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Homeless Response System Integration of Recovery Housing and Recovery Frameworks

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HOMELESS & HOUSING RESOURCE CENTER

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Contents

Disclaimer

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Introduction

Welcome to *Homeless Response System Integration of Recovery Housing and Recovery Frameworks*. This resource is designed to support homeless response system (HRS) leaders in understanding, engaging, and integrating recovery housing and recovery-oriented frameworks into local homeless response efforts. It is intended to guide collaboration between Continuums of Care (CoCs), coordinated entry leads, local governments, shelters, outreach teams, housing navigators, behavioral health partners, recovery housing providers, peers and peer-led organizations, and recovery community organizations.

The cornerstone of this resource is a simple truth: People who are homeless or unstably housed often also navigate substance use, mental health challenges or serious and persistent mental illness, or co-occurring conditions. These conditions can lead to, or be exacerbated by, parallel experiences of trauma, justice involvement, social isolation, medical needs, and limited access to income or employment. This reality necessitates that HRS leaders have a fundamental understanding of recovery housing and recovery supports to ensure they are visible, available, and meaningfully included among local housing and service options.

It is important to recognize that this guide is neither a stand-alone recovery housing manual nor a primer on all behavioral health services. Rather, it is a practical guide for HRS leaders who want to better understand where recovery housing, recovery community organizations, peer support, and recovery-oriented systems of care fit within homeless response. It builds on the understanding that recovery housing is part of a broader housing and support continuum; integrating recovery frameworks does not replace supportive housing, shelter, or other housing models. This guide offers opportunities for HRS leaders to expand choice; strengthen referral pathways; build partnerships with recovery providers; and support people in ways that reflect their goals, needs, and preferred pathways toward a unified vision of stability and recovery.

Recovery as a Framework for Stability

> Homeless response system leaders need to know what recovery is and what it is not. Not everyone who is [homeless] meets the recovery housing criteria; it is very individualized and nuanced."
>
> —Oklahoma-based recovery housing partner

Recovery housing leaders express that before homeless response systems can effectively integrate recovery housing, they need a shared understanding of recovery itself. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery as "a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential."[1] For people who are homeless or unstably housed, recovery may include substance use recovery, mental health recovery, trauma healing, family reunification, reconnection with community, employment, education, spiritual support, or rebuilding daily routines and relationships. SAMHSA's recovery framework is described in four dimensions: Health, Home, Purpose, and Community. These dimensions are especially relevant for HRS because housing stability is recognized as one of the conditions that helps make recovery more possible.

What Is a Recovery-Oriented System of Care?

A **recovery-oriented system of care**, or ROSC, is a values-driven, person-centered, and recovery-oriented network of intentionally aligned services, supports, systems, and partnerships across community, state, and federal levels. In a homeless response context, ROSC is a framework for organizing care and support around recovery, choice, connection, and system continuity. This means helping people access housing, behavioral health care, recovery supports, peer supports, treatment, recovery housing, and community resources in ways that reflect their goals and preferred pathways.

In HRS generally, and this guide specifically, ROSC offers a foundational framework for strengthening community-based supports that promote health and wellness across various systems. ROSC's focus on coordinated systems is reflected throughout this guide as fundamental to making it easier for people to move across services and between systems without losing support.

Housing as a Recovery Support

In SAMHSA's dimensions of recovery framework, home means having a safe, stable, and supportive place to live.[2] HRS leaders already recognize that housing is critical to reducing crisis, helping people reconnect with services, supporting medication and treatment routines, and creating the stability needed to focus on life and recovery goals. Recovery housing is one option within this dimension, but it is not the only one; supportive housing, rapid rehousing, affordable housing, family housing, transitional housing, and other models may also support recovery, depending on a person's goals, needs, and preferences.

Stable housing should be understood as a leading functional recovery support because it creates a strong foundation from which people can address health needs, build routines, pursue employment or education, reconnect with community, and make choices about their future.[3] For many, the absence of housing makes recovery harder to sustain. This factor underscores the importance of HRS leaders recognizing that housing can support recovery and that different people may need different housing environments to stabilize and thrive.

What Is Recovery Capital?

Recovery capital refers to the internal and external resources that help a person begin, sustain, or strengthen recovery. These may include safe housing, health care, peer support, community connection, supportive relationships, income, employment, transportation, and hope.

