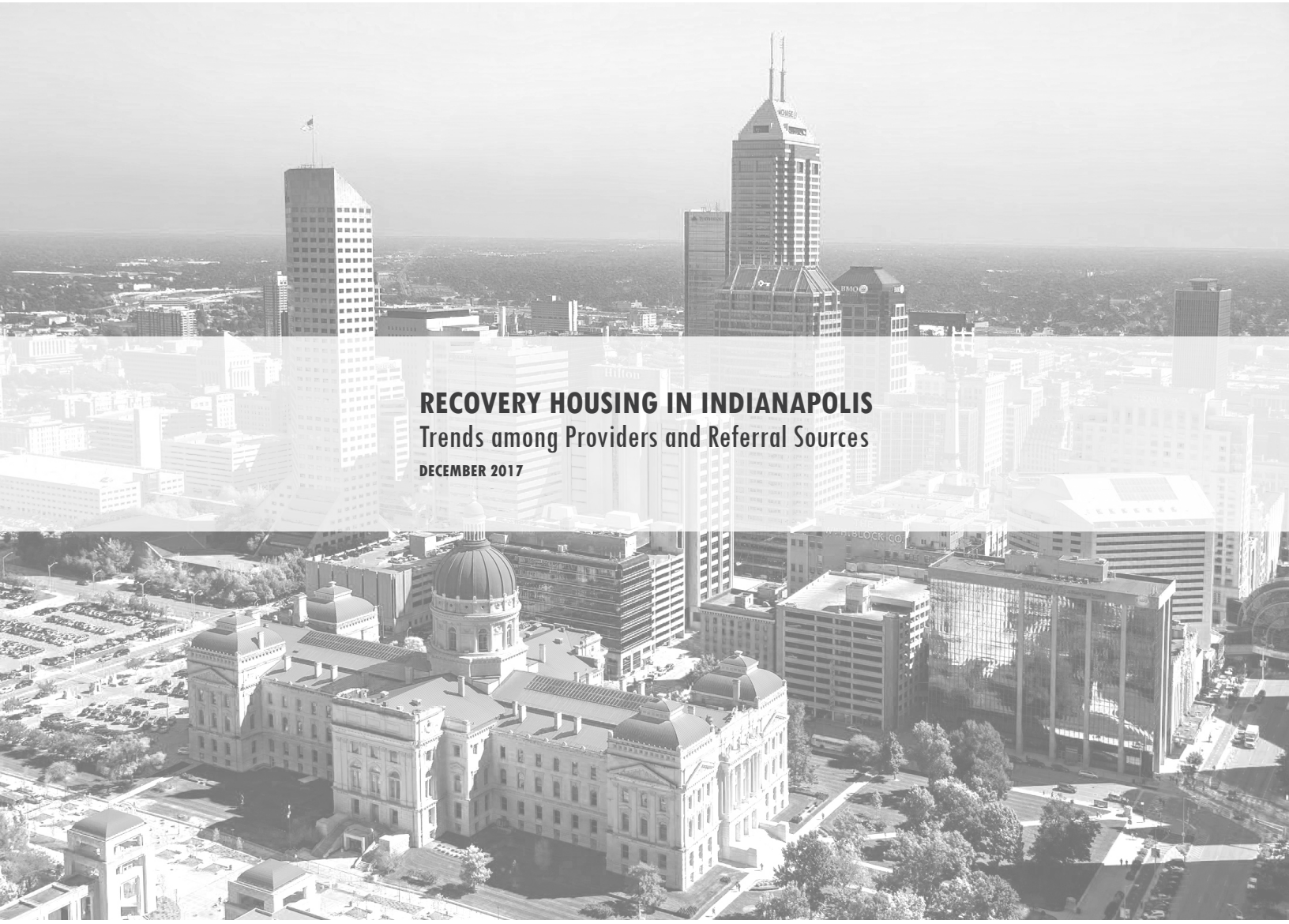

RECOVERY HOUSING IN INDIANAPOLIS

Trends among Providers and Referral Sources

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BACKGROUND & RECOVERY HOUSING DEFINITION

HUD defines recovery housing as "housing in an abstinence-focused and peer-supported community for people recovering from substance use issues." These programs help individuals recover from substance use and abuse by building community through activity participation among residents, havinge many staff members who are in recovery, and support individual choice in participating in the programming. Specifically, similar models are effective at obtaining housing stability for individuals with substance abuse disorders and chronic homelessness.

Recovery Housing programs differ from residential treatment programs, which typically include a medical component, 24-hour supervision, mandatory services, and a highly structured environment over a relatively short period of time (usually around 90 days).

In December 2015, HUD issued a policy brief regarding recovery housing programs.[1] The brief provided guidelines for how local Continuums of Care can incorporate transitional recovery housing programs into their strategies to address homelessness. HUD maintained an emphasis on Housing First and Permanent Supportive Housing as best practices for addressing homelessness; but HUD largely focused on the importance of transitional recovery housing models for some individuals who face both homelessness and substance use issues. By providing a variety of housing options, individuals experiencing homelessness and those who work with them can identify ideal ways in which they receive long-term growth that extends past sobriety, and helps remove barriers to promote self-sufficiency.

Through the policy brief, HUD encouraged each CoC to examine the current inventory of recovery housing, demand for such housing, expressed preferences of people being served, performance of all programs to determine the appropriate mix of housing options and to ensure the most effective use of resources, and providing meaningful choice to people experiencing homelessness with substance use disorders who are in all stages of recovery.

It is within this context that CHIP contracted with the IU Public Policy Institute (PPI) to investigate the number and characteristics of recovery housing programs in Indianapolis, and how those programs fit into the broader community of homeless service providers within the Indianapolis Continuum of Care . All but a few survey respondents among both providers and referral sources considered themselves to be a part of the Continuum of Care, suggesting that the findings would be particularly relevant to almost all of the organizations discussed.

The following report examines how the current inventory of recovery housing programs follows the guidelines identified by the HUD policy brief, and identifies key areas for growth to improve the strength of Indianapolis' network of housing options for those experiencing homelessness.

The report is structured to identify the extent to which Indianapolis complies with HUD-recommended structures related to recovery housing programs. Each section notes one or more HUD recommendations identified in its Recovery Housing Brief, as well as survey responses that generally reflect how well Indianapolis programs comply. When appropriate, the report also identifies relevant research that supports HUD's recommendations or survey responses.

1. *https://www.hudexchange.info/resources/documents/Recovery-Housing-Policy-Brief.pdf*

METHODOLOGY

To understand the range of recovery housing options in Indianapolis, PPI created and distributed two surveys to a) organizations that provide recovery housing and b) homeless-serving organizations that are likely to make referrals to recovery housing, respectively. The goal was to identify the extent to which local recovery housing programs complied with HUD recommendations, and to understand the preferences and referral processes that homeless-serving organization consider to be most important.

The programs were identified by using an existing list of providers identified as providing recovery housing, as well as additional web searches and recommendations from other providers. Of the providers who completed the survey, most of the individuals responding to questions identified themselves as administrative staff within the organization.

PPI researchers sent the survey for recovery housing providers to 28 programs in the Indianapolis area, 12 of which had staff members who completed the survey questions (a 43 percent response rate). From the research team's observations, some providers to whom the survey was sent may no longer be in operation. It is also possible that some programs may not have identified with the definition of recovery housing, and thus selected not to complete the survey.

The survey designed for referral sources was completed by 21 individuals representing 16 different agencies in the community who work with individuals experiencing homelessness. Individuals and organizations were selected to receive this survey based on membership in Professional Blended Street Outreach (PBSO), receipt of an Emergency Solutions Grant, or other membership in the Continuum of Care. The individuals completing this survey were primarily engaged in direct service provision. A full list of recovery housing providers and referral sources contacted by PPI is provided in Appendix A.

In order to further assess the role of recovery housing trends in Indianapolis and clarify the context in which recovery housing providers work, the research team also utilized information from HMIS ' ClientTrack system, when appropriate. The team aimed to identify trends among individuals who might be eligible for recovery housing services, including those who present with substance abuse-related issues. Both the client trends and survey responses helped highlight several key issues in Indy's recovery housing environment.

KEY FINDINGS

Areas in which recovery housing providers aligned with HUD recommendations:

- Indianapolis recovery housing providers generally report minimal barriers to program entry related to income requirements or convictions.
- Most providers do not have sobriety requirements for residents.
- Most providers and referral sources allow clients to initiate interest in recovery housing.
- All but one provider reported using evidence-based programming.
- All but one provider evicts clients only if they substantially disrupt the welfare of the recovery community.
- Most providers highly emphasize respecting residents' privacy, safety, building a sense of community, and developing meaning and purpose in their lives.
- If a client is discharged from the program, most providers refer clients to other residential treatment options, or housing options that use harm-reduction practices.
- Eighty percent of providers reported that more than half of their staff are in recovery, and 90 percent reported that recently graduated residents are given an opportunity for employment within the recovery program.

Areas in which recovery housing providers did not fully align with HUD recommendations:

- Though not all local recovery providers are funded by CoC or ESG, seventeen percent of recovery housing respondents reported that all clients had experienced homelessness. HUD recommends that clients participating in CoC or ESG-funded programs should have experienced homelessness.
- None of the recovery housing providers surveyed provide services to families with children, though only a few exist in Indianapolis.
- Few recovery housing providers reported being licensed or accredited.
- Half of respondents identified relapse as a reason for evicting clients.
- Nearly half of respondents reported not requiring a lease or occupancy agreement for housing.
- Providers reported that an average of about a third of clients do not leave their programs with stable housing.
- Providers may lack consistent performance measures across sites.

OPPORTUNITIES FOR GROWTH

- A service gap exists between the number of beds available among recovery housing providers relative to the number of clients in need of recovery housing services. This gap suggests a need for additional beds.
- Referral providers were concerned about a lack of detox facilities, long wait times for enrollment, and program cost to participate.
- Faith-based programming prompted both positive and negative perceptions among referral sources. Understanding how to best maximize strengths and reduce weaknesses of these organizations may be helpful.
- The use of evidence-based practices is not a determining factor for many referral sources, regarding whether they should refer clients to a recovery housing provider.
- Discrepancies may exist between referral sources and providers' perceptions of case management services and understanding service quality, as case management was not perceived to exist among providers that offered it.
- Responding providers did not provide programs targeting youth (individuals under age 25), for whom addictions recovery is increasingly important.
- Most providers did not emphasize clients' maintenance of physical health, which may present an opportunity to integrate additional wellness components among recovery housing programs.
- Local convening of recovery housing providers may provide an opportunity to create clarity of expectations among providers, as well as organizations that refer clients to them. Such relationships may also create an opportunity to develop and maintain programmatic consistency, expectations, and performance outcomes; as well as the development of a common performance measurement system.

