

[Music]

**Ivette:**

Hello, I'm Ivette Torres and welcome to another edition of the Road to Recovery. Today we'll be talking about preventing and addressing homelessness among people with a mental and substance use disorder. Joining us in our panel today are: Steven Samra, Associate at the Center for Social Innovation, Needham, Massachusetts; Jayme Marshall, Branch Chief for the Homeless Programs Branch, Substance Abuse and Mental Health Services Administration, Rockville, Maryland; Nan Roman, President and Chief Executive Officer of the National Alliance to End Homelessness, Washington, D.C.; Jason Howell, Board President of the National Alliance for Recovery Residences, Austin, Texas. Nan, why is it important to address the issue of homelessness and about how many people are homeless in the United States?

**Nan:**

There are about 578,000 people who are homeless on a given night in the United States. That's about 1.4 million people a year. And obviously, it's important because not having housing makes people very vulnerable to illness. It's not good for them. All of us need the stability of a home. It's hard to maintain employment, education your children, to really function at all if you don't have a home.

**Ivette:**

Jayme, how many people specifically are homeless that have a mental or a substance use disorder or a co-occurring disorder?

**Jayme:**

Well, people all across the nation conduct point and time counts every year and we also track how many folks are in shelters throughout the year. But keep in mind, however, that some people do not want to disclose that they have a behavioral health condition because of the stigma they feel. But even with those caveats an estimated 117,000 individuals are out of the 578,000 people in the last point and time count identified they had a serious mental illness. And a similar number reported having a chronic substance abuse problem. This compares to about 4% of U.S. adults in the general population who have a serious mental illness and about 6.6% who have an alcohol use disorder. So the numbers are quite high. And there's about a 23% lifetime prevalence rate of co-occurring disorders for people experiencing homelessness. But we do believe those are underestimates and that the numbers are actually quite higher.

**Nan:**

One thing I think to think about is that the point in time counts—there's probably an overrepresentation of people with substance abuse and mental health illnesses. They're compared to the annual number so my guess would be it would not be 20% for the annual number because people with disabilities stay in

the system longer. It's a little hard to explain. It's just a factor of the way they're counted whereas if you look over a year—

**Ivette:**

So more than one entity could count them and then therefore inflate the number, is that possible?

**Nan:**

It's more that they stay homeless longer. It's like looking at the people who are in a hotel on one night versus looking at all the people that go through a hotel in a year. So if you look at one night, any characteristic is gonna seem larger.

**Ivette:**

I'm going to Jason to really address the whole issue of why are there more people with a substance and mental use disorder that are homeless?

**Jason:**

As a person in long term recovery, I can speak to that. The hierarchy of needs for a brain on drugs is more drugs is because of this dysfunction between the mid brain and the cerebral cortex which makes drugs almost life itself. And so we forego shelter, we forego relationships, we forego many, many things which has a spiral down. And so the good news is that recovery is possible and we can engage people higher up in this spiraling down and maybe prevent homelessness and definitely engage them in recovery.

**Ivette:**

And Steven, Nan just mentioned that there are different levels at which people experience homelessness. Some may experience it for a day, others a week or a month. So can you address the whole notion of temporary homelessness versus chronic homelessness?

**Steven:**

Sure. Chronic homelessness is defined by having homelessness for one year or more, or more than four episodes of homelessness within three years. Temporary homelessness is when an individual or a family finds themselves homeless but is able to, either through support or through family or service delivery, obtain housing relatively quickly. There's a lot of leeway between relatively quickly. But that is the distinction between temporary and chronic homelessness.

**Ivette:**

Very good. Jayme, how does homelessness affect physical and mental health of individuals?

**Jayme:**

Well, individuals without homes often lack access to healthcare treatment. Chronic health problems and inaccessibility to medical and dental care leads to lower life expectancies. The National Healthcare for the Homeless Council actually reports that the life expectancy among people experiencing homelessness is between 42 and 52 years. That's at least 25 years earlier than the average lifespan which is a terrible tragedy.

**Ivette:**

Yes. So, Nan, what is the impact of homelessness on the entire society? Obviously, we don't want people to be homeless but are there other costs to society to have the issues that we're facing with the homelessness population?

