique but demonstrates the power of strategic collaborations across government agencies, community organizations and private entities. Maintaining these partnerships across various stakeholder groups also helps reduce stigma within each community.





## **Additional Strategies for Financing Recovery Housing**

### **Extend the Medical Model to Include Wraparound Services**

Insurance companies can reimburse for services if they contribute to generating outcomes and improving social determinants of health and recovery capital.<sup>9</sup> Recovery housing should be incorporated into current insurance plans as a wraparound service, especially since recovery housing contributes to improved health outcomes and cost savings within the health care system.<sup>10,11</sup>

The U.S. Centers for Medicare and Medicaid Services looks to the ASAM Criteria to inform reimbursement for addiction and treatment services under the medical model. As the country moves toward a value-based system and starts reimbursing for services that address social determinants of health, recovery services should be incorporated into the Criteria. This integration will allow recovery housing to be a more fully integrated complement to the medical model instead of treated as an add-on service. Recovery housing advocates should work with the ASAM to integrate the NARR Standards into the ASAM Criteria.

### **Develop a System for Third-party Payers**

Although it will not be fully integrated into the medical system, third-party medical payers are a way to finance recovery housing on a steady basis instead of depending on unpredictable funding contracts and grants. Third-party payers have been used to cover other housing services, such as assisted living and nursing home services. While this is a feasible option, there are concerns that third-party payers could increase administrative burdens and operating costs and implement unnecessary coverage limits and billing requirements. Furthermore, this type of model might not be compatible with the grassroots nature of recovery housing.

Stakeholders should conduct an assessment of third-party payers and develop a cost/benefit analysis. This assessment will look drastically different for each recovery house and/or state based on current financing and administrative structures already in place.

### **Implement a Voucher Program**

By implementing a national voucher program, individuals will have greater access to recovery services and flexibility in choosing which services are right for them. Prior initiatives, including SAMHSA's Access to Recovery (ATR) voucher program, could serve as the basis for a new voucher program to be implemented quickly.<sup>12</sup> Similar to the ATR voucher program, funding would be granted to states through a competitive SAMHSA grant process and could provide an opportunity to collect data on the impact of recovery housing.

Public and private insurers are also exploring voucher program models to address SDOH, which could present an opportunity for the recovery housing community to participate in innovative benefit programs.<sup>13</sup> While voucher programs can be highly effective in the short-term, it is difficult to implement nationwide and there are concerns about the long-term sustainability of such programs. Stakeholders should convene meetings with SAMHSA, public and private payers to better understand the current landscape regarding voucher programs and assess if there are opportunities to further advocate for recovery housing in this space.

## Improve Waiver and Block Grant Opportunities

Federal and state funding opportunities for recovery housing vary drastically by state, but some of the most common federal sources come from SAMSHA's Substance Abuse Prevention and Treatment (SAPT) Block Grants and SOR Grants.<sup>14,15</sup> Some states are also using Medicaid section 1115 substance use disorder demonstration waivers, but are prohibited from billing for room and board.<sup>16</sup> While grant funding is critical to supporting recovery housing, strategies for improving these funding opportunities will look drastically different for each state. It is also important to acknowledge that grant funding is not a sustainable solution for long-term support of recovery housing services. Access to capital funding for housing acquisition and periodic renovations need to be a part of any funding model. Funding models should also be flexible enough to allow providers to stockpile resources to address emergent needs such as the need for personal protective equipment (PPE) brought on by COVID-19 and the public health emergency that ensued. Stakeholders should capitalize on opportunities to secure policy language that allocates a certain amount of block grant funds to be directed specifically to recovery supports, including recovery housing.

### *Recommendations*

While the TEP did not come to a consensus on the best model to pursue, there was agreement that a workgroup should be established to determine the most strategic direction for the recovery housing community to pursue, both in the short-term and long-term. It is recommended that the workgroup pilot demonstration projects and conduct research to determine which models would allow for maximum flexibility between states and recovery housing types. The workgroup should be comprised of recovery housing experts from different geographic locations to help represent the diverse needs of communities across the country.

