Upper Valley Recovery Housing Assessment

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Research conducted for Lebanon Housing First

Under direction from the Public Health Council of the Upper Valley

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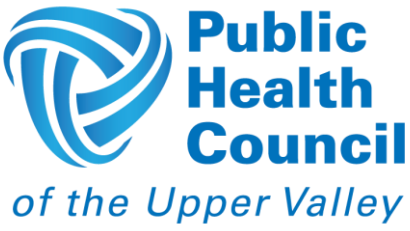


Table of Contents

I. **Executive Summary** 2
   1. Purpose of Internship 2
   2. Methodology 2
   3. Summary of Why the Upper Valley 2
II. **Introducing Recovery and Recovery Housing Concept** 3
   1. Recovery and Recovery Capital 3
   2. Relapse Predictors 4
   3. What is a Recovery Residence? 4
   4. Recovery Housing Difficulties 6
III. **Scale of Need for Recovery Housing in the Upper Valley** 8
   1. Upper Valley 9
   2. Recovery Residences in the Upper Valley 10
   3. Substance Use Rates 11
   4. Substance Use Disorder Rates 11
   5. Homelessness Rates in the Upper Valley 12
IV. **Needs Statements** 15
V. **Overall Summary** 16
   1. Summary 16
   2. Conditions and Recommendations for Success 16
VI. **Bibliography** 18

Tables and Figures

I. **I.1** 24-Month Follow-Up Outcomes Oxford House Study 4
II. **I.2** National Association of Recovery Residence levels 5
III. **II.1** Resources in the Upper Valley 8
IV. **II.2** Substance Use Rates by Substance in Vermont & New Hampshire, 2021-2022 11
V. **II.3** Substance Use Disorder Among Individuals 12 & Older, Vermont, New Hampshire, and the United States, 2021-2022, by Alcohol and Illicit Drug Dependence 12
VI. **II.4** Substance Use Disorder Treatment Rates Among Individuals 12 & Older, Vermont, New Hampshire, and the United States, 2021-2022 13

I. Executive Summary

In spring 2024, the Public Health Council of the Upper Valley requested a summer intern through the Southern Vermont Area Health Education Center. The following describes the purpose of the internship project, the methods used, and a summary of why recovery housing is needed in the Upper Valley.

1. Purpose of Internship Project

The internship aimed to complete a needs assessment and gaps analysis to establish the need for additional recovery housing in the Upper Valley region. While addressing several of the following questions:

1. Why is recovery housing so important for recovery?
2. What is the need for recovery housing?
3. What are the best models? Nonprofit vs For Profit? Levels of Service?
4. What other services does an ideal recovery home offer, in-house or through agreements? E.g., peer support, recovery coaching, and job coaching.
5. While offering recovery housing with different levels of service is ideal, what level of care would be the most effective if we can only offer one?

To complete the assessment, I worked alongside a sub-committee of Lebanon Housing First to determine the need and approach for gathering secondary data and conducting interviews to understand what is currently available and the level of perceived need. Secondary data collection and interviews were conducted to understand what is available, what is needed, what barriers exist for such housing, and what services people living in these housing situations need to be successful. Finally, I authored this report summarizing all the data collected, articulating the need for recovery housing, and recommendations for developing such recovery housing.

2. Methodology

To complete this report, I used a variety of sources including the US Substance Abuse and Mental Health Services Administration, the National Survey on Drug Use and Health, interviews, and other secondary data sources.

3. Summary of Why the Upper Valley Needs More Recovery Housing

Based on my research, especially interviews with people working in the addiction field in the Upper Valley, adding more recovery housing to the area is essential due to the growing demand for post-residential treatment housing and interventions. Housing is a main tenet of enabling individuals in recovery to maintain their sobriety and stability, which pays countless dividends to our community.

II. Introducing Recovery and Recovery Housing Concept

The following section outlines the definition of recovery, the influence of recovery capital, relapse predictors, and answers the question of what a recovery residence is. It reviews level I, II, III, and IV recovery residences and their associated outcomes. The section also touches on some difficulties related to funding and stigma around recovery housing.