**Nan:**

Well, I would say there are three impacts that homelessness has on society. One is just the human impact that I think people have talked about. It affects us as people to see people on the street. We don't really know what to do. We want to help. We're not sure how to help. So I think that's difficult. There is also a social impact. It's not a positive reflection on our society. It really is a failure of society, especially a society such as the U.S., which has so many resources, really shouldn't have homelessness. So there is the social cost I think to us as a nation. And third, there's a very real economic cost. It turns out to be really silly from an economic standpoint for us to allow people to become homeless. They use crisis systems when they're homeless because they have to. They get involved with criminal justice because they're living on the street. They get arrested, they get bench warrants. These are not because they're robbing the bank, it's because they're doing things outdoors that the rest of us can do inside. They get hospitalized more frequently. When they're hospitalized, they stay hospitalized longer. Treatments don't work on them as well. They have to be repeated. So it often costs more, costs the public more, to allow someone to be homeless than to house them with services.

**Ivette:**

You talked about the human aspect of being homeless; I've often talked to some of the homeless and they really say that society as a whole really doesn't even see them. You know how people walk past the homeless and don't even look at them, and look at them in the eye. And I think that a lot of them would say that they miss that sort of connectedness.

**Nan:**

Absolutely. I thought of it walking over here today because sadly here in D.C. there are a lot of people on the street and every time you pass somebody, you have to think about what should I be doing, should I be doing something; or else avoiding because you don't know what to do.

**Ivette:**

That's a very good point. So, Jayme, the federal government realizes that there is a homeless problem and I believe that there is a partnership going on of federal agencies. Do you want to talk a little bit about that for us?

**Jayme:**

Sure. The U.S Interagency Council on Homelessness or USICH coordinates the federal response to homelessness across 19 federal agencies. There is a lot of coordination going on through the strategic plan to end homelessness called Opening Doors. They have four goals: to finish the job of ending chronic homelessness by 2017, to prevent and end homelessness among veterans, and to prevent and end homelessness for families, youth and children. They have 58 strategies that we're all working on together in coordination and collaboration that build upon the lessons that mainstream housing, health, education and services must be fully engaged and coordinated to prevent and end homelessness. And this is across the federal, state and local levels.

**Ivette:**

Who actually coordinates all the agencies? Is it at the HHS level or at the administration?

**Jayme:**

It's at the USICH level. That is a small federal agency, a micro federal agency.

**Ivette:**

And are they under any other agency or they're a standalone?

**Jayme:**

No, they're a standalone agency and they've been very effective at bringing us all together and really helping us to coordinate a number of different messages for the field and resources as well.

**Ivette:**

So SAMHSA's participation in that coalition of federal agencies is to really bring the component of mental and substance use disorders and what needs to happen in terms of coordinated services for the homeless.

**Jayme:**

Absolutely, and being a small agency it's amazing how much work we do with them because we have so many resources at SAMHSA to offer to improve services.

**Ivette:**

And when we come back we're gonna talk about those resources and much more and what Jason is doing and what others are doing. We'll be right back.

**Male VO:**

For those with mental or substance use disorder, recovery starts when you ask for help. Join the Voices for Recovery. Speak up. Reach out.

**Female VO:**

For information on mental and substance use disorders, including prevention and treatment referral, call 1-800-662-HELP. Brought to you by the U.S. Department of Health and Human Services.

[Music]

**Pamela Hyde:**

I think federal agencies have to have the resources to address these issues. If we want to make sure we don't have veterans on the streets, if we want to make sure we don't have families on the streets, if we want to make sure that people have housing, we need to provide resources for that housing. What we understand is and what the research tells us is that actually providing housing reduces the cost of healthcare, emergency care and other kinds of care that may not be as needed or necessary and might not be as expensive if someone were in a house and a stable place to live. The United States Interagency Council for Homelessness brings together HUD so the Housing and Urban Development Department as well as HHS which has Medicaid and SAMHSA and a number of other entities within it that look at how we can provide the services that people need whether they are veterans or whether they are other individuals who have mental health and substance use issues that may relate to their homelessness.

**Ivette:**

Jason, I believe you wanted to add something about what we touched on on the last panel.

**Jason:**

Right. I was really glad that Jayme was talking about collaboration because oftentimes our systems can be so siloed and so bringing those silos together is really important. I think there's a huge opportunity to bring the recovery community into this conversation because for the most part we've been excluded from the housing conversation.

**Ivette:**

You're absolutely right. The whole issue of particularly individuals that are coming out of the justice system that have a substance use or a mental disorder really do need to be placed in stable housing, correct? That's one of the elements of really sustaining, if they're already in recovery, sustaining their recovery.

**Jason:**

Absolutely. I think SAMHSA did a great job with defining what recovery is and the four domains that support recovery; home being one of those, safe stable

housing. And I think depending on the individual we need to look at what does stable look like for different individuals, and that can look different. You know, for someone with a severe substance use issue, it's about getting them into an environment that's going to sustain their recovery, and for many people that looks like a recovery residence. You know, safe, sober and peer supportive living environments.