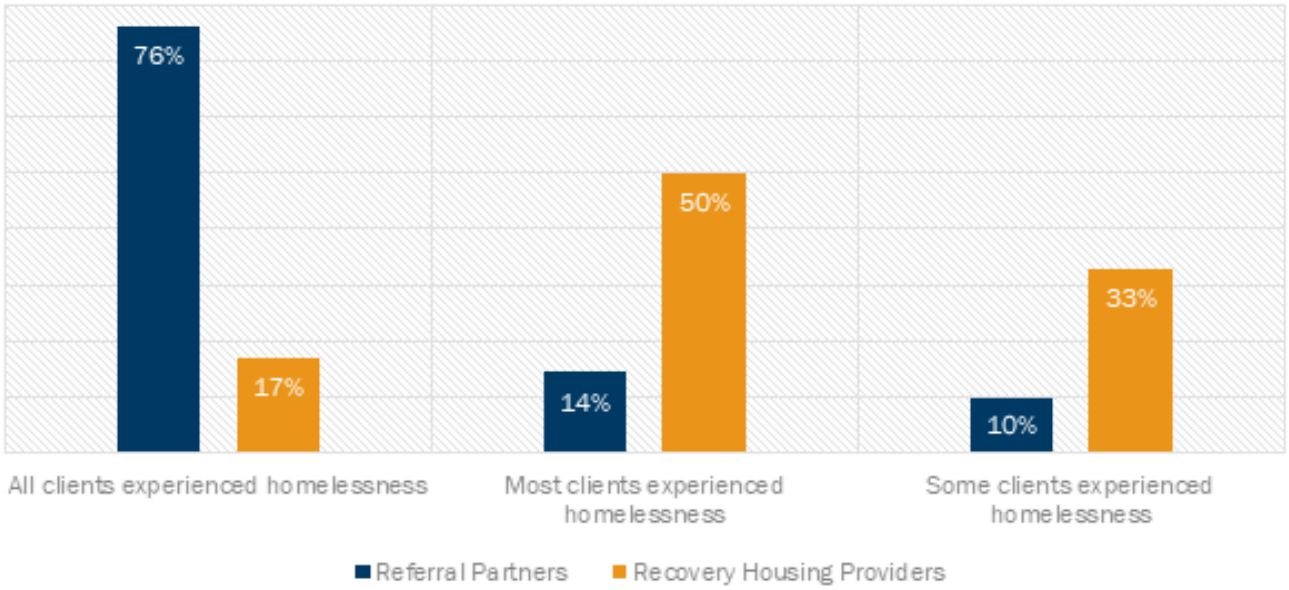
RECOVERY HOUSING CLIENTELE

HOMELESSNESS AMONG CLIENTS

HUD Recommendation: Residents entering CoC and ESG funded programs must be homeless according to HUD's homeless definition to determine the appropriate mix of housing options and to ensure the most effective use of resources, and provided meaningful choice to people experiencing homelessness with substance use disorders who are in all stages of recovery.

Both recovery housing providers and referral sources were asked about the proportion of their clients who experience homelessness. Among recovery housing providers, only 17 percent report that all clients have experienced homelessness, though half report that most clients have. Among referral sources, over three-quarter of respondents report that all their clients have experienced homelessness prior to being assisted. These differences suggest that most housing providers responding to the survey do not solely serve the homeless, per HUD's suggestion.

FIGURE 1. Reported proportion of clients experiencing homelessness



SERVICE DEMOGRAPHICS

HUD Recommendation: Programs serving families with children have an appropriate range of services for all members of such households and are partnering with mainstream systems, including TANF, child welfare systems, that serve families with children.

Both recovery housing providers and referral sources were asked about the proportion of their clients who experience homelessness. Among recovery housing providers, only 17 percent report that all clients have experienced homelessness, though half report that most clients have. Among referral sources, over three-quarter of respondents report that all their clients have experienced homelessness prior to being assisted. These differences suggest that most housing providers responding to the survey do not solely serve the homeless, per HUD's suggestion.

The 12 recovery housing providers that participated in the survey represent a total of 571 beds, with 289 of those specifically for men and 107 for women. Additionally, 175 beds were provided by Hoosier Veterans Assistance Foundation (HVAF) to both men and women who are veterans.

Comparing respondents with the number of individuals who may be eligible for recovery housing programs, numbers suggest that an opportunity exists for additional recovery housing. Among individuals enrolled in ClientTrack with a substance use disorder, two-thirds are male, a quarter female, and fewer than 10 are transgender. For all projects excluding permanent supportive housing and rapid rehousing, the same breakdown exists by gender. Although the survey did not account for beds specifically for transgender

individuals, four of the 12 recovery housing programs indicated that they provide services to the LGBTQ community. It is unclear whether transgender residents are specifically included in those providers' clientele. These numbers are reflective of survey data that indicated a substantial gap between the availability of recovery housing programs and the need for them, as was observed in survey responses by referral sources. One individual commented:

"There are simply not enough recovery programs…There is always a long waiting list if you are able to find a program."

FIGURE 2. Clientele served among recovery housing providers and referral sources

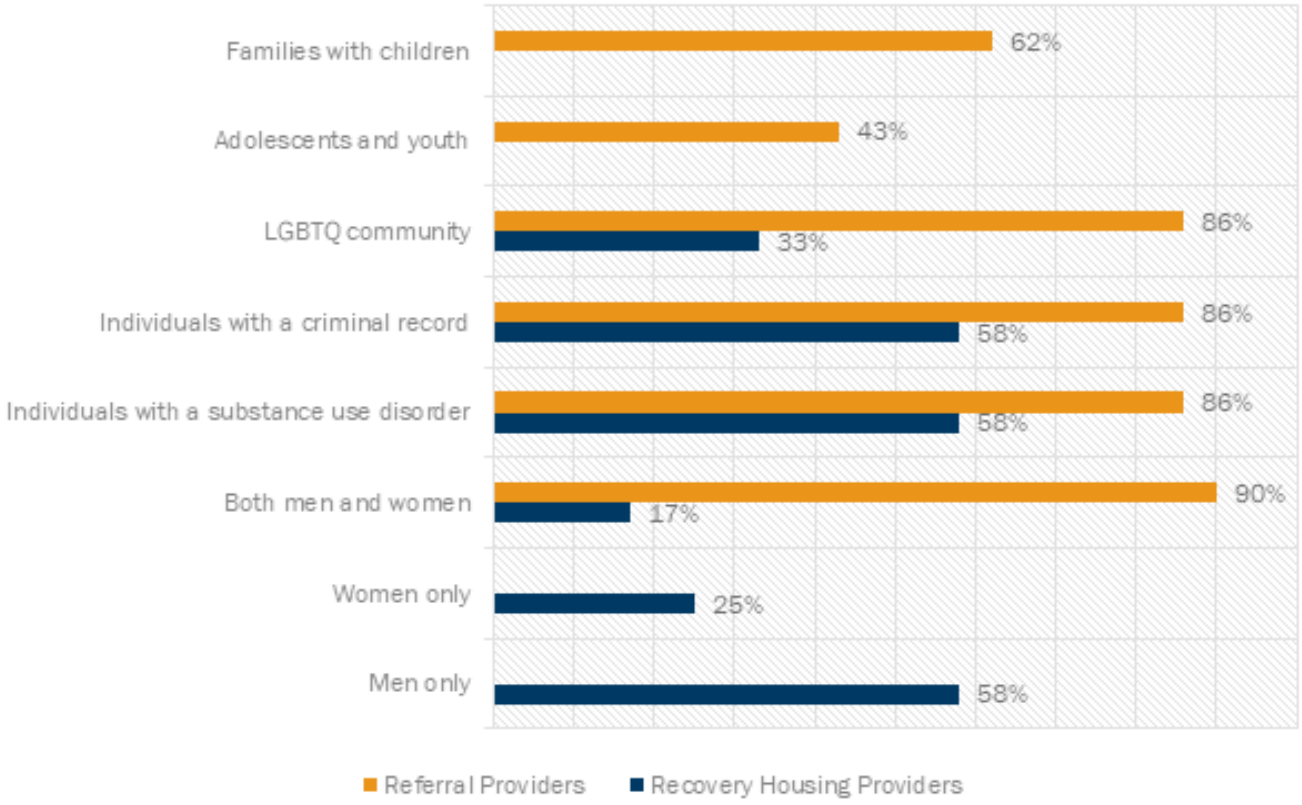


Figure 2 shows that a gap exists between the types of clients served by recovery housing providers compared to organizations that provide referrals. Specifically, referral providers responding to the survey tend to serve adolescents, youth, and families with children in addition to those with a substance use disorder or criminal record. An additional gap identified by referral sources working with families experiencing homelessness was a lack of recovery housing programs that provide services to families with children. None of the recovery housing providers that responded to the survey accept families with children.

Based on 2017 data provided by CHIP, there are currently 134 families with minor children where the head of household has an identified substance use disorder. Excluding permanent supportive housing and rapid rehousing projects, there are 84 households meeting that criteria. Given the number of families that

might meet family recovery housing criteria in Indianapolis, identifying best practices for existing or future providers is important.

Previous studies have found multiple examples of effective substance abuse treatment among homeless mothers. Successful programs provided residential placement and participation in a community that allowed them to receive needed therapies.[2] One program consisted of homeless substance abusing mothers who were primary caretakers of their children.[3] This program provided housing, services, and community housing programs. Participants who also received rental and utility assistance, case management, and substance abuse counseling decreased their alcohol use and improved their housing stability. Another program with a similar approach found reductions in substance use, homelessness, and mental health issues, as well as improved relational skills with their children.[4]

Multiple referral sources identified a need for recovery housing programs with particular expertise in dually diagnosed and/or disabled individuals. One referral source identified multiple relevant services missing in Indianapolis' recovery housing community:

> *"Dual Diagnosis Program; Educated, experienced, trained service providers that understand mental illness and other disabling conditions; willingness to coordinate care with service providers…"*

This gap in services could contribute to the referral sources' identification of one barrier to accessing services: program requirements that interfere with either client obligations or client medical and mental health treatment. One recovery housing provider was identified that specializes in dually diagnosed individuals, but it was among the providers that did not complete the survey, and was not reflected in the information analyzed for this survey.

Researchers have identified effective dual diagnosis programs as taking comprehensive, long-term approaches for recovery. These programs should also provide motivational interventions, provide supports to improve life skills among clients, and operate using cultural competence.[5] Homeless clients in dual diagnosis programs that used a housing first approach remained stably housed while improving their mental health and substance abuse issues.[6]

2. *Smith, E. M., North, C. S., & Fox, L. W. (1996). Eighteen-month follow-up data on a treatment program for homeless substance abusing mothers. Journal of Addictive Diseases, 14(4), 57-72.*
3. *Slesnick, N., & Erdem, G. (2013). Efficacy of Ecologically-Based Treatment with Substance-Abusing Homeless Mothers: Substance Use and Housing Outcomes. J Subst Abuse Treat, 45(5), 416-425.*
4. *Slesnick, N., & Erdem, G. (2012). Intervention for homeless, substance abusing mothers: Findings from a non-randomized pilot. Behavioral Medicine, 38(2), 36-48.*
5. *Drake, R. E., Essock, S. M., Shaner, A., Carey, K. B., Minkoff, K., Kola, L. & Rickards, L. (2001). Implementing dual diagnosis services for clients with severe mental illness. Psychiatric services, 52(4), 469-476.*
6. *Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. American journal of public health, 94(4), 651-656*

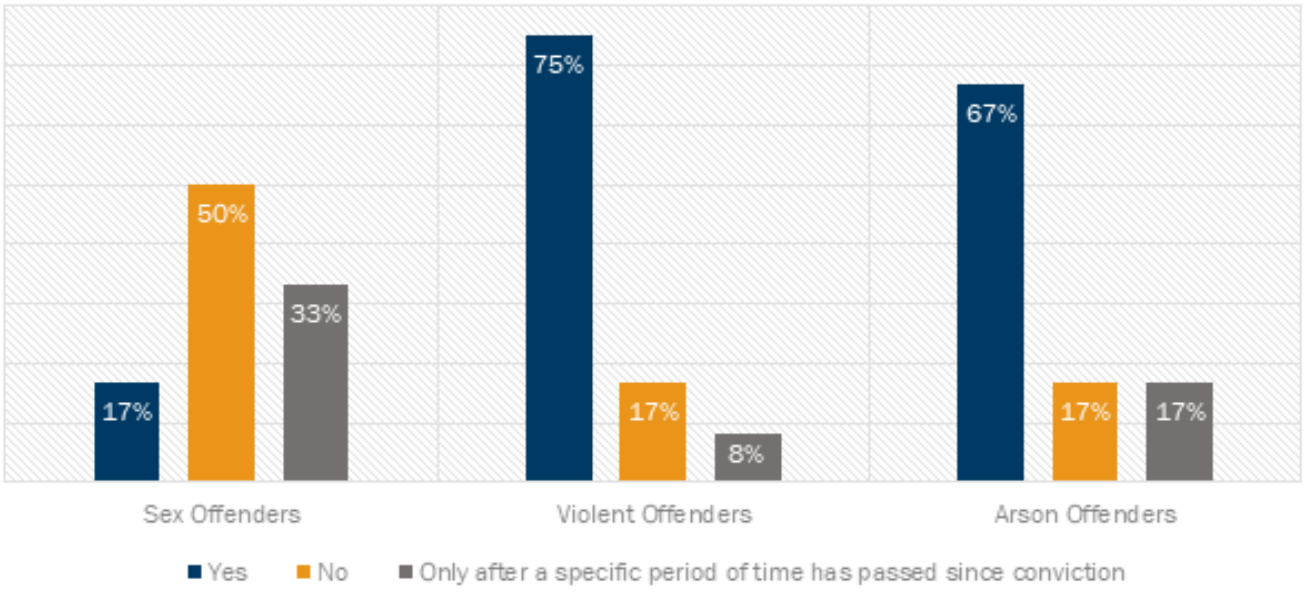
PROGRAM STRUCTURE

BARRIERS TO PARTICIPATING IN RECOVERY HOUSING

HUD Recommendation: There should be minimal barriers to entry into programs, so that long periods of sobriety, income requirements, clean criminal records, or clear eviction histories are not required for program entry.