Homelessness can reduce recovery capital by disrupting safety, stability, relationships, and access to care. HRS partners can help restore recovery capital by connecting people to housing, supports, resources, and relationships that align with their goals.

Multiple Pathways and Person-Centered Choice

The strongest recovery frameworks recognize that people define recovery differently. A recovery-oriented HRS recognizes that there are multiple pathways to recovery. Whereas some may prefer and pursue abstinence-based recovery, others may use medications to support the treatment of a substance use or opioid use disorder. Recovery options often include treatment, peer support, mutual aid, faith-based support, and recovery community organizations. Housing stability in recovery may include both securing housing and focusing on wellness, safety, reunification, employment, or crisis resolution.

Recovery is a person-centered approach to wellness and healing; it means that HRS partners do not impose a single definition of recovery or assume that one housing model is the right fit for everyone. Instead, HRS leaders can create opportunities for people to understand their options, name their preferences, ask questions, and choose supports that align with their goals.

> "Housing supports having basic needs met. Having basic needs met is essential to helping people [sustain] recovery."
>
> —Oklahoma-based recovery housing partner

ADDITIONAL RESOURCES

- SAMHSA's "Working Definition of Recovery"
- SAMHSA's "Housing Supports Recovery and Well-Being: Definitions and Shared Values"
- Faces & Voices of Recovery, "Recovery Capital: Its Role in Sustaining Recovery"

Recovery Housing in the Housing Continuum

SAMHSA defines recovery housing as "safe, healthy, family-like, substance-free living environments that support individuals in recovery from addiction."[4] Sometimes referred to as recovery residences, sober homes, or sober living, recovery housing is grounded in a social model of recovery, which means the residential setting intentionally cultivates community, connection, and peer relationships with a focus on shared accountability and actively linking residents to community-based support services.[5]

HRS leaders should understand that recovery housing is primarily a supportive living environment, and peer support, shared expectations, and a recovery framework are important. This meaning situates recovery housing as one option within a broader continuum.

> "Just because someone wants housing, doesn't mean someone wants to be sober or access mental health services. [We need] to give people the tools that they need to succeed so that their victories are their own."
>
> —Oklahoma-based recovery housing partner

How Recovery Housing Differs from Other Housing Models

In recent years, recovery housing leaders and behavioral health services have worked to enhance partnerships with HRS and CoCs. Leaders have emphasized the importance of understanding the difference between recovery housing and other housing models as a first step toward sustainable partnerships and enhanced services to those being served.

Recovery housing differs from other housing models in terms of its purpose, culture, expectations, and support structure. Emergency shelter is designed to provide immediate temporary safety. Transitional housing provides time-limited housing with services to support movement toward more permanent housing. Permanent supportive housing combines permanent housing with voluntary supportive services for people with significant service needs. Residential treatment provides clinical treatment in a structured setting. Recovery housing is designed for people desiring a living environment that actively supports their recovery.

It is important for HRS leaders to understand these differences to ensure meaningful referrals and warm handoffs are made in an informed, productive way. Because recovery housing relies on shared living and recovery principles, HRS partners should develop a basic understanding of the model and its principles to support informed choice for people considering this option as part of their care and healing journey.

Avoiding One-Size-Fits-All Referrals

Recovery housing is often an appropriate fit for people who want a substance-free, peer-supported living environment. However, it may not be the right fit for every person who is homeless or unstably housed. HRS leaders should not use recovery housing as an automatic referral simply because someone has a substance-use history or needs housing.

> "It's not about micromanaging their methods. When you micromanage someone's methods, you're responsible for the results."
>
> —Oklahoma-based recovery housing partner

Avoiding one-size-fits-all referrals means ensuring referral conversations are person-centered and explore a person's individual goals, preferences, and support needs. It also means respecting multiple pathways to recovery while avoiding the assumption that one is more valid than another. When recovery housing is not the right fit, HRS leaders can help the person identify other housing and recovery-supportive options. A person should not lose access to housing assistance because they decline or are not accepted into a recovery home, because they use prescribed medications, they return to use, or they need a different level of support. Strong integration of recovery housing and recovery principles into homeless care systems and networks requires clear referral and reconnection pathways that help people move between recovery housing, coordinated entry, shelters, treatment, peer support, and other housing options without falling out of the system or between transitional cracks.

