Housing for People with Substance Use Disorders: Best Practices, Innovations and Gaps

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Disclosure Information

- Presenter 1: Elizabeth Salisbury-Afshar, MD, MPH, FAAFP, FACPM, DFASAM
  - Presenter 1: No Disclosures
  - Acknowledgement: Thanks to Dr. Dennis Watson, Senior Research Scientist, Chestnut Health Systems for his review of slide content.
- Presenter 2: Sarah Holland, MSW, MPH
  - Presenter 2: No Disclosures
- Presenter 3: Gordon Keepers, LCSW
  - Presenter 3: No Disclosures

Learning Objectives

- Describe the negative health impacts associated with the experience of homelessness.
- Describe Housing First and Recovery Housing models, including intended population, evidence-based practices, and funding mechanisms.
- List at least two ways SUD treatment providers can support patients experiencing homelessness.

Why Talk about Housing at an Addiction Medicine Meeting?

- Homelessness:
  - Increases an individual's vulnerability to drug-related harms
  - Increases barriers to treatment
  - Increases risk of traumatic experiences

- Access to housing:
  - Can facilitate stabilization of substance use disorder
  - Can reduce utilization of emergency medical care

Trauma and Homelessness

- Risk of violence
  - More than 1/3 experienced physical or sexual violence during this episode of homelessness (49% violence by a stranger and 21% by intimate partner)
- Risk of sexual violence
  - 16% of Cis-women during current episode of homelessness
  - 35% of non-binary, transgender or other gender during current episode of homelessness
  - 7% cis-men during current episode of homelessness
- Forced displacement / “sweeps”
  - Create unpredictability
  - Cause people to lose supplies, medications, cell phones, state-issued IDs
  - Increase hopelessness, loss and despondency

Kushel, M., Moore, T., et al. (2023). Toward a New Understanding: The California Statewide Study of People Experiencing Homelessness. UCSF Benioff Homelessness and Housing Initiative.

Goldshear JL, Kitonga N, Angelo N, Cowan A, Henwood BF, Bluthenthal RN. "Notice of major cleaning": A qualitative study of the negative impact of encampment sweeps on the ontological security of unhoused people who use drugs. *Soc Sci Med*. 2023;339:116408. doi:10.1016/j.socscimed.2023.116408

Trauma and Homelessness

JOHN'S STORY

John is living in an encampment with about 20 other people on a riverbed—a spot that is well known to the local police. Early morning raids mean that he often must quickly gather his things and leave, or he might be searched and arrested. He has started using methamphetamine to stay up all night. He used to drink, but when he passed out in the encampment his things would get stolen and he would miss the others' signals that the police had arrived. Methamphetamine makes him feel antsy and wired. Sometimes he isn't able to sleep for several days in a row, which makes him feel worse. But right now, he doesn't see a way to be sober given where he is living.

Kushel, M., Moore, T., et al. (2023). Toward a New Understanding: The California Statewide Study of People Experiencing Homelessness. UCSF Benioff Homelessness and Housing Initiative.

Homelessness and Overdose

- In Boston, overdose accounted for **1 in 4 deaths** among people experiencing homelessness (PEH) (2003-2008)
- In LA County, **overdose was the leading cause of death** among PEH (2015-2019)
- In San Francisco, **82% of deaths** among PEH were due to overdose during the first year of the COVID pandemic (2020-21)

Fine DR, et al. Drug Overdose Mortality Among People Experiencing Homelessness, 2003 to 2018.*JAMA Netw Open*. 2022. doi:10.1001/jamanetworkopen.2021.42676

Nicholas W, et al. Using Point-in-Time Homeless Counts to Monitor Mortality Trends Among People Experiencing Homelessness in Los Angeles County, California, 2015–2019. *Am J Public Health*. 2021. doi:10.2105/AJPH.2021.306502

Cawley C, et al. Mortality Among People Experiencing Homelessness in San Francisco During the COVID-19 Pandemic. *JAMA Netw Open*. 2022. doi:10.1001/jamanetworkopen.2022.1870

Homelessness and SUD Treatment

- Among PEH who used illicit drugs:
  - 7% were currently in treatment (4% in 12 step programs)
  - 19% wanted treatment but were unable to access it
- Among PEH who used opioids:
  - 11% currently in treatment (5% on MOUD)
  - 29% wanted treatment but were unable to access it

- Barriers to Treatment
  - Need to manage other priorities (food, safe place to sleep)
  - Availability/wait times
  - Lack of money, transportation, phone, internet, mailing address

Kushel, M., Moore, T., et al. (2023). Toward a New Understanding: The California Statewide Study of People Experiencing Homelessness. UCSF Benioff Homelessness and Housing Initiative.

Kushel M. National Academy of Science, Engineering, and Medicine Harm Reduction Services for People who Use Dugs: Exploring Data Collection, Evidence Gaps, and Research needs- A workshop. Presented live 1/31/2024.