1. Recovery

The substance use disorder epidemic has been plaguing the United States since the mid-to-late 1990s. In 2022, 48.7 million, or 17.3% of the United States population met the diagnostic criteria for a substance use disorder in the past year. The highest prevalence of diagnostic substance use disorders was among young adults aged 18-25, approximately 9.7 million people (SAMHSA, 2022). Addiction research and related fields have recognized that people can recover from substance use disorder but the factors and scientific knowledge of when and what sparks recovery is still minimal. The gold standard devised by researchers and clinicians is 'recovery capital,' which refers to a set of resources necessary to sustain recovery (Best and Laudet). Recovery capital has four components: physical, social, human, and cultural.

1. Physical capital is defined as assets, like money or housing, that may increase recovery potential - for example, being able to live away from friends who engage in substance misuse or affording residential treatment.
2. Social capital is resources from personal relationships, such as family or support groups.
3. Human capital is skills, good physical health, positive outlook, etc.
4. Lastly, cultural capital includes "values, beliefs, and attitudes" that move a person away from the social conformity of drug culture and toward societal behaviors.

Chances of sustained sobriety increase as one's recovery capital increases. The growth of personal recovery capital has ripple effects for families, others in recovery, and the community. However, it is important to acknowledge that recovery is not a linear process and to recognize the potential signs and predictors of relapse.

2. Relapse Predictors

More than 60% of people will relapse within their first-year post-treatment. It can take four to five years of remission for the risk of relapse to drop below 15% (HHS, 2016). A **relapse** is defined as when a person returns to using drugs or alcohol after a time of sobriety. A **lapse** is when an individual uses drugs or alcohol briefly before promptly stopping (American Addiction Centers, 2024).

Risk factors for substance use relapse can be broken down into three categories: biological, psychological, and environmental/social.

1. Several frequently researched biological factors are age, state of physical health, and genetics (HHS, 2016; Sliedrecht et al., 2019).

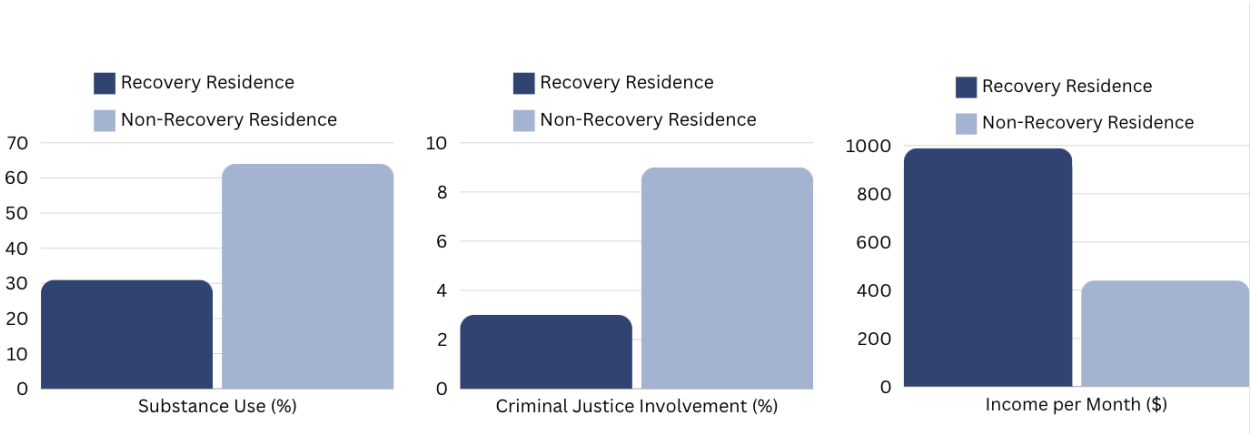
2. Psychological factors include coexisting psychiatric conditions, the severity of symptoms, history of use and treatment, and low self-efficacy (Alemi et al., 2009; Chiappetta et al, 2014; Sliedrecht et al., 2019).
3. Environmental and social factors related to substance use relapse include employment, exposure to triggers, interpersonal conflicts, lack of social support, and physical environment (Alemi et al., 2009; American Addiction Centers, 2024). Environmental and social factors are becoming the basis for relapse prevention with interventions like peer support, recovery-oriented living, and community-based organizations/assistance.

