Best Practices Toolkit

Addressing Homelessness and Addiction through "Treatment First"

Acknowledgements

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Introduction

Homelessness and Addiction in the United States

The persistent nexus between homelessness and addiction in the United States remains a complex and urgent national crisis, impacting individuals, families, veterans, and entire communities, with direct implications for public safety, public health, and human dignity. A substantial portion of homeless individuals have co-occurring substance use disorders, often compounded by untreated mental illness, trauma, and long-term joblessness and economic instability.[1,2] For these individuals, homelessness is not an isolated crisis but a recurring condition shaped by cycles of addiction, trauma, instability, and repeated contact with emergency departments, shelters, addiction treatment programs, and the criminal justice system.[3]

Despite significantly increased public investment, too many individuals remain trapped in these cycles without achieving lasting recovery, self-sufficiency, or reintegration into their communities.[1-3]

One of the most serious outcomes associated with homelessness is the increased risk of death. Research shows that non-elderly homeless individuals face 3.5 times the mortality risk of people who are housed, and a 40-year-old homeless individual faces a mortality risk similar to that of a housed person nearly twenty years older.[4]

Recent actions by the Trump Administration underscore the urgency of addressing this national crisis through policies and programs that meaningfully advance recovery and self-sufficiency. Executive Order 14321, Ending Crime and Disorder on America's Streets, Executive Order 14379, Addressing Addiction Through the Great American Recovery Initiative, and the 2026 National Drug Control Strategy, issued by the White House Office of National Drug Control Policy, call for a more effectively coordinated and accountability-driven national response to homelessness and addiction.

1,456,923

people were **homeless or living in taxpayer-subsidized/ funded housing for the homeless** in 2025[5]

266,320

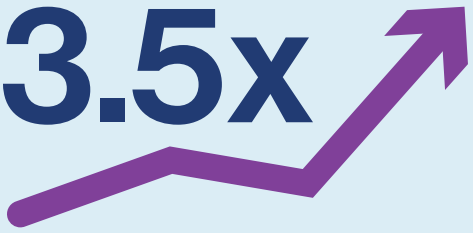
unsheltered homeless individuals were **sleeping in places not meant for human habitation**, such as sidewalks, parks, vehicles, abandoned buildings, and bus stations[6]

230,366

homeless individuals in families with **children**[6]

Non-elderly homeless individuals have **higher mortality risk** compared to those who are housed[4]

3.5x



46%

of adults who have a substance use disorder also report **co-occurring mental illness**[7]

> *"We'll engage people continuously, from first contact on the street through recovery, through employment and through self-sufficiency. Law enforcement, courts, housing providers and healthcare systems will work as one team, so people will no longer fall through the cracks."*
>
> Secretary Robert F. Kennedy, Jr.
> U.S. Department of Health and Human Services

Current fundamental failure points include “Housing First” approaches, which emphasize connections to permanent supportive housing and too often fail to align services around long-term recovery-oriented outcomes. This results in difficult-to-navigate and fragmented systems of care, repeated relapses, and recurrent homelessness. This toolkit presents a new “Treatment First” model for homelessness and addiction, prioritizing evidence-based treatment that promotes sustained recovery, accountability, self-sufficiency, social connectedness, and family and community reintegration.

The “Housing First” model provided housing without sufficient integration of addiction treatment or recovery support services. A recent large-scale study found that veterans in supported housing were consistently more likely to die from drug overdose than homeless veterans.[8] These findings underscore the need for a new approach to homelessness and addiction that intentionally integrates evidence-based substance use disorder treatment and recovery support services to achieve long-term stability and self-sufficiency.

Fundamental failures in the current system:

“Housing First” and “Housing Only” models fail to prevent overdoses, increase access to addiction treatment, or help people establish and sustain self-sufficiency.

Policies and practices that enable homelessness, open-air drug markets, and crime create an environment that expands, rather than deters or resolves, the homeless crisis.

Difficult to navigate and fragmented service systems undermine continuity of care and long-term stabilization, especially for people with dual diagnoses of mental illness and addiction.[9]

Funding and performance structures prioritize symptom-focused, short-term interventions, such as “Housing First” models, over progress toward long-term recovery-oriented outcomes, including sustained abstinence from drugs, improved mental health, employment, success in non-subsidized housing, social connectedness, and family and community reintegration.[2,5]

Insufficient availability of recovery housing, centered on peer support and connection to services, endangers treatment gains and increases likelihood of relapse.[10,11]

Barriers to work, including criminal records and long periods of disengagement from the workforce, prevent individuals in recovery from achieving economic independence.[12,13]

Regulatory and administrative funding restrictions that exclude capable community-based and faith-based organizations or providers, or restrict collaborative efforts by local law enforcement agencies, undermine treatment and recovery support services.

As a result of these challenges, rates of relapse to homelessness remain high in addiction treatment programs, shelters, housing programs, and correctional systems. This continued cycle imposes significant human costs and carries heavy burdens for individuals, families, veterans, health systems, and community-wide resources.[3]

> *"It is critical we focus on real solutions that lift Americans out of homelessness. We must abandon the failed 'Housing First' policies that have misused taxpayer funded resources without any expectation of results and too often leave individuals trapped in addiction, untreated mental illness, and indefinite dependence on government systems. HUD will promote treatment, recovery, and self-sufficiency."*
>
> Secretary Scott Turner
> U.S. Department of Housing and Urban Development

A "Treatment First" model prioritizes coordinated and accountability-driven engagement in evidence-based treatment and recovery support services, to ensure access to the comprehensive and coordinated care necessary for homeless individuals with addiction to achieve and sustain self-sufficiency. Success must be transparently defined, measured, and evaluated by meaningful progress toward long-term recovery-oriented outcomes, including sustained abstinence from drugs, improved mental health, stable housing, employment, social connectedness, and family and community reintegration, rather than by service utilization alone. Achieving long-term outcomes requires coordinated, recovery-oriented strategies that promote public safety, strengthen community stability, and support the inherent dignity and potential of every individual.

Addressing homelessness and addiction requires a comprehensive and integrated "Treatment First" approach that supports recovery as a long-term, multi-dimensional, and nonlinear process. This includes coordinated, accountability-driven services that span the full continuum of care from initial outreach and engagement through evidence-based treatment, recovery support services, employment, stable housing, and reintegration into family and community life.

Effective solutions must:

Lead with a "Treatment First" approach, aligning evidence-based treatment, recovery support services, and housing pathways from the outset.

Incorporate evidence-based treatment; life-management skills, relationship skills, and job skills education; housing; and recovery support services.

Ensure sufficient time for healing from trauma and addiction.

Be transparent, effective, and accountable for meaningful outcomes that reflect long-term stability, self-sufficiency (i.e., employment and housing), and social reintegration.

White House Summit: Best Practices for Addiction Treatment within Homelessness

In response to the persistent, complex, and urgent national crisis of homelessness and addiction, the White House Office of National Drug Control Policy (ONDCP) convened a national summit on Best Practices for Addiction Treatment within Homelessness on April 12 through 14, 2026. The three-day Summit brought together federal, state, and local leaders, law enforcement officers, clinicians, medical practitioners, researchers, individuals with lived experience, and leaders of programs with demonstrated success to share best practices. See Appendix A for Summit attendees and Appendix B for information about the successful programs contributing to this toolkit.

The Summit was convened by ONDCP's Office of Addiction Prevention and co-sponsored by the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (HHS/SAMHSA) and the Department of Housing and Urban Development's Office of Community Planning and Development (HUD/CPD). The Summit proceedings are the foundation for this toolkit, which provides a clear, actionable, and scalable framework for communities seeking to improve long-term outcomes for homeless individuals with addiction.

This toolkit covers the full continuum from street engagement to evidence-based treatment, transitional and recovery housing, community-based recovery support services, employment, and reintegration. It is intended for federal, state, and local leaders responsible for policy, funding, and program oversight and implementation, as well as for leaders of community-based nonprofits and faith-based groups working at the nexus of homelessness and addiction.

The Best Practices Toolkit does not prescribe a single program model for addressing homelessness and addiction through "Treatment First." Rather, it identifies core components and evidence-informed practices that support long-term recovery, self-sufficiency, and public safety, providing a practical foundation upon which to inspire "Treatment First" solutions in our communities. Outlining actions to align systems around shared, measurable outcomes, the toolkit promotes innovation grounded in accountability to inform future policy, program, and funding decisions. Practical examples, resources, references, and contacts are also included to support deeper exploration, implementation, and evaluation across a range of local contexts.

The approaches outlined here reflect what is working now. Future efforts must strengthen the evidence base through systematic data collection, transparent and standardized outcome reporting, and rigorous evaluation of progress toward long-term recovery-oriented results. Continuous collaboration across federal, state, and local partners will enable learning from both successes and failures. As communities implement these practices, ongoing learning, consistent data collection, and data-driven refinement will be essential to identifying approaches that produce durable recovery at scale.

The long-term vision is to dramatically reduce homelessness, treat addiction and mental illness, and prevent the pipelines of drug use and its serious consequences.

> *"Recovery is often a difficult and uncomfortable road. We cannot abandon those in recovery—because no one is a lost cause. There is inherent value and dignity to every human life, no matter their current circumstances or addiction. Under President Trump's leadership, this toolkit will transform and heal Americans struggling with drug addiction."*
>
> Sara Carter
> Director, White House Office of National Drug Control Policy

Chapter 1: Core Elements of Best Practices

This Best Practices Toolkit is intended to help state and local policymakers, continuum of care providers, funders, and program leaders strengthen transparency and accountability, improve outcomes, and support durable recovery and community reintegration for homeless individuals with addiction.

Several core values and insights inform this Toolkit. Summit experts collectively agreed that these foundational elements are essential to effectively addressing homelessness and addiction, and therefore should be reflected in all programs.