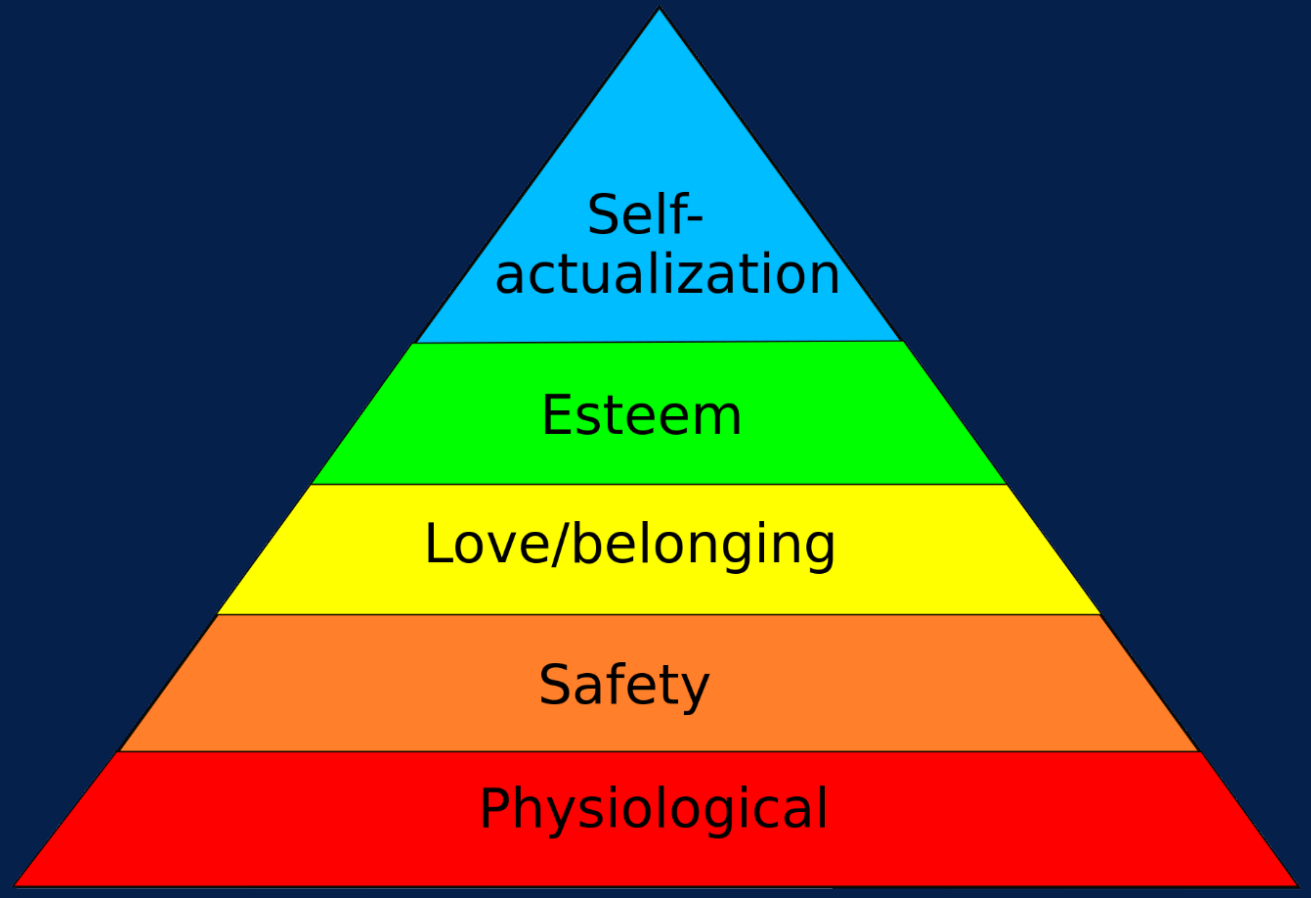
Homelessness and Substance Use

"Well, if I found housing I probably wouldn't even get high at all… But as long as I'm out here, I have to do it. It's like a survival tactic."

–participant quote in CA Statewide Survey

Kushel, M., Moore, T., et al. (2023). Toward a New Understanding: The California Statewide Study of People Experiencing Homelessness. UCSF Benioff Homelessness and Housing Initiative.

Hierarchy of Need



OUD Treatment for PEH

- PEH experience more barriers to OUD treatment than housed counterparts
  - PEH access inpatient and detoxification treatment more than pharmacotherapy
- Available literature suggests that PEH have similar outcomes once engaged in pharmacotherapy
- Efficacious interventions:
  - Low-barrier services, provision of comprehensive care, focus on PEH
  - Housing interventions demonstrate benefit

