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Whole-Person Care for People Experiencing Homelessness and Opioid Use Disorder: Toolkit Part 2

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HOMELESS & HOUSING RESOURCE CENTER

SAMHSA
Substance Abuse and Mental Health Services Administration

Contents

Disclaimer

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I. Introduction

Welcome to Part 2 of the Whole-Person Care Toolkit. In this section, we will focus on understanding the neurobiology of opioid use disorder (OUD) and the treatment and recovery pathways for OUD. We offer best practices for referrals and warm handoffs. We introduce the whole-person approach to tenancy support and the three homes model for supporting housing stability and recovery for people with OUD.

We encourage you to download the *Whole-Person Care for People Experiencing Homelessness and Opioid Use Disorder Toolkit: Part I* to learn more about the Whole-Person Care approach and best practices.

Whole-Person Care: Core Elements

Person-Centered

Trauma-Informed and Healing-Centered

Recovery-Oriented

Racially Equitable

Non-Stigmatizing

Housing-Focused

A Note about Self-Care

As you continue the journey of supporting people who have OUD and are experiencing homelessness, we encourage you to start by taking time to bolster your own foundations of support, resilience, and strength. Providing care to people experiencing homelessness, poor health, behavioral health challenges, discrimination, stigma, and high levels of traumatic stress and marginalization is demanding. We bear witness to tremendous human suffering and wrestle with helping people access needed care, housing, and other services, often while working within underfunded and dysfunctional service systems.

Self-care is most effective when approached with forethought, not as an afterthought. In the same manner that we provide care for others, we must care for ourselves by first acknowledging and assessing the realities of our condition, creating a realistic plan of care, and acting upon it. Though many providers practice self-care creatively and effectively, we sometimes lose our sense of balance and fail to provide the necessary care for ourselves with the same resoluteness we offer others.

- → **Self-care is *not* an emergency response plan to activate when stress becomes overwhelming.** Instead, self-care is an intentional way of living where we integrate our values, attitudes, and actions into our day-to-day routines. The need for emergency care should be an exception to usual practice.
- → **Self-care is *not* about acting selfishly.** Instead, self-care is about being a worthy steward of the self—body, mind, spirit—with which we have been entrusted. It is foolhardy to think we can provide care to others without being the recipients of proper nurture and sustenance ourselves.

→ **Self-care is *not* about doing more or adding more tasks to an already overflowing to-do list.** Instead, self-care is as much about letting go as it is about acting. It has to do with taking time to be a human *being* as well as a human *doing*. It is about letting go of hectic schedules, meaningless activities, unhealthy behaviors, and attitudes such as worry, guilt, judgment, or unforgiveness.

The ABCs (awareness, balance, connection) of self-care we describe here are a useful guide for as you reflect on your own practices and attitudes.

AWARENESS

Self-care begins in stillness and self-reflection. By quieting our busy lives and entering a space of solitude, we can develop an awareness of our own true needs and act accordingly. Too often, we act first without understanding and then wonder why we feel burdened and not relieved.

BALANCE

Self-care is a balancing act. It requires equalizing action and mindfulness. Balance guides decisions about embracing or relinquishing certain activities, behaviors, or attitudes. It also shapes the degree to which we attend to the physical, emotional, psychological, spiritual, and social aspects of our being. In other words, we should balance how much time we spend working, playing, and resting.

CONNECTION

Healthy self-care cannot take place solely within oneself. It involves connecting meaningfully with others and to something larger than ourselves. We are interdependent, social beings. We grow and thrive through connections in friendships, family, social groups, nature, recreational activities, spiritual practices, therapy, and many other ways. Often, we find our most renewing connections right in our midst in the workplace, with coworkers and the individuals we care for.

Of course, there is no formula for self-care. Our self-care plans are unique to us and will change over time. As we seek resiliency and renewal in our lives and work, we must listen to our bodies, hearts, and minds as well as the counsel of trusted friends.[2]

LEARN MORE

Whole-Person Care for People Experiencing Homelessness and Opioid Use Disorder Tool Kit: Part I | Homeless and Housing Resource Center [HTML]

BounceBack | Canadian Mental Health Association [HTML]

II. Understanding Opioid Use Disorder

The Neurobiology of Opioid Use Disorder

Opioid addiction is a complex neurobiological process. Opioids essentially hijack the brain's reward system, making it incredibly difficult to stop using them. One of the major factors in developing opioid use disorder, or OUD, is the biology of the body's internal opioid system and evolutionary survival mechanisms that can become counterproductive as the disease progresses.

THE BODY'S INTERNAL OPIOID SYSTEM

Opioids work by filling opioid receptors located throughout the brain and body. When the opioid receptors are filled, they become activated, blocking pain signals from the body to the brain. This harkens back to an earlier time in human evolution when our bodies developed an internal opioid system as a mechanism for survival. Pain serves a purpose. It alerts us when there is something wrong or when we need to act to protect ourselves, such as needing to remove our hand from a hot stove.

Pain becomes counterproductive, however, when it becomes incapacitating. When pain is too intense, we lose our ability to focus on getting out of danger. In response, the body developed the internal—also known as *endogenous*—opioid system. When our bodies are under extreme duress, they release internal opioids known as *endorphins*. When the body releases these endorphins and they land on the opioid receptors in the body and brain, they stop the perception of pain and produce a calming effect. This brief respite allows us to take action to protect ourselves, which explains how people can have calm, coherent conversations with rescuers despite having severe, life-threatening injuries.

OPIOID DEPENDENCE

External (or *exogenous*) opioids are those that can be ingested, such as fentanyl, heroin, Oxycontin®, Percocet®, and others. They work on the same receptors and travel the same neural pathways as the body's endogenous opioids. Exogenous opioids, however, are much more efficient and potent and magnify the opioid's effects, such as feelings of relaxation and euphoria. In addition to pain relief, opioids trigger the release of *dopamine*, the brain's feel-good neurotransmitter, which accounts for the euphoria people experience when using opioids.

Though opioids provide immediate relief, their effects are short-lived, and it quickly takes increasing amounts of the substance to achieve the desired effects, a process known as *tolerance*. As a person continues using opioids, the brain becomes reliant on the exogenous opioids and stops producing its own adequate levels of *neurotransmitters*, that is, endorphins and dopamine. Consequently, when a person stops taking opioids, their brain experiences a volatile reaction because it can no longer access the neurotransmitters it needs to function. This is what is known as *withdrawal* or being *dope sick*. Opioid withdrawal causes extreme discomfort, including flu-like symptoms, such as sweating, insomnia, irritability, severe anxiety, muscle cramps, nausea, vomiting, and diarrhea.

Opioids are inherently addictive to humans, and opioid dependence can develop as quickly as in a few weeks.[3] A person who develops OUD faces two options:

- → Use the opioid and feel really good; or
- → Abstain from using the opioids and feel really sick.

Here, our evolutionary biology comes into play: humans are hardwired to pursue pleasure and avoid pain. That's why we go back for seconds of delicious food but only touch that hot stove once. These actions ensure our survival. Our biological hardwiring for survival means that most of the time, we choose that first option: to use an opioid. This choice is not a personal moral failing, a character flaw, or a lack of willpower; it is simply how we are wired biologically for survival. Being aware of this neurobiological reality helps us understand why it is incredibly difficult for people to walk away from opioids without treatment.

LEARN MORE

Brain Circuit Presentation | National Neuroscience Curriculum Initiative, Columbia Psychiatry [Video]

Racial Disparities and OUD

There is a disproportionate disease burden of OUD on communities of color in the United States.[4] In 2020, American Indians and Alaska Natives had the highest drug overdose death rate (42.5 deaths per 100,000 people) of all racial and ethnic groups. In the same time period, non-Hispanic Black individuals experienced a 44 percent increase in the rate of drug overdose deaths.[5] Clearly, current efforts for OUD prevention, harm reduction, treatment, and recovery supports are not reaching Black, Indigenous, or people of color (BIPOC).

Communities of color are less likely to receive evidence-based treatment and more likely to be criminalized for opioid use. Black people are less likely to have access to medications for opioid use disorder (MOUD) and other evidence-based treatments.[6] While Black people represent 12 percent of those who use drugs, they represent 38 percent of those arrested for drug offenses and are 10 times more likely to be incarcerated for drug use than White people.[7] These disparities lock many BIPOC into damaging, racially inequitable cycles of substance use, lack of access to treatment, drug-related crime, lack of justice diversion, incarceration, homelessness, and recidivism. Systemic racism, implicit bias, and over-policing of communities of color contribute to these disparities.

BIPOC experience barriers to recovery beyond their White counterparts because of the explicit, implicit, and systemic racism they experience daily. For example, BIPOC are overrepresented among those who experience poverty and incarceration, which are two significant risk factors correlated with developing a substance use disorder. A BIPOC mother supporting her family with a minimum-wage job may be unlikely to have the resources to leave her work and family responsibilities to participate in inpatient treatment or take two buses across town midday to reach the methadone clinic during clinic hours. In addition, there are many barriers to housing and employment for those who have a criminal justice record, making it difficult to achieve meaning, purpose, stability, health, and recovery.

BIPOC also face generational and historical trauma associated with past policies and practices that targeted them in negative ways. When the crack cocaine epidemic hit predominantly Black communities in the 1970s, the federal response was to declare a war on drugs to combat illegal drug use. The related creation of mandatory minimum prison sentences for various drug offenses effectively incarcerated Black people for substance use. In contrast, when the opioid epidemic hit predominantly White rural and suburban communities, the federal response was to address the "public health crisis."[8]

To learn more about racial inequities, please see Toolkit Part 1, page 8.