Current recovery housing providers are already aligned relatively well with this HUD recommendation. Of the 12 respondents, no providers reported income requirements nor clear eviction histories as prerequisite for program entry; however, variation existed related to prior offenses and sobriety.

FIGURE 3. Program eligibility based on criminal history



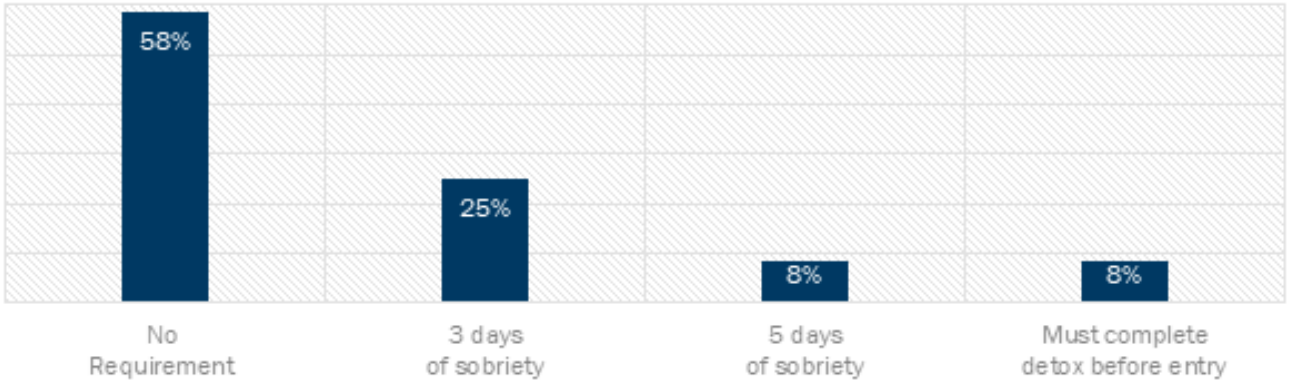
Providers indicated that they all accept individuals with felony and misdemeanor convictions into their program. However, several programs limit entry for individuals with specific types of offenses. Most providers indicated that individuals with violent offenses or arson-related offenses would be eligible for their program. However, substantial differences existed in serving individuals with sex offenses. Only two providers indicated that those with sex offenses would be eligible for their programs; half of providers indicated that individuals with sex offenses would only be eligible after a period of time passed since conviction; and a third of providers noted that individuals with sex offenses were ineligible for their program. This trend mirrors the

barriers to any type of housing faced by sex offenders. Housing barriers for sex offenders is often beyond the control of individual providers, as sex offenders may face restrictions on where they live (i.e. distance from schools or other places where children congregate).

Housing Availability

Of note is that between the two providers who indicated that sex offenders retain eligibility, there are 47 beds available to men and 56 beds available to women. For providers who open eligibility to sex offenders after a certain amount of time since conviction, there are 136 total beds available to men and 13 total beds available to women.

FIGURE 4. Sobriety requirements among recovery housing providers

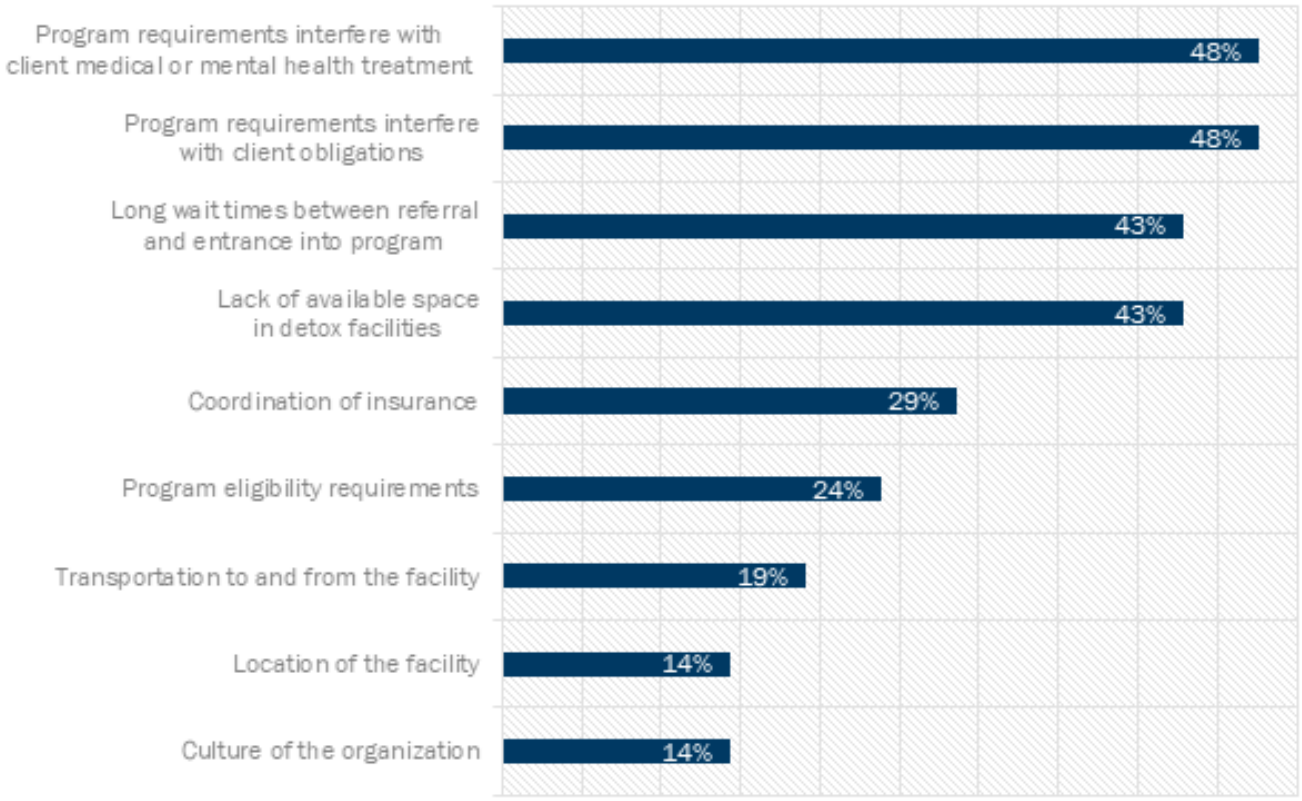


Indianapolis recovery housing providers are also in line with HUD guidance discouraging providers from requiring long periods of sobriety before entry into recovery housing programs. Most do not require a specific time period of sobriety before program entry. Of those remaining, one requires applicants to the program to complete detox before entry, another requires five days of sobriety before program entry, and three programs require three days of sobriety before entry.

In addition to HUD recommendations, referral sources participating in the study identified additional barriers to successful program participation for their clients who sought entry into recovery housing programs. The primary barriers identified by referral sources were program requirements that interfere with client obligations (such as work, family); or that the program prevents clients from receiving medical and mental health treatment by discontinuing their medications or treatments. Additional barriers included cost, lack of available space in recovery housing programs, lack of available space in detox facilities, and long wait times between referral and entrance into program.

These findings are also reflected in referral sources' open-ended responses. When asked about what factors would lead a referral source to feel uncomfortable making a referral, cost was mentioned on four occasions. In addition to concerns related to program quality, such as lack of professional support and a generally poor reputation among referral sources, there was a conflict about the extent to which organizations should be faith-based and serve clients. Specifically, concerns existed about clients being "required" to join a church affiliated with the provider. Conversely, one respondent indicated that not being a faith-based organization

FIGURE 5. Barriers to program participation identified by referral sources



would prevent them from referring clients. Respondents also noted that clients have reported substance use among other recovery housing residents, which would inhibit their own recovery. Those concerns support HUD's notions of the importance of self-initiation into such housing.

TABLE 1. Factors that prevent referrals to recovery housing programs

ISSUE	NUMBER OF TIMES MENTIONED
Cost/Out-of-Pocket Costs	4
Bad reputation/Poor reviews	3
Being a faith-based organization	2
Client concerns about drug use/lack of sobriety in the facility	2
Lack of professional support (i.e. case managers) for the clients	2
Long wait lists	1
Program does understand nor work with persons with dual diagnoses	1
Not being a faith-based organization	1

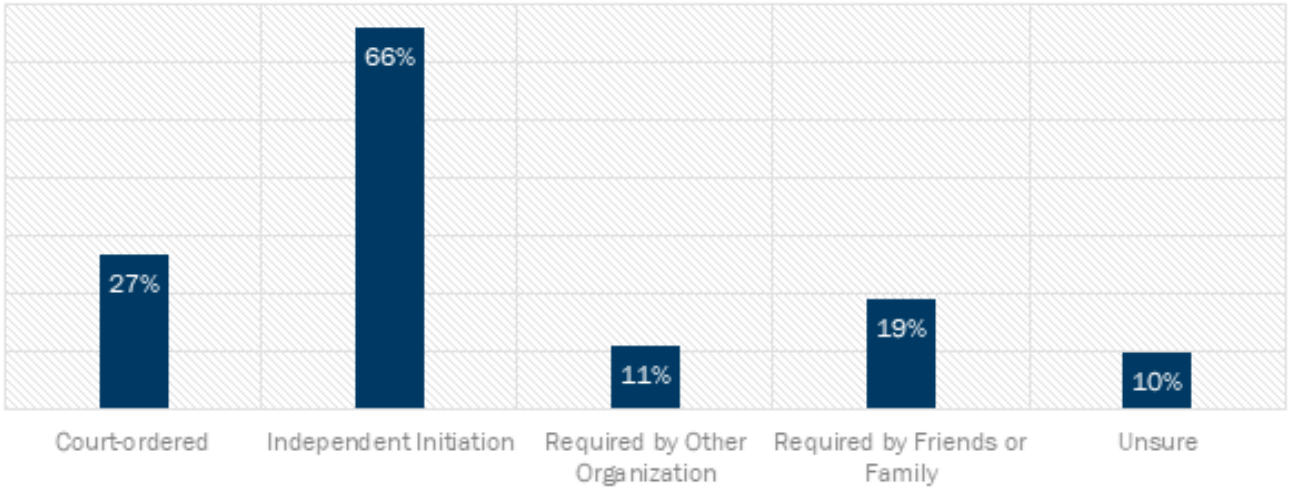
Two recovery housing providers representing a total of 275 beds reported that they do not charge any fee to residents in their program. One of these providers was HVAF, so those beds would be limited to veterans and not available to the general population seeking recovery housing programs. Most providers charge a weekly fee ranging from $75 to $190, with some providers charging an upfront fee as well.

SELF-INITIATED PROGRAM PARTICIPATION

HUD Recommendation: Program participation is self-initiated (there may be exceptions for court ordered participation) and residents have expressed a preference for living in a housing setting targeted to people in recovery with an abstinence focus.

In the policy brief, HUD emphasizes that recovery housing programs should be voluntary, and free from coercion or restraint. It emphasizes that choice should be provided, especially if a resident has expressed a preference for abstinence-focused housing settings. HUD strongly suggests CoC-funded projects support self-initiation as it indicates their personal commitment to sobriety and housing recovery, which suggests a greater likelihood of obtaining these long-term goals.

