Appendix A

HOUSING: A CRITICAL LINK TO RECOVERY

An Assessment of the Need for **RECOVERY RESIDENCES** In Vermont

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Thanks goes first to **Downstreet's** Executive Director Eileen Peltier for stepping up so fully to address a critical need in the state and to the **Vermont Housing & Conservation Board** for providing the funding for this Needs Assessment.

This report would not be possible without the insights and information provided by many individuals working day to day to support the recovery of Vermonters with substance use disorders. My gratitude to each of you. A special thanks goes to the staff of **Vermont's Alcohol & Drug Abuse Prevention programs** (ADAP) for the generosity of their time providing critical information to this study and for their ongoing efforts to support Vermonters whose challenges are the subject of this report.

The author would also like to acknowledge the **Governor's Opioid Coordination Council** for their tireless work identifying the challenges, gaps and opportunities of Vermont's system of prevention treatment and recovery. Their efforts to highlight the need for a system of long-term recovery placed a spotlight on the need for recovery housing in Vermont.

Thanks also goes to **NeighborWorks America** and the **Hoehl Family Foundation** for their financial support for this effort.

Report design and data visualization: Scott Sawyer

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EXECUTIVE SUMMARY

Downstreet Housing & Community Development of Barre, VT engaged consultant John Ryan, Principal of Development Cycles in East Montpelier, VT to assess the statewide need for Recovery Residences (hereafter referred to as **RR**), a group housing approach to supporting Vermonters recovering from Substance Use Disorders (**SUDs**). The following summarizes key findings and recommendations from that assessment.

OVERALL ASSESSMENT

Vermont has a serious Substance Use Disorder problem affecting more than 52,000 residents, or one in 10 individuals over age 12. Only the District of Columbia has a higher concentration of substance use disorder.

The consultant estimates that roughly 1,200 individuals, or about 14% of the Vermonters entering treatment for an SUD in 2017, would benefit from access to a RR as a means of transition from a residential treatment facility or to support their recovery while in non-residential treatment.

Vermont's RR supply currently offers its form of transitional housing to just 2% of those leaving treatment each year. These 212 beds are disproportionately located in Burlington or Brattleboro. Several treatment hubs[1] have no RR option. Only one residence accommodates women with dependent children despite the fact that this sub-group represents a significant share of those in treatment.

Vermonters with SUDs and their families are among our most vulnerable neighbors. Though the disorder affects individuals at all income levels, those with SUDs are overwhelmingly poor. More than 3/4 of Vermonters in treatment today are Medicaid-eligible, placing nearly all of them in the category of Extremely Low Income. Housing instability represents one of the greatest external hurdles to a recovery that is already inherently difficult.

RECOMMENDATIONS

The consultant recommends that, provided certain conditions can be met, RR options in the state be increased, starting in those communities with the highest priority needs:

- **Rutland City:** one RR dedicated to men, and one dedicated to women and/or women with dependent children
- **St. Albans City:** one RR dedicated to men and one dedicated to women and/or women with dependent children
- **Barre/ Berlin (Montpelier):** one RR dedicated to women and/or women with dependent children

- **Burlington and/or South Burlington:** one RR dedicated to women with dependent children
- **St. Johnsbury:** One RR dedicated to women and/or women with dependent children.
- **Morrisville:** one RR dedicated to men

EX-1: New Admissions to Substance Use Disorder Treatment, By County, 2017

Hub Community & Counties Served	Men In Treatment	RR Beds	Women and Women w/ Dependent Children in Treatment	RR Beds
Middlebury Addison County	134	0	87	0
Bennington Bennington County	225	0	152	0
St. Johnsbury Caledonia Co. & Essex Co.	265	6	249	0
Burlington & S. Burlington Chittenden County	1312	81	752	33
St. Albans Franklin Co. & Grand Isle Co.	493	6	479	0
Morrisville Lamoille County	273	0	188	0
Newport Orleans County	212	0	129	0
Rutland Rutland County	377	0	522	0
Barre-Berlin Washington County	515	20	438	0
Brattleboro Windham County	454	42	303	8
Springfield & White River Junction Windsor County[2]	363	3.5	262	12.5
May Support Separate Hub				
Randolph Orange County	211	0	134	0

SOURCE: ADAP and Development Cycles Survey of RRs, 2018.

Each of these priority hub communities has more than sufficient need to sustain the RRs recommended. Developing these priority RRs represent a substantial undertaking requiring a large commitment of money and human effort. These highest-priority projects also represent an opportunity to continue to test the efficacy and demand for units in this model before taking it to communities with lower overall levels of SUD Treatment.

Conditions for Success

These recommendations are predicated on the ability of the Vermont Alliance of Recovery Residences (VTARR) and the other key stakeholders to successfully address the challenges identified in the assessment, specifically, the need to:

- Strengthen the delivery of wrap-around services by strengthening the network of service providers that play a programmatic role with the RR and its residents.
- Develop these projects at a pace that ensures a strong, seasoned and well-trained supply of mentors, coaches, house managers and case managers to whatever degree these roles interact with the residents of these RRs.
- Stress the importance of building a sense of community, self-worthiness and belonging both within the RR and within the community as a whole.
- Find a sustainable funding mechanism to bridge the gap between the true operational cost of a well-functioning RR and the extremely limited capacity of most residents to cover that cost.
- Commit to investing in the community organizing and messaging aspects of the process in order to manage expectations and build the capacity and resilience needed to address the inevitable setbacks the RR's residents will face.
- Develop a clear and flexible set of strategies to significantly reduce the capital risk associated with acquiring or substantially renovating properties that may have limited market potential should their purpose as RRs need to change.

WHAT IS A RECOVERY RESIDENCE?

A Recovery Residence is a group home dedicated to supporting individuals to live independently in the early stages of their recovery from any type of Substance Use Disorder. The residences mix adult residents of all ages, but they typically house men, women, and women with dependent children separately. Most commonly, a RR is a single-family structure housing between 4 and 10 residents in some combination of separate and shared rooms. Small multi-family recovery apartment buildings are growing as a common approach outside of Vermont. Residents pay something for their housing and commit to not using alcohol or illicit drugs during their tenure. RRs may or may not limit the duration of occupancy, but most stays range between 5 and 12 months. Residents typically sign contracts rather than leases, affording the sponsoring entity greater capacity to, among other things, remove individuals who do not abide by the terms of their agreements.

The RR model is predicated on supported, peer-based accountability. It leverages the common intention of residents to overcome their addiction and reassemble their lives. This

assessment presumes that the residents will receive a range of non-residential supports, including an individual coach or mentor; an array of recovery services offered at nearby Recovery Centers; and medication-assisted treatment (MAT), when needed, as well as other services provided by nearby Treatment Centers. Live-in residential supervision is not an element of the RR model assessed, though some RRs in Vermont and many nationally do hire live-in "house managers" to support the group life and the recovery process of the residents.

THE SCALE OF NEED

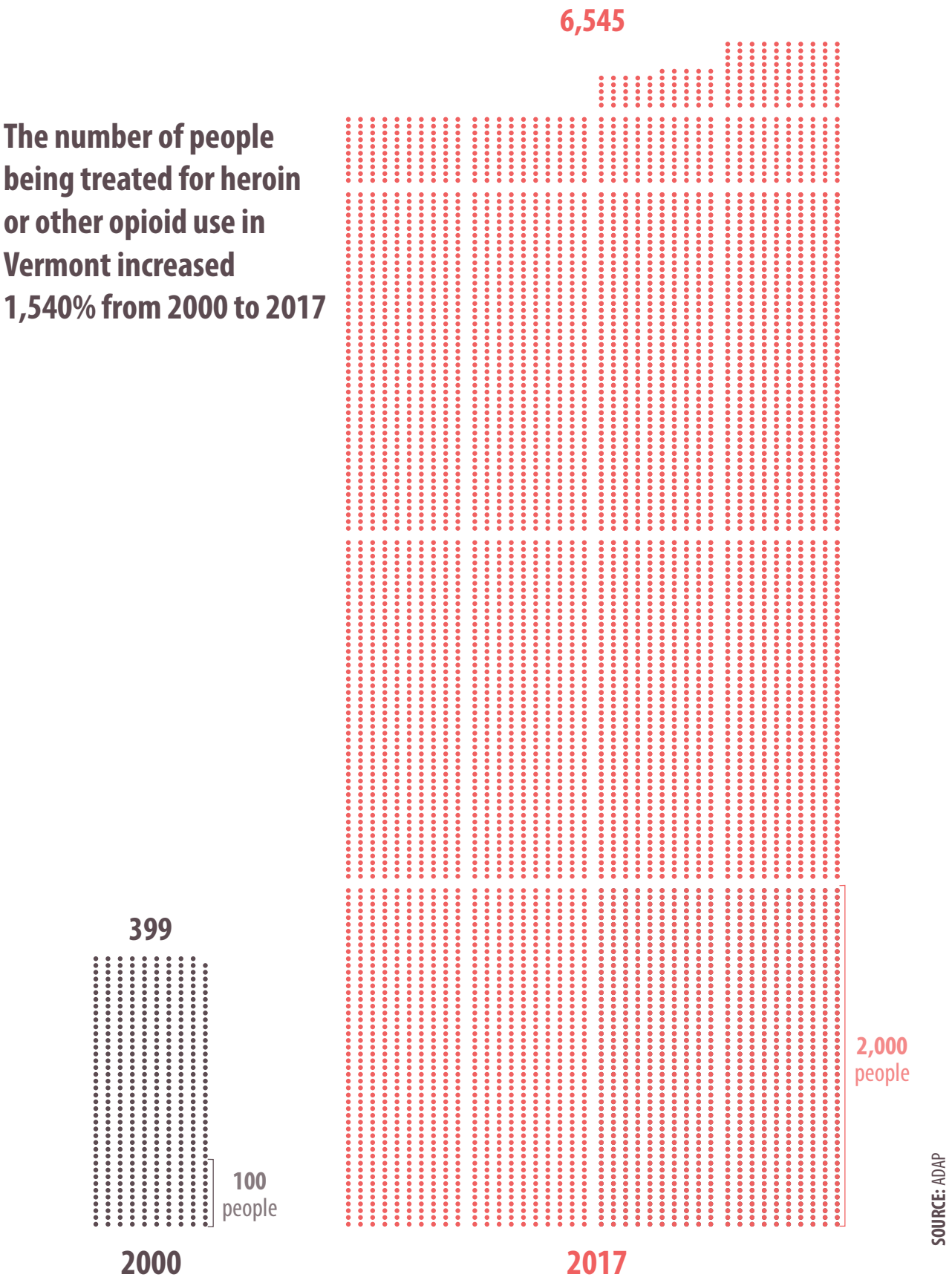
Among the 50 states, Vermont has the 4th highest rate of alcohol dependence and the highest rate of illicit drug use disorder in the country. Of the estimated 52,000 Vermonters who suffer from some form of Substance Use Disorder, alcohol dependence accounts for roughly 2/3rds of all cases. In 2016-17, 7% fewer Vermonters age 12 and over reported an alcohol use disorder compared to 2010-2011. Illicit drug use disorders, on the other hand, increased by 13% during those six years. The data suggests that **between 80-90% of Vermonters with a SUD are not in treatment for their disorder.**

Treatment for heroin and other opioid use has increased exponentially among Vermonters since 2000. In 2000, there were only 399 Vermonters in treatment for use of heroin or other opioids. By 2017, that number had risen by 1,500% to 6,545. **There are more Vermonters being treated for heroin or other opioids today than were treated for all forms of substance use disorder in 2000.**

The number of Vermonters receiving treatment for all types of SUDs is up 77% from 2000. In 2017, there were 11,498 individuals involved in Substance Use Disorder treatment programs that receive funding from the VT Department of Health's Alcohol and Drug Abuse Programs (ADAP). In addition to these individuals, an unknown number of others are treated at hospitals, by private physicians, or private counselors not funded by ADAP.

Young adults are at particular risk. The rate of substance use disorder is greatest among Vermonters aged 18-25. Within this cohort, 22.7% have a substance use disorder, a level that is a startling **51% higher than the national rate for this age group.** This cohort represents just over 10% of the state's population but accounts for a third of all of all SUDs and more than a third of all heroin and opioid use in the state. It is also a population underrepresented among those in treatment.

EX-2: Persons Receiving Treatment for Heroin or Other Opioids, Vermont, 2001 & 2017



EXISTING RECOVERY RESIDENCES IN VERMONT

The consultant identified 22 residences in Vermont that have recovery from SUDs as their primary purpose and also function as independent living with only limited in-house staff support.[3] These RRs offer a total of 212 beds representing about 2% of those currently in treatment for SUDs.

- 73% of these existing RR beds are reserved for men and 24% for women,[3] despite the fact that women currently make up 42% of all Vermonters receiving treatment for SUDs.
- Only one RR provides housing for mothers with their dependent children although a large number of admits to treatment are women with dependent children, many of whom have lost custody of those children.
- 65% of the RR beds are located in Chittenden County though it makes up only 24% of the total persons receiving substance use disorder treatment statewide.
- Five hub communities—Rutland, Middlebury, Bennington, Newport, and Morrisville, whose service areas treat one-quarter of all those with SUDs in the state — have no RRs.
- Three of these 22 RRs are either newly opened or under development, while at least two others have closed in the past year due to lack of funding or shifting use to meet other priorities.
- The residences experience relatively high levels of turnover, averaging more than two resident turnovers per year. They seldom function at full occupancy. Operators describe lack of funding, limited referral awareness, and the logistics of multiple transitions, rather than demand, as the cause of vacancies.
- Fewer than half of these residences have direct contracts with ADAP or the Department of Corrections that help underwrite their cost of operations.
- **Operators were nearly unanimous in prioritizing women with dependent children as the population in greatest need of a RR option.**

ESTIMATE OF THE GAP IN RECOVERY RESIDENCE NEED

The consultant estimates that roughly 1,200 individuals, or about 14% of the 8,498[4] Vermonters entering treatment for an SUD in 2017, would benefit from access to a RR as a means of transition from a residential treatment facility or to support their recovery while in non-residential treatment. The consultant bases this estimate on a detailed breakdown of the housing status of new admits to treatment, as well as results from a 2017 survey of 84 service providers, and discussions with NARR, VTARR,[5] and operators of Treatment Facilities, Treatment Centers, and Recovery Centers in Vermont. Key drivers for this need include:

- **Homelessness:** According to 2017 ADAP Housing Status data, over 900 individuals report their housing status as homeless at the start of treatment for SUDs.[6] Additionally, facility operators report that hundreds of others spend part of their time in residential treatment facilities or hospitals largely because they have nowhere else to live. According to the ADAP data, the number of homeless individuals in treatment has risen four-fold since 2000.

- **Inability to Pay for Housing:** More than three-quarters of those in state-funded SUD Treatment Facilities qualify to have Medicaid cover the cost of that treatment. For most individual persons in Vermont, the income limit for Medicaid eligibility is $16,764, a number that qualifies them as Extremely Low Income (<30% of Area Median Income or AMI). For Medicaid recipients at any household size, the income limits would qualify them as below 50% of AMI. These represent the income levels where housing is most insecure, where cost burdens are greatest, and where the ability to find affordable housing options are most constrained. These roughly 8,000 Medicaid-eligible individuals in treatment constitute between 20% and 30% of all the Extremely Low Income Households in the state.

- **Insecure Housing as an Impediment to Recovery:** The following comes from a report summarizing an October 2017 survey conducted by the Governor's Opioid Coordination Council and responded to by 84 treatment providers in Vermont:

  "For 75% of respondents from across the state, housing issues and stressors are complicating (and potentially undermining) treatment and recovery progress in at least 1/3 of their cases—and for most of those respondents, between 66% and 100% of their clients are dealing with a housing situation that they think is interfering with the client's recovery."

  28% of these respondents identified the need for RRs as the biggest gap in housing services available to their clients, while nearly half described housing affordability as the greatest challenge.

Currently, there are about 212 recovery-residence beds in Vermont, with a total potential to serve roughly 425 residents a year staying an average of six months. These beds are not distributed geographically, or in terms of sex or the presence of dependent children, to optimally serve those who need it. The consultant estimates that at least 1,200 Vermonters annually enter SUD Treatment who would meet all three of the following criteria: 1) they are at the appropriate level of recovery to be successful in the RR model;[7] 2) their alternative housing options would undermine their recovery efforts; and 3) they would choose to take up the RR option if it was located within their treatment hub, they knew about it, and it was affordable to them. To serve this population sustainably would require as many as 300 additional beds distributed statewide. **The population with the greatest unmet need is women with dependent children.**

AVAILABILITY OF APPROPRIATE HOUSING IN HUB COMMUNITIES

The treatment hubs are located in the same communities that serve as the primary focus of affordable housing efforts in Vermont. For the most part, established nonprofit housing organizations base their operations in these same communities. Outside of Chittenden County, the Recovery Centers and Treatment Centers are located in neighborhoods with home values, rents, and household incomes that are often well below the statewide median. All 12 communities assessed have a stock of at least 200 large single-family homes (4+ bedrooms) or small multifamily properties (2-4 units) that is within easy access of the existing treatment and recovery centers. Most have more than 500 appropriately sized properties for rent or acquisition. Ample stock combined with low acquisition prices and market rents in most of these target communities represents an opportunity to scale the RR model quickly. This advantage is balanced by the challenge of ensuring that these properties have enough value to cover acquisition and/ or renovation costs if their use changes.

CHALLENGES

Despite the scale of demand for RRs, the concept needs to effectively address several substantial challenges, including the following:

- The effort will need to significantly strengthen the network providing non-residential services to the RR residents, in order to, among other things, increase the effectiveness of the residence as a stabilizing influence; build social capacity and integration; and improve the readiness assessment and referral process. The importance of building a sense of community, self-worthiness and belonging both within the residence and within the community as a whole is paramount. Addressing this challenge effectively will require increasing the capacity of some of Vermont's existing Treatment Centers and Recovery Centers, especially in their provision of psycho-social and life-skills services.

- Scaling RRs within a peer-support model will require expanding the number of coaches, mentors, residence managers, and in some cases caseworkers, from among those who are themselves in recovery. Some service providers expressed concern that the opioid crisis was already promoting individuals too quickly from being in recovery to helping others in recovery, thus placing a great deal of stress and responsibility on individuals who were themselves vulnerable. A thoughtful process of vetting, training and seasoning those working in this space needs to go hand in hand with funding for the service elements needed for a sustainably successful RR model.

- Managing the community's expectations represents another major challenge. The problem these RRs are helping address is daunting. They will primarily serve residents with opioid addictions that carry an extraordinarily high relapse rate and potentially catastrophic consequences with each use. Despite the universal nature of addiction,

the reality is that those in greatest need for these RRs are predominantly young and extremely low income individuals, with low levels of employment, and relatively high levels of prior homelessness and co-occurring mental health issues. These residences will be located primarily in communities and neighborhoods where the incidence of drug and alcohol use and dependence are highest. It would be tragically naïve to imagine that these homes will not experience serious setbacks, including incidents of violence, drug dealing, overdose deaths, and adverse interactions with neighbors. Nothing will be more important to success in scaling the RR concept in Vermont than the commitment by stakeholders to building realistic expectations, resilience to setbacks, and long-term support for addressing these daunting challenges among those providing financial and community leadership.

- The concept that residents pay something to live in a RR is pretty much universally applied. At the same time, residents seldom have the capacity to cover the true costs needed to acquire (or rent), renovate, furnish, and maintain a home, much less pay for the in-house services required. **The consultant estimates that less than 30% of all Vermonters receiving treatment for SUDs can afford to pay more than $100/week for housing during their tenure in a RR.** Many will be unable to pay anything for the first few months of residency. Finding sustainable sources of revenue to bridge the gap between resident contributions and true costs will be critical.

- A RR is special needs housing that will be located, with few exceptions, in areas of Vermont where the demand for large single-family homes is weakest. Siting these residences will require even more sensitivity to its immediate surroundings than does traditional affordable rental housing, for it needs to balance convenience to treatment, buffer residents from negative community influences, and have the capacity to build a welcoming response from abutters and neighbors. That will be no small task. Even with a well-sited property, the RR provider looking to acquire or substantially renovate such a home may face a serious challenge demonstrating that those costs can be recouped if the property stops functioning as a RR. Some combination of the following strategies may be needed to address this challenge effectively:

    - Leasing rather than owning the RR
    - Fundraising rather than borrowing for acquisition and/or rehabilitation costs
    - Repurposing homes that are already in the non-profit housing or special needs housing portfolio
    - Negotiating long-term service contracts and operating subsidy commitments as a pre-condition to acquisition
    - Selecting only those single-family properties that have viable adaptive reuse potential as small multi-family rentals
    - Modifying the RR model to allow for the RR to have separate apartments within existing 2-4 family buildings
    - Attaching project-based rental assistance that can transfer to a change of use if needed
    - Funding a loss-reserve pool or loan guarantee program available to the portfolio of VTARR certified properties.

NOTES

1 Hub and Spoke is Vermont's system of Medication Assisted Treatment, supporting people in recovery from opioid use disorder. Communities with Regional hubs offer daily support for patients with complex addictions. At over 75 local Spokes, doctors, nurses, and counselors offer ongoing opioid use disorder treatment fully integrated with general healthcare and wellness services.

2 The 7-unit Springfield RR is open to men and women equally.

3 Vermonters with SUDs may access supportive or transitional housing whose primary function is other the recovery from substance use. These may include homes for veterans, for the homeless, for those previously incarcerated, or for those with physical or mental health disabilities. Vermonters with SUDs may also reside in residential facilities that have more restrictive freedom of movement and provide greater levels of on-site supervision than what is allowed and provided for in the RR model being assessed here.

4 8,498 represents the number of Vermonters who entered treatment in 2017 regardless of whether that was the first time they were receiving treatment; 10,498 represents the total number of people being treated; the difference is the number whose treatment spanned more than one year.

5 The 2017 Vermont State Housing Authority's "Annual Point in Time Statewide Count of the Homeless" counted a smaller number—228 of the 1,225 (19%)—of homeless persons in Vermont as describing themselves with an SUD.

6 Vermont Alliance of Recovery Residencies (VTARR): VTARR is a coalition of people and organizations from the recovery community focused on improving the RR landscape throughout Vermont. VTARR's mission is to support persons in recovery from addiction by improving their access to quality RRs through standards, support services, placement, education, research and advocacy. RRs that gain voluntary certification adopt a base standard of quality that positively impacts their members and communities. VTARR is an affiliate of NARR, the National Alliance of RRs.

7 Not everyone in treatment for a SUD needs a RR nor is everyone in treatment at the right stage of recovery to make good us of the option if they had it. The National Association for RRs (NARR) has identified four stages of RR, each based on the level of supervision and independence appropriate to the individual's wellbeing (see Appendix B for more information). The Recovery Residence model assessed in this study is only for residents in Recovery Level I and Level II.

I. INTRODUCTION

1. Purpose of Study

The purpose of this assessment is to provide a detailed and thoughtful estimate of the number of Vermonters whose recovery from Substance Use Disorder (SUD) relies upon the availability of transitional group housing, specifically Recovery Residences (hereafter referred to as RR) located near to existing Recovery Centers and Treatment Centers in Vermont's designated Hub communities.

2. Scope of Work

The assessment includes the following elements:

- Provides information on the scale, trends and demographics of substance use and substance use disorder in Vermont
- Provides information on the scale, trends and demographics of Vermonters receiving treatment for SUDs
- Assesses the adequacy of currently available residences to support Vermonters in recovery from SUDs
- Assesses the availability and appropriateness of the housing stock in neighborhoods near existing Recovery Centers and Treatment Centers in Vermont's designated 12 hub communities
- Identifies keys to success and critical challenges to RRs both in Vermont and elsewhere in the United States
- Projects the need for additional RRs in Vermont to serve the needs of three distinct sub-groups of Vermonters in recovery: men, women, and women with dependent children
- Prioritizes the level of need within the network of hub communities.

3. Methodology

In order to complete this Scope of Work the consultant utilized a wide range of sources, including:

- The US Substance Abuse & Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health

(NSDUH) for current and historical prevalence estimates of Vermonters and Americans both who use alcohol as well as prescription and illicit drugs and develop SUDs

- The Alcohol and Drug Abuse Programs (ADAP) of the VT Department of Health for a wide array of data on Vermonters receiving treatment for SUDs in state-funded programs

- The US Census Bureau's 2017 Five Year American Community Survey for census tract level housing, rents, and household income data

- Zillow.com for current listings of large single-family homes and small multi-family properties for sale in target areas of hub communities

- Google Maps to identify the location of recovery and treatment Centers, transportation hubs, and supermarkets in the target areas of hub communities

- Additionally, the consultant spoke with more than 25 subject experts including officials at ADAP and SAMHSA; operators or staff at Treatment Programs, Treatment Centers, Recovery Center and RRs in Vermont; and RR experts at or referred by the Vermont Association of RRs (VTARR) and the National Association of Recovery Residences (NARR). Appendix A lists those individuals interviewed.

4. Certifications & Limitations

John J. Ryan, Principal of Development Cycles located in East Montpelier, VT prepared this assessment and certifies that the recommendations and conclusions of this study are based solely on his professional opinion and best efforts. The study has a number of key limitations to consider when reviewing the findings and recommendations provided:

- Much of the data presented here for those who use alcohol and other illicit drugs come from annual surveys performed by SAMSHA. SAMSHA reports their estimates with a mid-level estimate as well as a range of high and low estimates that have at least a 95% confidence level based on the sample size. For clarity sake, the consultant reported only the mid-level estimate. It should be understood that, depending on the sub-group being detailed, the range between high and low estimate might be 50% or more. In general, it is best to think of these numbers in terms of scale. It certainly makes a difference if there are 4,000 or 15,000 young heroin users in the state, but the 7,750 number reported conveys a scale of use that puts the 212 beds of RRs into a meaningful context regardless of whether the reality is at the top or the bottom of that range.

- The information provided by ADAP for Vermonters in treatment for SUDs comes from direct unduplicated counts of recipients in state-funded programs. This clearly understates the total number of treatment recipients, for it does not include those treated in hospitals, and by private physicians and counselors not receiving funding

by ADAP. There was no reliable way to estimate how many more people might be in recovery but are not counted by the ADAP totals. For that reason, this assessment is based solely on the scale and demographics of those in state-funded treatment programs and should be seen as a conservative estimate of the real total need.

- The information, estimates, and opinions contained in this report were derived from sources considered reliable. The consultant assumes the possibility of inaccuracy of individual items and for that reason relied upon no single piece of information to the exclusion of other data, and analyzed all information within a framework of common knowledge and experienced judgment.

5. Introducing the Recovery Residences Concept

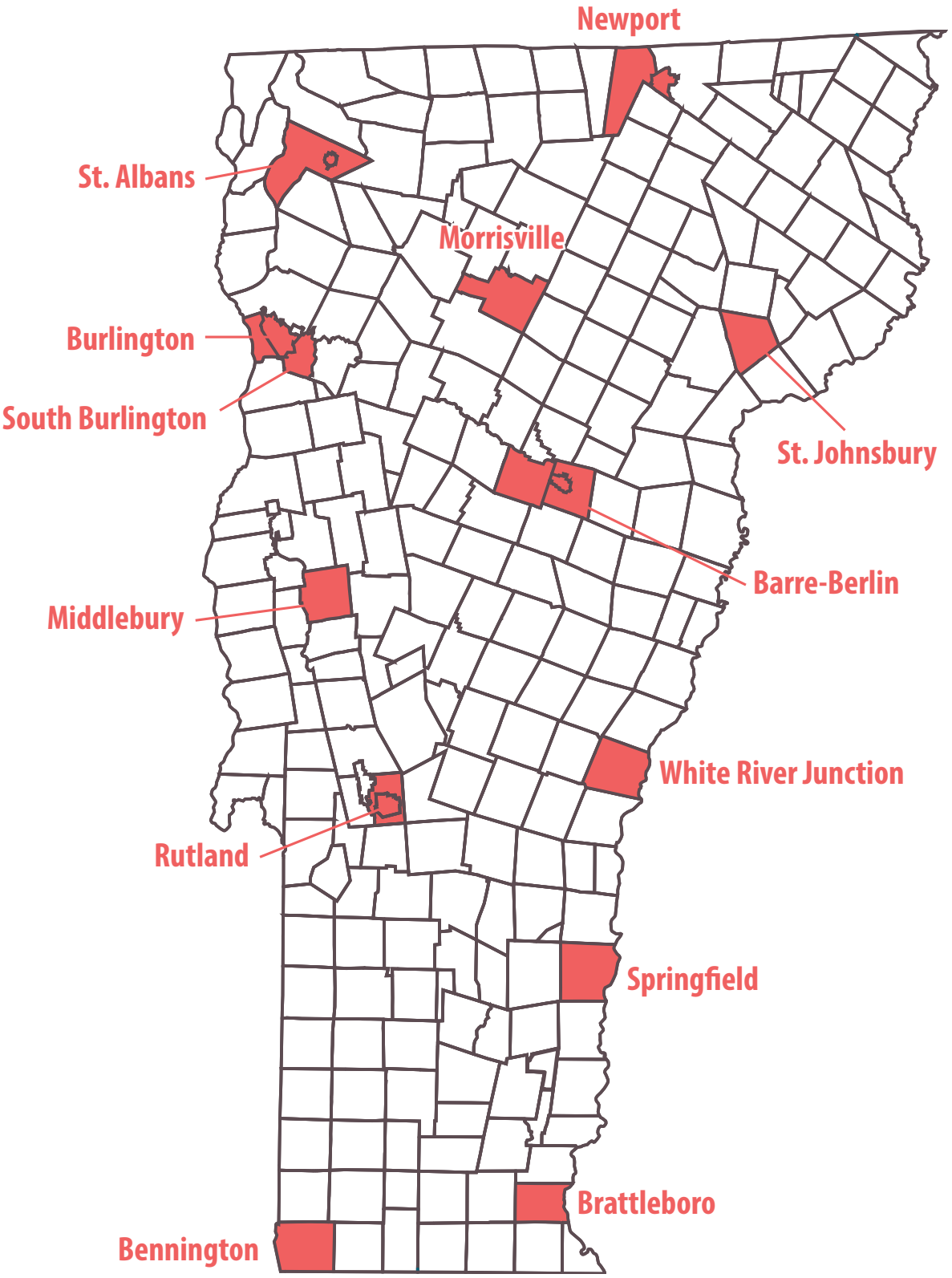
A Recovery Residence is a group home dedicated to supporting individuals to live independently in the early stages of their recovery from a Substance Use Disorder. This assessment presumes that any new RRs will be created within relatively easy access to the existing network of Treatment Centers and Recovery Centers located in the 12 designated hub communities:

1. Barre-Berlin
2. Bennington
3. Brattleboro
4. Burlington
5. Middlebury
6. Morrisville
7. Newport
8. Rutland
9. St. Albans
10. St. Johnsbury
11. South Burlington
12. Springfield

The RR model houses, without distinction, those whose disorder stems from alcohol, opioid, marijuana, or other kinds of substance use. The residence houses adults of all ages, but they typically house men, women, and women with dependent children separately. Most commonly, a RR is a single-family structure housing between 4 and 10 residents in some combination of separate and shared rooms. Residents pay something for their housing and commit to not using alcohol or illicit drugs during their tenure. RRs may or may not limit the duration of occupancy, but most stays range between 5 and 12 months. Residents typically sign contracts rather than leases, affording the sponsoring entity greater capacity to, among other things, remove individuals who do not abide by the terms of their agreements.

The RR model is predicated on supported, peer-based accountability. It leverages the common intention of residents to overcome their addiction and reassemble their lives. This assessment presumes that the residents will receive a range of non-residential supports,

I.1: Vermont's Treatment Hubs



including an individual coach or mentor; an array of recovery services offered at nearby Recovery Centers; and Medication-assisted treatment (MAT), when medically necessary, as well as other services provided by nearby Treatment Centers. Live-in residential supervision is *not* an element of the RRs model assessed, though some RRs in Vermont and many nationally do hire "house managers" to support the group life and the recovery process of the residents. Appendix B provides more details about the RR model.

II. ESTIMATING THE SCALE OF RECOVERY RESIDENCES NEED IN VERMONT

The following section looks at several underlying indicators of need for residences to assist Vermonters recovering from Substance Use Disorders (SUDs). These indicators include: alcohol and illicit drug use; substance use disorders; untreated SUDs; those in treatment for SUDs; and housing status and income level of those in treatment. The evaluation presents this information by age, by sex, by the presence of children, and by county wherever information is available at this level of detail and is important to understanding the scale of need.

1. Use Rates for Alcohol and Illicit Drugs

Vermont has one of the highest alcohol, marijuana and other illicit drug usage rates in the country. This is significant because use predicts use disorder, which is at the source of the need for RR development. For nearly every substance and age cohort measured, Vermont's usage rate exceeds the national average and is among the 10 highest rates of use.

II.1: Substance Use Rates By Substance, Vermont, 2016-17

Substance	Use Interval	% of Population Who Use In:		Vermont's % of National Average
		Vermont	US	
Alcohol	*Past month*	62.0%	51.0%	121%
All Illicit Drugs	*Past month*	19.4%	10.9%	178%
Marijuana	*Past month*	18.6%	9.3%	203%
Opioid Misuse	*Past year*	5.2%	4.6%	113%
Pain Reliever Misuse	*Past year*	0.4%	0.4%	101%
Cocaine	*Past year*	3.5%	2.0%	173%
Methamphetamine	*Past year*	0.5%	0.6%	191%

SOURCE: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016 and 2017.

To give a sense of scale, based on the SAMSHA survey, roughly 25,000 Vermonters used heroin or other opioids in the past year. Of these, an estimated 7,750[1] were 18 to 25 years. Though this age cohort represents only 13% of Vermonters age 12 and over, they constitute 30% of all Vermonters who used opioids in the previous year.

2. Substance Use Disorders (SUDs)

According to SAMSHA's 2016-2017, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 9.64% of Vermonters age 12 and over suffer from some form of Substance Use Disorder.[2] That represents more than 52,000 people in the state.

II.2: Substance Use Disorder Among Persons 12 Years & Older, Vermont, 2010-2011 & 2016-2017, By Alcohol & Illicit Drug Dependence

Primary Source of Disorder	Percentage		Number	
	2010-2011	2016-2017	2010-2011	2016-2017
Alcohol	7.8%	7.3%	42,205	39,285
Illicit Drugs	3.4%	3.8%	18,034	20,346
Primary Source of Disorder	**Rank Among States**		**Percent of National Average**	
	2010-2011	**2016-2017**	**2010-2011**	**2016-2017**
Alcohol	19	4	116%	133%
Illicit Drugs	2	1	125%	136%

SOURCE: FY 2010-2011 and FY 2016-2017 NSDUH State Prevalence Estimates; ranking does not include the District of Columbia.

Overall, Vermont is tied with Massachusetts as the state with highest rate of SUD in the United States. At 9.64%, Vermont's SUD rate is 31% higher than the national average.

Substance use disorder is greatest among Vermonters aged 18-25, for which it leads the nation by a considerable margin. Within this cohort, 22.65% have a substance use disorder, a level that is a startling 51% higher than the national rate. This cohort alone represents an estimated 16,708 individuals or 32% of all SUDs in the state. Less than 10% of that total currently receives treatment for their condition.

II.3: Substance Use Disorder Among Persons 12 Years & OLDER, Vermont, 2010-2011 & 2016-2017, By Age

Age Group	Percentage		Number	
	2010-2011	2016-2017	2010-2011	2016-2017
12 to 17	9.0%	5.5%	3,764	1,983
18 to 25	25.2%	22.7%	18,121	16,708
26 & Older	7.4%	7.8%	31,301	33,582
Total 12 & Over	10.0%	9.6%	53,618	52,164
Age Group	**Rank Among States**		**Percent of National Average**	
	2010-2011	**2016-2017**	**2010-2011**	**2016-2017**
12 to 17	2	5	127%	132%
18 to 25	1	1	131%	151%
26 & Older	10	7	111%	124%
Total 12 & Over	6	1	119%	131%

SOURCE: FY 2010-2011 and FY 2016-2017 NSDUH State Prevalence Estimates; ranking does not include the District of Columbia.

Alcohol use constitutes roughly two-thirds of all SUDs in Vermont, with illicit drug use constituting the other one-third. This is consistent with national data.

Neither SAMSHA nor ADAP track substance use disorders by sex or by the presence of dependent children at the state level. Nationally, however, 12% of dependent children under age 18 live with at least one parent with an SUD. Vermont has a 31% higher rate of SUD than the national average. This suggests that somewhere between 14,000- 18,000 children in Vermont are growing up in a household with some form of SUD.

The Department of Children and Families reported that in 2016, Vermont had 1,302 children in custody. Of the 266 children ages 0-5, over half (53%) were in custody due to opioid use within their household.

3. Persons Needing But Not Receiving Treatment

According to the SAMSHA estimates, 91% of Vermonters with a SUD are not currently receiving that treatment. For young adults (18-25) only about 5% report being in treatment for their SUD. The SAMSHA estimates do not correspond to the number of Vermonters who are actually receiving treatment. In order for there to be 11,498 Vermonters receiving SUD Treatment (this is ADAP's most recent count for 2017) either the number of Vermonters with SUDs is much higher than the SAMSHA estimates or the percentage not receiving treatment would need to be lower. As a result of this discrepancy, the consultant estimates that somewhere between 80-90% of those with a SUD in the state are not receiving treatment for the disorder.

II.4: Persons Needing But Not Receiving Treatment For A Substance Use Disorder, Vermont, 2010-11 & 2016-17, By Age

Age Group	Percentage		Number	
	2010-2011	2016-2017	2010-2011	2016-2017
12 to 17	8.2%	4.9%	3,442	1,766
18 to 25	23.1%	21.5%	16,613	15,853
26 & Older	6.5%	6.9%	27,734	29,788
Total 12 & Over	8.9%	8.8%	47,858	47,348
Age Group	**Rank Among States**		**Percent of National Average**	
	2010-2011	2016-2017	2010-2011	2016-2017
12 to 17	3	8	123%	125%
18 to 25	1	1	128%	153%
26 & Older	18	11	107%	116%
Total 12 & Over	8	1	114%	128%

SOURCE: 2010-2011 and 2016-2017 NSDUH State Prevalence Estimates

Despite the increased access to treatment and the dramatic increase in those in treatment in Vermont, the SAMSHA data suggests that Vermont is falling further behind other states in its effort to treat those with SUDs.

4. Trends in Substance Use Disorders

According to SAMSHA data, since 2010-2011 Vermont's overall level of SUDs has dropped by 2.7%. Underlying this relatively small change, are larger shifts in SUDs among cohorts that suggest demographics and public health response both play a role in the overall decline. The number of 12-17 year-olds reporting SUDs in 2016-17 was only about half the number who did so in 2010-11, representing a decline three times sharper than the decline in children this age. Clearly efforts to reduce SUDs for this youngest population are having an impact. The number of 18-25 year-olds with a SUD dropped by 7.4%, even as that population grew slightly. At the same time, SUDs among the much larger cohort of those 26 years and over increased by 7.3% in six years.

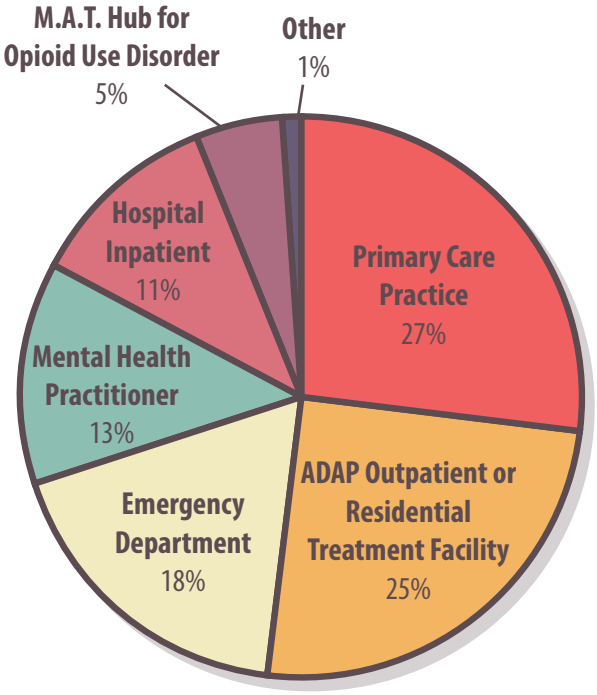
ADAP looks to patterns of use and attitudes toward use, especially among young people 12-17, as a means of looking at future trends in SUD. The range of data ADAP provided for this study (see Appendix C) suggest that while there may be some positive signs, especially regarding attitudes regard the risks of heroin and other opioid use, most of the indicators are pointing toward greater use and are not suggesting lower rates of SUD going forward. The overall impression left by these numbers is that while the particular substance of use may vary, the overall number of Vermonters who will suffer from a Substance Use Disorder is not trending downward. This is a view almost acknowledged by many of the professionals interviewed for this study.

Even where overall SUD rates have declined, as in the case of alcohol dependence, the rate of decline in Vermont is considerably lower than change experienced by the country as a whole. In 2010-2011, Vermont ranked 18th among the 50 states for alcohol dependence. Six years later, alcohol dependence in Vermont fell by 7.4% but it was now ranked as the state with the 4th highest level of alcohol SUD.[3]

5. Referral to Treatment

Individuals may be identified as potentially needing SUD treatment in many different places. In 2015, people were initially identified with a potential substance use disorder in the following locations:

II.5: Where The Need For Treatment Gets Identified, Vermont, 2015

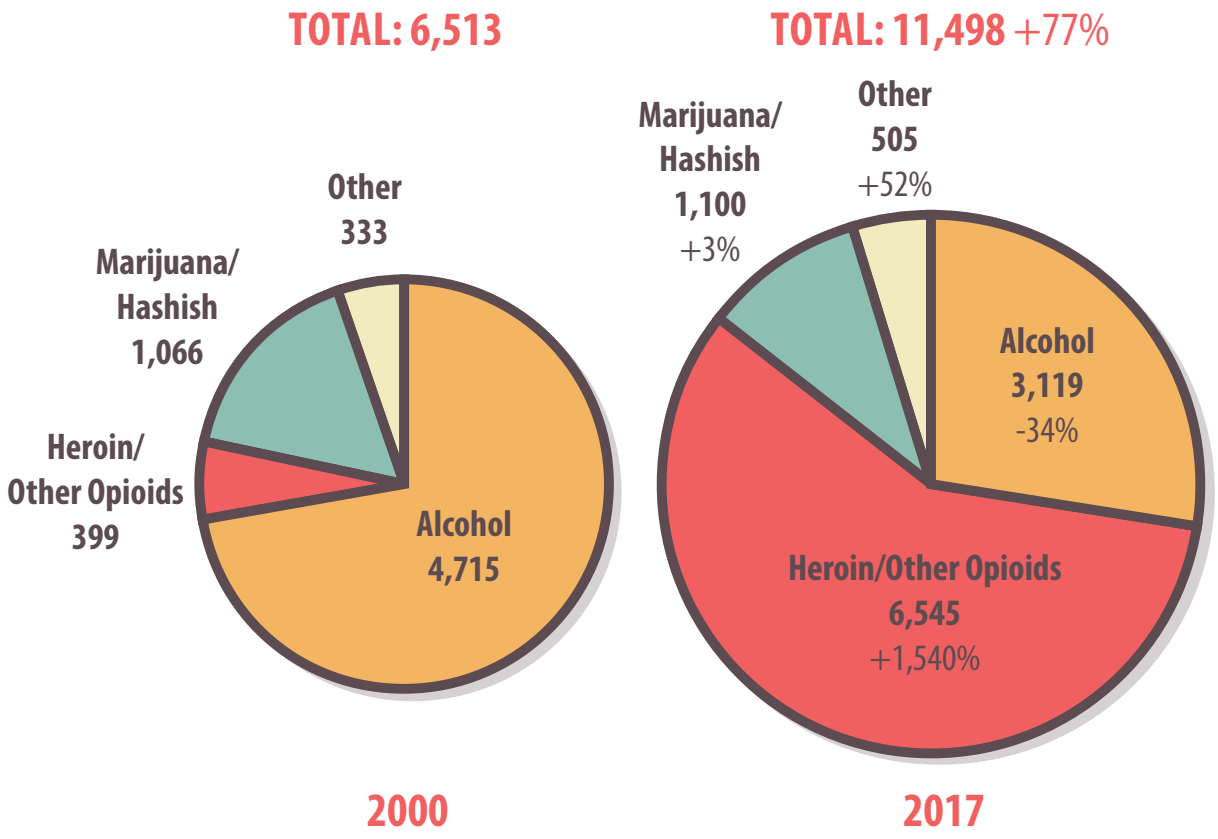


SOURCE: VDOH Alcohol & Other Drug Use Scorecard, 2015

6. Vermonters Currently Receiving Treatment for SUDs

In 2017, there were a total of 11,498 Vermonters receiving treatment for a substance use disorder. That number has increased by 77% since 2000. At the turn of the millennium, alcohol treatment accounted for 72% of all those receiving treatment and heroin and other opioids just 6%. By 2017, heroin/ opioids represented 58% of all those treated, while alcoholism accounted for just 28% of the total.