LEARN MORE

Black/White: A Tale of Two Opioid Epidemics | Center for Practice Transformation, University of Minnesota [HTML]

Opioid Misuse and Overdose Prevention in Native Communities | SAMHSA Native Connections [PDF]

The Opioid Crisis and The Black/African American Population: An Urgent Issue | SAMHSA [PDF]

Co-Occurring Physical and Mental Disorders

Opioid use disorder affects physical and mental health in many ways. As a service provider, it's helpful to be aware of co-occurring physical and mental illnesses among people with OUD. Injection drug use and high-risk sexual behaviors associated with OUD put people at a high risk of blood-borne diseases such as HIV and hepatitis C, both potentially fatal viral infections. Other serious health concerns include skin and soft tissue infection, infective endocarditis (infection of the heart valves, lining, or muscles), and sexually transmitted infections.[9]

Co-occurring disorders, or the coexistence of both a mental and a substance use disorder, are common among people with OUD. People with mental conditions are more likely to experience a substance use disorder and are at an increased risk of nonmedical use of opioids.[10] Many people with OUD also have an undiagnosed mental condition. One study found that 37.9 percent of people seeking treatment for OUD also had a psychiatric disorder.[11]

LEARN MORE

Treatment Improvement Protocol (TIP) 55: Behavioral Health Services for People Who Are Homeless | SAMHSA [HTML]

III. Recovery-Oriented Framework for OUD Treatment and Recovery Pathways

Harm Reduction

> *"Harm reduction saved my life. When I was still actively using, I used the needle exchange. Looking back, I'm so grateful for it. I can't imagine what would have happened to me without it. Narcan® saved my life so many times. It's such a blessing. I really hope we can continue to expand harm reduction services." —Julia Mullins, Service Provider and Person in Recovery, Kentucky*[12]

Harm reduction is an integral component of whole person care and part of the continuum of treatment and recovery services for OUD. Practicing harm reduction means meeting people where they are and offering interventions to increase safety around high-risk behaviors with motivational strategies for positive behavior change. Harm reduction incorporates a spectrum of practical strategies such as these:

- Needle exchange
- Naloxone (also known as Narcan®) distribution
- Hotlines for supervised use
- Pre-exposure prophylaxis, or PrEP, to prevent HIV in those at risk of contracting HIV through injection drug use
- Tailored practices for safer use, such as not using while alone or not mixing substances

To learn more about harm reduction and best practices, please see Toolkit Part 1, page 30.

LEARN MORE

Harm Reduction Education On-Demand | National Harm Reduction Coalition [HTML]

Never Use Alone [HTML]

PrEP (Pre-exposure Prophylaxis) | Centers for Disease Control and Prevention [HTML]

City of Boston Harm Reduction Toolkit | City of Boston [PDF]

Treatment for Opioid Use Disorder

More than 2.1 million people in the United States have OUD, roughly equivalent to the populations of New Hampshire and Vermont combined.[13] Since the 1990s, over 500,000 people have lost their lives from opioid overdoses in the United States.[14] OUD is a serious, life-threatening chronic disease, but it *is* treatable. People with OUD can experience successful outcomes and live a life in full recovery when they receive behavioral therapies, medications, and recovery supports that work for them.

Current best practices for treating OUD feature these three components:

- FDA-approved medications to reduce cravings and alleviate withdrawal symptoms, which frequently compel a person to continue using, even in the face of harm and severe consequences from their use
- Psychosocial or behavioral interventions to address the root cause of the addiction and promote positive behavior change
- Recovery support services to address basic needs and develop the social support and stability needed for recovery

MEDICATIONS FOR OPIOID USE DISORDER (MOUD)

MOUD, when used in conjunction with counseling and support services, are considered the gold standard for treating opioid use disorders by SAMHSA, the Centers for Disease Control and Prevention, and the World Health Organization. MOUD treat OUD by normalizing brain chemistry, blocking the euphoric effects of opioids to reduce the motivation to use, and relieving physiological cravings and withdrawal symptoms that lead people to continue using. As a result, MOUD prevent death from overdose, improve outcomes for long-term recovery, reduce infectious disease transmission, and reduce criminal justice involvement. According to one study by the National Institute of Health, deaths from overdose decreased by 38 percent in those taking buprenorphine (brand name Suboxone®) and 59 percent in those receiving methadone.[15]

MOUD were first introduced in the 1960s, and decades of research show them to be safe and effective. However, myths, misinformation, and stigma continue to hinder access to and acceptance of this evidence-based, lifesaving treatment. Much of this discrimination comes from outdated, inaccurate beliefs that addiction is a moral failing. Addiction is a chronic brain disease like Alzheimer's disease, epilepsy, or schizophrenia. Few people would ever suggest a person with Alzheimer's disease forgo medication and try to treat the brain disorder with sheer willpower. Yet this belief is widespread when it comes to treating substance use.

Damaging and stigmatizing misinformation—such as "MOUD are a crutch" or "MOUD are exchanging one drug for another"—persists and often prevents people from starting or continuing MOUD. Inaccurate information and beliefs are especially dangerous when they come from service providers or members of the recovery community. It is critical to affirm all pathways to treatment and recovery, including MOUD, and combat stigmatizing and incorrect misinformation about MOUD.

To learn more about stigma, please see Toolkit Part 1, page 19.

Locating Treatment: SAMHSA's National Helpline

Call: 1-800-662-HELP (4357)

Visit: Findtreatment.gov

Text: Text your 5-digit ZIP Code to 435748 (HELP4U).

The helpline is free, confidential, and provides information in English and Spanish. In addition to listings of treatment services by location and type, FindTreatment.gov includes resources on understanding treatment options and paying for treatment.

There are three FDA-approved medications to treat OUD and improve patients' health and wellness: methadone, buprenorphine, and naltrexone. Research shows that 80 percent of people who stop using opioids without the use of medications return to active use.[16]

LEARN MORE

Medication for Opioid Use Disorder: Myths and Facts | Legal Action Center [PDF]

Addressing the Opioid Crisis: Medication-Assisted Treatment at Health Care for the Homeless Programs | Henry J. Kaiser Family Foundation [PDF]

Decisions in Recovery: Treatment for Opioid Use Disorder | SAMHSA [PDF]

"With OUD, sometimes there are setbacks and relapses. People need to be educated because there is a lot of ignorance, and many people think that having an opioid use disorder makes you a terrible person and that you should just fall off the earth. There is a lot of misunderstanding and a real lack of education." —Danielle Moye, Service Provider and Person in Recovery, Florida[17]

Methadone

Methadone is a long-acting opioid used to treat OUD. It is prescribed at low doses and lasts for 24–32 hours, compared to 4–6 hours for other opioids. Methadone works by filling the opioid receptors, preventing withdrawal symptoms and cravings while preventing a high.

Methadone comes in pill, liquid, and wafer form. Because it is a federally controlled narcotic, it is dispensed at federally licensed opioid treatment programs. The typical starting dose is 30 milligrams (mg), and the dosage is adjusted to an individualized therapeutic level (usually 60 mg–120 mg). The *therapeutic dose*—the level at which one receives the greatest benefit with the fewest side effects—is determined by a clinician using the Clinical Opioid Withdrawal Scale. This tool includes 11 items that are scored by the clinician and informed by self-report and objective measures, including vital signs, the presence or absence of sweating, pupil size, and tremors.

Methadone maintenance treatment is typically provided in phases. In phase one, participants come in for daily dosing. As they continue to meet program requirements, they work their way up to the final treatment phase—five or six—that allows them to take multiple weeks' worth of doses home at a time. If they fail to meet requirements at any phase, they move back to a lower phase, which signifies a need for more intensive support. Treatment phases are determined by the following:

- → Length of treatment
- → Meeting counseling requirements

- → Presenting drug-free urine specimens
- → Consistently showing up for each clinic dosing

Transportation and scheduling limitations are two significant barriers to methadone treatment. People who are unhoused and those living in rural areas have limited access to transportation to get to a methadone clinic. Methadone clinics often have limited opening hours, making it difficult for people who work or have caregiving responsibilities to meet daily visit requirements. As a result of the COVID-19 pandemic, federal rules have been modified to increase access to methadone and to ensure COVID-19 health and safety measures. Research shows that this policy change has led to better engagement in treatment, decreased stigma, better patient satisfaction, and fewer incidents of diversion or misuse.[18]

Learn more about methadone.

Buprenorphine and Suboxone

Buprenorphine (brand name Subutex®) is a *partial agonist*, which means that it only partially fills opioid receptors but does so enough to prevent withdrawal symptoms and cravings. Suboxone® is the brand name for a formulation of buprenorphine that includes naloxone. Unlike methadone, it can be prescribed in emergency rooms and doctor's offices by prescribers who have received specialized training and licensure (known as the X waiver). These prescribers are required to limit their caseloads. Buprenorphine prescriptions are more accessible than methadone treatment, although it typically does not require the formal counseling support that methadone programs require.

Buprenorphine comes as a pill; sublingual tablet; or monthly injection, known as Sublocade®. Therapeutic doses are between 4 mg and 24 mg of the pill or sublingual tablet or 100 mg for the monthly injection, following two initial 300 mg monthly injections.

Learn more about buprenorphine.

Naltrexone

Naltrexone is an opioid *antagonist*, not an opioid. It works by blocking the opioid receptors so nothing can attach and activate them, thus effectively preventing the body from getting high or experiencing the effects of the opioid. Naltrexone is used after a medically supervised withdrawal from opioids. If taken by someone actively using opioids, it will send them into withdrawal with its associated painful symptoms. Naltrexone is best prescribed for those who are less vulnerable to recurrence of use and stable in their recovery. Because of its antagonist effects, taking naltrexone increases the risk of overdose if a person attempts to override it or make it ineffective by taking large amounts of opioids.