FIGURE 6. Client initiation into recovery housing: Provider responses



In the survey administered to recovery housing providers, respondents were asked to estimate the percentage of individual participants in their programs who were independently initiating participation compared to those who were being required to participate. Figure 6 shows the average proportion of those clients among provider responses. Survey respondents estimated anywhere from 0 to 50 percent of their participants as being court-ordered to participate. Providers reported a much higher level of participants—ranging from

28 to 100 percent—independently initiating participation in recovery housing. However, providers also reported up to 39 percent of their residents as being required to participate in recovery housing by friends, family members, or another social service program.

Of the 16 referral sources who responded to the question, "Which of the following situations best describe how you typically determine whether to refer a client to a recovery housing program?", most indicated a response in line with HUD guidance of "when a client initiates interest in a recovery housing program." Five providers indicated that they make referrals "when (they) and/or other staff members know it is in the client's best interest to enter a recovery housing program," and one provider indicated they make referrals in instances where the client is "required and/or court-ordered to participate in a recovery housing program." As this question allowed for multiple responses to be selected, there is some overlap represented in the number of referral sources responding in each category. Generally, compared with providers, most clients appear to self-initiate participation.

Referral sources were asked to name and rank the top three recovery housing providers in Indianapolis to which they would prefer to send clients. Harbor Light was the top recovery housing choice among referral respondents, followed by Progress House, and a tie for Pathways and Dove House at third. Harbor Light may have been a popular choice due to its lack of requiring insurance, low barriers to entry, and their service to both men and women.

FIGURE 7.

Client initiation into recovery housing as reported by referral sources

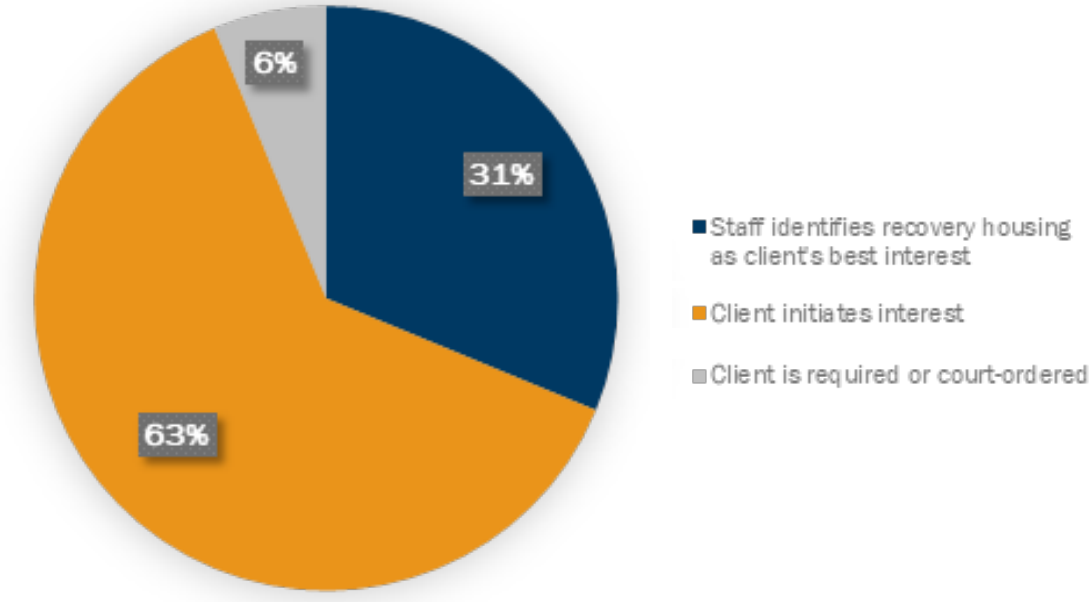


TABLE 2. Preferred recovery housing providers among referral sources

RECOVERY HOUSING PROVIDER	FIRST CHOICE	TIMES MENTIONED (Out of 33)
Harbor Light	Y	9
Progress House	Y	5
Pathway to Recovery		4
Dove House	Y	4
ARC		2
Buckner House	Y	1
Community Health Network	Y	1
Safe Haven	Y	1
Wheeler Mission Addictions Program	Y	1
Agape House		1
Fairbanks		1
Reuben Engagement		1
Simply Divine		1

LICENSING AND EVIDENCE-BASED PRACTICES

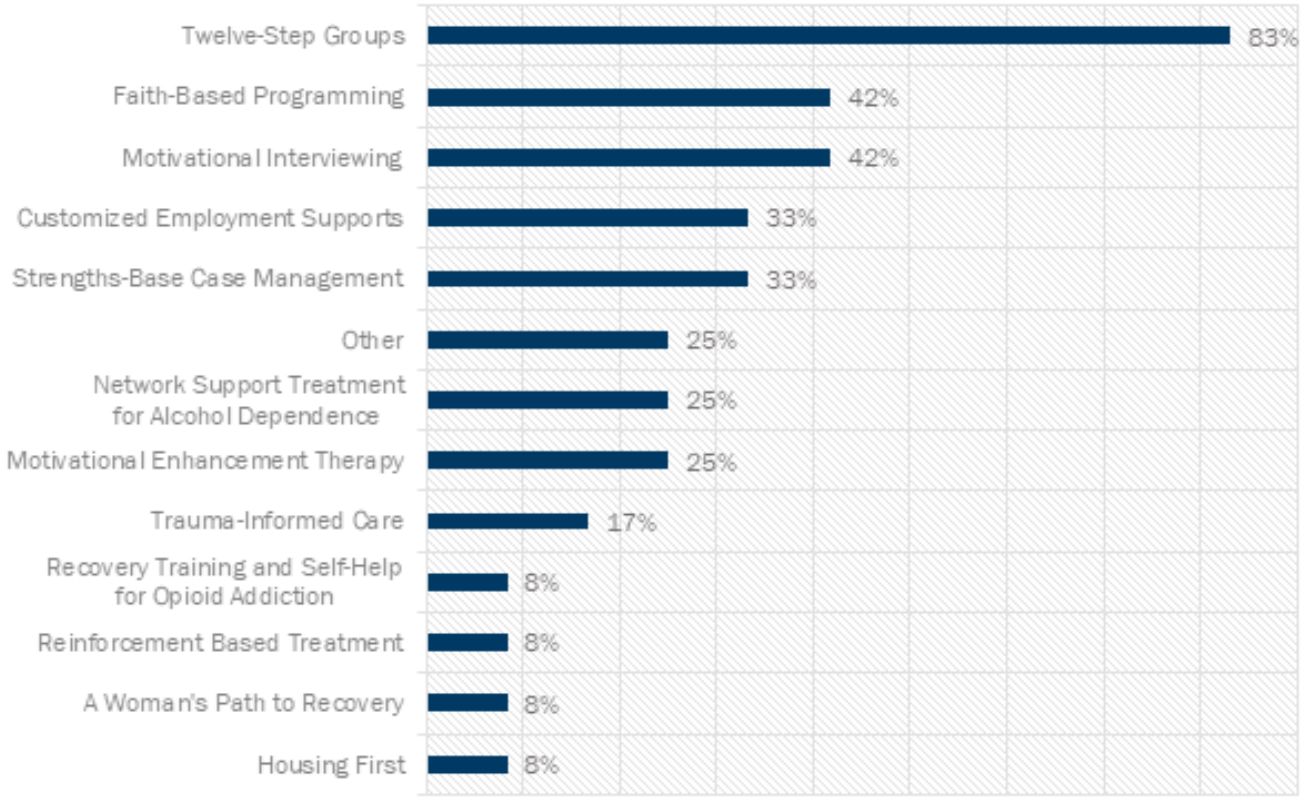
HUD Recommendation: Providers should provide programs that are a) based on evidence-based practices and models; and b) receive the highest levels of national, state or local accreditation and licensure.

The HUD policy brief recommends that "as appropriate, programs receive the highest levels of national, State or local accreditation and licensure," citing the National Alliance for Recovery Residences as one resource in support of the guidelines described in the brief. Only four of the 12 providers surveyed reported that they have recently been certified, accredited or licensed through the Indiana Alliance for Recovery Residences (INARR), and one provider cited an additional certification through IMHA.

Referral sources were also asked about how certification, accreditation and/or licensure of a program affected their likelihood of making a referral to that program. Thirty-eight percent of respondents reported that they would be more likely to make a referral to a program they knew to be accredited or licensed, and 62 percent reported that accreditation or license does not affect whether they make a referral.

PPI researchers examined resources available through the Substance Abuse and Mental Health Services Administration (SAMHSA) website to identify 15 potential evidence-based models that recovery providers

FIGURE 8. Program models used by Indianapolis recovery housing providers



could utilize in their programing. Three additional practices (faith-based programming, motivational interviewing, and strengths-based case management) were not identified in the literature, but were included in the survey to gain a broad understanding of the types of programming currently being offered by recovery housing providers. One respondent only selected faith-based programming as a program model used for its work. Almost all providers identified use of twelve-step groups as a model employed by their program, resulting in this model as the most frequently utilized model among the respondents. Of those responding "other", responses included Eye Movement Desensitization and Reprocessing (EMDR), Eye Zone Differential, intensive outpatient programming, having recovery coaches, and Bible study groups.

Of the remaining identified evidence-based practices, seven providers reported using at least one of the identified practices or models, meaning that at least 411 available recovery housing beds represented by the survey respondents use at least one evidence-based practice in addition to twelve-step programming. Six providers reported using faith-based programming, comprising half of all providers surveyed and 260 available beds.

Referral sources were more likely to consider whether a program utilizes evidence-based practices when considering whether to make a referral. Sixty-nine percent of respondents indicated they are more likely to make a referral to a program that uses evidence-based practices, while 31 percent reported that the use of evidence-based practices does not affect whether they make a referral. Referral source preference in this area aligns with HUD's guidance that recovery housing program design should be based on evidence-based practices and models.

HOME: EVICTION

HUD Recommendation: Relapse is a) not treated as an automatic cause for eviction from housing or termination from a program; b) includes relapse support that does not automatically evict or discharge a program participant from the program for temporary relapse; c) eviction should only occur when a participant's behavior substantially disrupts or impacts the welfare of the recovery community in which the participant resides.

HUD Recommendation: Permanent housing programs must also abide by all local and state landlord tenant laws that govern grounds for eviction.

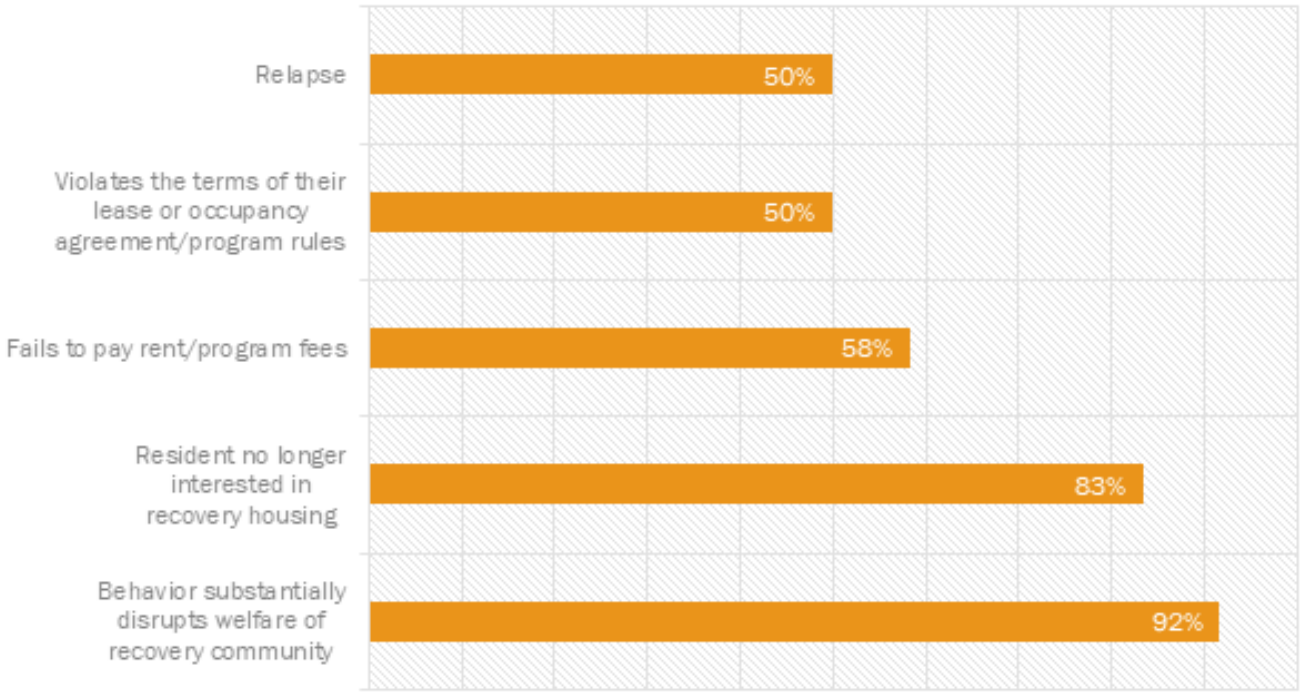
Indianapolis' local and state landlord/tenant laws suggests that landlords may evict tenants when a tenant has not paid the rent, after giving the tenant at least ten days to pay the rent or move.