Self-sufficiency as the central goal. Prioritize stable employment; various housing options that are not reliant on government assistance; and the life management, relationship, and job skills required for independent living, family and community reintegration, and long-term recovery.

Cultures of dignity and trust. Foster a sense of community and promote mutual accountability to build expectations of mutual respect between clients and staff, recognition of each individual's worth, and shared trust.

Understanding recovery as a long-term, nonlinear process. Ensuring an individualized approach, sustained engagement, structure, and accountability, care plans should be regularly reassessed to support long-term recovery, self-sufficiency (i.e., employment and housing), and public safety. Short-term treatment models and episodic services do not produce lasting results.

Trauma-informed, evidence-based, client-centered care. Starting at initial engagement, street outreach, or crisis intervention and continuing throughout the entire continuum of care, ensure services are trauma-informed, evidence-based, and individualized.

Warm handoffs, navigation, and ongoing coordination. Cultivate connections among otherwise siloed programs, at all stages from crisis intervention to long-term housing, to ensure people do not fall between the cracks. Staff or peers should accompany clients to initial appointments and between different programs, to increase follow-through and help reduce anxiety. Consider physical transportation, maintenance of human contact from service to service, and the criticality of follow-up with clients.

"Whole-of-community" approach. Establish trusted relationships across systems of care and partner with trusted organizations to build a collaborative community infrastructure that maximizes efficiencies and effectiveness. Develop workflows that incorporate regularly scheduled communications to coordinate services and improve client outcomes.

No wrong door. Ensure program entry points are possible through multiple pathways, including self-referral, community and family referral, law enforcement deflection, emergency services, linkage from community-based health or behavioral health providers, and referrals from emergency departments, other hospital settings, courts, and other components of the justice system. Build strong partnerships within the "whole-of-community" approach to ensure clear communications and networks that are ready to engage.

Integration of faith and medicine. Incorporate spiritual support to complement evidence-based treatment and bolster the process of long-term recovery. Faith-based organizations are essential contributors to the "whole-of-community" approach, helping to provide a sense of hope and strengthening engagement.

Peer recovery specialists. Deliberately integrate people with lived experience of recovery, via influential positions across the full continuum of care and through coordination with peer-led community-based service organizations, to strengthen trust; improve accountability and long-term outcomes; and support outreach, coordination, counseling, ongoing engagement, and community reintegration.

Structure and routine. Establish consistent schedules to ensure stability and clear expectations on daily activities, such as regular wake-up times, classes, job training, paid work, chores, and treatment, to mirror the structure and routine of a work week. Difficulties with structure and routine should prompt evaluation of potential barriers and challenges or the need for more services.

Sources of strength and connectedness. Identify and leverage individual strengths and "resources," such as faith, spirituality, or participation in a faith-based community; educational background; skills and expertise; positive attitude; and connections to family and other social supports, including pro-social communities, groups, and interests.

Phased housing. Offer a range of recovery housing options, from shelter to recovery residence to independent living, based on where individuals are in the recovery process. Effective housing does not have to be expensive and can include dormitory-style living or repurposed buildings.

Substance-free living spaces. Mandate alcohol- and drug-free living environments to ensure daily safety and set conditions for ongoing success. Prevent exposure to substances that endanger health and derail recovery. If relapse occurs, individuals should be connected to a different level of care, to allow for stabilization and second chances, before returning to a similar housing environment.

Learning and skill building. Provide education and training that build life-management skills, relationship skills, and job skills.

Understanding employment readiness as a mechanism for building self-esteem and self-efficacy. Provide practice opportunities to build skills for workforce development, including through on-site work and chores, "work therapy" mentorship or modeling, and off-campus contracts. Explore creative employment avenues, including social enterprises, especially for individuals facing barriers such as criminal records. Where possible, employment options should lead to certifications that increase future job prospects.

Program champions. Find dedicated leaders who will effectively advocate for the program, support staff, and cultivate community relationships and trust, to ensure long-term sustainability.

Celebrations of progress. Celebrate progress, including both small and large milestones, through recognition, peer-led nominations, and non-financial, socially positive rewards that will be meaningful and reinforce success.

Standardized assessments and individualized care planning. Use validated clinical screening scales and standardized questionnaires, including for critical issues like trauma (Adverse Childhood Experiences [ACEs] Assessment) and recovery capital (e.g., Assessment of Recovery Capital, Recovery Capital Questionnaire, Recovery Capital Index). Structure treatment programs around individual progress and stability rather than one-size-fits-all time-based milestones.

Transparent long-term outcomes. Measure clear goals that extend beyond service utilization alone. Success should be transparently defined, measured, and evaluated by meaningful progress toward long-term recovery-oriented outcomes, including sustained abstinence from drugs, improved mental health, stability of non-subsidized housing, employment, social connectedness, and family and community reintegration.

In addition to the approaches outlined in this toolkit, each community should evaluate its own policies, practices, and enforcement aspects to ensure that they deter rather than enable homelessness and drug use.

Chapter 2: Measuring Outcomes

Pivoting from "Housing First" to "Treatment First" prioritizes accountability for the outcomes that are measured. Outcome measures should track participants' progress toward achieving self-sufficiency. Long-term outcomes should include sustained abstinence from drugs, improved mental health, stable housing, employment, social connectedness, and family and community reintegration. Understanding that the journey isn't quick or immediate is critical. Relapses may occur and should be understood as part of the process, not a reason to give up on the goal of long-term recovery and self-sufficiency.

Core Measures for All Programs: Accountability and Transparency

Summit participants collectively agreed that accountability and transparency are core organizational metrics for effectively serving homeless people with addiction. The core essential measures for all programs include:

- Price per client per day
- Self-sufficiency – market rate or independent housing, housing stability vs. days unhoused or returns to homelessness, and employment
- Recidivism (rate per 100 participants), including with levels (e.g., probation/parole violation, new offense)
- Customer service and professionalism
- Successful warm handoffs at all steps of the continuum and at discharge
- Abstinence from alcohol and drugs at 12 months

Additional Client-Level Metrics: Tracking Clear Goals and Standardized Outcomes

Abstinence from alcohol and drug use at 12 months; length of time drug-free

Mental health stability, using validated scales

Stable and safe market-rate housing

Employment self-sufficiency (meaningful employment)

Progress towards employment self-sufficiency

Social connectedness

Educational attainment

Reliable transportation

Housing self-sufficiency (at market rate or independent housing; housing stability vs. days unhoused or returns to homelessness)

Progress towards housing self-sufficiency

Rate of service engagement

Family and community reintegration

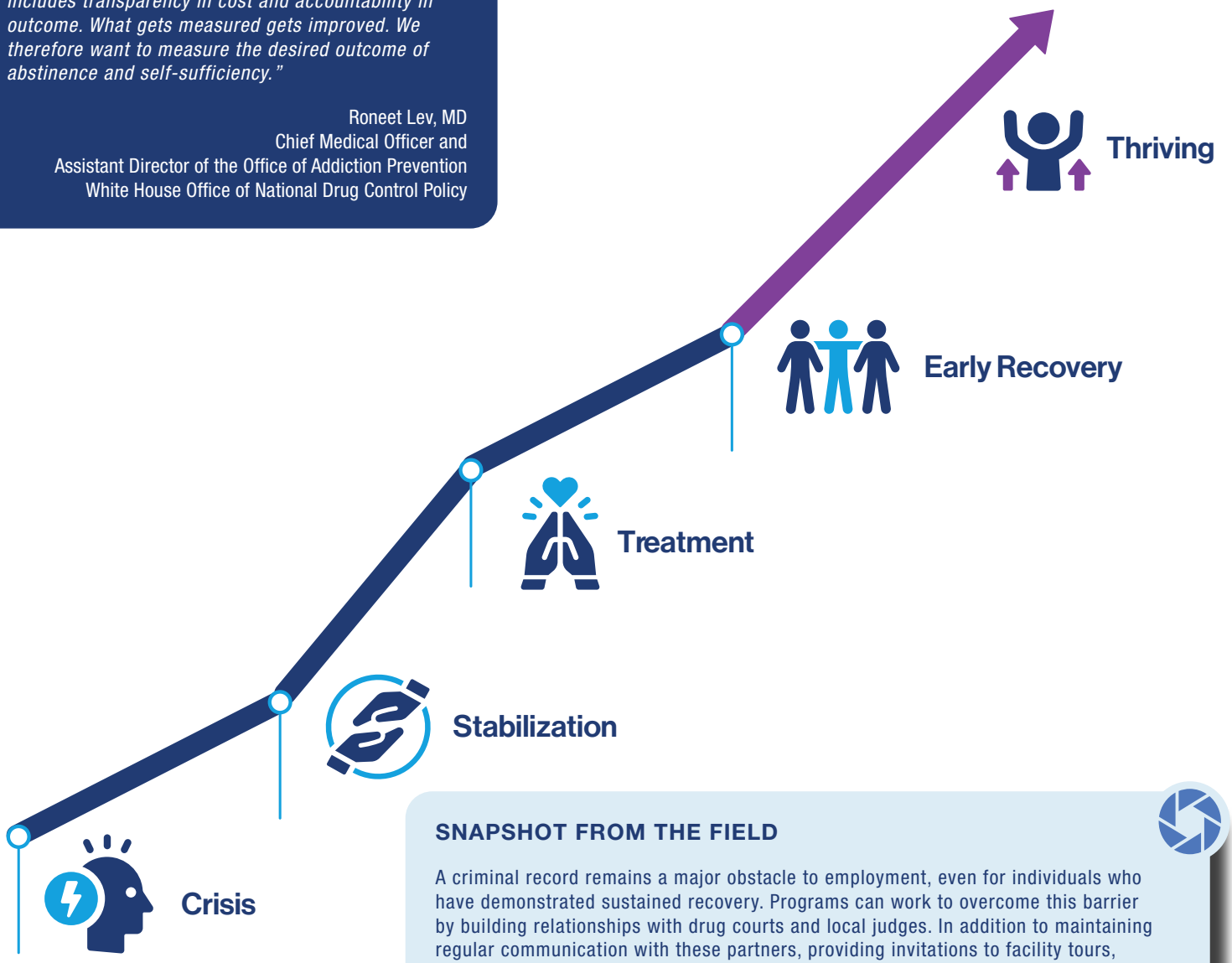
Client-Level Outcome Measures by Phase

Phase-specific outcome measures are essential. The phases listed here span the continuum from crisis, stabilization, treatment, early recovery, and thriving. They allow programs to track progress, adjust services, promote accountability, and measure success. Programs that serve homeless individuals with addiction should support them through each phase of recovery. Progress between the phases is seldom linear. Relapses may occur and should trigger continued or increased engagement in treatment and/or recovery support services, paired with recognition of progress made to date and clear expectations for participation and improvement.

