

Vermont

UNIFORM APPLICATION

FY 2016/2017 - STATE BEHAVIORIAL HEALTH ASSESSMENT AND PLAN

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 06/30/2018
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Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

State Information

State Information

Plan Year

Start Year 2016

End Year 2017

State DUNS Number

Number 8093761550

Expiration Date

I. State Agency to be the Grantee for the Block Grant

Agency Name Agency of Human Services

Organizational Unit Vermont Department of Health, Division of Alcohol and Drug Abuse Programs

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City Burlington, VT

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II. Contact Person for the Grantee of the Block Grant

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Last Name Clark

Agency Name Agency of Human Services

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Zip Code 05495

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III. Expenditure Period

State Expenditure Period

From

To

IV. Date Submitted

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name Joyce

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Footnotes:

The State expenditure period that is most recently closed out is 7/1/14 - 6/30/15.

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2016

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 as required by
 Substance Abuse Prevention and Treatment Block Grant Program
 as authorized by
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
 and
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Section 1935	Core Data Set	42 USC § 300x-35
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee¹: _____

Title: _____

Date Signed: _____

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

[Standard Form LLL \(click here\)](#)

Name	<input type="text" value="Dixie Henry"/>
Title	<input type="text" value="Deputy Secretary"/>
Organization	<input type="text" value="Vermont Agency of Human Services"/>

Signature: _____ Date: _____

Footnotes:

Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

- 1 Vision Statement, ADAP's Strategic Plan, 2012-2017, p. 1, <http://healthvermont.gov/adap/documents/ADAPStrategicPlan2012-2017.pdf>.
- 2 State of Vermont Substance Abuse Assessment and Epidemiological Profile, Executive Summary, March 2012, p. 2.
- 3 The Health Disparities of Vermonters, June 2010.

VERMONT SAPT BLOCK GRANT 2016-2017 NARRATIVE PLAN – STEP 1

Step 1 Narrative

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems.

Overview of the State's Health Systems - Authorization

Vermont statute establishes the Department of Health as the state's lead agency for public health policy and advocacy. The Division of Alcohol and Drug Programs (ADAP) is also designated as Vermont's Single State Authority (SSA), and all of its duties, responsibilities and authorities are carried out and exercised by and within the Department of Health. Recently, the Vermont legislature has worked to update and streamline many of the Single State Authority's authorizations, shifting most to 18 VSA Chapter 94 establishing the Alcohol and Drug Abuse Council within the Agency of Human Services, and re-authorizing the Division of Alcohol and Drug Abuse Programs (ADAP) to plan, operate and evaluate a consistent, effective program of substance abuse programs within the Department of Health, <http://legislature.vermont.gov/statutes/section/18/094>; and Chapter 93 authorizing the Department of Health to establish a regional system of opioid addiction treatment, <http://legislature.vermont.gov/statutes/chapter/18/093>.

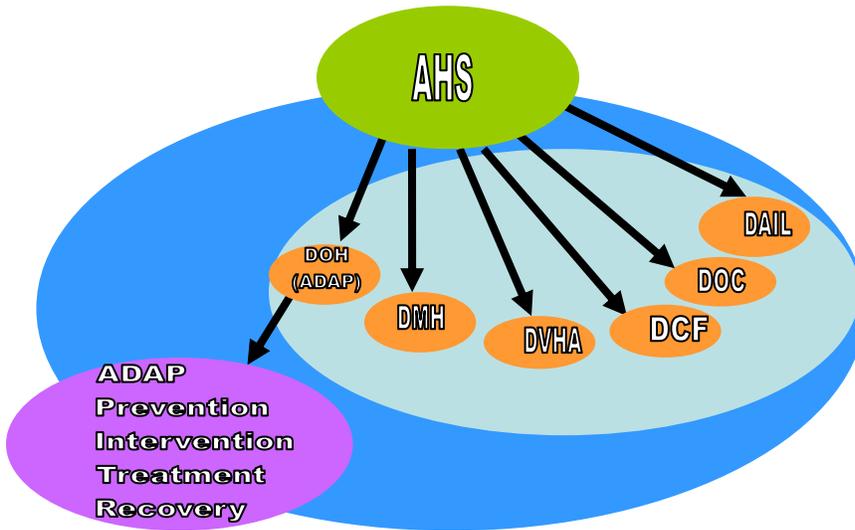
Per statute, the Division of Alcohol and Drug Abuse Programs (ADAP) shall be responsible for the following services: (1) prevention and intervention; (2) licensure of alcohol and drug counselors; (3) project CRASH schools; and (4) alcohol and drug treatment. Under the direction of the Commissioner of Health, the Deputy Commissioner of Alcohol and Drug Abuse Programs shall review and approve all alcohol and drug programs developed or administered by any State agency or department, except for alcohol and drug education programs developed by the Agency of Education in conjunction with the Alcohol and Drug Abuse Council pursuant to 16 V.S.A. § 909. Any federal or private funds received by the State for purposes of alcohol and drug abuse treatment shall be in the budget of and administered by the Department of Health. The Commissioner of Health may contract with the Secretary of State for provision of adjudicative services of one or more administrative law officers and other investigative, legal, and administrative services related to licensure and discipline of alcohol and drug counselors.

Agency of Human Services Structure

As part of the Agency of Human Services (AHS), the Department of Health (DOH) works in concert with the Departments of Mental Health (DMH), Children and Families, Disabilities, Aging and Independent Living (DAIL), Corrections (DOC), and the Department of Children and Families (DCF) to improve the health and wellbeing of Vermonters. Vermont's Agency of Human Services (AHS) also includes the Department of Vermont Health Access (DVHA), Vermont's Medicaid agency. All Departments work together in support of a common mission:

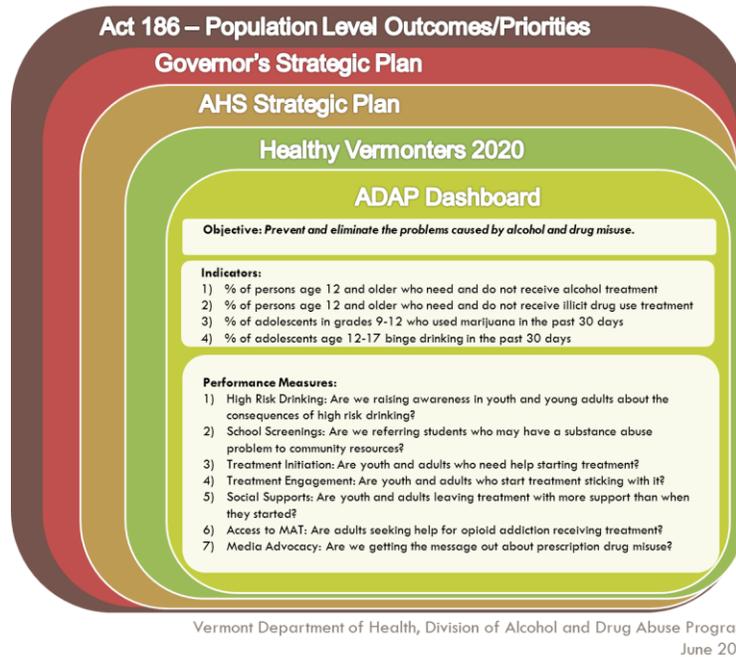
to improve the health and well-being of the thousands of Vermonters who count on the Agency for support and assistance and to protect those who cannot protect themselves. See Figure: Agency of Human Services & ADAP below.

FIGURE: AGENCY OF HUMAN SERVICES & ADAP



ADAP’s Strategic Plan 2012-2017 is a long range plan that emerges out of the State Health Improvement Plan (SHIP), as well as the Agency of Human Services and the Department of Health’s strategic plans, in order to ensure mutually reinforcing and harmonized effort statewide, and to respond to legislatively mandated results-based accountability. See the figure below: Towards an Aligned Performance Management System.

Figure: Towards an Aligned Performance Management System



Organized around goals that align with the AHS/VDH, ADAP’s Strategic Plan sets out a comprehensive array of priorities and strategic actions, ranging from policy priorities, community based substance abuse systems and services, internal business processes, structures and culture, workforce development, a communication plan and infrastructure to reach all Vermonters, and health equity, all designed to support the achievement of key outcomes. These key outcomes are mirrored in Vermont’s State Priorities as set out in SAPT Plan Table 1 Set: Priority Area and Annual Performance Indicators (see the SAPT Block Grant Table 1).

State Priorities are also informed by the framework for Healthy People 2020, including select nationally tracked population level indicators and performance measurements that focus on substance abuse issues. These measures, together with other carefully selected variables, form a subset of the Vermont Department of Health’s Comprehensive Dashboard intended to provide the public and policy makers with a way to monitor program performance in key areas across all the core programming and service units, measure progress toward achieving the Vermont’s State Health Improvement Plan.

The goals and objectives reflect a relatively recent, and significant, paradigm shift from an acute care to a chronic care model that encourages linkages and coordination between various community services. It emphasizes a locally-based, collaborative approach involving diverse groups and partners to address the innumerable interrelated issues that impact on the lives of Vermonters, such as housing, health care, education, mental health, substance abuse, corrections, communities and community organizations, and calls for more holistic ways to support Vermonters.

Planning involves on-going engagement with stakeholders and partners reflective of the diverse array of interrelated issues. For example, ADAP convened a partner and stakeholders meeting in spring 2015 representative of the entire continuum of care from prevention through recovery,

and each region of the state, to promote regional networking across the continuum, to identify key components, linkages, gaps, strengths and successes within each region, and to brainstorm possible solutions or technical assistance needs. ADAP also often turns to key partners for input or direct involvement in drafting strategic plans, guidance design documents, and reports with recommendations as was done recently when preparing the Sober Housing Report and Recommendations, the MAT Rules, and Substance Abuse Services Guidelines.

Overview of Our Substance Abuse Service System

The Structure of the Division of Alcohol and Drug Abuse Programs (ADAP) -- ADAP aims to create an accountable, community-based system of services and supports that empowers Vermonters to embrace resiliency, wellness and recovery by becoming active participants in self-management. This system includes the entire range of services from prevention through recovery, and will be composed of a continuum of timely, interconnected and coordinated components with multiple entry points.¹

The Division of the Alcohol and Drug Abuse Programs (ADAP) operates under the Department of Health, and includes a central staff responsible for policy, planning, resource allocation, monitoring and evaluation, and oversight for prevention, early intervention, treatment and recovery programs and services. The central office staff is organized into four integrated, mutually reinforcing units – Planning and Community Services; Operations; Performance Management and Evaluation; and Clinical Services – that all support programming across the entire continuum of care statewide.

Essential public health and disease prevention services are available across Vermont through the Department of Health's (DOH's) twelve district offices. The district offices work in partnership with local health care providers, voluntary agencies, schools, businesses and community organizations to improve health and extend statewide initiatives in local communities throughout the state. A team of Regional Substance Abuse Prevention Consultants (PC's) provide substance abuse training, technical assistance and information services through the twelve district health offices. Many of the direct services are contracted to local providers throughout the state, and overseen by ADAP to help Vermonters prevent and eliminate the problems caused by alcohol and other drug use.

Additionally, the Substance Abuse system is made up of an array of statewide partner organizations from prevention, early intervention, treatment and recovery, including state and community based public and private organizations that help plan, support, and evaluate the comprehensive system of services.

The Vermont Alcohol and Drug Abuse Advisory Council (VADAAC) was established in 1983 by the Vermont legislature and located within the Agency of Human Services to promote the reduction of problems arising from alcohol and drug abuse. Recently, the legislature revised the membership and role of VADAAC to reflect Vermont's approach to health reform and best practices in the substance abuse field. The Council is established within the AHS to promote the dual purposes of reducing problems arising from alcohol and drug abuse and improving prevention, intervention, treatment and recovery services by advising the Secretary of AHS on policy and program improvement.

Membership represents the full continuum of services, providers, peers and state departments most critical to the integration of substance abuse services into Vermont health care system. More detail will be provided in Section 22.

Full text of legislation available at:

<http://legislature.vermont.gov/assets/Documents/2016/Docs/ACTS/ACT058/ACT058%20As%20Enacted.pdf>

(See pages 195-199)

Prevention Works (PW) is made up of substance abuse prevention coalitions across the state focused on strengthening local, regional and statewide capacity for Alcohol And Other Drug Prevention (aka AOD prevention) in Vermont, creating broad partnership structures to support policy approaches and practices that promote prevention, health and wellness and advancing prevention practices, policies and skills in statewide, regional and national arenas. ADAP staff attends PW meetings to share key information coming from and /or relating to federal, state and legislative updates, as well as to address program oversight and monitor deliverables throughout the year.

Treatment Approved/Preferred Provider Working Group – The substance abuse treatment system is made up of ADAP approved preferred provider treatment programs. Several of these providers are community mental health centers. All of these providers are essential to direct clinical programs and services into their local communities. Currently, there are 24 approved preferred providers serving multiple sites, with a total of 43 ADAP approved community sites overall. There are also now 12 recovery centers, with the last center opening in Newport, Vermont on August 1, 2015.

The Vermont Association of Addiction Treatment Providers (VAATP) is made up of all substance abuse treatment providers funded by ADAP. The Association meets regularly to discuss issues pertaining to substance abuse treatment in Vermont. This association is chaired by one of the providers on a rotating basis. ADAP staff is invited to attend the VAATP meetings on an as-needed basis to share key information coming from and/or relating to federal, state and legislative updates, as well as to address program oversight and development issues as they relate to substance abuse.

The Vermont Association for Mental Health & Addiction Recovery (VAMHAR) is a statewide information and advocacy organization that supports all paths to recovery from addiction and mental health conditions. VAMHAR promotes “mental wellness” in Vermont, and provides education, community mobilization and training including but not limited to recovery coach training.

The Vermont Recovery Network represents the state’s twelve community-based recovery centers, which provide a range of peer recovery supports.

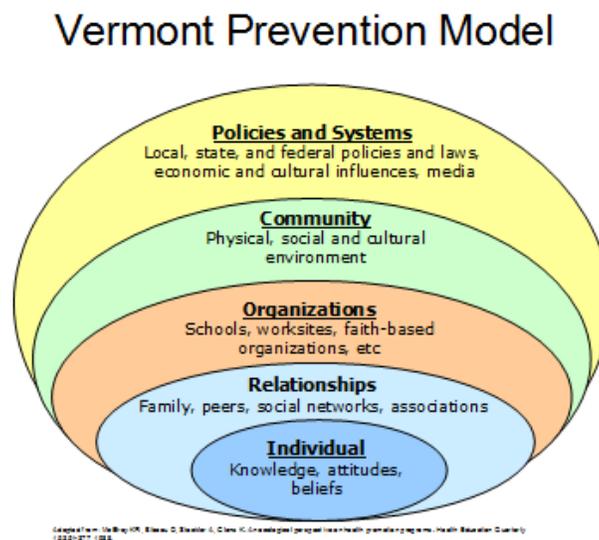
The Division of Alcohol and Drug Abuse Programs (ADAP) – Programs and Systems for Prevention, Early Identification, Treatment and Recovery Support Services:

Prevention

A Public Health Approach -- The Vermont Department of Health and the Division of Alcohol and Drug Programs (ADAP) takes a public health approach to preventing substance related problems, focusing on population level change in which the goal is to reduce community-level and/or state-level indicators of substance use and related consequences. Vermont utilizes the work of the State Epidemiological Outcomes Workgroup (SEOW), initially organized as part of the Vermont Strategic Prevention Framework State Incentive Grant (SPF-SIG), to systematically assess the prevalence and consequences of substance-related issues in Vermont.

Substance abuse prevention reduces the risks that contribute to alcohol, tobacco, or other drug misuse, while promoting factors that support health lifestyles and communities. ADAP's approach to prevention includes evidence-based strategies and services at the state, community, school, family and individual levels (See Figure: The Vermont Substance Abuse Prevention Model below):

Figure: The Vermont Substance Abuse Prevention Model



Prevention Strategic Planning

The Vermont Prevention Model was developed as a cross-disciplinary planning framework for prevention plans. The prevention model illustrates that there are many factors at play that influence individual and population health.

The program is guided by the knowledge that health promotion efforts are most likely to be effective if they are:

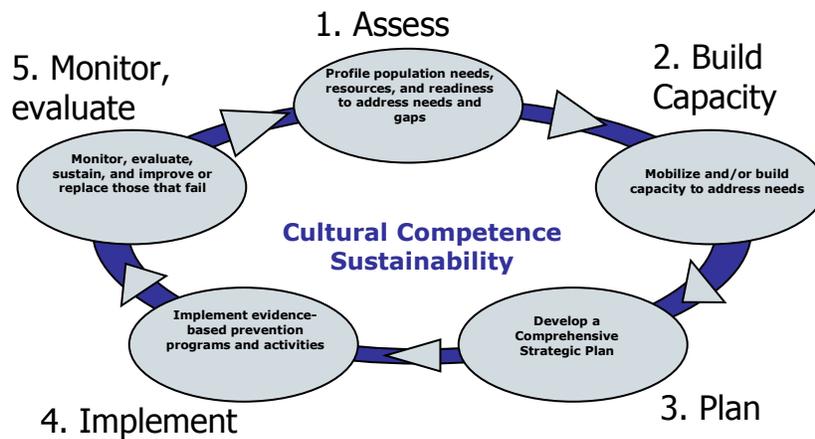
- consistent with the needs and resources of the community
- developed with an understanding of the factors contributing to the problem
- designed to specifically address those factors
- inclusive of strategies addressing multiple levels of the model simultaneously

- sustainable over time
- age, gender and culturally appropriate
- evidence based or based on best and promising practices

The Division of Alcohol and Drug Abuse Program’s (ADAP’s) Planning and Community Services Unit utilizes the Strategic Prevention Framework (See Figure: The Strategic Prevention Framework) as the overarching process for guiding public health work.

Figure: The Strategic Prevention Framework

Strategic Prevention Framework



The Strategic Prevention Framework involves five strategic processes: 1) Assessment – to profile population needs, resources and readiness to address needs and gaps; 2) Capacity – to mobilize and build capacity to address needs; 3) Planning to develop a comprehensive strategic plan; 4) Implementation – to implement evidence-based prevention programs and activities, and 5) Evaluation – to monitor, evaluate, sustain and improve or replace things that fail. This model, in addition to Vermont Prevention Model above, have been adopted across the Vermont Department of Health as means of facilitating and communicating about our prevention strategies across disciplines.

Prevention System

Vermont has a well-trained workforce with expertise in substance abuse (and mental health) prevention. The regional Substance Abuse Prevention Consultants (PCs), Planning and Community Services Unit, and the entire Division of Alcohol and Drug Abuse Programs support the Chronic Disease Prevention initiatives of the Vermont Department of Health and continue to connect with the local District Offices serving as important substance abuse resources. Each District Office (DO) is establishing an interdisciplinary prevention team as part of the state’s health reform strategy. The PC’s are an integral part of these teams. Since the PC’s have the

most experience with the SPF model and community mobilization they provide TA and support to their team members.

Vermont has a strong community-based infrastructure of coalitions, schools, and other community organizations already established under the SPF SIG and the support of other earlier federal investments. ADAP's Planning and Community Services Unit is working with The Department of Health's Division of Health Promotion and Disease Prevention, and other public health partners, to support collaboration and strategic integration to build more sustainable and effective community based prevention infrastructure.

Prevention Programs

Substance Abuse Prevention Consultant (PC) System:

The goal of this system is to increase local capacity to carry out substance abuse prevention initiatives. The State of Vermont will support primary prevention programs for substance abuse. For FY16/17, training, technical assistance, information and referral services will be delivered statewide through the twelve Department of Health District Offices (DOH). The PC network is being expanded by one FTE to enhance services to low capacity regions. PCs will provide information, community education, technical assistance and community mobilization services to a range of schools and community groups, the District Office integrated prevention teams, grantees under the SAPT Block Grant, DCF grantees and other state and community programs aimed at reducing underage drinking, high risk drinking, marijuana, prescription drug and other substance abuses.

Community-wide and Environmental Strategies:

A network of community coalitions and organizations provide both population-based and individually-based interventions. Coalitions and local organizations are supported through competitive grants. Community-Based Prevention Grants, jointly funded by ADAP and DOH's Tobacco Control Program, aim reduce health care costs through the creation of healthy communities where Vermonters can lead healthy lives. Funded strategies include: media and social marketing campaigns targeted at parents and youth; local policy changes to reduce access to alcohol; joint efforts with local law enforcement; community education; family education and support. The PreventionWorks organization is supported to provide advocacy and involve communities who may not be served by a local coalition. ADAP also supports public information prevention efforts, workforce development opportunities, the development and maintenance of performance standards, and monitoring and evaluation on a statewide basis.

Health Communications:

Prevention staff maintain and promote the ParentUp website and campaign. Recently updated, ParentUp now includes information for parents of school age youth on how to take steps to reduce underage drinking, marijuana use and other substances, and to increase awareness about community resources to help prevent and treat substance abuse issues. The Vermont Alcohol and Drug Information Clearinghouse (VADIC) provides information and educational tools to Vermont's prevention and treatment providers on mental health promotion and alcohol and drug issues. This includes a webpage, print materials, audiovisual materials and at least one electronic

newsletter during the year. In FY16/17 a social marketing campaign targeting young adult binge drinkers will be piloted.

The Partnership for Success (PFS):

Originally awarded in 2012, this three-year initiative funded by the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration Grant, is targeted to the reduction of underage drinking, binge drinking and prescription drug misuse. This project is designed to build on the significant outcomes achieved through the federally funded Strategic Prevention Framework State Incentive Grant (SPF-SIG) that has expired. The Vermont Department of Health (VDH) PFS grant has been supporting regional prevention strategies in six of twelve districts selected based on need and capacity to carry out the deliverables of the project. The grant supports training and communications activities statewide in all twelve districts of the state. VDH District Office directors and regional substance abuse prevention consultants facilitated the needs assessment and planning phases of this project, consistent with the VDH's health reform strategy and the Strategic Prevention Framework. We are grateful to expand the objectives and reach of this program through a newly awarded Partnership for Success five-year grant.

Family Based Educational Support Services:

In addition to the treatment supports ADAP funds family support and education services designed to reach families through the support of evidence-based programs such as the Nurturing Program and Guiding Good Choices. In addition, The Rocking Horse program is an educational support group serving low income pregnant and parenting women who are at risk for substance abuse or experiencing the effects of a partner's substance abuse. This prevention program is offered statewide through the state's preferred treatment provider network. The program is designed to provide knowledge, build skills, and offer a safe and caring interpersonal climate in which to discuss needs, problems, and issues. Training and consultation for group facilitators and program evaluation are supported through a statewide grant to the Vermont Center for Rural Woman.

School Based Substance Abuse Services:

School Based Substance Abuse Services grants provide and enhance substance abuse prevention and early intervention services in Vermont schools, leading to reductions in students' alcohol and other drug use. The focus of this program is delivery of selected substance abuse prevention and early intervention services based on school need, namely substance abuse screening and referral services, classroom health curricula, training for youth empowerment groups, parent education, teacher and support staff training and delivery of educational support groups. The program will evaluate the extent to which partner schools were able to increase their capacity for health promotion for all students and early intervention for students affected by substance abuse and mental health issues. It is expected that programming activities and impact is expected to extend into FY16/17.

Other Youth Education and Support Programs:

These programs are focused on promoting mental health and increasing the perception of risk that are associated with alcohol, marijuana, and other drug use. Perception of risk is strongly associated with lower rates of substance abuse among youth. ADAP regularly engages in joint

planning with the Division of Maternal and Child Health, Agency of Education and the Department of Mental Health to design, plan, refocus and evaluate initiatives. These efforts also rely on the engagement and partnership with community coalitions, youth service programs or schools to advance progress toward achieving goals and objectives identified in Division, Department and Agency strategic plans. Youth prevention services are greatly enhanced by youth treatment services described below under treatment services.

Intervention Services

Substance abuse intervention is a process to identify and act on early signs of substance misuse before it becomes a lifelong problem. Since substance abuse screening and brief counseling has been found to be as effective as other health prevention screenings, ADAP is working to increase screening for substance abuse in primary care, increase referrals for at-risk students, and improve quality of patient care through prescription drug monitoring. Other intervention priorities include increasing the completion rate of the drinking driver rehabilitation program, and decreasing the diversion of prescription drugs.

Vermont offers substance abuse intervention services in several formats: Project Rockinghorse that offers prevention and intervention activities targeting pregnant and high risk parenting women (see description above); School based health service referrals that offers prevention and intervention activities targeting high risk students in schools (see School based Substance Abuse Program Services described above); and the Public Inebriate Program that provides services for inebriated individuals; Naloxone Opioid Overdose Prevention Pilot Program to prevent potentially fatal overdoses; SBIRT – Screening, Brief Intervention, Referral to Treatment; the Project CRASH program addressing individuals caught drinking and driving; and the Vermont Prescription Monitoring System (VPMS), all described in this section.

Public Inebriate Program:

The Public Inebriate Program is a crisis intervention program for individuals under the influence and provides screening and referral services. ADAP continues to work to assure a safe and effective response to address the need for additional community inebriate services and coordinated community level collaborations between public inebriate programs, emergency rooms, law enforcement and the Department of Corrections. Under the Challenges for Change initiative, with funding through the Justice Reinvestment Act, ADAP was able to add 6 new community shelter beds for public inebriates in FY11. ADAP will continue to work to enhance capacity for alternatives to correctional facilities for these Vermonters.

Naloxone Opioid Overdose Prevention Pilot Program:

Vermont law (18 VSA§ 4240) allows health care professionals acting in good faith to prescribe, dispense and distribute and opioid antagonist to a person who is at risk of overdose, under certain specified conditions. The Department has partnered with several community-based organizations to distribute overdose rescue kits containing nasal naloxone under the Opioid Antagonist Pilot program. As these new sites come on board, and as the word is spread about the accessibility of the Naloxone Rescue Kits, the number of kits distributed has continued to rise. The Opioid Antagonist Pilot program has distributed a total of over 2,000 Overdose Rescue kits

containing naloxone to over 1,000 unique clients/citizens to individuals who either had personally experienced an overdose or witnessed an overdose.

SBIRT – Screening, Brief Intervention, Referral to Treatment:

SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services. Vermont Department of Health received a 5 year -10 million dollar grant award from SAMHSA's Center for Substance Abuse Treatment (CSAT) to implement evidence-based SBIRT services to identify and reduce substance misuse in Vermont adults aged 18 and older. The grant objective is to serve a total of 95,000 individuals across the state. This grant extends Vermont's progress under the Blueprint for Health initiatives by further integrating behavioral health with medical care to reduce substance use risk for all Vermonters. Healthcare providers receive SBIRT training to address the risk associated with substance misuse and to make it part of the routine care in healthcare settings.

The Project CRASH Program:

The Project CRASH program (Counter measures Related to Alcohol and Safety on Highways) is a legislatively mandated program for individuals convicted of an alcohol or drug driving offense. The CRASH Program has been designed to provide information to help the individuals understand clearly how alcohol and other drugs affect behavior and driving skills so that they can prevent trouble in the future. The CRASH program contains both screening and educational components and is self-funded by fees paid by participants. This includes Vermonters and out-of-state residents with offenses occurring in Vermont. When an individual's privilege to drive is suspended due to an alcohol related offense, they are required to successfully complete the Project CRASH Program. In addition, individuals may also have license reinstatement requirements, such as reinstatement fees, outstanding fines, proof of insurance, etc. There are currently 14 CRASH sites with a 94% completion rate for those registered in 2013. If through screening it is determined that treatment is required, successful completion of a treatment program by a Licensed Alcohol and Drug Counselor (LADC) as a condition of completion.

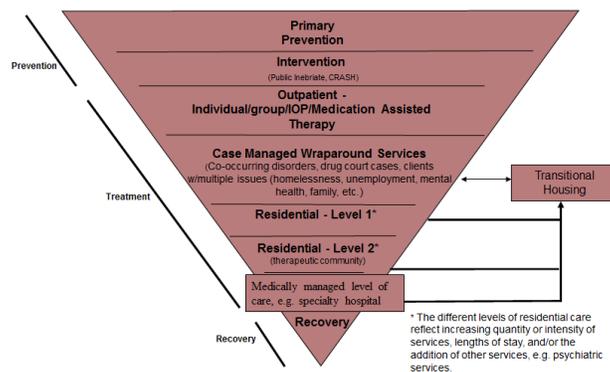
The Vermont Prescription Monitoring System (VPMS):

The VPMS, created by Act 205 in 2006, became operational allowing prescribers and dispensers to access the database in January 2009. The VPMS provides a database of all dispensed scheduled II-IV controlled prescription information to prescribers and dispensers for their patients. The purpose of the database is to provide a complete picture of a patient's controlled substance use, so that the provider can properly manage the patient's treatment, including the referral of a patient to services offering treatment for drug abuse or addiction. ADAP continues to strengthen and expand the VPMS to prevent diversion and abuse of prescription controlled substances, while ensuring the availability of appropriate drugs for legitimate medical use (e.g., activities to increase use of the VPMS by prescribers and pharmacists, develop reports and analysis that will increase patient care, provide best practice continuing medical education courses for providers and development of interstate data sharing through the Prescription Monitoring Information Exchange (PMIX)).

Vermont's Treatment and Recovery System

The treatment and recovery system is designed to be a continuum of timely, interconnected and coordinated components spanning the entire spectrum from prevention to recovery, with multiple entry points. It relies on an array of partnerships that exist between ADAP, the ADAP preferred providers, schools, recovery centers, transitional housing agencies, the courts, other state agencies, physical and mental health care providers, and local nonprofit agencies. ADAP also works to facilitate meaningful engagement between substance abuse treatment providers and the larger Agency of Human Services (AHS) to ensure effective collaborations across Departments in order to better address the complexities and interrelated challenges that surround individuals and their families struggling with addictions and/or co-occurring issues. These collaborations also span the continuum of care from prevention through to recovery. See Figure: Continuum of Care below:

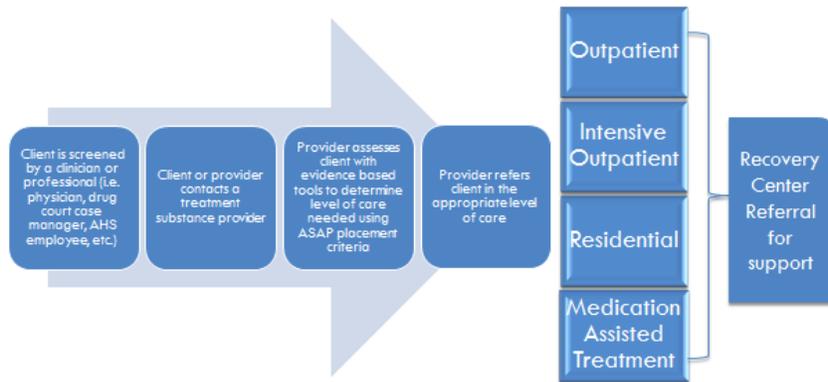
Figure: Continuum of Care



Substance abuse treatment is an ongoing process to change behaviors and attitudes that have a negative impact on one's life and those family members affected by alcohol and other drug (AOD) issues. Treatment for substance use disorders is paid for primarily by commercial insurers, Medicaid, and/or ADAP depending on the particular services. Effective services for substance use disorders include behavioral therapy as well as use of medications when appropriate. For example, for individuals with opioid addictions, studies have shown that treatment is most effective when behavioral therapy is combined with Medication Assisted Treatment (MAT). Substance abuse recovery is a process of promoting a supportive environment to assist individuals with a smooth and sustained transition to wellness.

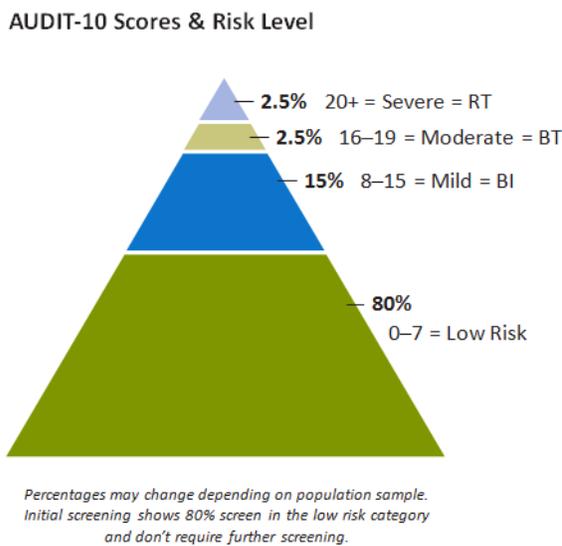
Below you will find a figure illustrating the general process for accessing treatment services in Vermont. The need for treatment is often identified through screening, which includes screening for co-occurring substance abuse issues. If indicated, a comprehensive assessment will be conducted and the individual will be referred to treatment services appropriate to the needs of the individual, and/or to on-going support through the recovery centers. ADAP employs age appropriate tools. Decisions regarding level of care are guided by the ASAM placement criteria, and rely on a client/patient-centered approach at all levels to promote the initiation and maintenance of a recovery lifestyle for those with substance abuse addictions. See Figure: Process for accessing treatment services in Vermont below:

Figure: Process for accessing treatment services in Vermont.



Note that the first box reflects efforts under the SATC pilot and through SBIRT screening to ensure AHS clients who are accessing broader services are screened earlier for substance abuse issues, with the second box representing how other individuals might be entering the system directly on their own initiative or through the referral of a health care provider. A key tool used in early screening within the SATC and SBIRT is the Alcohol Use Disorders Identification Test (AUDIT-10). It is one of the most accurate alcohol screening tests available, rated 92% effective in detecting hazardous or harmful drinking. The population level results are presented in a triangle showing disbursement of risk levels and need for type of service, including brief intervention (BI), brief treatment (BT) and/or referral to treatment (RT). For example, of Vermonters screened, 20% of the population requires further screening, distributed at the upper levels by necessity of care percentages; 80% are at low risk and would require no further screening. See Figure: Population Disbursement of Risk Levels and Need for Type of Service below:

Figure: Population Disbursement of Risk Levels and Need for Type of Service



Through Vermont's health reform initiatives, medical care practitioners are enhancing their own screening and referral services, so more clients are being screened and directed to substance abuse specialists from primary care facilities. Efforts are underway to enhance the linkages between primary care practitioners and specialty substance abuse and/or mental health practitioners.

Person-centered services:

Every individual or family that comes through the system is asked to participate in developing and implementing an individualized treatment plan. The plan identifies the most appropriate level of care (e.g., outpatient services (OP), intensive outpatient services (IOP), residential services (Res) and medically assisted treatment (MAT Tx). As clients embrace a recovery oriented lifestyle, they can be referred to "recovery centers", and/or an array of local community services designed to support recovery.

Admissions Preference and Best Practices:

All program efforts prioritize recovery focused, community-based and data driven strategies to provide the most appropriate response to Vermonters impacted by, and concerned about, substance abuse. However, admission preference for treatment services is assured by ADAP standards and provider protocols for the following types of individuals in order of priority: pregnant injecting drug users, pregnant substance abusers, injecting drug users, persons in need of immediate services as determined by DSM5 criteria for substance use disorders. Age appropriate tools for screening and assessment are used for all populations.

Ongoing partnerships exist between ADAP and the ADAP preferred treatment providers (as described above in the Overview of Our Service System), the Vermont Recovery Network Centers, and transitional housing agencies to assist clients in succeeding in a drug-free lifestyle. This is an exciting transformation that builds upon a person-centered system of care that encourages partnerships to meet the needs of the client and their family. This approach is designed to position the substance abuse treatment providers and community grantee organizations to be able to participate in, and integrate with, the various collaborations and initiatives of the Agency of Human Services and health care reform. ADAP has identified as a goal to bring prevention activities, as well as treatment and recovery services into the planning and integration for all community-based services statewide.

Adolescent Services:

ADAP continues to develop the adolescent and family substance abuse treatment service delivery system to meet the needs of this population. ADAP is represented on the workgroups leading and designing the Integrating Family Services (IFS) initiative at the Agency of Human Services. Under the SAMHSA State Youth Treatment Grant (awarded 2013), ADAP is training the youth serving workforce on identifying, referring and working with youth with substance use disorders, and the youth substance abuse treatment providers on age appropriate evidence based treatment assessments and models. Also under the auspices of this grant, ADAP is convening cross agency and department policy level meetings to address obstacles to providing effective, preventive and coordinated services to youth.

High Risk and Complex Client Capable System:

ADAP is working in partnership with DVHA and Blueprint to supplement the existing treatment and recovery infrastructure to meet the needs of high risk and complex clients through the Care Alliance for Opioid Addiction (Hub and Spoke) Initiative. This initiative focuses on regionally developing “hubs” that provide comprehensive assessment, care coordination and medication-assisted treatment. These “hubs” have been developed as needed in key regional centers to serve substance abusing populations with histories of multiple complex issues that require a systemic, coordinated response to achieve positive outcomes. A total of 5 hubs representing 8 program sites are currently in operation.

Integration with Primary Care and Blueprint for Health:

ADAP continues to improve coordination between patient-centered medical homes (PCMH’s) and specialty substance abuse treatment providers for individuals with substance abuse related issues (e.g., through referral protocols, care coordination, Substance Abuse benefits packages, information sharing, etc.). This work is also connected to the “Hub” initiative described above. These and other collaborations are contributing to stronger relationships between primary care practices and local community mental health and substance abuse service centers, leading to more effective recovery management of physical and behavioral health services.

Criminal Justice Capable System of Care:

ADAP participates in the work overseen by the Tri-Branch Task Force on Mental Health and Co-Occurring Disorders (for more details see systems description below); this work strives to create a more seamless approach for intervention with individuals who come in contact with the criminal justice system. The overall goal is to intervene early to interrupt the patterns of mental health and substance use disorders that contribute to repeated contact with law enforcement, the courts and the corrections system.

Drug Courts:

Select partner treatment providers support Drug Court services in regions around the state. The largest and most structured drug court programs are in Chittenden, Rutland and Washington counties. These programs offer an alternative to incarceration that includes assessment, treatment as needed and case management.

Drug Free Housing:

Many clients served, particularly those reentering the community from Department of Corrections’ facilities, have great difficulty finding and affording safe, drug free housing because of limited services capacity, and limited availability of alternative affordable housing. Clients served, therefore, often return to live with people who are drug users, and/or return to the risky environment they previously abused alcohol and drugs, reflecting a major barrier to recovering individuals remaining clean and sober.

Recovery Supports

Recovery Centers:

There are now 12 recovery centers across the state with the opening of the Newport center in August. The centers provide a local place for people to attend recovery support meetings and to

receive a variety of peer delivered support services such as recovery coaching. These centers are a critical element in the development and integration of the Resiliency, Recovery Oriented System of Care (RROSC).

Transitional housing/Half-way Housing:

Housing is a core need for many of the people receiving services through the Agency of Human Services, including those who are recovering from substance abuse. ADAP now makes grants that support 71 units of short-term transitional housing for persons in recovery, including 11 family units for women with children.

This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services.

SSA/SMHA

Vermont's Specialty Behavioral Health Services that address substance abuse and mental health are overseen by two separate authorities. The Vermont Department of Health's Division of Alcohol and Drug Abuse Programs (VDH/ADAP) as the SSA, and the Department of Mental Health (DMH) as the State Mental Health Authority (SMHA). The Department of Mental Health (DMH), Vermont's State Mental Health Authority (SMHA), contracts with private, nonprofit service providers, called Designated Agencies, to provide direct mental health services to each region of the state.

The DMH is organized into two programmatic units – one for adult services and another for children, adolescents, and family services. It also administers the Vermont State Hospital. ADAP continues to partner with the Department of Mental Health in developing co-occurring treatment capacity, through the use of tools, like the DD-CAT, to provide on-going assessment of provider agencies. Other areas of collaboration with the Department of Mental Health include: involvement in various Agency of Human Services Initiatives, including Severely Functioning Individual (SFI); Criminal Justice Collaboration (CJC); Integrated Family Services (IFS); Trauma Training for the Preferred Provider Network; Vermont's State Dashboard and State's Health Improvement Plan; and Consultation Pertaining to On-Going/Future Grant Initiatives.

Vermont's treatment and recovery system addresses both substance-related and co-occurring needs. Collaboration with Mental Health and Substance Abuse recovery and advocacy organizations also continue to ensure the most appropriate service design and capacity is in place for addictions and co-occurring populations at the state and community levels. ADAP works closely with its preferred provider network to analyze the treatment system, and to jointly look for ways to enhance easy access to the most appropriate, coordinated and continuous care needed. This includes evaluating step down processes and referral linkages, e.g., from residential treatment, and working to develop more streamlined and coordinated responses between treatment providers and identifying factors contributing to failure to step down, as well as improving a systems wide approach to performance management, including identifying and using common measures, determining how to measure, and defining who is accountable/responsible, etc. ADAP continues to promote best practices in treatment and recovery through the Vermont Association of Addictions Treatment Providers (VAATP),

Community Coalitions, and community grants. Furthermore, continued efforts and planning are ongoing about how to better integrate specialty substance abuse systems, services and care into traditional health care.

Age Appropriate Screening, Tools and Referrals

Treatment Referrals (CFR 45.10) – The Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (ADAP) continues to work with treatment providers (as well as other stakeholders in Health Reform and the Blueprint Health Initiative) to further improve policies and procedures for prescreening and referring clients to appropriate levels of care (e.g., outpatient, intensive outpatient, medically assisted treatment, and residential treatment). ADAP will continue to require all providers to employ age appropriate tools to determine appropriate levels of care. ADAP will also continue to extend trainings on evidence based practice in areas of interest to providers. Direct services are designed for specific adolescent and adult populations; ADAP employs evidence based practices and data driven decision making to develop, implement and oversee substance abuse programming.

Assess the strengths and needs of the service system to address the specific populations.

Service system strengths

1. Support of leadership and normalizing substance use disorders as a public health issue

Vermont’s policymakers have demonstrated an unprecedented focus on substance abuse over the last two years. This focus was precipitated, in part, by the public concern about opioid misuse and dependence, and its impact on public safety and human services systems. In January of 2014, Governor Shumlin devoted his entire State of the State address to the challenge posed by opiate addiction, and steps to address it. This address dramatically increased the awareness and interest of leaders around the state and the public in general. It has fueled several initiatives to strengthen our service system as detailed below.

2. Increased focus on Screening in Human Services and Criminal Justice System

a. Substance Abuse Treatment Coordination Initiative

Vermont’s Secretary of Human Services has prioritized the enhancement of screening, early intervention and assessment of those at highest risk for opioid dependence and other substance use disorders. Substance abuse was identified as the sole focus of the Agency of Human Services (AHS) Public Health Stat process, leading to the Substance Abuse Treatment Coordination Initiative (SATC). The SATC establishes a coordinated approach to serving Vermonters with substance abuse problems across all AHS departments. This initiative includes: (1) Establishing AHS-wide policy on screening AHS clients; (2) Developing a systemized method of screening clients and a menu of evidence-based screening tools approved for use by AHS departments; (3) Establishment of Department-level protocols for implementation of the policy including a mechanism for referring clients who screen positive to appropriate assessment

services; (4) Training AHS staff and managers to recognize substance abuse and co-occurring disorders and implement the screening protocol; (5) Coordination and determination of best methods to ensure Departments are working together on cases that involve more than one Department; and (6) Regional needs assessments and plans for addressing treatment service gaps (led by the Criminal Justice Capable Core Team Work group).

Further, future SATC actions include: (1) adopting a standard definition of case management across AHS, and investigating integration with case management data system development; (2) developing an AHS housing plan for high need clients, particularly those being released from residential treatment or the Department of Corrections (led by the AHS Housing workgroup).

b. Pre-Trial Services

The Vermont Pretrial Services Program was established by the General Assembly through Act 195 Section 2.13 VSA 7554c. The intent of Act 195 was to ensure that law enforcement officials and criminal justice professionals develop and maintain programs at every stage of the criminal justice system to provide alternatives to a traditional criminal justice response for people who, consistent with public safety, can effectively and justly benefit from those alternative responses. The first program goal is to offer universal and voluntary needs screenings and risk assessment to the aforementioned eligible populations. These screenings are conducted by Pretrial Monitors (PTM) who are contracted to perform all Pretrial Service Program elements. They are trained by the Director, and supervised by regional managers through the same contract. Defendants who have contact with law enforcement and who are cited/arrested are provided a universal (used statewide) citation that includes information about the Pretrial Service Program and a phone number to contact the county/jurisdiction. Defendants can therefore self-refer into the program by contacting the PTM, learn if they are eligible as per the statute, and complete the needs screening (MMS for mental health and SIMPLE for substance use), risk assessment (Ohio Risk Assessment System- Pretrial Assessment Tool), Brief Negotiated Intervention (BNI) modeled after the evidence based practice called the same, and follow through on a plan to improve their health and wellbeing. This program is in start-up phase and training is underway.

3. Prevention and Treatment of Opioid Misuse

a. Governor's Statewide and Regional Forums on Opiate Addiction

Vermont has greatly enhanced its service system in this area particularly in response to the Governor's State of the State Address. Over 200 Vermonters representing every region of the State came together at the Statehouse on June 16, 2014 to hear the Governor's Call to Action, learn about opiate addiction and hear from stakeholders around the state on prevention, treatment and recovery strategies underway in Vermont communities. Implementation at the community level of the Governor's Community Forum on Opiate Addiction involved having the Regional Substance Abuse Prevention Consultants and District Health Directors recruit diverse groups of community members representing prevention, health care, substance abuse treatment and recovery, human services, local United Ways, business, housing, law enforcement and community justice from each of Vermont's twelve human services districts. Regional prevention consultants and district directors continued to provide facilitation, planning and community

mobilization support to these regional teams as they continued their follow-up efforts. At least 500 Vermonters participated in follow-up regional forums and developed action plans for each region. In addition to the plans, new and creative partnerships were established and communities became aware of how to take action to address this important public health issue.

b. The Vermont Prescription Monitoring System (VPMS)

The VPMS, created by Act 205 in 2006, became operational allowing prescribers and dispensers to access the database in January 2009. The VPMS provides a database of all dispensed scheduled II-IV controlled prescription information to prescribers and dispensers for their patients. The purpose of the database is to provide a complete picture of a patient's controlled substance use, so that the provider can properly manage the patient's treatment, including the referral of a patient to services offering treatment for drug abuse or addiction. ADAP continues to strengthen and expand the VPMS to prevent diversion and abuse of prescription controlled substances, while ensuring the availability of appropriate drugs for legitimate medical use (e.g., activities to increase use of the VPMS by prescribers and pharmacists, develop reports and analysis that will increase patient care, provide best practice continuing medical education courses for providers and development of interstate data sharing through the Prescription Monitoring Information Exchange (PMIX)).

c. The Care Alliance for Opioid Addiction

The Care Alliance for Opioid Addiction (Hub & Spoke Model) has become fully implemented. As of January, the number of people receiving care had increased by more than 40%. The majority of those receiving treatment remain in treatment longer and those who remain in treatment for more than 90 days show improved overall functioning at discharge. The model now:

- Expands access to Methadone treatment with the opening of a new additional methadone program in the Rutland area and supporting providers to serve all clinically appropriate patients. Vermont now has 5 Hubs, with 8 sites, for treating people with methadone.
- Enhances Methadone treatment programs (Hubs) by augmenting the programming to include Health Home Services to link with the primary care and community services, provide buprenorphine for clinically complex patients, and provide consultation support to primary care and specialists prescribing buprenorphine.
- Embeds new clinical staff (a nurse and a Master's prepared, licensed clinician) in physician practices that prescribe buprenorphine (Spokes) through the Blueprint Community Health and the Vermont Department of Health.

d. Opioid Overdose Prevention

Vermont law (18VSA§ 4240) allows health care professionals acting in good faith to prescribe, dispense and distribute an opioid antagonist to a person who is at risk of overdose – or to a family member, friend or other person in a position to help – so long as the recipient of the opioid antagonist has completed a training program approved by the Department of Health,

including how to recognize a possible opiate/opioid overdose and what life-saving actions to take, including administering naloxone intra-nasally. The Department has partnered with several community-based organizations to distribute overdose rescue kits containing nasal naloxone. As these new sites come on board, and as the word is spread about the accessibility of the Naloxone Rescue Kits, the number of kits distributed has continued to rise. The Opioid Antagonist Pilot program, since its start in late 2013, has distributed a total of over 2,000 Overdose Rescue kits containing naloxone to over 1,000 unique clients/citizens. Overall, 38% of these individuals had personally experienced an overdose, and 65% had witnessed an overdose. As of May 2015, data has been collected on the use of 204 Overdose Rescue kits that were reportedly used by individuals on a person (62% of which were reported as a "friend") whom they believed was experiencing an overdose. Over 92% of these incidents were reported to have involved an overdose of heroin.

4. Grant opportunities allow increased dissemination of E-B approaches

Vermont has been able to utilize demonstration grant opportunities to further strengthen and disseminate evidence-based practices targeting programmatic areas of high need. State staff supported by SAPT Block Grant funds, are instrumental in the planning and management that makes these opportunities possible. Some of the grant opportunities include:

SAMHSA's **Partnership for Success (PFS)** grant has allowed Vermont to increase training on and dissemination of evidence-based prevention strategies through 6 lead agencies and 21 sub-grantees. Vermont's PFS is a regional approach to support substance abuse prevention through implementation of evidence-based strategies targeted at underage and high risk drinking and prescription drug misuse and abuse. Each regional sub-recipient implements an array of evidence-based strategies from a menu. The grant supports program enhancements to Department of Liquor Control's (DLC) Responsible Beverage Service Training, recognition of retailers for passing alcohol compliance checks, prescriber and dispenser education on proper storage and safe disposal of unused prescription drugs, promotion of "take back" events, and promotion of Vermont's Most Dangerous Leftovers campaign on safe storage and disposal.

SAMHSA's **Screening, Brief Intervention and Referral to Treatment (SBIRT)** grant has supported promotion and dissemination of this model through medical settings, such as federally qualified healthcare centers, emergency departments and free clinics. Many medical practitioners and practices have been doing some sort of substance use screening for years but may not have a clear method for reviewing and responding to the results of these screenings. SBIRT offers a step-by-step integration of evidence-based screenings and interventions that practitioners can use with their patients based on level of risk.

The **Vermont Prescription Monitoring System (VPMS)** was successfully awarded the 2014 Harold Rogers Prescription Drug Monitoring Program (PDMP) enhancement grant to support efforts to increase the data quality and utility of the VPMS, increase the utilization of the VPMS, improve prescribing practices, increase public knowledge about the consequences of prescription drug misuse, carry out public education on safe disposal methods, and to plan for an evaluation of the VPMS. Evidence based approaches include:

- Increasing awareness of the VPMS by providing and promoting prescriber education and the value of VPMS. Data shows increased utilization following prescriber education on prescribing controlled substances (including use of VPMS data).
- Uniform data standards may facilitate cross-state data sharing, analyses, and inter-organizational collaboration; more recent standards provide for more complete data fields, improved error correction, and additional reporting functionalities.
- Evaluation of PDMP activities can inform and improve activities and demonstrate the value of a PDMP.

SAMHSA's **Youth Treatment Enhancement Program** aims to increase referrals of youth and young adults in need of substance abuse treatment, to enhance adolescent substance abuse treatment, and to support the improved integration of behavioral health services for adolescents and transitional aged youth. Two pilot sites, Centerpoint Adolescent Services and the Washington County Youth Services Bureau, have been trained in the use of the CASI assessment tool (Comprehensive Adolescent Severity Index) and two Evidence Based treatment practices (Seven Challenges for ages 12-17 and Seeking Safety for ages 18-24), and are providing clinical treatment based on these models. Sites are focusing on reducing obstacles to care, strengthening existing partnerships, and developing new collaborative relationships. Careful evaluation of the impact of these treatment models and systems level outcomes are being tracked by an independent evaluator and reported to SAMHSA. Training in these tools will be rolled out to adolescent and young adult treatment providers state-wide in an effort to expand the use of evidence based programming, and to sustain improvements to Vermont's substance abuse treatment system beyond the completion of the grant. Oversight by the Youth Service System Enhancement Council will guide policy and infrastructural changes as we undergo a financial mapping process, implement workforce development opportunities for Vermont's youth-serving professionals, and work toward a state-level partnership in meeting the needs of adolescents and transitional aged youth.

5. Service system collaborations

Much of Vermont's work involves collaboration with multiple Agencies, Departments and VDH Divisions. In addition to the initiatives already described the **Combined Community Grant Program** and the **Youth Service System Enhancement Council** are both collaborations aimed at improving outcomes among school aged youth and young adults, and worthy of note. SAMHSA's Substance Abuse Prevention and Treatment (SAPT) Block Grant supports community-wide chronic disease prevention through community-based prevention grants. This is a joint initiative of ADAP and VDH's Tobacco Control Program. The aim of the community-based grants programs is to reduce health-care costs through the creation of healthy communities where Vermonters can lead healthy lives. The Youth Service Systems Enhancement Council promotes shared responsibility across state and community stakeholders for achieving positive outcomes for youth and young adults in Vermont. The Council promotes, advocates for, and monitors the continued evolution of culturally competent, holistic, strengths-based service systems for Vermont's young people, advocates for improved quality of and access to these services, organizes policy responses to remove barriers to achieving these goals, and, importantly, involves youth, parents and communities in the design of these services. The Council works within a health promotion/prevention/intervention/treatment/recovery framework.

ADAP's Vermont Youth Treatment Enhancement Program is informed and guided by this council.

Service System Needs and Challenges

1. Workforce Development needs across the continuum

Increased recognition of substance use disorders as a public health issue has naturally led to a substantial increase in demand for services. The focus on screening and early intervention through the Pre-Trial Services Initiative, the Substance Abuse Treatment Coordination Project, the Screening, Brief Intervention and Treatment initiative, the Reach-Up Initiative and the School-based Substance Abuse Services Program have and will generate increasing referrals to our treatment system, particularly the outpatient infrastructure. Expansion of the Hub & Spoke Model alone has produced increasing pressure on the system. There has already been a shortage of workforce to staff such expansion, compounded by some atrophy as it relates to an aging workforce. Retention, recruitment and training are all challenges. There is a need to expand the professional base of counselors as well as to equip physicians with specialized behavioral and substance abuse knowledge and skills. Because much of the community-based prevention workforce is funded thru time-limited grants, the workforce lacks sufficient opportunity to develop and deepen the more complex and mature skill sets to carry out this challenging work. Given the significant benefits and cost savings of effective prevention, there is a desire to increase standards, as well as to build a sufficiently skilled and populated workforce to set higher objectives in this area. Key priorities for investment include establishing a path of continuing education and skill development for the workforces and establishing links with institutions of higher education to help grow the workforces.

2. IT systems and data collection

Data collection systems and the information technology needed to adequately support them continue to pose a significant challenge across our system. Lack of a web-based prevention data collection system makes it very difficult to collect consistent performance measures across all prevention programming. Vermont has identified a solution for prevention data collection but state budget rescissions made it impossible to implement the original plan.

An antiquated treatment data collection system poses an additional challenge. The state is evaluating requirements to move the data collection system online as Vermont is currently maintaining and updating individual databases at some providers. Mental health and substance abuse have different data collection requirements, and with different overlapping providers offering co-occurring services to those in need, creates additional data collection and systems challenges. Vermont is waiting for SAMHSA to finalize the requirements for the combined substance abuse and mental health data reporting to help inform some of these system changes.

3. Purchase of Services

In the context of healthcare reform we have identified a need to update our strategy for the purchase of services. Over the past two years' Block Grant implementation period, Vermont has

made significant progress breaking down traditional siloes and working to build a comprehensive continuum of care for the state. This has involved identifying both a common set of overarching, data driven population level objectives, as well as the more recently identified common set of performance measures to reflect ADAP's work across the entire continuum. This has also ignited interest in moving from a "widget" focused purchasing model (or service units purchasing, e.g., x hours or y things) to a more outcome focused purchasing approach that aims to improve outcomes, i.e., "getting people better." There are challenges related to each of these type models and the requirements of the different systems; coordination and overlapping purchasing within the state where people are served in more than one program represents another type of related challenge. Finding an optimal method to pay for these services, and assuring that there is no duplication of effort, is a difficult prospect.

4. Prevention, intervention and treatment capacity to reach youth and young adults

Although we have made progress, the state continues to have low capacity to reach young adults with population-level prevention interventions and specialized treatment. This has been exacerbated by the marijuana policy debate in Vermont. There is high need, but low perception of risk. Models of evidence-based, culturally competent outreach strategies are not yet widely available. Vermont has few treatment providers with expertise in serving this population and few specialty programs. Although SAMHSA's Youth Treatment Enhancement grant is improving the system, the need remains very high.

States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services.

- Services offered through Agency of Human Services departments, including DOH, are organized primarily through a system of twelve regions, or "districts". DOH District Health Directors (DD's) have strong relationships with hospitals, federally qualified health centers and accountable care organizations. They are well versed in health promotion and chronic disease prevention efforts in their districts. DD's supervise ADAP's regional Substance Abuse Prevention Consultants (PC's) while ADAP sets the priorities and deliverables for the PC network based on the ADAP plan. Given the PC's expertise in community mobilization and their position in the region, as our "eyes and ears", PC's play a critical role in promoting collaboration between prevention, treatment and recovery providers in the region. VDH District Office— ADAP is working with chronic disease prevention partners through the twelve Health District Office Integrated Prevention Teams to develop one training system on core prevention skills for implementing community based prevention strategies.
- Substance Abuse Treatment Services are available in every district, and some providers have multiple sites within districts. Although there is not a residential facility physically located in all twelve districts, residential services are available to Vermonters statewide.
- As noted above many local communities have access to prevention programs through school-based programs and local community coalitions, but this is inconsistent around the state.
- The Care Alliance for Opioid Addiction described above furthers the coordination and collaboration of ADAP, the Blueprint and DVHA to support and expand treatment services for those with opioid addictions through the Hub and Spoke initiative. As noted above, total of 5

regional hubs representing 8 program sites are currently in operation, providing services statewide.

- Existing collaboration with the community partners (e.g. Vermont Child Health Improvement Project, Court Diversion, Vermont Program for Children, Youth, and Families/AHS' Child Integrated Services initiative) will continue in order to increase screening and brief intervention services provided by pediatricians and family physicians.
- Collaboration continues between primary care, behavioral health and community based prevention on chronic care strategies in a public health model through “The Blueprint Health Initiative” in pilot communities. Work will also include developing collaborations and relationships with Federally Qualified Health Centers throughout the state.
- Through the Blueprint for Health Initiative, Vermont continues its efforts to implement comprehensive health care reform including statewide expansion of Vermont’s Blueprint for Health Initiative. The Vermont Blueprint for Health reforms the way Vermont pays for and practices primary care to better meet the Triple Aim, as promoted by the Institute for Healthcare Improvement, to improve the health of the population, to enhance the patient experience of care (including quality, access, and reliability), and to reduce, or at least control, the per capita cost of care. Through the establishment of advanced primary care practices and community health teams to provide enhanced consumer services, the Blueprint is working to improve the capacity of these practices to recognize and address substance abuse, mental health and other co-occurring conditions (e.g. developmental disabilities). Primary care practices now regularly screen for substance abuse and mental illness and most community health teams and Blueprint primary care practices now employ mental health and substance abuse treatment specialists.
- Workforce Development Training and technical assistance will continue to focus on use of evidence based treatment and assessment tools. Collaborations with the Vermont Center for Health and Learning, the Vermont Addiction Professionals Association, the Vermont Association for Mental Health and Addiction Recovery and the Vermont Recovery Network, the Blueprint for Health the Center for the Application of Prevention Technology and the Addiction Technology Transfer Center (ATTC) will continue to inform ADAP’s efforts on workforce training and technical assistance.

The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Demographics –Vermont ranks 49th in population and 45th in geographic area among the 50 States. The State has a relatively homogeneous racial make-up with 96.5% of the population listing their race as white; 1.3% Hispanic; 1.2% Asian; 0.8% African American; 0.4% American Indian; and 1.1% list two or more races. Vermont has the second highest median age in the nation at 41.2 years.² Vermont has no federally recognized Tribes. With new infusions of refugee populations and influx of new diverse populations, the challenge of health disparities may grow more complex over time.

Priority Populations –Vermont utilizes the work of the State Epidemiological Outcomes Workgroup (SEOW), initially organized as part of the Vermont Strategic Prevention Framework State Incentive Grant (SPF-SIG), to systematically assess the prevalence and consequences of

substance-related issues in Vermont. Through regular population-wide monitoring and more targeted analysis as described above, Vermont remains vigilant to identify gaps and barriers, and improve access to services for all Vermonters.

ADAP's SAPT Block Grant goals are operationalized to address these concerns, and arise principally out of the Healthy People 2020 objectives for substance abuse. The data shows few regional differences in the risks and prevalence rates (with the exception of difficulty of accessing services due to rural geographical features such as transportation and access to services) across population demographics. Because most refugees and minority groups live in Chittenden County, DOH resources are currently housed in our Burlington District Office but serve programs statewide. The major populations of focus for the Division of Alcohol and Drug Abuse Programs (ADAP), therefore, are pregnant women and women with dependent children, adolescents 12 – 17, adults ages 18-25, and high risk drug abusers in all age groups (namely, IV drug users, prescription drug abusers, and those requiring medically assisted treatment). Additional focus is being placed on reaching military families, at risk adolescents identified by schools and/or law enforcement, and those involved in the criminal justice system.