**Ivette:**

Very good. Nan, I'm gonna come back to you and as we're throwing all these terms, let's really talk about what is the continuum? Let's describe the continuum of housing services that are available for the homeless.

**Nan:**

Sure. So for the short term homeless people there's really shelter largely so that's just overnight accommodation usually with some services attached, sometimes not even 24 hours. Then there's also transitional housing which is longer term, up to two years typically housing for people. The federal government I think has agreed on a definition that transitional housing should be largely for people in recovery, victims of domestic violence, youth and sometimes people who have difficulty finding placement, finding a unit in the community. And then there are a variety of permanent housing types. There's Permanent Supportive Housing for people with disabilities, behavioral health issues and physical health issues, that's housing, long term housing with subsidy so that it's affordable to people who are extremely low income, as well as services. There's rapid re-housing which is a shorter housing subsidy intervention that involves help with finding a landlord and a unit, a little bit of rent subsidy for a few months, and then connection to services in the community. There's recovery housing for people who need a sober environment and are recovering from substance abuse issues. There's also Housing First which is not a particular kind of housing, it's really an approach to housing. I don't know if you want me to quickly define that.

**Ivette:**

I do because I think that's one of the components that I think SAMHSA has brought forward in terms of having the field consider it.

**Nan:**

Sure. So really the approach that we used to take to homeless people was to give them services first to get them ready for housing and then provide housing, or else expect them to sort of get it together while they're living in shelter and on the street and then provide them with housing. And that turned out to not work so well. It's pretty difficult for people who are just completely destabilized and don't have any stability of a home to take on these very difficult issues. And so the Housing First approach arose. It arose for families sort of independently but in terms of our conversation today it arose really for people with mental illness and substance abuse. And it's pretty simple. It just says let's get people into housing first and then deliver the services and once they have the stability of the

home they're gonna do much better with the services. There are obviously some—sometimes people need a little treatment first and so forth but that's the basic premise of it.

**Ivette:**

Very good. Steven, Nan mentioned the Permanent Supportive Housing. Why is that type of housing important in addressing homelessness among people with a mental or substance use disorder?

**Steven:**

So the first piece of this for me is really around housing and having a home as an issue of human dignity, and all of us deserve safe affordable housing. For folks—and I certainly am somebody with lived experience with mental health challenges and serious addiction issues. The difficulty in trying to survive whether it's in a transitional housing or an emergency shelter was beyond my ability to cope with that and actually, I think, exacerbated my substance use because the stress and the challenges that that day-to-day existence were beyond what I could handle. With Permanent Supportive Housing, what you get is wonderful—first you have housing. It's permanent, it's yours and there is a sense of ownership and I think even a sense of pride that you're able to do that. The other piece of it is the wraparound support, the wraparound services that are brought to those of us in Permanent Supportive Housing, to not only help us move forward in our recovery but it also teaches us I think life skills that certainly I needed to understand what it meant to live month by month with basic responsibilities and demands on who I was and how I was supposed to interact.

**Jason:**

If I can interject, there's really great conversations going on right now to look at, so where does permanent supportive housing and recovery residences intersect because what you just described sounds a whole lot like what we would call a level three recovery residence but with peer support kind of included there. I think it's so important if we truly believe that recovery from either mental health or substance use is a person-driven process, then we need to be empowering people around their housing choices. For some individuals it's gonna be Housing First. For other people it's gonna be recovery residences. I spoke earlier this month at the Corporation for Supportive Housing Summit and there was a woman in the back of the room, this radiant woman, who stood up, she's a person in recovery living in supported housing and when she first moved in, it was more like a recovery residence. Then over time it converted to a housing first model. She said prior, 95% of the individuals living in that building were in recovery and abstinent; currently 95% of the people were using. So she felt very unsafe. So for this particular individual, Housing First wasn't the right fit. That's not saying that Housing First is not right for other people, but we should really be looking at how do we empower people in their recovery including their housing choices and making sure that our funding policies match up.

**Ivette:**

And also looking at if a person is not ready to be in full sobriety, can we put them in a place where they can at least begin to contemplate getting to the point of seeking the help they need in order to reach sobriety and in order to sustain their recovery. Jayme, how is SAMHSA dealing with the homeless issue? Basically what are the programs that SAMHSA has put forth in this area?

