

“Helping Vermonters recover from substance use disorder with support of safe and sober homes allowing individuals to focus on recovery and achieve long term recovery”

Vermont Recovery Housing Program Action Plan

2021



ROAD TO RECOVERY

Table of Contents

Definitions	1
Program Summary	2
Vermont's Recovery Residency Needs	2
Vermont Recovery Advocacy	3
Vermont Recovery Network	5
Vermont Recovery Service Centers	5
Recovery Residences.....	6
Vermont Foundation on Recovery (VFOR).....	6
Phoenix House New England RISE Programs	6
Dismas House.....	6
Stonecrop.....	6
Jenna's Promise Rae of Hope Sober Home.....	7
Willow Grove.....	7
Agency of Human Services (AHS).....	7
Department of Corrections (DOC) Theory of Change	7
Department of Health (DOH), Division of Alcohol & Drug Abuse Programs (ADAP)	8
AHS Hub & Spoke Opioid System.....	8
Vermont's Opioid Use Disorder Treatment System	8
Medication Assisted Treatment (MAT): The Evidence-Based Approach to Opioid Addiction	10
Hubs Offer Intensive Treatment for Complex Addictions.....	9
Spokes Provide Ongoing Treatment in Community Settings.....	9
State Oversight, Supplemental Funding, Quality and Measurement Support	9
Evidence of Program Impact.....	10
Vermont Harm Reduction Programs	10
Co-occurring Disorders	11
Goals	11
Resources.....	12
Other Federal Resources.....	12
State Resources.....	12
Administration Summary	12
Use of Funds - Methods of Distribution.....	13
Use of Funds - Activities Carried Out Directly.....	13

Eligible Entities to Apply	13
National Objective	13
Eligible Activities	14
Non-Eligible	14
Use of Funds - Evaluation and Criteria.....	14
Evaluation Process	14
Criteria	15
Anticipated Outcomes	16
Expenditure Plan	16
Citizen Participation Summary.....	16
Partner Coordination	23
Monitoring	24
Pre-Award/Pre-Agreement Costs	24
Program Income.....	25
424 and 424D Forms and State Certifications	25
Appendix A - Housing: A Critical Link to Recovery, An Assessment of the Need for Recovery Residences In Vermont	25
Appendix B - Current Legislation undergoing review – H.211 to support individuals in recovery with a substance use disorder	25

Definitions

Individual in recovery – is a person that is in the process of change to improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Substance use disorder, as defined by Substance Abuse and Mental Health Services Administration (SAMHSA) - the recurrent use of alcohol and/or drugs causing clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.

Mental Illness (SAMHSA) - is someone over the age of 18 having (within the past year) a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities.¹

Serious Emotional Disturbance (SAMHSA) – is someone under the age of 18 having a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities.²

Recovery Residence - means a safe, sober living environment that support persons recovering from a substance use disorder in a single-family home(s) or apartment that provides:

- peer support with the environment that prohibits the use of alcohol, use of prescription drugs in a manner other than as prescribed and other illegal substances.
- assistance accessing support services to persons recovering from substance use disorder.
- a residence certified by the Vermont affiliate of National Alliance for Recovery Residences and adheres to the national 4 standards established by the Alliance or its successor in interest.
- or an individualized unit that meets the standards of the Agency of Human Services for supporting individuals with substance use disorders.

Level 1 – Peer Run recovery residence democratically run, drug screenings, self-help meetings encouraged house meetings, there is no paid position within the residence.

Level 2 – Monitored recovery residence with a formal operator and staff where the individuals in recovery are most likely working (employed). House rules provide structure, services are peer run groups and involvement with self-help treatment services.

Level 3 – Supervised recovery residence with formal oversight with a facility manager and certified staff or case managers available. Life skill development, clinical services utilized in outside community and services hours provided in house.

¹ The definition is from Substance Abuse and Mental Health Services Administration (SAMHSA)

² The definition is from SAMHSA

Program Summary

The Federal Register Notice No. FR-6225-N-01 as authorized under Section 8071 of the SUPPORT for Patients and Communities Act, entitled Pilot Program to Help Individuals in Recovery from a substance use disorder become stably housed, herein referred to as the Recovery Housing Program (RHP). The pilot program authorizes assistance to grantees (states) to provide stable, temporary housing to individuals in recovery from a substance use disorder. Federal Register Notice No. FR-6225-N-01 provides how the FY2020 allocation shall be used and administered. Federal Register Notice No. FR-6265-N-01 is the updated Notice to the Support Act to provide the instructions for submitting the Action Plans for FY2020 and 2021.

The State of Vermont's 2020 Recovery Housing Program Action Plan will guide the use of approximately \$753,000 of the first allocation and \$791,652 of the second allocation³ in Recovery Housing Program (RHP) funding received by the State through the U.S. Department of Housing and Urban Development's Community Development Block Grant Program (CDBG) for the period July 1, 2021 through September 1, 2028. These funds are administered by the Agency of Commerce and Community Development (ACCD), Department of Housing and Community Development (DHCD) that administers the State's CDBG funding. There will be collaboration with the Agency of Human Services. A staff person from the Division of Alcohol & Drug Abuse Programs (ADAP) and a staff person from Department of Corrections (DOC) will participate in the review and selection process of the applications.

This plan identifies the State's priorities and needs for transitional housing for persons recovering from substance use disorder based on an extensive needs' assessment, and citizen and stakeholder input. It establishes goals for meeting the priority needs for the period of funding and reflects anticipated resources and outcomes.

The State will use RHP funding to provide safe and supportive transitional housing to persons recovering from substance use disorders through Recovery Residences (RR) that are certified recovery homes through the Vermont Alliance for Recovery Residences, the Vermont Affiliate of the National Alliance for Recovery Residences, or individualized units that meet the Agency of Human Services standards. Persons in recovery will have peer support, access to services, and integration into the community with the goal of moving to permanent, independent housing.

Vermont's Recovery Residency Needs

Downstreet Housing & Community Development received funding from Vermont Housing and Conservation Board (VHCB) to work with a consultant to conduct an assessment of the needs for recovery residences in Vermont. The study "HOUSING: A CRITICAL LINK TO RECOVERY, An Assessment of the Need for RECOVERY RESIDENCES in Vermont" was completed in February of 2019, **Appendix A**.

According to the study done by Downstreet the State of Vermont has beds to meet the needs of only 2% of the state's recovery population. There are only 212 beds throughout the state to serve individuals in recovery, with the potential to serve 425 individuals annually. There are roughly 1,200 Vermonters annually that enter Substance Use Disorder treatment. To adequately meet the demand 300 additional

³ For purposes of expediency, the Action Plan will present both allocations pending receipt of the Federal Register specific to the second allocation.

beds are needed statewide. The study found the highest unmet need was facilities for women in recovery with dependent children. The plan also identified the need for 34 more recovery residences (RR) outside Chittenden County that include outpatient treatment services. The study recommended the following locations and types of recovery residences needed in Vermont:

- 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.

The plan also outlined the need:

- to strengthen the delivery of wrap around services by strengthening the network of services providers that play a role with the recovery residence and its residents;
- to develop projects at a pace that ensures a strong seasoned and well-trained mentors, coaches, and case managers;
- to stress the importance of community and self-worthiness and belonging to the residents; to find sustainable funding to bridge the gap between operational costs and the limited capacity of most residents to cover that cost;
- to invest in community organizations and messaging aspects to manage expectations and build capacity and resiliency needed to address the inevitable setbacks residents of recovery residences will have; and
- to find ways to reduce capital risk associated with acquiring and substantially renovating properties as recovery residences that may need to change.

Vermont Recovery Advocacy

The **Vermont Association for Mental Health and Addiction Recovery (VAMHAR)** is a statewide information and advocacy organization that supports all paths to recovery from substance use disorder and mental health conditions. (<https://vamhar.org/>) VAMHAR supports the following Programs:

- **Recovery Vermont** trains Vermont's recovery workforce through the Vermont Recovery Coach Academy. It is the home of some of the most innovative Recovery Specialty Trainings in the country, including their recovery coaches in the Emergency Department and Family Recovery Coach trainings. It was one of the country's first training and certification programs. Recovery Vermont provides information services to certified recovery residences, advocates through awareness campaigns, trainings, and events, and works every day to end the stigma of SUD across Vermont and beyond. Recovery Vermont works to ensure that people in recovery have a robust workforce opportunity and a diverse network of supports to stay strong in their recovery. (<https://recoveryvermont.org/>)

- **Vermont Alcohol & Drug Information Center (VADIC)** is a program supported by a grant from the Vermont Department of Health, Division of Alcohol & Drug Abuse Programs that provides publications and resources that are free to all Vermonters. (<https://vadic.org/>)
- **Camp Daybreak** is a residential summer camp for Vermont Kids ages 8-11 with a range of social emotional and behavioral needs. (<https://campdaybreak.org/>)
- **Vermont Alliance for Recovery Residences (VTARR)** supports those in recovery from Substance Use Disorders by improving access to Recovery Residences through established standards, a fair and transparent certification process, community engagement, education, technical assistance, research, and advocacy in Vermont. VTARR currently has 130 beds throughout 17 homes that are certified in Vermont. Below is a listing of recovery residences certified through VTARR in Vermont. (<https://vtarr.org/>)

Community	Organization
Brattleboro	Phoenix House Rise
Brattleboro	Phoenix House Rise
Burlington	Dismas of Vermont
Burlington	Phoenix House Rise
Burlington	Stonecrop
Burlington	Vermont Foundation of Recovery, Lyman Avenue
South Burlington	Vermont Foundation of Recovery, Suburban Square
Essex, VT	Vermont Foundation of Recovery, Lincoln Street
Hartford	Dismas of Vermont
Johnson	Rae of Hope
Morrisville, VT	Vermont Foundation of Recovery, Maple Street
Rutland	Dismas of Vermont, Park Avenue
St. Albans, VT	Vermont Foundation of Recovery, Lake Street
St. Johnsbury, VT	Vermont Foundation of Recovery, Elm Street
White River	Willow Grove
Winooski	Dismas of Vermont

Substance Misuse Prevention and Oversight and Advisory Council (SMPC) is a council established by [18 V.S.A § 4803](#). The Department of Health serves as the liaison between SMPC and the Governor's office. The purpose of SMPC is to improve state prevention policies and programs to improve the health outcomes of all Vermonters through a consolidated and holistic approach to substance misuse prevention that addresses all categories of substances. This Council provides advice to the Governor and General Assembly for improving prevention policies and programming throughout the State and to ensure that population prevention measures are at the forefront of all policy determination.

There is current Legislation undergoing review – H.211 to support individuals in recovery with a substance use disorder; reduce homelessness, trafficking, incarceration, and fatal drug overdoses caused by the disease of substance use disorder; and exceptions made to existing landlord and tenant relationships are to support the expansion of recovery residences throughout the State and to ensure accessibility to the recovery residences to individuals recovering from substance use disorder(s).

Appendix B.

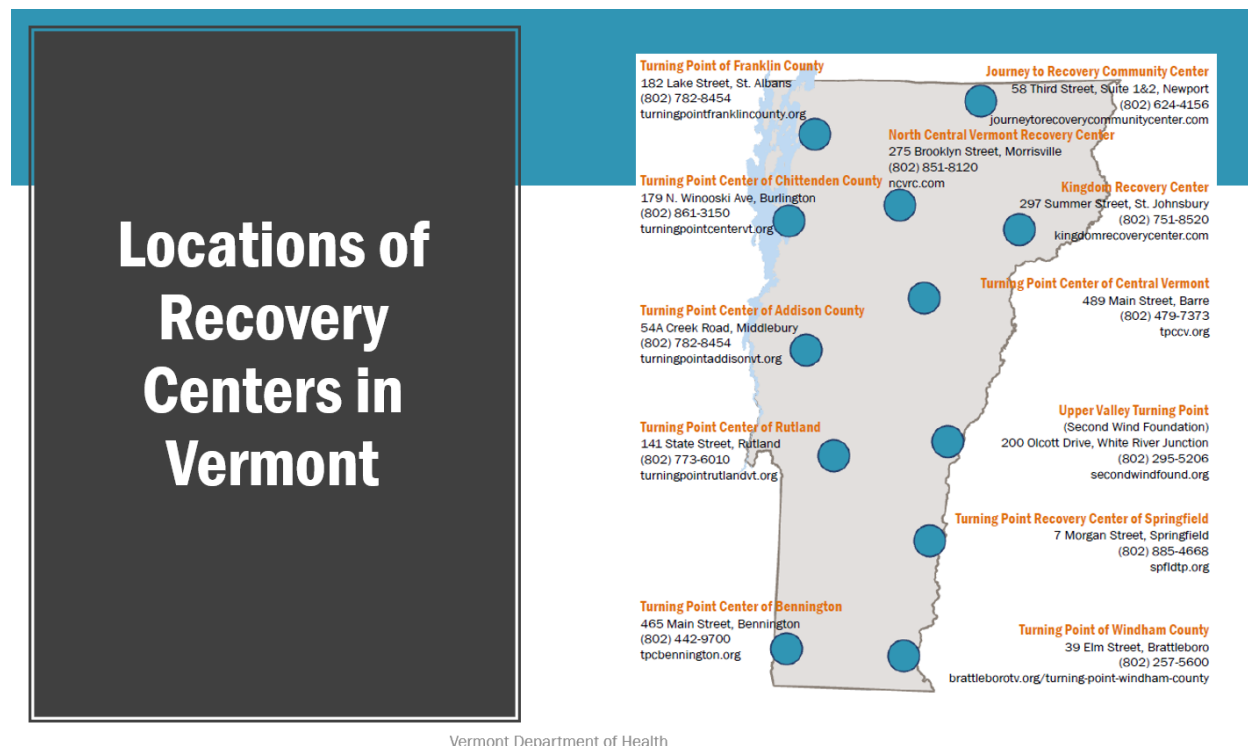
This Bill proposes to: (1) provide residential agreement exclusions for recovery residences; (2) require that recovery residences have policies and procedures pertaining to residential agreements, temporary removal, separation, and drug testing; (3) require a municipality to treat a recovery residence as a single-family residential home under its land use bylaws; (4) require the Department of Corrections to submit a report to the General Assembly of the number of individuals on furlough who reside in recovery residences; and (5) establish the Recovery Stabilization Study Committee.

Vermont Recovery Network

The Vermont Recovery Network mission is to help people who have experienced problems with substance use disorders to find, maintain, and enhance their recovery through peer supports, sober recreation, and educational opportunities. A recovery-oriented system of care that supports self-directed pathways to recovery by building on the strengths and resilience of individuals, families, and communities. Recovery centers are places for people looking for assistance with recovery to find information about recovery and substance abuse services in a drug and alcohol-free environment and to find people who have direct personal experience with the recovery process.

Vermont Recovery Service Centers

Below are the twelve Service Centers in the Vermont Recovery Network throughout the state that assist individuals in recovery through peer supports, sober recreation, and educational opportunities. Each center is an independent 501c3, many of whom have, or are exploring, recovery residences as part of their mission. Recovery Vermont partners with the centers and provides training for their staff. The challenge is there are communities where there are service centers but non-existent recovery residences.



Recovery Residences

Vermont Foundation on Recovery (VFOR)

Vermont Foundation on Recovery (VFOR) mission is to create a network of Recovery Homes (clean and sober living homes) to help people suffering from Substance Use Disorder, re-assimilate into society by supporting the transitions from active use, to recovery, to independent living. VFOR currently has 43 beds across six homes. Since VFOR's opening in 2014, 423 people have been served.

Currently VFOR charges \$150 a week per person in Chittenden County., and \$145 a week outside of Chittenden County, and \$650/month per person for the transitional apartments. Rental fees do not fully cover VFOR's operational costs. Currently the organization budgets for about 52% of their revenues from membership dues paid by the individuals in recovery who live in the homes. A more sustainable solution for the organization would be if they only had to rely on 30% of their revenues coming from membership dues, due to the potential inability for individuals in recovery to pay.

VFOR is currently working with several communities throughout the state to create additional recovery residences to increase bed capacity throughout the state. Individuals with substance use disorders can apply for VFOR housing at <https://www.vfor.org/>.

Below is a listing of current VFOR recovery residences.

Community	Location	Serves	Beds
Essex, VT	Fort Ethan Allen, 2 Homes	Men	16 beds
Essex, VT	Lincoln Street	Men	7 beds
Morrisville, VT	Maple Street	Women	6 beds
St. Albans, VT	Lake Street	Men	8 beds
St. Johnsbury, VT	Elm Street	Men	6 beds

Phoenix House New England RISE Programs

The Phoenix House New England RISE programs are transitional living facilities designed to support adult men and women in early recovery. Through contracts with the Vermont Department of Health's Alcohol and Drug Abuse Program (ADAP), the Department of Corrections, and the Office of Veterans Affairs, RISE maintains five locations throughout Vermont. With a length of stay ranging from three to 24 months, RISE provides a structured, supportive environment that allows clients to practice and reinforce new behaviors and attitudes that will lead them toward long-term recovery. RISE work collaboratively with various community agencies and services to help ensure the best possible outcomes for our clients.

Dismas House

Dismas House is a supportive community for former prisoners transitioning from incarceration. Dismas provides transitional housing for formerly incarcerated people and recruits university students and international volunteers to live in the house. Living in community accomplishes the Dismas mission of reconciliation and continues the original Dismas model. Dismas offers homes for both men and women and programs are located in Burlington, Rutland and Hartford.

Stonecrop

Stonecrop is a structured sober living home for women in recovery. It's a 12-step centered residence located in Burlington, Vermont. Their belief is that substance use disorder is a disease of the mind,

body, and spirit. In order to overcome substance use disorder, an entire psychic change and recreation of their lives with a set of new principles. Residents are encouraged to continue their spiritual growth through their three-phase program. Their goal is to provide recovery in a structured and supportive environment for women to gain ultimate freedom from substance use disorder.

Jenna's Promise Rae of Hope Sober Home

Jenna's Promise Rae of Hope Sober Home was created with the fundamental belief that people can recover from substance use disorder and trauma with the support of a positive community. The program currently has capacity for 6 women but is also working on expansion of access and transitional housing. At Rae of Hope, they ask that residents arrive with desire and motivation to embark on a holistic journey towards wellness. Their mission is to minimize barriers to success while empowering residents to create a network of support. The home offers a trauma informed, structured housing approach, utilizing mental health/substance use treatment, education/vocation, and community connections to support client- centered recovery in substance use disorder and psychological trauma.

Willow Grove

Willow Grove is a supportive transitional residence for women who are in the early stages of recovery from substance use disorder. Established in 2004, Willow Grove offers family-style, substance-free housing for residents who work or volunteer and pay a modest fee for the opportunity to share living quarters with others who are on the same path. The average length of stay is 6-12 months while the resident is actively engaged in all of his/her recovery plan goals. The goal of their transitional housing program is for residents to strengthen the foundation of their recovery and move toward independent, productive lives.

Agency of Human Services (AHS)

Department of Corrections (DOC)

The Agency of Human Services - Department of Corrections has aligned its grant-funded housing portfolio with a theory of change that optimizes for Housing First and scattered site approaches while still maintaining some congregate settings throughout the state. Housing First is a permanent supportive housing model that has been identified by several federal institutions, including the Department of Housing and Urban Development (HUD), the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Veterans Administration (VA), as a best practice in promoting housing stability among extremely vulnerable populations.

- Housing Model: facilitate permanent housing (short-long term rental assistance and link to vouchers) and integrate supportive services to participants that choose to engage toward their goals.
- Re-entry & Case Management Model: focus on the individuals and communities needs by providing the appropriate level of supervision based on risk, while having strong connections to probation and parole, mental health, substance use treatment, and supportive services. Utilizing restorative justice, harm-reduction and trauma informed principles.

For more information regarding DOC's transitional housing go to their website:

<https://doc.vermont.gov/content/transitional-housing>.

Department of Health (DOH), Division of Alcohol & Drug Abuse Programs (ADAP)

The Department of Health is Vermont's Single State Agency (SSA) who works with and administers funding from the Substance Abuse and Mental Health Services Administration (SAMHSA). DOH leads public health efforts to advance the behavioral health of the state and to improve the lives of individuals living with mental and substance use disorders, and their families.

ADAP supports a network of community partners to promote and deliver a wide range of substance misuse information, prevention, intervention, treatment and recovery programs and services. ADAP funds services from school-based prevention services to the Care Alliance for Opioid Addiction, Hub & Spoke model of treatment and coordinates with professionals to support healthy lifestyles for Vermonters of all ages.

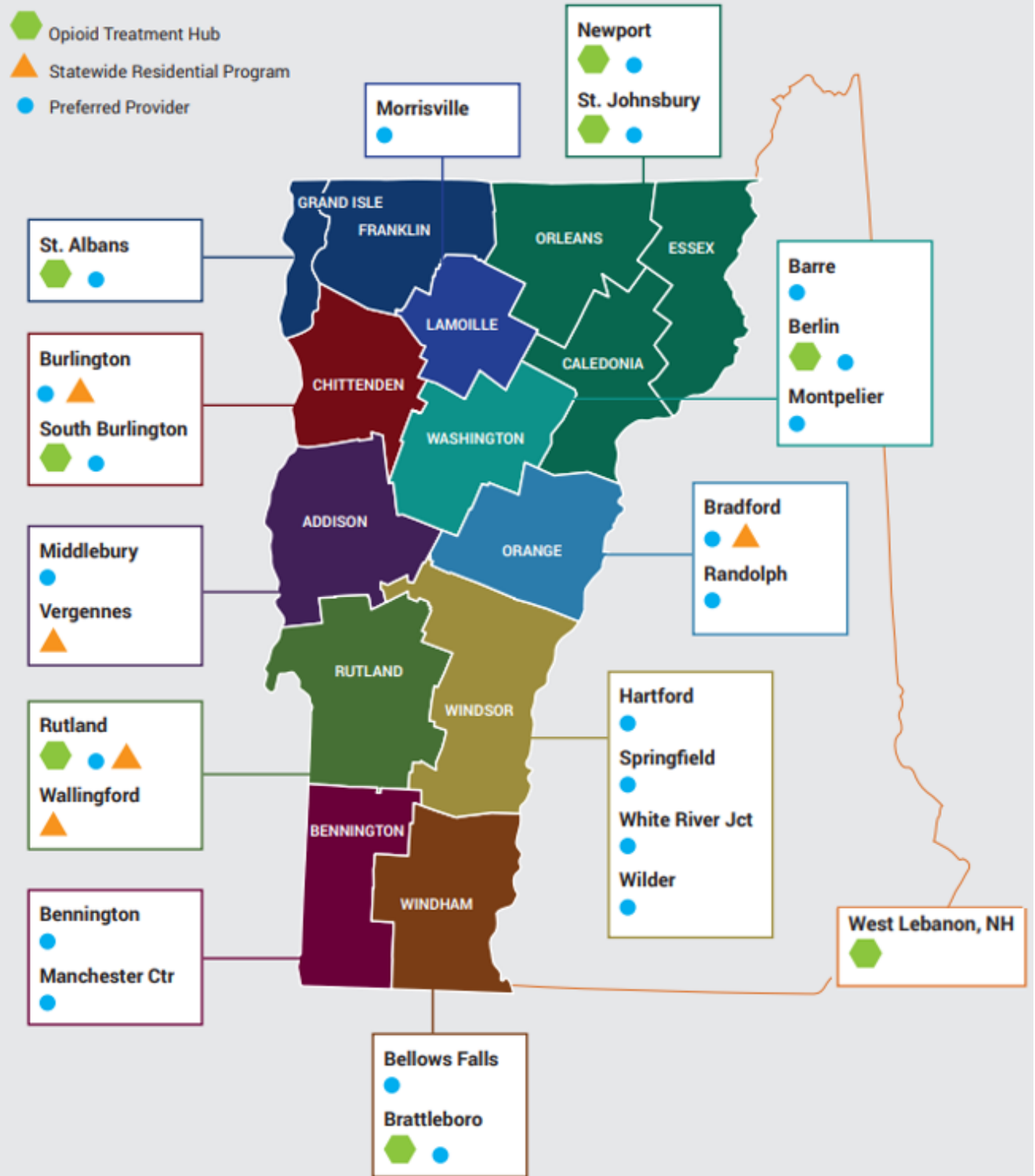
ADAP funds the [VT Helplink Alcohol & drug support center](#) which provides free support and referral services that is accessible by phone or online to AIRS certified clinicians that are knowledgeable of Vermont's Recovery system.

AHS Hub & Spoke Opioid System

Vermont's Opioid Use Disorder Treatment System

Hub and Spoke is Vermont's system of Medication Assisted Treatment, supporting people in recovery from opioid use disorder. There are nine Regional Hubs that offer daily support for patients with complex addictions. In over 75 local Spokes, doctors, nurses, and counselors offer ongoing addiction treatment fully integrated with general healthcare and wellness services. This framework efficiently deploys addictions expertise and helps expand access to opioid user disorder treatment for Vermonters.

Location & Services Overview



Vermont Department of Health/Alcohol and Drug Abused Program Preferred Providers

[BAART Behavioral Health Services-Northeast Kingdom](#)

[BAART Behavioral Health Services-St Albans](#)

[BAART Behavioral Health Services-Central Vermont](#)

[Brattleboro Retreat](#)

[Central Vermont Substance Abuse Services](#)

[Clara Martin Center](#)

[Counseling Services of Addison County](#)

[Habit OpCo](#)

[Health Care & Rehabilitation Services of Southeastern VT](#)

[Howard Center-Hub](#)

[Howard Center-Outpatient](#)

[Lamoille Health Partners \(Behavioral Health and Wellness Center\)](#)

[Lund Family Center](#)

[NFI - Centerpoint](#)

[Northeast Kingdom Human Services](#)

[Northwestern Counseling Services](#)

[Recovery House/Grace House](#)

[Rutland Mental Health-Evergreen](#)

[Rutland Regional Medical Center - Westridge](#)

[Spectrum Youth and Family Services](#)

[Treatment Associates](#)

[United Counseling Services](#)

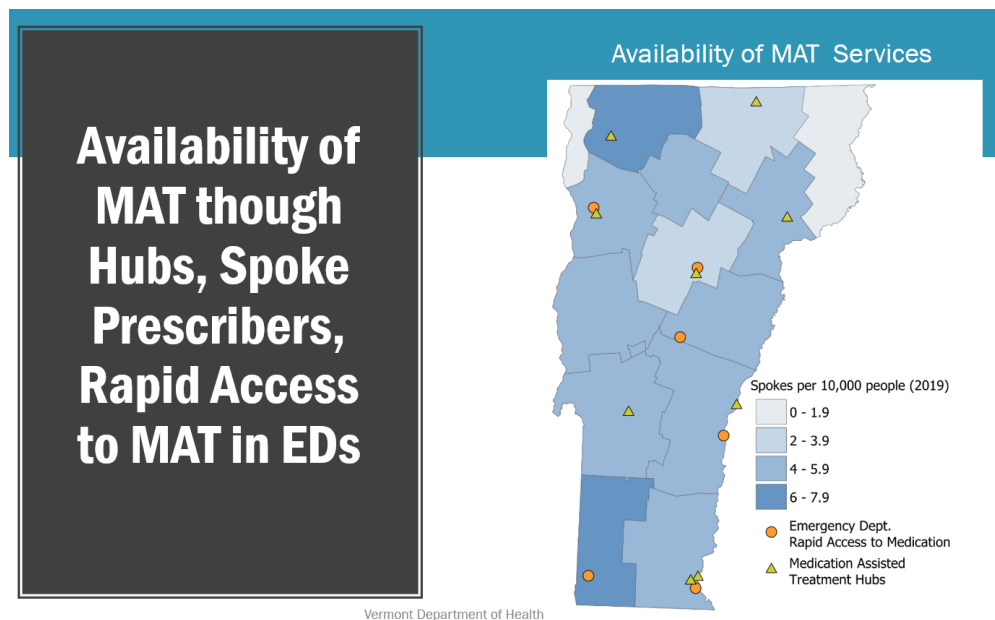
[University of Vermont Medical Center - Day One](#)

[Valley Vista-Bradford/Vergennes](#)

[Washington County Youth Services Bureau](#)

Medication Assisted Treatment (MAT): The Evidence-Based Approach to Opioid Addiction

Medication Assisted Treatment (MAT) uses medication such as methadone and buprenorphine, as part of a comprehensive opioid use disorder treatment program that includes counseling. Medication Assisted Treatment is not the only treatment for opioid addiction, but it is the most effective treatment for many people. It is supported by the American Medical Association, the American Academy of Addiction Psychiatry, and the American Society of Addiction Medicine. Federal regulations designate two settings where Medication Assisted Treatment can take place, Opioid Treatment Programs (OTPs) and Office Based Opioid Treatment (OBOT) settings. Vermont takes this structure as a starting point to strengthen and connect the elements to support people for recovery.



Hubs Offer Intensive Treatment for Complex Addictions

Hubs are Opioid Treatment Programs, with expanded services and strong connections to area Spokes. There are currently 9 Hubs in Vermont. Each Hub is the source for its area's most intensive opioid use disorder treatment options, provided by highly experienced staff.

- Hubs offer the treatment intensity and staff expertise that some people require at the beginning of their recovery, at points during their recovery, or all throughout their recovery.
- Hubs provide daily medication and therapeutic support.
- Patients receiving buprenorphine or vivitrol may move back and forth between Hub and Spoke settings over time, as their treatment needs change.
- Hubs offer all elements of Medication Assisted Treatment, including assessment, medication dispensing, individual and group counseling and more.
- Additional Health Home supports are made available at Hubs through the staffing and payment model. These health home services include case management, care coordination, management of transitions of care, family support services, health promotion, and referral to community services.
- In addition to treating their own patients, Hubs offer trainings and consultation to the Spoke providers.

Spokes Provide Ongoing Treatment in Community Settings

Spokes are Office Based Opioid Treatment settings, located in communities across Vermont. At many Spokes, addictions care is integrated into general medical care, like treatment for other chronic diseases.

- The Spokes are mostly primary care or family medicine practices, and include obstetrics and gynecology practices, specialty outpatient addictions programs, and practices specializing in chronic pain.
- Prescribers in Spoke settings are physicians, nurse practitioners, and physician's assistants federally waived to prescribe buprenorphine. They may also provide oral naltrexone or injectable Vivitrol.
- People with less complex needs may begin their treatment at a Spoke, other patients transition to a Spoke after beginning recovery in a Hub.
- Spoke care teams include one nurse and one licensed mental health or addictions counselor per 100 patients. These Spoke staff provide specialized nursing, counseling and care management to support patients in recovery, this staff assures team-based care and helps primary care providers balance MAT patient care with the needs of their full patient panel.

State Oversight, Supplemental Funding, Quality and Measurement Support

- The Hub & Spoke concept was first introduced by John Brooklyn, MD and the model was designed and operationalized by the State of Vermont through the Blueprint for Health, the Department of Vermont Health Access, and the Vermont Department of Health's Division of Alcohol and Drug Abuse Programs.
- The State of Vermont pays for Hub and Spoke services via Medicaid. The Hub programs bill a monthly bundled rate, and the Blueprint distributes funds to support Spoke staffing through its existing Community Health Team payment infrastructure.

- The State of Vermont provides oversight for the program, helping communities monitor treatment needs, waitlist length, average time to treatment, and program performance.
- The Blueprint for Health provides each Vermont community with a data profile showing Hub & Spoke patient demographic data and key program measures, to support data-driven quality improvement.

Evidence of Program Impact

- Access to treatment has grown since program inception, with more than 6000 people now participating.
- The Blueprint for Health uses claims and clinical data to evaluate program impact and program costs. The Blueprint is working with other state agencies to incorporate additional data, such as Corrections data, into its evaluation.
- A peer-reviewed article published in the journal Substance Abuse Treatment showed that health care costs for Vermonters in Medication Assisted Treatment were lower than for Vermonters with opioid addiction not in Medication Assisted Treatment, even when including the substantial treatment costs. Individual and group counseling, and more.

Vermont Harm Reduction Programs

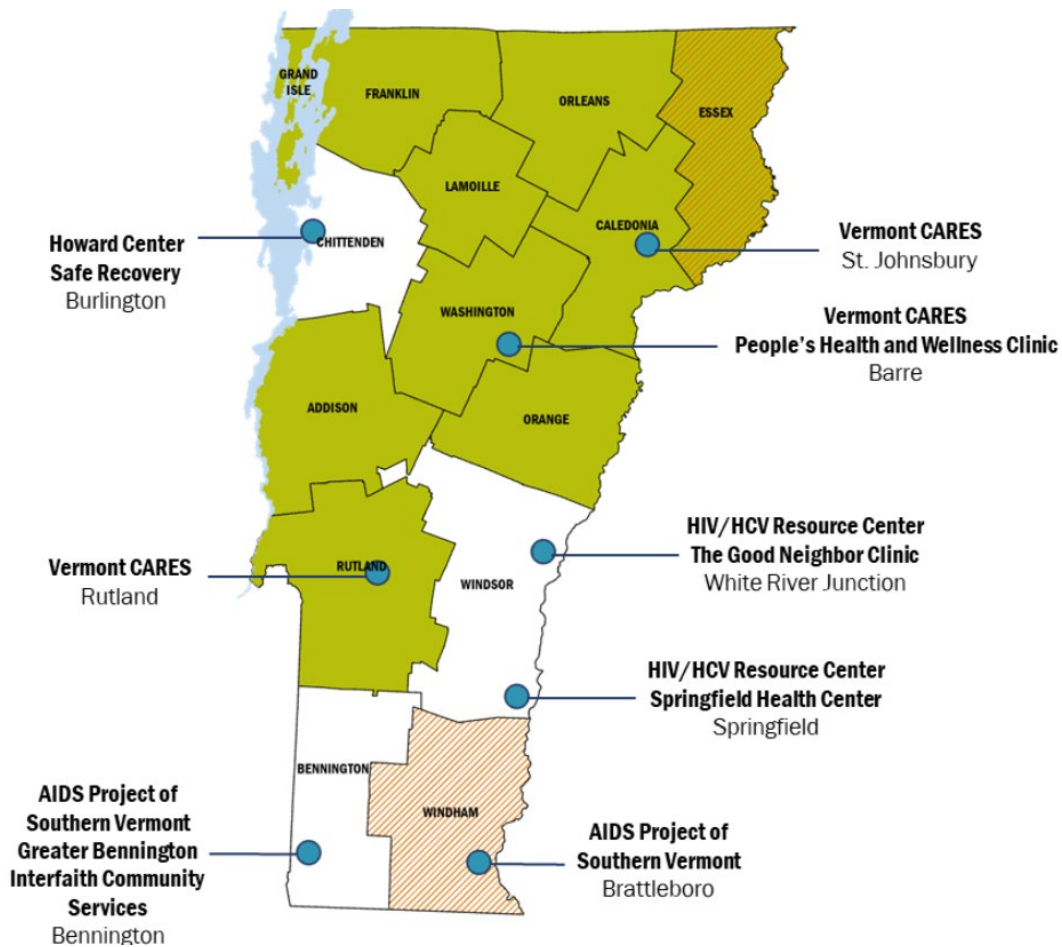
Vermont CARES works for and with Vermonters affected by HIV/AIDS to promote wellbeing through a continuum of prevention, support, and advocacy services. VT CARES manages a syringe service program, provides testing for HIV and HEP C, has a new Prevention program called “Let me PrEP u” and has a mobile unit that travels around the state to be able to assist Vermonters with their services.

(<https://vtcares.org/>)

AIDS Project of South Vermont is a regional AIDS service organization that provides direct services to people living with HIV/AIDS, and prevention services to those at high risk in Windham, Bennington, and southern Windsor counties. (<http://www.aidsprojectsouthernvermont.org/>)

Howard Center Safe Recovery Programs distributes free Fentanyl test strips and Narcan overdose reversal kits. The program also offers HIV and Hepatitis C testing, syringe exchange program, Hepatitis A and B vaccines, abscess and wound care, legal clinic, treatment options counseling and low barrier, and medication-assisted treatment (buprenorphine). (<https://howardcenter.org/substance-use/needle-exchange-free-hiv-hepatitis-screening/>)

HIV/HCV Resource Center distributes fentanyl test kits and Narcan/naloxone, provides services to persons living with HIV, offers HIV and Hepatitis C testing to persons in Orange and Windsor counties in Vermont. (<http://www.h2rc.org/>)



Co-occurring Disorders

It is important to note that many individuals with substance use disorders may also have challenges with multiple disorders. It is common for many to have mental health issues such as anxiety, eating disorders, mood-related disorders, trauma related issues, psychoses, along with alcohol or drug addiction. Sometimes these disorders are genetic. It is helpful for staffing of recovery residences to understand mental illness and substance use disorders behaviors and treatments. To be effective for the individual in recovery, the dual conditions should be treated at the same time.

Goals

Vermont's Recovery Housing Programs goals are to support:

- Levels 1, 2 & 3 Recovery Residences certified by VTARR.
- Individualized Units that meet AHS – DOC standards.
- Creation of Recovery Residences in service HUB areas where none exist.
- Recovery Residences with priority given to parents with children.
- Recovery Residences that include programs that have wrap around services for long term recovery that are onsite or in the vicinity of the home.
- Individuals will transition to permanent independent housing within two years of entry to the Recovery Residences

Resources

Other Federal Resources

Although there is not a direct set aside of Vermont's regular Community Development Block Grant (CDBG) program annual funding for Recovery Housing Program (RHP) projects, they will be given preference due to meeting a housing need which is a higher priority in the State's Consolidated Plan.

Housing developers may be able to utilize the following federal funding sources when developing transitional housing Recovery Residences:

- NeighborWorks of America
- USDA Rural Development -community facility grants or low interest loans.
- Affordable Housing Program Federal Home Loan Bank of Boston (AHP)

State Resources

The Department of Corrections annually funds some transitional housing for persons coming out of incarceration that supports persons in recovery.

The Vermont Housing and Conservation Board has funding available to assist with transitional housing.

Some municipalities have revolving loan funds from previous HUD funding that may be available.

Efficiency Vermont is also a resource for housing developers to utilize to assist the recovery residence with any energy efficiency needs.

Administration Summary

DHCD will be the responsible agency for overall administration and will use existing staff to administer the Program. There will be collaboration with Vermont's Single State Agency (SSA), the Agency of Human Services/Department of Health. A staff person from the Division of Alcohol & Drug Abuse Programs (ADAP) and a staff person from Department of Corrections (DOC) will participate in the review and selection process of the applications.

Contact Person

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Agency of Commerce and Community Development
Department of Housing and Community Development -Vermont Community Development Program
1 National Life Drive
Montpelier VT 056201-0501

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Use of Funds - Methods of Distribution

Minimum \$100,000 Maximum \$500,000

Open to all communities in Vermont, including the states only entitlement community City of Burlington.

FY2020 Total Award **\$753,000**

-5% General Admin \$ 37,650

- 3% Technical Assistance \$ 22,590

Total amount to Grant Out \$692,760

FY2021 Total Award **\$791,652**

-5% General Admin \$ 39,583

- 3% Technical Assistance \$ 23,749

Total amount to Grant Out \$728,320

Total available to grant to projects from both allocations: \$1,421,080⁴

Lease, Rent and Utilities activities are not limited to the 15% Public Service CAP.

Use of Funds - Activities Carried Out Directly

Eligible Entities to Apply

All Vermont municipalities are eligible to apply for Recovery Housing Program funding.

National Objective

All projects must meet the Low- and Moderate-Income Limited Clientele national objective which requires at least 51% of the individuals served be at/or below 80% of area median income.

If a project serves individuals that meet the criteria below they are automatically are presumed Low- and Moderate-Income Limited Clientele:

- Persons that meet the federal poverty limits
- Persons insured by Medicaid
- Abused children
- Battered spouses
- Elderly persons (55 and older)
- Severely disabled persons
- Homeless persons
- Illiterate adults
- Persons living with AIDS
- Migrant farm workers

The Slums and Blight (SB) and Urgent Need (UN) national objectives are not eligible.

⁴ Of the \$1,421,080 30% must be expended within one year of signing the HUD Grant Agreement - \$463,396

Eligible Activities

- **Public Facility Improvements** - Acquisition, construction, reconstruction, rehabilitation or installation of public facilities and improvements for the purpose of providing stable, temporary housing for individuals in recovery from a substance use disorder.
- **Acquisition of Real Property** - For the purpose of providing stable, temporary housing to persons in recovery from a substance use disorder.
- **Lease, Rent & Utilities (only to LMI)** - associated costs on behalf of an individual in recovery from a substance use disorder for the purpose of providing stable, temporary housing. Payments must be made to the provider, such as the landlord or utility provider. Payments must NOT be made directly to individuals.
 - RHP cannot supplant funds that previously covered for an individual.
 - New or Expanded Service that have been above and beyond the last 12 months.
 - Assistance can be provided for up to 2 years or until the individual secures permanent housing, whichever is earlier.
- **Rehabilitation and Reconstruction**
 - Single Unit – publicly or privately owned residential building(s)
 - Multi-Unit up to 2 or more units - publicly or privately owned residential building(s)
 - Public Housing – owned or operated by a public housing authority.
- **Disposition of Real Property Acquisition** - Disposition through sale, lease, or donation of otherwise of real property acquired with RHP funds for the purpose of providing stable, temporary housing for individuals in recovery from a substance use disorder.
 - Legal documented surveys for transfer of Ownership
- **Clearance and Demolition** - Clearance, demolition, and removal of buildings and improvements, including movement of structures to other sites. Eligibility limited to projects where RHP funds are used only for the clearance and demolition.
- **Relocation** - Relocation payments and other assistance for permanently or temporarily displaced individuals and families in connection with activities using RHP funds.
- **New Construction** - Expansion of existing eligible activities to allow RHP funds to be used for new construction of housing. New construction of housing is subject to the same requirements that apply to rehabilitation activities.

Non-Eligible

- **Operational Costs**
- **Paying for staffing**
- **Planning**

Use of Funds - Evaluation and Criteria

Evaluation Process

The Pilot Recovery Housing Program (Dockets No. FR-6225-N-01 and FR-6265-N-01) funds shall be competitive and will ensure the eligible community development activities are met. The applications will be based on a system that measures the need, impact and feasibility of the proposed projects and will be scored using the scoring criteria below. RHP applications will be managed through DHCD's Web-

based Application System known as GEARS. Applications are completed online and are submitted by municipalities.

DHCD staff will review each application for eligibility and completeness, before conducting a thorough analysis of each eligible applications and scoring them. AHS staff from ADAP and DOC will also participate in the review and scoring process of the applications. DHCD staff will compile all the scoring of the applications by all the reviewers and will provide that documentation along with a recommendation to the Community Development Board. The CD Board reviews each application, analysis, compiled scores and makes funding recommendations to the ACCD Secretary on behalf of the Governor.

Criteria

The application must meet HUD's National Objective - Low- and Moderate-Income Limited Clientele.

Staff analyses of the applications are written based on Project Need, Project Impact and Project Feasibility. The selection criterion is as follows:

Scoring Criteria	Maximum Points
Project Need:	
Project response to documented need/issue	8
Project response to units near service hub and underserved by Recovery Residences	8
Project provides safe, healthy, and sober living environment	7
Design of program that provides holistic, wrap around services	7
Project response to units for parents with children	5
Project leverage of other resources	5
Total Need	40
Project Impact:	
Project LMI benefit	9
Readiness to proceed and obligate and expend funds within 4 months	7
Community support for recovery housing	4
Coordination with state, local or regional service providers	4
Demonstrated data collection for outcomes	4
Use of green, energy efficient, and sustainable construction methods	2
Total Impact	30
Project Feasibility:	
Project adheres and will be certified to VTARR standards or unit meets AHS recovery programs standards	8
Project long term viability (reserves, cash flow coverage)	6
Project includes trained recovery housing staff (peer to peer)	6
Demonstrated capacity and experience to carry out the project	5
Project cost effectiveness and reasonability	5
Total Feasibility	30
Total Score	100

Each project assisted shall develop and provide model documents for their marketing materials, financial management process for operator, recovery services provided and recovery plans. Residents should be provided policies and procedures for medication treatment, fair housing, financial management, residential agreement, residents household responsibility, drug screening, relapse plans, confidentiality laws, and staffing/leadership plan. House rules are typically established by the residents, once established a copy should be provided to each resident.

Anticipated Outcomes

Vermont anticipates being able to serve 4 or 5 projects between \$100,000-\$500,000 each out of FY2020 and FY2021 allocations. Projects assisted will be required to provide data on the following outcomes:

Outcome Measures	Vermont's Projections
Number of Transitional Housing Units Created	1
Number of Transitional Housing Units Rehabilitated	4
Number of Transitional Housing Beds Created	30
Number of individuals assisted with transitional housing.	26
Number of individuals assisted with transitional housing able to transition to permanent housing.	8
Number of individuals with children assisted with transitional housing.	4
Number of individuals with children assisted with transitional housing able to transition to permanent housing.	2

Expenditure Plan

The state has received two applications through its regular CDBG program that are eligible and meet the scoring criteria of the Recovery Housing Program, and through the allowability of the act both projects are included under Pre-Award/Pre-Agreement Cost. The state will start receiving additional applications for the Recovery Housing Program in late summer with a Board meeting in early fall to award the remaining funds.