For a more detailed review of relapse predictors, see my companion report, *Predictors of Substance Misuse Recovery and Relapse: A Literature Review*, published on the Public Health Council's website.

3. What is a Recovery Residence?

Recovery housing is an intervention designed by persons in recovery and specifically for individuals in the initial stages of recovery from a substance use disorder. A recovery home enables an individual to have a safe and substance-free environment and provides peer-to-peer support deemed necessary by the Substance Abuse and Mental Health Services Administration's tenants of recovery (2012; 2023). Research has illustrated that recovery residences are associated with positive outcomes for residents and their communities. **Outcomes include higher abstinence rates, lower criminal justice involvement, higher rate of employment, higher income, and higher rates of productivity** (Jason et al., 2006; Polcin et al., 2010; Lo Sasso et al., 2012).

I.1 24-Month Follow-Up Outcomes Oxford House Study



Source: Jason et al., 2006

How these houses operate varies widely. Recovery homes go by various names, including recovery homes, sober living homes, sober living environments, Oxford Houses, and therapeutic environments. The homes also offer different services. The National Association of Recovery

Residences (NARR) created four recovery housing levels to delineate the type of home and services offered, which range from peer support to a more clinical modality (SAMHSA, 2023). The table below summarizes the recovery residence's level of support.

I.2 National Association of Recovery Residence Levels

NARR National Association of Recovery Residences		RECOVERY RESIDENCE LEVELS OF SUPPORT			
		LEVEL I Peer-Run	LEVEL II Monitored	LEVEL III Supervised	LEVEL IV Service Provider
STANDARDS CRITERIA	ADMINISTRATION	• Democratically run • Manual or P& P	• House manager or senior resident • Policy and Procedures	• Organizational hierarchy • Administrative oversight for service providers • Policy and Procedures • Licensing varies from state to state	• Overseen organizational 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
	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 in 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

Source: Indiana Alliance of Recovery Residences, 2024

Most homes in Vermont and New Hampshire are level I or II. Thus, this report will focus on the associated outcomes with levels I and II.

Level I: Oxford Houses are an example of a level I recovery residence (SAMHSA, 2023). Jason et al. completed a 24-month follow-up study of individuals placed into an Oxford House post-residential treatment (2006). The study found that individuals placed in an Oxford House compared to the usual continuum of care (i.e., out-patient or 12-step programming) had lower rates of substance use (31.3% vs 64.8%), higher monthly income ($989.40 vs. $440.00), and lower incarceration rates (3% vs 9%) (Jason et al., 2006). The economic benefit of the Oxford Houses from the study (derived from self-reported data on monthly income, incarceration, and substance use) was $29,000 per person (Lo Sasso et al., 2012).

Level II: Sober living homes are a level II recovery residence. This type of home is mostly operated in California. However, Jack's House and Willow Grove in White River Junction,

Vermont are both examples of level II recovery residences and serve parents with dependent children. More information can be found here: https://www.uppervalleyturningpoint.org/recovery-housing. In California, researchers completed an 18-month follow-up of the individuals living in a sober home and found improved abstinence, mental health symptoms, and decreased arrests (Polcin et al., 2010). Sober-living homes are an underutilized alternative for a clean-living environment post-residential treatment or while engaging in outpatient services (Polcin and Henderson, 2008).

Level III: A level III recovery residence still promotes peer support and resident input. Additionally, the residences offer other non-clinical support, like life skills, recovery coaching, and peer-support specialists (SAMHSA, 2023). These services are provided in the home or the outer community. Headrest operates a sober living home in Boscawen, New Hampshire, that serves as a transitional intervention for men. More information can be found at https://headrest.org/renew-recovery-house-sober-living-for-men/.