As stated previously and under the section on Health Disparities, Vermont's Department of Health Strategic Plan 2014-2018 has as its mission to protect and promote the best health for all Vermonters. One of the major goals is health equity, and the plan includes measurable objectives to reduce health disparities. See http://healthvermont.gov/hv2020/strategic_plan.aspx

Furthermore, the state prepares a specialized publication that presents the results of a comprehensive evaluation of health disparities in Vermont, and sets out key recommendations to further reduce health disparities.³

In ADAP's Strategic Plan, this commitment is reflected across many of its goals, but most directly articulated in Strategic Directions 6.1 and 6.2: Recognize and respond to health disparities; and Cross-Divisional and Department Collaborations to achieve health equity among the most vulnerable Vermonters and to improve reach and services to vulnerable Vermonters.

Also, as stated above, ADAP's Preferred Providers and other partner provider organizations submit data on the age, gender, ethnicity, and other demographic criteria of its clients through SATIS. Through site visits and the newly revised Vermont Substance Abuse Treatment Standards, ADAP works with its partners to identify and eliminate systemic barriers that hinder certain sectors of its population from being able to access services.

This narrative must include a discussion of the current service system's attention to the SABG priority populations: Pregnant Women, Injecting Drug Users, Women with Dependent Children, Persons at Risk for Tuberculosis, Individuals in Need of Primary Substance Abuse Prevention, and, for HIV-designated states, Persons at Risk for HIV.

Priority Populations

Persons at Risk for Tuberculosis

The TB Program of the Vermont Department of Health provides periodic training for public health nurses and Vermont Department of Corrections health care staff on core TB principles. The state's TB medical consultant provides one to two trainings per year at hospitals around the state. These trainings are designed primarily for physicians but are usually open to other hospital health professionals. The TB Program is available to provide a TB updates for large meetings or training sessions for other professionals, and can recommend training materials for smaller groups as needed.

Based on language in all substance abuse treatment providers' grants with ADAP, clients admitted for treatment are to be provided counseling, education, testing and referral services with respect to HIV and TB. These services must be made available either directly or through arrangements with other entities for such persons who may be in need of such services. Program staff confirm these procedures are followed during the yearly reviews/audits conducted by ADAP to assure compliance with ADAP grant/contract assurances, the recently revised Vermont Substance Abuse Services Guidelines. See

<http://healthvermont.gov/adap/treatment/documents/SubstanceAbuseServicesGuidelines.pdf>.

For the recently adopted Substance Abuse Treatment Certification Rule for all ADAP Approved Providers and Preferred Providers, see

http://healthvermont.gov/regs/documents/substance_abuse_treatment_certification_rule.pdf.

Pregnant Women

Pregnant women are a Vermont and block grant priority population. As defined in Table 1, one of the top program priorities is articulated using the following measurable objective:

Pregnant women or women with dependent children: Increase early intervention and access to treatment for pregnant or parenting women.

As described in Step 2, women represent about 40% of the treatment population overall. The major exception to the gender data showing a predominance of males in the treatment system is the gender mix among the opioid treatment population which is closer to 50%. All ADAP funded treatment programs are required to provide gender specific and trauma informed services using evidence-based practices. Such evidenced-based curricula are "Seeking Safety" and "Beyond Trauma" by Dr. Stephanie Covington. Vermont's "Project Rockinghorse" is an example of a prevention and early intervention program providing important education and group support for high risk pregnant women and women with dependent children (i.e., "parenting women") around the state.

In state fiscal year 2014, 7% of women treated through the ADAP-funded system of care were pregnant and 75% of pregnant women entering the substance abuse system had opioids as the primary substance of abuse (Source: Vermont Substance Abuse Treatment Information System). Since 2002, Vermont hospitals have worked with pregnant women who are opioid dependent and their infants who are exposed to opioids in utero. Both provider awareness of opioid dependence

during pregnancy and increased training in the treatment of infants exposed to opioids have changed dramatically in Vermont over the past decade. Initiatives such as the Improving Care for Opioid-exposed Newborns (ICON) project at the University of Vermont and University of Vermont Medical Center have greatly expanded training and awareness in the Vermont provider community. As women have learned they will be treated with respect, and provider awareness and openness to treating women with opioid dependence have increased, so has the willingness of women to come forward and seek help.

Infants Exposed to Opioids

In Vermont, four out of five opioid dependent pregnant women giving birth are in treatment. Once a pregnant woman is identified as opioid dependent, her infant is diagnosed as “exposed to opioids” with a diagnosis code for neonatal abstinence syndrome (NAS). Opioid-exposed infants are monitored for four days in the hospital. Many of these infants never show symptoms of NAS. While some do have signs and symptoms of NAS, only a small proportion of those need to be treated with methadone or morphine.

Vermont is a leader in treating opioid dependent pregnant women. The Vermont practice of coding all opioid exposed infants with the NAS diagnosis code and other practices can partially be attributed to the increase in provider awareness and the increased access to treatment.

Within the state funded treatment system, successful discharges of pregnant and parenting women, defined as those who complete treatment or transfer to another level of care, have been trending downward. These numbers are likely influenced by the increasingly high rate of Medication Assisted Treatment (MAT) because clients are retained in treatment, rather than being discharged, so successful treatment is ongoing.

Intravenous Drug Users

Intravenous Drug Users are also a Vermont and block grant priority population. As defined in Table 1, one of the top program priorities is articulated using the following measurable objective:

Intravenous drug users: Increase early intervention and access to treatment for intravenous drug users.

With increases in the number of people receiving treatment for heroin and opioids Vermont has seen increases in intravenous drug use. IV use of heroin has increased significantly over the past several years and IV use of other opioids is continuing to increase. There are three syringe exchange programs with four exchange sites in different counties in the state of Vermont. Additionally, one of exchange programs has a mobile outreach arm that services four additional underserved communities. These services are funded through state general funds for HIV prevention services rather than federal funds. The goal of the syringe exchange initiative is to decrease the transmission of infectious disease (Please note that Vermont is not an HIV designated state). Between 2010 and 2014, there has been a 178% increase in the number of people exchanging needles through the exchanges but only an 80% increase in the number of needles distributed, largely due to lack of funding for needle purchase. The trend in the number

of people participating in needle exchanges is trending upward at a rate somewhat greater than that of the admissions associated with intravenous drug use.

Despite the increase in admissions associated with IV drug use, the percent of IV drug users with successful treatment discharges, those who complete treatment or transfer to another level of care, has remained stable over time. Source: Vermont Substance Abuse Treatment Information System. (Please note that Vermont is not an HIV designated state).

Footnotes:

¹ Vision Statement, ADAP's Strategic Plan, 2012-2017, p. 1,

<http://healthvermont.gov/adap/documents/ADAPStrategicPlan2012-2017.pdf>.

² State of Vermont Substance Abuse Assessment and Epidemiological Profile, Executive Summary, March 2012, p. 2.

³ The Health Disparities of Vermonters, June 2010.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet services needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the populations relevant to each block grant within the state's behavioral health system, especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet these unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data set including, but not limited to, the [National Survey on Drug Use and Health](#) (NSDUH), the [Treatment Episode Data Set](#) (TEDS), the [National Facilities Surveys on Drug Abuse and Mental Health Services](#), the annual [State and National Behavioral Health Barometers](#), and the [Uniform Reporting System](#) (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance abuse prevention, and substance abuse treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase behavioral health services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

[SAMHSA's Behavioral Health Barometer](#) is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the [National Survey of Substance Abuse Treatment Services](#) (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the [Behavioral Health Barometers](#). States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the [Healthy People Initiative](#)¹⁸ HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

¹⁸ <http://www.healthypeople.gov/2020/default.aspx>

Footnotes:

1 Vermont State Level Report from the National Survey on Drug Use and Health (NSDUH), 2012/2013 Selected Results (Substance Abuse and Mental Health Services Administration, 2013, State Estimates of Substance Use from the 2012-2013 National Survey on Drug Use and Health, NSDUH. Rockville, MD. Link: <http://www.samhsa.gov/data/population-data-nsduh>

2 State of Vermont Substance Abuse Assessment and Epidemiological Profile, Executive Summary, November 2012, p.4.

3 <http://www.samhsa.gov/data/sites/default/files/2010%20-%20NSSATS%20State%20Profiles/2010%20-%20NSSATS%20State%20Profiles/VT10.pdf>

4 TEDS admissions <http://www.dasis.samhsa.gov/webt/quicklink/VT13.htm>

5 NSDUH Injection Drug Use and Related Risk Behaviors. <http://oas.samhsa.gov/2k9/139/139IDU.htm>

VERMONT SAPT BLOCK GRANT 2016-2017 NARRATIVE PLAN – STEP 2

Step 2 Narrative

“Step 2: Identify the unmet service needs and critical gaps within the current system.

This step should identify the unmet services needs and critical gaps in the state’s current systems, as well as the data sources used to identify the needs and gaps of the populations relevant to each block grant within the state’s behavioral health system, especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet these unmet service needs and gaps.

ADAP’s Data-driven Priority Setting

Background

The Single State Authority (SSA) for substance abuse is the Vermont Department of Health Division (VDH) of Alcohol and Drug Abuse Programs (ADAP). Vermont has a central Health Department with local offices throughout the state, allowing for effective state coordination facilitated by local implementation capacity. VDH also has a centralized Health Surveillance Division able to provide long-term surveillance and data tracking systems.

On June 18, 2014, the Public Health Accreditation Board awarded five-year accreditation status to the Vermont Department of Health. The Department received commendation from the Accreditation Committee for our ability to use and present data and track performance through the use of an online performance management system and the Public Health Stat process. Public Health Stat is an internal cross-divisional management process facilitated by the Performance Improvement Manager that promotes data-driven decision making, relentless follow through and a focus on accountability. Every month key department decision-makers and stakeholders come together to do program planning and resource allocation around one of six high priority, department-wide goals. The meetings engage managers at all levels in developing and owning solutions that are data-driven with an eye toward achieving efficiencies that will positively impact health outcomes.

ADAP’s Approach to Need and Gap Identification

- A Public Health Approach -- The Vermont Department of Health and the Division of Alcohol and Drug Programs (ADAP) takes a *public health approach* to preventing substance related problems, focusing on population level change in which the goal is to reduce community-level and/or state-level indicators of substance use and related consequences.
- Vermont utilizes the work of the State Epidemiological Outcomes Workgroup (SEOW), initially organized as part of the Vermont Strategic Prevention Framework State Incentive Grant (SPF-SIG), to systematically assess the prevalence of substance-related issues in Vermont. Established in 2005, the SEOW is made up of individuals with backgrounds in epidemiology and health statistics, as well as key state agency staff whose responsibilities include data collection, review and analysis. In addition to members with substantial data expertise and access to relevant data sets, the SEOW has representatives from the community, external evaluators from

the Pacific Institute for Research and Evaluation, and key stakeholders who have an interest in an ongoing systematic assessment of substance use and abuse in Vermont (e.g., selected staff from ADAP treatment, prevention, Department of Mental Health, and Department of Health, Division of Health Surveillance, individuals from the University of Vermont, as well as the Burlington Chief of Police). Currently, the SEOW is comprised of 37 members. The Chair of the SEOW is the current Substance Abuse Research and Policy Analyst for ADAP. The purpose of the Vermont SEOW is to apply systematic reporting and analysis regarding the prevalence, causes, and consequences of the use and abuse of alcohol, tobacco and other drugs in order to effectively and efficiently utilize prevention resources. The SEOW will also audit a range of mental health indicators that pertain to substance use and abuse, and explore the potential integration of additional indicators relevant to behavioral health more broadly. The SEOW promotes data-driven decision making by examining and analyzing all relevant data sets relating to substance use and abuse across geographical and demographic categories. Furthermore, to the extent possible, the SEOW works to identify groups that are at particularly high risk of having or developing substance abuse problems in order to focus limited prevention resources. The SEOW received funding in 2011-2012 under a contract with Synectics to continue and expand its mission to include behavioral health in general. Under the auspices of the Partnerships for Success II grant, referred to in Vermont as the Regional Prevention Partnership (RPP), the SEOW was independently funded to continue to function as a vital resource for that program. In addition, the SEOW has expanded its mandate beyond prevention to include ADAP wide programs (i.e., treatment and recovery).

- Consumption and consequence patterns -- Effective substance abuse program planning is grounded in a solid comprehension of alcohol, tobacco, and other drug *consumption and consequence patterns*. Understanding the nature and extent of consumption (e.g., underage drinking) and associated consequences (e.g., motor-vehicle crashes, substance-related hospital admissions, etc.) is critical for determining state priorities, aligning strategies to address them, and assessing progress in reducing them.

Performance Management

In 2010, the Health Department was awarded a National Public Health Improvement Initiative cooperative agreement from the Centers for Disease Control and Prevention. This grant accelerated a movement already underway to increase performance accountability in Vermont. As of 2015, the Health Department has become a leader within state government in the implementation of performance management. Currently, the Health Department performance management framework is integrated with the State Health Assessment Plan, State Health Improvement Plan, outcomes-based legislation (Act 186), and core departmental operations. It functions at the program, organization, and system levels to ensure the Health Department is using performance data to improve the public's health. This work is overseen by the Performance Improvement Manager and the cross-divisional Performance Management Committee.

Scorecards

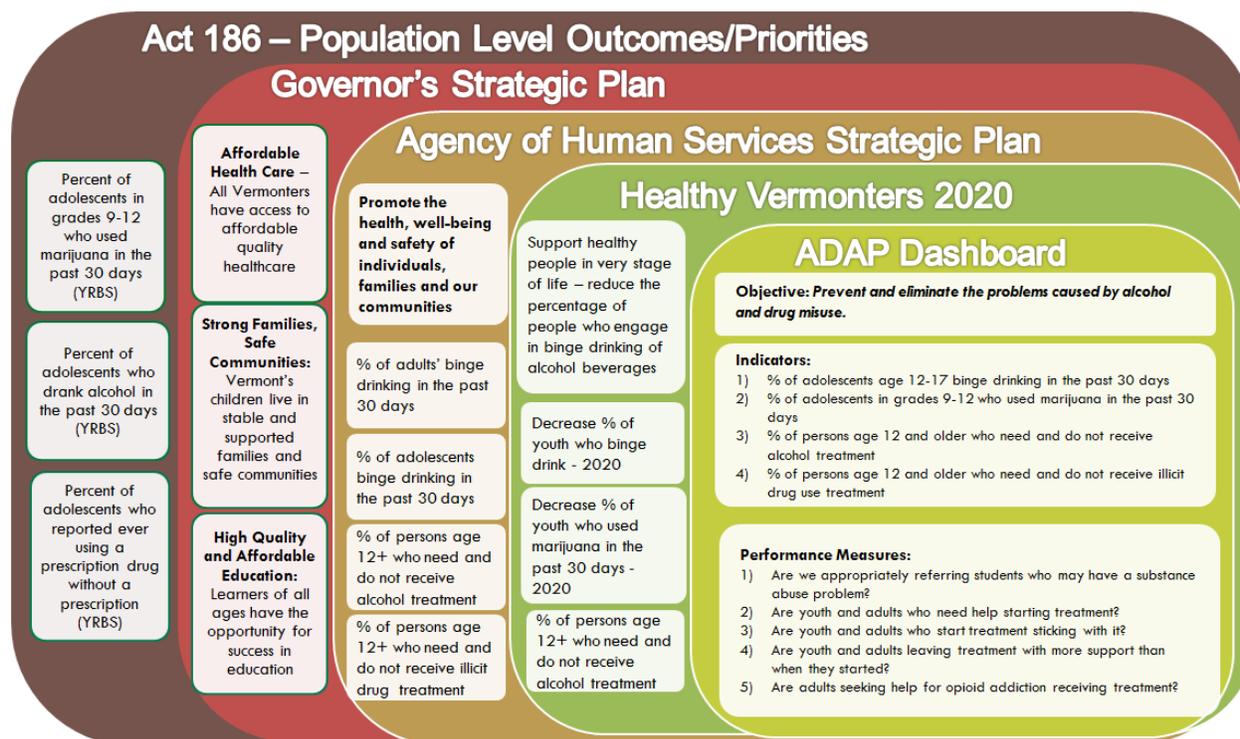
As part of a larger performance management framework, the Healthy Vermonters 2020 performance management system brings together population health data at statewide and local levels as well as program performance data. The novel Healthy Vermonters 2020 performance management system utilizes two web-based software solutions to support transparent, accessible, data-driven decision making. This publicly available system holds the Health Department

accountable for its strategies to improve health outcomes (<http://healthvermont.gov/hv2020/>). Composed of thematic Scorecards to track performance and geographically-focused Maps and Trends reports, the system utilizes Results Scorecard and InstantAtlas software. Each component displays 121 Healthy Vermonters indicators – the measures of population health status that constitute the State Health Assessment priorities, including those around substance abuse. The Scorecard components also display program performance measures to help staff track how well their work contributes to those population indicators. To facilitate local-level decision making, the Maps & Trends pages disaggregate the indicators into three relevant regional geographies.

The Healthy Vermonters 2020 performance management system is used to promote accessible data display, consistent and responsive systems, accreditation readiness, transparency, and responsiveness to Community Health Needs Assessment (CHNA) requirements. The system supports accountability by directly linking population health status and ongoing health department work. Linking the outcomes to work, regardless of program title or funding, helps support transparency and understanding with stakeholders in and outside of government. Staff and managers provide narrative context, or stories behind the curve, for population indicators and program-performance measures that include interpretations of data, lists of partners, and citations of effective evidence-based strategies, action plans, and available links to additional resources. Providing these resources across priority health topics in a consistent, data-centric platform is more meaningful and comprehensive than what has previously been available on the Health Department's website and has been integral to the success of the Health Department's performance management process.

ADAP's Strategic Plan and associated program implementation and service contracting is influenced by multiple planning processes that cascade down from legislation, the Governor's office, the AHS, Federal priorities, and the Department of Health. Having a common, well aligned performance management system ensures mutually reinforcing and harmonized effort statewide. See Figure: Towards and Aligned Performance Management System (Expanded View) below:

Figure: Towards and Aligned Performance Management System (Expanded View)



Vermont routinely uses a wide variety of datasets for setting strategic priorities as shown below. Treatment Episode Data Set (TEDS) information is collected through the Substance Abuse Treatment Information System (SATIS). Below, you will see the diverse sources of in-state date. See Table: Vermont's In-state Database Sets for Substance Abuse Monitoring below:

Table: Vermont's In-state Database Sets for Substance Abuse Monitoring

Name of Database	Measures	Frequency of Collection/Distribution	Who Manages Data	Capacity to Analyze
Early Aberration Reporting System	Emergency Department overdose rates	Overly 24 hours. Available weekly.	Infectious Disease Surveillance. Division of Health Surveillance.	Strong. Recent work with CDC.
Vermont Uniform Hospital Discharge Data Set	Emergency and Inpatient Discharges for overdose.	Annually. Available one to two years after collection.	Health Statistics. Division of Health Surveillance.	Strong. Recent work with SAMHSA.
Office of the Chief Medical Examiner	Overdose mortality	Monthly. Available three months after death.	Office of the Chief Medical Examiner. Vermont Department of Health.	Strong. Recent work with CDC.
Vital Records Death Certificate Data	Overdose mortality	48 hours after death. Available upon request.	Health Statistics. Division of Health Surveillance.	Strong.

Behavioral Risk Factor Surveillance System	Prevalence of prescription drug misuse among adults 18+	Annually. Available 8-10 months after collection.	Health Statistics. Division of Health Surveillance.	Strong.
Youth Risk Behavior Survey	Prevalence of prescription opioid and heroin use among youth in grades 6-12	Every other year. Available 8-10 months after collection.	Health Statistics. Division of Health Surveillance.	Strong.
National Survey on Drug Use and Health	Prevalence of prescription pain reliever misuse and heroin misuse among Vermonters ages 12+	Annually. Available a year after collection	SAMHSA	Medium.
Pregnancy Risk Assessment Monitoring System	Prevalence of substance use during and prior to pregnancy among pregnant women in Vermont	Will become available in 2017.	Health Statistics. Division of Health Surveillance.	Strong.
Naloxone Pilot Data	Number of reported overdose reversals by laypeople in the community	24 hours. Available monthly.	Health Statistics. Division of Health Surveillance.	Strong.
Substance Abuse Treatment Information System (TEDS Data)	Number of people treated for substance abuse, by substance	Monthly. Available quarterly.	Alcohol and Drug Abuse Programs.	Strong.
Statewide Incident Reporting Network	Number of overdose EMS calls	Available quarterly.	Division of Emergency Medical Services	Strong.
Vermont Prescription Monitoring Program	Many measures	Weekly. Available weekly.	Health Statistics. Division of Health Surveillance.	Strong.

This illustrates the challenge that there is no one data source for determining total reach of substance abuse services. For instance, the substance abuse treatment data for the ADAP-funded providers, the SATIS data, includes all substance abuse treatment services provided by those providers for all payers. It does not include fully identifying information to allow “de-duplication” when used in conjunction with other data sources, and includes only information for those providers within the ADAP-funded treatment system. In addition to the ADAP funded treatment services, substance abuse services are provided by mental health treatment providers and within hospitals, by private practitioners, and through physician’s offices through support of Medicaid. Vermont is beginning to explore the feasibility of using the VHCURES (an all payer database) for estimating the total number of people receiving substance abuse treatment services in Vermont. While this data source will provide information about the insured population, it excludes information about people without insurance coverage.

The Data

Vermont General Population Prevalence Data

- The following, Table: Summary of Statewide Prevalence Estimates from National Survey on Drug Use and Health (NSDUH)¹ shows the Vermont ranking of prevalence rates relative to the rest of the states and the District of Columbia. Vermont prevalence rates are among the highest in the nation for underage drinking, underage binge drinking, young adult drinking, young adult binge drinking, and marijuana use across all age groups.

**Table: Summary of Statewide Prevalence Estimates 2012-2013 from NSDUH
(Source: Office of Applied Studies, SAMHSA)**

Substance by Age Group	Past Month %	VT Rank* 1-5	Past Year %	VT Rank* 1-5
Alcohol (12+)	59	2		
Binge (12+)	21	4		
Underage Consumption (12-20)	30	1		
Underage Binge (12-20)	20	1		
12-17 Consumption	15	1		
12-17 Binge	9	1		
18-25 Consumption	69	1		
18-25 Binge	45	2		
26+ Consumption	62	2		
26+ Binge	18	5		
18+ Consumption	63	2		
18+ Binge	22	5		
Marijuana (12+)	12	1	19	1
12-17	11	1	20	1
18-25	29	1	47	1
26+	9	1	14	1
18+	12	1	19	2
			<i>Cocaine</i>	
Illicit Drugs Other than Marijuana (12+)	3	3	2	1
12-17	4	2	1	1
18-25	8	1	6	1
26+	3	3	1	2
18+	3	3	2	1
Non-Medical Use of Pain Relievers (12+)			4	5
12-17			5	4
18-25			9	4
26+			3	5
18+			4	5

* Rank among 50 States and DC (1 = highest 10, 5 = lowest 10)
Quintiles more accurately reflect rankings due to instability in year-to-year

individual ranks

Red in Rankings indicates VT in first quintile

Note: **Green** indicates significant reductions from 2011-2012. There are no significant increases.

Alcohol Consumption

Vermont Alcohol Prevalence Rankings – State-level surveys (see TABLE: Summary of Statewide Prevalence Estimates from NSDUH) indicate that Vermont ranks in the first quintile (50 States plus Washington D.C.) in underage drinking, underage binge drinking, young adult drinking, and binge drinking. Consumption has decreased over time, but the relative ranking of Vermont has remained high. Furthermore, Vermont young adults (ages 18-25) are also in the 1st quintile in past month alcohol consumption rate. Early Onset -- Research has consistently demonstrated that early onset of regular drinking is predictive of later alcohol use disorders. For example, children who begin drinking alcohol before the age of 15 are five times more likely to develop alcohol problems than those who start after age 21. Fortunately, the proportion of Vermont students who report drinking before age 13 has decreased significantly since 1993 for both males and females as reported on the Youth Risk Behavior Survey (YRBS), although the downward trend is less dramatic compared to that reflected nationally.²

Binge Drinking

- Binge Drinking – Vermont is in the 1st quintile for underage binge drinking in the past month (ages 12-20) in the country. Among young adults (ages 18-25), Vermont is also in the 1st quintile.

Marijuana Prevalence and Perception of Risk

- Marijuana – Except for the age category 18+ Vermont is in the first quintile for all age categories for marijuana use. For 18+ Vermont is in the 2nd quintile.

Other Illicit Drugs

- Illicit Drugs Other than Marijuana [cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type opioids used non-medically] -- Vermont is in the first quintile in the rate of past month use of illicit drugs other than marijuana among those 12+ and the 18-25 age group. Among 18-25 year olds, Vermont is also in the first quintile for past year use of cocaine.
- Non-medical Use of Pain Relievers – Overall (12+ as well as 18+ and 26+) Vermont is in the 5th quintile for NMUPR. For 12-17 and 18-25 year olds, Vermont is in the 4th quintile. Furthermore, for all age groups except 26+ there was a significant decrease in prevalence from 2011/2012 to 2012/2013.

Alcohol and Drug Disorders

- Alcohol Abuse or Dependence (Past Year) [Data not shown in table] Vermont is in the 3rd quintile overall (12+) of those who meet DSM-IV criteria for alcohol abuse or dependence. For 12-17 year olds, Vermont is in the 1st quintile; 18-25 year olds Vermont is in the 2nd quintile, and for 26+, Vermont is in the 4th quintile. *Please note that DSM5 is now being used in Vermont, however data summaries reported here and below reflect diagnoses based on the DSM-IV criteria and are expected to continue to be reflected in the data through to at least 2014/2015.

- Illicit Drug Dependence or Abuse (Past Year) [Data not shown in table] Vermont is in the 2nd quintile overall (12+) for those meeting DSM-IV criteria for illicit drug abuse or dependence. For 12-17 year olds and for 18-25 year olds, Vermont is in the 1st quintile. For those 26+, Vermont is in the 2nd quintile. (See note * above).

Vermont Addiction Treatment Data

- **Treatment Admissions** -- The 2013 N-SSATS survey³ showed that Vermont had a one-day total of 5,230 clients, a 25% increase over 2011, in addiction treatment. The majority of whom (4124 or 79%) were in outpatient, including methadone/buprenorphine addiction treatment. Of the total clients served, more are treated for both drug and alcohol abuse (42%) than drug abuse only (38%) or alcohol abuse only (20%). Of the total number of clients in addiction treatment on this date, 324 (7%) were under the age of 18.
- **Treatment Admission Changes** -- According to Treatment Episode Data (TED)⁴, there has been an increase in the number of treatment admissions between 1992 and 2013. Over this time, there has been a substantial decline in the number of admissions citing alcohol (87% vs. 35%) but a very significant increase in opioid related admissions (7% to 38%). Over the past two years admissions for heroin have increased 242% while those for other opioids have increased only 15%. These increases are driven in part by increased funding and capacity for Medication Assisted Treatment. See the Table: Vermont Treatment Admissions by Substance below.

Table: Vermont Treatment Admissions by Substance – Source: TEDS

Measure	1992	2011	2013	Change (%) 1992 to 2013	Change (%) 2011 to 2013
Total Admissions	5485	8200	9710	77%	18%
Alcohol Only	2951	2009	2022	-31%	1%
Alcohol with Drug	1805	1601	1404	-22%	-12%
Heroin	37	636	2178	5786%	242%
Other Opioids	22	2240	2574	11600%	15%
Marijuana	368	1179	1089	196%	-8%

- **Demographics of Treatment** -- The demographics of the treatment clients have also changed during this time period. Clients have become less likely to be male (77% vs. 60%) and more likely to be under the age of 31 (52% vs 56%). Those using heroin and other opioids are typically younger than those using alcohol only, and older than those using heroin. Those with primary alcohol and marijuana are more likely to be male but the sex of those using heroin and other opioids is split fairly evenly. See Table: Demographics of Treatment below:

Table: Demographics of Treatment – Source: TEDS

Demographic Measure	1992	2013
Male	77.1%	60.1%
Female	22.9%	39.9%
Under Age 21	14.9%	14.3%

Age 21-30	36.9%	41.6%
Age 31 and Over	48.2%	44.1%

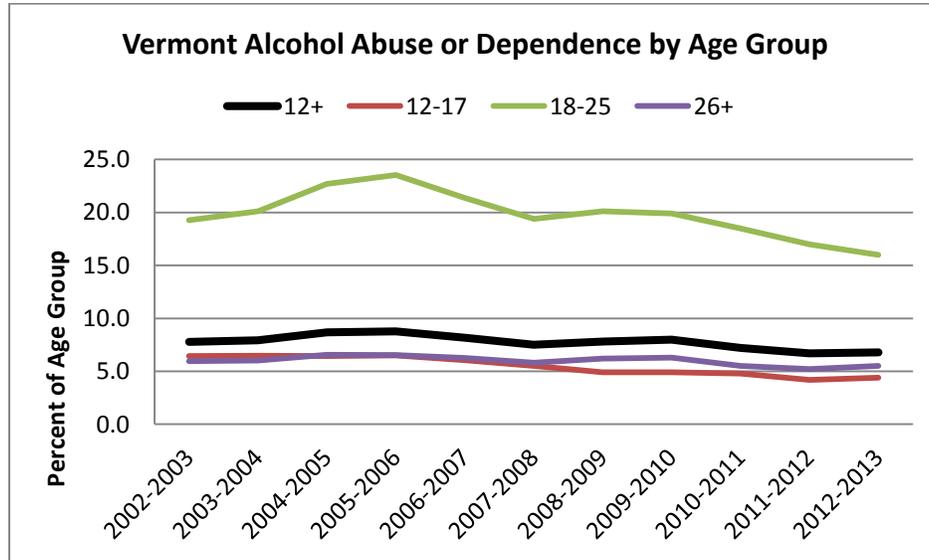
White	96.0%	94.0%
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By Substance and Age - 2013	Alcohol Only	Marijuana	Heroin	Other Opioids
Under Age 21	10.6%	51.9%	7.8%	6.1%
Age 21-30	19.3%	29.1%	59.1%	55.4%
Age 31 and Over	70.1%	19.0%	33.1%	38.5%

By Substance and Sex - 2013	Alcohol Only	Marijuana	Heroin	Other Opioids
Male	68.0%	71.3%	55.3%	49.6%
Female	32.0%	28.7%	44.6%	50.4%

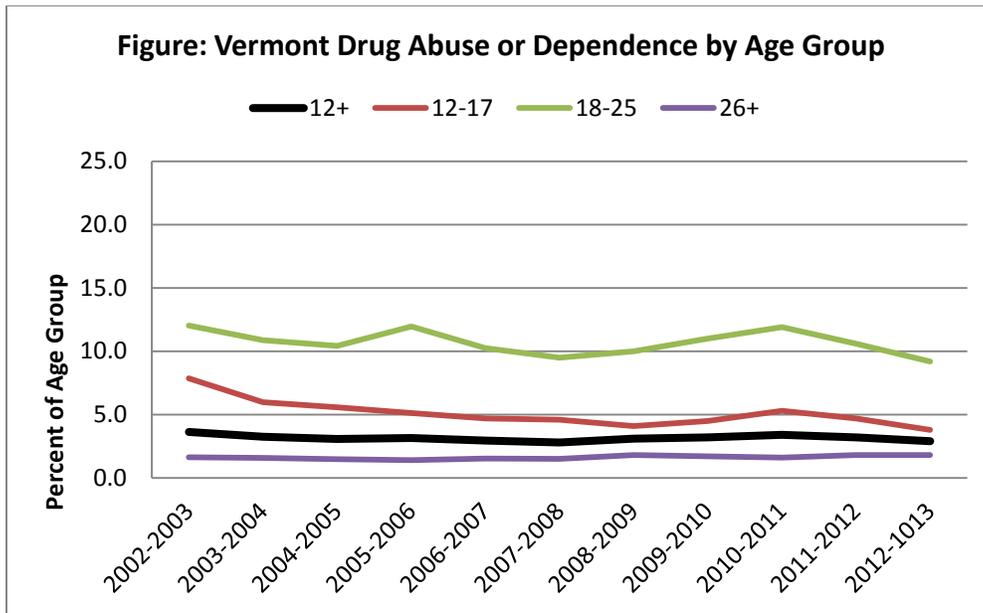
- Vermont Alcohol Dependence or Abuse by Age Group -- National Survey on Drug Use and Health (NSDUH) shows that rates of alcohol abuse and dependence are highest among people aged 18-25 years old. See Figure: Vermont Alcohol Dependence or Abuse by Age Group below:

Figure: Vermont Alcohol Dependence or Abuse by Age Group – Source: NSDUH



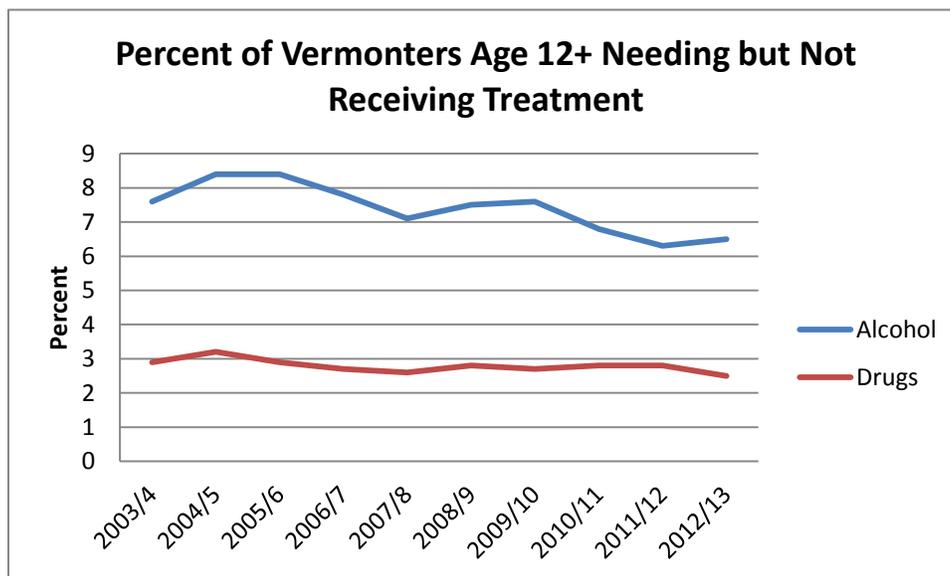
- Vermont Drug Dependence or Abuse by Age Group – NSDUH shows the same age group, individuals aged 18-25, have the highest rates of drug dependence or abuse. See Figure: Vermont Drug Dependence or Abuse by Age Group below:

Figure: Vermont Drug Dependence or Abuse by Age Group – Source: NSDUH



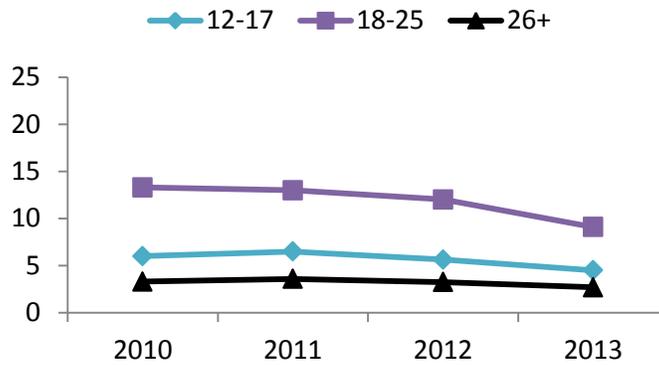
- NSDUH defines unmet addiction treatment need as an individual who meets the criteria for abuse of or dependence on illicit drugs or alcohol according to the DSM-IV, but who has not received specialty addiction treatment for that problem in the past year. (Please see note * above). Rates of unmet drug addiction treatment have generally remained flat and the rate for alcohol addiction treatment is trending slightly downward over time. During the time period covered in the most recent NSDUH reports Vermont has received significant federal prevention grants, which have focused largely on alcohol, and also increased state funding for substance abuse treatment. See Figure: Percent Needing but Not Receiving Treatment below:

Figure: Percent Needing but Not Receiving Treatment – Source: NSDUH



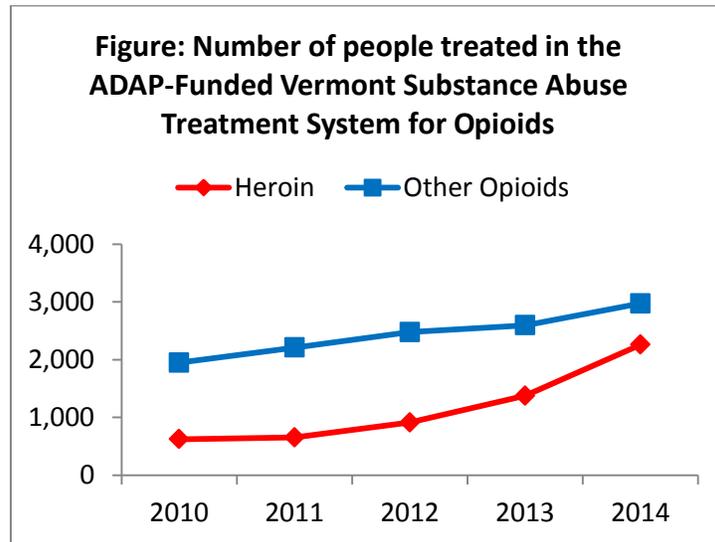
- NSDUH data indicate prevalence of prescription pain reliever misuse is decreasing in Vermont. This is statistically significant for younger Vermonters, those 12-17 and 18-25 years old. See Figure: Prevalence of Prescription Pain Reliever Misuse in Past Year below:

Figure: Prevalence of prescription pain reliever misuse in the past year



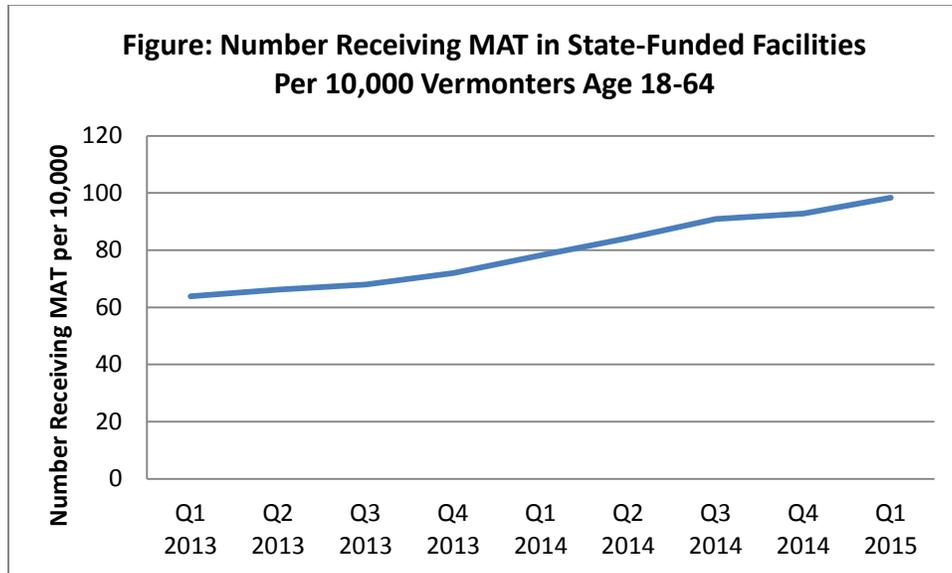
- Vermont has seen a significant increase in the number of Vermonters receiving treatment for opioid abuse and dependence. The number of Vermonters treated for heroin addiction increased 365% between 2010 and 2014. The state expanded the availability of medication assisted treatment to address demand for care. Source: Vermont Substance Abuse Treatment Information System (SATIS). See Figure: Number of People Treated in the ADAP Funded Vermont Substance Abuse System for Opioids below:

Figure: Number of People Treated in the ADAP Funded Vermont Substance Abuse System for Opioids



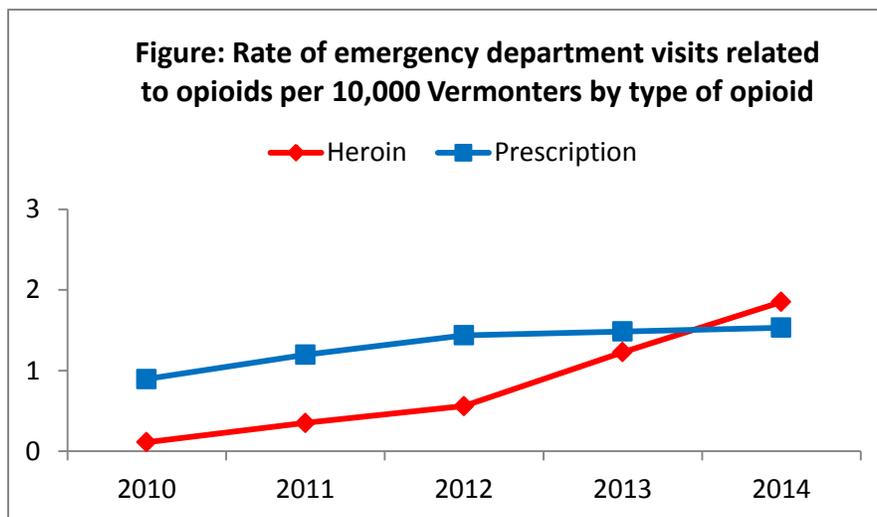
- Through the Care Alliance for Opioid Addiction, Vermont has increased capacity for Medication Assisted Treatment (MAT). Capacity has been increased both through ADAP-funded specialty treatment facilities (Hubs) where both methadone and buprenorphine are used, and through Medicaid-funded physician-based buprenorphine programs. The number of Vermonters per 10,000 Vermonters aged 18-64 receiving MAT through these programs has increased rapidly. Source: Vermont Substance Abuse Treatment Information System and Vermont Medicaid Claims Data. See Figure: Number Receiving MAT in State-Funded Facilities Per 10,000 Vermonters Age 18-64 below:

Figure: Number Receiving MAT in State-Funded Facilities Per 10,000 Vermonters Age 18-64



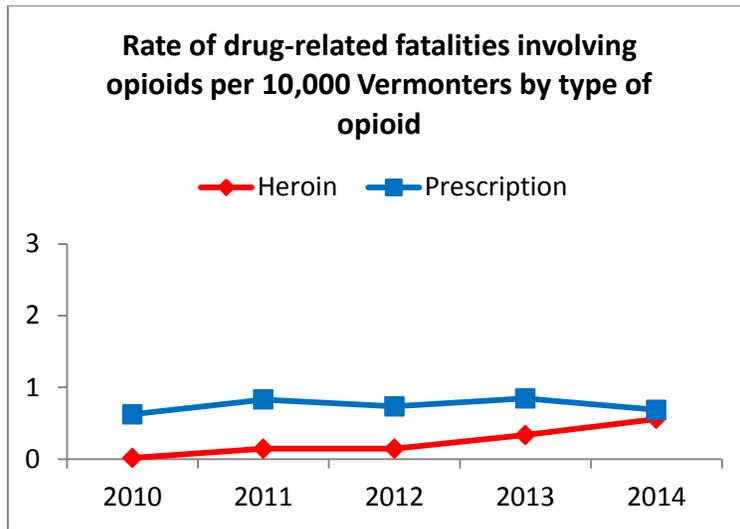
- There has been a significant increase in heroin-related visits to the Emergency Department while the prescription drug visits have not increased in the past 2 years. Source: Vermont Early Aberration Reporting System. See Figure: Rate of Emergency Department Visits Related to Opioids per 10,000 Vermonters by Type of Opioid below:

Figure: Rate of Emergency Department Visits Related to Opioids per 10,000 Vermonters by Type of Opioid



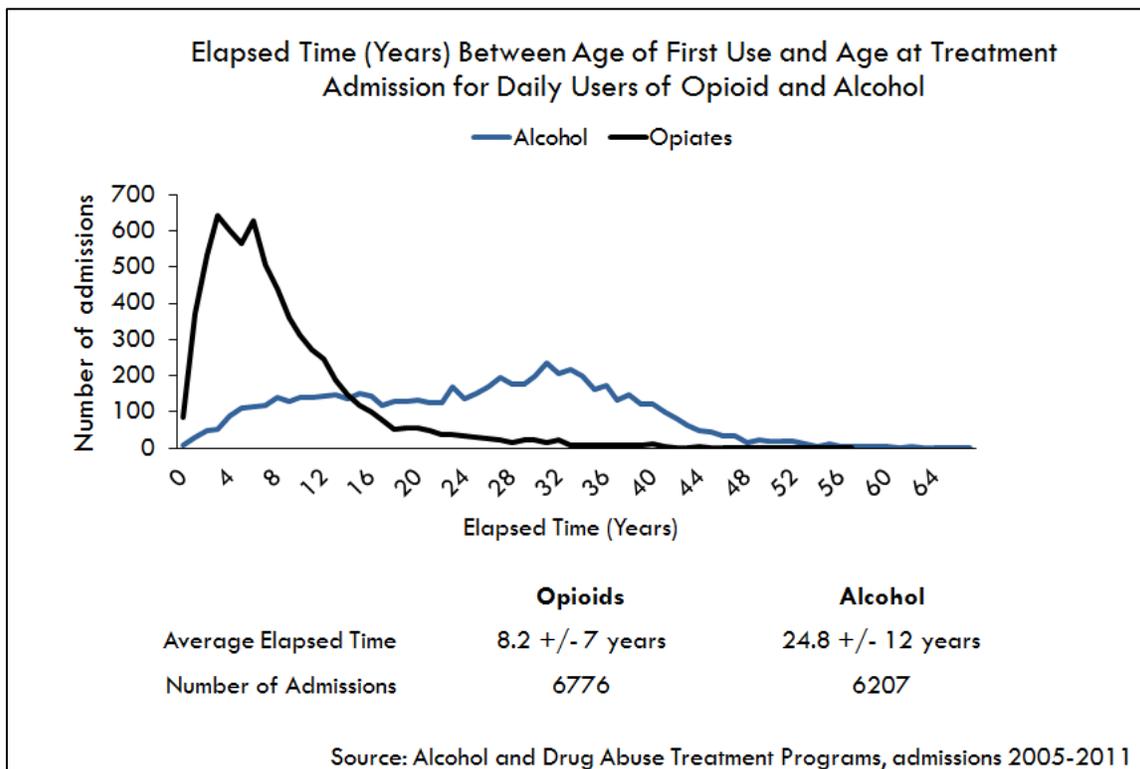
- Heroin-related fatalities increased from 9 deaths in 2012 to 35 deaths in 2014. The number of deaths from prescription opioids that did not include heroin has remained stable. Source: Office of the Chief Medical Officer. See Figure: Rate of Drug-related Fatalities Involving Opioids per 10,000 Vermonters by Type of Opioid below:

Figure: Rate of Drug-related Fatalities Involving Opioids per 10,000 Vermonters by Type of Opioid



- Vermont data indicate that people seek treatment for opioid addiction much sooner after the age of first use for opioids than for alcohol. See Figure: Elapsed Time (Years) Between Age of First Use and Age at Treatment Admission for Daily Users of Opioid and Alcohol below:

Figure: Elapsed Time (Years) Between Age of First Use and Age at Treatment Admission for Daily Users of Opioid and Alcohol



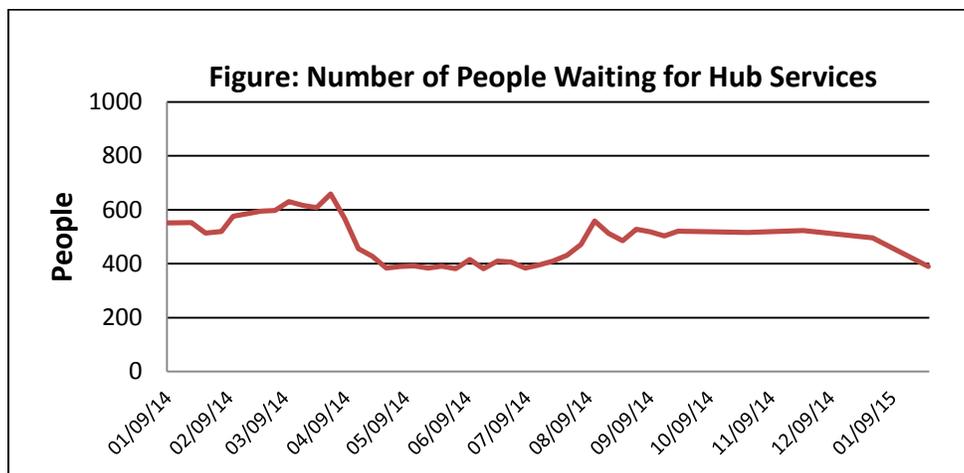
Program Gaps

- SAMHSA’s Strategic Prevention Framework State Incentive Grants (SPF-SIG) and the Partnership for Success II (PFS II) grant provided substantial funding to address priorities

identified by the SEOW. Evaluation of the SPF-SIG determined that these prevention efforts “led to significant reductions (relative to non-funded communities) in binge drinking and marijuana use among high school students.” [http://healthvermont.gov/adap/documents/SPF-SIG_EvalExecutiveSummaryApr2012.pdf]. The Partnership for Success II grant addresses underage drinking and prescription drug misuse in 6 of 12 health districts across the state. This 3-year program has provided prevention resources to higher need areas and has increased prevention capacity across the state through these VDH’s district offices. Evaluation is anticipated to be complete in 2016. Vermont has been awarded the SAMHSA CSAP “Strategic Prevention Framework Partnerships for Success State and Tribal Initiative (SPF-PFS)” (SP-15-003) grant to continue to fund prevention efforts in Vermont, which we refer to as the Regional Prevention Partnerships (RPP).

- Another challenge is the lack of a consolidated web-based data system for collection of prevention NOMS and other prevention data. A solution was identified but funding cuts to ADAP resulted in elimination of the position to support implementation. This solution would encompass prevention efforts not only for substance abuse, but also the community coalition work in other public health areas such as tobacco and obesity. This is in alignment with the VDH goal of streamlining programs to achieve a broad-based behavioral health prevention effort. As funding becomes available, Vermont may revisit this priority.
- Vermont’s data indicates a high need for culturally appropriate services among 18 to 25 year-old Vermonters. This includes prevention and intervention as well as treatment and recovery. The state recognizes a system gap in this area and this will be a focus of system development over the next period.
- Despite the increase in capacity for MAT for opioid addiction, there are still people waiting for MAT services in Hubs suggesting that additional capacity is needed. At this time, expansion has begun to slow due to workforce challenges. Not all physicians are willing to treat opioid addiction in their practices and hubs find recruiting and maintaining staff very challenging. Source: ADAP Hub Waitlist and Census. See Figure: Number of People Waiting for Hub Services below:

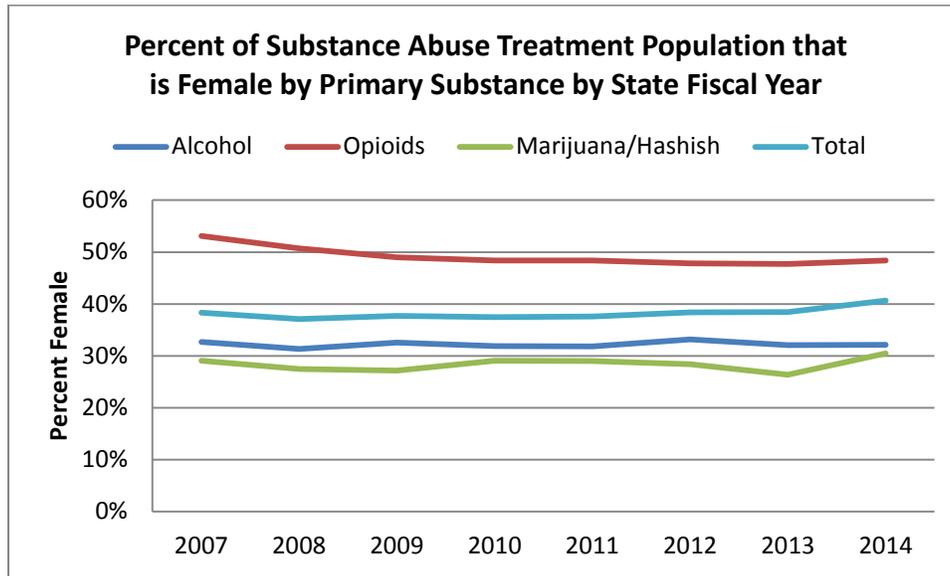
Figure: Number of People Waiting for Hub Services



- Women represent about 40% of the treatment population overall. The major exception to the gender data showing a predominance of males in the treatment system is the gender mix among the opioid treatment population which is closer to 50%. All ADAP funded treatment programs are required to provide gender specific and trauma informed services using evidence-

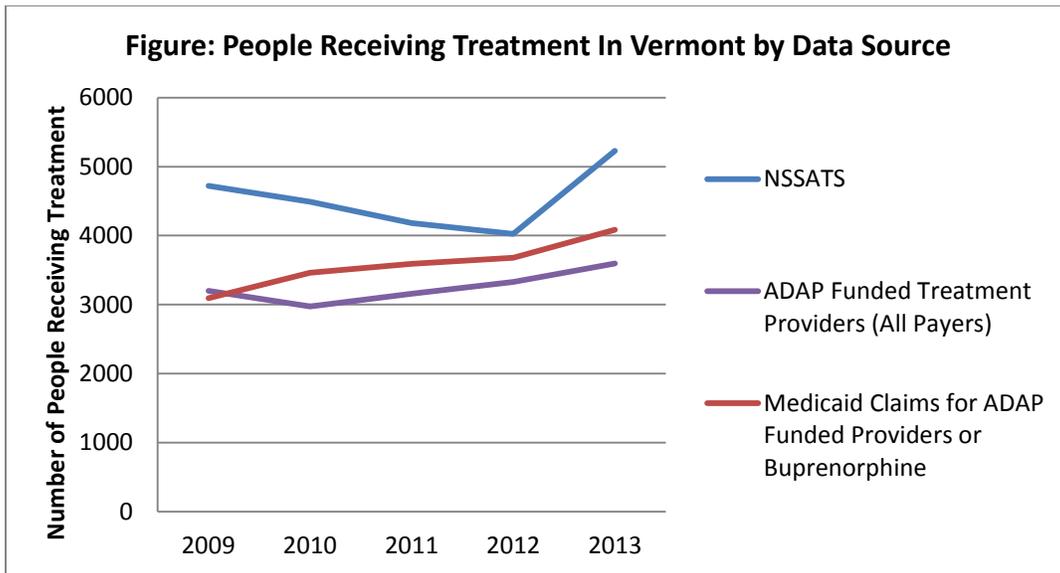
based practices. Such evidenced-based curricula are” Seeking Safety” and “Beyond Trauma” by Dr. Stephanie Covington. Vermont’s “Project Rockinghorse” is an examples of a prevention, early intervention and treatment program intervention providing important education and group support for high risk pregnant women and women with dependent children (i.e., “parenting women”) around the state, attempting to reverse the trend in women’s substance abuse. See Figure: Gender Mix – Total Treatment Population by Fiscal Year below:

Figure: Gender Mix – Total Treatment Population by Fiscal Year



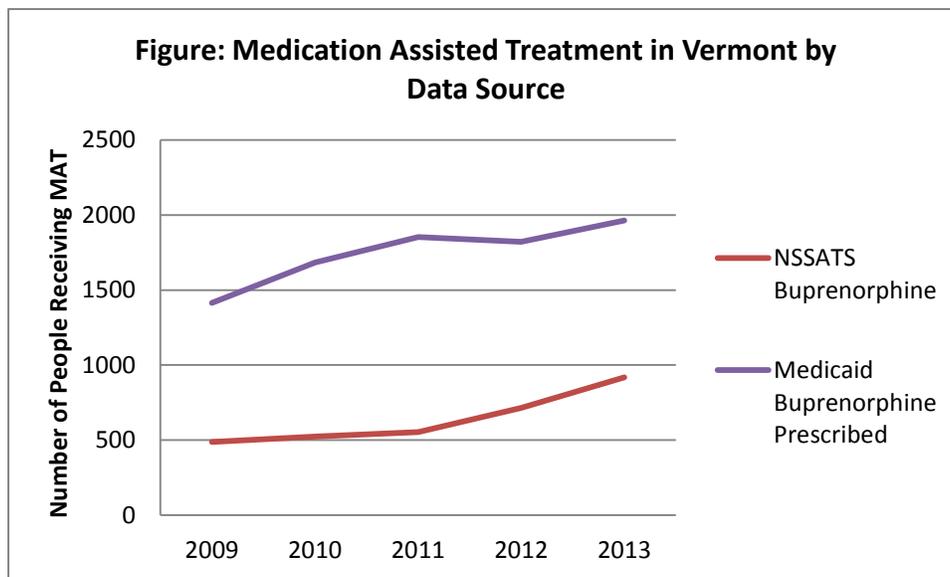
- For the most part, the information included on Vermont’s Performance Dashboard is consistent with the information used in SAMHSA’s Behavioral Health Barometer. We have noted some differences in counts of people receiving care as a result of different data sources. While that is to be expected, in some cases the trends are different than expected from Vermont data sources. For instance, NSSATS single day data from the Barometer shows a decrease in people treated but the March Vermont Substance Abuse Treatment Information which includes information for all payers (but only at the ADAP-funded specialty treatment providers) and the March Vermont Medicaid Claims Data (which includes the ADAP-funded specialty treatment providers as well as individuals receiving buprenorphine to treat opioid addiction) trends upward. See Figure: People Receiving Treatment in Vermont by Data Source below:

Figure: People Receiving Treatment in Vermont by Data Source



Buprenorphine for opioid addiction, which in Vermont is funded by Medicaid, is not well represented in the NSSATS numbers because the majority of people receive care through physicians in office based opioid treatment. The number of Medicaid funded individuals receiving buprenorphine for opioid addiction in March of each year is more than twice that shown in the NSSATS data. See Figure: Medication Assisted Treatment in Vermont by Data Source below:

Figure: Medication Assisted Treatment in Vermont by Data Source



This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the SABG priority populations: Pregnant Women, Injecting Drug Users, Women with Dependent Children, Persons at Risk for Tuberculosis, Individuals in Need of Primary Substance Abuse Prevention, and, for HIV-designated states, Persons at Risk for HIV.

Vermont Priorities

- Vermont's State Priorities as set out in SAPT Plan Table 1 Set: Priority Area and Annual Performance Indicators (see the SAPT Block Grant Table 1), as previously stated in Step 1, align with the AHS, VDH, and ADAP Strategic Plans. All of the performance measures establish long term targets and we do not anticipate reaching them in the near future. Five of the seven measures are used as grant performance measures and VDH Dashboard measures. Two measures focus on priority populations – pregnant women and intravenous drug users. All performance measures roll up to the population-level indicators that are also reflected on the dashboard. These, in turn, are expected to impact on the longer term objective of preventing and eliminating the problems caused by alcohol and drug misuse that is shared by the AHS, Department of Vermont Health Access, VDH and ADAP.
- Vermont's substance use and abuse prevalence data (See above, Table: Summary of Statewide Prevalence Estimates from NSDUH) clearly and unambiguously point to three specific areas of concern that will continue to receive high priority in the state's prevention efforts -- underage drinking, high risk drinking (ages 21-25), and marijuana use under age 25. These priorities are reflected in the State's Priorities (see SAPT Block Grant Plan Table 1: Priority Area and Performance Indicators). They are also congruent with the specific goals established in the US Healthy People 2020, those identified within the Vermont Department of Health Strategic Plan, and those identified in the Division of Alcohol and Drug Abuse Programs (ADAP's) Strategic Plan.
- In addition to these high prevalence issues ADAP has identified opioid misuse, abuse, and dependence as a priority area. This is associated with demand for treatment, opioid-related overdoses, and death.
- ADAP continues to gather data and monitor the behavioral-cultural shifts with respect to substance abuse. Accordingly, ADAP strives to adapt its services to most effectively address both the more significant problems as well as to quickly position itself to respond to emerging concerns for the greatest impact and reach across target populations.