When asked under what circumstances their program would evict or discharge a resident, the most common responses included when the resident's behavior substantially disrupts the welfare of the recovery community, and when the resident is no longer interested in recovery housing. These situations align with guidance provided by HUD. Six recovery housing providers indicated that they would evict or discharge a resident in the case of relapse, and six providers indicated that they would evict or discharge a resident if the resident failed to pay rent or program fees. The survey responses suggest that relapse may be one of multiple reasons to evict a resident, in which case, it would not create an automatic eviction.

When asked about types of recovery-related services that are missing in Indianapolis that would be helpful for clients experiencing homelessness, the theme of cost was discussed in seven responses. Specifically, having low to no-cost programming that does not require private insurance was associated with the cost of the programs. Additionally, the need to serve diverse groups, namely families and disabled individuals, was identified, along with the need for more detox services. With detox services, the concern was about a need for more of them, as well as less of a wait for those that do exist.

HUD details several points of guidance regarding how both transitional and permanent supportive recovery housing should operate. As nearly all of survey respondents operate transitional housing programs, this report will focus on HUD's guidance for those types of programs. However, it should be useful to keep in mind some key attributes of permanent supportive recovery housing as Indianapolis examines the need for future development of these resources within its service network.

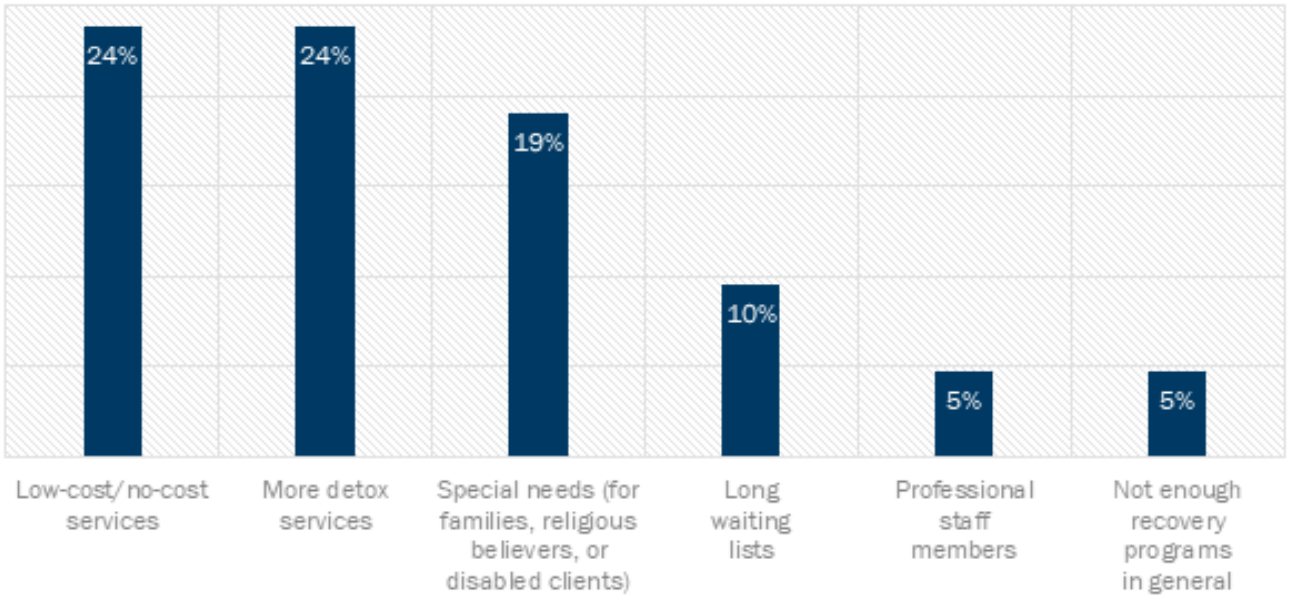
FIGURE 9. Causes of eviction among recovery housing providers



HUD defines permanent supportive recovery housing as less structured than transitional projects, without time limits, and targeting people experiencing homelessness, whose "substance use disorder or a co-occurring disability impedes their ability to live independently." HUD's discussion of permanent supportive recovery housing additionally stipulates that residents must have a lease, programs must comply with all landlord-tenant laws, and may hold space for up to 90 days for a resident who needs to access residential treatment following a relapse.

For transitional recovery housing projects, HUD provides guidance that, "Participants could have a lease, but must at least have an occupancy agreement." Seven of 12 recovery housing respondents reported that all residents sign a lease or occupancy agreement upon moving into their facilities. This leaves 5 of 12 providers who do not implement use of occupancy agreements or leases, indicating an area for potential growth. The survey also inquired about the amount of access residents were granted to the housing facilities and found that 11 out of 12 providers grant residents 24/7 access to their assigned sleeping and living areas, and 10 of the 12 providers grant 24/7 access to communal areas.

FIGURE 10. **Missing services among Indianapolis recovery housing programs, identified by referral sources**



BUILDING COMMUNITY IN RECOVERY HOUSING

HUD Recommendation: Make holistic services and peer-based recovery supports available to all program participants.

HUD Recommendation: Residents have personal privacy and 24/7 access to the housing, with community space for resident gatherings and meetings.

HUD Recommendation: Policies and operations should ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint.
HUD Recommendation: policies and operations should optimize autonomy and independence in making life choices.

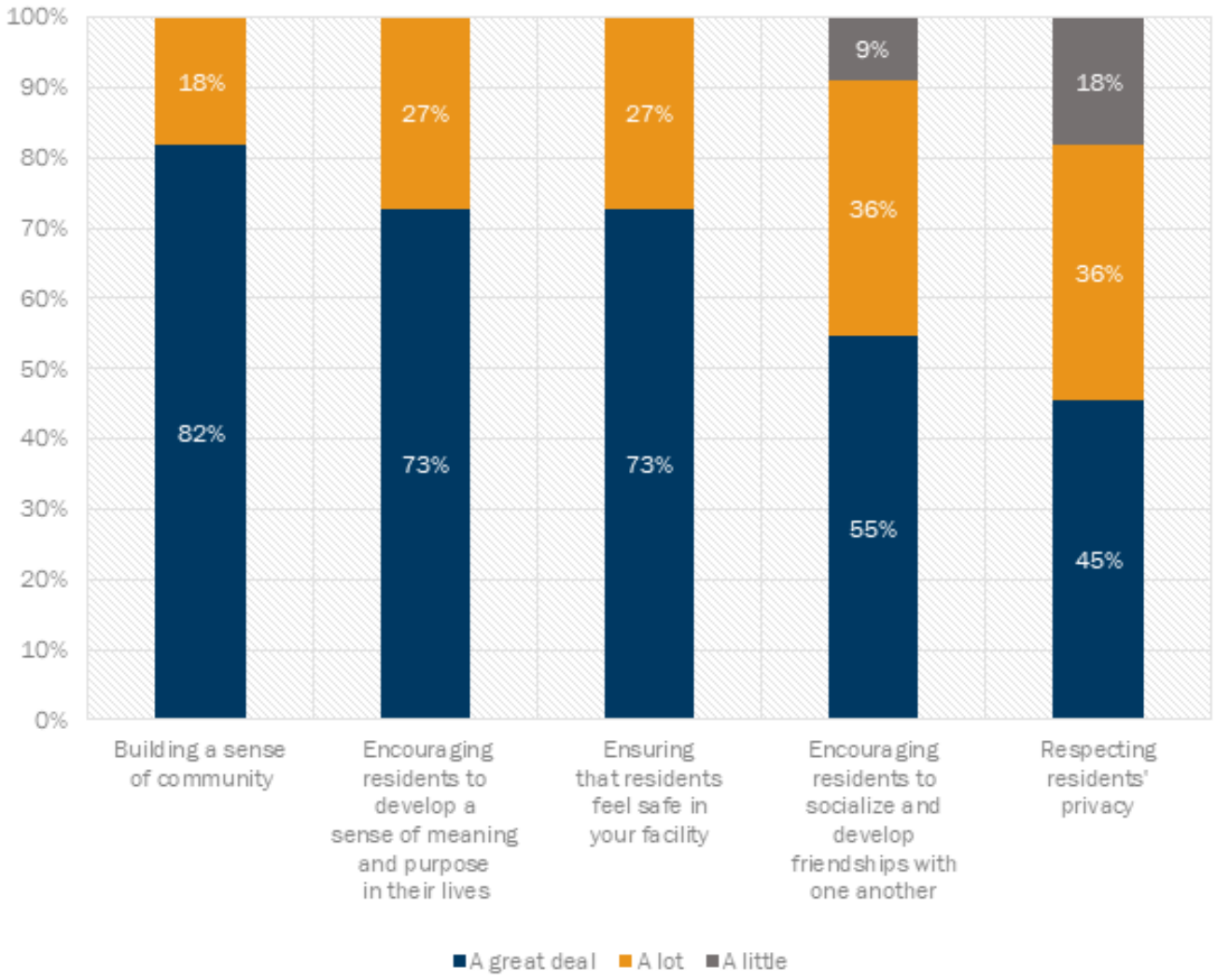
HUD emphasizes in its policy brief the effectiveness of creating a peer-based support community within recovery housing, identifying multiple avenues through which this is accomplished. Community is a key dimension to successful programs, and HUD notes:

> *"Many Recovery Housing programs include a high percentage of staff in all areas of the organization that are in recovery themselves. Not only does this type of staffing advance the goals of the program through peer support, but it provides program participants, in some cases, with an opportunity to become employed in a mission-oriented work environment. This creates an environment that benefits both the organization and the individual program participants."*

Recently graduated residents are individuals who have completed their recovery program. In response to the survey, 80 percent of providers reported that more than half of their staff are in recovery, and 90 percent reported that recently graduated residents are given an opportunity for employment within the recovery program. Of the two programs that do not offer on-site employment to recently graduated residents, one clarified that residents could be considered for employment one year after graduating from the program. To concretely support development of a recovery community, all recovery housing respondents reported that their facility provides communal space for resident gatherings or meetings, and 10 of those facilities provide 24/7 access to those spaces for residents. At the same time, less than half of respondents said they emphasized respecting residents' privacy, compared to three-fourths of those who emphasized ensuring residents felt safe in their facility. Related to communal spaces, fewer facilities reported highly emphasizing friendships among residents.

Building a sense of community within the residence was a top priority in terms of how much emphasis recovery programs place on it. Other areas of emphasis include encouraging residents to develop a sense of meaning and purpose in their lives, ensuring that residents feel safe in the facility, and encouraging residents to make healthy choices that support their emotional wellbeing. In support of their emphasis on developing

FIGURE 11. Recovery housing providers' emphasis on community building and safety



a sense of meaning and purpose, seven of the 12 recovery housing providers reported that most residents are engaged in meaningful activities on a daily basis such as employment, school, volunteer work, time with family, or creative activities or other hobbies. Four providers indicated that all of their residents are engaged in such endeavors on a daily basis, and one provider indicated that they did not know how many residents were engaged in productive activities. This aligns with HUD's identification of purpose, defined as "meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society," as a key dimension for recovery programs to incorporate.