Level IV: Therapeutic Communities (TCs) are level IV recovery residences. TCs combine the social model of recovery and clinical services (SAMHSA, 2023). The social model of recovery impacts how recovery homes operate and are organized. The social model of recovery highlights the value of experiential knowledge, peer interaction, and community engagement both in clinical and non-clinical settings (Borkman, 1998). Research has consistently found that TCs are a successful and cost-effective modality of treatment for certain subgroups with substance use disorders (De Leon, 2010).

4. Recovery Housing Difficulties

Recovery housing remains outside the formal substance use treatment continuum of care, therefore, owners and operators face several obstacles to building and keeping open recovery residences. Negative attitudes and stigma persist around substance use disorders and recovery homes. In part, this comes from misunderstandings of the manifestation of substance use disorders and how recovery is achieved. The misunderstanding of what recovery housing is and how it operates compounds communities' hesitancy towards these establishments (Mericle et al., 2023). Furthermore, peer-to-peer support is the basis of recovery housing, which differs from more traditional medical and other clinical services. This has led to more public and professional speculation and stigma about recovery housing. Peer-administered services are often seen as less valuable or impactful than services administered in a traditional setting by medical professionals (Jack et al., 2018; Moran et al., 2013). The lack of a universal definition of recovery housing and an overarching framework contributes to this phenomenon.

Unstable financial sources, like resident fees and government funding, challenge the sustainability of recovery housing. The Fletcher Group report about New Hampshire's recovery housing found that financial resources were the top challenge to operating residences and 67% of

the (6 out of the 22) residences that responded to the survey experienced great difficulty in finding grants to apply to. Some of the difficulty is because most of the grants are for nonprofit organizations. However, some operators struggled to find grants that would meet the needs of their organizations. Operators also noted difficulty navigating the grant system, stating that they do not know where or how to look for grants. Recovery housing must be financially resilient to continually operate. Financial resilience is defined as an organization's capability to deal with and overcome financial shocks and unexpected circumstances. The New Hampshire operators were asked to rank their financial resilience on a scale from one to ten. On average for-profit homes ranked their resilience as 6.4 whereas on average nonprofit homes ranked their resilience as 3.7. For-profit and nonprofit recovery houses differ in operational costs, financial sources, and financial resiliency. For-profit organizations tend to have lower annual operating costs (the median was $95,000 per year) and lower costs per resident than nonprofit houses (The Fletcher Group, 2024). There needs to be an increase in grant availability, an increase in the cultivation of community partnerships, and education for operators about applying for grants/financial diversification.

III. Scale of Need for Recovery Housing in the Upper Valley

The following section analyzes several underlying indicators to predict the need for recovery housing in the Upper Valley. Indicators include substance use disorder and treatment rates, and homelessness rates in the area. The information is presented at a state level, aside from the homelessness rates for Lebanon, New Hampshire, and Hartford, Vermont.

1. The Upper Valley

The Upper Valley is a bi-state region, which includes four counties, two in New Hampshire (Grafton and Sullivan) and two in Vermont (Windsor and Orange), with a total population of approximately 223,000 people (United States Census Bureau). The Upper Valley is a hub that serves populations from both states, placing it in a unique position for the creation of recovery residences. This region is rural, but it has many resources such as its proximity to Dartmouth Hitchcock Memorial Hospital, recovery groups, employment opportunities, and other resources that are vital for substance use recovery. What follows is a list of some, but not all, programs that serve people seeking substance use treatment and recovery.