**Jayme:**

Well, one of our key priorities at SAMHSA is to prevent homelessness by ensuring that adequate and effective services are available, and we really have a Permanent Supportive Housing approach. We work closely with our federal partners which I mentioned earlier to coordinate a number of different activities. And if I might just tell you a little bit about some of our grants programs that we have, the Projects for Assistance and Transition from Homelessness, or the PATH program, is our oldest program. It's been around for over 20 years and it's a very loved program across the country for states and territories and then it goes down to fund providers. But it is one of the only funding sources for outreach and getting out and really reaching and engaging people and trying to get them into services and that is for individuals experiencing a serious mental illness or a co-occurring disorder. And we also have several targeted homeless programs, the Cooperative Agreements to Benefit Homeless Individuals for States, which we call our CABHI-States program, is to really improve systems and services for individuals experiencing chronic homelessness and veterans and to connect them with mainstream benefits and access to housing as well as all of the other services that can help them live a full life. We also have the Grants for the Benefit of Homelessness, SSH Services in Support of Housing, GBHI-SSH, another acronym but that goes to community-based organizations to do much of the same, to improve the systems and the services. And then I do want to mention our Supplemental Security Income, SSI, and Supplemental Security Income Disability Outreach Access and Recovery, the SOAR program which is a training that has been extremely successful in helping states and local agencies expedite benefits through the Social Security Administration.

**Ivette:**

So you teach them actually how to fill out the application in a way that someone can actually—they don't have to return the application and say, you missed this or you skipped that.

**Jayme:**

Exactly and the effectiveness of that has been phenomenal. We have an average of 91 days for first approval.

**Ivette:**

Very good. Well, when we come back we're gonna continue to learn what other programs are available to help the homeless. We'll be right back.

[Music]

**Daryl Kade:**

SAMHSA grant programs help to ensure that permanent housing and supportive services are available for individuals with mental and/or substance use disorders. SAMHSA also supports the Homeless Resource Center; this is a searchable website that has many resources for providers who work with people who are homeless, including training materials and resources on integrated services, screening and assessment, workforce development and training, financing, and using data. It provides information and resources on best practices and evidence-based methods of service provision for people who are homeless.

[Music]

**Steven Samra:**

I started my recovery in 2000 and I was actually a medication-assisted treatment client so I was taking methadone for 16 years and so from 2000 to 2014, really I started in 1999 but then really entered the program in 2000. So for a good portion of my recovery I was in this methadone program and it was fantastic. It helped stabilize me, it helped get me the housing, the employment, the education, all the things that I really needed. The bottom line for me in the medication-assisted treatment program was that it allowed me control over my addiction even when I was completely unable to control that previously, and it gave me now the freedom to expand on my recovery journey and really understand what that means. So when I mentioned this health, home, community and purpose, the first thing for me that was critical was how was my health. I was an IV drug user for 30 years. I put myself at great risk and I am miraculously come out of that unscathed. So my health is good. Stable home. Once I was in recovery I was able to get that together. I did that in partnership with my significant other and that was a huge help. The community, absolutely essential in my life. Without my community, without people around me who support me, understand everything about my past and who I am and what I've accomplished and overcome to get where I'm at, I don't know that I could do what I do today. My community is absolutely essential to me. Recovery today for me has opened so many doors and made life so livable and enjoyable, I don't ever want to go back.

[Music]

**Ann Chauvin:**

So Others Might Eat, otherwise known as SOME, has—since we've started and still—as our core belief, treating people who are homeless and poor with respect and dignity, meeting their needs no matter what they are ...

**Karie Ferguson:**

We really can treat someone off the street all the way into housing and beyond that through therapy, so I think that's the most unique part of SOME.

**Ann Chauvin:**

SOME started in 1970 as a feeding program and we still have our feeding program, which serves more than 800 meals a day, 7 days a week.

**Teressa:**

I was hungry, I hadn't eaten for about a week. One day, I stopped a lady on the street and asked her is there any place around here that feeds you. She said there's a place called SOME. And I came up here and I sit down and I ate some breakfast. After eating that meal I didn't know that's where my recovery was going to begin. And I've been here ever since.

**Ann Chauvin:**

From that feeding program all of our services came from what was seen as needs not being met in the community.

**Karie Ferguson:**

It's really important to offer both mental health and substance abuse, I would say probably over 80% of our clients come in with mental illness. Having been on the streets we know homelessness and mental illness go together as well as the addiction.

**Ann Chauvin:**

We meet their immediate needs with emergency services like food, shower, clothing if they need that, and then we help them rebuild their lives by addressing whatever problems are keeping them in that state and then helping them sustain and maintain a better life for themselves by providing housing, employment assistance, and continued health care and support.

**Karie Ferguson:**

I think what we do here at SOME is again, take that holistic approach to help them stay clean. We're not just focusing on the addiction, we're focusing on what's deeper than that.

**Teressa:**

I realized I had to get to the core of what it was that made me use. They provided me with the therapy that I need, they provide me with the psychiatrist I need, they provided me with the help that I need, if I needed a lawyer or if I need a doctor, or whatever. They take away your excuses because we can make up some good excuses to want to go back out there.