The state fully anticipates being in compliance with the requirement of expending 30% of funds from one year of the date of grant agreement executed with HUD due to the majority of its RHP 2020 funding being allocated under Pre-Award/Pre-Agreement Costs.

The ACCD is currently tracking staff hours specific to RHP and will include those expenditures under Pre-Agreement Costs.

Citizen Participation Summary

In developing the plan DHCD followed the states Citizen Participation plan and consulted with a broad range of local, regional and state organizations.

It should be noted that the Recovery Housing Program has been included in the State's Consolidated Plan and discussed since the allocation was announced as in 2019. The RHP was also more fully discussed at this year's public hearing on April 5, 2021 where it was brought to our attention that the

maximum award per project should be no less than \$500,000. The reasoning was that it is so difficult to find all the funding sources to bring a project fruition that it takes so much time with smaller amounts. A larger amount can make a project more shovel-ready which is critical with a deadline to expend 30% of the funding within one year of signing the grant agreement with HUD.

The Draft Recovery Housing Plan was widely distributed by email to local, regional and state organizations and posted on the Agency's website on **May 25, 2021** seeking comment through **June 11, 2021** to obtain citizens' views about how the plan addresses the needs for transitional housing for people recovering from substance use disorder in the state.

Comments

Vermonters for Criminal Justice Reform

1. Please consider omitting stigmatizing language such as "addiction" (better to use substance use disorder), "misuse" (better to use use), "clean and sober" (better to say in recovery).
2. This document reflects the perspectives of sober house operators, but it does not appear that feedback from sober house tenants or their advocates (like Vermont Legal Aid or Vermonters for Criminal Justice Reform) was solicited or included prior to this draft.
3. The proposed legislation included in the draft report as an attachment (and referred to in the narrative) is controversial and has not been enacted by the legislature. It is not appropriate to include, especially without that context.
4. The report does not clearly explain that sober house/recovery residence operators are private landlords, residents are tenants, and both are governed by standard Vermont landlord/tenant law. The report should use standard language relating to landlords, tenants and lease agreements, and should acknowledge that tenants can not legally be removed from the residence without a court eviction order (the report seems to imply otherwise).
5. Overall, the report does not seem consistent with the Theory of Change policy being implemented by the Vermont Department of Corrections.

ACCD Actions Taken or Comments

1. Modified the use of the word addiction to substance use disorder where appropriate. In some cases, the choice of the word's addiction, misuse and clean and sober are specific to the Agency or Organizations referenced.
2. We have participated with the Intervention, Treatment and Recovery Committee which includes members that are in recovery, as well as conversations with many individuals that are in recovery from substance use disorder.
3. The proposed legislation is merely referenced to inform our HUD officials of what the state of Vermont is currently reviewing to support recovery housing.
4. All congregate housing will need to be certified by Vermont Alliance for Recovery Residences (VTARR) as such are required to have resident agreements and therefore do not fall under the landlord tenant law. For the protection of all the residents in the home our plan does require a relapse plan for the removal of individuals. The plan requires measures to avoid people being homeless.

5. This plan is to encompass all individuals in recovery not just those coming out of incarceration. In consultation with Department of Corrections (DOC), there is a need for both the Theory of Change policy housing and supportive congregate housing.

Northeastern Vermont Development Association

As the Regional Planning Commission and Regional Development Corporation for the Northeast Kingdom, NVDA has developed goals, policies and strategies related to housing, energy, and economic development, which have relevance to the Recovery Housing Program Action Plan. We offer the following comments:

1. We support DHCD in its efforts to address the need for appropriate, stable housing for Vermont residents recovering from substance abuse.
2. We support the inclusion in the scoring criteria of added points for energy efficient construction, as weatherization and improved energy efficiency of the housing stock is also a goal in our regional plan.
3. We support the change in the model for recovery residences from congregate housing to individualized units, as discussed on page 6 of the Action Plan. While this is evidently in the best interests of those in recovery, it is also in the best interests of hosting communities. The individualized units model would allow RRs to blend in with market rate units, and benefit from a location close to services, commercial, civic, and active recreational uses. In time, if the units no longer functioned as RRs, they would be available to general tenancy without the need for modification.
4. Keeping in mind that funding programs and needs change while the rental unit remains, we recommend against the placement of permanent easements on new or renovated RR housing units that restrict the use or income of tenants in perpetuity.
5. To forward our regional plan's goal of supporting economically integrated communities and avoiding concentrations of poverty, we suggest that the scoring criteria take neighborhood context into consideration when selecting projects, i.e., locations with an existing high concentration of subsidized units should be avoided when siting recovery residences. Based on the information included with the Action Plan, the location of recovery residences in stable and economically integrated neighborhoods is also in the best interests of those in recovery.

ACCD Actions Taken or Comments

1. No Comment
2. Not Comment
3. This plan is to encompass all individuals in recovery. In consultation with DOC, there is a need for both individualized units and supportive congregate housing.
4. Easements will depend upon the other funding sources generally and their federal requirements.
5. Our emphasis is on locations near service HUB's where there are service providers for substance use disorders.

Town of Colchester

The housing outlined in their response was for housing the homeless during the COVID19 pandemic in hotels which impacted their emergency services. The Town of Colchester feels recovery housing would require a very high level of municipal services.

ACCD Actions Taken or Comments

Recovery Housing Program funding has come to the State of Vermont as a result of the Opioid Fatalities. The funding is to provide housing for individuals in recovery from substance use disorder. The housing will have mandated standards of drug-free, sober environment to support the individuals to stay in recovery and be active members of the community. The goal is for the individuals to move from transitional recovery housing to permanent stable housing.

Town of Shelburne

The housing outlined in their response below was for housing the homeless during the COVID19 pandemic in hotels which impacted their emergency services.

“Thanks for passing this along. Having given it a quick scan, my question is how and whether this all relates to the so-called temporary transitional housing that we have all been providing in what were previously tourism-related lodging establishments. It should be no secret that these locations have created skyrocketing numbers of calls for emergency services, exhausting our Police Department and Rescue Squad; and quite a few of these calls involve difficult circumstances and violence on a scale far beyond that which existed before this housing program. This is hardly limited to Shelburne; other area municipalities are experiencing similar, constant challenges.

Based on our experiences, we believe firmly that any existing or planned state programs for housing, recovery, or other similar matters must necessarily also include appropriate and necessary 24/7/365 oversight and management of these facilities and persons. These should not and cannot simply be left to municipalities to handle.”

ACCD Actions Taken or Comments

Recovery Housing Program funding has come to the State of Vermont as a result of the Opioid Fatalities. The funding is to provide housing for individuals in recovery from substance use disorder. The housing will have mandated standards of drug-free, sober environment to support the individuals to stay in recovery and be active members of the community. The goal is for the individuals to move from transitional recovery housing to permanent stable housing.

Town of Milton

The Plan’s eligible activities are reflective of the needs and appropriate strategic approaches to addressing the housing needs of those recovering from addiction. I support the Plan’s list of parallel socioeconomic characteristics that will be used to presumably identify Low and Moderate-Income-Limited Clientele. I am especially supportive of the incorporation of holistic service strategies into the

scoring system for projects because transportation, as one example, is important in a rural context to the viable effectiveness of a program serving this population.

Rural communities typically depend on neighboring regional nonprofit centers such as the Howard Center in Milton's local context, to assist those recovering from an addiction; and this makes transportation essential to accessing recovery services and other complementary services, particularly because there is limited public transit. Alternative transportation options also provide those recovering from an addiction with safe options to access services without risking encounters with law enforcement due to an expired driver's license or for other reasons.

The Federal 5311 program provides transportation services to LMI individuals, particularly the elderly, in order to access their doctor's appointments and other services. This program is particularly valuable in rural communities because of limited public transportation and because of the program's typical demand-response model. I wonder if a similar transportation model for those recovering from addiction specifically, could work as a holistic housing strategy in the future. Certainly, this plan leaves open enough room for such integrative housing projects to be considered.

ACCD Actions Taken or Comments

We recognize the challenges of transportation in a rural state such as Vermont. The Intervention, Treatment and Recovery Committee is currently discussing transportation issues for people in recovery and looking for ways to improve.

Vermont Legal Aid

See attached comments.

ACCD Actions Taken or Comments

1. Request for commitment to tenancy protections and Department of Corrections (DOC) involvement:
 - a. The RHP action plan was drafted in consultation with DOC, and with Theory of Change principles in mind. DOC has further communicated that part of the Theory of Change is to provide multiple options for those seeking care. The RHP plan was drafted to provide for congregate housing that caters to individuals in need of specific care, as well as for individual units. After consultation with providers, it was determined that this congregate housing needs the ability to protect residents and maintain safe and supportive housing by removing residents who violate the terms of their stay. To mitigate effects of removal, the RHP plan requires that all participating recovery residences must have a plan in place with at least one alternative housing option for residents to ensure safe transitional shelter is available to any resident being removed.
2. Request to prioritize scattered site rather than congregate residences.
 - a. RHP allows for both types of housing. The Towns listed in the report identified the areas with highest need at that point in time in the Housing; A Critical link to Recovery report. RHP is not excluding any location in the state. The RHP Action Plan goal is to develop units near service HUB areas. RHP is not putting any

permanent easement restrictions on the recovery housing units which may allow for alternative use in the future.

3. Discussion of H. 211:

- a. At this time H. 211 has not been passed. The latest action in the Vermont House of Representatives on February 9, 2021. Further, the RHP plan requires that all participating recovery residences must have a plan in place with at least one alternative housing option for residents to ensure safe transitional shelter is available to any resident being removed.

St. Johnsbury Housing Committee

See attached comments.

ACCD Actions Taken or Comments

The RHP Action Plan goal is to develop units near service HUB areas. RHP is not putting any permanent easement restrictions on the recovery housing units, which would allow for future alternative use. RHP allows for both congregate housing and individual units to be developed. ACCD acknowledges the need for more affordable housing across Vermont. The RHP budget is limited and as such is concentrated on helping a particular group in need, versus generally addressing affordability.

Robert A. Oeser

See comments attached.

ACCD Actions Taken or Comments

The RHP action plan was drafted in consultation with DOC, and with Theory of Change principles in mind. DOC has further communicated that part of the Theory of Change is to provide multiple options for those seeking care. The RHP plan was drafted to provide for congregate housing that caters to individuals in need of specific care, as well as for individual units, to support a diversity of housing options. The RHP plan requires that all participating recovery residences must have a plan in place with at least one alternative housing option for residents to ensure safe transitional shelter is available to any resident being removed.

John S. Rogers

My name is John Rogers and I'm a member of the community in Bennington County. I run a 12-step program in Bennington (Celebrate Recovery, Bennington), sit on the local CoC, represent the county on the Vermont Coalition to End Homelessness and recently joined the board at VFor. I'm in longterm recovery and have been active in the recovery community in our small corner of the state. I know the former Executive Director at DownStreet and appreciate the study that was conducted in 2019 attempting to identify the need across the state. While I

agree with most of what is proposed in the study I do think the 2015-16 SAMSHA used to project the number of beds needed is out of date and feel skipping Bennington County as a place that needs Recovery Residence support is an oversight. From my analysis (attached) we are in need of 45-50 beds in Bennington County. Your draft action plan looks solid, the only correction I would have is to broad the geographic scope of the goal to include Bennington. Take a look at the attached we are getting some good traction in the community around Recovery Housing and with the necessary funding should be in a position to open two residences (1 men and 1 women/women w/kids) in 2022.

Thanks for the consideration.

ACCD Actions Taken or Comments

The Towns listed in the report identified the areas with highest need at that point in time in the Housing; A Critical link to Recovery report. RHP is not excluding any location in the state and is currently working with the Town of Bennington on two potential RHP projects.

Mike Cammock and I run River Valley Property Management, LLC

Good Afternoon Cindy,

My name is Mike Cammock and I run River Valley Property Management, LLC in Windsor, Vermont. I was just copied on an email relating to RHP funds for transitional housing programs in the State of Vermont.

I would be interested in talking with you more about what you are needing.

One of the properties we manage is a beautiful Vermont Inn that the owners are looking to stop operating as an Inn (mostly due to COVID-19). The primary goal has been to sell the property, but I would interested in finding out more about your program, as transitional housing could be a very productive use for this sort of property.

The property can be seen at www.snapdragoninn.com and is a beautiful heritage property. It is about 15 mins walk from Ascutney hospital (literally 2 mins drive).

I would be interested in finding out more about what you are needing in terms of transitional housing resources to see if this property could play a role.

Cheers,

ACCD Actions Taken or Comments

Referred Mike Cammock to VTARR and VFOR for additional action.

Tony Redington

See attached

ACCD Actions Taken or Comments

No comments.

Lila Bennett with Journey to Recovery Center in Newport

Reached out to us to discuss the need for Social Detox Housing in her area as well as the need for recovery housing.

ACCD Actions Taken or Comments

VCDP staff met with Lila to go over the Recovery Housing Program and coordinated a connection with VTARR and VFOR.

Partner Coordination

Since this was a new realm for DHCD, DHCD initially reached out to the Agency of Human Services (ADAP, DOC) and Downstreet to discuss their current programs and initiatives for transitional housing for persons that are recovering from substance use disorder.

VCDP staff also reached out to the Continuum of Care Program, Emergency Solutions program and HUD-VASH.

DHCD staff met with Vermont's affiliate of National Alliance for Recovery Residences (VTARR), Vermont Foundation on Recovery, Vermont CARES, to learn about their organization's and what their role is in recovery of substance use disorders.

DHCD staff met with the liaison from the Department of Health that coordinates the Governor's Substance Misuse Prevention and Oversight and Advisory Council (SMPC) to gain information on what that council is working on to assist with recovery of substance use disorders. The liaison for SMPC invited DHCD Staff to join the Intervention, Treatment, and Recovery Committee (ITR) monthly meetings that meets with SUD service providers, recovery residences providers, recovery advocacy groups, harm reduction programs, state agencies to look at the four priorities area identified by ITR as issues for persons in recovery 1) Housing, 2) Transportation, 3) Employment and 4) Residential Treatment. ITR will also be discussing cross cutting issues for persons in recovery such as access, childcare, communication, connection, COVID 19 and Stigma to address each priority identified.

DHCD staff communicated with Vermont Housing and Conservation Board (VHCB) staff regarding the use of HOPWA funds and how that program population is impacted by SUD. Vermont receives HOPWA awards every three years. The last award was in 2020 and was for \$1.4 million for the period of March 1, 2021 – February 28, 2024. About \$475,000 of the funding is expended per year. Vermont's state-wide competitive HOPWA award is administered through 4 partner organizations: VSHA and three AIDS Service Organizations (ASO's) – Vermont CARES, AIDS Project of Southern Vermont, and HIV/HRC Resource Center. VSHA administers approximately 30 tenant-based vouchers for low-income people

with AIDS/HIV. The ASO's deliver HOPWA services in 3 categories: 1) Emergency Assistance to remain appropriately housed, including payments for mortgage, rent or utilities; 2) Permanent Housing Placement – provides assistance to clients with first month's rent and security deposits to allow them to obtain housing; and 3) Supportive Services – providing housing and other counseling to clients to help them remain appropriately housed. Although it is an eligible activity, Vermont does not utilize our HOPWA grant for permanent supportive housing or other housing development.

DHCD considered resources provided by the Agency of Human Services (OEO, DOC, ADAP), Downstreet, Substance Abuse and Mental Health Services Administration (SAMSHA's), Vermont affiliate of National Alliance for Recovery Residences and H.783 Bill currently before Vermont's General Assembly.

Monitoring

RHP Action Plan must follow ***State Bulletin #5 Policy for Grant Issuance and Monitoring*** which incorporates the provisions of the new "Uniform Guidance" issued by OMB.

RHP will take a risk-based monitoring approach that is based on such factors as size of award; first time receiving an award; complexity of project; staff turnover; past performance; outstanding or delinquent reports from other Programs; and one or more audit findings/internal control issues regarding program performance or compliance.

All grantees are monitored on a regular basis in accordance with program specific guidelines, as well as state and federal regulations. Monitoring of all programs includes desk review of requisitions and supporting back-up documentation; review of program reports; and audit reports. RHP monitoring will also include onsite reviews to interview program and administrative staff; and conduct onsite construction inspections, as permitted with COVID, or virtual monitoring will be conducted.

All grantees shall ensure adequate Subrecipient Oversight Monitoring per the Uniform Guidance using the Subgrantee Financial Monitoring Worksheet that will be an award condition. Only a Municipal staff person can complete and be responsible for the subrecipient monitoring. All Subrecipients will complete a Subgrantee Financial Monitoring Worksheet that complies with Subrecipient Monitoring per the Uniform Guidance and upload the documentation to the Agency's on-line grants management system (GEARS).

Pre-Award/Pre-Agreement Costs

Grants Management conducts a Pre-Award Eligibility Determination and Risk Assessments on a project prior to an award to ensure no award is made to an ineligible organization and to mitigate any high-risk awards through special conditions in grant agreements and monitoring and reporting.

RHP funds can only pay for pre-award/pre-agreement costs of a project providing the environmental release has been issued for the project.

The Agency has been tracking expenditures for pre-award costs back to December 2, 2020, which correlates to an estimate of \$700,000 in pre-award costs at the time of receipt of a Grant Agreement from HUD. \$7,002 of the cost is for general administration and environmental review. The Agency intends on funding \$692,760 from FY20 and \$7,240 from FY21 to the following two projects:

City of Barre – Barre Recovery Residence

\$500,000 of RHP funding will be granted to the City of Barre to be subgranted to Down Street Housing & Community Development for the purchase and rehabilitation of a historic building located at 31 Keith Ave, Barre, VT 05641. The building will be renovated into a transitional Recovery Housing residence that will serve women and women with families – many of whom have experienced domestic violence and are currently experiencing homelessness. The building will include 3 family units – two single person apartments and one group housing unit which can hold up to 4 families. There will be 6 direct beneficiaries at or below 50% AMI. Downstreet has partnered with Vermont Foundation of Recovery (VFOR) to staff and operate the program.

Town of Johnson – Jenna’s Promise

\$200,000 in RHP funding will be granted to the Town of Johnson to be subgranted to Jenna's Promise LLC for the rehabilitation and revitalization of a vacant building in downtown Johnson to be turned into a coffee shop and supportive housing for people in recovery from substance use disorder. The project also includes \$300,000 of CDBG funding. The coffee shop will be located on the lower level of the building with the housing on the upper level. The project, Jenna’s Sober Living, will run one building as essentially a Level I facility; it will be run with house rules and drug screening. Six bedrooms will house up to eight women in recovery, maintaining full occupancy of eight LMI individuals (women) over 5 years with turnover as needed. Income level projections are based on the likely income of those participating in recovery. Tenants will complete income surveys.

Program Income

If any Program Income is generated by a program served with RHP funds, all the generated program income received must be returned to the municipality and the municipality must return the program income funds to ACCD. ACCD will transfer any program income generated from a RHP grant to another open RHP grant. If all other RHP grants are closed it will be part of ACCD’s regular CDBG program income and will be subject to regular CDBG program rules. Revolving Loan Funds are prohibited.

424 and 424D Forms

Appendix A - Housing: A Critical Link to Recovery, An Assessment of the Need for Recovery Residences In Vermont

Appendix B - Current Legislation undergoing review – H.211 to support individuals in recovery with a substance use disorder

June 11, 2021

Cindy Blondin
Grants Management Analyst
Vermont DHCD
1 National Life Drive,
Davis Building, 6th Floor,
Montpelier, VT 05620

RE: Vermont Legal Aid Comments on Recovery Housing Program Action Plan

Thank you for the opportunity to comment on the Recovery Housing Program Action Plan. The creation of additional housing for Vermonters with substance use disorders is direly needed. Vermont Legal Aid applauds the Department of Housing and Community Development for securing this federal funding. We are encouraged that the federal government is explicitly seeking projects that “provide *stable*, temporary housing to individuals in recovery from a substance use disorder.” Federal Register Notice No. FR-6225-N-01, *Italics added*. Vermont Legal Aid has two main recommendations: wherever possible, this plan should more explicitly prioritize projects that demonstrate a housing-first approach, including a commitment to tenancy protections that prevent immediate evictions, and a commitment to responding to tenancy issues with harm reduction and restorative justice practices. We also recommend that to the maximum extent possible, this plan prioritize non-congregate housing projects. Finally, while more a comment than a recommendation, Vermont Legal Aid does not support H. 211 as drafted because it would remove eviction protections for Vermont tenants living in recovery residences, which does not further stability for these vulnerable tenants.

I. The Recovery Residence Context

Historically, in Vermont and across the United States, housing designated for people with substance use disorders has been under-regulated and unstable for tenants. Through the Justice Reinvestment II process¹, Vermont’s own administration acknowledged that Department of Corrections (DOC)-contracted recovery homes were routinely terminating the tenancies of Vermonters under supervision with little process and minimal advance notice, resulting in immediate reincarceration.² This exacerbated tenants’ mental health and substance use disorders; it was disruptive and traumatic for tenants and expensive and counterproductive for the state. Fortunately, it is also entirely avoidable with a simple policy shift. These findings

¹ <https://csgjusticecenter.org/2020/07/16/explainer-the-significance-of-vermonts-justice-reinvestment-legislation/>

² “Baker said many of the congregate housing facilities operate as a ‘sober house’ and dismiss people from the program who are found to have used drugs or alcohol, and as a result a released offender is out of housing and sent back to jail.” <https://vtdigger.org/2021/05/24/corrections-makes-shift-in-transitional-housing-catches-lawmakers-off-guard/>.

prompted DOC to restructure its transitional housing program, now premised on their Theory of Change³, cited in this Recovery Housing Program Action Plan.

Vermont Legal Aid agrees that DOC oversight of and assistance with the application process for the Recovery Housing Program Plan is necessary; DOC has decades of experience with recovery housing and just completed an investigation about the connection between housing practices, substance use disorder recovery and relapse, and recidivism. DOC has maintained that the Housing First philosophy is the most evidence-based model. While Housing First is a philosophy typically associated with permanent housing programs, the practices and methods used are applicable and appropriate for transitional housing as well.⁴

There is a lot to learn from DOC's findings that are directly applicable to the RHP. Vermont Legal Aid encourages DHCD to follow DOC's lead and prioritize projects that employ trauma-informed, housing first, harm reduction and restorative justice housing practices. These are the gold standard practices for working with marginalized people who are in recovery from substance use disorder. Vermont's administration and housing policies should be consistent across departments, and the important lessons DOC learned are directly applicable here.

- i. *Require applicants to demonstrate that their projects will maintain tenancy protections, pursuant to Vermont landlord-tenant law, and are committed to employing best-practice harm reduction and restorative justice responses to tenancy issues.*

Eviction is destabilizing. It exacerbates underlying mental health and medical conditions, it has deleterious impacts on employment and education, and its effects reverberate for years.⁵ It is also costly for a local and state system that necessarily will pick up the pieces. Tenancy protections from sudden eviction create more stability for tenants and avoid these costly results. The inverse is also true: housing programs that do not protect against eviction—and that permit sudden eviction—are inherently destabilizing for tenants, especially tenants who are socially, economically, and medically vulnerable.

Vermont Legal Aid first recommends that DHCD amend the RHP Action Plan to clarify that all grantees must retain basic tenancy protections that currently apply to recovery home tenants under Vermont law. Specifically, this plan should clarify that all recovery residence tenants do—and will continue to have—eviction protections that include sufficient notice that their lease will terminate, and all other basic due process protections afforded to every other tenant in Vermont.

To do this, DHCD can embed this requirement into the scoring criterion of new projects and should require each grantee to provide a model lease agreement that is compliant with current

³https://doc.vermont.gov/sites/correct/files/documents/Restorative_Justice/Transitional_Housing/Theory%20of%20Change.pdf

⁴ See, generally: <https://www.usich.gov/news/four-clarifications-about-housing-first/>

⁵ <https://www.healthaffairs.org/doi/10.1377/hpb20180313.396577/full/>

landlord-tenant law. Relatedly, the plan should require—or prioritize—grantees who demonstrate a commitment to resolving substance use-related tenancy issues with harm reduction interventions and other tenancy issues with restorative justice measures.

Brief explanation: Tenants who have substance use disorders are some of the *most* vulnerable Vermont tenants and are most in need of housing protections provided under Vermont law. Vermonters with SUD have very high rates of housing instability. As the 2019 Downstreet Housing Report (Appendix A) stated, “[h]ousing instability represents one of the greatest external hurdles to a recovery that is already inherently difficult.” See, Appendix A, HOUSING: A CRITICAL LINK TO RECOVERY: An Assessment of the Need for RECOVERY RESIDENCES In Vermont, at i. Housing instability that *jeopardizes recovery*—the survey found— is a significant issue for at least *one third* of people receiving treatment. *Id.*, at vii. That report also highlights that 75% of Vermonters in treatment are Medicaid eligible, indicating that this group is made up of some of the lowest income Vermonters. *Id.* That report continued “the reality is that those in greatest need for these Recovery Residences 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.”

The threat of eviction—or actual termination of tenancy—is inherently more difficult for this population to navigate because they are some of the least-resourced Vermonters.⁶ There should be explicit requirement that Vermont landlord-tenant law will apply to these projects.

ii. Prioritize RHP projects that are scattered site rather than congregate.

From the Fair Housing perspective,⁷ scattered site housing for people with substance use disorders is preferable to congregate settings. First, and as a practical matter, Vermont Legal Aid’s experience is that zoning scattered site apartments is accomplished more expeditiously than zoning a larger, congregate recovery residence building. Second, congregating one group of people who belong to a protected class—here people with a disability, substance use disorder—can effectively segregate this group, which puts congregate housing projects at greater risk of running afoul of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. People with disabilities must be provided services in the most integrated setting. See generally, *Olmstead v. L.C.*, 527 U.S. 581 (1999). As explained by the *Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C.*: the “[m]ost integrated setting” is defined as “a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest

⁶ Additionally, Vermont’s vacancy rate is so low, that even people who are evicted through the normal court process will be evicted into homelessness, especially tenants with lower incomes, imperfect credit, and co-occurring disorders.

⁷ Vermont’s own DOC has found that from a treatment and recidivism perspective, scattered site, housing-first model is the gold standard for housing individuals with substance use disorders who are coming out of incarceration.

extent possible.”⁸ Vermonters with substance use disorders can and should live among our community to the greatest extent possible, and scattered site housing would achieve that goal.

The RHP draft action plan seems to favor a recovery housing model, and has already promised funds to two traditional RR projects. But in the study cited in Appendix A, only 25% of respondents in the treatment providers survey thought that creation of more recovery housing was the solution to housing problems. More built housing with services that can meet the needs of this population is necessary, but this does not have to be done in a congregate setting premised on the recovery home model. Furthermore, the Downstreet Study includes a recommendation in its “Conditions of Success” section that any housing created should be flexible enough to be used for another purpose later.⁹ Scattered site housing for Vermonters with substance use disorder is a model that is flexible enough to be used later by another population struggling to obtain housing in the private market without supports. We encourage the prioritization of support for scattered site programs.

iii. Vermont Legal Aid does not support H. 211 as drafted because it would permit immediate eviction, which is destabilizing to this vulnerable group of tenants.

Vermont Legal Aid does not support H. 211 as drafted, which was cited in the RHP action plan as Appendix B. Vermont Legal Aid testified about this bill in House General Committee in 2021, explaining that the current version will not achieve the laudable goals set out in Section 1 (“to support individuals with substance use disorder who are in recovery; to reduce homelessness, trafficking, incarceration, and fatal drug overdoses caused by the disease”).

Our chief concern is that, as drafted, Section 3 of H. 211 exempts recovery residences from the eviction provisions in Vermont landlord-tenant law. If passed, the eviction protections afforded to every other Vermont tenant would cease to apply to Vermonters with substance use disorders living in recovery residences. Instead, these tenants could be removed from recovery residences, *immediately*, with no recourse to court. This group needs more, not fewer, protections.

To mitigate the dangers inherent in removing eviction protections for this population would require first that Vermont develop and implement a robust, state-wide “safety net” that would require all recovery homes to have a safe, designated place for tenants who have relapsed to go if they need to leave the recovery home for a period. Section 5 of H. 211, as drafted, creates a study committee to study Vermont’s safety net (called recovery stabilization programs) for

⁸ https://www.ada.gov/olmstead/q&a_olmstead.htm#_ftnref6, explaining the interpretation and enforcement of the Olmstead decision.

⁹ HOUSING: A CRITICAL LINK TO RECOVERY: An Assessment of the Need for RECOVERY RESIDENCES In Vermont, at ii: “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.*”

people who relapse but who the recovery residence believes should go elsewhere until they have stopped using.

The stakeholder group working on this bill all agrees that currently there is no robust, state-wide safety net. It needs to be built and coordinated. Vermont Legal Aid does not support the passage of Section 3 of this bill until and unless a recovery stabilization program is in place, and even then we do not believe exemption from the eviction process is necessary or helpful.

Thank you for your time and consideration of these comments. I am happy to answer any questions or discuss further. I can be reached at 802-383-2225 and mcoreilly@vtlegalaid.org.

Sincerely,

/s/

Mairead C. O'Reilly

Please consider these comments in response to the [Vermont DRAFT Recovery Housing Program Action Plan](#). While many of these comments are anecdotal in nature, it is hoped that they provide some guidance and insight. Principally, I think it important to emphasize that:

Greater coordination among state agencies and localities needs to be given priority; and,

More robust and comprehensive support needs to be provided in an accessible way to those who are marginalized, in need of housing and services and to those individuals that try to respond to those needs.

- It is stated that AHS-DoC “is changing their support of congregate transitional housing to a Housing First Model which supports private and community integrated individualized apartment units for serving individuals leaving incarceration.” On paper this may seem a worthy goal, because it envisions independent living and being able to access the support services that are wanted and needed. ["Corrections makes shift in transitional housing, catches lawmakers off guard."](#) Alan J. Keays, *VT Digger*, May 24 2021
 - However, a community member who has volunteered at a community apartment housing site with services, provided this recent observation: “The growth of the community at [the permanent supportive housing apartment site] was ... tentative, at best. There was inadequate staffing for the kinds of needs people had. And the pandemic led to a huge breakdown for the residents and a feeling of utter abandonment.”
- It is hoped that the move toward supportive housing will not be analogous to the mental health deinstitutionalization model of the 1960's.
 - [Whatever Happened to Community Mental Health?](#) "Because 'service follows the dollar,' and discriminatory insurance coverage was and continues to be a major obstacle to the success of community-based approaches, outpatient care remains fiscally problematic." p. 618
- Recovery houses might consider voluntarily adopting some of the provisions of H.211, introduced in 2021, [An act relating to recovery residences](#), particularly, “the identification of a verified location where the tenant may be housed in the event of temporary removal, including at least one alternative housing option.” A minor rules infraction should not result in homelessness or jail, but the infraction might still need to be assessed and addressed. Alternatively, these provisions could be incorporated into RFP's going forward.
- Windham Superior Court Judge Michael Kainen noted a landlord who was taken to task for housing code violations is “a landlord of last resort. Many of the people he is renting to are people who just got out of jail, people with significant mental health issues, people with substance abuse issues, people who would not have housing if not for Mr. Hunter's

properties.” [‘Landlord is no-show in Superior Court.’](#) by Bob Audette, *Brattleboro Reformer*, March 5, 2020.

- A landlord, who strives to provide marginalized individuals with housing, complains that local mental health service providers and community corrections professionals are by and large **not** responsive to calls for assistance. A recovery residence administrator comments on that observation by noting that those providers are extremely limited in what they can do.
 - Recalling incidents at food pantries:
 - An individual was yelling incoherently, remaining in the curtilage, having been previously trespassed. Speaking later with the investigating police officer, the consensus was that this “wasn’t the crime of the century,” but when a call is received, one needs to do “something.”
 - Another time, an attendee, found to be trespassing, after hours, was discovered to be the subject of two pending cases. The Deputy State’s Attorney did not recall the charges; he asked our help to get him to court as the intent was to have him seen by a psychiatrist. My notes at the time stated that the attorney “threw up his hands and said he had so many folks at loose ends, without resources, including victims.”
 - An individual previously living in a town park, through extraordinary intervention, relocated to a hotel room, albeit only temporarily. [“Cleaning up the Common.”](#) March 12, 2021, *Brattleboro Reformer*.
- One bright note is that [Project CARE](#) tries to fill the gaps. The underlying admission is that there are gaps and they are not easy to fill. [Rocky Mountain Crisis Partners](#) might be a similar model worth investigating. Can towns be expected to *adequately* finance and staff such endeavors without assistance?
- In one local police department, Welfare Checks make up between 4.8 to 5.5% of all calls to dispatch. [Brattleboro Community Safety Review Final Report](#), 12/31/2020, p. 94
- A police agency’s supervisor’s manual states with respect to “Mental Health Welfare Checks”: “If the request is simply for a check of one of their clients, the request should be denied on the basis that [the community mental health center (CMHC)] is better equipped to assess and treat MH problems than police are. If [CMHC] requests that police accompany them to a check based on specifically articulated safety concerns, we will honor that request. It is recommended officers wait for [CMHC] to arrive before contacting the subject unless there is clear urgency.”

- There needs to be much better Inter-agency cooperation. The report discussed co-occurring disorders: "To be effective for the individual in recovery, the dual conditions should be treated at the same time." However, services are separately funded and administered through ADAP, part of DoH and alternatively, by DMH. Despite grants of state Mental Health funding in 2019 and 2020, the Brattleboro Retreat stopped providing a Medication Assisted Treatment program, part of the Hub & Spoke model, 'transferring' these services to a private for-profit entity, Habit OpCo.
 - "I've also seen a lack of services in the Brattleboro community. Because of the pandemic, we don't have outpatient programs for people to attend. There's only one more alternative for people who have substance-use disorder, and that's to go back out, unfortunately. So we have seen a[n] increase in those numbers. "And after the closing of different programs at the Brattleboro Retreat, we have seen an increase in visits to the emergency department." ['Before recovery. I never lived'](#), *Commons*, Feb 10, 2021.
- While the need for housing in Windham Co is great; [the overall vacancy rate for rental housing is 0.5%](#), the capacity of existing organizations to take on additional projects, even with additional funding, has been called into question by those who have more in depth knowledge than I have.
- To make matters worse, once the state of emergency comes to an end and along with it the temporary respite of hotel rooms providing emergency housing, an acute emergency need for housing will immediately become evident. There are opportunity costs.
 - In October 2019, I was involved with a Source to the Sea cleanup of an area in town used for camping by people who were without homes. One of the residents that I knew helped us by keeping the crew oriented to the areas needing attention. Afterwards, I reported to a worker at a homeless advocacy group and received this reply: Both Green Up Day and Source to the Sea "did not even touch the amount of clean up needed. [We] paid clients to remove 70-80 trash bags out of there before the summer and then continually coordinated w the town around trash pick up all the way until the first snow. I personally have picked up so many garbage backs [sic] from there and have returned w more to empty them. There's no doubt we will need to do the same again this year."
 - It has since been determined that that location is not an adequate site for camping and alternatives are actively being sought.
- The only word of hope I can end with is a lesson that perhaps was learned when local agencies' responded to the pandemic: "It wasn't about how patients access care, it was about how care can access patients." "[Response to pandemic 'truly humbling'](#)," June 5, 2021, *Brattleboro Reformer*.

s/ Robert A. Oeser June 11, 2021

The St. Johnsbury Housing Committee was formed following a 2015 Council on Rural Development set of Community Visits in St. Johnsbury. One of the five priorities was to look at housing as a force of economic development. Many people participated in the initial conversations around housing and interested residents looked at various models in other Vermont communities. As a result, we commissioned a housing needs assessment in December of 2016. This needs assessment studied market conditions, projected changes and influencers to future housing needs. The goals were to better understand the Town's evolving housing market, modify or expand Town housing policies, and enhance and/or expand the Town's housing market to meet current and future housing needs. (Bowen National Research, 2016). In particular, and related to the Recovery Housing Program's goals, this statement of need comes from their research:

“Special Needs Housing (II-8) – While many special needs groups were evaluated in the market and each, to some degree, had insufficient housing to meet the needs of these groups, it was determined that the greatest need appears to be for persons with disabilities, adults with mental illness, victims of domestic violence and persons experiencing substance abuse issues. Housing policies and priorities should consider some level of implementation of the development of housing that serves these special needs populations, as well as others.”

The Housing committee has the following comments which connect with our purpose and reflect the issues pertinent to St. Johnsbury. Concerning the goals of Vermont's Recovery Housing Program:

1. Levels 1, 2, & 3 Recovery Residences certified by VTARR.
 - a. The Committee understands that this is a fairly recent certification and support the work of VTARR in the benchmarks and standards that have been developed.
2. Individualized Units that meet AHS-DOC standards.
 - a. The DOC standards are geared toward more individualized needs and specify consideration of the “Theory of Change” in all housing models. The Community Restorative Justice Center Director is a member of this committee and recently received the grant to work with DOC in the implementation of these standards.
 - b. Page ix of the needs assessment (3rd paragraph) notes the financial risk associated with a substantial renovation of a single-family home to convert it to a recovery residence. The strategy of modifying the RR model to allow separate apartments within existing multi-family buildings is noted in bullet 6 on this page. This strategy would also address the need for improved rental housing in town across the board, and if the units no longer functioned as RRs, they would be open to any tenant without the need for modification. This committee would like to voice support for individualized units that meet individualized needs rather than a formula for congregate facilities and suggest the scoring criteria on page 16 of the Action Plan reflect this.
 - c. It is very difficult to convert these properties to a new use if program funding is discontinued. The need is great and the recommendation to move away from congregate facilities to more individual units is easier for a developer to adapt.
3. Creation of Recovery Residences in service HUB areas where none exist.
 - a. This is agreeable to the committee as long as public transportation is also available.
 - b. The Housing Committee would like to suggest that the placement of any new RRs take into consideration the context of the neighborhood to avoid exacerbating concentrations of poverty, and have this policy reflected in the scoring criteria. Although page 29 of the needs assessment highlights the financial benefit of developing new RRs in depressed areas based on the cost savings of acquiring or leasing housing in low-income districts, this practice may further concentrate poverty in downtown neighborhoods and may be at odds with the St. Johnsbury Housing Committee's objective to raise the value of rental properties to increase developer confidence in building additional high-quality market rate units in the downtown.
4. Recovery Residences with priority given to parents with children.
 - a. Many families are housed in local motels when housing options are not available.
 - b. The table on page 25 of Development Cycles needs assessment (Appendix A of the Action Plan) lists only 6 recovery residence beds for men in St. Johnsbury and none for women. In addition to the Recovery

Residence on Elm Street, the Covered Bridge provides recovery services (Christian centered) and the newly opened FIRST House (Families in recovery staying together) on Railroad Street is currently seeking applicants. This house provides four rooms and services for women who have completed rehabilitation and are expecting or reuniting with their children is not currently listed. It has project-based rental assistance for all four units so that when someone moves from the program after spending at least a year there (occupancy is anticipated to run 18 months to two years), they will be able to take with them a rental subsidy voucher.

5. Recovery Residences that include programs that have wrap around services for long-term recovery that are onsite or in the vicinity of the home.
 - a. St. Johnsbury's VFOR house does work closely with the Kingdom Recovery Center.
6. Individuals will transition to permanent independent housing within two years of entry to the Recovery Residences.
 - a. Although we recognize that people need self-motivation in order to accomplish this, the housing committee acknowledges that we have identified the need for more diversity in our housing stock. Providing options in the community is achieved through collaboration of many agencies and the town.
 - b. Page 24 of the needs assessment notes that affordability of housing for residents in recovery was a more significant problem than the gap in housing services. The payment of lease, rent and utilities to LMI residents in recovery is an eligible activity for grant funding listed on page 14, provided it doesn't exceed two years, after which the resident is expected to find permanent housing. Based on this information the housing committee would like to suggest the scoring criteria give greater weight to increased payment assistance to residents of existing recovery residences.
 - c. The creation of additional high-quality rental units, accompanied by increased access to housing choice vouchers for income-eligible tenants, would serve both the St. Johnsbury Housing Committee's objective to increase the quantity and quality of rental units and the need expressed in the study for affordable and appropriate housing options for those transitioning to permanent housing. While the criteria on page 15 states that the project must serve Low- and Moderate- Income Limited Clientele, it is unclear how long the units created/renovated must be income-restricted. The Housing Committee recommends against the placement of permanent easements on new or renovated RR housing units that restrict the income of tenants in perpetuity, and support better access to Housing Choice vouchers which should be able to be used in any market-rate rental unit in accordance with Vermont's fair housing provisions (9 V.S.A. § 4503).

From: [TONY Redington](#)
To: [Blondin, Cindy](#)
Subject: \$1.5 Million Housing Plan
Date: Saturday, May 29, 2021 8:40:35 AM

EXTERNAL SENDER: Do not open attachments or click on links unless you recognize and trust the sender.

Good Day:

Thank you for the opportunity to comment on the Plan for use of federal recovery funds received by Vermont.

This opportunity to comment was provided by a VHFA tweet in the last day.

First and foremost as anyone knows who even takes a cursory look at Vermont governmental activity in the area of housing, there is no comprehensive housing plan and the pandemic has held up a Agency of Human Services doing even a plan for older Vermonters. The housing "problem" is summed by the Center for Budget Priorities as a need for an additional 16,000 fed type "affordable housing assistance" (shelter security at 30% income max rent) for Vermont (not including homeowners and mobile homes on rental sites) with 14,000 units in place serving on in five renters.

Vermont so-called "affordable housing" (tax credit non-profit and Burlington "inclusionary zoning") is best described in the annual HUD report of tax credit housing where 24% of households pay in excess of 30% of income and 6% pay over half their income for rent.

So, no plan for Vermont and a need which is clearly not addressed. The use of any public for funds for homeownership makes no sense while the 1,000 households, for example, sit on the Burlington Housing Authority waitlist, for example.

New York City's City Council remarkably this week passed a veto proof budget with 6%--for the first time--set for affordable fed type Section 8 assistance vouchers (30% income max rent). There really are no such City budgeted units like this today! Vermont and BTV also do zilch here while doing "pretend" short term treatments, sort of like having an emergency room of housing with no wards for longer term treatment. If Burlington employed 6% of their general fund for fed type vouchers it would create about 600 vouchers, end homelessness overnight and address a good chunk of our Housing Authority waitlist. It is also time for Vermont state government to stand up and act like an adult in the room.

The 30% requirement for a household income needs to be dropped to 25% as it was until the Reagan administration--30% is frankly confiscatory and exploitive of the lower income classes.

The entire are of providing transitional assistance where there is no promise of longer term assistance is in itself cruel and unusual aid--depressing to those who administer the funds and those who received them. We must--as then Sen. Harris' Rent Relief Act called for--make Section 8 type aid as universal and not dependent on the drugs you do or do not consume. Drug addiction is a health issue not a housing issue.

Finally I would refer you to Mathew Desmond's book "Eviction" and particularly the 60 or so pages of notes which comprise a graduate course in housing policy--and note that he like

myself subscribe to universal vouchers--when we reach that point the behavior issues can be handed off where they belong--in the human services and health fields!

Thank you for the opportunity to comment and this program design--it is not a plan. There is no housing plan for Vermont or the City of Burlington. That must also be addressed!

Yours truly,

Tony Redington
125 Saint Paul St Apt 3-03
Burlington, VT 05401

--

What can you do?

Sign the **Stop the Champlain Parkway Project and Choose the Champlain RIGHTway Petition:**

<http://chng.it/tS9Ts5FjDx> SafeStreetsBurlington.com

HOUSING: A CRITICAL LINK TO RECOVERY

An Assessment of the Need for RECOVERY RESIDENCES In Vermont



Prepared by
John Ryan, Principal
DEVELOPMENT CYCLES
East Montpelier, VT

Prepared for
DOWNSTREET HOUSING & COMMUNITY DEVELOPMENT
With Funding from the Vermont Housing & Conservation Board

February 2019

ACKNOWLEDGEMENTS

The author would like to express appreciation to all of those who helped make this assessment possible.

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.