II.1 Resources in the Upper Valley

Resource	Services Offered	Location
Dartmouth Hitchcock Addiction Recovery Program	Comprehensive evaluation, co-occurring treatment, psychiatric evaluation, individual outpatient therapy	Lebanon, New Hampshire
The Doorway at Dartmouth Hitchcock	Care planning, continuous recovery monitoring, diagnostic evaluation, Naloxone distribution, etc	Lebanon, New Hampshire
Headrest	Low-intensity residential program, 24/7 hotline, outpatient treatment, Headrest Opportunities for Work (H.O.W), Recovery friendly workplace EAR (employee assistance resource) program	Lebanon, New Hampshire
Mom's in Recovery Program at Dartmouth Hitchcock	Case-management, peer-recovery services, intensive outpatient services, etc	Lebanon, New Hampshire
Veteran's Hospital Addiction Treatment	Homeless veteran care, detoxification, outpatient treatment, groups, transitional housing, etc	White RIver Junction, Vermont

Resource	Services Offered	Location
Clara Martin	Outpatient recovery, support groups, Medically Assisted Treatment, Justice Involved Program, etc	White River Junction, Vermont
West Central Behavioral Health	Outpatient counseling, care coordination, supported employment, group counseling, etc	Lebanon, New Hampshire
Health Care and Rehab Services	Intensive outpatient treatment, assessment services, peer support, etc	Hartford, Vermont
West Lebanon CTC	Methadone maintenance, Suboxone maintenance, Vivitrol maintenance, counseling	Lebanon, New Hampshire
Upper Valley Turning Point	Drop in center, recovery coaching, recovery groups, space for substance-free recreation and fellowship, etc	Hartford, Vermont
TLC Recovery Center	Individual counseling, group counseling, peer-recovery services/groups,	Lebanon, New Hampshire
Upper Valley Haven	Food shelter, family and adult shelters, supportive housing, services for financial needs, employment, etc	White River Junction, Vermont

2. Recovery Residences in the Upper Valley

There are two recovery residences centrally located in the Upper Valley. Jack's House and Willow Grove are run by the Second Wind Foundation/Upper Valley Turning Point. Between the two residences, there are eleven beds available. Originally, these homes were meant to serve women and men with dependent children, but currently, there are restrictions in place that only children under the age of one are accepted. There is often only one child in the home at a time (Snow and Bryer, 2024).

Within Vermont, there are 13 certified recovery residences and approximately 140 beds, the majority being in the Burlington and Brattleboro areas (Moreau, 2024; Ryan, 2019). Since the COVID-19 pandemic, the number of beds in Vermont's recovery residences has shrunk due to housing closures and increased expenses. New Hampshire has 97 certified recovery residences and 1,276 beds, most are for-profit and the majority are in the Southern part of the state (The Fletcher Group, 2024; NHCORR, 2024).

During interviews with local stakeholders, several themes were prevalent about the feasibility and demand for recovery housing. Overall, there needs to be more recovery housing serving rural communities in both Vermont and New Hampshire. New Hampshire has more recovery residences than Vermont. Thirty-two (32%) of the residents New Hampshire serves are from rural areas, yet only 7% of residences are in rural localities (The Fletcher Group, 2024). In part, this is due to the low availability of properties to develop into recovery residences. However,

zoning, other ordinances, and funding also contribute to the difficulty of establishing recovery residences (Cayton, 2024; Moreau, 2024). Operating a recovery residence requires experience. With background knowledge and education, it is easier to navigate all the nuances, challenges, and difficulties of operating a recovery residence (Cayton, 2024). There should be more training and courses available about grant applications, financial diversification, trauma-informed care, etc.

For individuals discharged from local residential programs and who want to stay in the area after establishing support systems and employment, more affordable housing options are needed. A recovery residence could act as an appropriate setting for individuals to transition from a residential program back into the community and increase stability until permanent housing becomes available (Snow and Bryer, 2024). Without recovery residences centrally located in the Upper Valley, individuals must leave the area to get their housing needs met. The closest recovery residences are in Claremont, New Hampshire. However, many individuals are hesitant to relocate to Claremont, as there is a perspective that substances are more readily available which is triggering and increases relapse risk (Snow and Bryer, 2024). Transportation is also a compounding factor. Public transportation in the Upper Valley is more accessible. An individual employed in the Upper Valley but living in a recovery home in Claremont would have a hard time getting to work if they did not have a car. Finally, if there are no available beds in the Claremont recovery residences, individuals who want to access this service will be forced to go further south in New Hampshire or Vermont, away from their support systems.