ADDITIONAL RESOURCES

- HHRC, "Recovery Housing: Expanding Access and Supporting Choice"
- HUD Exchange, "Recovery Housing Program Models Quick Guide"
- SAMHSA's "Best Practices for Recovery Housing"

Building Recovery-Oriented Partnerships Across Homeless Response and Behavioral Health Systems

Many people who access homeless services are also navigating behavioral health challenges and concerns, histories of trauma, chronic health conditions, justice system involvement, social isolation, and financial instability. Behavioral health providers regularly serve individuals who are unstably housed, at risk of eviction, living unsheltered, transitioning frequently between institutions, in temporary living situations, or in community settings. These overlaps in need show us that these experiences rarely occur in isolation. However, individuals often move between systems that were not designed to coordinate with one another. Challenges related to wellness, stability, and community connection often overlap between systems. Simply securing housing or engaging with a behavioral health provider is clearly not enough to offer the strongest supports to participants on their own. Rather, maintaining housing, navigating systems, and rebuilding stability frequently require ongoing behavioral health and recovery support and vice versa. When these connections are not integrated, systems can unintentionally create barriers through independent operations.

The Importance of HRS and Behavioral Health Partnerships

Historically, HRS and behavioral health systems (BHS) have operated in parallel rather than in partnership. In many communities, coordination has relied heavily on referral-based relationships, in which one provider identifies a need and directs an individual to another organization for support. Unfortunately, reliance on referrals has been recognized as a largely insufficient framework for people navigating complex behavioral health, housing, medical, and social needs and systems, resulting in the risk of higher rates of disconnection from essential supports.[6]

Traditional referral models can unintentionally place the burden of coordination on the person receiving services. People are left to independently schedule appointments, manage transportation, complete multiple intake processes, retell traumatic experiences, and navigate differing expectations across systems.[7] For those already experiencing crisis, trauma, behavioral health concerns or challenges, or housing instability, these barriers can lead to disengagement or unmet needs. Rather than continuing with the traditional referral model, many organizations are moving toward more coordinated partnership models emphasizing shared responsibility, collaborative problem-solving, and ongoing communication between providers.

Bringing Recovery and Behavioral Health Partners to the Table

Recovery-oriented partnerships work best when behavioral health providers, recovery housing operators, recovery community organizations, peer-led organizations, and people with lived and living experiences are included in planning. Recovery and behavioral health partners can help HRS leaders better understand local recovery pathways, service gaps, eligibility barriers, medication-related considerations, peer support resources, and policies or procedures that may unintentionally limit choice. HRS leaders can strengthen system integration by inviting these partners into meaningful CoC membership, coordinated entry planning, case conferencing, housing inventory discussions, policy review, training, and other partnership efforts. These conversations should clarify partner roles, how their expertise will influence practice, and where each may need the support of other agencies or organizations at the partner table.

Meaningful partnership and participation require more than simply attendance. They also require clear roles, meaningful engagement, and practical influence so that involvement moves beyond tokenization toward valued participation in system design, implementation, and improvement.

> "This should not feel novel. This type of partnership represents a major paradigm shift."
>
> —Arizona-based shelter service and behavioral health partnership

Building Strong Relationships to Integrate Recovery into HRS

When working to establish partnerships and reduce silos between homeless resource services and BHSs, consider the following:

- → Identify local behavioral health support organizations, recovery housing providers, recovery community organizations (RCOs), peer-run organizations (POs), treatment providers, and state recovery housing affiliates.
- → Invite partners and providers into conversations and coordination processes.
- → Develop shared orientation sessions between HRS and behavioral health and recovery providers.
- → Establish points of contact for referrals, questions, and urgent coordination.
- → Create shared processes to coordinate entry or reentry into options across the continuum and supports that meet shifting or co-occurring needs.
- → Build regular communication structures so partners are not trying to solve problems for the first time during a crisis.

ADDITIONAL RESOURCES

- SAMHSA, "Behavioral Health Services for People Who Are Homeless" (TIP 55)

Centering Peer Support and Lived Expertise

Organizations with established partnerships between HRS and BHS consistently identify peer support and lived expertise as among the most effective tools to build trust, increase engagement, and strengthen long-term connections across systems. Individuals who are homeless and are navigating behavioral health challenges, institutionalization, or justice involvement may carry deep mistrust of systems due to past experiences of stigma, exclusion, coercion, or fragmented care.