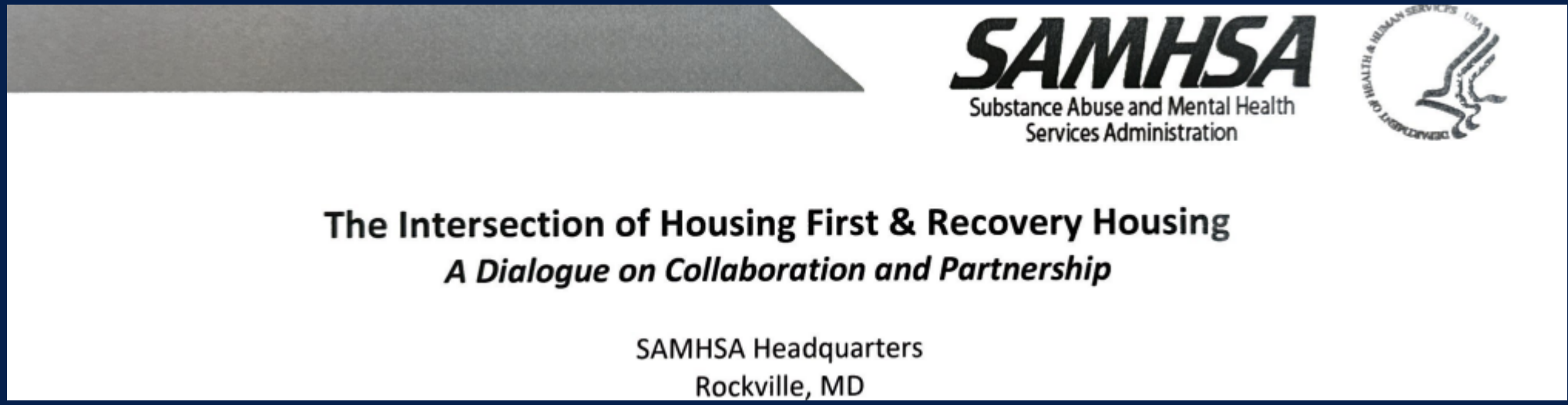
McLaughlin MF, Li R, Carrero ND, Bain PA, Chatterjee A. Opioid use disorder treatment for people experiencing homelessness: A scoping review. *Drug Alcohol Depend*. 2021;224:108717. doi:10.1016/j.drugalcdep.2021.108717

Fine DR, Critchley N, Hart K, et al. "I'm on the Right Path": Exploring 1-Month Retention in a Homeless-Tailored Outpatient-Based Opioid Treatment Program. *Subst Use Addctn J*. Published online January 7, 2024. doi:10.1177/29767342231218529

So Housing is Important… What can we do about it?

- Be aware of the challenges PEH face (trauma informed care)
- Adapt treatment models and plans as appropriate
  - Open access / ability for walk-in appointments
  - Transportation assistance
  - Discussions around medication safety
  - Long-acting injectable medications as available/medically appropriate
- Understand local housing/recovery resources and link to services!

Fine DR, Critchley N, Hart K, et al. "I'm on the Right Path": Exploring 1-Month Retention in a Homeless-Tailored Outpatient-Based Opioid Treatment Program. *Subst Use Addctn J.* Published online January 7, 2024. doi:10.1177/29767342231218529



Housing First

- Permanent supporting housing model for people experiencing chronic homelessness with or without SUD
- Focuses on providing rapid housing
- Case management/health care supports vary by program

Recovery Housing

- Structured living environment for people with SUD
- Historically most have focused on abstinence-based recovery
- On-site staffing and linkage to clinical supports vary

Treatment First

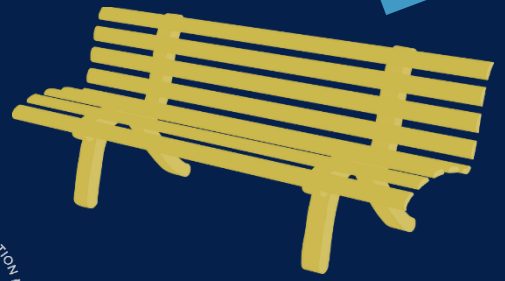
<u>Requires:</u>

- Abstinence
- Required service involvement

Permanent Housing

Temporary Housing

Homeless Shelter



Street

Department of Housing Office of Policy Development and Research. “Housing First: A Review of the Evidence.” Accessed 2/18/24 at https://www.huduser.gov/portal/periodicals/em/spring-summer-23/highlight2.html

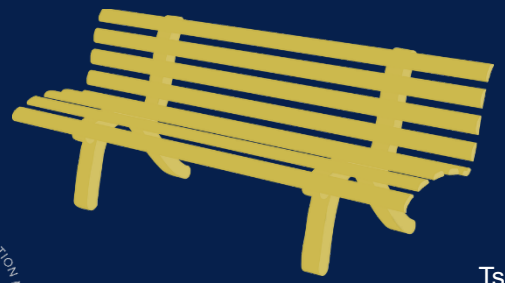
Slide re-used with permission from Dr. Dennis Watson, Senior Research Scientist, Chestnut Health Systems.

Housing First

Principles:

- Housing is a right
- Prioritizes tenant choice
- Low-threshold admissions
- Minimal service requirements
- Assertive supports
- Harm reduction oriented

Permanent Housing



Street

Tsemberis, S., & Asmussen, S. (1999). From streets to homes: The pathways to housing consumer preference supported housing model. *Alcoholism Treatment Quarterly*, *17*(1-2), 113-131.

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Housing First

Housing First

- Original model had 38 fidelity measures
- Utilized ACT (assertive community treatment) teams to provide intensive services for people with BH conditions in permanent supportive housing

Model Drift

housing first

- Philosophy of addressing a person's homelessness by quickly housing people and ensuring they have access to housing and some level of supportive services
- Often utilizes a system-level centralized wait list approach

Watson, D. P et al. (2013). Understanding the critical ingredients for facilitating consumer change in Housing First programming: A case study approach. *The journal of behavioral health services & research*, *40*(2), 169-179.