Priority Populations

Pregnant Women

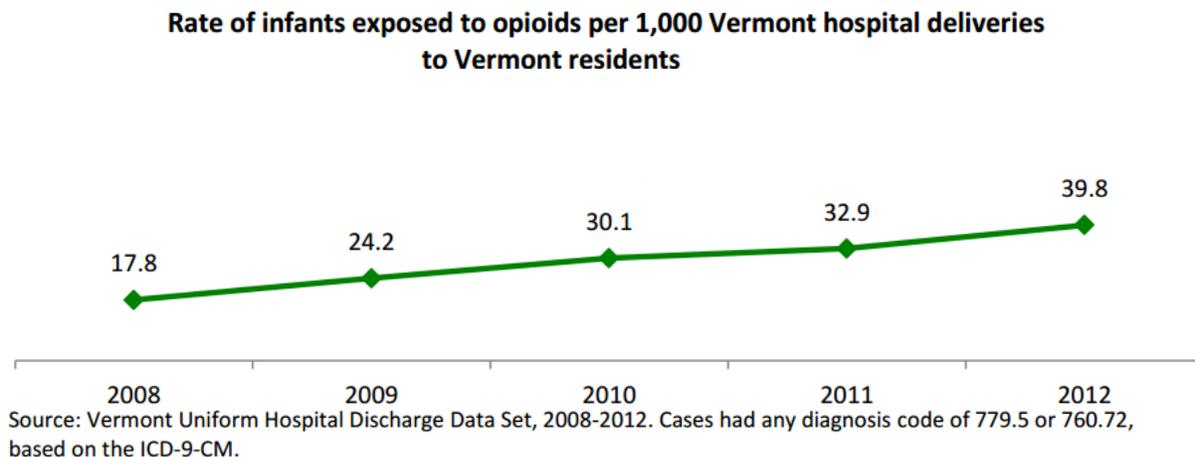
Pregnant women are a Vermont and block grant priority population. In state fiscal year 2014, 7% of women treated through the ADAP-funded system of care were pregnant and 75% of pregnant women entering the substance abuse system had opioids as the primary substance of abuse (Source: Vermont Substance Abuse Treatment Information System). The American College of Obstetricians and Gynecologists recommends that all pregnant women with opioid dependence be in active treatment, including the use of MAT. Since 2002, Vermont hospitals have worked with pregnant women who are opioid dependent and their infants who are exposed to opioids in utero. Both provider awareness of opioid dependence during pregnancy and increased training in the treatment of infants exposed to opioids have changed dramatically in Vermont over the past decade. Initiatives such as the Improving Care for Opioid-exposed Newborns (ICON) project at the University of Vermont and University of Vermont Medical Center have greatly expanded training and awareness in the Vermont provider community. As women have learned they will be treated with respect, and provider awareness and openness to treating women with opioid dependence have increased, so has the willingness of women to come forward and seek help.

Infants Exposed to Opioids

In Vermont, four out of five opioid dependent pregnant women giving birth are in treatment. Once a pregnant woman is identified as opioid dependent, her infant is diagnosed as “exposed to opioids” with a diagnosis code for neonatal abstinence syndrome (NAS). Opioid-exposed infants are monitored for four days in the hospital. Many of these infants never show symptoms of NAS. While some do have signs and symptoms of NAS, only a small proportion of those need to be treated with methadone or morphine.

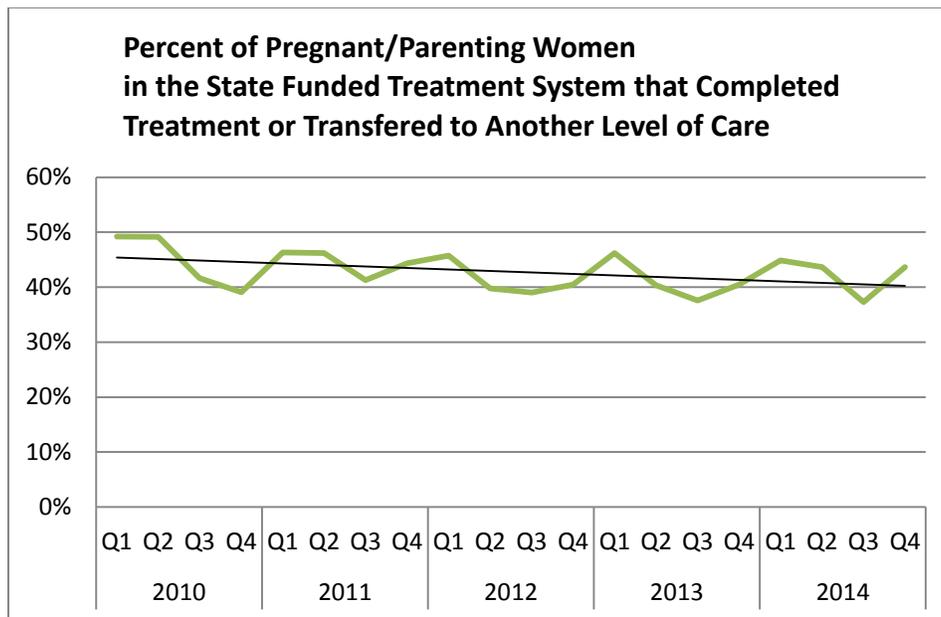
Trend Over Time

According to the Kid’s Inpatient Database (a national sample of hospital discharges), the U.S. average rate of NAS in 2009 was 3.4 infants per 1,000 hospital deliveries. Comparing this directly to the 24.6 per 1,000 deliveries in Vermont might lead one to think that Vermont’s rate is seven times higher. However, because Vermont is a leader in treating opioid dependent pregnant women, provider awareness and access to care might be plausible explanations for the disparity. In addition, the Vermont practice of coding all opioid exposed infants with the NAS diagnosis code could contribute to the difference. The increase in the Vermont rate of opioid exposed infants from 2008 to 2012 can partially be attributed to the increase in provider awareness and the increased access to treatment. See Figure: Rate of Infants Exposed to Opioids per 1,000 Vermont Deliveries to Vermont Residents below:



Within the state funded treatment system, successful discharges of pregnant and parenting women, defined as those who complete treatment or transfer to another level of care, have been trending downward. These numbers are likely influenced by the increasingly high rate of Medication Assisted Treatment (MAT) because clients are retained in treatment, rather than being discharged, so successful treatment is ongoing. Source: Vermont Substance Abuse Treatment Information System. See Figure: Percent of Pregnant/Parenting Women in the State Funded Treatment System that Completed Treatment of Transferred to Another Level of Care below:

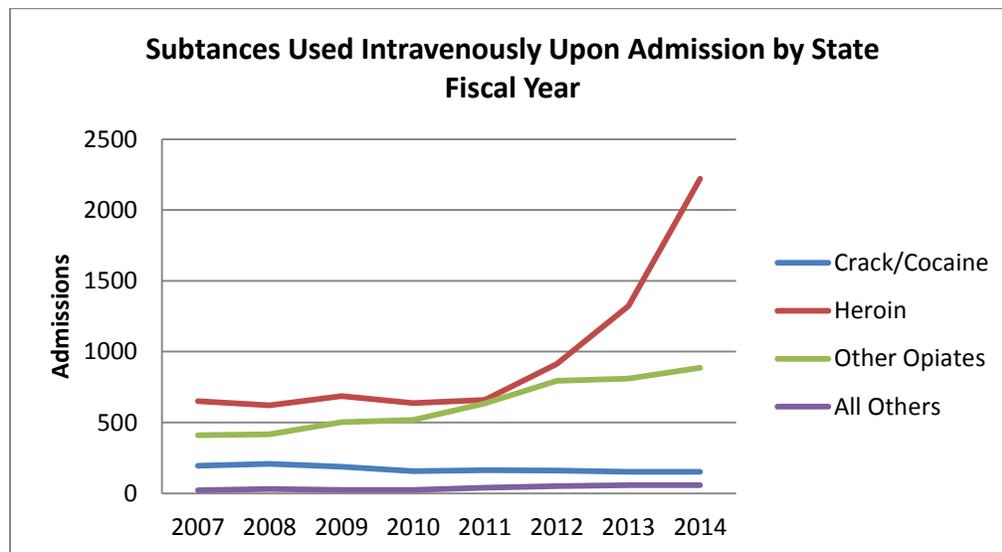
Figure: Percent of Pregnant/Parenting Women in the State Funded Treatment System that Completed Treatment of Transferred to Another Level of Care



Intravenous Drug Users

With increases in the number of people receiving treatment for heroin and opioids Vermont has seen increases in intravenous drug use. Source: Vermont Substance Abuse Treatment Information System (SATIS). See Figure: Substances Used Intravenously below:

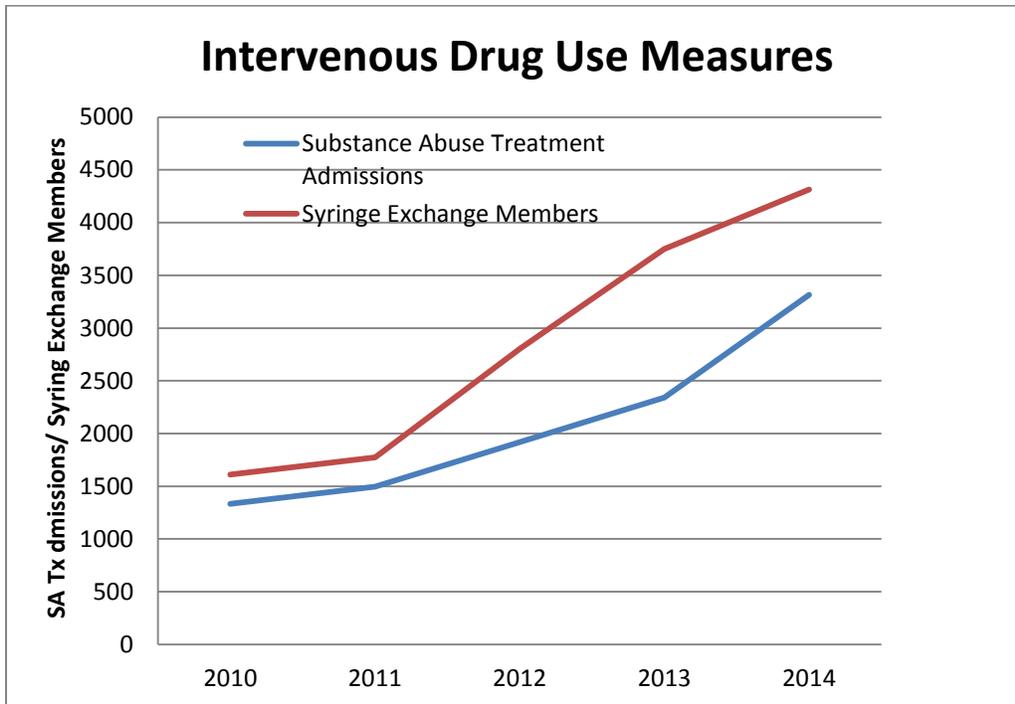
Figure: Substances Used Intravenously



IV use of heroin has increased significantly over the past several years and IV use of other opioids is continuing to increase. There are three syringe exchange programs with four exchange sites in different counties in the state of Vermont. Additionally, one of exchange programs has a mobile outreach arm that services four additional underserved communities. These services are funded through state general funds for HIV prevention services rather than federal funds. The goal of the syringe exchange initiative is to decrease the transmission of infectious disease (Please note that Vermont is not an HIV designated state). Between 2010 and 2014, there has been a 178% increase in the number of people exchanging needles through the exchanges but

only an 80% increase in the number of needles distributed, largely due to lack of funding for needle purchase. The trend in the number of people participating in needle exchanges is trending upward at a rate somewhat greater than that of the admissions associated with intravenous drug use. See Figure: Intravenous Drug Use Measures below:

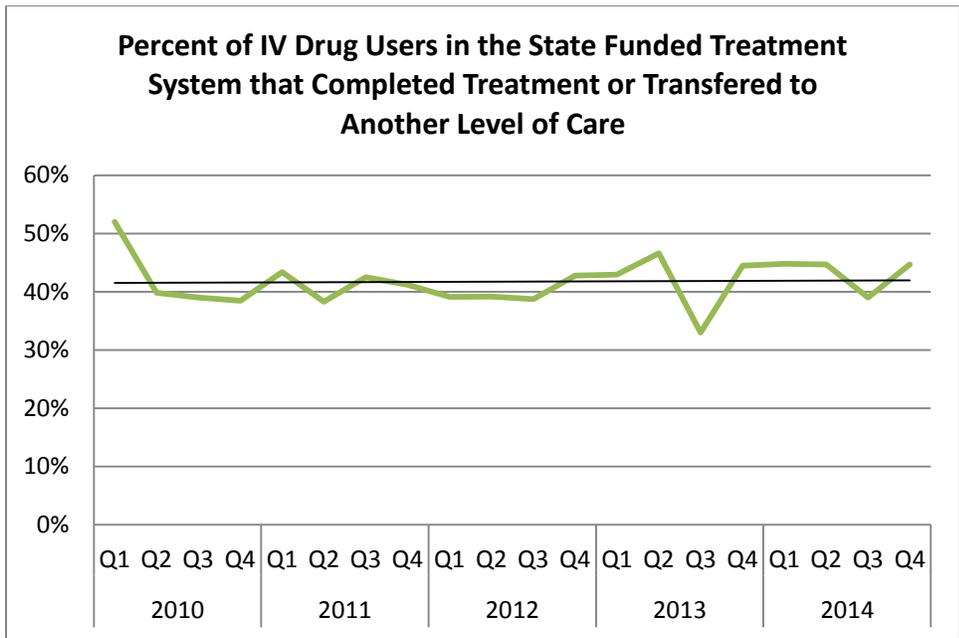
Figure: Intravenous Drug Use Measures



NSDUH estimates that 0.17% of the US population age 12 or older used a needle to inject heroin, cocaine, methamphetamine or other stimulants in the last year.⁵ If we simply apply the National prevalence rate to the Vermont population (for purposes of estimation only) the result is the equivalent of 920 people. This estimate, however, is less than the number actually seen in our treatment system for IV drug use. It is likely there is regional and state-level variation in the prevalence of injection drug users, along with the NSDUH data lag, which could account at least in part for this discrepancy. Therefore, it is difficult at this time to determine a more accurate estimate of IV drug prevalence above those seeking treatment.

Despite the increase in admissions associated with IV drug use, the percent of IV drug users with successful treatment discharges, those who complete treatment or transfer to another level of care, has remained stable over time. Source: Vermont Substance Abuse Treatment Information System. See Figure: Percent of IV Drug Users in the State Funded Treatment System that Completed Treatment or Transferred to Another Level of Care below:

Figure: Percent of IV Drug Users in the State Funded Treatment System that Completed Treatment or Transferred to Another Level of Care



Footnotes:

¹Vermont State Level Report from the National Survey on Drug Use and Health (NSDUH), 2012/2013 Selected Results (Substance Abuse and Mental Health Services Administration, 2013, State Estimates of Substance Use from the 2012-2013 National Survey on Drug Use and Health, NSDUH. Rockville, MD. Link: <http://www.samhsa.gov/data/population-data-nsduh>

² State of Vermont Substance Abuse Assessment and Epidemiological Profile, Executive Summary, November 2012, p.4.

³ <http://www.samhsa.gov/data/sites/default/files/2010%20-%20NSSATS%20State%20Profiles/2010%20-%20NSSATS%20State%20Profiles/VT10.pdf>

⁴ TEDS admissions <http://www.dasis.samhsa.gov/webt/quicklink/VT13.htm>

⁵ NSDUH Injection Drug Use and Related Risk Behaviors. <http://oas.samhsa.gov/2k9/139/139IDU.htm>

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's [NBHQF](#). The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at <http://www.samhsa.gov/data/quality-metrics/block-grant-measures>. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?
4. If not, what changes will the state need to make to be able to collect and report on these measures?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance needed at this time.

Footnotes:

1 Vermont Information Technology Leaders, Inc. (VITL) is a nonprofit organization that assists Vermont health care providers with adopting and using health information technology, to improve the quality of care delivery, to enhance patient safety, and to reduce the cost of care. VITL is legislatively designated to operate the health information exchange (HIE) for Vermont, and is governed by a collaborative group of stakeholders including health plans, hospitals, physicians, other health care providers, state government, employers, and consumers.

Quality and Data Collection Readiness

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

Background: In Vermont, there are some providers that serve both mental health (MH) and substance abuse (SA) clients, some serve only mental health, and some serve only substance abuse. The providers serving both MH and SA clients generally have one data system/EHR (electronic health record) from which they extract the separate data sets needed by the Division of Alcohol and Drug Abuse Programs (ADAP) or the Department of Mental Health (DMH). Providers serving ADAP only exclusively collect Treatment Episode Data Set (TEDS) information; those serving DMH collect MH information.

The TEDS information reported to ADAP includes admission, and discharge records at both the provider and client levels as well as service level data for state use. There is a unique client identifier to allow identification of a specific person across providers (and dependent on the accuracy of data collected by providers) in the system but it does not include full identifying information.

The MH data system collects full identifying information for those served.

Prevention data is collected through a variety of paper and online tools, such as Survey Monkey. This includes process data including demographics and strategy progress for Block Grant funded individual, evidence-based strategies while demographics for funded environmental evidence-based strategies are calculated using census data. Some limited pre/post outcome data is collected on family-based programs. Vermont currently has no common data system for collecting, storing, and analyzing prevention data. The only "client level" prevention data currently collected is demographic data, even with individual based strategies. Prevention is heavily focused on environmental strategies, which is not conducive to collection of "client-level" data.

2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations. (e.g., Medicaid, child welfare, etc.).

Many of the providers of substance abuse and mental health services also provide services to other populations served through the Vermont Agency of Human Services. Vermont funds many of these services through Medicaid so provider data systems/EHRs generally also include the ability to extract necessary billing information of Medicaid and other insurers. In most cases, the populations being served drive the data that is collected – if there are combined systems, it is largely at the provider level rather than at the State level.

At the State level, ADAP and DMH maintain separate data systems. ADAP's full data system doesn't link to any other data system and 42 CFR Part 2 has prevented substance abuse treatment data from being included in Vermont's Health Information Exchange, VITL.¹ Mental Health's system does not link to any other data source.

Prevention data is not part of a larger data system as explained above.

3. Is the state currently able to collect and report on the draft measures at the individual client level (that is, by client served, but not with client-identifying information):

Vermont cannot report on measures other than those that can be calculated using current mandatory TEDS reporting.

While VT has access to Medicaid claims data we can't use this because this data often doesn't indicate that screenings have occurred since they're done within a general wellness visit and there is no specific coding for this. Even when codes have been opened we see minimal billing for the services.

Demographic data and strategy progress is collected for all individual strategies and the demographic reach of environmental strategies are calculated using census data. No client specific data for prevention programs is collected.

4. If not, what changes will the state need to make to be able to collect and report on these measures?

More specific definitions are needed for nearly all proposed measures, particularly the prevention measures. It is unclear, for instance, how to measure employment for prevention programming. Many of the measures would need to continue to come from prevalence and population level data sets. It would also be helpful to have clarification of how the measures would be used.

Treatment measures: Some of the measures requested are best suited to data available on health information exchanges – information such as tobacco use and other medical conditions is not included in the current systems. The Vermont exchange, VITL, currently connects over 90% of physicians and hospitals. However, substance abuse and mental health specialty providers are not included in VITL for a couple of reasons. One is that EHR/meaningful use incentive funding is not available to these providers which mean that many providers do not have systems capable of connecting with the exchange. Another issue is regulatory -- 42 CFR Part 2 prevents substance abuse treatment providers from exchanging data freely in the health exchanges and Vermont has not yet found a way to connect these providers to VITL, because of the legal complexities associated with consent and because individual providers interpret 42 CFR 2 differently.

Vermont needs to invest in data collection systems as we currently use legacy systems to collect data from SA and MH providers. These systems are critical to funding and monitoring of the systems and to comply with SAMHSA's block grant funding requirements. Vermont has not had the funding and staff support necessary to pursue a common data system.

Most providers lack the funding and information technology expertise to make changes to existing systems and implement new systems.

Prevention measures: As a department of public health, prevention evidence-based strategies are heavily weighted toward environmental population-based outcomes. Reach and demographic information is calculated using census data.

Footnotes:

¹ Vermont Information Technology Leaders, Inc. (VITL) is a nonprofit organization that assists Vermont health care providers with adopting and using health information technology, to improve the quality of care delivery, to enhance patient safety, and to reduce the cost of care. VITL is legislatively designated to operate the health information exchange (HIE) for Vermont, and is governed by a collaborative group of stakeholders including health plans, hospitals, physicians, other health care providers, state government, employers, and consumers.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1
Priority Area: School Screenings: Are we referring students who may have a substance abuse problem to community resources?
Priority Type: SAP, SAT
Population(s): PP, Other (at risk youth and young adults)

Goal of the priority area:

Refer students who may have a substance abuse problem to community resources

Objective:

Percent of students at funded schools who screen positive for possible substance abuse disorders who are referred for a substance abuse assessment

Strategies to attain the objective:

Centers for Disease Control and Prevention (CDC) has developed an evidence-based model for coordinated school health. The School-Based Substance Abuse Services (SBSAS) grants support a comprehensive substance abuse prevention effort based on that model. Supported activities include: Classroom curricula; Advising and training of youth empowerment groups; Family outreach and community involvement; Staff training; Delivery of educational support groups; Screening and referral.

Providing screening and appropriate referral in schools for early identification of substance use issues is best practice.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Percent of students at funded schools who screen positive for possible substance abuse disorders who are referred for a substance abuse assessment
Baseline Measurement: 88%
First-year target/outcome measurement: 89%
Second-year target/outcome measurement: 90%

Data Source:

The School Based Substance Abuse Survey Reports (SBSAS)

Description of Data:

Over the last decade, the Division of Alcohol and Drug Abuse Programs has supported a comprehensive, evidenced-based substance abuse prevention approach. This means prevention efforts are delivered across a wide range of categories including individual, family, school, community, and through effective policy implementation. These efforts have been successful in reducing Vermont youth involvement with alcohol and drugs. For example, according to the Vermont Youth Risk Behavior Survey (YRBS), the number of students reporting alcohol use prior to age 13 has significantly decreased (-62%). Significant reductions were also achieved in the proportion of students who have ever used alcohol. Schools are indispensable partners in Vermont's substance abuse prevention strategy. Early identification of substance use issues has been shown to improve treatment and recovery efficacy and significantly enhance overall prevention outcomes. Screening and referral services for substance abuse and mental health using evidence-based tools (CRAFT and GAIN short screener) are essential components of our School-based Substance Abuse Services (SBSAS) grants. Select staff at funded schools are trained in the use of these tools. Screening should be used to supplement (not replace) the judgment of clinical line staff. Additional information should also be considered, such as collateral reports, background information, etc. While in most cases referral is appropriate, not everyone who screens positive should be referred on for additional services, which is why the target for this performance measure is less than 100%.

Data issues/caveats that affect outcome measures::

While in most cases referral is appropriate, not everyone who screens positive should be referred on for additional services, which is why the target for this performance measure is less than 100%.

Priority #: 2
Priority Area: Treatment Initiation: Are youth and adults who need help starting treatment?
Priority Type: SAT
Population(s): PWWD, IVDUs, HIV EIS, TB, Other (at risk youth and young adults)

Goal of the priority area:

Initiate treatment through an inpatient alcohol or drug admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

Objective:

Percent of adolescent and adult Medicaid recipients with a new episode of alcohol or other drug dependence who initiate treatment through an inpatient alcohol or drug admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

Strategies to attain the objective:

Screening, Brief Intervention, and Referral to Treatment (SBIRT); increasing access to treatment by removing barriers; follow-up by providers

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Percent of adolescent and adult Medicaid recipients with a new episode of alcohol or other drug dependence who initiate treatment through an inpatient alcohol or drug admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.
Baseline Measurement: 33%
First-year target/outcome measurement: 34%
Second-year target/outcome measurement: 35%

Data Source:

Medicaid Data

Description of Data:

When a Medicaid patient is identified by a medical provider as potentially needing treatment for substance dependence (addiction), it is often difficult to get the patient to seek treatment. This may be due to a variety of perceived roadblocks such as waiting lists for treatment providers, lack of transportation, or inability to find childcare, etc. The most frequently cited reason that people don't initiate treatment is because he or she doesn't believe there is a problem so treatment is perceived as unnecessary. Like other chronic diseases such as diabetes or heart disease, the sooner a person seeks treatment, the more likely the person is to recover. People with substance use disorders need to know where to get help (access), initiate treatment, and stay in treatment for long enough to recover (engagement). Providers can help by offering screening in their offices.

The Division of Alcohol and Drug Abuse Programs (ADAP) has received a federal grant to institute an evidence-based protocol called Screening, Brief Intervention, and Referral to Treatment (SBIRT). Screenings occur at the provider's office and can identify those at risk for a substance use disorder. For mild forms of misuse, a brief (10-15) minute discussion about the patient's substance use may be all that is necessary. For those with more severe forms of a disorder (e.g., diagnosis of dependence) a referral to a specialty clinic is appropriate. Providers and their staffs should follow up on missed appointments and urge people to enter a treatment program. As the numbers in the graph suggest, we need to develop better methods and practices that remove barriers and encourage treatment initiation in a timely manner.

Data issues/caveats that affect outcome measures::

The HEDIS measure and the ACA Medicaid bundled payment structure are impacting on Treatment Initiation rates. Discussions are underway with the Medicaid division to resolve these problems and adjust the measure to more accurately reflect Vermont's substance abuse initiation rate.

Priority #: 3

Priority Area: Treatment Engagement: Are youth and adults who start treatment sticking with it?

Priority Type: SAT

Population(s): PWWD, IVDUs, HIV EIS, TB, Other (at risk youth and young adults)

Goal of the priority area:

Engagement of outpatient and intensive outpatient clients with 2 or more substance abuse services within 30 days of treatment initiation.

Objective:

Percent of outpatient and intensive outpatient clients with 2 or more substance abuse services within 30 days of treatment initiation.

Strategies to attain the objective:

Services must match the needs of the clients. They must be evidence based, the appropriate level of care needed by the individual, and population specific. For instance, women's services must address needs specific to women such as trauma informed treatment and provision of childcare. Adolescent care must be aligned with the client's developmental stage.

Providers who offer attendance incentives to individuals (contingency management) have better engagement rates than those who don't.

Providers focus on quality improvement processes such as Network for the Improvement of Addiction Treatment, NIATx (<http://www.niatx.net/>), to determine the root causes of low treatment engagement. For example, a survey of treatment participants indicates that the primary reasons people miss appointments is because of lack transportation or childcare. The quality improvement process may test the reallocation of resources to address one or both of those issues.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percent of outpatient and intensive outpatient clients with 2 or more substance abuse services within 30 days of treatment initiation.

Baseline Measurement: 56%

First-year target/outcome measurement: 57%

Second-year target/outcome measurement: 58%

Data Source:

Vermont Substance Abuse Treatment Information System (SATIS)

Description of Data:

Behavioral health treatment for substance abuse is an ongoing process which requires multiple visits in order to modify behavior, build the skills needed to address the contributing factors in addiction, and prevent relapse. In order for substance abuse treatment to be effective, the client must stay in treatment. Research indicates that those who are engaged in treatment have better treatment outcomes. For more information on this, please see the Journal of Behavioral Health Services and Research.

Treatment engagement is a measure of the portion of individuals entering treatment who have two or more appointments within 30 days.

Data issues/caveats that affect outcome measures::

The Division of Alcohol and Drug Abuse Programs at the Vermont Department of Health began tracking treatment engagement rates and rewarding providers with high engagement rates in state fiscal year 2013.

Priority #: 4

Priority Area: Social Supports: Are youth and adults leaving treatment with more support than when they started?

Priority Type: SAT

Population(s): PWWD, IVDUs, HIV EIS, TB, Other (at risk youth and young adults)

Goal of the priority area:

Treatment clients with more social supports on discharge than on admission.

Objective:

Percent of treatment clients (excluding residential detoxification and detoxification treatment) who have more social supports on discharge than on admission.

Strategies to attain the objective:

Social Supports must match the need of the individual and be available on a timely basis. They must be appropriate and supportive to the individual's needs and wants. Supports must align with the stage of recovery and be population specific. For instance, women may have different social support needs than men. Those with trauma in their lives may need unique supports. Adolescent social supports must be aligned with the client's developmental stage.

Providers focus on quality improvement processes such as NIATx (<http://www.niatx.net/>) to determine the root causes of low change in social support between admission and discharge.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Percent of treatment clients (excluding residential detoxification and detoxification treatment) who have more social supports on discharge than on admission.
Baseline Measurement:	17%
First-year target/outcome measurement:	18%
Second-year target/outcome measurement:	19%

Data Source:

Vermont Substance Abuse Treatment Information System (SATIS)

Description of Data:

Individuals with addiction have lives in chaos. There is also shame associated with this disease which results in isolation for those struggling with addiction. This isolation prevents people from accessing positive supports that are needed to recover from addiction.

Social supports include recovery-oriented self-help groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), supported housing, recovery coaching, faith-based services, as well as substance free gathering places such as the recovery centers. Research indicates that people with positive social networks are more likely to succeed in their recovery.

The Division of Alcohol and Drug Abuse Programs (ADAP) collects information about the level of social supports at both treatment admission and discharge and has set a goal of increasing the level of social supports at discharge over that at admission.

Data issues/caveats that affect outcome measures::

This measure is a new focus for ADAP for state fiscal year 2015. Current data indicates that 65% of those receiving outpatient and Medication Assisted Therapies (MAT) in Vermont have no social supports on admission. Only 45% of the population has social supports on discharge.

Priority #: 5

Priority Area: Access to MAT: Are adults seeking help for opioid addiction receiving treatment?

Priority Type: SAT

Population(s): PWWDC, IVDUs, HIV EIS, TB

Goal of the priority area:

Medication Assisted Treatment for adults who need help for opioid addiction.

Objective:

Number of people receiving Medication Assisted Treatment per 10,000 Vermonters ages 18-64.

Strategies to attain the objective:

Medication assisted treatment is an effective evidence-based treatment for opioid addiction.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Number of people receiving Medication Assisted Treatment per 10,000 Vermonters ages 18-64
Baseline Measurement: 115 per 10,000 Vermonters ages 18-64
First-year target/outcome measurement: 118
Second-year target/outcome measurement: 121

Data Source:

Vermont Substance Abuse Treatment Information System (SATIS) and Vermont Prescription Monitoring System (VPMS)

Description of Data:

The use of heroin and misuse of other opioids (e.g., prescription narcotics) has been identified as a major public health challenge in Vermont. The potential health, social, and economic consequences of this problem have led to the development of a comprehensive treatment system that is focused on opioid addiction. This system, called the Care Alliance for Opioid Addiction (also called the hub and spoke system), has increased access to care in Vermont

Vermont has a multifaceted approach to addressing opioid addiction that involves multiple community partners. Programs and services include regional prevention efforts, drug take back programs, intervention services through the monitoring of opioid prescriptions with the Vermont Prescription Monitoring System (VPMS), recovery services at eleven Recovery Centers, overdose death prevention through the distribution of Naloxone rescue kits, and a full array of treatment modalities of varying intensities to fit individual needs.

For those with opioid dependence, treatment with methadone or buprenorphine, medications used to reduce cravings for opioids (e.g., heroin, prescription pain relievers, etc.), allow patients the opportunity to lead normal lives. Medication assisted treatment (MAT) was originally developed because detoxification followed by abstinence-oriented treatment had been shown to be ineffective in preventing relapse to opiate use. There is clear evidence of a high level of effectiveness for medication assisted treatment using either methadone or buprenorphine. Positive medication assisted treatment outcomes include: abstention from or reduced use of illicit opiates; reduction in non-opioid illicit drug use (e.g., cocaine); decreased criminal behavior; and decreased risk behavior linked to HIV and hepatitis C.

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcome measures.

Priority #: 6
Priority Area: Pregnant Women and Women with Dependent Children
Priority Type: SAT
Population(s): PWWDC

Goal of the priority area:

Early intervention and access to treatment for pregnant or parenting women.

Objective:

Rate of pregnant and/or parenting women with a discharge reason of treatment completion or transfer to another level of care.

Strategies to attain the objective:

Procedures followed by the Preferred and Approved Providers for ensuring priority access and gender informed and trauma based services for treating pregnant women and women with dependent children, as set out in the recently updated Substance Abuse Services Guidelines.

AHS Substance Abuse Treatment Coordination project requires substance abuse screening and referral to treatment when indicated in all Departments including but not limited to the Department of Children and Families, to identify and support PWWDC

Strengthen connections to physical health, with a primary focus on providers of obstetrics, in an integrated fashion.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Rate of pregnant and/or parenting women with a discharge reason of treatment completion or transfer to another level of care
Baseline Measurement: 53.6%
First-year target/outcome measurement: 54.45%
Second-year target/outcome measurement: 55.3%

Data Source:

TEDS data collected through the Vermont Substance Abuse Treatment Information System (SATIS)

Description of Data:

Numerator:

Total number of discharges in the SFY which, upon admission for treatment services, were for pregnant or parenting women discharged due to treatment completion or transfer to another level of care

Denominator:

Total number of discharges in the SFY which, upon admission for treatment services, were for pregnant or parenting women

Includes all levels of care (outpatient, intensive outpatient, residential, halfway, methadone or other medication assisted treatment but excluding residential detoxification) within the in ADAP-funded Vermont Preferred Provider system regardless of payment responsibility.

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcome measures.

Priority #: 7
Priority Area: Intravenous Drug Users
Priority Type: SAT
Population(s): IVDUs

Goal of the priority area:

Early intervention and access to treatment for intravenous drug users.

Objective:

Rate of discharges of IVDUs with a discharge reason of treatment completion or transfer to another level of care.

Strategies to attain the objective:

Procedures followed by the Preferred and Approved Providers for ensuring priority access and gender informed and trauma based services for treating intravenous drug users, as set out in the recently updated Substance Abuse Services Guidelines.

Strengthen the Treatment Preferred Provider System through use of ASAM PPC-2.

Provide best practices in treatment and recovery through site visits and subsequent technical assistance

Further expand effective evidence-based medication assisted treatment for opioid addiction through the "Hub & Spoke" integrated services initiative.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Rate of discharges of IVDUs with a discharge reason of treatment completion or transfer to

another level of care.

Baseline Measurement: 53.9%

First-year target/outcome measurement: 55.3%

Second-year target/outcome measurement: 56.7%

Data Source:

TEDS data collected through the Vermont Substance Abuse Treatment Information System (SATIS)

Description of Data:

Numerator:

Total number of discharges which, at admission, included intravenous as route of administration (primary, secondary, or tertiary), that were discharged due to treatment completion or transfer to another level of care.

Denominator:

Total number of discharges in the SFY which, at admission, included intravenous as route of administration (primary, secondary, or tertiary)

Includes all levels of care (outpatient, intensive outpatient, residential, halfway, methadone or other medication assisted treatment but excludes residential detoxification) within the in ADAP-funded Vermont Preferred Provider system regardless of payment responsibility.

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcome measures.

Footnotes:

Priorities 1-5 are expressed as "Performance Measures" located on the Vermont Department of Health Performance Dashboard: Population Indicators and Performance Measures.

http://healthvermont.gov/hv2020/dashboard/alcohol_drug.aspx

Planning Tables

Table 2 State Agency Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	\$4,557,722		\$29,872,775	\$3,728,072	\$3,042,229	\$0	\$0
a. Pregnant Women and Women with Dependent Children*	\$0		\$0	\$0	\$0	\$0	\$0
b. All Other	\$4,557,722		\$29,872,775	\$3,728,072	\$3,042,229	\$0	\$0
2. Substance Abuse Primary Prevention	\$1,215,393		\$0	\$1,426,134	\$646,056	\$0	\$0
3. Tuberculosis Services	\$0		\$0	\$0	\$0	\$0	\$0
4. HIV Early Intervention Services	\$0		\$0	\$0	\$0	\$0	\$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention							
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	\$303,848		\$0	\$106,948	\$272,256	\$0	\$0
13. Total	\$6,076,963	\$0	\$29,872,775	\$5,261,154	\$3,960,541	\$0	\$0

* Prevention other than primary prevention

Footnotes:

The State of Vermont financial system is not designed to provide data on funding for specialized services for pregnant women and/or women with dependent children. The Women's MOE amount is obtained by abstracting from the client data system the data codes for pregnant women and/or women with dependent children. The number obtained is multiplied by the applicable Medicaid-compatible reimbursement rates. All Vermont substance abuse services providers, as part of their grants/contracts, are required to comply with 45CFR, Part 96, Subpart L to provide the appropriate level of services to this priority population.

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Expenditures
Healthcare Home/Physical Health	\$
General and specialized outpatient medical services;	
Acute Primary Care;	
General Health Screens, Tests and Immunizations;	
Comprehensive Care Management;	
Care coordination and Health Promotion;	
Comprehensive Transitional Care;	
Individual and Family Support;	
Referral to Community Services;	
Prevention Including Promotion	\$

Screening, Brief Intervention and Referral to Treatment ;	
Brief Motivational Interviews;	
Screening and Brief Intervention for Tobacco Cessation;	
Parent Training;	
Facilitated Referrals;	
Relapse Prevention/Wellness Recovery Support;	
Warm Line;	
Substance Abuse Primary Prevention	\$1,215,393
Classroom and/or small group sessions (Education);	
Media campaigns (Information Dissemination);	
Systematic Planning/Coalition and Community Team Building(Community Based Process);	
Parenting and family management (Education);	
Education programs for youth groups (Education);	
Community Service Activities (Alternatives);	
Student Assistance Programs (Problem Identification and Referral);	

Employee Assistance programs (Problem Identification and Referral);	
Community Team Building (Community Based Process);	
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental);	
Engagement Services	\$17,591
Assessment;	
Specialized Evaluations (Psychological and Neurological);	
Service Planning (including crisis planning);	
Consumer/Family Education;	
Outreach;	
Outpatient Services	\$1,119,550
Individual evidenced based therapies;	
Group Therapy;	
Family Therapy ;	
Multi-family Therapy;	

Consultation to Caregivers;	
Medication Services	\$2,471,817
Medication Management;	
Pharmacotherapy (including MAT);	
Laboratory services;	
Community Support (Rehabilitative)	\$754,200
Parent/Caregiver Support;	
Skill Building (social, daily living, cognitive);	
Case Management;	
Behavior Management;	
Supported Employment;	
Permanent Supported Housing;	
Recovery Housing;	
Therapeutic Mentoring;	
Traditional Healing Services;	

Recovery Supports	\$1,385,104
Peer Support;	
Recovery Support Coaching;	
Recovery Support Center Services;	
Supports for Self-directed Care;	
Other Supports (Habilitative)	\$
Personal Care;	
Homemaker;	
Respite;	
Supported Education;	
Transportation;	
Assisted Living Services;	
Recreational Services;	
Trained Behavioral Health Interpreters;	

Interactive Communication Technology Devices;	
Intensive Support Services	\$
Substance Abuse Intensive Outpatient (IOP);	
Partial Hospital;	
Assertive Community Treatment;	
Intensive Home-based Services;	
Multi-systemic Therapy;	
Intensive Case Management ;	
Out-of-Home Residential Services	\$665,930
Crisis Residential/Stabilization;	
Clinically Managed 24 Hour Care (SA);	
Clinically Managed Medium Intensity Care (SA) ;	
Adult Mental Health Residential ;	
Youth Substance Abuse Residential Services;	
Children's Residential Mental Health Services ;	

Therapeutic Foster Care;	
Acute Intensive Services	\$913,752
Mobile Crisis;	
Peer-based Crisis Services;	
Urgent Care;	
23-hour Observation Bed;	
Medically Monitored Intensive Inpatient (SA);	
24/7 Crisis Hotline Services;	
Other	\$
Total	\$8,543,337

Footnotes:

Planned expenditure estimates are for a twelve month period. Vermont expends each SABG award, in its entirety, annually.

Vermont funds outpatient, intensive outpatient and case management as a coordinated funding source. All funds in this programming area are listed under outpatient.

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Expenditure Category	FY 2016 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	\$4,557,722
2 . Substance Abuse Primary Prevention	\$1,215,393
3 . Tuberculosis Services	\$0
4 . HIV Early Intervention Services**	\$0
5 . Administration (SSA Level Only)	\$303,848
6. Total	\$6,076,963

* Prevention other than primary prevention

** 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by CDC, National Center for HIV/AIDS, Hepatitis, STD and TB Prevention. The HIV Surveillance Report, Volume 24, will be used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective FY 2016 SABG allotments to establish one or more projects to provide early intervention services for HIV at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state does not meet the AIDS case rate threshold for the fiscal year involved. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend FY 2016 SABG funds for EIS/HIV if they chose to do so.

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Strategy	IOM Target	FY 2016
		SA Block Grant Award
Information Dissemination	Universal	\$21,615
	Selective	\$4,405
	Indicated	\$148
	Unspecified	\$0
	Total	\$26,168
Education	Universal	\$260,687
	Selective	\$53,132
	Indicated	\$1,781
	Unspecified	\$0
	Total	\$315,600
Alternatives	Universal	\$51,724
	Selective	\$10,542
	Indicated	\$353
	Unspecified	\$0
	Total	\$62,619
Problem Identification and Referral	Universal	\$29,076
	Selective	\$5,926
	Indicated	\$199
	Unspecified	\$0
	Total	\$35,201

Community-Based Process	Universal	\$628,952
	Selective	\$128,190
	Indicated	\$4,377
	Unspecified	\$0
	Total	\$761,519
Environmental	Universal	\$11,867
	Selective	\$2,419
	Indicated	
	Unspecified	
	Total	\$14,286
Section 1926 Tobacco	Universal	\$0
	Selective	\$0
	Indicated	\$0
	Unspecified	\$0
	Total	\$0
Other	Universal	\$0
	Selective	\$0
	Indicated	\$0
	Unspecified	\$0
	Total	\$0
Total Prevention Expenditures		\$1,215,393
Total SABG Award*		\$6,076,963
Planned Primary Prevention Percentage		20.00 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Vermont does not list tobacco expenditures, and has not in previous applications, because Vermont does not use SABG funds for tobacco

prevention. As a division within the Vermont Department of Health, ADAP partners programmatically with Vermont's Tobacco Control Program but tobacco prevention expenditures are part of Vermont's tobacco settlement.

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award	
Universal Direct	\$304,309	
Universal Indirect	\$699,612	
Selective	\$204,614	
Indicated	\$6,858	
Column Total	\$1,215,393	
Total SABG Award*	\$6,076,963	
Planned Primary Prevention Percentage	20.00 %	

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: Planning Period End Date:

Targeted Substances	
Alcohol	b
Tobacco	e
Marijuana	b
Prescription Drugs	b
Cocaine	b
Heroin	b
Inhalants	b
Methamphetamine	b
Synthetic Drugs (i.e. Bath salts, Spice, K2)	b
Targeted Populations	
Students in College	b
Military Families	b
LGBT	b
American Indians/Alaska Natives	b
African American	b
Hispanic	b
Homeless	b
Native Hawaiian/Other Pacific Islanders	b
Asian	b
Rural	b
Underserved Racial and Ethnic Minorities	b

Footnotes:

Planning Tables

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award			
	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	\$6,614	\$0	\$0	\$6,614
2. Quality Assurance	\$0	\$115,819	\$0	\$115,819
3. Training (Post-Employment)	\$767	\$0	\$0	\$767
4. Education (Pre-Employment)	\$0	\$0	\$0	\$0
5. Program Development	\$0	\$0	\$0	\$0
6. Research and Evaluation	\$6,613	\$0	\$0	\$6,613
7. Information Systems	\$435	\$0	\$0	\$435
8. Total	\$14,429	\$115,819	\$0	\$130,248

Footnotes:

Environmental Factors and Plan

1. The Health Care System and Integration

Narrative Question:

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.²⁶ Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but “[h]ealth system factors” such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.²⁷ It has been acknowledged that there is a high rate of co-occurring mental illness and substance abuse, with appropriate treatment required for both conditions.²⁸ Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The [Framingham Heart Study](#) produced the idea of “risk factors” and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence-based practices^{29 30} that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.³¹ Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.³² In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.³³ Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.³⁴ Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.³⁵ In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.³⁶

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.³⁷ Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between mental and substance abuse treatment providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as federally qualified health centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.³⁸ Use of EHRs – in full compliance with applicable legal requirements – may allow providers to share information, coordinate care and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, care, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes³⁹ and ACOs⁴⁰ may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

The Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. Non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.⁴¹ Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.⁴²

One key population of concern is persons who are dually eligible for Medicare and Medicaid.⁴³ Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.⁴⁴ SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.⁴⁵ Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or finding a provider.⁴⁶ SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.⁴⁷ It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.⁴⁸

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.⁴⁹ Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, which includes information and resources to help promote health, good outcomes and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.⁵⁰

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.⁵¹ However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment and recovery support for persons with, or at risk of, mental illnesses and substance use disorders.

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be charged with coordinating care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?
2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?
6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?
7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?
8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?
9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

10. Indicate tools and strategies used that support efforts to address nicotine cessation.
 - Regular screening with a carbon monoxide (CO) monitor
 - Smoking cessation classes
 - Quit Helplines/Peer supports
 - Others _____
11. The behavioral health providers screen and refer for:
 - Prevention and wellness education;
 - Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
 - Recovery supports

Please indicate areas of technical assistance needed related to this section.

²⁶ BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011 Jun;49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, *Bulletin of the World Health Organization*, 2013;91:102–123

<http://www.who.int/bulletin/volumes/91/2/12-108282.pdf>; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, *World Psychiatry*. Feb 2011; 10(1): 52–77

²⁷ Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts,

<http://www.promoteacceptance.samhsa.gov/10by10/default.aspx>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <http://www.integration.samhsa.gov/health-wellness/samhsa-10x10> Schizophrenia as a health disparity, <http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

²⁸ Comorbidity: Addiction and other mental illnesses, <http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses> Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014;71(3):248-254. doi:10.1001/jamapsychiatry.2013.3726; <http://www.samhsa.gov/co-occurring/>

²⁹ 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC 8); *JAMA*. 2014;311(5):507-520.doi:10.1001/jama.2013.284427

³⁰ A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines: 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk: <http://circ.ahajournals.org/>

³¹ Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>: <http://www.cdc.gov/socialdeterminants/Index.html>

³² Depression and Diabetes, NIMH, <http://www.nimh.nih.gov/health/publications/depression-and-diabetes/index.shtml#pub5>; Diabetes Care for Clients in Behavioral health Treatment, Oct. 2013, SAMHSA, <http://store.samhsa.gov/product/Diabetes-Care-for-Clients-in-Behavioral-Health-Treatment/SMA13-4780>

³³ J Pollock et al., Mental Disorder or Medical Disorder? Clues for Differential Diagnosis and Treatment Planning, *Journal of Clinical Psychology Practice*, 2011 (2) 33-40

³⁴ C. Li et al., Undertreatment of Mental Health Problems in Adults With Diagnosed Diabetes and Serious Psychological Distress, *Diabetes Care*, 2010; 33(5) 1061-1064

³⁵ TIP 54: Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders, SAMHSA, 2012, <http://store.samhsa.gov/product/TIP-54-Managing-Chronic-Pain-in-Adults-With-or-in-Recovery-From-Substance-Use-Disorders/SMA13-4671>

³⁶ Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. <http://www.nami.org/Content/ContentGroups/CAAC/FG-Integrating.pdf>; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011,

http://www.nami.org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Integration_MH_And_Primary_Care_2011.pdf; Abrams, Michael T. (2012, August 30). *Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and challenges*. Baltimore, MD: The Hilltop Institute, UMBC.

<http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf>; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>; American Psychiatric Association, <http://www.psych.org/practice/professional-interests/integrated-care>; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, http://books.nap.edu/openbook.php?record_id=11470&page=210; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, <http://nasadad.org/nasadad-reports>

³⁷ Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

³⁸ Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, SAMHSA, 2009, <http://store.samhsa.gov/product/Characteristics-of-State-Mental-Health-Agency-Data-Systems/SMA08-4361>; Telebehavioral Health and Technical Assistance Series, <http://www.integration.samhsa.gov/operations-administration/telebehavioral-health> State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, <http://www.americantelemed.org/docs/default-source/policy/ata-best-practice---telemental-and-behavioral-health.pdf?sfvrsn=8>; National Telehealth Policy Resource Center, <http://telehealthpolicy.us/medicaid>; telemedicine, <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html>

³⁹ Health homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>

⁴⁰ New financing models, http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx

⁴¹ Waivers, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS

⁴² What are my preventive care benefits? <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); Preventive services covered under the Affordable Care Act, <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>

⁴³ Medicare-Medicaid Enrollee State Profiles, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html>; About the Compact of Free Association, <http://uscompact.org/about/cofa.php>

⁴⁴ Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>

⁴⁵ BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

⁴⁶ TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014;71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013;70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

⁴⁷ <http://www.nrepp.samhsa.gov/>

⁴⁸ Clarifying Guidance on Peer Support Services Policy, May 2013, CMS, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Clarifying-Guidance-Support-Policy.pdf>; Peer Support Services for Adults with Mental Illness and/or Substance Use Disorder, August 2007, <http://www.medicaid.gov/Federal-Policy-guidance/federal-policy-guidance.html>; Tri-Agency Letter on Trauma-Informed Treatment, July 2013, <http://medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf>

⁴⁹ Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, <http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORk/PEP13-RTC-BHWORk.pdf>; Annapolis Coalition, An Action Plan for Behavioral Health Workforce Development, 2007, <http://annapoliscoalition.org/?portfolio=publications>; Creating jobs by addressing primary care workforce needs, <http://www.hhs.gov/healthcare/facts/factsheets/2013/06/jobs06212012.html>

⁵⁰ About the National Quality Strategy, <http://www.ahrq.gov/workingforquality/about.htm>; National Behavioral Health Quality Framework, Draft, August 2013, <http://samhsa.gov/data/NBHQF>

⁵¹ Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, <http://www.cms.gov/ccio/resources/letters/index.html>; Affordable Care Act, Indian Health Service, <http://www.ihs.gov/ACA/>

Please use the box below to indicate areas of technical assistance needed related to this section:

As TA needs are identified, ADAP will request TA.

Footnotes:

Environmental Factors and Plan

1. The Health Care System and Integration

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by Qualified Health Plans offered through the Health Insurance Marketplace as of January 1, 2016?

Please note that Vermont worked in partnership with Centers for Medicare & Medicaid Services (CMS) to develop two new innovative 1115 demonstration waiver programs, Global Commitment to Health (GC) and Choices for Care (CFC). As explained in this document <http://dvha.vermont.gov/administration/1vt-11-w-00194-1-1115-demonstration-renewal-request-revised-5-17-13.pdf>, the GC and CFC Demonstrations have enabled the State to preserve and expand the affordable coverage gains made in the prior decade; provide program flexibility to more effectively deliver and manage public resources; and improve the health care system for all Vermonters.

The Global Commitment (GC) to Health Section 1115(a) Demonstration, implemented on October 1, 2005, was designed to provide flexibility with regard to the financing and delivery of health care to promote access, improve quality and control program costs. The majority of Vermont's Medicaid program currently operates under the GC Demonstration, with the exception of its Children's Health Insurance Program (CHIP), individuals enrolled in Vermont's Section 1115 Long Term Care Demonstration (Choices for Care), and Vermont's Disproportionate Share Hospital (DSH) program. More than 95% of Vermont's Medicaid program participants are enrolled in the GC Demonstration.

The essential benefits for the quality health plans in Vermont are listed here: <http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/vt-state-required-benefits.pdf>

Service	Medicaid	QHP offered through the Health Insurance Marketplace
Healthcare Home/Physical Health		
General and Specialized Outpatient Medical Services	Yes	Yes
Acute Primary Care	Yes	Yes
General Health Screens, Tests and Immunizations	Yes	Yes
Comprehensive Care Management	Health home services are available only for patients served in MAT hubs and spokes; QHP's provide	
Care Coordination and Health Promotion		
Comprehensive Transitional Care		
Individual and Family Support		

	through an agreement with DVHA. Individual and Family Support services are available to Medicaid IFS populations.	
Referral to Community Services		
Prevention examples of approaches include:		
a. Prevention including Promotion		
Screening, Brief Intervention and Referral to Treatment	Yes	If within a medical visit
Brief Motivational Interviews	Yes	
Screening and Brief Intervention for Tobacco Cessation	Yes	
Parent Training	IFS/Yes	
Facilitated Referrals	No	No
Relapse Prevention/Wellness Recovery Support	No	No
Warm Line	No	No
b. Substance Abuse Primary Prevention		
Classroom and/or small group sessions (Education)	GC Investments	No
Media campaigns (Information Dissemination)	No	No
Systematic Planning/Coalition and Community Team Building (Community- Based Process)	No	No
Parenting and family management (Education)	No	No
Education programs for youth groups (Education)	GC Investment	No
Community Service Activities (Alternatives)	No	No
Student Assistance Programs (Problem Identification and Referral)	GC Investment	No
Employee Assistance Programs (Problem Identification and Referral)	No	No
Community Team Building (Community-Based Process)	No	No
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental)	No	No
Engagement Services		
Assessment	Yes	Yes
Specialized Evaluations (Psychological and Neurological)	Yes	Yes
Service Planning (including crisis planning)	Yes	Yes
Consumer/Family Education	No	No
Outreach	No	Condition Specific initiated by QHP
Outpatient Services		
Individual Evidenced-based Therapies	Yes	Yes

Group Therapy	Yes	Yes
Family Therapy	Yes	Yes
Multi-family Therapy	No	No
Consultation to Caregivers	No	No
Medication Services		
Medication Management	Yes	Yes
Pharmacotherapy (including MAT)	Yes	Yes
Laboratory Services	Yes	Yes
Community Support (Rehabilitative)		
Parent/Caregiver Support	No	No
Skill Building (social, daily living, cognitive)	Yes	No
Case Management	Yes	No
Behavior Management	Yes	No
Supported Employment	No	No
Permanent Supported Housing	No	No
Recovery Housing	No	No
Therapeutic Mentoring	No	No
Traditional Healing Services	No	No
Recovery Supports		
Peer Support	GC Investment	No
Recovery Support Coaching	GC Investment	No
Recovery Support Center Services	GC Investment	No
Supports for Self-directed Care	No	No
Other Supports (Habilitative)		
Personal Care	Yes	No
Homemaker	No	No
Respite	GC Investment	No
Supported Education	Yes	No
Transportation	Yes	No
Assisted Living Services	Yes	No
Recreational Services	GC Investment	No
Trained Behavioral Health Interpreters	No	No
Interactive Communication Technology Devices	Yes	No
Intensive Support Services		
Substance Abuse Intensive Outpatient (IOP)	Yes	Yes
Partial Hospital	Yes	Yes
Assertive Community Treatment	Yes	No
Intensive Home-based Services	GC	No

	Investment	
Multi-systemic Therapy	No	No
Intensive Case Management	Yes	No
Out of Home Residential Services		
Crisis Residential/Stabilization	CRT Case Rate/GC Investment	Yes
Clinically Managed 24-hour Care (SA)	Yes	Yes
Clinically Managed Medium Intensity Care (SA)	Yes	Yes
Adult Mental Health Residential	CRT Case Rate/GC Investment	Yes
Youth Substance Abuse Residential Services	Yes	Yes
Children's Residential Mental Health Services	Yes	Yes
Therapeutic Foster Care	GC Investment	No
Acute Intensive Services		
Mobile Crisis	Yes	No
Peer-based Crisis Services	No	No
Urgent Care	Yes	Yes
23-hour Observation Bed	Yes	No
Medically Monitored Intensive Inpatient (SA)	Yes	Yes
24/7 Crisis Hotline Services	Yes	No

2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?

The Department of Vermont Health Access (DVHA) and the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (ADAP) will jointly monitor access to care. DVHA monitors the provider network through mapping with, at a minimum, an annual review by the Managed Care Medical Committee. Access to the Hub & Spoke/MAT treatment system is monitored monthly. ADAP will continue with current monitoring plans using TEDS admissions data for total admissions and payment mix. ADAP performs quality assurance/compliance site visits on the contracted network with the support of TEDS/SATIS data.

The Green Mountain Care Board is responsible for monitoring access for the QHPs.

3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.

Identifying and monitoring QHPs is the responsibility of the Vermont Department of Financial Regulation (DFR). DFR produces annual Health Plan Report Cards for Vermont managed health care plans.

http://www.dfr.vermont.gov/sites/default/files/2014_MCODataFilingEvalRpt_UpdateDec2014.pdf.

The methodology for this report is described here:

http://www.dfr.vermont.gov/sites/default/files/2014_MCODataFilingEval_Appendix%20B-Technical%20Doc_FINAL.pdf

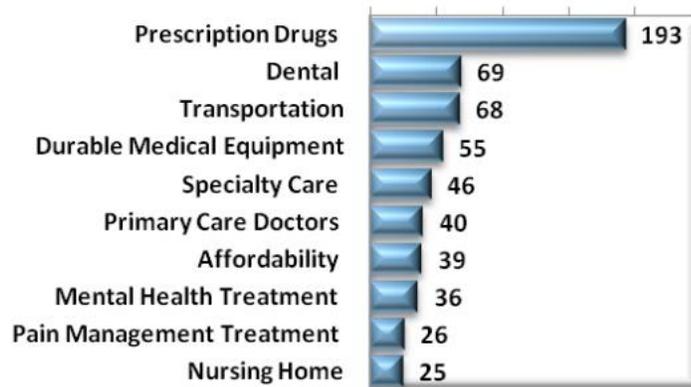
The purpose of this report is primarily to assess compliance with Vermont's Rule H-2009-03 quality requirements of the care and services that Vermonters received as members of the four major managed health insurers in Vermont for HMO, POS, and PPO products. In doing so, the report chronicles and compares standardized annual clinical and administrative performance measures against accepted national and regional benchmarks and multi-year performance trends of Vermont's health care plans (known as Managed Care Organizations (MCOs)). This report also identifies areas of performance that fall short of reaching a benchmark and may provide an opportunity for improvement. Key performance domains in this report include:

- 1) MCOs Overview, Enrollment, Market Share, and Access to Providers/Services
- 2) Member Satisfaction, UR Decisions, and Grievances
- 3) MCO Performance on Quality Measures
- 4) Analyses of MCO Performance Over-Time
- 5) Department Recommendations to Improve MCO Quality

The report uses symbols to denote the results of statistical tests comparing MCO performance against two different benchmarks. For the most part, the benchmarks represent national and New England regional averages calculated by the National Committee for Quality Assurance (NCQA). Although not every MCO in the United States submits data to NCQA, most do. Therefore, NCQA's national and regional averages provide reasonable and generally accepted points of comparison. The Department performs additional statistical significance testing for performance measures, measures subsets, as well as conducts longitudinal analyses.

In addition, complaints are monitored by the Office of Health Care Advocate. The FY2014 report (<http://www.vtlegalaid.org/assets/Uploads/Vermont-Health-Care-Advocate-Annual-Report-SFY-2014.pdf>) compiles issues around access to treatment. Access to substance abuse treatment no longer falls within the top ten access to care issues; it is now number 11.

Top 10 Access to Care Issues



4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?

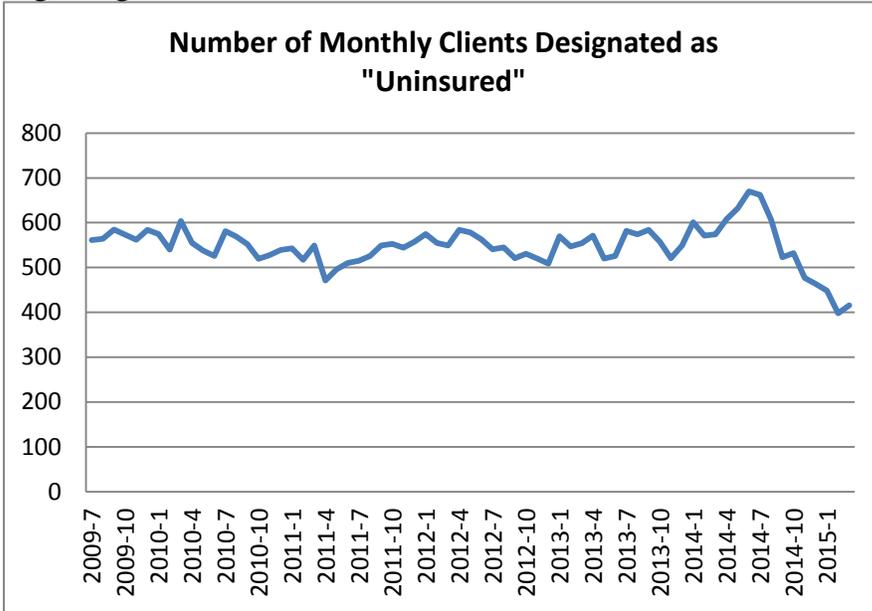
There are multiple avenues where complaints and violations may be received. The Office of Health Care Advocate (<http://www.vtlegalaid.org/our-projects/health-care-advocate-project/>), which is funded in part through ACA, provides help to Vermonters that have problems and questions about health care and health insurance through a telephone hotline service. The HCA represents the interests of all Vermont consumers of health care in the Legislature and before state agencies. They help individuals navigate the complexities of health insurance and assist them with health care problems. They advise and assist Vermont residents, regardless of income, resources or insurance status and services are free. As part of Vermont Legal Action, they are able to utilize the expertise of the attorneys.

The SSA and their designees are involved in investigation of grievance and appeals related to complaints around substance abuse treatment in the Approved/Preferred Provider system. The Medicaid division and HCO refer complaints to the SSA/designee as appropriate.