Some individuals will need more intensive or longer-term support before advancing through phases. For example, they may require detoxification, psychiatric hospitalization, inpatient or residential addiction care, or stabilization through medications for opioid use disorder, alcohol use disorder, or psychiatric conditions. Movement across phases will vary based on individual needs and circumstances. For many people, long-term recovery and stabilization require sustained, structured support over time.

"Bringing addiction to the mainstream of healthcare includes transparency in cost and accountability in outcome. What gets measured gets improved. We therefore want to measure the desired outcome of abstinence and self-sufficiency."

Roneet Lev, MD
Chief Medical Officer and
Assistant Director of the Office of Addiction Prevention
White House Office of National Drug Control Policy



SNAPSHOT FROM THE FIELD

A criminal record remains a major obstacle to employment, even for individuals who have demonstrated sustained recovery. Programs can work to overcome this barrier by building relationships with drug courts and local judges. In addition to maintaining regular communication with these partners, providing invitations to facility tours, celebrations, and other events can foster trust in participants' commitment, especially after completion of a full year in a results-driven program.

The chart below is an example of measures for phases of crisis, stabilization, treatment, early recovery, and thriving. It includes measures for abstinence from drugs, improved mental health, housing, employment, and education. It is important to note that although many programs and payment models follow 30-day or 90-day timelines, individuals often require longer periods of treatment for neurological resetting of addiction and training for community integration.

	Crisis	Stabilization	Treatment	Early Recovery	Thriving
Abstinence from Drugs	Still using substances Introduced to services (e.g., assessment, detox, withdrawal management), initiating medications for addiction or psychiatric conditions, as well as general medical services	6 months of abstinence from impairing, addictive drugs Engages in treatment and recovery support services	9 months of abstinence from impairing, addictive drugs Regularly attends treatment or support meetings or engages in other recovery support services	12 months of abstinence from impairing, addictive drugs Remains active in the recovery community or engages with supports that promote abstinence and recovery	18 months to 5+ years of abstinence from impairing, addictive drugs Knowledgeable about treatment and recovery supports in the community, and actively participates in the recovery community
Mental Health	Untreated and undiagnosed mental illnesses Introduced to services (may require psychiatric hospitalization or initiation of medications)	Evaluated and diagnosed Expresses willingness to engage in treatment	Engaged in treatment, which may include talk therapy or prescribed psychotropic medication	Mental health is improving, and symptoms becoming manageable	Mental health is stable Treatment may be ongoing Support structures are in place
Self-Sufficiency: Housing	Using shelter services	Transitional housing, treatment, and recovery housing Individuals may require inpatient or residential addiction treatment before entering housing	Transitional housing, treatment, and recovery housing	Transitional or non-subsidized housing	Non-subsidized housing
Self-Sufficiency: Meaningful Employment	Unemployed Employment may be precluded by inpatient or residential treatment	Part-time employment in a recovery-informed environment and/or social services	Full-time work, potentially at the minimum wage	Full-time work above the minimum wage, with or without health insurance benefits	Full-time employment above minimum wage, generally with employer- provided benefits
Education*	Educational attainment may be absent or unassessed	If high school diploma or GED absent, enrolled in GED program	If appropriate, completed high school diploma or GED	If appropriate, pursuing post-high school vocational or academic education	If appropriate, pursuing an associate's, bachelor's, or other post-secondary training or degree

*Educational progression may not align directly with phases. Prior attainment, stabilization needs, and treatment engagement can affect timing and sequencing.

Supplemental Measures

In addition to core client-level measures, many programs collect broader outcome measures to establish baselines and track change over time.

Community- and System-Level Indicators

Measuring impact on homelessness, health systems, and the criminal justice system

- Number of homeless individuals in the community (overall and unsheltered).
- Number of encampments or street locations, stratified by those identified and resolved.
- Number of interactions between homeless individuals and first responders, stratified by law enforcement, crisis response teams, and fire or emergency medical services (EMS).
- Number of emergency department visits and inpatient hospitalizations among homeless populations.
- Number of overdose-related EMS calls, emergency department visits, and fatalities among homeless populations.
- Number of interactions between homeless individuals and the criminal justice system, stratified by arrests, jail detentions, convictions, and incarcerations.
- Average length of jail stay for homeless individuals with substance use disorders.

Program Access, Engagement, and Utilization

Measuring treatment access, participation, and continuity of care

- Number of community referrals, stratified by law enforcement, courts, hospitals, shelters, and outreach teams.
- Number of individuals admitted into treatment services, stratified by substance use treatment, mental health treatment, and physical healthcare treatment.
- Number of individuals placed in housing, stratified by shelter, transitional housing, subsidized housing, recovery residences, and other housing options.
- Number and percentage of scheduled services attended, missed, or cancelled.
- Average time from referral to treatment or placement (days), stratified by referral source.
- Length of stay in treatment, stabilization, or structured recovery programs.

Treatment, Recovery, and Health Outcomes

Measuring substance use, stability, and health improvement

- Number and percentage of participants completing treatment phases.
- Number of program graduates.
- Number of participants maintaining abstinence from drugs or recovery status, stratified by 6-month and 1, 2, 3, 4, and 5 years.
- Average rate of relapse and re-admission to treatment due to relapse.
- Average rate of engagement with peer recovery support services (e.g., number of contacts, minutes, referrals).
- Number of emergency department visits related to substance abuse or mental health conditions.
- Number of overdose risk behaviors and overdose incidents.
- Average score on validated recovery capital measure (e.g., Assessment of Recovery Capital [ARC], Brief Assessment of Recovery Capital [BARC-10], Recovery Capital Questionnaire [REC-CAP], or the Recovery Capital Index [RCI]).

Housing Stability and Community Reintegration Outcomes

Measuring movement from homelessness toward independence

- Number of participants transitioning from the street or shelter to transitional or recovery housing.
- Number of participants successfully completing transitional and recovery housing.
- Number of participants living independently (their own home or unsubsidized housing).
- Number of participants with housing retention rates at 6, 12, and 24 months.
- Number of participants who return to homelessness after program exit.

"Our philosophy is operationalized through evidence- and strengths-based engagements, recognizing that most participants present with layered challenges tied to the social determinants of health - housing instability, unemployment, lack of education, justice involvement, and untreated trauma."

Brandon D. Lackey
Chief Program Officer, Foundry Ministries
Founding Board Member, Association of Christian Recovery Ministries
Executive Administrator, Alabama Rescue Services Association

Employment, Workforce, and Self-Sufficiency Outcomes

Measuring employment, economic participation, and progress toward long- term recovery

- Number of participants employed, stratified by part-time employment and full-time employment.
- Number of participants enrolled in job training, education, or credentialing programs.
- Number of participants obtaining educational degrees, stratified by high school diploma, GED, technical degree, Associate's degree, Bachelor's degree, Master's degree, and higher.
- Number of participants with employment retention at 6 and 12 months.
- Number of participants enrolled in public benefits, stratified by Medicaid, Supplemental Security Income (SSI), Social Security Disability Income (SSDI), and Supplemental Nutrition Assistance Program (SNAP).

Public Safety and Criminal Justice System Outcomes

Measuring alignment with justice and community safety goals

- Reduction in the number of repeat arrests and citations among participants.
- Number of participants successfully diverted from jail, stratified by treatment, assisted outpatient treatment, and civil commitment.
- Number of participants who successfully complete drug/treatment courts and/or comply with supervision requirements.

SNAPSHOT FROM THE FIELD

The partnership between the medical and educational centers of Johns Hopkins and the faith-based Helping Up Mission in Baltimore, MD required extensive negotiation and coordination to decide how much time each guest should spend in clinically/medically directed activities, versus other types of daily activities, such as educational, career development, life skills and optional spiritual services. Through years of research and practice, the formula for success was found to be an up to 40-hour therapeutic week, of which at least 12 hours are clinically/medically directed services, and 28 hours are for other types of living activities, such as recovery classes and work therapy.

Cost, Efficiency, and System Impact Measures

Measuring value, sustainability, and cost avoidance

- Cost per guest/bed per day.
- Cost per successful program completion.
- Estimated avoided costs associated with emergency department utilization, hospital admissions, and incarceration days.
- Estimated avoided costs associated with first responder engagement, including emergency medical services and law enforcement.
- Program capacity utilization rates.
- Estimated cost-offset due to participant employment.