**Ann Chauvin:**

At SOME we have an inpatient component and an outpatient component. Our inpatient is in West Virginia and we have a small medical staff—we have

substance abuse counselors and we have recovery support staff 24 hours a day. In our outpatient clinic, we have doctors, nurses, therapists, addiction counselors, case managers, so pretty much anything our clients could need.

**Ann Chauvin:**

SOME was able to morph from the small program that we started as to the large program that it became in large part because of the SAMSHA grant we received in the '90s but also because we had very generous donors. Having diversity in funding is critical. If the only thing a program can do or knows how to do to start is to get some government assistance, to use that wisely so that then they are demonstrating the impact and the effectiveness of their service or of their new service so that then they can market those results, market those outcomes and learn how to send a powerful message.

**Ivette:**

Nan, let's talk about now some—I think Jayme did a wonderful job of highlighting what SAMHSA is doing but as we look at the homelessness problem and challenge, talk to us a little bit about the various types of individuals that are homeless. We know for a fact that youth that are at risk that have been abused at home or that have an abusive situation or difficulty, quite frankly, getting along with your parents, run away and become homeless. We know that at each stage of our lifecycle there are individuals that can at any moment experience homelessness. Do you want to touch on the various types of groups that we can find that are homeless in this nation.

**Nan:**

I'd say the groups, the sub populations we typically break down, one would be families with children, so families with children, I think there are about 70,000 family households that are homeless at a given point in time. It's usually the parents are disproportionately young, a lot of them are under 24. It's a lot of times really a poverty-related issue. There's a very small number of families that are chronically homeless so meet that definition of repeated or long term homelessness and a disability. So that's one group. Veterans is a group that's come up several times. Very important. Used to be very much disproportionately represented. There's been a tremendous investment in ending veteran homelessness and now I think there's around 49,000, just below 50,000 homeless veterans. That's down a lot. There are homeless, you know, poverty is obviously an issue as a driver has been brought up, but also there are things particular to veterans. Trauma, military, sexual trauma, PTSD, brain injury. So a lot of issues there, co-occurring disorders and mental health issues, so that's veterans. There are a lot of individuals who are not chronically homeless, so individuals who are homeless for short periods of time. That's the largest group, several hundred thousand people. And then you mentioned youth. We consider homeless youth to be 24 and under. There are a lot that are under 18. So, again, poverty is often the cause. You described already the family issues and that's a major issue, family dysfunction, but there are also a lot of

families that really fall apart because they're too poor to afford housing. The family falls apart, the kids end up in various places and eventually end up homeless on their own. So those, I think, are the major sub populations we think about.

**Ivette:**

And, Steven, you spoke about having lived experience. Is it lived experience? Were you homeless yourself at one point.

**Steven:**

Absolutely.

**Ivette:**

Do you want to talk a little bit about that experience?

**Steven:**

Sure. My experience really comes from kind of a coalescing of forces around criminal justice involvement, addiction issues and mental health challenges. The driving piece for me always was poverty and that poverty really was present before I began heavily using substances. I think for me, my primary issue was substance use. That certainly exacerbated the mental health conditions that I experienced. I would have been considered chronically homeless. This would've been in 1996 through 1998—99 actually, and the challenge for me really at that point was that there weren't any resources, particularly where I was at. I was in the mountains of the Sierra Nevadas, northeastern California. It was extraordinarily challenging to find resources. All the things that we understand about rural homelessness also applied to me as well.

**Ivette:**

It's funny you should say that because my next question was gonna be about rural issues. So expand.

**Steven:**

So the challenges around rural homelessness, I mean from a provider perspective it is related to transportation, lack of resources, a lack of community involvement, the siloing of resources, the use of most of the funding going to large urban areas, and then struggling to supply outreach engagement specialists out into the field and actually find people who are homeless in rural areas. It is extraordinarily challenging. Time, distance, resources, all those things were in short supply in any homeless service provider's toolkit. When you apply that to rural outreach, sometimes there are days where people don't even have contact with folks. And we make due with often faith-based charities, food pantries, clothing giveaways, but part of that challenge is even if you know that they exist, how do you access them without transportation? So wherever you're at, you're essentially stuck in that particular location and whatever resources are there or aren't there, that's what you get to play with.

**Ivette:**

Homelessness, we had talked about homelessness for unaccompanied youth. One of the things, Jason, that I've noticed is that a lot of the recovery emphasis is more on adults, and I know that we now have young people in recovery that are doing a great job at bringing forward the needs of the youth. But talk to us about the special needs of the younger population, particularly those that are facing substance use disorder issues.