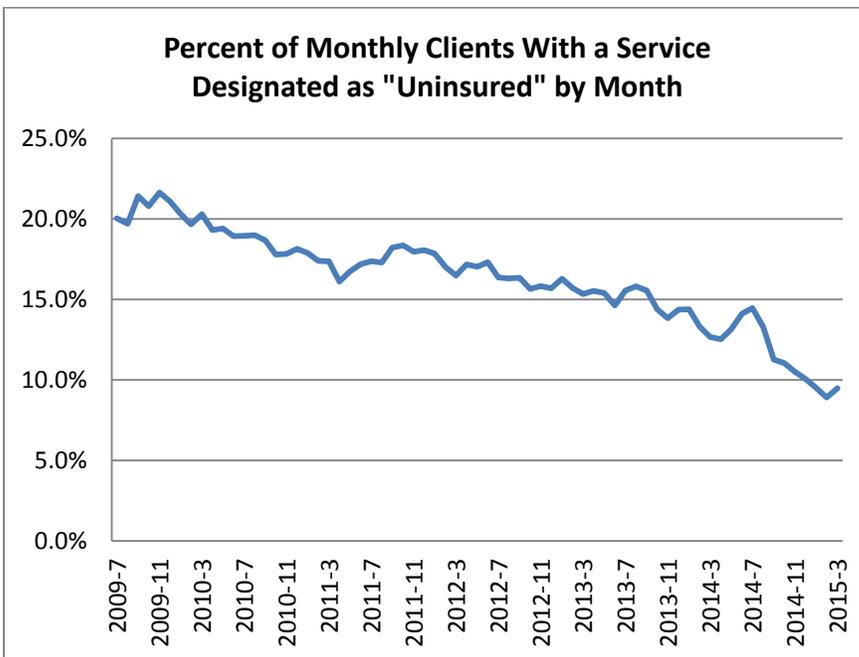
There is a possibility that SMHA and/or the SSA may be involved in reviewing possible violations or are MHPAEA associated with the Institute of Mental Disease (IMD) exclusion which prevents federal funds from being used to pay for medically necessary care.

5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

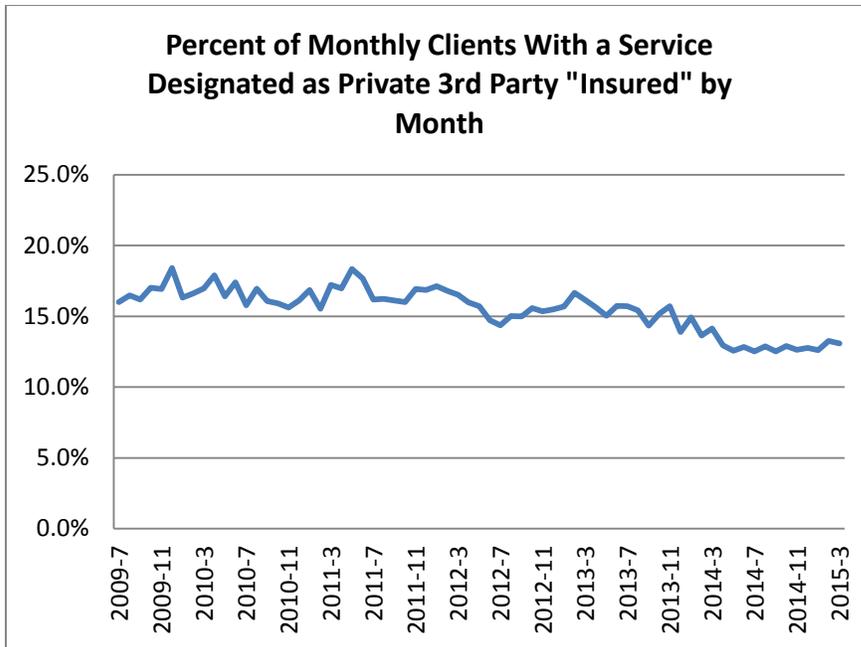
Vermont has just begun to see a decrease in the number of clients designated as “uninsured” beginning in mid-2014.



Despite the relative stability in the number of uninsured individuals, as a portion of the system they have been decreasing steadily while the overall number of people being served has increased.



At the same time, the percent of the substance abuse treatment population with private third party insurance has also been trending downward. The vast majority of substance abuse treatment services are now Medicaid-funded.



As Medicaid has been expanding, Vermont has also increasingly utilized Medication Assisted Treatment (MAT) for opioid addiction, a more expensive treatment option. There are more people designated as “uninsured” in the MAT programs, both in total numbers and as a percentage of those involved in the program, than any other level of care, a change that began in 2014. In order to respond to the demand for MAT, Vermont has increasingly been using both block grant and Medicaid funds to support the Care Alliance for Opioid Addiction,

<http://healthvermont.gov/adap/treatment/documents/CareAllianceOpioidAddiction.pdf>, a treatment mode of hubs and spokes to provide care supervised by a physician and supported by nurses and counselors who work to connect the patient with community-based support services. Depending on need, these services may include mental health and substance abuse treatment, pain management, life skills and family supports, job development and recovery supports.

ADAP is also considering the use of block grant funds to pay for co-pays and insurance premiums pending final approval of OMB.

6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?

ADAP works closely with other state agencies and departments with various coordinated care initiatives. Many of the recent priorities are associated with the increase in demand and treatment for opioid addiction. The Care Alliance for Opioid Addiction mentioned above is a coordinated effort between ADAP, the Department of Vermont Health Access (DVHA, which administers Medicaid) and the Blueprint for Health. The Vermont Blueprint for Health is a state-led, nationally-recognized initiative transforming the way primary care and comprehensive health services are delivered and paid for. Clients receive CMS Health Home services through the Care Alliance.

As one of the strategies to address opioid addiction, DVHA's pharmacy lock in program has become an important tool to address issues related to doctor and/or pharmacy shopping. Medicaid clients served in spokes for opioid addiction are enrolled in the pharmacy lock in program.

Additional initiatives include:

Department of Mental Health/Department for Children and Families

The Department of Mental Health has been addressing co-occurring disorders for several years. First, funded by a five year infrastructure planning grant from SAMHSA, the Vermont Integrated Services Initiative (VISI) provided training and technical assistance to a wide group of service providers to increase their programmatic and clinical capacity to effectively treat clients with co-occurring disorders. Twenty-six different service provider agencies participated in the project including community mental health centers, federally qualified health centers, housing and homeless service providers, and specialty residential providers. This grant ended in 2011.

DVHA, DMH and ADAP have been working to improve the capacity of patient-centered medical homes statewide to provide mental health and substance abuse care to both individuals with mental health and substance abuse needs who are served by primary care practices, and individuals who live with varying substance abuse conditions.

DMH, VDH and the Blueprint are collaborating to examine a state wide expansion of bi-directional care delivery. This means that primary care, mental health, and substance abuse supports will be provided in both primary care and Community Mental Health Center settings. The model will work to foster an environment where individuals can receive access to high-level evidence-based care wherever they feel most comfortable accessing both primary and mental health care. While most Primary Care Medical Home (PCMH) providers offer some existing level of mental health and substance abuse support in house or as a referral to the Community Health Team, clients of Community Mental Health Centers often do not have a meaningful relationship with a primary care provider and often do not seek out primary care for various reasons. Bringing primary care to Community Mental Health Centers will improve access and utilization of primary care services by historically underserved individuals including the Community Rehabilitation Treatment and Adult Outpatient Populations. This model is currently being piloted by Clara Martin Center and Northwestern Counseling and Support Services.

Department for Children and Families/Economic Services Division – Reach Up

Substance abuse and mental health conditions are leading barriers to employment for families on Reach Up. To address this issue, three Agency of Human Services departments have partnered to provide services to Reach Up participants with mental health or substance abuse conditions: the Department of Mental Health (DMH), the Department for Children and Families Economic Services Division (ESD) and ADAP. The services provided under this

contract integrate substance abuse and mental health service planning and coordination, specialized support services, and clinical treatment services to enhance access to care increase duration of treatment and recovery services, increase family wellness and stability, and contribute to participant's transition to employment. The services being provided include emergency services, individual, family, and group therapy, intensive outpatient treatment, medication management, residential substance abuse treatment, and medication assisted therapy.

Integrated Family Services

DMH and ADAP actively participate in the Agency of Human Services (AHS) Integrated Family Services (IFS) initiative, which includes representatives from each of the AHS departments that serve children (0-22) and the Agency of Education (AOE). This group is identifying and undertaking changes in policy and internal operations (services, service design, grants, payment structures, etc.) that are needed to improve outcomes and achieve integrated child and family-centered responses from the various AHS and AOE programs.

Rapid Arraignment and Early Referral

The Rapid Referral Program is a partnership between a treatment provider and the district court to increase access to mental health and substance abuse assessment services for individuals involved in the criminal justice system whose charge(s) are related to substance use. The main objective of the program is to provide judges with a mechanism to rapidly refer defendants for substance abuse screening and treatment rather than delaying services until the case is disposed by the court. An evaluation has documented significant decreases in recidivism for participants completing the program – fewer than 20% of participants had subsequent convictions compared to nearly 85% of a control group.

Treatment Courts

Treatment Courts are a coordinated effort of the judiciary, prosecution, defense bar, probation, law enforcement, mental health and substance abuse treatment to actively intervene and break the cycle of substance abuse addiction and crime. Eligible offenders are offered treatment in exchange for reduced or dismissed charges when they successfully complete the program. Treatment Courts provide an intense regimen of substance abuse and mental health treatment, links to health services, wrap around case management, drug testing, regularly scheduled status hearings before a judge, links with job skills training and employment, educational services, housing and other needed support. Treatment Courts promote positive community trends, increase public safety, reduce recidivism rates, and are a less expensive alternative to prisons. Recidivism rates for treatment court completers are lower than rates for those who do not participate or complete the program. Treatment court graduates who do commit additional crimes have significantly fewer felony convictions than those who do not complete the program.

7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?

ADAP works with the University of Vermont College of Medicine, Office of Primary Care (UVM-OPC) which is a statewide network of community and academic partners working together to improve the health of Vermonters. ADAP has contracted UVM-OPC to provide educational and quality improvement programming to Vermont's medical professionals, including the FQHCs and CHCs, to promote community-based health education across the state. With funding from ADAP, UVM-OPC developed the "Prescriber Toolkit" of materials which includes practice-wide strategies, work flow change, and implementation and evaluation processes to bring opioid prescribing practices into conformance with best practice. UVM-OPC has also provided academic detailing services on behalf of VDH since 1999. Each year, select topic areas are chosen and chronic pain and opioid prescribing practices have been past topics.

8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?

Vermont incorporated tobacco into all FY15 substance abuse treatment provider agreements as shown below:

General Assurances: Grantee shall develop policies designating their facility(s) as tobacco-free environments by July 1, 2015. These policies must include best practice strategies. Resources, including procedures and sample policies, are available on the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs' (ADAP) website at <http://healthvermont.gov/adap/grantees/Grantees.aspx> under the Treatment section. Technical Assistance is available through the Vermont Department of Health, Division of Health Promotion and Disease Prevention, Tobacco Control Program, (802) 863-7330.

Clinical Assurances: Grantee will screen and if applicable offer assessment to all clients over the age of 12 engaged in formal addiction treatment, using an evidence-based screening tool, for nicotine dependence. If applicable, tobacco cessation will be included as part of the treatment plan. Tobacco cessation therapy treatment tools and reference materials are available at <http://healthvermont.gov/adap/grantees/Grantees.aspx>.

The timeline described above has been amended for FY16. Outpatient facilities will be tobacco-free by July 1, 2015 and residential facilities are expected to be tobacco free by January 1, 2016.

9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

ADAP developed the strategy shown in #8 in conjunction with the Vermont Department of Health Division of Health Promotion and Disease Prevention (HPDP). HPDP oversees

tobacco cessation programming and is in the process of developing an evaluation of tobacco cessation efforts in behavioral health providers.

ADAP also reviews records in annual site visits to verify inclusion of tobacco cessation in treatment plans.

10. Indicate tools and strategies used that support efforts to address nicotine cessation.

HPDP supports the following nicotine cessation activities for Vermonters:

- a. Regular screening with a carbon monoxide (CO) monitor - NO
- b. Smoking cessation classes - YES
- c. Quit Helplines/Peer supports - YES
- d. Others: Online cessation service, Nicotine Replacement Therapy, option of additional text messaging support of quit attempt, screening and brief intervention following 2008 Clinical Practice Guidelines for the Treatment of Tobacco Use and Dependence

11. The behavioral health providers screen and refer for:

- a. Prevention and wellness education; the five hubs, which have health home services, provide some education and prevention services.
- b. Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and, -- The five hubs, which have health home services, screen and refer. Other providers include self-reported health information in treatment planning but do not formally screen.
- c. Recovery supports. All block grant funded providers include recovery support resources through discharge planning.

Please note that a barrier to integrating health and behavioral health services is 42 CFR Part 2. This prevents free disclosure of information between specialty substance abuse treatment providers and the medical system. It has also prevented the specialty treatment providers from connecting electronic health records (EHRs) to the Vermont Health Information Exchange through the Vermont Information Technology Leaders (VITL) and prevented MAT providers which dispense methadone and buprenorphine from providing information about clients receiving these substances to the prescription drug monitoring program. If the individual doesn't disclose that he is receiving MAT when accessing other care, this incomplete information may mask drug seeking behavior or result in individuals receiving MAT also receiving opioid pain relievers through primary care physicians and emergency departments despite all providers properly using all the tools at their disposal.

Technical Assistance needed related to this section: As TA needs are identified, ADAP will request TA.

Environmental Factors and Plan

2. Health Disparities

Narrative Question:

In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)⁵², [Healthy People, 2020](#)⁵³, [National Stakeholder Strategy for Achieving Health Equity](#)⁵⁴, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, and people living with HIV/AIDS or other chronic diseases/impairments) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards).⁵⁵

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The top Secretarial priority in the Action Plan is to "[a]ssess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."⁵⁶

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.⁵⁷ This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations.⁵⁸ In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the population they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?
2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.
3. Are linguistic disparities/language barriers identified, monitored, and addressed?
4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.
5. Is there state support for cultural and linguistic competency training for providers?

Please indicate areas of technical assistance needed related to this section.

⁵²http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁵³<http://www.healthypeople.gov/2020/default.aspx>

⁵⁴<http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf>

⁵⁵<http://www.ThinkCulturalHealth.hhs.gov>

⁵⁶http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁵⁷<http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208>

⁵⁸http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please use the box below to indicate areas of technical assistance needed related to this section:

As TA needs are identified, ADAP will request TA.

Footnotes:

1 The Health Disparities of Vermonters, June 2010. <http://healthvermont.gov/research/healthdisparities.aspx>

2 The Agency of Human Services Standards for Translation of Vital Documents for Persons with Limited English Proficiency. AHS Limited English Proficiency Committee, May 19, 2009.

3 The most common languages in Vermont requiring translation are French, Spanish, Serbo-Croatian, Somali, Swahili, Nepali and Burmese. Authorizations for adjustments to this list are possible in special circumstances.

Environmental Factors and Plan

2. Health Disparities

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?

As part of the Substance Abuse Treatment Information System (SATIS), Vermont collects, analyzes and uses demographic and systems data for priority setting and mitigating against health disparities in order to ensure that programs meet the needs of all Vermonters regardless of sex, race, ethnicity, etc. All providers in the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (ADAP) are required to report all admissions, transactions and discharges through SATIS. National Outcome Measures (NOMs) are collected on all SABG supported prevention services, including age, gender, race and ethnicity.

Every two years, the Vermont Departments of Health and Education sponsor the Vermont Youth Risk Behavior Survey (YRBS) to measure the prevalence of behaviors that contribute to the leading causes of death, disease, and injury among youth. The Data Briefs provide detailed analyses of these risk behaviors. Our Vermont Department of Health's Surveillance team regularly conducts more targeted analyses of Vermont's sub-populations to better understand the risks and patterns among these at risk populations, including recent investigations of the LGBQ students, and of racial and ethnic minority students. See YRBS Data Briefs http://healthvermont.gov/research/yrbs/data_briefs.aspx#db. These briefs help bolster our ability to monitor progress in eliminating health disparities and protecting and promoting health for all Vermonters, our mission and top priority articulated in our Strategic Plan 2014-2018. See http://healthvermont.gov/hv2020/strategic_plan.aspx.

Furthermore, Vermont recently updated its Substance Abuse Services Guidelines, effective April 1, 2015, that requires all providers to have in place written non-discrimination policies and procedures, a code of ethics governing behavior of staff and business practice, plans relating to cultural competence and supervisory practices, and criteria for prioritizing need and high risk populations. See the Guidelines at: <http://healthvermont.gov/adap/treatment/documents/SubstanceAbuseServicesGuidelines.pdf>.

The Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (VDH/ADAP) takes seriously the issue of health disparities, and checks systems, processes and procedures to determine where improvements might be made to ensure that all Vermonters are being effectively reached and able to access services regardless of sex, race, ethnicity, etc. Through site visits and the newly revised Vermont Substance Abuse Services Guidelines, ADAP works with its partners to identify and eliminate systemic barriers that hinder certain sectors of its population from being able to access services.

2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.

As stated above, Vermont's Department of Health Strategic Plan 2014-2018 has as its mission to protect and promote the best health for all Vermonters. One of the major goals is health equity, and the plan includes measurable objectives to reduce health disparities, recruit and retain qualified candidates from diverse backgrounds, and to ensure linguistic competency by translating documents for people with limited English proficiency. See http://healthvermont.gov/hv2020/strategic_plan.aspx.

Furthermore, the state prepares a specialized publication that presents the results of a comprehensive evaluation of health disparities in Vermont, and sets out key recommendations to further reduce health disparities.¹

The Vermont Department of Health Office of Minority Health and Health Disparities (VOMH) established a plan for how the Vermont Department of Health will adhere to the 14 National Culturally and Linguistically Appropriate Services (CLAS) Standards, including assuring the competence of language assistance (see Standard 6); and developing participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities to coordinate disparities elimination initiatives and ensure culturally competent practices with state and external partners (Standard 12).

In ADAP's Strategic Plan, this commitment is reflected across many of its goals, but most directly articulated in Strategic Directions 6.1 and 6.2:

Strategic Direction 6.1: Health Disparities: Recognize and respond to health disparities 6.1.1 Complex Clients and High Risk, Hard to Reach Populations: Improve infrastructure, services and reach to complex and high risk client populations; Strategic Direction 6.2: Cross-Divisional and Department Collaborations: Collaborate across state government to achieve health equity among the most vulnerable. Vermonters 6.2.1 Compound Impact through Collaboration: Identify opportunities for collaboration and establish partnerships across Divisions, State Departments and other state programs to improve reach and services to vulnerable Vermonters.

The Department has a Refugee and Health Equity Coordinator position to guide our work on these strategic priorities. This position and the Office of Minority Health and Health Disparities (OMH) are based in the Burlington District Office in the Office of Local Health because most refugees and minority groups live in Chittenden County. This coordinator is partially funded with SBIRT grant funds and serves a statewide function. A minority health workgroup consists of community members from most of Vermont's refugee/New American communities and other racial minority groups. It also includes members who identify as LGBTQ*. Members of the group are paid to provide input on work going on in the SBIRT program and this will provide a model for other substance abuse services as well.

With new infusions of refugee populations and influx of new diverse populations, the challenge of health disparities may grow more complex over time. Through regular population-wide monitoring and more targeted analysis as described above, Vermont remains vigilant to identify

gaps and barriers, and improve access to services for all Vermonters. ADAP has at its disposal its site visits, grievances investigations, correspondence with partner providers, treatment standards, and grant management processes, to further address any gaps in services or to take corrective action when discrepancies are identified.

3. Are linguistic disparities/language barriers identified, monitored, and addressed?

Yes. As stated above, Vermont's Department of Health Strategic Plan 2014-2018 has as one of its major goals health equity, including the measurable objective to ensure linguistic competency by translating documents for people with limited English proficiency. See http://healthvermont.gov/hv2020/strategic_plan.aspx. The measures include: 6.3.1 By 2015, the department's website will contain information on how to access translated materials and interpreter services, and 6.3.2, by 2017, 90% of the materials needing translation, as identified by the department's translation committee, will be translated. Progress on these two measures are monitored and being addressed across the entire Department.

4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.

The Vermont Department of Health Office of Minority Health and Health Disparities (VOMH) is charged with development and implementation of Vermont's Strategic Plan to eliminate health disparities in the delivery of health prevention and health care services to Vermonters. One major achievement was to establish a plan for how the Vermont Department of Health will adhere to the 14 National Culturally and Linguistically Appropriate Services (CLAS) Standards. For example, upon request the VDH now has access to and will provide a translator and interpreter for consumers through the Agency of Human Services Refugee Coordinator at no cost to consumers (see Standard 4); and although not a health care organization, the VDH provides when requested translation and interpretation services to consumers regarding the availability of our services, notably the Women Infant and Children (WIC) program. The department's 2014-18 Strategic Plan specifies that by 2017, 90% of materials needing translation will be translated. (Standard 5); and VDH provides signage of our services, and educational materials to the most commonly encountered groups in each service area, most notably our Women, Infants and Children (WIC) Clinic services (Standard 7).

The Agency of Human Services has established Standards for Translation of Vital Documents for Persons with Limited English Proficiency.² This standard, currently under review for updating, requires that departments and offices must translate all vital documents that they are legally required to provide to an applicant or recipient, into the most common languages in Vermont.³ ADAP has a representative on the Vermont Department of Health's Translations Workgroup that provides guidance to all the Divisions on the types of documents qualifying as "vital" and needing to be translated, and in what languages. This work also supports the Department's own Strategic Plan goals and accreditation standards. Recent work has or is nearing completion to make available vital documents in the seven most common languages relating to the Vermont Prescription Monitoring System (VPMS) Program and for the Screening, Brief Intervention & Referral to Treatment (SBIRT) program and services.

5. Is there state support for cultural and linguistic competency training for providers?

Yes. The Vermont Department of Health Office of Minority Health and Health Disparities (VOMH) established a plan for how the Vermont Department of Health will adhere to the 14 National Culturally and Linguistically Appropriate Services (CLAS) Standards, including enhancing Vermont's infrastructure to coordinate disparities elimination initiatives with state and external partners (Standard 12).

Furthermore, the VOMH has and continues to provide technical assistance and support to ADAP staff and grantees in three areas: (1) improved data quality, collection and reporting; (2) support a diverse and culturally competent public health workforce through training, technical assistance and recruitment; and (3) enhance VT's infrastructure to coordinate disparities elimination initiatives with state and external partners. This work started with cultural competency training for 60 senior VDH/AHS employees, including two ADAP staff. And the Minority Health Coordinator plays a lead role in the Minority Health advisory group focused on substance use (SBIRT grant).

Both the Partnership for Success Grant (PFS) and the SBIRT grant have supported additional training to ADAP staff and providers across all the Districts. The goals of the training included providing foundational language around culture, cultural and intercultural competence utilizing the CLAS standards, understanding of how our personal experiences impact our culture/intercultural competence, to foster an appreciation for the impact that culture has on promoting good health, and providing a framework for engaging in this work. This type of training and technical assistance will be provided on an annual basis.

As stated above, Vermont's Department of Health Strategic Plan 2014-2018 has as one of its major goals health equity, including the measurable objective to recruit and retain qualified candidates from diverse backgrounds. See http://healthvermont.gov/hv2020/strategic_plan.aspx. The measures include: 6.2.1 by 2015, hiring practices that are designed to recruit and retain qualified candidates from diverse backgrounds will be integrated into department processes, and 6.2.2, by 2016, all department staff will complete on-line cultural competency training within 60 days of hire. This raises the bar for all state employees across the state and sets a model for our providers and partners.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

¹ The Health Disparities of Vermonters, June 2010.

<http://healthvermont.gov/research/healthdisparities.aspx>

² The Agency of Human Services Standards for Translation of Vital Documents for Persons with Limited English Proficiency. AHS Limited English Proficiency Committee, May 19, 2009.

³ The most common languages in Vermont requiring translation are French, Spanish, Serbo-Croatian, Somali, Swahili, Nepali and Burmese. Authorizations for adjustments to this list are possible in special circumstances.

Environmental Factors and Plan

3. Use of Evidence in Purchasing Decisions

Narrative Question:

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including mental health and substance abuse services. Over the past several years, SAMHSA has received many requests from CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance abuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states use of the block grants for this purpose. The NQF and the Institute of Medicine (IOM) recommend that evidence play a critical role in designing health and behavioral health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP⁵⁹ is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with (SED). The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General⁶⁰, The New Freedom Commission on Mental Health⁶¹, the IOM⁶², and the NQF.⁶³ The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."⁶⁴ SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), and CMS) have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocols (TIPs)⁶⁵ are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (CSAT) draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)⁶⁶ was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding mental health and substance abuse services.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.
2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
4. Does the state use a rigorous evaluation process to assess emerging and promising practices?
5. Which value based purchasing strategies do you use in your state:
 - a. Leadership support, including investment of human and financial resources.
 - b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
 - c. Use of financial incentives to drive quality.

- d. Provider involvement in planning value-based purchasing.
- e. Gained consensus on the use of accurate and reliable measures of quality.
- f. Quality measures focus on consumer outcomes rather than care processes.
- g. Development of strategies to educate consumers and empower them to select quality services.
- h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.
- i. The state has an evaluation plan to assess the impact of its purchasing decisions.

Please indicate areas of technical assistance needed related to this section.

⁵⁹ [Ibid, 47, p. 41](#)

⁶⁰ United States Public Health Service Office of the Surgeon General (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

⁶¹ The President's New Freedom Commission on Mental Health (July 2003). *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

⁶² Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*. Washington, DC: National Academies Press.

⁶³ National Quality Forum (2007). *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices*. Washington, DC: National Quality Forum.

⁶⁴ <http://psychiatryonline.org/>

⁶⁵ <http://store.samhsa.gov>

⁶⁶ <http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345>

Please use the box below to indicate areas of technical assistance needed related to this section:

As TA needs are identified, ADAP will request TA.

Footnotes:

- 1 <http://www.samhsa.gov/ebp-web-guide>
- 2 <http://www.thecommunityguide.org/>
- 3 <http://www.asam.org/>
- 4 <http://innovation.cms.gov/initiatives/state-innovations/>
- 5 <http://www.samhsa.gov/grants/grant-announcements/sm-16-001>

Environmental Factors and Plan

3. Use of Evidence in Purchasing Decisions

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.

At present the Chairperson of the State Epidemiological Workgroup (SEOW) also chairs the Evidence-based Practices Workgroup (EBPW). Membership includes ADAP staff, community stakeholders and the Pacific Institute for Research and Evaluation (PIRE). PIRE is contracted with support through the Partnership for Success (PFS) and Regional Prevention Partnerships (RPP) demonstration grants to summarize the evidence and make recommendations to the state on evidence-based practices (EBPs) that relate to the state's logic model for prevention services. The EBPW makes final recommendations and state staff will disseminate information on EBPs via trainings, symposia and briefings about EBPs within grantee requirements. In FY16/17 the EBPW workgroup will increase the number of community stakeholder members to assure attention to health disparities and practical fit to Vermont communities in the selection of EBP's. Tracking of implemented EBPs is completed through our NOMs data collection system and monitoring of narrative reports. ADAP staff and PIRE have developed fidelity guidelines which serve as a framework for grantee progress reports. The extent to which fidelity measures can be integrated into a future web-based data collection system is now under discussion as part of our PFS planning process. For services on the treatment and recovery side of the continuum of care, the Clinical Services Unit staff are assigned to be topic experts and in that role, are responsible for researching and disseminating information about EBPs and/or promising practices.

In particular, ADAP's Vermont Youth Treatment Enhancement Program, through the SAMHSA State Youth Treatment Cooperative Agreement, selected two Evidence Based Treatment Models and two Evidence Based Assessments, in conjunction with clinical grant partners, to be implemented and rolled out at pilot sites under the grant. The intent of the SAMHSA SYT Agreement is for sites to enhance and improve assessment and treatment services for adolescents and young adults (first at pilot sites and then through dissemination throughout the field as appropriate) through the use of EBPs with fidelity to the model.

2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?

The state uses available resources such as SAMHSA's *Identifying and Selecting Evidence-based interventions* guidance document, *Evidence-Based Practices (EBP) Web Guide*¹/National Registry of Evidenced-based Programs and Practices (NREPP), the CDC *Guide to Community Preventive Services*², the American Society of Addiction Medicine placement criteria³, and SAMHA's Treatment Improvement Protocols to research the programs and practices that are available. Grant and contract documents include

requirements for use of evidence based programs and practices. For example, all treatment providers are required to use ASAM placement criteria and a standard list of assessment tools. Prevention providers must select evidence-based programs and practices from a pre-determined list based on ADAP priority areas.

3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?

ADAP works very closely with the State Medicaid Authority, the Department of Vermont Health Access (DVHA) in the provision of substance abuse treatment services. This collaboration has recently resulted in the implementation of a residential prior authorization process for medically necessary residential treatment services through the use of the McKesson InterQual® Behavioral Health Decision Support Tool to assure clients are placed at the appropriate ASAM level of care.

ADAP and DVHA also developed the Care Alliance hub and spoke model, a statewide partnership of clinicians and treatment centers to provide evidence based Medication Assisted Therapy and support services to Vermonters who are addicted to opioids. This model was jointly developed using methadone and suboxone, both strongly supported as effective treatment for opioid addiction.

4. Does the state use a rigorous evaluation process to assess emerging and promising practices?

The state relies largely on national resources, such as SAMHSA's Evidence Based Practices Web Guide and the CDC Guide to Community Preventative Services to assess practices. The SEOW and PIRE reviewed these materials and organized the evidence-based and promising practices based on Vermont's needs assessment and strength of evidence.

5. Which value based purchasing strategies do you use in your state:

- a. Leadership support, including investment of human and financial resources.

Leadership strongly supports the use of value-based purchasing strategies; however, ADAP has limited human and financial resources. Even so, significant state resources were used to develop the Vermont's Care Alliance for Opioid Addiction. There are also statewide efforts associated with the Center Medicare & Medicaid Services (CMS) State Innovation Models (SIM)⁴ which supports development and testing of state-led, multi-payer health care payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and Children's Health Insurance Program (CHIP) beneficiaries—and for all residents of participating states. While this effort is not specific to the block grant, ADAP is involved in the initiative and substance abuse measures are included in the quality measures. Vermont has also applied for the SAMHSA Certified Community Behavioral Health Clinics (CCBHC) demonstration planning grant⁵ which includes value based purchasing/payment.

- b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.

Vermont uses the Treatment Episode Data Set (TEDS), Prevention evaluation results, National Survey of Drug Use and Health (NSDUH), Youth Risk Behavior Survey (YRBS), claims data, National Outcome Measures (NOM's) and other data sources to monitor quality improvement interventions. ADAP reports continuous progress toward our objective, indicators, and performance measures on the Vermont Department of Health Performance Scorecard. Please follow the link below to review the most recent results and trends as well as read the "Story Behind the Curve" for each measure. http://healthvermont.gov/hv2020/dashboard/alcohol_drug.aspx

- c. Use of financial incentives to drive quality.

Vermont has used financial incentives to drive quality with mixed success. This year, we have had to eliminate the program due to reductions in state funding.

- d. Provider involvement in planning value-based purchasing.

Providers were involved in planning for financial incentives and are integral to the work being done through the CMS SIM grant. They also contributed to the preparation of the CCBHC planning grant.

- e. Gained consensus on the use of accurate and reliable measures of quality.

Vermont is using an integrated framework of indicators and performance measures that encompass statewide priorities outlined in the Governor's, Agency of Human Services, and Vermont Department of Health Strategic Plans. These plans all support the priorities set out in Vermont Act 186 (2014), an act relating to reporting on population-level outcomes and indicators and on program-level performance measures.

The primary objective and population level indicator measures apply to the overall system of care. There are five primary performance measures, with additional measures added as needed. These indicators and performance measures are used during grant management processes, both for reporting progress to funders and for monitoring the performance of the organizations we fund. This assures a consistent state-wide substance abuse prevention, intervention, treatment and recovery system of care. This is an ongoing process, led by the SEOW and with the input of providers.

- f. Quality measures focus on consumer outcomes rather than care processes.

The performance measures support the indicators which are measures of overall statewide desired outcomes. Prevention programs funded by demonstration grants include an extensive evaluation component using a variety of tools and survey results. While the treatment programs' National Outcomes Measures (NOMS) show short

term outcomes for clients in treatment, ADAP is investigating in the use of a standardized tool for collecting more extensive and useful post treatment data. Still, ADAP relies heavily on research supported evidence-based programs and processes and uses process measures, such as fidelity to the model, in place of outcomes measures.

- g. Development of strategies to educate consumers and empower them to select quality services.

No strategies are currently implemented.

- h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.

See “e” above.

- i. The state has an evaluation plan to assess the impact of its purchasing decisions.

The state has a goal of developing program specific evaluation plans. At this time, evaluation capacity is limited and generally associated with specific demonstration grants.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

1 <http://www.samhsa.gov/ebp-web-guide>

2 <http://www.thecommunityguide.org/>

3 <http://www.asam.org/>

4 <http://innovation.cms.gov/initiatives/state-innovations/>

5 <http://www.samhsa.gov/grants/grant-announcements/sm-16-001>

Environmental Factors and Plan

4. Prevention for Serious Mental Illness

Narrative Question:

SMIs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.⁶⁷ The “Prodromal Period” is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.⁶⁸ In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.⁶⁹ The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.^{70 71} This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

****It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Please indicate areas of technical assistance needed related to this section.

⁶⁷ Larson, M.K., Walker, E.F., Compton, M.T. (2010). Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. Expert Rev Neurother. Aug 10(8):1347-1359.

⁶⁸ Fusar-Poli, P., Bonoldi, I., Yung, A.R., Borgwardt, S., Kempton, M.J., Valmaggia, L., Barale, F., Caverzasi, E., & McGuire, P. (2012). Predicting psychosis: meta-analysis of transition outcomes in individuals at high clinical risk. Arch Gen Psychiatry. 2012 March 69(3):220-229.

⁶⁹ Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J., Norman, R.E., Flaxman, A.D., Johns, N., Burstein, R., Murray, C.J., & Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. Nov 9;382(9904):1575-1586.

⁷⁰ van der Gaag, M., Smit, F., Bechdolf, A., French, P., Linszen, D.H., Yung, A.R., McGorry, P., & Cuijpers, P. (2013). Preventing a first episode of psychosis: meta-analysis of randomized controlled prevention trials of 12-month and longer-term follow-ups. Schizophr Res. Sep;149(1-3):56-62.

⁷¹ McGorry, P., Nelson, B., Phillips, L.J., Yuen, H.P., Francey, S.M., Thampi, A., Berger, G.E., Amminger, G.P., Simmons, M.B., Kelly, D., Dip, G., Thompson, A.D., & Yung, A.R. (2013). Randomized controlled trial of interventions for young people at ultra-high risk of psychosis: 12-month outcome. J Clin Psychiatry. Apr;74(4):349-56.

Footnotes:

Not applicable to SSA

Environmental Factors and Plan

5 Evidence-Based Practices for Early Intervention (5 percent set-aside)

Narrative Question:

P.L. 113-76 and P.L. 113-235 requires that states set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age.⁷² SAMHSA worked collaboratively with the NIMH to review evidence-showing efficacy of specific practices in ameliorating SMI and promoting improved functioning. NIMH has released information on Components of Coordinated Specialty Care (CSC) for First Episode Psychosis. Results from the NIMH funded [Recovery After an Initial Schizophrenia Episode \(RAISE\) initiative](#)⁷³, a research project of the NIMH, suggest that mental health providers across multiple disciplines can learn the principles of CSC for First Episode of Psychosis (FEP), and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. The CSC components emphasize outreach, low-dosage medications, evidenced-based supported employment and supported education, case management, and family psycho-education. It also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. Peer supports can also be an enhancement on this model. Many also braid funding from several sources to expand service capacity.

States can implement models across a continuum that have demonstrated efficacy, including the range of services and principles identified by NIMH. Using these principles, regardless of the amount of investment, and with leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state will be able to begin to move their system toward earlier intervention, or enhance the services already being implemented.

It is expected that the states' capacity to implement this programming will vary based on the actual funding from the five percent allocation. SAMHSA continues to provide additional technical assistance and guidance on the expectations for data collection and reporting.

Please provide the following information, updating the State's 5% set-aside plan for early intervention:

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.
2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.
3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.
4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.
5. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

Please indicate areas of technical assistance needed related to this section.

⁷² <http://samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf>

⁷³ http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm_source=rss_readers&utm_medium=rss&utm_campaign=rss_full

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:
Not applicable to SSA

Environmental Factors and Plan

6. Participant Directed Care

Narrative Question:

As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them through the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

As TA needs are identified, ADAP will request TA.

Footnotes:

Environmental Factors and Plan

6. Participant Directed Care

Vermont is not pursuing participant directed care at this time. We would, however, be interested in receiving information from states that have successfully implemented voucher systems including program scope, partners, processes, data system for monitoring the vouchers, and outcomes.

Environmental Factors and Plan

7. Program Integrity

Narrative Question:

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 USC § 300x- 55, SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for substance abuse, SAMSHA will release guidance imminently to the states on use of block grant funds for these purposes. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance abuse programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include:(1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?
2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?
3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:
 - a. Budget review;
 - b. Claims/payment adjudication;
 - c. Expenditure report analysis;
 - d. Compliance reviews;
 - e. Client level encounter/use/performance analysis data; and
 - f. Audits.
4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.
5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How does the state ensure block grant funds and state dollars are used for the four purposes?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

As TA needs are identified, ADAP will request TA.

Footnotes:

1 <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/vermont.html>

2 250% is maximum eligibility criteria for out of pocket savings for the Silver health care plan available through the Health Care Marketplace.

3 <https://www.healthcare.gov/glossary/federal-poverty-level-FPL/>

4 <https://portal.healthconnect.vermont.gov/VTHBELand/welcome.action>

Environmental Factors and Plan

7. Program Integrity

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?

The Vermont Department of Health (VDH), Division of Alcohol and Drug Abuse Programs (ADAP) is required to conform to the Vermont Agency of Administration's (AOA) Department of Finance and Management's policies and procedures to ensure financial operations are conducted uniformly and in accordance with established laws, executive orders, bulletins, regulations, and standards. These policies and procedures include, but are not limited to, US Office of Management and Budget Uniform Guidance compliance, sub-recipient monitoring, internal controls, contracting procedures, VISION accounting system management, external audit reporting, federal funds cash management, etc. These can be found on the AOA website at <http://aoa.vermont.gov/bulletins>

In addition to the policies and procedures listed above, ADAP has an established Substance Abuse Treatment Certification Rule. These rules are meant to implement the provisions of Title 8, Chapter 107, § 4089b (Health insurance coverage, mental health and substance abuse) and § 4099 (Applicability) of the Vermont Statutes Annotated (VSA). ADAP treatment program staff conduct regular standard adherence site visits that include client record review, fiscal management, human resources policies and procedures, rights of the person served, quality and appropriateness of services, screening and assessment, level of care standards, case management, on-going needs assessment requirements, utilization review, etc.

All ADAP sub-grants and contracts issued with Substance Abuse Block Grant dollars include general assurances language, such as:

- 45 CFR and 42 CFR compliance;
- The Grantee will comply with the Medication Assisted Therapy rules: (http://healthvermont.gov/reg/documents/opioid_dependence_rule.pdf)
- The provider must comply with the State of Vermont, Agency of Human Services Substance Abuse Treatment Certification Rule: (http://healthvermont.gov/reg/documents/substance_abuse_treatment_certification_rule.pdf)
- Attachment F, Agency of Human Services Standard Provisions Medicaid contract services language includes: Inspection of Records: Any contracts accessing payments for services through the Global Commitment to Health Waiver and Vermont Medicaid program must fulfill state and federal legal requirements to enable the Agency of Human Services (AHS), the United States Department of Health and Human Services (DHHS) and the Government Accounting Office (GAO) to: Evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed; and Inspect and audit any financial records of such Contractor or subcontractor.

2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?

Yes, the grant/contract agreements include mandatory compliance with federal and state regulations and procedures.

Examples:

Public Inebriate Program: The process of screening and determining appropriate placement for individuals meeting criteria for Incapacitation, due to either the intoxication or withdrawal from alcohol or other drugs, as defined in 18 V.S.A. Chapter 94. Results of the screening process may include individuals being referred for further medical assessment, alternative placements to incarceration, or placement within restrictive facilities.

Uncompensated Care: Grantee will provide clinical services as described in the Substance Abuse Treatment Certification Rule and approved through their organization's certification process. The Certification Rule is available electronically at:

http://healthvermont.gov/reg/documents/substance_abuse_treatment_certification_rule.pdf

45 CFR: The Vermont Department of Health is required to comply with 45 CFR, Part 96, Subpart L – Substance Abuse Prevention Treatment Block Grant. (<http://www.ecfr.gov/cgi-bin/text-idx?SID=75dbc359d207da390bc68bb25a8f431c&node=45:1.0.1.1.53&rgn=div5#45:1.0.1.1.53.12>)

In addition to compliance with 45 CFR, Part 96, Subpart L, the Grantee will also provide the following:

Specifically, Grantee accepts that notwithstanding the need to provide services to persons in crisis (persons in danger to self or others), persons seeking treatment assistance will be scheduled for their first face-to-face treatment services within five (5) working days of the request for assistance except when the program is at capacity.

Expectations are pregnant injecting drug users and pregnant women must be given preference for admission. They are to be seen within 48 hours of initial contact. If unable to provide services to this population then the Treatment Chief (ADAP) needs to be notified immediately.

In the event of a waiting list, the provider shall give preference for admission to the following clients, in order of priority:

6. Pregnant injecting drug users
 7. Pregnant substance abusers
 8. Injecting drug users
 9. All other substance abusers
3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:

- a. Budget review: Annually, providers review and discuss the State’s proposals for service with the ADAP Program and Operations staff. These proposals include budgets tied to levels of client service, evidence based practices and capacity management. The budgets as well as the service levels are weighed against prior year levels of funding, service delivery/utilization and needs assessment analysis. This determines continued funding, and the level at which that funding will continue.
- b. Claims/payment adjudication;

Because Vermonters are increasingly covered by insurance, Vermont has redefined the use of block grant funds for treatment for the fiscal year 2016 grants. In the past, Vermont relied on a utilization based system to allow providers to served uninsured clients. Those definitions have now been updated as shown below.

The mandatory activities described below must be provided throughout the full grant period. The optional/suggested activities may be performed if all mandatory requirements are being fulfilled. The Grantee’s approach to providing the mandated and, if applicable, optional activities described below can include, but are not limited to, a Fee for Service – rate based approach or the funding of full time employees (FTEs) responsible for fulfilling the activities.

Mandatory Clinical Service Activities

- 1. Uncompensated care
 - a. Grantee will provide clinical services as described in the Substance Abuse Treatment Certification Rule and approved through their organization’s certification process. Certification rule is available electronically at: http://healthvermont.gov/regs/documents/substance_abuse_treatment_certification_rule.pdf
 - b. The Grantee is required to demonstrate due diligence in assisting the client in acquiring appropriate insurance in a timely fashion.
 - c. Grantee must ensure that Substance Abuse Treatment Block Grant funds are the payer of last resort for direct clinical treatment services.
- 2. Grantee will link clients to health insurance and assist clients in maintaining insurance coverage.
- 3. Grantee will ensure clients successful transition between clinically appropriate levels of care.
- 4. Grantee will provide clinical supervision to all direct service staff.
- 5. Grantee will participate in the following quality improvement activities:
 - a. Activities that support VDH/ADAP priority areas:
 - i. Substance abuse treatment engagement;

- ii. Social supports;
 - iii. Performance measures included in the grant agreement;
 - iv. Performance measures and indicators included on the state scorecard
http://healthvermont.gov/hv2020/dashboard/alcohol_drug.aspx;
- b. Activities to support VDH/ADAP Program Approval Certification in accordance with the Substance Abuse Treatment Certification Rule.
6. Grantee will maintain and manage a waitlist.
 7. Grantee will provide interim services for clients on the waitlist.
 8. Grantee will participate in VDH/ADAP initiatives and activities.
 9. Grantee will provide support for administrative and data system needs associated with VDH/ADAP data collection and reporting requirements.

Optional/Suggested Activities

1. Grantee may pursue NCQA Specialty Program certification
2. Grantee may attend training associated with VDH/ADAP requirements. These may include training(s) for evidence-based programing.
3. Grantee may assist clients in finding and retaining housing.

For purposes of uncompensated care, this is Vermont’s definition of an uninsured client: In order for a client to be considered to be “uninsured”, the following criteria must be met and documented in the client files:

1. Client is not receiving and is not eligible to receive Medicaid at the time services are provided.
2. Client family income is greater the Medicaid and CHIP Eligibility Levels¹ and less than 250%² of the Federal Poverty Level (FPL)³
3. Client is not covered by other 3rd party payer at the time services are provided.
4. Client has Medicare insurance (excluding dually eligible Medicaid/Medicare or Medicare/other 3rd party) unless the provider meets the requirements to allow Medicare billing.
5. Client has Tricare insurance and the services provided are not eligible for coverage when provided by the ADAP provider.
6. Documented review of insurance eligibility and coverage occurs at intake and at least once per month but ideally with each visit, consistent with other forms of medical treatment.
7. Clients may not be considered “uninsured” indefinitely. Providers must assist clients in accessing health insurance through the Health Exchange⁴
 - a. Clients who were eligible to apply for coverage prior to receiving substance abuse treatment at the provider facility but did not do so are required to apply for coverage through the health exchange during the first available enrollment period and whenever there is a qualifying life event. The enrollment dates and life events are available on the Vermont

Health Connect

website. <http://info.healthconnect.vermont.gov/QualifyingEvents>

- b. Documentation must be maintained by provider in the client file that shows:
 - i. The client was informed of these requirements.
 - ii. The client understands that refusal to enroll and/or maintain coverage means they will become a self-pay client and are no longer eligible to receive state-subsidized care.
 - iii. The documentation includes both provider and client signatures verifying that these conditions are understood and have been met.
- c. In the event a client refuses to apply for and/or maintain health insurance, providers may discontinue provision of services. This process must allow a safe transition from care (i.e. appropriate titration from medication assisted treatment, referrals to recovery centers and self-help groups, etc.) over a time not to exceed the medically appropriate time necessary from end of the first open enrollment period or the first qualifying life event. ADAP will continue to subsidize care during the transition period.
8. Providers must have a process to collect required co-pays and deductibles.
9. It is the responsibility of the provider to document client insurance status. Providers must also document continuing work with clients related to access and retention of health insurance.
10. Providers must have the ability to provide documentation verifying uninsured status upon request of ADAP.
11. Providers must maintain and update a sliding fee scale based on the federal poverty index.

Medicaid: In addition to direct services to uninsured, ADAP oversees Medicaid used by all Preferred Providers for utilization and adherence to Medicaid standards. Medicaid claims are processed through the Division of Vermont Health Access (DVHA), Vermont's Medicaid division. Record reviews of select clients are completed during annual site visits to verify compliance with appropriate treatment protocols and billing standards. If discrepancies are discovered, ADAP takes action to recoup funds and requires corrective action. ADAP works directly with DVHA and the provider to resolve Medicaid claims issues.

In addition to direct treatment services, ADAP vendors provide indirect services for which other reporting and monitoring methods are required. These methods are specific to the type of service being provided and may range from the simplicity of an annual program report to monthly reporting of services provided. Reporting requirements are outlined within the grants and in order to process payments, all documentation and services required must be received.

- c. Expenditure report analysis;

Providers are required to submit quarterly financial reports showing expenditures for the current period and year to date measured against the annual budget of the grant. Each of

these documents is reviewed as it comes in to determine if appropriate expenditure levels are being maintained.

d. Compliance reviews;

Including the ADAP Substance Abuse Treatment Certification Rule standards referenced in Question #1; the Vermont Department Health has an established Sub-recipient Monitoring Policy with compliance thresholds that include Office of Management and Budget Uniform Guidance requirements, A-133 requirements, sub-recipient monitoring site visits and fiscal/program monitoring reporting.

All FY16 ADAP grants/contracts include performance measures tied to payment and include the following language in the payment provisions, "Payment of invoices is contingent upon the timely receipt, review and approval of required reporting in Attachment A of this document. Incentive payments are contingent upon the meeting and/or exceeding of the Performance Indicators as outlined in Attachment A of this document."

e. Client level encounter/use/performance analysis data; and

Please see b. above. Analysis of both uninsured and Medicaid claims is completed by ADAP personnel. This information is used in summarizing client mix, reporting per client costs, and calculating performance measures.

f. Audits.

Under the auspices of the auditor of accounts, the State of Vermont is audited annually for fiscal and program integrity. This Uniform Guidance/A-133 audit is conducted by an external auditing firm with the results posted on the Vermont Auditors website <http://auditor.vermont.gov>. On a regular basis this audit also looks at some of the major programs within state government in greater detail. The Substance Abuse Block Grant is periodically chosen for that detailed level examination.

4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.

Vermont's grant and contract standard templates include deliverables and payment provisions that outline the agreement between the State and the provider as to the capacity levels, evidence-based practices to be implemented and delivered, what payment structures will be used to pay for the services (i.e. Medicaid, block grant, other), and how those payments will be rendered to the vendor.

5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?

ADAP assists providers in adopting practices that promote compliance with Vermont's Substance Abuse Treatment Certification Rules through an oversight process that involves yearly program site visits. The visits identify areas such as quality and safety that require a performance improvement project in order to be in compliance with the standards set forth by the state. Once the areas for improvement are identified the state works with the provider to prioritize planning needs to implement the performance improvement plans. If the provider does not feel it has the expertise or resources to implement a plan the state offers technical assistance.

6. How does the state ensure block grant funds and state dollars are used for the four purposes?

All grants clearly describe the services that are to be provided. ADAP provides grants that address all four purposes. They are: services for those without insurance; services not provided by Medicaid and/or Medicare and private insurance for low income individuals that demonstrate success in improving outcomes and/or support recovery; primary prevention services for persons not identified as needing treatment; collection performance and outcome data to determine ongoing effectiveness of services and to plan the implementation of new services.

Prevention grants and contract work plans are reviewed and approved prior to payment and work is monitored thru quarterly narrative and National Outcome Measures (NOM's) reports. Treatment records reviews are conducted during annual site visits where the appropriateness of the use of funds is verified.

Recovery services are also monitored through quarterly reports and data submissions.

Footnotes:

¹ <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/vermont.html>

² 250% is maximum eligibility criteria for out of pocket savings for the Silver health care plan available through the Health Care Marketplace.

³ <https://www.healthcare.gov/glossary/federal-poverty-level-FPL/>

⁴ <https://portal.healthconnect.vermont.gov/VTHBELand/welcome.action>

Environmental Factors and Plan

8. Tribes

Narrative Question:

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the [2009 Memorandum on Tribal Consultation](#)⁷⁴ to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.
2. Describe current activities between the state, tribes and tribal populations.

Please indicate areas of technical assistance needed related to this section.

⁷⁴ <http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president>

Please use the box below to indicate areas of technical assistance needed related to this section:

No applicable to Vermont SSA.

Footnotes:

Vermont does not have any federally recognized tribes.

Environmental Factors and Plan

9. Primary Prevention for Substance Abuse

Narrative Question:

Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.
- Education builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.
- Alternatives provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- Problem Identification and Referral aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment.
- Community-based Process provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning
- Environmental Strategies establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.

States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- Universal: The general public or a whole population group that has not been identified based on individual risk.
- Selective: Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated: Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data-driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs.

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or an equivalent planning model that encompasses these steps:

1. Assess prevention needs;
2. Build capacity to address prevention needs;
3. Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;
4. Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and
5. Evaluate progress towards goals.

States also need to be prepared to report on the outcomes of their efforts on substance abuse- related attitudes and behaviors. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data driven substance abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

Please consider the following items as a guide when preparing the description of the state's system:

1. Please indicate if the state has an active SEOW. If so, please describe:
 - The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
 - The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
 - The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).
2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. Please describe if the state has:
 - a. A statewide licensing or certification program for the substance abuse prevention workforce;
 - b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
 - c. A formal mechanism to assess community readiness to implement prevention strategies.
5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.
7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.
8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.
9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?
10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

No areas of technical assistance needed are identified at this time, but as these needs emerge ADAP will submit requests to the Center for the Application of Prevention Technology.

Footnotes:

Environmental Factors and Plan

9. Primary Prevention for Substance Abuse

Please consider the following items as a guide when preparing the description of the state's system:

1. Please indicate if the state has an active SEOW. If so, please describe:

- The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
- The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
- The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).

Vermont has a robust and highly functioning State Epidemiological Outcomes Workgroup (SEOW). The SEOW has regularly examined and analyzed all data relevant to substance use/abuse in Vermont, including data from the Youth Risk Behavior Survey (YRBS), National Survey on Drug Use and Health (NSDUH), the Vermont Behavioral Risk Factor Surveillance Survey (BRFSS), hospital discharge data, motor vehicle crash data, Young Adult Survey (YAS), National College Health Assessment, in Vermont titled the VT College Health Survey, and law enforcement data. These tools allow the state to collect data by age, race, ethnicity and geographic region. Vermont is particularly fortunate in that 122 out of 124 public middle schools and 65 out of 67 public high schools participate in the Vermont Youth Risk Behavior Survey, with a high student participation rate. This allows for the development of data profiles by school supervisory union.

2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.

Based on the analysis of these data, the SEOW has determined that the following priorities should be the primary (though not exclusive) focus of prevention efforts throughout the State:

1. Reduce underage drinking
2. Reduce high risk drinking among those under 25
3. Reduce marijuana use among those under 25
4. Reduce the misuse of prescription drugs (based on treatment demand)

SABG funds are allocated based on these priorities.

Although prevalence point estimates of substance use do not vary significantly across regions or counties, state and community planners have access to VT YRBS profiles that identify where their county stands on these priorities: either better than, worse than or consistent with the state average. For example, Windham County has a significantly higher rate of student use of marijuana and misuse of prescription drugs than the state average (based on 2013 YRBS data).

The state employs a combination of both equity and competitive funding strategies. On those programs where a competitive process is used to allocate funds, needs assessment data is always factored into the selection criteria.

In addition, the state has increased the allocation of SABG funds to high need populations such as young adult high risk drinkers.

3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?

The goal of the ADAP Prevention Consultant System is to increase the local communities' capacity to lead and carry out effective substance abuse prevention initiatives. The Prevention Consultant (PC) system is the one system through which technical assistance on substance abuse prevention is made available around the state. There are 10 Prevention Consultants who serve the Health Department's 12 District Offices, the agencies, community coalitions, organizations, and individuals within those Districts on a variety of core substance abuse issues, as well as ensure use of the strategic prevention framework process across the state.

The goal of increasing local and regional capacity is accomplished by the PC system through the delivery of five essential services:

- Community Organizing
- Program Planning & Consultation
- Presentations & Training
- Community Grants Information & Guidance
- Information & Referral

The PCs' work plans outline a core set of services available region to region and are related to each of their major job duties and performance expectations. The Prevention Consultants major job duties are organized by the IC&RC standard domains of planning and evaluation; education & skill development; community organization; public policy & environmental change; professional growth & development.

A core team of ADAP Prevention Consultants participated in the Substance Abuse Prevention Skills Training (SAPST) Training of Trainer (TOT) in the summer of 2013, and the remainder of PC's and central office prevention staff completed the training in December of 2014. The core team will be responsible for delivering the SAPST training in Vermont for sub-recipient grantees and ADAP prevention staff into FY15/17, with the SAPST TOT available to train and equip state staff and providers 1-2 times each fiscal year depending upon need. This training increases skills and knowledge to the field of prevention and is a key component of our Workforce Development plan.

Current community-based substance abuse prevention grantees with staff who have not participated in the SPF-SIG or addictions training will participate in the "Basics of Prevention" course which is available yearly through access via a web portal provided by the Center for the Application of Prevention Technology (CAPT), and the SAPST course that is offered yearly in Vermont and completion of the course is a requirement of funding in Vermont.

At the time of the last application, planning was just starting on the development of prevention workforce standards to be completed in FY14. The Center for the Application of Prevention Technology (CAPT) assisted us in assessing and updating our direction with workforce development standards. ADAP staff reviewed information from 3 states regarding their system, including one that has prevention certification, one that has a blended model and one that does not have certification. From this research, recommendations were developed that include making the Substance Abuse Prevention Skills Training, or SAPST, available in Vermont. ADAP has required that all prevention staff be required to complete the course by the end of FY 14, and established an in-state training team mentored by CAPT associates to develop internal capacity for providing the training using existing staff. Since FY 14, the SAPST course has been held twice with all ADAP staff trained, as well as 19 substance abuse providers. The SAPST is an entry level training designed to cover the basics of the Strategic Prevention Framework. "Prevention Works! VT" is a statewide coalition of coalitions and yearly organizes a stakeholder training education event called "Prevention Day" to be held each April. The focus of the most recent Prevention Day was networking, results-based accountability, brain research and the negative health effects of marijuana. The benefits of this training education event will be extended into FY15/15, and is expected to stimulate enhanced programming and new stakeholder organized prevention initiatives for the fiscal year.

4. Please describe if the state has:

- a. A statewide licensing or certification program for the substance abuse prevention workforce;
- b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
- c. A formal mechanism to assess community readiness to implement prevention strategies.

Vermont has no formal licensing or certification program for the substance abuse prevention workforce. Regional substance abuse consultants do have the option of pursuing IC&RC Prevention Specialist certification in NH or Connecticut. To date two PC's have been certified. In addition to the training and TA system described above the Department of Health conducts workforce development needs assessments with all department staff, based on the domains of public health, and provides training in areas of high need identified through that assessment. ADAP staff can access that training. ADAP also contracts with a statewide workforce development organization, the Center for Health and Learning, to provide skill-development opportunities to Partnership for Success sub-recipients. These opportunities are opened to the entire prevention workforce. Lastly, ADAP has recently completed an assessment of workforce development needs across the continuum, from prevention through recovery, a process expected to inform future investments in workforce development.

The 10 regionally based Prevention Consultants (PC) are highly trained in community readiness and mobilization including assessing community readiness to implement prevention strategies. Our formal mechanism is the Strategic Prevention Framework (SPF) and all PC's utilize the readiness assessment tools provided by our Center for the Application of Technology (CAPT) which may include the Stages of Community Readiness (Edwards, et al), meeting with community leaders to identifying resources, resource gaps, cultural competency considerations and levels of readiness at each stage of the prevention strategy.

5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?

ADAP has approached the selection of evidence-based programs, policies and practices to be implemented in Vermont by developing state-level logic models that reflect: a) the infrastructure necessary to support these activities, and b) the key risk factors and recommended interventions for addressing the above priority substance abuse outcomes for the state. The Pacific Institute for Research and Evaluation (PIRE) completed these models in 2013 in consultation with ADAP staff and stakeholders. The models were also developed in consultation with the Strategic Prevention Enhancement Policy Consortium, as well as a review of the most recent comprehensive literature reviews, including guides published by federal agencies, and federally-sponsored registries for specific examples of evidence based practices and programs.

PIRE met with key ADAP staff, statewide partners (law enforcement, Department of Liquor Control, Agency of Education, etc.) and the Evidence-based Practice Workgroup to review which interventions from the logic models should be included on the final menu of options for community-level implementation. Interventions were included in the menu if they were: 1) not already being implemented statewide by a partner agency; 2) they had been empirically shown to impact drinking related behaviors at the population level; and 3) they are feasible to implement in Vermont communities. Additional strategies were included as complementary or supporting activities/strategies if they were recommended by partner agencies as supporting statewide strategies currently underway, or if they have been shown to affect one or more intervening variables or have theoretical support for their effectiveness in addressing drinking related behaviors. A similar process was completed for the selection of interventions to address marijuana and other illicit drugs, with the strategies to reduce the misuse of prescriptions drugs having been identified by the Vermont Prescription Drug Abuse Workgroup. These include educating the community about proper storage and safe disposal of unused prescription drugs, publicizing permanent safe drop off, promoting Vermont's Most Dangerous Leftover media campaign, and supporting media advocacy resulting in earned media. Also, activities focused on pharmacists and prescribers include providing them with information on proper storage and safe disposal of unused prescription and over the counter drugs, promotion of Vermont's Most Dangerous Leftover media campaign, working with pharmacists to share specific information regarding caution in using controlled substances with patients when such medications are purchased, and working collaboratively with statewide organizations who are providing training and education to pharmacists, doctors, and dentists around prescribing practices, drug education and disposal.

6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.

Vermont's substance abuse prevention services are guided by Healthy Vermonters 2020 Goals identified earlier in this application, Vermont's Health Improvement Plan, the Agency of Human Services Strategic Plan, the Vermont Department of Health Strategic Plan, and the Alcohol and Drug Abuse Programs Strategic Plan 2012 – 2017, which is attached to this application. Note that allocation of SABG prevention set-aside funds are most specifically driven by the following ADAP Strategic Directions:

2.1Prevention: Ensure that basic primary substance abuse prevention is aligned with wellness and health reform processes, structures, programs and services.