> "Peer support is the ability to say, 'I've been here, and this doesn't have to be the rest of your life'."
>
> —Minnesota-based peer support service provider

Peer support workers help bridge these trust gaps by bringing personal understanding, credibility, and relational connection that traditional systems may struggle to establish on their own, making lived and living experience a critical form of expertise.[8]

Terms like "peer," "person with lived and living experience or expertise," or "peer support specialist" are often used interchangeably, and each role plays an important part in expanding opportunities for connection when serving people who are homeless or have behavioral health challenges. However, each represents a distinct role in behavioral health and homelessness support:

A **peer** in both homelessness and behavioral health support is commonly defined as an individual who shares similar life experiences with the people and populations with whom they work, often without professional training.[9] Peers share backgrounds with those they work alongside, offering a sense of relatability with the struggles others may face.

A **person with lived and living experience (PWLLE)** is someone who has been directly affected by a condition or situation and thus has personal knowledge, awareness, and understanding of homelessness, mental health or substance use conditions, and recovery.[10] PWLLEs often serve voluntarily to offer advocacy, empathy, guidance, and insight.[11]

SAMHSA defines a **peer support specialist** as a person with lived or living experience who has completed state- or agency-administered training and credentialing to provide specialized, nonclinical, community-based support services. Peer support specialists often use their experiences to bridge gaps between clinical staff and participants.

The Value of Lived and Living Experience

People with lived and living experience bring forms of knowledge that cannot easily be replicated through formal education or training. Peer professionals offer strong benefits for the partnered work of HRS and BHS organizations:

- → Strong relationship-building skills rooted in shared experience.
- → Insights into the lived realities of homelessness, recovery, and trauma.
- → The ability to recognize early signs of disengagement, decompensation, or crisis.
- → Deep understanding of system navigation barriers.
- → Practical knowledge of community resources and survival strategies.
- → The ability to communicate across both communities and systems.

Peers often serve as "translators" between systems and the people navigating them. This translation helps individuals better understand complex systems while also helping systems better understand the experiences and needs of the people they serve.

The lived and living experiences of peers also support bridging trust gaps. Many people who engage with systems have learned through experience to distrust those systems that have stigmatized, institutionalized, or criminalized them or failed to support them effectively. Some people may avoid disclosing important information during assessments or intake meetings because they fear that honesty could jeopardize their access to critical resources. Peer support workers can help reduce these fears by explaining processes transparently, helping individuals prepare for assessments, accompanying people to appointments, clarifying rights and expectations, and creating emotionally safer environments for disclosure and engagement. This strong, relationship-based approach allows individuals to engage at their own pace rather than feeling pressured into compliance-oriented systems.

Peer Roles Across the Continuum

Outreach and Initial Engagement	System Navigation and Coordination	Engagement and Retention
• Conducting street outreach. • Building rapport in shelters and day centers. • Supporting initial conversations about services. • Reducing fear and mistrust during first contact. • Helping individuals identify goals and priorities.	• Accompanying participants to appointments. • Supporting service (housing, behavioral health) navigation. • Preparing people for assessments. • Connecting people to resources. • Coordinating transportation. • Supporting communication between systems.	• Maintaining consistent relationships. • Supporting reengagement after setbacks. • Encouraging connection to treatment/recovery supports. • Helping individuals navigate retention challenges (housing, behavioral health support services). • Reinforcing hope and self-determination.

Embedding Peers Within Cross-System Teams

Peer support is often most effective when peers are fully integrated into cross-system teams rather than positioned as peripheral or symbolic supports. Examples include embedding peer specialists in shelters, offering peer-run outreach and navigation programs, and ensuring that peer staff participate in coordinated care discussions. Partnered organizations often see stronger relationships and increased engagement among participants when peer specialists are employed alongside clinicians in behavioral health organizations, and peers are integrated into day-to-day operations within HRSs. The benefits of embedded peers within cross-system teams are numerous:

- → Increased trust and engagement.
- → Stronger communication with participants.
- → Greater understanding of community realities.
- → Reduced stigma within organizations and systems.
- → Improved continuity of support across systems.

ADDITIONAL RESOURCES

- SAMHSA, "Peer Support Workers for Those in Recovery"
- SAMHSA, "Peer Support Specialists: A Growing Mental Health and Addiction Workforce"
- SAMHSA, "What Are Peer Recovery Support Services?"
- HHRC, "Expanding Peer Support Roles in Homeless Services Delivery"

Care Coordination and Cross-System Alignment

Aligning homelessness resources, BHSs, and recovery frameworks creates meaningful pathways to successful recovery, housing security, and ongoing support. The following recommendations provide actionable guidance for cultivating relationships and partnerships across systems to support alignment in meeting an individual's needs.