Learn more about naltrexone.

LEARN MORE

Pocket Guide: Medication-Assisted Treatment of Opioid Use Disorder | SAMHSA [PDF]

Medication-Assisted Treatment for Opioid Use Disorder: A Printable Pocket Guide | Arizona State University Center for Applied Behavioral Health Policy [PDF]

Medications for Opioid Use Disorder: TIP 63 | SAMHSA [PDF]

MOUD AND TREATMENT CONSIDERATIONS

This section offers an overview of considerations to be aware of regarding MOUD and program participants with specific conditions or lived experiences. This is not meant to be a substitute for medical advice; consult a licensed health-care provider or your local Health Care for the Homeless (HCH) project for medical guidance.

Co-Occurring Mental Health Disorders

Without targeted mental health treatment, people with co-occurring OUD and mental disorders have higher rates of continued substance use and overdose. Collaboration between MOUD providers and mental health providers is imperative for safety and continuity of care. MOUD and medications for mental disorders can interact with one another. For example, combining MOUD with benzodiazepines, a class of drugs that treats anxiety, can have serious adverse effects. Both medications are respiratory depressants and put a person at increased risk of overdose.

Pregnancy

If a pregnant person abruptly stops opioid use, withdrawal symptoms can harm the developing fetus and even terminate the pregnancy. Best practices for pregnant persons with OUD incorporate MOUD during and after pregnancy, including methadone, buprenorphine (Subutex®), and buprenorphine/naloxone (Suboxone®), all of which have been proven safe to use during pregnancy.

When compared to untreated opioid dependence, pregnancies treated with MOUD are associated with these outcomes:

- → Improved participation with obstetrical care
- → Higher birth weights
- → Improved outcomes in neonatal opioid withdrawal syndrome, known as NOWS
- → Lower rates of pre-term birth, fetal mortality, and neonatal death[19]

LEARN MORE

Pregnancy | The Journey Recovery Project [HTML]

HIV and Hepatitis C

All three FDA-approved OUD medications are approved for persons with or at risk for both hepatitis C and HIV. MOUD help decrease or eliminate opioid use as well as the high-risk behaviors associated with opioid use while improving HIV and hepatitis C treatment engagement and success.[20] PrEP is recommended for people who do not have an HIV infection but are engaging in high-risk behaviors, such as injection substance use.

LEARN MORE

PrEP Topics | Centers for Disease Control and Prevention [HTML]

Chronic Pain

A review of electronic medical records in the United States over a decade found that more than 64 percent of people being treated for OUD also had a chronic pain condition;[21] 61 percent presented with chronic pain as their primary diagnosis before being given an opioid prescription.[22] Prescribing opioids was a common practice in the 1990s and 2000s when opioids were considered a first-line therapy to address pain. Since then, the impact of opioids has become readily apparent, and opioids have moved to the last line of defense for treating pain that is unresponsive to other therapies, including non-opioid medications, physical therapy, and cognitive behavioral therapy, to manage anxiety and shore up coping skills. Finding adequate ways to address ongoing pain is imperative in treating an opioid use disorder because unmanaged pain makes a person vulnerable to relapse as they try to self-medicate and find relief.

LEARN MORE

TIP 54: Managing Chronic Pain in Adults with or in Recovery from Substance Use Disorders | SAMHSA [PDF]

Post-Incarceration

Because few legal systems in the United States offer access to evidence-based OUD treatment for those who are incarcerated, people exiting incarceration are at a high risk of overdose and death. People who are released from prison are 129 times more likely to die from a drug overdose than those who have never been incarcerated.[23] While incarcerated, people experience a decrease in drug tolerance because of limited drug access or only accessing low-purity drugs, making a post-release return to drug use in the community perilous. Formerly incarcerated individuals may also be more vulnerable to overdose and relapse because of sociocultural norms that encourage drug use, little to no access to treatment facilities or health insurance, a lack of social support networks, and high rates of homelessness.[24] Service providers and systems should make every effort to connect returning citizens with health care, OUD treatment, recovery support services, and other reentry supports.

Legal systems that have implemented MOUD in prisons show promising results. Access to MOUD increases follow-up with community treatment and supports upon release while also reducing illegal drug use, criminal activity, probation revocations, and reincarceration.[25]

LEARN MORE

Jail Based Recovery Programs | McShin Recovery Resource Foundation [HTML]

Psychosocial and Behavioral Interventions

Psychosocial and behavioral interventions, including counseling and peer support, are a vital part of treating OUD. They help support people to understand their addiction, address the root causes of substance use, and develop new and healthier coping skills and thought processes. This section provides an overview of common treatment options.

Cognitive behavioral therapy (CBT) is an evidence-based form of psychotherapy that helps people identify and address problematic thought processes that contribute to their substance use while fostering the development of healthier ways of thinking, interacting with the world, and coping with life stressors.

Motivational interviewing (MI) is an evidence-based practice that uses a collaborative conversation style to elicit a person's internal motivation for recovery. MI is person centered and goal oriented. It supports a person in resolving ambivalent feelings about change, increasing motivation to change, and fostering commitment to make a change. MI starts with the assumption that people already have what they need to make positive changes in their life and supports them to identify and access the resources to make changes.

To learn more about MI, see Toolkit Part 1, page 33.

Peer recovery support is perhaps one of the most powerful and effective behavioral interventions for those with OUD. Addiction is a disease of isolation. Most people with OUD have limited insight into the mechanisms that drive their drug use. They may experience deep shame and internalized stigma. Connecting to someone who has experienced the same struggles and is in recovery themselves provides a source of hope, helping them understand that they are not alone. Peers are role models who have made it to the other side of their addiction, living fulfilling lives in recovery.

Peer support also helps provide sober social support, replacing social connections provided by others who are actively using. It is imperative to develop social connections with others in recovery to replace less healthy forms of social support. Finding peers who can model and promote a life in recovery inspires hope that recovery is possible and provides concrete assistance to help achieve it.

To learn more about peer support, see Toolkit Part 1, page 13.

Contingency management (CM) is a type of behavioral therapy that provides tangible rewards to reinforce positive behaviors. For example, a program participant may be given a voucher to exchange for retail goods or services for each negative urine analysis. CM is also part of 12-step programs, where participants receive specially made coins or tokens based on the length of their sobriety. Such practices have been shown to effectively promote and sustain motivation for people pursuing recovery from substance use disorders.[26]

Family therapy or **family counseling** can help address patterns that affect the family's psychological health. It is often said that substance use disorders are a family disease. Even if other family members never touch a

substance, they are still affected by a loved one's use. Unhealthy family patterns can hold both the individual and their family members hostage to the substance use disorder. For example, unaddressed family patterns can contribute to the recurrence of use when a person returns from inpatient treatment to toxic family members and dynamics. Family therapy addresses unhealthy coping strategies, patterns, and interactions to promote recovery and healing for the entire family unit.

There are many different types of **group therapy**, **mutual aid**, and **treatment groups** to support people with OUD. Groups are powerful for reducing isolation, building social support and connection, fostering hope, and mobilizing mutual support. Group therapy is often a part of inpatient and outpatient treatment programs. There are many types of mutual aid groups that support recovery from OUD.

To learn more about mutual aid support groups, see Toolkit Part 1, page 14.

Group-based opioid treatment is an emerging approach that combines medications and psychosocial support. It can be delivered through shared medical appointments or group psychotherapy sessions. It helps to activate mutual support among members of the group, fostering hope and validation and reducing stigma and isolation. In addition, it can increase access to OUD treatment by enabling medical providers to serve greater numbers of people.[27]

LEARN MORE

What Does It Really Mean to Be Providing Medication-Assisted Treatment for Opioid Addiction? | Hazelden Betty Ford

THE VALUE OF PEER SUPPORT IN HOMELESS SERVICES

- Individuals with the lived experience of homelessness who are trained in peer support are uniquely qualified to deliver recovery supports because they have "been there."
- Recovery support provided by individuals who have extricated themselves from homelessness inspires hope and helps people resolve the challenges and barriers of trying to get housing.
- Homelessness is highly traumatic. Trained peer workers recognize and understand the impact of trauma and can help people find ways to address trauma as part of their recovery process.
- Both substance use and mental health disorders are prevalent among people experiencing homelessness. Peer support workers bring the lived experience of recovery from addiction or mental illness and serve as role models and beacons of hope to those who may be contemplating change.
- Peer support workers with lived experience of legal system involvement bring credibility, deep understanding, and respect to rapidly engage individuals returning to their community from jail or prison.

- → Peer workers recognize the critical importance of housing to reduce chronic traumatic exposure and facilitate recovery, hope, and dignity.
- → Recovery supports are a critical component of a whole-person approach when addressing the ancillary challenges of homelessness, including mental and substance use disorders, trauma, and lack of foundational resources, such as transportation, identification documents, clothing, and communication tools.