Watson, D. P et al. (2013). The housing first model (HFM) fidelity index: designing and testing a tool for measuring integrity of housing programs that serve active substance users. *Substance Abuse Treatment, Prevention, and Policy*, *8*(1), 1-16.

Simiriglia C. Primer on Recovery Housing and Housing First Models. SAMHSA Office of Recovery. "Intersection of Housing First and Recovery Housing Meeting: A Dialogue on Collaboration and Partnership." August 29, 2023.

Housing First: Evidence Base

- 4 randomized controlled trials (3 in US)
- Strong Evidence:
  - Led to quicker exit from homelessness and greater housing stability
- Moderate Evidence:
  - Reduced ED service utilization
  - Less time hospitalized
- Weak Evidence:
  - RCTs have not found reduction in symptoms associated with mental illness or substance use disorder, and individual observational studies have varied findings

Tsai J. Is the Housing First Model Effective? Different Evidence for Different Outcomes. *Am J Public Health*. 2020;110(9):1376-1377. doi:10.2105/AJPH.2020.305835
Baxter AJ, Tweed EJ, Katikireddi SV, Thomson H. Effects of Housing First approaches on health and well-being of adults who are homeless or at risk of homelessness: systematic review and meta-analysis of randomised controlled trials. *J Epidemiol Community Health*. 2019;73(5):379-387. doi:10.1136/jech-2018-210981

Housing First: Funding

- Housing First is a housing intervention
- Recognized as a preferred practice by US Department of Housing and Urban Development (HUD) and Interagency Council on Homelessness
- “Braided funding” often needed
  - Federal- HUD
  - State/ County/ Local funding
  - Philanthropy

Recovery Housing

- Not considered SUD treatment, but a recovery support service
- Designed by persons in recovery specifically for those interested in abstinence
  - Founded on social model recovery principles
  - Focuses on populations with higher needs
- Actively link residents with other types of supports, clinical services in community

https://store.samhsa.gov/sites/default/files/pep23-10-00-002.pdf

National Alliance for Recovery Residences' (NARR) Levels of Recovery Housing

	Typical Residency	On-site staffing	Governance	On-site supports
Level 1 (Oxford House)	Self-identifies as someone in recovery	No on-site paid staff (peer-led)	Democratically run	On-site peer support, Off-site mutual support groups
Level 2 (Sober living homes)	Stable recovery but wishes to have more structure; Supportive living environment	Resident house manager (paid or compensated by free or reduced fees)	Residents participate in governance (house rules often set by organization that runs home)	Community/house meetings, peer recovery supports
Level 3	Individuals who want moderately structured daily schedule and life skills supports	Paid house manager; administrative support; peer recovery support service provider	Resident participation varies; peer recovery support staff are supervised	Community/house meetings, peer recovery support
Level 4 (therapeutic community)	Require clinical oversight or monitoring; stays are typically briefer	Paid, licensed/credentialed staff and admin support	Resident participation varies, clinical supervision	On-site clinical services, on-site mutual support group meetings, life skills training

SAMHSA Best Practices for Recovery Housing. 2023. https://store.samhsa.gov/sites/default/files/pep23-10-00-002.pdf

Recovery Homes: Best Practices

Best Practice 1	Be Recovery-Centered
Best Practice 2	Promote Person-Centered, Individualized and Strengths-Based Approaches
Best Practice 3	Incorporate the Principles of the Social Model Approach
Best Practice 4	Promote Equity and Ensure Cultural Competence
Best Practice 5	Ensure Quality, Integrity, Resident Safety and Reject Patient Brokering
Best Practice 6	Integrate Co-Occurring and Trauma-Informed Approaches
Best Practice 7	Establish a Clear Operational Definition
Best Practice 8	Establish and Share Written Policies, Procedures and Resident Expectations
Best Practice 9	Importance of Certification
Best Practice 10	Promote the Use of Evidence-Based Practices
Best Practice 11	Evaluate Program Effectiveness

SAMHSA Best Practices for Recovery Housing. 2023. https://store.samhsa.gov/sites/default/files/pep23-10-00-002.pdf

Recovery Homes: Evidence

- **Level 1-** Oxford House (Self-run, self-supported recovery house, no time limits)
  - RCT with 24 month follow up: Oxford House arm had lower substance use, higher monthly income, and lower incarceration rates compared to usual-care condition

- Level 2- Sober Living Home (typically have rent/fees; no time limits)
  - No RCTs
  - Observational study in CA found improved rates of abstinence, improved mental health scores, and decreased criminal legal involvement at 6, 12, and 18 months compared to baseline

Jason LA, Olson BD, Ferrari JR, Lo Sasso AT. Communal housing settings enhance substance abuse recovery. *Am J Public Health*. 2006;96(10):1727-1729. doi:10.2105/AJPH.2005.070839

Polcin DL, Korcha RA, Bond J, Galloway G. Sober living houses for alcohol and drug dependence: 18-month outcomes.*J Subst Abuse Treat*. 2010;38(4):356-365. doi:10.1016/j.jsat.2010.02.003

Recovery Homes: Evidence

- Level 3 (paid house manager with peer supports)
  - Several papers describing model, but not outcomes

- Level 4- Therapeutic community (requires clinical oversight)
  - No RCTs
  - Controlled studies showed improved outcomes in illicit substance use and recidivism (controls included outpatient services and day programs)

SAMHSA Best Practices for Recovery Housing. 2023. https://store.samhsa.gov/sites/default/files/pep23-10-00-002.pdf
De Leon, G. (2010). Is the therapeutic community an evidence-based treatment? What the evidence says. International Journal of Therapeutic Communities, 31(2).