HEALTH: HEALTHY BEHAVIORAL SUPPORT AND RELAPSE

HUD Recommendation: Program participants who determine that they are no longer interested in living in a housing setting with an abstinence focus, or who are discharged from the program or evicted from the housing, are offered assistance in accessing other housing and services options, including options operated with harm reduction principles.

HUD Recommendation: Along with services to help achieve goals focused on permanent housing placements and stability, and income and employment, programs provide services that align with participants' choice and prioritization of personal goals of sustained recovery and abstinence from substance use.

Providers were asked the extent to which they worked with clients to make health decisions that support their physical health and support their emotional wellbeing. Most providers indicated that they support residents' emotional wellbeing, but only about a third reported encouraging physical health.

The survey specifically examined recovery housing providers' responses to resident relapse and found that half of respondents would continue to work with the resident in the program, encouraging a return to sobriety/abstinence using the resources and programming already available through the program. Five providers indicated that they would respond with eviction, a third indicated they would respond by referring the individual to residential treatment, and one indicated that the program would hold the resident's place for up to 90 days while they completed treatment. When asked specifically about actions taken at discharge or eviction from their programs, 11 of 12 providers indicated that they refer evicted residents to other residential treatment options and eight of 12 providers indicated that they would refer to other housing options that may use other models or practices, such as harm reduction.

Aligning with HUD guidelines that a "participant may apply to reenter the housing program if they express a renewed commitment to living in a housing setting targeted to people with an abstinence focus," all providers indicated that evicted or discharged residents would be eligible to reapply and/or return to the program, and six of those providers stipulated that reapplication or return to the program could only occur after a resident meets certain conditions.

FIGURE 12. Recovery housing providers' emphasis on residents' physical and mental health

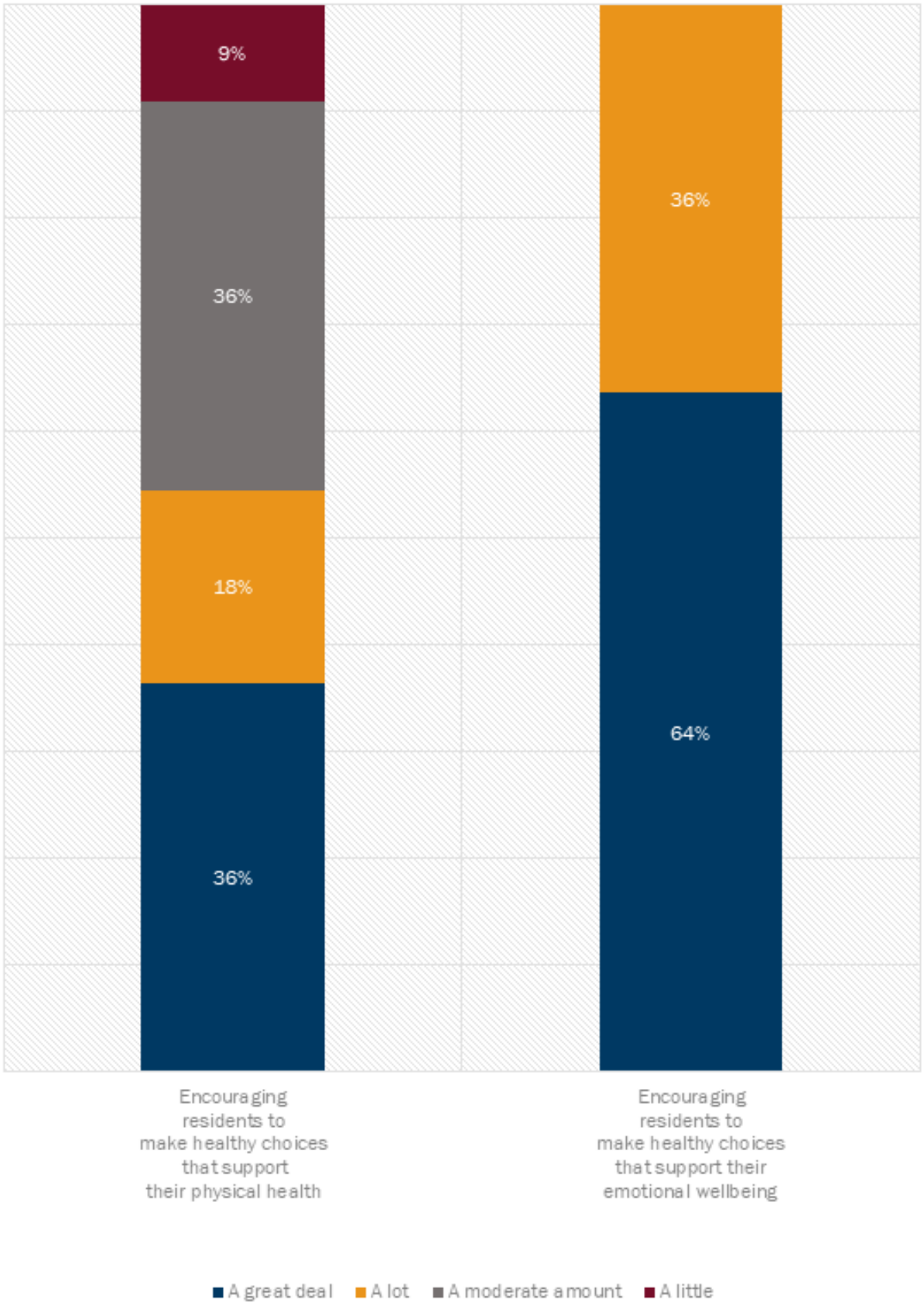
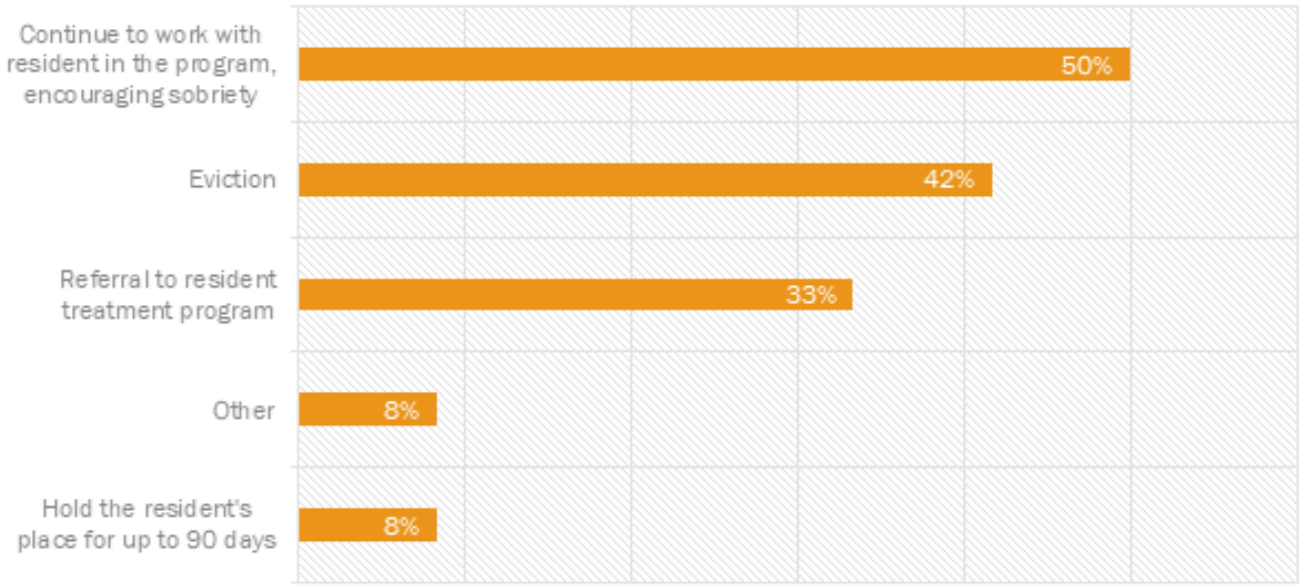


FIGURE 13. Recovery housing providers' responses to resident relapse



Programming provided by the recovery housing providers participating in the survey maintains a strong focus on a peer-supported community, employment services and support, assistance with basic needs, and faith-based programming. Some referral sources identified case management as a gap in service. As two referral sources observed:

"(There's a) lack of professional support for clients. I believe the clients in recovery programs need to be assigned a case manager."

"(There should be programs) that provide case management once in the program: i.e., transportation to medical appointments, connection w/ outside agencies/services. There are some…but few and far between."

However, some recovery housing providers reported that case management is a service they provide. Seven providers representing 510 available beds reported providing case management at their facility. Four of those 7 providers specifically identified using a strengths-based case management approach, and one provider identified using strengths-based case management at their facility although they did not initially report case management as a service they provide to their residents. Additionally, six providers reported using motivational interviewing techniques in their programs. The majority (10) of providers are engaging in connecting residents with benefits for which they are eligible (such as Medicaid, TANF, Social Security, SNAP Benefits, Ryan White Grant, etc.), and five of the 12 providers reported providing referrals to medical or mental health to providers when necessary.

The survey instruments did not define case management services for survey respondents, instead relying on respondents' interpretation of this and related terms. The discrepancy in referral sources' perception of the case management being offered through these programs and the recovery housing providers reports may be attributed to a difference in definition and expectations of what case management entails.

Provision of case management services points to a larger theme in both HUD guidelines and referral sources' feedback: the professionalization of recovery housing providers. HUD's policy brief identifies that particularly recovery housing that is transitional "is less restrictive than inpatient treatment settings but often includes 24 hour staff, access to ongoing treatment options, high level of services and supports available and offered by both peers in recovery and professionals, and required periodic meetings with a case manager."

The survey of recovery housing providers inquired about 24/7 staff supervision and professionalization of staff. Not all recovery housing providers responded to these questions as they were only visible to respondents who indicated their role within the organization as administrative. Nine of the 11 providers that responded to these questions reported that their facility had 24/7 staff supervision, and seven of 11 providers reported that their facility employs staff with professional degrees or certifications.

OUTCOMES

HUD Recommendation: Core outcomes should emphasize long-term housing stability and minimizing returns to homelessness in addition to the personal recovery goals of program participants.

HUD Recommendation: Providers should have performance measures in place that take into account the needs and challenges of the population being served.

HUD Recommendation: Programs successfully help people move into permanent housing destinations if and when they exit the program.

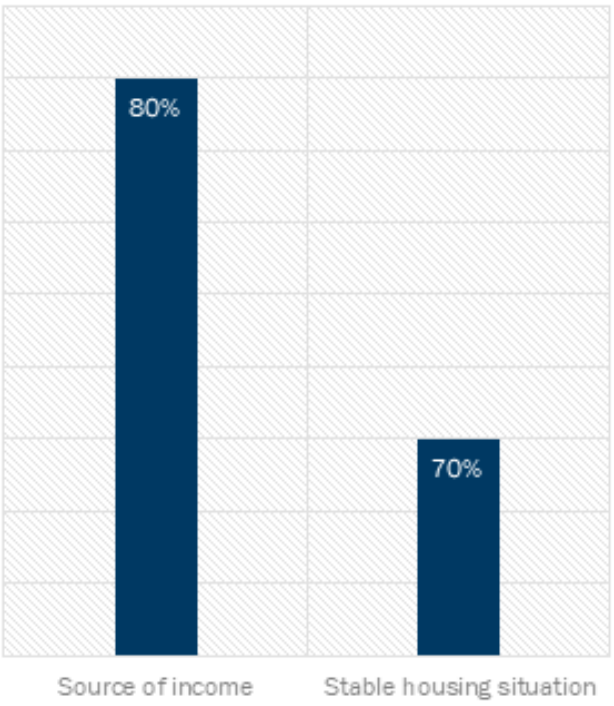
The HUD policy brief provides guidance on tracking performance measures to ensure the quality of recovery housing programs, recognizing that these measures should "take into account the needs and challenges of the population being served." HUD identifies core outcomes in the areas of housing sustainability, personal recovery goals, income and employment, placing the most emphasis on permanent housing placement and stability. The policy brief outlines an expectation that "programs successfully help people move into permanent housing destinations if and when they exit the program." The survey did not ask providers about the types of performance measures they use, but as there are not requirements locally, providers across sites may not follow a consistent set of indicators that identify needs and challenges of the population.