Recovery Support Services

> *"When your client has a recurrence of use, do not look down on them. Do not degrade or talk down to them. Affirm that recurrence can be a part of recovery. Be patient and tolerant." —Ray Lay, Service Provider and Person in Recovery, Indiana*[28]

SAMHSA defines *recovery* through four dimensions:

- → **Health:** Overcoming or managing one's disease(s) or symptoms and making informed, healthy choices that support physical and emotional well-being
- → **Home:** Having a stable and safe place to live
- → **Purpose:** Conducting meaningful daily activities and having the independence, income, and resources to participate in society
- → **Community:** Having relationships and social networks that provide support, friendship, love, and hope

People seeking recovery from OUD may experience many barriers to achieving stability, support, and balance in these four areas. *Recovery support services* are nonclinical services that are part of a holistic treatment plan to address these barriers. Research shows that people on MOUD who receive high-quality psychosocial support remain engaged in treatment longer and are more likely to abstain from using opioids than those who do not.[29]

To achieve the stability needed for long-term recovery, one's basic needs must be met in all four areas. Lacking housing or being unstably housed is a significant barrier to engaging successfully in treatment or recovery services. Being unemployed is another barrier; boredom from having an unstructured day, shame associated with being unemployed, and stress related to financial strain can all contribute to the development and progression of a substance use disorder. Supporting people in finding and maintaining meaningful employment can go a long way in supporting their recovery journey.

Recovery support services such as these can support individuals to achieve health, home, purpose, and connection:

- → Employment services, job training, education
- → Benefits programs such as TANF, SNAP, WIC, SSI/SSDI
- → Housing assistance and services

- Physical and mental health care
- Legal assistance
- Transportation assistance
- Childcare
- Means of communication, including cell phone and Internet access
- Life skills development and coaching, for example, prevention of the recurrence of use, stress management, or coping skills

To learn more about recovery and recovery support, please see Toolkit Part 1, page 10.

IV. Community-Level Coordination and Collaboration

Providing whole-person care means offering holistic wraparound support. Often, this is beyond the scope of any one organization or service provider. To support whole-person needs, it is key to know what other services and resources are available in your community to support people experiencing homelessness and OUD and where gaps may exist. *Asset mapping* is a strengths-based process of identifying community assets and creating an easy-to-use directory that can be widely disseminated and easily updated. It is also important to develop strong relationships with other organizations or community members providing complementary services to meet the whole-person needs of those you serve. Communities with a higher level of coordination and collaboration are better able to meet the whole-person needs of those who are experiencing homelessness and who have an OUD and to support them on the pathway to recovery and stable housing.

One of the challenges of the opioid epidemic is that so many different services systems and providers are involved in addressing the challenges and collateral damage, making them integral to community-wide solutions. Many communities and counties have developed opioid or harm reduction task forces to coordinate efforts that support individuals and families affected by homelessness and OUD. Engaging the myriad stakeholders and service systems that interface with people with OUD is critical to developing community collaborations and solutions. These might include the following:

- First responders (EMS, firefighters, law enforcement)
- Health-care providers (emergency department staff, primary care, HCH projects, community health centers, and dental care)
- Certified behavioral health clinics
- Harm reduction providers
- Behavioral health providers, including mental health and substance use treatment providers
- Recovery community members (peer support workers, recovery housing staff, and recovery community organizations)
- Child welfare
- Courts, judges, and probation and parole offices
- Schools and youth programs
- Public sanitation staff
- Homeless services
- Housing providers

In addition, every community has a Continuum of Care Program, a local or regional body composed of nonprofit and government groups that coordinates housing, rental assistance, funding, and other housing resources for those who meet Housing and Urban Development (HUD) eligibility criteria. Community-level coordination is critical for ending homelessness and should include the following:[30]

- Coordinated assessment and intake processes (i.e., coordinated entry)
- Community-wide plans

- → Data collection (e.g., point-in-time or other counts to determine needs and demographics)
- → A shared data system that collects individual-, program-, and system-level data (i.e., Homeless Management Information System)
- → Performance measurement and evaluation

Community Asset Mapping for Collaboration and Coordination

Community asset mapping is the process of identifying, gathering, and organizing information about the assets in your community related to a specific objective. For example, you may want to identify all possible resources and services that can support community members who are unhoused and have OUD.

An asset can be any existing community resource or strength that can improve the well-being of community members or uncover solutions. Asset mapping starts with identifying a community's existing strengths and assets, not its deficits. The core belief of asset mapping is that many solutions already exist within a community. It is a strengths-based approach to community planning.

There are many benefits to undertaking an asset mapping project. It creates an opportunity to develop and strengthen relationships and promotes community involvement, ownership, and pride. It can also increase access to existing community resources. Asset mapping also provides a framework for community planning; it can guide conversations with community leaders and advocates, help determine needed investments, and identify gaps as well as assets.

STEPS FOR CREATING AN ASSET MAP

- → **Define the purpose of the asset map.** What are the goals, and what do you hope to accomplish? Defining objectives will guide the process of developing your map and keep you on target.
- → **Establish the boundaries of the asset map.** Geographic limits will keep your efforts focused. Will you target a neighborhood, ZIP code, city, or county?
- → **Determine the types of assets to include.** Keeping your purpose in mind, what types of assets will meet your goals? Assets may include community members' capacities, skills, and abilities; public institutions and services; private, faith-based, or nonprofit organizations; and funding sources.
- → **Gather asset information.** Collect, record, and inventory assets. Use Google or social media searches, post requests for information, check local newspapers and community bulletin boards, and contact community-based organizations, including ethnic identity or neighborhood groups, faith-based communities, advocacy groups, and grassroots initiatives (like community fridges or mutual aid groups), in addition to more traditional service providers.
- → **Organize the assets.** There are many ways to organize your assets, but it is important to select an approach that works best for your community's needs. However you choose to organize the assets, aim to make the information accessible, and organize it in a way that increases awareness of what is available and where service overlaps and gaps may exist.
- → **Create a map.** Creating a publicly available map or directory is a good way to visualize community assets and the relationships among them. There are many options, and you may want to use more than one approach.

- **Physical or online map.** You can use a physical map or an online map, such as Google Maps or another software program. Online maps are fast and easy to access and share, and multiple users can access the same map and contribute to the process. Create a legend and use color-coding dot stickers or pushpins to identify locations and types of assets.
- **Create a comprehensive list, database, or spreadsheet.** You can also create a searchable list or database using Microsoft Excel or Google Sheets (a free online spreadsheet program) to organize your assets.
- **Create a visual model.** You can create Venn or other diagrams, word clouds, drawings, or other visual tools to represent available assets and the relationships among them.

→ **Disseminate and use the map.** Share the map with community members and partners invested in the map's purpose. Hold community meetings to discuss the map. A few questions for consideration include the following:

- Where is the community excelling?
- Are there underused assets the community could expand?
- Are there obvious gaps in services or resources where needs are unmet?

→ **Conduct a gap analysis.** You may want to use your map to identify gaps and where reallocations of funding or services might address them. A few questions for consideration include the following:

- Where are we now?
- Where do we want to be?
- How do we get there?

→ **Update the map regularly.** Create a plan to ensure you update the map regularly so it remains useful.

If the asset mapping process seems daunting or time and resources are limited, don't be discouraged. These steps can be easily adapted and scaled up or down to fit your community's needs and resources. For example, you might just pick one service to research and map. Or you could take a crowd-sourcing approach by creating an open-access, online map and inviting community partners to add their services and resources to the map. There are many ways to adapt the asset mapping process to fit your needs and capacity.

Implementing Warm Handoffs

In addition to understanding the resources and assets available to support people with OUD who are experiencing homelessness, it's critical to develop relationships across service systems so that you can conduct warm handoffs as often as possible. For example, you can provide a personal, in-person introduction instead of simply providing a name and number or web address when you refer a person to a service. As an evidence-based practice, a *warm handoff* refers to the process of transferring an individual from one provider to another in real time.

Warm handoffs work best when you have built trust and rapport with the individual you are referring *and* you have a relationship of trust and respect with the service provider you are referring to. During a warm handoff, you—the trusted person—can help the person you are referring feel at ease. The trust you have built can facilitate a successful handoff and foster the person's willingness to accept help from the new service provider. For example, a care coordinator may provide a warm handoff to a mental health counselor

for a person who has a mental condition and is uncomfortable seeking help and trusting new people. Or a warm handoff could take place between a homeless outreach worker and a physician assistant at a community health center, a needle exchange or harm reduction program, or a dental specialty clinic.

"As providers, we need to really listen to the person and understand the situations that people have gone through. We need to look at folks and say, 'OK, these are the services I feel that you may need,' but then let them build their plan [from there]. It's already overwhelming to try to survive being homeless. It's so overwhelming for someone to actually walk into a clinic, and say, 'I need services.' The big phrase around here is 'meet people where they're at,' but sometimes, it's '**let people be, just let people be here**.'

If they're not ready, they're not ready. But we can always check in with them, and that's the best that we can do as a provider." —Arthur Rios, service provider and person in Recovery from OUD, Portland, Oregon[31]

LEARN MORE

Continuum of Care (CoC) Program | HUD [HTML]

Inclusivity and Innovation in Homeless Services: Findings from a National Study of Continuums of Care | University of Chicago School of Social Service Administration [PDF]

SPOTLIGHT: Pennsylvania's Warm Hand-Off | Addiction Policy Forum [PDF]

V. Supporting Housing Stability and Recovery for People with OUD

> *"When all is said and done. We're all just walking each other home." —Ram Dass*

Housing

Several housing models offer stability and services for people who are exiting homelessness and have OUD. Unfortunately, many communities have limited availability of these housing models.