Recovery Homes: Licensing and Payment

- Licensing:
  - Some states require a license, some have voluntary certification, some have no formal process in place
- Billing:
  - Not able to bill Medicare or private pay
  - Some states use SAMHSA or state dollars to help with costs of recovery homes
  - Several states are using 1115 Medicaid waiver to bill to Medicaid
- Concerns of fraud in multiple states

US Government Accountability Office. Report to Congressional Requesters: Substance Use Disorder, ,Information on Recovery Housing Prevalence, Selected States' Oversight, and funding. March 2018. Retrieved from https://www.gao.gov/assets/gao-18-315.pdf

Comparison of Populations served by Housing First and Recovery Housing

	Housing First	Recovery Housing
Intended participants:	People experiencing chronic homelessness +/- SUD; +/- goal of abstinence	People with SUD desiring structured living environment with goal of abstinence (or reduced use)
Funding:	HUD State/local grants Philanthropy	Self Pay SAMHSA or state funds Philanthropy 1115 waiver in limited states
Addiction Treatment Linkage:	Highly variable, but original model with intensive behavioral health supports	Highly variable, but SAMHSA best practices recommend linkage with community treatment

Clinical Integration Models

- Model A: Housing In-Reach
  - Example: Overdose Prevention and Aftercare (OPA)
- Model B: Co-Located / Integrated
  - Example: Cedar Commons / Riverhaven / Karibu
- Model C: Outreach, Stabilization, Placement, and Retention Support
  - Example: Community Engagement Program (CEP)

Example from Portland, OR

Transitional Supportive ADFC Housing – 8x8 Program

Day 1 — On-Boarding Phase

- Lease signing
- Resident Support Services appointment (10 days)
- Resident orientation, which includes referrals to Housed & Healthy Coordinator and Employment Specialist (10 days)
- On-boarding survey by RSC or Community Manager (30 days)
- Unit inspection (90 days)

Day 91 — Stabilization and Retention Phase

Tenant:

- Comply with lease
- Stay housed
- Fully engage w/ resources
- Increase income with benefits or employment

Property Management:

- Collect rent
- Enforce lease
- Maintain premises, respond to maintenance requests
- Annual unit inspections

Resident Services:

- Income Attainment
  - -Refer to Emp. Services
  - -Refer to benefits, resources
  - -Provide financial training
- Housing Stability
  - -Eviction Prevention
  - -Respond to client requests
  - -Provide community meetings & activities
- Housed & Healthy
  - -As requested, H&H coordinator assists with connection to medical resources
- Permanent Housing Placement
  - -Support long-term housing stability
- Connect tenant to resources

Month 24 ->

Transition Phase

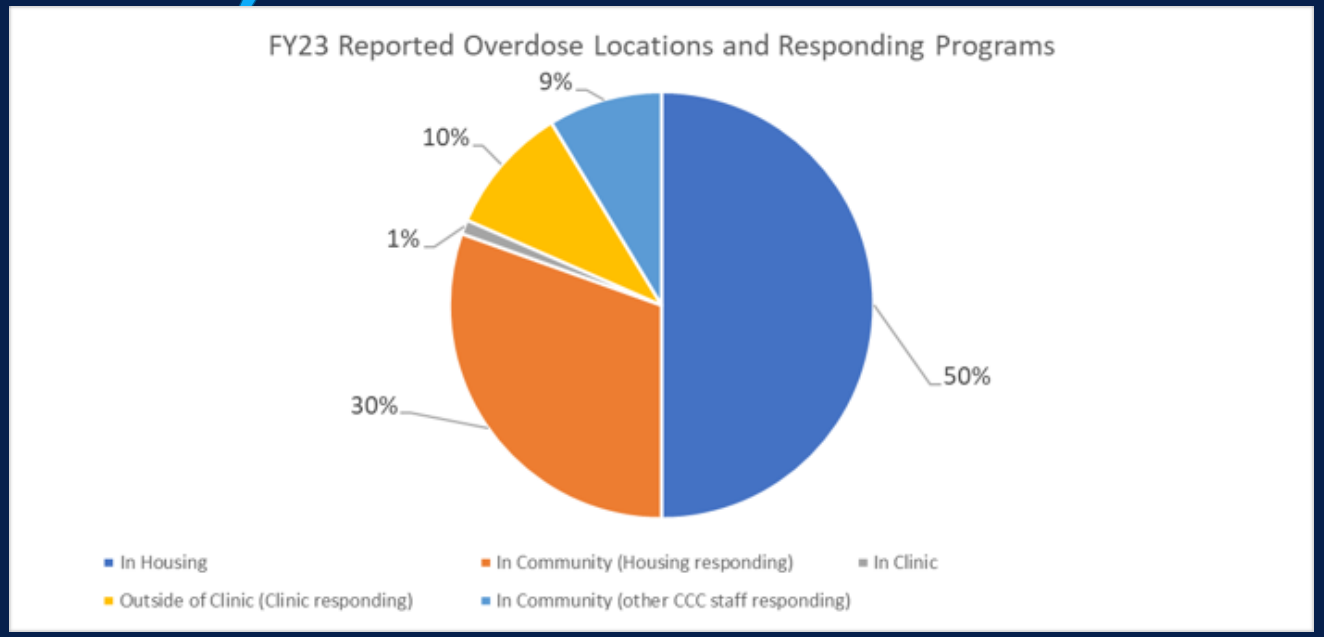
- Client transitions to non-CCC housing
- Resident Support Staff assist tenants with finding next-step housing when possible