Timely connection. Timely access to support is one of the most important components of successful alignment and partnership. Delayed engagement can lead to missed opportunities to connect individuals with housing, treatment, crisis support, and other essential services. Cross-staffing or colocation of staff increases opportunities for informal, immediate engagement. Peer specialists and outreach workers are empowered to build strong relationships; accompany participants to appointments; assist with assessments; and generally reduce fear, mistrust, and disengagement.

> "[Our teams] work in lockstep through recognition that [we] can address parallel challenges together . . . [Our providers] rotate in colocation to support coordination of care and provision of crisis and general care."
>
> —Arizona-based behavioral health agency

Continuous communication. Ongoing communication is one of the strongest predictors of successful partnerships between service organizations and systems. Alignment and meaningful partnerships depend on regular, transparent communication between organizations, including leadership teams and frontline staff. Partners can engage both formal and informal communication strategies that support coordination while maintaining confidentiality protections. Examples include shared releases of information, memorandums of understanding, regular check-ins between providers, shared crisis communication pathways, and defined communication expectations. Communication protocols should clarify what information can be shared, when communication should occur, who should be included, how to escalate urgent concerns, and what consent processes are necessary or required. It is important to recognize that communication challenges are inevitable, particularly in complex systems and environments with staff turnover, limited resources, and high-acuity needs. Maintaining honesty and flexibility between partner organizations is critical to ensure that challenges can be addressed collaboratively rather than becoming sources of conflict or blame.

> "Having honesty with another organization keeps things progressing without feeling 'shame' for hiccups . . . Creating connections [opens] pathways to clear, quick communications."
>
> —Arizona-based shelter service and behavioral health partnership

Warm handoffs and co-navigation. Warm handoffs and co-navigation are another essential tool for reducing disconnection when navigating systems or disengagement during transitions between systems. Examples include coordinated introductions between providers, peer accompaniment to appointments and

during assessments, joint outreach visits, follow-up after referrals or discharges, and colocating staff across service locations. This collaborative approach helps reduce fear and uncertainty, missed appointments, confusion between systems, and loss of engagement during transitions.

> "A lot of this work started as street outreach [and] building personal relationships. Everybody here was looking for something to hold on to . . . any glimmer of hope for a solution."
>
> —Oklahoma-based recovery housing provider

ADDITIONAL RESOURCES

- National Alliance to End Homelessness, "The Role of Outreach and Engagement in Ending Homelessness"

Increasing Accessibility Across Systems

Accessibility within systems is not limited to physical access or service availability. It also includes how systems are equipped to respond to people's readiness, histories, communication styles, personal backgrounds, and lived realities. It is critical for partnered organizations to reduce barriers, increase flexibility, and design systems that support engagement without expecting participants to navigate overly complex or rigid processes on their own.

Meeting people at different levels of readiness. Readiness for change, engagement, treatment, housing, and other services offered by HRS and BHS providers is not linear. People engage differently over time based on personal history, trauma, symptoms, safety concerns, prior system experiences, changing life circumstances, and more. It is important to create intentional, flexible engagement models that allow people to do the following:

- → Connect at their own pace, choosing when, how, and for how long they engage.
- → Cycle naturally through different stages of engagement over time.
- → Experience repeated connections and reengagement as needed.
- → Engage freely without punitive responses to missed appointments, setbacks, relapse, or periods of disengagement.

> "You can see the relief in the client's face when you say . . . 'I'm here to support you, no matter what you do'."
>
> —Washington-based faith-based coalition and homeless service provider

Designing systems that adapt to people. It is important for HRS and BHS partnerships to move away from systems that expect people to adapt to rigid structures and toward systems designed to respond flexibly to human needs and circumstances. Time has shown that traditional service models can unintentionally create barriers to care through the following:

- → Strict appointment timelines.
- → Complicated intake procedures.
- → Repeated documentation requirements.
- → Limited service hours.
- → Transportation expectations.
- → Fragmented communications between providers.
- → Punitive responses to missed appointments or noncompliance.

Accessibility increases when systems meet people where they are, physically, emotionally, and relationally. This process may look like embedding behavioral health staff within shelters and supportive housing settings. Some organizations offer same-day intake and triage processes. Others offer virtual service options in rural areas or areas with limited transit options, utilizing a framework that calls on them to go to people rather than requiring people to come to their sites for service. Generally, systems can adapt to offer flexible, informal engagement approaches that support people at their unique stages of readiness and provide greater access to support and services as needed.