## 2. A NATIONAL STANDARD

Today, there are two prominent frameworks for recovery housing in the United States – the NARR Standards and the Oxford House Charter – which utilize the ROSC and social models as the base of their organizations. NARR has 30 state affiliates that have certified more than 3,000 recovery houses<sup>17</sup> and Oxford House is a network of 2,060 chartered recovery houses in 49 states and the District of Columbia.<sup>18</sup> In addition to these models, SAMHSA also issued Recovery Housing Best Practices.<sup>19</sup> However, SAMHSA's guidance is clinically oriented and not suitable to all levels of recovery housing, especially those that are fully ensconced in the social model.

Developing a single, payer-responsive national standard will increase cohesion throughout the recovery housing community and reduce confusion in the field about recovery house models and standards. This table lists some of the benefits of developing and implementing a national standard, as put forth by the TEP.

### Informs a Sustainable Payment Model

- Provides structure for payment based on the type/level of recovery housing.
- Decouples needs for clinical services from needs for recovery housing and other non-clinical recovery support services.
- Creates alignment between medical and social models to secure a broader spectrum of care.

### Develops a Framework for Collecting High-Quality Data

- Identifies quality housing and eliminates the bad players.
- Builds external credibility by demonstrating resident outcomes and cost-effectiveness for the broader health care system.
- Informs an actuarial review of the costs of running different levels of recovery housing.
- Basis for evaluating access and quality of services provided to marginalized demographic groups and geographic areas of need.

### Establishes National Infrastructure and a Reliable Workforce

- Develops an integrated network of recovery houses across the country that reinforces quality standards, increases opportunities to share best practices and builds a stronger workforce.
- Creates consistent language for recovery housing community to communicate with medical providers, policymakers, consumers, funders and nonprofit organizations.
- Provides opportunities to establish stronger partnerships with state and local governments (e.g., developing incentive structures).

## State Spotlight: Ohio

**Standards:** Ohio’s model for quality recovery housing is built on a strong public-private partnership. While Ohio does not require certification, Ohio Recovery Housing (ORH) is the NARR state affiliate organization that has been supported by the Ohio Department of Mental Health and Addiction Services (OhioMHAS). To build trust within the recovery housing community, ORH’s model is peer-driven and local recovery housing operators comprise the organization’s Board of Directors.

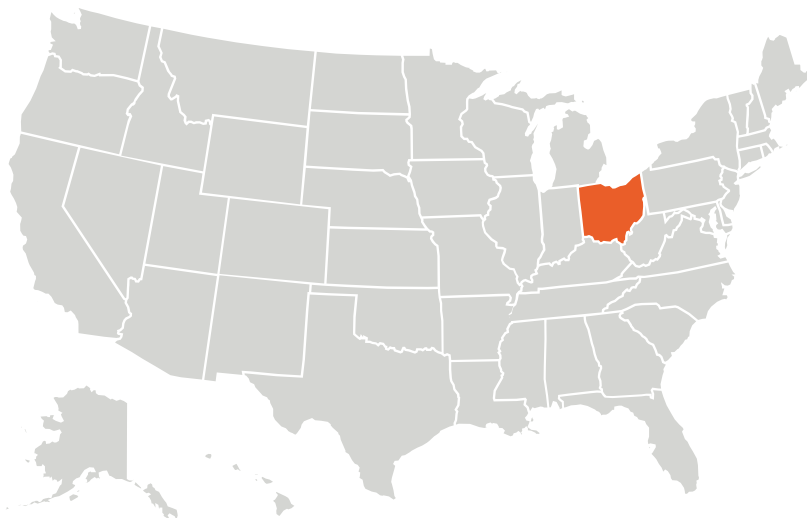
Utilizing the NARR standards as the basis of Ohio’s certification, ORH and the OhioMHAS worked together to implement the standards in a way that is suitable for local operators. Realizing that there is not a single, uniform way to meet NARR standards, Ohio sought input from community partners, referenced research and consulted with NARR to develop a unique implementation process for the state. As operators express interest in becoming certified, ORH works with them to meet the standards. OhioMHAS and ORH have also implemented a training and technical assistance strategy to build consistency for quality improvement and expectations for recovery houses that become certified.