Staffing

- 1:25 Case Managment
- 24/7 Site Staff

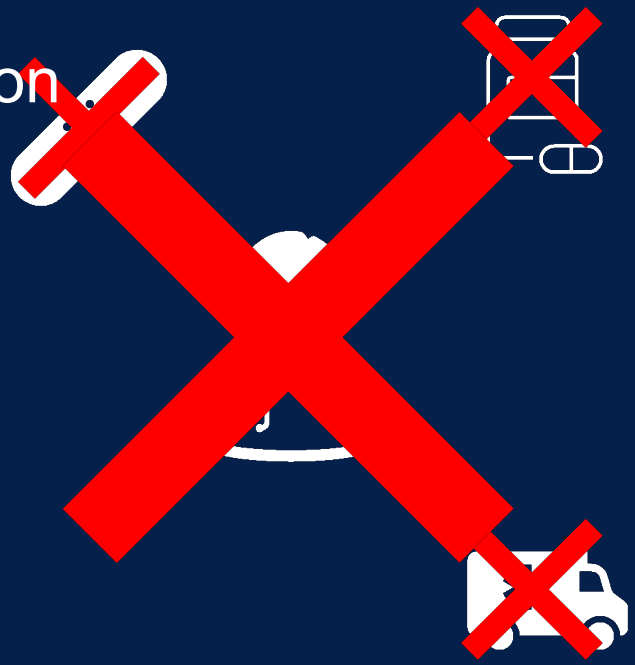
Overdose Prevention and Aftercare (OPA)

- CCC's clients profoundly affected by the rise in overdose deaths in Oregon
- Significant increase in fatal and nonfatal overdoses within our continuum
- 80% of reported overdose incidents in or just outside of our Housing buildings



Developing an Intervention

High Risk Huddle vs. Clinical Care Coordination



Developing an Intervention

Stage
Appropriate
Harm
Reduction
Interventions

Example from Portland, OR

River Haven, a 65-room transitional supportive housing community with an early recovery focus.

Culturally-Specific support
Imani, Puentes (Black & African American; Latinx)
NARA (Native American, partner agency)

Provides integrated supportive housing and clinical services in a team-based model along with access to supported employment. Ongoing relapse support with a focus on continued housing stability.

Staffing
1:25 Supportive Housing case management
19 Hours IOP with dual license CADC \ QMHP
24/7 site staff

Cedar Commons in the Beginning – A Pilot

- Cedar Commons was a dual organizational pilot – population served and service delivery model.
- CCC's first housing development intended primarily for people with diagnosed mental health challenges.
- First CCC housing location to offer onsite clinical services as part of the overall service delivery package.
- Represented a "missing link" in our housing continuum's ability to serve key segments in our core population – those experiencing homelessness, especially chronic homelessness (and also driving high cost and utilization of the healthcare system).
- Opportunity to chart a new course for the organization in overall site-based integrated care delivery, improved coordination between housing site and clinic site coordination of care, and improved care interventions (including crisis response) resulting in both improved housing stability and behavioral health outcomes for harder-to-house populations.
- Responding to both unmet client housing needs (ACT, Summit, etc.) as well as increasing complexity of street homeless populations.
- Mix of public and private dollars to balance revenue and costs – connected to growing policy awareness of intersection of homelessness, under-treated behavioral health needs, housing instability and ineffective and revolving high-cost healthcare (in the absence of supported shelter options)

Cedar Commons

CENTRAL CITY CONCERN
HOMES HEALTH JOBS

11450 SE DIVISION ST., PORTLAND

PROJECT OVERVIEW

Cedar Commons is a 60-unit planned development located on a 1.07 acre vacant parcel on SE 115th and SE Division. The project is a turn-key venture with Related NW serving as the lead developer and Central City Concern (CCC) retaining full ownership and operations at project completion.

The project is funded by the Portland Housing Bureau and several other partners, and will contain 40 Single Room Occupancy (SRO) units and 20 studio apartments. Forty of the units are Permanent Supportive Housing (PSH), of which at least 10 will serve people living with severe mental illness (SMI). The funding package is unique in that it provides long-term operating subsidies from Multnomah County's Joint Office of Homeless Services to support ongoing services, including case management, at the community.

Construction began in June, 2020 with completion in June, 2021.