Another factor influencing the ability to access recovery housing is parole status. The Upper Valley is split by the Connecticut River and state lines. Individuals involved in the criminal justice system, on parole or probation, cannot cross state lines. It is estimated that 65% of the United States prison population meets the diagnostic requirements for an SUD (NIDA, 2020). This sub-population would benefit from additional resources; therefore it is important to have recovery housing on both sides of the river so individuals can access it (Snow and Bryer, 2024). Founders, donors/grantors, and stakeholders should create an open dialogue with Vermont and New Hampshire, the criminal justice system, and the parole board to determine how recovery housing can be readily available to this sub-population.

3. Substance Use Rates

Vermont and New Hampshire have some of the highest alcohol and illicit drug use rates in the nation for individuals aged 12 and above. While rates have improved since the 2016-2017 National Survey on Drug Use and Health prevalence estimates, both states still have significant progress to make.

II.2 Substance Use Rates by Substance in Vermont & New Hampshire, 2021-2022

% of Population Who Use In:						
Substance	**Use Interval**	**Vermont**	**New Hampshire**	**United States**	**Vermont's percent of national average**	**New Hampshire's percent of national average**
Alcohol	*Past Month*	57.24%	58.73%	48.05%	119%	122%
All Illicit Drugs	*Past Month*	26.16%	16.21%	15.51%	169%	105%
Marijuana	*Past Month*	24.18%	14.41%	14.11%	171%	102%
Cocaine	*Past Year*	2.78%	1.27%	1.79%	155%	71%
Hallucinogen	*Past Year*	4.3%	3.07%	2.86%	150%	107%
Methamphetamine	*Past Year*	0.52%	0.64%	0.95%	55%	67%
Pain Reliever Misuse	*Past Year*	2.83%	2.52%	3.09%	92%	82%
Opioid Misuse	*Past Year*	3.12%	2.74%	3.26%	96%	84%

Source: NSDUH prevalence estimates 2021-2022

Vermont and New Hampshire have higher rates of alcohol and drug misuse disorders compared to the national averages (Ryan, 2019; CBHSQ, 2011). According to the "Housing: A Critical Link to Recovery" report, Vermont ranks 4th highest in the country for alcohol dependence and the highest for illicit drug use disorder (Ryan, 2019). It is estimated that 52,000 residents, or one in ten individuals over the age of 12, suffer from a substance use disorder. Alcohol dependence disorder accounts for 2/3 of all cases (Ryan, 2019). The rate of substance use is highest among Vermont residents aged 18-25. Within this age cohort, 22.7% have a substance use disorder, 51% higher than the national average for this age group (Ryan, 2019). Despite only representing 10% of the state's population, this age group represents one-third of substance use disorders in Vermont. New Hampshire has consistently ranked in the top ten in the nation for youth binge drinking and illicit drug use for the last several years. The state is also marked by high rates of substance use disorders.

4. Substance Use Disorder Rates

II.3 Substance Use Disorder Among Individuals 12 & Older, Vermont, New Hampshire, and the United States, 2021-2022, by Alcohol and Illicit Drug Dependence

Primary Source of Disorder	Vermont	New Hampshire	United States
Alcohol	*11.81%*	11.56%	10.55%
Drug Misuse	12.55%	7.46%	9.20%
Pain Reliever	1.67%	1.41%	1.89%
Opioid Misuse	2.21%	1.68%	2.08%

Source: NSDUH prevalence estimates 2021-2022

It is unclear the exact number of New Hampshire residents affected by a substance use disorder in the state. However, according to the National Survey on Drug Use and Health averages from 2005-2010, the Manchester-Nashua Metropolitan Statistical Area (MSA) has approximately 8.8 percent or 29,000 individuals aged 12 and older who suffer from a substance use disorder (SAMHSA, 2012). It is estimated in 2021 that 17% of New Hampshire residents aged 12 and older met the DSM-5 criteria of a substance use disorder, and the majority do not receive any treatment (SAMHSA, 2022, *Key Substance Use and Mental Health…*).