Reducing Barriers

Documentation, intake, and access. Intake and documentation processes are among the most common barriers across both homeless response and behavioral health systems. People are often required to complete multiple assessments, provide repetitive information or disclosures, or navigate conflicting eligibility requirements

between systems. Organizations can engage in shared release of information processes, supported by memorandums of understanding between agencies, to minimize duplication and clarify processes. They can also coordinate case conferencing, engage in joint triage meetings, offer flexible intake pacing, provide warm handoffs between providers, and share communication protocols. Systems should communicate transparently about what information is needed, what confidentiality protections exist, and how information will be used, to avoid participants avoiding disclosure due to fear of losing access to opportunities and support.

Identifying common access challenges. Recurring barriers to engagement across both HRS and BHS programs include transportation limitations, geographic service gaps, long wait times, and limited access to technology. Organizations must navigate limited staffing capacity and fragmented communications. Participants may navigate stigma and distrust of systems, fear of institutionalization or criminalization, and difficulty navigating multiple systems simultaneously. These barriers often compound one another, creating greater challenges in accessing critical support. Stigma itself often functions as a major barrier to access.

Practical strategies for flexibility. Organizations use many practical strategies to increase flexibility and accessibility within their programs and shared supports, and they may assess their operational capacity and partnerships to determine which strategies work best for them. A few strategies are as follows:

- → Colocated services
- → Embedded clinicians/peer specialists
- → Flexible scheduling
- → Informal engagement opportunities
- → Joint staffing and case conferencing
- → Multi-session assessments
- → Open-door/drop-in engagement models
- → Ongoing opportunities to reengage after missed appointments/setbacks
- → Outreach-based services
- → Same-day access models
- → Virtual/hybrid service options
- → Warm handoffs between systems

As organizations partner to reduce barriers to support, it is important to remember that flexibility is not a lowering of standards or expectations. Rather, it offers a way to recognize the realities people may face as they build pathways toward stability, safety, and wellness.

Coordinating Prevention and Early Intervention

HRS and BHS do not operate in isolation from other community systems. Effective prevention and early intervention often require coordination across systems (e.g., justice and reentry, hospitals, child welfare, public health agencies, law enforcement, schools, community-based recovery organizations, peer organizations). Coordination and partnership across organizations and systems improves coordination of care and helps organizations identify opportunities for early intervention. Prevention efforts are often most effective when systems intervene before crises escalate.

Organizations have several opportunities for early connection and intervention before crises escalate:

- → Outreach before housing loss occurs.
- → Hospital and jail discharge planning.
- → Early behavioral health engagement within shelters.
- → Rapid connection to peer support.
- → Coordinated follow-ups after emergency or crisis interventions.

Partnerships should be built on a foundation of relationship-building and trust; these aspects are often more critical to success than formal systems alone. Peer support, outreach, and low-barrier engagement models are critical tools for creating opportunities for connection before situations escalate.

Strengthening Continuity Across Transitions

Entry points. People may enter HRS or BHS through multiple pathways. It is important to create community across these entry points to avoid repeated disruptions, duplicated assessments, or disconnected care plans. The colocation of staff and coordination of communications are effective tools for improving continuity during system entry. Such continuity supports crisis response, builds relationships, and supports ongoing coordination across staff.

Transitions across systems. Transitions are among the highest-risk moments for disengagement or crisis escalation. It is important to coordinate across transitions to ensure ongoing support and reduce risk. Transitions are most successful when organizations coordinate proactively rather than expecting people to navigate next steps independently. Strategies to support transitions include warm handoffs, joint care planning, and shared releases of information. Ongoing communication between providers is critical, as is peer accompaniment and navigation through transitions. Transitions are also supported and strengthened through coordinated outreach after discharge or missed appointments within services and support agencies.

Preventing drop-off in service engagement. Participant disengagement is often less about unwillingness to participate in programs or services and more about systems failing to maintain connection during periods of instability, crisis, and transition. It is important to intentionally design systems that allow people to reconnect after missed appointments, setbacks, or periods of disengagement without shame or punishment. Continuity is strengthened when providers maintain relationships over time, rather than viewing engagement as transactional or contingent upon perfect participation or immediate progress. HRS and BHS programs can build relationships that follow the person through any system or phase of life. Focusing on the continuity of relationships, rather than that of singular programs or services, supports long-term engagement, recovery, and stability.