**Data Collection:** ORH recognized the importance data collection can have in storytelling and building support for recovery housing at the local and state level. When developing a data collection tool, ORH worked with a researcher to identify national data collection trends and gaps in national data that could be collected at the local level. By creating simple and resident-driven tools, ORH was able to implement a comprehensive voluntary data collection system that is easy for operators to implement and quick for residents to complete.

The data collection tool can be used on a smartphone, tablet or desktop and it takes less than 10 minutes to complete. Data is typically collected at move-in, three-months, six-months and move-out. The tool also has a qualitative section where residents can share their story, which helps build the narrative around some of the data given in the surveys. All data is stored on a dashboard that is updated every four minutes and compiled into state-level data. This data collection system allows ORH to demonstrate effectiveness of the programs and, when coupled with the qualitative data, is compelling for their advocacy efforts. This data collection system also allows for individual operators to have quick and easy access to their data for analysis, impacting local advocacy efforts as well as assisting in continuous quality improvement efforts.

***“You may have gotten the seat at the table with a champion, but you keep that seat with what you’re able to offer and bring to the table in terms of data and resources.”***

— Lori Criss, Ohio Department of Mental Health and Addiction Services







## Recommendations

The TEP strongly supports adopting a national standard that is derived from the Oxford House model and the NARR standard. Since there is already broad adoption of the Oxford House model and the NARR standard, the transition to the new standard should not be burdensome for most recovery housing operators. In order to accomplish a smooth transition to a national standard, the panel offered additional recommendations:

- **Non-governmental oversight:** A national standard should be developed and the corresponding certification process should be housed and administered through a non-governmental entity in partnership with a state entity to ensure credibility and quality of the program.
- **Certification, not licensure:** The process should remain a certification and not transition to a licensure where requirements could become highly political and the administration more burdensome for operators to meet.
- **Provide technical assistance:** For those operators that are not currently chartered by Oxford House or certified by NARR, technical assistance resources should be developed and offered to help houses raise to the standard level.
- **Provide resources for capacity expansion:** Most states lack capacity in high-need areas and rural areas and aren't responsive to the needs of marginalized and traditionally under-served populations. These activities require more and different resources than supporting existing providers and homes.

### 3. EVIDENCE-BASED RESEARCH AND DATA COLLECTION SYSTEMS

There is a strong foundation of research and data that supports recovery housing,<sup>20</sup> but more consistent information is needed to implement new practices, advocate for funding, improve policy and inform payment models. Collecting high-quality data on recovery home services, individual outcomes, actuarial data and population-specific information are all critical to strengthening the system. By building consistent data collection systems and filling in the gaps through research, the recovery housing community can develop a stronger narrative to demonstrate the value of recovery housing throughout the U.S.

			
<p><b>Education &amp; Advocacy Efforts</b></p> <ul style="list-style-type: none"> <li>• Knock down stigma barriers</li> <li>• Build a stronger evidence-based narrative</li> </ul>	<p><b>Funding Opportunities</b></p> <ul style="list-style-type: none"> <li>• Create database of “hard numbers” to increase support</li> <li>• Demonstrate ROI</li> </ul>	<p><b>Identify Best &amp; Promising Practices</b></p> <ul style="list-style-type: none"> <li>• Collect outcomes data</li> <li>• Identify best engagement and referral strategies</li> </ul>	<p><b>Sustainable Payment Model</b></p> <ul style="list-style-type: none"> <li>• Provide data consistency to build the case for a sustainable model</li> </ul>

It’s critical that recovery housing research and data collection include health outcomes, but it’s equally important to track recovery capital and the environmental/contextual issues that lead to substance use. The TEP identified a number of data gaps that should be prioritized by the research community and their funders:

- Efficacy studies/comparison studies
  - » National efficacy study (all types of recovery housing)
  - » Primary substance
  - » Different types of recovery housing
  - » Abstinence-based programs vs. harm reduction
  - » Recovery housing vs. treatment modalities
  - » Recovery housing vs. housing first
  - » Traditional care services with and without recovery housing
- Recovery housing best practices and improved outcomes
  - » Evidence-based referrals
- Cost-benefit analysis and return on investment (ROI)
- Racial health equity
  - » Access equity
  - » Quality equity, including cultural appropriateness/responsiveness
- Environmental and contextual determinants of SUD

Since recovery is undervalued in the U.S., funding opportunities and grants for research on recovery housing are difficult to secure. Typically, government funding does not allow for sufficient follow-up in recovery studies. Government funded research usually allows for two years of research but research on recovery supports requires between five and 10-years follow-up, which is difficult to secure. Despite the current landscape, recovery housing researchers should capitalize on opportunities as the health care system transitions to value-based care and interest grows in understanding social determinants of health.