TABLE OF CONTENTS

Executive Summary.....	i
I. Introduction.....	1
1. Purpose of Study.....	1
2. Scope of Work.....	1
3. Methodology.....	1
4. Certifications & Limitations.....	2
5. Introducing the Recovery Residences Concept.....	3
II. Estimating the Scale of Recovery Residences Need in Vermont.....	6
1. Use Rates for Alcohol and Illicit Drugs.....	6
2. Substance Use Disorders.....	6
3. Persons Needing but Not Receiving Treatment.....	8
4. Trends in Substance Use Disorder.....	9
5. Referral to Treatment.....	10
6. Vermonters Currently Receiving Treatment for SUDs.....	11
7. Housing Status of Those Receiving Treatment.....	16
8. Capacity to Afford Housing.....	17
9. Housing as an Impediment to Recovery.....	18
10. Readiness for Residence in a Recovery Residence.....	19
III. Existing Recovery Residences in Vermont.....	20
IV. Estimate of Housing Gap.....	23
1. Overall Recovery Residences Gap Statewide.....	23
2. Recovery Residences Need at the Hub Community Level.....	25
V. Housing Availability in the Hub Communities.....	28
VI. Challenges, Recommendations & Conditions for Success.....	30
1. Challenges.....	30
2. Recommendations.....	32
3. Conditions for Success.....	32
APPENDICES	
Appendix A. Persons Interviewed for Recovery Residences Assessment.....	34
Appendix B. More Details about the Recovery Residences Concept.....	35
Appendix C. Additional Data on Recovery Residences Need.....	42
Appendix D. Recovery Residences Conditions Profile, Hub Communities.....	50

LIST OF FIGURES & TABLES

I.1	Vermont's Treatment Hubs.....	4
II.1	Substance Use Rates by Substance, 2016-2017.....	6
II.2	Substance Use Disorder Among Persons 12 Years & Over, Vermont & US, 2010-2011 & 2016-2017, By Alcohol & Illicit Drug Dependence.....	7
II.3	Substance Use Disorder Among Persons 12 Years & Older, Vermont & US, 2010-2011 & 2016-2017, By Age.....	7
II.4	Persons Needing But Not Receiving Treatment For A SUD, Vermont & US, 2010-2011 & 2016-2017, By Age.....	8
II.5	Where The Need For Treatment Gets Identified, Vermont, 2015.....	10
II.6	Persons Receiving Treatment for Substance Use Disorder by Substance, Vermont, 2000-01 & 2016-17.....	11
II.7	Persons Receiving Treatment for Heroin or Other Opioids, Vermont, 2001 & 2017.....	12
II.8	Men Receiving Treatment For Substance Use Disorder By Primary Substance, Vermont, 2001 & 2017.....	13
II.9	Women Receiving Treatment For Substance Use Disorder By Primary Substance, Vermont, 2001 & 2017.....	14
II.10	Persons Receiving Treatment For Substance Use Disorder By Primary Substance, Vermont Counties, 2017.....	15
II.11	Housing Status Of Persons In Treatment For SUD By Status At Admission To Treatment, Vermont, 2001-2017.....	16
II.12	Homelessness By Primary Substance of Abuse At Time Of Admission To Treatment, Vermont, 2001-2017.....	17
II.13	Source of Payment For Persons In Treatment For SUDS, Vermont, 2017.....	18
III.1	Hub Communities & Existing Recovery Residences in Vermont.....	22
IV.1	New Admissions to Substance Use Disorder Treatment, By County & By Men, Women, & Women With Dependent Children, 2017.....	25
IV.2	Estimated Need For Additional Six-Person Recovery Residences By HUB Community, 2019.....	26

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 hubs¹ 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

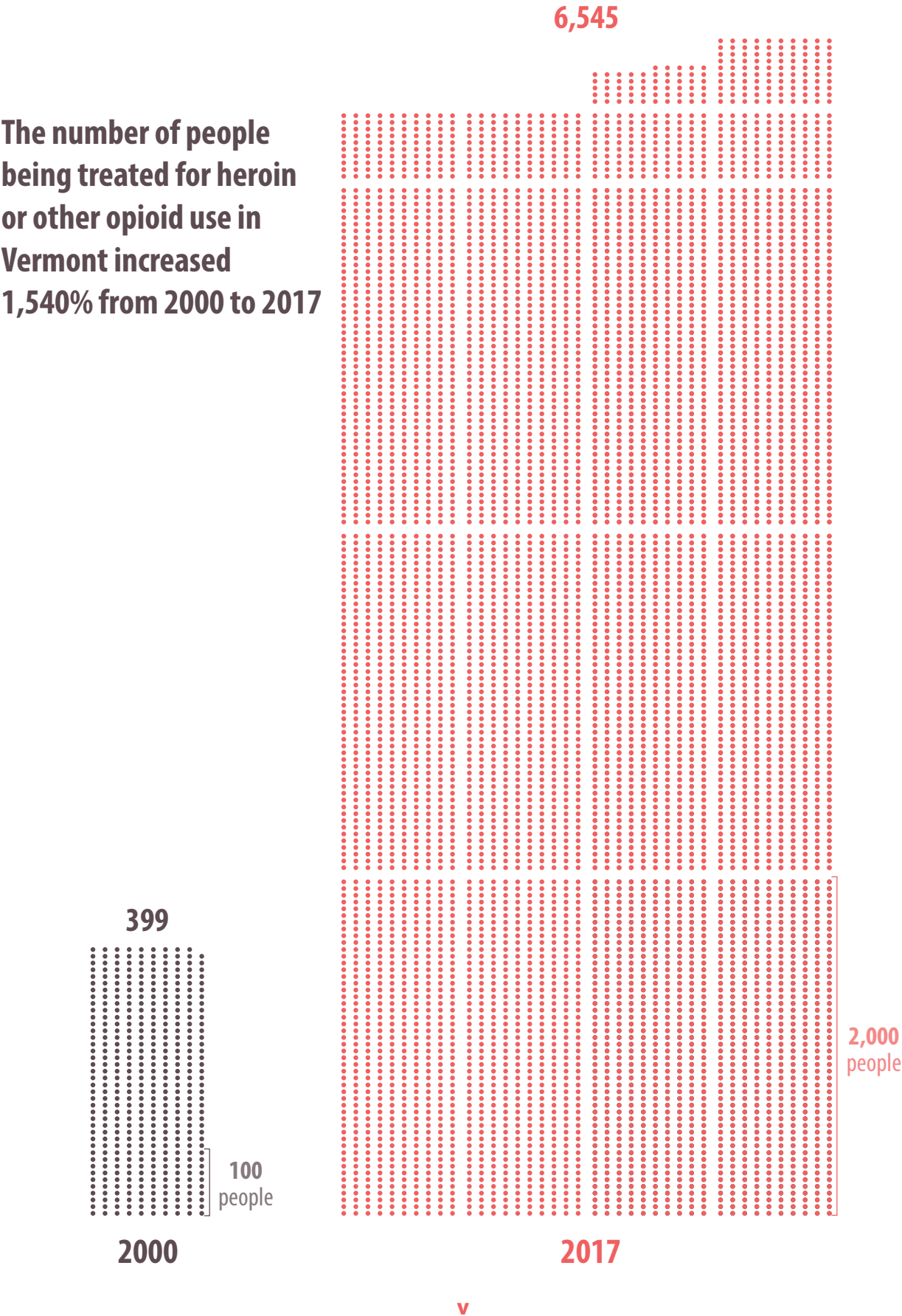
Among the 50 states, Vermont has the 4th highest rate of alcohol dependence and the highest rate of illicit drug use disorder in the country. Of the estimated 52,000 Vermonters who suffer from some form of Substance Use Disorder, alcohol dependence accounts for roughly 2/3rds of all cases. In 2016-17, 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 8,498⁴ 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 than 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 use 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

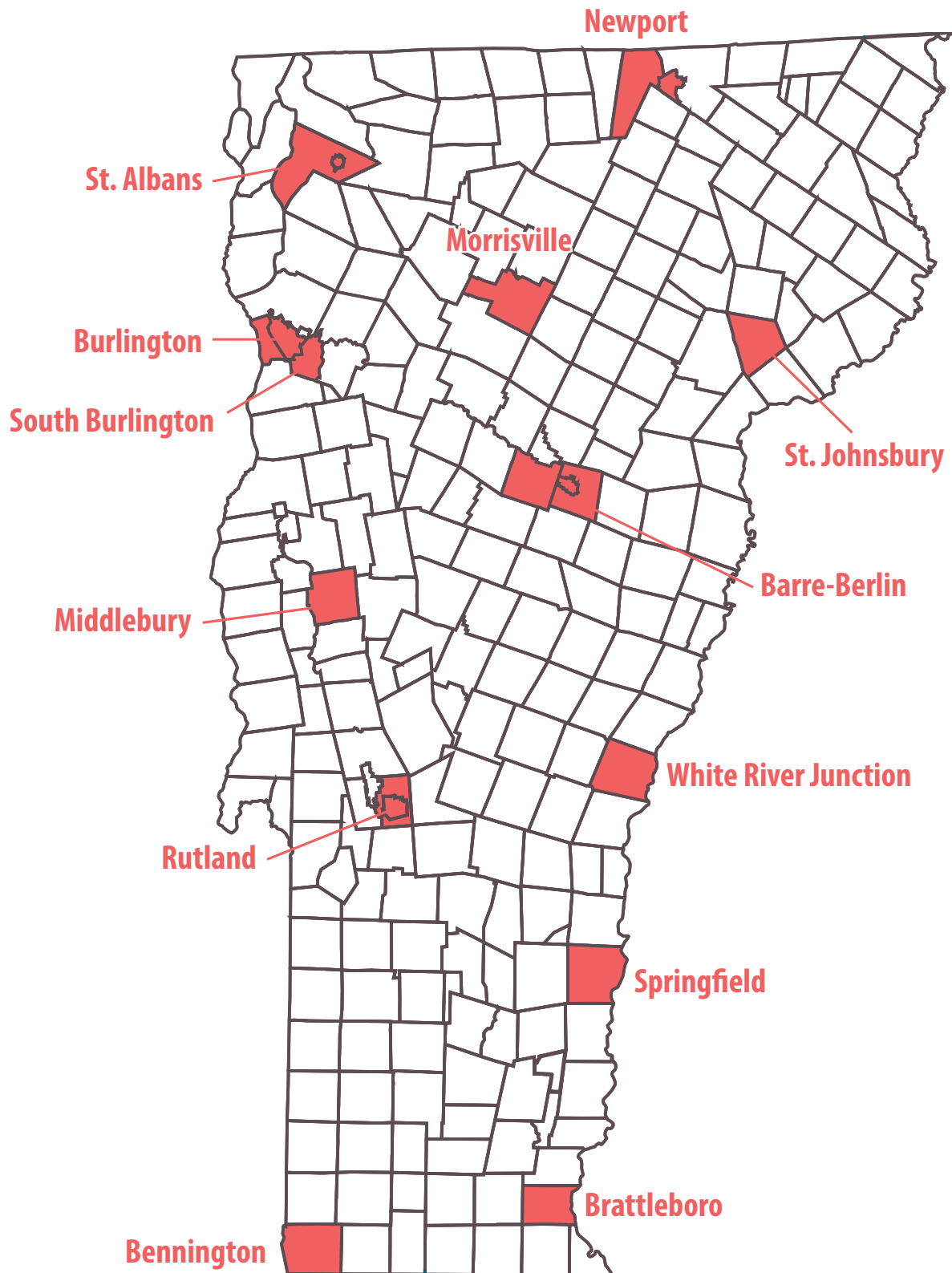
A Recovery Residence is a group home dedicated to supporting individuals to live independently in the early stages of their recovery from a Substance Use Disorder. This assessment presumes that any new RRs will be created within relatively easy access to the existing network of Treatment Centers and 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 7,750¹ 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.

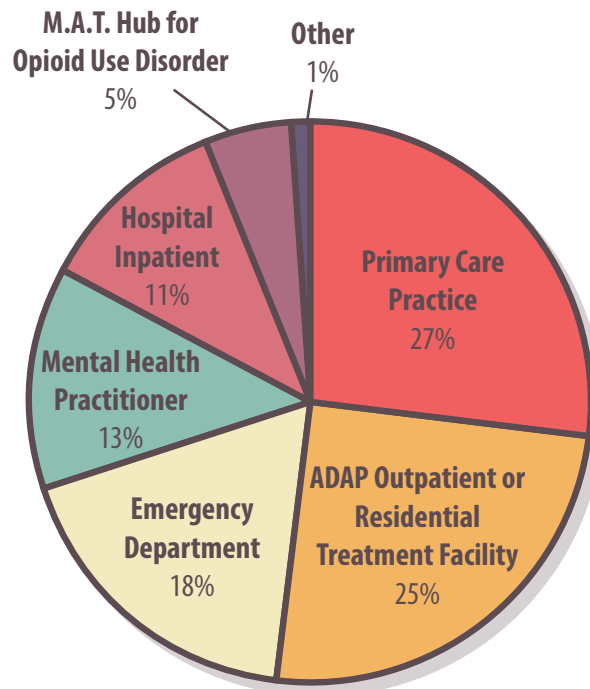
ADAP looks to patterns of use and attitudes toward use, especially among young people 12-17, as a means of looking at future trends in SUD. The range of data ADAP provided for this study (see Appendix C) suggest that while there may be some positive signs, especially regarding attitudes regard the risks 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

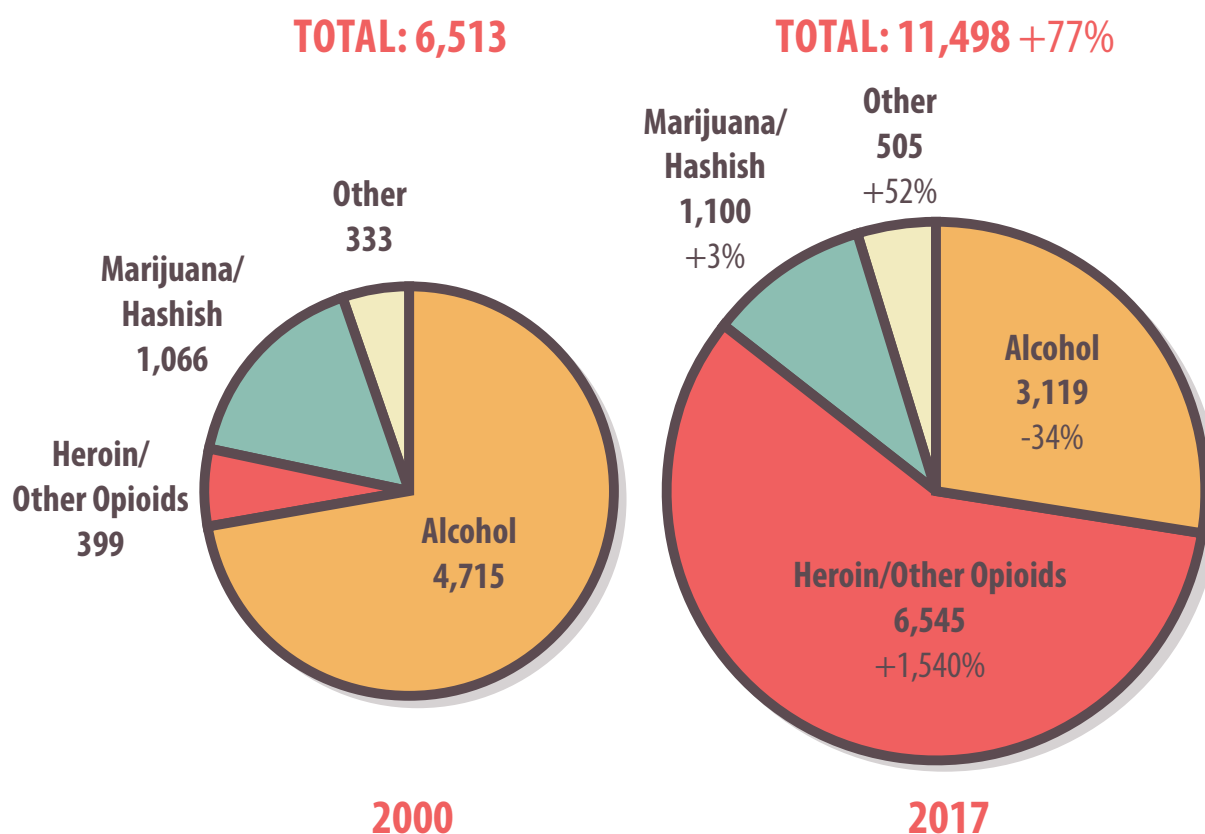


SOURCE: VDOH Alcohol & Other Drug Use Scorecard, 2015

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

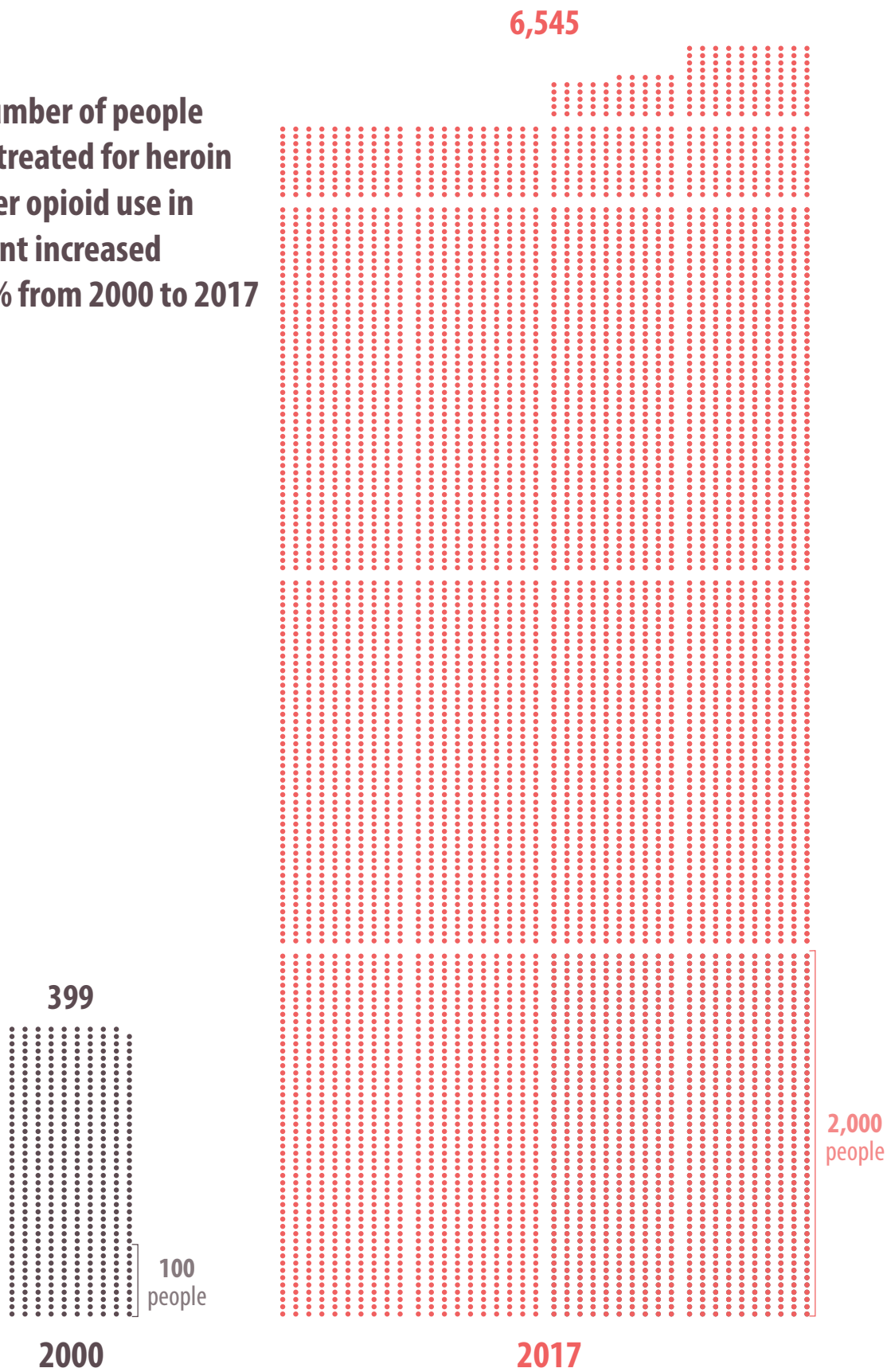


SOURCE: ADAP, Vermonter in SUD Treatment in ADAP Funded Programs, 2000-2017. Note: ADAP recently updated Total numbers for 2017 but Substance numbers have not been updated. Consequently, Substances in 2017 pie chart will not sum to Total.

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

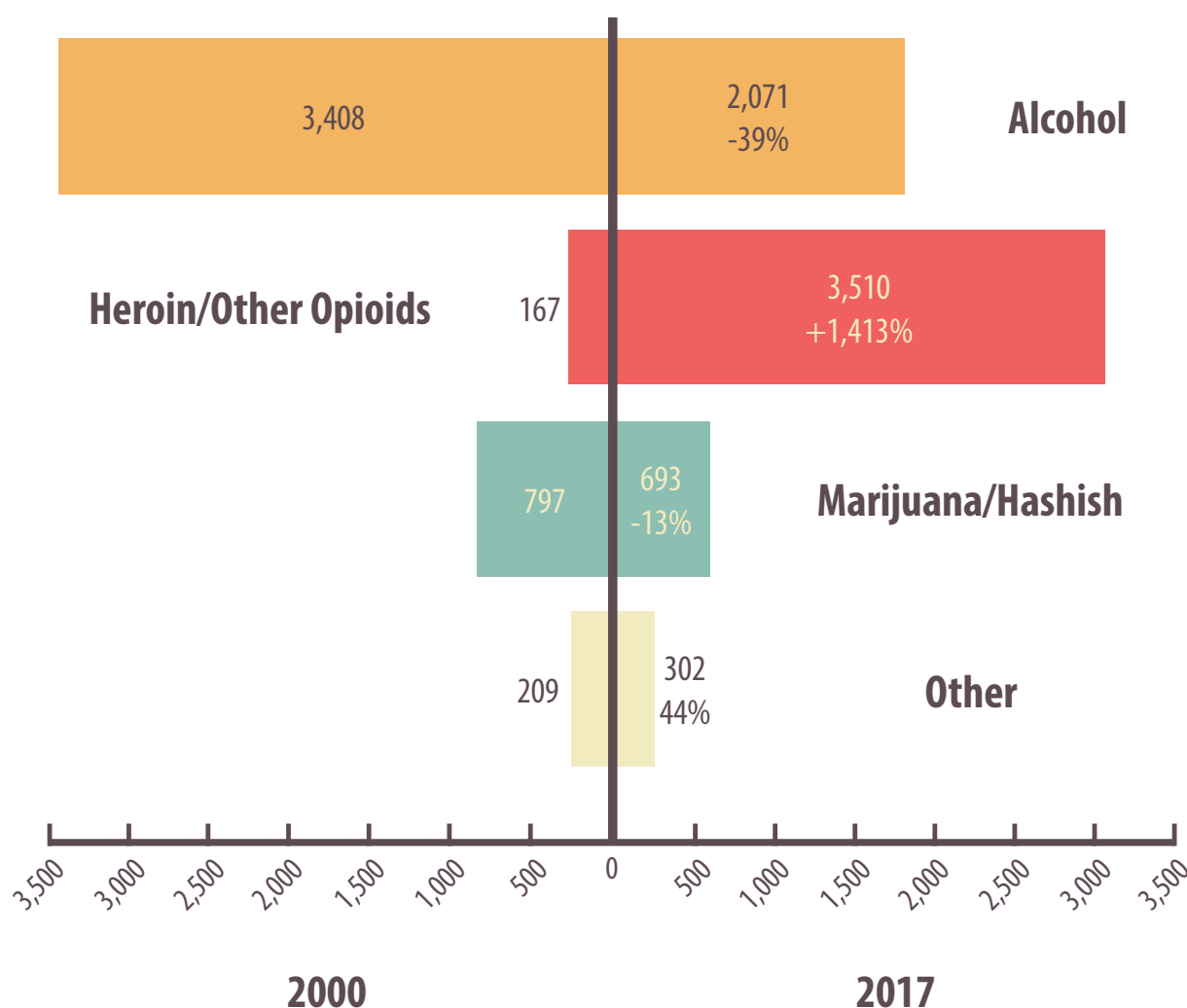
The number of people being treated for heroin or other opioid use in Vermont increased 1,540% from 2000 to 2017



SOURCE: ADAP

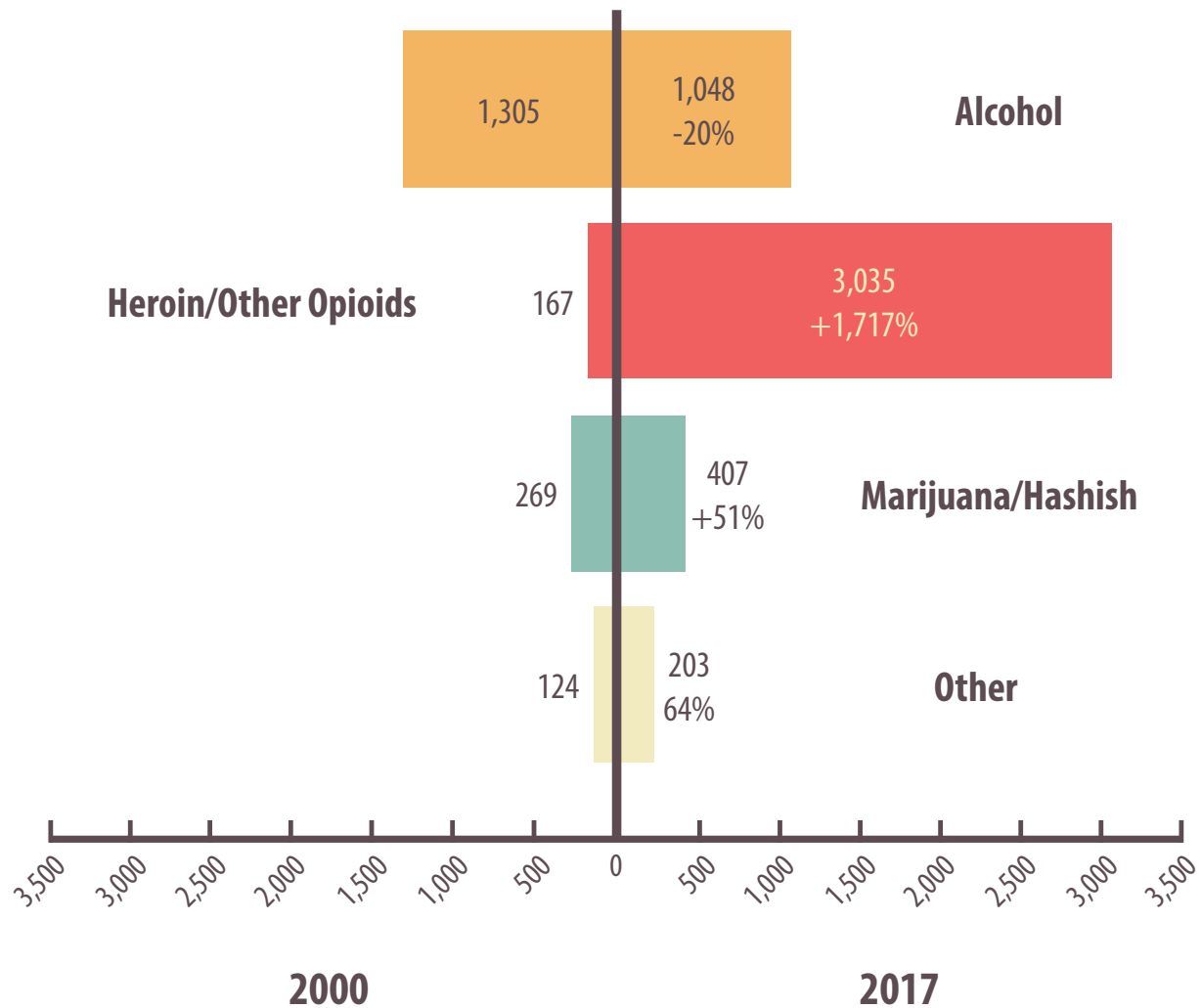
Figures II.8 and II.9 show the increase from 2000 to 2017 by the primary substance for those in treatment by the sex of the patient. It shows men are twice as likely to be in treatment for an alcohol-related disorder than women but only slightly more likely to be in treatment for heroin or other opioid 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

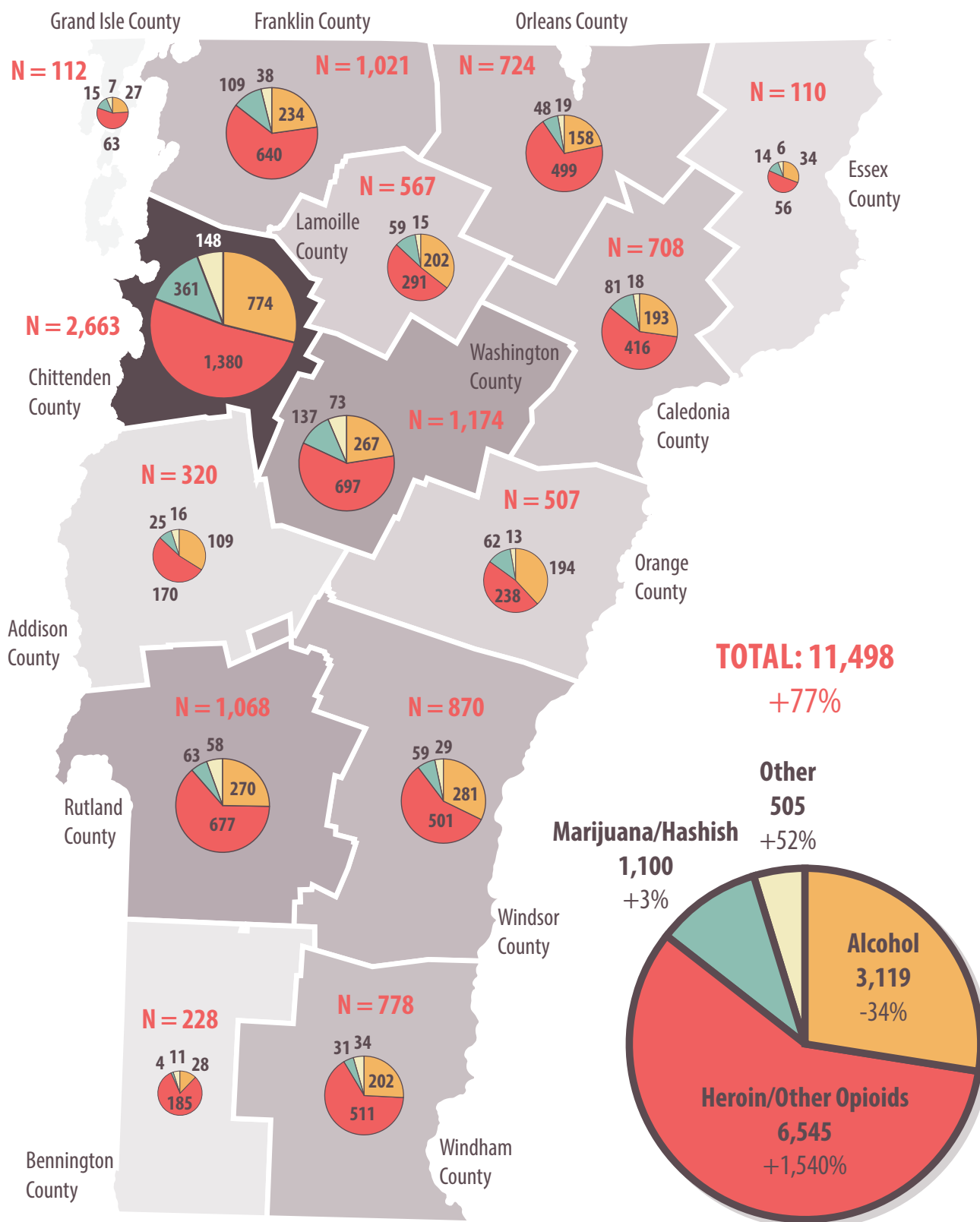
II.9: Women Receiving Treatment For Substance Use Disorder By Primary Substance, Vermont, 2000 & 2017



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

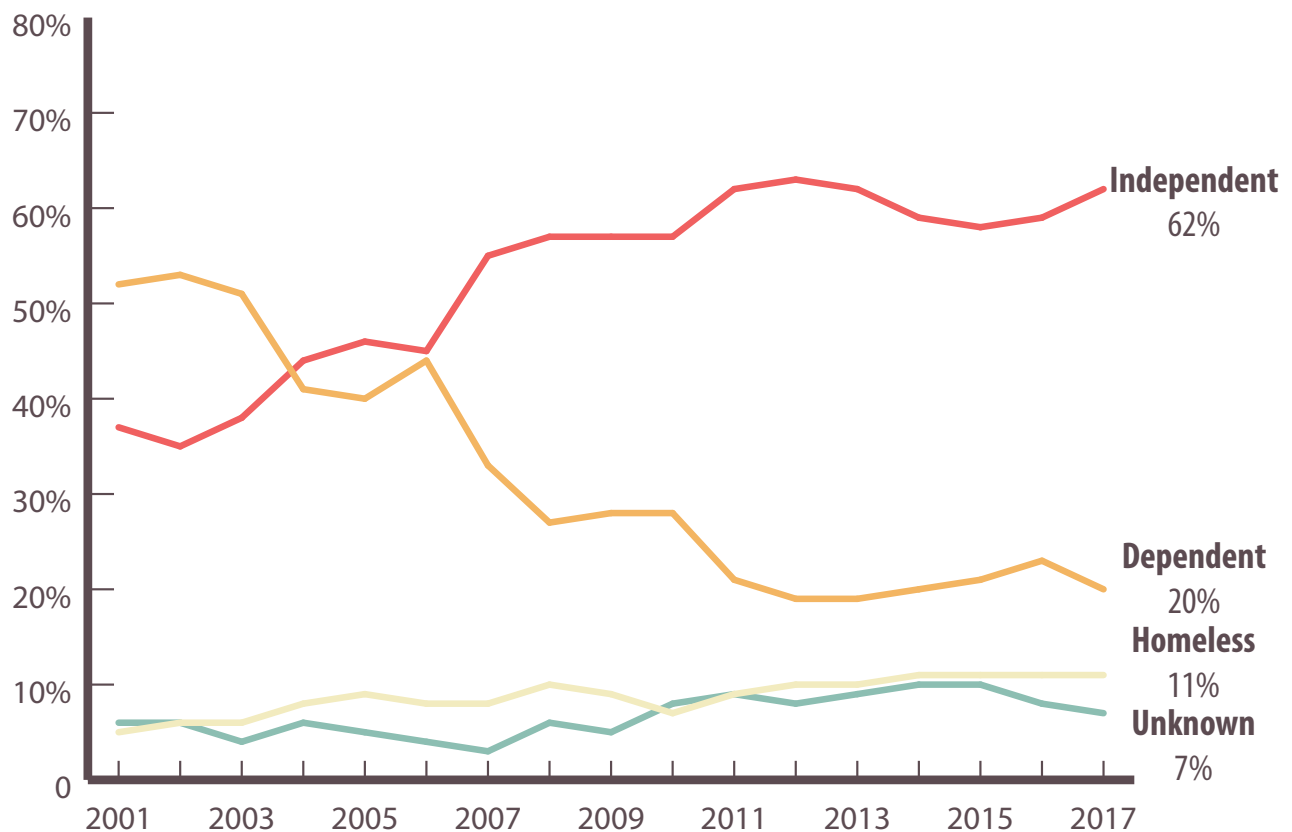


SOURCE: ADAP, Vermonter in SUD Treatment in ADAP Funded Programs, 2000-2017. Note: ADAP recently updated Total numbers for 2017 but Substance numbers have not been updated. Consequently, Substances in 2017 pie chart will not sum to Total.

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



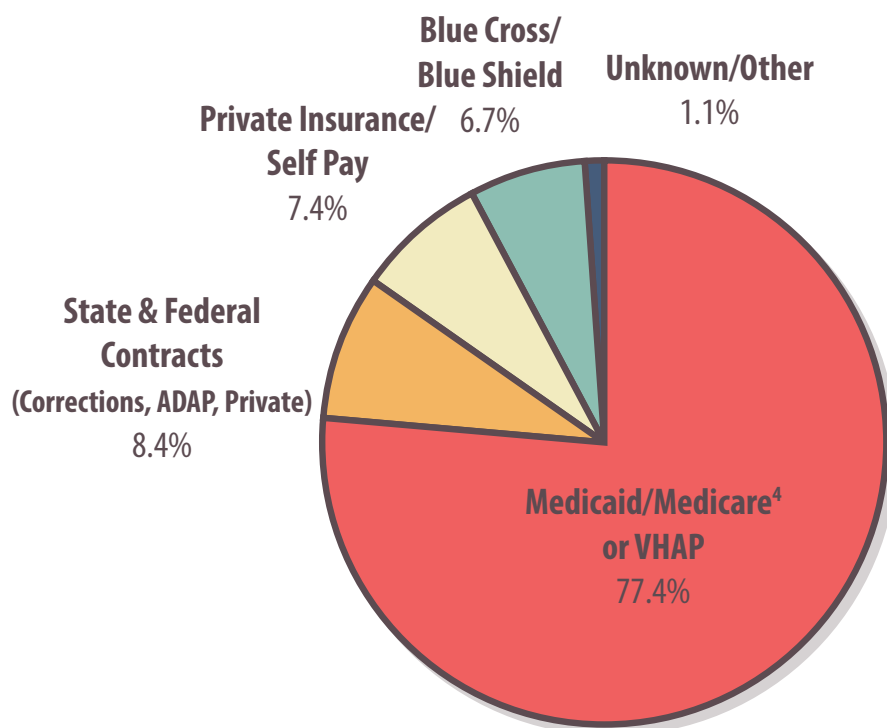
SOURCE: ADAP, 2001-2017

According to 2017 ADAP Housing Status data, over 900 individuals reported their housing status as homeless³ 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 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 than 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 the 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.

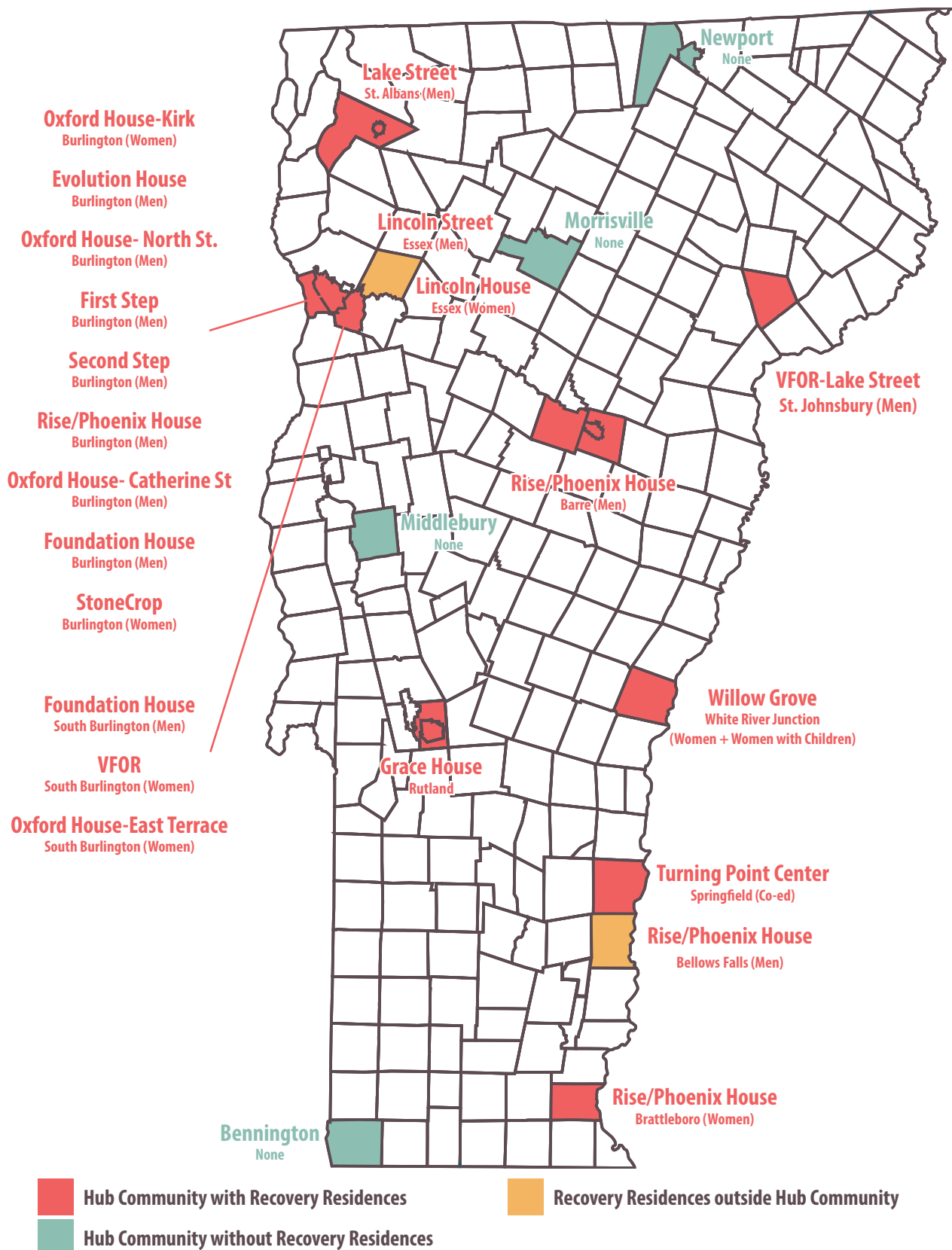
Five hub communities—Rutland, Middlebury, Bennington, Newport, and Morrisville, whose service areas treat one-quarter of all those with SUDs in the state — have no RRs.

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 use 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 AVAILABILITY 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					
STANDARDS CRITERIA		LEVEL I Peer-Run	LEVEL II Monitored	LEVEL III Supervised	LEVEL IV Service Provider
	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 as 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 communities: 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 communities: 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) & Clinic 18 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 minutes 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.