SNAPSHOT FROM THE FIELD

Comprehensively assessing well-being and growth across significant life domains is a key component of the Better Together Project, a collaborative effort between CityGate Network, Adult & Teen Challenge, and The Salvation Army. This project enables The Salvation Army to track how effectively its Adult Rehabilitation Center programs achieve their mission of caring for people, creating faith pathways, and building healthy communities. Their framework includes:

- Happiness, Resilience, and Life Satisfaction
- Positive Emotional States (such as joy, gratitude, and optimism)
- Meaning and Purpose
- Character and Virtue
- Close Social Relationships
- Financial and Material Stability
- Spiritual Growth and Connection (including connection back to family and friends)

"By engaging with national practice leaders and policymakers, we continue to define and refine our approach to recovery, ensuring that every man and woman we serve receives the highest support, dignity, and opportunity for lasting life transformation. We are grateful to be part of the ongoing conversation shaping the future of addiction treatment and harnessing the power of community on a national level."

K. Daniel Stoltzfus, MPA
CEO, Helping Up Mission, Baltimore, MD

Chapter 3: Warm Handoffs from Crisis to Thriving

> *"The primary reason we chose to move our John Hopkins addiction medicine clinic into the Helping Up Mission was that both parties believed co-location of counseling, addiction medicine, and psychiatric services would decrease barriers to treatment and decrease the need for re-hospitalization by having a higher rate of engagement in the outpatient setting."*
>
> Dr. Denis Antoine
> Associate Professor, Psychiatry and Behavioral Sciences
> Johns Hopkins University School of Medicine

The journey from homelessness to meaningful social and community reintegration is long and challenging. Effective programs must integrate a core set of services that span the full continuum of care, adopt a "No Wrong Door" approach, and operate within a responsive network supported by outcome measures for every stage of the journey.

This chapter outlines the many phases at which successful programs require a warm handoff to ensure individuals do not drop off between phases.

While the journey towards long-term recovery, self-sufficiency, and thriving is described in a linear format, it must be understood that people may start at any phase and move forward and occasionally backward towards their goals. Warm handoffs between programs and phases should be bidirectional and coordinated. Care navigators, social workers, and peer support can be utilized during engagement and warm handoffs.

Phases of the Journey from Homelessness and Addiction to Long-Term Recovery

CRISIS:

EMS, Emergency Departments, Hospitals, Hotlines

Immediate safety, shelter, and lifesaving treatment, including initiation of addiction or mental health treatment medications.

STABILIZATION:

Detox Centers, Sobering Centers, Healthcare Settings

Trauma-informed engagement, withdrawal management, development of trust, rapport, and integration into services, including continuation of addiction or mental health treatment medications.

TREATMENT:

Primary Care, Specialty Care, Outpatient Treatment, Inpatient and/or Residential Treatment

Active engagement in evidence-based treatment, incorporation of faith-based support, peer recovery support services, transitional and recovery housing, mutual support groups (AA, MA, NA, SMART Recovery, etc.), education, employment training, and skills building.

EARLY RECOVERY:

Continuing Outpatient Treatment and Residential Treatment

Continuing treatment as needed, recovery housing or market-rate housing, community-based recovery support services, abstinence from drugs, education, sustainable income, and reintegration into community and family.

THRIVING:

Self-Sufficient (Stable Housing and Meaningful Employment), Continued Supportive Social Network

Sustained abstinence from drugs, independent living, meaningful social and community integration, and ongoing access to peer recovery support services and/or mutual support groups.

> *"Currently, it's easy to get high and hard to get treatment. We need to flip this on its head and make it hard to get high and easy to get treatment."*
>
> Dr. Robert G. Marbut Jr.
> U.S. Department of Housing and Urban Development

Services by Phase

I. Emergency Medical Services (EMS), emergency departments, hospitalization for acute care treatment, and hotlines.

II. Inpatient and outpatient crisis care and stabilization services, including withdrawal management, addiction treatment, and mental health treatment.

III. Inpatient and outpatient evidence-based substance use treatment services, including regular assessment of progress using standardized screening tools.

IV. Inpatient and outpatient evidence-based mental/behavioral health treatment services, including regular assessment of progress using validated clinical screening scales and standardized questionnaires.

V. Community recovery support services (e.g., peer recovery support services offered through recovery community centers) and mutual support groups such as Alcoholics Anonymous, Narcotics Anonymous, Marijuana Anonymous, SMART Recovery, Celebrate Recovery, or Jewish Alcoholics, Chemically Dependent Persons, and Significant Others (JACS).

VI. Range of housing options tailored to phase and individual needs (i.e., shelters, transitional housing, recovery housing, recovery residences certified by the National Alliance for Recovery Residences, and other options).

VII. Employment preparedness support, including skill-building and training interventions.

VIII. Opportunities for education (e.g., high school diploma completion, GED, technical colleges, and universities).

IX. Transportation (e.g., public transportation or other alternatives).

X. Care coordination or case management (e.g., peer specialists or healthcare workers).

XI. Legal services and financial education.

Partnerships Based on Trust Build Collaborative Community Infrastructure

Collaborative community infrastructure is built through partnerships based on trust. Most programs provide additional services to meet the needs of their communities and homeless populations. While some programs can incorporate additional services within their own organizational infrastructure, most partner with other organizations. Leveraging existing community infrastructures reduces costs and increases efficiency.

Trusted partnership networks include:

- 988 crisis contact centers
- Addiction treatment providers (available in inpatient, residential, and outpatient settings)
- Case managers and social workers
- Certified Community Behavioral Health Clinics (CCBHCs)
- Child psychiatrists and other pediatric mental health providers
- Child welfare and social services agencies
- Community-based nonprofits that address health and welfare
- Community mental/behavioral health centers
- Continuums of care
- Courts, especially drug courts, mental health courts, and other problem-solving/treatment courts
- Crisis stabilization units
- Dentists
- Detox centers
- Drop-in centers
- Educational institutions (i.e., universities, technical colleges, junior colleges, local school districts)
- Emergency departments and hospitals
- Employers
- Faith-based organizations
- Family support groups
- Federally Qualified Health Centers (FQHCs)

SNAPSHOT FROM THE FIELD

If a guest who arrives at Helping Up Mission for treatment does not quality for services, either because they require detox or are seeking a shorter-term of outpatient program, a peer recovery coach tracks that individual's progress and stands ready to provide transportation and a warm handoff back to the Mission.

Additionally, a mobile street outreach bus from Helping Up Mission provides hot soup to homeless individuals to build relationships, encourage them to seek treatment, and support their transition off the streets. The goal is to connect individuals to treatment, with peer recovery staff leading the outreach.

SNAPSHOT FROM THE FIELD

At East County Transitional Living Center (ECTLC), substance use and mental health treatment are viewed as essential first steps in the recovery journey. ECTLC works closely with community-based behavioral health and substance use providers to ensure that every participant can quickly access care and begin treatment. The program also helps sustain efficient operations through therapeutic work assignments that support daily functions such as clerical assistance, laundry, and food services, providing participants with opportunities to build practical skills, establish a positive work history, and engage productively within the community.

- First responders (i.e., police, firefighters, mobile crisis units, and ambulance staff)
- Housing providers
- Housing shelters
- Legal services for clients
- Libraries
- Mental/behavioral health providers (available in inpatient, residential, and outpatient settings)
- Mutual support groups (e.g., 12-step groups, SMART Recovery, Celebrate Recovery)
- Peer recovery and support organizations
- Peer respite centers
- Places of worship
- Primary care providers
- Prisons and jails
- Public housing agencies
- RESET centers
- Residential addiction treatment
- Schools
- Urgent care clinics
- Veterinarians
- Vocational rehabilitation services

Integration of Faith and Medicine

Faith-based organizations have long played a foundational and enduring role in addressing homelessness in the United States and globally. For centuries, they have been pioneers in providing shelter, food, and social support to individuals in need, often stepping in where formal systems were limited or absent.[14] Today, these organizations remain deeply embedded in communities and should be recognized as essential partners in homelessness response systems. Their reach and trust within communities are particularly important given that spirituality remains central to many Americans' lives; with 83% of American adults reporting believing in God or a universal spirit,[15] faith-based organizations are vital contributors to addressing homelessness and supporting recovery.[16]

In advancing responses to homelessness and addiction, it is important to leverage the full range of tools available. In a historic first, the 2026 National Drug Control Strategy prioritizes the strength of faith and spirituality in prevention, treatment, and long-term recovery. The objective is not to impose belief, but to recognize and support its relevance for the many individuals who identify faith or spirituality as being meaningful in their lives.

SNAPSHOT FROM THE FIELD

At Haven for Hope, emergency medical technicians were employed on campus to expand the workforce and provide participants with unique, specialized support that complements traditional medical care, helping to reduce ambulance calls and emergency room visits.

Research indicates that recovery deepens when paired with faith. Evidence suggests that faith-based approaches can play a constructive role in substance use recovery.[17,18] Individuals with substance use disorder frequently identify spiritual beliefs as a source of motivation, resilience, and meaning in their recovery journeys. Spiritual and religious frameworks may support mental health by providing positive coping strategies, connection to supportive communities, and the reinforcement of hope and purpose.[19] In turn, these factors provide a sense of hope and recovery support. Studies on spiritually integrated approaches have found associations with improved recovery outcomes, increased engagement in recovery supports, and strong social connectedness.[18] Other findings suggest that individuals who engage in spiritual or religious approaches may experience improved treatment engagement and recovery outcomes, including higher rates of abstinence from drugs and continued recovery over time.[18] Approximately three-quarters of substance use recovery programs in the United States incorporate a spiritual component,[20] including models such as 12-step programs that emphasize reliance on a higher power.[21]

While there are many outstanding examples of faith-based organizations successfully helping homeless people re-integrate back into their communities, there needs to be a more systematic effort to scientifically study and publish the outcomes from faith-based programs.[19]

Recent federal policy efforts emphasized the importance of ensuring that faith-based and community organizations can fully participate in service delivery systems. Executive Order 14205 set conditions for faith-based entities, community organizations, and houses of worship to compete on a level playing field for federal funding, strengthening the capacity of these organizations to contribute to prevention, treatment, and recovery services as part of a broader and coordinated system of care.