## State Spotlight: Virginia

In 2018, Virginia's legislature approved VARR as one of two credentialing organizations for state certification for recovery homes in Virginia. Oxford is the other organization, which only certifies/charters Oxford houses. Virginia law does not require certification to operate but does require it to receive some referrals and funding opportunities. VARR drives strategic partnerships in the state to advance their work:

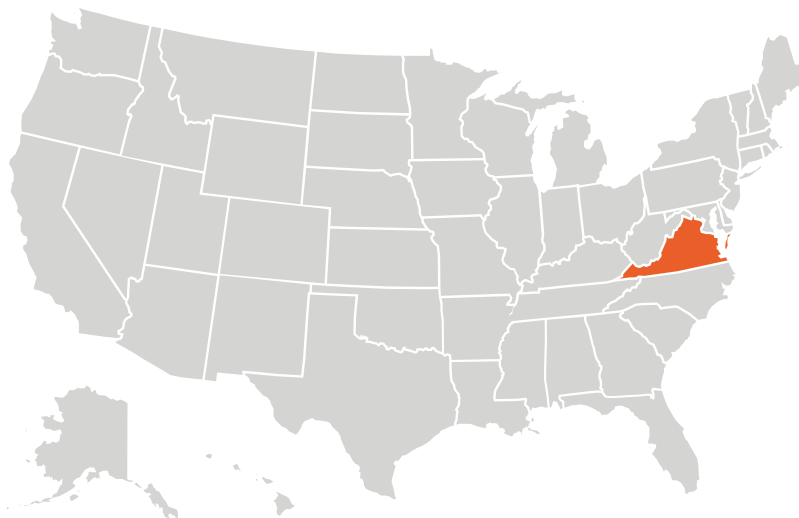
- **VARR & DBHDS:** In 2019, legislation identified the Virginia Association of Recovery Residences (VARR) to work on behalf of the Virginia Department of Behavioral Health and Developmental Services (DBHDS) to assess community needs and certify recovery houses in the state.
- **VARR & VA Communities:** VARR has conducted community needs assessments and worked with the Department of Corrections, minority-owned businesses, LGBTQ+ communities and others to make recovery housing accessible to communities most in need of long-term supports.

**Data Collection:** When the VARR/DBHDS collaboration began, it was critical for VARR to demonstrate the value and impact of recovery housing in the state. In 2019, VARR adopted the Advanced Recovery Management System (ARMS) Data Platform, which contains the Recovery Capital (REC-CAP) module to capture data from certified recovery houses in the state. REC-CAP enables VARR and certified residences to measure outcomes, engage individuals and track recovery capital throughout a person's recovery journey.

The REC-CAP program is simple to operate and requires little training or additional resources to implement. The program also has a funding mechanism to help operators enhance their operations. Most importantly, REC-CAP provides consistency in measuring evidence-based practices and establishes standardized data collection/reporting to ensure validity. This gives recovery housing legitimacy and reduces stigma, especially among service providers in the state.

***“REC-CAP has given validity to recovery housing in Virginia in a way that we never had previously, and it promotes fiscal stewardship.”***

— Anthony Grimes, VARR



Successes	Challenges
<p>The collaboration between VARR and DBHDS has established recovery housing as a valuable, high-quality service within Virginia. Introducing the REC-CAP program has helped VARR demonstrate the impact of recovery housing, which has leveraged their advocacy efforts to secure funding and additional supports for the service.</p> <p>Recent data show that over the past six months, certified houses went from serving 80% White individuals and 20% non-White individuals to serving 70% White individuals and 30% non-White individuals, demonstrating their dedication to reduce barriers to recovery and ensure equitable access to high quality, safe and supportive recovery residences across the state.</p>	<p>Although REC-CAP has helped secure funding at the state level, federal funding streams are unpredictable and complex. SOR grants are also a major source of funding. If SOR was no longer available, there would be a severe negative impact in Virginia and throughout the country. VARR hopes to advocate for a line item in the Virginia budget to help address funding concerns.</p>