ABOUT CENTRAL CITY CONCERN

Central City Concern (CCC) serves approximately 14,000 people each year through our mission of providing comprehensive solutions to ending homelessness, including affordable and supportive housing, integrated health care and employment support.

CCC's real estate portfolio includes 2,100 units of housing (including both owned and managed properties) and 220,000 SF of commercial space, including 150,000 SF of health care facilities.

For more information contact Mary-Rain O'Meara, Director of Real Estate Development, at 971-244-5014 or mary-rain.omeara@cccconcern.org.

BUILDING PROFILE

Project type	New construction
Total units	60 (40 SRO, 20 studio)

FUNDING

Sources:	
PHB Funding	$8,475,000
Metro TOD	$500,000
Meyer Grant	$300,000
CCC Equity	$100,000
OHCS MEP	$43,050
LIHTC Equity	$5,505,689
Deferred Dev. Fee	$899,533
Total	**$15,823,272**

Uses:	
Acquisition	$1,138,500
Construction	$10,001,942
Development	$4,682,830
Total	**$15,823,272**

PROJECT TEAM

Developer	Related NW
Owner	Central City Concern
Architect	Ankrom Moisan
Contractor	Walsh Construction

Incidents and Behavioral Event Trends

Trend #1 Cyclical Pattern

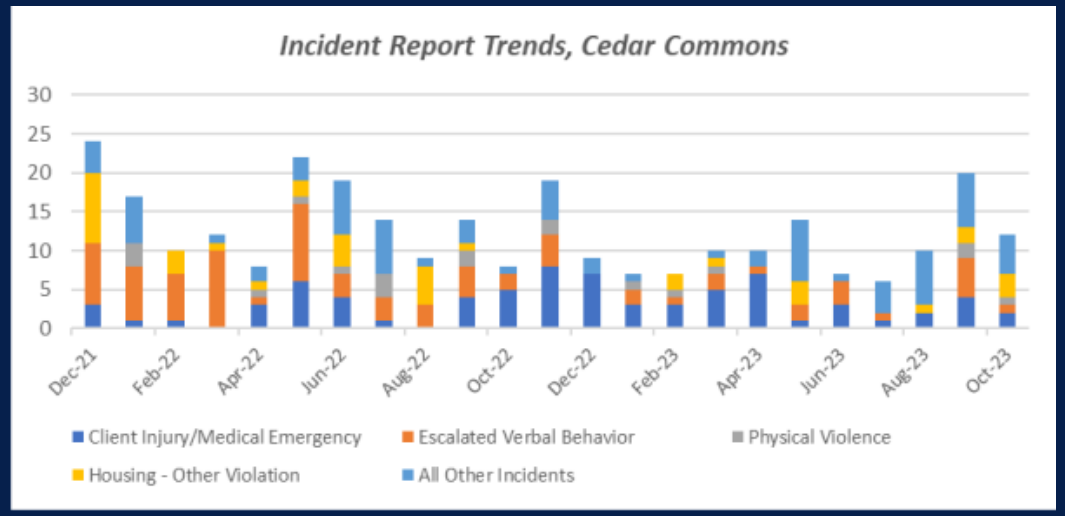
- ❑ Overall, incident trends at Cedar Commons move in a cyclical pattern.

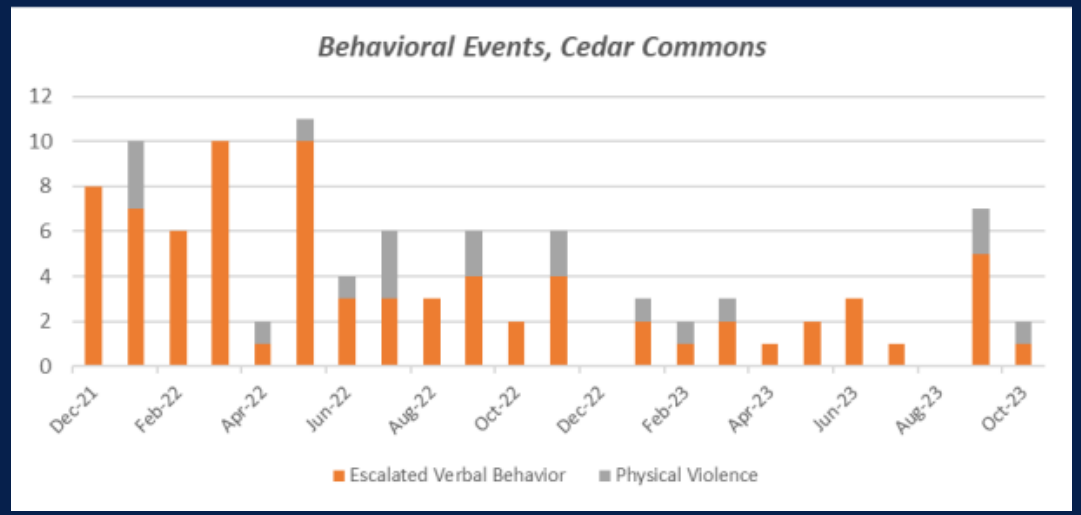
- ❑ This cycle is driven predominantly by lease violations, visitor violations, and medical emergencies.