2.1.1 Sustainable community-level infrastructure – Identify and support sustainable community-level approaches and strategies that promote evidence-based practices and understanding of addictions.

2.1.2 Integration and Alignment – Support increased alignment of the community-level substance abuse prevention system with the Treatment System, BluePrint for Health, Primary Health Care, and community level entities to advance evidence-based practices and understanding of addictions.

For example, a priority for investment of SABG prevention set-aside resources is capacity-building with stable community organizations most likely to be sustained over the long term.

7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.

The state has an evidence-based workgroup that informs selection of funded prevention strategies. It is our intention to revitalize the group as part of our SABG and Partnership for Success strategy. Representation from the SEOW, the Pacific Institute on Research and Evaluation (PIRE), community practice experts and the office of Local Health will continue to be recruited for this workgroup.

Our method for ensuring primary substance abuse prevention services are coordinated is collaboration and coordination with key state partners including but not limited to the Department of Health's Divisions of Maternal and Child Health, Health Promotion and Disease Prevention, and the Departments of Mental Health, Liquor Control, Public Safety, and the Agency of Education (AOE). In addition, ADAP is informed by the Vermont Alcohol and Drug Abuse Advisory Council (VADAAC), which includes representatives from health care, education, youth services, law enforcement, treatment and recovery. VADAAC provides regular feedback on ADAP initiatives. In addition state partners share funding strategies with each other via face to face networking sessions, electronic updates and sharing of program plans.

8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.

The state intends to fund the following services, based on need, capacity, and readiness described above, and Vermont legislative requirements:

- Environmental Strategies, such as: Education on Policy Approaches, Community Mobilization, Media Advocacy, Restricting Outlet Density; Social Marketing, and Enhanced Local Enforcement strategies such as Saturation and Party Patrols. As described above the SSA is developing a menu of allowed interventions among which community organizations select based on their own local process employing the Strategic Prevention Framework (SPF). In FY16/17 SABG funds will support a social marketing campaign targeting binge drinking young adults, ages 21-25.
- Problem Identification and Referral: Individual-based strategies such as eCHECKUP to go for alcohol and marijuana, training and technical assistance on evidence-based Screening and referral for school-aged youth.
- Education: School and family-based educational programs such as: evidence-based health curricula (e.g. Alcohol EDU), school staff and youth training; educational support groups, family education (Nurturing Parent Program, Guiding Good Choices and Active Parenting).
- Information Dissemination: Vermont Alcohol and Drug Information Clearinghouse provides print and electronic information to ADAP providers and the general public about alcohol and other drugs, signs and symptoms, prevention and treatment, and community resources. ADAP staff manage ADAP's ParentUp website and social media campaign to increase parent awareness of their influence whether or not their child uses alcohol or other drugs. Our Parent UP website has been revised to include all substances and action steps parents can take to increase their influence on their child and youth. See <http://parentupvt.org/>.
VDH has an active website that posts informational fact sheets on prescription drugs, alcohol, marijuana and other drug effects. Our website also posts all national awareness months, such as Alcohol Awareness Month, Alcohol Screening Day, Drug Facts Week, Recovery Month and links to NIDA materials and tool kits. See <http://healthvermont.gov/adap/adap.aspx> and <http://healthvermont.gov/adap/prevention/Prevention.aspx>.
- Community-based Process: Utilizing the Strategic Prevention Framework (SPF), PC's, together with community partners, gather and analyze data, assess capacity and readiness, develop logic models and strategic plans, ensure implementation with fidelity and utilize process and outcome evaluation results to improve strategy outcomes. Youth leadership groups that focus on policy, education and substance free opportunities are a vital component of the community-based process. The PC's provide technical assistance to all communities utilizing the SPF model and also provide training and networking activities with traditional and non-traditional partners.
- Alternatives: Through the education on alcohol policy being done at the regional and community level, the outcome of such work has produced town and county festivals with

no access to alcohol, as well as, provided opportunities for youth to participate in activities that are substance free through youth leadership groups.

9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?

Both program planning and monitoring of business practices are designed to clearly identify what programs are funded by the SABG versus other funding streams. For example, Vermont's Combined Community-Based Grants Program is supported by the SABG, Vermont's School-based Substance Abuse Services grants are state supported, and both are separate from the Partnership for Success. Where appropriate, however, all prevention grantees have been included in training opportunities funded through the Partnership for Success as a key opportunity for leveraging multiple funding opportunities. Regional Prevention Consultants and Coordinators are SABG supported.

10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?

National Outcome Measures (NOM's) as well as participant satisfaction are collected on funded prevention strategies. In addition, data is collected through the review of grantee work plans, progress reports, quarterly conference calls, and site visits. Specific datasets are included in the Department's Performance Dashboard as described in this application. Process data will be regularly reviewed to assess reach and quality of implementation, including fidelity to evidence-based strategies, collaborative partnerships, and outreach to youth.

11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

The Health Department performance management framework is integrated with the State Health Assessment, State Health Improvement Plan, outcomes-based legislation (Act 186), and core departmental operations. This work is overseen by the Performance Improvement Manager and the cross-divisional Performance Management Committee.

As part of a larger performance management framework, the Healthy Vermonters 2020 performance management system brings together population health data at statewide and local levels as well as program performance data. Vermont's online performance management system was noted as an Area of Excellence by the PHAB Accreditation Committee. The novel Healthy Vermonters 2020 performance management system utilizes two web-based software solutions to support transparent, accessible, data-driven decision making. This publicly available system holds the Health Department accountable for its strategies to improve health outcomes (<http://healthvermont.gov/hv2020/>). The comprehensive system is built around Healthy People 2020 priorities and creates a results-oriented frame for public health work. Composed of thematic Scorecards to track performance and geographically-focused Maps and Trends reports, the system utilizes Results Scorecard and InstantAtlas software. The Scorecard components

also display program performance measures to help staff track how well their work contributes to those population indicators. To facilitate local-level decision making, the Maps & Trends pages disaggregate the indicators into three relevant regional geographies.

Substance abuse primary prevention outcomes being collected are the following:

1. Percent of adolescents in grades 9-12 who reported ever using a prescription drug without a prescription (Youth Risk Behavior Survey (YRBS) data source)
2. Percent of persons 12 and older who misused a prescription pain reliever in the past year (National Survey on Drug Use and Health (NSDUH) data source)
3. Percent of persons 12 and older reporting 30-day prescription drug misuse and abuse (NSDUH)
4. Percent of adolescents (12-17 years) binge drinking in the past 30 days (YRBS)
5. Percent of adolescents in grades 9-12 who drank alcohol in the past 30 days (YRBS)
6. Percent of adolescents in grades 9-12 who use marijuana in the past 30 days (YRBS)
7. Perception of parental or peer disapproval/attitude (NSDUH state estimate and YRBS for HS students)
8. Perceived risk/harm of use (NSDUG state estimate, YRBS for HS students and Young Adult Survey (YAS) for young adults)
9. Alcohol and/or drug-related car crashes, fatalities and injuries (Dept. of Transportation NHTSA data and VT State Police Crash Analysis database)
10. Alcohol and drug related crime (Uniform Crime Reports and VT Criminal Information)
11. Alcohol and prescription drug-related emergency room visits (VT Uniform Hospital Discharge Data Set)

All data will be analyzed by the State Epidemiology Outcomes Workgroup (SEOW) and utilized to assess progress. This analysis will include recommendations for improvements, modifications, expansion and/or change to evidence-based strategies, dosage of strategies, coverage of population and impact on special populations.

Please indicate areas of technical assistance needed related to this section.

No areas of technical assistance needed are identified at this time, but as these needs emerge ADAP will submit requests to the Center for the Application of Prevention Technology.

Environmental Factors and Plan

10. Quality Improvement Plan

Narrative Question:

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

In an attachment to this application, states should submit a CQI plan for FY 2016-FY 2017.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:
As TA needs are identified, ADAP will request TA.

Footnotes:

Environmental Factors and Plan

10. Quality Improvement Plan

In an attachment to this application, states are asked to submit a CQI plan for FY 2016-FY 2017.

Accreditation

The Public Health Accreditation Board (PHAB) awarded five-year accreditation status to the Vermont Department of Health on June 18, 2014. With accreditation, the Health Department is demonstrating its commitment to improving and protecting the health of Vermonters and advancing the quality of public health services nationally. The process has allowed our department to assess our strengths and identify areas for improvement in order to continue to improve the quality of our services and performance.

The Public Health Accreditation Board's standards and measures provide a means for the department to continually assess its effectiveness in delivering the ten essential public health services. Health Department services that will be enhanced from this funding opportunity align with accreditation Domain 7, which focuses on the promotion of strategies to improve access to health care services.

Performance Management

In 2010, the Health Department was awarded a National Public Health Improvement Initiative cooperative agreement from the Centers for Disease Control and Prevention. This grant accelerated a movement already underway to increase performance accountability in Vermont. As of 2015, the Health Department has become a leader within state government in the implementation of performance management. Currently, the Health Department performance management framework is integrated with the State Health Assessment, State Health Improvement Plan, outcomes-based legislation (Act 186), and core departmental operations. It functions at the program, organization, and system level to ensure the Health Department is using performance data to improve the public's health. This work is overseen by the Performance Improvement Manager and the cross-divisional Performance Management Committee.

The performance management framework includes six components that guide performance management at the Health Department.

- 1) Population health status accountability and strategic planning set direction and identify outcomes.
- 2) Program performance accountability quantifies and reports how Health Department programs are functioning.
- 3) Public Health Stat is an internal management process facilitated by the Performance Improvement Manager that promotes data-driven decision making, relentless follow through, and a focus on accountability. This engages managers at all levels in developing

and owning solutions that are data-driven with an eye toward achieving efficiencies that will positively impact health outcomes.

- 4) Continuous quality improvement through the Agency Improvement Model, a Plan-Do-Study-Act cyclical process improvement model.
- 5) Performance-based budgeting to ensure sub-grants and subcontracts are aligned with public health priorities.
- 6) Staff and workforce performance to promote individual understanding and alignment with department outcomes.

Performance management was noted as an Area of Excellence by the PHAB Accreditation Committee, in specific, the Healthy Vermonters 2020 performance management system and Public Health Stat.

Scorecards

As part of a larger performance management framework, the Healthy Vermonters 2020 performance management system brings together population health data at statewide and local levels as well as program performance data. Vermont's online performance management system was noted as an Area of Excellence by the PHAB Accreditation Committee. The novel Healthy Vermonters 2020 performance management system utilizes two web-based software solutions to support transparent, accessible, data-driven decision making. This publicly available system holds the Health Department accountable for its strategies to improve health outcomes (<http://healthvermont.gov/hv2020/>). The comprehensive system is built around Healthy People 2020 topic areas and creates a results-oriented frame for public health work. Composed of thematic Scorecards to track performance and geographically-focused Maps and Trends reports, the system utilizes Results Scorecard and InstantAtlas software. Each component displays 121 Healthy Vermonters indicators – the measures of population health status that constitute State Health Assessment priorities. The Scorecard components also display program performance measures to help staff track how well their work contributes to those population indicators. To facilitate local-level decision making, the Maps & Trends pages disaggregate the indicators into three relevant regional geographies. Together, this data-rich resource has had over 5,000 unique page views from internal and external stakeholders.

The Healthy Vermonters 2020 performance management system is used to promote accessible data display, consistent and responsive systems, accreditation readiness, transparency, and responsiveness to Community Health Needs Assessment (CHNA) requirements. The system supports accountability by directly linking population health status and ongoing health department work. Linking the outcomes to work, regardless of program title or funding, helps support transparency and understanding in stakeholders in and outside of government. Using this, managers provide narrative context for population indicators and program performance measures that offer interpretation of the data, lists partners, cites evidence-based strategies, creates action plans, and links to additional resources. Providing this across priority health topics in a consistent, data-centric platform is more meaningful and comprehensive than what has previously been available on the Health Department's website and has been critical to the success of the Health Department's performance management process.

Public Health Stat

The department received commendation from the Accreditation Committee on our ability to use and present data and track performance through the use of an online performance management system and the Public Health Stat process. Public Health Stat is an internal management process facilitated by the Performance Improvement Manager that promotes data-driven decision making, relentless follow through and a focus on accountability. Every month key department decision-makers and stakeholders come together to do cross-divisional program planning and resource allocation around one of six high priority, department-wide goal. The meetings engage managers at all levels in developing and owning solutions that are data-driven with an eye toward achieving efficiencies that will positively impact health outcomes. In 2015 ADAP's Public Health Stat has focused on the priority of reducing youth and young adult marijuana prevalence. This has promoted a department wide focus on planning practice and policy improvements aimed at improving marijuana outcomes among this population. As noted in the planning section of this application, this is a high need area for our state and this Stat will inform the allocation of block grant resources, moving forward.

Quality Improvement Plan

The mission of the Vermont Department of Health is “to protect and promote optimal health for all Vermonters.” To carry out this mission, the department must ensure that services are delivered as effectively and efficiently as possible. The Health Department's *Quality Improvement Plan*, uploaded separately as requested, describes the department's efforts to build capacity and improve health outcomes. This plan covers:

- The department's Performance Management Framework
- How the department identifies improvement opportunities
- How the department ensures identified goals are met
- The department's approach to making change through quality improvement efforts
- Evaluation and revision of the Quality Improvement Plan

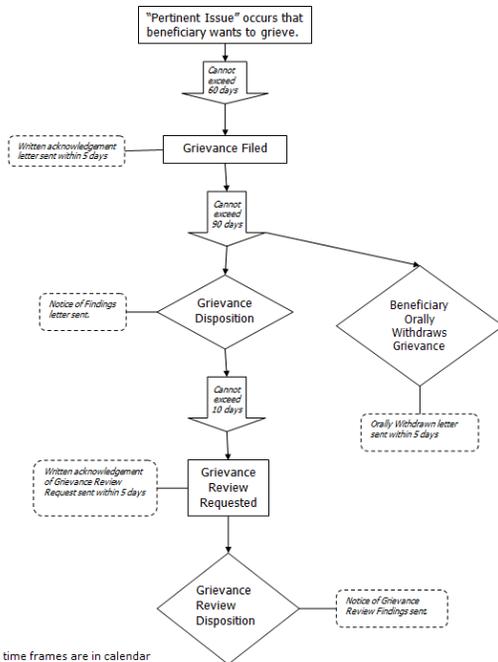
The *Quality Improvement Plan* is global in nature and does not delve into detail on every element making up the plan. In several instances, it is supplemented by additional plans and procedures, e.g., in the areas of emergency response, critical incidents, and complaints and grievances. The Vermont Department of Health's emergency response plan, called the “Continuity of Operations Plan”, or COOP, ensures that all mission-essential functions continue in the event of a utility failure, natural disaster, significant hazardous material incident, civil disturbance, or terrorist or military threat or attack. This plan is tested regularly and was most recently used to respond to a potential Ebola threat.

Furthermore, ADAP-funded treatment providers are required to maintain their own emergency response, critical incidents, and complaints and grievances processes as outlined in the Substance Abuse Certification Rules. ADAP personnel make regular site visits with providers to ensure that funding and service protocols are consistent with these standards and assurances. Current standards are available on our website at:

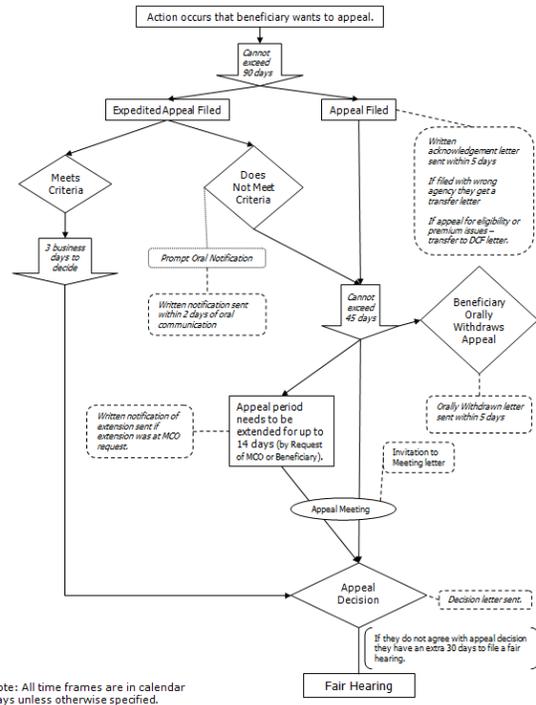
http://healthvermont.gov/reg/documents/substance_abuse_treatment_certification_rule.pdf

All Medicaid and uninsured clients have ADAP providing and overseeing the complaint and grievance process which follows a standard procedure for all beneficiary complaints and grievances as illustrated below:

Grievance Flow Chart



Appeal Flow Chart



In addition, ADAP investigates and responds to complaints around substance abuse credentialed counselors statewide. The process is outlined at the cited link:

<https://www.sec.state.vt.us/professional-regulation/file-a-complaint.aspx>

Please indicate areas of technical assistance needed related to this section.

We have no identified technical assistance needs at this time.

Environmental Factors and Plan

11. Trauma

Narrative Question:

Trauma⁷⁵ is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems⁷⁶. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing “business as usual.” These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed approach consistent with “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach”.⁷⁷ This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma⁷⁸ paper.

Please consider the following items as a guide when preparing the description of the state’s system:

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?
2. Describe the state’s policies that promote the provision of trauma-informed care.
3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

Please indicate areas of technical assistance needed related to this section.

⁷⁵ Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.*

⁷⁶ <http://www.samhsa.gov/trauma-violence/types>

⁷⁷ <http://store.samhsa.gov/product/SMA14-4884>

⁷⁸ *Ibid*

Please use the box below to indicate areas of technical assistance needed related to this section:

As TA needs are identified, ADAP will request TA.

Footnotes:

Environmental Factors and Plan

11. Trauma

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?

ADAP recently updated the Substance Abuse Treatment Guidelines, effective April 1, 2015, for Vermont. As with the previous standards, the new standards require that a trauma history is documented in the assessment, using an evidence-based screening tool to establish a score, and are conducted in all providers and hubs. ADAP requires that a client centered and client directed treatment plan with specific time limited treatment goals are developed with full client participation. If, as a result of the assessment, a trauma history is incorporated into a treatment goal, the provider system is required to appropriately address this specific treatment need. See the Guidelines relating to History of Trauma, section 16.2.11, p. 27 <http://healthvermont.gov/adap/treatment/documents/SubstanceAbuseServicesGuidelines.pdf>.

ADAP is also available and has provided TA for those agencies that need more education on best practice as it relates to providing trauma informed services. ADAP continues to encourage that Stephanie Covington's "Beyond Trauma" curriculum is used in programs working with these survivors. In addition to this, ADAP sponsored trainings to support the inclusion of *Seeking Safety* and author Lisa M. Najavits came to present.

2. Describe the state's policies that promote the provision of trauma-informed care.

Vermont's Agency of Human Services' (AHS) policy Trauma Informed System of Care has been effective since 2008 to ensure that client interactions are respectful of and sensitive to trauma. And specifically, the AHS will work to assure the provision of trauma-informed services by identifying and eliminating insensitive practices, combating system challenges, conducting on-going evaluation of their practices, and providing training to staff and/or providers in contact with trauma victims.

In May 2003, Act 45 was passed by the Vermont legislature restructuring the AHS stating, "Service delivery systems should recognize the prevalence of the many kinds of trauma, including psychological trauma, and agency staff and service providers should be trained to ensure that client interactions are respectful and sensitive to trauma." The AHS policy, therefore, provides the framework for meeting this legislative mandate.

As in the past, the newly revised standards require providers to assess and provide trauma-informed services. There are trainings related to trauma and its various impacts for advocates and providers throughout the health care system.

ADAP is also involved with the Agency of Human Services (AHS) Trauma Workgroup established in 2001, with the aim of expanding agency-wide understanding of the correlation between trauma and addiction. This workgroup is tasked with identifying state of the art trauma practices to integrate within the agency. It has included consumer and direct provider representatives in more recent years to enhance knowledge and expertise to create a trauma-informed public human services system through inter-departmental strategies.

AHS also sponsored statewide training on the adverse family experiences. From that statewide effort some regional Adverse Childhood Experiences (ACE) workgroups are organized to encourage local training, school and community based prevention practices aimed at reducing ACEs.

3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?

The *Seeking Safety* curriculum, Marcia Linahan's *Dialectical Behavior Therapy for Substance Abusers*, and Stephanie Covington's *Beyond Trauma* curriculum are offered by Vermont's Preferred/Approved Providers.

Lisa Najavits's development of exercises and practice materials adapted for the Vermont context and provided by experienced peer facilitators to address the needs of those individuals with both addiction recovery and trauma issues, and particularly coping with the symptoms of Post-Traumatic Stress Disorder (PTSD).

Meetings held in recovery centers across the state include targeted peer recovery outreach to some of these higher risk populations, e.g.,: Vet - to - Vet (an organization of veterans committed to helping ourselves and other veterans achieve recovery from the issues we face), Vermont Psychiatric Survivors, Inc. (an independent, statewide, survivor - run organization dual diagnosis support groups), Wit's End, with newly forming groups emerging.

The Vermont Child Trauma Collaborative (VCTC) has been established within the Department of Mental Health with funds from a SAMHSA grant to work with stakeholders in the larger system of care to implement a best practice called the Attachment, Self-regulation and Competencies (ARC) Framework in Vermont's community mental health system.

4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

In response to multiple requests from the Preferred Provider community, ADAP has and continues to offer training in trauma informed care. As mentioned above trainings and TA offered on an ongoing basis to our providers to ensure that trauma is in the fore front of the work they are doing.

Technical Assistance needed related to this section: As TA needs are identified, ADAP will request TA.

Environmental Factors and Plan

12. Criminal and Juvenile Justice

Narrative Question:

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one third meet criteria for having co-occurring substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.⁷⁹

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance use disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.^{80 81} Rottman described the therapeutic value of problem-solving courts: "Specialized courts provide a forum in which the adversarial process can be relaxed and problem-solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs." Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.⁸²

Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

Please consider the following items as a guide when preparing the description of the state's system:

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?
2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?
4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

Please indicate areas of technical assistance needed related to this section.

⁷⁹ <http://csqjusticecenter.org/mental-health/>

⁸⁰ The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman, 2000.

⁸¹ A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs, U.S. Department of Justice, Renee L. Bender, 2001.

⁸² Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice*. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNeil, Dale E., and Renée L. Binder. [OJJDP Model Programs Guide](#)

Please use the box below to indicate areas of technical assistance needed related to this section:

As TA needs are identified, ADAP will request TA.

Footnotes:

Environmental Factors and Plan

12. Criminal and Juvenile Justice

Please consider the following items as a guide when preparing the description of the state's system:

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?

Vermont presently has an insured rate in excess of 90% and is committed to expanding coverage to all Vermonters through single source healthcare coverage. Individuals involved in the criminal and juvenile justice systems will be covered per the same terms as all Vermonters.

2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?

Individuals that encounter the criminal justice system because of an alcohol and/or other substance related issue are regularly screened prior to adjudication. These court diversion and/or pre-trial services programs are available throughout the state for youth and adults. These programs emphasize treatment in lieu of initial sanction. Police social work programs are available and offered. Vermont utilizes the Sequential Intercept Model as the guiding framework for the on-going development of a criminal justice capable system of care.

3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?

The Vermont Department of Health, Division of Alcohol and Drug Abuse Programs, (ADAP), has a staff member specifically assigned to intersect with the criminal justice service providers and Department of Corrections. Monthly meetings are held by the Criminal Justice Capable Core Team made up of select service providers, advocacy organizations, the Department of Corrections and staff members from the State of Vermont's Agency of Human Services. In addition, the Deputy Commissioner of Health, Director of Alcohol and Drug Abuse Programs is an integral member of the Tri-Branch Taskforce which is comprised of the Chief Justice of the Vermont Supreme Court, Members of the Legislative Branch and The Secretary of the Agency of Human Services representing the administration. This group meets quarterly to discuss promising practices and interventions for individuals involved in the judicial systems with substance abuse and/or mental health issues as well as providing oversight and direction for the statewide Criminal Justice Capable Core Team.

For individuals with severe functional impairments, the Department of Corrections, Department of Mental Health, and the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (VDH/ADAP) in conjunction with various advocacy and provider groups, offer enhanced discharge planning for those exiting incarceration.

4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

In addition to the on-going meetings between service provider representatives and criminal justice service providers, the State of Vermont hosts various cross training opportunities from nationally-renown and regional experts in the field. For example, Vermont has drawn on and will continue to draw on such expertise as the following individuals: Doug Marlowe, who has presented on several occasions including to providers as well as to the judiciary; Edward Latessa, PhD, from the University of Cincinnati; and Faye Taxman, PhD from George Mason University. In addition, the Vermont Department of Corrections offers conferences and trainings widely attended by both corrections and behavioral health staff. In addition, Team Two trainings are held statewide for law enforcement and mental health substance abuse co-first responders to teach strategies for intervening with individuals in crisis.

Technical Assistance needed related to this section: As TA needs are identified, ADAP will request TA.

Environmental Factors and Plan

13. State Parity Efforts

Narrative Question:

MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment - and to comply with MHPAEA. Guidance was released for states in January 2013.⁸³

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.⁸⁴

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. SMHAs and SSAs should collaborate with their state's Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Please consider the following items as a guide when preparing the description of the state's system:

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?
2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?
3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

Please indicate areas of technical assistance needed related to this section.

⁸³ <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>

⁸⁴ Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. *Psychiatric Services*. 60(12) 1589-1594

Please use the box below to indicate areas of technical assistance needed related to this section:

As TA needs are identified, ADAP will request TA.

Footnotes:

Environmental Factors and Plan

13. State Parity Efforts

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?

There are no plans to use block grant dollars to communicate and raise awareness of behavioral health parity. Vermont passed parity legislation in 1998 (study of results of parity legislation: <http://store.samhsa.gov/shin/content/SMA03-3822/SMA03-3822.pdf>) and has reviewed MHPAEA requirements for compliance.

One parity issue was identified -- the inability for those with only a Licensed Alcohol and Drug Counselor (LADC) certification to bill Medicaid for services which had the potential impact of limiting substance abuse treatment services. As of 7/1/15, legislation has been passed to allow LADCs to bill Medicaid for services provided. See Act 59: <http://legislature.vermont.gov/assets/Documents/2016/Docs/ACTS/ACT059/ACT059%20As%20Enacted.pdf>.

2. Does the state coordinate across public and private sector entities to increase awareness and understanding about benefits of the law (e.g., service benefits, cost benefits, etc.)?

There are no plans to address awareness and understanding of the benefits because these benefits already exist in Vermont. Substance abuse services have been defined and included in the essential health benefits in the RFP for the Qualified Health Plans.

3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

No. Parity is not new for Vermont insurers.

Please indicate areas of technical assistance needed related to this section.

No technical assistance needs have been identified at this time.

Environmental Factors and Plan

14. Medication Assisted Treatment

Narrative Question:

There is a voluminous literature on the efficacy of FDA-approved medications for the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for medication-assisted treatment of these disorders is described in SAMHSA TIPs 40⁸⁵, 43⁸⁶, 45⁸⁷, and 49⁸⁸. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?
2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?
3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

Please indicate areas of technical assistance needed related to this section.

⁸⁵ <http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939>

⁸⁶ <http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214>

⁸⁷ <http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131>

⁸⁸ <http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380>

Please use the box below to indicate areas of technical assistance needed related to this section:

As TA needs are identified, ADAP will request TA.

Footnotes:

Environmental Factors and Plan

14. Medication Assisted Treatment

Please consider the following items as a guide when preparing the description of the state's system:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?

As stated in Step 1 of this application, Vermont's policymakers have demonstrated an unprecedented focus on substance abuse over the last two years. This focus was precipitated, in part, by the public concern about opioid misuse and dependence, and its impact on public safety and human services systems. In January of 2014, Governor Shumlin devoted his entire State of the State address to the challenge posed by opiate addiction, and steps to address it. This address dramatically increased the awareness and interest of leaders around the state and the public in general. The governor's speech can be found at: <http://governor.vermont.gov/newsroom-state-of-state-speech-2013>.

In response to the Governor's State of the State, over 200 Vermonters representing every region of the State came together at the Statehouse on June 16, 2014 to hear the Governor's Call to Action, learn about opiate addiction and hear from stakeholders around the state on prevention, treatment and recovery strategies underway in Vermont communities. Implementation at the community level of the Governor's Community Forum on Opiate Addiction involved having the Regional Substance Abuse Prevention Consultants and District Health Directors recruit diverse groups of community members representing prevention, health care, substance abuse treatment and recovery, human services, local United Ways, business, housing, law enforcement and community justice from each of Vermont's twelve human services districts. Regional prevention consultants and district directors continued to provide facilitation, planning and community mobilization support to these regional teams as they carried out their follow-up efforts. At least 500 Vermonters participated in follow-up regional forums and developed action plans for each region. In addition to the plans, new and creative partnerships were established and communities became aware of how to take action to address this important public health issue.

The Care Alliance for Opioid Addiction described elsewhere in this application furthers the coordination and collaboration of ADAP, the Blueprint and DVHA to support and expand treatment services for those with opioid addictions through the Hub and Spoke initiative. The model now expands access to Methadone treatment with the opening of a new additional treatment hub, so Vermont now has 5 Hubs, with 8 sites; enhances Hub programming to include Health Home Services to link with the primary care and community services, provide buprenorphine for clinically complex patients, and provide consultation support to primary care and specialists prescribing buprenorphine, and embeds new clinical staff (a nurse and a Master's prepared, licensed clinician) in DATA 2000 Waivered Physician Offices (Spokes).

ADAP provided support to Kingdom Country Productions for the movie “The Hungry Heart” produced by Bess O’Brien, a documentary featuring Dr. Fred Holmes a pediatrician and Buprenorphine prescriber. This film was shown throughout the state with an accompanying panel of experts and cast members to be available for discussion of MAT. ADAP also teamed up with the Vermont Recovery Network to ensure wide access to “Anonymous People” to discuss recovery issues, and supported the showing of “The Opiate Effect” within the state, depicting a young man who experienced a lethal overdose at the University of Vermont (UVM).

The Vermont Department of Health website provides comprehensive information about the substance abuse systems, services and programs statewide (see the link: <http://healthvermont.gov/adap/adap.aspx>), including detailed information about opioid addiction and treatment (see the link: <http://healthvermont.gov/adap/treatment/opioids/index.aspx>). In response to the recent increase in public attention on the challenge of opioid addictions, the Vermont Departments of Health and Public Safety have jointly launched a focused dashboard made up population level indicators and performance measures to monitor the impact and progress of collaborative efforts including community partners of the coordinated, systematic response to the complex issue of opioid addiction in Vermont. See the link: <http://healthvermont.gov/adap/dashboard/opioids.aspx>.

2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?

Pregnant women are a Vermont and block grant priority population. Block Grant funded ADAP providers are required to admit pregnant woman within 48- hours per all grants and agreements.

Initiatives to increase outreach to individuals needing MAT include:

Children and Recovery Mothers (CHARM) collaborative, based in Burlington, Vermont, is a multidisciplinary group of agencies serving pregnant women with opioid dependence, their infants and families. The collaborative focuses on the array of services provided, the collaborative practice elements across systems, and the multiple points of intervention – prenatal, birth, and postpartum.

Babies and Mothers Beginning In-Sync (BAMBI) is a program led by physicians and addiction/mental health professionals to provide integration of medical and counseling services to expectant and new moms with substance abuse problems. This unique approach to care involves engaging both the hospital and community resources needed to help women get into a treatment program that works for them. The BAMBI program also ensures that newborns and young children have access to needed health and human services.

Initiatives such as the Improving Care for Opioid-exposed Newborns (ICON) project at the University of Vermont and University of Vermont Medical Center have greatly expanded training and awareness in the Vermont provider community.

The Vermont (Opioid Treatment Providers (OTPs) prioritize pregnant women for MAT and offer services for women postpartum with their infants. There are 5 Vermont OTP's representing 8 program sites in the state. Additionally, there are currently 133 active Medicaid prescribing "Data 2000 Waivered Physicians", i.e. eligible to prescribe and treat individuals including pregnant women with Buprenorphine. All of the ADAP adult outpatient and HUB providers serve pregnant women. Lund Family Center provides residential and outpatient services for women and their infants up to age 5.

In addition to treatment supports, ADAP funds family support and education services designed to reach women in the family environment. Please refer to descriptions of Rocking Horse Circle of Support and Nurturing Parenting Programs in the response to question 5.

3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

- The Care Alliance for Treatment of Opioid Addiction (Hub and Spoke) is a statewide initiative to improve MAT for all Vermonters addicted to Opioids. The Initiative includes the development of new services (Health Homes), deploys new staff (RN's and LADC's) in Spoke practices, and enhances Hub programming. The Care Alliance is a joint initiative of VDH-ADAP and DVHA, VT Blueprint for Health. The Care Alliance in Vermont seeks professional services to support the services enhancements of the Hub and Spoke Program from Dartmouth College. This consultation offers field based learning collaborative that include; social work, physicians, nursing, counseling, and providers in the field to have a forum to learn.
- Vermont has an initiative, called "Learning Collaboratives," to present research to ensure and identify evidence-based approaches to MAT, support development of protocols, and share guidelines from SAMSHA, AATOD, and ASAM to help develop best practices.
- The MAT Rules for Vermont were established in 2011 ensuring safeguards are in place for practices prescribing for 30 or more patients as well as psychosocial assessments and referrals. Under these Rules a Diversion Control Plan is required for each entity to minimize the risk of diversion.
- Patients in Office Based Opioid Treatment (OBOT) services are affiliated with Pharmacy lock in Programs requiring enrollment in only one pharmacy home.
- Prior to prescribing or dispensing medications, prescribers are required to look up patients in the Vermont Prescription Monitoring System, the state prescription drug monitoring program, in order to minimize contraindicated drug combinations and reduce prescription drug diversion and abuse.
- The Recovery Centers partner regionally with the Hubs and offer services and programming specific to individuals engaged in MAT treatment. This includes the inclusion of Pathway Guides, peers specifically trained to support individuals in MAT.

- Opioid Treatment Providers (OTPs) as health homes are in varying degrees of NCQA accreditation, with one OTP having achieved level-2 accreditation to date.

Hubs, known by the federal government as Opioid Treatment Programs (OTP's), are highly regulated by the federal Drug Enforcement Agency (DEA) and the Substance Abuse and Mental Health Services Administration (SAMHSA). They must also be approved by the State Opioid Treatment Authority (SOTA), or ADAP in Vermont, and be accredited by a national accreditation body such as The Joint Commission, or Commission on Accreditation of Rehabilitation Facilities (CARF) or the Council on Accreditation. Treatment requirements are prescribed by federal regulations, 42 CFR part 8 iii, and the Vermont Department of Health's Medication Assisted Therapy for Opioid Dependence Rules iv. Medications must be dispensed in a highly controlled manner with any decrease in treatment structure determined by factors including behavioral stability, treatment engagement/compliance and response, and required time in treatment. The storage, security, safe handling and record keeping requirements are highly regulated and reviewed by the DEA to ensure compliance with their requirements.

Please indicate areas of technical assistance needed related to this section.

As TA needs are identified, ADAP will request TA.

Environmental Factors and Plan

15. Crisis Services

Narrative Question:

In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises.

SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](#)⁸⁹,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports being used to address crisis response include the following:

Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning
- Psychiatric Advance Directives
- Family Engagement
- Safety Planning
- Peer-Operated Warm Lines
- Peer-Run Crisis Respite Programs
- Suicide Prevention

Crisis Intervention/Stabilization:

- Assessment/Triage (Living Room Model)
- Open Dialogue
- Crisis Residential/Respite
- Crisis Intervention Team/ Law Enforcement
- Mobile Crisis Outreach
- Collaboration with Hospital Emergency Departments and Urgent Care Systems

Post Crisis Intervention/Support:

- WRAP Post-Crisis
- Peer Support/Peer Bridgers
- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

Please indicate areas of technical assistance needed related to this section.

⁸⁹Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. <http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:
Not applicable to SSA

Environmental Factors and Plan

16. Recovery

Narrative Question:

The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.

Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of health (access to quality health and behavioral health treatment), home (housing with needed supports), purpose (education, employment, and other pursuits), and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- | | | |
|--|---|--|
| • Drop-in centers | • Family navigators/parent support partners/providers | • Mutual aid groups for individuals with MH/SA Disorders or CODs |
| • Peer-delivered motivational interviewing | • Peer health navigators | • Peer-run respite services |
| • Peer specialist/Promotoras | • Peer wellness coaching | • Person-centered planning |
| • Clubhouses | • Recovery coaching | • Self-care and wellness approaches |
| • Self-directed care | • Shared decision making | • Peer-run crisis diversion services |
| • Supportive housing models | • Telephone recovery checkups | • Wellness-based community campaign |
| • Recovery community centers | • Warm lines | |
| • WRAP | • Whole Health Action Management (WHAM) | |
| • Evidenced-based supported | | |

SAMHSA encourages states to take proactive steps to implement recovery support services, and is seeking input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Recovery is based on the involvement of consumers/peers and their family members. States should work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

Please consider the following items as a guideline when preparing the description of the state's system:

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?
6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?
11. Describe how the state is supporting the employment and educational needs of individuals served.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

As TA needs are identified, ADAP will request TA.

Footnotes:

- 1 Alcohol and Drug Abuse Programs Annual Overview December 2014, p.2.
- 2 From the Vermont Recovery Center Handbook, page 4, https://vtrecoverynetwork.org/PDF/Recovery_Center_Handbook.pdf
- 3 Vermont's Health Plan 2005, pp.2-19, http://healthvermont.gov/pubs/Health_Plan_complete.pdf
- 4 AHS Substance Abuse Treatment Coordination Initiative Overview, May 2015, <http://healthvermont.gov/adap/treatment/documents/SATCOOverview.pdf>
- 5 https://vtrecoverynetwork.org/PDF/ETHICAL_GUIDELINES.pdf

Environmental Factors and Plan

16. Recovery

Please consider the following items as a guideline when preparing the description of the state's system:

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?

Yes.

a. the definition of recovery and recovery values:

In ADAP's Annual Overview December 2014, substance abuse recovery is defined as "a process of promoting a supportive environment to assist individuals with smooth and sustained transition to wellness."¹

Since 2009, Vermont's network of recovery centers known as the Vermont Recovery Network (VRN), proposed a definition of recovery that has since been adopted by ADAP. This definition continues to be used throughout Vermont's network of recovery centers, which has expanded to 12 centers as of August 1, 2015.

"Recovery Solutions' is the term we have begun to use, to describe the recovery support services that staff and volunteers have universally been providing for people who enter our recovery centers. Recovery Solutions consist of a blend of recovery supports that run the gamut from a welcoming engagement, to information or intervention, referrals, work at preventing relapse and general support."²

b. evidence of hiring people in recovery leadership roles:

VDH/ADAP works to ensure meaningful stakeholder and partnership engagement from design to implementation. Particular persons in recovery are not documented to protect individual rights of privacy.

The state continues to support the priorities that emerged from SAMHSA's BRSS TACs grant support, including: increased peer leadership capacity, creation and support of a peer recovery leadership training academy, and support for broader peer advocacy and leadership development.

Also, ADAP's long-range strategic plan articulates its strong commitment to recruit the highest quality of substance abuse expertise and leadership and/or utilize such expertise through strategic partnership.

c. strategies to use person-centered planning and self-direction and participant-directed care:

The principle of self-directed care has been expressly emphasized as a core state value since at least 2005. As set out in the desired outcome of Vermont's Health Plan of 2005, Vermonters will "participate as full partners in improving personal and population health and health system outcomes by effectively managing their own health needs."³ This principle continues to be reflected in various plans, patient bills of rights documents and other key documents throughout the health care system, and considered essential to good health outcomes.

Furthermore, The Division of Alcohol and Drug Abuse Programs (ADAP) works with community partners to create and maintain an accountable, community based system of services and supports that empowers Vermonters to embrace resiliency, wellness and recovery by becoming active participants in self-management. As reflected in all treatment standards throughout the system, individuals and families participate in a patient-centered approach of shared decision making for treatment and recovery planning. See, for example, the commitment and requirement to a patient-centered approach in the recently updated Substance Abuse Treatment Standards at:

<http://healthvermont.gov/adap/treatment/documents/SubstanceAbuseServicesGuidelines.pdf>.

d. variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?

Vermont continues its work to increase the variety of recovery supports for those seeking or in recovery. We have continued to fund recovery supports via Vermont Recovery Network (VRN) centers and have funded the Vermont Association for Mental Health and Addiction Recovery (VAMHAR) to continue its Recovery Coach Academy trainings as well as to prepare peer based services to support more potential applicants for the role of peer navigators.

2. How are treatment and recovery support services coordinated for any individual served by block grant funds?

Individuals in Vermont first access treatment services by receiving an age appropriate screening, and where necessary a referral to and assessment by a preferred provider using evidence based tools to identify the clinically appropriate levels of care needed. Every individual or family that comes through the system is asked to participate in developing and implementing an individualized treatment plan. As clients embrace a recovery oriented lifestyle, they can be referred to "recovery centers", and/or an array of local community services designed to support recovery. Recovery referrals within discharge after care plans are standard practices.

Through Vermont's health reform initiatives, medical care practitioners are enhancing their own screening and referral services, so more clients are being screened and directed to substance abuse specialists from primary care facilities. Efforts are underway to enhance the linkages between primary care practitioners and specialty substance abuse and/or mental health practitioners. Vermont also relies on Pathway Guides to work with Opioid Treatment Programs (OTPs) and Office Based Opioid Treatment (OBOT) programs to work with MAT treatment providers to refer clients to peer recovery supports.

Furthermore, through the Substance Abuse Treatment Coordination (SATC) Initiative, Vermont's Agency of Human Services' leadership is working through a Stat process to establish a coordinated approach to serving Vermonters with substance abuse problems across all departments. This includes developing an agency-wide screening policy; training staff; developing referral coordination methodologies for cases that involve more than one department; adopting a standard definition of case management; developing an AHS housing plan for high needs clients; and completing regional needs assessments and plans for addressing treatment gaps, namely, the work being carried out by the Criminal Justice Capable Core Team Work Group.⁴

3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?

Yes. The newly updated Substance Abuse Services Guidelines, effective April 1, 2015, requires all providers to have in place written non-discrimination policies and procedures, a code of ethics governing behavior of staff and business practices, plans relating to cultural competence and supervisory practices, and criteria for prioritizing need and high risk populations. See the Guidelines at:

<http://healthvermont.gov/adap/treatment/documents/SubstanceAbuseServicesGuidelines.pdf>.

Furthermore, the Vermont Recovery Network together with their 12 peer run recovery centers jointly adhere to their Ethical Guidelines for people providing recovery support services. Recently, the Vermont Recovery Network adopted standards for ethical behaviors vetted by the Vermont Department of Health, Division of Drug Abuse Programs (VDH-ADAP) and the Department of Mental Health (DMH).⁵ Furthermore, each Recovery Center within the Vermont Recovery Network (VRN) has a written policy which outlines a commitment to preventing discriminatory practices. The policy addresses nondiscrimination based on race, religion, gender, ethnicity, age, disabilities, sexual orientation, addictive process, mental health status, and/or real or perceived HIV status.

Meetings held in centers across the state include targeted outreach to some of these higher risk populations, e.g.: Vet - to - Vet (an organization of veterans committed to helping ourselves and other veterans achieve recovery from the issues we face), Vermont Psychiatric Survivors, Inc. (an independent, statewide, survivor - run organization of dual diagnosis support groups), Wit's End (a parent support group for parents and other adults concerned about young person's use and abuse of substance), with newly forming groups emerging.

4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?

Yes. We have continued to support training via statewide provider forums, which bring together key stakeholders across the continuum of care. Peer providers have been a key part of all our forums.

Yes. In 2012, the Vermont legislature offered the Vermont Recovery Network (VRN) a funding increase contingent on the development of Provider Standards for Recovery Services completed collaboratively with the Vermont Department of Health and Department of Mental Health, and officially approved that same year. In 2012 the VRN also began collaborating with the Connecticut Certification Board, to develop and test their process, and has led to the formal certification of more than 30 Vermont recovery coaches.

5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?

The Vermont Recovery Network formalized protocols for tracking recovery coaching including adopting an outcome measurement tool. The data collected on recovery coaching has been demonstrating statistically significant changes in the lives of the participants and reductions in the use of crisis services.

The Vermont Recovery Network (VRN) continues to work with one of the developers of Making Alcoholics Anonymous Easier (MAAEZ), an empirically tested approach gaining increasing popularity. Other research tested practices and examples of innovation in the area of recovery include: Lee Ann Kuskutas's implementation of peer facilitated Seeking Safety trainings; and Lisa Najavits's development of exercises and practice materials adapted for the Vermont context and provided by experienced peer facilitators to address the needs of those individuals with both addiction recovery and trauma issues, and particularly coping with the symptoms of Post-Traumatic Stress Disorder (PTSD). Wellness Recovery Action Planning (WRAP) and the Rocking Horse Circle of Support are Vermont home-grown models that are now recognized as evidence-based practices. As a recipient of a BRSS TACS Leadership grant ADAP has worked closely with the Vermont Recovery Network (VRN), Vermont's Mental Health and Addiction advocacy group, the Blueprint for Health, as well as various peer run groups to enhance the peer services in a physical health care setting. And lastly, research is underway through a contract with Harvard University to assess the effectiveness of peer supports and recovery centers in Vermont, with findings and recommendations expected by spring 2016.

6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).

As mentioned previously, Vermont uses a patient-centered care approach for all treatment services where clients (and families) directly participate in treatment plans and after care

planning. Furthermore, through the certification process of all treatment providers, interviews of direct clients and their families are utilized to identify possible ways to improve care. Patient satisfaction surveys are mandated within grants to ensure steady input of customer feedback, as well.

ADAP ensures on-going engagement with stakeholders and partners. For example, ADAP convened a partner and stakeholders meeting in spring 2015 representative of the entire continuum of care from prevention through recovery, and each region of the state, to facilitate regional networking across the continuum, to identify key components, linkages, gaps, strengths and successes within each region, and to identify possible solutions or technical assistance needs. ADAP also often turns to key partners for input or direct involvement in drafting strategic plans, program design documents, and reports with recommendations as was done in preparing the Sober Housing Report and Recommendations, the MAT Rules, and Substance Abuse Services Guidelines.

7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

The ADAP Strategic Plan 2012-2017 Strategic Direction 2.3 prioritizes “increasing access and opportunities for treatment and recovery services by ensuring a comprehensive, coordinated system of support with the health care system.” This includes continued expansion and enhancements to the existing systems, ensuring a system of care capable of meeting the needs of high risk and complex clients, and improving coordination between patient-centered medical homes (PCMH’s) and specialty substance abuse treatment providers for individuals with substance abuse issues.

Vermont invests in a statewide network of regional centers, the network itself, and the provision of recovery supports to those in need, including those high priority specialty populations through targeted programs like vet-to-vet mentioned above. Additionally, Vermont supports the college symposium and works in partnership with colleges to support establishment of recovery centers on campus, carrying out prevention activities such as sober activities at college-wide events.

VAMHAR is supported by ADAP to implement the Vermont Alcohol and Drug Information Clearinghouse to provide information to all treatment and prevention service professionals and organizations, as well as individuals who request information on the various types of services and resources available in Vermont.

8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.

As mentioned previously, the Vermont Recovery Network (VRN) gathers data on service utilization, visits and services provided through its recovery centers. VAMHAR maintains records of the numbers of individuals receiving training in recovery coaching and other leadership development and peer support capacity building efforts.

9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.

All ADAP Preferred Providers must adhere to a tobacco free campus. The Substance Abuse Service Guidelines have been modified to screen for and identify tobacco use disorders. Furthermore, tobacco training has targeted the Preferred Provider network to ensure that a tobacco specialist is available within each treatment provider. Uninsured individuals with tobacco use disorders are offered free nicotine replacement, and others are directed to cessation services available throughout the state.

Treatment providers also are incorporating nutrition and wellness messaging and support services, particularly through MAT/Hub and Spoke linkages as part of health home services. Obesity BMI is a target measure being utilized throughout the state. More and more recovery centers, too, are incorporating health and wellness, including nutritional programs, as avenues for supporting ongoing recovery.

10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?

Vermont has a housing shortage, particularly in the sector of affordable housing, with less than 1% vacancy. The housing needs of those affected by addictions and/or co-occurring mental health issues, therefore, are all the more challenging. ADAP is part of the Agency of Human Services Housing committee and works to educate legislature, the public and other key stakeholders of the critical link between safe, affordable, drug free housing and successful recovery for its highest priority populations, including pregnant women, women with dependent children, and adults previously incarcerated.

Together the VDH/ADAP and AHS Housing convened a working group and produced a formal report with recommendations to the Vermont legislature on Sober Housing. In particular, Vermont is exploring the adoption of the National Association of Recovery Residences (NARR) standards for credentialing recovery residences, as well as securing NARR regional representation.

11. Describe how the state is supporting the employment and educational needs of individuals served.

In Vermont, a substance use disorder is a qualifying disability making individuals eligible for Vocational Rehab services and training to support employment placement, education, job training, as well as supplementary supports for equipment and/or materials required to pursue a particular job. Furthermore, the entire Agency of Human Services has robust complementary services to address needs of specialty populations, e.g., programs and services provided through the Department of Disabilities, Aging and Independent Living.

Please indicate areas of technical assistance needed related to this section.

No technical assistance needs are identified at this time, but ADAP will notify SAMHSA as such needs emerge.

Footnotes

¹ Alcohol and Drug Abuse Programs Annual Overview December 2014, p.2.

² From the Vermont Recovery Center Handbook, page 4,

https://vtrecoverynetwork.org/PDF/Recovery_Center_Handbook.pdf

³ Vermont's Health Plan 2005, pp.2-19,

http://healthvermont.gov/pubs/Health_Plan_complete.pdf

⁴ AHS Substance Abuse Treatment Coordination Initiative Overview, May 2015,

<http://healthvermont.gov/adap/treatment/documents/SATCOverview.pdf>

⁵ https://vtrecoverynetwork.org/PDF/ETHICAL_GUIDELINES.pdf

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead

Narrative Question:

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in [Olmstead v. L.C., 527 U.S. 581 \(1999\)](#), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated arrangement appropriate and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to Section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office of Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:
Not applicable to SSA

Environmental Factors and Plan

18. Children and Adolescents Behavioral Health Services

Narrative Question:

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.⁹⁰ Most mental health disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.⁹¹ For youth between the ages of 10 and 24, suicide is the third leading cause of death.⁹²

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.⁹³ Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with more than 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or substance use disorders and co-occurring disorders and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.⁹⁴

According to data from the [National Evaluation of the Children's Mental Health Initiative](#) (2011), systems of care⁹⁵:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance

use, and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?
6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?
7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

Please indicate areas of technical assistance needed related to this section.

⁹⁰ Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

⁹¹ Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

⁹² Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

⁹³ The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁹⁴ Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010>.

⁹⁵ Department of Health and Human Services. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions: Joint CMS and SAMHSA Informational Bulletin. Available from <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf>.

Please use the box below to indicate areas of technical assistance needed related to this section:

As TA needs are identified, ADAP will request TA.

Footnotes:

Environmental Factors and Plan

18. Children and Adolescents Behavioral Health Services

Please consider the following items as a guide when preparing the description of the state's system:

1. *How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?*

In FY' 13, ADAP was awarded a four year SAMHSA Cooperative Agreement for State Adolescent and Transitional Aged Youth Treatment Enhancement and Dissemination Grant. This grant funded project aims to increase referrals of youth and young adults in need of substance abuse treatment, to enhance adolescent substance abuse treatment, and to support the improved integration of behavioral health services for adolescents and transitional aged youth. Through this four-year, \$3.8 million Cooperative Agreement, two pilot sites have been trained in the use of the CASI assessment tool (Comprehensive Adolescent Severity Index) and two Evidence Based treatment practices (Seven Challenges for ages 12-17 and Seeking Safety for ages 18-24), and are providing clinical treatment based on these models. Sites are focusing on reducing obstacles to care, strengthening existing partnerships, and developing new collaborative relationships. Careful evaluation of the impact of these treatment models and systems level outcomes are being tracked by an independent evaluator and reported to SAMHSA. Training in these tools have been rolled out to adolescent and young adult treatment providers state-wide in an effort to expand the use of Evidence Based programming, and to sustain improvements to Vermont's substance abuse treatment system beyond the completion of the grant.

YOUTH TREATMENT ENHANCEMENT GRANT OBJECTIVES

Treatment Level

- Increased rates of abstinence
- Increased enrollment in education/training/employment, as well as social connectedness
- Decreased juvenile justice involvement
- Increased access, service use, outcomes for populations vulnerable to health disparities
- Increased referrals to and total number of youth served by ADAP's Preferred Provider network

Systems Level

- Changes in state policies and procedures relating to youth treatment service delivery
- Creation of enhanced financing structures to support sustained delivery of EBP's
- Creation of a statewide workforce development/training plan for widened use of EBP's

ADAP is strengthening the statewide prevention and health care systems through improving capacity and capability to provide early, brief screening and referral protocols. ADAP is working in conjunction with the Treatment Preferred Provider system (Adolescent and Adult) to ensure identification and treatment is provided to this age group, further improve the principles of a Resiliency, Recovery Oriented System of Care (e.g., OP, IOP, Recovery Centers, the Vermont Treatment Provider Association, etc.), and work to identify best practices in reaching and serving this population.

2. *What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance use, and co-occurring disorders?*

In FY'15, ADAP completed the rewrite of the Substance Abuse Services Guidelines for Vermont. The new standards strengthen the requirement for the Preferred Provider system to have available expertise and resources within their agency, or through collaboration, to deliver comprehensive, co-occurring capable, behavioral health care to all age groups, including age-specific screening and assessment tools and intervention services. In the spirit of on-going collaboration, ADAP is meeting with the Department of Mental Health to further ensure that the new standards further solidify the treatment expectations of both systems.

3. *How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?*

ADAP continues to collaborate across state government to achieve health equity among the most vulnerable Vermonters.

Integrating Family Services represents an unprecedented collaboration between all state agencies to ensure that the behavioral health needs of youth and families are met in the most efficient and effective manner possible. The Integrating Family Services Initiative seeks to bring all Vermont Agency of Human Services children, youth and family services together in an integrated and consistent continuum of services for families. The premise being that giving families early support, education and interventions will produce more favorable outcomes at a lower cost than waiting until circumstances are bad enough to access high end, more costly interventions and services that often take place in out of home or out of state placement sites. Knowledge and skilled response to parent and child mental health and substance abuse issues, trauma, post adoption, impact of significant disabilities on families, positive behavior support strategies, and promotion of wellness in the family system are all key considerations in this re-design.

Integrating Family Services (IFS) is an innovative approach spearheaded by the Secretary's Office in the Vermont Agency of Human Services. IFS aims to transform how Vermont provides services and resources to support children and youth (prenatal to age 22) and their families, including:

- **Maternal** and child health, which focuses on health promotion, prevention and wellness.
- **Mental** health and social emotional health;
- **Special** health care needs;
- **Early** childhood development;
- **Substance** use and abuse;
- **Strengthening** families; and
- **Integration** and working partnerships with health care providers.

Integrating Family Services creates a cultural shift in the way human services does business. It moves the focus from counting how much we are doing to looking at how well we are doing. Is anyone better off because of our investment? This shift is created by giving communities more flexibility with funding and decision-making so agencies can offer children, youth and families the right supports and services, and at the right time. ADAP is represented in the leadership group for this initiative, as well as in all related workgroups. ADAP will continue to support this initiative as it moves forward and to help ensure efforts are well integrated with other systems developments and initiatives throughout the state.

In FY'15, ADAP led a Department-wide Public Health Stat on Adolescents and Young Adults with a particular focus on marijuana use and marijuana use disorders. The action steps derived from this effort continue to be addressed. The "Public Health Stat" is a management process and tool that facilitates data-driven decision making, and focused on advancing progress in an area of common interest that would benefit from cross-divisional coordination. Recommendations and cross-divisional action steps are identified by managers and key stakeholders, and aligned with established strategic goals and performance measures. Key recommendations include identifying ways for mutually reinforcing prevention messaging, coordinated school health, work with college campuses, expanding partnerships with primary health, and expanding understanding of the relationship of trauma and addictions to reduce underage drinking, binge drinking and other behavioral health risks among this population through more coordinated effort.

ADAP participated in a collaborative process with the Agency of Human Services, including the Department of Mental Health, to ensure that the statewide suicide plan reflects an addiction focus in

combination with mental health, and to ensure the State's plan addresses the unique risks and needs of youth and young adults.

ADAP is represented in the Agency of Human Services (AHS) Child Trauma Workgroup, with the aim of expanding agency-wide understanding of the correlation between trauma and addiction. This workgroup is tasked with ensuring that trauma best practices are integrated within the Agency.

ADAP regularly engages in joint planning with the Division of Maternal and Child Health, Agency of Education and the Department of Mental Health to design, plan, refocus and evaluate initiatives. These efforts also rely on the engagement and partnership with community coalitions, youth service programs or schools to advance progress toward achieving goals and objectives identified in the Division, Department and Agency strategic plans. Other initiatives of this nature highlighted in other sections of this application include Integrating Family Services, School-based grants, and Project Rockinghorse.

4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?

ADAP supports Workforce Development opportunities for Behavioral Health Professionals that promote best practices in the prevention, treatment and recovery of substance abuse and addiction. It will do so through various avenues including updates to the certification and licensure statutes and procedures, provision of training and technical assistances to preferred providers, and work to bring compensation levels to more nationally competitive levels. ADAP will follow the recommendations of the Center for Health and Learning following a recent independent review of resources and professional development needs for Vermont's substance abuse workforce.

All substance abuse Prevention funding to community and state providers includes required training that is provided statewide on evidence-based substance abuse prevention strategies. ADAP grantees are required to identify evidence-based strategies, and ADAP provides training and technical assistance to all providers on their implementation, evaluation, as well as other topics as identified in the yearly training needs assessment.

The SAMHSA State Youth Treatment Cooperative Agreement grant mentioned above is supporting training in adolescent evidence based assessment and treatment practices for treatment providers across the state. ADAP is working to ensure these adolescent treatment enhancements are sustained post grant.

Under the School Based Substance Abuse Services Grant, twenty Vermont Supervisory Unions are receiving funds to support classroom health curricula and educational support groups related to substance use, and to deliver parent information and educational programs in schools. ADAP has partnered with the Agency of Education (AOE) to implement a learning needs assessment with school staff who are carrying out the deliverables of Vermont's School Based Substance Abuse Services grants and Tobacco Prevention grants.

The Vermont Department of Health has in place a comprehensive performance management framework that seeks to improve the health status of Vermonters by ensuring the efficacy of services delivered. Performance management systems at the Health Department provide a means to identify and regularly report on population objectives and performance measures, perform quality improvement activities, and assess and emphasize the need to fund and implement evidence-based practices to change population outcomes. Performance measures are displayed on the Health Department Performance Dashboard linked on the department's website, and are reflected in the State's Health Improvement Plan and ADAPs long range strategic plan.

5. *How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?*

ADAP currently monitors and tracks children and adolescent behavioral health service utilization through the Substance Abuse Treatment Information System (SATIS) and costs through the grant and Medicaid system. Also, through the Public Health Stat process, ADAP is focusing on substance abuse and dependence in adolescents and young adults. This Stat looks at a range of prevention and treatment outcomes to reveal areas in which ADAP can better collaborate with other Agency of Human Services and Vermont Department of Health activities to have more success in the prevention and treatment of substance abuse and dependence, and achieve greater movement on key indicators identified to monitor progress in this priority area. Population-level outcomes are tracked through the National Survey on Drug Use and Health (NSDUH) and the Youth Risk Behavior Survey (YRBS). Vermont is unique in that most schools participate in the YRBS, and a rich set of data is available at the Supervisory Union level for planning and assessment. In 2011, the survey was expanded to both middle schools (grades 6-8) and high schools. The response rate for middle schools was 100% and the response rate for high schools was 96%. The State Epidemiological Outcomes Workgroup (SEOW) updates Vermont's epidemiological profile with this information regularly.

6. *Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?*

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The Agency of Education has been notified of the substance abuse liaison, and is a partner in supporting efforts to strengthen behavioral health supports and interventions within schools, including working with VDH/ADAP in ensuring the availability of mental health and/or substance abuse screening and referral (as needed) to treatment and recovery support services.

7. *What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.*

Vermont Department of Mental Health child, youth & family services follow Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) regulations and can provide mental health treatment and supports for youth up to age 22 if determined appropriate. If it makes sense for a particular youth to transition to adult supports and services prior to age 22, the local team develops the transition plan at the identified time (it may be as the youth prepares to turn 18, or any point before 22). DMH has protocols for transitioning youth out of Vermont's Department of Children and Families (DCF) foster care into Community Rehabilitation Treatment (CRT) and for transitioning non-custody youth into CRT.