WARM HANDOFF ENTRY POINTS

- Behavioral health providers
- Child protective services
- Courts
- Crisis stabilization teams
- Detox
- Emergency Departments
- Family referrals
- Hotlines
- Law enforcement
- Online
- Social service agencies
- Peer support/peer-led organizations
- Places of worship
- Prisons/jails
- Public health services
- Respite care
- Stabilization/sobering centers
- Street outreach
- Walk-ins
- Work

Community Asset Mapping and Needs Assessment

Communities must take a clear-eyed, systematic approach to understanding their existing resources and unmet needs. Asset mapping provides a structured framework for identifying strengths, surfacing gaps, reducing fragmentation, and improving coordination across public, private, secular, and faith-based organizations.[22] When done well, it supports the development of a recovery-oriented system of care grounded in accountability, measurable outcomes, and long-term stability.[23]

Assess the Community's Full Continuum of Care

This includes emergency shelters and street outreach teams; detoxification, substance use treatment, and mental health providers; access to addiction and mental health medications; healthcare systems such as hospitals and primary care; transitional and non-subsidized housing; workforce development and employment services; faith-based and community organizations; criminal justice and law enforcement partnerships; and peer recovery support providers and recovery housing. Mapping these assets helps communities understand their strengths and weaknesses in available services and sheds light on how individuals move, or fail to move, among systems and services. Providing housing alone, without integration of treatment and recovery services, is often insufficient to support long-term stability and may be associated with an increased risk of adverse outcomes, including overdose.

Ask Key Community-Level Questions

- What services currently exist, and who can access them? Who is not being served?
- Where are our most significant gaps in care or continuity?
- Which of our systems struggle to coordinate, and why?
- What clinical, operational, regulatory, or cultural barriers impede recovery, and how might they be addressed?
- What public policies, zoning rules, or funding constraints limit effective program implementation or integration?

Engage Community Stakeholders in Mapping

Broad stakeholder engagement is essential: a range of perspectives strengthens accuracy, builds shared ownership, and increases the likelihood of sustainable solutions. Communities stakeholders should include:

- Local, state, tribal leaders.
- Healthcare and behavioral health providers.
- Law enforcement and criminal justice partners.
- Leaders from faith-based and community-based organizations, including local peer-led nonprofits.
- Employers, workforce agencies, and housing developers.
- Nonprofit and philanthropic leaders.
- Individuals with lived experience of homelessness, addiction, and long-term recovery.

Commonly Identified System Gaps

- Incentives for continued homelessness.
- Lack of deterrence for vagrancy and crime.
- Open-air drug markets and open use of drugs.
- Fragmented service delivery and silos among systems.
- Insufficient long-term recovery and stabilization programming.
- Workforce limitations, including shortages of peer workers and clinicians.
- Regulatory or administrative funding restrictions that slow innovation or exclude faith-based organizations or providers.
- Weak coordination between treatment, housing, and public safety systems.
- Policies that constrain collaborations and partnerships across systems.

Desired Community-Level Outcomes

Desired outcomes at the community level include reductions in unsheltered, acute, and chronic homelessness; decreased access to drugs; higher rates of engagement in evidence-based treatment and recovery support services; lower recidivism and reduced strain on emergency and justice systems; and greater housing stability, employment, and long-term recovery. Asset mapping plays a critical role in identifying system gaps and informing coordinated action to achieve these outcomes. By intentionally aligning healthcare, housing, behavioral health, faith-based organizations, workforce development, public health, and public safety within a shared framework, communities can strengthen accountability and build more integrated and long-term recovery-centered systems of care.

Chapter 4: Financing

There is no single funding source that comprehensively covers the longer-term programming needs required to help people move from addiction and homelessness to long-term recovery and social and community reintegration. Successful programs rely on a mix of public and private funds. These sources often include federal and state funds, philanthropy, opioid settlement restitution funds, in-house businesses, and client contributions or existing funds at the patient level (e.g., private health insurance, SNAP, Medicaid).

Many Summit participants reported that philanthropy was their largest source of funding. Partnerships are also critical, particularly with criminal justice agencies, courts, and academic institutions, which often have complementary resources and are not competing for the same funding streams. Some successful programs operate in-house businesses, such as thrift stores or other social enterprises, to fill funding gaps. Others use work therapy models, allowing clients to earn income and contribute toward housing costs. Some programs emphasize the value of partnering with academic institutions to support grant-writing, as well as the data collection and reporting necessary to sustain most federal and state funding.

While many successful programs continue to use opioid settlement restitution funds to support significant portions of their programs, those funds are state-controlled and generally short-term, limiting sustainability.[24,25] As a general matter, programs should seek to ensure multiple funding sources to reduce exposure to shortfalls from a single source, avoid limitations imposed by the rules of a single funding source, and maximize flexibility in the use of funds.

There was shared agreement among Summit participants on the foundational and interconnected importance of faith, community, and evidence-based treatment for long-term recovery. Summit participants consistently noted challenges associated with faith-based organizations accessing federal and state funding. Many faith-based organizations are ineligible for public funds unless they significantly change how they operate, including faith-based curricula, counseling, and hiring practices.

Coverage for Healthcare, Behavioral Healthcare, and Addiction Treatment

Access to healthcare, behavioral healthcare, and substance use disorder treatment for homeless individuals is supported through a range of public and private funding mechanisms and service delivery systems. These programs vary significantly in their eligibility requirements, scope of covered services, funding structures, and regulatory frameworks at the federal, state, and local levels. As a result, the availability, continuity, and comprehensiveness of care differs greatly across communities and populations. Understanding these differences is important for program design and aligning resources to meet the complex and service-intensive needs of homeless individuals and individuals with addiction.

Medicaid, the largest public payer of health insurance for those under the age of 65, is state-administered in accordance with federal requirements. Eligible homeless individuals may be covered by state Medicaid plans; however, homelessness does not in itself qualify an individual for Medicaid eligibility. For eligible homeless individuals, Medicaid can be an important source of healthcare coverage, including for behavioral healthcare. Find your state Medicaid agency for more information on eligibility.

Medicare, which is administered at the federal level, provides health insurance for homeless individuals enrolled in Medicare, typically on the basis of disability or being age 65 or older.

HRSA Health Center Program-Funded Health Centers provide low- and no-cost physical healthcare, mental healthcare, and substance use disorder treatment services in many communities. Find a location close to you.

Community Mental Health/Behavioral Health Clinics provide low- and no-cost mental health and substance use disorder care in many communities. Find a location close to you.

Certified Community Behavioral Health Clinics (CCBHCs) provide comprehensive, coordinated outpatient mental health and substance use disorder care to those they serve. They are required to provide services regardless of an individual's ability to pay or place of residence. Find a location close to you.

Private insurance may be available in some cases. This is especially true among individuals who are twenty-six years of age or younger and may still be getting health insurance through their parents. The Health Insurance Marketplace is a good starting point.

Out-of-pocket payments are often the only option for homeless populations. There may be some existing funds at the patient level (e.g., health insurance, SNAP), and in some cases, family members may be able and willing to offset some expenses.

SNAPSHOT FROM THE FIELD

Miracle Hill Ministries, the largest provider of residential services to homeless people in South Carolina, found it difficult for their guests to obtain employment opportunities. Many of the formerly homeless guests had criminal histories, health barriers, and poor work histories in their past; community employers were reluctant to hire them. To address this lack of employment options, the organization established four workforce reentry programs, including a staffing agency, and ten thrift stores, all of which hire program participants as employees. Profits from these businesses go back to fund program activities.

Program funds, raised by the parent program organization, are often used to cover healthcare and mental/behavioral healthcare costs. Many programs rely on fundraising; discretionary federal, state, or community grants; and philanthropic contributions.

Federal Funding Opportunities

Federal funding through competitive grant programs and block grants can cover some program requirements. Attention needs to be given to combining funding sources. While State Block Grant funds are available nationally, states ultimately make the decisions regarding which programs receive funding, based on state priorities.

U.S. Department of Housing and Urban Development (HUD) Funding Opportunities

Grants	Description
Continuum of Care (CoC) program	The CoC Program is designed to promote a community-wide commitment to the goal of ending homelessness, provide funding to quickly rehouse homeless individuals and families while minimizing the trauma and dislocation caused by homelessness, promote access to and effective utilization of mainstream programs by the homeless population, and optimize self-sufficiency. **Nonprofit providers, states, Indian Tribes, tribally designated housing entities, and local governments** can compete through local Continuums of Care to receive funding for transitional and permanent housing for homeless individuals and families, as well as a wide range of supportive services, including substance use disorder (SUD) treatment.
Emergency Solutions Grant Program (ESG)	The ESG Program is designed to assist people with quickly regaining stability in permanent housing after experiencing a housing crisis and/or homelessness. **States, metropolitan cities, urban counties, and territories** can apply for funding to conduct street outreach; improve the number, quality, and operation of emergency shelters; provide essential services to shelter residents; and rapidly re-house homeless individuals and families.
HUD-VA Supportive Housing (HUD-VASH)	HUD-VASH is designed to help homeless veterans and their families sustain permanent housing and access the healthcare, mental/behavioral health treatment, and other supports necessary to help them improve quality of life and maintain housing. **States and territories** can apply for funding that pairs HUD Housing Choice Voucher (HCV) rental assistance with VA case management and supportive services.
Recovery Housing Program (RHP)	RHP provides funding for **states** to provide stable, transitional housing for individuals in recovery from SUD. RHP eligible activities include public facilities and improvements; acquisition and disposition of real property; payment of lease, rent, and utilities; rehabilitation, reconstruction, and construction of single family, multifamily, and public housing; clearance and demolition; relocation; and administration and technical assistance. Funding covers a period of not more than two years or until the individual secures permanent housing, whichever is earlier.