Trend #2 Decline in Behavioral Events

- ❑ When we look specifically at concerning client behavior—escalated verbal behavior, physical violence—there is a noticeable downward trend beginning early summer 2022.

- ❑ This trend follows a restructure of behavioral health services at the site and significantly improved partnership between Health Services and Supportive Housing.





Oregon 1115 Waiver

Per OHA, goals for the benefit are as follow:

1. Advance health equity
2. Maintain health coverage
3. Improve h**ealth outcome by addressing SDOH**
4. Flexible spending for SDOH and health equity

Housing Supports Eligibility :

✓**Nov. '24 :** start with at risk for being homeless (HUD) + medically and financially vulnerable

✓**Jan. '25 :** expand target population

Implications:

OHA estimate around **100,000+ will be eligible** as at risk for homelessness **(eviction prevention)**

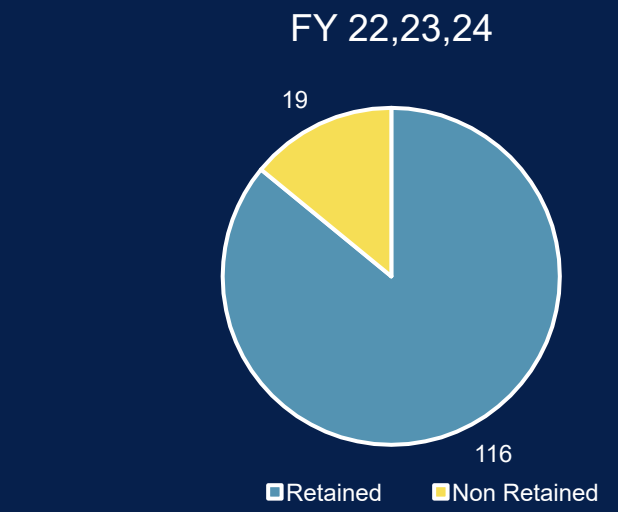
Community Engagement Program

- CADC II / QMHA case managers
- Dual credentialed counselors
- 1.0 Clinical Supervisor
- Housing specialist (credentialed and can bill under 1115)
- Peer Support
- front desk and after hours support from supportive housing / housing

Community Engagement Program

- Case load size 15-20 (120-130 maximum census)
- LOS target 12-18, though about ¼ of clients end up receiving services until end of life (palliative SUD Tx)
- Immediate emergency shelter placement upon enrollment
- 1.0 ASAM LOC, FFS and wrap billing

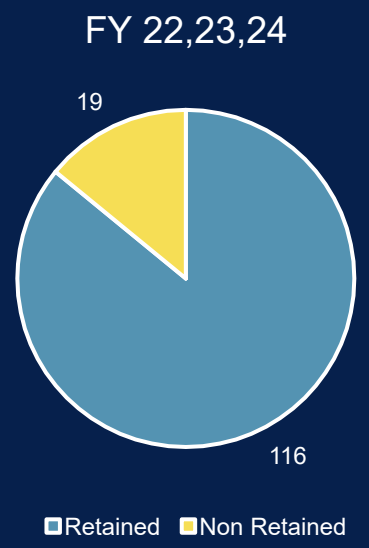
	Lease-Ups	Retained
FY 22	48	37
FY 23	56	48
FY24	31	31

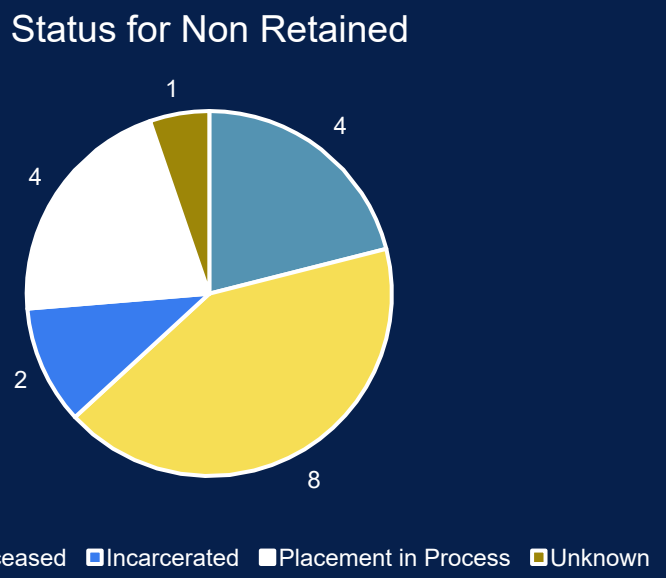


Community Engagement Program

- Excellent housing and retention outcomes, even post discharge from clinical program
- Highly reliant on federal and regional housing subsidy programs

	Lease-Ups	Retained
FY 22	48	37
FY 23	56	48
FY24	31	31





Example from Portland, OR

Housing First

100 units

70 through Coordinated Access

Partnership with culturally specific service providers

Starlight

Final Takeaways

- The experience of homelessness is traumatic, and increases risk for negative health outcomes
- Clinicians should:
  - Offer trauma informed care
  - Adapt treatment models and treatment plans to meet needs of PEH
  - Understand local housing/recovery resources and link as appropriate
  - Consider partnerships with area housing first providers and recovery home providers to ensure clients have access to evidence-based treatment services