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SNAPS In Focus: Recovery Housing

Last week, we released a brief that we at HUD have been discussing and working on for some time on the topic of *Recovery Housing.* I am excited about the opportunity to share with you our thoughts on how *Recovery Housing* programs should be structured, how they fit into the Continuum of Care (CoC), and how *Recovery Housing* programs can offer meaningful choices for people with substance use disorders.

Many CoCs have programs funded through the CoC Program that serve people experiencing homelessness who also have substance use disorders. In fact, HUD funds about 1,600 projects across the country that serve this population – more than 600 of which serve this population exclusively. This is a significant part of our portfolio, and we want to be sure that programs provide the highest quality housing and services using the most promising practices. In that spirit, we started looking into program models that would point us in the right direction. Some projects use a *Housing First* and harm reduction model, some are treatment-oriented transitional housing programs, others refer to themselves as "sober-living environments," while others refer to themselves as "Recovery Housing." The focus of the policy brief is the model referred to as *Recovery Housing* – which the brief also defines.

As you will see in the brief, and in the guest blog by Ed Blackburn from Central City Concern – a highly respected agency in this field – *Recovery Housing* is a model that is intended for people whose preference is to live in a recovery-oriented environment. While this might not be the appropriate or preferred option for everyone with a substance use disorder, it is important that CoCs provide a range of housing and service options for people experiencing homelessness. At its core, *Recovery Housing* is a peer-supported model that a participant self-initiates, and that is low barrier in all ways except the requirement that the participant is committed to recovery. Entry into the program is not predicated on a set amount of clean time, strict income requirements, background checks, or other barriers. It is not only low barrier in terms of entry into the program, but maintains that value by ensuring that relapse does not necessarily mean eviction from the program.

Although it is low barrier, the Recovery Housing model does require a personal commitment to sober living. This can make it difficult for Recovery Housing programs to find an appropriate place at the table in CoCs that have adopted a CoC-wide *Housing First* orientation. But I would argue that *Recovery Housing* and *Housing First* as concepts are not at odds and have much more in common than not. In both cases, people experiencing homelessness have a choice as to how and where they live and receive services. In both cases, it is the self-determination of the program participant to choose the type of program in which they want to reside. CoCs should allow for meaningful and low-barrier options based on the needs and preferences of those who present for assistance.

There are a variety of program design models for serving persons with substance use disorders. CoCs should carefully review all programs within their geographic area that serve this population to determine if any of the available programs use a *Recovery Housing* model. If not, I would urge you to consider whether a *Recovery Housing* program would benefit persons in your CoC, and whether even small changes to existing program designs to make projects align with the *Recovery Housing* model would result in better options for those seeking these housing/service options.

As always, thank you for all the work you do serving people experiencing homelessness – especially those who are struggling with substance use disorders. If you have questions about the *Recovery Housing* brief, please submit them through the Ask A Question (AAQ) portal on the HUD Exchange website.

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