U.S. Department of Veterans Affairs (VA) Funding Opportunities

Grants	Description
Supportive Services for Veteran Families (SSVF)	SSVF grants provide housing stability services to low-income, homeless veteran families or who are at imminent risk of becoming homeless through compassionate and responsive services. Grantee services center on four core concepts: housing with supportive services, crisis response, veteran choice, and progressive assistance. **Organizations** can apply for funding to provide trauma-informed services that are flexible and veteran-centered to meet the individual housing needs of veterans and their families.
HUD-VA Supportive Housing (HUD-VASH)	HUD-VASH is designed to help homeless veterans and their families sustain permanent housing and access the healthcare, mental/behavioral health treatment, and other supports necessary to help them improve quality of life and maintain housing. **States and territories** can apply for funding that pairs HUD Housing Choice Voucher rental assistance with VA case management and supportive services.
Grant and Per Diem (GPD)	The GPD program awards grants to **community-based organizations** to offer transitional supportive housing through a range of housing models tailored to the unique needs of veterans. The GPD program also provides Case Management grants to support permanent housing retention for previously homeless veterans.
Health Care for Homeless Veterans (HCHV)	The central goal of the HCHV program is to reduce homelessness among veterans by reaching out to the most vulnerable and engaging them in supportive and rehabilitative services. HCHV provides funding to local VA Medical Centers (VAMCs), which contract with **community-based agencies** to provide short-term residential treatment to veterans in need of immediate housing placement, including while they are seeking permanent housing and/or additional services. Outreach services are also provided through Community Resource and Referral Centers (CRRCs), located in many large urban areas, and at Stand Down events. Many HCHV programs serve as the hub for a myriad of housing and other services, providing a way to reach and assist homeless veterans by offering them entry to VA care.
Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program	SSG Fox SPGP promotes a public health approach to suicide prevention that blends community-based efforts with linkage to evidence-based clinical strategies. Eligible **organizations**, including private institutions or foundations, a corporation owned or controlled by an incorporated private institution, Indian tribes, community-based organizations that can effectively network with local civic organizations; regional health systems, and state or local governments, can apply for funding to provide suicide prevention services for eligible Veterans and service members at risk of suicide and their families, including outreach to identify eligible veterans at risk for suicide; baseline mental health screening; education on suicide risk and prevention for families and communities; clinical services for emergency treatment; case management services; peer support services; assistance in obtaining benefits, including assistance with emergent needs; and nontraditional, innovative, or other services as defined in the Notice of Funding Opportunity and approved by VA.

HRSA
Health Resources & Services Administration

U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA) Funding Opportunities

Grants	Description
Health Center Program	Provides grants to **community-based and patient-directed health centers** that provide comprehensive primary healthcare services to medically underserved people across the nation. Health centers treat people's medical and dental needs, and also may provide mental/behavioral health, substance use, and other healthcare services. Health centers adjust fees based on income and family size. The Health Center Program also provides targeted funding to support Health Care for the Homeless programs in health centers.

SAMHSA
Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration (SAMHSA) Funding Opportunities

Grants	Description
Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS BG)	The SUPTRS BG program's objective is to help plan, implement, and evaluate activities that prevent, treat, and provide recovery support services for substance use. **States** can apply annually for funds, which they have the flexibility to distribute to local government entities, such as municipal, county, or intermediaries, including administrative service organizations, and nongovernmental sub-recipients, such as community- and faith-based organizations, to deliver primary prevention activities and substance use disorder (SUD) treatment and recovery support services to individuals, families, and communities. Grantees are required to spend no less than twenty percent of their SUBG allotment on substance use primary prevention strategies, directed at individuals not identified to be in need of treatment. Funds can be used to support residential SUD treatment and sober/recovery housing through qualified programs, including American Society of Addiction Medicine Levels 3.1–3.5 residential services and National Association for Recovery Residences Levels I–IV recovery residences.
Community Mental Health Services Block Grant (MHBG)	The MHBG program's objective is to support **states** in carrying out plans for providing comprehensive community mental health services. Grantees can be flexible in the use of funds for both new and unique programs or to supplement current activities. Targeted populations are adults who have a diagnosable serious mental illness (SMI), which substantially interferes with or limits one or more major life activities; and children who have a diagnosable serious emotional disturbance (SED), which substantially interferes with or limits the child's role or functioning in family, school, or community activities. MHBG funds cannot be used for sober or recovery housing, for room and board payment, or to provide inpatient services. If a person with SMI or SED is receiving treatment in a residential setting (such as a group home), with residence there as part of their treatment plan, states may choose to use MHBG funds to support that care. MHBG funds can also be used for evidence-based services that provide wraparound support and person-centered case management, helping coordinate and connect individuals with SMI or SED to additional needed treatment and recovery services.
State Opioid Response (SOR) grants	SOR and TOR funding provides critical resources to **states and Tribal communities** to address the overdose crisis through prevention, opioid overdose reversal medications, SUD treatment (including medications for opioid use disorder [MOUD]), and recovery support. Focused on expanding access to evidence-based MOUD approved by the U.S. Food and Drug Administration, and the full continuum of recovery support services for opioid and stimulant use disorders, including adult and youth recovery housing.
Projects for Assistance in Transition from Homelessness (PATH)	PATH funds **states** to solicit proposals and award funds to **local public or nonprofit organizations** that provide services for homeless people with SMI. Supported activities for PATH include outreach; screening and diagnostic treatment; habilitation and rehabilitation; community mental/behavioral health; SUD treatment; referrals for primary healthcare, job training, educational services, and housing; and some housing services, as specifie in the Public Health Services Act.
Grants for the Benefit of Homeless Individuals (GBHI)	The goal of the GBHI program is to help communities expand and strengthen treatment and recovery support services for homeless individuals, including youth and families, who have SUD or co-occurring mental and substance use disorders. Grants are awarded for up to five years to **public and private nonprofits** to support outreach and engagement; mental and substance use screening and assessment; direct treatment for substance use and co-occurring disorders; assistance in accessing permanent housing; case management and recovery support services; enrollment for health insurance, Medicaid, and other mainstream benefits; and access to recovery support services.
Treatment for Individuals Experiencing Homelessness (TIEH) grants	The Treatment for Individuals Experiencing Homelessness (TIEH) program supports **states, tribes, localities, and non-profits** to provide comprehensive, coordinated, and evidence-based services for homeless or at-risk individuals, youth, and families with a serious mental illness (SMI), serious emotional disturbance (SED), or co-occurring mental and substance use disorders (COD). Grants are awarded for up to five years to states, governmental units within political subdivisions of a state, Tribal communities, tribal organizations, Urban Indian Organizations, and public and private nonprofits to support three primary types of activities: (1) integrated mental and substance use disorders treatment and other recovery-oriented services; (2) efforts to engage and connect clients to enrollment resources for health insurance, Medicaid, and mainstream benefits; and (3) coordination of housing and services that support sustainable permanent housing. Linkages to HUD's Coordinated Entry system are required.
Safety Through Recovery, Engagement, and Evidence-based Treatment and Supports (Streets) Initiative	The Safety Through Recovery, Engagement, and Evidence-Based Treatment and Supports (STREETS) program advances evidence-based approaches that promote recovery, self-sufficiency, and safety. The STREETS program funds **political subdivisions of states (cities, counties), Indian tribes, and tribal organizations** to support comprehensive, street-based engagement, treatment, and recovery support services for individuals who are homeless and have serious mental illness (SMI), serious emotional disturbance (SED), substance use disorders (SUD), or co-occurring mental and substance use disorders (COD). Housing assistance requires participation in treatment and focuses on moving people to sobriety and self-sufficiency.
Other SAMHSA grants	Depending on the specific grant statute, program design, and allowable activities, certain SAMHSA grant programs may support recovery housing, residential treatment, and supportive services for homeless individuals with substance use disorders.

Chapter 5: A Community Response Model for Homeless Encampments*

Encampments are formed when groups of homeless people sleep in places not meant for human habitation, such as sidewalks, abandoned buildings, parks, underpasses, or vacant lots.[26] People living in encampments face serious, at times life-threatening, challenges, including untreated mental illness, substance use disorders, physical health conditions due to unsanitary and unsafe conditions, limited healthcare access, and long histories of trauma.[26-28] The traditional response of allowing the growth of homeless encampments has not produced lasting solutions and often worsened outcomes for both individuals and neighborhoods.[26-29]

The Homeless Outreach Services Teams (HOST) provide a fundamentally different model, bringing public safety, healthcare, housing, and community partners together in a coordinated model of "compassionate strength." The program embraces a humanitarian approach and includes the following components:

- Outreach, building intentional relationships within encampments.
- Triage.
- Crisis stabilization.
- Boundary setting.
- Rapport building.
- Collaborative partnerships – "whole-of-community" approach.
- Transparency and timelines for regular engagement.
- Long-term housing stability.
- Public safety.

The Homeless Outreach Services Teams (HOST) program has achieved full encampment resolution for over 1,500 encampments with:

- *No arrests*
- *No use of force*
- *No litigation*

Rather than reacting once a crisis occurs, the model emphasizes repeated outreach, trauma-informed engagement, and deliberately planned pathways off the street.

Delivering a Coordinated Response

The model emphasizes that homelessness is a community-wide issue, not just a law enforcement issue. It requires multiple systems to work together simultaneously. The model integrates:

- Specialized law enforcement teams.
- Homeless outreach and housing navigation services.
- Substance use and mental health treatment providers.
- Medical and public health services.
- Public works and environmental remediation teams.
- Community-based organizations, faith partners, and local stakeholders.