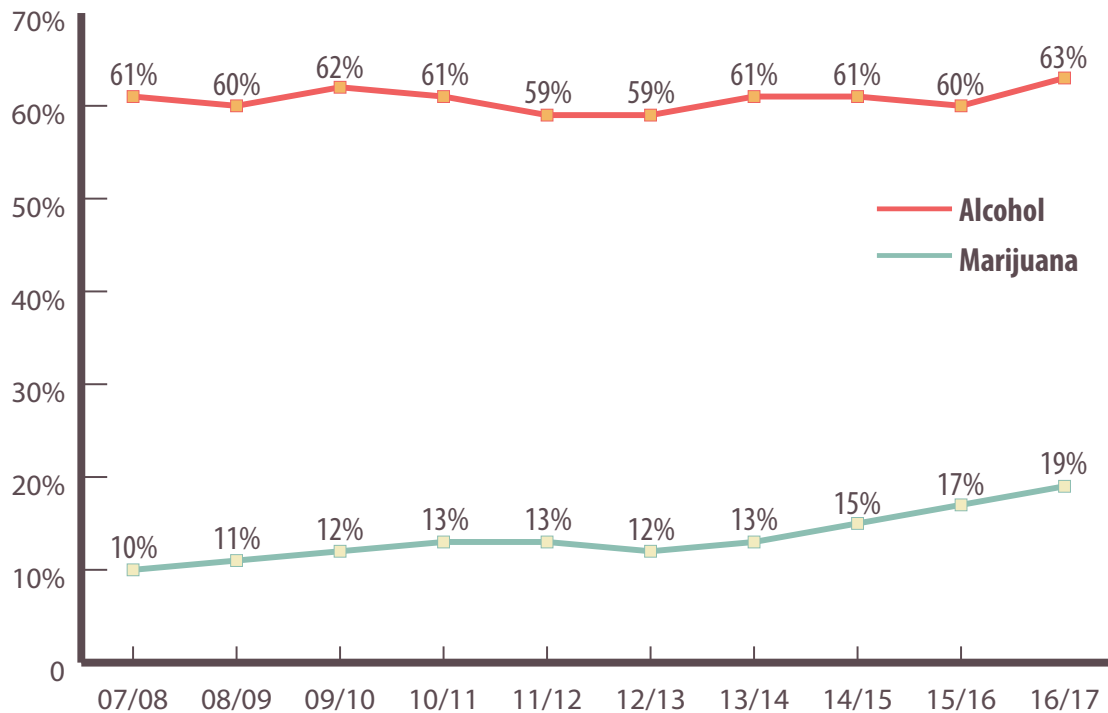
Persons Receiving Treatment for Substance Use Disorder, By Type of Treatment Received, Vermont, FY 2008-2017

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

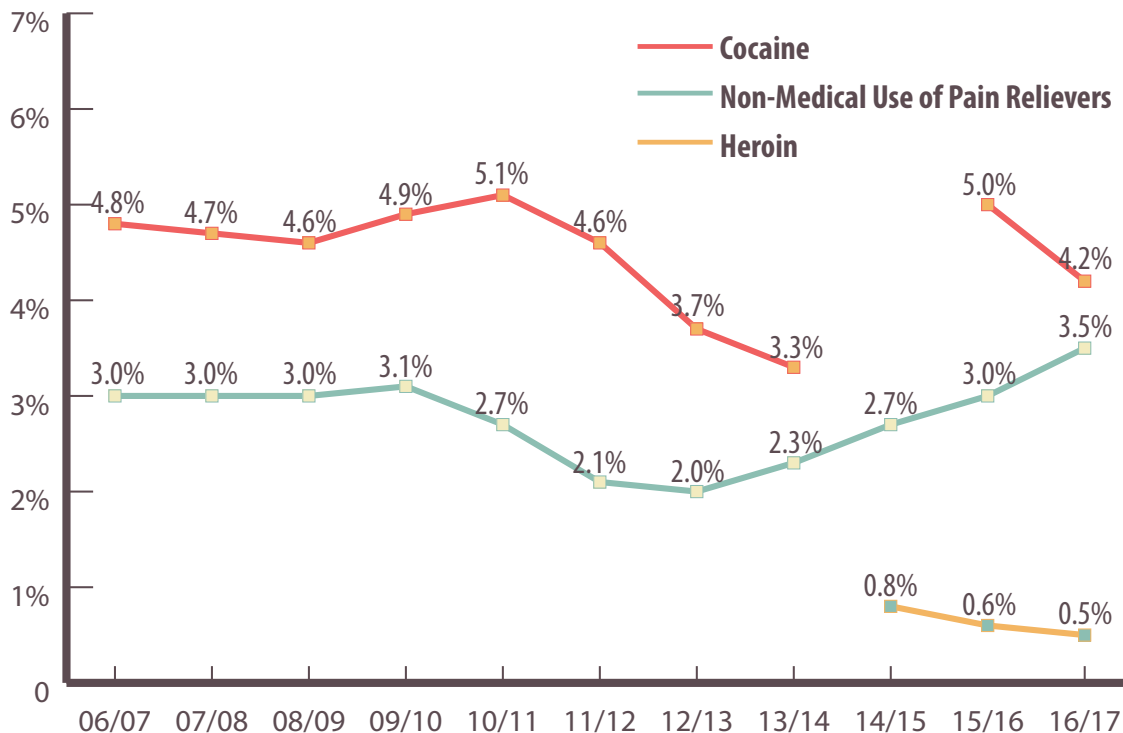
Data Trends Used by ADAP to Consider Future Levels of Substance Use and Substance Use Disorder

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

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



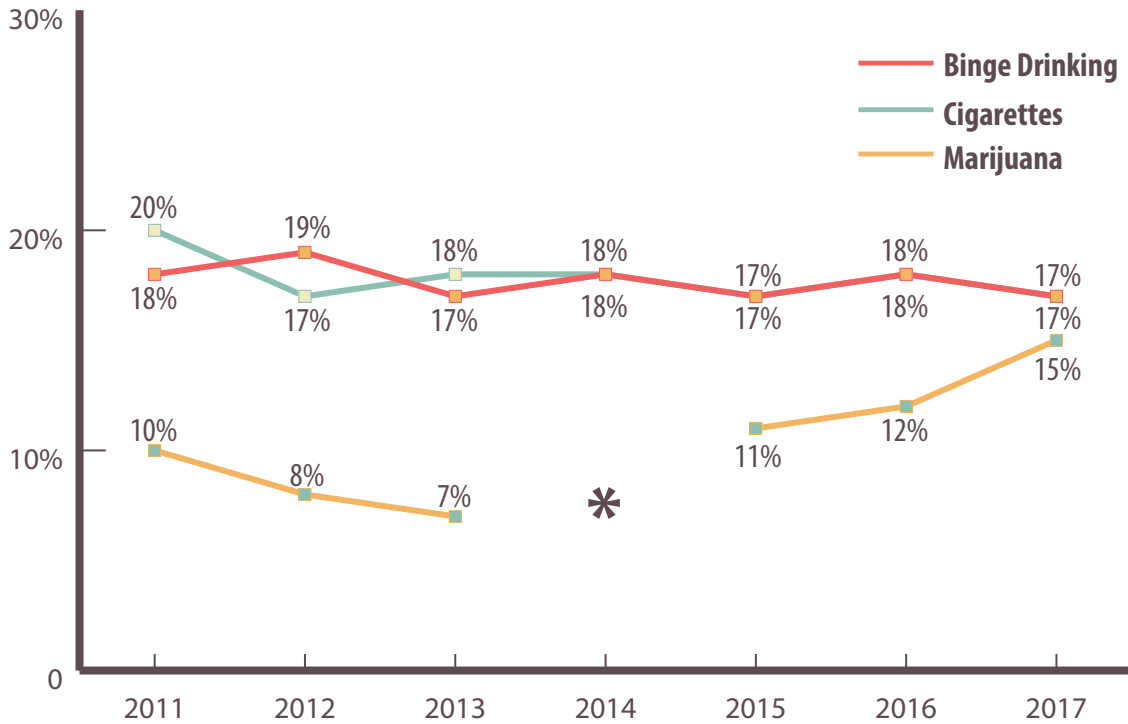
Percent of Vermonters Age 12+ Using in the PAST YEAR



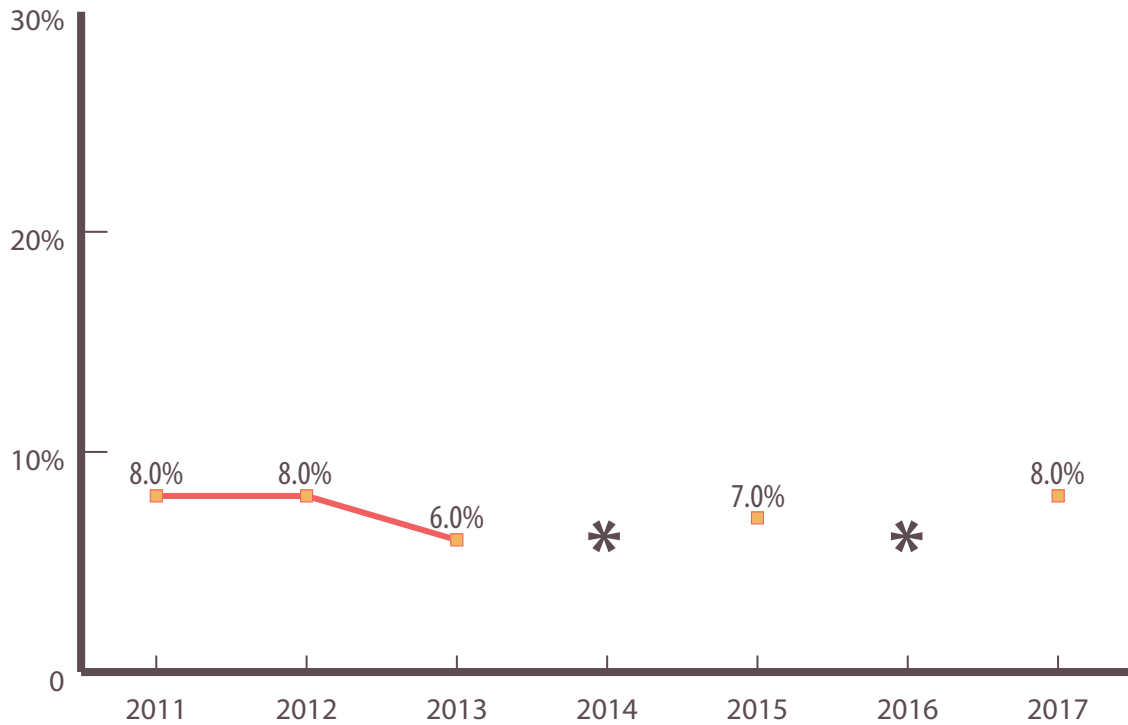
Note: Methodology changed for non-medical use of pain relievers and data prior to 2015/2016 are not comparable to 2013/2014 and earlier.

Substances Use Trends by Vermonters Ages 18+ (BRFSS)

Percent of Vermonters Age 18+ Using in the PAST MONTH



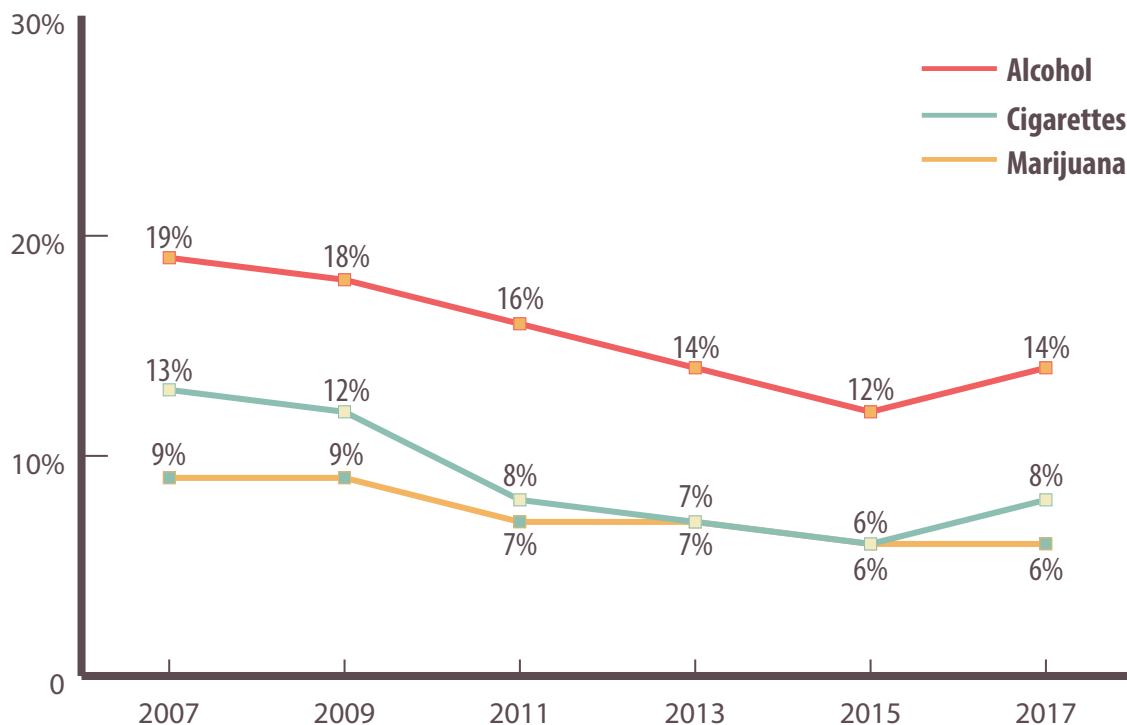
Percent of Vermonters Age 18+ EVER Misusing a Prescription Drug (Any Type)



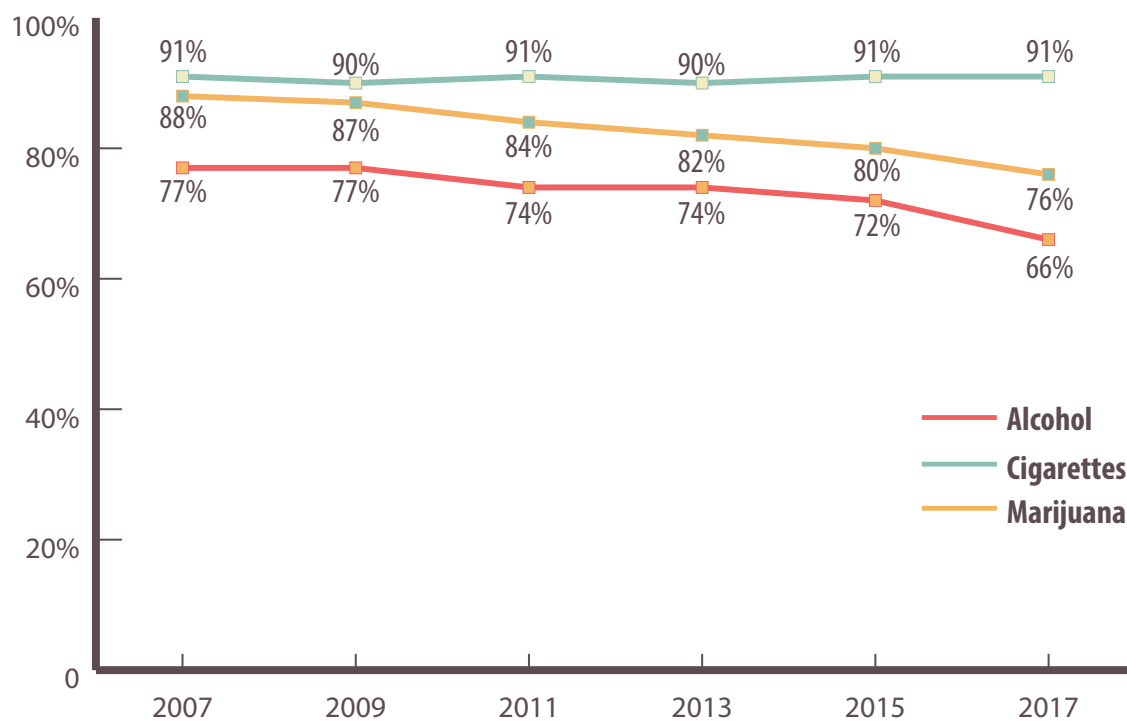
Note: *Question was not asked in 2014.

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

Percent Using Substances Before Age 13

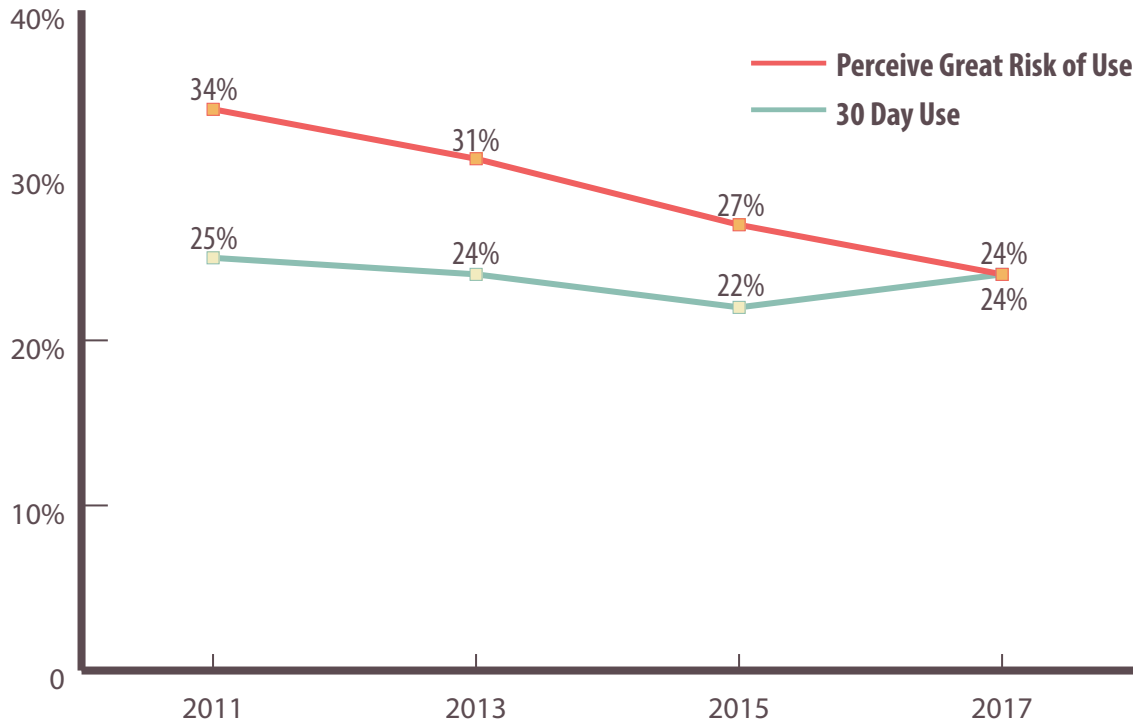


Percent of Vermonters Age 18+ EVER Misusing a Prescription Drug (Any Type)

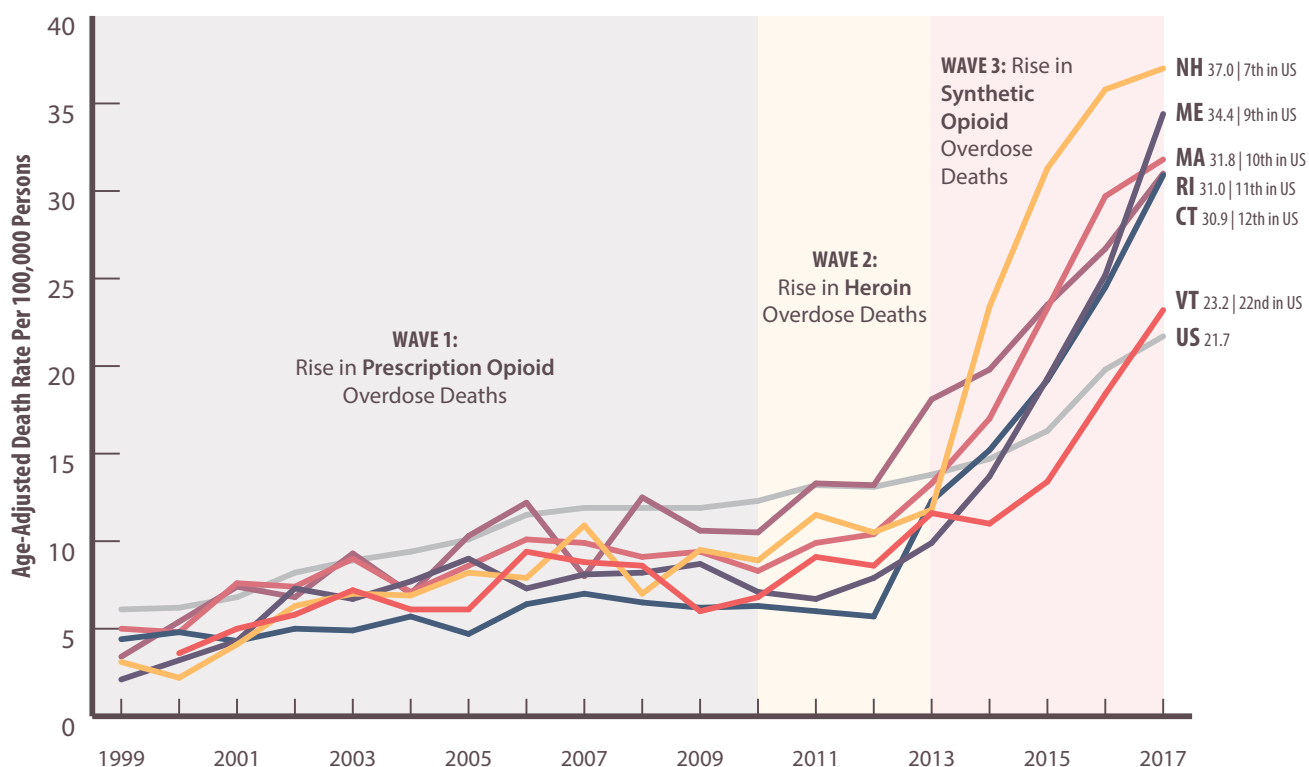


Substances Use by Vermonters 9-12th Grade Students (YRBS)

30 Day Mariuana Use, Perception of Great Risk of Use

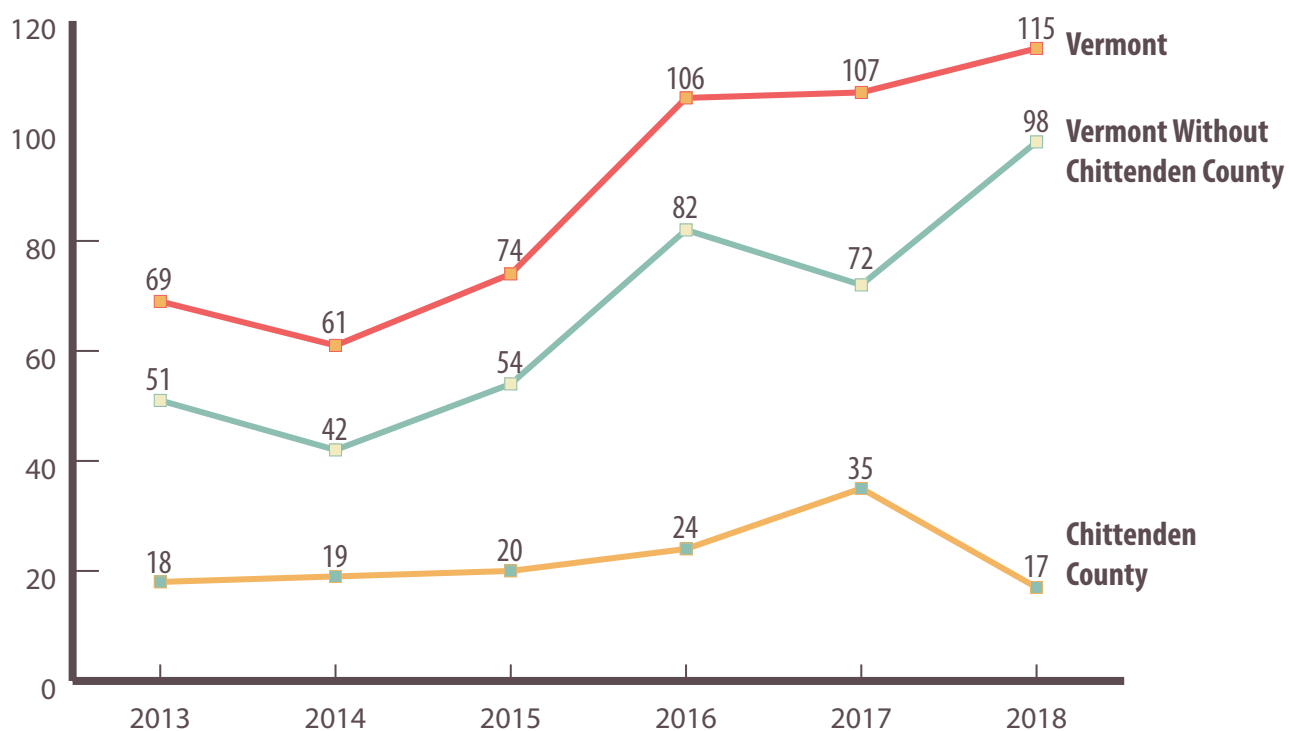


New England Opioid-Related Overdose Deaths, 1999-2017



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

		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	2017 % of Total Admits	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

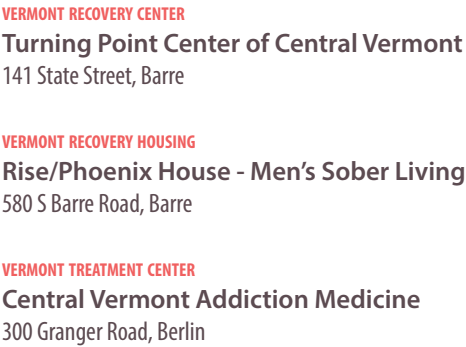
Appendix D

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

BARREFFERIN

with median monthly rents for 3+ bedrooms



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%

Central Vermont Substance Abuse Services

Price Chopper

BAART Berlin

Turning Point Center of Central Vermont

Phoenix House - Men's Sober Living

Hannaford

Dollar Store

Airport Road

VERMONT 302

VERMONT 62

VERMONT 14

9551

9552

9554

9545

INSET

\$114k 6 beds

\$159k 7 beds

\$125k 5 beds

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

Barre Hospital Hill
every 1 hour

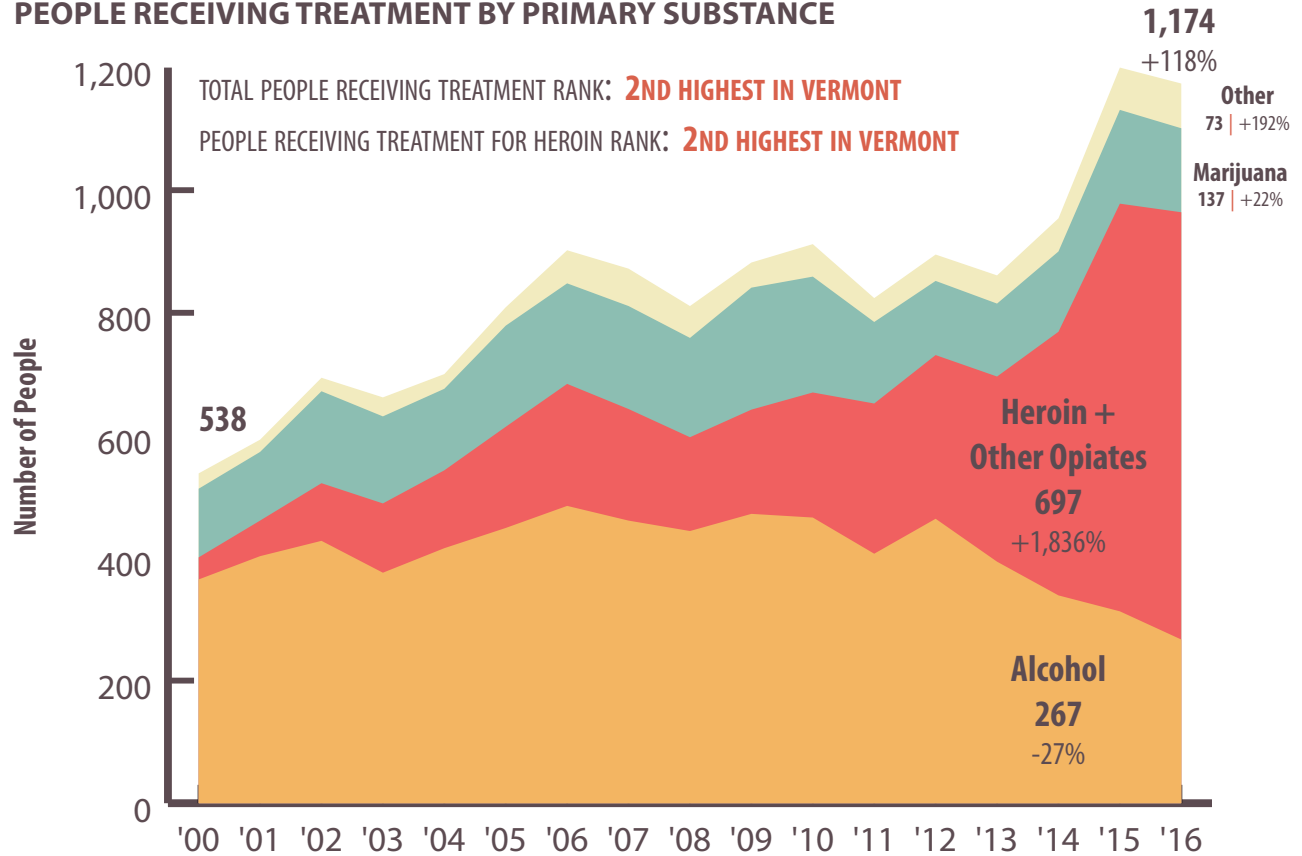
Hannaford Shopping Special
Tuesdays only

Turning Point to Hospital Loop: 2 hour walk
5 miles

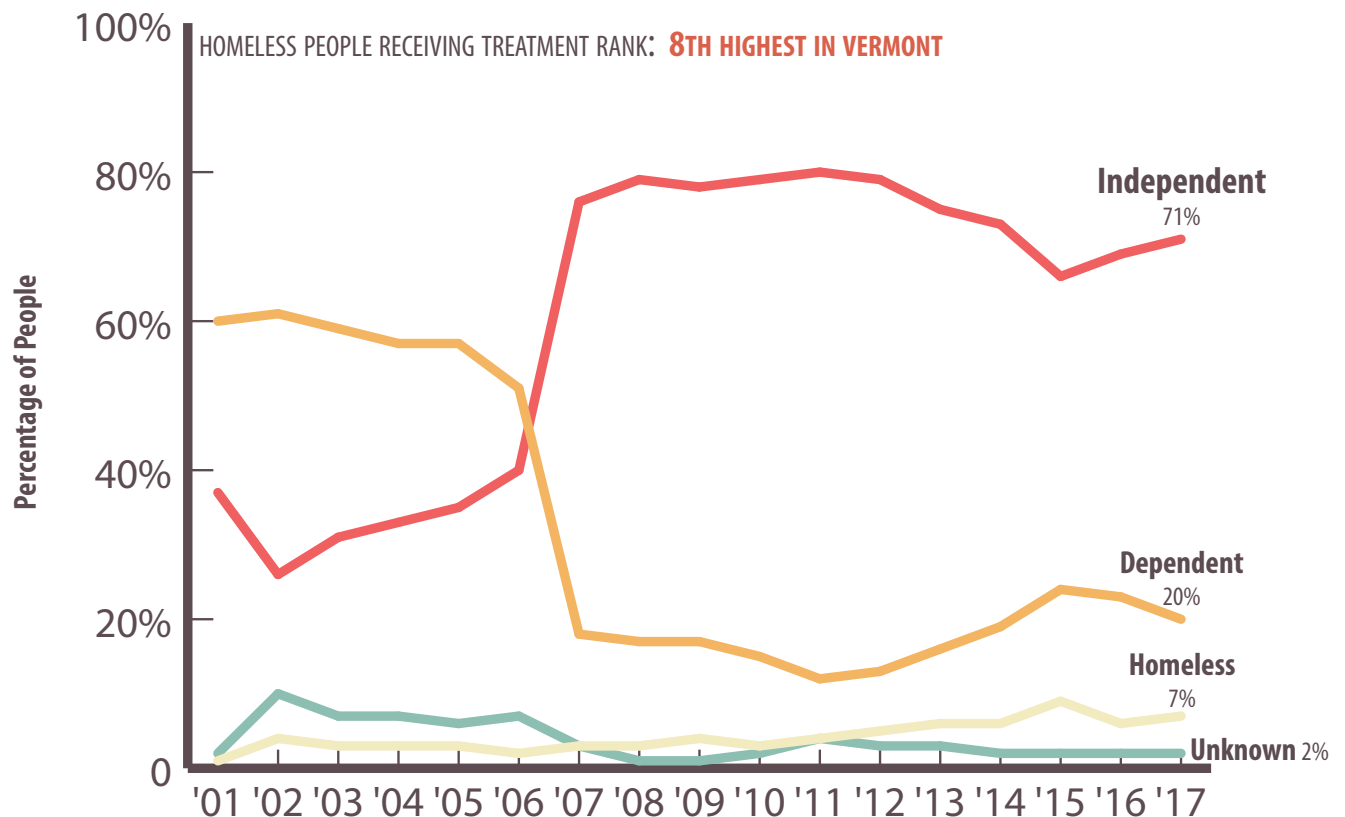


WASHINGTON COUNTY

PEOPLE RECEIVING TREATMENT BY PRIMARY SUBSTANCE

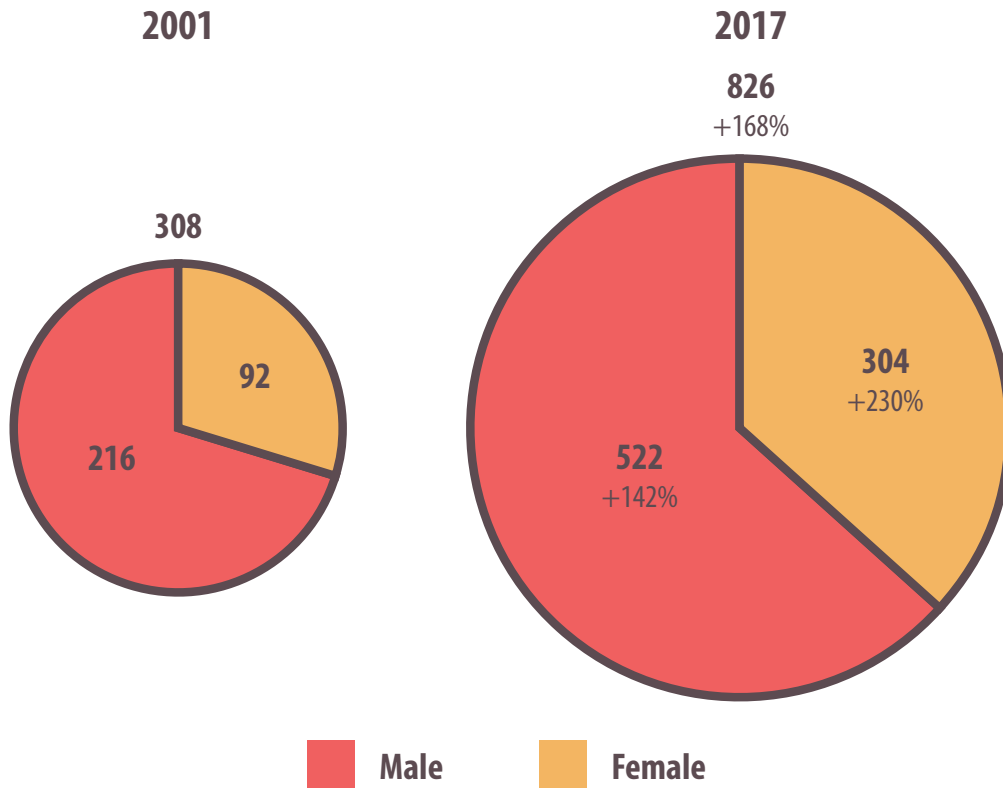


HOUSING STATUS AT TIME OF ADMISSION TO TREATMENT

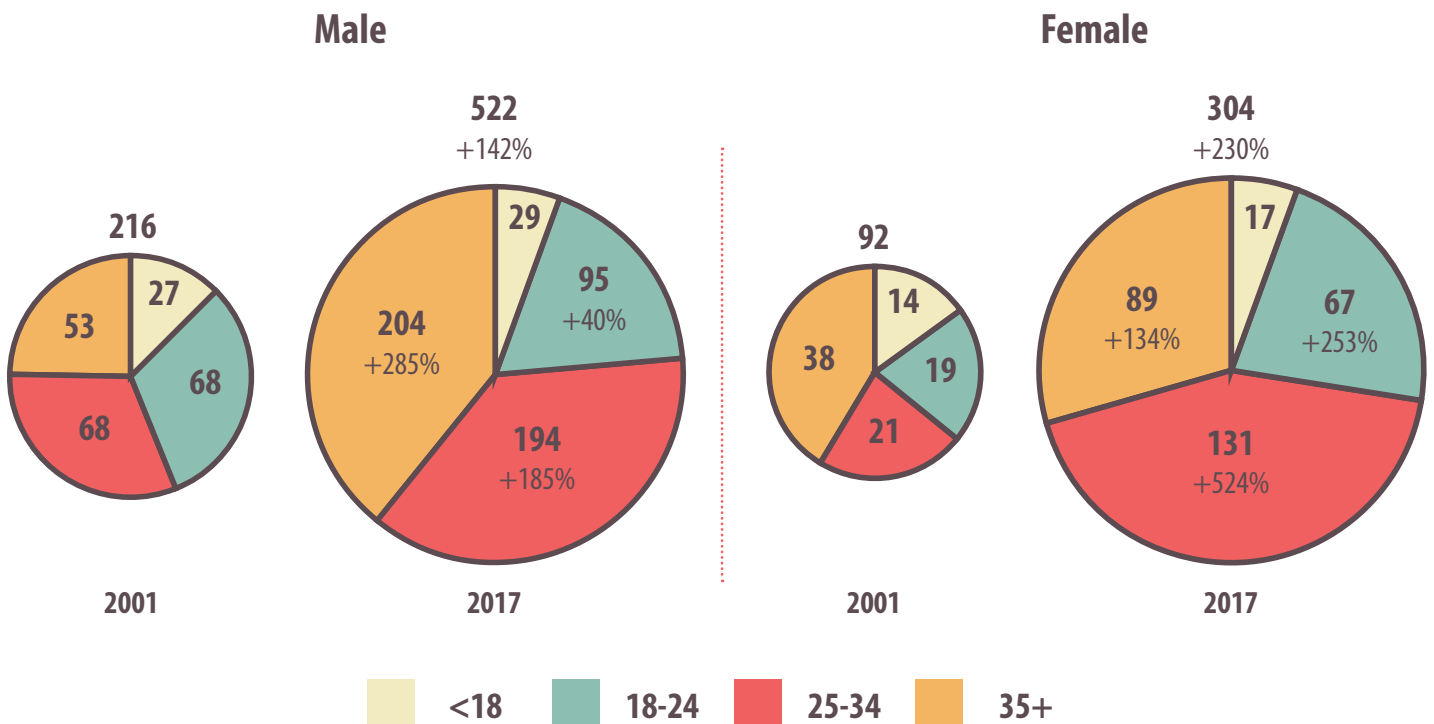


WASHINGTON COUNTY

PEOPLE RECEIVING TREATMENT BY SEX



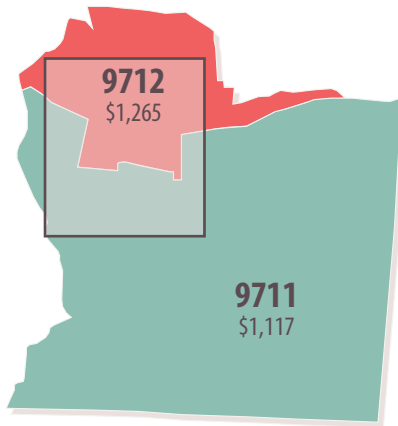
PEOPLE RECEIVING TREATMENT BY AGE



BENNINGTON

Census Tracts

with median monthly rents for 3+ bedrooms



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

VERMONT RECOVERY CENTER

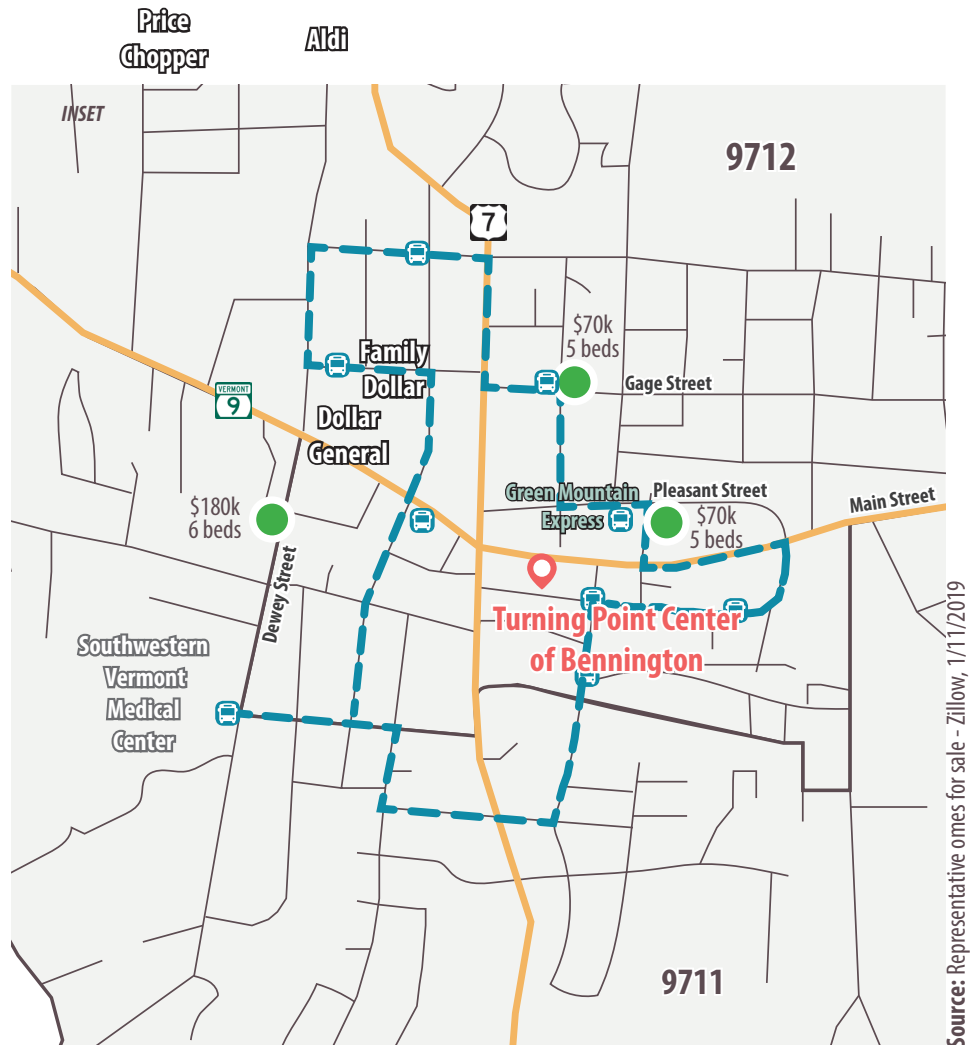
Turning Point Center of Bennington
465 Main Street

VERMONT RECOVERY HOUSING

VERMONT TREATMENT CENTER

Logistics

 **Blue Line**
every 30 min



Source: Representative homes 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

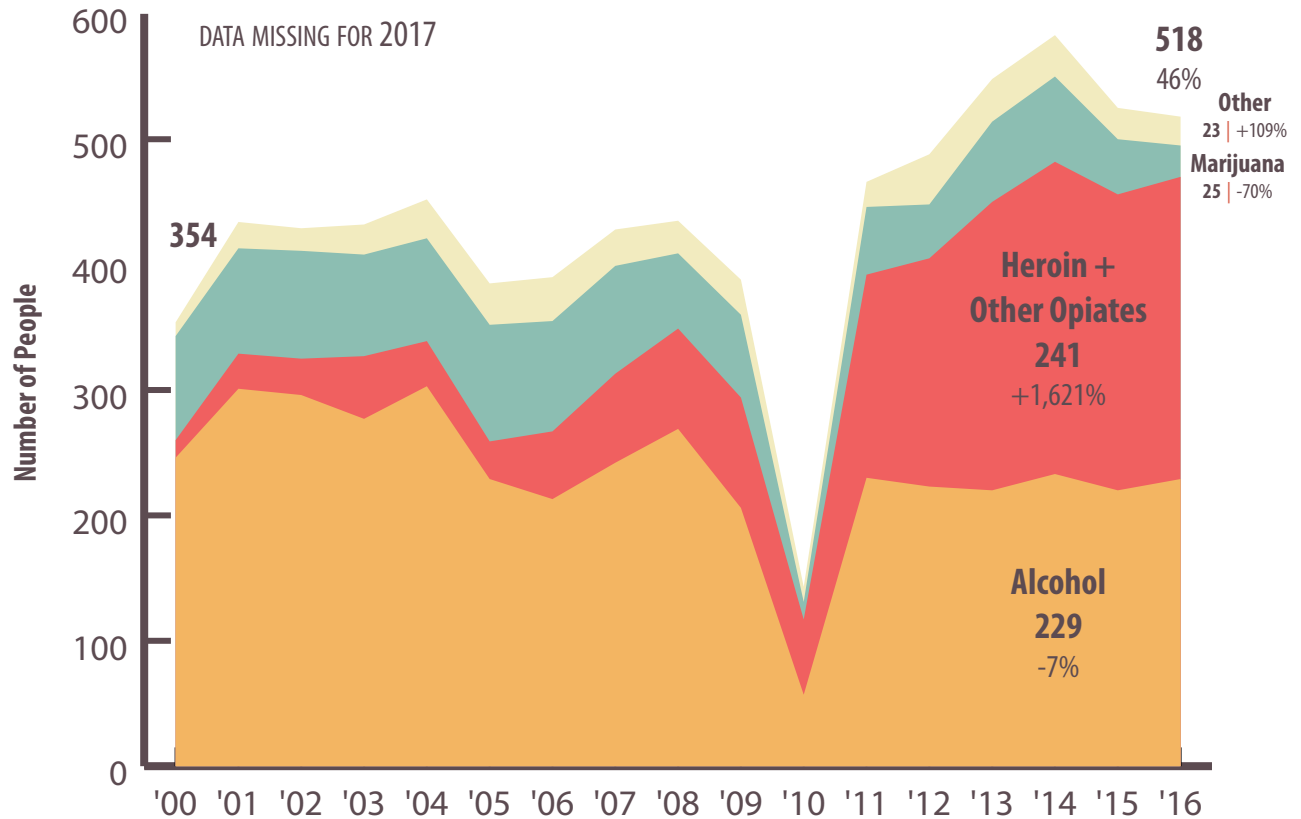


DEWEY STREET

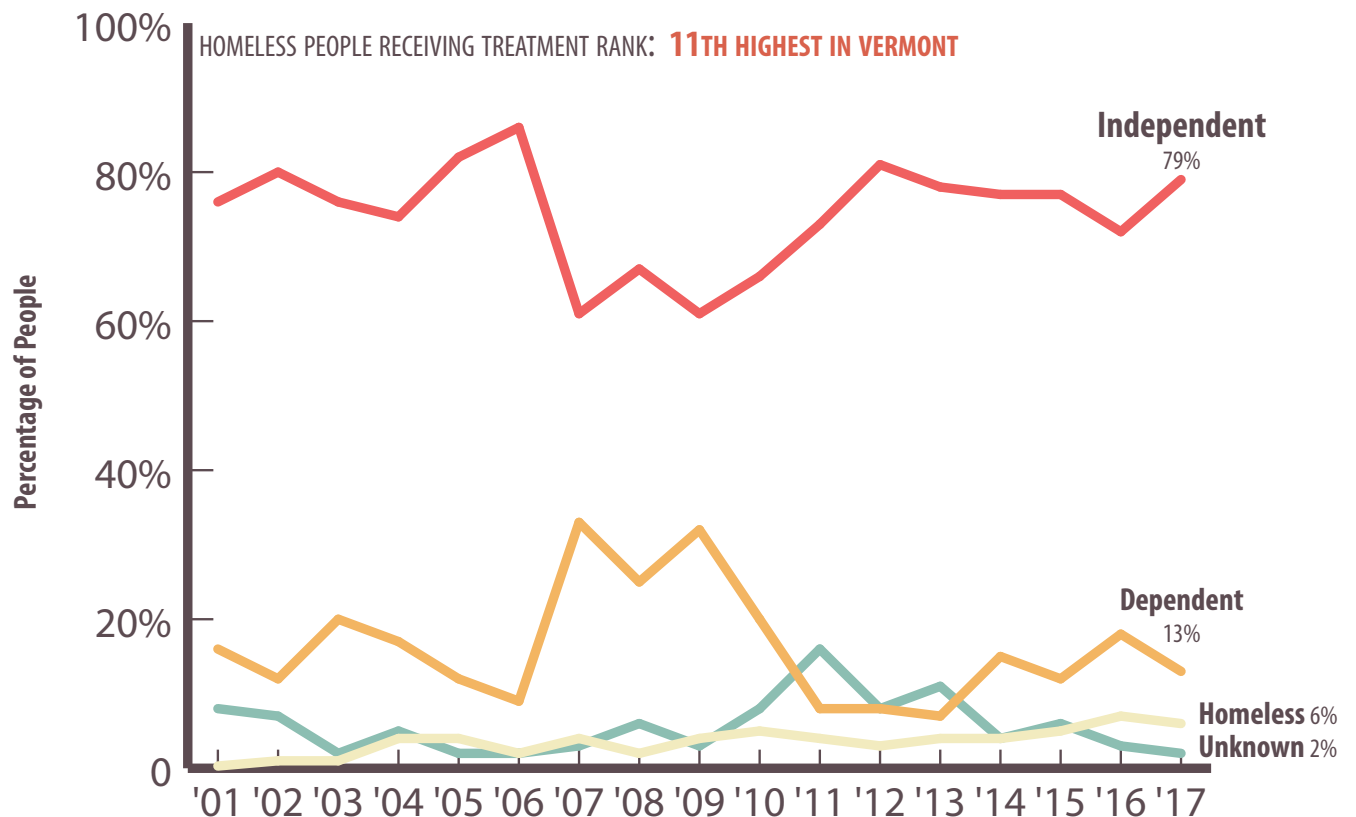
\$179,900 • 6 bedrooms • 3,000 square feet