**Jason:**

Well, I think that they're underserved in our population and there is a lot of great things going on. Like you said, we've got young people in recovery, we've got recovery high schools, even recovery collegiate programs. But still, it's adolescents and youth that are still underserved and developmentally we may need to be supporting them a little differently than we do say an adult. I think that topically we need to talk about the opiate epidemic that's happening in our youth and the importance of trying to engage them early because a relapse for an opiate addict oftentimes ends up in death. So the more aggressive we can, you know, doing prevention and engaging people in early recovery and getting them into resources is very important.

**Ivette:**

So, Jayme, we've got the age differential in terms of youth that may be homeless and facing other challenges as Jason has just said, and then we get into the cultural differences. Are there cultural differences related to how we approach assisting individuals that have a homeless problem?

**Jayme:**

Absolutely. Homelessness is an issue that affects people of all races, ages, and ethnicities, and we're a very culturally diverse country and it's important to really meet people where they are because it affects how clients receive or choose to engage in services. At SAMHSA, cultural competence is very emphasized and we're also getting into a new area that we're calling cultural humility which begins with the understanding of our own biases both conscious and not and how that impacts how we deliver services and how we really interact with individuals.

**Steven:**

Ivette, if I could interject. I think culture is very important. Since we're talking about individuals with substance use, Bill White came up with the Culture of Addiction Enmeshment Scale looking at what keeps people in addiction. And recovery is really about taking people out of that culture of addiction and planting them into a culture of recovery and then keeping them there so they can gain a new identity, what does it mean to be in recovery. And from a recovery housing standpoint we call this the social model for recovery. It's that peer support that helps the next person coming in to understand what recovery is.

**Ivette:**

And as Jayme was saying, there is the culture of addiction, there are cultural differences between ethnic, racial and other sub groups and how they perceive others as wanting to help them, correct, in terms of how we actually go out and service these individuals.

**Steven:**

Absolutely and one of the things that I think Jason touched on is really around this idea of community and what you have to understand, I mean certainly this is from my own experience, when I began to really contemplate recovery, particularly for my addiction issues, what I found myself doing was stepping—putting a toe into the larger community but keeping my foot firmly planted in my subculture. And the reason for that is because even though I recognized that it was dysfunctional and threatening even to my life, it was comfortable and I had developed coping skills in that environment that served me very well. When I stepped into the larger community, those coping skills became maladaptive, very destructional and very challenging for people around me to deal with. This is also why I think Jason's point around the piece around peer support is so important and that cultural competence in peer support, moving beyond just kind of a recovery residence and into every facet of the recovery from whether it's homelessness, addiction, mental health, criminal justice trauma, we need culturally competent people, particularly people with lived experience in those areas who walk alongside people and support them.

**Ivette:**

And I think you just hit a key point, lived experience. I think someone like yourself is probably contributing tremendously to this area because you have had lived experience. And when we come back, we're gonna continue to talk about some of the programs that are actually doing great things for the homeless population. We'll be right back.

[Music]

**Jason:**

I want to tell my story and so that other people understand that Recovery is possible. The first time I planned my suicide, I was 13. I was a young kid growing up in a frontier rural part of Texas and trying to figure out my sexuality. It was either running away, committing suicide – those were the thoughts that I was having in my head. That mental health issues kind of continued throughout my life. I think it was when I went to college at 17 that substances starting playing and playing havoc in with all of that. It took me a couple of years to realize, hm, maybe the substance use issues were kind of causing some problems as well. So once that light came on, my journey has included sobriety ever since. And Recovery is definitely a journey and the more and more I awaken to it, I think the better I like myself. I have purpose now, I think I am a better brother now, I am a better friend and I'm making a difference in the world so that gives me a lot of

satisfaction. I sustain my Recovery by keeping connected with my peers in Recovery and by being of service. I helped found the National Alliance for Recovery Residences which I am currently the Board President of. And we were able to look across this 170 year history of people living together and supporting people in Recovery and look at so what are best practices, what are standards? So we've been able to define the standards for the four different types of Recovery residences and now are bringing certification programs to the state on a local level.

**Male VO:**

For more information on **National Recovery Month**, to find out how to get involved or to locate an event near you visit the **Recovery Month** website at [recoverymonth.gov](http://recoverymonth.gov).

[Music]

**Teresa:**

SOME shows you how to live. They don't just get you clean and sober, they teach you how to live again. I didn't get the help til I came here and I'm 63 years old today and I was 59 when I came here. I've been on the streets since I was 13 years old. 13 years old and I'm 63 now (tears).