For regions participating in the Integrating Family Services (IFS) initiative services/supports are provided up to the youth's 22nd birthday. The following is language specific to expectations for IFS transition and discharge planning:

- a. A **transition plan** should be developed when any time a child and family are moving from one service to another, including but not limited to, from one level of care to another, from early childhood to school age, school age to young adult services or from one provider to another.
- b. A **transition plan** will be developed with the family and the family's team no less than 30 days prior to transition date. Grantees will ensure a transition plan is developed that addresses any pregnant/postpartum woman, child, or child care program leaving services or transitioning to another region. Circumstances in which transition plans do not meet this minimum shall be documented.

The Department of Children and Families (DCF) ensures former foster youth age 18-22 receive services to support a smooth transition into adulthood. DCF provides the Youth Development Coordinators (YDC) in each DCF district region. YDC's serve current and former foster youth ages 15-22 providing and assisting youth in education, progressive employment, support for housing, secondary and post-secondary education and training. In addition to these supportive activities, the program provides financial living support for youth over 18 to complete high school, live with a supportive adult following completion, and to establish their own independent residence. The housing support funds are available to youth 18-21 inclusive. The program also provides flexible financial supports to youth of all eligible ages to enrichment activities, education, for relationships, transportation, and employment. The program also provides tuition support for post-graduate study through a partnership with the Vermont Student Assistance Corporation.

Please indicate areas of technical assistance needed related to this section.

No technical assistance needs are identified at this time, but ADAP will notify SAMHSA as such needs emerge.

Environmental Factors and Plan

19. Pregnant Women and Women with Dependent Children

Narrative Question:

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant ([Title XIX, Part B, Subpart II, Sec.1922 \(c\)](#)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at <http://www.samhsa.gov/women-children-families>: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges*.

Please consider the following items as a guide when preparing the description of the state's system:

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.
5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
 - a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
 - b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
 - a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
 - b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

As TA needs are identified, ADAP will request TA.

Footnotes:

Environmental Factors and Plan

19. Pregnant Women and Women with Dependent Children

Please consider the following items as a guide when preparing the description of the state's system:

- 1. The implementing regulation **requires** the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.*

ADAP continues to require that pregnant women be given priority access to services in order to be in compliance with the expectations of SAMHSA and the State of Vermont. This requirement has been written into the state rules, division treatment services guidance document and the grants/contracts. The language dictates that pregnant women be given priority access and receive services within 48 hours.

ADAP has worked very closely with our Medicaid office to ensure that all women have access to services. Part of this collaboration ensures that transportation is available to aid with access to services given Vermont's rural landscape.

- 2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.*

The requirement that pregnant women are admitted to treatment within 48 hours has been written into the state rules, division treatment services guidance document and the grants/contracts.

- 3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.*

If services are not available upon request providers must notify the Director of Clinical Services at ADAP immediately. If no treatment service option is available then case management services and other interim services are offered until formal clinical treatment is available. The Director of Clinical Services stays apprised of all developments in these individual situations.

- 4. Discuss who within your state is responsible for monitoring the requirements in 1-3.*

These requirements are monitored through a combination of ADAP provider audits and Medicaid system monitoring. ADAP conducts yearly site visits. These site visits fall under the direction of the Director of Clinical Services and are conducted in the field by the Substance Abuse Coordinator/Quality Oversight Specialist. When the Specialist performs

chart audits during these yearly visits the auditor looks to ensure pregnant women receive prompt admission and appropriate services.

5. *How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)*

All of the ADAP adult providers serve pregnant women. This includes 17 OP/IOP provider organizations with multiple sites, 3 residential programs and 5 hubs as noted below. In addition, Lund Family Center provides residential and outpatient services for pregnant women and their infants.

In addition to treatment supports, ADAP funds family support and education services designed to reach women in a family environment.

Rocking Horse Circle of Support:

The Rocking Horse program is a ten week (20 hours) psycho-educational group intervention delivered by 2 female leaders; a substance abuse specialist and a maternal child professional. The groups are community based and receive referrals from the network serving these women in a variety of capacities. The program follows a dedicated 10 session curriculum that frames substance use in four major domains- substance use for women's health, substance use and relationships, the effects of substance use in the family, and substance use influence for life troubles and life management. The program describes the risk associated with substance use behavior and presents strategies to boost self-efficacy and life management. The program is accessible providing child care and transportation and is no cost to the participants. At each group the women are given a token incentive gift and snacks are served. Participant outcomes include a decrease in binge drinking behavior, and increased perception of risks to women's health due to alcohol use. Positive changes in increased coping and increased social support have also been reported. The presence of these groups is filling a "gap" in the care system. The group referrals come from a variety of programs that suspect substance abuse risk in the women they serve and are using the Rocking Horse Program where it is available as a care continuum step in addressing this risk. ADAP prevention staff have worked to expand the program to all 12 Districts, and groups are implemented in at least 12 sites. The anticipated direct reach of the program: 150 pregnant or parenting women living in poverty.

Nurturing Parenting Program:

Nurturing Parenting Programs (NPP) are curriculum-based parenting education programs that work with the entire family. Families participate in weekly 2-5 hour sessions for 9 – 26 weeks, depending on the curriculum. These specially designed evidence-based programs teach at-risk parents how to understand their children's developmental needs and behaviors, positively communicate with their children and manage their own stress so that they create healthy, nurturing homes for their children. Parents are able to become better role models by learning about their own needs and how to meet those needs in healthy ways, while meeting the needs of their children. Nurturing Parenting Programs take place in communities throughout Vermont. Participant outcomes include an increase in parents'

comfort level in discussing alcohol and other drug use (AOD use) with their children; an increase in parents' and children's abilities and willingness to establish family rules and expectations regarding AOD use and an increase in parents' knowledge of community resources addressing AOD use. ADAP collaborates with other departments in the Vermont Agency of Human Services to support the statewide delivery of a variety of NPP groups including NPP for Families in Recovery from Substance Abuse, NPP for Families with Children, and NPP for Military Families. A minimum of 50 Nurturing Parenting Programs will be conducted statewide.

ADAP continues to work with local providers to improve the ways in which the needs of this population are addressed. The needs of this population include treatment as well as supports for housing, jobs, day care, and transportation.

Lastly, ADAP partners with the DOH Division of Maternal and Child Health to implement "049". "049" is an outreach campaign designed to encourage health care providers to advise women to not drink alcohol if they are pregnant or trying to become pregnant. The objective of this initiative is to increase the percentage of women receiving this advice from their health care provider. VDH District Office staff work with medical practices and medical providers statewide who provide services to child bearing age women. This includes promotion of "049" messages and materials, as well as face-to-face contact with providers.

a. How many of the programs offer medication assisted treatment for the pregnant women in their care?

The Vermont (Opioid Treatment Providers (OTPs) prioritize pregnant women for MAT and offer serves for women postpartum with their infants. There are 5 Vermont OTP's representing 8 program sites in the state. Additionally, there are currently 133 "Data 2000 Waivered Physicians" treating individuals including pregnant women with Buprenorphine.

b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?

ADAP continues to evaluate and address the need for expansion of MAT services. Using the HUB and Spoke framework, ADAP is expanding office and center based MAT programming with the most recent expansion occurring as of August 1, 2015. Currently, pregnant women throughout the state are given priority and are able to access MAT in a timely manner.

6. *How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)*

All of the ADAP adult outpatient and HUB providers serve women and their dependent children. Lund Family Center provides residential and outpatient services for women and their infants up to age 5. The other ADAP providers serve both adults and children with

identified needs. Women with dependent children are referred for additional “wrap around” services as needed, including temporary assistance for needy families (TANF), childcare and “success by 6” programming.

In addition to treatment supports, ADAP funds family support and education services designed to reach women in the family environment. Please refer to descriptions of Rocking Horse Circle of Support and Nurturing Parenting Programs in the response to question 5 above.

ADAP continues to work with local providers to improve the ways in which the needs of this population are addressed. The needs of this population include treatment as well as supports for housing, jobs, day care, and transportation.

a. How many of the programs offer medication assisted treatment for the pregnant women in their care?

Lund Family Center offers office based opioid treatment for individuals requiring methadone maintenance. Lund has an MOU with the local Opioid Treatment Provider (OTP) for these services. All state treatment providers either offer MAT services or, through arrangements with local health providers, psychosocial treatment components for individuals receiving opioid replacement medications.

b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

ADAP continues to evaluate and address the need for expansion of MAT services. Using the HUB and Spoke framework, ADAP is expanding office and center based MAT programming. Currently women with dependent children experience the same waitlists for MAT treatment that exist for the rest of the population in some regions of the state, but are identified as a priority population to receive services as soon as they are available, with interim and care management services provided until they can be served. Expansion has resulted in ensuring that at least one hub is available to provide services in each region with additional sites opening up as resources and need dictate.

Environmental Factors and Plan

20. Suicide Prevention

Narrative Question:

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised [National Strategy for Suicide Prevention \(2012\)](#).
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#).⁹⁶

Please indicate areas of technical assistance needed related to this section.

⁹⁶ http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf

Please use the box below to indicate areas of technical assistance needed related to this section:

As TA needs are identified, ADAP will request TA.

Footnotes:

1The Health Disparities of Vermonters, June 2010. <http://healthvermont.gov/research/healthdisparities.aspx>

Environmental Factors and Plan

20. Suicide Prevention

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1a. Provide the most recent copy of your state's suicide prevention plan;

(See Documents Listed Below, both of which are also appended):

- Vermont Injury Prevention Plan, 2010
- The Vermont Suicide Prevention Platform, 2015 (See http://vtspc.org/wp-content/uploads/2015/06/VSPP_2015_Interactive.pdf)

1b. describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised [National Strategy for Suicide Prevention \(2012\)](#).

On May 11, 2015 the VT Suicide Prevention Coalition presented the draft Vermont Suicide Prevention Plan graphic below with the narrative still under development.



The VT Suicide Prevention Coalition has representation from over 45 key state, and local partners, including, but not limited to, the Vermont Department of Health (VDH), Vermont Department of Mental Health (VDMH), Agency of Education (AOE), VT National Guard, Youth in Transition, Outright VT, as well as medical providers, schools, community treatment and mental health providers, survivors of suicide, and the VT chapter of the American Foundation for Suicide Prevention. VDH's Division of Alcohol and Drug Abuse Programs (ADAP) is represented on the statewide coalitions whose mission is to create communities of hope throughout VT in which schools, agencies and people of all ages are given the knowledge, attitudes, skills and resources to respond effectively to suicidal behavior. The message is UMatteer (see link <http://umatterucangethelp.com>).

The VT Suicide Prevention Coalition, supported by funding from VDMH, provides direction to the VT Suicide Prevention Center (see the VT-SPC link www.vtspc.org) whose mission is to create health-promoting communities in which schools, Institutions of Higher Education, public and private agencies and people at all ages, have the knowledge, attitudes, skills, and resources to reduce the risk of suicide. The purpose of the VT-SPC is to support statewide suicide prevention efforts and help local communities implement recommendations of the VT Suicide Prevention Platform. The focus of the VYSPP is to develop broad based community awareness and protocols; provide training and public information to promote consistent and comprehensive state and local systems aimed at youth suicide prevention and intervention. In August 2012, the Center for Health & Learning and the Vermont Department of Mental Health were awarded another three year grant from SAMHSA to continue the work of the Coalition and in March 2015 submitted an application for continued funding. The funds have supported the VYSPC in building statewide capacity and systems for addressing suicide prevention with a focus on mental health promotion and substance prevention. ADAP's Prevention Coordinator and Deputy Commissioner and several other Vermont Department of Health staff serve as members of the VYSPC.

As previously reported, in February 2012 the Vermont Suicide Prevention Coalition (VYSPC) and the Center for Health & Learning presented the *Vermont Youth Suicide Prevention Platform (VYSPP)*, as a guide for suicide prevention efforts in the state. In May 2015, a second edition of the Platform was released (see link <http://vtspc.org/vsp/vt-platform-for-suicide-prevention/>). These have been collaborative efforts undertaken by the Agency of Human Services, including VDH and VDMH, AOE, individual citizens affected by suicide, and over 15 key state and community level partners. ADAP's Prevention Coordinator and Deputy Commissioner have contributed to the development of the Platform.

The *Vermont Suicide Prevention Platform* incorporates recommendations from the revised National Strategy for Suicide Prevention (2012) with involvement and support from SAMHSA. Furthermore, this second update to the *Vermont Suicide Prevention Platform* builds on a decade of work by dedicated individuals and organizations working to shape the state's response to suicide. The updated and revised Platform presents a broader lifespan scope, championed by the Vermont Department of Mental Health and the Vermont Suicide Prevention Coalition, and now folds in the 2012 Youth Suicide Prevention Platform into the one platform. This Platform also represents Vermont's attention to and incorporation of the latest evidence-based policies and practices from across the nation, and details the state's effort to combat suicide prevention, provides statistical evidence of the need for prevention and offers a background for addressing suicide as a public health problem in Vermont. The Platform serves as an important framework for identifying Vermont's priorities in suicide prevention and works to keep the various efforts around the state aligned with each other and the most current findings in the field of suicide prevention.

As the country has recognized suicide as a largely preventable public health crisis, research on and utilization of best practices has expanded. The goals of the Platform has shifted since 2012, and they reflect trends in national suicide prevention efforts, including increased emphasis on promotion of mental and emotional health, de-stigmatization of help-seeking and utilization of mental health services, integration of suicide prevention efforts throughout systems of care, and

expanded surveillance and data systems. The 2015 Vermont Suicide Prevention Platform has 11 goals and they are as follows.

The Eleven Goals of the 2015 Vermont Platform:

1. Promote awareness that suicide is a public health problem.
2. Build sustainable and integrated infrastructure in Vermont for mental health promotion, suicide prevention, intervention and postvention.
3. Develop and implement strategies to promote positive public attitudes toward being socially and emotionally healthy.
4. Develop, implement and monitor programs that promote social and emotional wellness.
5. Promote efforts to reduce access to lethal means among people at risk of suicide.
6. Provide training to community members and professionals on how to recognize suicide related behaviors and how to intervene.
7. Promote suicide prevention, screening, intervention, and treatment as core components of health care services with effective clinical and professional practices.
8. Improve coordination and accessibility of mental health and substance abuse treatment services.
9. Promote responsible reporting and accurate portrayals of suicidal behavior, mental health conditions and substance abuse in the media.
10. Improve and expand surveillance systems in order to: 1) monitor trends and profiles of at-risk populations, 2) assess the impact of existing policies and programs, and 3) inform the development of future efforts.
11. Provide care and support to individuals affected by suicide deaths and attempts.

In addition to the work detailed above, ADAP's Clinical Services unit, in collaboration with the Vermont Department of Mental Health, is supporting peer recovery groups to veterans at each of the state's twelve Recovery Centers through the Vet-to-Vet program. This cooperative initiative with mental health includes suicide prevention and intervention with this high risk population in Vermont.

2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.

As stated in other sections of this application, Vermont's Department of Health Strategic Plan 2014-2018 has as its mission to protect and promote the best health for all Vermonters. One of the major goals is health equity, and the plan includes measurable objectives to reduce health disparities, recruit and retain qualified candidates from diverse backgrounds, and ensure linguistic competency by translating documents for people with limited English proficiency. See http://healthvermont.gov/hv2020/strategic_plan.aspx.

Furthermore, the state prepares a specialized publication that presents the results of a comprehensive evaluation of health disparities in Vermont, and sets out key recommendations to further reduce health disparities.¹ Within these reports includes a focused study entitled "Stress, Disability & Depression" and a comprehensive analysis of associated factors among Vermonters, including depression, stress, chronic disease, income, age, education, disability, and also suicide attempts and suicide deaths. See <http://healthvermont.gov/pubs/healthdisparities/stress.pdf>.

In ADAP's Strategic Plan, the commitment to addressing health disparities (and similar factors that may be associated to higher risk of suicide) is reflected across many of its goals, but most directly articulated in Strategic Directions 6.1 and 6.2:

Strategic Direction 6.1: Health Disparities: Recognize and respond to health disparities

6.1.1 Complex Clients and High Risk, Hard to Reach Populations: Improve infrastructure, services and reach to complex and high risk client populations.

Strategic Direction 6.2: Cross-Divisional and Department Collaborations: Collaborate across state government to achieve health equity among the most vulnerable Vermonters

6.2.1 Compound Impact through Collaboration: Identify opportunities for collaboration and establish partnerships across Divisions, State Departments and other state programs to improve reach and services to vulnerable Vermonters.

The above cited *Vermont Suicide Prevention Platform (2015)* summarizes the latest data on suicide deaths and populations and highest risk of suicide including high school students and other youth suffering depression and/or with mental health concerns, the elderly above 65 years of age affected by grief, depression, isolation, and chronic pain, and a higher risk for men than women.

ADAP and the Vermont Suicide Prevention Center (VTSPC), under the Center for Health and Learning (CHL), have agreed to provide mutual support to the implementation of the Partnership for Success (recently awarded) and the SAMHSA Youth Suicide Prevention and Intervention grant (applied in June). For example, ADAP's SEOW will provide data to DMH and the VTSPC and ADAP will continue to promote Umatter training among school and community grantees. CHL will provide training to ADAP grantees on enhancing support and outreach to LBGQT youth.

Last, the Agency of Human Services (AHS) has identified suicide prevention as an agency priority. ADAP is represented on the Suicide Prevention Policy Group, to assure that ADAP programs are coordinated with the various efforts cited above.

3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#).

The 2015 Vermont Suicide Prevention Platform follows the key elements and characteristics of the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#) and mirrors the national recommendations from the revised [National Strategy for Suicide Prevention \(2012\)](#).

The progress achieved since the first plan and summarized in the second edition and current 2015 plan, the *Vermont Suicide Prevention Platform (2015)*, includes the following:

- Provided 24-hour phone service by trained responders for suicidal response across the state, through the United Ways of VT 2-1-1 system, which received 786 suicide-related calls.

- Trained 514 educators and school personnel in 115 schools in Umatter gatekeeper model including how to recognize signs of suicide, what to say and do, how to refer to help; school related protocols and how to implement the Lifelines curriculum.
- Trained eight high-needs communities with prevention training and technical support for a coordinated community response to suicide, reaching the professions described immediately below.
- Trained 308 professionals from Mental Health, Law Enforcement, First Response, Social Services, Primary Care, and Faith Leadership in the use of profession-specific protocols.
- Developed and published Vermont Suicide Prevention and “Postvention” Protocols for those six professions, and for Workplace Supervisors.
- Launched three websites:
 1. www.UmatterUCanHelp.com with information and resources for adults and professionals
 2. www.UmatterUCanGetHelp.com with information and resources for youth and young adults
 3. www.vtspc.org as the go-to source for suicide prevention resources in Vermont
- Launched and maintained the Umatter Public Information Campaign promoting awareness and help-seeking through newspapers, radio, Facebook, and YouTube.
- Coordinated the Campus Suicide Prevention Work Group and Symposium for Institutions of Higher Education, in which professionals from 13 colleges participate.
- Expanded the focus of the Vermont Youth Suicide Prevention Coalition to a lifespan focus, and supported and expanded the awareness of suicide as a public health issue across the lifespan.
- Identified and referred 345 youth who were depressed or suicidal (61% girls, 39% boys), via trained school personnel.
- Developed a Cadre of 30 gatekeeper trainers and 9 “postvention” trainers across the state.
- Launched Umatter for Youth Community Action, engaging 95 youth and 35 adult leaders in education about key concepts of mental health wellness, and in the development of local action projects promoting mental health wellness.

Please indicate areas of technical assistance needed related to this section.

Footnote:

¹The Health Disparities of Vermonters, June 2010.
<http://healthvermont.gov/research/healthdisparities.aspx>

VERMONT INJURY PREVENTION PLAN

2010

**Vermont Department of Health
Injury Prevention Program
January, 2011**

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1. INTRODUCTION

Over two decades ago the Centers for Disease Control and Prevention (CDC) was named as the coordinating agency for injury prevention and control because of its “strong history of interdisciplinary research, data collection and analysis, information sharing, and relationships with states.” The need for a coordinating agency was in response to the unrelenting historical trend of injury as the leading cause of death for all Americans, accounting for more than 170,000 deaths in 2005.¹ The Institute of Medicine later recommended a multiagency collaborative approach “with each agency leading in its area of expertise” to effectively address injury prevention.² As the coordinating entity for injury prevention efforts CDC instituted a public health approach and over the course of the two decades, in collaboration with its federal and state partners, worked to change the false perception that injury is not preventable but a result of random events. By defining the problem, identifying risk and protective factors, developing and testing prevention strategies, and assuring widespread adoption of effective injury prevention principles and strategies public health leaders and partners have endeavored to reduce the burden of this epidemic.

In Vermont, injury continues to have indiscriminant impact on our population regardless of age, race, ethnicity, sex or socioeconomic status. The rural nature of our state presents its own set of challenges—rural populations experience significantly increased risk for serious injury when compared to their urban counterparts.³ Rurality also presents challenges associated with access to care; disperse rural populations and a fragile emergency responder system factor in to the treatment (immediacy) and consequently health outcomes of those suffering from injury. Each year, nearly 350 Vermonters lose their lives to injuries and thousands more suffer serious, sometimes permanent disabilities as a result of their injuries. Unintentional injury was the fourth leading cause of death in Vermont in 2007 and only cancer, heart disease and chronic lower respiratory disease (COPD) accounted for more deaths in that same year with suicide being the eighth leading cause of death for Vermonters.

Whether the injuries are intended or accidental, most physical injuries can be prevented by identifying their causes and working towards reducing people’s exposure to them. In 1999 Vermont’s Injury Prevention Program was established with a grant from the CDC to understand and address unintentional and intentional injury trends in the state. Modeled after the federal government’s multiagency collaborative approach, the Program provides a coordinated response to injury prevention throughout the state by applying the well endorsed public health approach. Central to this approach is the involvement of communities in the implementation of identified strategies. The role of communities in tailoring strategies to their unique environment and culture is essential—it assures a higher likeliness that these strategies will be adapted and sustained. The Vermont Injury Prevention Community Planning Group is one mechanism used to solicit input from communities and other stakeholders. The Injury

¹ CDC—insert source

² CDC—insert source

³ Insert source--Rural article

Community Planning Group is convened by the Injury Prevention Program to address relevant injury prevention issues, advise the program regarding program activities, and promote the integration and coordination of these activities. Since the initiation of the Injury and Violence Prevention Program and the establishment of the Community Planning Group work continues to focus on the leading cause of injury deaths and injury hospitalizations.

Figure 1.

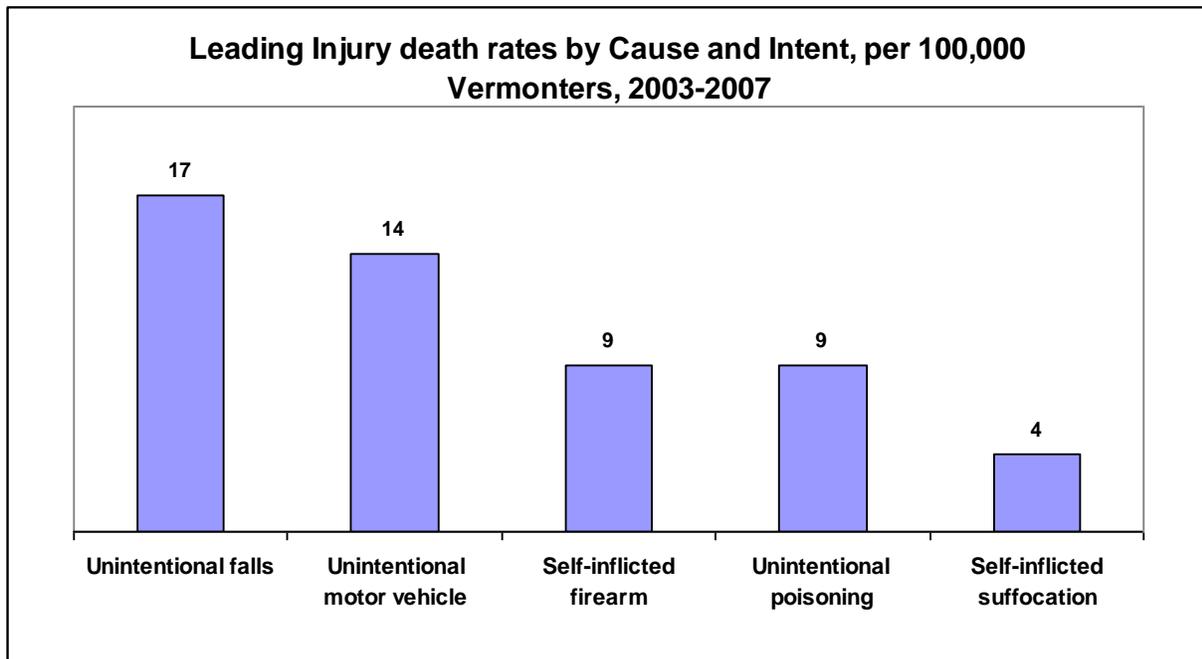


Figure 2.

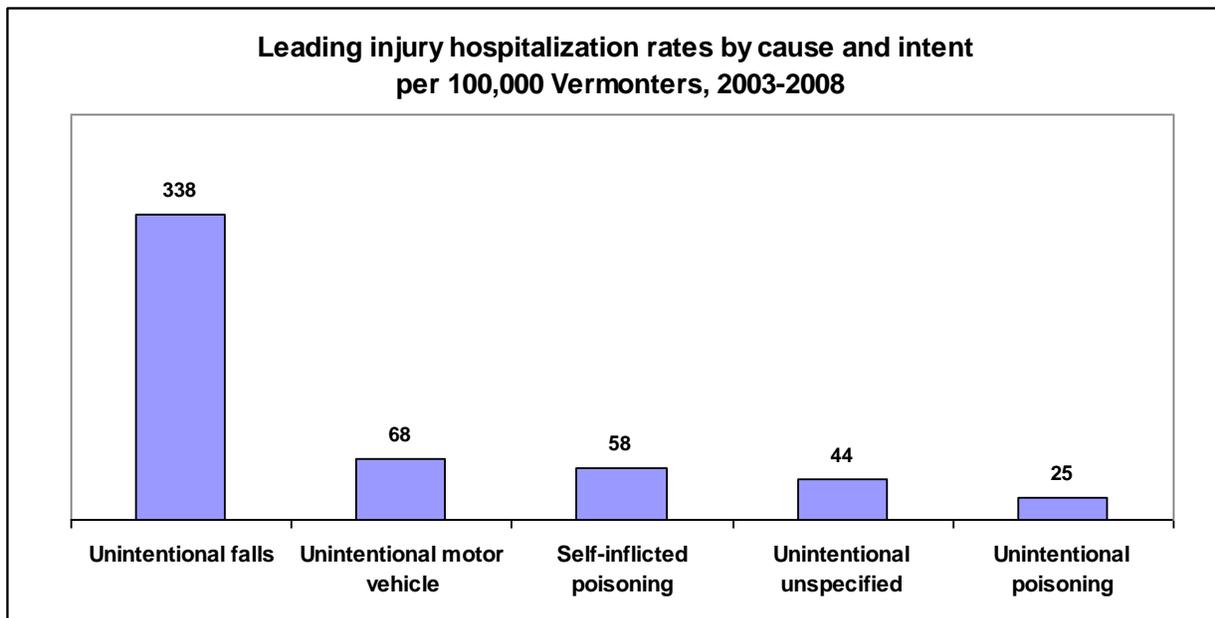
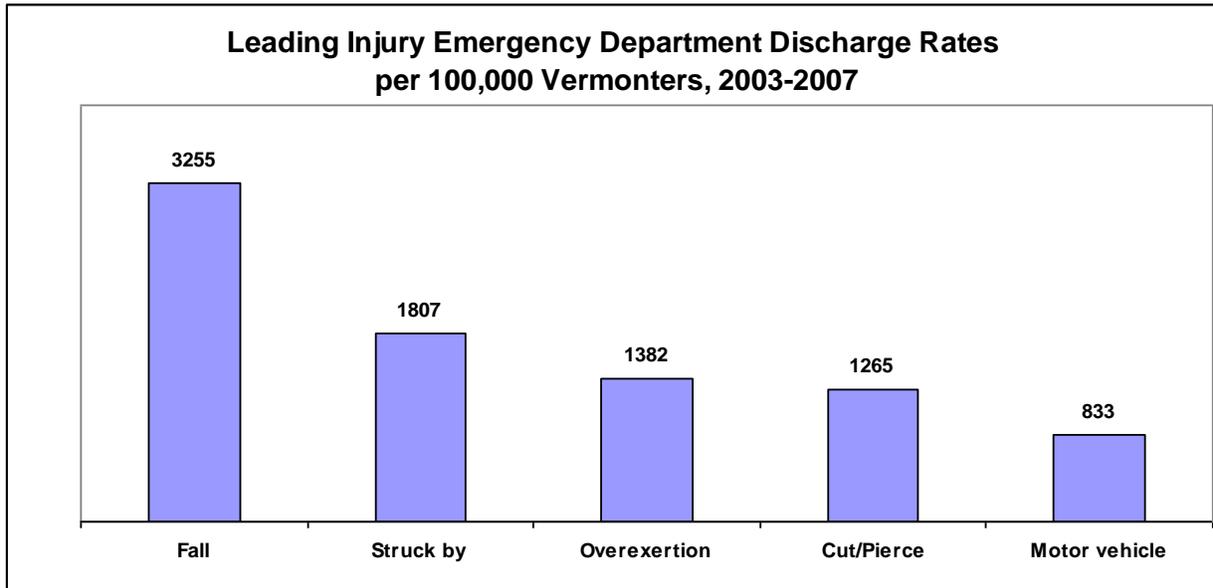


Figure 3.



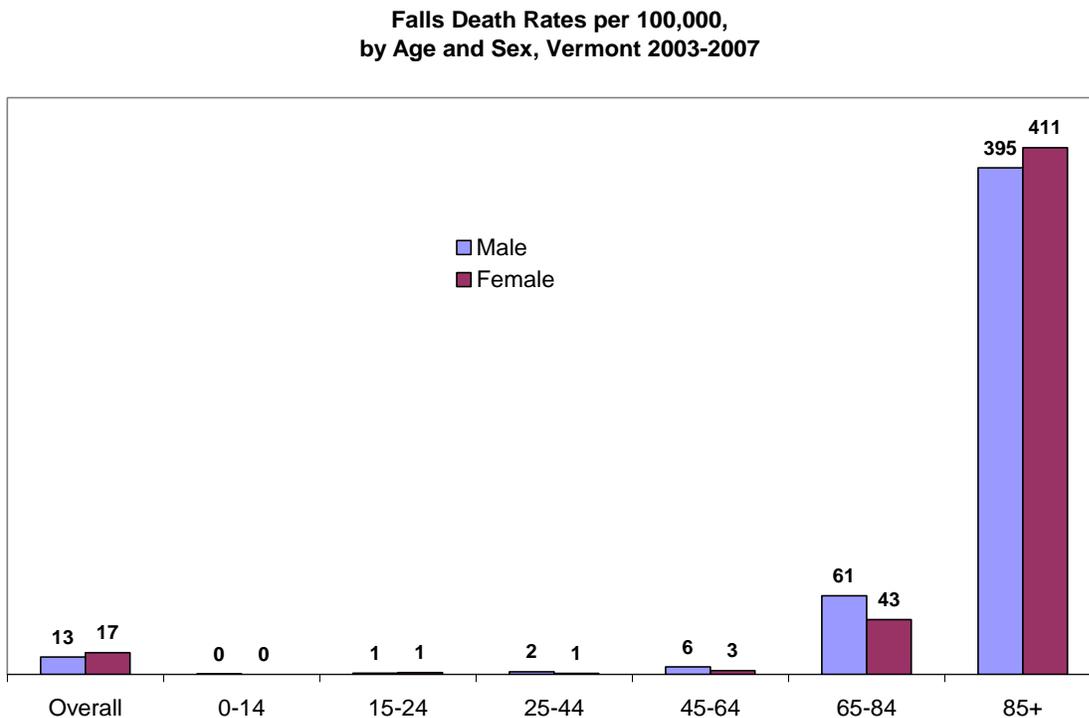
As with all public health issues, the first step is to assess and describe the risks to more fully understand the factors that are associated with risk for morbidity and mortality for the public’s health. The 2010 Vermont Injury Prevention Plan offers up-to-date data and assessments that are the first step in a call to action for the Vermont Department of Health, the Injury Community Planning Group, and many other concerned Vermont stakeholders to come together. This collaborative effort will result in a comprehensive approach to assess and create evidenced based strategies designed to reduce the burden of injury for all Vermonters. The Vermont Department of Health looks forward to working on the action steps as described in the 2010 Plan and to evaluating our progress, year by year, in reducing the effects on injury for our Vermont citizens.

2. FALLS

For everyone, injury related falls are not accidents, but preventable. Nationally, from 2003-2007 falls were the third leading cause of injury death, and the leading cause of death in Vermont.⁴ And both nationally and in Vermont, falls were the number one reason among for nonfatal hospital discharges and emergency room visits.⁵

In 2007 in Vermont there were 133 deaths, 2,261 hospital discharges and 21,526 ED Visits for falls related injuries.⁶ During this time period, the fall death rate increased by 98%, from 10.8 to 21.4 per deaths per 100,000%; the highest death rate occurring among people age 85 or older, particularly for woman.⁷

Figure 4.



⁴ Office of Statistics and Programming, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

⁵ National Center for Injury Prevention and Control, CDC Office of Statistics and Programming. The exception is for the 15-24 year old age group where unintentional falls is the second leading cause of nonfatal injuries treated in hospital emergency rooms.

⁶ Vermont Department of Health – Jason.

⁷ Vermont Department of Health – Caroline.

Unlike the dramatic trend upwards for fall injury related death, the hospitalizations and emergency room visits did not increase as much for the same time period (9% and 14%, respectively). Like deaths, the elderly, and especially those over age 85, are more likely to have injuries due to falls.

Figure 5.

Hospital Discharge Rates per 100,000, By Age and Sex, 2003-2007

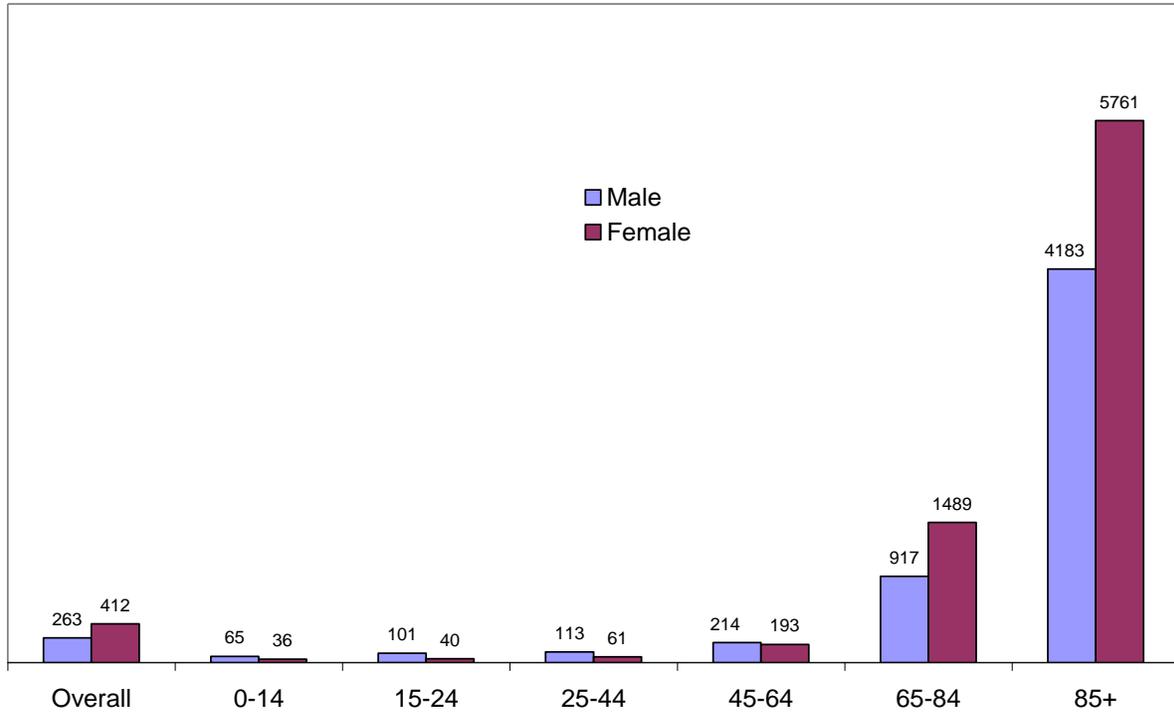
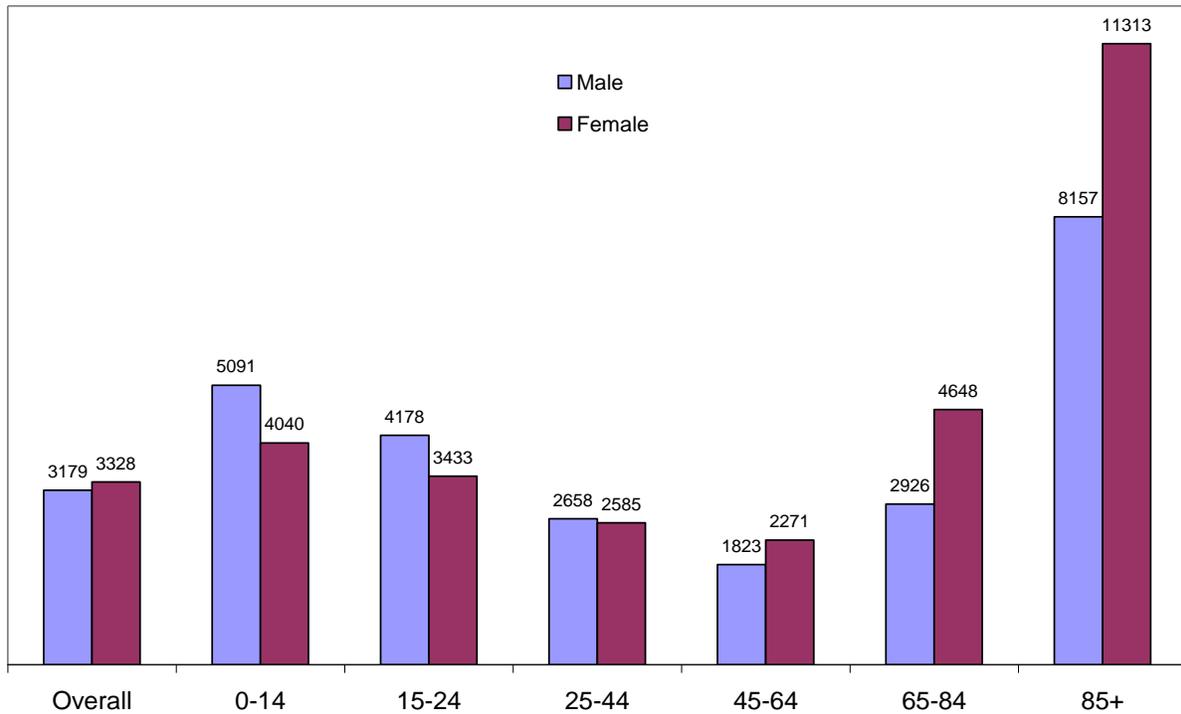


Figure 6.

Falls ED Discharge Rates per 100,000, By Age and Sex, 2003-2007



From 2003-2007 in Vermont, the majority of death-related falls occurred on the same level (59%), and fall-related hospitalizations were most often attributed to slipping, stumping, or tripping (34%).

2.1. Falls and Vermont Seniors

Falls among the elderly are both common, preventable, and in many cases, have a profound effect on their lives. Fall related injuries decrease a person’s mobility, limit their ability to live independently, may result in a nursing home placement, and increase the risk of an early death.⁸ Contributing factors to fall-related injuries among those over 65 are indoor environmental hazards, poor eyesight, poor balance due to medications, and poor physical fitness. For this population, falls are the leading cause of death from injury. More than one third of individuals over the age of 65 falls each year and of those two thirds fall again within six

⁸ Sterling DA, O'Connor JA, Bonadies J. Geriatric falls: injury severity is high and disproportionate to mechanism. *Journal of Trauma–Injury, Infection and Critical Care* 2001;50(1):116–9., and Alexander BH, Rivara FP, Wolf ME. The cost and frequency of hospitalization for fall-related injuries in older adults. *American Journal of Public Health* 1992;82(7):1020–3.

months.⁹¹⁰ According to the 2008 BRFSS, 19% of Vermonters age 65+ have fallen in the past at least once in the past three months, with 27% of these falls resulting in injury. Even if not injured, people who fall may develop a fear of falling which can lead them to limit their activities, reducing their mobility and physical fitness, and actually increase their actual risk of falling in the future.¹¹

Mirroring the national trend, in Vermont the death rate, hospitalization rate, and emergency room visit rate for fall related injuries significantly increases after age 65, and dramatically rises for those over 85. However, in Vermont women are more likely to die as a result of a fall than men, and the rate of women being hospitalized for falls (412 per 100,000) was more than 50% higher than men (263 per 100,000).¹²

Of all the fall related injuries, hip fractures cause the greatest number of deaths, lead to the most severe health problems, and change to quality of life. Women sustain 75% to 80% percent of all hip fractures.¹³ People who are 85 years or older are 10 to 15 times more likely to experience hip fractures than are people between the ages of 60 to 65.¹⁴ In Vermont, between 2003- 2007, 89% of all hospital discharges for hip fractures were the result of a fall. Furthermore, consider the following:

- Most patients with hip fractures are hospitalized for one week,¹⁵
- Up to one in four adults who lived independently before their hip fracture has to stay in a nursing home for at least a year after their injury;¹⁶
- Half of all older adults hospitalized for hip fractures cannot return home or live independently after their injury;¹⁷ and
- One in five individuals with hip fractures dies within a year.¹⁸

⁹ “Falls Among the Elderly, Common but Preventable;” <http://www.astho.org/ASTHO-Presidential-Challenge/2010-02/>; Hausdorff JM, Rios DA, Edelber HK. Gait variability and fall risk in community–living older adults: a 1–year prospective study. Archives of Physical Medicine and Rehabilitation 2001;82(8):1050–6, and Hornbrook MC, Stevens VJ, Wingfield DJ, Hollis JF, Greenlick MR, Ory MG. Preventing falls among community–dwelling older persons: results from a randomized trial. The Gerontologist 1994;34(1):16–23. ‘Caroline, Feller, Falls and Traumatic Brain Injury: The Basics.’ produced by the Brain Injury Association of America (2007).

¹⁰ Governor’s Commission on Healthy Aging: Executive Summary (2010).

¹¹ Vellas BJ, Wayne SJ, Romero LJ, Baumgartner RN, Garry PJ. Fear of falling and restriction of mobility in elderly fallers. Age and Ageing 1997;26:189–193.

¹² Vermont Department of Health

¹³ VTDOH 2010 Healthy Vermonters page 15.

¹⁴ VTDOH 2010 Healthy Vermonters page 15.

¹⁵ [NCHS] National Center for Health Statistics, Trends in Health and Aging. <http://209.217.72.34/aging/ReportFolders/ReportFolders.aspx>. Accessed on [April 23, 2008].

¹⁶ Magaziner J, Hawkes W, Hebel JR, Zimmerman SI, Fox KM, Dolan M, et al. Recovery from hip fracture in eight areas of function. Journal of Gerontology: Medical Sciences 2000;55A(9):M498–507.

¹⁷ VTDOH 2010 Healthy Vermonters page 15.

¹⁸ Leibson CL, Toteson ANA, Gabriel SE, Ransom JE, Melton JL III. Mortality, disability, and nursing home use for persons with and without hip fracture: a population-based study. Journal of the American Geriatrics Society 2002;50:1644–50.

Falls are the most common cause of traumatic brain injuries (TBI) for our eldest citizens.¹⁹ In Vermont among those 85 and older, falls account for the majority of TBI deaths (61%).²⁰

2.2. Vermont's Children and Fall Related Injuries

While the death rate, hospitalization, and emergency room visit rate for fall-related injuries is considerably lower for children compared to seniors, falls are still the leading cause of injury for those under 14²¹. Nationally, falls represent the largest share of injury costs for children ages 14 and under, accounting for more than one-quarter of all childhood unintentional injury-related costs.²²

In Vermont from 2003-2007, 41% of all the hospitalizations for individuals under 18 were from recreational falls (e.g. snowboarding, skiing, skateboarding, non-motorized scooters, playground equipment, etc).²³

Children fall at home and while playing. While the risks for children falling differ based on their age, the distance of the fall and the landing surface determine the severity of their injuries.²⁴ All children under the age of 14 are at risk for playground related falls, although girls are slightly more likely to sustain injuries than boys.²⁵ The risk for fall related injuries due to sports increases with age.²⁶ In Vermont between 2003-2007, boys were more likely than girls to visit an emergency room or be hospitalized due to falls.

Head injuries are associated with the majority of deaths and severe injuries resulting from falls. Approximately 2 out of 5 traumatic brain injuries among children are associated with participation in sports and recreational activities;²⁷ 28% of all traumatic brain injuries among children are a result of falls.²⁸

Among the common contributing factors to fall-related injuries among children are the

¹⁹ Jager TE, Weiss HB, Coben JH, Pepe PE. Traumatic brain injuries evaluated in U.S. emergency departments, 1992–1994. *Academic Emergency Medicine* 2000;7(2):134–40. Vermont DOH Burden Document page 49.

²⁰ Vermont DOH Burden Document page 49.

²¹ Office of Statistics and Programming, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention for 2007.

²² Safe Kids Falls Fact Sheet. Miller TR, Romano ED, Spicer RS. The cost of childhood injury and the value of prevention. *The Future of Children: Unintentional Injury in Childhood* 2000; 10(1): 137-163.

²³ Vermont Health Department – Caroline numbers.

²⁴ Safe Kids Falls Fact Sheet.

²⁵ Safe Kids Falls Fact Sheet. Miller TR, Romano ED, Spicer RS. The cost of childhood injury and the value of prevention. *The Future of Children: Unintentional Injury in Childhood* 2000; 10(1): 137-163.

²⁶ Tinsworth D, McDonald J. *Special Study: Injuries and Deaths Associated with Children's Playground Equipment*. Washington (DC): U.S. Consumer Product Safety Commission; 2001.

²⁷ Rivara F. Epidemiology and prevention of pediatric traumatic brain injury. *Ped Ann* 1994;23:12-17, and National Youth Sports Safety Foundation, Inc. Factsheet: helmets.

²⁸ http://www.cdc.gov/TraumaticBrainInjury/tbi_concussion.html

following:

- Inadequate supervision of children around fall hazards or during sports;
- Children not wearing appropriate protective equipment for sports – such as helmets for biking, skiing, skating, skateboarding, snowboarding;
- Playground equipment not properly designed or maintained, and/or not having a safe “soft” landing material beneath; and
- Lack of safety devices such as stair gates and guardrails.

Healthy People 2020 Related Objectives

Arthritis, Osteoporosis, and Chronic Back Conditions (AOCBC)

AOCBC-11: Reduce hip fractures among older adults

Older Adults (OA)

OA-11: Reduce the rate of emergency department visits due to falls among older adults

Injury and Violence Prevention (IVP)

IVP-23: Prevent an increase in the rate of fall-related deaths

IVP-26: Reduce sports and recreation injuries

IVP-27: Increase the proportion of public and private schools that require students to wear appropriate protective gear when engaged in school-sponsored physical activities

Action Steps

Falls and Vermont Seniors

- **Action Step 1:** Promote best practice elder exercise programs that build strength, balance and coordination.
- **Action Step 2:** Promote access to regular vision and hearing screening for older adults.
- **Action Step 3:** Promote nutrition screening and education to prevent osteoporosis.
- **Action Step 4:** Support best practice community programs that provide education and in-home safety assessments to reduce risk of falls.
- **Action Step 5:** Improve elder adult fall-related injury data collection to include more information detailing the circumstance surrounding the event of the fall.

Falls and Vermont Children

- **Action Step 1.** Support falls in injury prevention education for families via parent education in home visits, community education programs, and in clinical well- child visits.
- **Action Step 2:** Assist providers in educating families about child injury risks in the home via the ESDPT Children’s Medicaid Program and using the AAP Bright Futures Guidelines.

- **Action Step 3:** Support schools and community fitness programs to insure child play and physical activity areas and related equipment are constructed and used according to latest safety recommendations.
- **Action Step 4:** Coordinate with organizers of sports, physical activity events (coaches, ski areas, school nurses, etc.) and community advocacy organizations to promote safe environments and regular use of safety equipment.
- **Action Step 5:** Improve child fall-related injury data collection to include more information detailing the circumstance surrounding the event of the fall.

3. FIRE-RELATED INJURIES

Analysis of Vermont's fire death and injury data shows that the young as well as older Vermonters continue to be at high risk from fire and burn injuries and death in their homes. Increased support of public fire safety education programs is one of the best ways to protect Vermonters where they live.

Vermont's housing stock is dominated by older, owner occupied homes. An estimated 44% of the housing stock is comprised of owner-occupied primary residence homes built before 1950. Vermont-based research suggests that the majority of these homes are likely to contain old outdated battery operated style smoke alarms or none at all, and many do not have carbon monoxide alarms.

Due to past fire prevention efforts the fire deaths in Vermont have been reduced in half during the last 5 years, but still remain at an average of 8 deaths per year. While one fire death is too many, 8 deaths in a small, rural state still present as a significant public health issue. In addition, Vermont continues to have over 1,000 flame and burn injuries each year that require emergency department care and there are around 500 incidents where elevated levels of carbon monoxide are found by responding fire departments.

There are a number of obstacles in reaching households to disseminate information on fire safety, including the lack of standard local fire prevention education and awareness efforts, the absence of home fire code and safety inspections, the age of housing in Vermont, the maintenance of home mechanical systems, the lack of fire sprinkler protection and the lack of working smoke and carbon monoxide (CO) alarms. These are all are factors in Vermont's high fire death and injury rates over the years.

Vermont has 240 fire departments. Over 90% are small rural volunteer departments with limited resources for fire prevention education programs. The majority of fire departments in Vermont are funded by local taxes and fundraising. Unlike many other states, Vermont's fire departments receive no capital funding from the county or state level. This means that fire departments will continue to struggle with significantly reduced budgets and have difficulty supporting fire prevention education activities because of continued municipal budget reductions and their inability to raise sufficient operating and capital funds without straining their local municipal budget.

Additional resources made available to fire departments for public fire safety educational programs will have a significant impact on public health and safety.

Healthy People 2020 Objectives

Injury and Violence Prevention (IPV)

IPV-28: Reduce residential fires.

Action Steps

- **Action Step 1:** Promote widespread and proper installation and maintenance of up-to-date smoke alarms in all housing, with specialized strategies for both rental housing and owner-occupied primary residence homes.
- **Action Step 2:** Educate children and families about fire and burn prevention in the home, including creating and practicing a home fire escape plan, setting hot water heaters at 120 degrees, and the importance of tending to lit stovetops and ovens, candle flames, and cigarettes.
- **Action Step 3:** Work with partners such as the Department of Public Safety to assess, update and standardize fire code and safety inspection procedures statewide.

4. INFANT SAFE SLEEP

Every year, about 4,600 U.S. infants die while sleeping. Nearly half of these sudden unexpected infant deaths (SUID) are attributed to Sudden Infant Death Syndrome (SIDS). Sudden Unexpected Death of an Infant is any infant death that is unexpected and initially unexplained. Frequently, a cause of death is determined after a thorough investigation, autopsy by a medical examiner or coroner, examination of the death scene, and review of the clinical history. The deaths that remain unexplained are defined as SIDS.²⁹ In Vermont for the years 2005-2010, 62% of sudden unexpected infant deaths were associated with unsafe sleep environments"

Nationally in 2006, SIDS was the third leading cause of infant deaths and the first leading cause of death among infants 1-12 months.³⁰ Furthermore, "undetermined suffocation," (typically while an infant was sleeping)³¹ was the fifth leading cause of death for children 0 to 12 months. According to the Vermont State Medical Examiner's Office, 62% of sudden unexpected infant deaths in Vermont for the years 2005-2010 were associated with unsafe sleep environments. These numbers indicate the importance of promoting "safe sleep" for infants, eliminating and minimizing all of the known risk factors for both SIDS and accidental suffocation.

Many SUID cases are not investigated, and when they are, cause-of-death data are not collected and reported consistently. According to the Centers for Disease Control, inaccurate classification of cause and manner of death hampers prevention efforts and researchers are unable to adequately monitor state and national trends, identify risk factors, or evaluate intervention programs. There is a need for valid and reliable data to support research and prevention efforts if we want to reduce these infant deaths.³²

What specifically causes SIDS remains unexplained. Research demonstrates that SIDS occurs in families of all religions, races, nationalities, and socio-economic groups. Research also indicates that SIDS is not caused by suffocation, child abuse, immunizations, vomiting, choking, or by minor illnesses such as cold or infection, and that it is not contagious.³³ Finally, research has also consistently shown the following practices and/or behaviors contribute independently to SIDS:

- Prone sleep position (infant laying on his/her tummy),
- Sleeping on a soft surface,
- Maternal smoking during pregnancy,
- Overheating, late or no prenatal care,
- Young maternal age,
- Prematurity and/or low birth weight, and

²⁹ <http://healthvermont.gov/family/SUDI/index.aspx>

³⁰ <http://www.cdc.gov/SIDS/SUID.htm>

³¹ CDC /www.cdc.gov/injury/Images/LC-Charts/10lc%20-Unintentional%20Injury%202006-7_6_09.jpg, and WIQSARS

³² <http://www.cdc.gov/SIDS/SUID.htm>

³³ <http://healthvermont.gov/family/SUDI/index.aspx>

- Male sex.³⁴

There are also studies that indicate co-sleeping, or bedsharing of parents and infants, may be particularly hazardous to infants, and that the risk of SIDS associated with co-sleeping is significantly increased among smokers.³⁵ While it is not possible to do anything to prevent SIDS from happening since the causes are unknown, it is possible to minimize or eliminate some of the risk factors such as the baby's sleeping position, sleeping environment, maternal smoking, and overheating.

SIDS is extremely difficult to diagnose, and it can be mistaken for neglect, abuse (address in a separate section of this report) or suffocation. Complicating the differentiation of SIDS from suffocation is that common scenarios for accidental infant suffocation are risk factors for SIDS; namely sleeping on soft surfaces and co-sleeping. When infants sleep with soft toys or on soft surfaces such as waterbeds, quilts, comforters, sheepskins, sofas, etc. they risk having their airways obstructed from bedding; as a result the infant may die from suffocation or rebreathing which increases the amount of CO₂. Even infants sleeping on their backs are at risk if the bedding covers faces.

While many feel that co-sleeping with an infant promotes breast feeding and is enjoyed by parents, epidemiological research indicates that it is hazardous for infants to sleep in the same bed with others, both adults and other children. Statistics demonstrate that half of all child suffocation deaths occur in adult-sized beds due to overlaying, suffocation from bedding, or becoming entrapped (e.g. between the bed and a wall, headboard, another mattress, etc). As a result, many experts, including the American Academy of Pediatrics, recommend that parents should never sleep with their babies, but should practice room-sharing (i.e., the baby sleep in the same room as the parents, but in a safety-approved crib.)

Healthy People 2020 Objectives

Injury and Violence Prevention (IVP)

IVP-24: Reduce unintentional suffocation deaths

Maternal, Infant, and Child Health (MICH)

MICH-1: Reduce the rate of fetal and infant deaths

MICH-1.8: Infant deaths from sudden infant death syndrome (SIDS)

³⁴ American Academy of Pediatrics Policy Statement: Changing Concepts of Sudden Infant Death Syndrome: Implications for Infant Sleeping Environment and Sleep Position. *Pediatrics*, Vol. 105, No. 3 March 2005, pp. 650-656. <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;105/3/650>

³⁵ Hauck FR, Kemp JS Bedsharing promotes breastfeeding and AAP Task Force on Infant Positioning and SIDS. *Pediatrics* 1998; 102:662-663; Kloneff-Cohen H, Edelstein S Bed sharing and the sudden infant death syndrome. *Br Med J* 1995; 311:1269-1272; Scragg RK, Mitchell EA, Taylor BJ, Bed sharing, smoking, and alcohol in the sudden infant death syndrome. *Br Med J* 1993; 307:1312-1318; Scragg RK, Mitchell EA Side sleeping position and bed sharing in the sudden infant death syndrome. *Ann Med* 1998; 30:345-349

MICH-1.9: Infant deaths from sudden unexpected infant deaths (includes SIDS, Unknown Cause, Accidental Suffocation, and Strangulation in Bed)

Action Steps

- **Action Step 1:** Develop and support systems that provide Safe Sleep education for parents and caregivers of infants.
- **Action Step 2:** Support clinical medical providers who see families with infants to deliver an accurate and timely safe sleep message to these families.
- **Action Step 3:** Collaborate with medical and public health stakeholders to develop an ongoing, statewide system of safe sleep trainings for professionals who work with families with infants, such as hospital personnel, child care workers, and community based home visitors.
- **Action Step 4:** Collaborate with the Vermont Child Fatality Review Team and the Vermont Department of Health Office of the Chief Medical Examiner to implement a system of regular trainings for first responders for infant death scene evaluation.
- **Action Step 5:** Coordinate with the Department for Children and Families to educate social workers on the elements of a safe sleep environment and to include this criteria when determining a family's ability to care for their infant safely.

4. OCCUPATIONAL

According to the American Time Use Survey, Americans on average spend almost a third of each day working; work (inside or outside of the home) represents the activity that accounts for the largest blocks of time for the majority of Americans.³⁶ Injuries and illnesses that result in time away from work or a person's needing to stop work altogether can have far reaching impacts on individuals' lives, our economy, the social welfare network, and our healthcare systems. Given the predominance and importance of work in our lives, injury prevention in the workplace is a public health concern.

Workplace related injuries are defined as any wound or damage to the body resulting from an event in the work environment is considered an occupational injury. In some cases, it is easy to identify and diagnose a workplace injury – the person may have fallen, sustained a cut, burn, bruise, or broken limb, or there was a transportation accident. In other cases, workplace injuries can be more difficult to identify as they are the result of long-term exposures or repeated motions such that there is a cumulative effect on the body such as a loss of hearing, respiratory issues from allergens or particles, illness from exposure to chemicals, or carpal tunnel syndrome. In some cases, there maybe environmental causes for the injuries or illness that are not easily detectable without special equipment and monitoring.

Yet while injury prevention in the work place is important, we are hampered in our ability by a lack of data. Emergency department, hospital records, and primary care physician records do not usually record if an injury is work related. Normally, only if a workman's compensation claim is made will it become apparent in formal records that an injury was the result of an event at a workplace. While all businesses that employ at least one other individual to the owner are required by Vermont state law to have workmen's compensation insurance, there are still a lot of individuals who are not covered by the system, namely: federal employees (they have their own), independent contractors, person's engaged in casual employment, owners or sole proprietors of an unincorporated business, family members, to name a few. These categories are important to understanding work related injuries in Vermont because they are common for the most hazardous industries and occupations – farms are often family owned (unincorporated businesses) where the workers are often the owners or family members, or where the farm employs casual labor or contract workers. For children working on farms the risks are great as they are asked to perform farm chores that may be inappropriate based on where they are developmentally.³⁷ This North America Guidelines for Children's Agricultural Tasks (NAGCAT) helps parents to determine when their children are ready to perform certain farm chores.³⁷

³⁶ <http://www.bls.gov/news.release/atus.nr0.htm>

³⁷ Larson-Bright M, Goodwin Gerberich S, Alexander BH, Gurney JG, Masten AS, ChurchT R, Ryan AD, Renier CM. Work practices and childhood agricultural injury. *Injury Prevention* 2007;13:409–415. doi: 10.1136/ip.2006.014233

The construction and transportation industries also have large numbers of contract workers who are not covered by workmen's compensation. There are a few federal surveys that seek to estimate work place injuries and illnesses, but there are no comprehensive surveillance systems in place and so the numbers, types, and severity of occupational injuries are not fully understood or known.