BENNINGTON COUNTY

PEOPLE RECEIVING TREATMENT BY PRIMARY SUBSTANCE

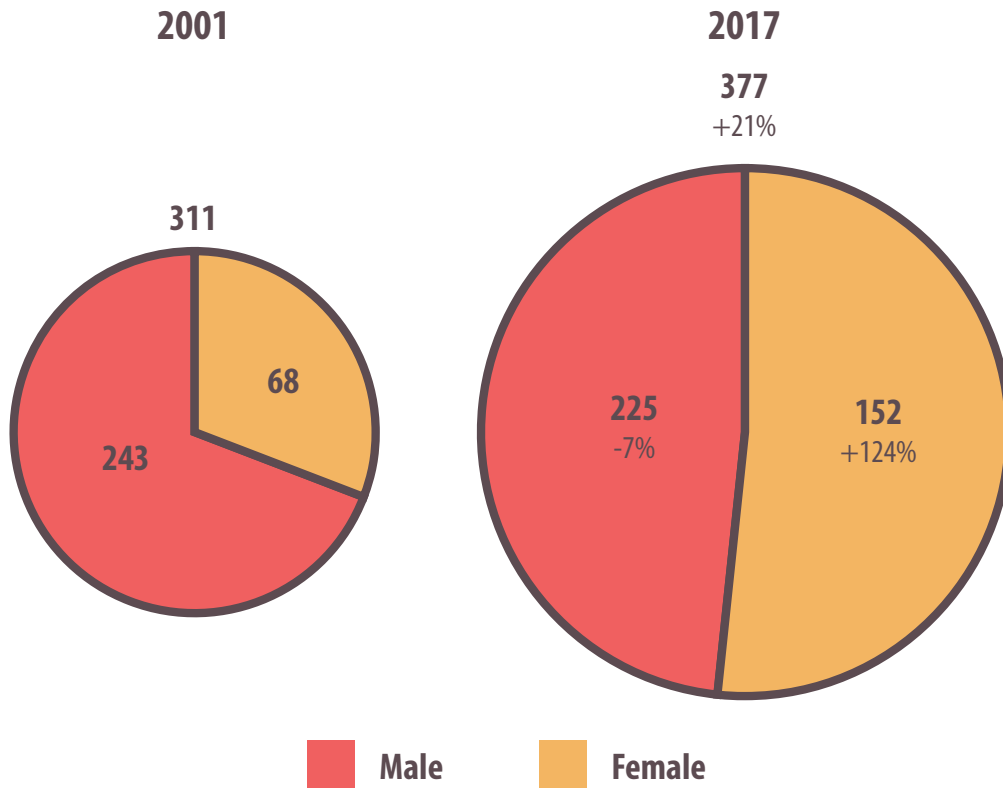


HOUSING STATUS AT TIME OF ADMISSION TO TREATMENT

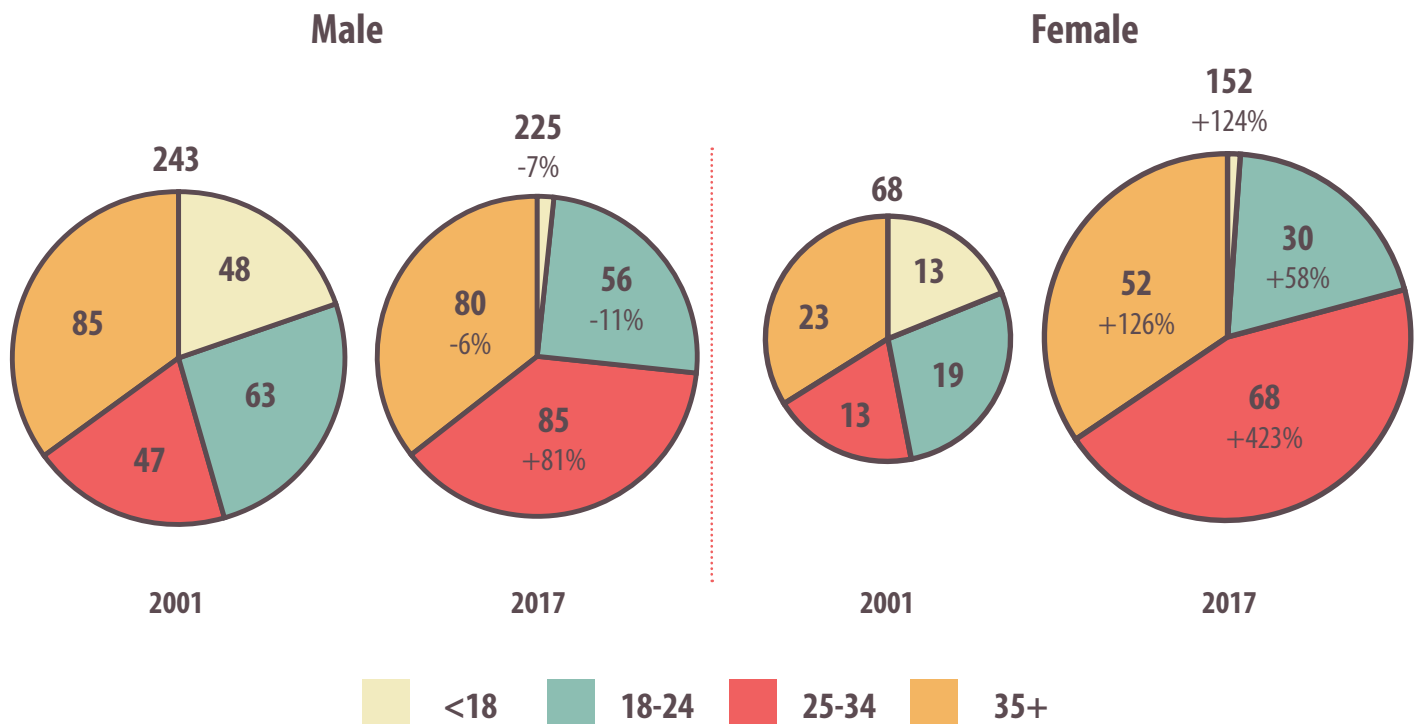


BENNINGTON COUNTY

PEOPLE RECEIVING TREATMENT BY SEX



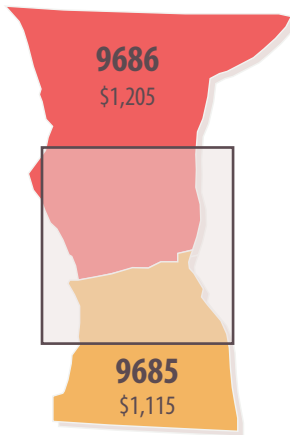
PEOPLE RECEIVING TREATMENT BY AGE



BRATTLEBORO

Census Tracts

with median monthly rents for 3+ bedrooms



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

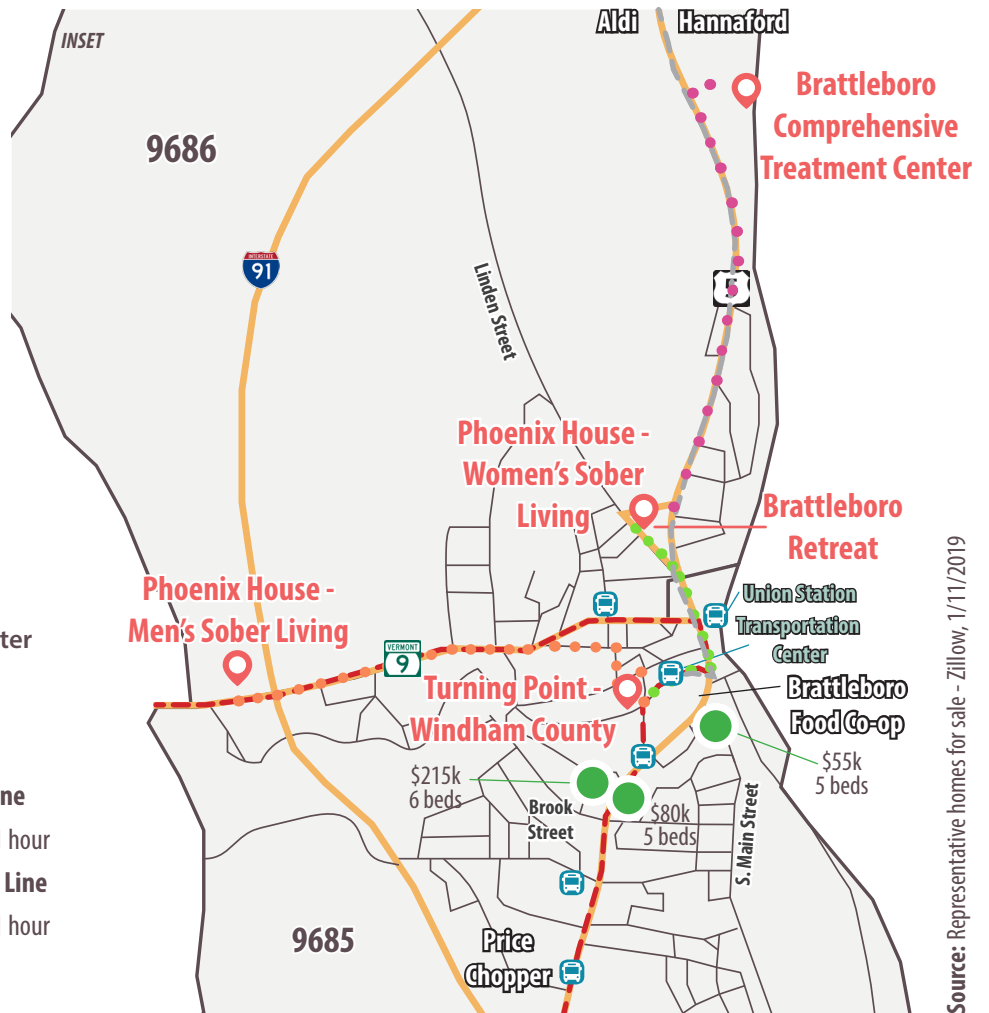
- ● ● ● ● 28 min walk
1.3 mile
- ● ● ● ● 17 min walk
0.8 mile
- ● ● ● ● 27 min walk
1.3 mile

- Red Line
every 1 hour
- White Line
every 1 hour

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



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

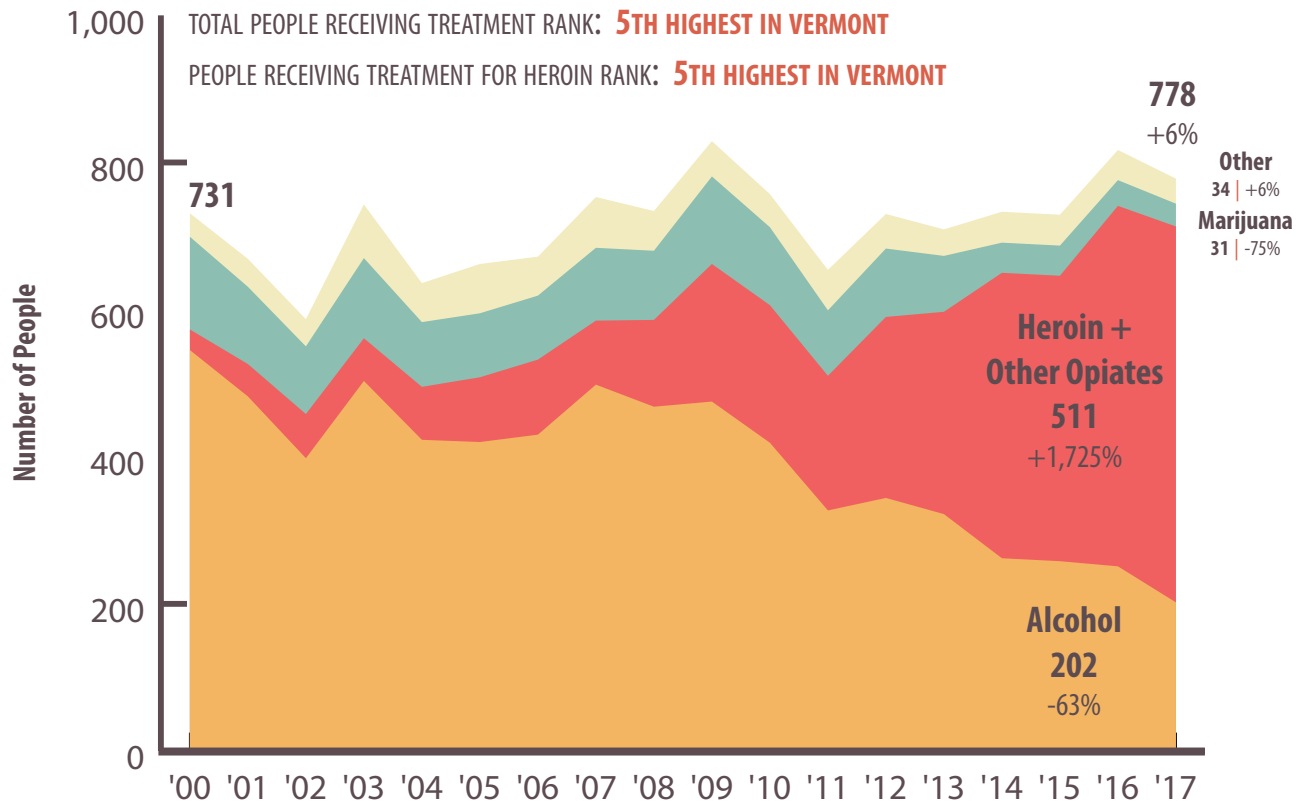


HORTON PLACE

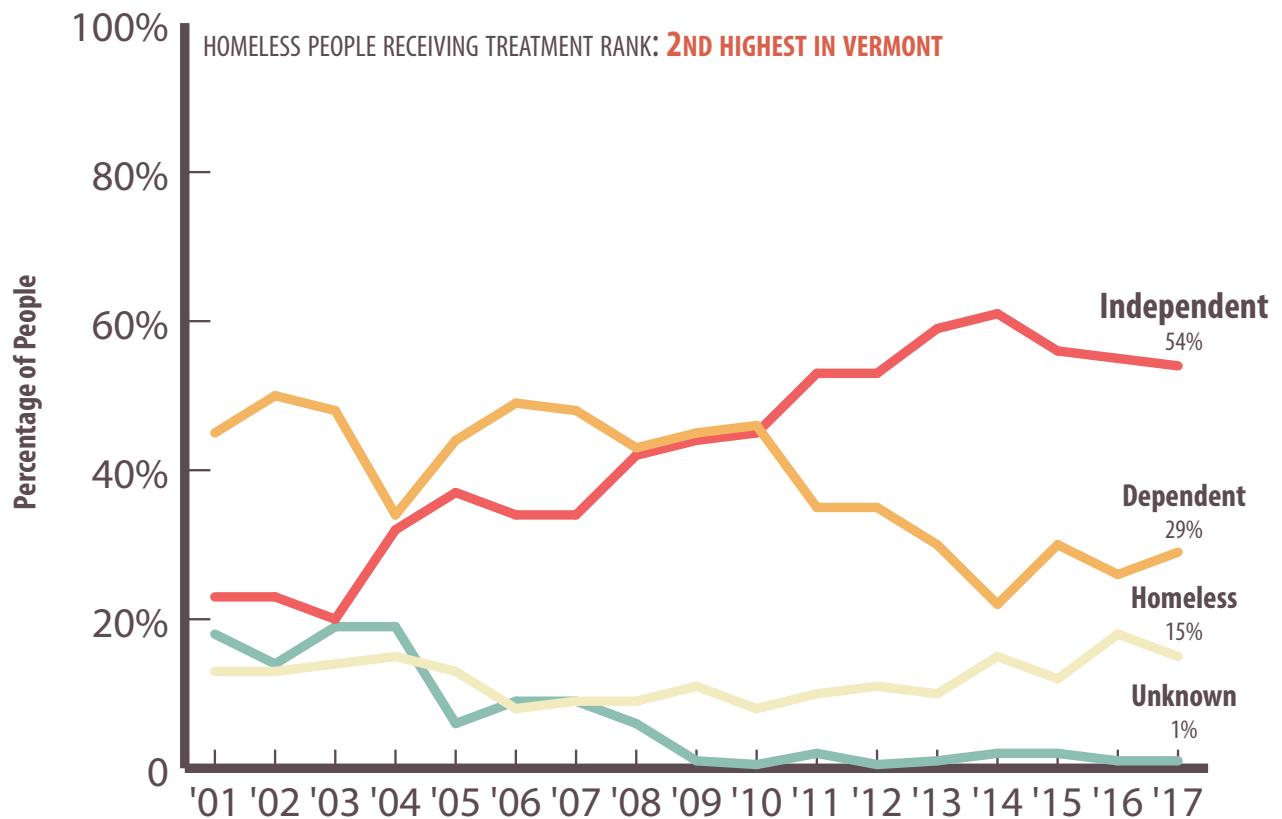
\$79,900 • 5 bedrooms • 2,409 square feet
(Reconstruction)

WINDHAM COUNTY

PEOPLE RECEIVING TREATMENT BY PRIMARY SUBSTANCE

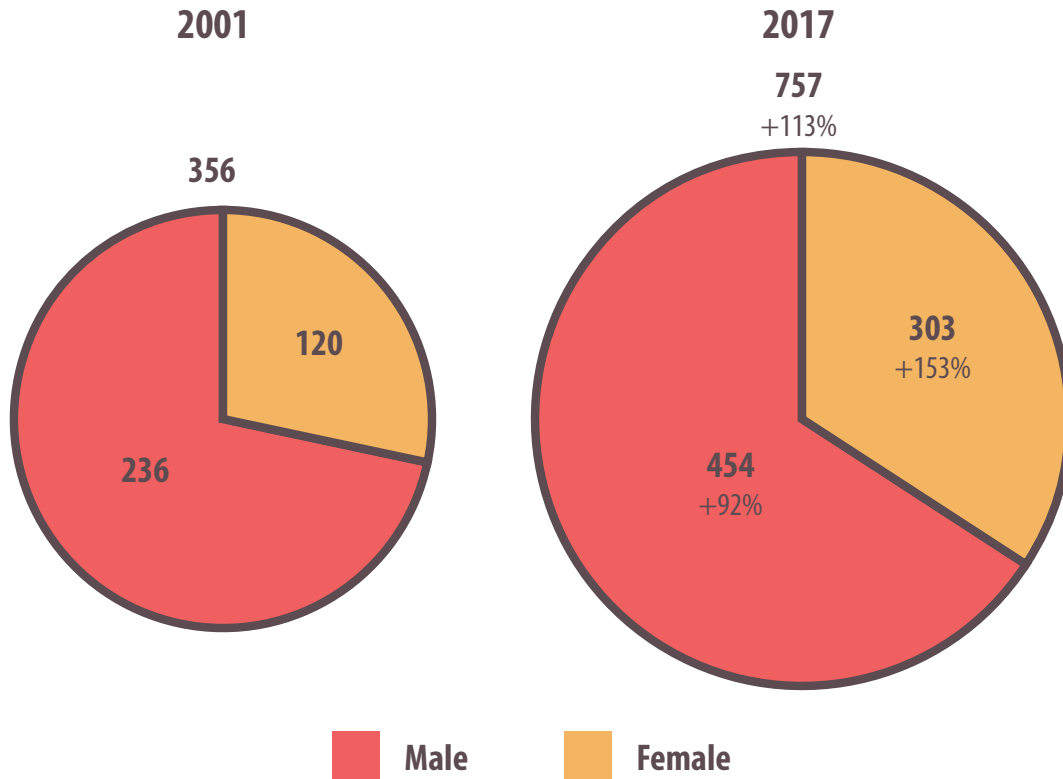


HOUSING STATUS AT TIME OF ADMISSION TO TREATMENT

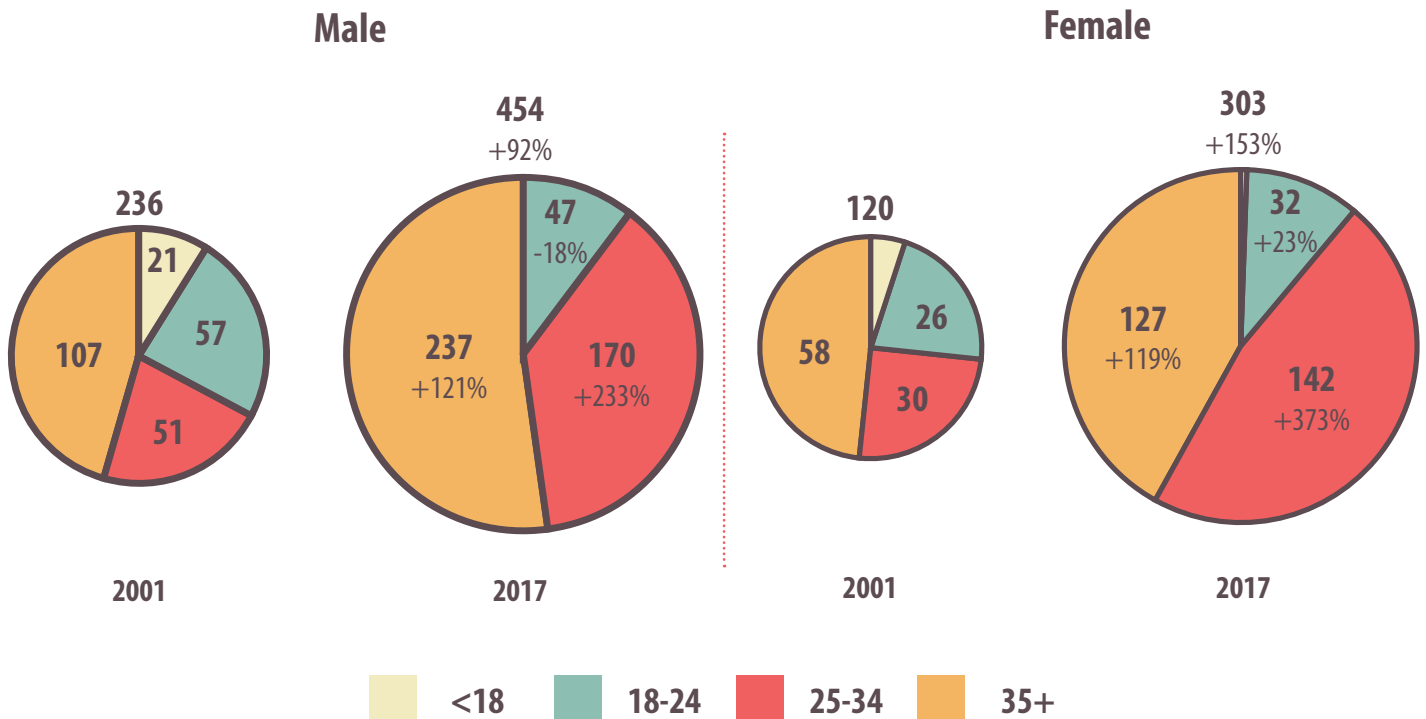


WINDHAM COUNTY

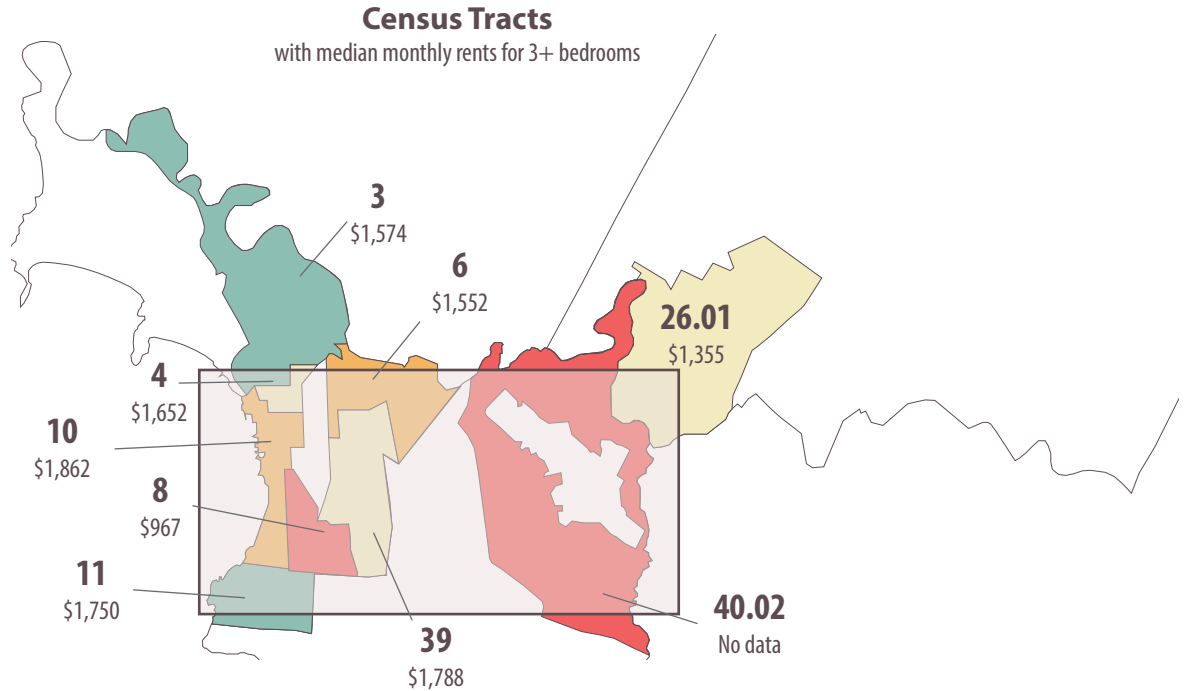
PEOPLE RECEIVING TREATMENT BY SEX



PEOPLE RECEIVING TREATMENT BY AGE



BURLINGTON



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

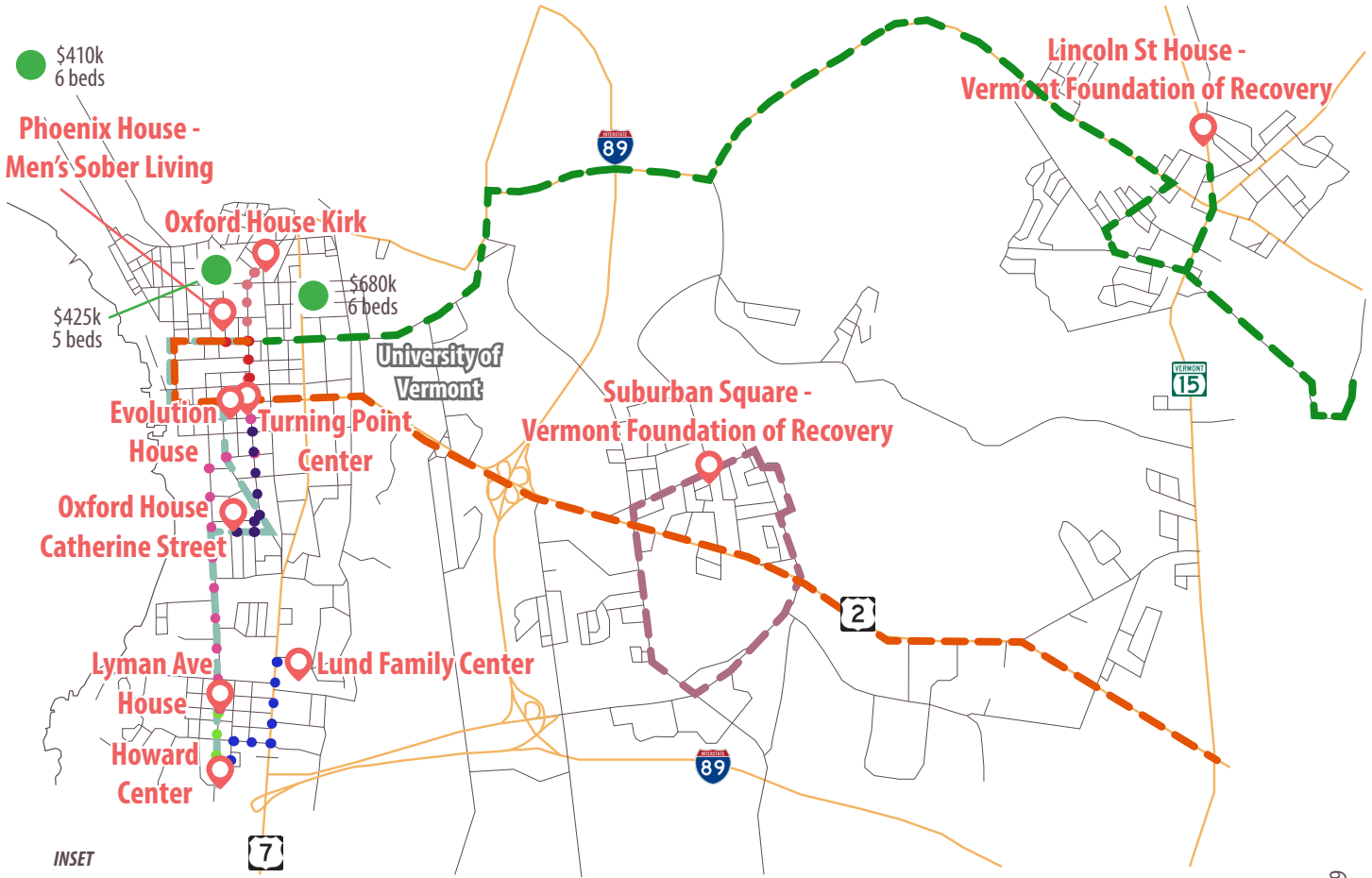
2nd Step
1477 North Avenue, Burlington

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: UMass/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

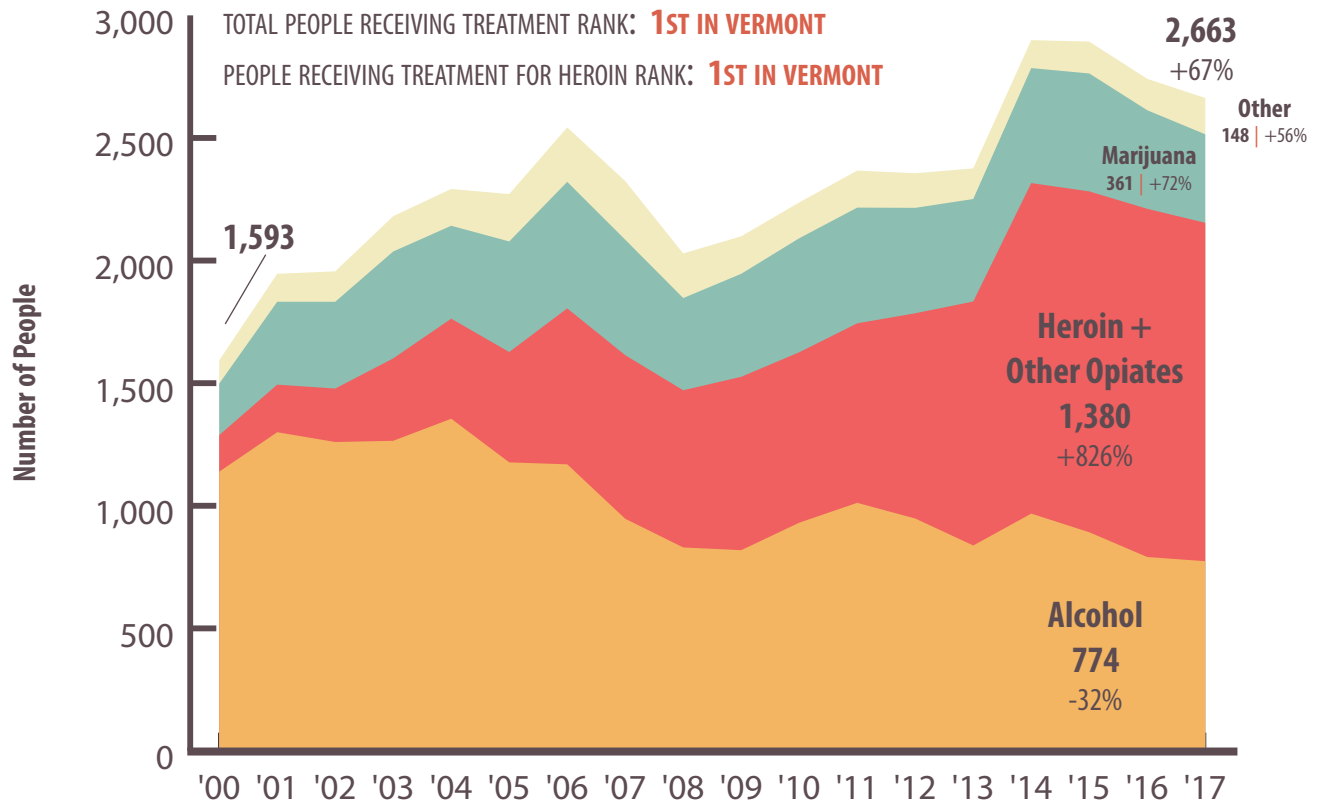


WESTON STREET

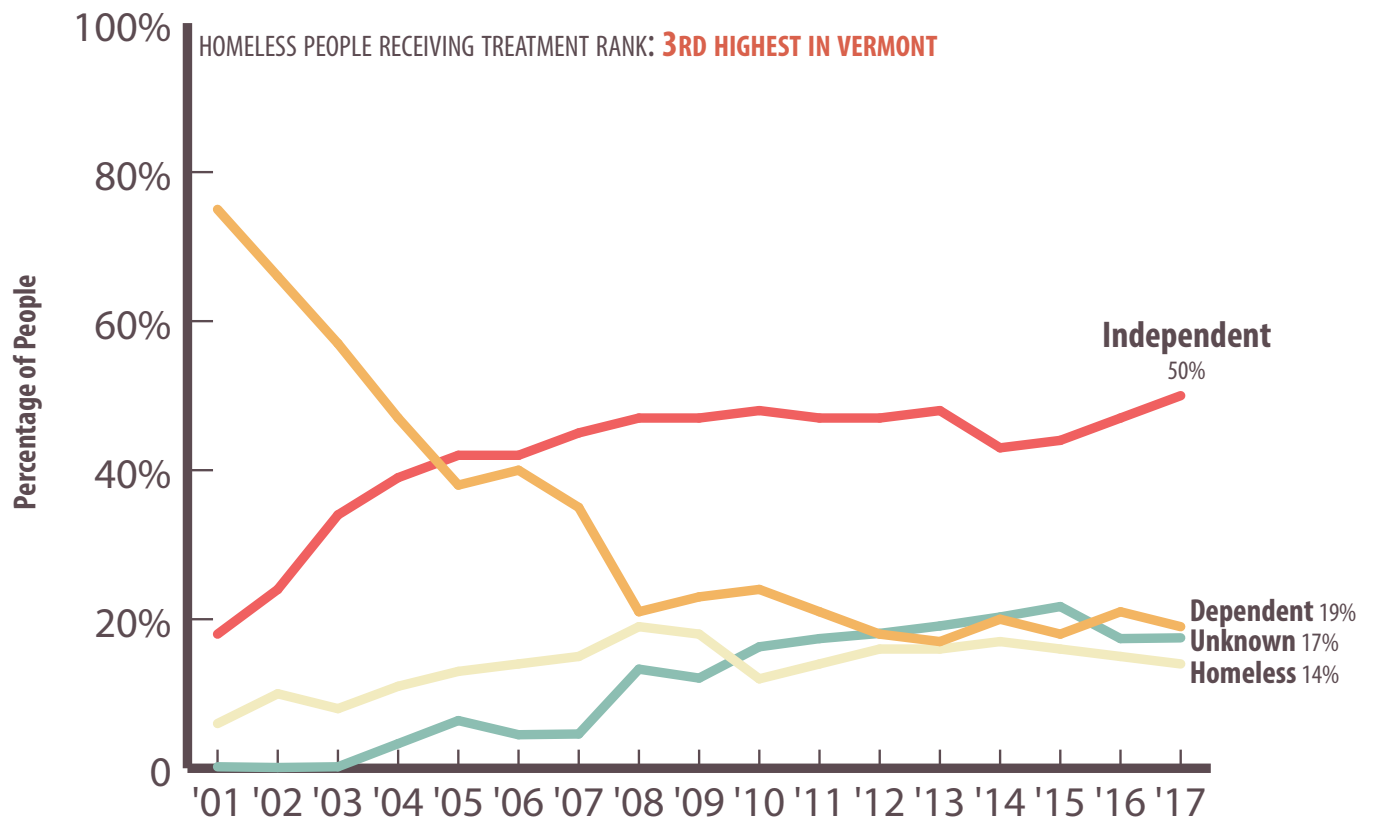
\$679,000 • 6 bedrooms • 2,244 square feet

