# HOUSING: A CRITICAL LINK TO RECOVERY

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


## *EXECUTIVE SUMMARY*

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# EXECUTIVE SUMMARY

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

## OVERALL ASSESSMENT

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

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

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

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

## RECOMMENDATIONS

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

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

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

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

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

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

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

### *Conditions for Success*

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

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

## WHAT IS A RECOVERY RESIDENCE?

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

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

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

## THE SCALE OF NEED

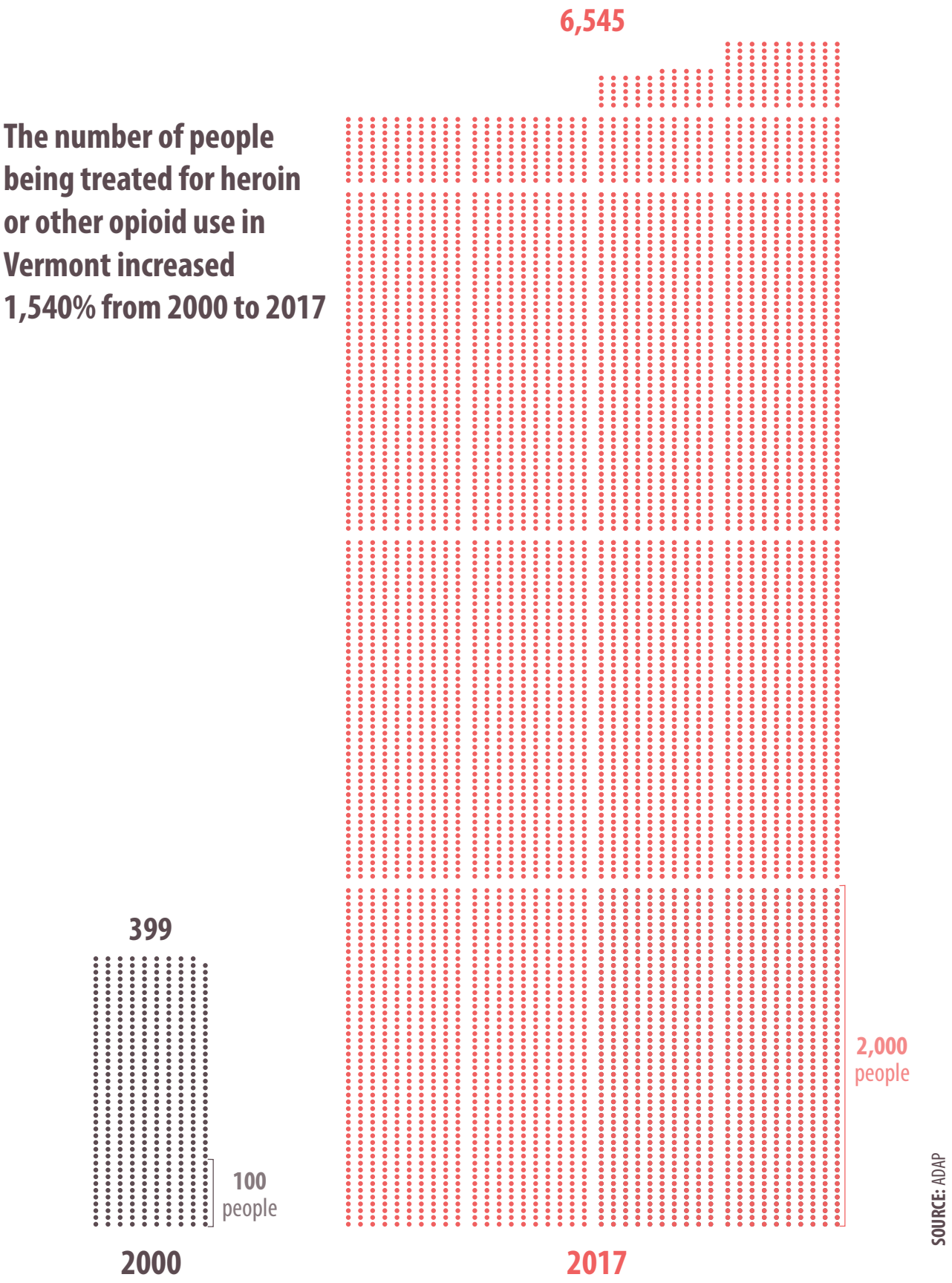
Among the 50 states, Vermont has the 4th highest rate of alcohol dependence and the highest rate of illicit drug use disorder in the country. Of the estimated 52,000 Vermonters who suffer from some form of Substance Use Disorder, alcohol dependence accounts for roughly 2/3rds of all cases. In 2016-17,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

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

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

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

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



## EXISTING RECOVERY RESIDENCES IN VERMONT

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

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

## ESTIMATE OF THE GAP IN RECOVERY RESIDENCE NEED

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

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

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

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

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

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

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

## AVAILABILITY OF APPROPRIATE HOUSING IN HUB COMMUNITIES

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

## CHALLENGES

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

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

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

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

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

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

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

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

# NOTES

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

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

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

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

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

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

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