Nationally, the most hazardous occupations are construction, agriculture (including forestry and fishing), and transportation.³⁸ Within Vermont, these occupations represent approximately 40 percent of the state's workforce and all of the fatalities.³⁹ All of the deaths occurred for private goods or service producing entities engaged in agriculture, forestry, fishing, hunting, or natural resources extraction. The occupations of the deceased were listed as farming, fishing or forestry, transportation and material moving occupations. More than half of these deaths involved contact with objects and equipment and a third were transportation related. Vermont's rate of work-related injuries has not changed dramatically in the last decade, and it's somewhat declined since the late twentieth century. In the 1980s and 1990s, Vermont average 13 deaths per year and had a death rate from occupational industries was 4.4 per 100,000 workers. From 2003-2008, Vermont has averaged 10 work-place related fatalities a year, this translates into a rate of 2.9 fatalities per 100,000 workers, which is lower than the national rate of 3.8.⁴⁰

Overall, Vermont's rates of work-related injuries and illnesses tend to equal or be higher than the National rates. In 2007, Vermont had a total number of 11,900 cases of workplace injuries or illnesses for a rate of 5.9 per 100,000 workers; the national rate was 4.2. Of these cases, 5,900 involved time away from work, job-transfer, or job-restriction as a result of the injury or illness for a rate of 2.8 per 100,000 workers compared to the national rate of 2.1.⁴¹

Healthy People Objectives

Occupational Safety and Health (OSH)

OSH-1: Reduce deaths from work-related injuries

OSH-2: Reduce nonfatal work-related injuries

OSH-2.1: Injuries in private sector industries resulting in medical treatment, lost time from work, or restricted work activity, as reported by employers

OSH-2.2: Injuries treated in emergency departments

OSH-2.3: Adolescent workers aged 15 to 19 years

OSH-3: Reduce the rate of injury and illness cases involving days away from work due to overexertion or repetitive motion

OSH-4: Reduce pneumoconiosis deaths

³⁸ BLS Census of Fatal Occupational Injuries Summary 2008 – news release.

³⁹ May 2008 Occupational and Employment Wage Estimates for Vermont
http://www.bls.gov/oes/2008/may/oes_vt.htm#b45-0000

⁴⁰ VT Injury Prevention Plan 2001, and BLS Census of Fatal Occupational Injuries 2003-2008.

⁴¹ Death on the Job: The Toll of Neglect: A National and State-by-State Profile of Worker Safety and Health in the United States. 18th Edition, April 2009.

OSH-5: Reduce deaths from work-related homicides

OSH-6: Reduce work-related assaults

Action Steps

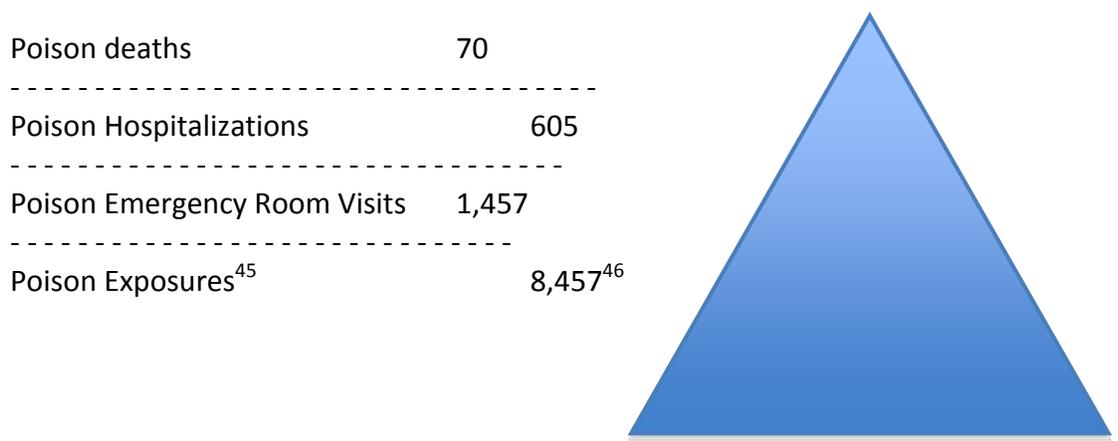
- **Action Step 1:** Improve surveillance and reporting systems to better understand the risk factors associated with work-related injuries, especially those events that are related to agricultural injuries.
- **Action Step 2:** Encourage the implementation of worksite programs to increase safety belt use among employees when driving vehicles in job-related travel.
- **Action Step 3:** With assistance from VOSHA, encourage employers to develop violence prevention programs in the workplace.
- **Action Step 4:** Work with partners, such as the UVM Extension and the Farm Health Task Force, to strengthen funding and capacity of evidenced based programs whose goals are to reduce agricultural related death and disability, such as Farm First and ROPS.

5. POISON

In many ways, Vermonters may not appreciate the common, serious, or pervasiveness nature of poison as a public health problem (see diagram below). According to the Northern New England Poison Control Center, in 2007, 75% of Vermont poison exposures occurred at home.⁴² Poisons are not just substances that come in packages with skulls and crossbones on the labels. In fact, poisons can be any substance that is taken in large quantities. A **poison** is any substance that is harmful to a person’s body when ingested (eaten), inhaled, injected, or absorbed through the skin. According to the Centers for Disease Control and the American Association for Poison Control Centers the most common agents for poison exposures in the United States opiod pain medications, heroin, cocaine, abuse or misuse of prescription medications or over the counter medications (e.g. analgesics, topical preparations, and cold and cough preparations), household products, personal care items, fertilizers, pesticides, lead, and carbon monoxide.

Poisons can kill, but the more common outcomes from poisonings are illnesses ranging from minor to severe. Emergency room visits, hospitalization, and death from poisoning represent significant costs for our healthcare systems. In 2000, poisonings led to \$26 billion in medical expenses and made up 6% of the economic costs of all injuries in the United States.⁴³ These costs can only have increased with time as the incidence of poisoning has also increased.

2007 Pyramid of Poison Effects in Vermont⁴⁴



Poisoning can be either intentional or unintentional (the person taking or giving a substance did

⁴²Northern New England Poison Center

⁴³ Finkelstein E, Corso P, Miller T. The incidence and economic costs of injury in the United States. New York: Oxford University Press; 2006.

⁴⁴ VDH and Northern New England Poison Center data

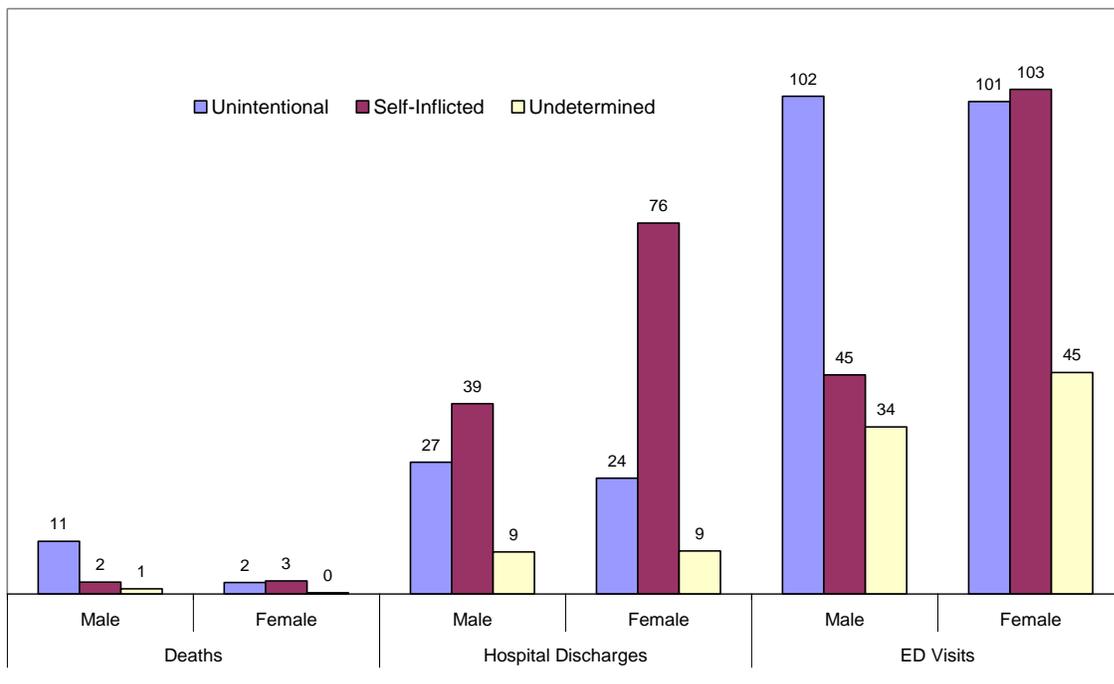
⁴⁵ An exposure represents contact with a potentially toxic substance.

⁴⁶Northern New England Poison Center

not mean to cause harm). Suicides, assaults, and homicides involving poisons are examples of intentional poisoning, and represent 38% of all Vermont poison-related deaths from 2003-2007.⁴⁷ Unintentional poisoning includes the use of drugs or chemicals for recreational purposes (such as an overdose), the excessive use of drugs or chemicals for non-recreational purposes represent 58% of all poison-related deaths for the same time period.⁴⁸ Males are more likely to die from both unintentional and intentional (self-inflicted) poisonings, and females are more likely to be hospitalized or have an ED visit for an intentional poisoning. Both types of poisoning injuries and deaths are preventable.

Figure 7.

Poisoning Injuries, by Sex and Intention, Per 100,000 Vermonters, 2003-2007



Poisons are one of the leading causes of death and injury in both Vermont and the nation. According to the 2008 Annual Report of the American Association of Poison Control Centers, reported human exposure to poison have steadily increased over the years, from approximately 866,000 exposures in 1985 to over 2.4 million in 2008.⁴⁹ Poisoning is among the five leading causes for injury death among Vermonters (16% of all injury deaths) and one of the five leading causes of injury hospitalizations (12%).⁵⁰ While poisoning is a leading cause of injury, 81% of poison exposures were managed there or at a non-healthcare facility and were treated through telephone management by a trained Specialists in Poison information in 2007.⁵¹

⁴⁷ VDH

⁴⁸ VDH

⁴⁹ AAPC 2008 Report

⁵⁰ VDH Burden document page 40.

⁵¹ Northern New England Poison Control Center

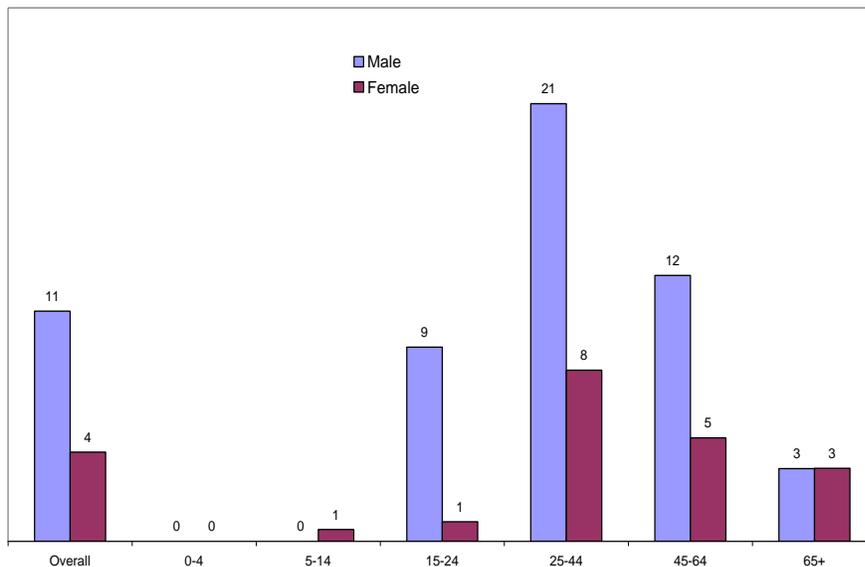
Age & Sex

While the stereotypical unintentional poisoning case maybe of a child, adults too are at risk. Children are involved in the majority of poison exposures reported to centers and ED visits for unintentional poisonings, but adults account for the overwhelming majority of poisoning fatalities and hospital discharges. From 2003-2007, unintentional poisoning was one of the five leading causes of injury death and hospitalization in Vermont, and one of the ten leading causes of injury-related to emergency department visits.

There are significant sex and age differences with respect to unintentional poisoning. Men experience unintentional poisoning death at a rate almost three times higher than women (11 per 100,000 versus 4); yet hospital discharge and emergency department visits are roughly similar for the two sex. Men between the ages of 25 and 4 have the highest death rates (21 per 100,000) for poison-related fatalities.⁵² Vermonters age 85+ have the highest hospital discharge rates, while children age 0-4 have the highest ED visit rate.

Figure 8.

Deaths Due to Unintentional Poisoning per 100,000 Vermonters, 2003-2007



⁵² VDH

Figure 9.

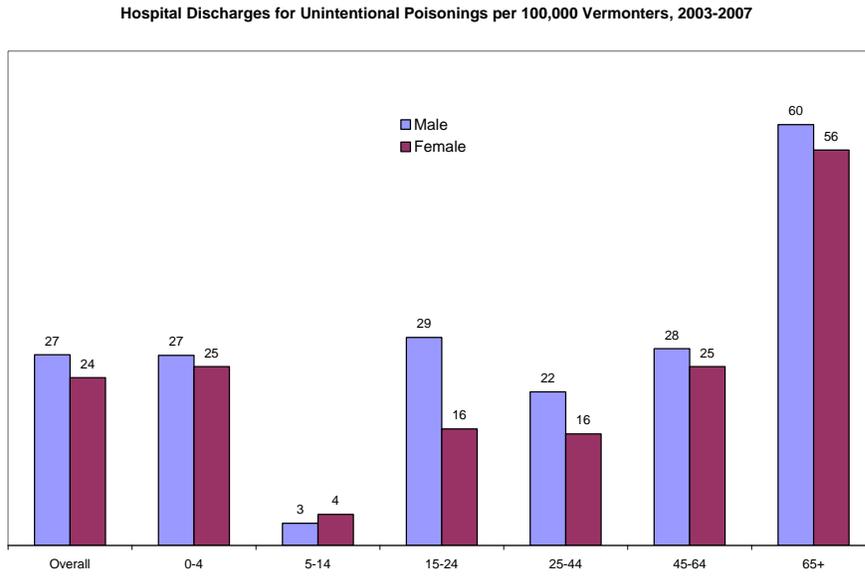
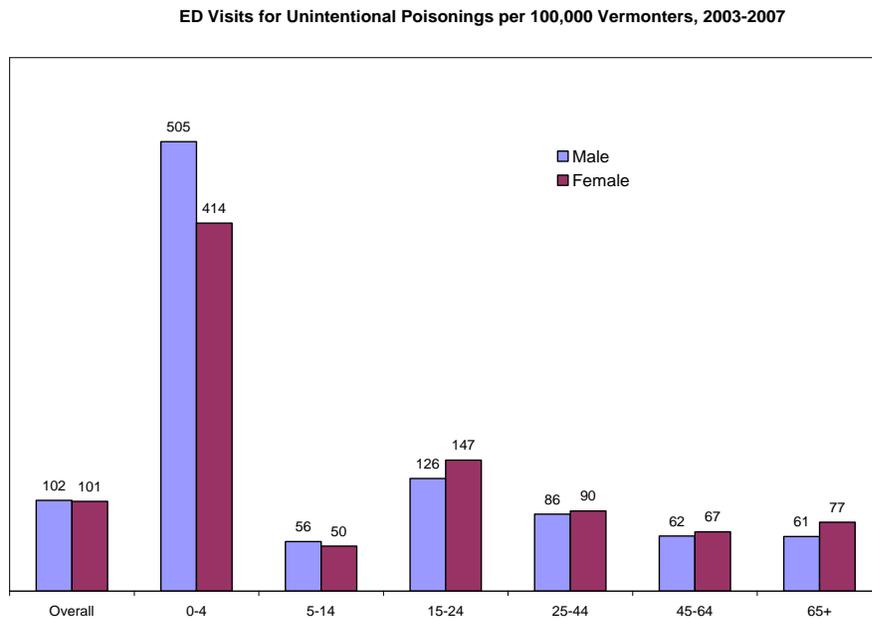


Figure 10.



Prescription and Illegal Drug Use, Abuse, and Misuse

Nationally, from 1994-2004, drug related poisoning death rates increased 68% while other substance poisoning death rates increased only 1.3%, the largest increase occurred in rural states including Vermont which saw a 168% increase in unintentional poisoning mortality rate.⁵³ Many of these deaths resulted from the abuse of prescription and illegal drugs. The increase in abuse has resulted in a recent increase in prescription pain medicine-related deaths.⁵⁴ Northern New England Poison Center (NNECP) reports that medications are the number one cause of unintentional poisonings for all age groups, representing 36% of all Vermont poisoning exposures.⁵⁵

There are three ways that drugs (i.e. prescription medication, over the counter, or illegal) becomes poisonous – taking too much (accidentally or too get high), mixing with other substances (e.g. alcohol, other medications), or taking someone else’s medications. The most commonly abused, and often poisonous, medications and drugs are the following:

- Illegal drugs such as heroin and cocaine.
- Prescription Pain Killers: Codeine, Fentanyl, Morphine, Oxycodone & Hydrocodone, Methadone, Buprenorphine.
- Prescription Stimulants: Amphetamine, Methylphenidate (Ritalin®)
- Prescription Depressants: Barbiturates, Benzodiazepines, Non-Benzodiazepines, Flunitrazepam.
- Over the Counter Medications: Doxylamine (found in sleep tablets such as Unisom®); Dextromethorphan (DXM found in cold medicines with “DM” or “Tuss” in the name); Diphenhydramine (found in antihistamines such as Benadryl®); and Pseudoephedrine and Ephedrine (found in cold products now sold behind pharmacy counters such as Sudafed®).

Childhood Poisoning

Normal childhood behavior puts children at risk; consider that in 2007, the NNECP reported that 45% of all Vermont poisonings involved children five and under.⁵⁶ Children are likely to put their hands or other objects into their mouth that may contain or have come into contact with hazardous substances, lead dust, cleaning products, personal care items, etc. Children may also ingest medicines or other substances while exploring or imitating behaviors of older children and adults. As a result, medication poisoning (excluding abuse and recreational use) is twice as common a reason for children’s emergency department visits as poisoning from other

⁵³ NNECP, “Know What’s In Your Medicine Cabinet” (adult powerpoint presentation).

⁵⁴ NNECP, “Know What’s In Your Medicine Cabinet” (adult powerpoint presentation).

⁵⁵ Northern New England Poison Control Center

⁵⁶ Northern New England Poison Control Center

household products (such as cleaning solutions and personal care products).⁵⁷ The important thing to remember is that childhood poisoning injuries are preventable largely by proper storage and usage of medicines and household products and supervising of children around them.

Healthy People 2020 Objectives

Injury and Violence Prevention

IVP-9: Prevent an increase in the rate of poisoning deaths

IVP-9.3: Prevent an increase in the rate of poisoning deaths

IVP-9.4: Unintentional or undetermined intent among all persons

IVP-10: Unintentional or undetermined intent among persons aged 35 to 54 years

IVP-11: Prevent an increase in the rate of nonfatal poisonings

Substance Abuse (SA)

SA-2: Increase the proportion of adolescents never using substances

SA-19: Reduce the past-year nonmedical use of prescription drugs

SA-21: Reduce the proportion of adolescents who use inhalants

Action Steps

- **Action Step 1:** Collaborate with programs such as Vermont Department of Health Drug and Alcohol and Drug Abuse Programs and Fletcher Allen Health Care Poison Control Program to support programs promoting public awareness of poisoning hazards in the home.
- **Action Step 2:** Collaborate with programs such as Vermont Department of Health Drug and Alcohol and Drug Abuse Programs and Fletcher Allen Health Care Poison Control Program to promote systems for safe disposal of prescription drugs (such as “take back” programs at pharmacies.)
- **Action Step 3:** Support poisoning prevention education programs for families via parent education in home visits, child care centers, community education programs, and in clinical well- child visits.

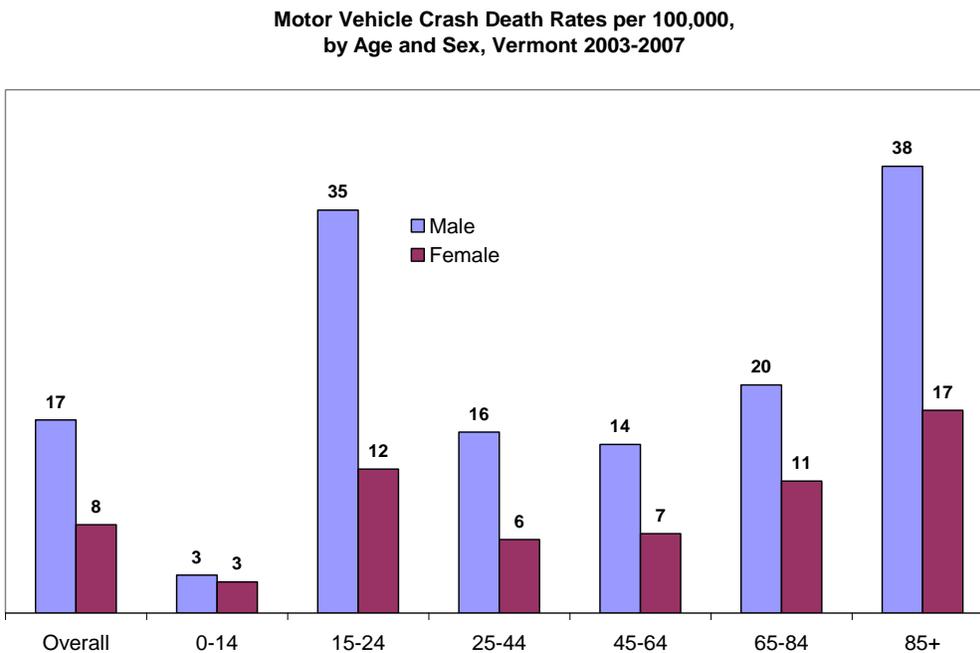
⁵⁷ Schillie SF, Shehab, N, Thomas, KE, Budnitz DS. Medication overdoses leading to emergency department visits among children. American Journal of Preventive Medicine 2009;37:181-187.

6. TRANSPORT

Unintentional transport injuries include those sustained while in traffic among motor vehicle occupants, pedal cyclists, pedestrians, and in other transport events. The significance of this public health issue is notable and has been addressed over the last several decades through prevention strategies including policy and public education with particular focus on improving car and booster seat and seat belt use, reducing impaired driving and helping groups at risk: child passengers, teen drivers, and older adult drivers.

In the United States, motor vehicle–related injuries are the leading cause of death for people ages 1–34, and nearly 5 million people sustain injuries that require an emergency department visit.⁵⁸ For children in the United States, in 2008 968 children ages 14 years and younger died as occupants in motor vehicle crashes, and approximately 168,000 were injured.² In Vermont, motor vehicles are the second leading cause of injury death among Vermonters, with males dying twice as much as females (17 vs 8 per 100,000). Motor vehicle crashes are also one of the five leading causes of injury hospitalizations and emergency department visits).

Figure 11.



⁵⁸ <http://www.cdc.gov/injury/index.html>

Teen Drivers

Motor vehicle crashes are the leading cause of death for U.S. teens, accounting for more than one in three deaths in this age group.⁵⁸ The risk of motor vehicle crashes is higher among 16- to 19-year-olds than among any other age group. Those at especially high risk for motor vehicle crashes are males, teens driving with teen passengers and newly licensed teens. In fact, per mile driven, teen drivers ages 16 to 19 are four times more likely than older drivers to crash.

In 2008, about 3,500 teens in the United States aged 15–19 were killed and more than 350,000 were treated in emergency departments for injuries suffered in motor-vehicle crashes.⁵⁸ The risk of motor vehicle crashes is higher among 16- to 19-year-olds than among any other age group. In fact, per mile driven, teen drivers ages 16 to 19 are four times more likely than older drivers to crash.⁵⁸ Teen drivers who are at especially high risk for motor vehicle crashes are:

- Male drivers and passengers ages 15 to 19
- Teens driving with teen passengers
- Newly licensed teens⁵⁹

Distracted Driving

Each day, more than 16 people are killed and more than 1,300 people are injured in crashes involving a distracted driver.⁵⁸ Distracted driving is driving while doing another activity such as using a cell phone, texting, eating, drinking and talking with passengers all of which can increase the chance of a motor vehicle crash. Using in-vehicle technologies (such as navigation systems) and portable communication devices can also be sources of distraction. While any of these distractions can endanger the driver and others, texting while driving is especially dangerous because it combines all three types of distraction.⁵⁹ “In 2008, nearly 6,000 people died in crashes involving a distracted driver and more than 500,000 people were injured.”⁵⁹ Younger, inexperienced drivers under the age of 20 may be at greater risk because they have the highest proportion of distraction-related fatal crashes.⁵⁹ Many states are developing laws—such as banning texting while driving and graduated driver licensing systems for teen drivers to help raise awareness about the dangers of distracted driving and to keep it from occurring.⁵⁹

6.1. Off Road Transport-Related Injuries

While motor vehicle related injuries are the leading cause of death for people ages 1–34 nationwide and the leading cause of injury death among Vermonters, the rural nature of our state calls upon us to examine injuries and deaths resulting from non traffic crashes and incidents such as those involving snowmobiles and all-terrain vehicles used for both recreational and transportation activities.

⁵⁹ Centers for Disease Control and Prevention, Injury Prevention and Control, Motor Vehicle. www.cdc.gov

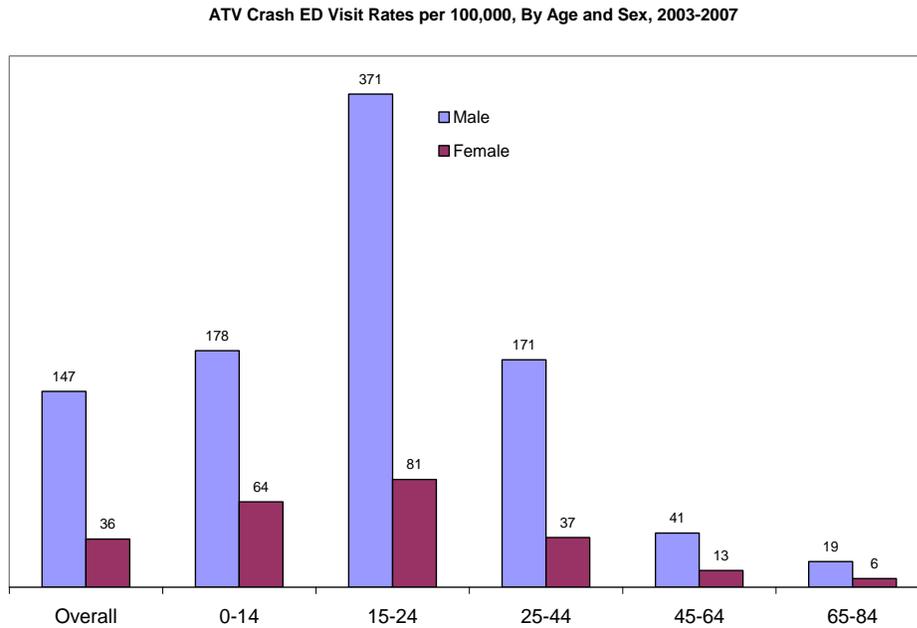
All-Terrain Vehicles

The all-terrain vehicle (ATV) has become a popular machine for both recreational and occupational use. The increase in prevalence of ATVs on farms calls for the need to address the importance of ATV safety on farms for children. The 2001 Childhood Agricultural Injury Survey (CAIS) data show that ATV related injuries to youth are prevalent on farms. The CAIS data indicate that there were approximately 1,653,317 farms in operation in the U.S. during the 2001 calendar year. An estimated 1,075,759 youth lived on these farms and 400,213 youth were hired by the farm operator to work on the operation during 2001. Of the hired and household youth, 450,397 (31%) had operated an ATV in 2001. An estimated 22,648 non-fatal injuries occurred on U.S. farms to youth less than 20 years of age during 2001. Approximately 10% of these injuries (2,246) were the result of ATV use. From 2003-2007, there were 280 hospital discharges and 2,827 ED visits and for ATV crashes in Vermont. Recognizing the potential risks of ATV-related injury, the American Academy of Pediatrics (AAP) issued several recommendations including but limited:⁶⁰

- Children who are not licensed to drive a car should not be allowed to operate off-road vehicles.
- Injuries frequently occur to passengers, therefore riding double should not be permitted.
- All riders should wear helmets, eye protection, and protective reflective clothing. Appropriate helmets are those designed for motorcycle (not bicycle) use, and should include safety visors/face shields for eye protection.

⁶⁰ American Academy Of Pediatrics Committee on Injury and Poison Prevention. All-Terrain Vehicle Injury Prevention: Two-, Three-, and Four-Wheeled Unlicensed Motor Vehicles PEDIATRICS Vol. 105 No. 6 June 2000, pp. 1352-1354

Figure 12.



Snowmobiles

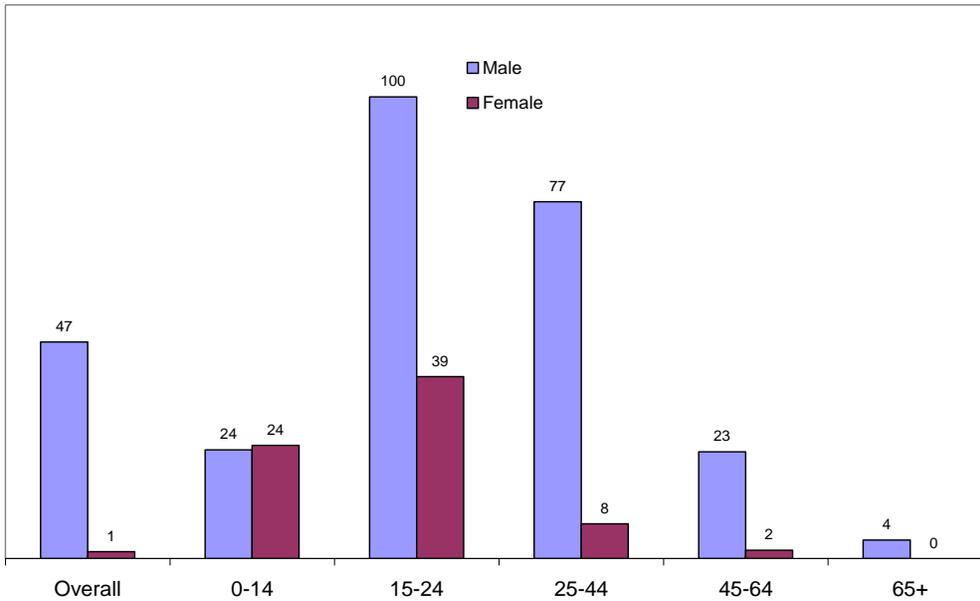
Snowmobiles are popular for winter recreation however the new higher-powered machines, traveling on inappropriate terrain, the burgeoning numbers of riders, and a large percentage of young or inexperienced riders present a number of risks for injury.^{61,62} Similarly to ATVs, The American Academy of Pediatrics (AAP) recognized the potential problem of snowmobile-related injuries in children and published a statement on the subject, concluding that snowmobiles were inappropriate for use by children and young adolescents and should not be used by children younger than 16 years.^{61,62} The AAP also recommended that riders older than 16 years be required by law to be licensed and that helmets be worn at all times for all occupants.^{61,62} From 2003-2007, there were 133 hospital discharges and 930 ED visits and for snowmobile crashes in Vermont.

⁶¹ Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report Weekly. Snowmobile Fatalities—Maine, New Hampshire and Vermont, 2002-2003. December 19, 2003 / Vol. 52 / No. 50

⁶²Nayci et al. Snowmobile Injuries in Children and Adolescents. Mayo Clinic Proceedings January 2006 vol. 81, no1, pp. 39-44.]

Figure 13.

Snomobile Crash ED Discharge Rates per 100,000, By Age and Sex, 2003-2007



6.2. Pedestrian Safety

Pedestrian safety has become an emerging issue nationally, especially with the recent emphasis on physical activity to combat obesity (such as recommendations for adults to walk for exercise and “Walking School Buses” for children.) As a rural state, Vermont presents a particular issue for pedestrians due the rural nature of our roads, such as narrow shoulders and no speed limits in rural sections of the state. Data for pedestrian related injuries is underreported and thus the exact nature of the elements influences pedestrian are still becoming fully understood and adequately addressed by funding sources, policy makers, and public health interventions.

6.3. Bike Safety

As with pedestrians, there recently has been more encouragement for Vermonters to use bikes for transportation and to promote physical activity. Of particular concern is that in bicycle crashes, head injury is the most common cause of death and serious disability. Correctly wearing a bicycle helmet reduces the risk of head injury by 85%. The 2009 YRBS the percent of bicycle riders in grades 8 – 12 reporting that they rarely or never wore helmets has recently increased. In 1993, 82% of riders reported rarely or never wearing helmets, compared to 50% in 2001 and 55% in 2007. However, 63% — over 17,000 students — reported rarely or never wearing helmets. In fact, riders were most likely to report *never* wearing helmets: 48% never;

15%, rarely; 11%, sometimes; 13%, almost always; and 13%, always. Males, older students, and students from racial or ethnic minority groups were more likely to report rarely or never wearing helmets. This data is troubling considering the many efforts to promote bike helmet use in the elementary age groups. More work need to be done to maintain the culture of bike helmet use through the high school years and into adulthood.

Healthy People 2020 Objectives

Injury and Violence Prevention (IPV)

IPV-13: Reduce motor vehicle crash-related deaths

IPV-13.1: Deaths per 100,000 population

IPV-13.2: Deaths per 100 million vehicle miles traveled

IPV-14: Reduce nonfatal motor vehicle crash-related injuries

IPV-15: Increase use of safety belts

IPV-16: Increase age-appropriate vehicle restraint system use in children

IPV-17: Increase the number of States and the District of Columbia with “good” graduated driver licensing (GDL) laws

IPV-18: Reduce pedestrian deaths on public roads

IPV-19: Reduce nonfatal pedestrian injuries on public roads

IPV-20: Reduce pedalcyclist deaths on public roads

IPV-21: Increase the number of States and the District of Columbia with laws requiring bicycle Helmets for bicycle riders

IPV-22: Increase the proportion of motorcycle operators and passengers using helmets

Action Steps

- **Action Step 1:** Support evidenced based programs that educate the public about risky driving behavior, such as not using safety restraints, texting or phoning while driving, and use of alcohol or other substances while driving.
- **Action Step 2:** Review current state policies and legislation and outline potential options for strengthening laws relating to seatbelt and child passenger restraints, distracted driving, and driving while under the influence of drugs or alcohol to reflect National Highway Traffic Safety Administration recommendations.
- **Action Step 3:** Support community education and training programs that educate about child passenger safety issues and provide infant and toddler safety seats to low income families.
- **Action Step 4.** Collaborate with partners such as Governor’s Highway Safety Commission and the VDH Drug and Alcohol Abuse Programs to strengthen public awareness programs about underage teen drinking and the link to risky driving practices.

- **Action Step 5:** Improve injury data collection to include more information and analysis about cyclist and pedestrian injuries, especially in comparison to rates of motor vehicle associated injury.
- **Action Step 6:** Collaborate with state agencies and nonprofit organizations such as Local Motion, AARP-VT, and the Vermont Agency of Transportation to develop and implement innovative transportation policies such as “Complete Streets” and “Slow Streets.”

Off Road Transportation

- **Action Step 1:** Work with partners such as UVM Extension Service and SafeKids Vermont to design and implement a statewide ATV safety awareness campaign.
- **Action Step 2:** Improve injury data collection to include more information about off-road crashes so as to accurately inform medical, public health professionals, and policy makers about evidenced based risk reduction interventions.

7. TRAUMATIC BRAIN INJURY

A traumatic brain injury (TBI) is caused when there is a bump, blow, or jolt to the head or a penetrating head injury that disrupts the normal function of the brain. TBI can occur even if the head is not hit; an indirect blow elsewhere on the body can transmit an “impulsive” force to the head and cause a concussion to the brain, one type of TBI. The symptoms of a TBI may show up immediately, but in some cases they may not be apparent until days or weeks after the injury. Often, people do not even realize that a brain injury has occurred; it goes unnoticed by themselves, family, and healthcare professionals. The severity of the TBI may range from “mild” (e.g. a brief change in mental status or consciousness) to “severe” (e.g. an extended period of unconsciousness or amnesia).

Concussions are among the most common type of mild TBI, representing three quarters of the TBI’s that occur each year.⁶³ Repeated mild TBIs occurring over an extended period of time (i.e., months, years) can result in cumulative neurological and cognitive deficits, and occurring within a short period of time (i.e., hours, days, or weeks) can be catastrophic or fatal.⁶⁴ It is the most common type of brain injury sustained in sports; an estimated 1.6-3.8 million sports- and recreation-related concussions occur in the United States each year. During 2001-2005, children and youth ages 5–18 years accounted for 2.4 million sports-related emergency department (ED) visits annually, of which 6% (135,000) involved a concussion. Yet while concussions are relatively common and have the potential for significant long-term health impacts, they are not often recognized by individuals, parents, coaches, teachers, caregivers, physicians, etc. when they occur, or even that they have occurred since symptoms may not immediately manifest.

Describing the scope and impact of TBI on the public’s health is difficult, as often TBI’s are not diagnosed, or even realized, at the time of injury. Furthermore, there is not a means to collect data for the number of people with non-fatal TBI seen outside of emergency departments or hospitals or who receive no care at all. However, with what numbers that do exist, it is estimated that each year in the United States 1.7 million people sustain a TBI. Of these people 52,000 die, 275,000 are hospitalized, and 1.4 million are treated and released from emergency departments. According to the CDC, TBI is a contributing factor to a third of all injury-related deaths in the United States.⁶⁵ It is also estimated that about 75% of TBIs that occur each year are concussions of others forms of mild traumatic brain injury (MTBI).⁶⁶

⁶³ Centers for Disease Control and Prevention (CDC), National Center for Injury Prevention and Control. Report to Congress on mild traumatic brain injury in the United States: steps to prevent a serious public health problem. Atlanta (GA): Centers for Disease Control and Prevention; 2003.

⁶⁴ Centers for Disease Control and Prevention (CDC). Sports-related recurrent brain injuries—United States. *MMWR* 1997;46(10):224–227.

⁶⁵ Faul M, XU L, Wald MM, Coronado VG. *Traumatic Brain Injury in the United States States: Emergency Department Visits, Hospitalizations and Deaths 2002-2006*. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2010.

⁶⁶ *Report to Congress on Mild Traumatic Brain Injury in the United States: Steps to Prevent a Serious Public Health Problems*. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2003.

The causes for TBI nationally and Vermont are similar. Nationally, the leading causes for TBI are falls (28%), motor vehicles crashes (20%), individuals being struck by/against something (19%) and assaults (11%).⁶⁷ These causes are prominent in Vermont for hospitalizations and emergency room visits. However, in Vermont, the leading cause of TBI deaths has been firearms, of which nearly all are suicides (90%), followed by motor vehicles (28%) and falls (20%). Less than 5% of TBI deaths are attributed to assault or being struck by something. Falls make-up almost half of all TBI hospitalizations (47%) and emergency department visits (48%). Motor vehicle TBI injuries are a third of hospitalizations (31% for traffic related and 5% for snowmobile or ATV non-traffic motor vehicle injuries), but less than a fifth of the emergency room visits (17%). Assaults or being struck by objects account for approximately 5% of Vermont’s TBI related hospitalizations (4%) or emergency department visits (6%).⁶⁸

Males, and especially older males, are more likely to have a hospital discharge involving a TBI. While for ED visits, males under 45 are more likely to have a visit involving a TBI, but after age 45 the rates between males and females are similar.

Figure 14.

Hospital Discharges for Traumatic Brain Injury per 100,000 Vermonters, 2003-2007

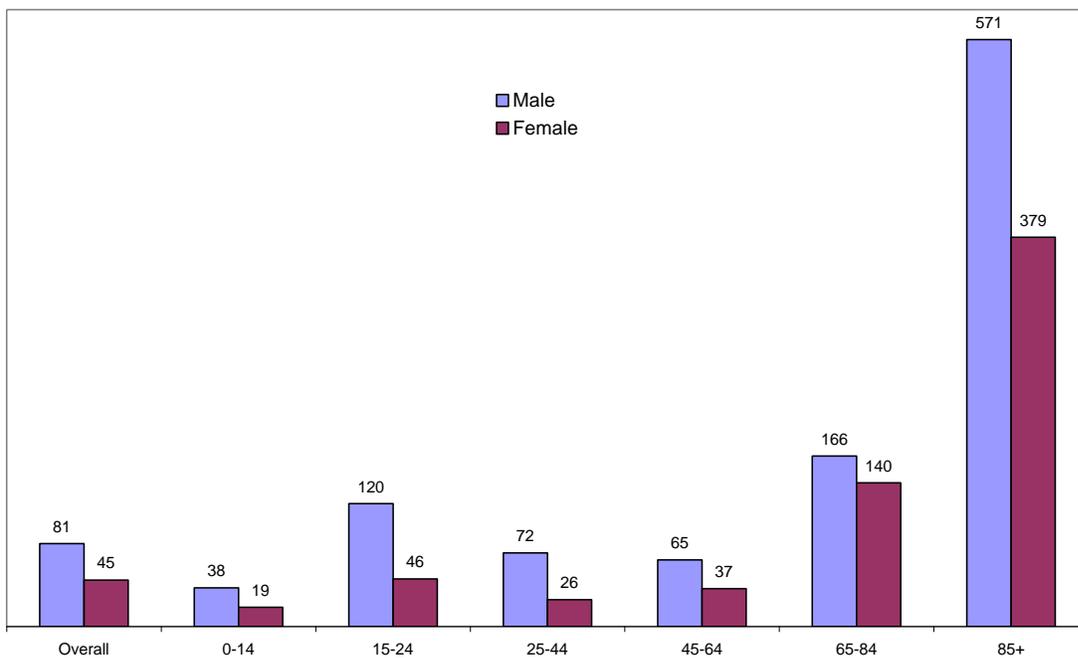
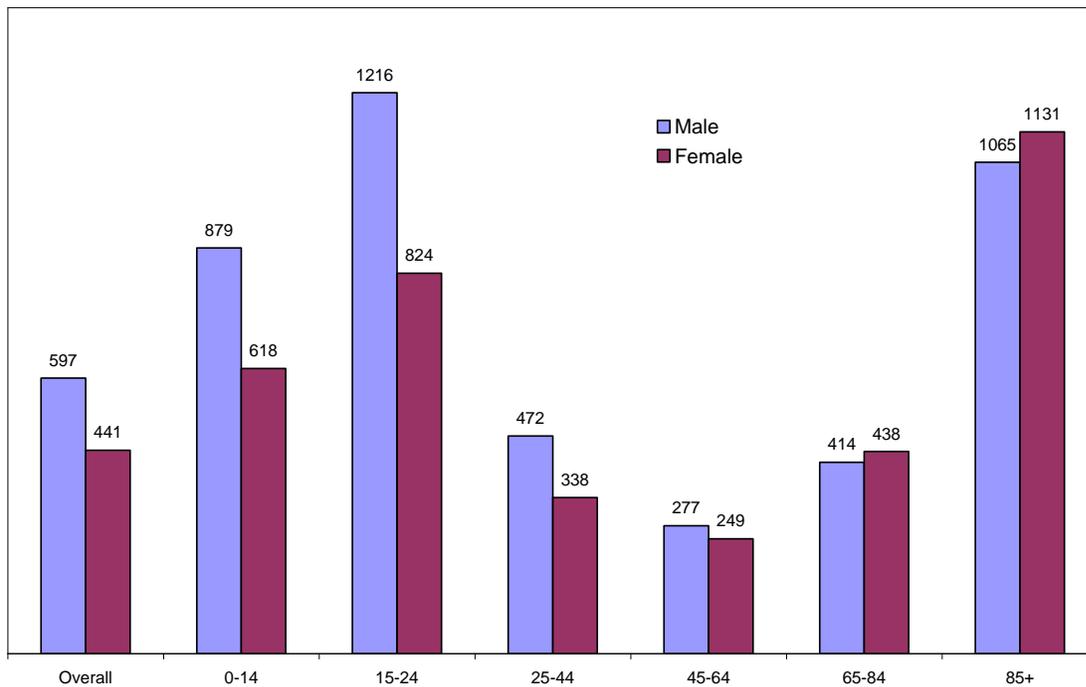


Figure 15.

⁶⁷ Langlois JA, Rutland-Brown W, Thomas KE. *Traumatic brain injury in the United States: Emergency Department Visits, Hospitalizations, and Deaths*. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2006.

⁶⁸ VDH Burden document.

ED Visits for Unintentional Poisonings per 100,000 Vermonters, 2003-2007



Children are at particular risk for TBI-related injuries mostly as a result of just doing the things that children like to do – walking, running, jumping, playing sports, riding biking, scootering, etc. Twenty-eight percent of all traumatic brain injuries among children are a result of falls of one type or another.⁶⁹ Approximately 2 out of 5 traumatic brain injuries among children are associated with participation in sports and recreational activities.⁷⁰ Among children and youth ages 5–18 years, the five leading sports or recreational activities, which account for concussions, include bicycling, football, basketball, playground activities, and soccer. According to the Brain Injury Association of American, approximately 5% of soccer players sustain a brain injury as a result of head-to-head contact, falls, or being struck on the head by a ball; heading a ball repeatedly can cause a concussion.⁷¹ The Consumer Product Safety Commission (CPSC) estimates that a third of the skiing related head injuries could be prevented or reduced in severity each year by using helmets, and that about 11 skiing and snowboarding-related deaths would be prevented annually with helmets.⁷² An important question with children is how long should a child with a concussion not play sports or engage in physical activity. The answer is not simple or straightforward. It all depends on the severity of the concussion, and should be

⁶⁹ http://www.cdc.gov/TraumaticBrainInjury/tbi_concussion.html

⁷⁰ Rivara F. Epidemiology and prevention of pediatric traumatic brain injury. *Ped Ann* 1994;23:12-17, and National Youth Sports Safety Foundation, Inc. Factsheet: helmets.

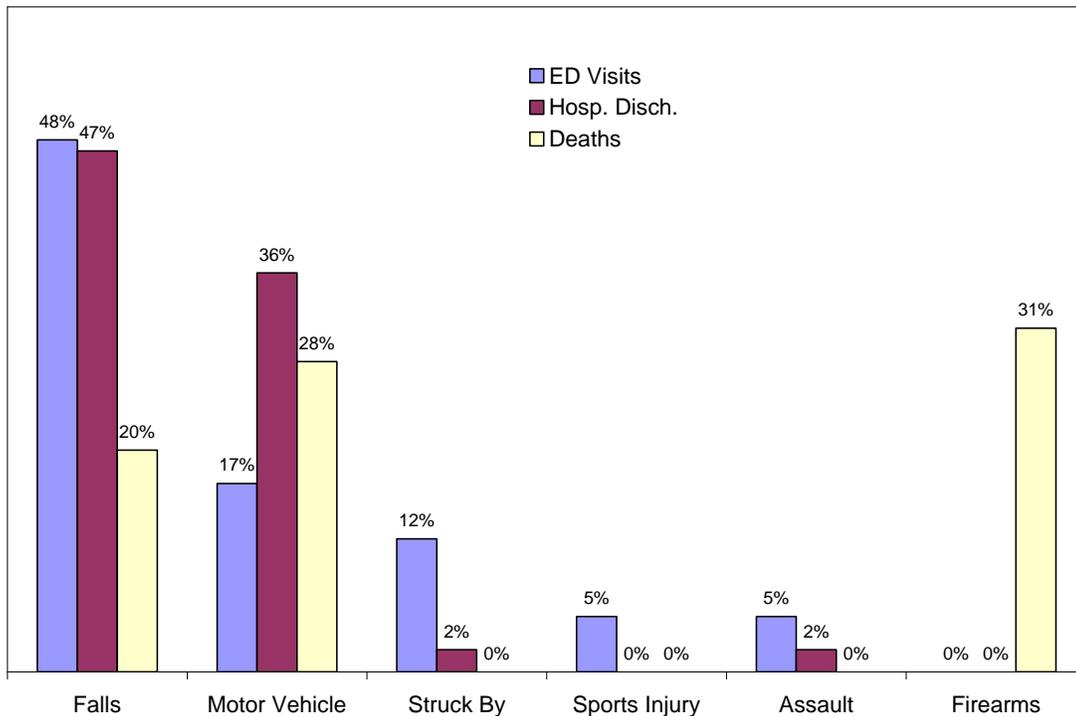
⁷¹ American Association of Neurological Surgeons/Congress on Neurological Surgeons, 1998. http://www.neurosurgery.org/pubpages/patres/faq_sports.html ((February 5, 2001)

⁷² Centers for Disease Control, SafeUSA: Winter Sports Injury Prevention - Safety on the Slopes. <http://www.cdc.gov/safeusa/slopes.htm> (January 26, 2001)

decided in conjunction with the child’s healthcare provider. It is important to give children time to recover from the concussion in order to avoid "second impact syndrome." This can occur when the symptoms of the first concussion haven't totally cleared and a second concussion is sustained. The second injury, even if minor, may cause brain swelling and even sudden death. The proper use of helmets, mouth guards, and other protective equipment whenever participating in sports, riding bicycles, scooters, skiing, snowboarding, skateboards, or using in-line skates. In addition, mouth guards can help to lessen the impact on the brain if a child is hit in the jaw or chin. Most importantly, instructing children in the proper techniques for safe sports involvement can also help children.

Figure 16.

TBI Causes for Death, Hospitalization, and Emergency Department Visits in Vermont 2001-2005 Combined (Source VTDOH Injury Prevention Program, Vital Statistics and Uniform Hospital Discharge Dataset).



Adults 65 and older experience the highest rates of TBI- related hospitalization and death, both nationally and in Vermont.⁷³ Falls are the most common cause of these injuries.⁷⁴ In Vermont among those 85 and older, falls account for the majority of TBI deaths (61%).⁷⁵ Seniors are at

⁷³ <http://www.cdc.gov/TraumaticBrainInjury/statistics.html>, VTDOH burden document.

⁷⁴ Jager TE, Weiss HB, Coben JH, Pepe PE. Traumatic brain injuries evaluated in U.S. emergency departments, 1992–1994. Academic Emergency Medicine 2000&359;7(2):134–40. Vermont DOH Burden Document page 49.

⁷⁵ Vermont Department of Health Burden Document page 49.

particular risk because the risk factors for falls are usually associated with health and aging conditions such as mobility problems due to muscle weakness or poor balance, loss of sensation in feet, chronic health conditions, vision changes or loss, medication side effects or drug interactions, and home environmental hazards such as poor lighting, clutter, etc.⁷⁶

A new and potentially growing population of individuals at risk for TBI are United States' military personnel, including National Guardsmen. Department of Defense and the Department of Veteran Affairs data indicate that in prior conflicts TBI was present in 14-20% of surviving combat casualties, but that with the current conflicts in Iraq and Afghanistan the numbers are now much higher due to better protective battle gear and medical attention in the field. Data also indicate that the leading cause of TBI amongst the United States' active duty military personnel, including National Guardsmen, are blasts injuries in war zones.⁷⁷

There can be significant long-term consequences to experiencing a TBI for anyone at any age. The CDC estimates that at least 3.17 million Americans currently have long-term or lifelong need for help to perform activities of daily living as a result of a TBI.⁷⁸ Many experts even claim that TBI is the leading cause of disability in children, although currently that data is lacking. TBI can cause a wide range of functional changes affecting thinking, language, learning, emotions, behavior, and/or sensation. It can also cause epilepsy, and increase the risk for conditions such as Alzheimer's disease, Parkinson's disease, and other brain disorders that become more prevalent with age.^{79,80}

Brain injuries are unlike other physical injuries. Our brains define who we are – are personality, emotions, physical capabilities, cognitive abilities, etc. As a result, an injury to the brain can affect all aspects of our lives – including our personalities. With physical injuries, such as a broken arm, our motor function may be impaired temporarily, and in most cases will return once the injury is healed, but our mental abilities and personality remain unchanged. However, with brain injuries, this is not always the case; sometimes even after people have thought to have recovered from their TBI their personalities may have altered permanently. No two brain injuries are alike, and the consequences of two similar injuries may be very different.⁸¹

Healthy People 2020 Objectives

⁷⁶ http://www.cdc.gov/TraumaticBrainInjury/tbi_falls_results.html

⁷⁷ Defense and Veterans Brain Injury Center (DVBIC). [unpublished]. Washington (DC): U.S. Department of Defense; 2005; and http://www.biausa.org/elements/pdfs/awareness/dvbic_fact_sheet.pdf

⁷⁸ Thurman D, Alverson C, Dunn K, Guerrero J, Sniezek J. Traumatic brain injury in the United States: a public health perspective. *Journal of Head Trauma Rehabilitation* 1999;14(6):602-15.

⁷⁹ National Institute of Neurological Disorders and Stroke. Traumatic brain injury: hope through research. Bethesda (MD): National Institutes of Health; 2002 Feb. NIH Publication No. 02-158. Available from: www.ninds.nih.gov/disorders/tbi/detail_tbi.htm.

⁸⁰ Ylvisaker M, Todis B, Glang A, et al. Educating students with TBI: themes and recommendations. *Journal of Head Trauma Rehabilitation* 2001; 16:76-93.

⁸¹ <http://www.traumaticbraininjury.com/content/understandingtbi/whatistbi.html>

Injury and Violence Prevention (IVP)

IVP-2: Reduce fatal and nonfatal traumatic brain injuries

IVP-2.1: Reduce fatal traumatic brain injuries

IVP-2.2: Reduce hospitalization for nonfatal traumatic brain injuries

IVP-2.3: Reduce emergency department visits for nonfatal traumatic brain injuries

Action Steps

- **Action Step 1:** Collaborate with Fletcher Allen Health Care and other programs such as Protect Your Head at All Times (PHAT) to promote public awareness of the importance of wearing helmets for activities such as skiing, snowboarding, bike riding, and use of all terrain vehicles (ATV) or snow machines.
- **Action Step 2:** Support efforts from groups such as Local Motion and schools to develop evidence based statewide programs to distribute helmets and bicycle safety education to children and youth.
- **Action Step 3:** Collaborate with relevant organizations such as Fletcher Allen Health Care, The Vermont Athletic Trainers Association, the Vermont Principals' Association to support a statewide system of ongoing training and education for professionals and volunteers who work with youth who are engaged in formal sports or other types of physical activity. These trainings will deal with information on concussion prevention, recognition, and treatment.
- **Action Step 3:** Improve injury data collection to include more information about injuries that are related to TBI.

8. VIOLENCE

Violence is a serious public health problem that affects everyone – it affects people of all ages, races, ethnicities, socio-economic groups, and sex. Physical assault, homicide, suicide, child maltreatment, elder abuse, rape, sexual assault, and domestic abuse are all intentional acts of violence. Violence is defined not only by such physical acts, but also by the violent threats or psychological/emotional abuse (e.g. intimidation, hazing, bullying, etc.). Nationally in 2006, more than 18,000 people were victims of homicide and more than 33,000 took their own life,⁸² while in Vermont there were 13 victims of homicide and 82 suicides.⁸³

The number of violent deaths tells only part of the story. Many more survive violence and are left with permanent physical and emotional scars. Violence also erodes communities by reducing productivity, decreasing property values, and disrupting social services.⁸⁴ The deaths, injuries, and disabilities cause by violence limits the potential of individuals and increases the risk of physical, reproductive, and emotional health problems. Domestic violence is associated with less optimal social, emotional and cognitive development of children who are witnesses; boys who have witnessed or experienced domestic violence are particularly at risk for perpetuating it when they are older. Violence is devastating not only to individuals but to communities. Each year in the United States it is estimated that interpersonal violence is 3.3% of the country's gross domestic product.⁸⁵ The costs of violence – physical, emotional, and material – add up.

A person's tendency to seek violent solutions for problems may take root early in childhood. The 2007 Vermont Youth Risk Behavior Survey reveals that more than one student in four reported being in a physical fight (27%) during the past year. Nine percent of all students in grades 8 through 12 reported having carried a weapon onto school property, and six percent indicate that they were threatened with a weapon while at school.⁸⁶ Almost One-fifth (18%) of Vermont students reported that they had been bullied, and four percent reveal that they did not go to school recently because they did not feel safe.⁸⁷

Violence is a complex, culturally embedded problem –but it is preventable. Preventing violence requires an intensified, coordinated, and sustained approach among public health, criminal justice, education professionals, and others.⁸⁸

Violence prevention strategies in Vermont must involve both short-term and long-term solutions. Short-term solutions must continue to focus on reducing firearm violence, as firearms continue to be the most common mechanism for death in suicides and homicides in

⁸² <http://www.cdc.gov/ViolencePrevention/>

⁸³ CDC WISQARS April 16, 2010

⁸⁴ <http://www.cdc.gov/ViolencePrevention/>

⁸⁵ http://www.who.int/violence_injury_prevention/publications/violence/economic_dimensions/en/

⁸⁶ VTDOH Injury Burden Document.

⁸⁷ VTDOH Injury Burden Document.

⁸⁸ VTDOH Injury Prevention Plan 2001 page 10.

Vermont.⁸⁹ Long-term solutions will involve broader issues of social equality, developmental assets, and a connection to one's community.⁹⁰

8.1. Suicide

Contrary to popular belief, suicide is neither a small problem nor one that affects only small segments of the population. Suicide affects everyone – people of all ages, sex, and backgrounds. Between 2003-2007, suicide was the fifth leading cause of death in Vermont^{91,92}. Nationally each year over 33,000 people kill themselves⁹³ – yet suicide deaths are only part of the problem. Even more people survive suicide attempts than actually die, are seriously injured, and are in need of medical care. Nationally, each year 395,000 people are treated with self-inflicted injuries in emergency rooms.⁹⁴

Vermont ranks above the national average for suicide related deaths, hospitalizations and emergency room visits.⁹⁵ In 2007, Vermont's death rate from suicide was 14.2 per 100,000 people while the national rate was only 11.4 per 100,000 people.⁹⁶ Mirroring national trends for 2003-2007, Vermont's suicide death rate and hospitalization rates have remained relatively stable.⁹⁷ However, the state's self-inflicted injury emergency department visits has significantly increased from 130 per 100,000 to 153 per 100,000.⁹⁸

The incidence of suicide among Vermont's adults, especially men, is troubling. Five percent of Vermont adults indicate that they have considered attempting suicide, according to the 2005 Behavioral Risk Factor Surveillance Survey.⁹⁹ Overall, 2% have actually attempted suicide.¹⁰⁰ Risk factors for adult suicide include recent divorce, separation, unemployment/retirement,

⁸⁹ VTDOH Injury Prevention Plan 2001 page 10.

⁹⁰ VTDOH Injury Prevention Plan 2001 page 11.

⁹¹ Vermont Department of Health

⁹² Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. FastStats Suicide and Self-Inflicted Injury (cited February 24, 2010) from: URL: <http://www.cdc.gov/nchs/fastats/suicide.htm>

⁹³ Centers for Disease Control and Prevention. Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. (2009). National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (producer). [cited 2009 February 24]. Available from: URL: www.cdc.gov/injury/wisqars/index.html.

⁹⁴ Centers for Disease Control and Prevention. Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. (2009). National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (producer). [cited 2009 February 24]. Available from: URL: www.cdc.gov/injury/wisqars/index.html.

⁹⁵ McIntosh, J. L. (for the American Association of Suicidology). (2009). *U.S.A. suicide 2006: Official final data*. Washington, DC: American Association of Suicidology, dated April 19, 2009, downloaded from

<http://www.suicidology.org>. Vermont was 22 second highest out of 51 units.

⁹⁶ Heron, Melonie Ph.D., Donna L. Hoyert, Ph.D., Sherry L. Murphy, B.S., Jiaquan Xu, M.D, Kenneth D. Kochanek, M.A, and Betzaida Tejada-Vera, B.S "Deaths: Final Data for 2006," *National Vital Statistics Reports*, Vol.57, No. 114; April 17, 2009.

⁹⁷ Vermont Department of Health

⁹⁸ Vermont Department of Health

⁹⁹ Vermont Department of Health, Injury Burden Document.

¹⁰⁰ Vermont Department of Health, Injury Burden Document.

depression (both diagnosed and undiagnosed), alcohol or other drug abuse, serious medical illness, living alone, and/or recent bereavement.

Within Vermont, men of all ages are more at risk from death by suicide than women. From 2003-2007, four times more Vermont men died from suicide on average than women, half as many men were hospitalized for an attempted suicide or seen in an emergency room for a self-inflicted injury.¹⁰¹ The higher death rate for men than women is most likely a result of their choice for more lethal means as 60% of male deaths result from firearm use, while the majority of female attempts involve poisonings.

Figure 17.