CHITTENDEN COUNTY

PEOPLE RECEIVING TREATMENT BY PRIMARY SUBSTANCE

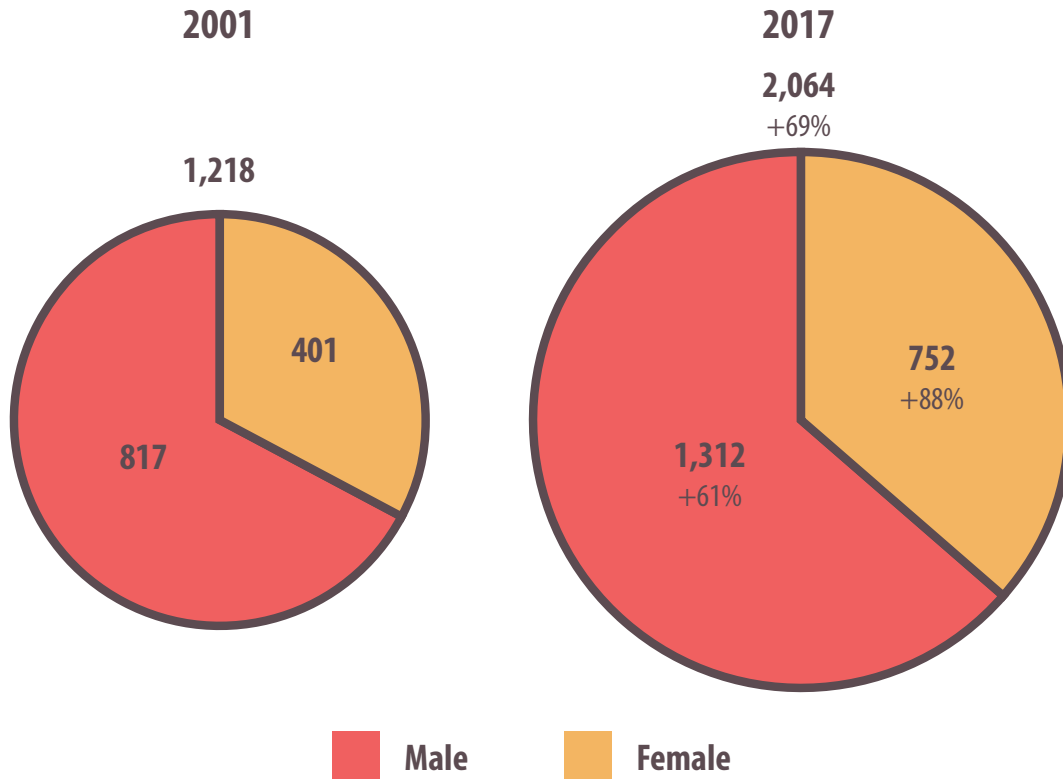


HOUSING STATUS AT TIME OF ADMISSION TO TREATMENT

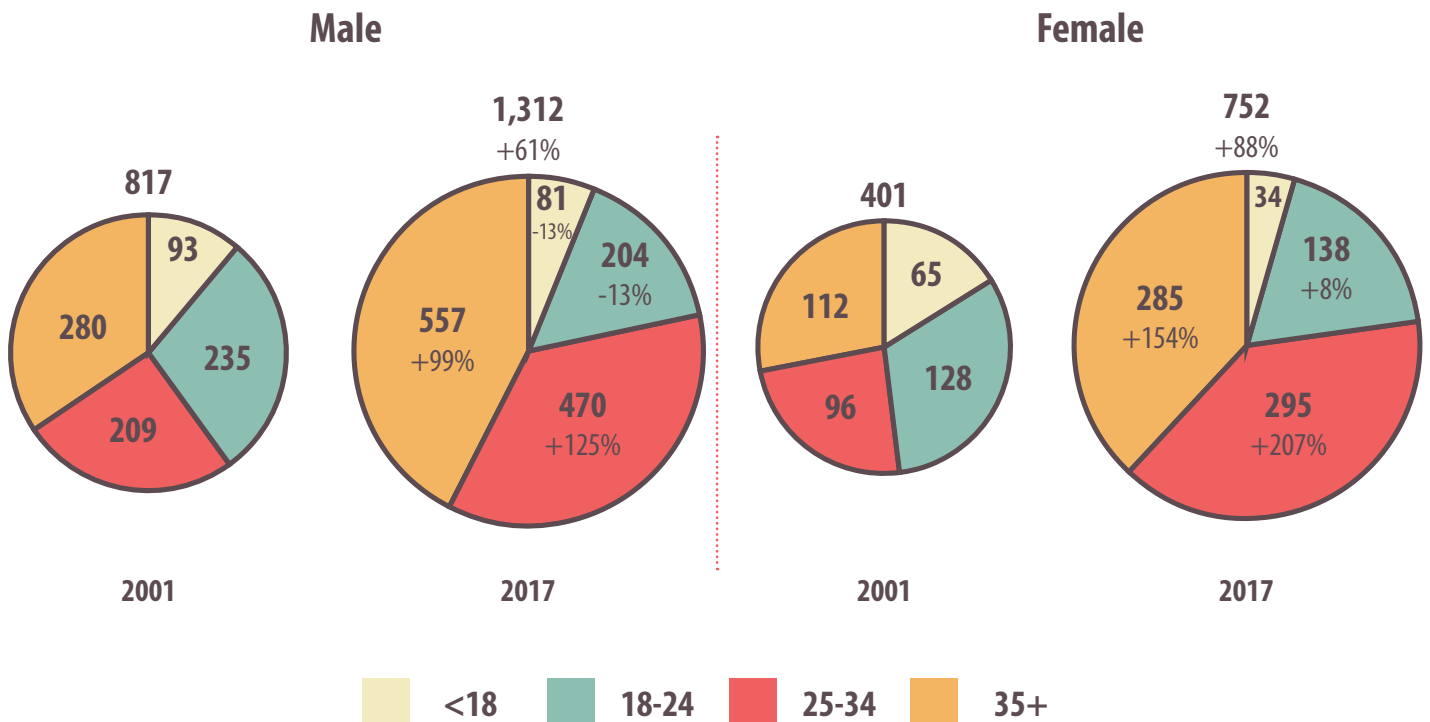


CHITTENDEN COUNTY

PEOPLE RECEIVING TREATMENT BY SEX



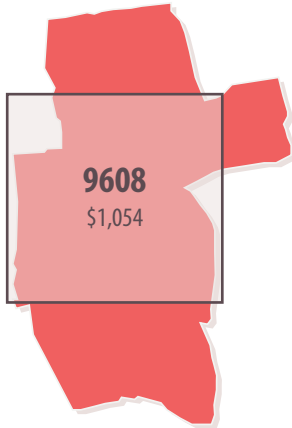
PEOPLE RECEIVING TREATMENT BY AGE



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

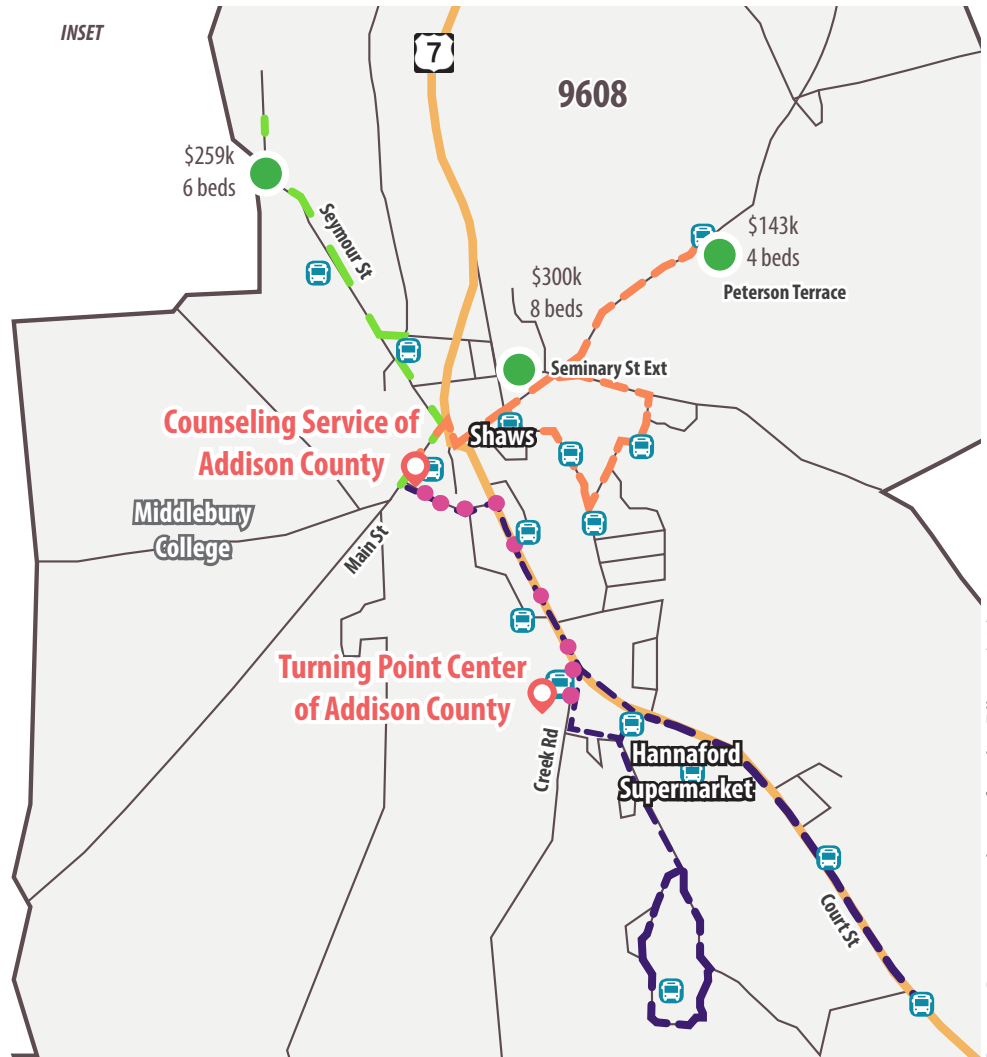
VERMONT RECOVERY HOUSING

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

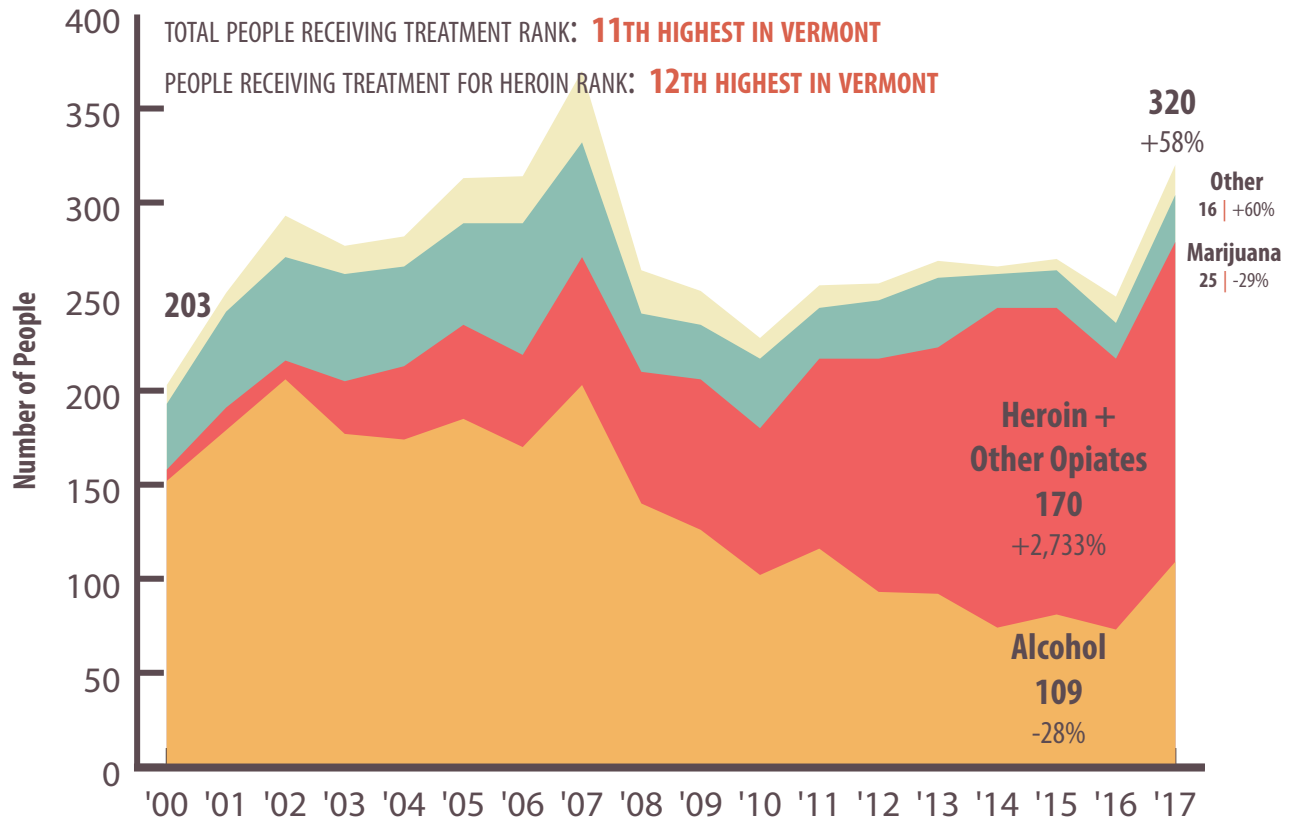


PETERSON TERRACE

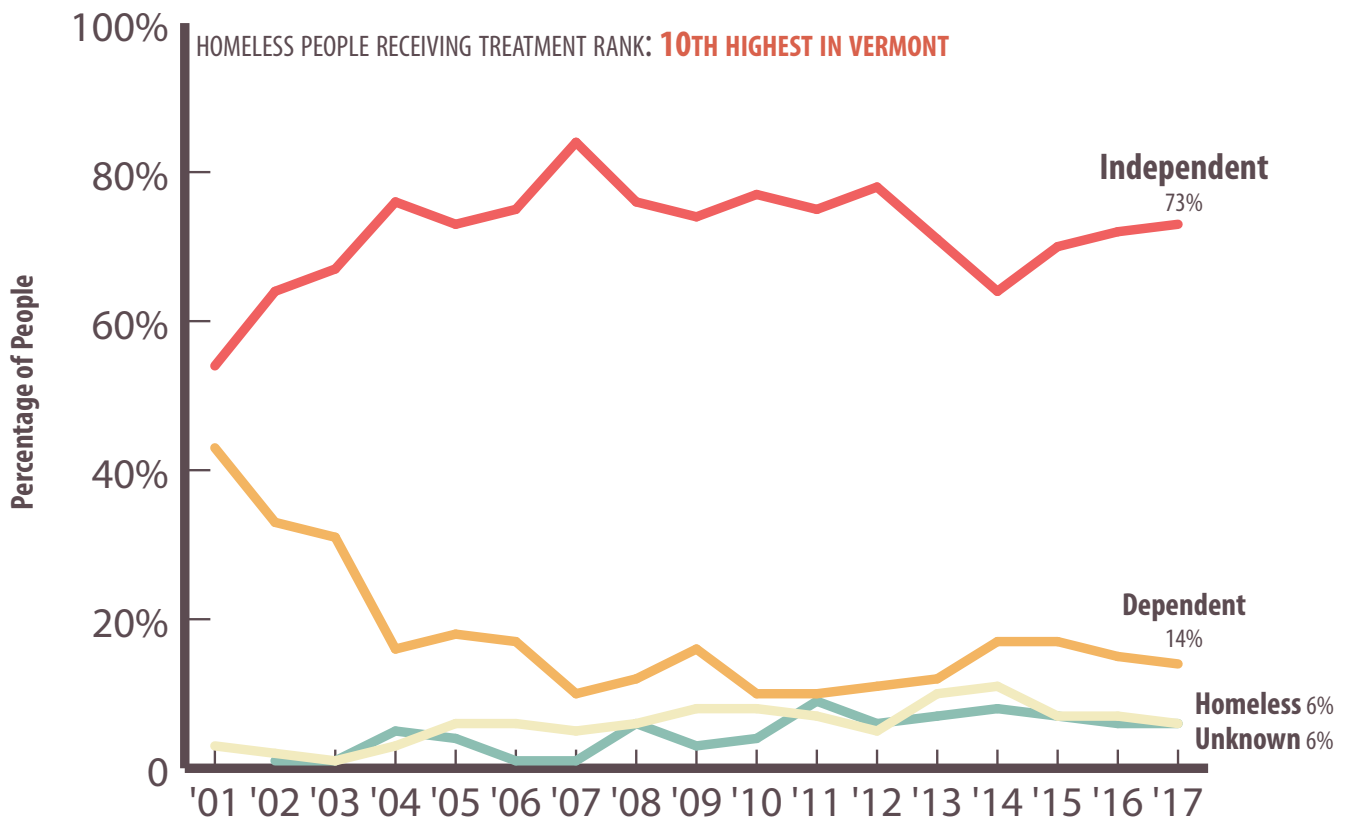
\$143,000 • 4 bedrooms • 1,669 square feet

ADDISON COUNTY

PEOPLE RECEIVING TREATMENT BY PRIMARY SUBSTANCE

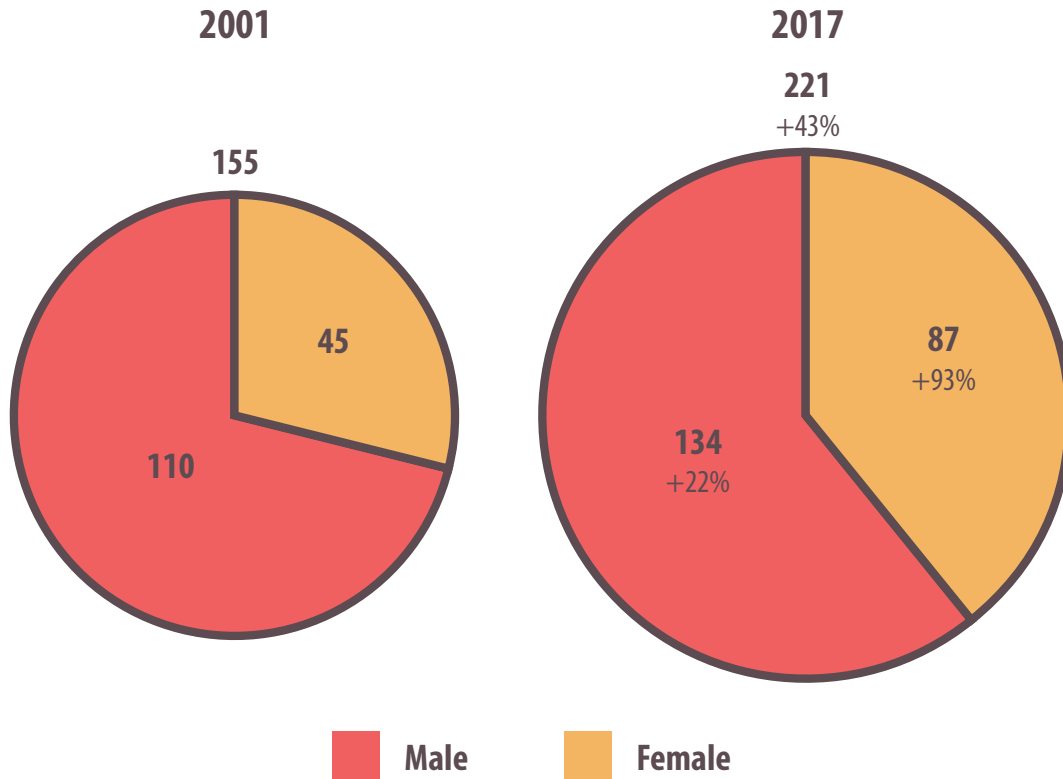


HOUSING STATUS AT TIME OF ADMISSION TO TREATMENT

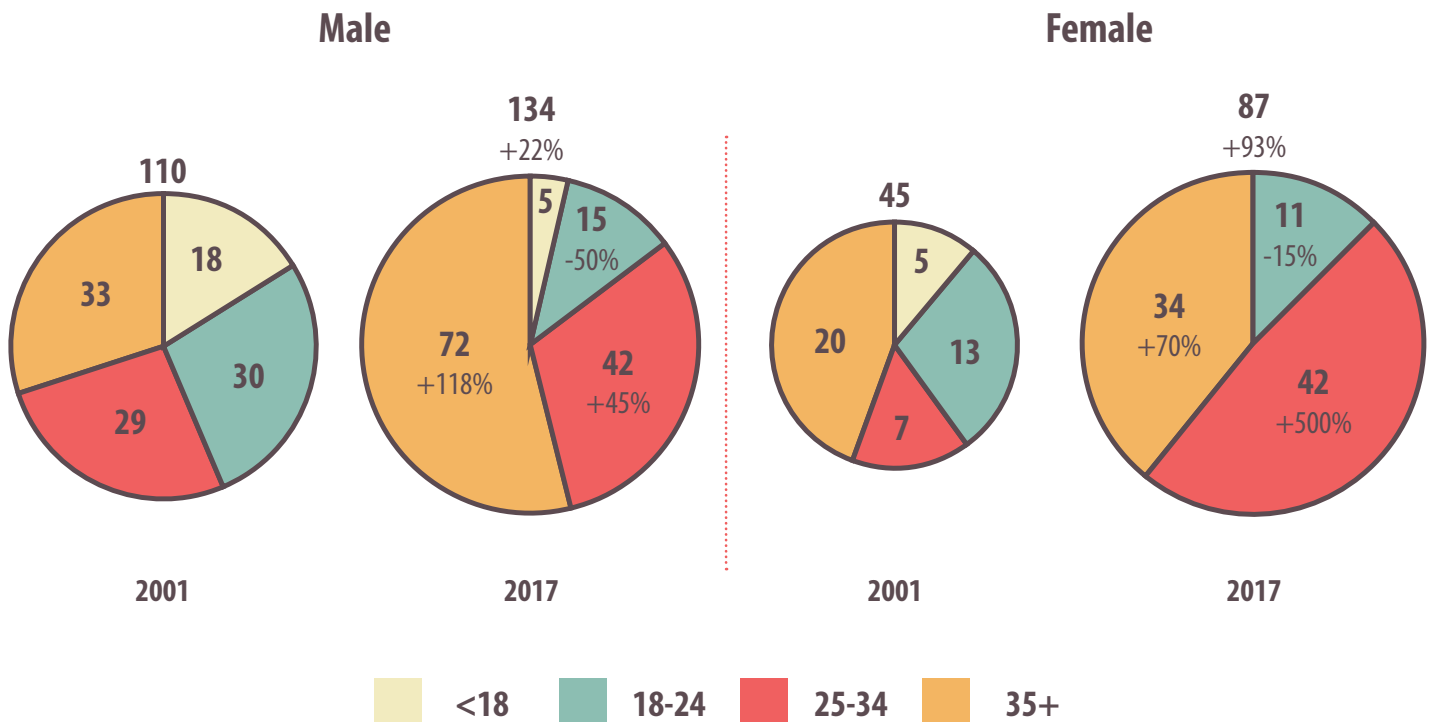


ADDISON COUNTY

PEOPLE RECEIVING TREATMENT BY SEX



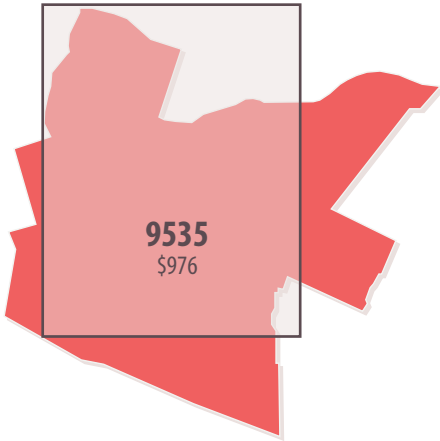
PEOPLE RECEIVING TREATMENT BY AGE



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

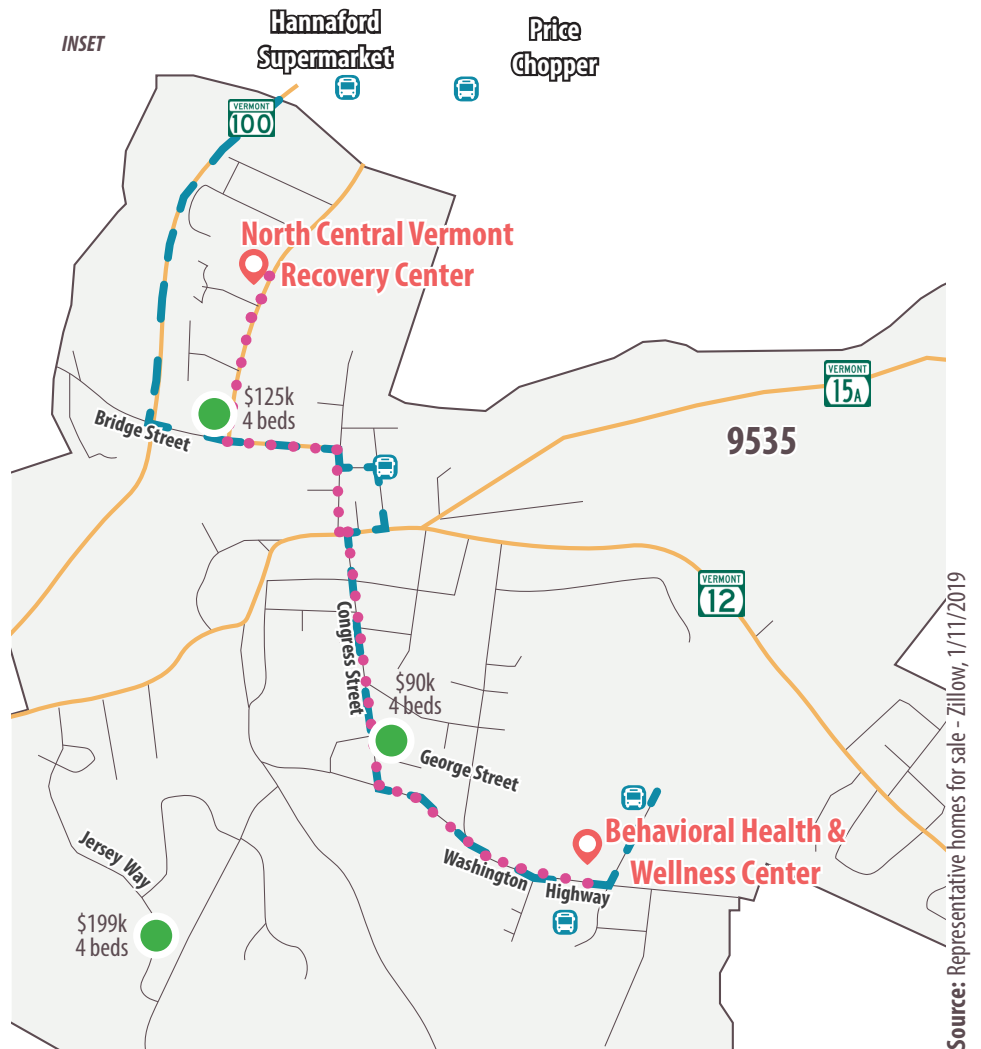
VERMONT RECOVERY HOUSING

VERMONT TREATMENT CENTER

Behavioral Health & Wellness Center
607 Washington Highway

Logistics

- • • • • 30 min walk
1.4 mile
- — — — — Morrisville Loop
every 35 min



\$89,900 • 4 bedrooms • 1,661 square feet



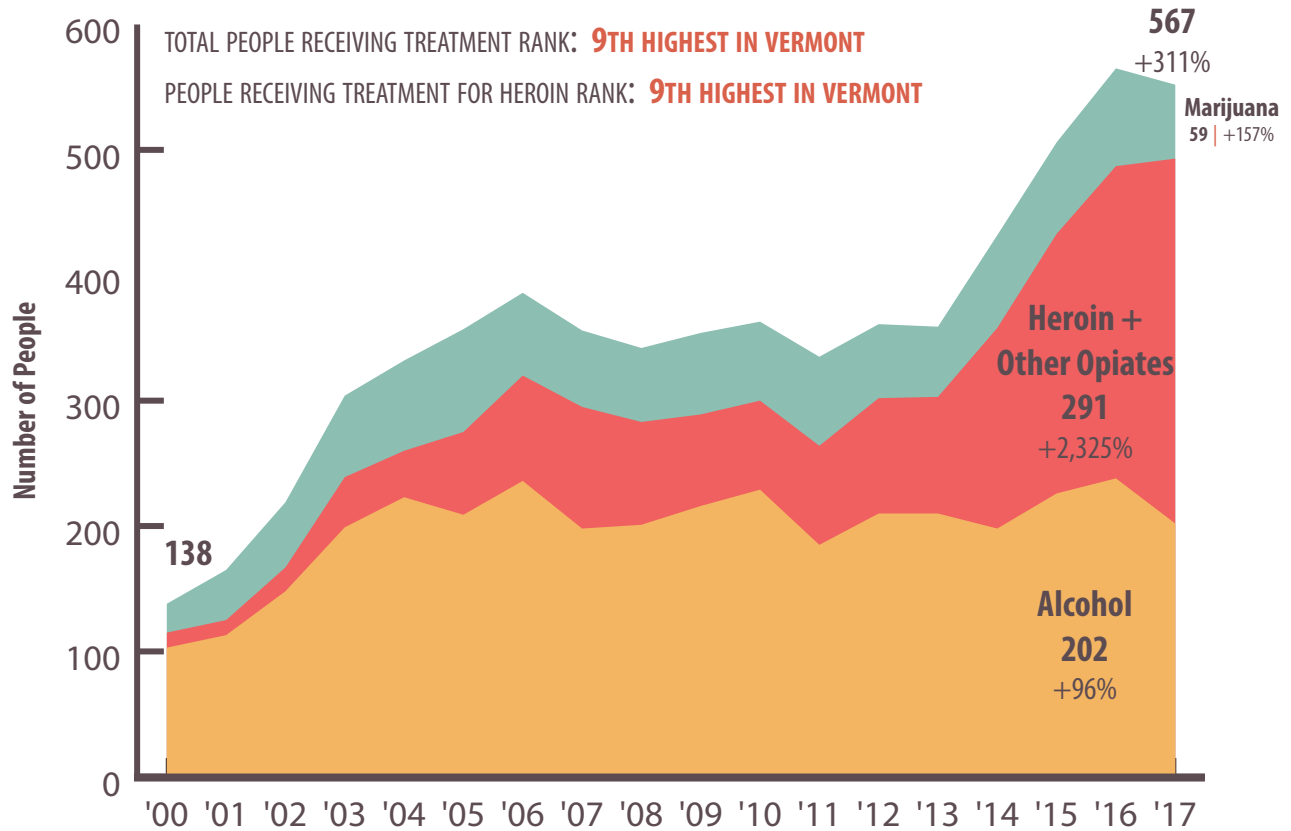
\$199,000 • 4 bedrooms • 2,052 square feet



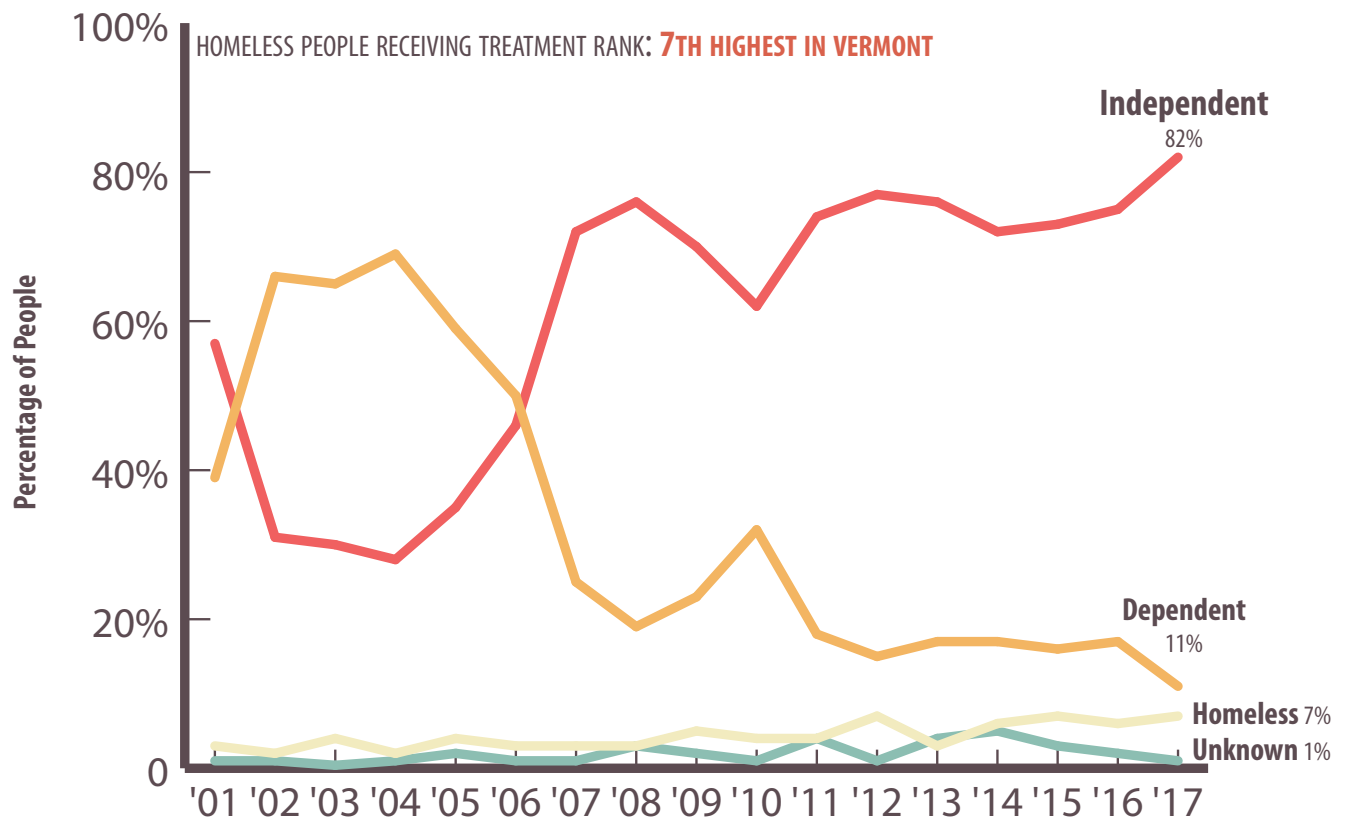
\$124,900 • 4 bedrooms • 1,769 square feet

LAMOILLE COUNTY

PEOPLE RECEIVING TREATMENT BY PRIMARY SUBSTANCE

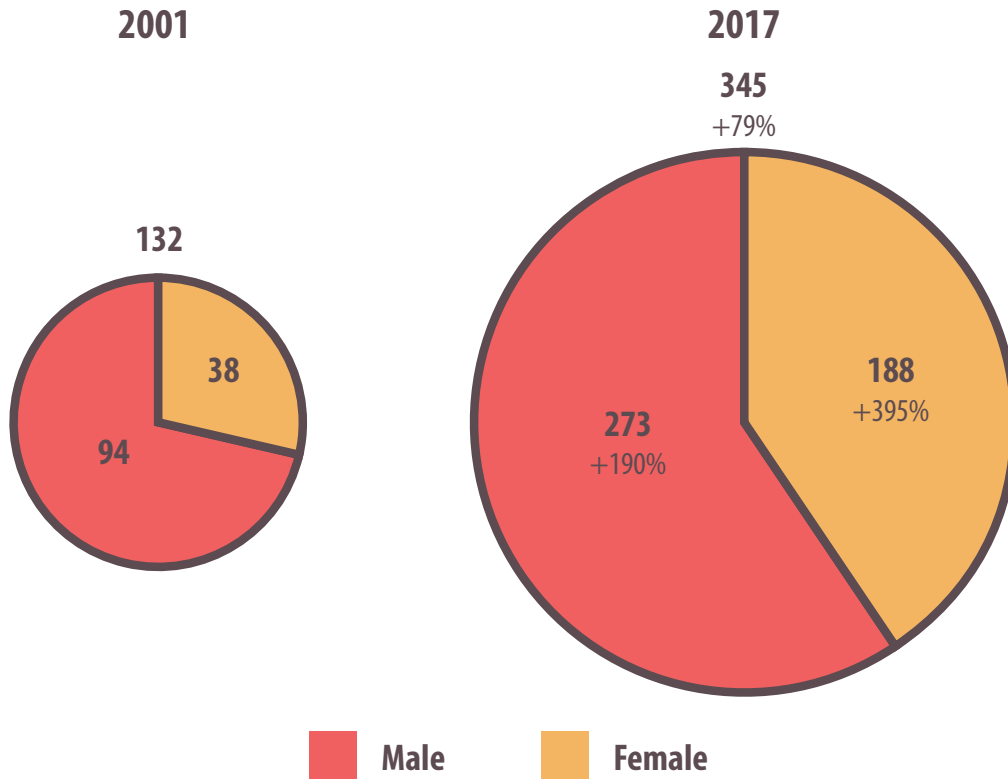


HOUSING STATUS AT TIME OF ADMISSION TO TREATMENT

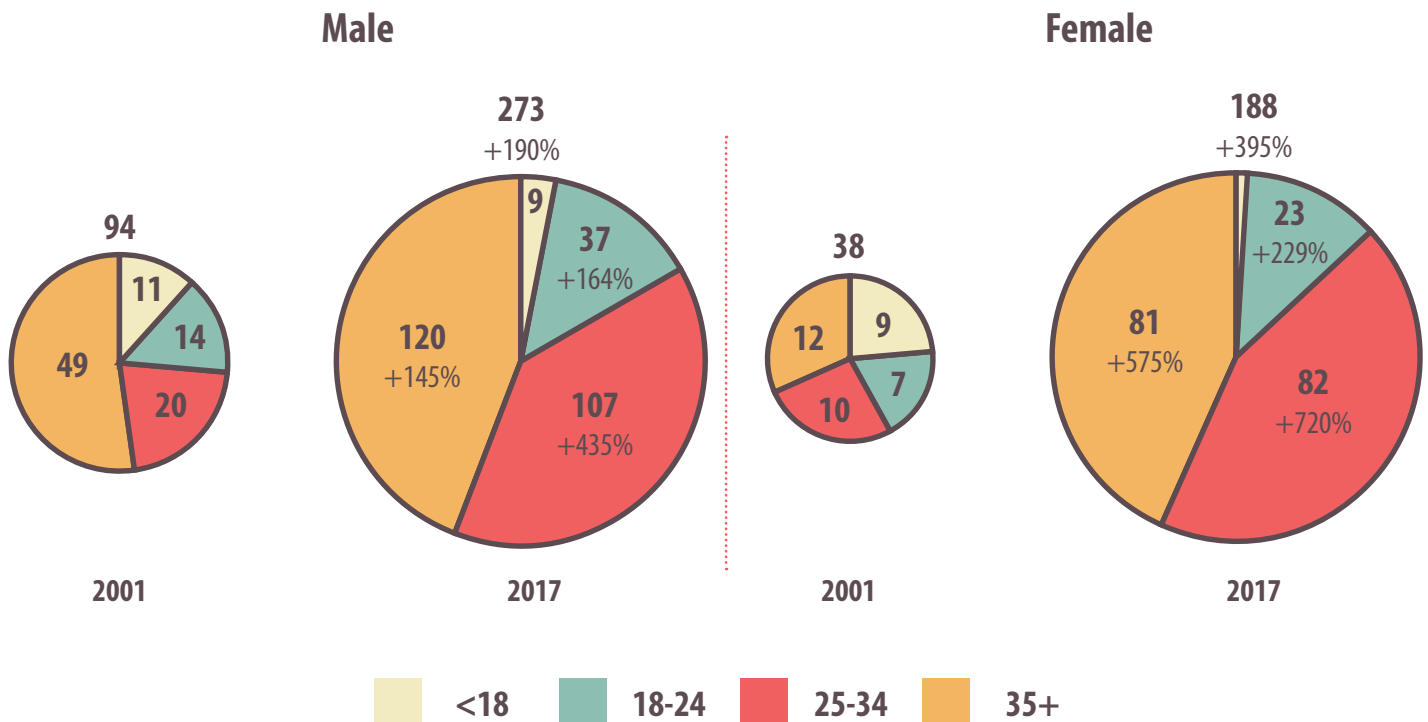


LAMOILLE COUNTY

PEOPLE RECEIVING TREATMENT BY SEX



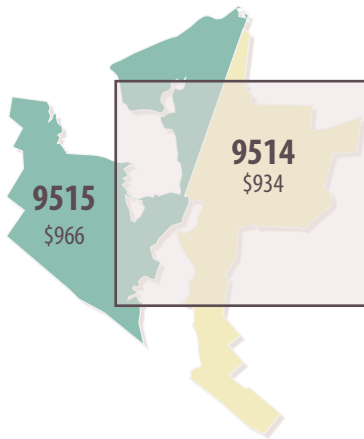
PEOPLE RECEIVING TREATMENT BY AGE



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

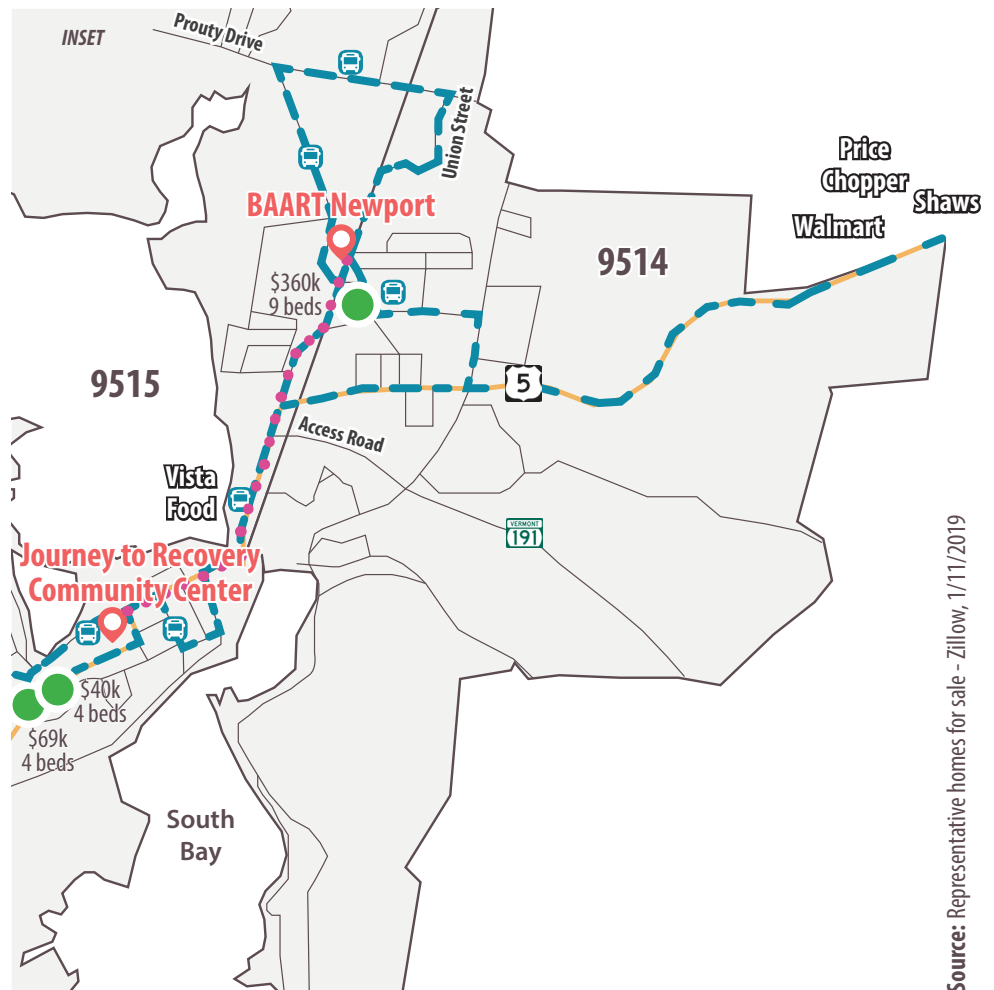
VERMONT RECOVERY HOUSING

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



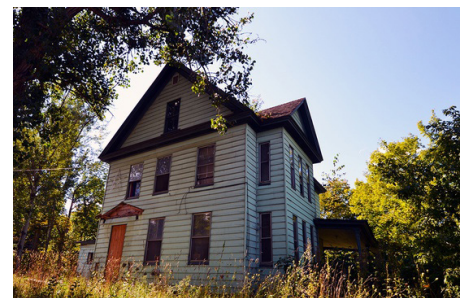
INDIAN POINT

\$359,900 • 9 bedrooms • 7,354 square feet



PLEASANT STREET

\$69,000 • 4 bedrooms • 2730 square feet

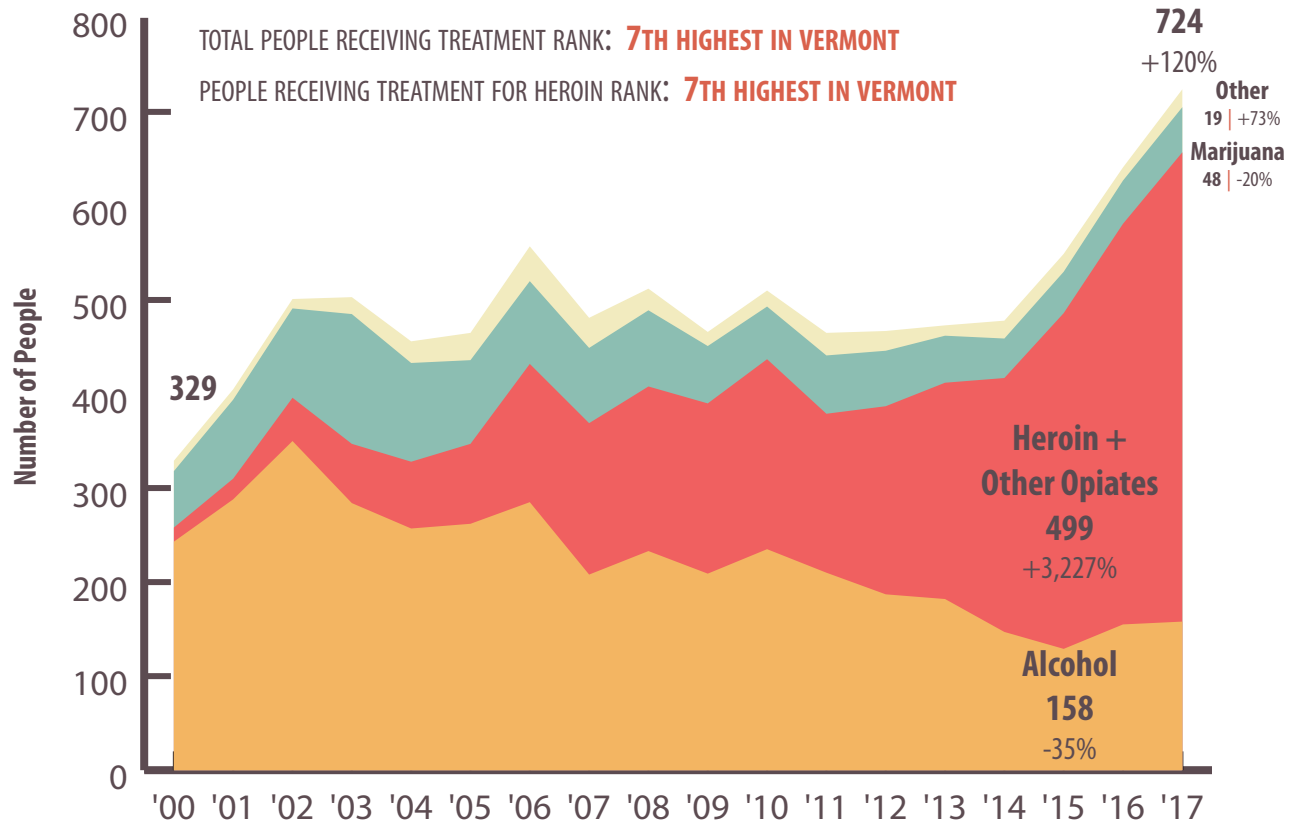


PLEASANT STREET

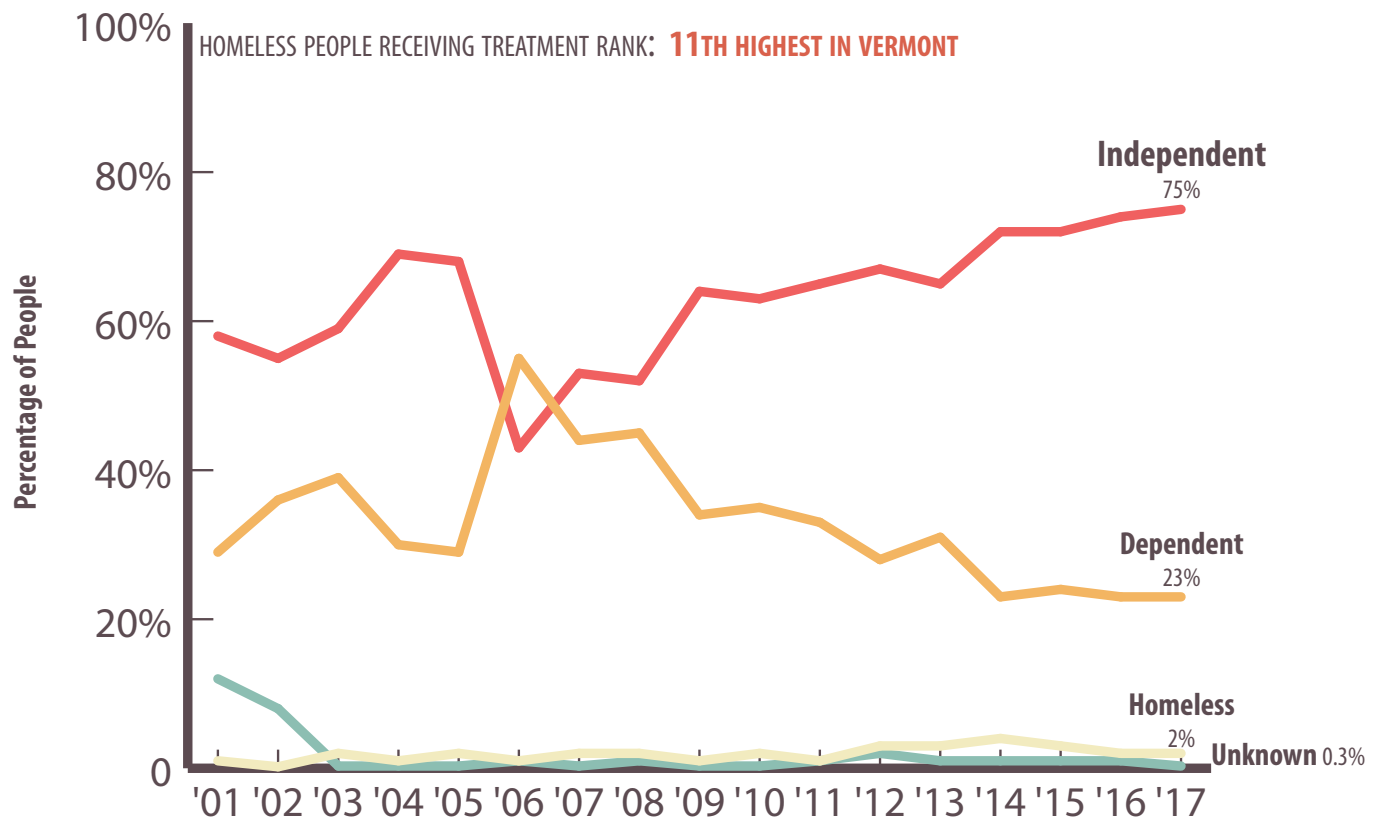
\$40,000 • 4 bedrooms
(Reconstruction)