The survey asked recovery housing providers to estimate a percentage of their clients who achieve housing stability, income and amount of time sober upon exit from the program. Recovery housing providers gave estimates ranging between 70 to 95 percent of residents exiting their program had some form of income. Three providers estimated that 90 percent or more of their clients exited with some form of income, four providers estimated that 80 percent of their clients exited with income, and five providers estimated that number between 70 to 79 percent.

The survey asked recovery housing programs to estimate the percentage of clients who exit to a stable housing situation. Overall, recovery housing programs estimated lower percentages in this area than their

estimates for clients exiting with income. Five providers estimated between 50 to 60 percent of their clients exit to stable housing, six providers estimated 75 to 80 percent of clients exiting to stable housing, and one provider estimated that 90 percent of their residents exit to stable housing. The HUD policy brief identifies that particularly transitional recovery housing projects should emphasize exits of permanent housing, suggesting that this may be an area for growth within the Indianapolis network of services.

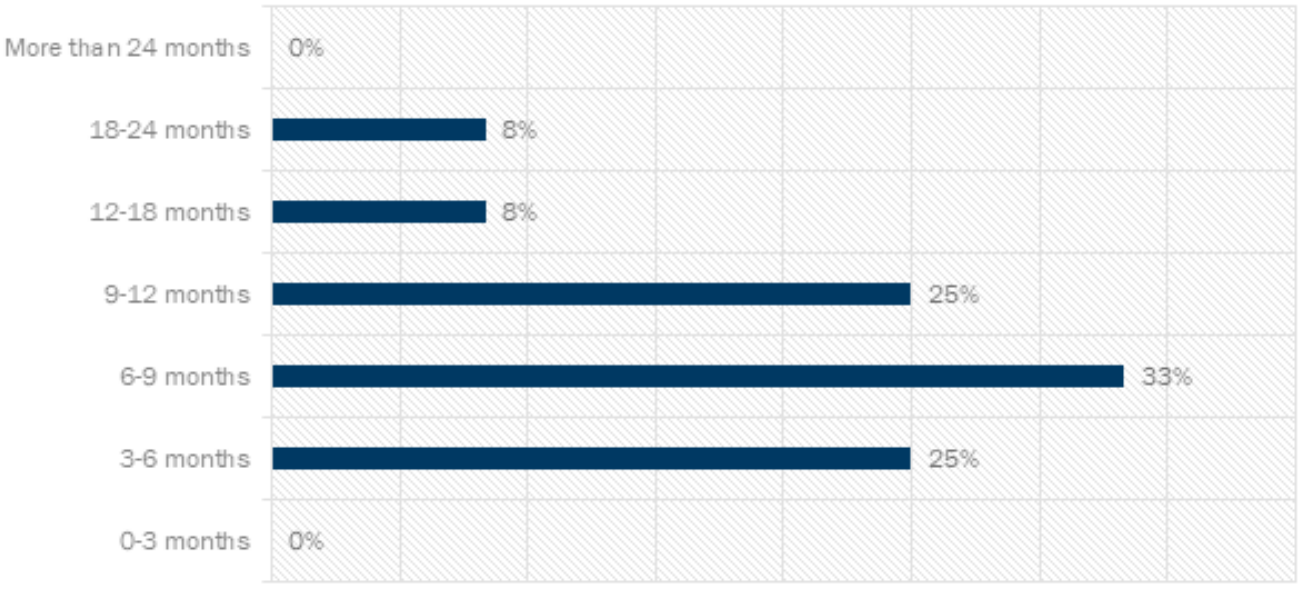
FIGURE 14. Average proportion of clients reporting income and stable housing upon program exit



Recovery housing providers reported the estimated number of days of sobriety for clients exiting their programs. Researchers compared responses with typical length of stay in the recovery program. For the 3 programs reporting that clients typically stay for 9 to 12 months, estimates of amount of time sober corresponded with an average number of days sober at 362. For the programs indicating typical length of stay to be between 3 to 6 months, one program indicated that number of days sober at exit was unknown. The other two programs indicating typical length of stay to be between 3 to 6 month reported an average 83 days of client sobriety at exit. Recovery housing programs where residents typically stay for 6 to 9 months on average estimated 135 days of sobriety at a resident's exit.

Fewer programs reported typical program stay as longer than 12 months. One program indicating typical program length as between 12 to 18 months estimated 300 days of sobriety

FIGURE 15. Length of stay among recovery housing residents



for clients at exit, and one program with typical stays of 18 to 24 months responded that clients exit their programs with a minimum of 90 days of sobriety. The longest program estimating shorter sobriety length likely relates to that program's philosophy and understanding of client relapse while in their program.

CONCLUSION

LIMITATIONS

Interpretations of these responses should account for a few issues. First, the survey asked providers to estimate their outcomes rather than requesting hard performance metrics, relying on provider perception rather than objective data. Additional research working directly with providers can help determine the extent to which these providers are collecting objective data regarding performance measures.

Second, though this response rate is relatively common among online surveys, a low number of recovery housing providers participated in the survey, including some key recovery housing providers. As mentioned earlier, some providers initially targeted may no longer be in operation.

KEY CONSIDERATIONS

The survey results present an initial snapshot of Indianapolis' recovery housing stock and how the network of services compares with guidelines recommended through the HUD policy brief.

Areas of Strength:

- ***Strong focus in peer support and recovery community among providers.***
  This emphasis on community building among providers suggests providers are addressing one of the main purposes of recovery housing: providing support systems to prevent client relapse and other factors that may lead to eventual eviction and continued housing instability.

- ***Low barriers to entry (length of sobriety required at entry, income requirements, clear eviction histories and lack of criminal history) do not create insurmountable barriers for program participants.***
  Reducing barriers to entry indicates providers take seriously the opportunity for individuals in need. The areas in which there are barriers to entry—sex offenses—are understandable given the myriad legal issues associated with that population.

- ***Building community through peer support and programming.***
  Providers responding to the survey indicated that they ensure client privacy and ongoing support through a variety of programming opportunities. They also provide support in facilitating a sense of purpose among residents and try to make their residents feel safe. Peer support is provided through staff, the majority of whom have been reported to be in recover. These support systems help support guide residents in paths to recovery, per HUD's recommendations.

Areas of Growth:

- ***Expanding the inventory of recovery housing options in general, but with a specific focus programs for families and programs focusing on dually-diagnosed individuals.***
  Not all providers responded to the survey or follow-up phone attempts. As such, it is not clear how well other providers meet HUD recommendations. At the same time, referral sources expressed a concern about a lack of recovery housing, as well as those that meet useful criteria related to shorter wait times and effective resident support. The current Continuum of Care in Indianapolis lacks recovery housing, and related funding, and may benefit from more strongly considering related opportunities.

- ***Improving outcomes in the area of housing stability.***
  The main goal of recovery housing, as discussed by HUD, is to ensure residents find a path of long-term stability, including housing stability. While most providers indicated moderate levels of housing stability, opportunities exist to increase those number. Notably, this survey did not obtain actual numbers from providers, and doing so may be a necessary step to understanding the effectiveness of recovery housing programs in Indianapolis.

- ***Increasing the implementation of evidence based practices and licensure, in addition to improving understanding between referral sources and providers about the importance of evidence-based practices.***
  Not all providers surveyed reported using evidence-based practices, yet referral sources did not all view evidence-based practices as an encouragement to refer clients to providers. Identifying a better understanding of client need and the practices that will best help them may help guide these practices, especially if few programs exist. Further, CHIP or another entity may consider providing guidance on the types of practices that should be considered by local providers. Additional education may help referral provider disentangle why evidence-based practices are ideal for helping clients meet their needs.

- ***Addressing the issue of cost associated with recovery housing.***
  Referral providers identified cost as a barrier to clients seeking recovery, which is understandable given that most clients are low-income. At the same time, providers likely do not have sufficient funds to cover costs of all resident needs. Helping providers find sustainable funding sources may help alleviate or reduce the cost of some facilities. Similar cost-related issues may be at play related to insurance requirements among residents, and costs related to obtaining or maintaining coverage.

- ***Response to relapse.***
  Half of providers utilized relapse as a reason for evicting clients. While other contextual factors may play a role in eviction (i.e. relapse in addition to disturbing other residents), ideally relapse should not be a primary factor for eviction in recovery housing facilities. Reading through and understanding of provider policies may help clarify and provide consistency identifying under what situations clients can or should be evicted for relapse-related issues. Also, increasing the number of detox beds may also help a greater number of residents recovery, thus reducing the likelihood of relapse.

- ***Perceptions of missing attributes by referral sources.***
  Additional research with local providers will need to identify referral sources perceptions of recovery housing providers is accurate. Specifically, having long wait times elapse between client-initiated interest in recovery housing and actual residence in those facilities may not support clients' needs, and increase their chances of success. As such, this lack of consistency may lead referral sources to direct clients to providers based on personal perceptions instead of objective knowledge of program capabilities.

- ***Developing performance measures and processes for recovery housing programs.***
  HUD recommends that local conveners of homeless-serving organizations work together to develop written standards to define appropriate access to and discharge of a program participant from the program for disrupting the welfare of the recovery community. Better identifying client need, and aligning those needs with HUD-preferred outcomes may help serve residents.

LIST OF RECOVERY HOUSING PROVIDERS AND REFERRAL SOURCES

Contact List: Indianapolis Recovery Housing Providers

- Agape House
- Celebration Freedom
- Coburn Place/Safe Haven - Domestic Violence Shelter
- Destination Recovery
- Dove House
- HVAF of Indiana
- Lighthouse Recovery Home
- Lucille Rains Residence, Inc.
- My Sister's Place
- Nehemiah House
- New Life - J.R. Jesse Recovery House
- Our Brother's Place
- Pathways to Recovery
- Primary Purpose
- Progress House
- Quest for Excellence/John's Delaware Lodge
- Salvation Army- Harbor Light
- Seeds of Hope
- Simply Devine (7 locations)
- SIS House
- Spain's House
- Steps to Life
- Talbot House
- The Julian Center - Domestic Violence Shelter
- Tikkun House
- Volunteers of America
- Wheeler Mission Center for Women & Children
- Wheeler Mission for Men

Contact List: Indianapolis Referral Providers

- Adult & Child Mental Health Center
- Coburn Place
- Damien Center
- Englewood CDC
- Eskenazi Health Pedigo Clinic
- Family Promise
- HealthNet HIP
- Holy Family Shelter of Catholic Charities Indianapolis
- Horizon House
- Indianapolis Interfaith Hospitality Network/Family Promise of Greater Indianapolis
- Indianapolis Marion County Public Library
- InteCare
- Mary Rigg Neighborhood Center
- Midtown Community Mental Health Center
- Outreach
- Partners In Housing
- Southeast Neighborhood Center
- Stopover, Inc.
- Street Outreach Animal Response (S.O.A.R.)
- Tear Down the Walls Ministries
- The PourHouse Inc.
- Volunteers of America
- Westside Community Development Corporation
- Wheeler Mission Center for Women & Children
- Wheeler Mission for Men
-

RECOVERY HOUSING PROVIDER AND REFERRAL PROVIDER SURVEYS

Recovery Housing Survey: Recovery Housing Providers

What is the name of your organization? (If you work for a large organization, please also provide your specific department, unit or focus within the organization, i.e. Eskenazi Health - Pedigo)

Please indicate your role within your organization:

- o Administrative Staff (1)
- o Front-line/Direct Service Staff (2)
- o Neither of these options. My title is: (3)

Which of the following services does your organization provide directly or on-site at your facility? (Do not include services to which your organization only provides referrals)

- o Case Management (1)
- o Peer Support (2)
- o Employment Services/Support (3)
- o Transportation (4)
- o Mental Health Treatment (5)
- o Medical Treatment (6)
- o Mental Health/Medical Referrals (7)
- o Legal Assistance (8)
- o Assistance with Basic Needs (food, clothing, hygiene, etc) (9)
- o Emergency Shelter (10)
- o Transitional Housing (11)
- o Permanent Supportive Housing (12)
- o Other Housing Assistance (Please describe): (13) _____
- o Other Services (Please describe): (14) _____

Approximately how many clients does your organization serve on a daily basis?