HOUSING FIRST

Housing First is an evidence-based practice that can be integrated into different housing models. It offers housing without prerequisites. It emerged as an alternative to programs that mandated sobriety, medication compliance, or meeting program participation requirements before people could access housing. Housing First acknowledges the reality that people cannot effectively address physical health, mental health, or substance use conditions while being unhoused or in unstable housing situations. Housing First offers access to housing and programs without regard to minimum income, sobriety, criminal record, treatment status, or other program participation requirements. The Housing First approach can be implemented within permanent supportive housing based on these five core principles:

- **Immediate access to housing with no "housing readiness" requirements:** Housing providers do not require people to demonstrate sobriety or abstinence. Participation is entirely voluntary, and housing is separate from treatment.
- **Consumer choice and self-determination:** As a rights-based and person-centered approach, people can choose the location and type of housing as well as the services and supports they receive.
- **Recovery-oriented:** Housing First offers recovery-oriented services and supports without requiring them. For those facing challenges in addiction recovery, harm reduction approaches and supports are offered.
- **Individualized and person-driven supports:** Housing First recognizes that everyone has unique needs and should be able to choose the services they engage in.
- **Social and community integration:** Housing First helps people engage in their community and promotes social connection.[32]

PERMANENT SUPPORTIVE HOUSING

Permanent supportive housing pairs affordable housing with supportive services, such as care coordination, health care, behavioral health care, and wraparound services. Designed for people exiting homelessness who may have medical, mental, or substance use disorders, permanent supportive housing offers the stability of a safe, affordable home combined with services to help people take care of their health and well-being. Permanent supportive housing is cost-effective, and research shows that it decreases residents' use of emergency services and their involvement in the legal system.[33]

RECOVERY HOUSING

Recovery housing, also called *sober homes* or *recovery residences*, typically requires abstinence and offers peer support and mutual aid for people recovering from substance use disorder.

To learn more about recovery housing, please see Toolkit Part 1, page 15.

LEARN MORE

Online Module: Introduction to Housing Models, Housing Navigation, and Engagement | SAMHSA's Homeless and Housing Resource Center [HTML]

Implementing Housing First in Permanent Supportive Housing | USICH [PDF]

Permanent Supportive Housing Evidence-Based Practices | SAMHSA [HTML]

Helping Recovery Residences Adapt to Support People with Medication-Assisted Recovery, National Alliance for Recovery Residences | National Council for Behavioral Health, and C4 Innovations [PDF]

National Alliance for Recovery Residences [HTML]

Whole-Person Tenancy Support

> *"Being homeless will take at least 90 percent of your active mental capabilities to learn how to survive because a person experiencing homelessness is looked down upon by everybody." —Ray Lay, Service Provider and Person in Recovery, Indiana*[34]

Homelessness is traumatic. The conditions of enduring life without a home places overwhelming demands on a person's whole being: physically, mentally, socially, spiritually, and communally. Yet as confounding as it may seem, for many people, it can be a formidable undertaking to move into housing successfully. Why is this transition so challenging? Here are several common reasons:

- A fear of becoming lonely and isolated
- The distress of "four walls closing in"
- Missing the familiar patterns of life on the streets
- Feeling disconnected from friends and acquaintances on the streets
- Concerns about being able to pay the rent each month
- A lack of confidence in their ability to maintain housing
- The feeling of being undeserving of housing
- Concerns about taking the place of others still on the streets

This is where *whole-person tenancy support* comes in. Whole-person tenancy support involves engaging with people in a compassionate, skillful, person-centered manner to help them find, move into, maintain, and thrive in housing to live their best lives. It is about helping them make a house into a home.

The Latin root word for *home* is the same word we use for "human being," "person," and "people." We can think of home as a space that enables us to live the full expression of our humanity and have healthy, interdependent lives. We each "reside" in three homes:

- **First home:** our body, mind, and spirit
- **Second home:** the place where we live and use as a base of operations, whether it is a tent or a friend's couch
- **Third home:** the various communities through which we interact with the larger world

Whole-person care in tenancy support helps people connect with each of these homes at varying times (see Three Homes handout).

"We need to be more flexible with our ideas about what works, because it's not the same thing for every single person. Everybody needs housing and they need a safe place immediately, but not everyone wants to live alone in an apartment right away, and some people want to live in a sober community." —Transitional Housing Service Provider, Maine[35]

SUPPORTING TRANSITIONS: CRITICAL TIME INTERVENTION

Critical Time Intervention (CTI) is a time-limited care coordination model that mobilizes support for individuals during critical times of transition, such as moving from homelessness and creating a new home in a permanent supportive housing unit. The aim of CTI is to facilitate continuity of care and community integration by ensuring individuals have enduring ties to their community. Developed to support people moving from shelters to permanent supportive housing, this evidence-based practice has been adapted for use with formerly incarcerated individuals, veterans who have a history of recurrent homelessness, young people who experienced first-episode psychosis, and other vulnerable groups during periods of transition.

CTI helps support housing stability through a time-limited, phased approach focused on building trust, identifying goals, connecting people with formal and informal support in their new community setting, strengthening support networks, and mediating conflicts.

Learn More

Center for the Advancement of Critical Time Intervention [HTML]

SUPPORTING THE TRANSITION TO HOUSING

> *"For so long, people were telling me what to do, how to do it, and when to do it. I never really got a chance to self-direct or ever have enough information to be able to do so." —Service Provider and Formerly Homeless Person, New York*[36]

While we may rush to judgment if a person who is experiencing homelessness hesitates or refuses to accept a housing offer, it is critical to respect choice and self-determination in the housing process. We cannot hurry, pressure, or make decisions for people. A whole-person approach offers choices about the type or location of their assigned housing unit and the timing of their move-in as much as possible.

It is important to help prepare a person exiting homelessness for the transition to housing by exploring their hopes and fears. Take time to ask questions about how they are feeling about the transition and listen deeply. Topics to explore include the type and location of housing; its affordability; access to transportation; and proximity to family, friends, services, and community resources. If they have regular appointments, what transportation options are available in the new location? Can someone accompany them to help them learn the new route? If they have children, what school will they attend, and how will they safely travel there? Where will they be able to get food and other necessities?

It is crucial to discuss OUD-related needs that affect housing choices and preferences. Those who are taking MOUD will need housing options that respect and support their treatment and recovery pathway and ensure continued access to health-care providers and medications. Some recovery housing operators and permanent supportive housing staff may hold outdated and misinformed beliefs about MOUD that reproduce stigma and create an environment that does not support recovery for people who take MOUD. These residences should be avoided. For people who are actively using substances, it is important to identify housing options that will be compatible with their needs and not interfere with safe use and harm reduction practices.

Explore the person's concerns about making a new home in the housing unit and review the community resources that will help provide furnishings and supplies. They may have deeper concerns about having what it takes—skills, memory, organization, confidence—to carry out the responsibilities of being a tenant. If they are moving to a new neighborhood, explore their perceptions and any preconceptions they may have related to their recovery process, safety, stigma, or discrimination.

WHOLE-PERSON SUPPORT FOR HOUSING STABILITY

> *"To support housing stability, it is important to ensure that people have their basic needs met. They need things like toilet paper, a shower curtain, and a bed. It's also important in those first few months to make sure there is a way for someone to continue the relationships they choose to continue. People are lonely when they are housed. There is nothing worse than social isolation. Of course, people [who are newly housed] are going to invite the people they love who are still homeless to stay with them. We should not be evicting them for that. We [service providers] need to help negotiate visitation policies." —Service Provider, Maryland*[37]

Recovery from homelessness and the physical, emotional, psychological, social, and spiritual demands it places on individuals and families is a process. Care coordinators and other service providers play an essential role in supporting this process using a strengths-based, trauma-informed, and recovery-oriented approach that acknowledges, validates, and cares for the whole person. Meeting the person where they are—especially with regard to their substance use—is a cornerstone of whole-person tenancy support.

The constant, oppressive stress of living in survival mode without a stable home affects a person's view of the world and what is possible as well as their habits and behavioral patterns. Part of the process of supporting someone through the transition into housing is helping them recognize that they have many strengths they can draw on to navigate the transition. You can also help them identify areas where they might need to acquire new knowledge and skills and how to do so. This may include problem-solving and conflict-resolution skills, learning how to access community resources, relationship-building skills, financial literacy, self-awareness, or other skills (see the Supporting Basic Needs section).

Especially during the early days and months after moving into housing, tenancy support aims to help people stabilize their own overall health and well-being and their living situation and establish a rhythm in their routines. Tenancy support includes helping tenants feel safe, acquire household necessities, and meet the obligations and responsibilities of tenancy. These are examples of areas where people typically need support, especially in the early days:

- **Safety.** Ensuring the unit meets building safety codes: locks work properly; tenants know how to get help in emergency and nonemergency situations; tenants can move about safely in their building and immediate neighborhood; tenants are not subject to discriminatory practices based on race, gender, or gender identity; and tenants have a way of screening visitors
- **Household necessities.** Helping tenants obtain furniture, bedding, cookware, dishware, bath and hygiene supplies, telephone, TV, food supplies, and decorative items
- **Obligations and responsibilities.** Supporting tenants to pay rent; comply with the terms of the lease; follow building rules, expectations, and norms; be a good neighbor; and maintain their living space
- **Access to MOUD and recovery supports.** Ensuring individuals will have continued and unimpeded access to MOUD, health-care providers, and recovery supports in their new homes, which may include helping with transportation, providing warm handoffs, or accompanying people to appointments or pharmacies
- **Harm reduction and overdose prevention.** Ensuring that harm reduction and overdose prevention supplies and supports are available and accessible in the new housing situation when supporting people who are using substances

PERSON-CENTERED CARE PLAN

It may be helpful to collaboratively develop a Care Plan with the person who is moving into housing. This plan is a living document that outlines the person's goals and addresses how to handle common challenges that might arise. The Care Plan is person-centered and focused on the individual's goals and priorities. Goals should be specific, measurable, and attainable. Service providers should normalize that adapting and changing goals over time is expected.[38] The Care Plan will serve as a road map to *the person's* desired destination.