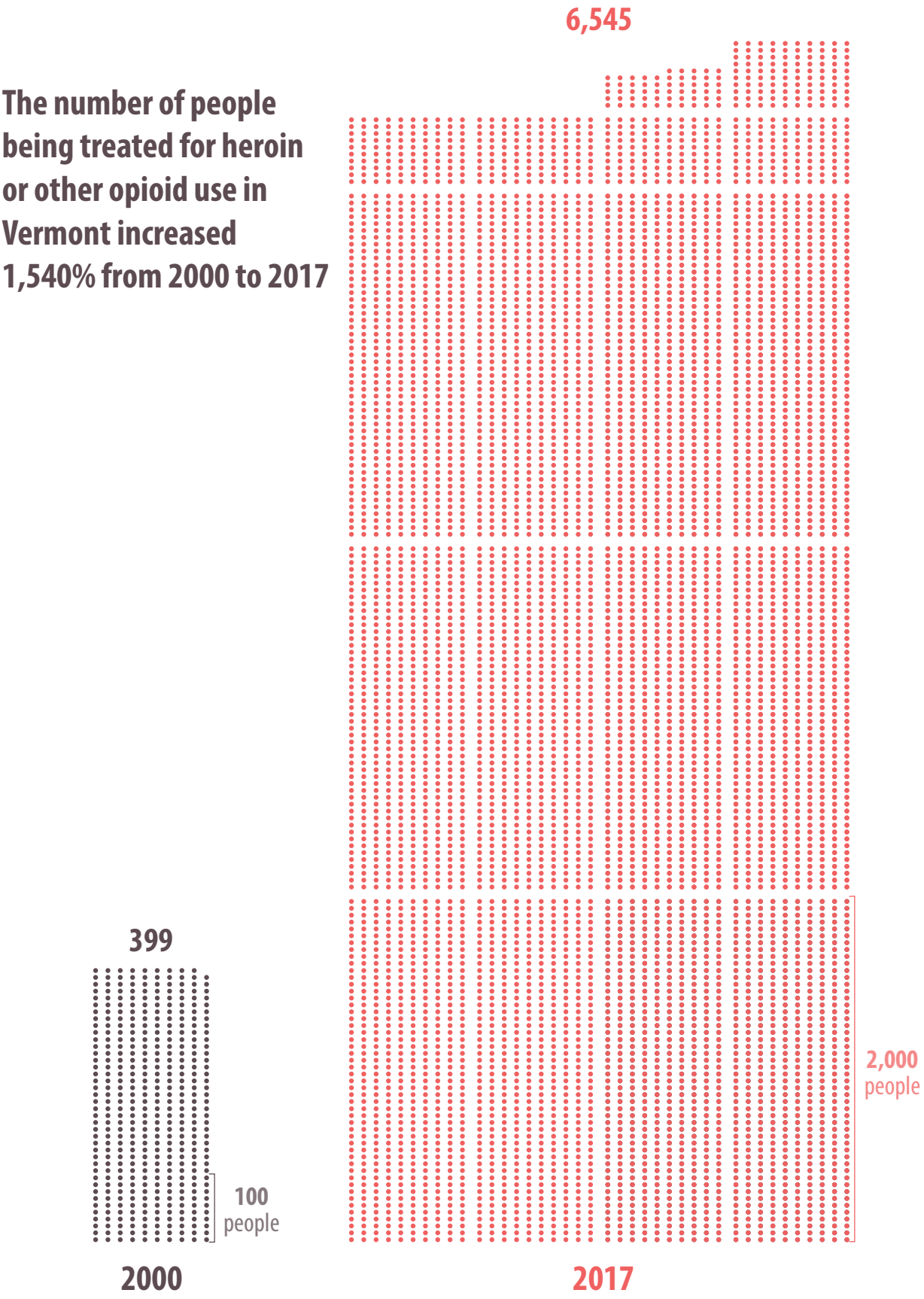
II.6: Persons Receiving Treatment By Primary Substance, Vermont, 2000-01 & 2016-17



SOURCE: ADAP, Vermonter in SUD Treatment in ADAP Funded Programs, 2000-2017. Note: ADAP recently updated Total numbers for 2017 but Substance numbers have not been updated. Consequently, Substances in 2017 pie chart will not sum to Total.

In raw numbers, there were 399 individuals receiving treatment with heroin and other opioids as their primary substance in 2000; by 2017 that number has increased to 6,545.

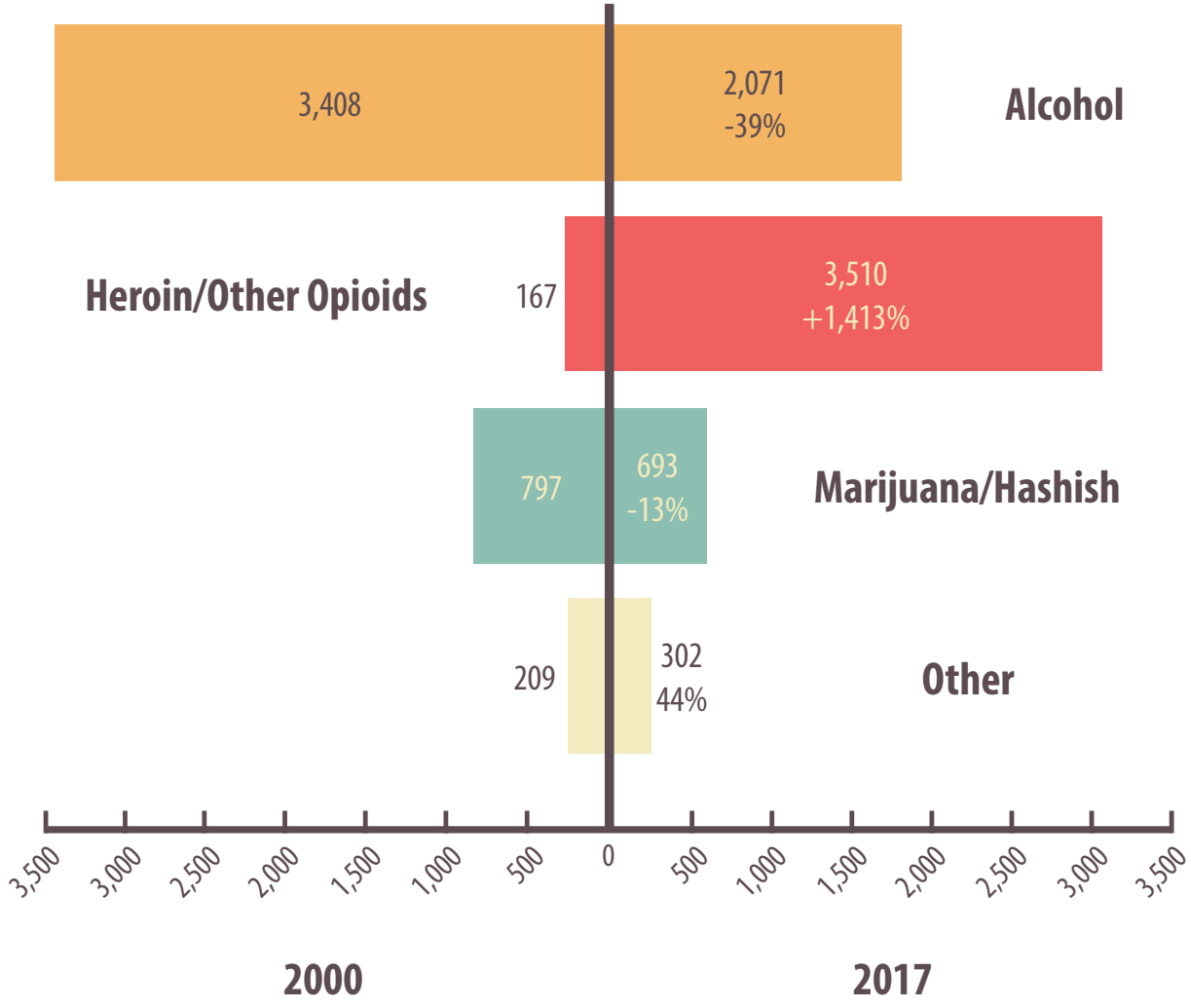
II.7: Persons Receiving Treatment for Heroin or Other Opioids, Vermont, 2000 & 2017



SOURCE: ADAP

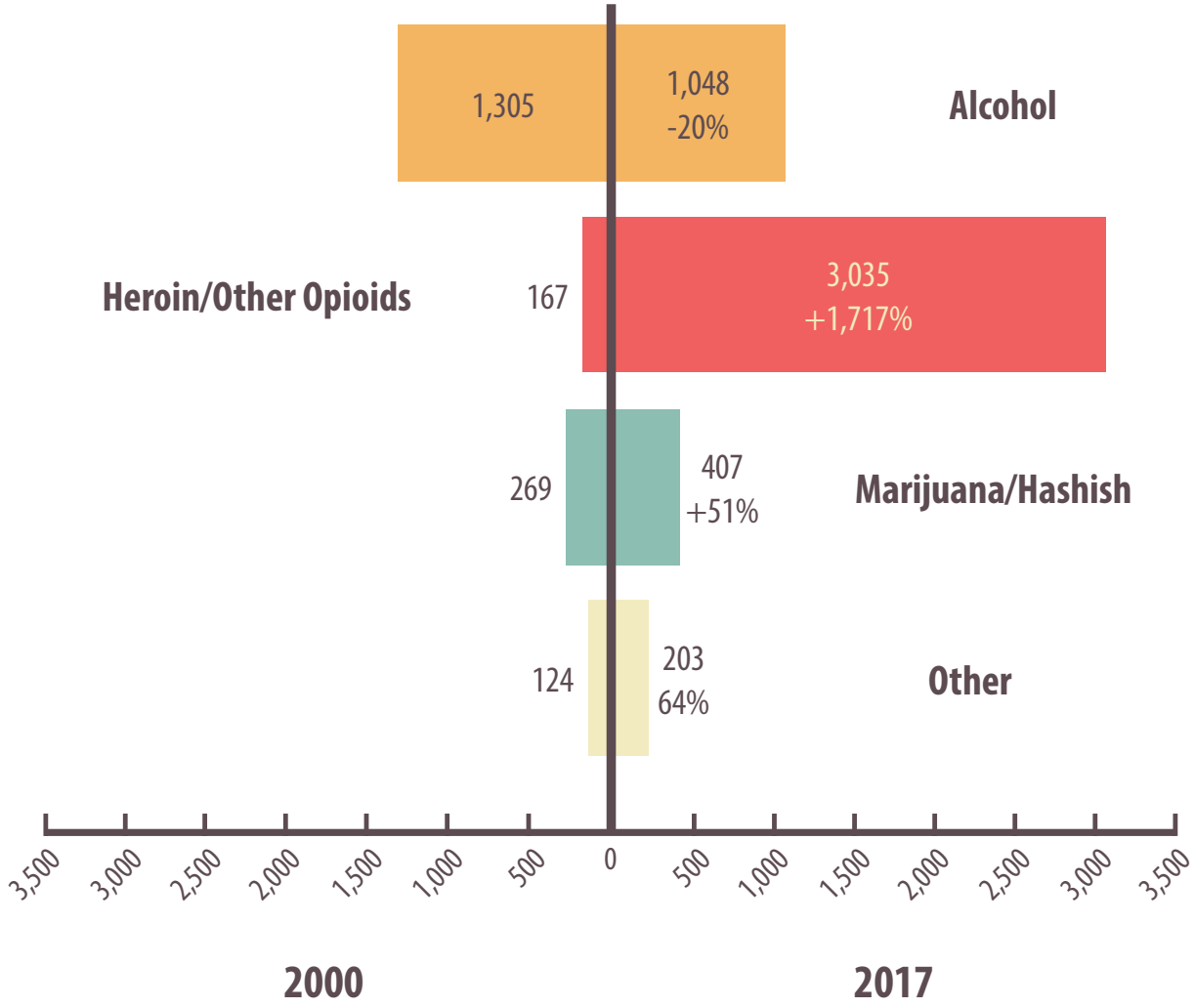
Figures II.8 and II.9 show the increase from 2000 to 2017 by the primary substance for those in treatment by the sex of the patient. It shows men are twice as likely to be in treatment for an alcohol-related disorder than women but only slightly more likely to be in treatment for heroin or other opioid use. Those seeking treatment for alcohol-related disorders has dropped by 20% for women and nearly twice that rate for men since 2000. Treatment for Heroin and Opioid use increased 14-fold for men and 17-fold for women during that period. **Treatment Center respondents note that the rapid decline in those being treated for alcoholism was not an indicator of lower rates of alcohol dependence but actually represented a gap in services as the state tries to get a handle on the explosion in heroin use.**

II.8: Men Receiving Treatment For Substance Use Disorder By Primary Substance, Vermont, 2000 & 2017



SOURCE: ADAP

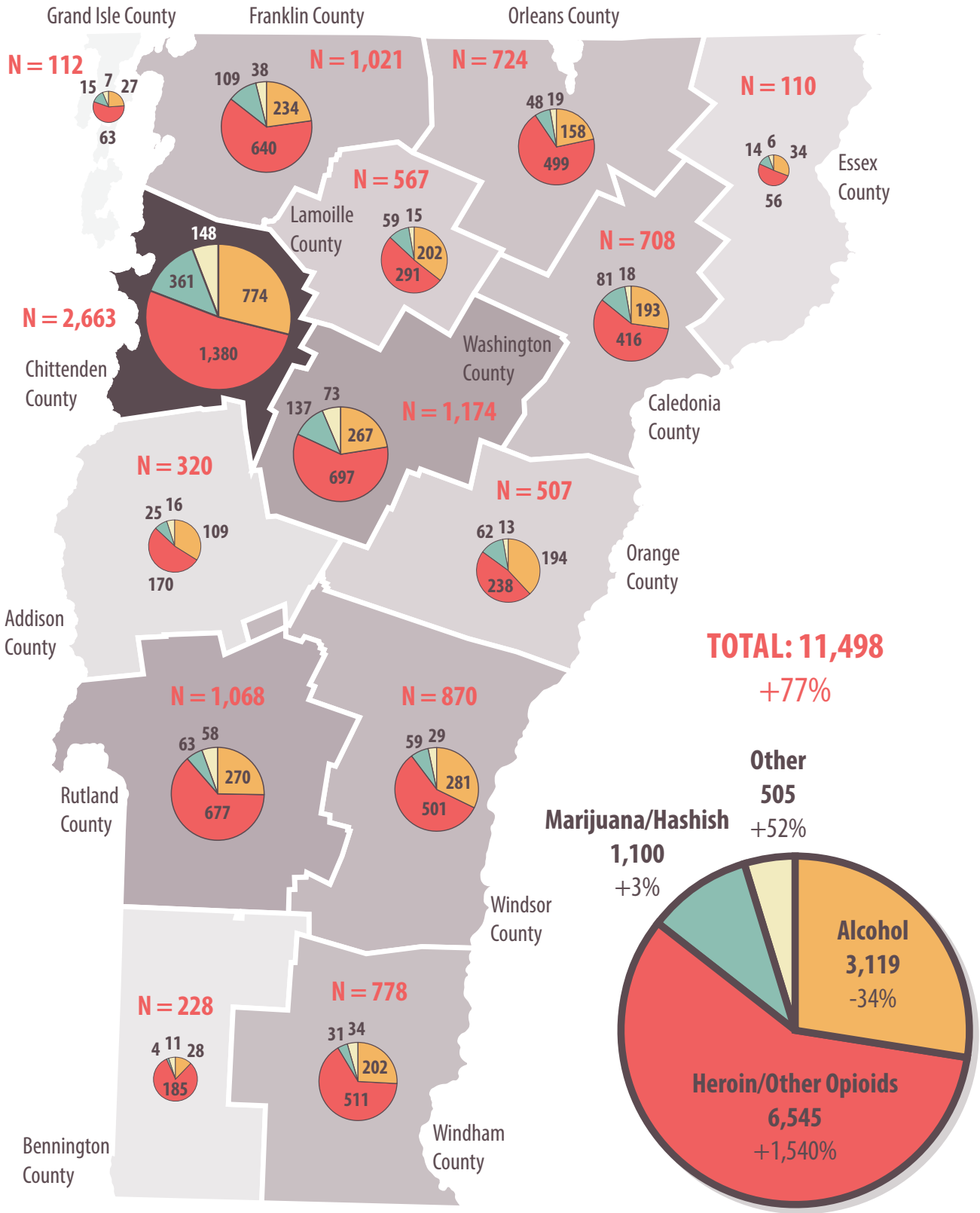
II.9: Women Receiving Treatment For Substance Use Disorder By Primary Substance, Vermont, 2000 & 2017



SOURCE: ADAP

Vermonters receive treatment all over the state. Figure II.10 looks at that distribution for 2017 at the county level.

II.10: Persons Receiving Treatment For Substance Use Disorder By Primary Substance, Vermont Counties, 2017

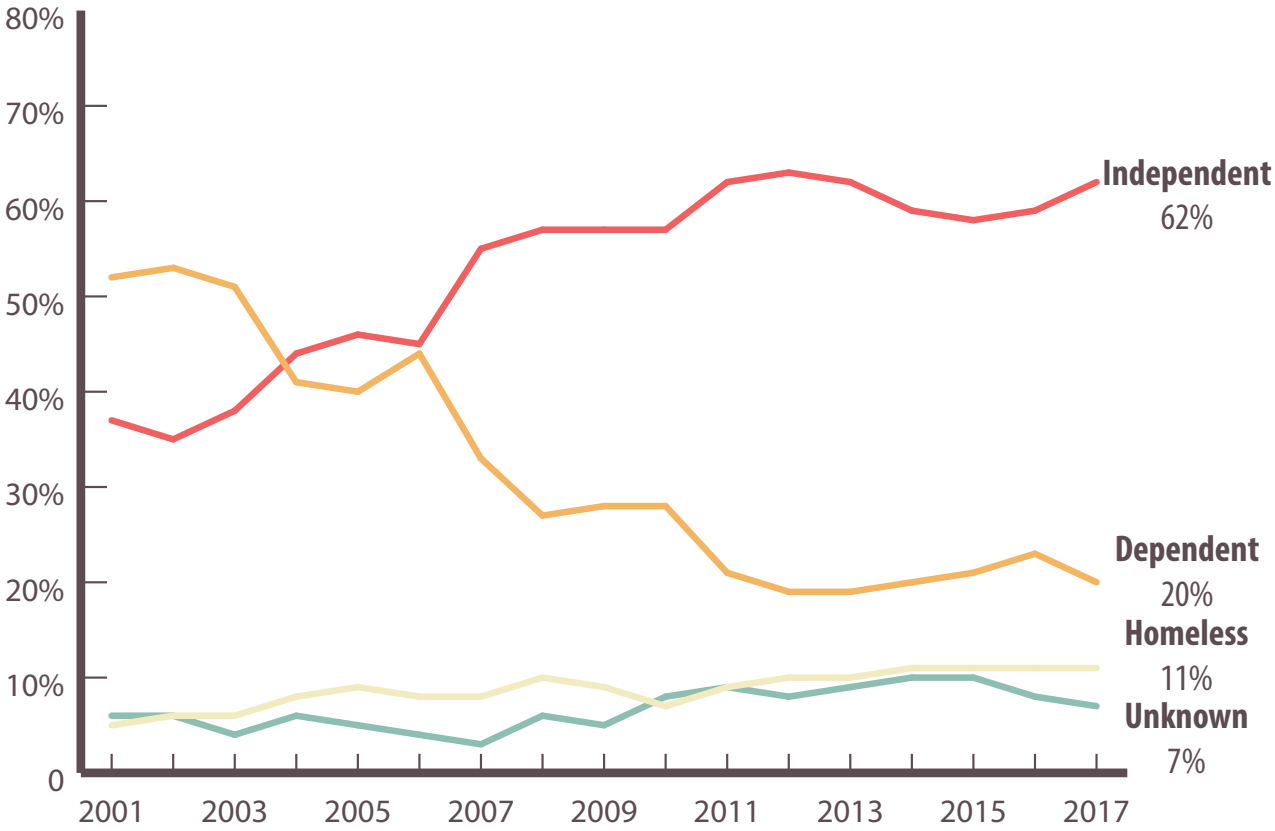


SOURCE: ADAP, Vermonter in SUD Treatment in ADAP Funded Programs, 2000-2017. Note: ADAP recently updated Total numbers for 2017 but Substance numbers have not been updated. Consequently, Substances in 2017 pie chart will not sum to Total.

7. Housing Status of Those Receiving Treatment

ADAP collects information on the housing status of those receiving treatment for SUDs upon their admission and discharge from treatment. In 2017, the following represents the status of all those in treatment at the time they began treatment.

II.11: Housing Status Of Vermonters In Treatment For SUDs By Status At Admission To Treatment, Vermont, 2001- 2017



SOURCE: ADAP, 2001-2017

In 2017, 64% of women and 60% of men lived independently at their time of admission. Eleven percent of both sexes experienced homelessness. While Vermonters with each housing status may have a need for RRs, the greatest need for housing belongs to those who are in the ***Homeless*** and the ***Dependent- Living in a Supervised Setting*** categories. The homeless need is obvious; the dependent need may be less so. Facility operators report that at any given time a significant share of those whose status is ***Dependent- Living in a Supervised Setting*** spend part of their time in residential facilities largely because they have nowhere else to live.

II.12: Homelessness By Primary Substance At Time Of Admission To Treatment, Vermont, 2001- 2017

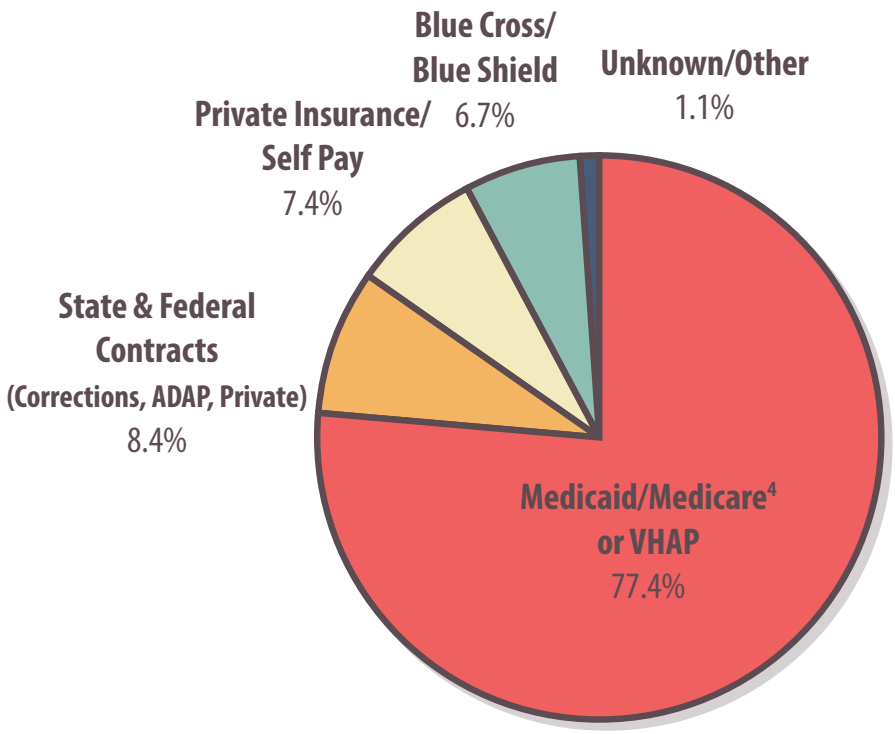
SOURCE: ADAP, 2001-2017

According to 2017 ADAP Housing Status data, over 900 individuals reported their housing status as homeless[3] at the start of treatment for SUDs. The number of homeless individuals in treatment has risen four-fold since 2001. Over that time, the number of homeless women increased from 61 to 352 and homeless men increased from 169 to 552. The percent of patients who report homelessness at admission does not vary by alcohol, opiates or other drug.[4]

8. Capacity to Afford Housing

According to ADAP, the vast majority of those receiving treatment in the ADAP system rely on Medicaid to cover the cost of treatment. For most individual persons in Vermont, the income limit for Medicaid eligibility is $16,764, a number that qualifies them as Extremely Low Income (<30% of Area Median Income or AMI). For Medicaid recipients at any household size, the income limits would qualify them as below 50% of AMI. These represent the income levels where housing is most insecure, where cost burdens are greatest, and where the need for affordable housing options are most constrained. These roughly 8,000 Medicaid-eligible individuals in treatment constitute a significant share of the poorest households in the state.

II.13: Source of Payment For Persons In Treatment For SUDs, Vermont, 2001- 2017



SOURCE: ADAP, 2017.

No reliable information exists concerning the employment status of Vermonters receiving treatment for SUDS, but the 2017 Annual Report of the Vermont Recovery Network indicates that at first intake, only 33% of those utilizing the Recovery Centers are employed. This underscores the limited capacity of potential RR occupants to cover the true cost of living in the home. The consultant estimates that less than 30% of all Vermonters receiving treatment for SUDs can afford to pay more than $100/ week for housing during their tenure in a RR.

9. Housing as an Impediment to Recovery

The following comes from a report summarizing an October 2017 survey conducted by the Governor's Opioid Coordination Council and responded to by 84 treatment providers in Vermont:

> ***"For 75% of respondents from across the state, housing issues and stressors are complicating (and potentially undermining) treatment and recovery progress in at least 1/3 of their cases—and for most of those respondents, between 66% and 100% of their clients are dealing with a housing situation that they think is interfering with the client's recovery."***

Twenty-eight percent of these respondents identified the need for RRs as the biggest gap in housing services available to their clients, while nearly half described affordability as the greatest challenge.

10. Readiness for Residence in a Recovery Residence

Not everyone in treatment for a SUD needs a RR to support their recovery efforts. As importantly, not everyone in treatment is at the right stage of recovery to make good use of the RR option if they had it. The National Association for Recovery Residences (NARR) has identified four stages of RR, each based on the level of supervision and independence appropriate to the individual's wellbeing (see Appendix B for more information). The RR model assessed in this study is only for residents in Recovery Level I and Level II. In the absence of hard data on the RR level of those in treatment for SUDs, the consultant asked 15 operators of RRs, Treatment Centers and Recovery Centers, as well as officials from NARR and VTARR for their estimates of the percentage of clients they see who would be appropriate candidates for a Level I or Level II transitional residence. Based on their response, the consultant estimates that that the percentage varies from as little as 33% among those currently homeless to 75% of those living independently at the time of their admission to treatment. Overall, the consultant estimates that between 55-60% of those currently in treatment would qualify as being appropriately housed at NARR's Level I or II (see Appendix C).

NOTES

1 Given the sample size for the SAMSHA survey, there is a 95% confidence level that ranges from a low of 4,000 to a high of 15,000 with 7,750 as the most likely estimate.

2 Substance Use Disorder is defined as meeting criteria for illicit drug or alcohol dependence or abuse. based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

3 Vermont has consistently been among the states with the highest level of SUD in all of the SAMSHA estimates reviewed, limiting the likelihood that the state's poor rankings are a result of small sample sizes.

4 The 2017 Vermont State Housing Authority's Annual Point in Time Statewide Count of the Homeless counted a smaller, though still substantial, 228 of the 1,225 (19%) homeless persons in Vermont as describing themselves with an SUD.

III. EXISTING RECOVERY RESIDENCES IN VERMONT

Vermonters with SUDs may access supportive or transitional housing whose primary function is other the recovery from substance use. These may include homes for veterans, for the homeless, for those previously incarcerated, or for those with physical or mental health disabilities. Vermonters with SUDs may also reside in residential treatment facilities that have more restrictive freedom of movement and on-site supervision than what is allowed and provided in the RR model. At the moment, there is no universally established definition of a RR, nor is there any licensing or accreditation requirement specific to this type of housing. This assessment focused on identifying those homes in the state (whether they were called recovery, sober, ¾-way, or transitional residence), if: 1) their **primary** purpose is to assist residents in their recovery from Substance Use Disorder, and 2) if they offer high degrees of independence with only limited in-residence staffing, thus distinguishing them from Level III and Level IV residences.

Using this screen, the consultant identified 22 residences in the state totaling 212 beds that could be called Recovery Residences. Sixteen of these residences have a capacity of between 4 and 12 residents, totaling 73 men and 42 women. Seven beds are co-ed. The five Phoenix Houses around he state generally have a larger occupancy capacity (16-26 beds in 5-12 rooms in four of their five residences). They provide residences to 82 men and 8 women.

In all, 73% of existing recovery home beds are reserved for men and 24% for women, though women currently make up 42% of all Vermonters receiving treatment for SUDs. More strikingly, only one RR provides housing for mothers with their dependent children although a large number of new admits to treatment are women with dependent children, many of whom have lost custody of those children. It is also worth noting that 65% of the RRs and total beds are located in Chittenden County. Though Chittenden County has by far the most residents in treatment for SUDs, it still makes up only 23% of the total statewide.

Five hub communities—Rutland, Middlebury, Bennington, Newport, and Morrisville, whose service areas treat one-quarter of all those with SUDs in the state — have no RRs.

Appendix B provides additional data from surveys of managers for these existing RRs. Some key findings from those interviews include:

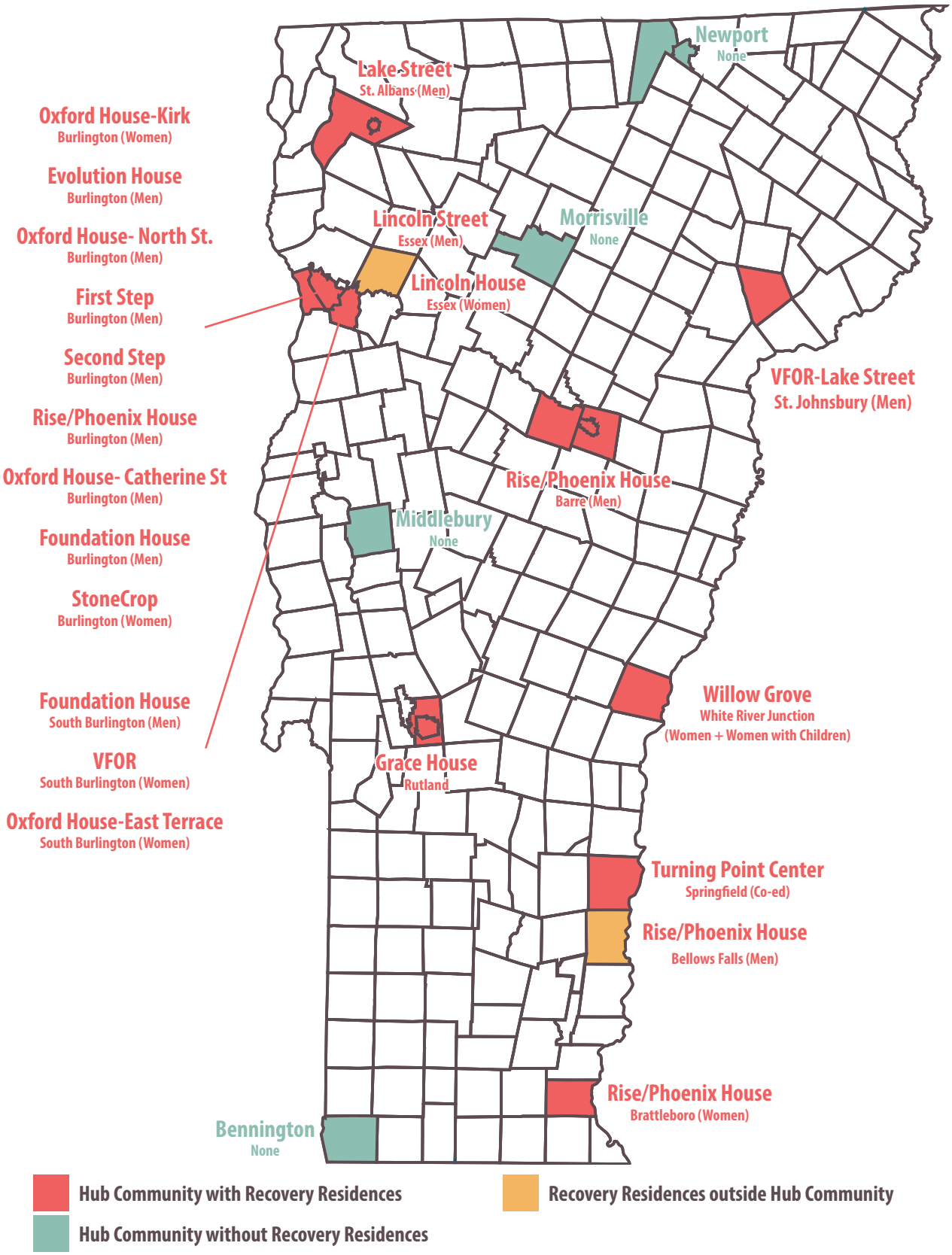
- Most existing RRs have walking or public bus access to Treatment Centers that provide Medication Assisted Treatment (MAT)
- Phoenix House has some spaces reserved in their houses for Department of Corrections or ADAP referred residents
- The average length of stay for all of the residences is somewhere between five and eight months.

- Rent-equivalents range from $100- $140/ week for single or double occupancy rooms; and $50-$75/ week for Phoenix House's multiple occupancy rooms. Phoenix House noted that they collect on only about 60% of the rents that charge. All RR operators underwrite the cost of some of their residents.

- RRs seldom operate at full capacity although several maintain waiting lists for occupancy. Overall, the existing facilities function at between 80-85% occupancy. Operators describe lack of funding, limited referral awareness, and the logistics of multiple transitions, rather than demand, as the cause of vacancies.

- Most houses can provide space for someone interested within five or six weeks.

III-1: Hub Communities and Existing Recovery Residences in Vermont



IV. ESTIMATE OF THE GAP IN RECOVERY RESIDENCES NEED

1. Overall Recovery Residence Gap Statewide

A key goal of this assessment was an estimate of how many Vermonters, upon completion of their treatment, would meet all three of the following criteria: 1) they are at the appropriate level of recovery to live successfully in a Recovery Home;[1] 2) their alternative housing options would undermine their recovery efforts; and 3) they would choose to take up the RR option if it was located near within their treatment hub, they knew about it, and it was affordable to them. There is no hard data to provide this magic number. Instead, having analyzed the data and asked the opinion of experts in the field, the consultant created three models for readiness, need and utilization based separately on a) housing status; b) gender and presence of children; and c) age cohort. Appendix C provides the model and the assumptions it uses. The consultant then averaged the three models to produce the following estimate of the gap between the current supply of RRs in the state and the need for that housing.

The consultant estimates that at least 1,200 individuals, or about 14% of the Vermonters entering treatment for an SUD in 2017, would benefit from access to a RR as a means of transition from a residential treatment facility or to support their recovery while in non-residential treatment. The consultant bases this estimate on a detailed breakdown of the housing status of new admits to treatment, as well as results from a 2017 survey of 84 service providers, and discussions with NARR, VTARR, and operators of Treatment Facilities, Treatment Centers, and Recovery Centers in Vermont. Key drivers for this need include:

- **Homelessness:** According to 2017 ADAP Housing Status data, over 900 individuals report their housing status as homeless at the start of treatment for SUDs.[2] Additionally, facility operators report that hundreds of others spend part of their time in residential treatment facilities or hospitals largely because they have nowhere else to live. According to the ADAP data, the number of homeless individuals in treatment has risen four-fold since 2000.

- **Inability to Pay for Housing:** more than three-quarters of those in state-funded SUD Treatment Facilities qualify to have Medicaid cover the cost of that treatment. For most individual persons in Vermont, the income limit for eligibility is $16,764, a number that qualifies them as Extremely Low-Income (<30% of Area Median Income or AMI). For Medicaid recipients at any household size, the income limits would qualify them as below 50% of AMI. These represent the income levels where housing is most insecure, where cost burdens are greatest, and where the need for affordable housing options are most constrained. These roughly 8,000 Medicaid-eligible individuals in treatment constitute between 20% and 30% of all the Extremely Low Income Households in the state.

- **Insecure Housing as an Impediment to Recovery:** The following comes from a report summarizing an October 2017 survey conducted by the Governor's Opioid Coordination Council and responded to by 84 treatment providers in Vermont:

  "For 75% of respondents from across the state, housing issues and stressors are complicating (and potentially undermining) treatment and recovery progress in at least 1/3 of their cases—and for most of those respondents, between 66% and 100% of their clients are dealing with a housing situation that they think is interfering with the client's recovery."

28% of these respondents identified the need for RRs as the biggest gap in housing services available to their clients, while nearly half described affordability as the greatest challenge.

Currently, there are about 212 RR beds in Vermont, with a total potential to serve roughly 425 residents a year staying an average of six months. These beds are not distributed geographically or in terms of sex or the presence of dependent children to optimally serve those who need it. While it might take several hundred additional RR beds to meet the current backlog of need, it may be more useful to think of that need in terms of the ongoing demand. The consultant estimates that as many as 1,200 Vermonters annually enter SUD Treatment, who upon completion of their treatment would meet all three of the criteria: named above. **To serve this population sustainably would require as many as 300 additional beds distributed statewide. The population with the greatest unmet need is women with dependent children.**

2. Recovery Residence Need at the Hub Community Level

Figure IV.1 looks at those admitted to treatment for each of the key sub-groups—men, women, and women with dependent children—at the county level in 2017.

IV.1: New Admissions To Substance Use Disorder Treatment, By County and By Men, Women, and Women With Dependent Children, 2017

Hub Community & Counties Served	Men In Treatment	RR Beds	Women and Women w/ Dependent Children in Treatment	RR Beds
Middlebury Addison County	134	0	87	0
Bennington Bennington County	225	0	152	0
St. Johnsbury Caledonia Co. & Essex Co.	265	6	249	0
Burlington & S. Burlington Chittenden County	1312	81	752	33
St. Albans Franklin Co. & Grand Isle Co.	493	6	479	0
Morrisville Lamoille County	273	0	188	0
Newport Orleans County	212	0	129	0
Rutland Rutland County	377	0	522	0
Barre-Berlin Washington County	515	20	438	0
Brattleboro Windham County	454	42	303	8
Springfield & White River Junction Windsor County[2]	363	3.5	262	12.5
May Support Separate Hub				
Randolph Orange County	211	0	134	0

SOURCE: ADAP and Development Cycles Survey of RRs, 2018.

In the consultant's opinion, 20 admissions to treatment in a given year for each RR bed represents a conservative benchmark for the sustainable demand for RRs statewide. For a 6-person home the minimum treatment requirement then would be 120 men or women, or women with dependent children. Using that benchmark, here is a listing of the hubs where additional residences are needed.

IV.2: Estimated Need For Additional Six-Person Recovery Residences By Hub Community, 2019

Hub Community & Counties Served	For Men	For Women or Women with Dependent Children
Middlebury Addison County	1	0
Bennington Bennington County	1	1
St. Johnsbury Caledonia Co. & Essex Co.	1	2
Burlington & S. Burlington Chittenden County	0	1
St. Albans Franklin Co. & Grand Isle Co.	3	4
Morrisville Lamoille County	2	1
Newport Orleans County	1	1
Rutland Rutland County	3	4
Barre-Berlin Washington County	0	3
Brattleboro Windham County	0	1
Springfield & White River Junction Windsor County	2	0
Randolph (With Presence of Hub) Orange County	1	1
Total Number of Homes Needed	15	19

The consultant focused on those hubs that could, by this standard, support more than one new RR to establish his priority location and type of need as follows:

- **Rutland City:** one RR dedicated to men, and one dedicated to women and/or women with dependent children
- **St. Albans City:** one RR dedicated to men and one dedicated to women and/or women with dependent children
- **Barre/ Berlin (Montpelier):** one RR dedicated to women and/or women with dependent children
- **Burlington and/or South Burlington:** one RR dedicated to women with dependent children
- **St. Johnsbury:** One RR dedicated to women and/or women with dependent children.
- **Morrisville:** one RR dedicated to men

Each of these priority hub communities has more than sufficient need to sustain the RRs recommended. Developing these priority RRs represent a substantial undertaking requiring a large commitment of money and human effort. These highest-priority projects also represent an opportunity to continue to test the efficacy and demand for units in this model before taking it to communities with lower overall levels of SUD Treatment.

NOTES

1 Not everyone in treatment for a SUD needs a recovery home nor is everyone in treatment at the right stage of recovery to make good us of the option if they had it. The National Association for Recovery Residences (NARR) has identified four stages of recovery, each based on the level of supervision and independence appropriate to the individual's wellbeing (see Appendix B for more information). The RR model assessed in this study is only for residents in Recovery Level I and II.

2 The 7-unit Springfield RR is open to men and women equally.

3 The 2017 Vermont State Housing Authority's "Annual Point in Time Statewide Count of the Homeless" counted a smaller number — 228 of the 1,225 (19%) homeless persons in Vermont as describing themselves with an SUD.

V. HOUSING AVAILABILTY IN THE HUB COMMUNITIES

There are Treatment Centers and/or Recovery Centers located in 12 Vermont communities: Barre (with the Treatment Center in Berlin), Bennington, Brattleboro, Burlington, Middlebury, Morrisville, Newport, Rutland, St. Albans, St. Johnsbury, South Burlington, and Springfield.