ORLEANS COUNTY

PEOPLE RECEIVING TREATMENT BY PRIMARY SUBSTANCE

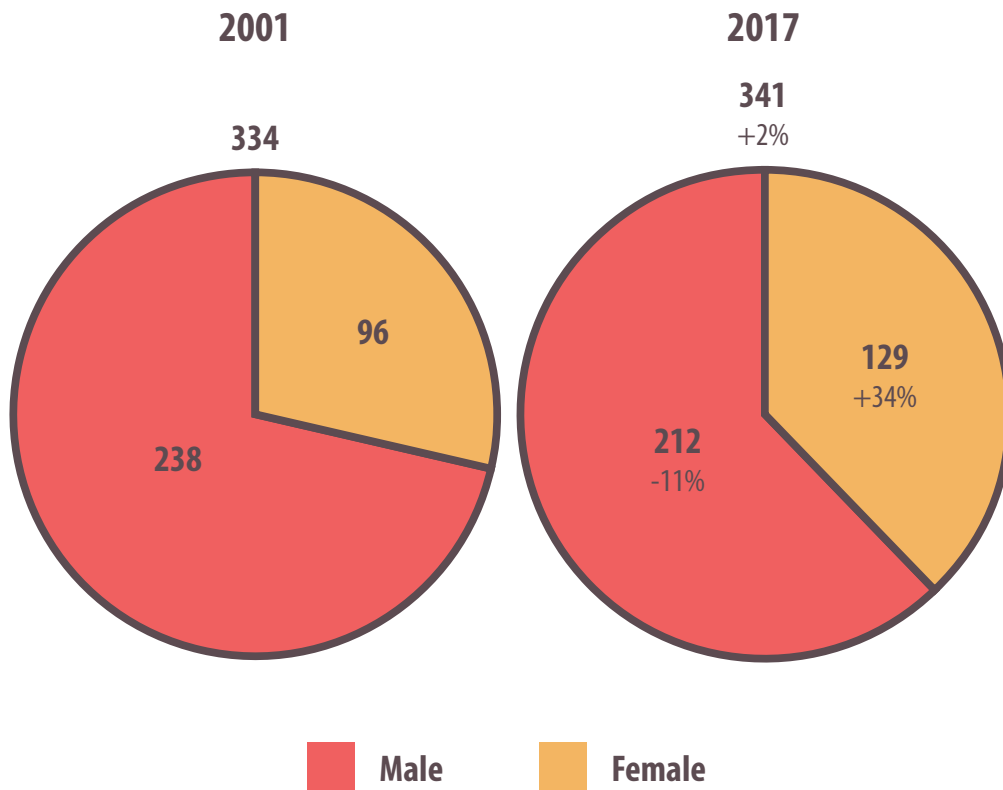


HOUSING STATUS AT TIME OF ADMISSION TO TREATMENT

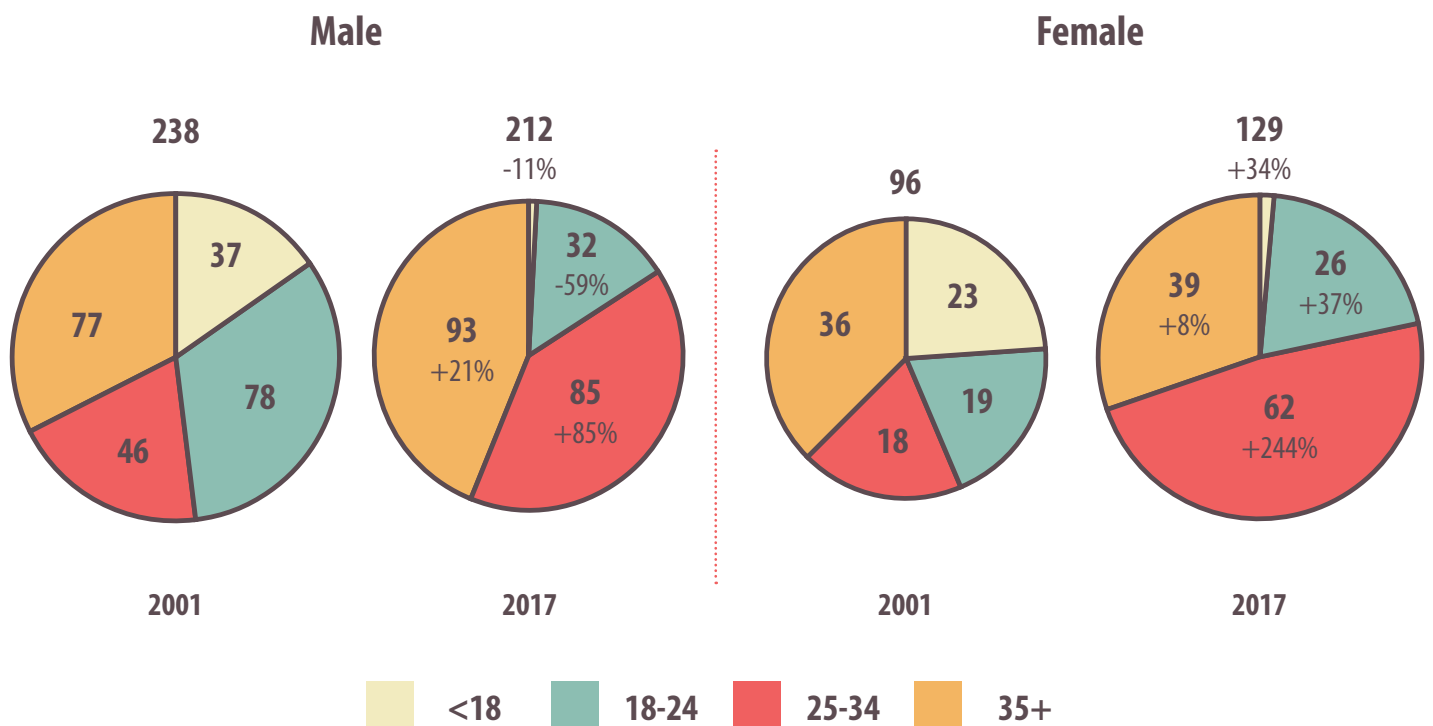


ORLEANS COUNTY

PEOPLE RECEIVING TREATMENT BY SEX



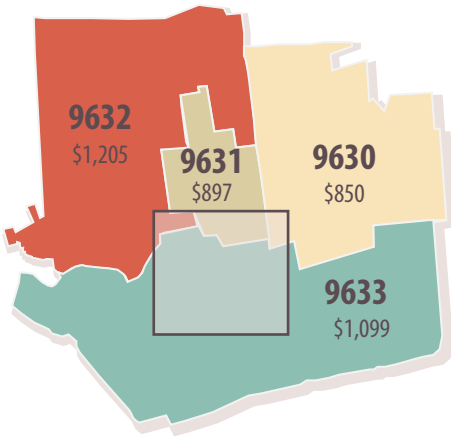
PEOPLE RECEIVING TREATMENT BY AGE



RUTLAND

Census Tracts

with median monthly rents for 3+ bedrooms



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

VERMONT RECOVERY CENTER

Turning Point Center of Rutland
141 State Street

VERMONT RECOVERY HOUSING

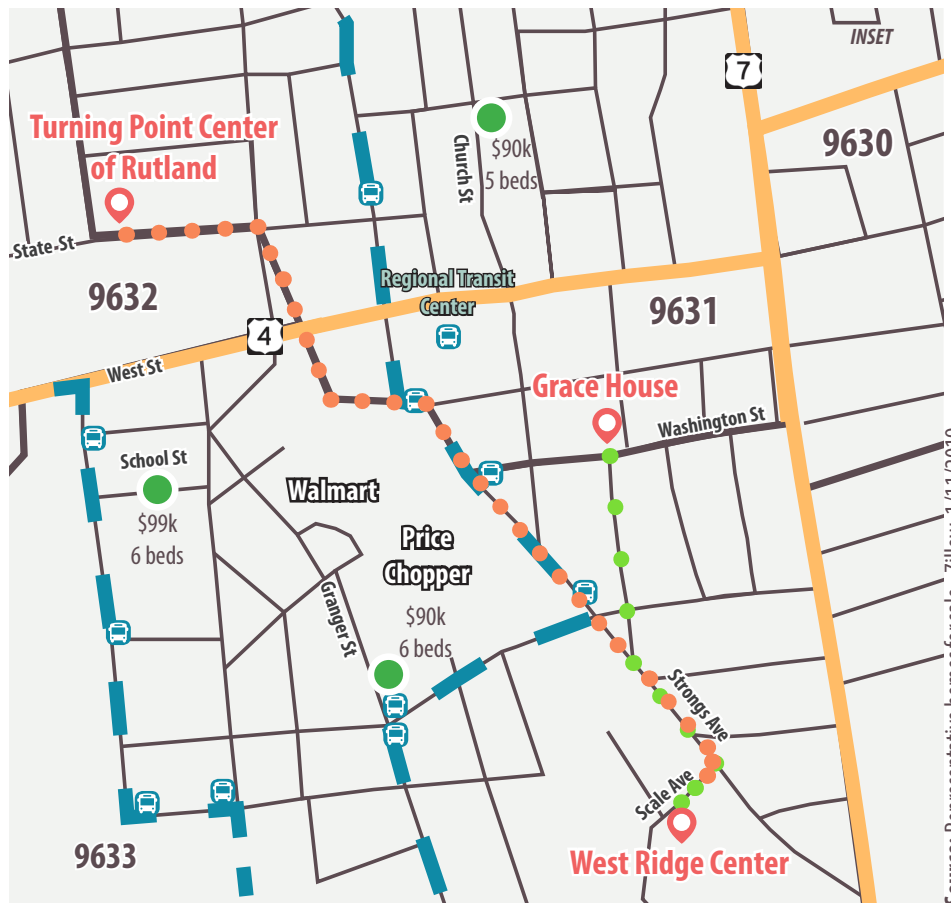
Grace House
34 Washington Street

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



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

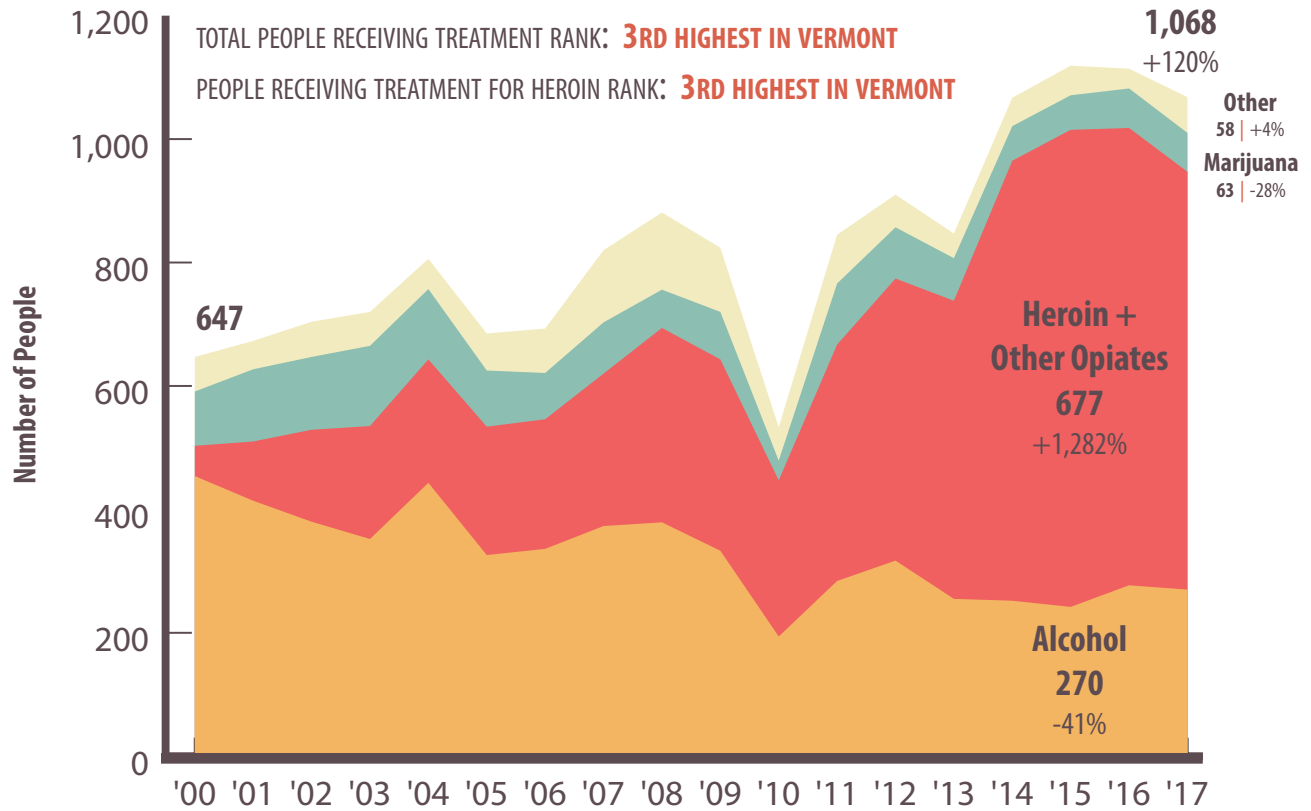


CHURCH STREET

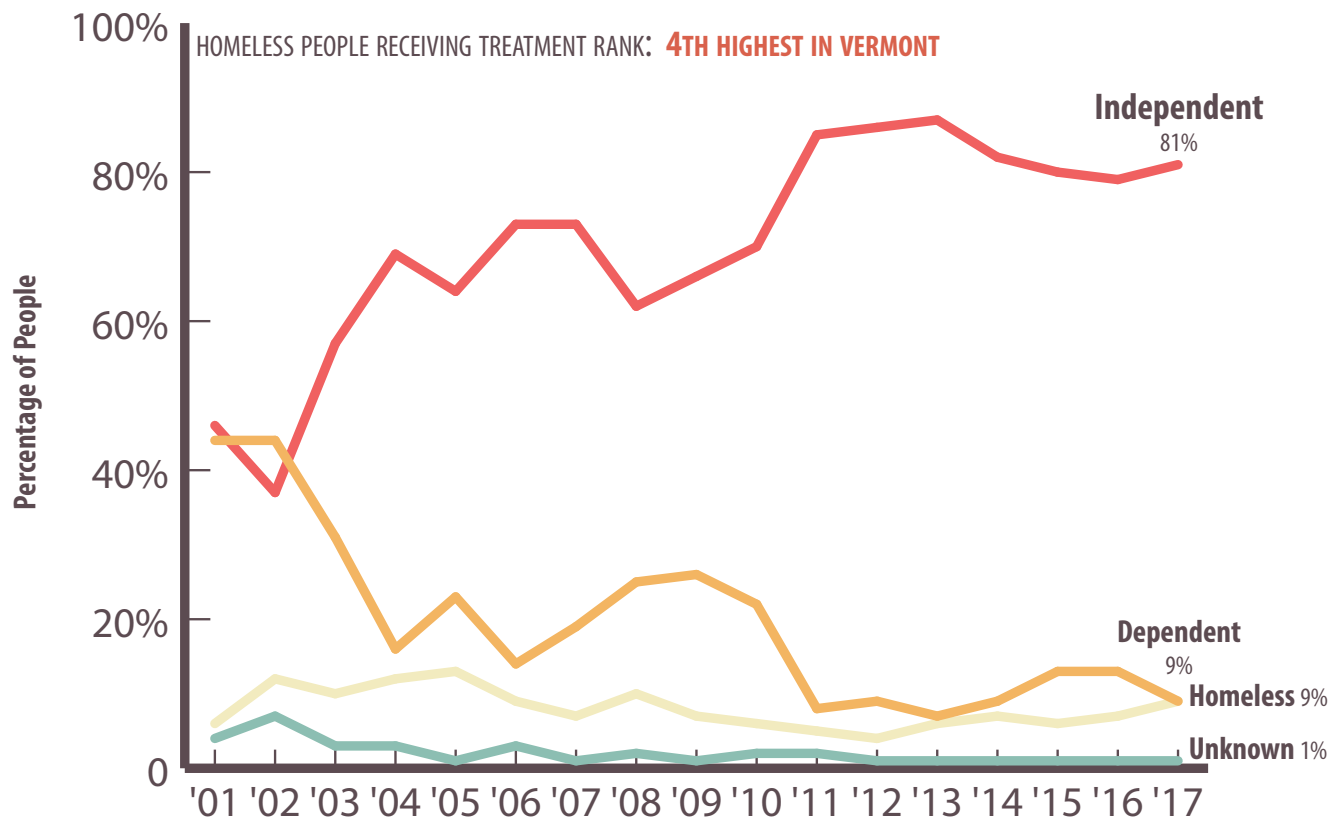
\$89,900 • 5 bedrooms • 1,984 square feet

RUTLAND COUNTY

PEOPLE RECEIVING TREATMENT BY PRIMARY SUBSTANCE

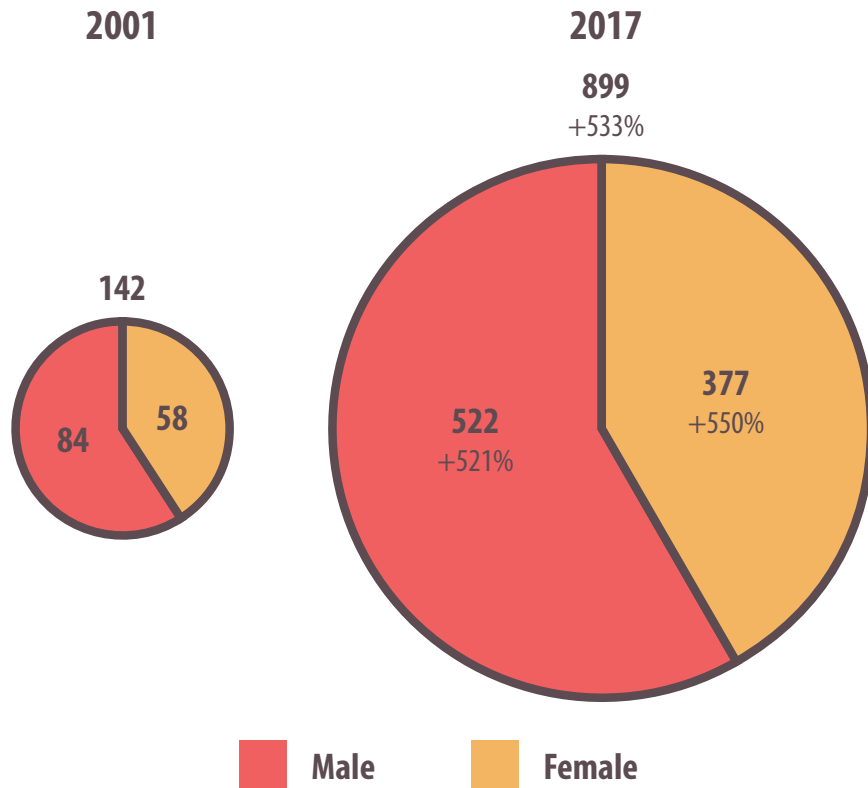


HOUSING STATUS AT TIME OF ADMISSION TO TREATMENT

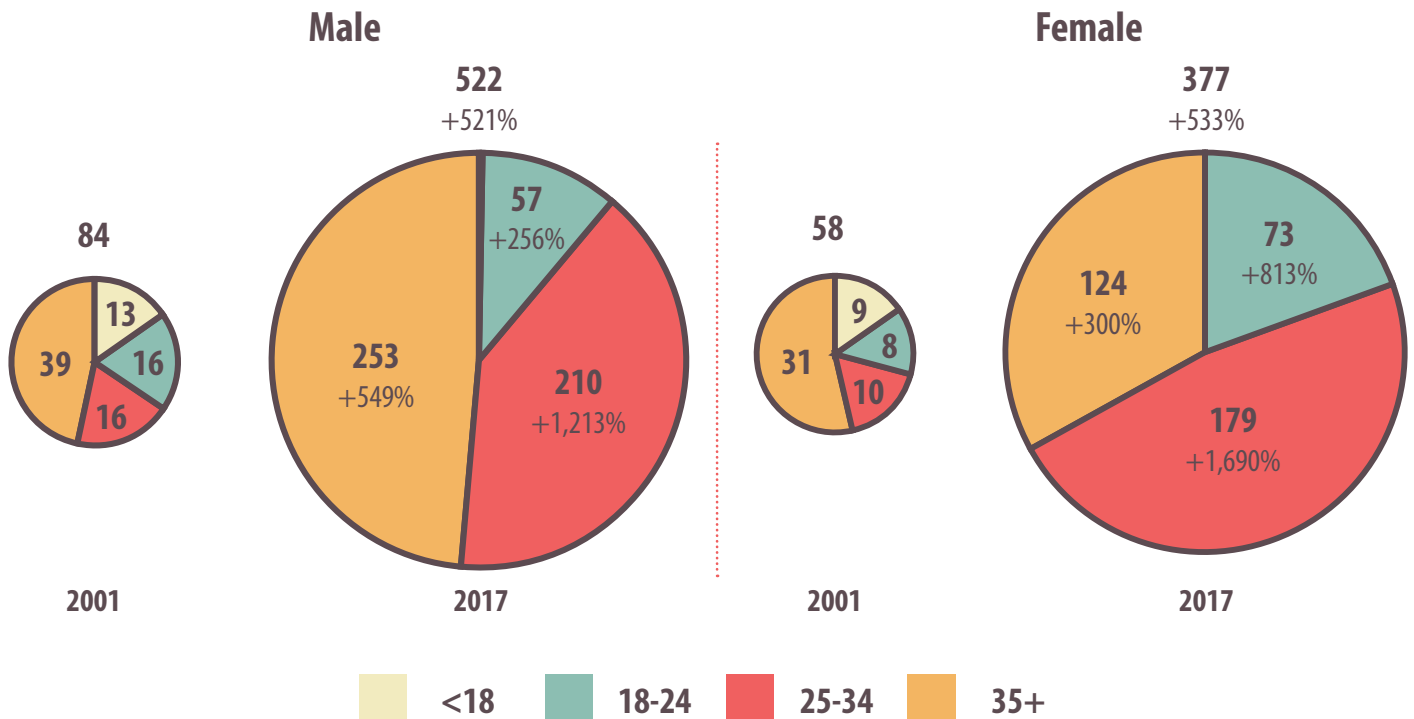


RUTLAND COUNTY

PEOPLE RECEIVING TREATMENT BY SEX



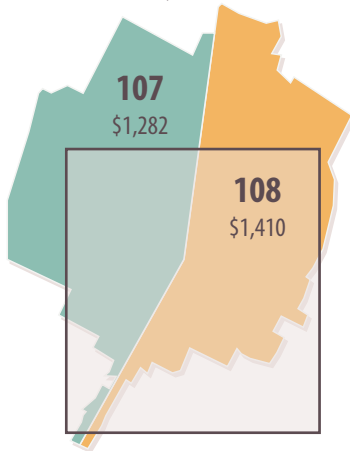
PEOPLE RECEIVING TREATMENT BY AGE



ST. ALBANS

Census Tracts

with median monthly rents for 3+ bedrooms



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

VERMONT RECOVERY CENTER

Turning Point Franklin County

182 Lake Street

VERMONT RECOVERY HOUSING

Lake Street House

135 Lake Street

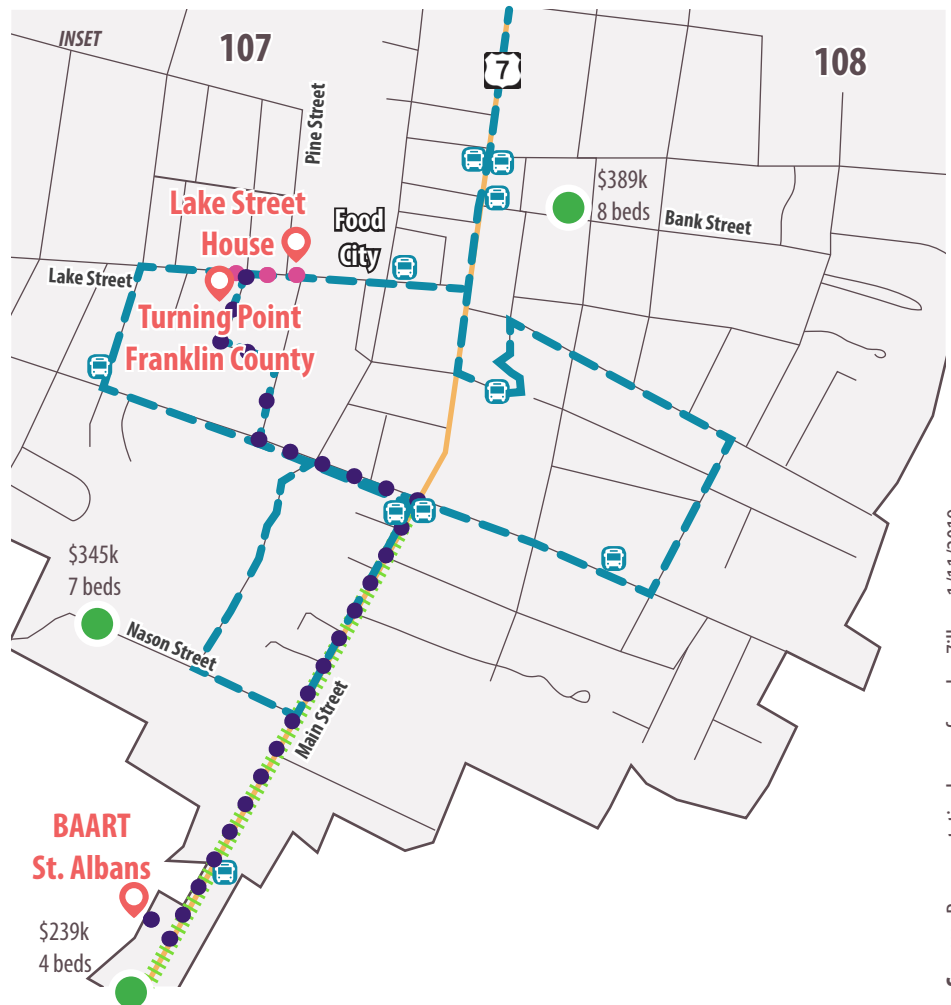
VERMONT TREATMENT CENTER

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



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

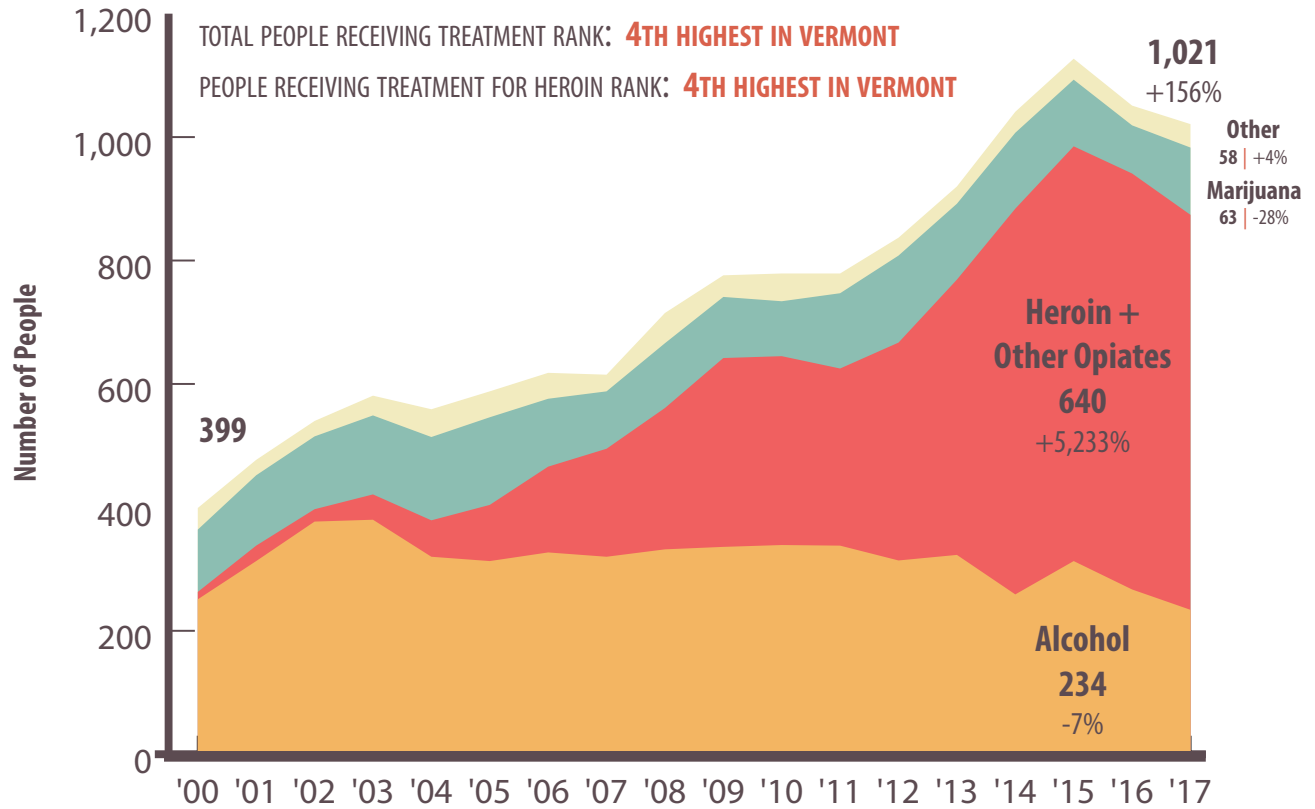


SOUTH MAIN STREET

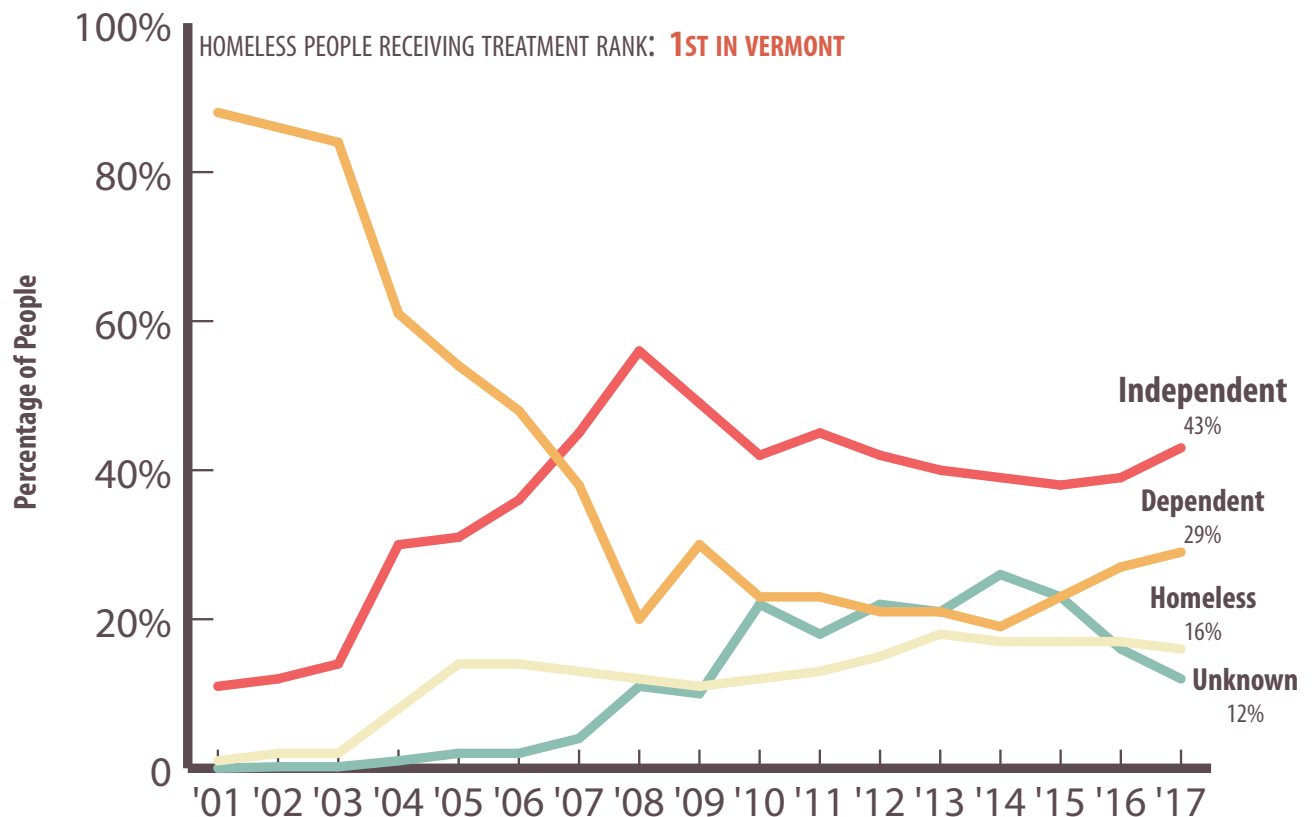
\$239,000 • 4 bedrooms • 3,240 square feet

FRANKLIN COUNTY

PEOPLE RECEIVING TREATMENT BY PRIMARY SUBSTANCE

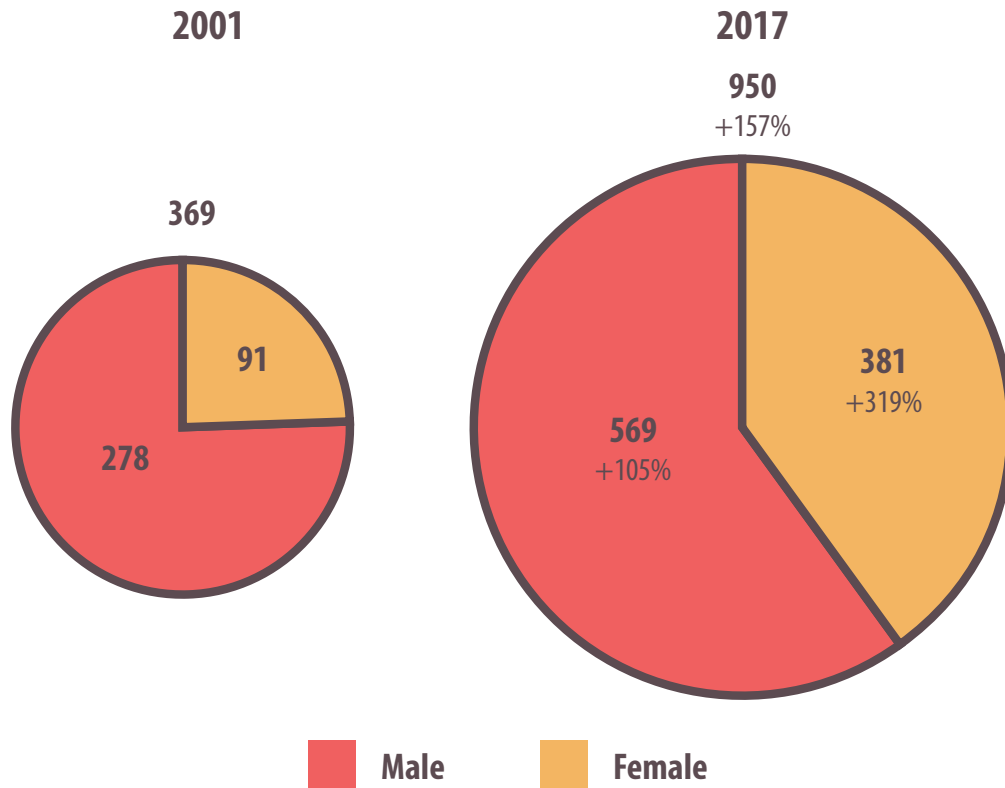


HOUSING STATUS AT TIME OF ADMISSION TO TREATMENT

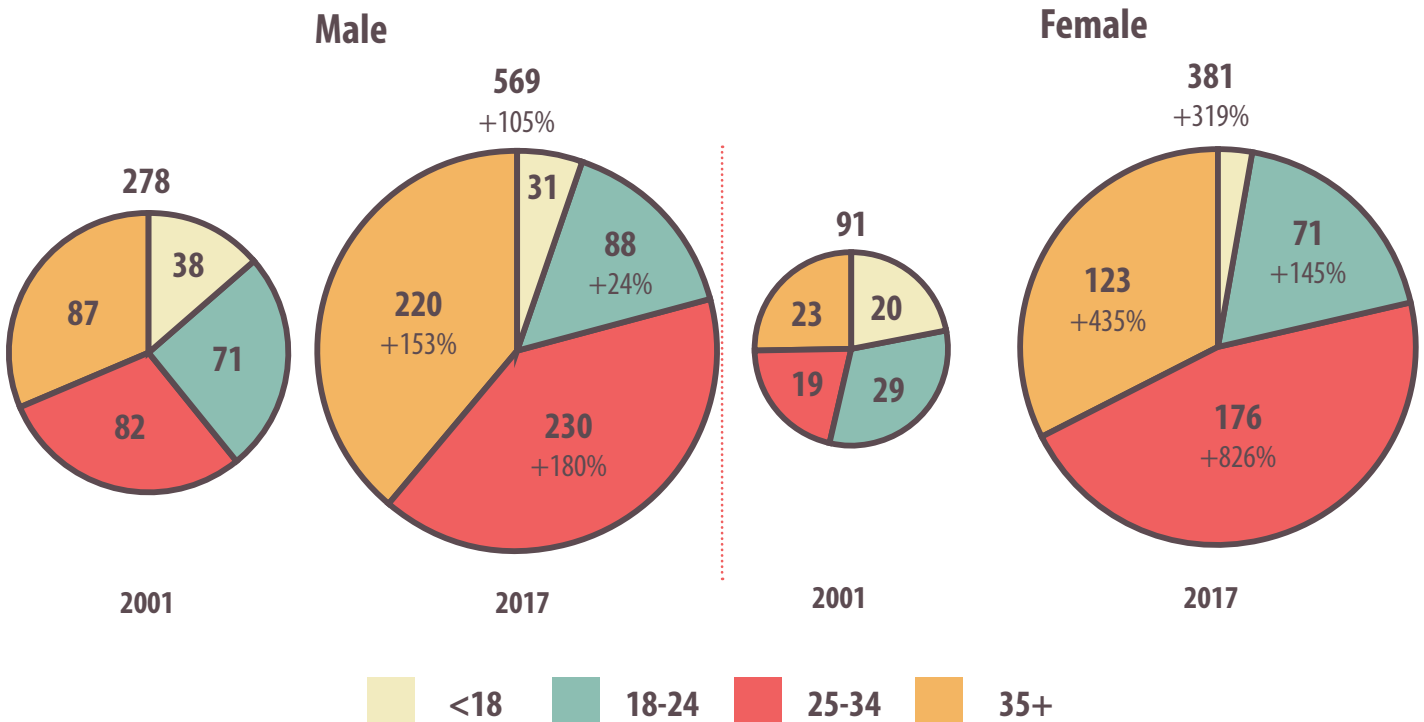


FRANKLIN COUNTY

PEOPLE RECEIVING TREATMENT BY SEX



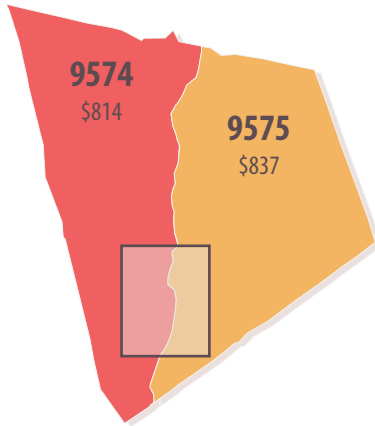
PEOPLE RECEIVING TREATMENT BY AGE



ST. JOHNSBURY

Census Tracts

with median monthly rents for 3+ bedrooms



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

VERMONT RECOVERY CENTER

Kingdom Recovery Center
297 Summer Street

VERMONT RECOVERY HOUSING

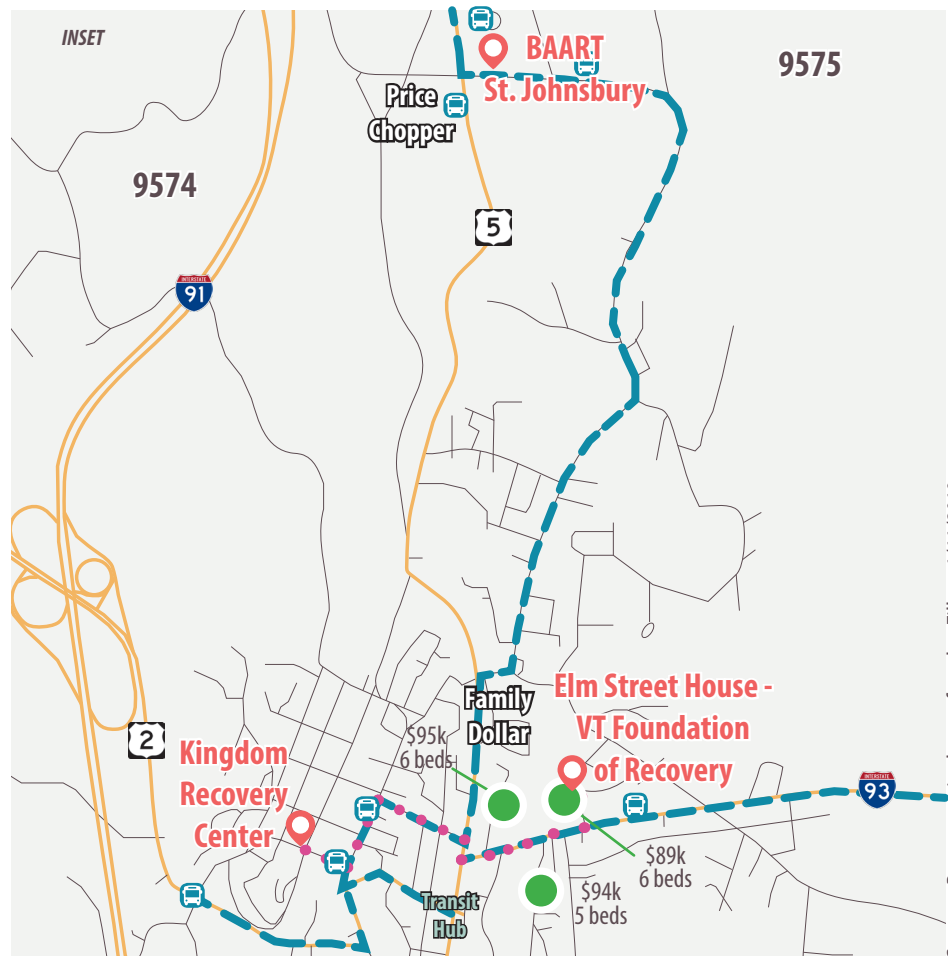
**Elm Stree House -
Vermont Foundation of Recovery**
87 Elm Street