Like Vermont, New Hampshire residents aged 18-25 have higher rates of illicit drug use than national averages -- 8% percent higher (NH Bureau of Drug and Alcohol Services). In the past decade, the New Hampshire overdose death rate has increased by 184% to 35 deaths per 100,000 in 2022. Vermont's overdose rate was 45.9 per 100,000 in 2022 (CDC, 2024). This is compounded by the inaccessibility of treatment services and non-traditional interventions.

5. Substance Use Disorder Treatment Rates

II.4 Substance Use Disorder Treatment Rates Among Individuals 12 & Older, Vermont, New Hampshire, and the United States, 2021-2022

Treatment	Vermont	New Hampshire	United States
Recieved	5.54%	4.67%	4.65%
Classified as Needing Treatment	22.26%	19.56%	19.35%
Did Not Receive	75.22%	76.09%	75.99%

Source: NSDUH prevalence estimates 2021-2022

Between Vermont and New Hampshire, an average of 5.01% of individuals suffering from a substance use disorder receive treatment. Conservatively 80-90% of individuals who could benefit from treatment are unable or unwilling to access services and interventions (Ryan, 2019). Thus, more treatment and non-traditional interventions are needed to serve the population and put them on a pathway toward recovery.

6. Homelessness Rates in the Upper Valley

According to the Homeless Management Information Systems (HMIS) between July 1st, 2023, to June 30th, 2024, there were 29 homeless individuals suffering from a substance use disorder in Lebanon, New Hampshire (HMIS, 2024). 10 of those individuals also suffered from co-occurring psychiatric conditions. All 29 individuals were living in a variety of locations within Lebanon, primarily the Lebanon winter shelter or local hotels (HMIS, 2024). This does not include individuals who were suffering from substance use disorders and had assistance like housing vouchers.

Comparable HMIS data for our Upper Valley Vermont communities was unavailable at the time of publication.

> “The Upper Valley has reached a tipping point for homelessness in the region” - *Danielle Cayton* (Director of Substance Use and Criminal Justice-Involved Program at Clara Martin)

Local experts in the addiction field have concluded that homelessness in the Upper Valley has never been worse (Cayton 2024; Snow and Bryer, 2024). Compounded by rising costs of living, little low-income housing, and the gentrification of urban families coming to the region post-COVID, many individuals do not have access to permanent housing. With only two homeless

shelters in the area, many individuals and families have resorted to staying long-term in local hotels, campers, or with family and friends. For individuals suffering from a substance use disorder, the instability of housing poses a risk for relapse. Many are forced to stay with family and friends who could still be using, which is a trigger during the early stages of recovery. If they remain at a shelter, it is not guaranteed to be a 'dry' environment. More housing options are needed for people in recovery, and the scale of the current recovery residences cannot meet the population's demands.

In the "*Housing: A Critical Link to Recovery*," the current landscape of the recovery homes in Vermont can only serve 2% of the population leaving treatment each year (Ryan, 2019). According to the 2017 Vermont ADAP Housing status data, approximately 900 individuals report their housing status as unstable or homeless at the start of the treatment for a substance use disorder, interfering with their ability to commit to recovery. John Ryan, the consultant writing the report, estimated that, in 2017, 1,200 or 14% of Vermonters in treatment for a substance use disorder would benefit from using a recovery residence as a means of transitional housing post-residential treatment (2019). This estimate is a Vermont estimate and thus excludes the prevalence of New Hampshire residents who could benefit from a recovery residence. However, this proves there is a high demand for the service.