## Recommendations

The TEP recommends developing a national, cross-sector workgroup – including recovery housing experts, researchers, research funders, public health practitioners, current and potential payers for services and communications specialists – that is tasked with:

- **Identifying Impactful Research:** Review current research and data to identify important gaps that can strengthen buy-in, expand services and build support.
- **Developing National Data Collection Standards:** Informed by the data review, the workgroup should develop standards that recovery housing operators can adopt at every level. Developing data standards will establish consistent reporting and help build a narrative regarding the impact of recovery housing at a national level.
- **Translating Research:** This cross-sector workgroup will be well-positioned to translate new and existing research and data, so it is effectively utilized at every level of the system, including in operations, development and policy.
- **Addressing Housing Rights/Protections for Individuals Against Abusive Practices:** Review existing laws and policies to address barriers to securing housing as well as prevent exploitation of potential residents.



## 4. COHESIVE MESSAGING

Developing a message that makes the case for recovery housing is an essential part of reducing stigma and increasing support across communities, including within the medical field, legal system, state/local government and among the general public. Local governments create significant barriers to recovery housing by using false and stigmatizing language about substance use and recovery that drives “Not In My Back Yard” (NIMBY) narratives throughout the country.

In states such as Florida, California, Utah and Arizona, local governments pass laws requiring licensure or equivalent planning permission, banning operations in residential neighborhoods and regulating the number of recovery houses in a given area. The narratives used to justify NIMBY laws blur the line between treatment centers and recovery housing – capitalizing on the fact that most people do not know the difference. In order to reduce stigma and combat these NIMBY narratives, it’s critical that the recovery housing community develop messaging that clearly defines recovery.

An effective message will align with similar messaging from other recovery disciplines and the larger recovery movement. This message should be:

- **Non-stigmatizing:** Using person-first language that establishes substance use disorder as a disease is critical.
- **Evidence-based:** As research and data becomes available, it should be incorporated into messages to demonstrate the value of recovery housing at the community, state and national levels.
- **Consistent:** Although the message should be tailored for different stakeholders, it is important for the concepts to remain consistent throughout.
- **Contextualized:** This message should underscore the importance of recovery housing as a vital component in a recovery-oriented system of care, especially during the period of early recovery.
- **Eye-opening:** It’s important to demonstrate the benefits of recovery housing, but also expose how detrimental discrimination and denial of housing services can be for people in recovery.

### Recommendations

The TEP recommends developing a workgroup to evaluate current data/research to inform cohesive, evidence-based messaging. This workgroup should develop a message that addresses each of the points above and can be geared toward different stakeholders, including medical providers, policymakers, funders and the general public. Message development should include housing rights experts.






# Collaborations

Throughout the TEP meetings and interviews, participants highlighted collaboration as a critical component for expanding access to recovery housing supports. When integrating recovery housing as part of the continuum of care and within housing first programs, it's critical that the recovery housing community – including operators, advocates and researchers – collaborate with the medical/treatment and housing communities. Interdisciplinary collaborations will create a stronger foundation for recovery housing to address long-standing challenges and act on the recommendations of the TEP. A unified voice is also essential for collaborations and advocacy efforts at the state and national level.

## STATE COLLABORATION

Recovery housing challenges are unique to each state and local jurisdiction. Establishing strong working relationships between local recovery housing organizations/communities and state government agencies is key to successful advocacy efforts and developing innovative solutions to local challenges. Although their approaches differ, participants from Kentucky, Ohio and Virginia highlighted the importance of the organization/state government relationship for improving recovery housing efforts in their states. In addition to legislative champions, the following collaborations have proven to be useful in advocating for recovery housing initiatives:

	Organization	Government Agencies
<b>Kentucky</b> 	The Fletcher Group	<ul style="list-style-type: none"><li>• Kentucky Housing Corporation</li><li>• Kentucky Department for Local Government</li><li>• Kentucky Department of Corrections</li></ul>
<b>Ohio</b> 	Ohio Recovery Housing	<ul style="list-style-type: none"><li>• Ohio Department of Mental Health and Addiction Services</li></ul>
<b>Virginia</b> 	Virginia Association of Recovery Residences	<ul style="list-style-type: none"><li>• Virginia Department of Behavioral Health and Developmental Services</li><li>• Virginia Department of Corrections</li></ul>