The RR model calls for residents to live in large (4+ bedroom) single-family homes that have easy access to the hub Treatment and Recovery Centers. Public transportation is an important condition supporting recovery for this population; one that should not be overlooked in siting RRs. Many of these individuals have either had their licenses revoked or cannot afford the cost of a car. With all of their daily commitments to treatment, counseling, and work, public transportation is a critical factor. Access to food shopping is another key locational requirement.

To test for the availability of appropriate housing for RRs in the hub communities, the consultant utilized 2017 American Community Survey data to identify the number of single-family homes with more than four bedrooms, the number of 2-4 unit buildings, as well as the median rent, and the homeownership rate for the census tracts that contain (or in some instances are immediately adjacent to) these treatment and Recovery Centers. In addition, the consultant identified key public transit routes and bus schedules in these communities, and located supermarkets and food stores nearby to the Recovery and Treatment centers. Finally, the consultant provided pricing information and snapshots of large single-family homes and 2-4 family buildings currently on the market in these target neighborhoods to characterize the cost of acquiring housing in these neighborhoods. Appendix D provides a summary profile of the appropriate housing supply for each of the 12 hub communities.

The data indicates that there is an adequate supply of appropriate housing within easy access of the existing Treatment and Recovery Centers in each of these hub communities. All 12 hub communities have a stock of at least 200 large single-family homes (4+ bedrooms) or small multifamily properties (2-4 units) located within approximately one mile of the existing treatment and recovery centers. Most have more than 500 appropriately sized properties for rent or acquisition.

Bus lines do connect reasonably closely to Treatment Centers and Recovery Centers in 10 of the 12 hubs. Their frequency of service varies considerably with scheduled hourly service available in only about half of these hubs. Where regular and frequent bus service does not exist, it may be necessary to shrink the distance between the Treatment Center, Recovery Center, and RR. This could entail the need to relocate the existing Center in those communities where such a need could exist. Alternatively, where community support systems are strong, there may be the possibility to create some form of volunteer ride service for residents such as in more commonly offered to older residents or those in need of dialysis treatment. In most of the 12 hubs, supermarkets are at least as accessible as the Treatment or Recovery Center.

The 12 treatment hubs are located in the same communities that serve as the primary focus of affordable housing efforts in Vermont. For the most part, established nonprofit housing organizations base their operations in these same communities. Outside of Chittenden County, the Recovery Centers and Treatment Centers are located in neighborhoods with home values, rents, and household incomes that are often well below the statewide median. Ample stock combined with low acquisition prices and market rents in most of these target communities represents an opportunity to scale the RR model quickly. This advantage is balanced by the challenge of ensuring that these properties have enough value to cover acquisition and/ or renovation costs if their use changes.

VI. CHALLENGES, RECOMMENDATIONS & CONDITIONS FOR SUCCESS

1. Challenges

Despite the scale of demand for RRs, the concept needs to effectively address several substantial challenges, including the following:

- The effort will need to significantly strengthen the network providing non-residential services to the RR residents, in order to, among other things, increase the effectiveness of the residence as a stabilizing influence; build social capacity and integration; and improve the readiness assessment and referral process. The importance of building a sense of community, self-worthiness and belonging both within the residence and within the community as a whole is paramount. Addressing this challenge effectively will require increasing the capacity of some of Vermont's existing Treatment Centers and Recovery Centers, especially in their provision of psycho-social and life-skills services.

- Scaling RRs within a peer-support model will require expanding the number of coaches, mentors, housing managers, and in some cases caseworkers, from among those who are themselves in recovery. Some service providers expressed concern that the opioid crisis was already promoting individuals too quickly from being in recovery to helping others in recovery, thus placing a great deal of stress and responsibility on individuals who were themselves vulnerable. A thoughtful process of vetting, training and seasoning those working in this space needs to go hand in hand with funding for the service elements needed for a sustainably successful RR model.

- Managing the community's expectations represents another major challenge. The problem these residences are helping address is daunting. They will primarily serve residents with opioid addictions that carry an extraordinarily high relapse rate and potentially catastrophic consequences with each use. Despite the universal nature of addiction, the reality is that those in greatest need for these RRs are predominantly young and extremely low income individuals, with low levels of employment, and relatively high levels of prior homelessness and co-occurring mental health issues. These residences will be located primarily in communities and neighborhoods where the incidence of drug and alcohol use and dependence are highest. It would be tragically naïve to imagine that these residences will not experience serious setbacks, including incidents of violence, drug dealing, overdose deaths, and adverse interactions with neighbors. Nothing will be more important to success in scaling the RR concept in Vermont than the commitment by stakeholders to building realistic

expectations, resilience to setbacks, and long-term support for addressing these daunting challenges among those providing financial and community leadership.

- The concept that residents pay something to live in a RR is pretty much universally applied. At the same time, residents seldom have the capacity to cover the true costs needed to acquire (or rent), renovate, furnish, and maintain a home, much less pay for the in-house services required. The consultant estimates that less than 30% of all Vermonters receiving treatment for SUDs can afford to pay more than $100/ week for housing during their tenure in a RR. Many will be unable to pay anything for the first few months of residency. Finding sustainable sources of revenue to bridge the gap between resident contributions and true costs will be critical.

- A RR is special needs housing that will be located, with few exceptions, in areas of Vermont where the demand for large single-family homes is weakest. Siting these residences will require even more sensitivity to its immediate surroundings than does traditional affordable rental housing, for it needs to balance convenience to treatment, buffer residents from negative community influences, and have the capacity to build a welcoming response from abutters and neighbors. That will be no small task. Even with a well-sited property, the RR provider looking to acquire or substantially renovate such a home may face a serious challenge demonstrating that those costs can be recouped if the property stops functioning as a RR. Some combination of the following strategies may be needed to address this challenge effectively:

    - Leasing rather than owning the RR
    - Fundraising rather than borrowing for acquisition and/or rehabilitation costs
    - Repurposing homes that are already in the non-profit housing or special needs housing portfolio
    - Negotiating long-term service contracts and operating subsidy commitments as a pre-condition to acquisition
    - Selecting only those single-family properties that have viable adaptive reuse potential as small multi-family rentals
    - Modifying the RR model to allow for the RR to have separate apartments within existing 2-4 family buildings
    - Attaching project-based rental assistance that can transfer to a change of use if needed
    - Funding a loss-reserve pool or loan guarantee program available to the portfolio of VTARR certified properties.

2. Recommendations

The consultant recommends that, provided certain conditions can be met, RRs options in the state be increased significantly, starting in these communities with the highest priority needs:

- **Rutland City:** one RR dedicated to men, and one dedicated to women and/or women with dependent children
- **St. Albans City:** one RR dedicated to men and one dedicated to women and/or women with dependent children
- **Barre/ Berlin (Montpelier):** one RR dedicated to women and/or women with dependent children
- **Burlington and/or South Burlington:** one RR dedicated to women with dependent children
- **St. Johnsbury:** One RR dedicated to women and/or women with dependent children.
- **Morrisville:** one RR dedicated to men

Each of these priority hub communities has more than sufficient need to sustain the RRs recommended. Developing these priority RRs represents a substantial undertaking requiring a large commitment of money and human effort. These highest-priority projects also represent an opportunity to continue to test the efficacy and demand for units in this model before taking it to communities with lower overall levels of SUD Treatment.

3. Conditions for Success

These recommendations are predicated on the ability of VTARR and the other key stakeholders to successfully address the challenges identified in the assessment, specifically, the need to:

- Strengthen the delivery of wrap-around services by strengthening the network of service providers that play a programmatic role with the RR and its residents.

- Develop these projects at a pace that ensures a strong, seasoned and well-trained supply of mentors, coaches, house managers and case managers to whatever degree these roles interact with the residents of these RRs.

- Stress the importance of building a sense of community, self-worthiness and belonging both within the RR and within the community as a whole.

- Find a sustainable funding mechanism to bridge the gap between the true operational cost of a well-functioning RR and the extremely limited capacity of most residents to cover that cost.

- Commit to investing in the community organizing and messaging aspects of the process in order to manage expectations and build the capacity and resilience needed to address the inevitable setbacks the RR's residents will face.

- Develop a clear and flexible set of strategies to significantly reduce the capital risk associated with acquiring or substantially renovating properties that may have limited market potential should their purpose as RRs need to change.

Appendix A
PERSONS INTERVIEWED FOR RECOVERY RESIDENCE ASSESSMENT

The following individuals were contacted for this study:

Recovery Residence Contacts	
Andrew Gonyea	Vermont Foundation of Recovery
James Henzel	Phoenix House (Barre, Bellows Falls, Burlington)
Megan Kirby	Oxford House
Drew Lingate	Oxford House- Catherine Street, Burlington
Sarah Mekos	Willow Grove
David Riegel	Vermont Foundation of Recovery
Tom Weston	Evolution House
Heather (last name withheld)	Oxford House- Kirk
Recovery Center Contacts	
Karen Heinlein Grenier	Turning Point of Franklin County St. Albans
Tracy Hauck	Turning Point Center Rutland
Michael Johnson	Turning Point Springfield
Robert Purvis	Turning Point Center of Central Vermont Barre
Treatment Center Contacts	
Deborah Hopkins	Central Vermont Addiction Medicine, Berlin, VT
Jeffrey McKee, RMC VP of Behavioral Health	West Ridge Center for Addiction Recovery, Rutland
Christina Plasik	BAART, St. Johnsbury and Newport VT
Konstanin von Krusenstiern and staff	Brattleboro Retreat, Brattleboro
In-State Expertise	
Amanda Jones	ADAP
Jody Kamon	Center for Behavioral Health Integration
Mariah Ogden	ADAP
Matt Prouty	Project Vision
Adam Sancic	AHS Field Director, Rutland
Anne Van Donsel	ADAP
Outside of Vermont Expertise	
Jonaki Bose	SAMSHA
Elizabeth Burden	Altarum Institute
Patty McCarty Metcalf, ED	Faces & Voices of Recovery (FAVOR)
Dave Sheridan	NARR
Phil Valentine, ED	CT Recovery Organization CCAR)

Appendix B
DETAILS ABOUT THE RECOVERY RESIDENCE CONCEPT

Provided by David Riegel, Vermont Foundation for Recovery with additional information provided by the consultant

LEVELS OF RECOVERY RESIDENCE: The National Association of Recovery Residences (NARR) provides the following criteria for determining the level of care appropriate to individuals at different stages of recovery. **This assessment looks specifically at Recovery Residents serving individuals at Level I and Level II.**

RECOVERY RESIDENCE LEVELS OF SUPPORT					
NARR National Alliance for Recovery Residences Community • Standards • Ethics • Education		**LEVEL I** Peer-Run	**LEVEL II** Monitored	**LEVEL III** Supervised	**LEVEL IV** Service Provider
STANDARDS CRITERIA	**ADMINISTRATION**	-Democratically run -Manual or P&P	-House manager or senior resident -Policy and Procedures	-Organizational hierarchy -Administrative oversight for service providers -Policy and Procedures -Licensing varies from state to state	-Overseen org. hierarchy -Clinical and administrative supervision -Policy and Procedures -Licensing varies from state to state
	SERVICES	-Drug Screening -House meetings -Self help meetings encouraged	-House rules provide structure -Peer run groups -Drug Screening -House meetings -Involvement in self help and/or treatment services	-Life skill development emphasis -Clinical services utilized in outside community -Service hours provided in house	-Clinical services and programming are provided in house -Life skill development emphasis
	RESIDENCE	-Generally single family residences	-Primarily single family residences -Possibly apartments or other dwelling types	-Varies—all types of residential settings	-All types—often a step down phase within care continuum of a treatment center -May be a more institutional environment
	STAFF	-No paid positions within the residence -Perhaps an overseeing officer	-At least 1 compensated position	-Facility manager -Certified staff or case managers	-Credentialed staff

SERVICES OFFERED: The greatest value of a RR is the peer-to-peer support provided by the environment. Therefore, most homes don't offer any direct services and instead try to create an atmosphere where people can learn and grow from the experiences of those around them. The extent to which the operators influence the atmosphere of the home will vary from levels I through IV. Many lessons are learned through communal living simply as a result of the peer-to-peer social model such as cleanliness (both personal and of the home), cooking/nutrition, financial management, work ethic, and personal responsibility.

SERVICE PROVIDERS: Most homes will look to connect house members with services in the community. This will often be through Recovery Centers, 12 step programs, counseling or therapy, employment resources and may include nutrition, financial, medical, and physical health services. Some RRs have an on-site house manager others do not.

OWNERSHIP STRUCTURE: RRs operate under various ownership structures. In Vermont, that could include having a separate nonprofit such as the Vermont Foundation of Recovery that owns or leases several homes around the state; nonprofit housing organizations such as Downstreet; Treatment Centers or Recovery Centers such as the home operated by the Turning Point Recovery Center in Springfield, VT; or a private owner. The key going forward is that these homes be in some way accredited by VTARR to ensure standards and promote best practices.

MANAGEMENT ISSUES: Operational decisions may vary based on the type of home and level of recovery involved. Some homes will allow the current house members to vote and have absolute say over who moves in while other homes will approve new house members and only allow the current members to voice concerns. Length of stay is also dependent on each home. Some will set a limit of a year while others have no limit at all. Most seem to encourage people to move on when they have become stable in their recovery and are ready to take the next step. This is both for the individual's growth and to make the spot available to someone who needs it. The home's operator sets the cost for each house member which may fluctuate depending on if the person is in a single, double, or triple room and how much responsibility they take on in the home.

COMMUNITY ENGAGEMENT: RRs should be good neighbors and have an ethic of giving back to their neighborhoods and communities. There should be participation in volunteer events, helping neighbors in need with projects around their homes, as well as making sure the RR is well maintained to fit in with the character of the neighborhood. One of the main tenants of recovery is helping others. The people living in an RR should be actively participating in their own recovery and want to be helpful to the people living around them. In addition RRs have house rules that will include maintaining the outside of the home and participation in events to give back to the community.

PERMITTING REQUIREMENTS: At the moment there is nothing in Vermont law that recognizes RRs as any type of entity. The Americans with Disabilities Act protects people in recovery and the Fair Housing Act says people with disabilities must be treated equally. It has been litigated at the federal level with an end result that RRs must be treated the same a Single Family Homes from a zoning standpoint.

Recovery Residence Interviews

	Barre RISE Men's Supported Living Program	Bellow Falls RISE Men's Supported Living Program	Brattleboro RISE Men's Supported Living Program
Sponsoring Agency	Phoenix House	Phoenix House	Phoenix House
Location (Street Address, Town)	580 South Barre Road, Barre	11 Underhill Avenue, Bellows Falls	435 Western Avenue, Brattleboro
Contact Name	James Henzel	James Henzel	James Henzel
Contact Phone Number	603-801-1017 (cell)	603-801-1017 (cell)	603-801-1017 (cell)
Contact Email Address	jhenzel@phoenixhouse.org	jhenzel@phoenixhouse.org	jhenzel@phoenixhouse.org
Date Opened	2012	2007	1999
Number of Beds/ Rooms	20 beds/9 rooms	16 beds/5 rooms	26 beds/12 rooms
Type (men, women, families)	Men	Men	Men
Proximity to nearest Recovery Center and HUB	5 miles	25 miles	3 miles
Average Length of Occupancy	5 months	5 months	5 months
Annual Room Turnover	200%	200%	200%
NARR Level (if appropriate)	Commission on Accreditation of Rehabilitation Facilities (CARF) Accredited	CARF Accredited	CARF Accredited
Average Occupancy Level (annually 2015-2017)	12	14	24
Size of Current Waiting List	4 Dept of Corrections (DOC)	1 DOC, 1 Agency for Drug and Alcohol Prevention (ADAP), 1 Veterans Administration	5 DOC, 2 ADAP
Average Rent Paid by Residents	$75/week[1]	$50/week[1]	$65/week[1]
Amount and Source of Direct Housing Subsidy	DOC and 1 bed with ADAP	DOC, ADAP, VA	DOC, ADAP
Is housing owned or leased by sponsor?	Leased/Downstreet	Leased/Private Landlord	Owned
Estimate of unmet need by each of the three primary sub-groups (men, women, & families)	Women/Families	Women/Families	Women/Families
Any concerns about expanding the program in your catchment area? Or in other unserved parts of the state?	Same funding level for 8 years, which is unsustainable. State level funding is worst in decades. Most underserved communites: Bennington, VT. Rutland, VT. St. Albans, VT. Bellows Falls, VT. Women in Burlington, VT		

1 Rent collection rate for Phoenix Houses is at approximately 40%.

Recovery Residence Interviews

	Brattleboro RISE Women's Supported Living Program	Burlington RISE Men's Supported Living Program	Oxford House Catherine Street
Sponsoring Agency	Phoenix House	Phoenix House	Oxford House, Inc.
Location (Street Address, Town)	178 Linden Street, Brattleboro	37 Elmwood Avenue, Burlington	8 Catherine Street, Burlington
Contact Name	James Henzel	James Henzel	Drew
Contact Phone Number	603-801-1017 (cell)	603-801-1017 (cell)	802-391-7668
Contact Email Address	jhenzel@phoenixhouse.org	jhenzel@phoenixhouse.org	
Date Opened	2008	2010	February, 2003
Number of Beds/ Rooms	8 beds/4 rooms	20 beds/9 rooms	10
Type (men, women, families)	Women	Men	Men
Proximity to nearest Recovery Center and HUB	2 miles	3 miles	1 Mile
Average Length of Occupancy	5 months	5 months	N/A
Annual Room Turnover	200%	200%	N/A
NARR Level (if appropriate)	CARF Accredited	CARF Accredited	NARR 1
Average Occupancy Level (annually 2015-2017)	11 (Had 14 beds. Moved Dec. 2018)	14	N/A
Size of Current Waiting List	6 DOC, 4 ADAP	3 DOC, 4 ADAP	N/A
Average Rent Paid by Residents	$65/week[1]	$75/week[1]	N/A
Amount and Source of Direct Housing Subsidy	DOC, ADAP	DOC, ADAP	N/A
Is housing owned or leased by sponsor?	Leased w/ option to purchase (likely)	Burlington Housing Authority	Owned
Estimate of unmet need by each of the three primary sub-groups (men, women, & families)	Women/Families	Women/Families	N/A
Any concerns about expanding the program in your catchment area? Or in other unserved parts of the state?	Same funding level for 8 years, which is unsustainable. State level funding is worst in decades. Most underserved communites: Bennington, VT. Rutland, VT. St. Albans, VT. Bellows Falls, VT. Women in Burlington, VT		

Recovery Residence Interviews

	Oxford House Kirk	Lake Street	Lincoln Street
Sponsoring Agency	Oxford House, Inc.	Vermont Foundation of Recovery	Vermont Foundation of Recovery
Location (Street Address, Town)	42 Bright Street, Burlington	135 Lake Street, St Albans	44 Lincoln Street, Essex
Contact Name	Heather	Andrew Gonyea	Andrew Gonyea
Contact Phone Number	802-399-2058	802-735-4340	802-735-4340
Contact Email Address	audrigrace2018@gmail.com	andrew@vermontfoundationofrecovery.org	
Date Opened	January, 2004	June, 2015	October, 2015
Number of Beds/ Rooms	8	6	5
Type (men, women, families)	Women	Men	Men
Proximity to nearest Recovery Center and HUB	1.5 miles	(RC) 5 mintue walk, (BARRT) 5 mintue drive	(RC) & Clinic18 minutes by car
Average Length of Occupancy	3 mo commitment. Approx. average stay is 6-8 months, but some stay for a few years.	4 Months	4.9 Months
Annual Room Turnover	80%	7 past Members in 2018 (as of 12/13/18)	8 past Members in 2018 (as of 12/13/18)
NARR Level (if appropriate)	NARR 1	NARR 2	NARR 2
Average Occupancy Level (annually 2015-2017)	100%	We are just now starting to track this, but estimate about 80%.	
Size of Current Waiting List	1-2 people	3 on Dept of Corrections (DOC) waiting list	2, plus 1 on DOC waiting list =3 total (Esx/Burl)
Average Rent Paid by Residents	$440/mo	$140/wk	$160/wk
Amount and Source of Direct Housing Subsidy	None	None	None
Is housing owned or leased by sponsor?	Owned by Burlington Housing Authority	Leased	Leased
Estimate of unmet need by each of the three primary sub-groups (men, women, & families)	More need for womens' housing.	VFOR sees the most unmet need in the category of family housing options (able to have their children living with them full time). A close second is more options for women.	
Any concerns about expanding the program in your catchment area? Or in other unserved parts of the state?	Funding. Bennington County is the most unserved community	Community Zoning regulations are always a challenge when trying to open a new recovery residence (what is considered a "family"), as well as staffing and communication challenges as we branch out from our hub in the Chittenden County area.	

Recovery Residence Interviews

	Suburban Square	Lyman Ave	Elm Street
Sponsoring Agency	Vermont Foundation of Recovery	Vermont Foundation of Recovery	Vermont Foundation of Recovery
Location (Street Address, Town)	82 Suburban Square, South Burlington	79 Lyman Ave, Burlington	87 Elm St., St. Johnsbury
Contact Name	Andrew Gonyea	Andrew Gonyea	Andrew Gonyea
Contact Phone Number	802-735-4340	802-735-4340	802-735-4340
Contact Email Address	andrew@vermontfoundationofrecovery.org		
Date Opened	January, 2014	July, 2015	No Members yet, but open for applications Nov. 2018
Number of Beds/ Rooms	6	6	6
Type (men, women, families)	Women	Men	Men
Proximity to nearest Recovery Center and HUB	(Clinic) 8 minute, (RC) 9 minute drive	(Clinic) 7 minute Drive (RC) 11 mintues drive	(BARRT) 6 minute drive (RC) 4 minute drive
Average Length of Occupancy	3.4 Months	5.6 Months	N/A
Annual Room Turnover	13 past Members in 2018 (as of 12/13/18)	14 past Members in 2018 (as of 12/13/18)	N/A
NARR Level (if appropriate)	NARR 2	NARR 2	NARR 2
Average Occupancy Level (annually 2015-2017)	We are just now starting to track this, but estimate about 80%.		Home just opened and does not have current house membership
Size of Current Waiting List	4, plus 6 on DOC waiting list =10 total	2, plus 1 on DOC waiting list =3 total (Esx/Burl)	3
Average Rent Paid by Residents	$140/wk	$140/wk	N/A (but will be $140/wk)
Amount and Source of Direct Housing Subsidy	None	None	ADAP Grant $53,000 allocated for the opening of this home
Is housing owned or leased by sponsor?	Leased	Leased	Leased
Estimate of unmet need by each of the three primary sub-groups (men, women, & families)	VFOR sees the most unmet need in the category of family housing options (able to have their children living with them full time). A close second is more options for women.		
Any concerns about expanding the program in your catchment area? Or in other unserved parts of the state?	Community Zoning regulations are always a challenge when trying to open a new recovery residence (what is considered a "family"), as well as staffing and communication challenges as we branch out from our hub in the Chittenden County area.		

Recovery Residence Interviews

	Willow Grove	Springfield Transitional Housing
Sponsoring Agency	Second Wind Foundation	Turning Point Recovery Center of Springfield
Location (Street Address, Town)	200 Olcott Drive, White River Junction	7 Morgan Street, Springfield
Contact Name	Sarah Mekos	Michael Johnson
Contact Phone Number	802-295-5206	802-885-4668
Contact Email Address	smekos@secondwindfound.org	spfldturningpoint@gmail.com
Date Opened	2004	N/A
Number of Beds/ Rooms	9	7
Type (men, women, families)	Women/Families	Coed
Proximity to nearest Recovery Center and HUB	2.6 mi to Recovery Center & 5 mi to HUB	Immediately adjacent to Recovery Center
Average Length of Occupancy	3.4 Months	5.6 Months
Annual Room Turnover	13 past Members in 2018 (as of 12/13/18)	14 past Members in 2018 (as of 12/13/18)
NARR Level (if appropriate)	NARR 2	NARR 2
Average Occupancy Level (annually 2015-2017)	We are just now starting to track this, but estimate about 80%.	
Size of Current Waiting List	5	None
Average Rent Paid by Residents	100.00/weekly	$110/ week
Amount and Source of Direct Housing Subsidy	$0	N/A
Is housing owned or leased by sponsor?	Owned	Owned
Estimate of unmet need by each of the three primary sub-groups (men, women, & families)	The need for a Men's Recovery Residence is unmet in the Upper Valley VT/NH	Women whose child ren are in foster care.
Any concerns about expanding the program in your catchment area? Or in other unserved parts of the state?	Willow Grove has no desire to expand; however, general need for adolescent treatment centers and sober living exists in Rutland, Montpelier, Upper Valley.	The need is there. Our desire is there. The limiting factors are resources: money and my capacity to do everything that needs doing with limited staff.

Appendix C
ADDITIONAL DATA ON RECOVERY RESIDENCE NEED

Definitions of Levels of Treatment for Vermonters with a Substance Use Disorder

Outpatient Treatment (OP): ASAM Level 1- An organized nonresidential treatment service or an office practice with designated addiction professionals and clinicians providing professionally directed alcohol and other drug treatment that is co-occurring capable. This treatment occurs in regularly scheduled sessions usually totaling fewer than 9 contact hours per week.

Intensive Outpatient Treatment (IOP): Level 2.1—An outpatient program with 9-18 hours of structured programming per week, consisting primarily of counseling and education about substance-related and mental health problems. The patient's needs for psychiatric and medical services are addressed through consultation and referral arrangements if the patient is stable and requires only maintenance monitoring. (Services provided outside the primary program must be tightly coordinated.

Residential Services: ASAM Level 3.7 *Co-Occurring Enhanced Program*. Level 3.7 programs provide a planned and structured regiment of 24-hour professionally directed observation, medical monitoring, and addiction treatment in an inpatient setting. They feature permanent facilities, including patient beds and functions under a defined set of policies, procedures, and clinical protocols. They are appropriate for patients with sub-acute biomedical and emotional, behavioral or cognitive problems so severe that they require inpatient treatment but who do not require the full resources of an acute care general hospital or a medically-managed inpatient treatment program. Co-occurring enhanced programs offer appropriate psychiatric services, medication evaluation, and laboratory services and provide a psychiatric assessment within 24-hours following admission and thereafter as medically necessary. Programs must comply with the requirements of ASAM Third Edition.

Hub & Spokes: A Hub is a specialty treatment center responsible for coordinating the care of individuals with complex opioid addictions and co-occurring opioid substance use and mental health conditions across the health and substance use treatment systems of care. Hubs will provide comprehensive assessments and treatment protocols; all methadone treatment is provided in hubs. For a subset of buprenorphine patients with clinically complex needs, hubs may: serve as the induction point and provide care during stabilization; coordinate referrals and provide support for ongoing care, prevention and treatment of relapse; and provide specialty addictions consultation. Hubs may provide care for patients for whom naltrexone is the medication of choice. Hubs may also provide support for tapering off MAT. Hubs are expected to maintain continuous and long-term relationships with selected clients. Programing will reflect the chronic and relapsing nature of addictions and be able to engage and re-engage clients in services. Hubs will also proactively assure that clients leaving their services have clinically appropriate referrals (e.g. to other hubs, MAT prescribers, health care, housing, recovery, and human services), that such referrals are completed to the extent

that there are entities to accept such referrals, and that the clients are not lost to contact. Hubs are Health Homes and will achieve and maintain the

Case Management (CM): Recipients are assisted with linkage to a community-based system of care. CMs coordinate service with the recipient, family, treatment provider and assists with negotiating various service systems. Develops an individualized community service plan and facilitates implementation, monitors services received, documents activities, and initiates periodic review.

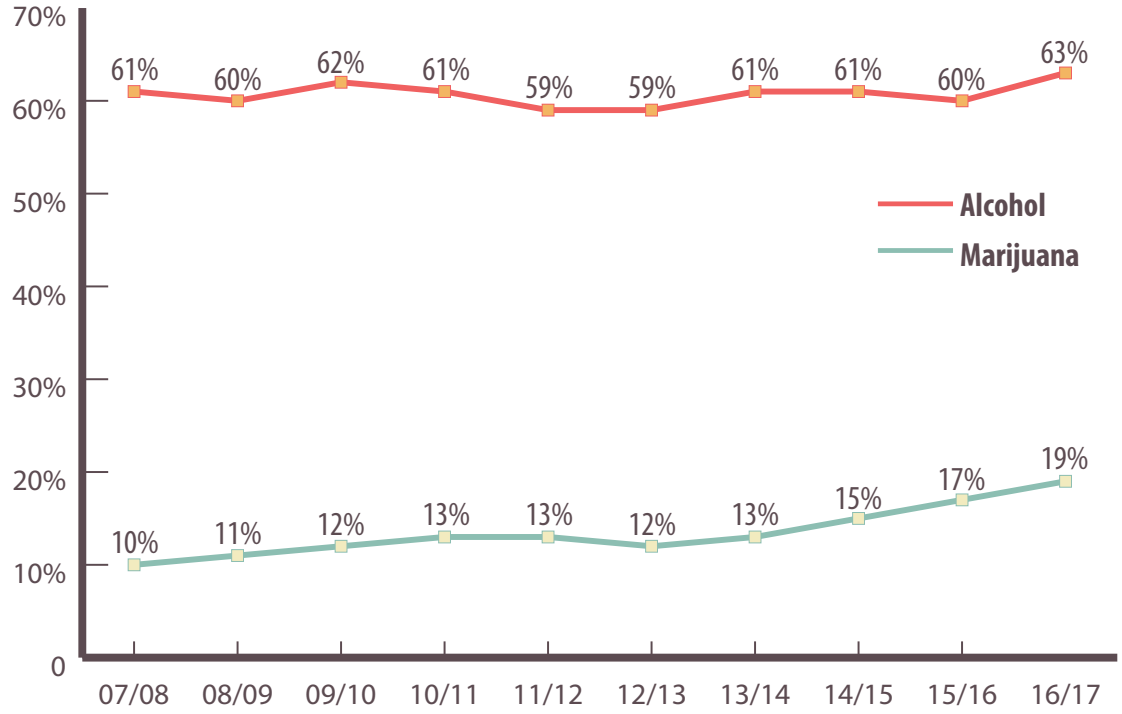
Persons Receiving Treatment for Substance Use Disorder, By Type of Treatment Received, Vermont, FY 2008-2017

Fiscal Year	Outpatient	Intensive Outpatient	Residential	Case Management	Hub
2008	6,872	909	2,000	1,931	485
2009	7,215	1,060	1,949	2,067	654
2010	6,394	923	1,977	1,951	677
2011	7,173	1,171	1,958	1,804	710
2012	6,892	1,190	2,084	1,893	947
2013	6,928	1,197	2,057	2,114	1,279
2014	7,025	1,165	2,328	2,439	2,642
2015	7,185	1,130	2,268	2,520	3,395
2016	6,932	1,125	2,310	2,494	3,956
2017	6,800	993	1,970	2,878	4,332

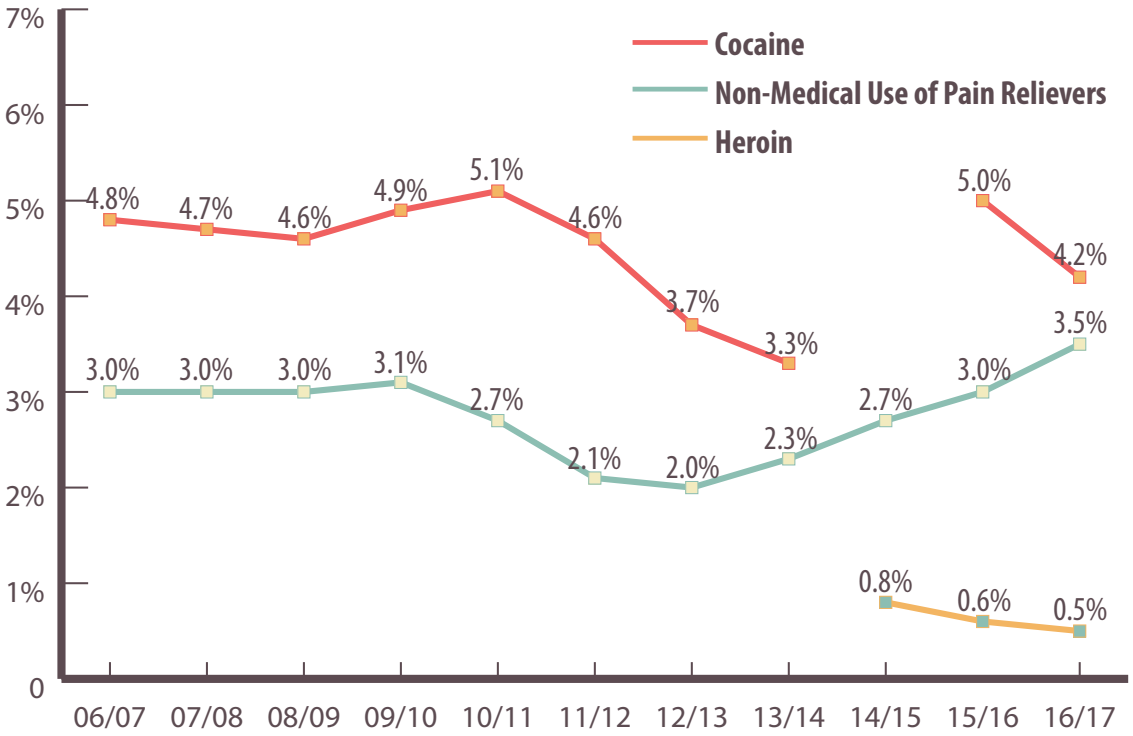
Data Trends Used by ADAP to Consider Future Levels of Substance Use and Substance Use Disorder

Substances Used by Vermonters Ages 12+ by Substance Type (NSDUH)

Percent of Vermonters Age 12+ Using in the PAST 30 DAYS



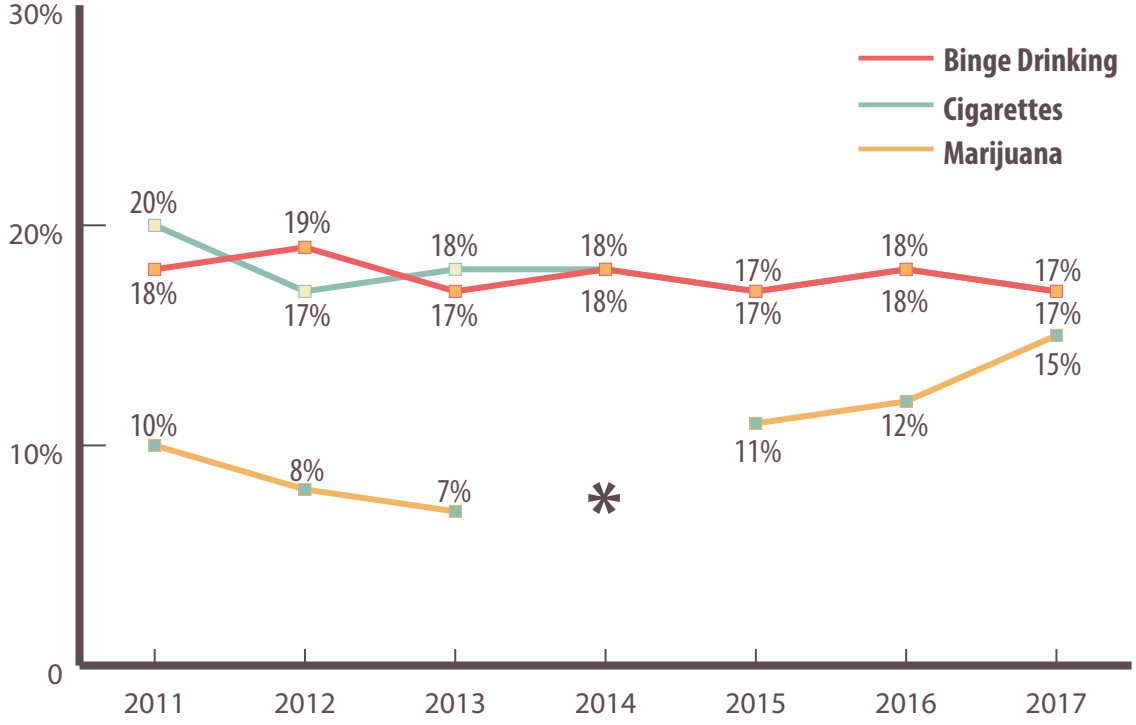
Percent of Vermonters Age 12+ Using in the PAST YEAR



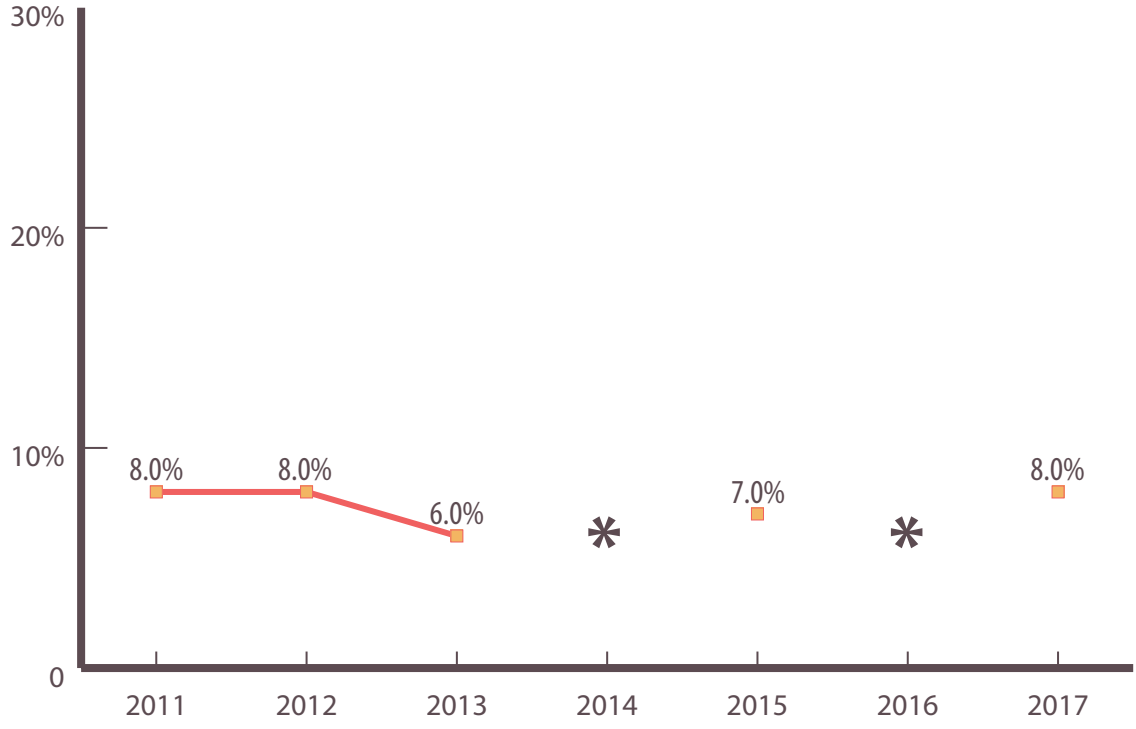
Note: Methodology changed for non-medical use of pain relievers and data prior to 2015/2016 are not comparable to 2013/2014 and earlier.

Substances Use Trends by Vermonters Ages 18+ (BRFSS)

Percent of Vermonters Age 18+ Using in the PAST MONTH



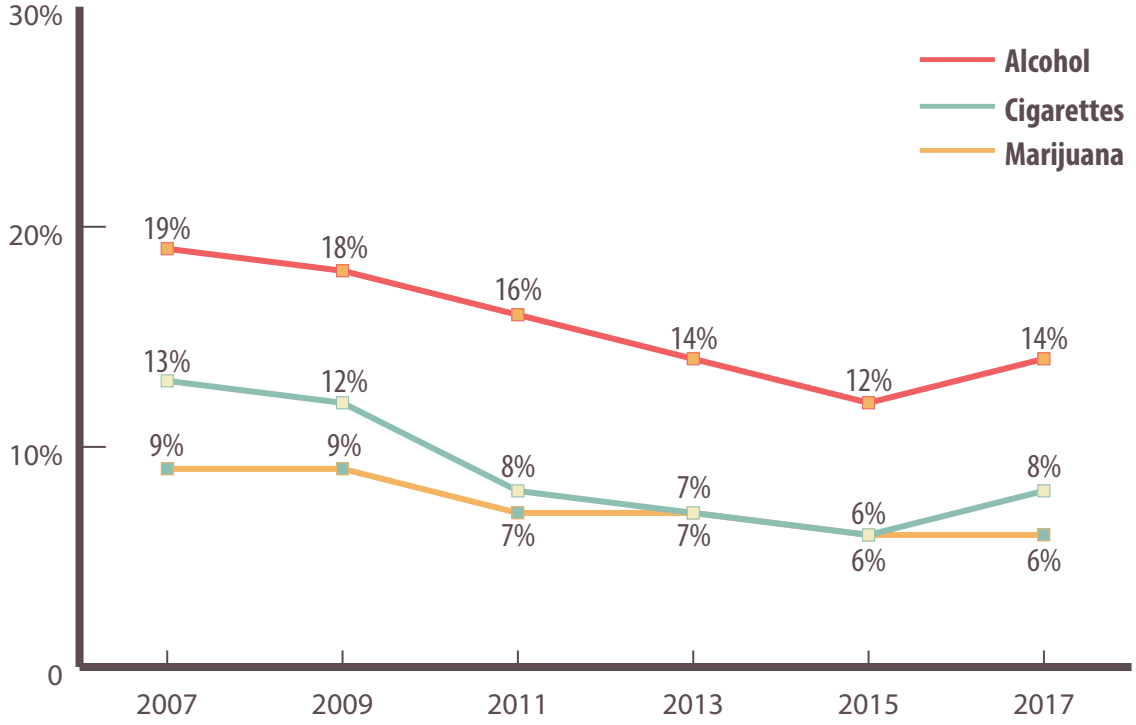
Percent of Vermonters Age 18+ EVER Misusing a Prescription Drug (Any Type)



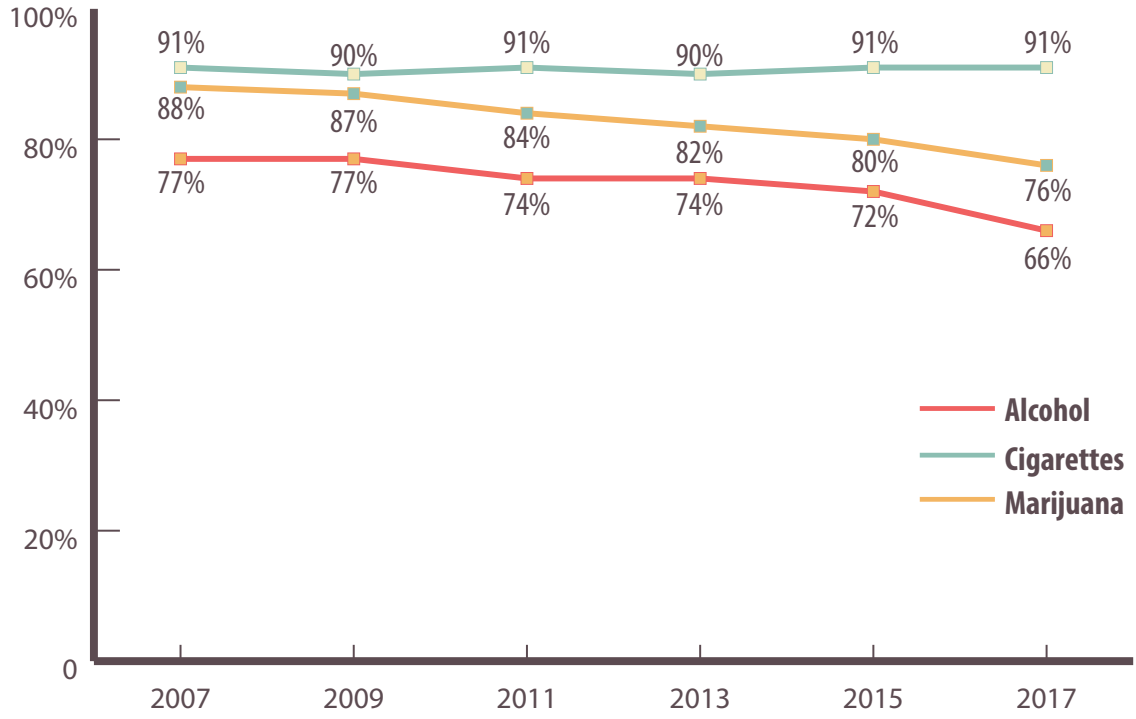
Note: *Question was not asked in 2014.