IV. Needs Statements

This section summarizes the specific needs for recovery residences in the Upper Valley. The two accredited recovery residences and the subsequent eleven beds cannot serve our population. Additional recovery housing is required.

I. Additional recovery residences for parents suffering from substance use disorder. The two residences in White River Junction, Vermont do not have enough beds to serve this sub-population sufficiently. The homes need to be able to serve children above the age of one (Snow and Bryer, 2024).
II. A recovery residence needs to be built in Lebanon, New Hampshire to better support our recovery services hub and catchment area. This also will enable individuals who suffer from substance use disorders and are involved in the New Hampshire criminal justice system to access the recovery residence service without violating their parole or probation.
III. Work with the town managers and housing boards/authorities to solidify zoning, ordinances, and housing regulations applicable to recovery residences to better understand the impediments to building the intervention.

V. Overall Summary

This section summarizes the report's key findings, relevant data points, and the need statements for the Upper Valley's future recovery residences. It concludes with conditions and recommendations for the success of these residences.

1. Summary

This report's goal was to demonstrate the need for and current gaps in recovery housing within the Upper Valley's bi-state region. Currently, there are two recovery homes located in White River Junction, Vermont, with a total capacity of eleven. During the interview process, the demand for recovery housing was made clear. Specifically for the sub-populations of parents in recovery and individuals who are currently involved in the criminal justice system (Snow and Bryer, 2024). The subsequent data at the Vermont and New Hampshire state levels corroborated the local addiction field experts' analysis. Substance use rates, particularly alcohol and illicit drugs, are exponentially higher than the national averages (NSDUH, 2021-2022). The rates of alcohol, illicit drug, and opioid substance disorders in Vermont are higher than the national level. New Hampshire's rate of alcohol use disorder is significantly higher than the national level. The rates of other illicit drugs are similar to the national level. However, once broken down by age group the rate of illicit drug use/disorder in the age cohort of 18-25 is higher than the national average (NSDUH, 2021-2022). The conservative estimates of individuals who could benefit from treatment but are unable to receive it are approximately 80-90% in both New Hampshire and Vermont (Ryan, 2019), proving that treatment inaccessibility continues to be an issue. Local addiction experts concur that homelessness in the Upper Valley has reached a tipping point (Cayton, 2024; Snow and Bryer, 2024). Compounded by rising costs of living and little low-income housing, many individuals who are released from treatment do not have stable housing and are resorting to couch surfing and sleeping in tents or cars (Snow and Bryer, 2024). Not having this basic need met raises the risk of a potential relapse. The homelessness rates are increasing yearly in the Upper Valley, particularly for individuals who have a substance use disorder. Transitional housing can serve as an intervention until one is more stable and can access permanent housing. The need statements included what sub-populations should be prioritized if a new recovery residence were to be built and the importance of solidifying zoning and ordinances applicable to recovery residences. The section below expands on these statements and relates recommendations for the success of a future residence.

2. Conditions and Recommendations for Success

I. Establish a relationship between future recovery residence(s) and wrap-around service providers to ensure residents can access outpatient treatments, groups, employment assistance, recovery coaching, case management services, etc.

II. Create regulations and house rules to promote continued recovery, such as required attendance for 12-step meetings. Develop a contingency plan for when/if an individual relapses which does not equate to asking them to leave the house.
III. Commit to educating peer mentors and other supports on the tenets of trauma-informed care and how they operate within a recovery residence setting. While also ensuring that the home is a safe and engaging environment.
IV. Involve and educate community stakeholders about the ability and successes of recovery residences in aiding individuals in substance use recovery to reduce stigma. Create an open dialogue between stakeholders and owners of the residence(s) to address concerns and create resiliency for setbacks that a recovery residence could face.
V. Educate about the sources of funding, available grants for either nonprofit or for-profit recovery residences, financial resiliency, and the possible mechanisms to bridge the gap between resident fees and operating costs (Ryan, 2019). Also, create a funded scholarship program dedicated to residents who are unable to pay their dues, ensuring that they do not get removed from their homes.

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