Each partner plays a clearly defined role, coordinated through shared planning, documentation, and timelines. This ensures individuals are not passed from agency to agency, but instead experience a single, coordinated system of care.

*This chapter is based on resources shared by the Homeless Outreach and Services Teams (HOST) during the White House April 2026 Summit.

The Five Step Encampment Response Framework

The model follows a five-step process that balances outreach, empathy, public safety, and accountability. This structure helps communities move from unmanaged encampments toward stabilized sites, eventually resulting in positive housing outcomes.

1

Identification

Encampments are identified through community reports, field observations, and partner referrals. Priority is given to sites with high public safety, health, or environmental risk.

2

Assessment

A multidisciplinary team evaluates conditions at the site, including:

- Individual needs (health, behavioral health, housing).
- Environmental risks (fires, sanitation, access).
- Vulnerable populations (seniors, veterans, people with disabilities).

Each individual's needs and engagement history are documented to guide appropriate service connections later.

3

Outreach and Engagement

Teams conduct repeated outreach to the homeless people at the encampment, often over the course of 30 days. Trust building is central to this phase, and outreach is trauma-informed. Outreach continues until individuals are placed into housing and engaged in services, or until all reasonable engagement efforts have been undertaken. Outreach includes:

- Explaining available services and housing options.
- Connecting people to medical, mental health, and substance use care.
- Respecting individual choice while consistently offering help.

4

Posting Timelines

The date by which individuals must vacate the encampment is clearly stated and posted so everyone is aware. Posting ensures transparency, due process, and time for final service engagement before the posted deadline.

5

Encampment Resolution

Encampment resolution focuses on positive housing outcomes, rather than arrests or involvement with the criminal justice system. Activities may include on-site housing placements, shelter transport, service linkage for those not immediately housed, cleanup and site restoration, and post resolution stabilization services to help prevent re-encampment. The site is returned to its intended public use, improving safety and quality of life for the surrounding community.

Specialized Teams and Targeted Responses

Program staff are carefully selected based on experience, maturity, communication skills, and emotional intelligence. Required training includes (1) crisis intervention, (2) trauma-informed engagement, (3) motivational interviewing, (4) autism awareness, and (5) veteran-specific training.

The program includes tailored responses for specific situations that pose heightened risk or complexity. These focused responses allow the program to adapt to a wide range of real-world conditions while maintaining a consistent service philosophy.

- **Pathway Home Model:** Long-term, trust-based engagement at encampment sites to support transitions into interim and permanent housing.
- **Vehicle Encampment Response:** Addressing the safety, traffic, and sanitation risks associated with vehicle habitation in encampments while offering service pathways and legal compliance options.
- **Fire and High-Risk Response Units:** Preventing and responding to fires, especially in wildfire-prone areas and high-hazard zones.
- **Veterans Outreach Teams:** Veteran-to-veteran engagement with embedded VA clinicians and peer support.
- **Weather and Emergency Advisements:** Proactive protection during extreme weather events.

HOST cleared over 1,500 encampments in twelve months with no arrests, no litigation, and no use of force. This framework is intentionally adaptable. Communities with different sizes, resources, and governance structures can modify the model while preserving its core principles. Aligning public safety with health, housing, and human services, the model demonstrates that communities do not have to choose between compassion and accountability.

With thoughtful implementation and strong partnerships, this model provides a clear pathway for developing safer public spaces, stronger communities, and lasting pathways out of homelessness.

Chapter 6: Integrating Care for Drug-Endangered Children in Homeless Families

Homelessness and addiction are typically addressed through adult-focused systems, rather than age-appropriate approaches that address the unique needs of children.[30] Homelessness and substance use frequently co-occur within family systems, creating intergenerational cycles that expose children to instability, trauma, and long-term impacts that often remain hidden.[31] The risks to children cluster and compound over time, creating a developmental cascade that can result in repeated system involvement throughout adolescence and adulthood.[31-33] Addressing the needs of drug-endangered children requires trauma-informed, family-centered approaches that span multiple systems. Children are our most precious resource. Investing in children is investing in the future of America.

The National Alliance for Drug Endangered Children (NADEC) defines drug-endangered children as those who are at risk of suffering physical or emotional harm as a result of legal and/or illegal drug use, possession, manufacturing, cultivation, or distribution; or whose parent's or caretaker's legal or illegal substance misuse interferes with the caretaker's ability to parent and provide a safe and nurturing environment.

The scope of this issue is significant. According to NADEC, nearly one in four drug-endangered children experience unstable housing, compared to approximately 1 in 17 non-drug-endangered children.* A cross-sectional study found that, between 2011 and 2021, an estimated 321,566 community-dwelling children in the United States lost a parent to drug overdose.[34] A 2025 JAMA Pediatrics study estimated that nearly 19 million children in the United States live with at least one parent or primary caregiver who meets the criteria for a substance use disorder, representing approximately one in four U.S. children.[35] Data from the Adoption and Foster Care Analysis and Reporting System (AFCARS) indicated that 62,944 children who entered out of home care in 2021 were placed due to parental alcohol or drug abuse.[36] These findings reinforce the importance of early identification, prevention-focused intervention, and coordinated family-centered responses across systems.

Children exposed to homelessness and addiction are not only affected by today's crises; they are also at the center of tomorrow's outcomes. Communities that invest in evidence-based primary prevention, early identification, age-appropriate support or intervention, and cross-system collaboration can reduce long-term harm while strengthening families and communities. By embedding a child-centered lens into homelessness and addiction responses, communities can move beyond crisis management, toward lasting prevention.

How homelessness and parental addiction impact children:

- Higher risk for adverse childhood experiences[37]
- Higher rates of chronic absence from school and lower graduation rates[38]
- Greater likelihood of initiating alcohol or drug use at younger ages[39]
- Higher rates of depression and suicide[39]
- Increased behavioral issues[40]
- Higher risk for substance use in adulthood[39,41]
- Greater risk of becoming homeless in adulthood[41]
- Removal from the home[30]

*This information is based on resources shared by the National Alliance for Drug-Endangered Children during the White House April 2026 Summit.

What Communities Should Build into Homeless Programs to Identify and Meet the Needs of Drug-Endangered Children

Communities do not need to invest in building new programs and systems to support children affected by homelessness and addiction. Instead, they can strengthen existing programs by training personnel across programs to screen children for potential drug endangerment and to link families with needed resources.

> *"NADEC uses screening tools like SBIRT [Screening, Brief Intervention, and Referral to Treatment], multidisciplinary response teams, and school-based outreach to ensure children are identified sooner and supported consistently. Our goal is simple and urgent: children must be considered in every situation. They can no longer be the first impacted and the last to receive services. They cannot remain the forgotten ones. A parent or caregiver's recovery is not separate from a child's wellbeing; it is often the pathway to HOPE, stability, and healing for the entire family."*
>
> Eric Nation, Executive Director
> National Alliance for Drug Endangered Children

1. Identify Children Across Systems

Children should be screened wherever families interact with program services. This includes schools; homeless shelters; outreach and crisis stabilization teams; healthcare settings, including labor and delivery units; law enforcement; and emergency responders. Universal screening for drug-endangered children is a clear best practice, especially as a regular part of all intake assessments. Family shelters that allow parents and children to remain together, whenever possible, including as services are worked through, are a best practice. Bonding rooms in singles' shelters are of great value for individuals gaining custody. Reunification is a powerful motivator for recovery.

Train staff to recognize signs of child presence or risk. Treat a child's exposure to a parent's or caregiver's addiction as a clear warning flag for all children in the home environment.

2. Equip the Workforce

Frontline staff often encounter families before child-serving systems do. Training should include:

- Trauma-informed engagement and feedback with children and families.
- Understanding developmental needs, including age and developmentally appropriate communication and engagement strategies for children.
- Recognizing indicators that children may be present or affected, including environmental cues and caregiving dynamics.
- Mandatory reporting requirements and specific expectations for implementation.
- Family stabilization strategies.
- Programs and social resources to address each family member's needs (e.g., treatment or recovery program, parent peer networks, parenting classes, family therapy).
- Monitoring strategies (e.g., home or school-based observations or visits).

SNAPSHOT FROM THE FIELD

There are risks of secondary fentanyl exposure among children. In one case, a toddler presented symptoms of fentanyl poisoning, while a twin tested positive despite remaining asymptomatic. Clinical observations from Rady's Children's Hospital in San Diego indicate that children living in environments where a fentanyl overdose has occurred may test positive for fentanyl even in the absence of symptoms. These findings support the practice of testing all children who may have been exposed to fentanyl following an overdose event. A positive test result has serious implications for child safety and may warrant further assessment of the home environment.

3. Coordinate Across Systems

Housing, treatment, education, child welfare, and public safety agencies often serve the same families separately. Multidisciplinary collaboration is needed to prevent duplication, gaps, and missed opportunities.

4. Measure Child Outcomes

Programs commonly track adult outcomes such as housing placement or treatment engagement, but not child-specific indicators. Adding child-focused indicators such as school stability, safety, and well-being can support better decisions and accountability.

Adopting a Developmental Age-Appropriate Lens*

Children's needs change across development, and interventions should be tailored accordingly. While most programs will likely partner with existing child-focused agencies to address the needs of children, attention should be given to best practices to achieve optimal outcomes for children.

Infants and Toddlers (0–2 years old): Young children rely entirely on caregivers for safety and regulation. Exposure to chaos or neglect can disrupt brain development. Program considerations include:

- Predictable routines and stable caregiving relationships.
- Safe, calming environments.
- Support for caregiver capacity and responsiveness.