Substances Use by Vermonters 9-12th Grade Students (YRBS)

Percent Using Substances Before Age 13

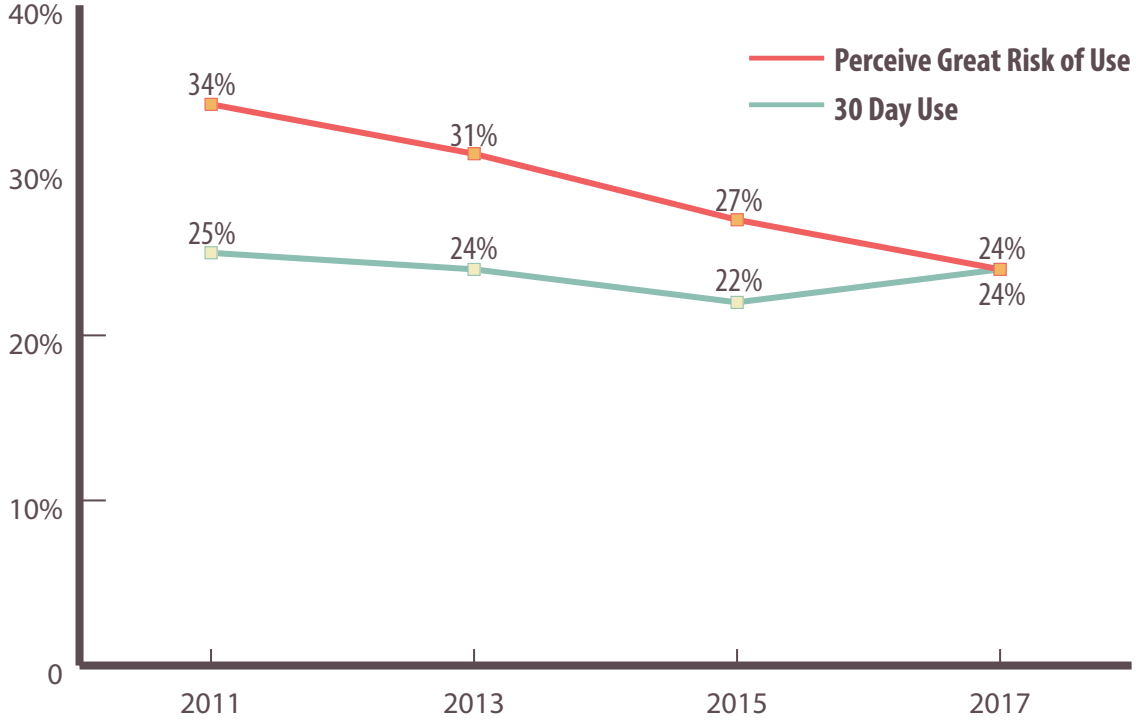


Percent of Vermonters Age 18+ EVER Misusing a Prescription Drug (Any Type)

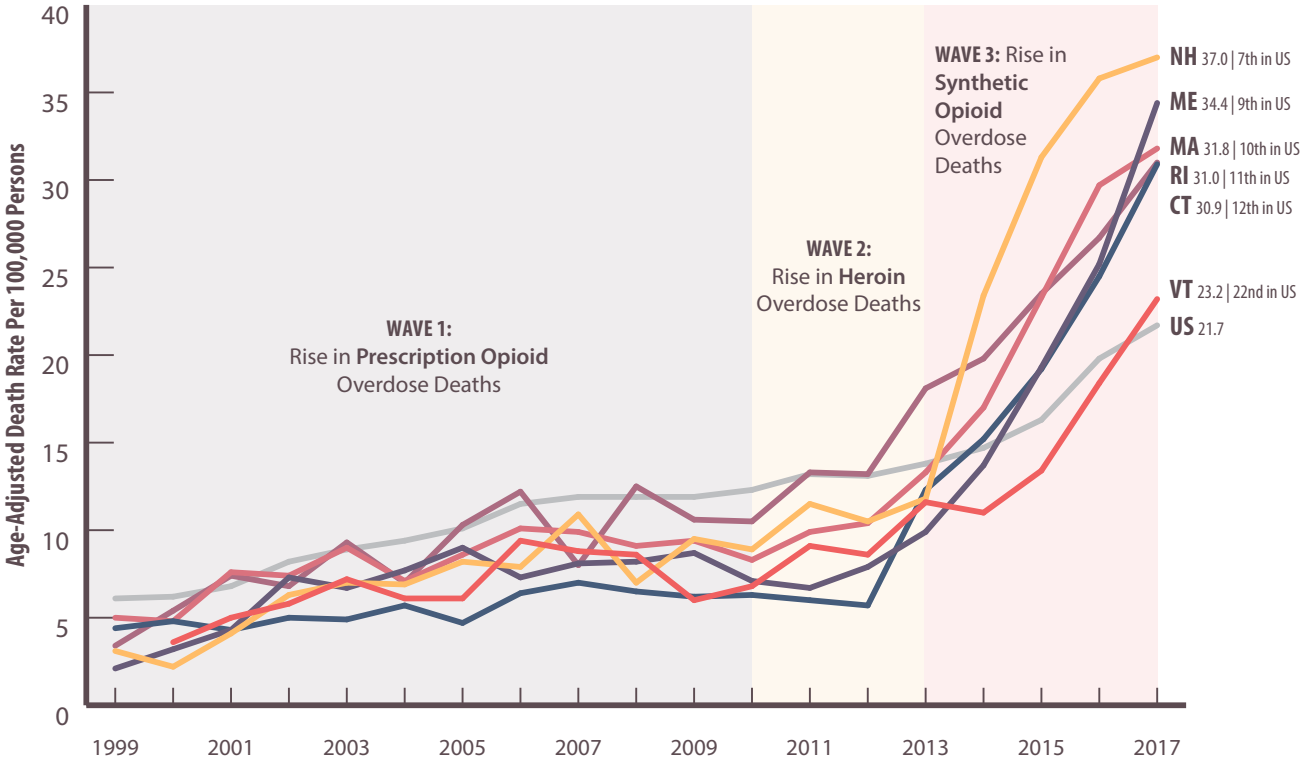


Substances Use by Vermonters 9-12th Grade Students (YRBS)

30 Day Mariuana Use, Perception of Great Risk of Use

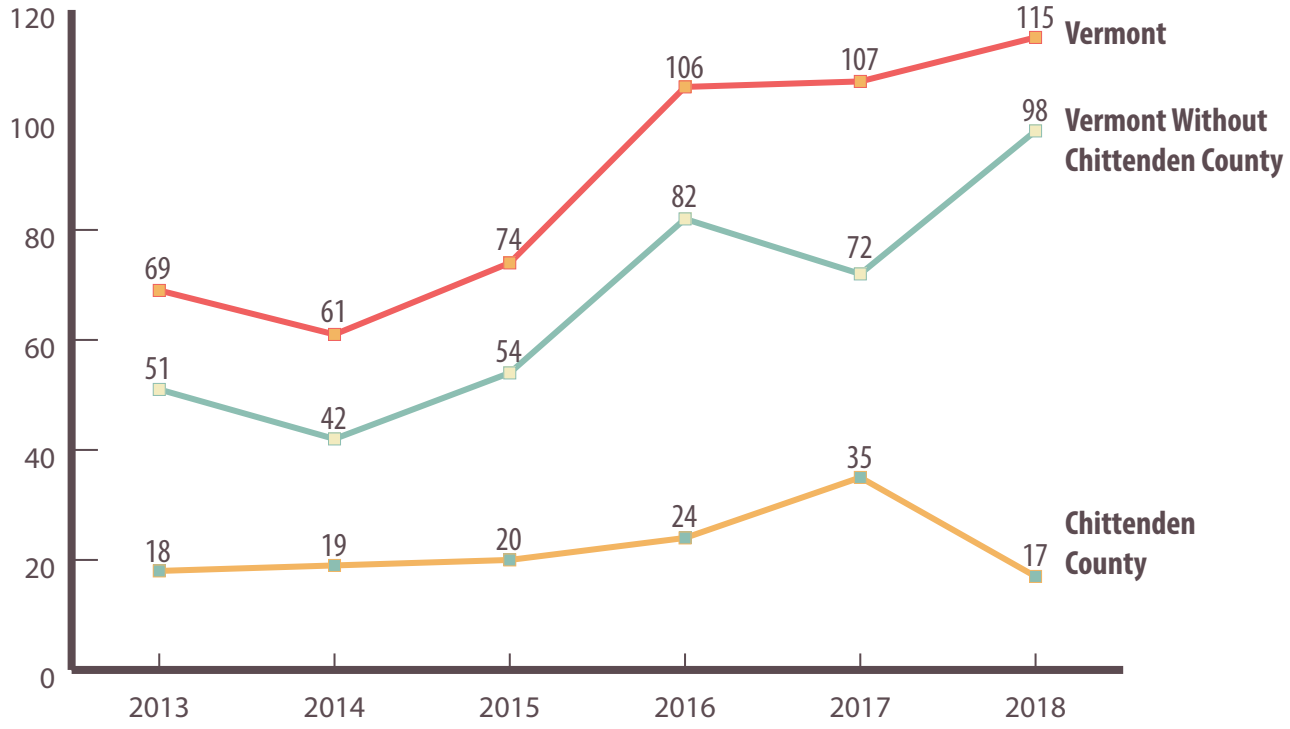


New England Opioid-Related Overdose Deaths, 1999-2017



Source: National Institute of Drug Abuse, Opioid Summaries by State. Online at www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state.

Opioid-Related Fatalities Among Vermonters



Source: Vermont Department of Health.

Model for Determining Recovery Housing Need

	2017 % of Total Admits	Step 1: Estimate of Persons Who Would Be at NARR Level I or II		Step 2: Of Those at NARR Level I & II, Estimate of Persons in Treatment Who Need a Different Housing Solution to Support Recovery		Step 3: Of Those at NARR Level I & II Who Need RR, Estimate of Persons in Treatment Who Would Opt for Recovery Housing		% of Original Total
A. By HOUSING Status		Estimated Percentage	Those At Level I, II	Estimated Percentage	Total Need	Estimated Percentage	Yields Total for Those in Need	
Homeless	904	33%	298	100%	298	75%	224	25%
Independent	5,283	75%	3,962	33%	1,308	50%	654	12%
Dependent-In Supervised Housing	1,730	33%	571	50%	285	50%	143	8%
No Information	563	33%	186	33%	61	50%	31	5%
TOTAL	**8,480**	**59%**	**5,017**	**39%**	**1,953**	**54%**	**1,051**	**12%**
B. By GENDER		Estimated Percentage	Those At Level I, II	Estimated Percentage	Total Need	Estimated Percentage	Yields Total for Those in Need	
Men	5,141	60%	3,085	40%	1,234	50%	617	12%
Women	1,839	60%	1,103	40%	441	60%	265	14%
Women with Dependent Children	1,500	60%	900	50%	450	70%	315	21%
TOTAL	**8,480**	**60%**	**5,088**	**42%**	**2,125**	**56%**	**1,197**	**14%**
C. By AGE Cohort		Estimated Percentage	Those At Level I, II	Estimated Percentage	Total Need	Estimated Percentage	Yields Total for Those in Need	
12 to 17	270	0%	0	0%	0	0%	0	0%
18-24	1,367	50%	684	75%	513	67%	343	25%
25-34	3,444	50%	1,722	67%	1,154	67%	773	22%
35 and Over	3,399	67%	2,277	33%	752	33%	248	7%
TOTAL	**8,480**	**55%**	**4,683**	**52%**	**2,418**	**56%**	**1,364**	**16%**
Average of Three Approaches	**8,480**	**58%**	**4,929**	**44%**	**2,165**	**56%**	**1,204**	**14%**

SOURCE: Development Cycles, 2/19

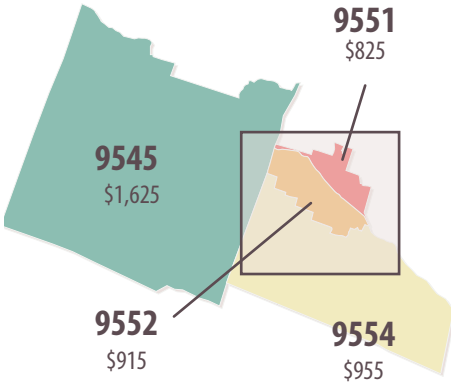
Appendix D
RECOVERY HOUSING CONDITIONS PROFILES

- Barre-Berlin
- Bennington
- Brattleboro
- Burlington
- Middlebury
- Morrisville
- Newport
- Rutland City
- St. Albans City
- St. Johnsbury
- South Burlington
- Springfield
- White River Junction

BARRE-BERLIN

Census Tracts

with median monthly rents for 3+ bedrooms



Housing Characteristics

Census Tract	Single Family Homes 4+ Bedrooms	2-4 Family Buildings	Median Rent (3+ bdrms)	Percentage of Renter Occupied Housing
9545	153	46	$1,625	19%
9551	255	292	$825	56%
9552	289	145	$915	44%
9554	229	80	$955	26%

Source: American Community Survey, 2017 5-year estimates

VERMONT RECOVERY CENTER

Turning Point Center of Central Vermont
141 State Street, Barre

VERMONT RECOVERY HOUSING

Rise/Phoenix House - Men's Sober Living
580 S Barre Road, Barre

VERMONT TREATMENT CENTER

Central Vermont Addiction Medicine
300 Granger Road, Berlin

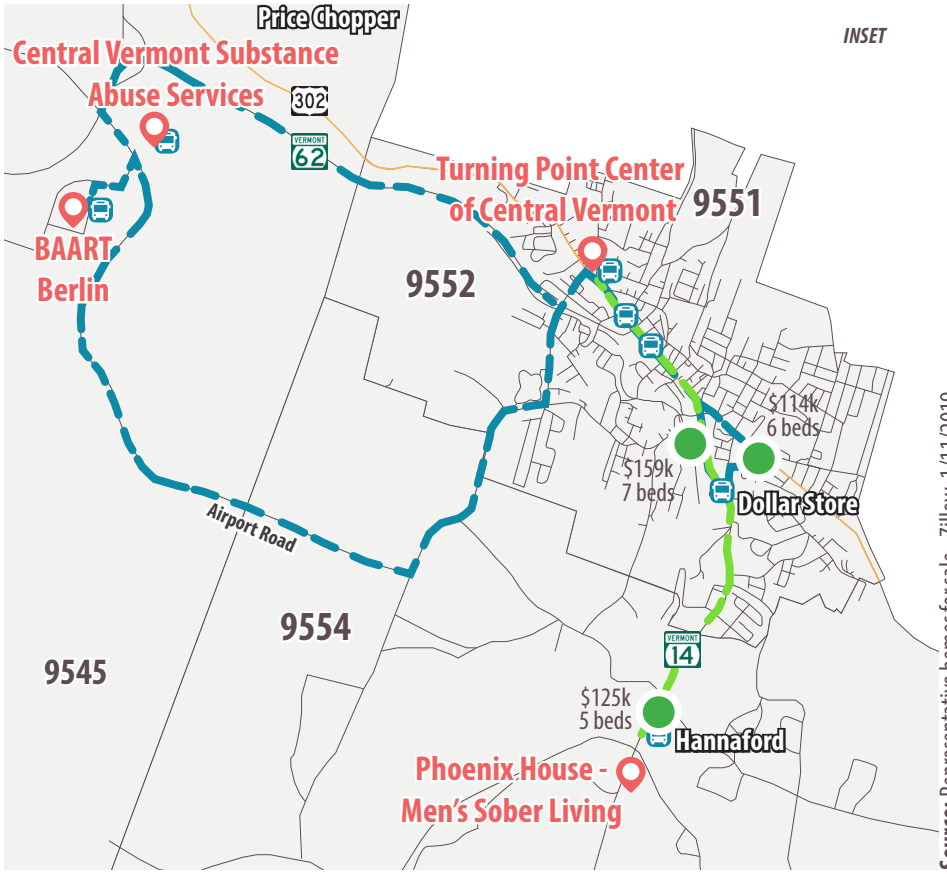
Logistics

Barre Hospital Hill
every 1 hour

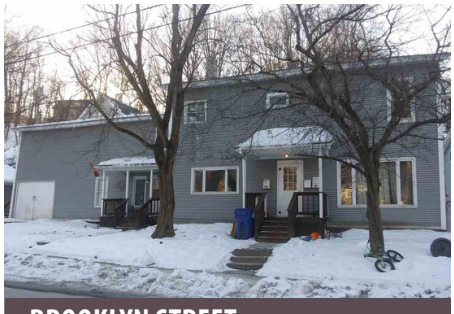
Hannaford Shopping Special
Tuesdays only

Phoenix House to Turning Point: 1 hour walk
2.8 miles

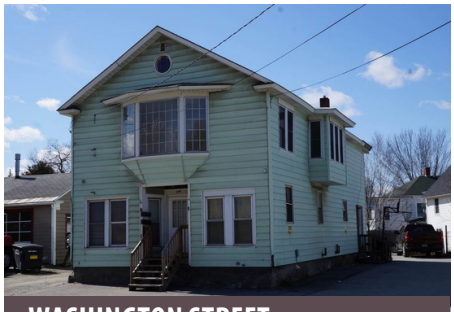
Turning Point to Hospital Loop: 2 hour walk
5 miles



Source: Representative homes for sale - Zillow, 1/11/2019



BROOKLYN STREET
$159,000 • 7 bedrooms • 2,708 square feet

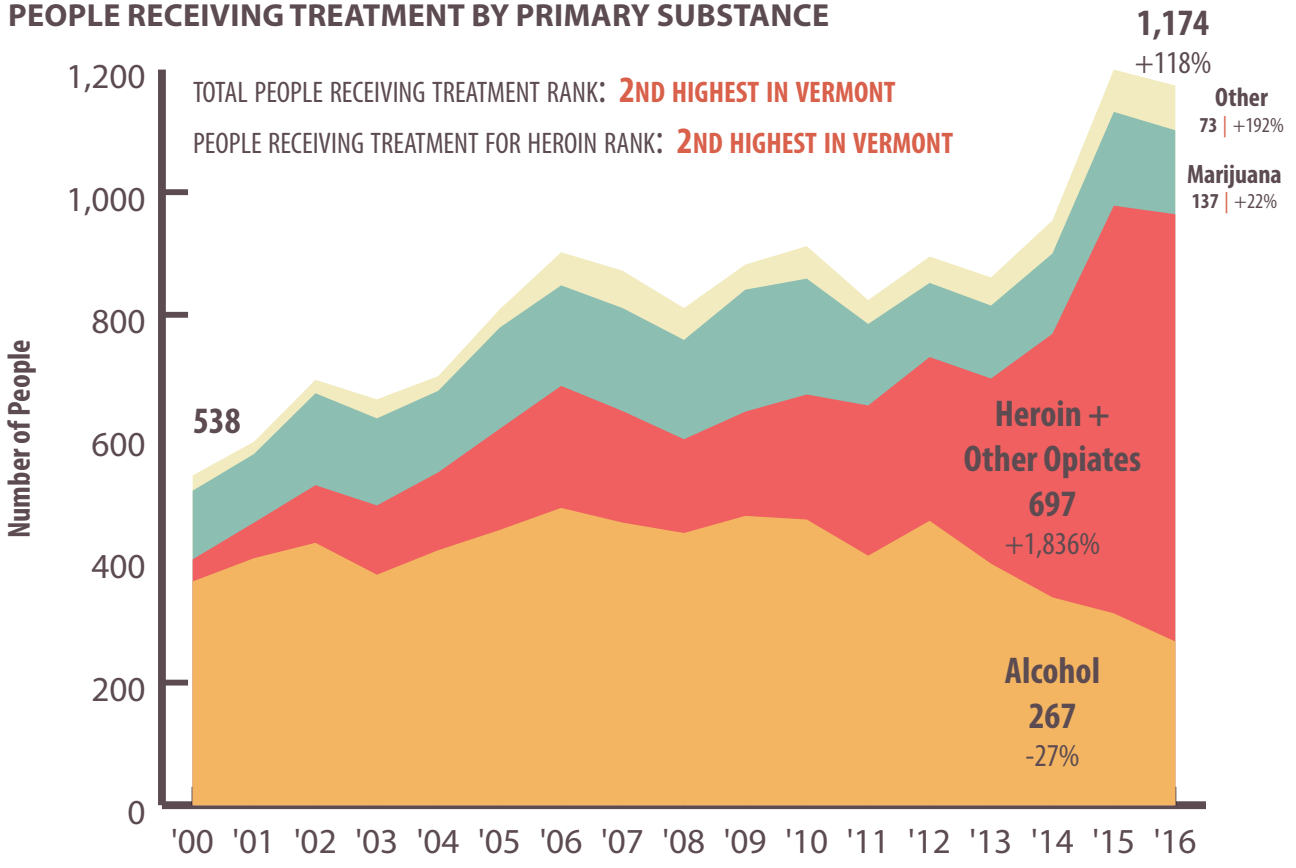


WASHINGTON STREET
$114,000 • 6 bedrooms • 1,888 square feet

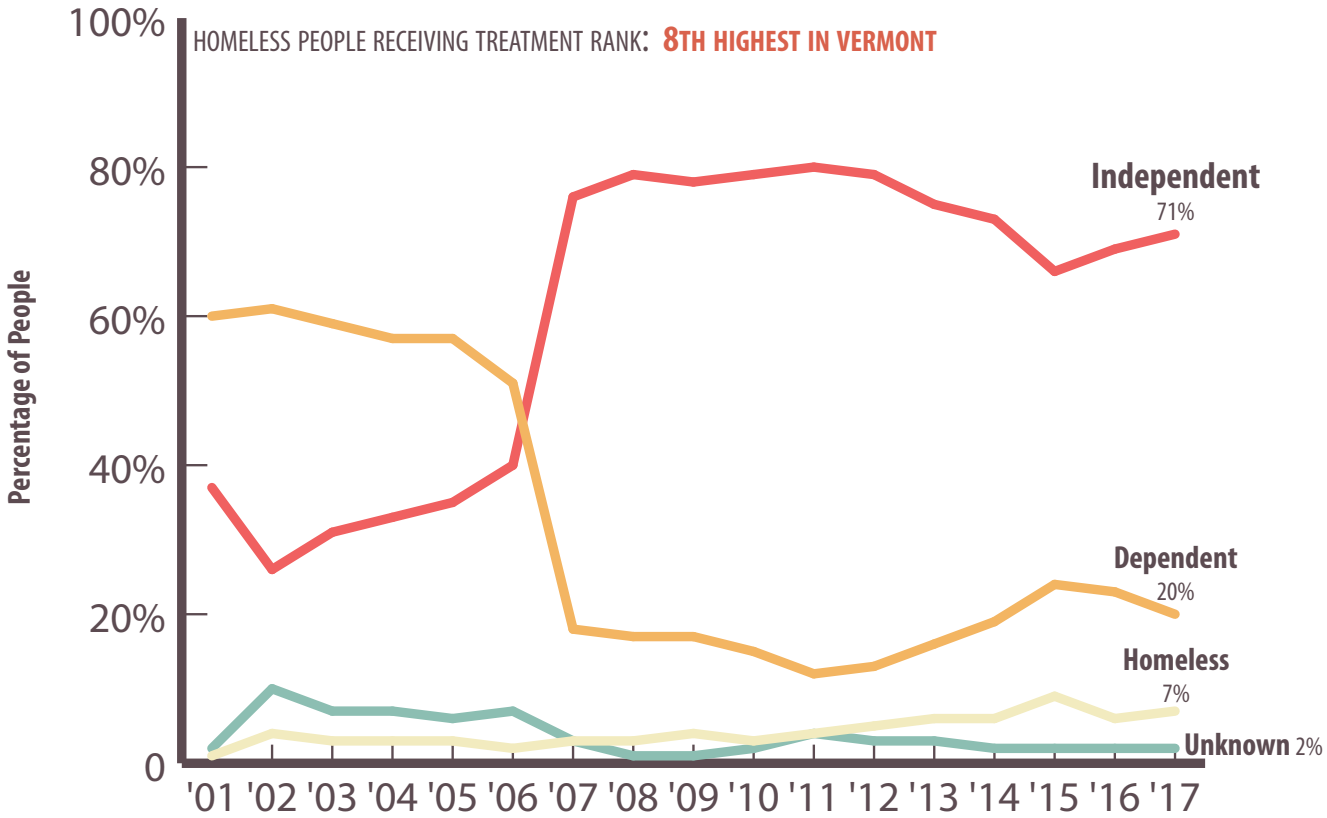
S BARRE ROAD
$125,000 • 5 bedrooms • 2,352 square feet

WASHINGTON COUNTY

PEOPLE RECEIVING TREATMENT BY PRIMARY SUBSTANCE

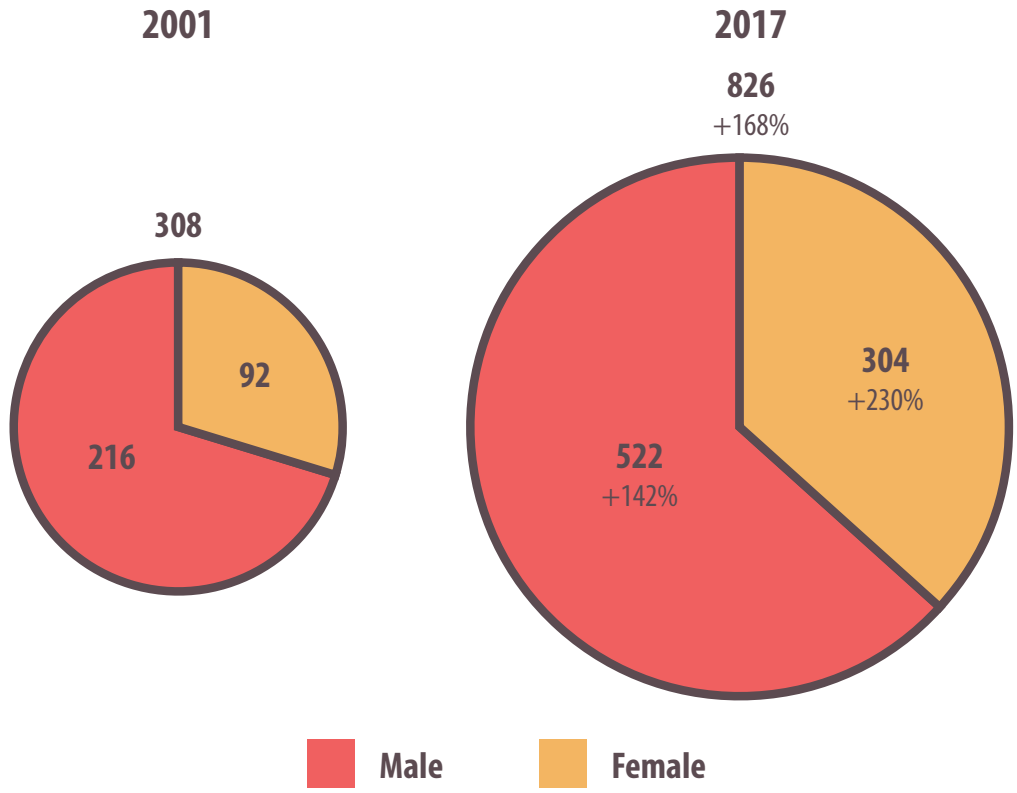


HOUSING STATUS AT TIME OF ADMISSION TO TREATMENT

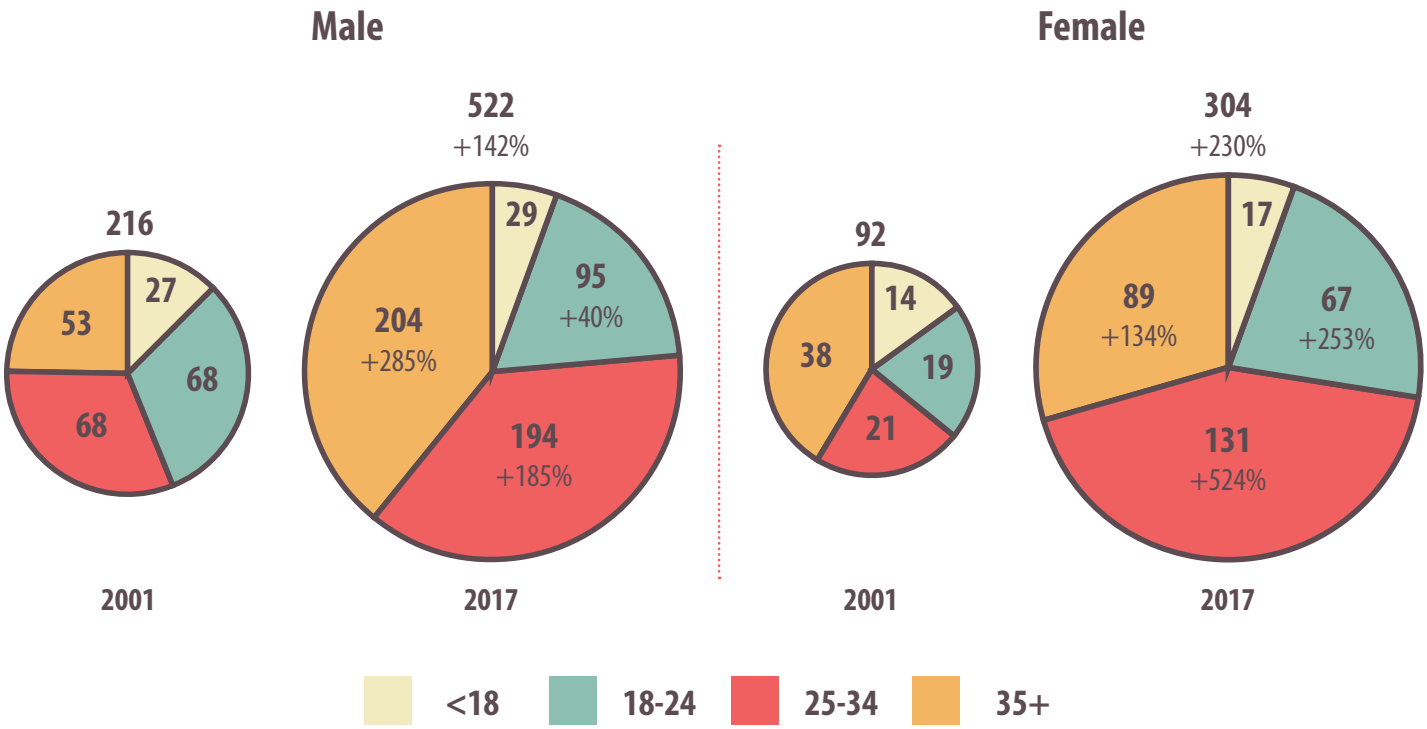


WASHINGTON COUNTY

PEOPLE RECEIVING TREATMENT BY SEX



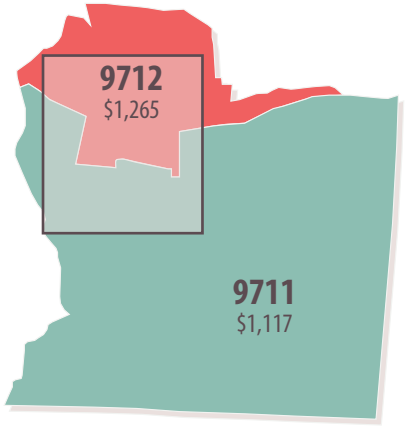
PEOPLE RECEIVING TREATMENT BY AGE



BENNINGTON

Census Tracts

with median monthly rents for 3+ bedrooms



VERMONT RECOVERY CENTER

Turning Point Center of Bennington
465 Main Street

VERMONT RECOVERY HOUSING

VERMONT TREATMENT CENTER

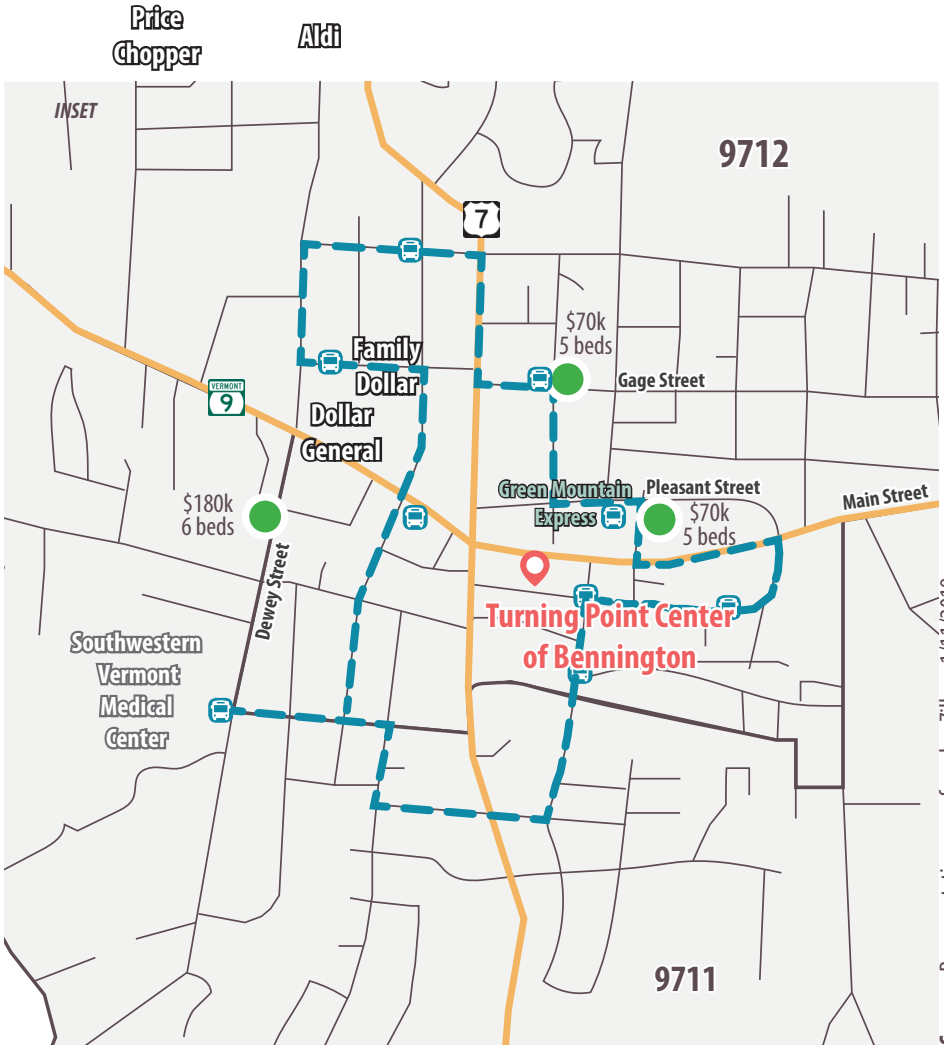
Logistics

Blue Line
every 30 min

Housing Characteristics

Census Tract	Single Family Homes 4+ Bedrooms	2-4 Family Buildings	Median Rent (3+ bdrms)	Percentage of Renter Occupied Housing
9711	385	99	$1,117	20%
9712	359	331	$1,265	61%

Source: American Community Survey, 2017 5-year estimates



Source: Representative omes for sale - Zillow, 1/11/2019

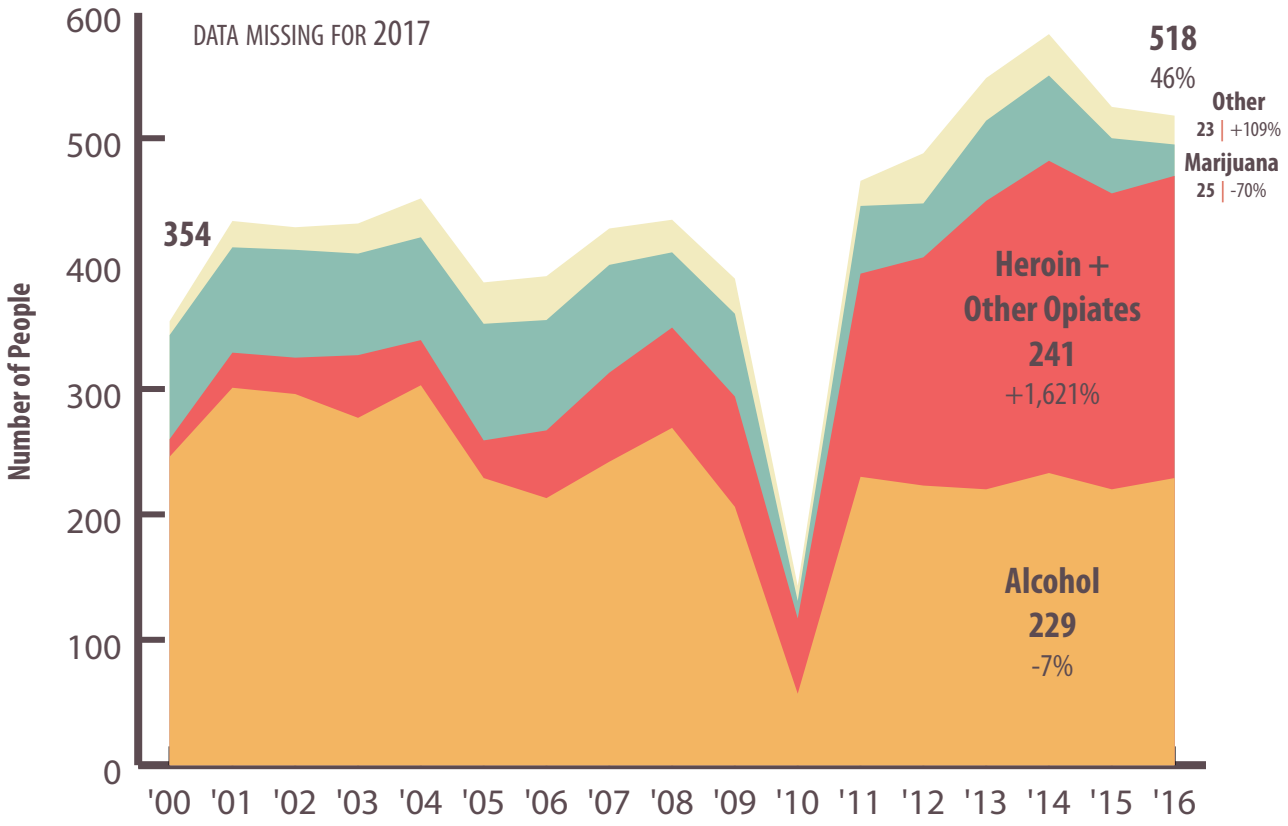
PLEASANT STREET
$101,000 • 4 bedrooms • 1,794 square feet

GAGE STREET
$69,900 • 5 bedrooms • 1,784 square feet

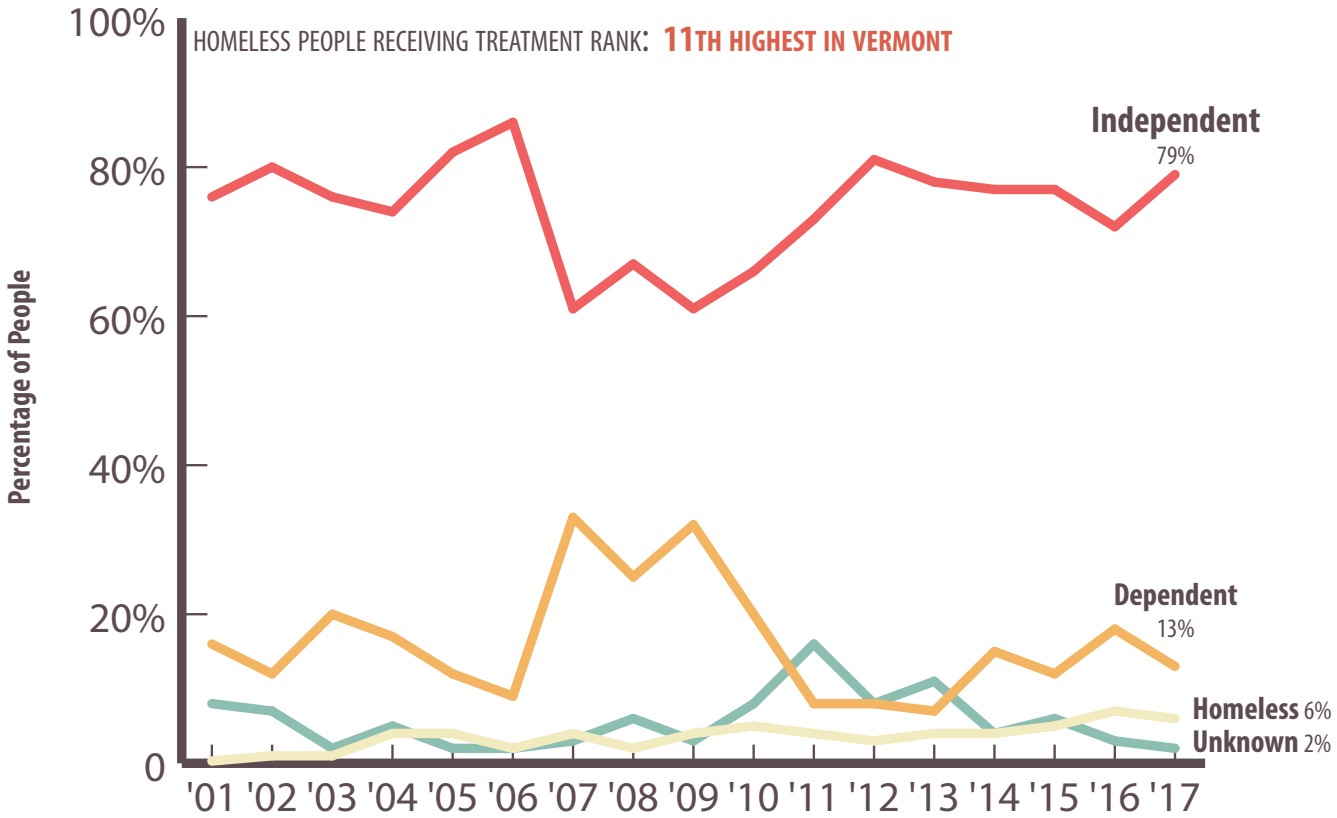
DEWEY STREET
$179,900 • 6 bedrooms • 3,000 square feet

