U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

CHOICE MATTERS:

HOUSING MODELS THAT MAY PROMOTE RECOVERY FOR INDIVIDUALS AND FAMILIES FACING OPIOID USE DISORDER

June 2019

Office of the Assistant Secretary for Planning and Evaluation

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The Office of Disability, Aging and Long-Term Care Policy (DALTCP), within ASPE, is responsible for the development, coordination, analysis, research, and evaluation of HHS policies and programs. Specifically, DALTCP addresses policies and programs that support the independence, health, and long-term care of people of all ages with disabilities; that promote the health and wellbeing of older adults; and, that prevent, treat, and support recovery from mental and substance use disorders.

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Choice Matters: Housing Models that May Promote Recovery for Individuals and Families Facing Opioid Use Disorder

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LIST OF EXHIBITS

ACRONYMS

The following acronyms are mentioned in this report and/or appendices.

ADA	Americans with Disabilities Act
ASPE	HHS Office of the Assistant Secretary for Planning and Evaluation
CEO	Chief Executive Officer
COR	Contracting Office Representative
CSH	Corporation for Supportive Housing
DCPP	New Jersey Division of Child Protection and Permanency
DESC	Downtown Emergency Service Center
EBP	Evidence-Based Practice
FDA	HHS Food and Drug Administration
FQHC	Federally Qualified Health Center
HHS	U.S. Department of Health and Human Services
HUD	U.S. Department of Housing and Urban Development
KFT	Keeping Families Together
LPC	Licensed Professional Counselor
MAT	Medication-Assisted Treatment
MS	Master of Science
NARR	National Alliance for Recovery Residences
OBOT	Office-Based Opioid Treatment
OTP	Opioid Treatment Program
OUD	Opioid Use Disorder
PSH	Permanent Supportive Housing
SAMHSA	HHS Substance Abuse and Mental Health Services Administration
SMI	Serious Mental Illness
STEP	Stepped Treatment Engagement Program
SUD	Substance Use Disorder

EXECUTIVE SUMMARY

Introduction. The purpose of the Opioid Use Disorder, Housing Instability and Housing Options for Recovery project was to help the U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation and U.S. Department of Housing and Urban Development (HUD) describe the housing models available for individuals with opioid use disorder (OUD) who experience housing instability or homelessness. The association between OUD and homelessness has been examined and established.[1,2] Veterans -- who have higher rates of both homelessness and OUD than are observed in the general population -- and youth are particularly at risk.[3,4] To better understand housing models that may support those with OUD, the study team conducted an environmental scan and held discussions with experts and providers in four communities. Medication-assisted treatment (MAT), using the HHS Food and Drug Administration-approved medications methadone, buprenorphine, and naltrexone, along with counseling and behavioral therapies, is well documented as an evidence-based treatment for OUD.[5] All community housing providers chosen for discussions allowed people receiving MAT to be housed in their programs. Some housing programs the study team examined partnered with treatment providers who used naltrexone. Others used buprenorphine and/or coordinated with opioid treatment programs to treat individuals in need of methadone. Most closely collaborated with MAT providers. Two of the housing programs served families with children, and two served single adults.

Elements of the Housing First Model

- Immediate access to housing and supportive services with a philosophy of participant choice.
- Recovery-oriented approach.
- Prioritizing people most at risk.
- No requirement for participation in treatment.
- Housing and treatment provided independently of each other.
- No sobriety requirements.
- Harm reduction approach.
- No requirement for housing readiness.
- Intensive case management.
- Individual choice of permanent housing.
- Full tenant rights.
- Pay reasonable rent.
- Access to and coordination with education/employment, mental health, SUD, and other social services.
- Personalized goals.
- Use of motivational interviewing.
- Multi-disciplinary teams.
- Crisis supports.
- 24/7 staffing.
- Collaboration with/support for landlords.
- Outreach.
- Systems approach.

Findings. People without stable housing are less able to engage in MAT.[6] Further, although MAT has been well documented as an evidence-based practice (EBP) to treat OUD,[5]

individuals without housing who are receiving MAT still experience barriers to supportive housing because of misconceptions about medications used for MAT.[7]

Despite the strong relationship between OUD and housing instability,[1,2] we found few programs that specifically targeted individuals with OUD who also had housing instability. The most relevant models we identified include: the Housing First Model, other permanent supportive housing that follow housing first approaches, and recovery housing.

The Housing First model emphasizes immediate access to housing with intensive supports and case management without the preconditions of sobriety or participation in supportive services.[8] If Housing First services are integrated or coordinated with provision of MAT and substance use disorder (SUD) treatment, the model shows promise for assisting individuals with OUD and other SUDs to remain housed and attain recovery. The HHS Substance Abuse and Mental Health Services Administration and HUD recognize the Housing First Model as a best practice for reducing chronic homelessness.[5,9] The U.S. Interagency Council on Homelessness supports the Housing First approach and a system-wide Housing First orientation.[10] Importantly, individuals served through the Housing First Model are more likely than individuals served through other programs to continue taking MAT medications as prescribed for at least three years.[11] Individuals served through the Housing First Model are also less likely to misuse substances compared to clients who are involved in programs that require SUD treatment as a condition of housing.[12]

Recovery housing programs are intended to support individuals with SUD in their recovery, often as a step-down from inpatient or residential SUD treatment. The recovery housing approach is based on the belief that individuals with a history of SUD are better off in a home environment of peer support that emphasizes abstinence. Those who treat and provide support for individuals with OUD understand that some individuals find the sober environment and peer support provided through recovery housing to be beneficial to their recovery. Some recovery housing programs serve people receiving MAT, and others do not.[13] Unlike Housing First providers,[14] the recovery housing community differs in opinion as to the appropriate role for MAT for those with OUD living in recovery housing.[15]

Also unlike Housing First,[13] recovery housing has no commonly established implementation model, and some recovery housing models consider MAT a violation of abstinence. State regulations for recovery housing programs still vary widely, and no federal regulations or standards address recovery housing.[13] Evaluations of recovery housing programs have been promising but would benefit from more-rigorous designs.

Experts interviewed as part of this study agreed that peer support, specifically support from an individual who has experienced both OUD and homelessness, is extremely important in outreach and treatment. Experts also mentioned that while co-location of services such as MAT and health care is ideal, housing programs with closely coordinated off-site services can also work well. Finally, the expert respondents in this study stressed that self-determination and individual choice of model and treatment are central to recovery and choice of housing model and treatment can vary over the course of recovery.

Staff from the programs we examined emphasized that persistence is key: staff need to continuously reach out to the population they seek to serve, to build trust. They also address other barriers such as the need for security deposits, credit histories, criminal records for drug-related offenses, and the lack of trust many individuals who experience chronic homelessness have in service providers. The programs we highlight in this issue brief work to build trust with individuals served, provide peer support services, coordinate closely with local pharmacies, engage the community, collaborate closely with health and behavioral health providers, and use funds braided from multiple sources to pay for housing, treatment, and supportive services.

Future Considerations. While some research is available, there are still major gaps in the research literature. Research is lacking that compares the Housing First EBP to other housing models for individuals and families with OUD. Additionally, we did not find programs that were specifically developed to meet the special needs of youth who were experiencing homelessness and OUD. Such research could assist individuals and providers to better understand which housing models are most effective for different populations of individuals and families with OUD before choosing a particular program. Finally, it should be understood that OUD is a chronic condition and should be treated as such. Housing and SUD treatment providers, and communities at large, could benefit from education about the nature of OUD, medications for its treatment, and the process of recovery.[16]