ADDITIONAL RESOURCES

- Homeless and Housing Resource Center, "Supporting Transitions of Care from Institutions"

Recovery Community Organizations and Peer-Led Supports

RCOs, POs, and peer support networks play an important role in bridging services and systems to build recovery-oriented homeless response systems. Although these organizations often look different across communities, each shares a common focus on lived experiences, cultivating connections, offering recovery support, and fostering community-based belonging.[12]

Recovery community organizations are typically nonprofit, community-based organizations led by people in recovery, family members, allies, and community members. RCOs often provide nonclinical recovery support services, such as peer recovery coaching, recovery education, support groups, community events, leadership development, system navigation support, family support, and connections to housing and other resources.[13] Because they are primarily community-based rather than taking a more clinical or treatment approach, they often help people build recovery capital and sustain recovery beyond a single program or housing placement.

Peer-run organizations are led and staffed by people with lived and living experiences of mental health, substance use, recovery, homelessness, or other systems.[14] POs provide peer support, wellness planning, advocacy, community education, and systems-change leadership. They model self-determination, mutuality, respect, and recovery leadership, offering tangible supports that make resources and engagement across systems and services more accessible.

Peer support networks are typically formal or informal groups of peer specialists, recovery coaches, mutual aid groups, recovery leaders, or community members who help people stay connected to support. These networks are especially important for those who are not currently engaged in treatment, who have had negative experiences with formal systems, or who need to establish deeper and more personal connections before they feel ready to accept other services.[15]

> "[Peers] do a lot of translation between institution speak and human speak."
> —North Carolina-based peer-run organization

RCOs, POs, and peer support networks are particularly effective in building trust with people who have experienced stigma or institutionalization and supporting long-term engagement and belonging. People are often more willing to engage when support comes from someone who understands recovery, homelessness, or system navigation through shared or similar lived experiences. They also help people understand and choose among supportive pathways, including treatment, housing options, medications, mutual aid, family support, and other community resources, from a peer-based perspective. The peers and support networks offered by these organizations can foster long-term engagement and belonging after an immediate crisis has passed or during transitions between housing placements.[16]

These organizations also help bridge communication gaps between systems and offer continuity beyond short-term crisis interventions. Peer-run and recovery organizations offer strong supports for warm handoffs, appointment accompaniment, service-option explanations, follow-ups, and reengagement. They also help expand recovery and other supports beyond traditional environments.[17] For these reasons, HRS leaders are encouraged to involve RCOs and peer-led organizations at every level of service and support planning and development. Below are examples of meaningful partnerships with RCOs and peer organizations or peer-led systems:

- → HRS and BHS can embed peer specialists within their shelters or outreach teams.
- → Organizations can engage recovery coaches to support housing transitions.
- → HRS can integrate peer-led support groups within shelters or supportive housing settings.
- → HRS and BHS organizations can ensure peers are available to offer navigation and accompaniment services, recovery education, and outreach and reengagement support after a crisis or disengagement.

Additional Models for Cross-System Partnerships

Alignment between homeless response and behavioral health systems can take many forms depending on community size, available resources, organizational capacity, and local needs. Effective partnerships can be developed through a range of formal and informal coordination approaches. The most successful partnerships are those that build clear pathways for communication, engagement, and support while recognizing the differing expertise and responsibilities of each organization.

Referral partnerships. Partnerships often begin with, and are strengthened by, intentional referral relationships between homeless response organizations and behavioral health providers. Clear, relationship-driven referral pathways improve access to care and help reduce system fragmentation. Referrals are most effective when they include warm handoffs, direct communication between providers, and follow-up after connection attempts. Below are examples of tangible referral partnerships to support participant care:

- → HRS team members can partner with behavioral health providers to directly connect participants across their services.
- → BHS organizations can prioritize appointments for people referred through homeless response systems.
- → HRS and BHS programs can partner to provide direct referral pathways to substance use treatment and recovery services.
- → HRS and BHS programs can coordinate referrals to peer support and recovery community organizations.