Preschool-Age Children (3–4 years old): Children begin to express emotions, but may blame themselves for instability. Program considerations include:

- Emotion naming and reassurance.
- Simple, honest explanations.
- Opportunities for play and expression.

Elementary-Age Children (5–8 years old): School-aged children are developing independence but still need adult guidance and validation. Program considerations include:

- Support with routines, school engagement, and emotional regulation.
- Opportunities to practice asking for help.
- Positive reinforcement and trust-building.

Preteens (9–12 years old): This age group becomes more aware of family challenges and may internalize stress. Program considerations include:

- Mentorship and trusted adult relationships.
- Creative outlets for processing experiences.
- Honest conversations paired with coping strategies.

Adolescents (13–18 years old): Teens may assume adult responsibilities, disengage from school, or be exposed to substance use themselves. Program considerations include:

- Open communication and prevention education.
- Connection to behavioral health and peer supports.
- Youth-centered decision-making and autonomy.

NATIONAL ALLIANCE FOR DRUG ENDANGERED CHILDREN

Communities can contact the National Alliance for Drug Endangered Children (NADEC) for assistance connecting with local DEC alliances, strengthening multidisciplinary partnerships, or developing a DEC approach within their communities. NADEC provides training, technical assistance, peer-to-peer learning opportunities, and resources to support child-centered, collaborative responses. Resources include the CheckDEC mobile application, which helps professionals identify potential risks and protective factors for drug-endangered children and connect to guidance and support tools.

* Content based on the Age-Appropriate Strategies to Help Children Impacted by Substance Use Disorder materials, provided by NADEC and Eluna Resource Center.

Chapter 7: Looking Ahead

"Each time I was released from jail, I went back to using drugs and could have died. Finally, I was given a choice: Stay in jail, go back to homelessness, or go to a program that provided treatment and accountability. I chose the program and it saved my life.

I am a living example of going from homeless and addiction to self-sufficiency and thriving. Thank you to both the police for rescuing me from the streets and to the program for introducing me to recovery and faith. We do recover."

Tom Wolf
Director of City Partnerships, Sunflower Sober
West Coast Director, Foundation for Drug Policy Solutions
Founder, The Pacific Alliance for Prevention and Recovery

Disrupting and dramatically reducing the cycles of homelessness and addiction is an urgent national priority and an achievable goal, but only if we act decisively and collectively. The approaches highlighted in this toolkit show how a "Treatment First" model can effectively help move people permanently from homelessness and addiction to self-sufficiency and long-term recovery.

Encouraging Innovative Best Practices

Leading programs are incorporating innovations that strengthen treatment effectiveness, support long-term recovery, and improve coordination across systems of care. These innovations emphasize evidence-based clinical practices, workforce development, cross-sector collaboration, and the use of technology to expand access, enhance accountability, and improve outcomes for homeless individuals, including those with addiction. Examples of innovative best practices include:

Advanced and trauma-informed clinical interventions

- Ensuring the use of evidence-based practices such as Motivational Interviewing, Dialectical Behavior Therapy, and Assertive Community Treatment.
- Utilizing contingency management for methamphetamine addiction.
- Addressing addiction to vaping and marijuana.
- Integrating Eye Movement Desensitization and Reprocessing (EMDR) therapy into programming.
- Including Transcranial Magnetic Stimulation (TMS), where clinically appropriate.

Technology-enabled care delivery and coordination

- Employing telehealth to expand access to licensed providers.
- Utilizing technology (e.g., AI-enabled tools, apps, and text-based therapy platforms) to complement and extend the peer recovery workforce.
- Incorporating proactive, automated scheduling systems to ensure treatment, work, and recovery supports do not overlap on the individual's personal daily schedule.
- Monitoring clients' daily activities via electronic ID card to ensure accountability in residential programs.
- Tracking clients throughout an entire county health system, from hospital through behavioral health, crisis center, detox, or rehab program.

Recovery support and accountability tools

- Incorporating recovery support apps that promote engagement, facilitate monitoring, link individuals to the broader recovery community, and support relapse prevention.

Workforce and system capacity development strategies

- Broadly utilizing the peer recovery workforce and partnership with peer-led organizations to support recovery, navigate systems and services, and learn the skills needed for successful community and family reintegration.
- Ensuring pathways to education for advancement.
- Intentionally integrating secular and faith-based institutions to expand recovery supports and reinforce values-based healing.

Cross-sector and community partnerships

- Collaborating between service providers and law enforcement to address safety and continuity of care. One example of this successful partnership is in Los Angeles County, where Homeless Outreach Services Teams (HOST) work with local homeless providers to get people out of homeless encampments and into programs.
- Cultivating partnerships among local government, universities, and faith-based organizations, such as the partnership between Johns Hopkins University, Helping Up Mission, and Manatee County, Florida. Clients from Manatee County are transferred to Helping Up Mission for treatment and integrated back to Manatee.

Economic stability and reintegration strategies

- Establishing social enterprise models that provide paid work experience and pathways to second-chance employment.

Supporting pet-friendly access to services

- Considering accommodation of pets on site. This can include providing designated spaces, outdoor access, and pet care services. Offering pet-friendly accommodations reduces a significant barrier for individuals who might otherwise have to choose between seeking services and keeping their pets.

Priority Areas for Scaling Impact

A shared understanding of long-term recovery should remain at the center of all efforts addressing homelessness and addiction. As defined by Summit attendees, recovery is the process of achieving meaningful self-sufficiency while remaining drug free. Long-term recovery-oriented outcomes include sustained abstinence from drugs, improved mental health, self-sufficiency (stable housing and employment), social connectedness, and family and community reintegration. The opportunity before us is to build a sustainable system that makes this process possible.

"Recovery is not a destination, but a process. A journey. We need to encourage growth, with the goal of seeing people maintain their recovery and bring others along with them. Identify and celebrate the victories. Celebrate them often. Watching someone achieve their goals makes others around them believe they can too."

Major Dawn McFarland, MA, LCDC
Salvation Army Officer, St Petersburg Suncoast Adult Rehabilitation Center - ARC Command

1. Build and Strengthen Program Infrastructure

Ensure consistent, high-quality recovery-oriented services across communities by:

- Disseminating toolkit practices broadly and supporting adoption and replication.
- Expanding training and technical assistance across the full housing and homelessness services continuum of care.
- Partnering with states, local governments, peer-led organizations, and certification bodies to expand the peer workforce and improve its integration with housing and homelessness services.
- Establishing national training initiatives that emphasize recovery supports beyond clinical substance use treatment.
- Helping new and emerging programs build on proven models rather than starting from scratch.
- Recognizing and strengthening the role of faith-based organizations and other trusted social anchors as core community partners and leaders.
- Providing clear guidance and training on confidentiality protections to safeguard client rights while expanding community-wide partnerships and enhanced communication.

2. Expand Sustainable and Flexible Funding

Increase access to funding that supports client choice and long-term outcomes by:

- Implementing national or statewide voucher-style funding models that allow resources to follow the individual to programs aligned with their needs and values.
- Requiring accountability through standardized and meaningful outcome reporting, including program completion and long-term recovery indicators.

3. Grow and Support the Workforce

Increase system capacity to deliver services by:

- Expanding training and technical assistance to optimize the incorporation of peer recovery specialists in influential positions across the full continuum of care.
- Supporting peer certification and credentialing pathways, as well as promoting adequate payment for services.
- Increasing trauma-informed training for healthcare providers, first responders, law enforcement, and crisis response teams.
- Expanding crisis intervention and crisis care training across emergency and mobile response systems.
- Providing clear confidentiality guidance so first responders, treatment providers, and recovery programs can collaborate effectively.
- Supporting pathways for faith-based organizations to be adequately reimbursed for services.
- Expanding the use of telehealth, including across state lines, to improve access.

4. Strengthen the Evidence Base

Improve accountability, effectiveness, and long-term impact through shared outcomes and data by:

- Focusing measurement on core organizational metrics and meaningful client outcomes, such as sustained abstinence from drugs, improved mental health, housing stability, employment, social connectedness, and family and community reintegration.
- Aligning program-level outcomes with long-term recovery goals.
- Developing a common set of data collection tools to enable consistency and national aggregation.
- Leveraging existing data from successful programs to expand the evidence base.
- Supporting learning collaboratives to help quickly share and disseminate best practices.
- Expediting rigorous evaluation of innovative and emerging models, including support of implementation science research, to help support rapid implementation to fidelity.

5. Improve Cross-System Collaboration

Reduce fragmentation across clinical and non-clinical systems by:

- Aligning language and expectations between recovery, housing, and clinical providers.
- Developing standardized frameworks for non-clinical recovery programs.
- Building on existing certification and accreditation models, such as from American Congress of Rehabilitation medicine (ACRM), the International Certification and Reciprocity Consortium, the National Alliance for Recovery Residences (NARR), and the Council on Accreditation of Peer Recovery Support Service (CAPRSS) to support shared standards and coordination.

Conclusion

An effective national response to addiction and homelessness requires compassion, accountability, and commitment. This Best Practices Toolkit represents a critical step and an urgent call to action. Continually collaborating and learning from successful programs will be essential to the successful advancement of this work. The subject matter experts who contributed to this work represent some of the most successful and innovative homeless programs in the country. The work ahead now is clear: We must move beyond isolated success stories and collectively commit to scaling these approaches, nationwide, through sustained investment and effort.

By recognizing recovery as a long-term, multi-dimensional, and non-linear process, and supporting the full continuum of care, policymakers, program leaders, and providers can help individuals move beyond crisis and short-term stability to lasting recovery and self-sufficiency. By adopting the core elements, ensuring transparency and accountability, and continuing to innovate, we can help more people achieve and sustain long-term recovery, and substantively reduce the number of people who find themselves without a home or hope for the future.

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