BENNINGTON COUNTY

PEOPLE RECEIVING TREATMENT BY PRIMARY SUBSTANCE

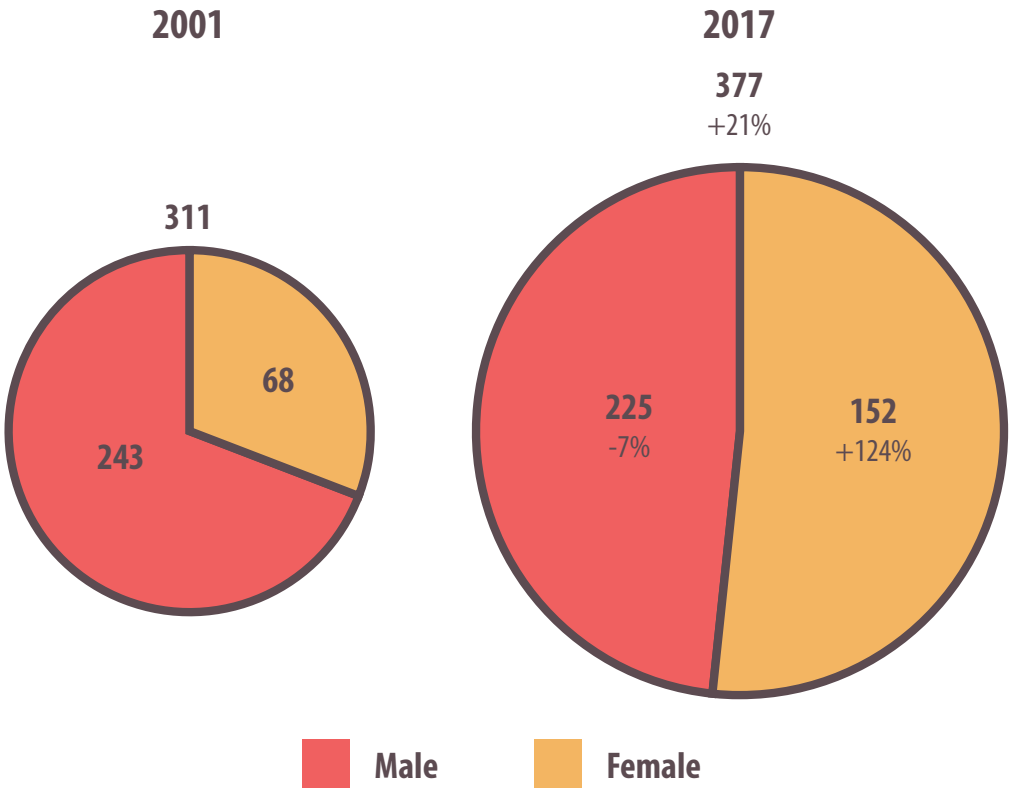


HOUSING STATUS AT TIME OF ADMISSION TO TREATMENT

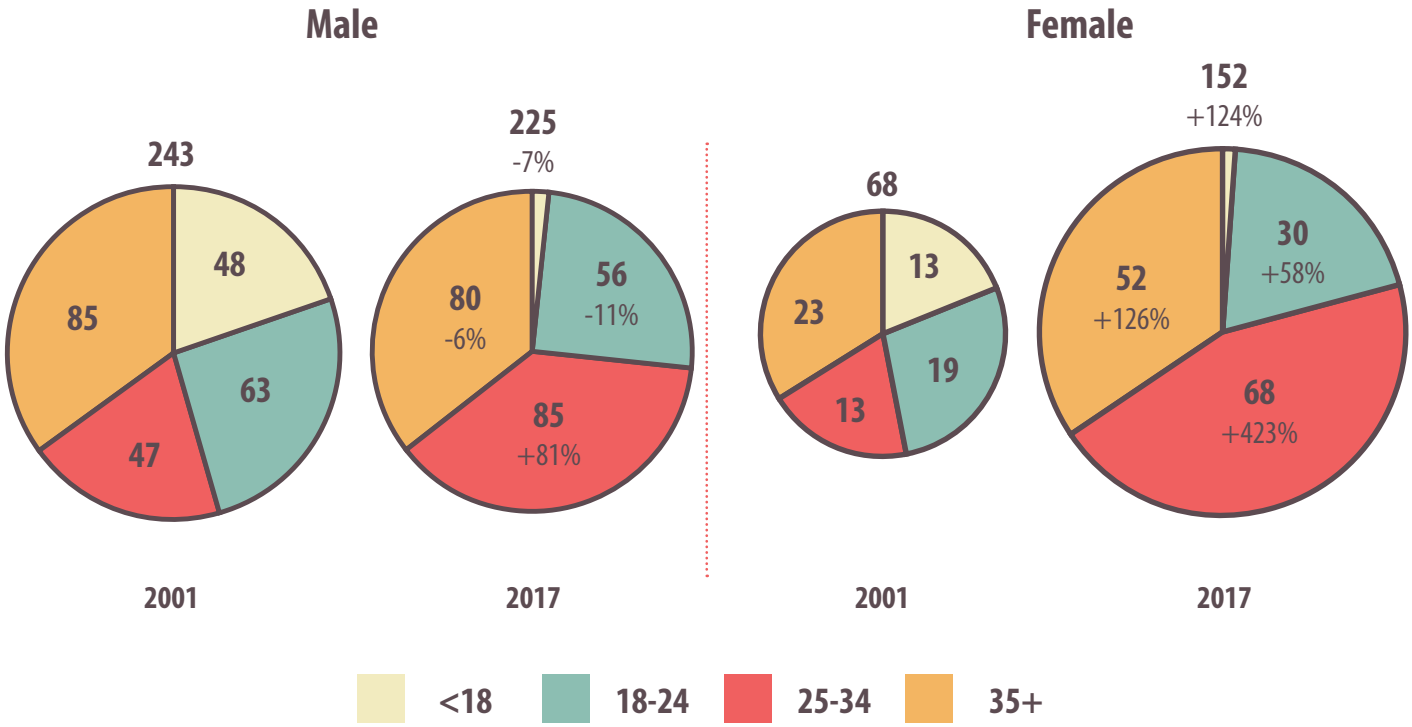


BENNINGTON COUNTY

PEOPLE RECEIVING TREATMENT BY SEX



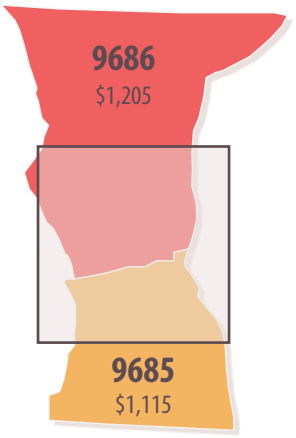
PEOPLE RECEIVING TREATMENT BY AGE



BRATTLEBORO

Census Tracts

with median monthly rents for 3+ bedrooms



Housing Characteristics

Census Tract	Single Family Homes 4+ Bedrooms	2-4 Family Buildings	Median Rent (3+ bdrms)	Percentage of Renter Occupied Housing
9685	213	267	$1,115	62%
9686	234	138	$1,205	45%

Source: American Community Survey, 2017 5-year estimates

VERMONT RECOVERY CENTER

Turning Point - Windham County
39 Elm Street

VERMONT RECOVERY HOUSING

Rise/Phoenix House - Women's Sober Living
178 Linden Street

Rise/Phoenix House - Men's Sober Living
435 Western Avenue

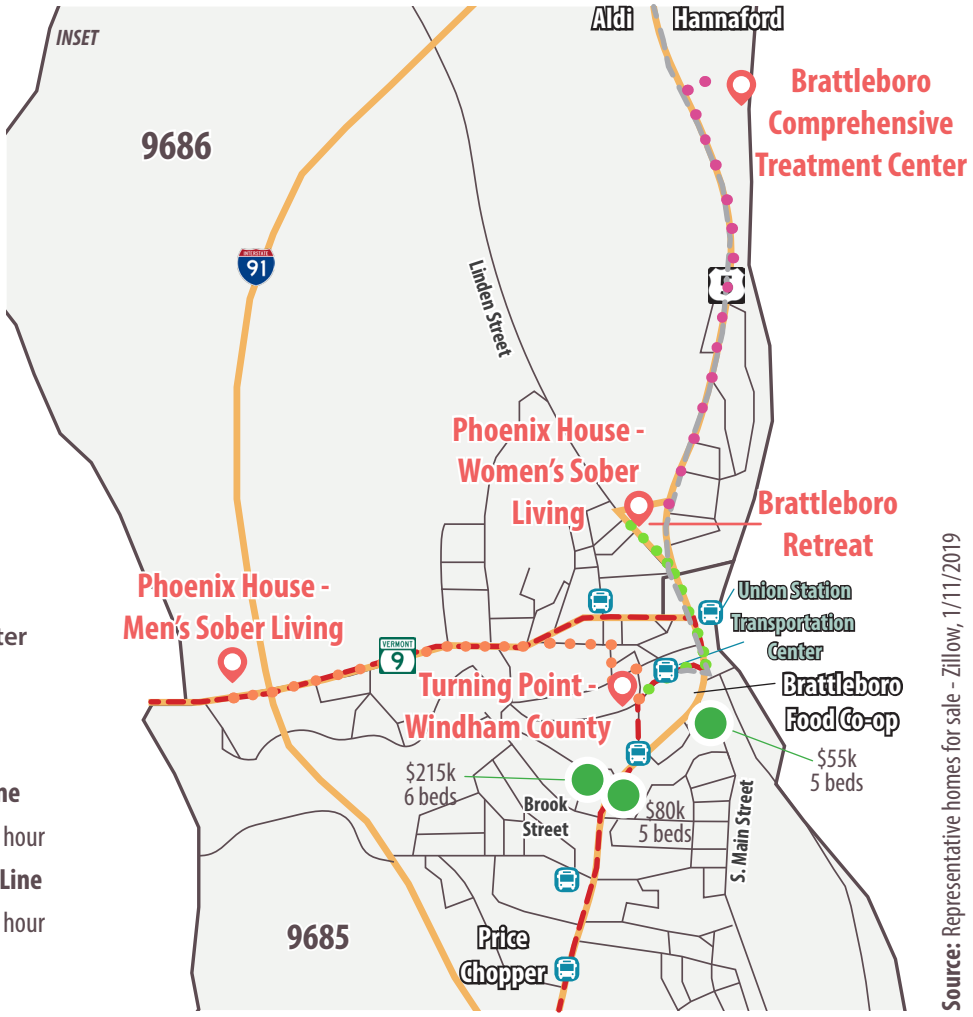
VERMONT TREATMENT CENTER

Brattleboro Retreat
1 Anna Marsh Lane

Brattleboro Comprehensive Treatment Center
16 Town Crier Drive

Logistics

- **28 min walk** — 1.3 mile
- **17 min walk** — 0.8 mile
- **27 min walk** — 1.3 mile
- **Red Line** — every 1 hour
- **White Line** — every 1 hour



Source: Representative homes for sale - Zillow, 1/11/2019

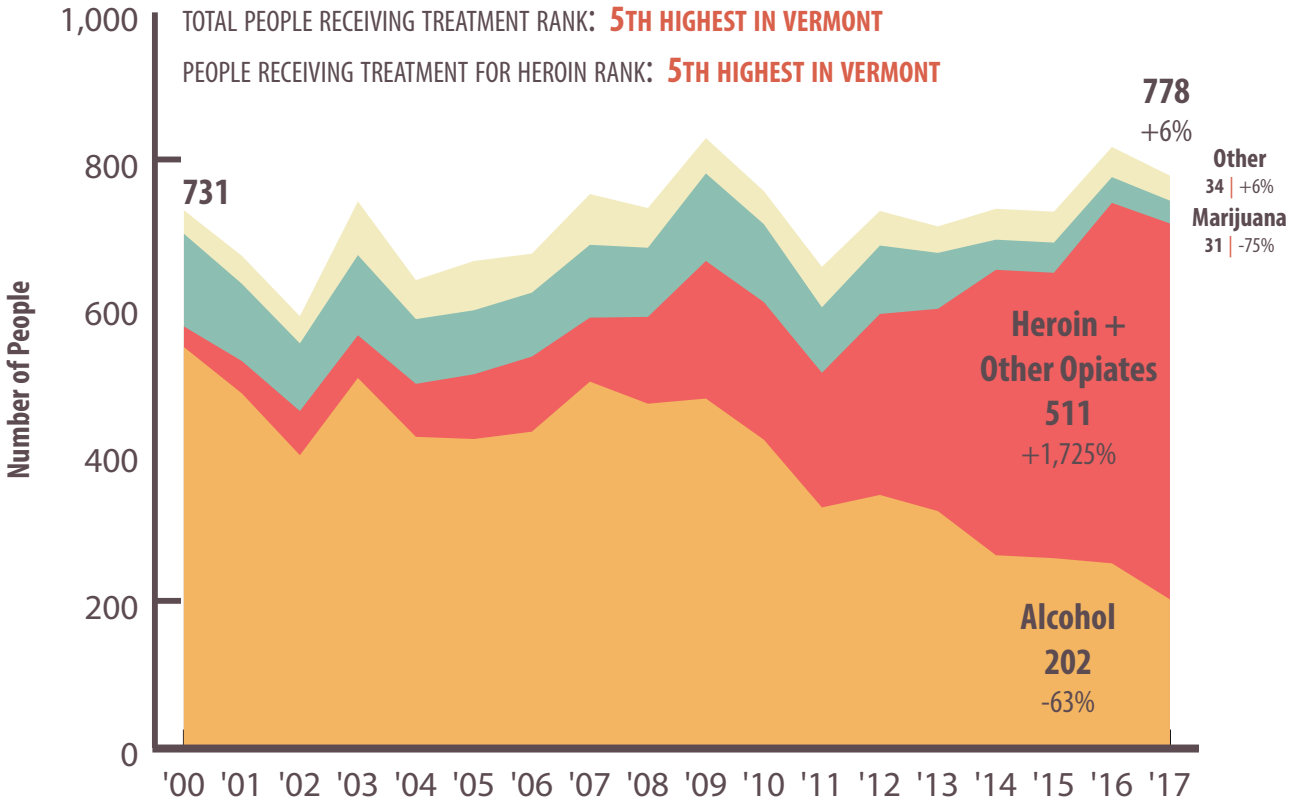
BROOK STREET
$215,000 • 6 bedrooms • 3,285 square feet

SOUTH MAIN STREET
$55,000 • 5 bedrooms • 2,622 square feet

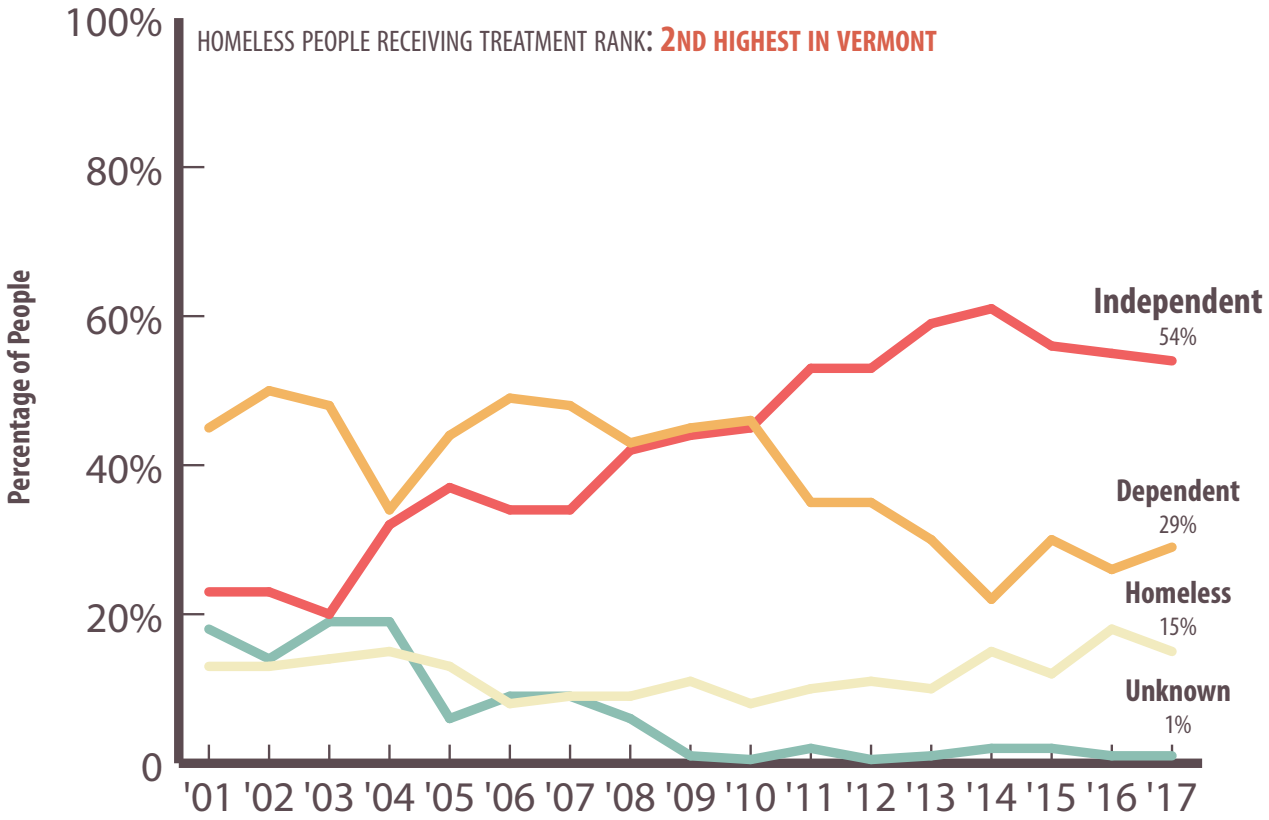
HORTON PLACE
$79,900 • 5 bedrooms • 2,409 square feet (Reconstruction)

WINDHAM COUNTY

PEOPLE RECEIVING TREATMENT BY PRIMARY SUBSTANCE

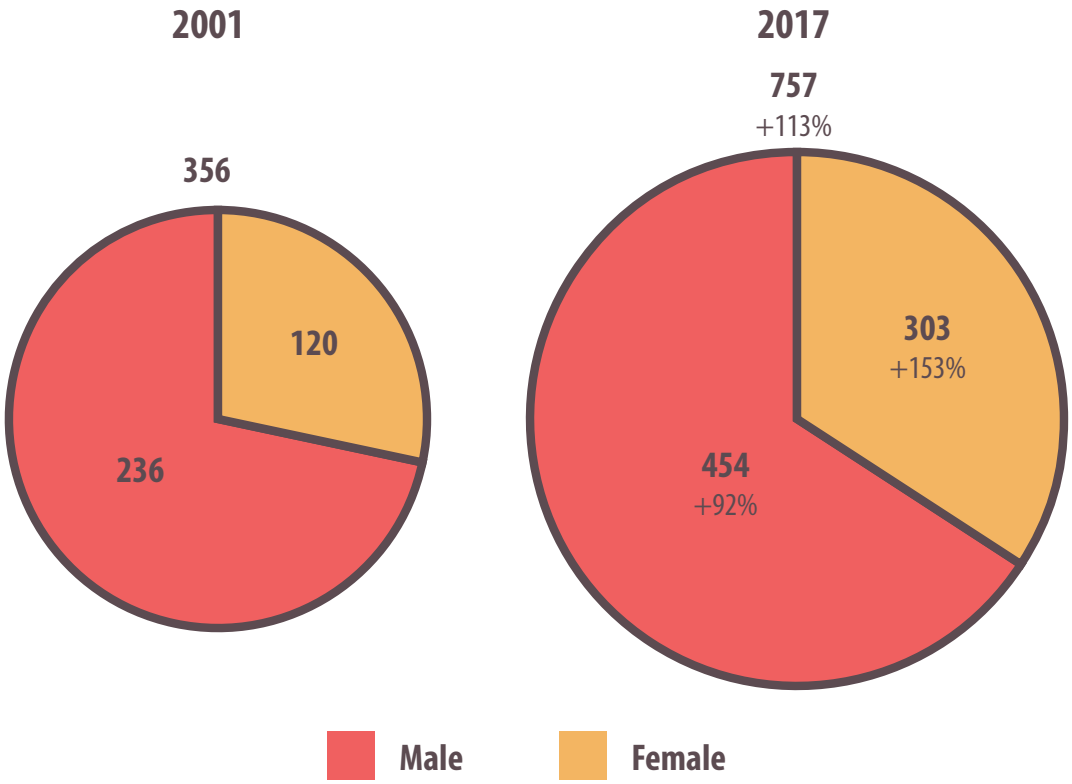


HOUSING STATUS AT TIME OF ADMISSION TO TREATMENT

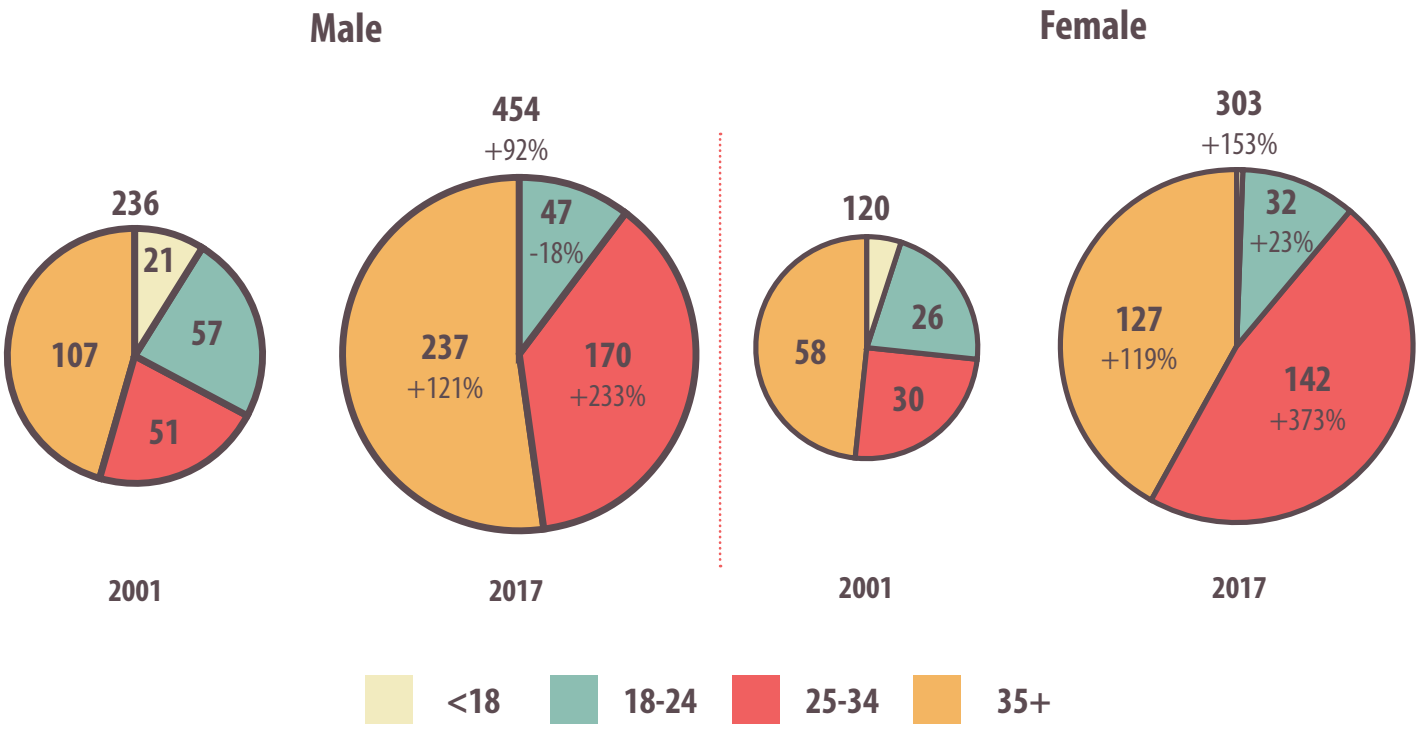


WINDHAM COUNTY

PEOPLE RECEIVING TREATMENT BY SEX



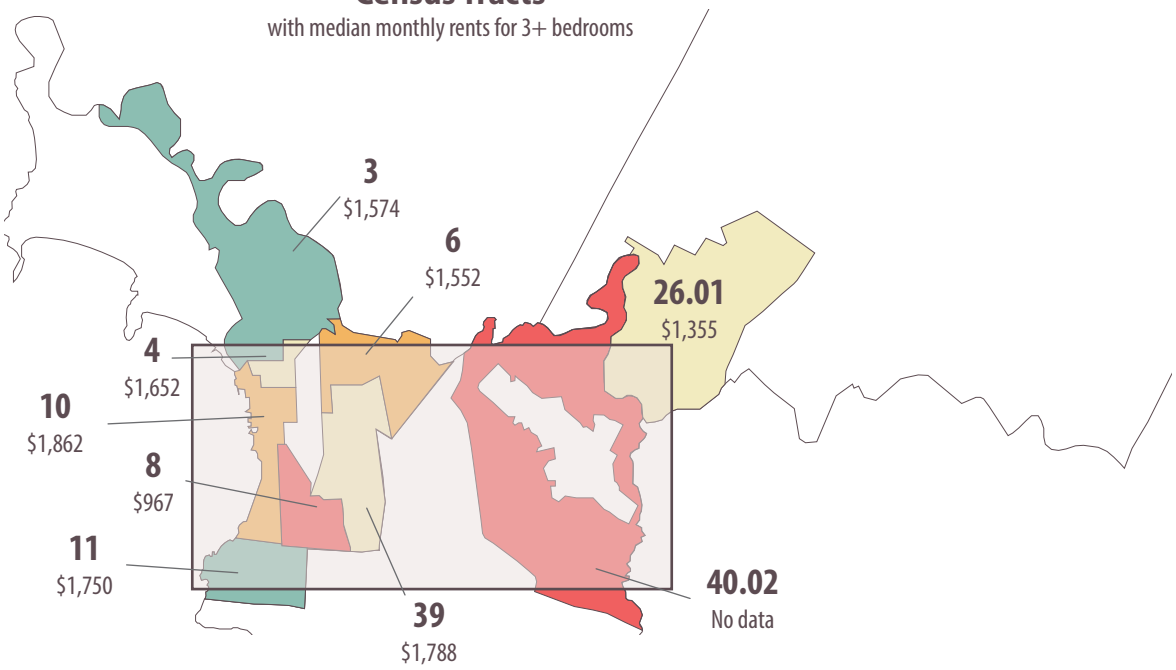
PEOPLE RECEIVING TREATMENT BY AGE



BURLINGTON

Census Tracts

with median monthly rents for 3+ bedrooms



VERMONT RECOVERY CENTER

Turning Point Center of Chittenden County
179 S Winooski Avenue

VERMONT RECOVERY HOUSING

Evolution House
123 King Street, Burlington

First Step Recovery
1174 North Avenue, Burlington

Liberty House (Women only)
Essex

Lincoln St House - Vermont Foundation of Recovery
44 Lincoln Street, Essex

Lund Family Center
76 Glen Road, Burlington

Lyman Ave House - VFOR
79 Lyman Avenue, Burlington

Oxford House Catherine Street
8 Catherine Street, Burlington

Oxford House Kirk
42 Bright Street, Burlington

Phoenix House - Men's Sober Living
37 Elmwood Avenue, Burlington

Housing Characteristics

Census Tract	Single Family Homes 4+ Bedrooms	2-4 Family Buildings	Median Rent (3+ bdrms)	Percentage of Renter Occupied Housing
3	167	322	$1,574	66%
4	91	296	$1,652	91%
6	255	188	$1,552	72%
8	191	77	$967	50%
10	94	136	$1,862	75%
11	98	138	$1,750	39%
26.01	459	218	$1,355	39%
39	151	49	$1,788	77%
40.02	312	156	No data	42%

Source: American Community Survey, 2017 5-year estimates

2nd Step
1477 North Avenue, Burlington

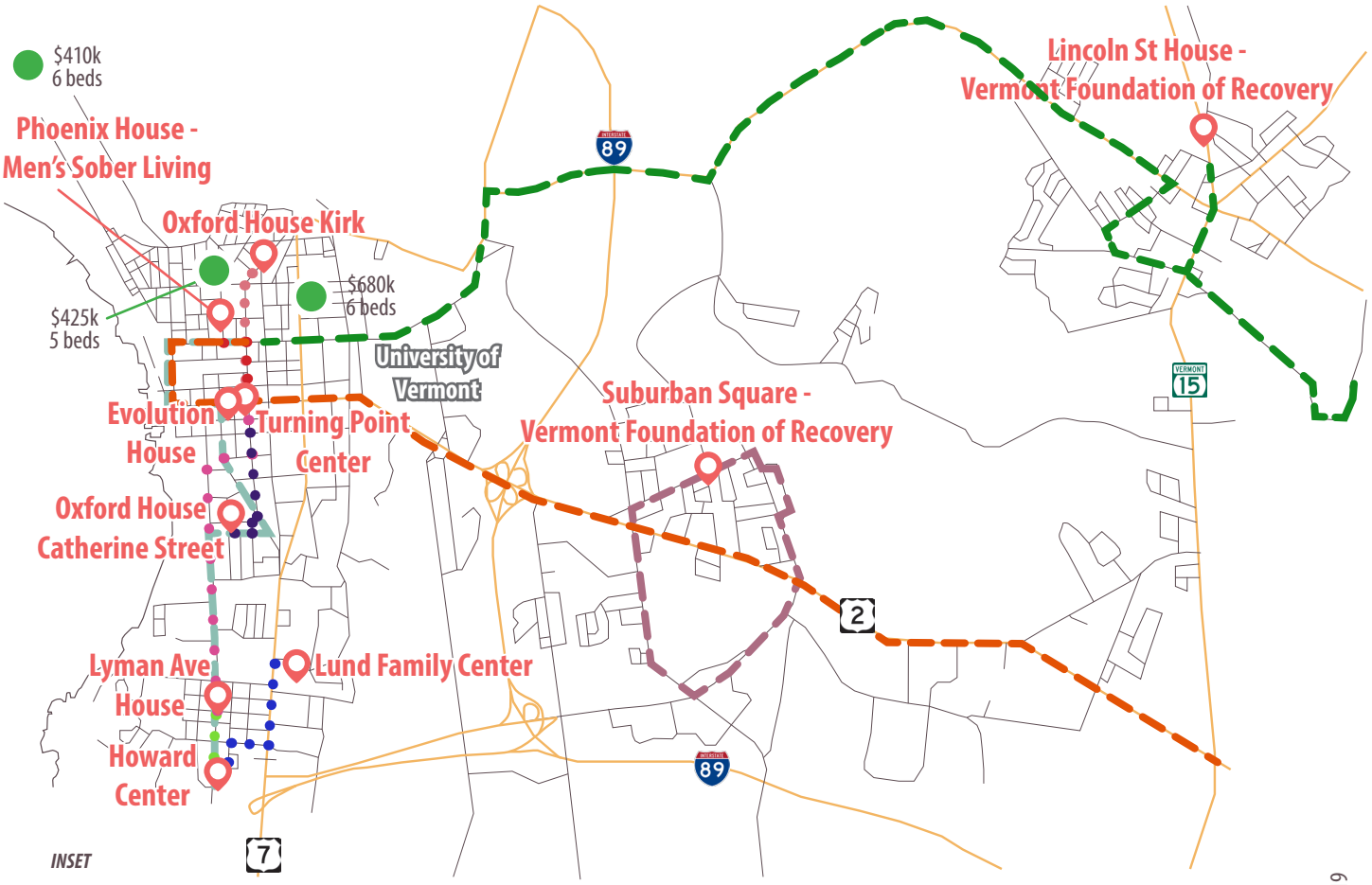
Stonecrop
Manhattan Drive, Burlington

Suburban Square - VFOR
82 Suburban Square, South Burlington

VERMONT TREATMENT CENTER

Howard Center
1138 Pine Street

CHITTENDEN COUNTY



Logistics

- **Lyman Ave House to Howard Center**
  9 min walk / .4 mile
- **Lyman Ave House to Turning Point Center**
  34 min walk / 1.7 mile
- **Catherine Street to Turning Point Center**
  15 min walk / 0.7 mile
- **Men's Sober House to Turning Point Center**
  11 min walk / 0.6 mile
- **Oxford House Kirk to Turning Point Center**
  20 min walk / 1 mile

- **2: Essex Junction**
  every 15-30 minutes
- **5: Pine Street**
  every 30 minutes
- **12: UMall/Airport**
  every 30 minutes
- **1: Williston Village/Walmart**
  every 15 minutes

Source: Representative homes for sale - Zillow, 1/19/2019

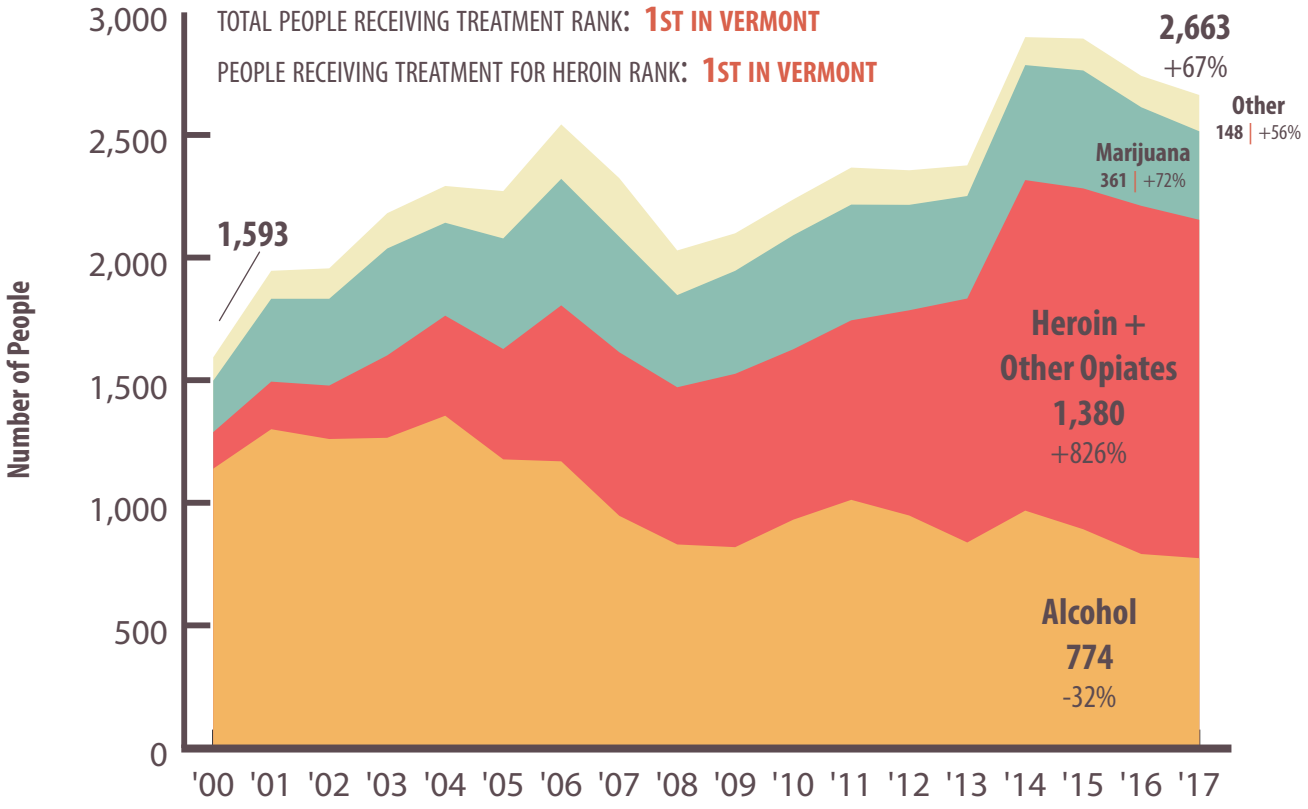
ELMWOOD STREET
$424,900 • 5 bedrooms • 1,769 square feet

TALLWOOD LANE
$410,000 • 6 bedrooms • 2,852 square feet

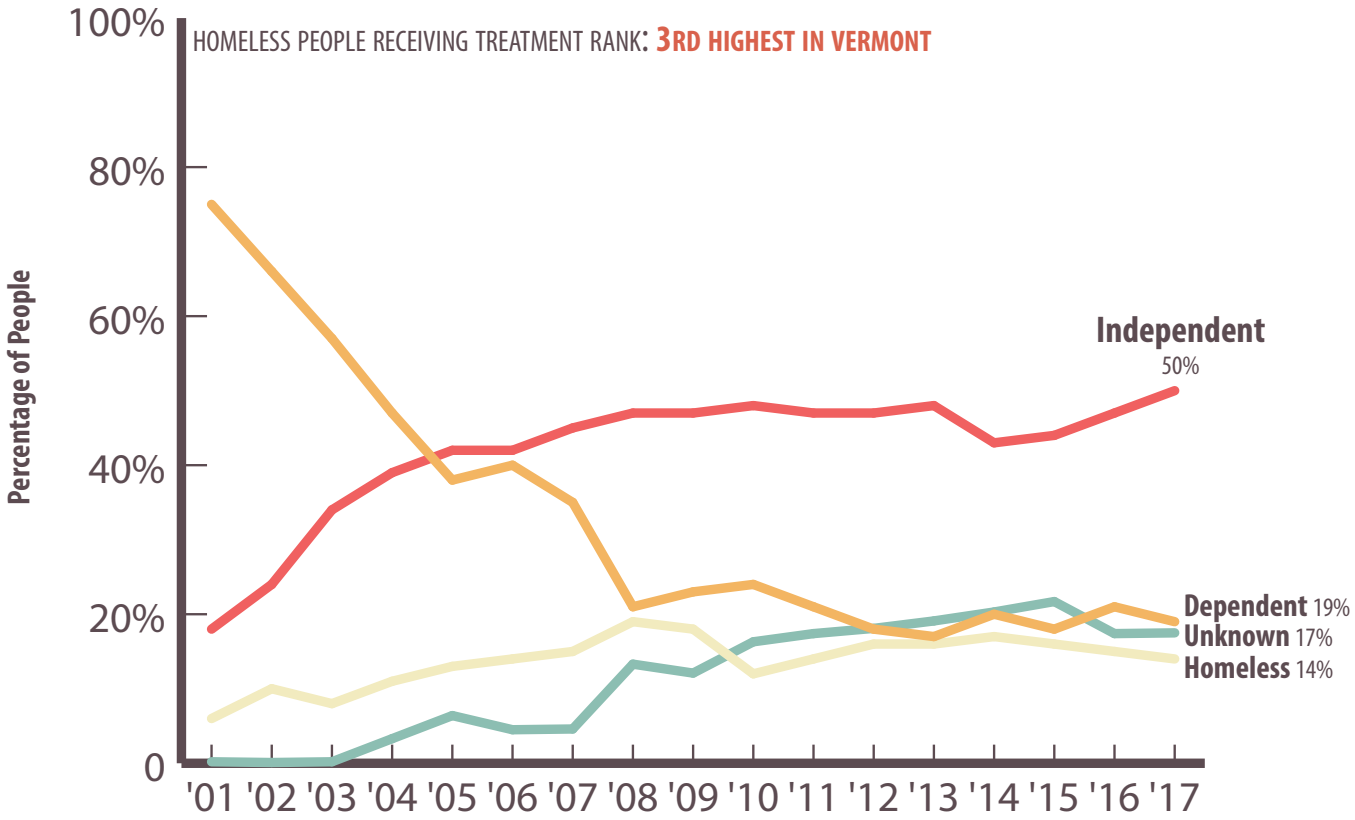
WESTON STREET
$679,000 • 6 bedrooms • 2,244 square feet