**Ann Chauvin:**

One of the things we do try to help clients with is building a life worth living while they learn how to budget and they learn how to cook and clean again, we also teach them how to have fun. They start right away with learning how to enjoy life without the use of drugs or alcohol.

**Teresa:**

And what I like about SOME is they take care of the whole person they don't take care of just half of you. When things, problems crop up in my life today, I don't make drugs and alcohol my first option. I pick up the phone and call somebody.

**Karie Ferguson:**

Every day she is growing and I don't think she knows the strength and how much work she's done and she's healing and she's a real product of this program and how great the work is and really how resilient our clients are as well. This work means a lot. I get teary-eyed just thinking about it.

**Teresa:**

I like doing what I'm doing, I like helping people because there's a lot of suffering people out there and all they need to know is someone to walk up to them and say, "there is help available, there's help here for you. Come on in."

**Ivette:**

So Nan, let me go to you and have you address now some of the evidence-based programs. If someone was in a community and they wanted to volunteer, what should they be looking for in a comprehensive program for the homeless?

**Nan:**

I'm glad you asked about that because I think one of the reasons we've been doing better on homelessness is because we've been using more evidence-based practices. There are many and I'm sure other people will have some to mention but Housing First is an evidence-based practice so we've already discussed that with respect to people with mental illness in particular and co-occurring disorders that's housing with services integrated in the community. Assertive Community Treatment is another one and that's a service team for people with mental illness that can deliver the services to people in their housing in the community, again, the community integration is very important. Permanent Supportive Housing and certain of the service interventions in that is an evidence-based practice and there are other key ones, Supported Employment that keep people employed. Motivational Interviewing. There are so many and I'm sure many people here are using other ones. But I think that the focus on housing and evidence-based services is really what is allowing us to drive down the number of homeless people now and that number has been going down.

**Ivette:**

And, Jayme, So Others Might Eat- they are here based in Washington, D.C. and their whole approach was really to have an incredibly comprehensive approach to providing services to the homeless even at a point where they may want to leave, they allow them to come back. They offer them health services, they offer them counseling services, they do assessments in every aspect of that person's life. That's certainly the ideal, is it not?

**Jayme:**

Yes, having the services integrated in one place is the ideal, and having that comprehensive approach and we have a lot of information on our Homeless Resource Center at [SAMHSA.gov](https://www.samhsa.gov) that goes through a lot of the evidence-based practices that Nan just mentioned.

**Ivette:**

Very good. Jason.

**Jason:**

Speaking of comprehensive, if we really want to be comprehensive and we really want to give people a housing choice, then we've got to include recovery residences.

**Ivette:**

Which is also an evidence-based practice.

**Jason:**

Yes, thank you for that Nan. You mentioned a lot of great evidence-based programs. One of the things that NARR did is we identified the four different types of recovery residences. We call them levels of support. As you go up levels, you get more support.

**Ivette:**

Why don't you take us through those so that the audience understands.

**Jason:**

So with our level one's, the iconic level one is gonna be an Oxford House. So that is individuals choosing together and living together in recovery. That's an evidence-based program and practice for individuals with substance use. Oxford House, studies show that 63% of the individuals living in Oxford House have a history of homelessness. So individuals are choosing recovery residences. On the other end of the spectrum, level four's, there's a number of therapeutic community models that are evidence based for individuals with both mental health and substance use issues. And then in between we have levels two's and three's. Again, this is individuals living together, supporting each other in recovery, a lot of peer support, and with level three's you see those wraparound services. Further evidence-based practices within those recovery residences: Motivational Interviewing, WRAP, Wellness Recovery Action Planning; the use of peers really kind of giving each other hope. I think so often times in the homeless world people don't understand that recovery is possible and the root of recovery is hope.

**Nan:**

If I could just mention, too, I think it would be probably wise of us to think of housing itself as an evidence-based practice that supports recovery, not just for substance abuse which we've talked about really primarily today, but also for mental health. And I think that Olmstead and the whole procedure around that has also taught us that community integration—I don't know if these are proven evidence-based practices but it seems that they're very important principles for us to keep in mind that community integration is always also essential to recovery.

**Ivette:** It's an absolutely desired goal.

**Steven:**

I think what we fail to do is really provide the array of options in our communities and it's not the fault of the federal government or SAMHSA or the state. It's really a matter of resources and the lack thereof and I think when we're challenged with individuals who are considered non-compliant or hard to house or difficult. It's because we really haven't been able to provide the appropriate options for them. I think Jason's point about the different levels of recovery housing is really important and I think we have the services and certainly the

evidence base behind them to really push this out further. The challenge is that we need to get our communities more involved, more funded and we really need to raise awareness about the complexity of homelessness.