## NATIONAL COORDINATION

In order to create a more cohesive infrastructure that supports recovery housing in a meaningful way, panelists suggested the need for an entity that can coordinate efforts at the federal level. At the governmental level, coordination needs to bridge the divide of existing recovery housing policies and programs that are overseen by the Department of Housing and Urban Development (HUD) and the Department of Health and Human Services (HHS). TEP participants offered that the White House Office of National Drug Control Policy (ONDCP) could play a critical role in facilitating this coordination at the government level. Non-governmental players hold specialized knowledge about those in the recovery housing community and national coordination of these experts is critical, especially outside of the government context. This national entity can be helpful in:

- Establishing a national infrastructure through the implementation of practice standards, data collection, communications and more.
- Advocating for recovery housing throughout the system at the national level, including coordination between government agencies (HHS, HUD, USDA, DOJ, ONDCP, etc.).
- Providing technical assistance to recovery housing organizations at the state and local levels.
- Communicating at the national level to give more credibility to recovery housing.

Momentum is building at the federal level to establish a stronger recovery support ecosystem throughout the United States. On April 1, 2021, ONDCP published the Administration’s first year priorities. Included in the seven priorities is “expanding access to recovery support services” – a demonstration of the Administration’s commitment to advancing long-term recovery supports, including recovery housing.<sup>21</sup>

In addition to Administration priorities, Representatives David Trone (Md.-06), Judy Chu (Calif.-27), Mike Levin (Calif.-49) and David McKinley (W.V.-01) recently introduced H.R. 8868 – The Excellence in Recovery Housing Act. If passed, the law would establish national standards for high-quality recovery housing, provide increased funding to states to support high-quality recovery housing, require the National Academy of Sciences to conduct research on recovery housing and create an interagency working group (including SAMHSA and HUD) to increase collaboration for improved recovery supports.<sup>22</sup>

These provisions have also been included in House and Senate versions of a Comprehensive Addiction Recovery Act (CARA) 3.0 omnibus bill addressing many needs relative to our addiction crisis.

These actions can serve as a great foundation for the recovery housing community and its allies to come together with a unified voice to support and guide these federal efforts. Collective input from the recovery housing community is essential to the success of each of these government advancements in recovery.



# Conclusion

As recovery supports become more recognized as an integral part of the continuum of substance use care, it's critical for all stakeholders to take action. Work has begun at the federal level with additional block grant funding for mental health and substance use treatment, but policymakers need to work with states to ensure recovery housing is funded sufficiently. Recovery housing operators and researchers are also essential in moving private stakeholders, such as payors, to cover recovery services. As the health care system begins to move toward value-based care, it is hoped that recovery housing will be recognized in its own right and an independent recovery payment model can be developed. As the United States emerges from the COVID-19 pandemic with more people in need of recovery supports than ever before, now is the time for state and federal stakeholders to develop a system that fully supports individuals throughout their recovery journey. Now is the time to make recovery housing accessible to all individuals seeking recovery supports.



# Appendix A. Agendas

## RECOVERY HOUSING TECHNICAL EXPERT PANEL

Design Elements of a Complete Payment Model for Recovery Housing

January 12, 13, & 27, 2021

### DAY 1: JANUARY 12, 2021

Goals:

- Review an overarching framework that encompasses ROSC, recovery management, recovery capital and the social model.
- Explore a conceptual and practical alignment between the social model (recovery housing) and the medical model (treatment) and strategies to bridge the cultural divide.