The Care Plan should address the core areas where tenants may need support to develop skills, experience, and comfort, which may include the following:[39]

- → Supporting social connection
- → Addressing lease issues
- → Managing finances
- → Caring for the home
- → Facilitating OUD supports

"It is important to not force someone to do something they don't want to do or that they're not ready for. You want to be a listening ear. A lot of times, that's all that you need to be. Be somebody who is open to listening to what the other person is saying.

"Everybody's needs are different. I've realized that when you are telling somebody: 'you need to go to AA, you need to go to treatment, you need to do this, and you really need to go to detox right now,' people are not receptive. They just aren't. They want to hear that you care and that you know their life is important to you. And then they trust what you're saying." —Danielle Moye, Service Provider and Person in Recovery, Florida[40]

SUPPORTING SOCIAL CONNECTION

People may feel isolated and disconnected when they first move into housing. They may have had to leave behind friends from the street or people they used drugs with—or they may be trying to navigate maintaining these relationships in a new context. It is important to remember that people have more than likely experienced extreme marginalization, discrimination, and alienation based on their drug use, homelessness, race, ethnicity, gender identity, or other identities or conditions. As a result, they may have challenges trusting new people and may only trust the people who were there for them in their life prior to moving into housing.

Service providers must recognize that many of these friends and relationships provided support, protection, solidarity, and meaning when no one else was there for them. We must put ourselves in the shoes of the people we serve and understand the value these social networks provide so we can help people navigate them in ways that support their well-being. For example, you can offer to be the "enforcer" of boundaries or visitor policies to take the pressure off the newly housed individual who might not be comfortable telling old friends they cannot spend the night. It is critical to have open and frank discussions about relationships and boundaries and explore the types of relationships the person wants to maintain, leave behind, or develop.

For those who are ready to build new relationships and social support networks, it is important to recognize that they may lack confidence in their ability to form new relationships and attachments. Internalized stigma and feeling uncomfortable navigating the norms of sober social relationships may pose additional barriers.

Care Plans should consider the personal and community resources that could be helpful for building social support and developing new relationships. To support people and mitigate isolation, service providers can work in partnership with the people they serve:

- → Have open and frank conversations about the types of relationships that are most important to them, the role of boundaries, and how you can support them to create and maintain boundaries.
- → Understand stressors that affect the person's ability and capacity to navigate existing relationships or connect with or trust new people.
- → Have compassionate and up-front conversations about relationships that might cause conflict with the terms of the person's leasing agreement or not be beneficial to the person's well-being.
- → For those entering recovery, explore their comfort with recovery community resources, including recovery community centers, sober social activities, and 12-step or peer support groups. Determine what might be getting in the way of participating.
- → Understand transportation and communications needs and available community resources. If the person has limited mobility, what are other options for forging social connections?
- → Foster friendly, informal connections with people they regularly encounter in their new neighborhood. These could be checkout clerks at the corner store, the local barber, a neighbor, building staff, librarians at the local public library, the postal carrier, or others they may encounter during the day.
- → Invite the person to describe what it looks and feels like to have a rewarding day—or part of a day. What are the most meaningful ways to spend or occupy their time? Connect them with resources that will facilitate access to these activities or communities.
- → Ask what meaningful relationships look and feel like for them. If they want to integrate into their community, how do their interests, skills, or affinities connect with opportunities in the community?

"There needs to be more connectedness because when they come from living on the streets for 10 to 11 years and you put them in housing, they are lonely. They are by themselves. You must fill that void because some people would prefer to stay in the woods because that has become their norm and their family." —Peer Specialist and Harm Reduction Coordinator, Maryland[41]

ADDRESSING LEASE ISSUES

It is critical to carefully review the terms of the lease agreement with the tenant before signing it so there are no surprises. It is helpful to review the agreement again after the person moves in to reinforce and

contextualize its terms. When reviewing and discussing the leasing agreement, you may want to follow these recommendations:

- → Ask the tenant to identify which lease restrictions are most concerning or relevant. Discuss strategies to address them.
- → Review lease agreements in a way that empowers the prospective tenant. For example, discuss their responsibilities as a tenant and your responsibilities to support them as a service provider.
- → When reviewing the lease agreement, pay special attention to the most critical rules and potential scenarios:
  - ↘ When is the rent due?
  - ↘ Is the tenant responsible for utility payments?
  - ↘ What happens if the rent is late?
  - ↘ Where is it permissible to smoke?
  - ↘ What should the tenant do if the heat or electricity doesn't work? Is there on-site maintenance staff?
  - ↘ What are the visitor policies? Can a partner stay over? Can the tenant's child(ren) stay over? What is the maximum length of time a guest can stay?
  - ↘ What happens if the tenant damages something? Who pays for what?
  - ↘ What are the quiet hours? How can they minimize disturbances to their neighbors?
  - ↘ What does a sanitary living space look like, and what crosses the line into unsanitary conditions?
  - ↘ What are the parking rules for tenants and guests?
  - ↘ Are pets allowed? If so, are there any specific rules about having pets?
- → Speak openly and frankly about how to approach difficulties with neighbors, maintenance staff, and property owners. Use the Care Plan to help develop problem-solving and conflict-resolution skills.

Care Plans should provide a road map for how people can advocate for themselves and take responsibility in the case of a lease violation. Make sure people understand the consequences of lease violations while also reinforcing that they are capable and deserving of a safe, stable home.

"People who are grown adults have the right to self-direct, have the right to make their own choices. What we should be doing is informing them of the choices, of the pros, of the cons, of what could potentially happen if you went left, what could happen if you went right, and totally involving them in every aspect of the decision-making process." —Service Provider[42]

MANAGING FINANCES

Many people who are exiting homelessness have not had the opportunity to develop financial management skills. It is important to support the people you serve in developing financial literacy skills and to give them

time to practice, build confidence, and learn from mistakes. Care Plans should lay out steps people can take to learn how to understand and manage their own finances with confidence. These are areas to explore and support with those you serve:

- → Ask what financial assets or management skills they need to feel secure in their housing. Do they want to learn how to create and manage a budget? What resources or employment services are available to them to facilitate earning? Do they want or need to set up a system to pay their bills?
- → If they receive disability or mainstream benefits, do they have a designated payee to direct those funds? Would they appreciate having somebody to help manage their money?
- → When situations arise where people must make difficult decisions about which bills to prioritize, how do they want to handle it? What kind of support do they want and need?
- → If a person isn't in charge of their finances—for example, a family member handles their money or a designated payee manages SSI or SSDI benefits—what are the challenges and advantages?

"Life skills [support and development] are so important. Even if a person gets sober, it doesn't mean that they know how to call the utility to turn on their electricity or they know how to grocery shop. I think those essential things help because it also builds a person's confidence when they learn how to maintain their own home." —Peer Specialist and Harm Reduction Coordinator, Maryland[43]

CARING FOR THE HOME

People who are exiting homelessness may have had limited experience with housekeeping or household management. They may need time and support to develop skills to care for their new home and transform it into *their* home, a place that provides peace, safety, security, comfort, and familiarity. Care Plans can outline ways in which a person wishes to make their housing into a home, how they plan to care for it regularly, and how to acquire the skills to do so. Here are a couple of areas to explore:

- → What happens if they lose their keys or get locked out? Go over the procedure for being let into the building/unit and obtaining new keys.
- → Explore their experience with household chores, like dishwashing, trash removal, cleaning, or doing laundry. What supplies and tools do they need? Do they need support to develop these skills and competencies? What kind of help is available?
- → What happens when things break? What repairs are the tenant's responsibility, and what is taken care of by the landlord? Consider their level of comfort in contacting the appropriate person for needed repairs. How can they advocate for quality maintenance within a reasonable time frame? How do they handle after-hours emergencies, like plumbing or heating/cooling issues?

FACILITATING OUD SUPPORTS

Care plans should cover the individualized OUD supports a person needs to maintain housing stability and meet their personal goals. As discussed in a prior section, it is vital to ensure that the housing option is compatible with an individual's specific OUD needs based on where they are on the continuum of substance use, treatment, and recovery. Service providers should have open and frank conversations about substance use, harm reduction and overdose prevention, and recovery support services.

Some important topics to discuss and include in the care plan might include the following:

- Supporting MOUD treatment
  - Contact information for MOUD provider, clinic, or pharmacy
  - Transportation resources for ensuring uninterrupted access to care providers and medications
  - How to handle issues with prescriptions or insurance coverage
  - How and where to store medications safely to prevent theft
- Social support and recovery support
  - Contact information for friends, family, neighbors, and other forms of support, like peer-run warm lines
  - Identifying triggers and cravings and developing coping, self-care, and self-soothing skills that can help prevent recurrence of use
  - Offer connections to recovery coaches, recovery community centers, mutual aid groups, and other recovery supports
- Harm reduction and overdose prevention support
  - Having naloxone (Narcan®) on hand and how to replenish it
  - Where to get clean needles
  - "Never use alone" phone lines or resources
  - An individual's preferences in the event of an overdose or recurrence of use, including emergency contacts
  - Emergency contacts and phone numbers for crisis lines or emergency lines/resources

To learn more about harm reduction, see Toolkit Part 1, page 30.

"Recovery doesn't have an endpoint. It's an ongoing journey . . . . The good part is that this forces you to develop skills that allow you to keep moving forward in a spirit of hope." —Gloria Dickerson, Author, Trainer, and Person in Recovery[44]

TENANCY SUPPORT TO HELP PEOPLE THRIVE

Once someone settles and is stable in housing, it is valuable to invite them to imagine how they want to move forward in their lives. Questions you may want to ask include the following:

- → Now that you have been able to settle into your new home . . .
  - ↘ What are a few of your interests, hopes, and aspirations?
  - ↘ What activities and involvements would you want to pursue?
  - ↘ What makes you happy?
  - ↘ Are there health issues you'd like to address? How can I support you?
  - ↘ Are there recovery supports you'd like to learn more about or try?
  - ↘ What's most important to you in your life?
  - ↘ What would add contentment and joy to your life?
  - ↘ What would give you a sense of purpose and meaning?
  - ↘ What's something new you would like to learn?
  - ↘ What do you value in a relationship?
  - ↘ What kinds of relationships would you like to develop?
  - ↘ What skills would you like to develop?
  - ↘ What skills are helping you feel at home in housing?