CHITTENDEN COUNTY

PEOPLE RECEIVING TREATMENT BY PRIMARY SUBSTANCE

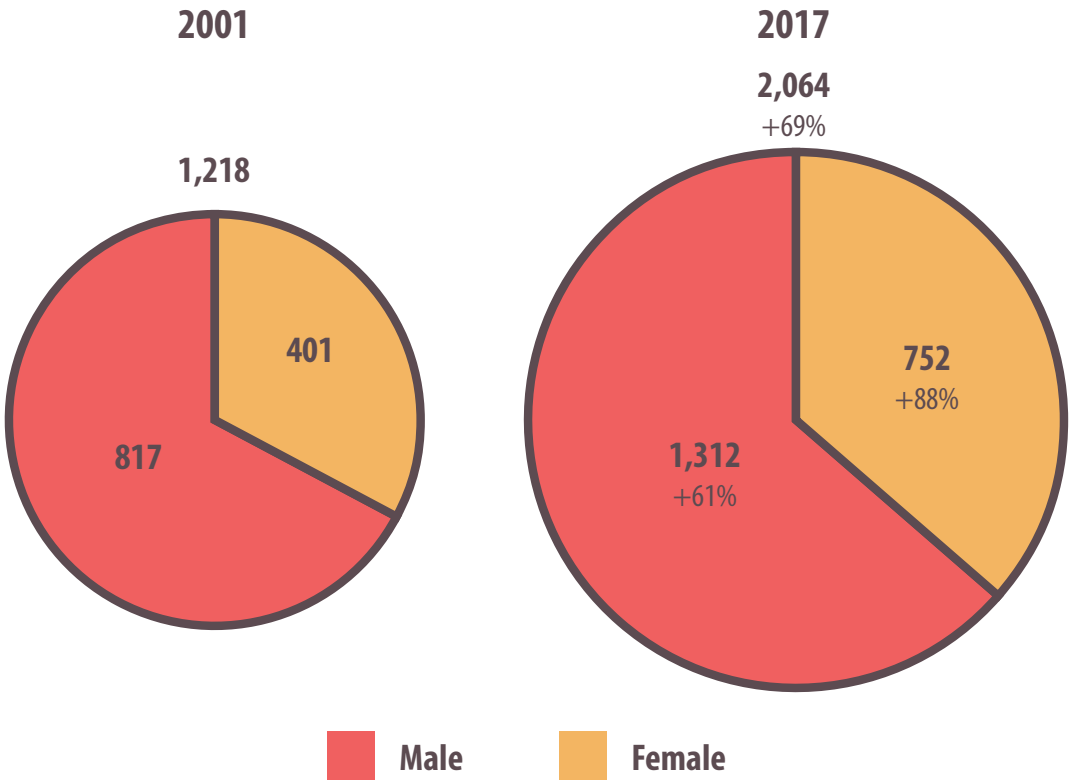


HOUSING STATUS AT TIME OF ADMISSION TO TREATMENT

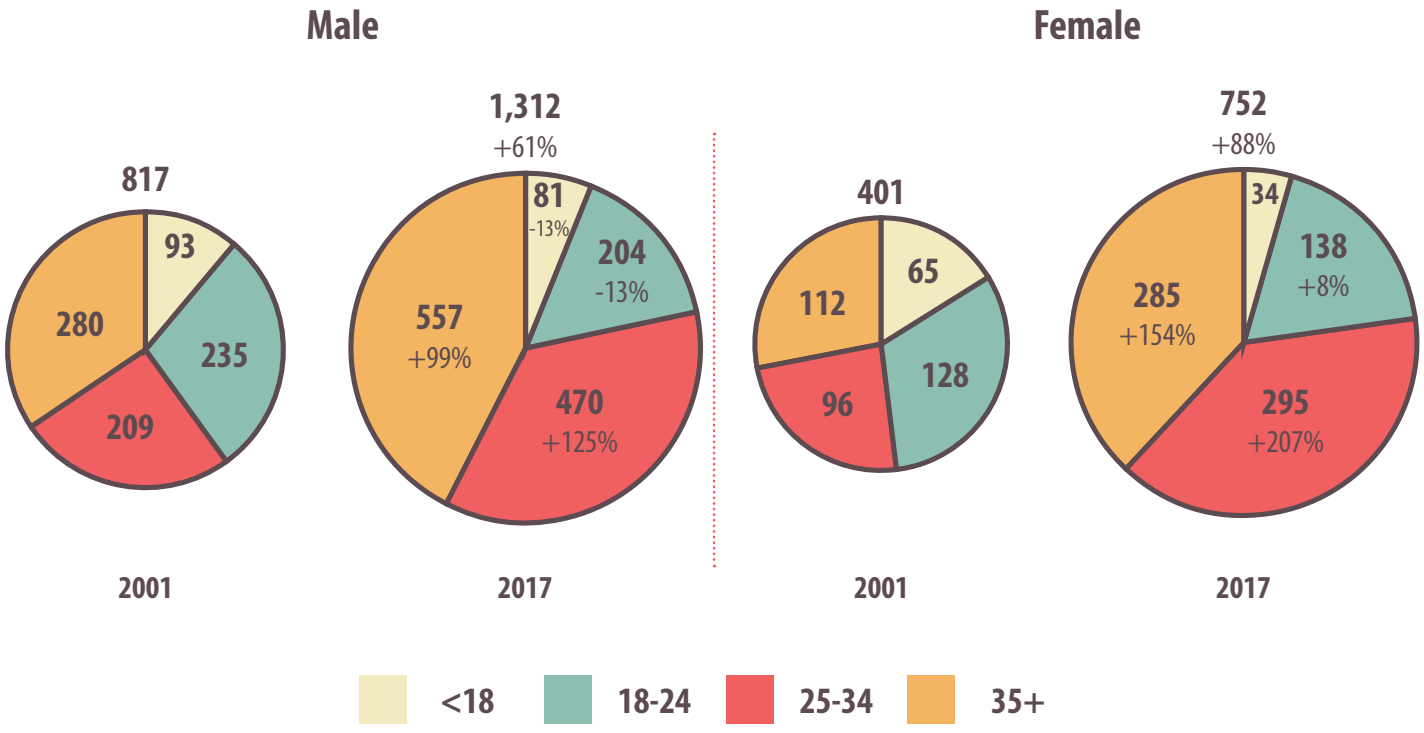


CHITTENDEN COUNTY

PEOPLE RECEIVING TREATMENT BY SEX

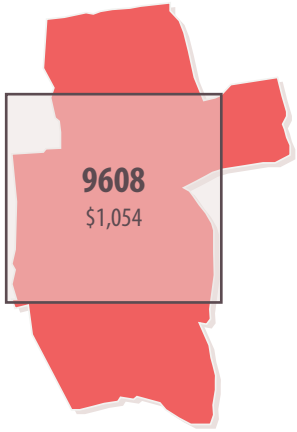


PEOPLE RECEIVING TREATMENT BY AGE



MIDDLEBURY

Census Tracts
with median monthly rents for 3+ bedrooms



Housing Characteristics

Census Tract	Single Family Homes 4+ Bedrooms	2-4 Family Buildings	Median Rent (3+ bdrms)	Percentage of Renter Occupied Housing
9608	128	85	$1,054	63%

Source: American Community Survey, 2017 5-year estimates

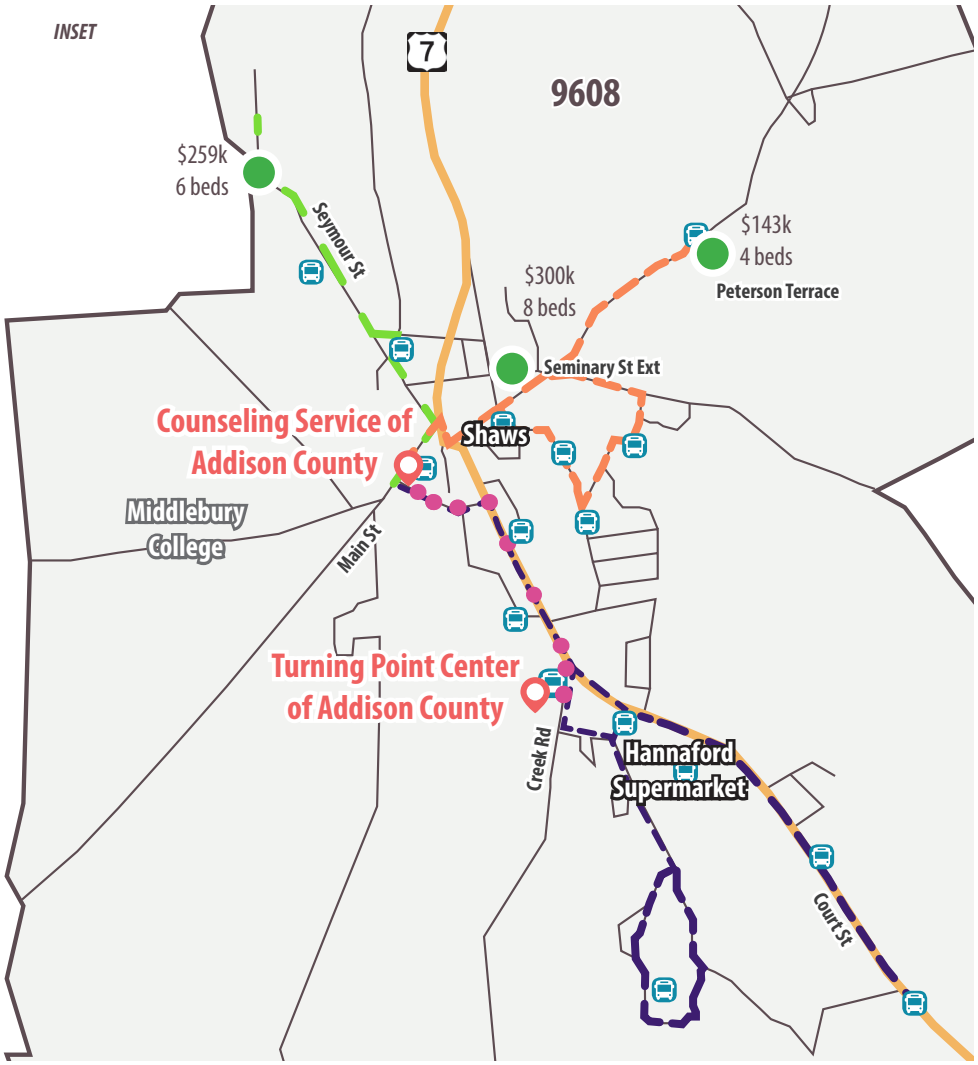
VERMONT RECOVERY CENTER
Turning Point Center of Addison County
54 Creek Road

VERMONT RECOVERY HOUSING

VERMONT TREATMENT CENTER
Counseling Service of Addison County
89 Main Street

Logistics

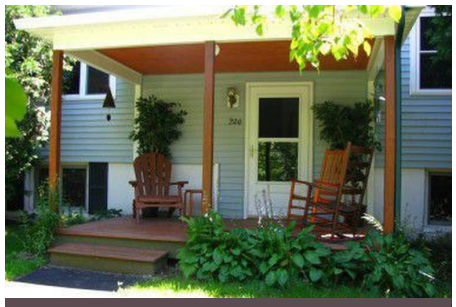
- **17 min walk** — 0.8 mile
- **Route 7 South** — every 30 min
- **Marble Works** — every 30 min
- **Shaws** — every 30 min



Source: Representative homes for sale - Zillow, 1/19/2019

SEMINARY STREET EXT
$300,000 • 8 bedrooms • 1,440 square feet

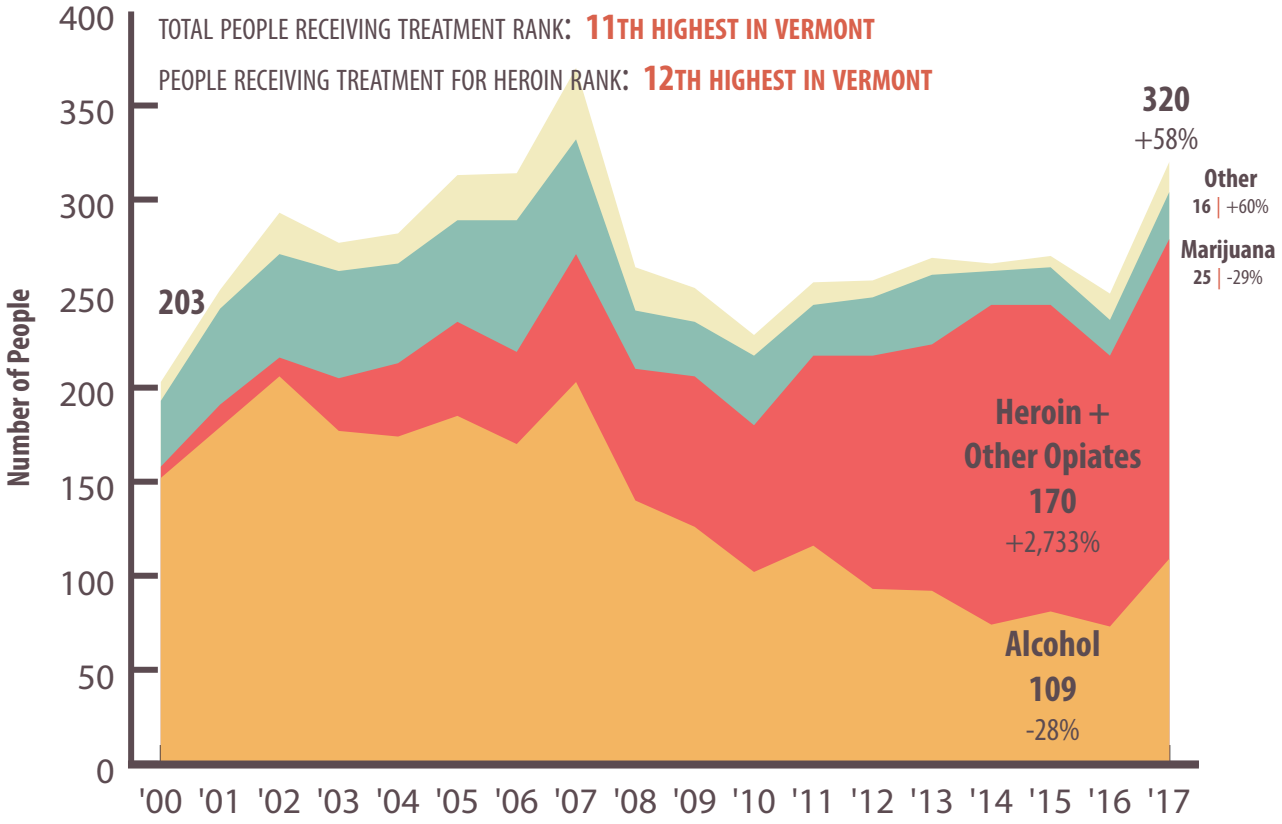
SEYMOUR STREET
$259,000 • 6 bedrooms • 2,048 square feet



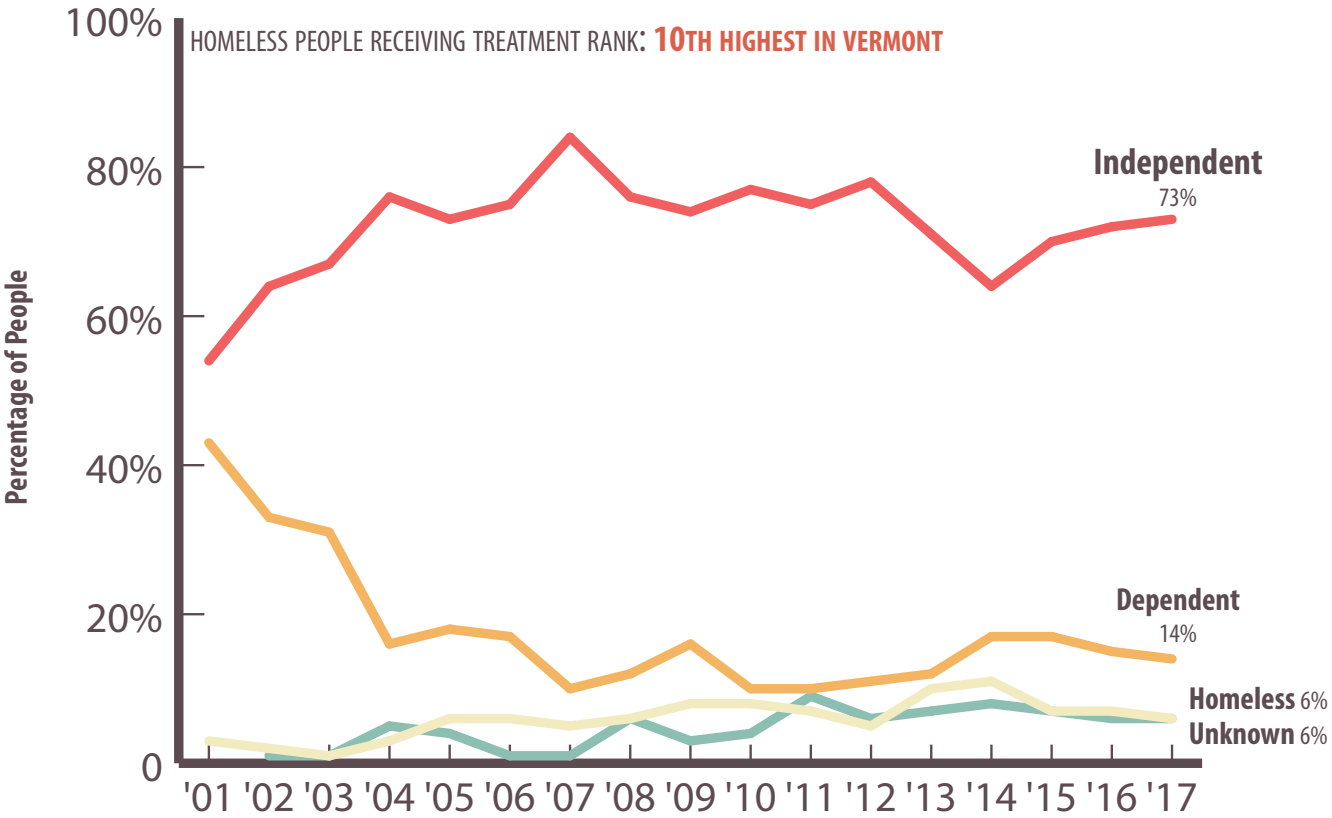
PETERSON TERRACE
$143,000 • 4 bedrooms • 1,669 square feet

ADDISON COUNTY

PEOPLE RECEIVING TREATMENT BY PRIMARY SUBSTANCE

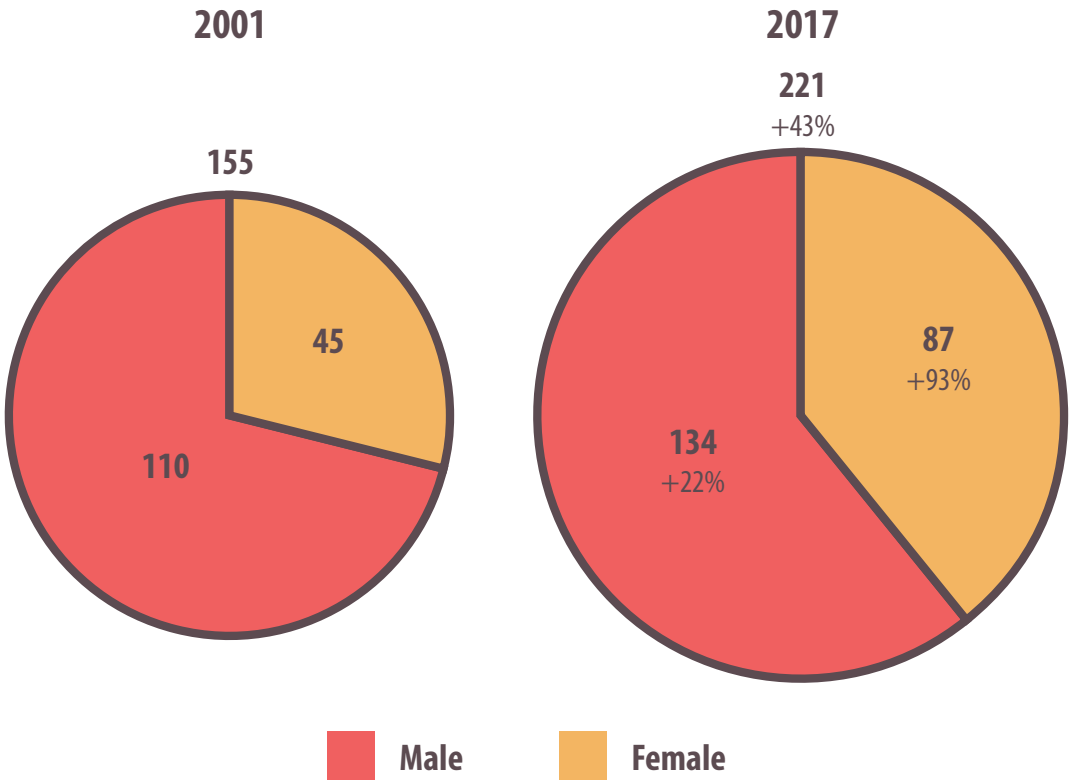


HOUSING STATUS AT TIME OF ADMISSION TO TREATMENT

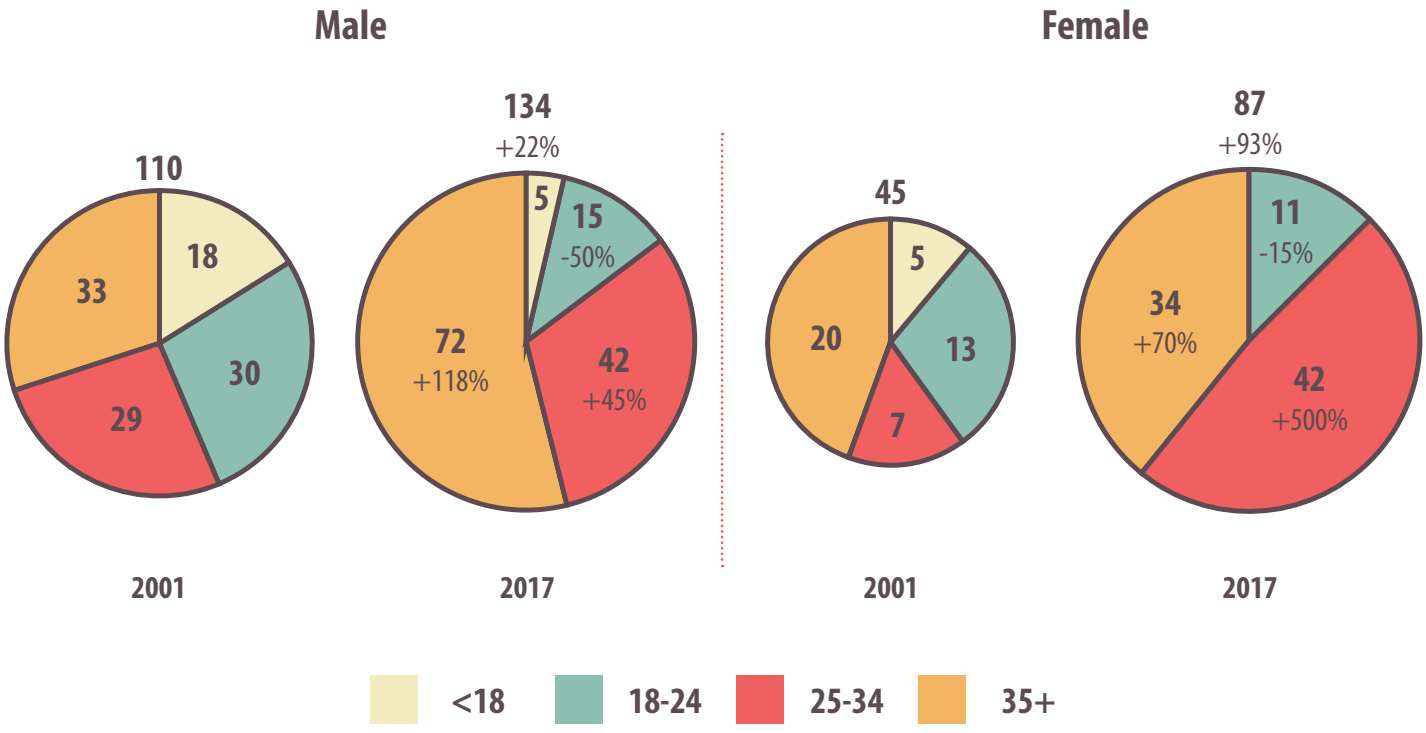


ADDISON COUNTY

PEOPLE RECEIVING TREATMENT BY SEX

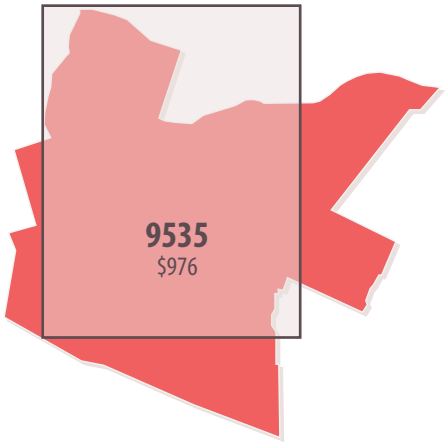


PEOPLE RECEIVING TREATMENT BY AGE



MORRISVILLE

Census Tracts
with median monthly rents for 3+ bedrooms



Housing Characteristics

Census Tract	Single Family Homes 4+ Bedrooms	2-4 Family Buildings	Median Rent (3+ bdrms)	Percentage of Renter Occupied Housing
9535	428	154	$976	30%

Source: American Community Survey, 2017 5-year estimates

VERMONT RECOVERY CENTER

North Central Vermont Recovery Center
275 Brooklyn Street

VERMONT RECOVERY HOUSING

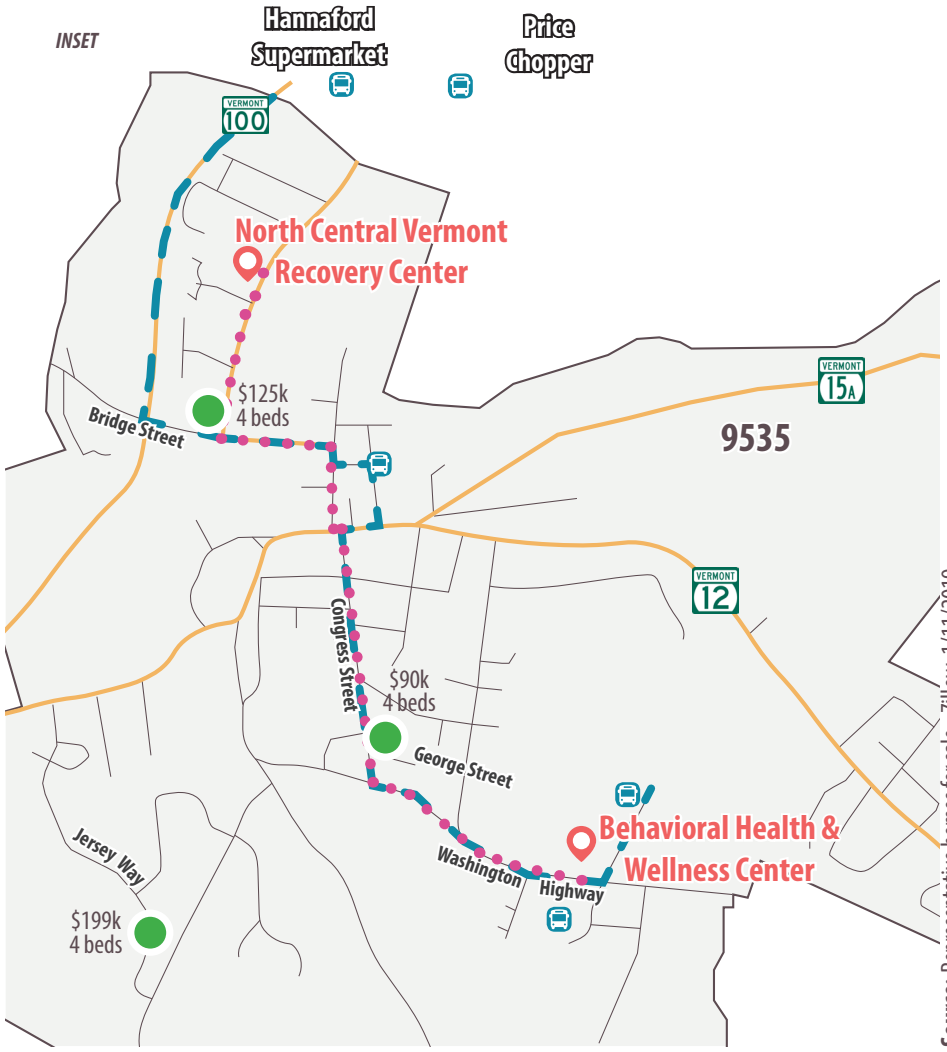
VERMONT TREATMENT CENTER

Behavioral Health & Wellness Center
607 Washington Highway

Logistics

30 min walk
1.4 mile

Morrisville Loop
every 35 min



Source: Representative homes for sale - Zillow, 1/11/2019

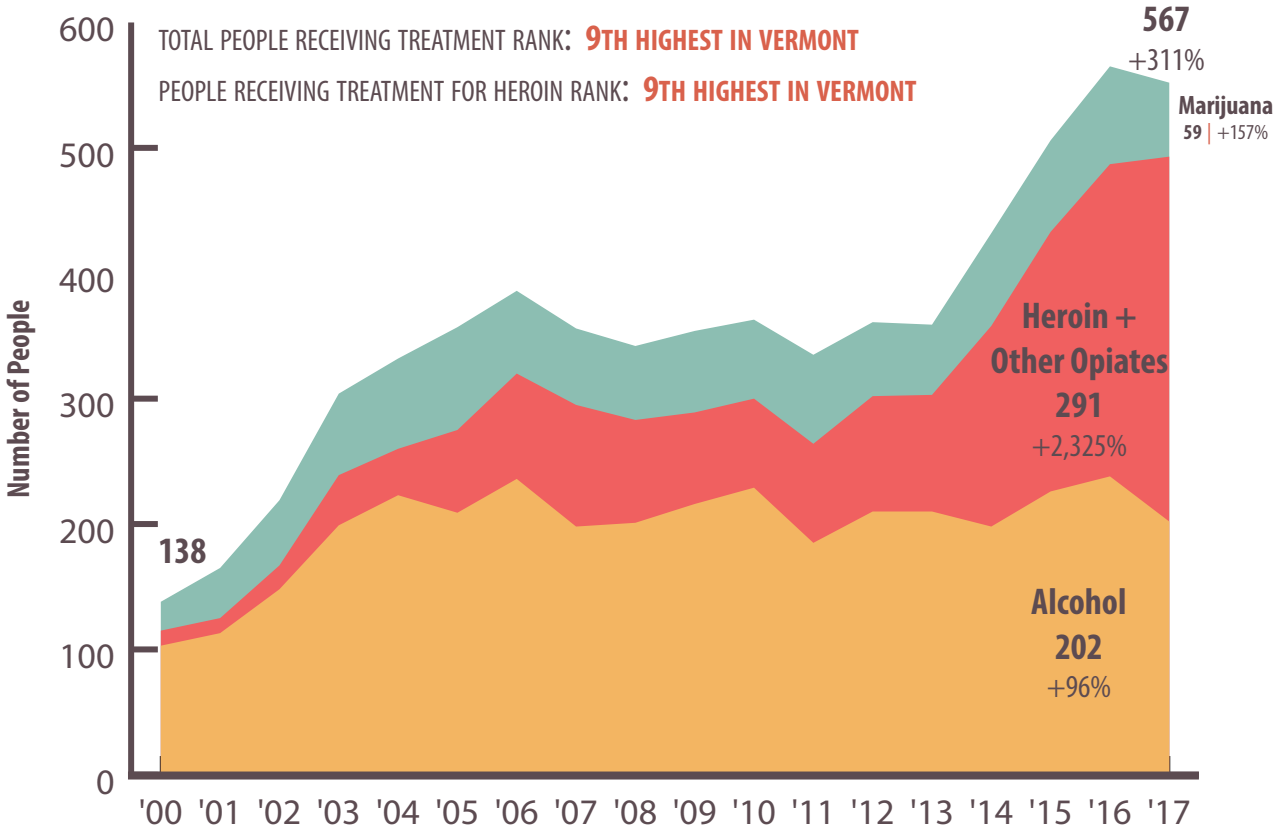
GEORGE STREET
$89,900 • 4 bedrooms • 1,661 square feet

JERSEY WAY
$199,000 • 4 bedrooms • 2,052 square feet

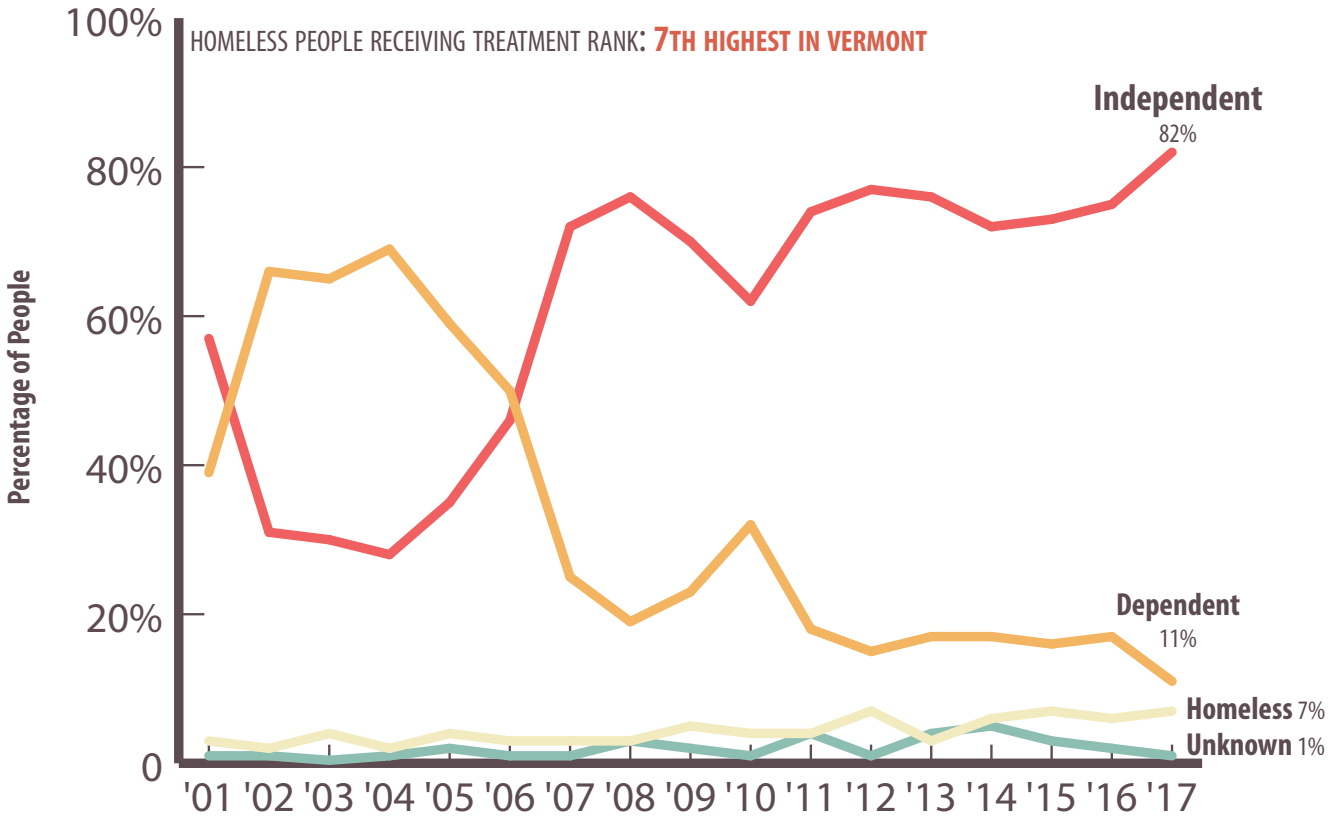
CHURCH STREET
$124,900 • 4 bedrooms • 1,769 square feet

LAMOILLE COUNTY

PEOPLE RECEIVING TREATMENT BY PRIMARY SUBSTANCE

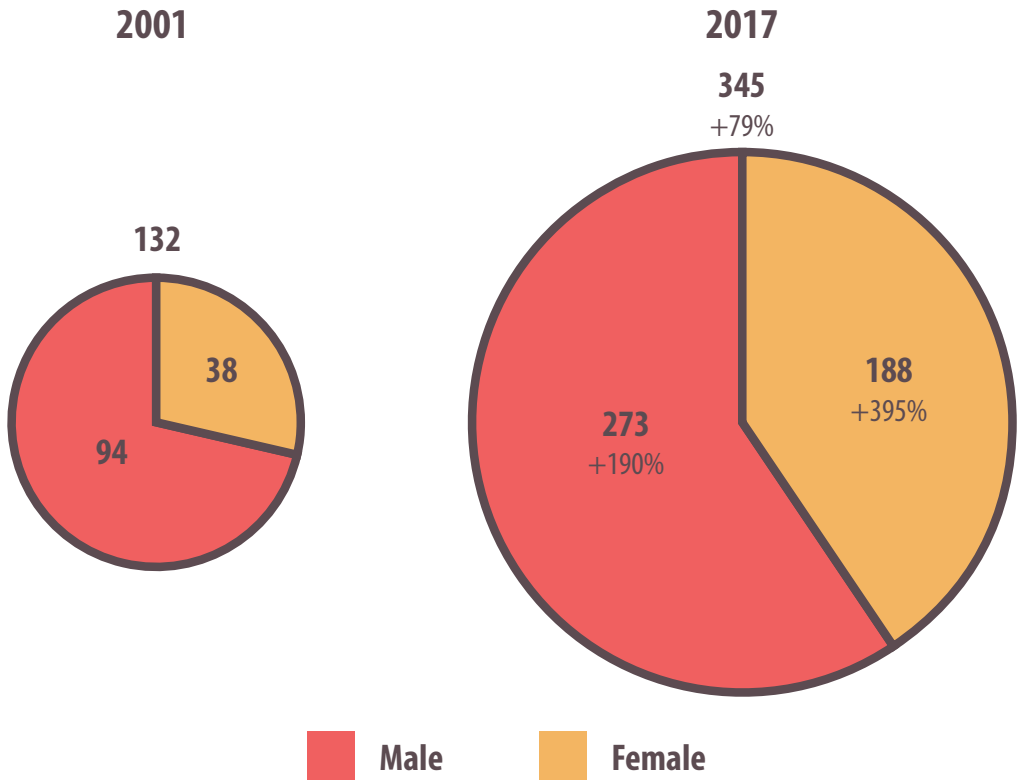


HOUSING STATUS AT TIME OF ADMISSION TO TREATMENT

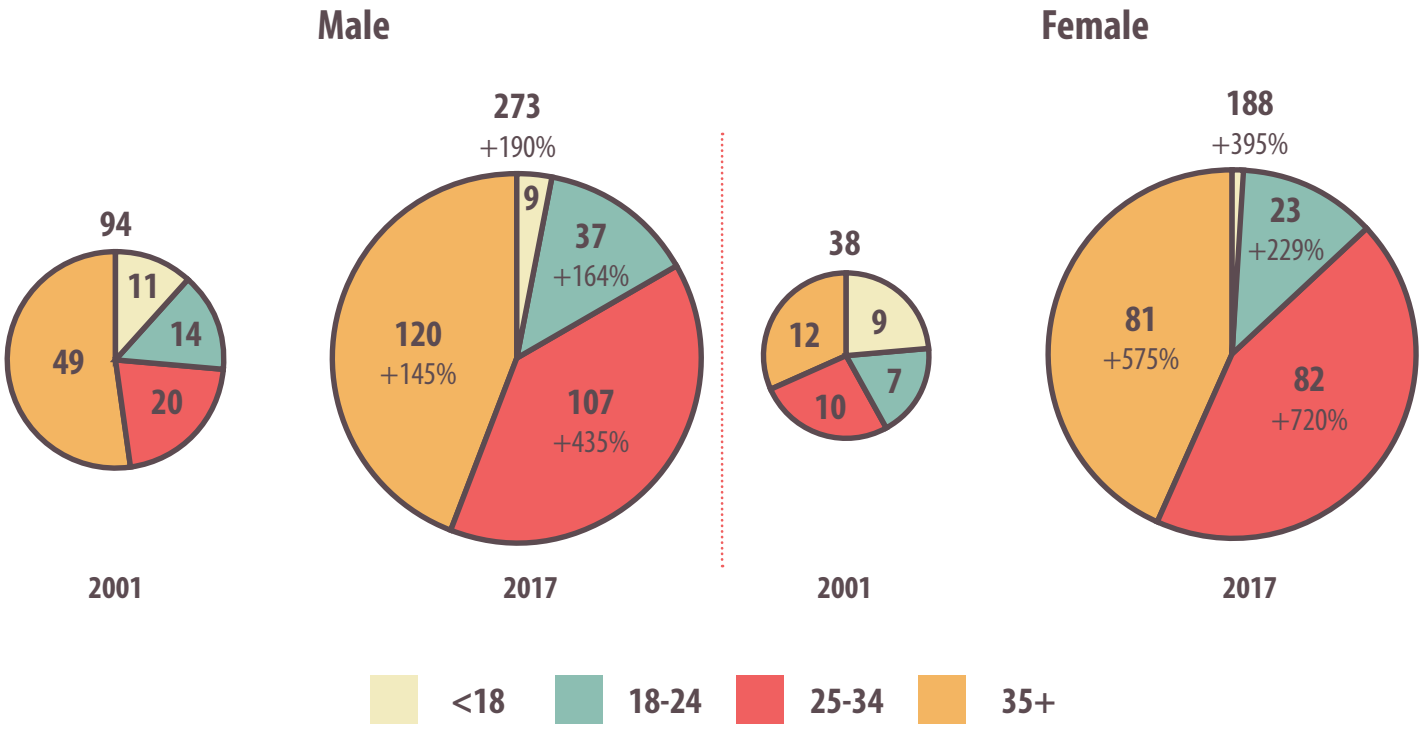


LAMOILLE COUNTY

PEOPLE RECEIVING TREATMENT BY SEX



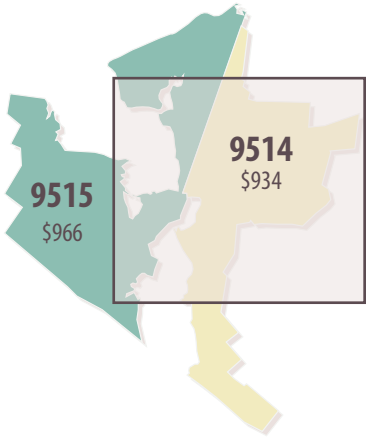
PEOPLE RECEIVING TREATMENT BY AGE



NEWPORT

Census Tracts

with median monthly rents for 3+ bedrooms



Housing Characteristics

Census Tract	Single Family Homes 4+ Bedrooms	2-4 Family Buildings	Median Rent (3+ bdrms)	Percentage of Renter Occupied Housing
9514	95	33	$934	36%
9515	189	156	$966	45%