_____

My organization serves... (Check all that apply)

- o Women only (1)
- o Men only (2)
- o Both men and women (3)
- o Families with Children (4)
- o Adolescents and youth (5)
- o Individuals with a Substance Use Disorder (6)
- o Individuals with a Criminal Record (7)
- o LGBTQ community (8)
- o Other: (9) _____

Approximately how many of your clients have experienced homeless prior to your assistance?

- o All clients have experienced homelessness (1)
- o Most have experienced homelessness (2)
- o Some have experienced homelessness (3)
- o Only a handful have experienced homelessness (4)
- o None of our clients have experienced homelessness (5)

Do you consider your organization to be part of the Continuum of Care?

- o Yes (1)
- o Maybe (2)
- o No (3)
- o I am unfamiliar with the Continuum of Care (4)

To the best of your knowledge, how many of your organization's staff are currently in recovery from an addiction?

- o Zero staff members (1)
- o Less than half of staff (2)
- o More than half of staff (3)

Are recently graduated residents (individuals who have completed your program successfully) given an opportunity for employment within the organization?

- o Yes (1)
- o No (2)

Does your facility have 24/7 staff supervision?

- o Yes (1)
- o No (2)

Does your facility employ any staff members with professional degrees or certifications (i.e. MSW, LCSW, CAP, NCAC I/II, LMHC, LCAC, etc.)

- o Yes (5)
- o No (6)

Please provide information about the cost of your program. What is the cost to the resident to participate in your program and how often is it due? Do you accept insurance payments? Do you have a sliding fee scale? Is the cost negotiable? What other information about the cost of your program is important for us to know?

_____

In order to be eligible for your program, do clients need to meet an income requirement?

- o Yes (1)
- o No (2)

Are people with the following criminal histories eligible for your program:

	Yes (1)	Only after a specific period of time has passed since conviction (2)	No (3)
Misdemeanors (1)	o	o	o
Felonies (2)	o	o	o
Sex Offenses (3)	o	o	o
Violent Offenses (4)	o	o	o
Arson Offenses (5)	o	o	o

Are people who have previous evictions from housing eligible for your program?

- o Yes (1)
- o Only after a specific period of time has passed since the eviction (2)
- o No (3)

How long do you require a resident to have maintained sobriety/abstinence before entering your program?

- o There is no requirement of any amount of time sober/abstinent before entering our program
- o A resident must have _____ days of sobriety before entering our program.

What is the approximate percentage of clients who are required to participate vs. those who are independently initiating participation in your program?

Court-ordered to participate (1)	
Independently initiating participation (2)	
Required to participate by another organization or program (3)	
Required to participate by friends or family members (4)	
Unsure (5)	

Which of the following sentences best describes how your program handles client referrals from other social service agencies?

- o We require a referral from a service provider before accepting a client into our program. (1)
- o We are always open to working with another service provider to accept a referral, but we don't require them. (2)
- o We accept referrals from other service providers only in certain cases, but prefer that clients contact us directly. (3)
- o We require clients to contact us directly instead of working through another service provider. (4)

What is your preferred method to receive a referral from another service provider?

- o Phone call at this number: (1) _____
- o Email at this address: (2) _____
- o Fill out an online application at this address: (3)
- o Physically come (drop-in) to this location: (4)
- o Come to our location at a specific "intake" time (5)
- o Other: (6) _____

What is the best way for a client to contact you about entering your program without a referral from another service provider?

- o The client should call this phone number: (1) _____
- o The client should email at this address: (2) _____
- o The client should fill out an online application at this address: (3) _____
- o Physically come (drop-in) to this location: (4) _____
- o Come to our location at a specific "intake" time. (5)
- o Other: (6) _____

How much emphasis does your program put on the following?:	A great deal (18)	A lot (19)	A moderate amount (20)	A little (21)	None at all (22)
Building a sense of community within the residence (4)	o	o	o	o	o
Encouraging residents to develop a sense of meaning and purpose in their lives (2)	o	o	o	o	o
Encouraging residents to make healthy choices that support their physical health (smoking cessation, diet, exercise, etc.) (5)	o	o	o	o	o
Ensuring that residents feel safe in your facility (7)	o	o	o	o	o
Encouraging residents to socialize and develop friendships with one another (8)	o	o	o	o	o
Encouraging residents to make healthy choices that support their emotional wellbeing (9)	o	o	o	o	o
Respecting residents' privacy (10)	o	o	o	o	o

How many of your residents are engaged in meaningful activities on a daily basis (i.e. employment, school, volunteer work, time with family, creative activities or other hobbies, etc.)?

- o All of the residents (11)
- o Most residents (12)
- o About half of the residents (13)
- o A few residents (14)
- o None of the residents (15)
- o Don't Know (16)

Do all residents sign a lease or occupancy agreement upon moving in to your facility?

- o Yes (23)
- o No (24)

Does your facility provide communal space for resident gatherings or meetings?

- o Yes (1)
- o No (2)

Do residents have 24/7 access to their assigned sleeping/living area?

- o Yes (4)
- o No (5)

Do residents have 24/7 access to communal areas in your facility?

- o Yes (5)
- o No (6)

The following is a list of interventions, models, programming and practices that you might be using in your recovery housing program. Please mark all that apply.

- o Faith-Based Programing (1)
- o Twelve-Step Groups (2)
- o Trauma-Informed Care (3)
- o Housing First (4)
- o Motivational Enhancement Therapy (5)
- o A Woman's Path to Recovery (A Woman's Addiction Workbook) (6)
- o Oxford House Model (7)
- o Strengths-Based Case Management (8)
- o Reinforcement Based Treatment (9)
- o Motivational Interviewing (10)
- o Network Support Treatment for Alcohol Dependence (11)
- o Contracting, Prompting and Reinforcing (CPR) Aftercare Treatment (12)
- o Seeking Safety Program (13)
- o Interim Methadone Maintenance (14)

- o Customized Employment Supports (15)
- o Mind-Body Bridging Substance Abuse Program (16)
- o Addiction Comprehensive Health Enhancement Support System (ACHESS) (17)
- o Recovery Training and Self-Help (RTSH) for opioid addiction (18)
- o Other interventions, models, programming, or practices not listed above. Please describe: (19) _____

Does your program assist residents in connecting with benefits for which they are eligible (such as Medicaid, TANF, Social Security, SNAP benefits, Ryan White, etc.)?

- o Yes (23)
- o No (24)

Under what circumstances will your program evict or discharge a resident? (Check all that apply)

- o Relapse (1)
- o Resident determines they are no longer interested in living in recovery housing (2)
- o Resident violates the terms of their lease or occupancy agreement (3)
- o Resident fails to pay rent/program fees (4)
- o Resident's behavior substantially disrupts the welfare of the recovery community (5)
- o Other: (6) _____

If a resident relapses, how does your program usually respond? (Check all that apply)

- o Eviction (1)
- o Referral to a residential treatment program (2)
- o Hold the resident's place in our program for up to 90 days (3)
- o Continue to work with the resident in the program, encouraging a return to sobriety/abstinence using the resources and programming already available (4)
- o Take no action (5)
- o Other: (6) _____

Please mark the any of the following statements that are true of how your program operates regarding residents who have been evicted or discharged from your program:

- o Evicted residents are referred to other residential treatment options (1)
- o Evicted residents are referred to other housing options that may use other models or practices such as harm-reduction (2)
- o Neither of the above options (4)

If a resident is evicted or discharged from your program, are they eligible to reapply and/or return to your program?

- o Yes (1)
- o Yes, only after they meet certain conditions (2)
- o No (3)

How long do residents typically stay in your program?

- o 0-3 months (1)
- o 3-6 months (2)
- o 6-9 months (3)
- o 9-12 months (4)
- o 12-18 months (5)
- o 18-24 months (6)
- o More than 24 months (7)

Upon leaving your program (successfully or otherwise), approximately what percentage of residents have some source of income?

Upon leaving your program (successfully or otherwise), approximately what percentage of residents exit to a stable housing situation?

Upon leaving your program (successfully or otherwise), on average, how many days of sobriety or abstinence do residents have?

Is your program certified, accredited or licensed by any state, national or local entity?

- o Yes. (Please provide specific information below) (1)
- o No (2)

Recovery Housing Survey: Referral Sources

What is the name of your organization? (If you work for a large organization, please also provide your specific department, unit or focus within the organization, i.e. Eskenazi Health - Pedigo)

_____

Please indicate your role within your organization:

- o Administrative Staff
- o Front-line/Direct Service Staff
- o Neither of these options. My title is: _____

Which of the following services does your organization provide directly or on-site at your facility? (Do not include services to which your organization only provides referrals)

- o Case Management
- o Peer Support
- o Employment Services/Support
- o Transportation
- o Mental Health Treatment
- o Medical Treatment
- o Mental Health/Medical Referrals
- o Legal Assistance
- o Assistance with Basic Needs (food, clothing, hygiene, etc)
- o Outreach
- o Emergency Shelter
- o Transitional Housing
- o Permanent Supportive Housing
- o Other Housing Assistance (Please describe) _____
- o Other Services (Please describe) _____

Approximately how many clients does your organization serve on a daily basis?

_____

My organization serves... (Check all that apply)

- o Women only
- o Men only
- o Both men and women
- o Adolescents and Youth
- o Individuals with a Substance Use Disorder
- o Individuals with a Criminal Record

- o LGBTQ Community
- o Families with Children
- o Other: _____

Approximately how many of your clients have experienced homeless prior to your assistance?

- o All clients have experienced homelessness
- o Most have experienced homelessness
- o Some have experienced homelessness
- o Only a handful have experienced homelessness
- o None of our clients have experienced homelessness

Do you consider your organization to be part of the Continuum of Care?

- o Yes
- o Maybe
- o No
- o I am unfamiliar with the Continuum of Care

A recovery housing program is defined as an abstinence-focused and peer-supported community for people recovering from substance use issues. Does your organization make referrals to any recovery housing providers?

- o Yes, frequently
- o Yes, infrequently
- o No

Name the top three recovery housing organizations you would prefer to send one of your clients to:

- o First Choice _____
- o Second Choice _____
- o Third Choice _____

Does a recovery housing program's accreditation or license affect whether or not you will make a referral there?

- o I am more likely to make a referral to a program that I know is accredited or licensed
- o I am less likely to make a referral to a program that I know is accredited or licensed
- o Accreditation or license does not affect whether I will make a referral

Does a recovery housing program's use of evidence based practices affect whether or not you will make a referral there?

- o I am more likely to make a referral to a program that uses evidence based practices
- o I am less likely to make a referral to a program that uses evidence based practices
- o The use of evidence based practices does not affect whether I make a referral

Which of the following situations best describe how you typically determine whether to refer a client to a recovery housing program?

- o When I and/or other staff members know it is in the client's best interest to enter a recovery housing program
- o When the client initiates interest in a recovery housing program
- o When the client is required and/or court ordered to participate in a recovery housing program

In your opinion, what types of recovery-related services are missing in Indianapolis that would be helpful for clients experiencing homelessness?

_____

What are the primary barriers for making successful referrals to recovery housing for your clients? (Check all that apply)

- o Program cost
- o Lack of available space in recovery housing programs
- o Lack of available space in detox facilities
- o Long wait times between referral and entrance into program
- o Program eligibility requirements
- o Program duration is too long
- o Program duration is too short
- o Program is faith-based
- o Culture of the organization
- o Coordination of insurance
- o Program requirements interfere with client obligations (work, family, mental health/medical appointments, etc.)
- o Program requirements interfere with client medical or mental health treatment (i.e. do not allow client to continue certain medications or medical treatments while in recovery)
- o Location of the facility
- o Transportation to and from the facility

What factors or information about a recovery housing program would lead you to feel uncomfortable referring a client there?

_____

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