Service providers might also suggest specific activities and opportunities, such as involving tenants in the management of a supportive housing project, providing work or volunteer opportunities in the building, or encouraging involvement in a tenant council or advisory group. You might want to encourage participation in the larger community, such as the following:

- ↘ Peer support groups or recovery community events and activities
- ↘ Special interest groups and clubs
- ↘ Education and advocacy efforts
- ↘ Playing sports
- ↘ Engaging in the arts
- ↘ Joining faith, ethnic identity, community, or civic groups

At the same time, "leaving people be," or simply listening and being there, is another way to provide support. It is important to remember this:

> "Empowerment also translates into tenants having control over lifestyle choices, even though they may conflict with the housing sponsor's preferences. Alcohol use and gambling, for example, are issues that can be challenging. Similarly, some tenants will prefer to have limited, if any, interaction with program staff or other tenants. In the final analysis, tenants are in their homes, and service providers are there to be supportive. Independence is expressed in many ways. Developing meaningful structures that empower tenants helps to ensure long-term success."[45]

WHEN HOUSING DOESN'T WORK OUT

Sometimes, housing doesn't work out for someone. Service providers may feel the frustration of going to great lengths to help someone find housing, only to see them turn around and leave after a few hours, days, or weeks. Rather than reflexively blaming the individual, we might consider how our support or preparation may have come up short.

Perhaps our own assumptions and expectations were out of sync with the person. Or they had little choice about the type or location of their assigned housing unit. Or the timing just wasn't right. When housing doesn't work out, we might also wonder whether the person was adequately prepared for this transition.

To what extent did we explore and address the person's hopes and fears regarding moving into housing, the type and location of housing, affordability, access to places and people significant to them, or feeling isolated or lonely? Did we explore the individual's concerns about their ability to successfully maintain housing? Is it possible the person felt rushed or pressured and thus felt that someone else made the decision for them? By reflecting on the situation and the larger structure context, we are better prepared to serve the next person.

SUPPORTING JUSTICE-INVOLVED PEOPLE

Justice-involved individuals often face additional barriers in accessing housing, increasing their risk of homelessness and recidivism.[46] People exiting incarceration are at a high risk of homelessness and opioid overdose. The two weeks after release are especially critical. During this period, those exiting incarceration are 129 times more likely to die of an overdose.[47] They may benefit from a range of support, especially support from peers with a history of justice involvement. Justice-involved individuals experience greater difficulty accessing public housing. For example, the housing authority will reject applications for the Housing Choice Voucher Program (Section 8) in these instances:[48]

- → If the person was convicted of manufacturing methamphetamine in federally assisted housing
- → If the applicant was registered as a lifetime sex offender in any state
- → If the person was convicted of a felony within the past five years; some housing authorities require 10 years

Justice-involved individuals might also be rejected from Housing Choice Vouchers on the grounds of drug-related crimes, violent crimes (note: the definition varies from state to state), or other crimes that could threaten the health, safety, or right to peaceful enjoyment of the building by other residents or employees.[49] Further, federal policies allow housing agencies to prohibit individuals who have histories of drug use or are considered at risk of engaging in illegal drug use from receiving assistance.[50]

There is room to advocate for justice-involved people who are experiencing these barriers. Conduct individualized assessments before determining that a particular criminal record disqualifies an applicant for housing. According to most housing authorities, these are relevant considerations:[51,52]

- → Nature and severity of the conviction(s)
- → Time passed since the crime occurred
- → Facts or circumstances surrounding the conduct
- → Age of the individual at the time of the conduct

- → Evidence of rehabilitation efforts
- → Evidence of the individual maintaining a good tenant history before or after the conviction

Another barrier that justice-involved individuals experience when trying to obtain housing is property owner reluctance. For a provider, building relationships with local property owners and encouraging them to engage with justice-involved applicants with an open mind and compassion can be critical work.

Some organizations and providers have created lists or databases of reentry-friendly property owners. Reach out to your networks to learn if these resources exist in your community. If they don't, consider starting one. Providers can also build relationships with organizations that help justice-involved individuals with expungements and pardons, which can expand justice-involved individuals' housing options.

"I love to speak with landlords knowing that they may have tried [housing justice-involved individuals] and gotten burnt. It is important to speak directly to them and engage them so that they can understand and take the chance." —Director, Transitional Housing for Women Exiting Incarceration[53]

HOUSING RIGHTS

Access to quality recovery housing can make a significant difference in the trajectory of an individual's recovery. It is imperative that supportive housing designed to meet the needs of people with substance use disorder be inclusive of all pathways to recovery, including MOUD. Myths and misinformation about MOUD often lead to housing discrimination.

To learn more about recovery housing and MOUD, see Toolkit Part 1, page 15.

People with OUD who are also members of historically and systematically marginalized groups, including Black, Latinx, LGBTQ+, and Indigenous people or those with disabilities, are at an even higher risk of experiencing housing discrimination. In fact, residential segregation, unfair and inequitable housing policies, and housing discrimination are major causes of homelessness, especially among Black Americans.

To learn more about racism and housing discrimination, see Toolkit Part 1, page 8.

The Americans with Disabilities Act (ADA) is a civil rights law put in place to protect people with disabilities in all areas of public and private life. ADA and the Fair Housing Act protect people diagnosed with OUD who are using MOUD as their treatment pathway from housing discrimination. ADA protects "persons addicted to drugs but who are no longer using drugs illegally and are receiving treatment for drug addiction or who have been rehabilitated successfully."[54]

The Fair Housing Act further prohibits housing discrimination based on "race, color, religion, sex, national origin, familial status, and disability."[55] Both laws apply to recovery homes and halfway houses. They stipulate that housing cannot be denied based on MOUD status and that reasonable accommodations must be provided for residents taking MOUD (for example, a safe place to store medication).

To deny someone participation in supportive housing based on the use of MOUD is illegal. If someone experiences housing discrimination because of their MOUD, they can file a complaint with the state agency that oversees substance use treatment and with HUD (within 180 days of the offense).[56]

LEARN MORE

Know Your Rights: Rights for Individuals on Medication-Assisted Treatment | SAMHSA [PDF]

Fair Housing and Housing for People with Disabilities | National Housing Law Project [HTML]

Racial Injustice in Housing and Homelessness in the United States | National Homelessness Law Center [PDF]

Fair Housing and Equal Opportunity | HUD [HTML]

Single State Agency for Substance Abuse Directory | National Association of State Alcohol and Drug Abuse Directors [HTML]

Supporting Basic Needs

A whole-person approach to supporting housing stability helps people who are newly housed connect with services and resources to meet their basic needs. In this section, we provide a brief overview of some of the most essential basic needs. While many of these services and resources are local and community-specific, we have included national resources and directories where applicable.

IDENTIFICATION DOCUMENTS

One of the most basic needs is obtaining identification documents, such as the following:

- → Social Security card
- → Birth certificate
- → State ID card or driver's license
- → Green Card or Permanent Resident Card
- → Certificate of Release or Discharge from Active Duty (DD214)

Many people experiencing homelessness lack these primary forms of identification, which are required to qualify or register for many services, including Medicaid, Social Security benefits, food stamps, or housing waiting lists. Not having identification documents can trap people in a cycle of homelessness and insecurity.

The process of obtaining identification documents varies by jurisdictions. Some states and cities have passed legislation to make it easier for people who are unhoused to obtain an ID card, whereas in other areas is more complicated. To obtain an ID card, one needs proof of identification, and there are fees associated with most forms of ID. Obtaining ID is becoming more difficult as many states implement REAL ID with more stringent documentation requirements across multiple categories. For example, one category requires a lease and W-2 Form or pay stub, documents that most people experiencing homelessness do not have.[57] Secure document storage is another need.

LEARN MORE

Helping Individuals Experiencing Homelessness Obtain Identification Documents | HHRC [HTML]

Without ID, Homeless Trapped in Vicious Cycle | Pew Charitable Trust [HTML]

The National Conversation about IDs [HTML]

Homeless ID Project (Arizona only) [HTML]

ACCESSING BENEFITS

Many people who are homeless and have OUD are eligible for federal or state benefits and entitlements that can help meet their basic needs, such as the following:

- → Temporary Assistance for Needy Families (TANF)
- → Supplemental Nutrition Assistance Program (SNAP), also known as food stamps
- → Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- → Supplemental Security Income (SSI)
- → Social Security Disability Insurance (SSDI)
- → Medicaid and Medicare

Disabling conditions may make it even harder for people to apply for and access the resources they need. People often need assistance understanding and verifying eligibility and applying for these programs. Therefore, ensuring people have benefits and navigation assistance is a critical step in preparing for housing and maintaining housing stability.

One important resource is the SSI/SSDI Outreach, Access, and Recovery (SOAR) program, which helps increase access to Social Security Administration disability benefits for eligible individuals (adults and children) experiencing or at risk of homelessness and who have a mental illness, medical impairment, or co-occurring substance use disorder. SOAR is designed to help overcome the barriers to qualifying for and receiving these benefits by providing comprehensive SSI/SSDI application assistance. Care coordinators can take the free SOAR Online Course to learn how to better support eligible adults and children.