Joint case work and coordinated service planning. HRS and BHS programs are increasingly engaging in partnerships built around ongoing coordination between systems. These partnerships may involve shared planning, collaborative problem-solving, and coordinated engagement strategies. Programs maintain their distinct organizational roles while coordinating efforts in key areas to strengthen cross-system support. Coordinated case planning reduces duplication, strengthens continuity, and improves communications while ensuring people do not need to independently navigate disconnected systems. Below are examples of joint case work and service coordination that support cohesive, ongoing participant care:

- → HRS and BHS may partner for weekly name-by-name meetings.
- → Organizations may hold joint triage meetings involving multiple agencies.
- → Organizations may engage in collaborative crisis response planning.
- → Organizations can commit to coordinated outreach and engagement, with ongoing communications between shelter staff, care coordinators, clinicians, and peer specialists.

> "Having everyone in the same call or meeting saves time [and] coordinates answers."
>
> —Oklahoma CCBHC and recovery housing provider

Colocated and embedded staff and services. As previously discussed, colocation or embedding of behavioral health staff, peer specialists, or outreach teams within partner response settings aligns them directly with those settings. Colocation increases timely access to support, informal relationship-building opportunities, and communication between providers. For participants, colocation supports crisis response coordination, continuity across transitions, and trust and engagement among program and service participants. Below are examples of effective colocation practices:

- → Behavioral health clinicians providing services within shelters and supportive housing sites.
- → Peer specialists embedded in outreach or navigation teams.
- → Mobile behavioral health support connected to homeless response programs.
- → Colocated crisis response staff or joint staffing models during high-need shelter hours.

Referral Pathways

Rather than maintaining referral lists, which simply tell someone where to call, develop referral pathways, which help participants understand options, make choices, and build and maintain connections. Core elements of effective referral pathways include the following:

- Plain-language explanations of options
- Consent-based information sharing
- Warm introductions and handoffs
- Peer accompaniment where possible
- Shared releases of information as appropriate
- Clear timelines and follow-up expectations
- Transportation planning
- Consideration of alternatives
- Planning for reconnection to coordinated entry
- Supportive, nonpunitive reengagement after disengagement or setbacks

ADDITIONAL RESOURCES

- National Alliance to End Homelessness, "Emergency Shelter: Reimagining a Housing-Focused Place People Want to Use" [Webinar]
- Center for Health Care Strategies, "Street Medicine and Outreach: Bringing Care to People Where They Are"
- HUD's Office of Policy Development and Research (PD&R), "Strategies for Improving Homeless People's Access to Mainstream Benefits and Services"

Conclusion: Implementation Road Map for HRS Leaders

Integrating recovery housing and recovery frameworks into homeless response systems is one way to expand choice and strengthen partnerships on the path to home, healing, and recovery. When recovery housing, frameworks, and principles are braided into the continuum of care, people have a better chance of finding the supports that reflect their goals, meet their needs, and support their recovery journey.

HRS leaders desiring to build stronger relationships and integrate recovery frameworks into their practice can consider these steps to strengthen awareness and connection:

- **Build internal recovery literacy.** HRS staff should be trained on recovery housing; recovery community organizations; peer support; recovery frameworks; medications for opioid use disorder; and the differences between treatment, recovery housing, and other housing models.
- **Map the local recovery ecosystem.** Team members can collaborate to identify recovery housing providers, formal and informal recovery networks, RCOs, and other potential partners who are missing from the support services table.
- **Bring partners together.** Invite partners into the CoC, coordinated entry processes, case conferences, planning, and policy review, and prioritize relationship-building before designing new workflows or processes.
- **Integrate recovery choice in coordinated entry.** Review assessment questions, referral workflows, and other processes to ensure that recovery housing is made visible and offered as an option when it aligns with a person's goals.
- **Develop partnered referral and reconnection pathways.** Coordinate to create clear referral, warm handoff, follow-up, and reentry processes as individuals transition between or reengage with different options and systems.
- **Integrate peer support.** Embed peers and peer specialists in outreach, shelter, navigation, coordinated entry, transition, and retention roles, ensuring that they have clear roles, support, supervision, and an engaged voice in decision-making and policymaking.
- **Align infrastructure.** Identify gaps in funding, resources, programs, documentation, peer navigation, supports, transportation, and so forth, to clarify what each partner can support and backfill gaps as much as possible with current or new partnerships.
- **Ensure consistent communication.** Track processes, progress, successes, and lessons learned, communicating with regularity, clarity, consistency, and transparency to grow and strengthen partnerships with trust and shared responsibility over time.

> "Never try to do everything yourself."
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> —Indiana-based homeless street outreach program

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