**Ivette:**

Nan, getting back to the whole issue of mental illness and the need for specialized services for the mentally ill to reintegrate, is there not a need also for people with lived experience to also think about volunteering to facilitate those scenarios where perhaps they can work with others that are in need and really facilitate that integration? Is that a factor that individuals need to also consider?

**Nan:**

Absolutely. That seems to be a very important factor. I think it's important for the peer counselors or whatever is the position because it gives them employment, stability meaning structure and also, of course, for the consumer, and really also letting people have a say on both sides of that relationship in their own lives the practical questions that need to be addressed. This is all key. So very, very important and valuable.

**Ivette:**

Very good. And now we've reached that level of the show where I come back to you for final thoughts. Steven, I want to start with you. Final thoughts.

**Steven:**

The difficulty that we are facing in addressing this issue of homelessness in our communities really, again, boils down to a lack of resources, a shortage of resources, a lack of options for those folks who are still on the street. And I think the critical piece here is being able to find them and connect them to the available services in our communities. It's one of the reasons I think that outreach engagement is perhaps the most important piece that as we're delivering services to the population of people experiencing homelessness. That piece of it is essential and to have that done by a peer team I think is really the quickest way to maximize engagement and move folks, at least get them entered into services or the start of the service delivery.

**Ivette:**

Absolutely. I couldn't agree with you more. Jayme.

**Jayme:**

Well, I would be remiss if I did not mention the importance of trauma-informed services in dealing with individuals that are experiencing homelessness, and I want to make sure the audience knows about SAMHSA's Center for Trauma-Informed Care and the many resources that they have available because homelessness and trauma go hand in hand and you really can't deal with one without dealing with the other.

**Ivette:**

And we do have some great training tools for individuals. Jason.

**Jason:**

As a person in long term recovery from both mental health and substance use issues, I'm living proof that recovery happens, and so to Steven's point, if we can get individuals connected with a peer in recovery and show them that there's many pathways to recovery, any door to recovery is what's important and then empower their choices because this is really a person-driven process.

**Ivette:** Nan.

**Nan:**

I would just close by saying that homelessness is really a poverty-driven problem. People are very poor. There are lots of people with behavioral health issues that aren't homeless. People are very poor and they can't afford housing. Housing is expensive. Having said that, people with behavioral health issues are at an additional disadvantage. They're poorer often and also they can't really access treatment services or get treatment services and it exacerbates the problem. So we're grateful to SAMHSA really on the services side for developing knowledge about the services, having rigor to the standards, doing the research, explaining to us all what are the better smarter things to do, and of course, funding those things as well. I think looking forward the bad news is that we have a growing shortage of affordable housing. We still have a lot of treatment needs. That doesn't look so good. But the good news is that we are getting a lot smarter. You've heard a lot about solutions here today from people. We know what to do now, we just need to do more of it and we're doing that and making progress. The number of homeless people is going down, so we just have to redouble our efforts.

**Ivette:**

Excellent point to end on and I want to remind our audience that September brings forth **National Recovery Month** where we're able to celebrate those in recovery from a mental and substance use disorder. And we want you to go to [recoverymonth.gov](http://recoverymonth.gov) to be able to access all the information related to how you can put together events and activities and celebrate everyone's recovery. Thank you for being here. It's been a great show.

[Music]

**Male VO:**

To download and watch this program or other programs in the *Road to Recovery* series, visit the website at [recoverymonth.gov](http://recoverymonth.gov).

[Music]

**Female VO:**

Every September, **National Recovery Month** provides an opportunity for communities like yours to raise awareness of mental and substance use disorders, to highlight the effectiveness of prevention, treatment and recovery services, and show that people can and do recover. In order to help you plan events and activities in commemoration of this year's **Recovery Month** observance, the free online **Recovery Month** kit offers ideas, materials, and tools for planning, organizing, and realizing an event or outreach campaign that matches your goals and resources. To obtain an electronic copy of this year's **Recovery Month** kit and access other free publications and materials on prevention, recovery, and treatment services, visit the **Recovery Month** website at [recoverymonth.gov](http://recoverymonth.gov), or call 1-800-662-HELP.

[Music]

**Female VO:**

We try to hide our truths about our mental and substance use disorders from the world and sometimes from ourselves. Saying "I'm fine" is a façade. By facing our problems, recovery begins, and we are empowered to speak our truth. Join the Voices for Recovery. Speak up. Reach out.

**Male VO:**

For information on mental and substance use disorders, including prevention and treatment referral, call 1-800-662-HELP. Brought to you by the U.S. Department of Health and Human Services.

[Music]

END.