People can start the disability application process for SSI/SSDI benefits without having identification documents.

LEARN MORE

SOAR

SOAR | SAMHSA [HTML]

SOAR Online Course Catalog | SAMHSA [HTML]

Social Security

People Experiencing Homelessness and Their Service Providers | Social Security Administration [HTML]

Temporary Assistance for Needy Families

TANF Programs by State | Administration for Children and Families [HTML]

Supplemental Nutrition Assistance Program

10 Myths and Facts About SNAP for Homeless Persons | USICH [PDF]

Supplemental Nutrition Assistance Program (SNAP) | USDA [HTML]

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) | USDA [HTML]

FOOD SECURITY

Be mindful of "food deserts" when placing someone in housing, and ensure that people have access to transportation or free meal delivery if needed. In addition to helping people sign up for SNAP or WIC benefits, connect them with local food security resources, such as food pantries, soup kitchens, community fridges, or food sharing programs. Seniors are eligible for Meals on Wheels, which operates more than 5,000 local programs. Children are eligible for free or reduced-cost school meals, after-school meal programs, or summer meal programs through the National School Lunch Program, which is typically administered through local school districts.

LEARN MORE

211: Finding Food | United Way [HTML]

Find Your Local Food Bank | Feeding America [HTML]

Find a Meals on Wheels Provider | Meals on Wheels [HTML]

Access to Food for Homeless or Highly Mobile Students | National Center for Homeless Education [PDF]

National School Lunch Program | USDA [HTML]

SUPPORTING FAMILIES WITH CHILDREN

Supporting the basic needs of families with children will take different forms depending on the children's ages; any special requirements; and the family's composition, situation, and dynamics. It is critical to build trust and rapport with family members and involve trained professionals, family, and peer support providers, as appropriate, to assess the individualized services and supports they may need. These services and supports might include the following:

- → Childcare
- → Head Start or school enrollment
- → School supplies and clothing
- → Developmentally appropriate therapy
- → Family therapy

- → Food assistance
- → Family or youth peer support or support groups
- → Support for caregivers, including kinship caregivers, grandparents, or others in this role
- → Legal assistance

School-aged children who are homeless or unstably housed are eligible for McKinney–Vento resources through their school district. Every local education agency is required to designate a staff person—known as a McKinney–Vento liaison—who coordinates services to ensure children who are homeless or unstably housed can succeed in school.

LEARN MORE

Parent Resources | National Center for Homeless Education [HTML]

Schoolhouse Connection Resources by Age (for children and youth experiencing homelessness) | Schoolhouse Connection [HTML]

Practice Improvement Tools: Practice Guides for Families (English and Spanish)| Early Childhood Technical Assistance Center [HTML]

Approaches to Supporting Families Affected by Opioid Use | SAMHSA [PDF]

Resources | National Federation of Families [HTML]

National Clearinghouse on Homeless Youth and Families | HHS [HTML]

SUPPORTING YOUTH AND YOUNG ADULTS

Unaccompanied youth and young adults need individualized, age-appropriate support to meet their basic needs. Often, this involves supporting them through transitions, such as from foster care to independence, from a youth-serving to an adult-serving behavioral health-care system, and from challenging family situations to living independently. Youth who identify as LGBTQ+ are overrepresented among youth who are experiencing homelessness and need support that is affirming of their identities.

Youth experiencing homelessness are especially vulnerable, and it is critical to build trust and provide youth-driven, individualized services and support. Youth peer support is especially valuable for engaging and supporting youth.

LEARN MORE

On Our Own: A Survival Guide for Independent LGBTQ Youth | True Colors United [HTML]

True Colors United [HTML]

A Guide for Youth: Understanding Trauma | Youth MOVE [PDF]

Ending Youth Homelessness Guidebook Series: Promising Program Models | HUD [PDF]

Pathways to Recovery: A Youth's Perspective | Changing the Conversation podcast [Podcast]

National Clearinghouse on Homeless Youth and Families | HHS [HTML]

COMMUNICATIONS

The COVID-19 pandemic showed that Internet access is a basic utility like electricity, heat, and water. Phone and Internet services are essential and help people in numerous ways:

- → Accessing health care
- → Staying safe
- → Finding resources
- → Applying for jobs, housing, and other benefits
- → Maintaining contact with friends and family

However, affordable broadband Internet access falls short in many communities, predominantly rural areas. In addition, people need access to devices and free charging stations to connect to the Internet. As well, pay phones are now rare in the era of smartphones.

If people meet income guidelines, receive certain benefits (such as SNAP, Medicaid, SSI), or live on tribal lands, they are eligible for Lifeline. Lifeline is a federal program that lowers the cost of phones, the Internet, or bundled services. The federal Affordable Connectivity program offers help with broadband service and Internet-connected devices for low-income families and individuals. States and municipalities may offer additional assistance for free or low-cost communications technology.

LEARN MORE

Smartphones Are the Smarter Way to Fight Homelessness | Invisible People [HTML]

Lifeline [HTML]

The Affordable Connectivity Program [HTML]

TRANSPORTATION

Helping people access transportation is fundamental to ensuring they can access health-care services, meet their basic needs, and participate in community and family life. Reliable transportation is especially critical for people who need to regularly visit clinics or doctor's offices for MOUD treatment. Those receiving methadone treatment need transportation that aligns with clinic hours. Transportation resources vary by community, and it is important to learn what options exist in your community. People who receive Medicaid benefits are eligible for nonemergency medical transportation to health-care appointments, including methadone clinic visits. However, requirements and services vary by state. Many health-care organizations offer free transportation through ride-sharing services. There may be special transportation services for older adults, people with disabilities, or Veterans. Recovery community organizations may also provide transportation help.

LEARN MORE

211: Transportation | United Way [HTML]

HEALTH CARE, BEHAVIORAL HEALTH CARE, DENTAL CARE

When people obtain housing, they may be in a better position to take care of other conditions, such as the following:

- → Physical health conditions
- → Behavioral health problems, including mental and substance use disorders
- → Dental care and oral health needs

It is important to help facilitate connections to these types of care but not to force people or require them to use it. Federally Qualified Health Centers offer services on a sliding fee scale. For those experiencing homelessness or who are low income, HCH projects specialize in *integrated care*, which typically means providing primary and behavioral health-care services in one location in combination with care coordination. Many HCHs also offer vision and oral health care.

LEARN MORE

Find a Federally Qualified Health Center | HRSA [HTML]

National Health Care for the Homeless Directory | National Health Care for the Homeless Council [HTML]

Behavioral Health Services for People Who Are Homeless | SAMHSA [PDF]

EMPLOYMENT AND EDUCATION

It is important to support people with their goals for employment, education, volunteer work, or other roles that afford purpose and meaning. For example, people may want to complete an interrupted education. Job training programs or social enterprises that hire formerly homeless individuals may be good options for those who have been out of the workforce. Local Department of Vocational Rehabilitation offices can assist those who have a disability. Some individuals may be eligible for Individual Placement and Support supported employment services. Resources vary by community, and there is a growing movement to build workplaces that support people in recovery.

LEARN MORE

How Health Care Providers Can Help Current and Former Patients Who Have Used Opioids Stay Employed | U.S. Equal Employment Opportunity Commission [HTML]

Finding Employment Services for People Experiencing Homelessness | SAMHSA SOAR TA Center [HTML]

Substance Use Disorders Recovery with a Focus on Employment and Education | SAMHSA [PDF]

Opioids At Work: Employer Toolkit | National Safety Council [PDF]

PETS

Pets are important members of the family and provide emotional support, affection, connection, and a sense of belonging and responsibility for people, regardless of their housing status. For people who are unhoused, being able to remain with their pets is a vital consideration. Therefore, it is important to support people in keeping and caring for their pets as they transition to housing. Consider supporting people to register their pet as emotional support animals. This can provide protection against housing discrimination for people who use an animal for assistance under the Fair Housing Act.[58] Animal shelters or community groups, such as the Southern Alliance for People and Animal Welfare, can help people care for their pets.

LEARN MORE

How to Register an Emotional Support Animal | The Spruce [HTML]

Southern Alliance for People and Animal Welfare | SAFPAW [HTML]

VI. Conclusion

> *"If I were training a new provider, I would emphasize the need for empathy, being compassionate, and also patience. When I was on opioids, you could not get through to me for a long time. The craving was just too strong for me to hear anybody. Even though I was losing everything, I just couldn't stop. I had people yelling at me constantly, telling me everything I was doing wrong. I think that if I had had people who had been more supportive, offering to get me help or resources, or just showing that they care, I could have gotten into recovery a lot sooner.*
>
> *As a provider, it's very easy to get frustrated, especially when people are not receptive to what you're saying or when their cravings are stronger than their desire to stop using. I think providers get frustrated because they think they're not getting through to people.*
>
> *But you just never know when it's going to be the day that someone hears you. And when it is that day, they'll say, 'Thank you for not leaving me and for continuing to work with me.' I've heard it a lot from other providers, and I have felt it as a provider. 'I'm not getting through to them. They're not hearing me. It is a waste of time.' But by continuing to just show up and be willing to help the person—it really does have an impact on them in the long run." —Danielle Moye, Service Provider and Person in Recovery from OUD, Florida*[59]

We hope you will continue to show up for those who you serve with compassion, patience, and empathy. The work you do matters deeply.

We hope this toolkit will be helpful to you as you integrate whole-person approaches and practices in your work supporting people with OUD who are experiencing homelessness. Please share and discuss these ideas and resources with your colleagues and other service providers in your community. We encourage you to stay connected with the Homeless and Housing Resource Center and explore the additional resources, online training, and toolkits available on the website.

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