Source: American Community Survey, 2017 5-year estimates

VERMONT RECOVERY CENTER

Journey to Recovery Community Center
58 Third Street

VERMONT RECOVERY HOUSING

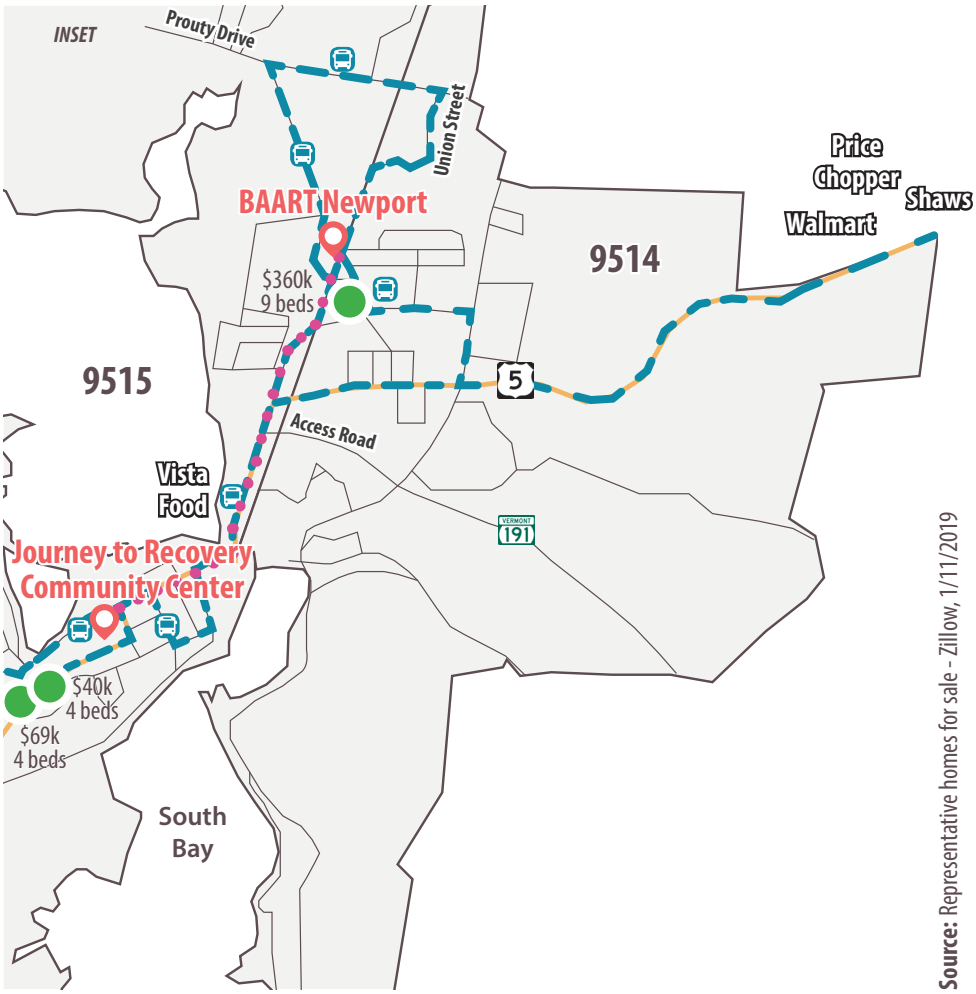
VERMONT TREATMENT CENTER

BAART Newport
475 Union Street

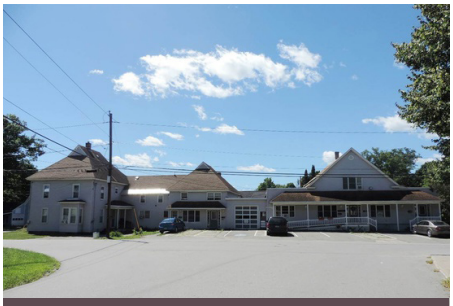
Logistics

26 min walk
1.3 mile

The Highlander
every 2 hours



Source: Representative homes for sale - Zillow, 1/11/2019



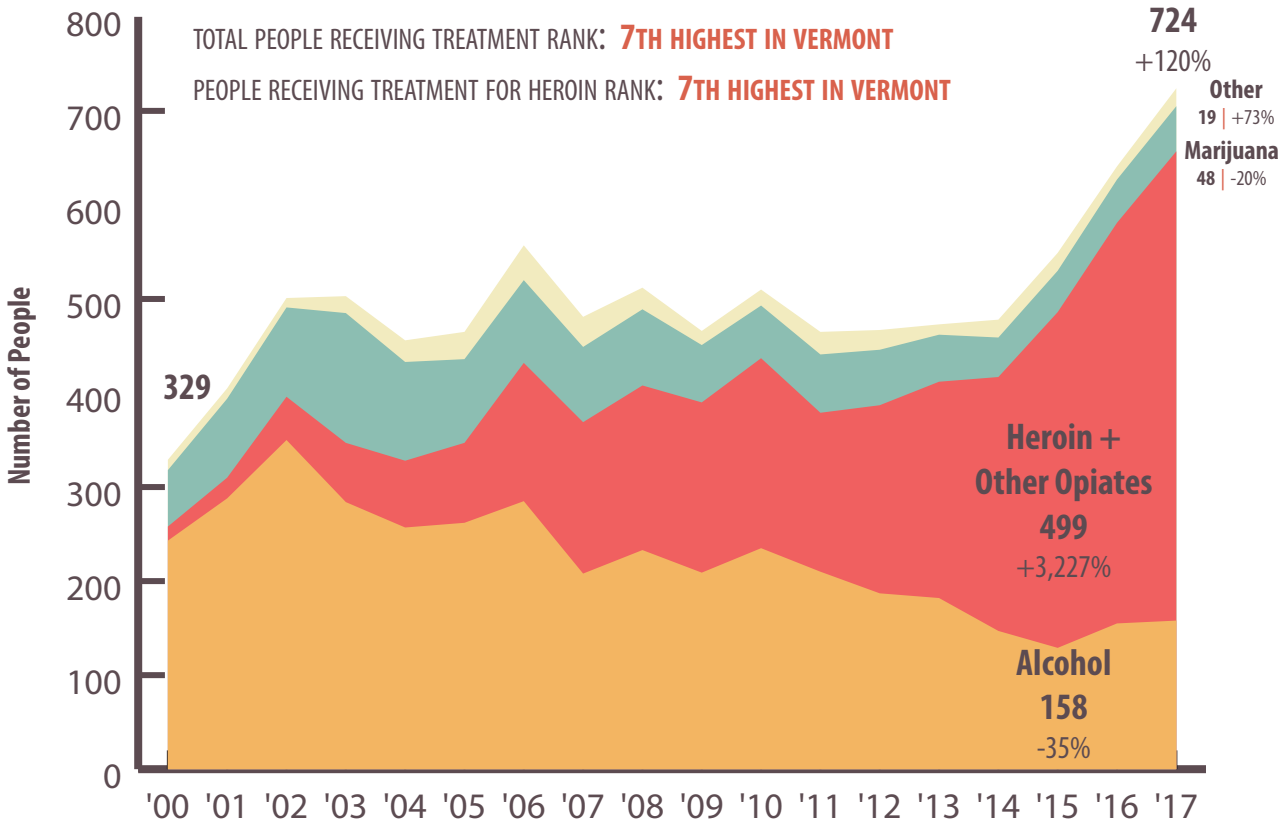
INDIAN POINT
$359,900 • 9 bedrooms • 7,354 square feet

PLEASANT STREET
$69,000 • 4 bedrooms • 2730 square feet

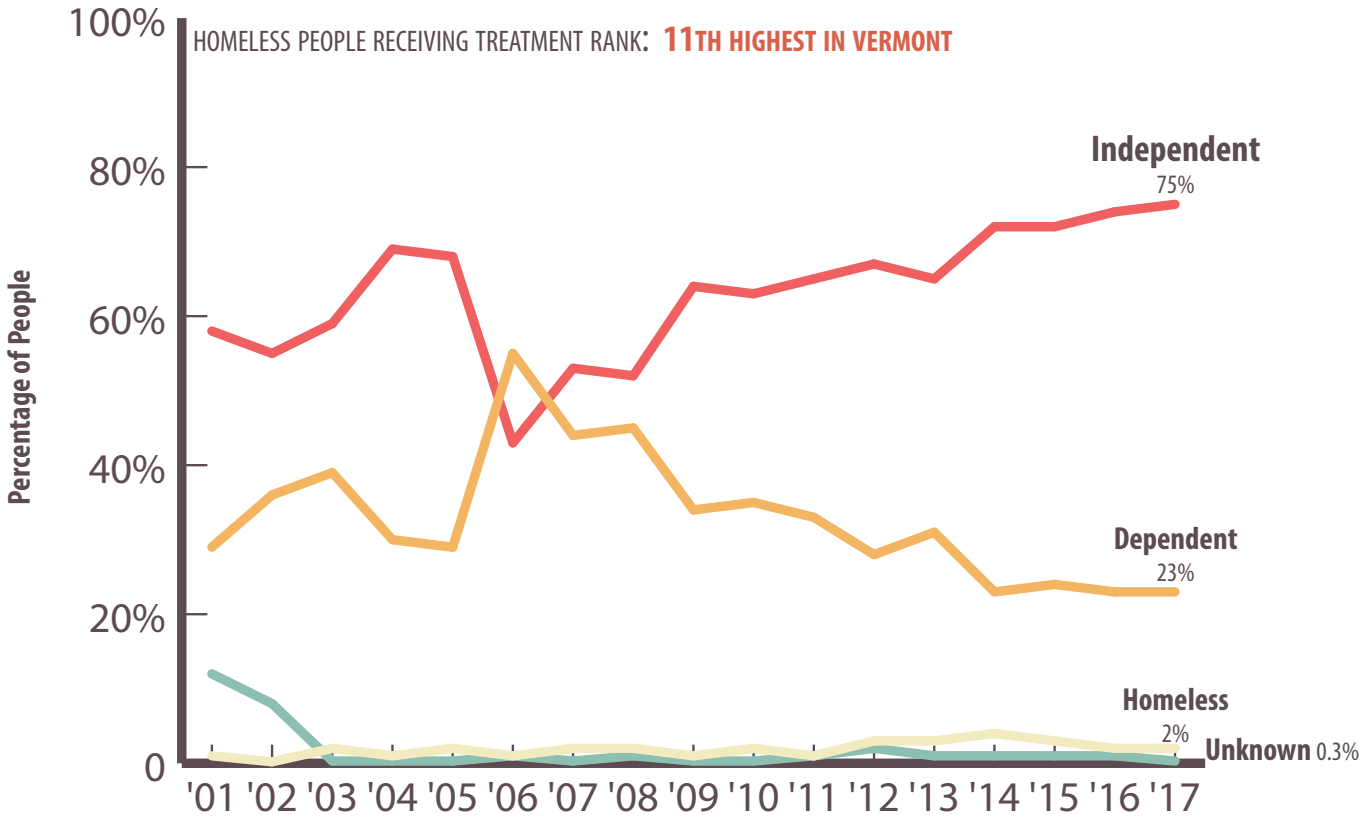
PLEASANT STREET
$40,000 • 4 bedrooms
(Reconstruction)

ORLEANS COUNTY

PEOPLE RECEIVING TREATMENT BY PRIMARY SUBSTANCE

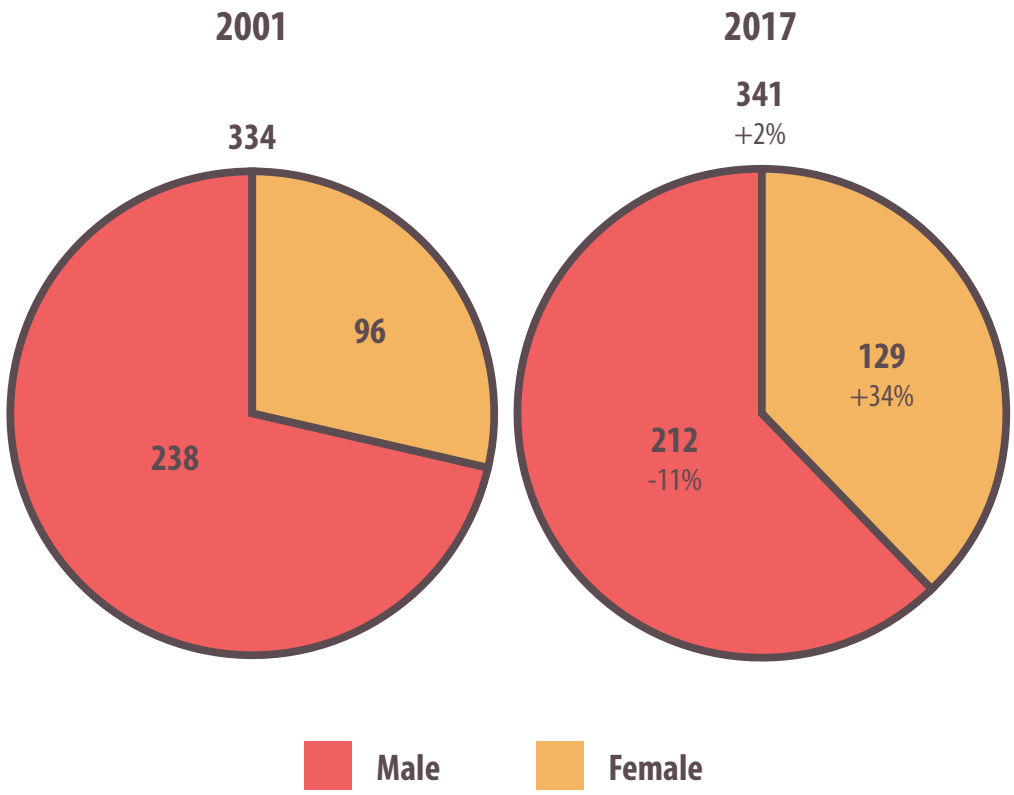


HOUSING STATUS AT TIME OF ADMISSION TO TREATMENT

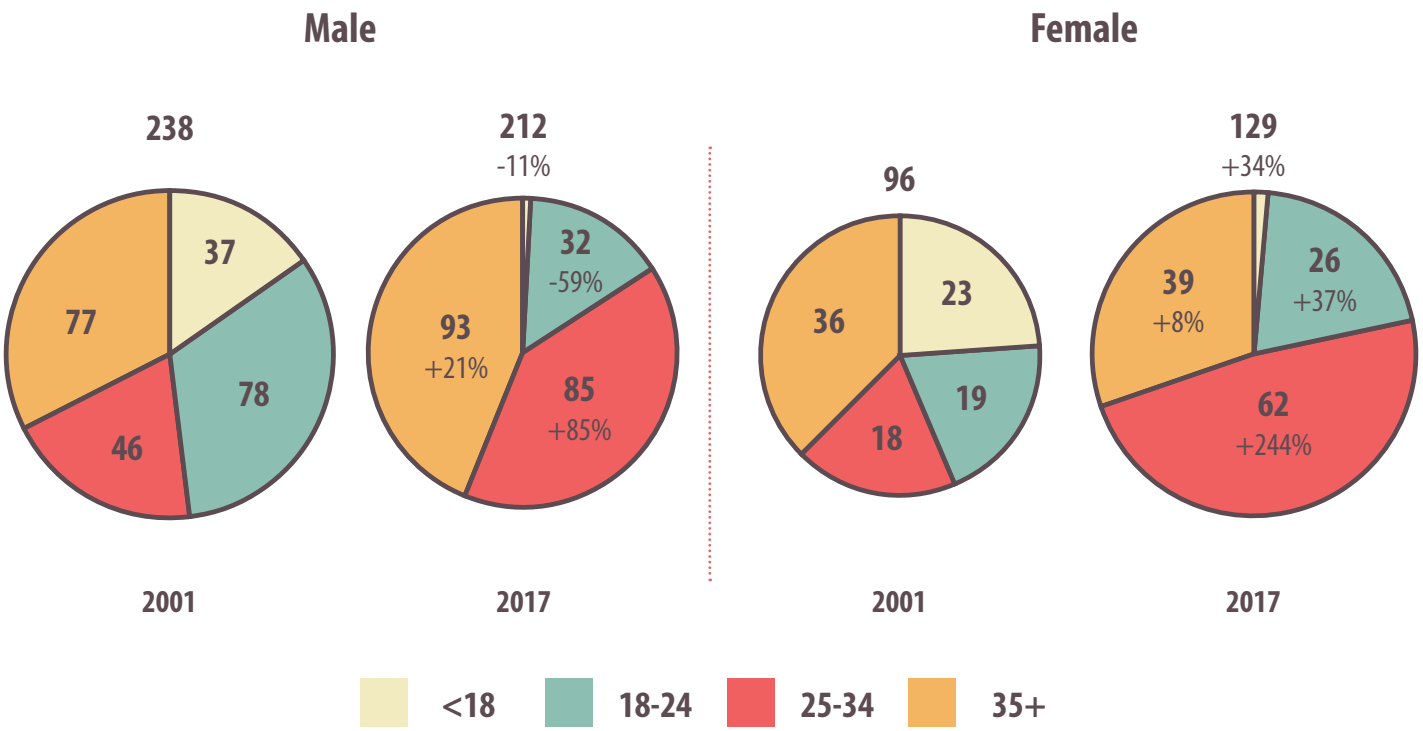


ORLEANS COUNTY

PEOPLE RECEIVING TREATMENT BY SEX



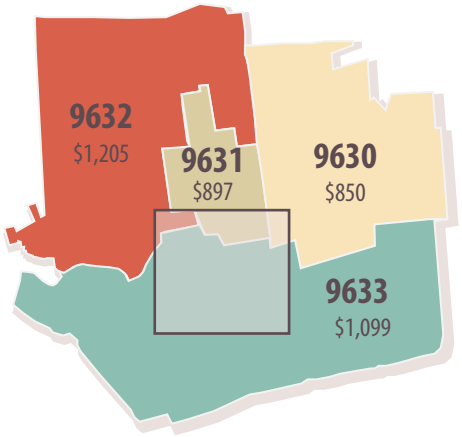
PEOPLE RECEIVING TREATMENT BY AGE



RUTLAND

Census Tracts

with median monthly rents for 3+ bedrooms



VERMONT RECOVERY CENTER

Turning Point Center of Rutland
141 State Street

VERMONT RECOVERY HOUSING

Grace House
34 Washington Street

VERMONT TREATMENT CENTER

West Ridge Center
1 Scale Avenue

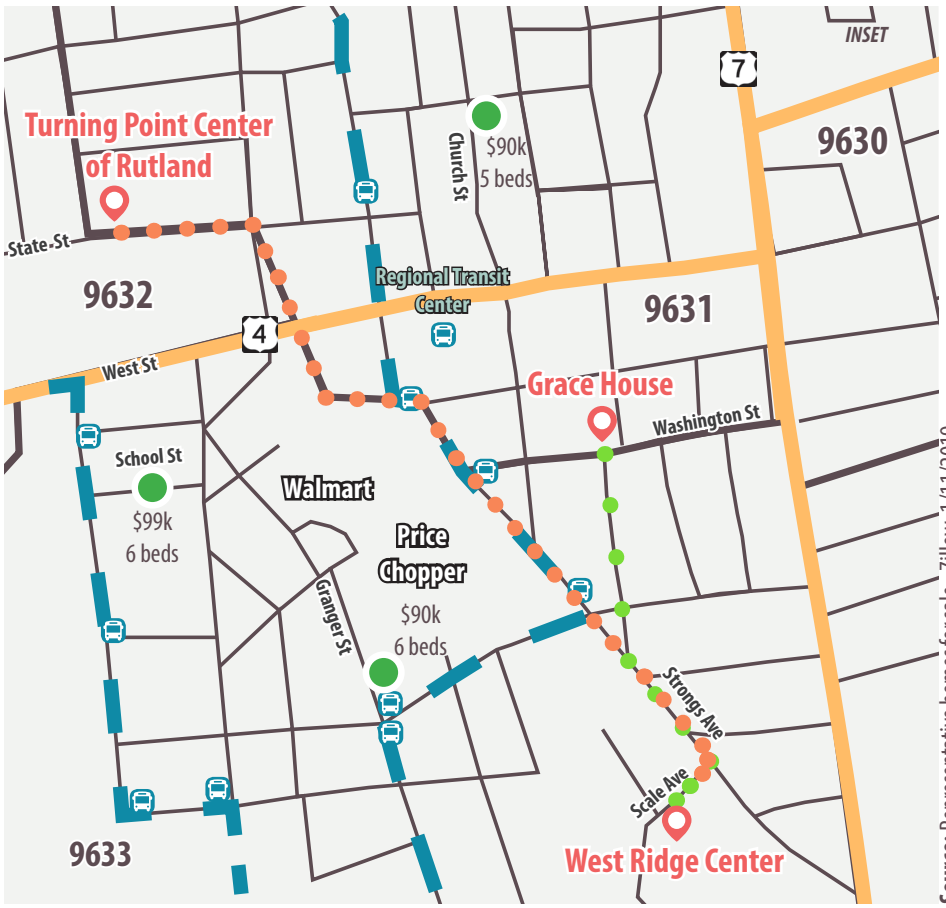
Logistics

- **20 min walk** — 1 mile
- **9 min walk** — 0.4 mile
- **13 min walk** — 0.7 mile
- **West Route** — every 30 min

Housing Characteristics

Census Tract	Single Family Homes 4+ Bedrooms	2-4 Family Buildings	Median Rent (3+ bdrms)	Percentage of Renter Occupied Housing
9630	374	117	$850	28%
9631	214	270	$897	63%
9632	230	126	$1,205	33%
9633	327	290	$1,099	55%

Source: American Community Survey, 2017 5-year estimates



Source: Representative homes for sale - Zillow, 1/11/2019

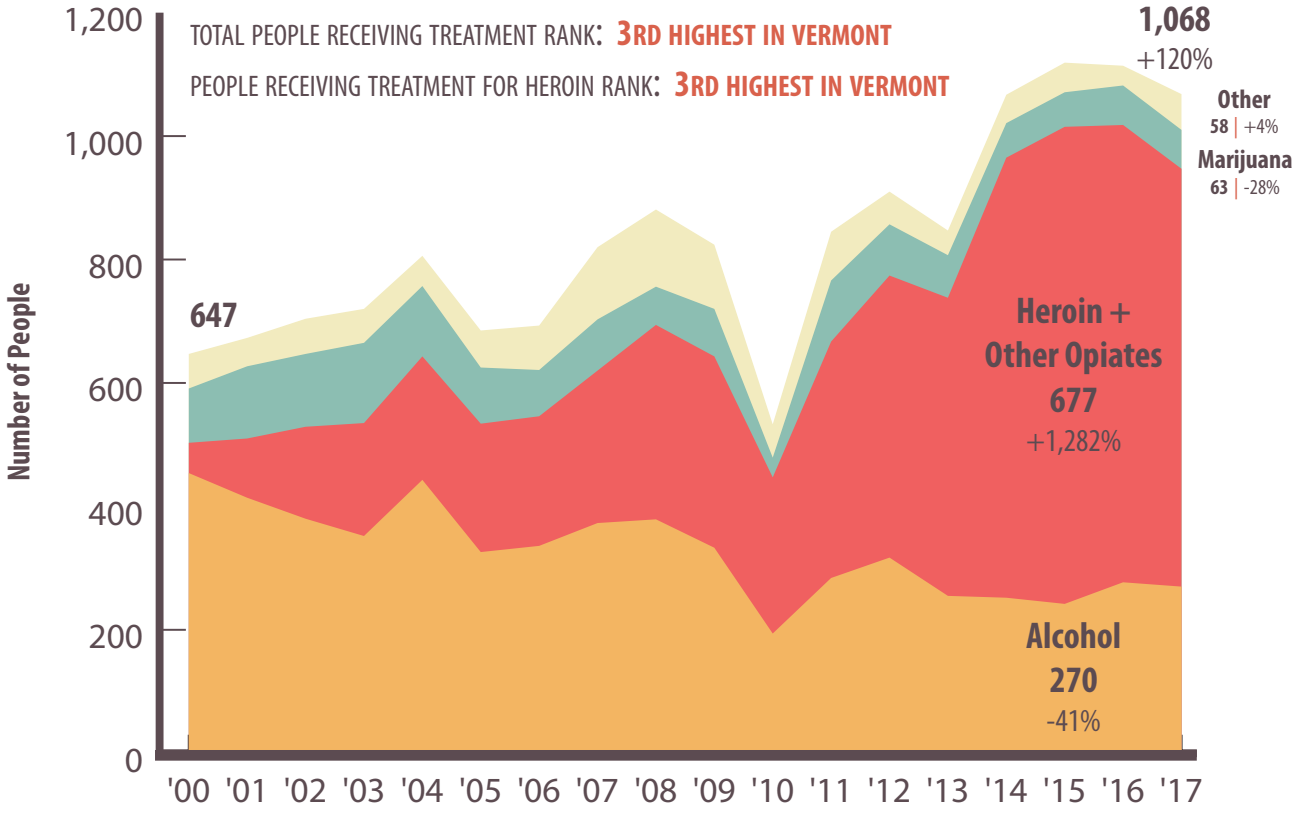
SCHOOL STREET
$99,900 • 6 bedrooms • 2,504 square feet

GRANGER STREET
$89,900 • 6 bedrooms • 2,771 square feet

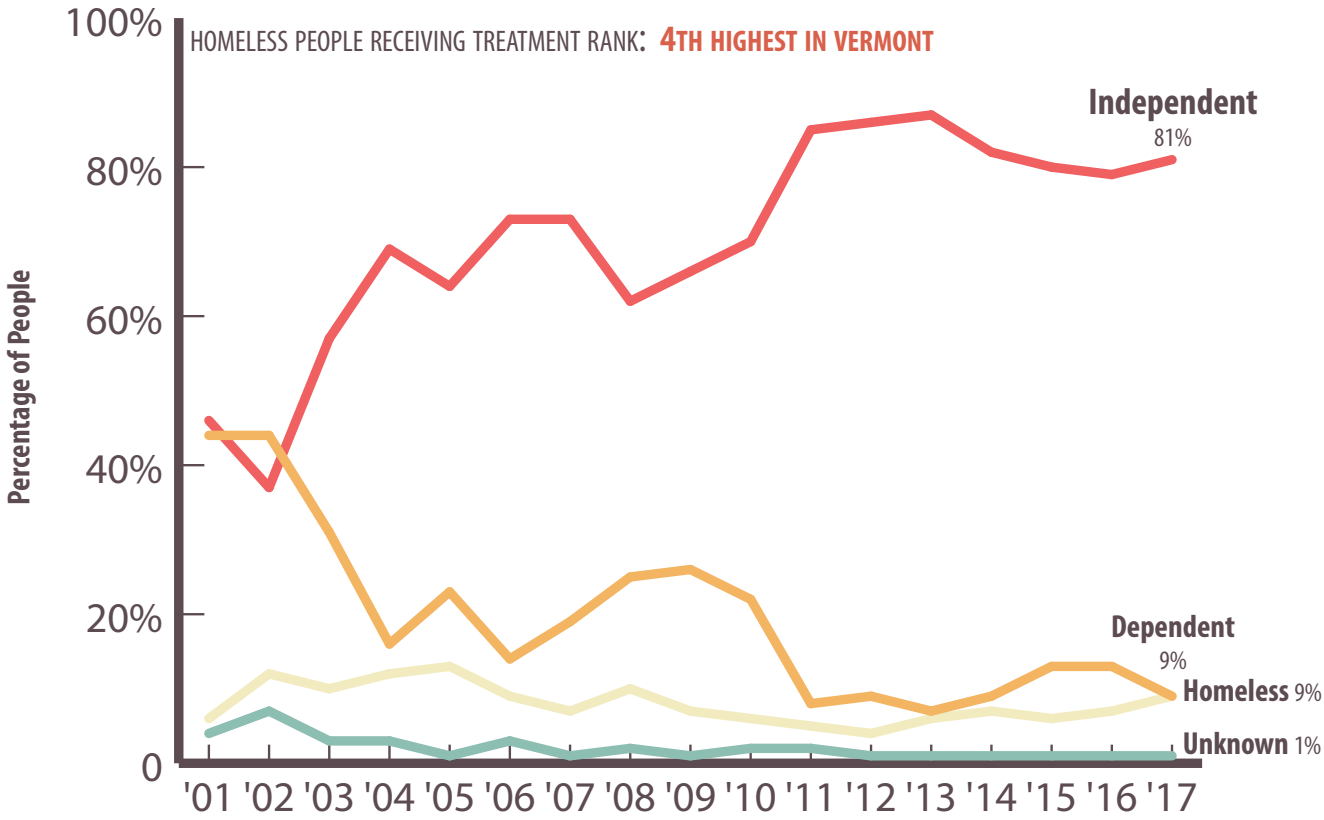
CHURCH STREET
$89,900 • 5 bedrooms • 1,984 square feet

RUTLAND COUNTY

PEOPLE RECEIVING TREATMENT BY PRIMARY SUBSTANCE

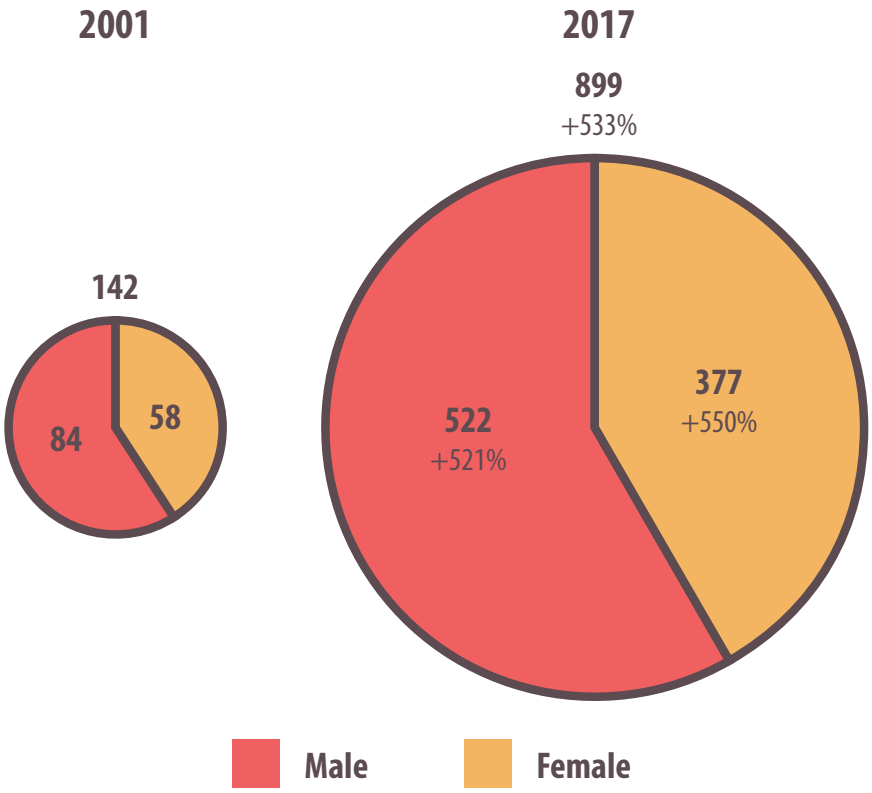


HOUSING STATUS AT TIME OF ADMISSION TO TREATMENT

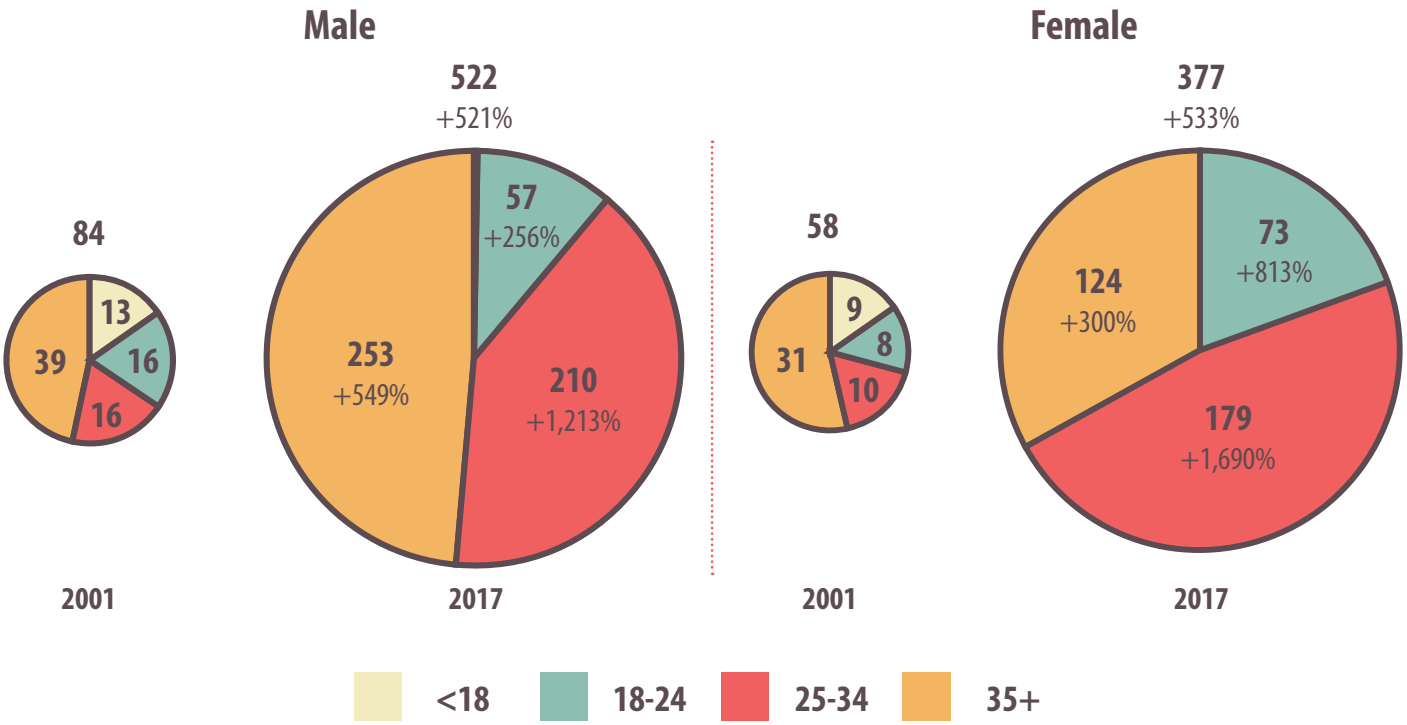


RUTLAND COUNTY

PEOPLE RECEIVING TREATMENT BY SEX

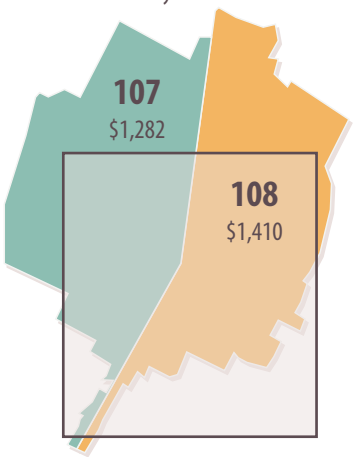


PEOPLE RECEIVING TREATMENT BY AGE



ST. ALBANS

Census Tracts
with median monthly rents for 3+ bedrooms



VERMONT RECOVERY CENTER
Turning Point Franklin County
182 Lake Street

VERMONT RECOVERY HOUSING
Lake Street House
135 Lake Street

VERMONT TREATMENT CENTER
BAART St. Albans
242 South Main Street

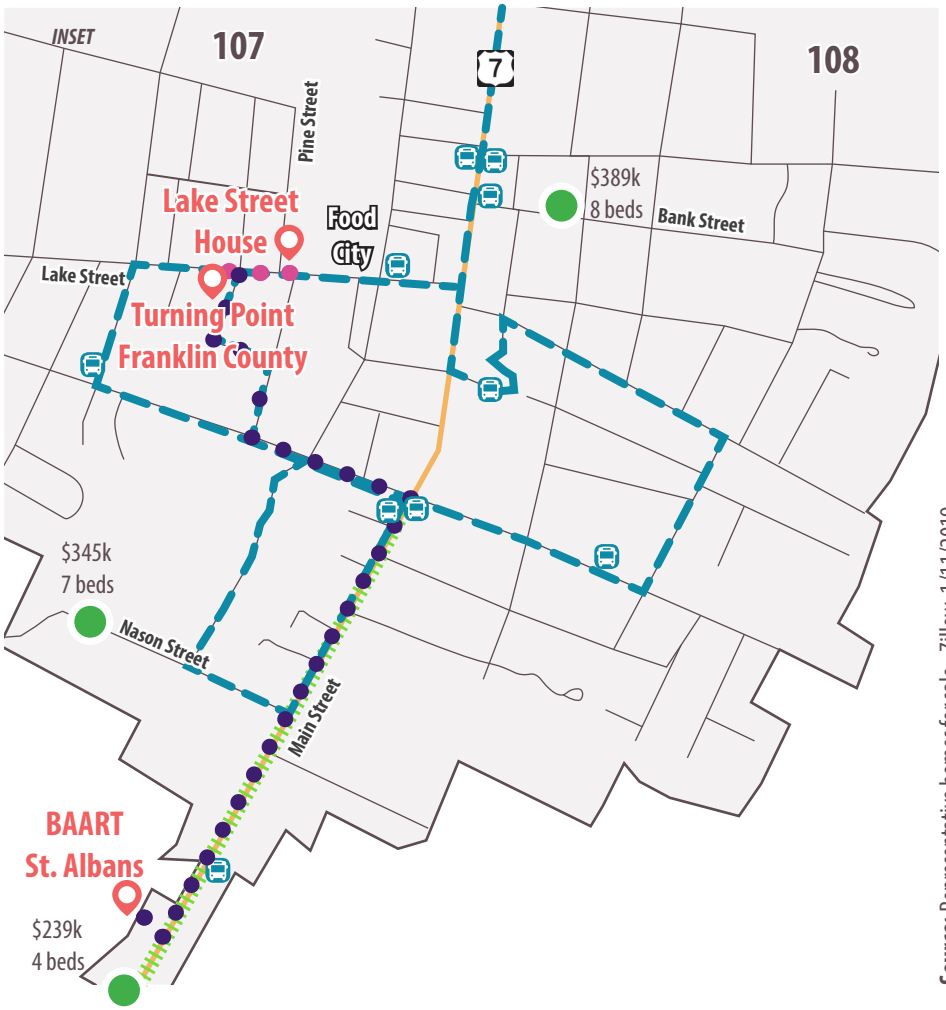
Logistics

- **2 min walk** — 482 feet
- **24 min walk** — 1.2 miles
- **Downtown Shuttle** — every 1 hour
- Twice daily or by request

Housing Characteristics

Census Tract	Single Family Homes 4+ Bedrooms	2-4 Family Buildings	Median Rent (3+ bdrms)	Percentage of Renter Occupied Housing
107	161	119	$1,282	51%
108	266	107	$1,410	46%

Source: American Community Survey, 2017 5-year estimates



Source: Representative homes for sale - Zillow, 1/11/2019

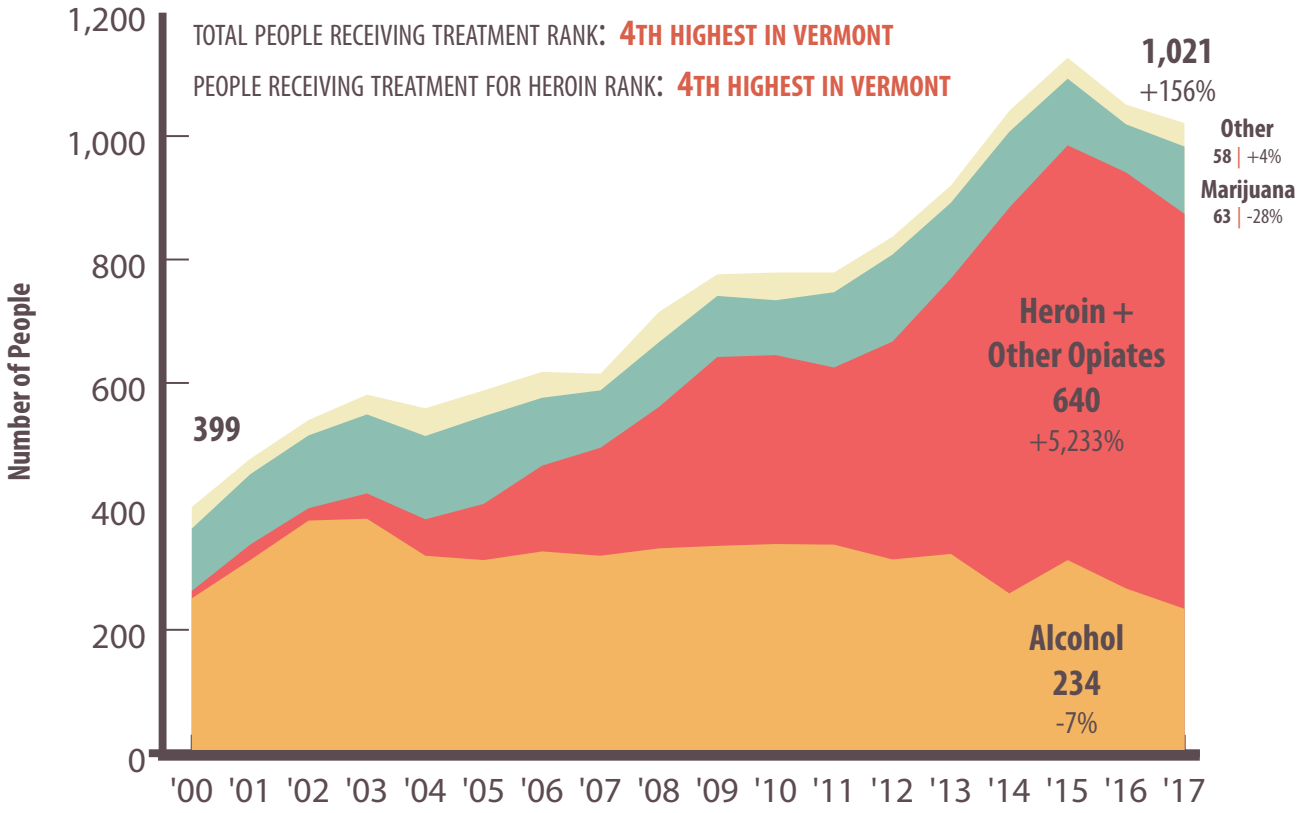
NASON STREET
$345,000 • 7 bedrooms • 3,156 square feet

BANK STREET
$389,900 • 8 bedrooms • 6,913 square feet

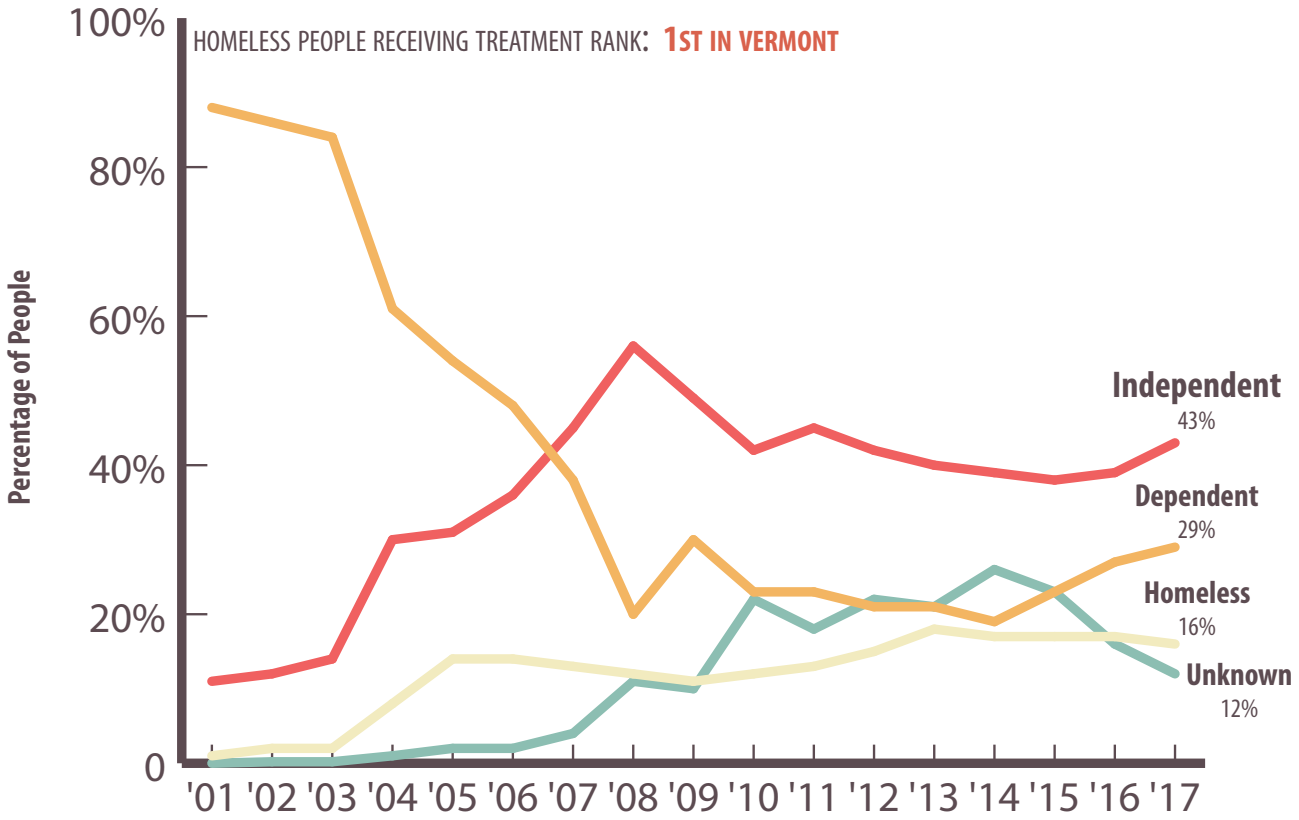
SOUTH MAIN STREET
$239,000 • 4 bedrooms • 3,240 square feet