Time	Activity	Facilitator
2:00 – 2:10 pm	Welcome; Purpose & Design of Meeting; Agenda Walk-Through; Participant Roles; Housekeeping	Tom Hill
2:10 – 2:45 pm	Introductions	Aaron Williams
2:45 – 3:05 pm	Presentation: Connecting the Dots: Prelude to a Discussion on ROSC and Related Items	Tom Hill
3:10 – 3:45 pm	Group Discussion	
3:45 – 3:55 pm	Break	Tom Hill Aaron Williams
3:55 – 4:15 pm	Presentation: The Social Model and Recovery Houses	Jason Howell, RecoveryPeople Dr. Amy Mericle, Alcohol Research Group
4:15 – 4:40 pm	Zoom Breakout Discussions	Kate Meyer, Aaron Williams, Sarah Flinspach, KC Wu
4:40 – 4:55 pm	Brief Report-Out	
4:55 – 5:00 pm	Review of Day Set Up for Day 2	Tom Hill
5:00 pm	Adjourn	

## DAY 2: JANUARY 13, 2021

Goals:

- Craft facets of an ideal funding model to sustain recovery housing as a community-based recovery support service.

Time	Activity	Facilitator
2:00 – 2:15 pm	Welcome and Review of Day 1	Tom Hill
2:15 – 3:00 pm	Group Discussion	Tom Hill Aaron Williams
3:00 – 3:10 pm	Break	
3:10–3:40 pm	Zoom Breakout Discussions	Kate Meyer, Aaron Williams, Stephanie Swanson, KC Wu
3:45 – 3:55 pm	Small Group Report Out	
3:55 – 4:00 pm	Set Up for Day 3	Tom Hill
4:00 pm	Adjourn	

## DAY 3: JANUARY 27, 2021

Goals:

- Explore elements of a pilot study to test the cost-effectiveness of different payment models.

Time	Activity	Facilitator
2:00 – 2:30 pm	Welcome to Day 3 Review Notes of Previous Days	Tom Hill
2:30 – 3:30 pm	Large Group Discussion	Tom Hill Aaron Williams
3:30 – 4:00 pm	Next Steps and Assign Tasks	Tom Hill Kate Meyer
4:00 pm	Adjourn	

# Appendix B. Participant List

## TECHNICAL EXPERT PANEL

### **Heather Asbury**

Project Manager  
SAFE (Stop the Addiction Fatality Epidemic) Project

### **Robert Ashford, PhD, MSW**

Graduate Research Assistant  
Substance Use Disorders Institute  
University of the Sciences

### **Mark Blackwell, CPRS, RPRS, MSA**

Director  
Office of Recovery Services  
Virginia Department of Behavioral Health and  
Developmental Services

### **Kathryn Cates-Wessel**

President  
American Academy of Addiction Psychiatry

### **Tom Coderre**

Acting Assistant Secretary  
Substance Abuse and Mental Health Services  
Administration

### **Lori Criss, BSSW, MSW**

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Ohio Director of Mental Health and Addiction Services

### **Michelle Daly, MSW, BA**

Lead Public Health Advisor  
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### **Sarah Duffy, PhD**

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### **Gerard (Peter) Gaumont, MA, BA**

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### **Danielle Gray, MPH, CPH**

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### **Anthony Grimes, CPRS**

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### **Brett Hagman, PhD**

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National Institute on Alcohol Abuse and Alcoholism

### **Karmen Hanson, MA**

Program Director  
National Conference of State Legislatures

### **Erin Helms, MA**

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**Tammy Jo Hill, BA, MA**

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**Jason Howell, MBA**

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RecoveryPeople

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**Leonard Jason, PhD**

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DePaul University

**Roland Lamb, MA**

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City of Philadelphia

**Amy Mericle, PhD**

Scientist  
Alcohol Research Group

**Jennifer Miles, PhD, MA, BA**

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**Douglas Polcin, EdD, MFT**

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Behavioral Health and Recovery Studies  
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**Dheeraj Raina, MD**

Regional Medical Director Lead  
Anthem

**David Rook**

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**Mike Santillo, LCADC**

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**Charlie Severance-Medaris, MPP**

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**Dave Sheridan**

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Health Scientist Administrator  
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**Mike Zohab**

President/Founder  
Virginia Recovery Foundation

**NATIONAL COUNCIL FOR MENTAL WELLBEING**

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Former Senior Advisor

**Kate Meyer, MPH**

Former Graduate Intern

**Sarah Flinspach**

Former Project Manager

**Aaron Williams, MA**

Senior Director

**KC Wu, MPH**

Project Manager

**Stephanie Swanson, MPH**

Project Manager

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