VERMONT TREATMENT CENTER

BAART St. Johnsbury
1097 Hospital Drive

Logistics

- • • • • 20 min walk
0.9 mile
- — — — — Twin City
twice daily



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

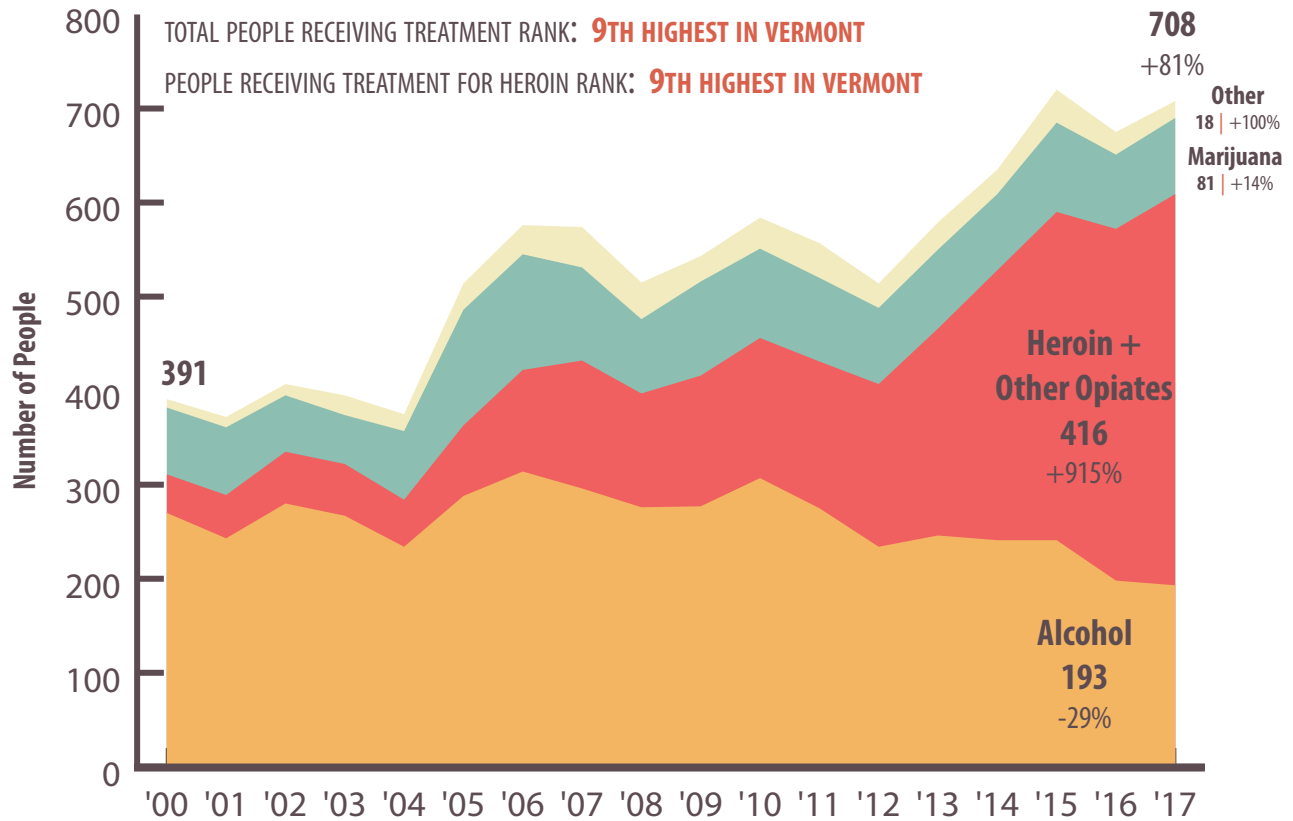


SAINT MARY STREET

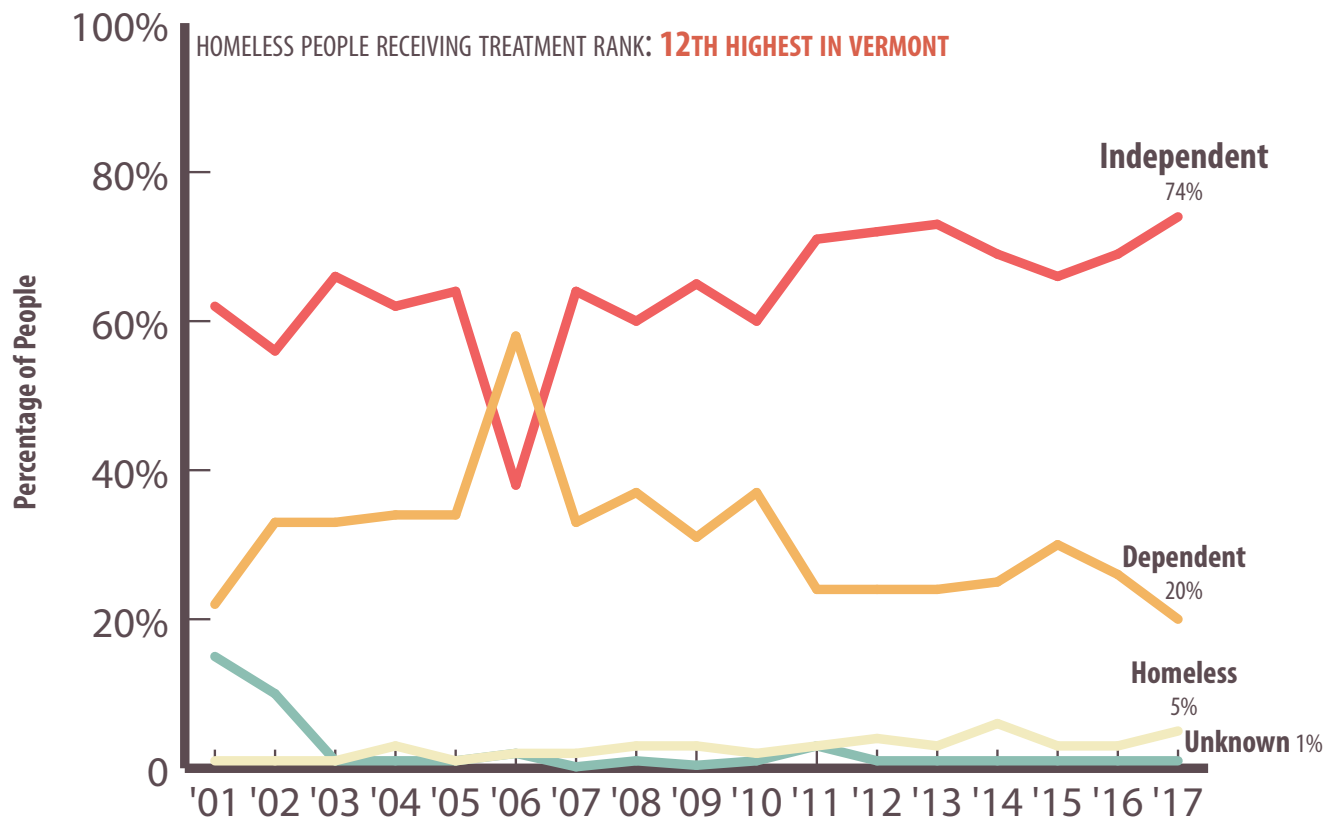
\$95,000 • 6 bedrooms • 2,282 square feet

CALEDONIA COUNTY

PEOPLE RECEIVING TREATMENT BY PRIMARY SUBSTANCE

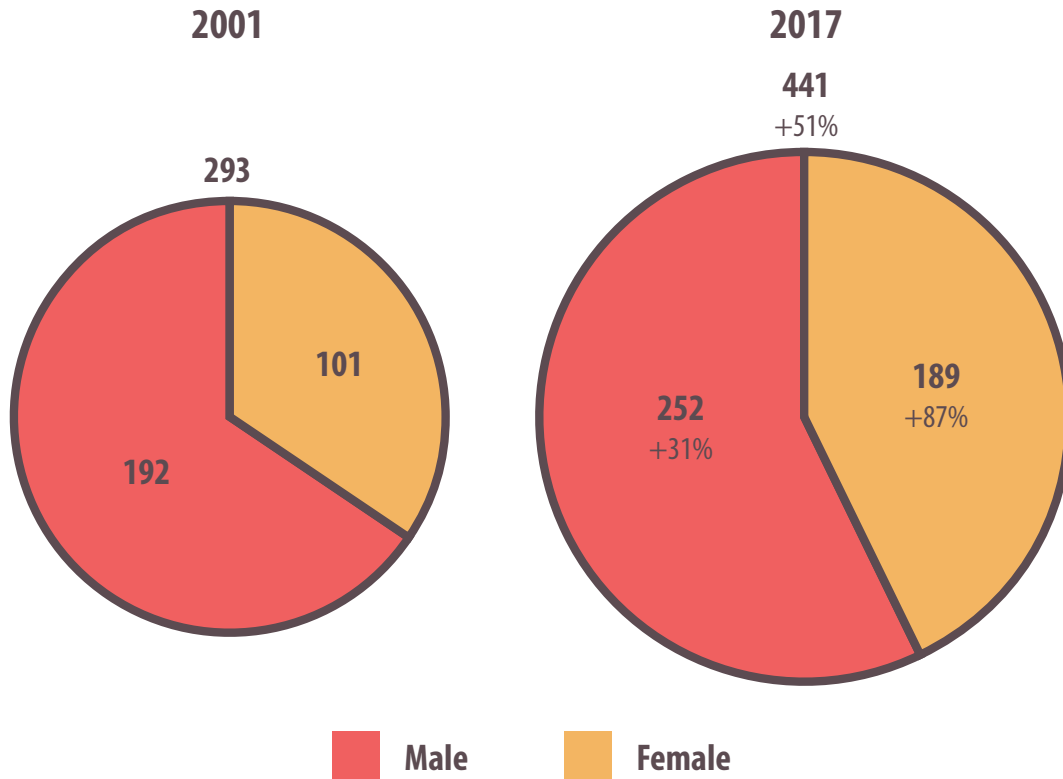


HOUSING STATUS AT TIME OF ADMISSION TO TREATMENT

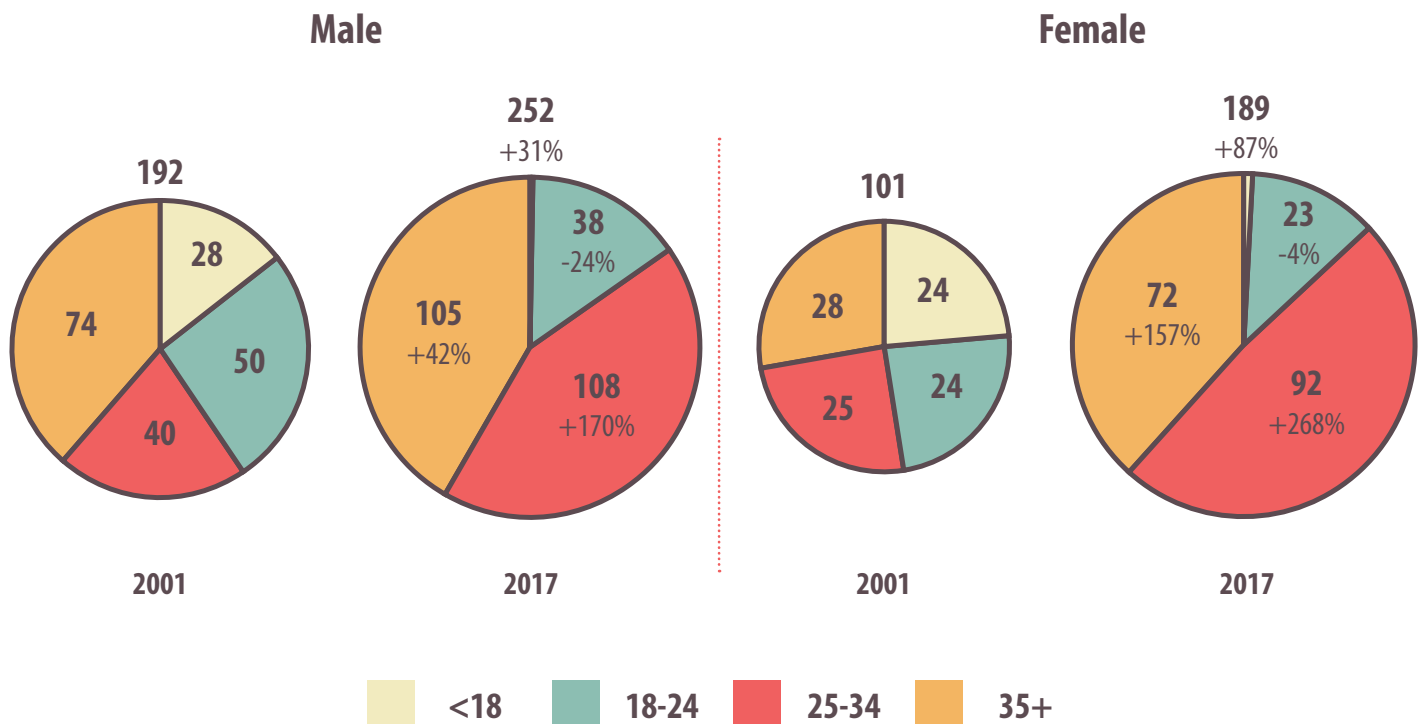


CALEDONIA COUNTY

PEOPLE RECEIVING TREATMENT BY SEX



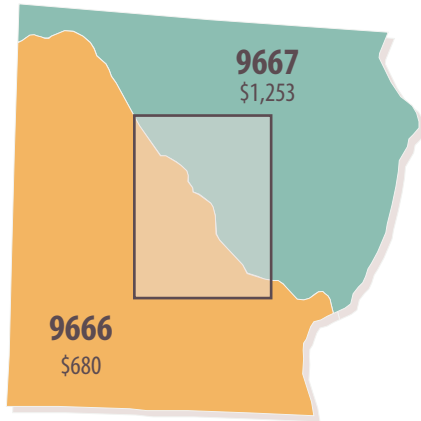
PEOPLE RECEIVING TREATMENT BY AGE



SPRINGFIELD

Census Tracts

with median monthly rents for 3+ bedrooms



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

VERMONT RECOVERY CENTER

Turning Point Recovery Center

7 Morgan Street Street

VERMONT RECOVERY HOUSING

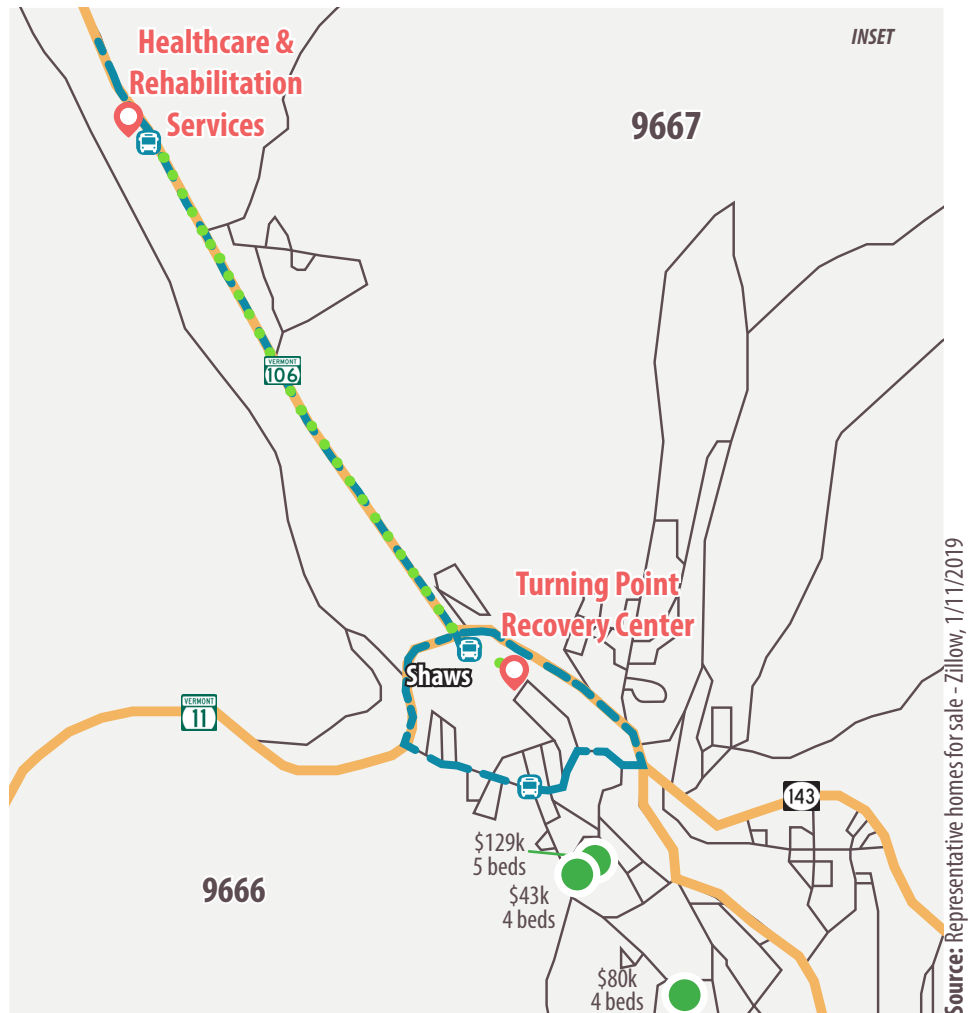
VERMONT TREATMENT CENTER

Healthcare & Rehab Services

390 River Street

Logistics

- • • • • 39 min walk
- 2 miles
- Springfield In-Town every 30 min



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



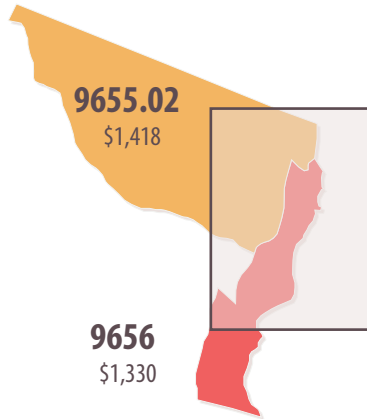
DEWEY STREET

\$80,000 • 4 bedrooms • 1,884 square feet

WHITE RIVER JUNCTION

Census Tracts

with median monthly rents for 3+ bedrooms



VERMONT RECOVERY CENTER

Upper Valley Turning Point

200 Olcott Drive, White River Junction

VERMONT RECOVERY HOUSING

Willow Grove

200 Olcott Drive, White River Junction

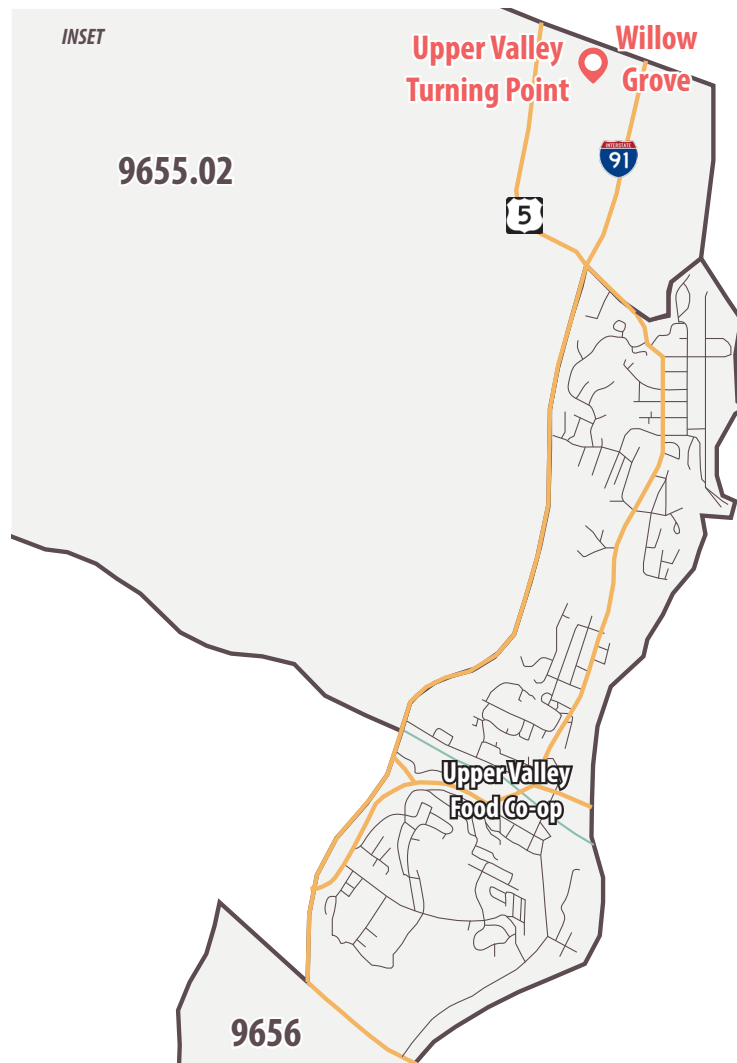
VERMONT TREATMENT CENTER

Logistics

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



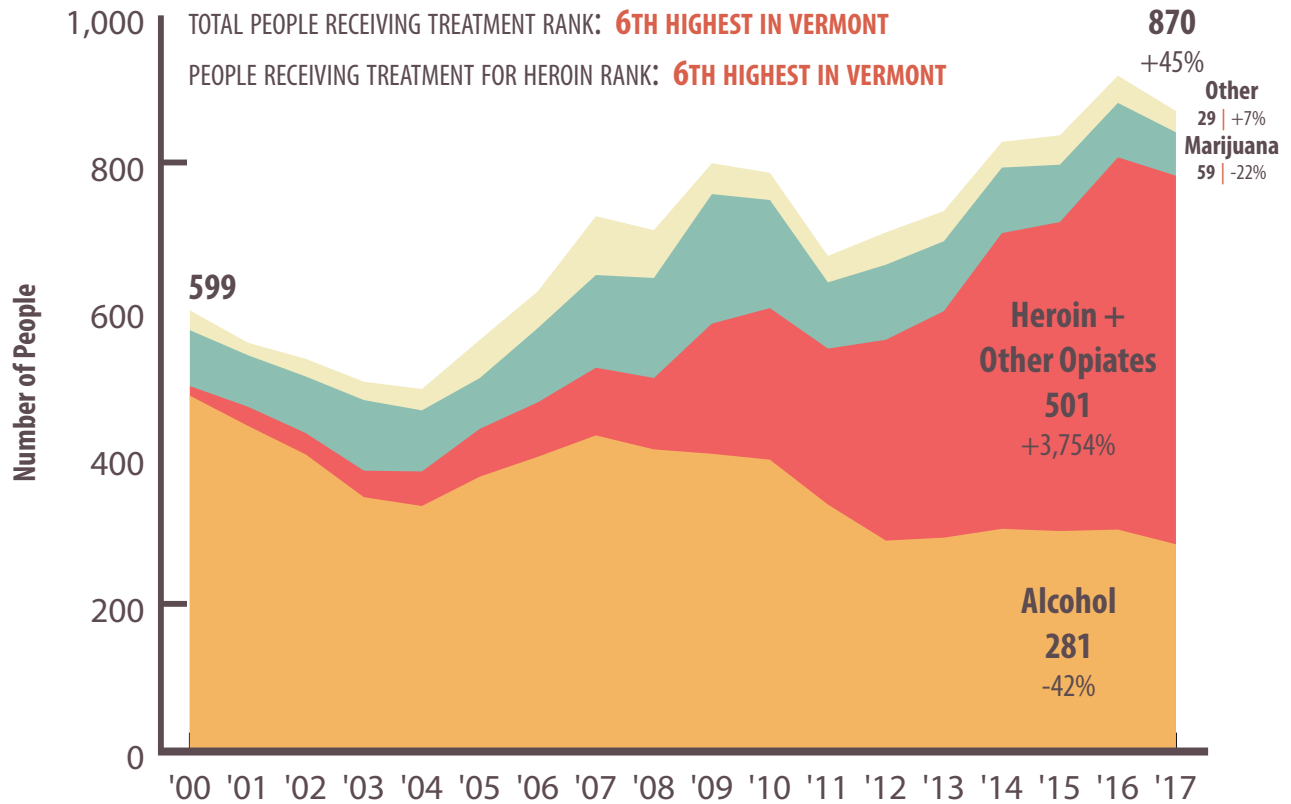
NO PROPERTIES FOUND ON ZILLOW

NO PROPERTIES FOUND ON ZILLOW

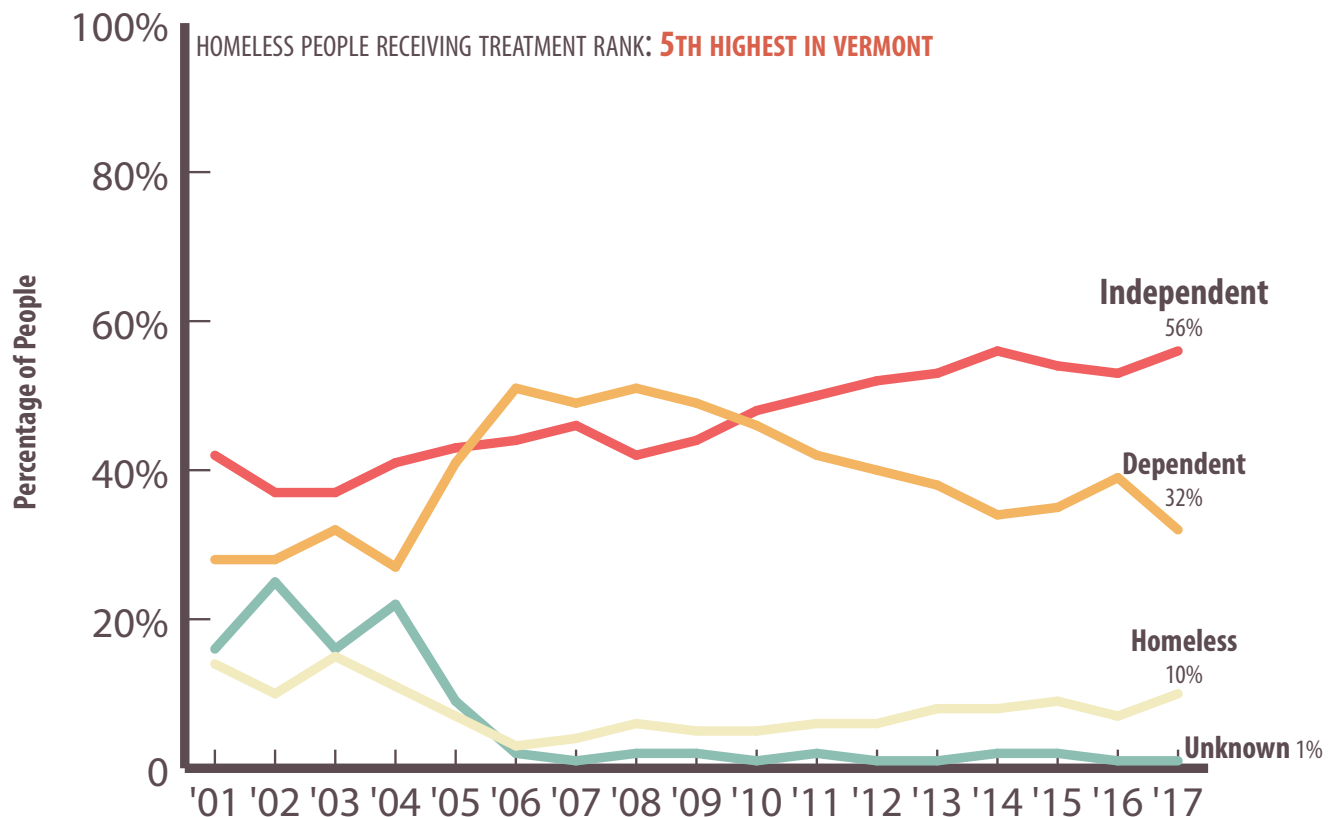
NO PROPERTIES FOUND ON ZILLOW

WINDSOR COUNTY

PEOPLE RECEIVING TREATMENT BY PRIMARY SUBSTANCE

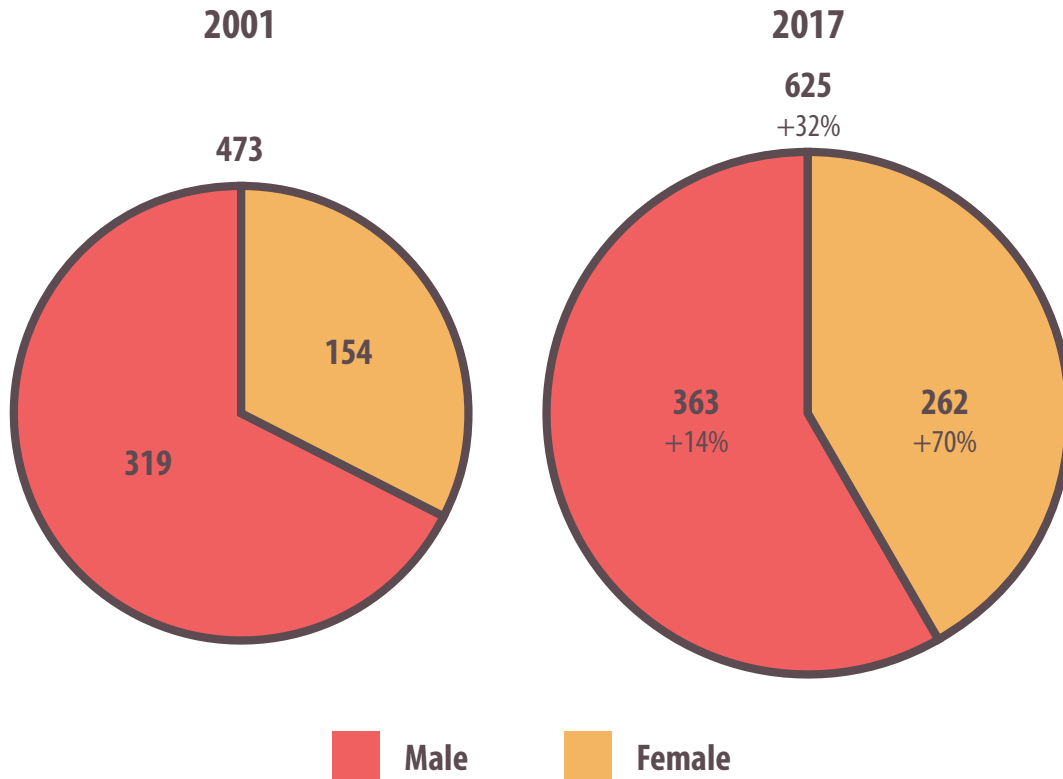


HOUSING STATUS AT TIME OF ADMISSION TO TREATMENT

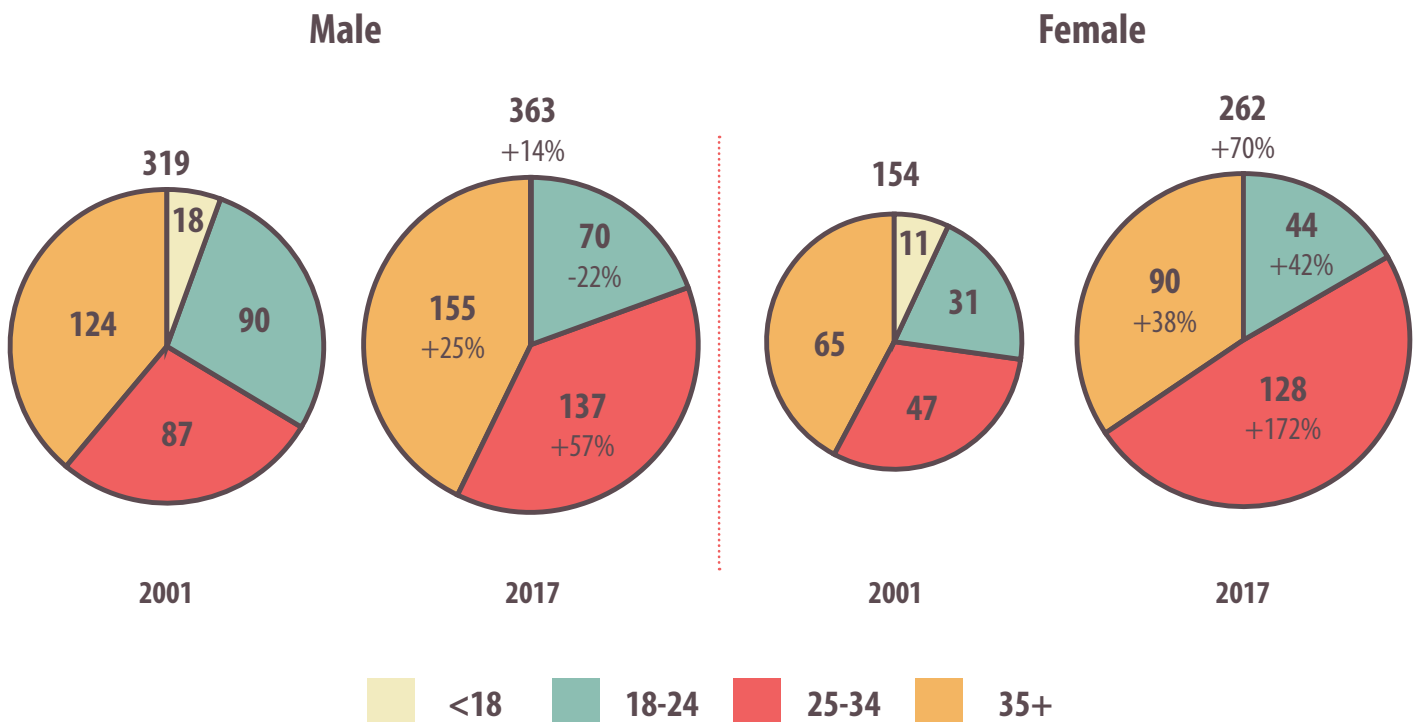


WINDSOR COUNTY

PEOPLE RECEIVING TREATMENT BY SEX



PEOPLE RECEIVING TREATMENT BY AGE



BILL AS INTRODUCED
2021

H.211
Page 1 of 13

1 H.211

2 Introduced by Representatives Killacky of South Burlington, Noyes of

3 Wolcott, Durfee of Shaftsbury, Houghton of Essex, Page of

4 Newport City, Stevens of Waterbury, Townsend of South

5 Burlington, Walz of Barre City, and Wood of Waterbury

6 Referred to Committee on

7 Date:

8 Subject: Human services; housing; substance use disorder; recovery residences

9 Statement of purpose of bill as introduced: This bill proposes to: (1) provide
10 certain residential rental agreement exclusions to recovery residences;

11 (2) require that recovery residences have certain policies and procedures

12 pertaining to residential agreements, temporary removal, separation, and drug

13 testing; (3) require a municipality to treat a recovery residence as a single-

14 family residential home under its land use bylaws; (4) require the Department

15 of Corrections to submit a report to the General Assembly pertaining to the

16 number of individuals on furlough who reside in recovery residences; and

17 (5) establishes the Recovery Stabilization Study Committee.

18 An act relating to recovery residences

1 It is hereby enacted by the General Assembly of the State of Vermont:

2 Sec. 1. LEGISLATIVE INTENT

3 It is the intent of the General Assembly:

4 (1) to support individuals with substance use disorder who are in
5 recovery;

6 (2) to reduce homelessness, trafficking, incarceration, and fatal drug
7 overdoses caused by the disease; and

8 (3) that any exceptions made to existing landlord and tenant
9 relationships in this act are limited solely to recovery residences operating
10 pursuant to this act, as these exceptions are intended to enable the expansion of
11 recovery residences throughout the State and ensure their accessibility to
12 individuals recovering from a substance use disorder.

13 Sec. 2. 18 V.S.A. § 4812 is added to read:

14 § 4812. RECOVERY RESIDENCES

15 (a) Definitions.

16 (1) As used in this section, “recovery residence” means a shared living
17 residence supporting persons recovering from a substance use disorder that:

18 (A) Provides tenants with peer support, an environment that prohibits
19 the use of alcohol and the illegal use of prescription drugs or other illegal
20 substances, and provides assistance accessing support services and community
21 resources available to persons recovering from substance use disorders.

1 (B) Is certified by an organization that is a Vermont affiliate of the
2 National Alliance for Recovery Residences or obtains a preliminary
3 certification within 45 days of operation and adheres to the national standards
4 established by the Alliance or its successor in interest, including duty of care
5 standards. If there is no successor in interest, the Department of Health shall
6 designate a certifying organization to uphold appropriate standards for
7 recovery housing.

8 (2) As used in this section, “the illegal use of prescription drugs” refers
9 to the use of prescription drugs by a person who does not hold a valid
10 prescription for that drug or in an amount that exceeds the dosing instructions.

11 (b) Voluntary arrangement.

12 (1) The decision to live in a recovery residence shall be voluntary and
13 shall not be required or mandated by any private or public entity or individual.

14 (2) The State shall not subject any individual to incarceration, penalty,
15 or sanction based solely on temporary removal or termination from a recovery
16 residence. This subdivision shall not limit the ability of the Department of
17 Corrections to incarcerate an individual based on criminal activity or a
18 substantial threat to public safety. If a tenant who is subject to temporary
19 removal or termination from a recovery residence is at immediate risk of
20 significant harm, the Department of Corrections shall use its best efforts to

1 transition the tenant from the recovery residence directly to another safe
2 community setting and shall incarcerate the tenant only as a last resort.

3 (c) Terms of residency; compliance.

4 (1) Landlord and tenant relationship. A recovery residence and a tenant
5 have a landlord and tenant relationship that is subject to 9 V.S.A. chapter 137,
6 except as otherwise provided in subdivisions (3)–(4) of this subsection.

7 (2) Residential rental agreement.

8 (A) A recovery residence and a tenant shall execute a written rental
9 agreement that includes:

10 (i) the policies and procedures governing the tenancy;

11 (ii) a statement that the recovery residence and the tenant will
12 comply with the policies and procedures;

13 (iii) the consequences of noncompliance;

14 (iv) the identification of a verified location where the tenant may
15 be housed in the event of temporary removal, including at least one alternative
16 housing option;

17 (v) payment requirements;

18 (vi) notice requirements and procedure for terminating the
19 tenancy;

1 (vii) the contact information for a tenant's probation or parole
2 officer if the tenant is on furlough or parole from the Department of
3 Corrections; and

4 (viii) any other provisions to which the parties agree.

5 (B) The parties may amend a rental agreement in a written record
6 signed by the parties.

7 (C) A tenant may have a support person present when negotiating
8 and executing a rental agreement or amendment.

9 (3) Temporary removal.

10 (A) A recovery residence shall adopt policies and procedures that
11 govern the temporary removal of a tenant. A recovery residence may
12 temporarily remove a tenant who is currently intoxicated and who is creating a
13 risk for other tenants by using alcohol or illegal substances; engaging in the
14 illegal use of prescription drugs; or engaging in violent, sexually harassing, or
15 threatening behavior.

16 (i) Minimally, a recovery residence's temporary removal policy
17 shall:

18 (I) provide written notice of the reason for temporary removal
19 and of the actions the tentant must take to avoid temporary removal or to be
20 readmitted after temporary removal;

1 (II) design and implement harm reduction strategies for a
2 tenant who is temporarily removed, which may include distribution of
3 naloxone to the tenant upon temporary removal or other strategies more
4 appropriate to the tenant's recovery needs; and

5 (III) take action that is consistent with the tenant's most recent
6 reoccurrence agreement to the extent possible, or if the reoccurrence agreement
7 is not actionable, help connect the tenant with community resources that may
8 include access to medical care, access to inpatient treatment, and services
9 provided by a local public inebriate program, homeless shelter, or recovery
10 center. Failure of a recovery residence to connect a tenant with one or more of
11 these community resources may result in rescission of certification.

12 (ii) A recovery residence shall not temporarily remove a tenant
13 based on the tenant receiving medication-assisted treatment, as defined in
14 section 4750 of this title.

15 (B) Notwithstanding 9 V.S.A. §§ 4463 and 4464, a recovery
16 residence that complies with the policies and procedures adopted pursuant to
17 this subdivision (c)(3) may temporarily deny a tenant access to the recovery
18 residence but shall allow a tenant to take essential medication and personal
19 property, such as clothing, money, telephone or related device, or any other
20 item the tenant deems necessary for safety when leaving the residence. The

1 recovery residence shall ensure safekeeping of property left at the recovery
2 residence during the temporary removal.

3 (4) Termination of tenancy.

4 (A) A recovery residence shall adopt policies and procedures that
5 govern the termination of tenancy of a tenant who violates one or more
6 provisions of the rental agreement, consistent with the following:

7 (i) A recovery residence shall:

8 (I) provide written notice of its intent to terminate the tenancy
9 that includes the reason for termination and the actions the tenant must take to
10 avoid removal;

11 (II) design and implement harm reduction strategies for a
12 tenant whose tenancy is terminated, which may include distribution of
13 naloxone to the tenant upon removal or other strategies more appropriate to the
14 tenant's recovery needs; and

15 (III) adopt a review process under which:

16 (aa) a person other than the original decision maker or a
17 subordinate of the original decision maker, which may include a Vermont
18 affiliate of the National Alliance for Recovery Residences, reviews the
19 decision to terminate the tenancy;

20 (bb) the tenant has a meaningful opportunity to present
21 evidence why the tenant should not be removed; and

1 (cc) the tenant receives prompt written notice of a final
2 decision.

3 (ii) A recovery residence shall not:

4 (I) terminate a tenancy because a tenant uses alcohol or illegal
5 substances or engages in the illegal use of prescription drugs unless:

6 (aa) the tenant fails to take the actions required to avoid
7 temporary removal or to be readmitted after temporary removal; and

8 (bb) the recovery residence has contemporary drug test
9 results verified by a laboratory approved by the State; or

10 (II) terminate a tenancy based on the tenant receiving
11 medication-assisted treatment, as defined in section 4750 of this title.

12 (B) Notwithstanding 9 V.S.A. §§ 4467 and 4468, a recovery
13 residence that complies with the policies and procedures adopted pursuant to
14 this subdivision (c)(4) may terminate the tenancy of a tenant pursuant to the
15 notice requirements and procedure for terminating the tenancy provided in the
16 rental agreement.

17 (d) Drug testing. A recovery residence shall adopt policies and procedures
18 that govern drug testing of tenants and shall apply the policies and testing
19 procedures fairly among tenants.

20 (e) Future services. A recovery residence shall not deny future services to
21 a tenant who has been either temporarily removed from a recovery residence or

1 whose tenancy has been terminated, based solely on the tenant's use of alcohol
2 or illegal substances or the illegal use of prescription drugs.

3 Sec. 3. 24 V.S.A. § 4412 is amended to read:

4 § 4412. REQUIRED PROVISIONS AND PROHIBITED EFFECTS

5 Notwithstanding any existing bylaw, the following land development
6 provisions shall apply in every municipality:

7 (1) Equal treatment of housing and required provisions for affordable
8 housing.

9 * * *

10 (G) A residential care home or group home to be operated under
11 State licensing or registration, serving not more than eight persons who have a
12 disability as defined in 9 V.S.A. § 4501, and a recovery residence as defined in
13 18 V.S.A. § 4812, serving not more than eight persons, shall be considered by
14 right to constitute a permitted single-family residential use of property. This
15 subdivision (G) does not require a municipality to allow a greater number of
16 residential care homes or group homes on a lot than the number of single-
17 family dwellings allowed on the lot.

18 * * *

19 Sec. 4. REPORT; RECOVERY RESIDENCE; FURLOUGH

20 On or before January 1, 2022 and annually thereafter through January 1,
21 2025, the Department of Corrections, in collaboration with the Vermont

1 Alliance for Recovery Residences, shall submit a report to the House
2 Committees on General, Housing, and Military Affairs, on Corrections and
3 Institutions, and on Human Services and to the Senate Committees on
4 Economic Development, Housing and General Affairs, on Health and Welfare,
5 and on Judiciary containing:

6 (1) the number of individuals on furlough who reside in recovery
7 residences as defined in 18 V.S.A. § 4812 during the preceding year;

8 (2) the number of individuals who have violated the conditions of their
9 furlough and were removed from their recovery residence and returned to
10 prison, including the action that caused the Department to find the individual
11 violated furlough; and

12 (3) data regarding the Department's efforts to transition each tenant
13 from a recovery residence directly to another community setting and thereby
14 incarcerating the tenant for lack of residence only as a last resort.

15 Sec. 5. RECOVERY STABILIZATION STUDY COMMITTEE

16 (a) Creation. There is created the Recovery Stabilization Study
17 Committee to monitor statewide access to recovery stabilization programs
18 that provide vulnerable persons with substance use disorders continuous
19 access to safe housing, including:

20 (1) during periods of instability associated with substance use; and

1 (2) following a temporary or permanent removal from a recovery
2 residence pursuant to 18 V.S.A. § 4812.

3 (b) Membership. The Study Committee shall be composed of the
4 following members:

5 (1) the Commissioner of Health or designee, who shall serve as chair;

6 (2) the Commissioner of Mental Health or designee;

7 (3) the Commissioner of Corrections or designee;

8 (4) one current member of the House of Representatives, serving on
9 either the Committee on General, Housing, and Military Affairs or on the
10 Committee on Human Services, who shall be appointed by the Speaker of the
11 House;

12 (5) one current member of the Senate, serving on either the Committee
13 on Economic Development, Housing and General Affairs or on the
14 Committee on Health and Welfare, who shall be appointed by the Committee
15 on Committees;

16 (6) a representative, who shall be appointed by the Vermont Alliance
17 of Recovery Residences;

18 (7) a representative, who shall be appointed by Vermont Legal Aid;

19 (8) a representative, who shall be appointed by Vermonters for
20 Criminal Justice Reform; and

21 (9) any other stakeholders who the chair deems appropriate.

1 (c) Powers and duties. The Study Committee shall study recovery
2 stabilization programming, including:

3 (1) access to current recovery stabilization programs in Vermont,
4 including any gaps in services;

5 (2) recovery stabilization models used successfully in other
6 jurisdictions to enable participants to find employment or attend school,
7 move into independent housing, and avoid relapse and those models'
8 applicability in Vermont; and

9 (3) recommendations for a more integrated system of recovery
10 stabilization programs.

11 (d) Assistance. The Study Committee shall have the administrative,
12 technical, and legal assistance of the Department of Health.

13 (e) Report. On or before December 1, 2021, the Study Committee shall
14 submit a written report to House Committees on General, Housing, and
15 Military Affairs and on Human Services and to the Senate Committees on
16 Economic Development, Housing and General Affairs and on Health and
17 Welfare with its findings and any recommendations for legislative action.

18 (f) Meetings.

19 (1) The Commissioner of Health or designee shall call the first meeting
20 of the Study Committee to occur on or before July 15, 2021.

21 (2) A majority of the membership shall constitute a quorum.

1 (3) The Study Committee shall cease to exist on December 15, 2021.

2 (g) Compensation and reimbursement.

3 (1) For attendance at meetings during adjournment of the General
4 Assembly, a legislative member of the Study Committee serving in his or her
5 capacity as a legislator shall be entitled to per diem compensation and
6 reimbursement of expenses pursuant to 2 V.S.A. § 23 for not more than four
7 meetings. These payments shall be made from monies appropriated to the
8 General Assembly.

9 (2) Other members of the Study Committee shall be entitled to per
10 diem compensation and reimbursement of expenses as permitted under
11 32 V.S.A. § 1010 for not more than four meetings. These payments shall be
12 made from monies appropriated to the Department of Health.

13 Sec. 6. EFFECTIVE DATE

14 This act shall take effect on July 1, 2021.