FRANKLIN COUNTY

PEOPLE RECEIVING TREATMENT BY PRIMARY SUBSTANCE

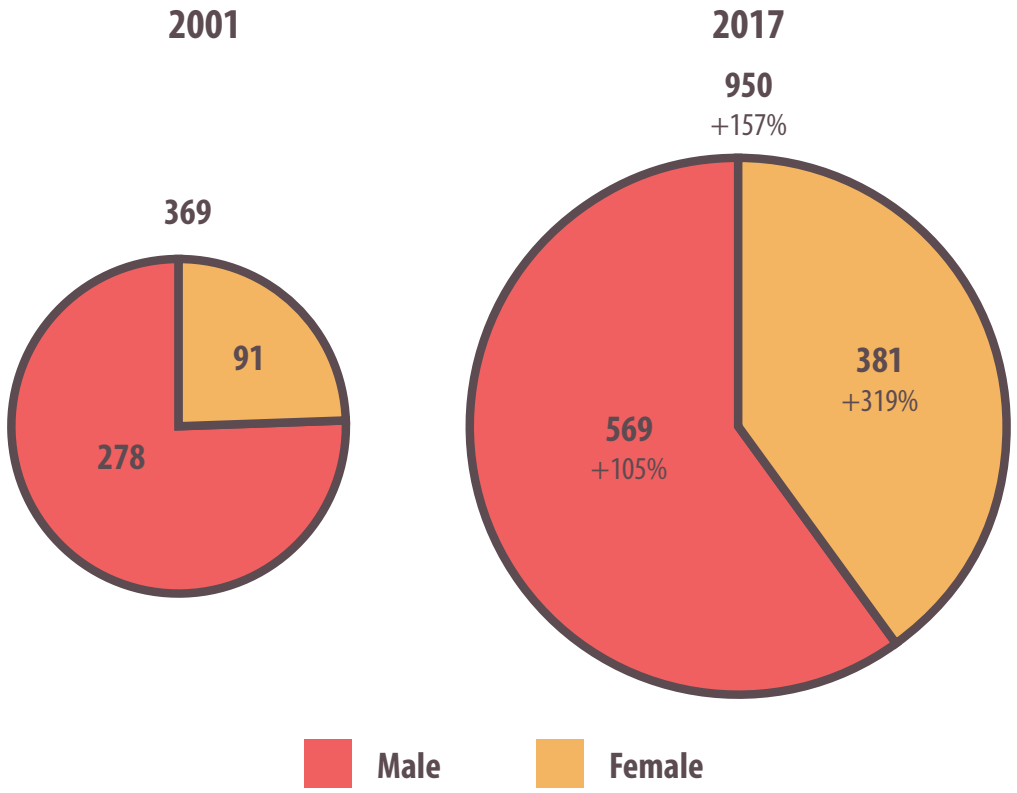


HOUSING STATUS AT TIME OF ADMISSION TO TREATMENT

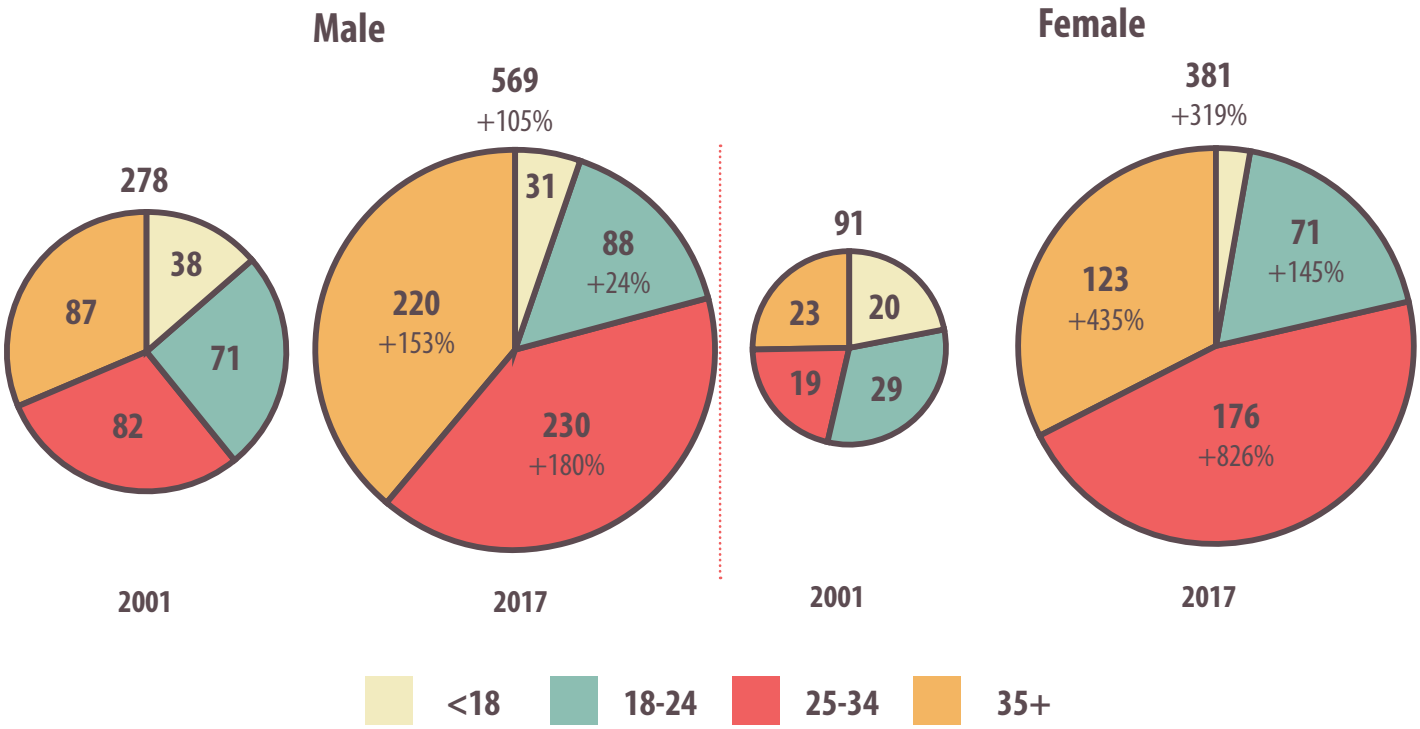


FRANKLIN COUNTY

PEOPLE RECEIVING TREATMENT BY SEX

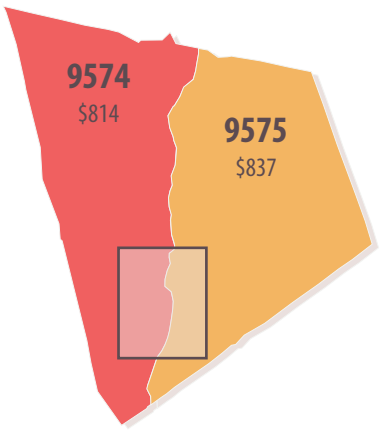


PEOPLE RECEIVING TREATMENT BY AGE



ST. JOHNSBURY

Census Tracts
with median monthly rents for 3+ bedrooms



VERMONT RECOVERY CENTER
Kingdom Recovery Center
297 Summer Street

VERMONT RECOVERY HOUSING
Elm Stree House - Vermont Foundation of Recovery
87 Elm Street

VERMONT TREATMENT CENTER
BAART St. Johnsbury
1097 Hospital Drive

Logistics

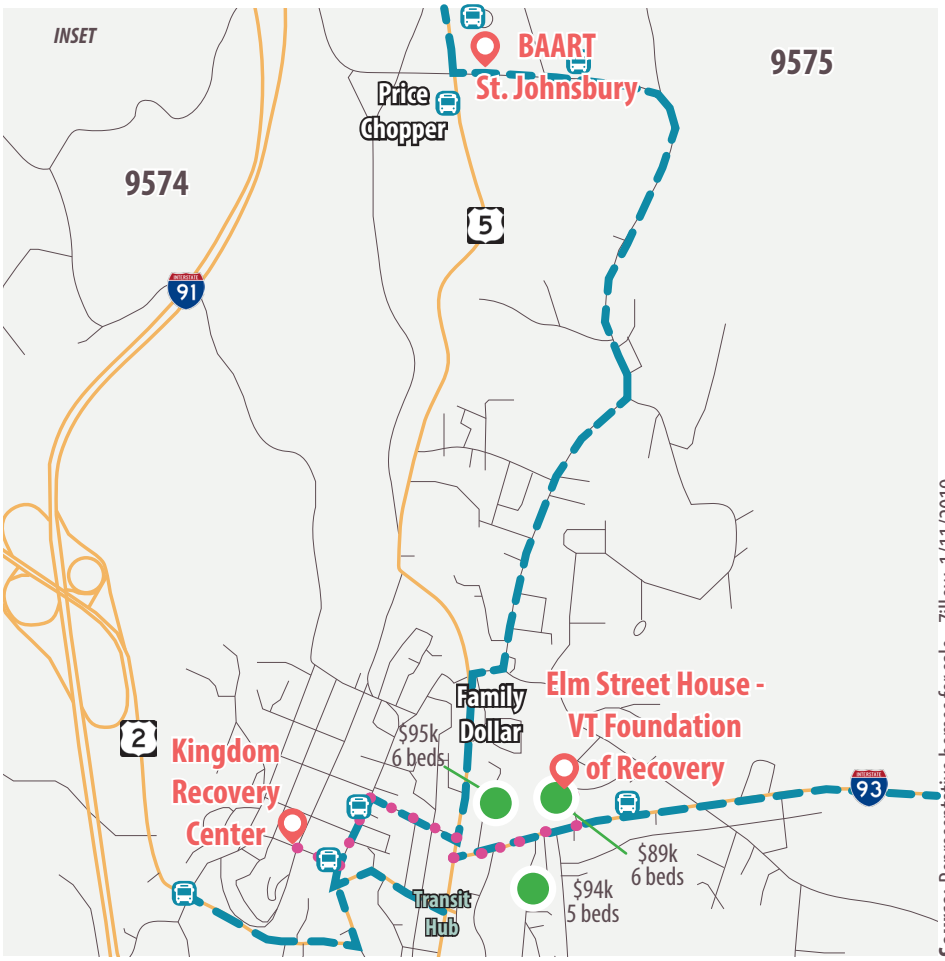
20 min walk
0.9 mile

Twin City
twice daily

Housing Characteristics

Census Tract	Single Family Homes 4+ Bedrooms	2-4 Family Buildings	Median Rent (3+ bdrms)	Percentage of Renter Occupied Housing
9574	264	158	$814	50%
9575	203	78	$837	28%

Source: American Community Survey, 2017 5-year estimates



Source: Representative homes for sale - Zillow, 1/11/2019

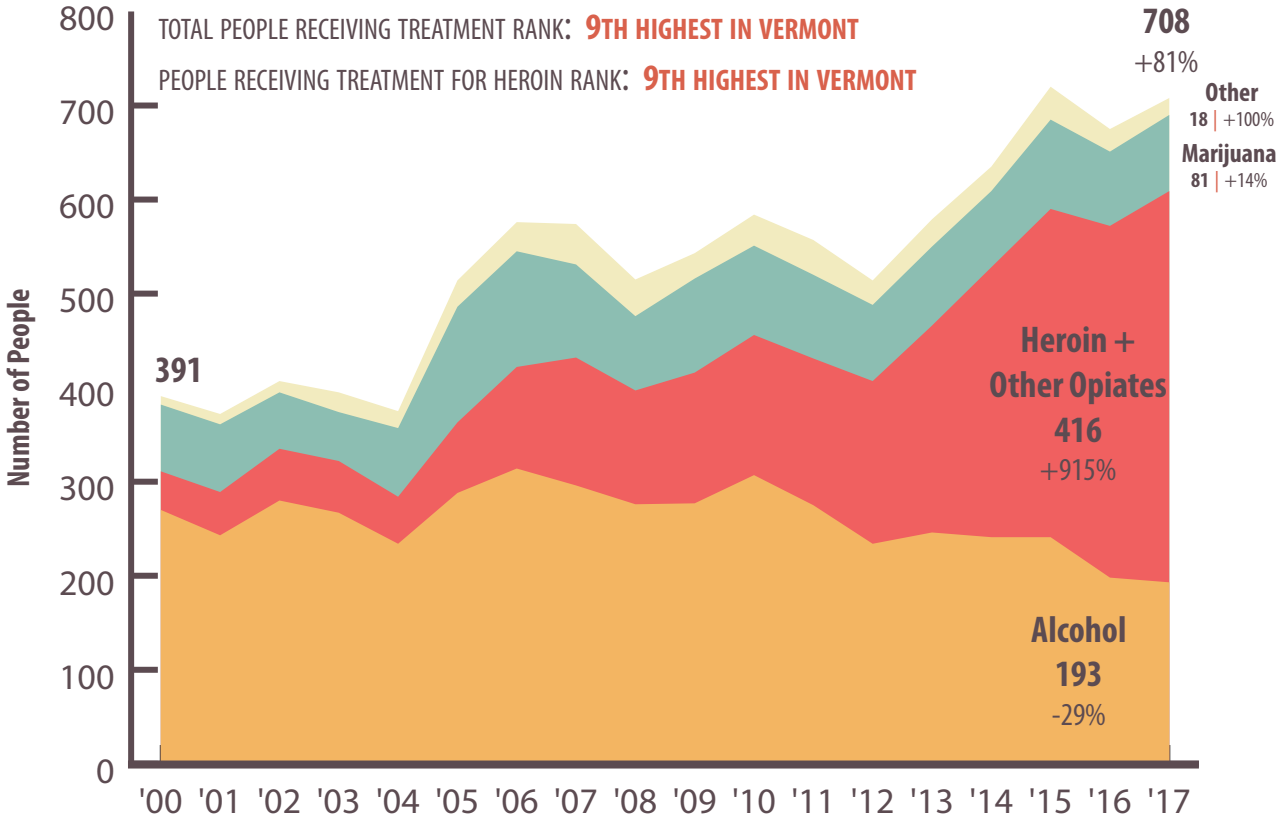
COTE COURT
$89,000 • 6 bedrooms • 2,700 square feet

RIVER ROAD
$94,500 • 5 bedrooms • 2158 square feet

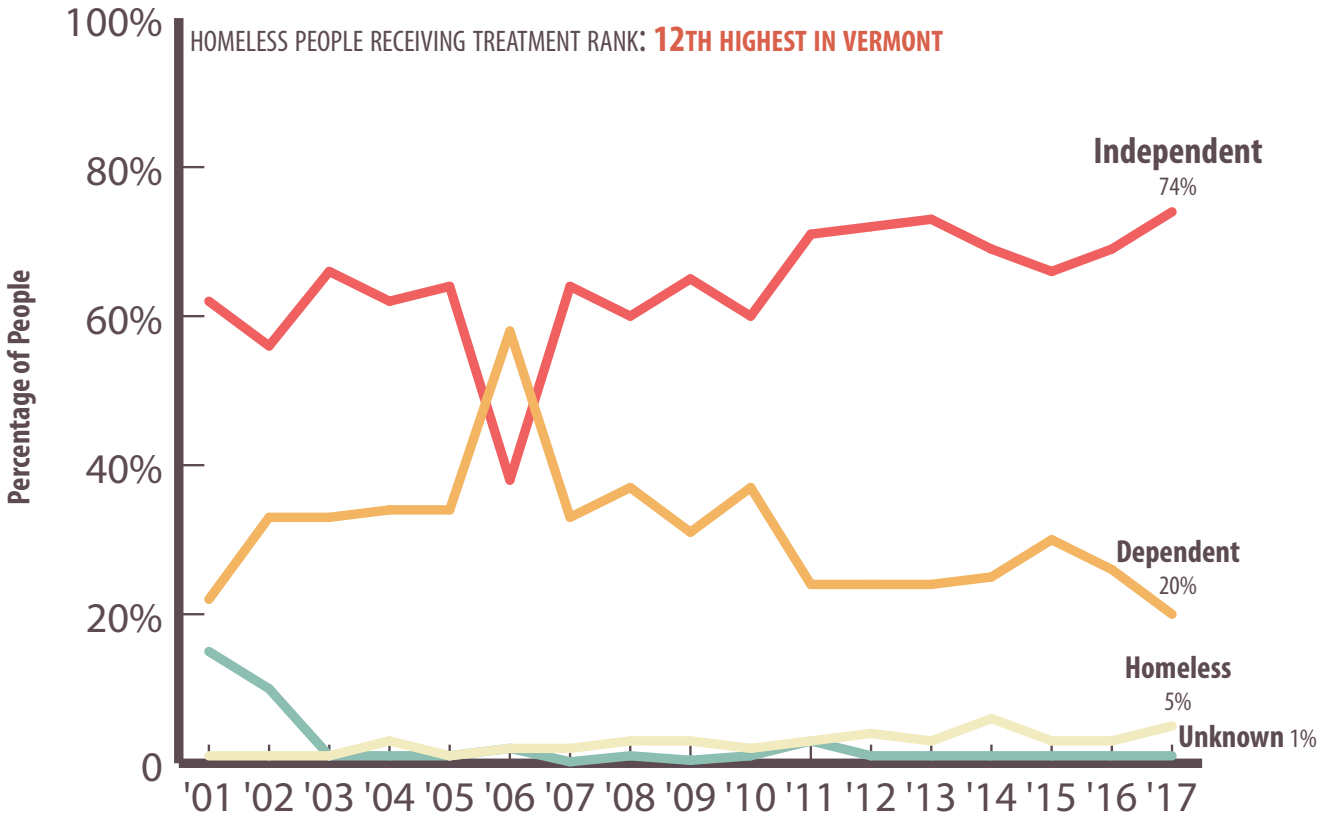
SAINT MARY STREET
$95,000 • 6 bedrooms • 2,282 square feet

CALEDONIA COUNTY

PEOPLE RECEIVING TREATMENT BY PRIMARY SUBSTANCE

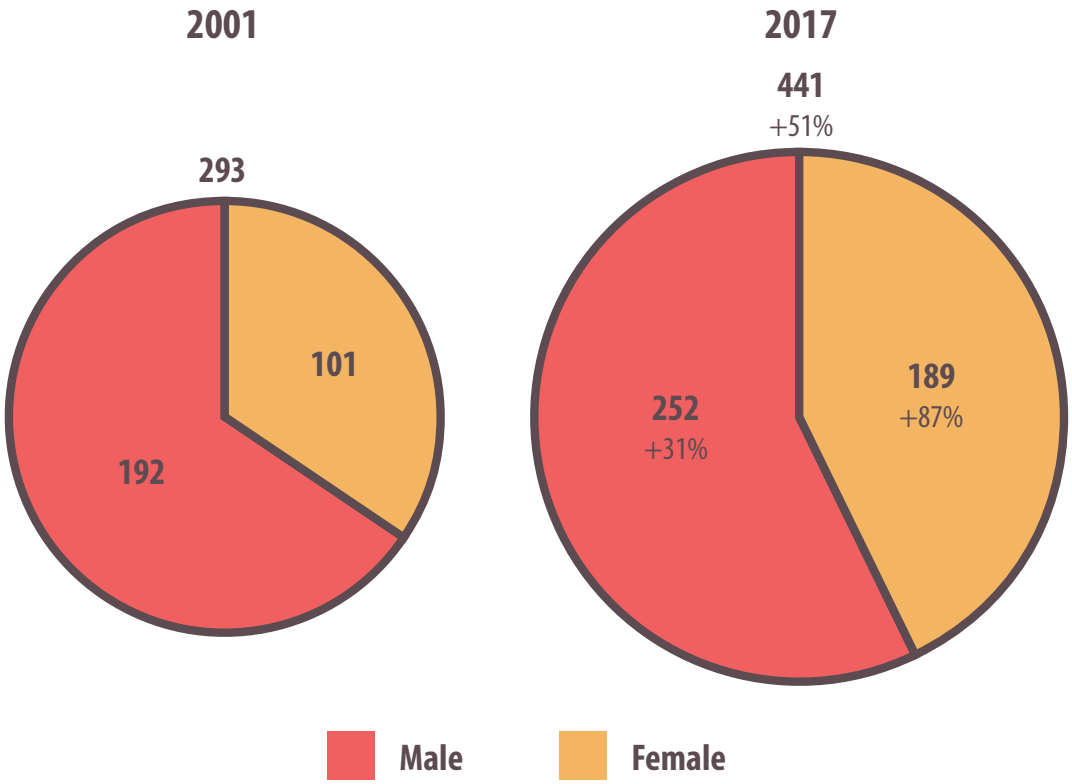


HOUSING STATUS AT TIME OF ADMISSION TO TREATMENT

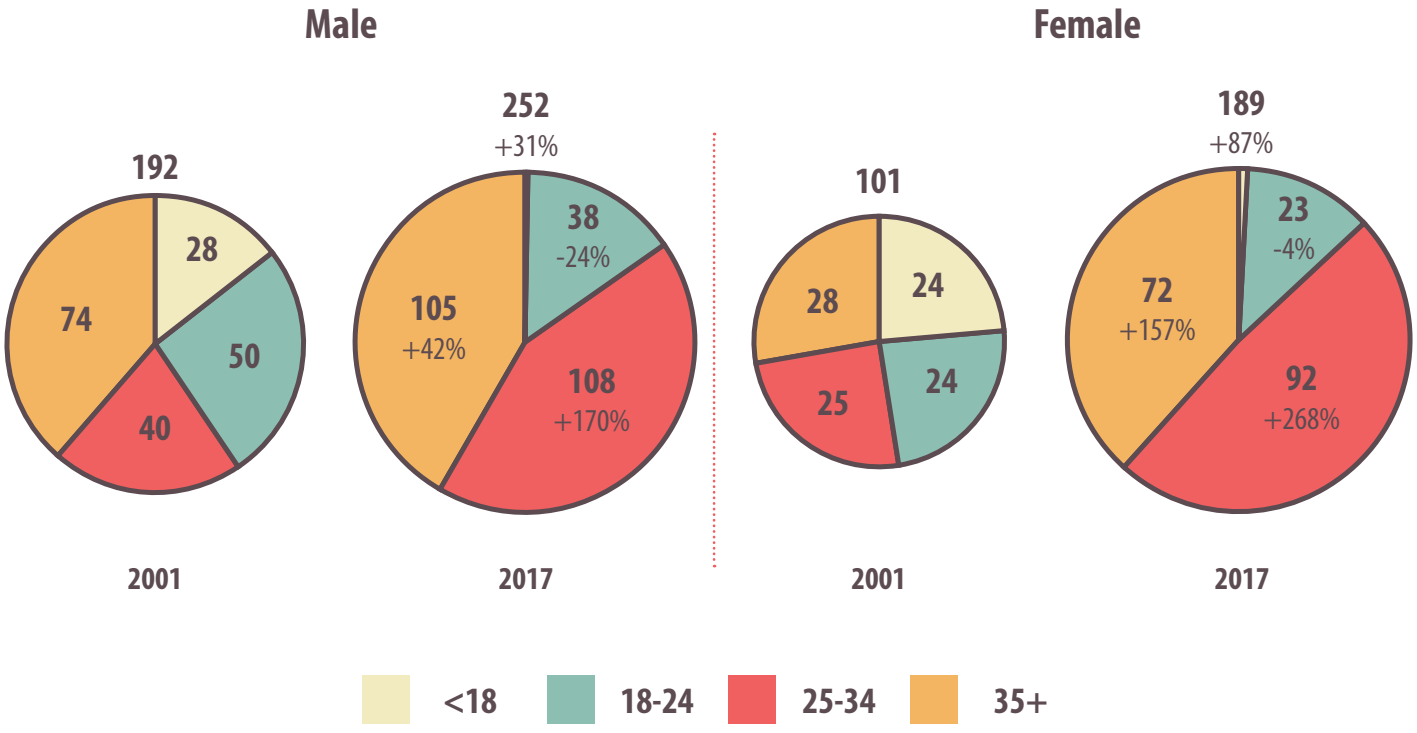


CALEDONIA COUNTY

PEOPLE RECEIVING TREATMENT BY SEX



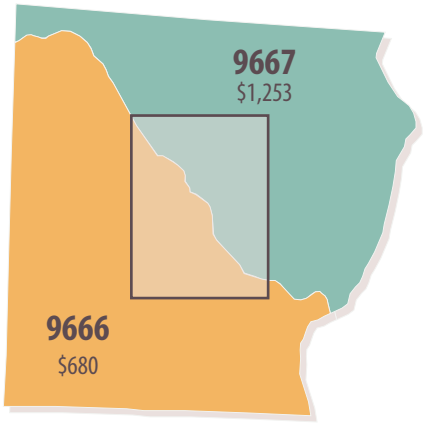
PEOPLE RECEIVING TREATMENT BY AGE



SPRINGFIELD

Census Tracts

with median monthly rents for 3+ bedrooms



VERMONT RECOVERY CENTER

Turning Point Recovery Center
7 Morgan Street Street

VERMONT RECOVERY HOUSING

VERMONT TREATMENT CENTER

Healthcare & Rehab Services
390 River Street

Logistics

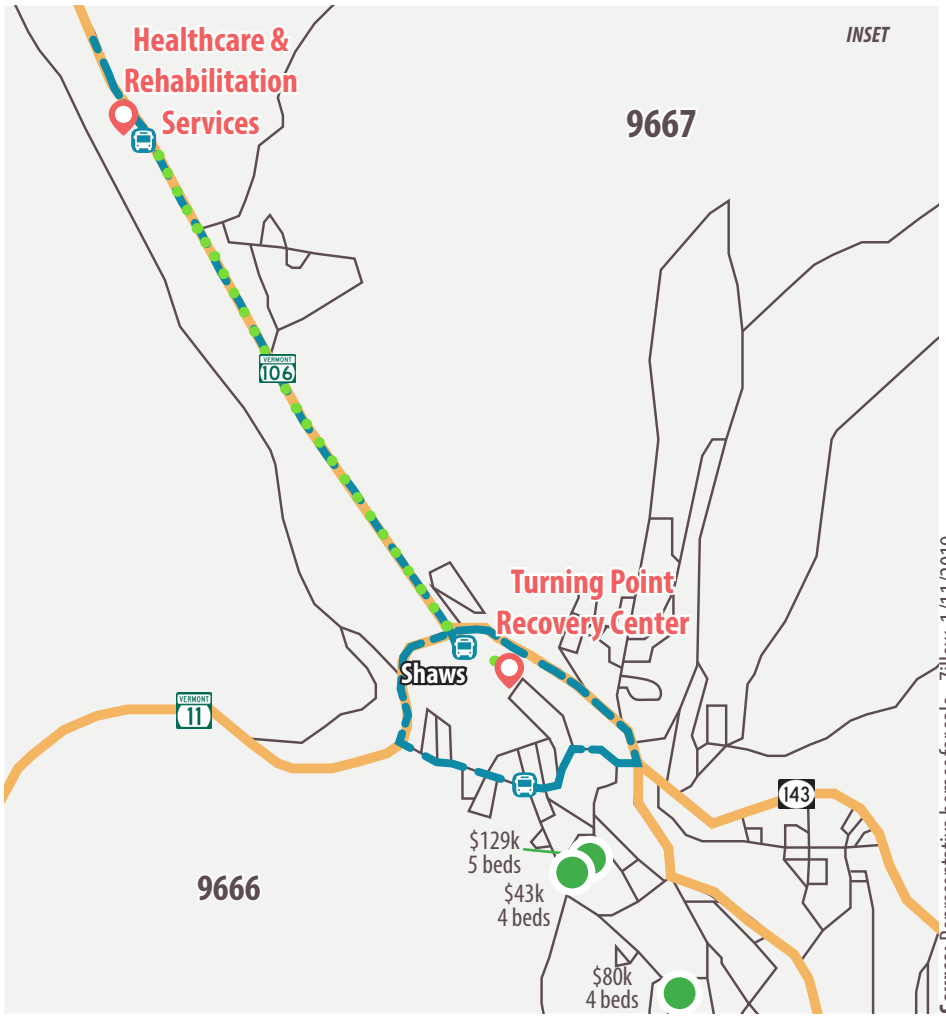
39 min walk
2 miles

Springfield In-Town
every 30 min

Housing Characteristics

Census Tract	Single Family Homes 4+ Bedrooms	2-4 Family Buildings	Median Rent (3+ bdrms)	Percentage of Renter Occupied Housing
9666	321	135	$680	34%
9667	366	81	$1,253	29%

Source: American Community Survey, 2017 5-year estimates



Source: Representative homes for sale - Zillow, 1/11/2019

CENTER STREET
$42,900 • 4 bedrooms • 1,550 square feet

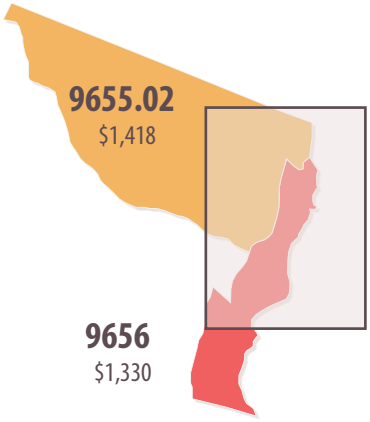
CRESCENT STREET
$129,000 • 5 bedrooms • 2838 square feet

DEWEY STREET
$80,000 • 4 bedrooms • 1,884 square feet

WHITE RIVER JUNCTION

Census Tracts

with median monthly rents for 3+ bedrooms



Housing Characteristics

Census Tract	Single Family Homes 4+ Bedrooms	2-4 Family Buildings	Median Rent (3+ bdrms)	Percentage of Renter Occupied Housing
9655.02	81	50	$1,418	35%
9656	260	126	$1,330	43%

Source: American Community Survey, 2017 5-year estimates

VERMONT RECOVERY CENTER

Upper Valley Turning Point

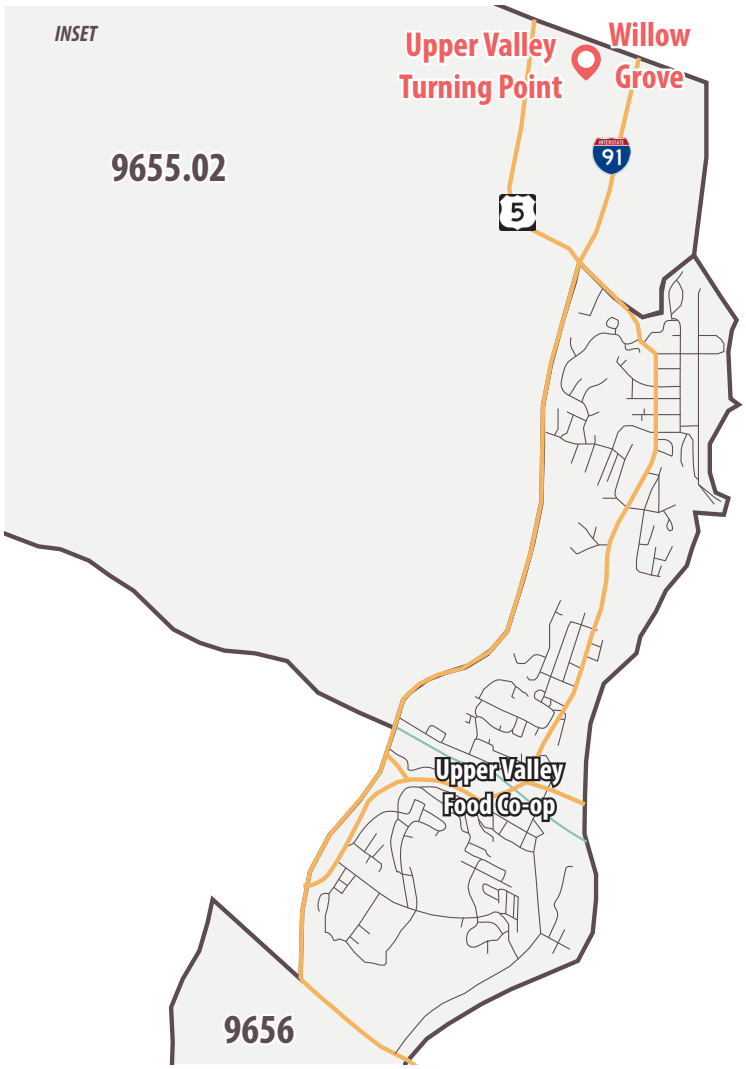
200 Olcott Drive, White River Junction

VERMONT RECOVERY HOUSING

Willow Grove

200 Olcott Drive, White River Junction

VERMONT TREATMENT CENTER



Logistics

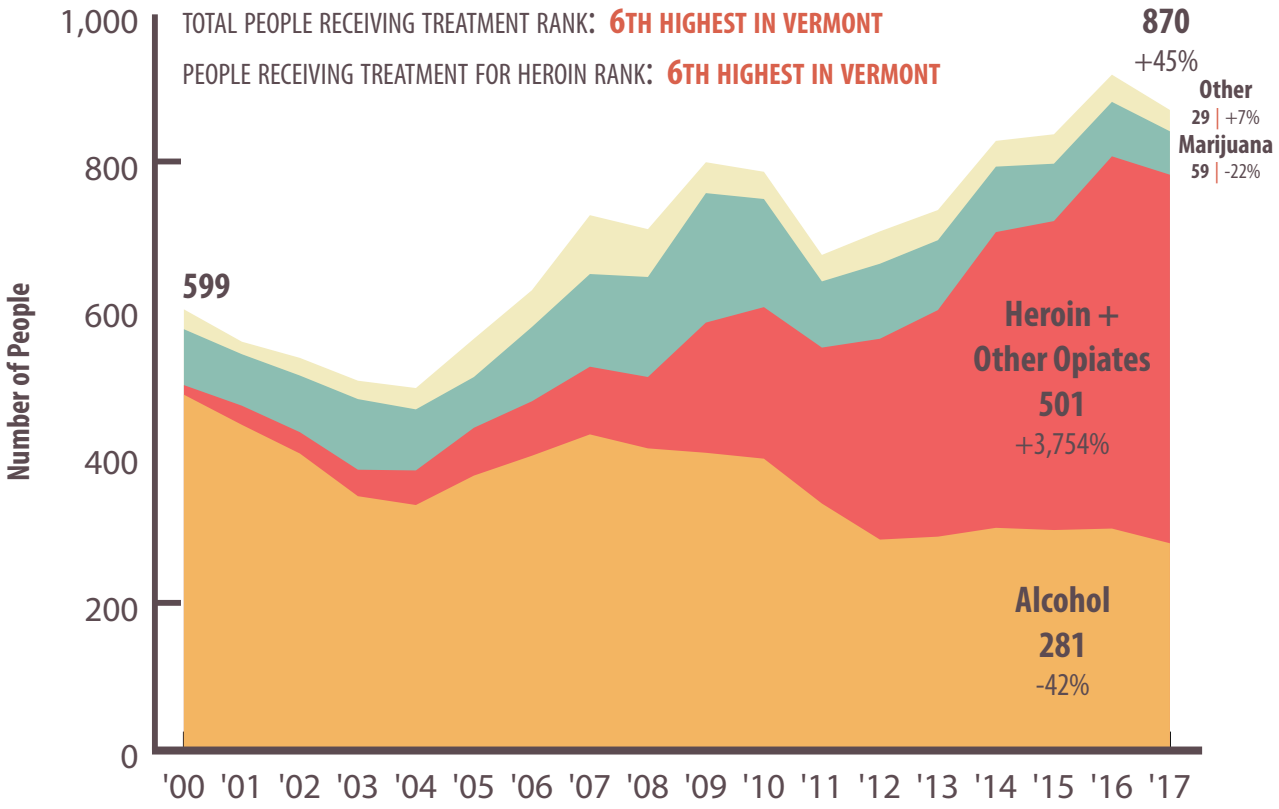
NO PROPERTIES FOUND ON ZILLOW

NO PROPERTIES FOUND ON ZILLOW

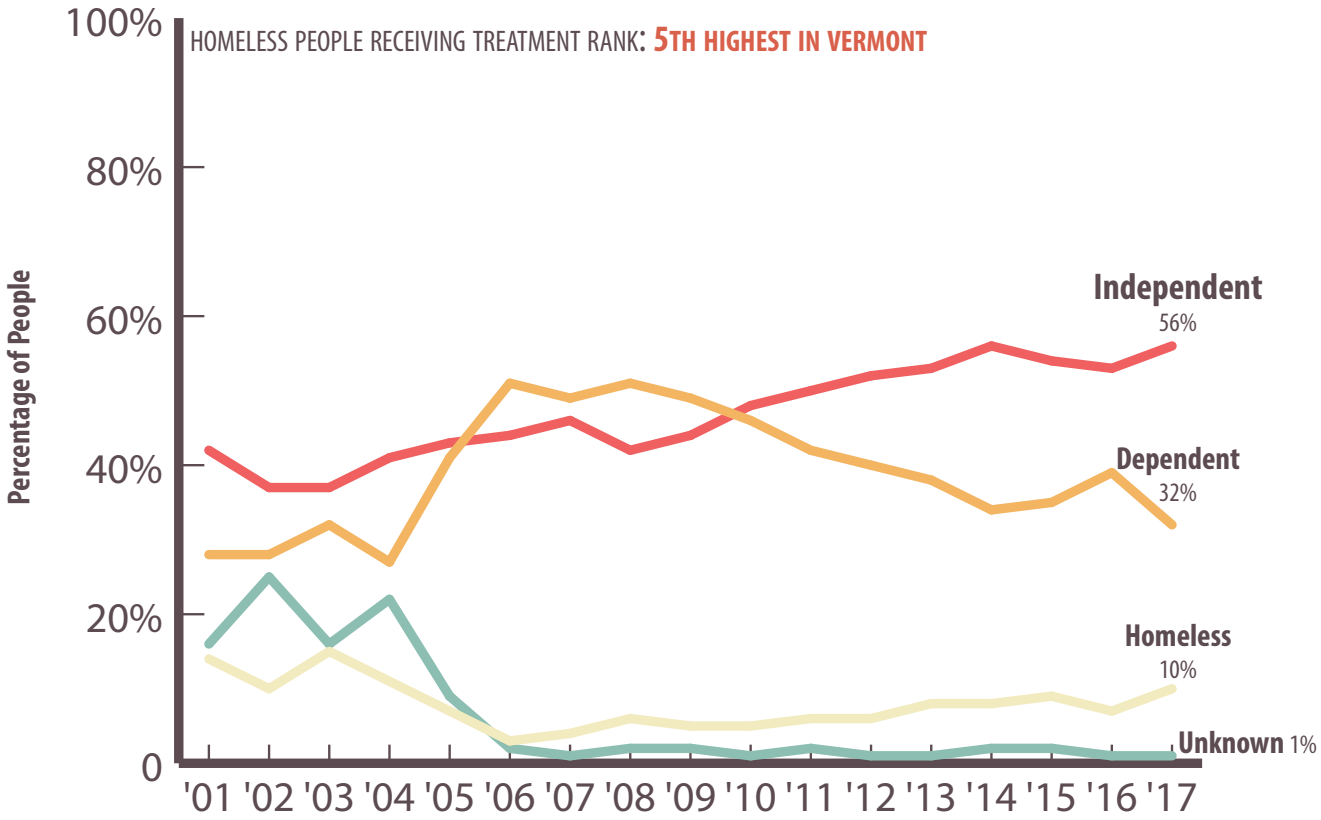
NO PROPERTIES FOUND ON ZILLOW

WINDSOR COUNTY

PEOPLE RECEIVING TREATMENT BY PRIMARY SUBSTANCE

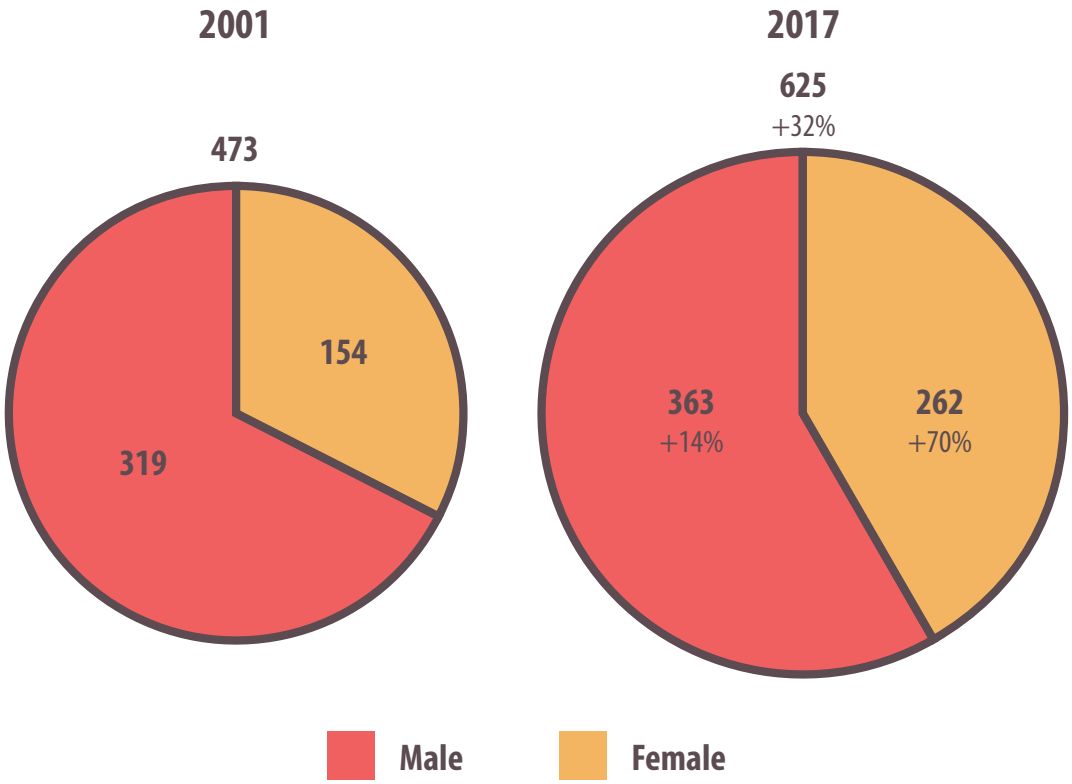


HOUSING STATUS AT TIME OF ADMISSION TO TREATMENT



WINDSOR COUNTY

PEOPLE RECEIVING TREATMENT BY SEX



PEOPLE RECEIVING TREATMENT BY AGE