Deaths Due to Suicide per 100,000 Vermonters, 2003-2007

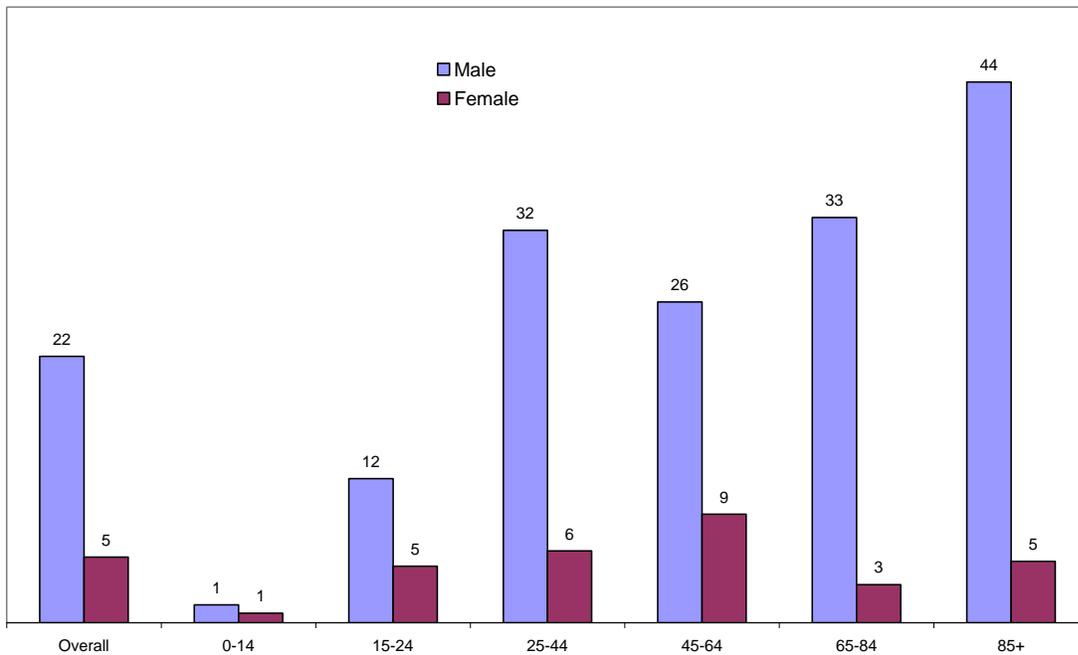


Figure 18.

¹⁰¹ VTDOH

Hospital Discharges for Suicide Attempts per 100,000 Vermonters, 2003-2007

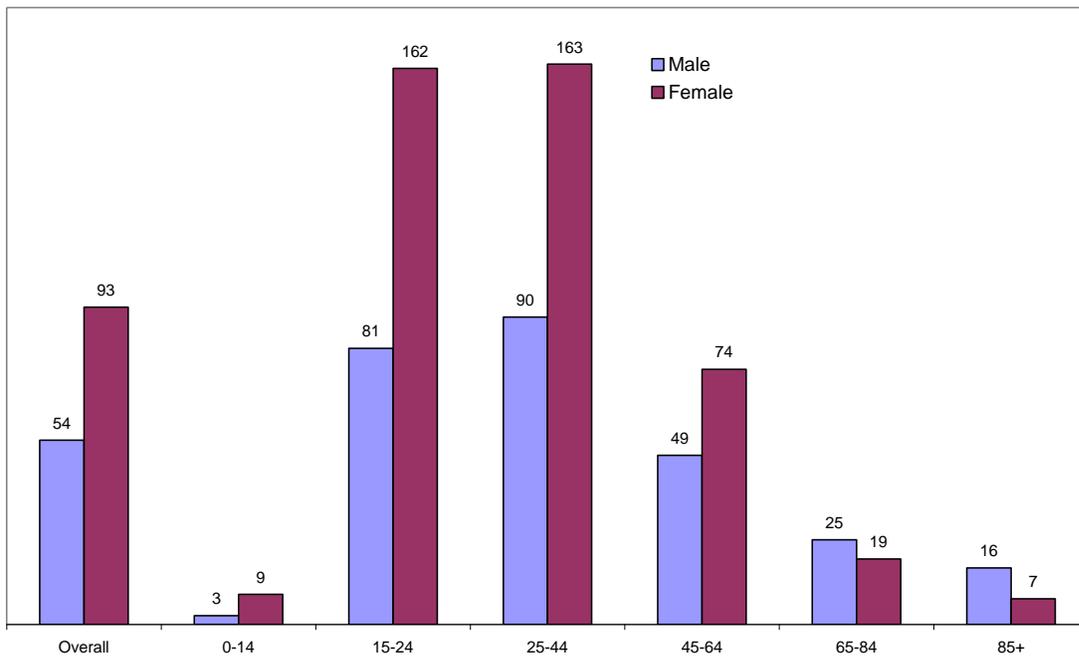
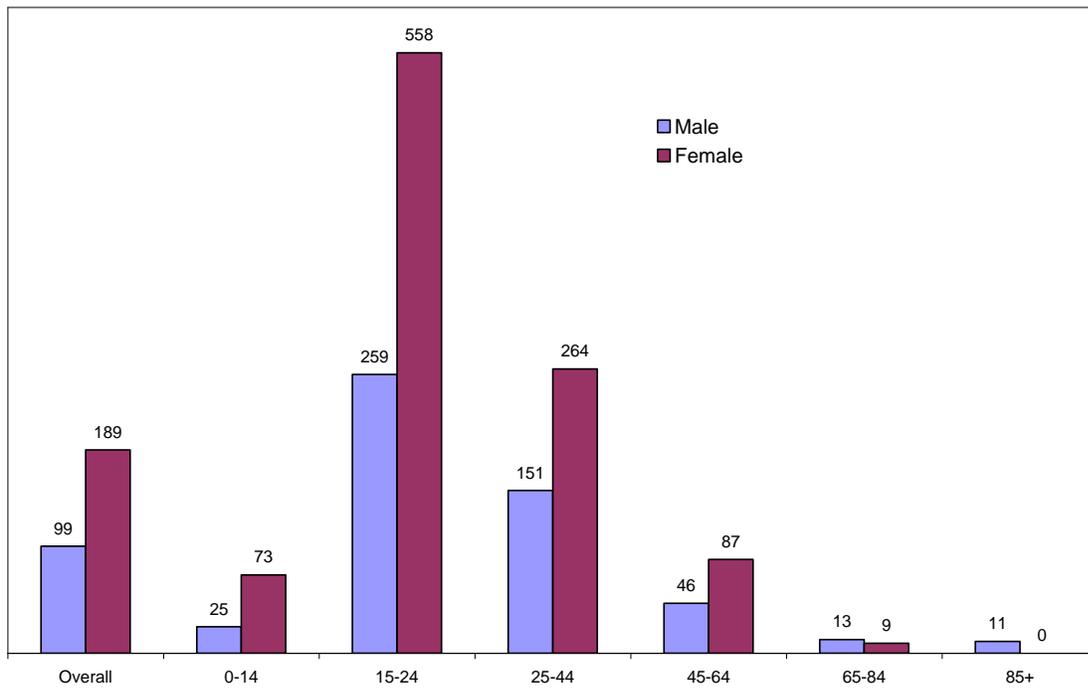


Figure 19.

ED Visits for Suicide Attempts per 100,000 Vermonters, 2003-2007



The incidence of suicide among Vermont’s oldest citizens is concerning. Those over 75 have the highest death rate from suicide, while the incidence of suicide is highest among adults 25 and 64.¹⁰² National studies estimate that 20% of those over 65 years of age who commit suicide visited a physician within 24 hours of their act, 41% visited within a week of their suicide, and 75% had been seen by their physician within a month of the act.¹⁰³ Suicidal tendencies among the elderly are often missed by medical professionals because what might be viewed as common risk factors or behaviors for younger individuals are seen as normal stages of growing older —wishing for death, depression, failure to adapt to multiple stressors, physical complaints without organic causes, putting affairs in order, giving away personal items, making a will/funeral plans.¹⁰⁴

Equally concerning is the rate of self-inflicted injuries among Vermont’s youth, as not all adolescent attempters may admit their intent for suicide. Even though youth developmentally are prone to behavioral impulsivity, deliberate self-harming behaviors should be considered serious and in need of further evaluation. According to the 2007 Youth Risk Behavior Survey (YRBS), 20% of all 8th through 12th graders felt sad or hopeless, 9% had made a plan, and 5% reported making an attempt, and 2% reported making an attempt that required medical treatment.¹⁰⁵ Female students are likely than male students to make a suicide plan (10% versus 7%) and actually attempt suicide (6% versus 4%).¹⁰⁶ Furthermore, in Vermont, from 2003-2007, twice as many young women compared to young men visit emergency rooms or are hospitalized for self-inflicted injuries. The 2007 YRBS also indicates that 14% Vermont youth of racial and ethnic minorities report having attempted suicide, a significantly higher rate than their white counterparts.

Identifying at risk youth is challenging, as the risk factors are common among adolescents while suicide is not. It is important that individuals who work with young people are aware of suicide risk factors and have the resources to make appropriate referrals. Common risk factors for these age groups can be of four types:¹⁰⁷

1. Fixed risk factors: family history of suicide or suicide attempts, male, parental mental health problems, gay or bisexual orientation, history of physical or sexual abuse, previous suicide attempt.

¹⁰² VTDOH Injury Burden Document.

¹⁰³ National Strategy for Suicide Prevention: a collaborative effort of SAMHSA, CDC, NIH, HRSA, HIS at <http://mentalhealth.samhsa.gov/suicideprevention/elderly.asp>

¹⁰⁴ University of South Carolina’s Ageworks http://www.ageworks.com/information_on_aging/mentalhealth/suicide.shtml

¹⁰⁵ VTDOH burden document.

¹⁰⁶ VTDOH Burden Document.

¹⁰⁷ Shain, Benjamin N. and the Committee on Adolescence, “Suicide and Suicide Attempts in Adolescents,” *Pediatrics: Official Journal of the American Academy of Pediatrics* (2007) downloaded from <https://www.pediatrics.org/cgi/content/full/120/3/669>

2. Social and environmental risk factors include the presence of firearms in the home, impaired parent-child relationship, living outside of the home (homeless or in a corrections facility or group home), difficulties in school, neither working nor attending school, social isolation, and presence of stressful life events such as legal or romantic difficulties or an argument with a parent.
3. Personal mental health problems: depression, bipolar disorder, substance abuse or dependence, psychosis, posttraumatic stress disorder, panic attacks, and a history of aggression, impulsivity, or severe anger.
4. Immediate risk factors include agitation, intoxication, and a recent stressful life event.

Vermont's rural character is also a contributing risk factor for suicide, particularly among our youth. There is insufficient health care coverage, provider shortages for primary care and mental health services, fewer community resources, and the physical isolation can reinforce an individual's feeling of being closed-in or closed off.¹⁰⁸ There are the additional challenges that are associated with rural culture and living in small communities such as lack of privacy/anonymity, heightened stigma around mental health issues, community norms and pressures to conform, economic stresses, substance abuse, and the availability and role of firearms.

For all age groups, firearms remain the most common method of suicide, followed by poisoning and suffocation. While firearms predominate as a suicide means, there are significant sex differences. Men tend to use firearms (60%), suffocation (25%), and poisoning (11%).¹⁰⁹ Women tend to choose poisoning (50%), suffocation (26%), and firearms (18%).¹¹⁰ Furthermore, 51% of all suicide deaths are the result of firearms and 76% of all suicide related hospitalizations are for poisoning.¹¹¹ It is concerning that of all the deaths attributed to firearms in Vermont from 2001-2005, more than four out of five were suicide (85%).¹¹²

8.2. Intimate Partner Violence¹¹³

Intimate Partner Violence (IPV) can be defined as a pattern of abusive behavior that one person uses to gain and maintain power and control over an intimate partner. "Intimate partner" can refer to current or former spouses or dating partners. Tactics may include physical, sexual, emotional and/or economic abuse, coercion, threats and isolation.¹¹⁴ Commonly, more than one tactic of IPV is employed. IPV exists along a continuum from a single episode of violence to

¹⁰⁸ Jaffe, Gayle MSW, MPH, "Strategies and Tools for Rural Youth Suicide Prevention," (powerpoint) presented at the New England Rural/Agricultural COP September 9, 2009.

¹⁰⁹ VTDOH

¹¹⁰ VTDOH

¹¹¹ VTDOH

¹¹² VTDOH burden document.

¹¹³ Global thanks to The Vermont Network Against Domestic and Sexual Violence.

¹¹⁴ Vermont Network Against Domestic and Sexual Violence, <http://www.vtnetwork.org/main.php//DomesticViolence>.

on-going battering and abuse.¹¹⁵ Overtime, IPV may escalate in severity from emotional abuse, progressing to physical or sexual assault, and sometimes even leading to homicide.

IPV does not discriminate; anyone can become a victim regardless of age, sex, sexual orientation, race, culture, class, economic status, ability, education, or any other defining factor. IPV is found in all types of relationships – heterosexual or same-sex, married or not. In heterosexual relationships, the majority of victims are women abused by men. In same-sex relationships, perpetrators appear to be non-gendered; both men and women are abusive at similar rates.

It is important to recognize that IPV is not caused by, or symptomatic of, substance abuse, skills deficit, or mental health issues (although those things can be co-occurring). Perpetrators choose to be abusive. It is a learned behavior, rooted in an abuser's beliefs that support an inflated sense of entitlement.¹¹⁶

While the term IPV may imply that it is a “private” matter between individuals, in fact IPV is a serious public health problem in the United States and Vermont with far reaching effects across generations. According to the Centers for Disease Control, each year 4.8 million women experience intimate partner related physical assaults and rapes and 2.9 million men experience intimate partner related physical assaults.¹¹⁷ The medical care, mental health services, and lost productivity (e.g. time away from work) cost of IPV was an estimated \$5.8 billion in 1995; this figure was updated to 2003 dollars to 8.3 billion. The costs can only have grown in the last seven years as the number of IPV incidents has increased as well as the cost of healthcare and living. Researchers consistently conclude that children exposed to domestic violence are at increased risk for problems in their behavioral, emotional, social, and cognitive development.¹¹⁸ Furthermore, among males there is a consistent association between witnessing domestic violence as a child and perpetuation of violence as an adult; the research among women is more mixed, but one well-controlled study has found increased risk of women being physically or sexually abused if their fathers were abusive towards their mothers.¹¹⁹

Estimating the incidence and prevalence of IPV are challenging tasks; many victims do not report it to police, friends, or family.¹²⁰ Studies in hospitals and emergency rooms have

¹¹⁵ <http://www.cdc.gov/violenceprevention>, “Understanding Intimate Partner Violence 2009 Fact Sheet.”

¹¹⁶ Vermont Network Against Domestic and Sexual Violence,
<http://www.vtnetwork.org/main.php//DomesticViolence>.

¹¹⁷ Centers for Disease Control and Prevention. Understanding Intimate Partner Violence Fact Sheet 2011.
www.cdc.gov/violenceprevention.

¹¹⁸ Rossman BBR. Longer term effects of children's exposure to domestic violence. In Graham-Bermans SA, Edleson JP, editors. *Domestic Violence in the Lives of Children*. Washington, DC American Psychological Association, 2001.

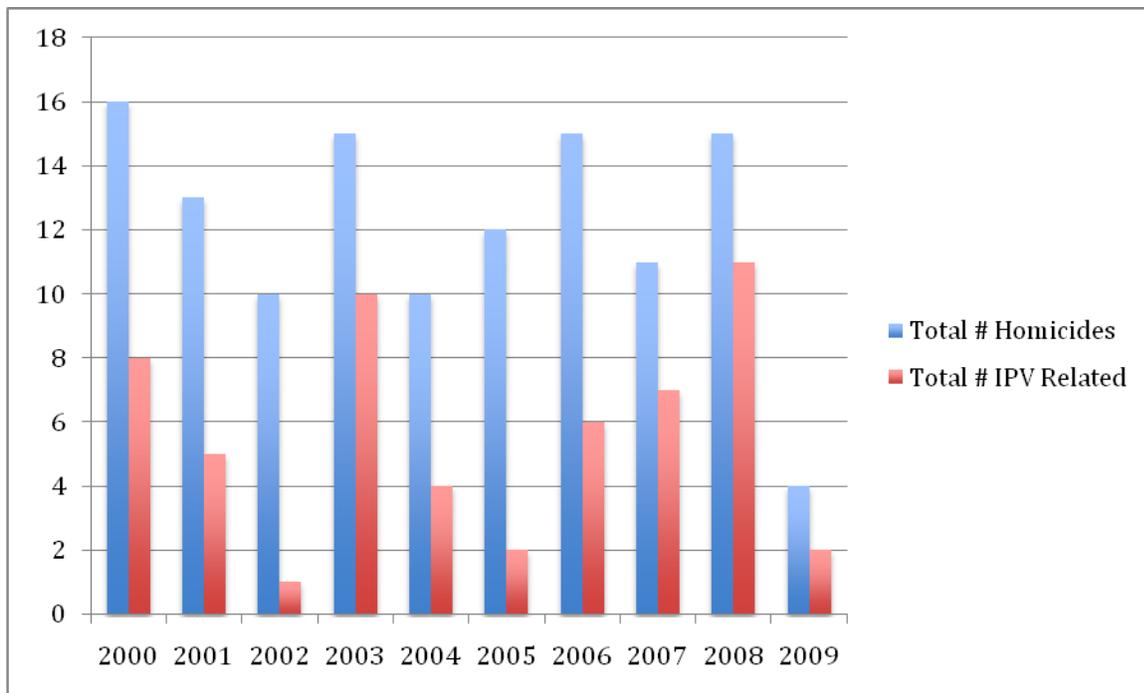
¹¹⁹ Coker, AL, Smith PH, McKeown RE, King MJ. Frequency and correlates of intimate partner violence by type: Physical, sexual and psychological battering. *AJPH* 2000; 90: 553-9.

¹²⁰ Tjaden P, Thoemnes N. Extent, nature and consequences of intimate partner violence: findings from the National Violence Against Women Survey. Washington DC: Department of Justice (US); 2000. Publication No. NCJ 181867. Available from: URL:www.ojp.usdoj.gov/nij/pubs-sum/181867.htm.

identified IPV as an often-unrecognized factor in female patient injuries.¹²¹ As a result, most official records we have relating to IPV most likely underestimate its occurrence. However, what records exist paint a troubling picture. *The Vermont Domestic Violence Fatality Review Commission Report 2010* that for the last ten years, approximately half of all the homicides that have occurred in Vermont were IPV related, and of these incidents 54% of the victims were female, 84% of the perpetrators were male.¹²² Firearms were used in over half of these homicides (57%). Children were either present at the time of the incident in one third of the cases.¹²³

Figure 20.

Total Number of Homicides and Total Number of IPV Related Homicides, 2000-2009



The Vermont Network Against Domestic and Sexual Violence member agencies track the numbers of people who come seeking assistance or contacting their hotlines. The Network’s numbers reflect cases reported to the police and those that are not; their numbers also paint a troubling picture corroborating *The Vermont Domestic Violence Fatality Review Commission’s* findings. According to their records, the numbers of people reporting that they have been the victims of sexual and/or domestic violence has risen overall slightly over the last six years, but declined from an apparent peak in 2006. Their records indicate a dramatic rise in the number

¹²¹ Abbot J, Johnson R, Koziol-McLain J, Lowenstein SR. Domestic violence against women: Incidence and prevalence in emergency department populations. *JAMA* 1995; 273:1763-7.

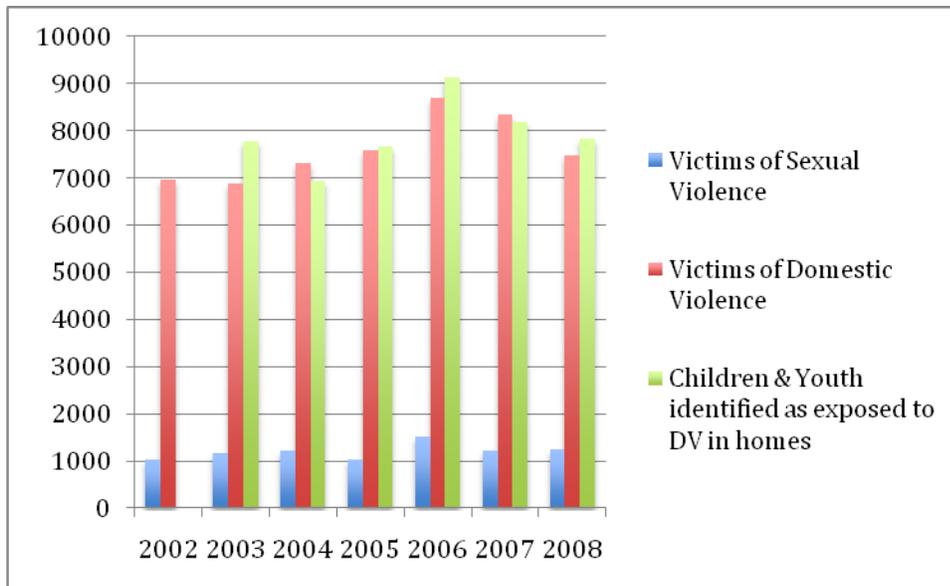
¹²² State of Vermont Domestic Violence Fatality Review Commission Report 2010.

¹²³ State of Vermont Domestic Violence Fatality Review Commission Report 2010

of senior Vermonters seeking services (69 in 2003, 119 in 2005, and 99 in 2008), and the number of emotionally or physically disabled individuals seeking services (384 in 2003, 1017 in 2006, and 805 in 2008). The number of people housed in shelters and safe houses has increased as well as the length of time that people stay during the time period. A “snapshot” of services provided to IPV victims is provided by *The 2009 Domestic Violence Counts: A 24-hour Census of Domestic Violence Shelters and Services* illustrating that on one day (September 15, 2009), Vermont Domestic Violence programs served 188 victims (102 received emergency shelter and 86 received advocacy or support services).¹²⁴

Figure. 21

Victims of Sexual Violence and Domestic Violence and Children and Youth Identified As Exposed to Domestic Violence In Homes, 2002-2008



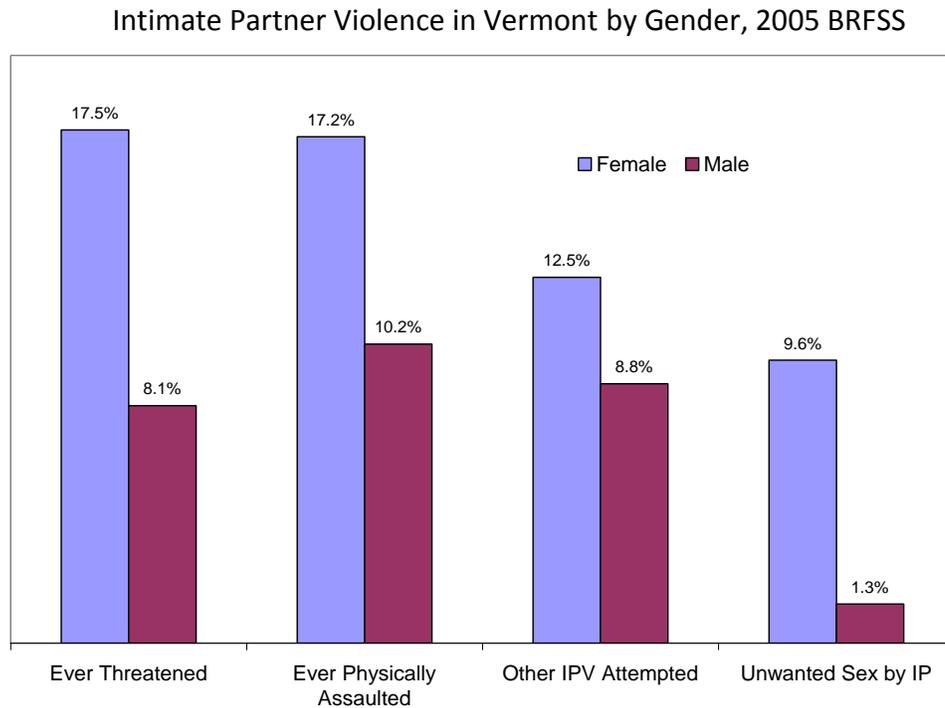
According to the 2005 BRFSS, 13% of adult Vermonters (ages 18 and older) indicate that, at some point in their life that an intimate partner threatened them with physical violence. Fourteen percent report they have been physically assaulted (e.g. hit, slapped, pushed, kicked, or physically hurt in any ways) by an intimate partner.¹²⁵ Women were more likely than men to report ever being threatened or physically assaulted by an intimate partner (18% versus 8% threatened; 17% versus 10% assaulted); women are also more likely to report experiencing unwanted sex with partner (10% versus 1%).¹²⁶

¹²⁴ 2009 Domestic Violence Counts: A 24-hour Census of Domestic Violence Shelters and Services Vermont Summary provided by the National Network to End Domestic Violence.

¹²⁵ These results are similar to those found in all 12 states that conducted the BRFSS IPV modules VTDOH Injury Prevention Burden Document

¹²⁶ VTDOH Injury Prevention Report.

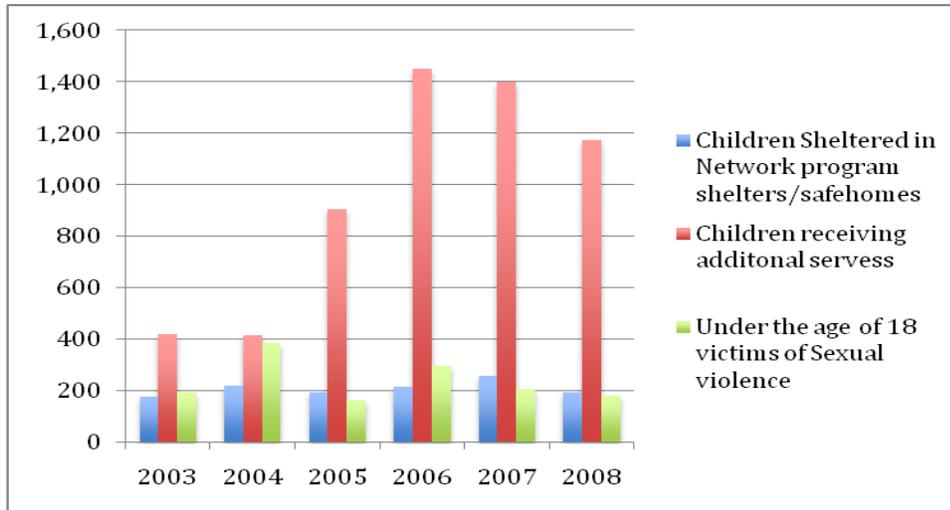
Figure 22.



IPV is not just an adult problem. IPV is also experienced by Vermont’s young people. The 2007 YRBS indicates that 7% of 8th and 12th graders report being physically hurt by a boyfriend or girlfriend in the past 12 months (no significant differences between boys and girls); one student in ten reports being touched against their wishes or being forced to touch someone else and half as many reported being forced to have sexual intercourse (5%). Girls were three times more likely than boys to report being touched or being forced to touch someone else (17% versus 5%).¹²⁷ Furthermore, the Vermont Network over the last five years has seen slight increases in the number of children reporting to have experienced sexual violence and seeking shelter in safe homes, and a dramatic increase in children seeking other services from their member agencies either as survivors or witnesses of some form of sexual or domestic violence.

¹²⁷ VTDOH Injury Burden Document

Figure.



While IPV occurs among all segments of society – men and women, children and adults, rich and poor, heterosexual and same sex, etc. – there are several factors that can increase the risk that someone will hurt his or her partner; however, having these risk factors does not mean that IPV will occur. Some of the risk factors for hurting a partner include:

- Using drugs or alcohol, especially heavily
- Seeing or being a victim of violence as a child
- Not having a job, which can cause feelings of stress.

Prevention strategies need to take long-term perspectives that seek to minimize these risk factors in a population that focus on young people learning about healthy dating relationships and skills.

8.3. Child Maltreatment

Child maltreatment is a public health problem that’s scope far exceeds the physical injuries received or the number of cases reported in the news. Child maltreatment includes all types of abuse and neglect that occur among children under the age of 18 of which there are four common types: physical, sexual, emotional, and neglect (i.e. the failure to meet a child’s basic needs such as housing, food, clothing, education, and access to medical care.)¹²⁸ It often goes unreported to either police or social services because people do not recognize the signs, children are scared to someone who can help, and others do not want to interfere in what they

¹²⁸ www.cdc.gov/violenceprevention Understanding Child Maltreatment Fact Sheet

see as private family matters. And while children of all ages, races, ethnicities, socio-economic statuses, religions, physical abilities, geographic residency, and family types may experience it, none of them are to blame for the harm that others do to them. Moreover, the harm they experience can be prevented by the people around them and the communities they live in.

Child maltreatment sometimes tragically results in death – although the exact numbers are not clear since many maltreatment fatalities are often misclassified as other types of deaths.¹²⁹ In 2007, 1,760 children died in the United States from abuse and neglect, and 794,000 were found to be victims of maltreatment by protective services.¹³⁰ In the same year in Vermont, there were three fatalities and 687 substantiated investigations for maltreatment. To put 2007 into perspective, nationally and in Vermont, that meant 2 out of every 100,000 children were victims of fatal treatment by their caregivers.

While Vermont's overall child maltreatment and fatality rates may mirror the nation's, the types of maltreatment incidents reported are different. In 2007, nationally, more children died from or were exposed to neglect than any other type of maltreatment - 60% of reported child maltreatment incidents were neglect but in Vermont only 1.6% of the incidents were attributed to neglect. In 2007, reports indicate that Vermont children experienced more frequently physical abuse (44.7% of reported incidents in Vermont compared to 10.8% nationally) or sexual abuse (46.8% in Vermont compared to 7.6% nationally).¹³¹ Vermont, unlike almost all other states, counts all incidents of child sexual abuse in Department for Children and Families statistics. Most other states count only in home offences/offenders and do not count acts perpetrated on children over 12 years of age or by offenders outside the immediate family. Thus, since almost half of all those who offend children are youths as well adults who are trusted family friends, acquaintances, people in positions of authority (e.g., teachers, faith leaders, etc.) a great many victims and incidents, while included in Vermont data, are not counted in many other states.

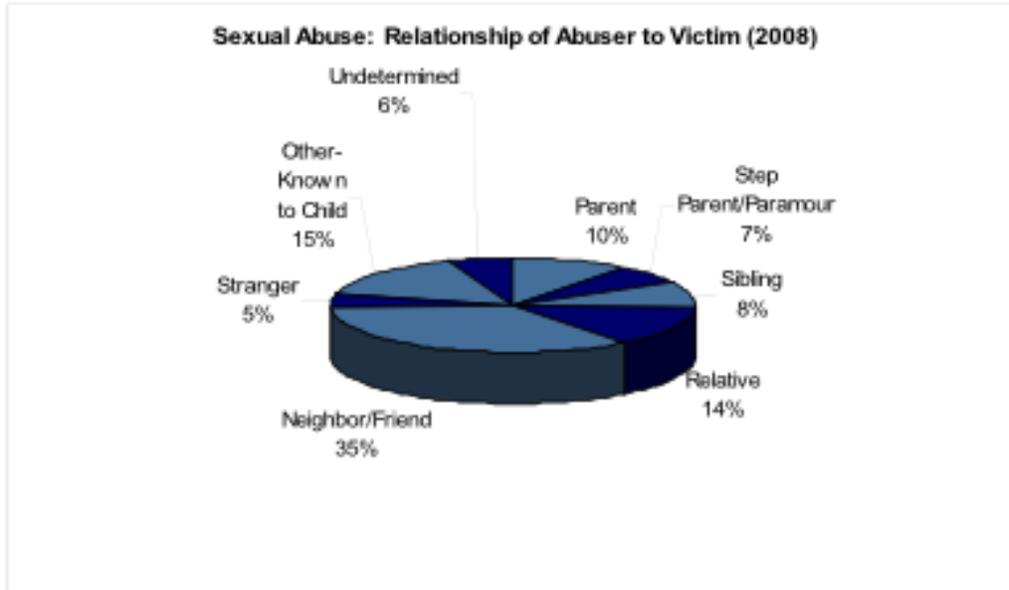
The sexual abuse of children is more common than most people realize, even in Vermont. Some surveys indicate that one out of five adult women and one out of 10 adult men report having been sexually abused as a child.¹³² In most cases, the abuser is someone the child knows – most often an authority figure that the child loves or trusts another child or teen.

¹²⁹ Herman-Giddens, M.E. et al. *Underascertainment of child abuse mortality in the United States*. JAMA, 1999. 282 (5): p. 463-467.

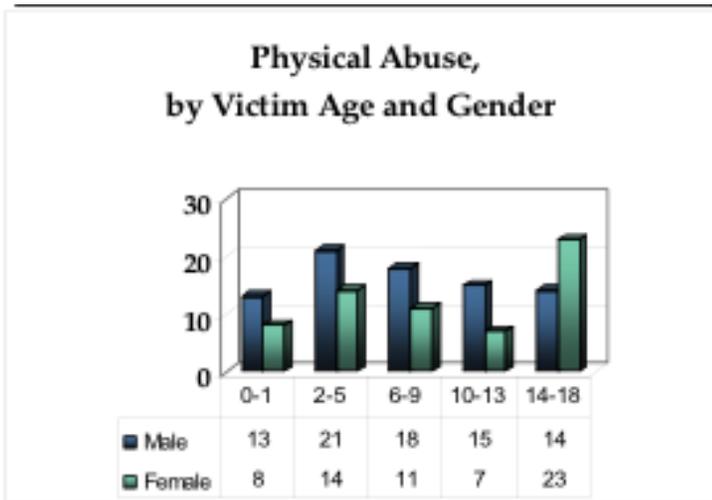
¹³⁰ Department of Health and Human Services, Administration of Children, Youth and Families. *Child Maltreatment 2007* [online]. Washington (DC): Government Printing Office. Available from: www.acf.hhs.gov

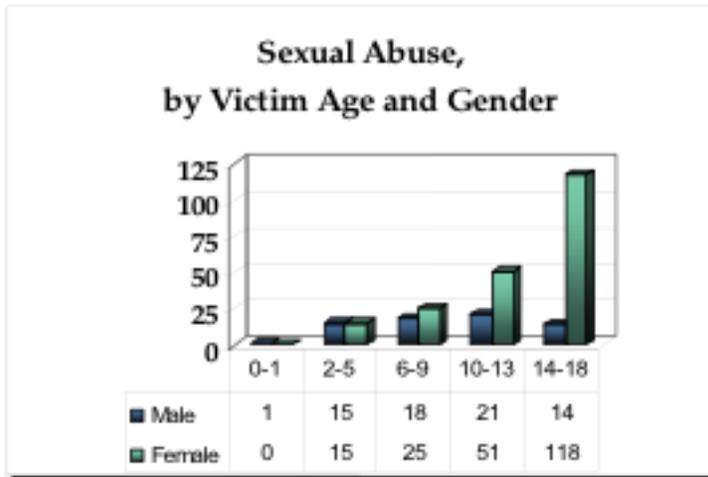
¹³¹ Child Maltreatment 2007. http://afterschool.ed.gov/progrmas.cb/pubs/cmo7/tables3_8.htm

¹³² VT Injury Prevention Plan 2001



The ages and sex of Vermont’s child victims are similar to the nation as a whole. Male children are more likely to be the victim of physical abuse from infancy until adolescence, and then girls are more likely to be a victim of physical abuse. Both male and female children are equally likely to be sexually abused as infants until the age of five, and then female children are increasingly likely to be victims.





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The negative effects of child maltreatment constitute more than just the immediate harm caused by abuse or neglect; they may continue to influence victims’ health throughout their lives. It is well documented that children who have been abused or neglected are more likely to experience adverse outcomes throughout their lives:

- Poor physical health (e.g. chronic fatigues, altered immune function, hypertension, sexually transmitted diseases, obesity);
- Poor emotional and mental health (e.g. depression, anxiety, eating disorders, suicidal thoughts and attempts, post-traumatic stress disorder);
- Social difficulties (e.g. insecure attachments with caregivers, which may lead to difficulties in developing trusting relationships with peers and adults in later life);
- Cognitive dysfunction (e.g. deficits in attention, abstract reasoning, language development, and problem-solving skills, which ultimately affect academic achievement and school performance);
- High-risk health behaviors (e.g. a higher number of lifetime sexual partners, younger age at first voluntary intercourse, teen pregnancy, alcohol, and substance abuse); and
- Behavior problems (e.g. aggression, juvenile delinquency, adult criminality, abusive or violent behavior).¹³⁴

Successful child maltreatment prevention interventions involve a combination of institutional, individual, and community approaches. Methods will focus on promoting resilience through the

¹³³ Vermont 2008 Child Abuse and Neglect Report.

¹³⁴ Child Welfare Information Gateway (2006). Long-term consequences of child abuse and neglect. http://www.childwelfare.gov/pubs/factsheets/long_term_consequences.cfm; Goldman, J., Salus, M.K., Wolcott, D., & Kennedy, K.Y. (2003). A coordinated response to child abuse and neglect: The foundation for practice. Child Abuse and Neglect User Manual Series. Washington, DC: Government Printing Office. <https://www.childwelfare.gov/pubs/usermanual/foundations/foundation.pdf>, Lowenthal, B. Child Maltreatment: Effects on Development and Learning on the Clearinghouse on Early Education and Parenting, <http://ceep.uicuc.edu/pubs/katzysm/lowenthal.html>

availability of parent education programs, alternative caregivers, social support systems, and home visiting.

Healthy People 2020 Related Objectives

Adolescent Health

- AH-8: Increase the proportion of adolescents whose parents consider them to be safe at school
- AH-9: (Developmental) Increase the proportion of middle and high schools that prohibit harassment based on a student's sexual orientation or gender identity
- AH-10: Decrease the proportion of public schools with a serious violent incident
- AH-11: Reduce adolescent and young adult perpetration of, as well as victimization by, crimes
- AH-11.1: Decrease the rate of minor and young adult perpetration of violent crimes

Educational and Community-Based Programs

ECBP-2: Increase the proportion of elementary, middle, and senior high schools that provide comprehensive school health education to prevent health problems in the following areas: unintentional injury; physical and sexual violence; suicide; tobacco use and addiction; alcohol or other drug use; cyberbullying; sexting; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; and inadequate physical activity.

ECBP-7: Increase the proportion of college and university students who receive information from their institution on each of the priority health risk behavior areas (all priority areas; unintentional injury; sexual violence; suicide; tobacco use and addiction; alcohol and other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; unlawful use of technology devices; and inadequate physical activity)

Injury and Violence Prevention (IPV)

- IVP-29: Reduce homicides
- IVP-30: Reduce firearm-related deaths
- IVP-31: Reduce nonfatal firearm-related injuries
- IVP-32: Reduce nonfatal physical assault injuries
- IVP-33: Reduce physical assaults
- IVP-34: Reduce physical fighting among adolescents
- IVP-35: Reduce bullying among adolescents
- IVP-36: Reduce weapon carrying by adolescents on school property
- IVP-37: Reduce child maltreatment deaths
- IVP-38: Reduce nonfatal child maltreatment
- IVP-39: (Developmental) Reduce violence by current or former intimate partners
- IVP-39.1: (Developmental) Reduce physical violence by current or former intimate partners
- IVP-39.2: (Developmental) Reduce sexual violence by current or former intimate partners
- IVP-39.3: (Developmental) Reduce psychological abuse by current or former intimate partners
- IVP-39.4: (Developmental) Reduce stalking by current or former intimate partners
- IVP-40: (Developmental) Reduce sexual violence

- IVP-40.1: (Developmental) Reduce rape or attempted rape
- IVP-40.2: (Developmental) Reduce abusive sexual contact other than rape or attempted rape
- IVP-40.3: (Developmental) Reduce non-contact sexual abuse
- IVP-41: Reduce nonfatal intentional self-harm injuries
- IVP-42: Reduce children's exposure to violence
- IVP-43: Increase the number of States and the District of Columbia that link data on violent deaths from death certificates, law enforcement, and coroner and medical examiner reports to inform prevention efforts at the State and local levels

Mental Health and Mental Disorders (MHMD)

- MHMD-1: Reduce the suicide rate
- MHMD-2: Reduce suicide attempts by adolescents

Action Steps

Suicide and Suicide Attempts

- **Action Step 1:** Work with partners to support a public media campaign to increase public awareness of suicide and suicide prevention.
- **Action Step 2:** Work with partners to promote policy and public educational efforts to reduce access to lethal means, such as firearms, drugs and poisons.
- **Action Step 3:** Work with partners, such as the Vermont Youth Suicide Prevention Coalition, to support school based and community gate keeper trainings to identify and refer individuals who may be at-risk for depression or suicide. These trainings will deal with youth through the college age years.
- **Action Step 4:** Promote screening for depression/ suicidal risk among adults and youth receiving care in such organizations as health care settings, emergency departments, and substance abuse treatment centers.
- **Action Step 6:** Work with partners to increase collaboration between mental health, substance abuse professionals and primary care providers to detect early signs of mental illness in individuals of all ages and begin early treatment.
- **Action Step 8:** Work with partners such as the Office of Minority Health and the Vermont Partnership for Fairness and Diversity to design specific interventions for minority youth at risk of suicide and suicide attempts.
- **Action Step 9:** Improve data collection and analysis capabilities on all aspects of suicide, especially on suicide attempts.

Intimate Partner Violence

- **Action Step 1:** Work with professional medical associations and health care providers to promote ongoing and regular screening for domestic violence and provide information on immediate assistance and ongoing support from community resources.

- **Action Step 2:** Support efforts to strengthen the statewide system of SANE training for nurses.
- **Action Step 3:** Work with partners, such as The Vermont Network and Prevention Child Abuse Vermont, to develop sustainable sexual violence prevention programs in Vermont schools.
- **Action Step 4:** Support the Vermont Domestic Violence Fatality Review Commission to implement the recommendations in their Annual Report for legal and social system improvement to protect women who are victims or are at risk of IPV.
- **Action Step 5:** Increase population and program data collection and analysis capacity for improving understanding of circumstances around events of IPV.

Child Maltreatment

- **Action Step 1:** Promote education and other support services for new parents and families at risk via home visits, parenting education and support groups, and community center based services.
- **Action Step 2:** In collaboration with partners such as Prevention Child Abuse Vermont, support the expansion of the system of statewide trainings to community professionals (home visiting and center based, medical professionals, early childhood care givers) about best practices in infant calming and management of infant crying.
- **Action Step 3:** Work with partners, such as the University of Vermont and Fletcher Allen Health Care and the statewide SANE system, to support programs for teaching medical professionals how to identify child abuse (such as symptoms of abusive head trauma) and how to refer to community resources or child protection authorities..
- **Action Step 4:** In collaboration with partners such as Prevent Child Abuse Vermont, expand existing programs (such as those using the Train-the-Trainer model) for training adults to learn ways to intervene and protect children from sexual abuse.
- **Action Step 5:** Increase population and program data collection and analysis capacity for improving understanding of circumstances around events of child maltreatment.

HEALTHY PEOPLE 2020 INJURY RELATED OBJECTIVES

Falls

Arthritis, Osteoporosis, and Chronic Back Conditions (AOCBC)

AOCBC-11: Reduce hip fractures among older adults

Injury and Violence Prevention (IVP)

IVP-23: Prevent an increase in the rate of fall-related deaths

IVP-26: Reduce sports and recreation injuries

IVP-27: Increase the proportion of public and private schools that require students to wear appropriate protective gear when engaged in school-sponsored physical activities

Older Adults (OA)

OA-11: Reduce the rate of emergency department visits due to falls among older adults

Infant Safe Sleep

Injury and Violence Prevention (IVP)

IVP-24: Reduce unintentional suffocation deaths

Maternal, Infant, and Child Health (MICH)

MICH-1: Reduce the rate of fetal and infant deaths

MICH-1.8: Infant deaths from sudden infant death syndrome (SIDS)

MICH-1.9: Infant deaths from sudden unexpected infant deaths (includes SIDS, Unknown Cause, Accidental Suffocation, and Strangulation in Bed)

Occupational

Occupational Safety and Health (OSH)

OSH-1: Reduce deaths from work-related injuries

OSH-2: Reduce nonfatal work-related injuries

OSH-2.1: Injuries in private sector industries resulting in medical treatment, lost time from work, or restricted work activity, as reported by employers

OSH-2.2: Injuries treated in emergency departments

OSH-2.3: Adolescent workers aged 15 to 19 years

OSH-3: Reduce the rate of injury and illness cases involving days away from work due to overexertion or repetitive motion

OSH-4: Reduce pneumoconiosis deaths

OSH-5: Reduce deaths from work-related homicides

OSH-6: Reduce work-related assaults

Poison

Injury and Violence Prevention

IVP-9: Prevent an increase in the rate of poisoning deaths

IVP-9.3: Prevent an increase in the rate of poisoning deaths

IVP-9.4: Unintentional or undetermined intent among all persons

IVP-10: Unintentional or undetermined intent among persons aged 35 to 54 years

IVP-11: Prevent an increase in the rate of nonfatal poisonings

Substance Abuse (SA)

SA-2: Increase the proportion of adolescents never using substances

SA-19: Reduce the past-year nonmedical use of prescription drugs

SA-21: Reduce the proportion of adolescents who use inhalants

Transport

Injury and Violence Prevention (IPV)

IPV-13: Reduce motor vehicle crash-related deaths

IPV-13.1: Deaths per 100,000 population

IPV-13.2: Deaths per 100 million vehicle miles traveled

IPV-14: Reduce nonfatal motor vehicle crash-related injuries

IPV-15: Increase use of safety belts

IPV-16: Increase age-appropriate vehicle restraint system use in children

IPV-17: Increase the number of States and the District of Columbia with “good” graduated driver licensing (GDL) laws

IPV-18: Reduce pedestrian deaths on public roads

IPV-19: Reduce nonfatal pedestrian injuries on public roads

IPV-20: Reduce pedalcyclist deaths on public roads

IPV-21: Increase the number of States and the District of Columbia with laws requiring bicycle Helmets for bicycle riders

IPV-22: Increase the proportion of motorcycle operators and passengers using helmets

Traumatic Brain Injury

Injury and Violence Prevention (IVP)

IVP-2: Reduce fatal and nonfatal traumatic brain injuries

IVP-2.1: Reduce fatal traumatic brain injuries

IVP-2.2: Reduce hospitalization for nonfatal traumatic brain injuries

IVP-2.3: Reduce emergency department visits for nonfatal traumatic brain injuries

Violence

Adolescent Health

- AH-8: Increase the proportion of adolescents whose parents consider them to be safe at school
- AH-9: (Developmental) Increase the proportion of middle and high schools that prohibit harassment based on a student's sexual orientation or gender identity
- AH-10: Decrease the proportion of public schools with a serious violent incident
- AH-11: Reduce adolescent and young adult perpetration of, as well as victimization by, crimes
- AH-11.1: Decrease the rate of minor and young adult perpetration of violent crimes

Educational and Community-Based Programs

ECBP-2: Increase the proportion of elementary, middle, and senior high schools that provide comprehensive school health education to prevent health problems in the following areas: unintentional injury; violence; suicide; tobacco use and addiction; alcohol or other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; and inadequate physical activity

ECBP-7: Increase the proportion of college and university students who receive information from their institution on each of the priority health risk behavior areas (all priority areas; unintentional injury; violence; suicide; tobacco use and addiction; alcohol and other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; and inadequate physical activity)

Injury and Violence Prevention (IPV)

- IVP-29: Reduce homicides
- IVP-30: Reduce firearm-related deaths
- IVP-31: Reduce nonfatal firearm-related injuries
- IVP-32: Reduce nonfatal physical assault injuries
- IVP-33: Reduce physical assaults
- IVP-34: Reduce physical fighting among adolescents
- IVP-35: Reduce bullying among adolescents
- IVP-36: Reduce weapon carrying by adolescents on school property
- IVP-37: Reduce child maltreatment deaths
- IVP-38: Reduce nonfatal child maltreatment
- IVP-39: (Developmental) Reduce violence by current or former intimate partners
- IVP-39.1: (Developmental) Reduce physical violence by current or former intimate partners
- IVP-39.2: (Developmental) Reduce sexual violence by current or former intimate partners
- IVP-39.3: (Developmental) Reduce psychological abuse by current or former intimate partners
- IVP-39.4: (Developmental) Reduce stalking by current or former intimate partners
- IVP-40: (Developmental) Reduce sexual violence
- IVP-40.1: (Developmental) Reduce rape or attempted rape
- IVP-40.2: (Developmental) Reduce abusive sexual contact other than rape or attempted rape
- IVP-40.3: (Developmental) Reduce non-contact sexual abuse
- IVP-41: Reduce nonfatal intentional self-harm injuries

IVP-42: Reduce children's exposure to violence

IVP-43: Increase the number of States and the District of Columbia that link data on violent deaths from death certificates, law enforcement, and coroner and medical examiner reports to inform prevention efforts at the State and local levels

Mental Health and Mental Disorders (MHMD)

MHMD-1: Reduce the suicide rate

MHMD-2: Reduce suicide attempts by adolescents

Vermont Suicide Prevention Platform



SECOND EDITION 2015

Working to Prevent Suicide Across the Lifespan

Published by:
Vermont Suicide Prevention Center





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Letters of Support

PETER SHUMLIN
Governor



State of Vermont
OFFICE OF THE GOVERNOR

May 18, 2015

Dear Vermonters,

There is nothing more painful than losing someone to suicide, and sadly, there isn't a Vermonter who is not touched in some way by these tragedies. That is why I am so grateful for the Vermont Suicide Prevention Coalition and its work on the 2015 Vermont Suicide Prevention Platform.

It is disheartening that suicide is the eighth leading cause of death in Vermont and the tenth leading cause of death in the United States in 2010. These statistics are too high and speak to the importance of the Suicide Prevention Coalition. In collaboration with state agencies, non-profits, health care providers, survivors, veterans, educators and young people, they have committed themselves to building a sustainable and comprehensive infrastructure for suicide prevention efforts. The Vermont Suicide Prevention Platform provides evidence based data, offers concrete goals and serves as a guide for all Vermonters working to address this issue.

I applaud the hard work and dedication of the coalition. My administration is proud to be an active partner in this fight to end suicide.

Sincerely,

A handwritten signature in black ink, appearing to be "Peter Shumlin", with a long horizontal line extending to the right.

Peter Shumlin
Governor

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Hal Cohen, Secretary

[phone] 802-871-3009
[fax] 802-871-3001

January 13, 2015

Dear Vermonters:

The Vermont Agency of Human Services is writing this letter of support on behalf of the Department of Aging and Independent living, the Department of Corrections, the Department of Vermont Health Access, the Department of Health, the Department of Children and Families in addition to the Department of Mental Health. The Agency Of Human Services seeks to address the many social, behavioral, and public health concerns faced by our families and communities when working to prevent suicide. When someone takes his or her own life, we are left with many conflicting emotions and endless questions that are difficult to answer. However, in many cases, suicide can be prevented if people know the signs and resources for how to get help for themselves or a friend or family member.

Suicide is a significant issue across our country, and in our state it is the eighth leading cause of death for Vermonters. Nationally, about 12 people per 100,000 die by suicide annually and, in Vermont, we average 19 deaths per 100,000. This number is much too high for our small state and the effect on families and our communities can be devastating.

Suicide is a complex behavioral phenomenon that requires comprehensive systems that support both effective clinical interventions and evidence-based community programs for treatment and prevention. The 2015 Vermont Suicide Prevention Platform expands our existing youth suicide prevention programming to include new approaches to suicide prevention across the lifespan. The 2015 Vermont Suicide Prevention Platform incorporates the application of knowledge from the latest research into the framework of community and provider evidence-based approaches that support prevention programming for communities, families and, specifically individuals who may be at risk for suicide.

The 2015 Vermont Suicide Prevention Platform is a valuable resource for our state that will reinforce and expand existing efforts in preventing suicide. I urge all Vermonters - clinicians, policy makers, community leaders, families, and co-workers - to join in this effort and contribute to the successful implementation of the strategies outlined in the Platform. We all need to embrace its goals and action steps and put it to work statewide in order to reduce the number of Vermonters who feel they need to take their own lives.

Hal Cohen
Secretary
Agency of Human Services



Letters of Support



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Agency of Education

May 2015

To Whom It May Concern:

Suicide is the second leading cause of death for young people in Vermont between the ages of 10 and 24. When young people die by suicide, they leave behind those who love them. Society loses what those young people would have achieved and contributed, if they had lived full adult lives. We want our young people to know that they matter in each Vermont community. The statistics are sobering:

- The rate of death by suicide is 17.9 per 100,000 across all ages in Vermont while the national rate is 13.0 per 100,000 (2013 official final data American Association of Suicidology published June 19, 2014/revised January 22, 2015)
- Data from 2013 showed that over the course of a 12 month period, 21% of all students felt sad or hopeless almost every day for at least two weeks, 11% made a suicide plan, and 5% attempted suicide (2013 YRBS, VDH)
- Eleven percent of high school students made a plan about how they would attempt suicide (2013 YRBS, VDH)
- Five percent of high school students actually attempted suicide in the past twelve months (2013 YRBS, VDH)

The Vermont Suicide Prevention Platform 2015 describes in detail the state's effort to combat the tragic problem of suicide. This Platform is the result of much hard work by many citizens dedicated to the well-being of youth and the prevention of suicide, and by public and private organizations whose work directly affects youth. It is a guide for all Vermonters to use, no matter where they work or live. The impact of suicide on families, schools, and the larger community is especially profound in Vermont's many small rural communities. The Platform highlights public concerns about suicide, gives statistical evidence of the need for prevention and offers a background for addressing suicide as a public health problem in Vermont.

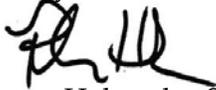


The Center for Health and Learning, with support from VDH and VDMH, received a grant to address several priorities- Infrastructure, Public Awareness and Gatekeeper Training. Some accomplishments of the grant are highlighted below:

- Created the VT Suicide Prevention Center (www.vtspc.org)
- Expanded website <http://umatterucangethelp.com/> (for youth ages 11-23) to also be available on mobile application
- Conducted successful public information campaign (newspaper, radio and internet advertisements) as evidenced by Umatter websites receiving over 6,500 hits every year
- Trained 514 school professionals from 115 schools within 48 Supervisory Unions in Gatekeeper, Protocol Development and Lifelines curriculum

The Vermont Agency of Education supports the ongoing work of the Platform and the impressive efforts toward suicide prevention that the Center for Health and Learning conducts throughout Vermont.

Sincerely,



Rebecca Holcombe, Secretary
Vermont Agency of Education



Vermont Suicide Prevention Coalition

The Vermont Suicide Prevention Coalition consists of representatives from public health, education, state agencies, suicide prevention advocacy groups, youth leadership, mental health services and survivors throughout the state.

Our **mission** is to create communities of hope throughout Vermont in which schools, agencies and people of all ages are given the knowledge, attitudes, skills and resources to respond effectively to suicidal behavior. Our message is *Umatter*.

Our strategies include:

- Promoting the message that suicide across the lifespan is preventable
- Equipping health care and community based providers with the knowledge and skills to respond effectively to anyone in distress
- Increasing public awareness of the importance of addressing mental health issues and the characteristics of mental health wellness
- Establishing a broad-based suicide prevention and intervention program throughout Vermont
- Sponsoring a public information campaign to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services and to increase connectedness and the promotion of mental health wellness
- Promoting positive youth development and life-long mental health
- Developing a five-year strategic plan to ensure long-term and sustainable approaches to prevention and early intervention

The work of the Vermont Suicide Prevention Coalition is based upon a number of **underlying principles** derived from the *2012 National Strategy for Suicide Prevention* and the *2015 Vermont Suicide Prevention Platform*. Those principles include:

- Suicide is generally preventable — suicidality is a diagnosable mental health condition which requires a pathway to care
- Suicide is a public health issue
- Mental health and physical health are important and inextricably linked components of overall health
- Suicide shares risk factors with substance abuse, bullying and harassment, traumatic events (including sexual abuse, violence, post-traumatic stress), as well as other mental health conditions
- Community, individuals and organizations must collaborate to prevent suicide

The Coalition has been instrumental in implementing the *Umatter* public awareness campaign statewide, promoting the message that everyone has a place in the Big Picture, and a role in preventing suicide. *Umatter* promotes mental health wellness through self-assessment, communication, coping and help-seeking skills.

Participating Organizations and Key Partners

- American Foundation for Suicide Prevention, Vermont Chapter
- Brattleboro Retreat
- Brattleboro Union High School
- Center for Health and Learning
- Clara Martin Center
- Counseling Services of Addison County, Inc.
- Fletcher Allen Health Care
- Green Mountain Crossroads
- GunSenseVT
- Hardwick Area Community Justice Center
- Hartford High School
- Health Care & Rehabilitation Services
- Howard Center
- Howard Center - First Call for Children & Families
- Lamoille County Mental Health Services
- National Alliance on Mental Illness - VT
- Northeast Kingdom Human Services
- Northern New England Poison Center
- Northwestern Counseling & Support Services
- Outright Vermont
- Rutland Mental Health Services
- St. Johnsbury School
- Survivors
- United Counseling Services
- University of Vermont
- University of Vermont, Center for Health and Wellbeing
- University of Vermont College of Medicine
- US Department of Veterans Affairs, White River Junction
- Vermont Association for Mental Health & Addiction Recovery – Friends of Recovery VT
- Vermont 2-1-1
- Vermont Agency of Education
- Vermont Agency of Human Services
- Vermont Agency of Human Services, Department of Vermont Health Access
- Vermont Child Health Improvement Program
- Vermont Correctional Academy
- Vermont Council of Developmental & Mental Health Services
- Vermont Department of Children and Families
- Vermont Department of Corrections
- Vermont Department of Disabilities, Aging and Independent Living
- Vermont Department of Health
- Vermont Department of Health, Division of Alcohol and Drug Abuse Programs
- Vermont Department of Health, Division of Maternal and Child Health
- Vermont Department of Mental Health
- Vermont Federation of Families for Children's Mental Health
- Vermont National Guard Military Family Services
- Washington County Mental Health
- Youth in Transition

The Vermont Suicide Prevention Center

The Vermont Suicide Prevention Center (VT-SPC) is a statewide resource fostering a sustainable approach to suicide prevention in Vermont. Under the advisement and direction of the Vermont Suicide Prevention Coalition, the VT-SPC's mission is to create health-promoting communities in which schools, Institutions of Higher Education, public and private agencies and people of all ages have the knowledge, attitudes, skills and resources to reduce the risk of suicide. The purpose of VT-SPC is to support statewide suicide prevention efforts and help local communities implement the recommendations of the Vermont Suicide Prevention Platform using data-driven evidence-based practices.

VT-SPC Goals:

- Promote mental health and emotional resilience in Vermont through collaborations focused on public education and prevention policies.
- Cultivate strong state and local leadership for suicide prevention and intervention.
- Involve youth and adults in suicide prevention activities, including public education that encourages the development of coping skills and help-seeking behavior.
- Equip youth and adult gatekeepers with the knowledge and skills necessary for responding effectively to signs of distress, and intervening early with those who are showing warning signs of suicide.
- Enhance strategies for early identification of mental health conditions and pathways leading to care and recovery.
- Encourage access to primary care and mental health services that provide effective intervention, treatment and follow-up.
- Support the use of data and personal stories to inform suicide prevention in Vermont.
- Provide strategic tools for developing suicide prevention programs, implement interventions, and promote policies to prevent suicide.

VT-SPC Serves:

- Educators and School Health Professionals
- First Responders
- Social Services
- Health Care and Mental Health Services
- Faith Communities
- Community Coalitions
- Legislators
- Special Interest Groups



VT-SPC Services:

The VT-SPC cultivates support for, develops, implements and evaluates:

- Suicide Prevention and Postvention Protocols for School and Community Professionals
- School Policy, Protocol and Curriculum Development
- Suicide Prevention and Postvention Trainers and Training
- Training and Technical Assistance for Schools, Institutions of Higher Education and Public and Private Organizations
- Suicide Prevention and Postvention; Alcohol, Tobacco and Other Drug Education; Mental Health, Depression Awareness and Compassion Training
- Development of Culturally Appropriate Prevention Strategies
- Development and Dissemination of Upstream Mental Health Promotion Public Information Materials

VT-SPC is a program of the Center for Health and Learning supported by funding from the Department of Mental Health and other grants and contracts, and public and private donations.

Executive Summary

This *Vermont Suicide Prevention Platform* offers a well-defined, structured guide to the priorities of suicide prevention in Vermont, built on a foundation of collaboration and ongoing research. A prioritized framework such as this directs prevention efforts and keeps them aligned to both Vermont's changing needs, and to the most current findings in the field of suicide prevention.

This second update to the *Vermont Suicide Prevention Platform* builds on a decade of work by dedicated individuals and organizations working to shape the state's response to suicide. Vermont received its second consecutive suicide prevention grant from the Substance Abuse and Mental Health Services Administration in 2012, and this has continued to support the efforts outlined in the *2012 Youth Suicide Prevention Platform*. This updated and revised Platform presents a broader lifespan scope, championed by the Vermont Department of Mental Health and the Vermont Suicide Prevention Coalition.

This Platform also represents Vermont's attention to, and incorporation of the latest evidence-based policies and practices from across the nation. As the country has recognized suicide is a largely preventable public health crisis, research on and utilization of best practices has expanded. These advances, and Vermont's participation therein, are detailed in the following sections on the *National Strategy for Suicide Prevention* – itself updated in 2012 – and the national Zero Suicide movement.

Our goals have shifted since 2012, and they reflect trends in national suicide prevention efforts, including increased emphasis on promotion of mental and emotional health, de-stigmatization of help-seeking and utilization of mental health services, integration of suicide prevention efforts throughout systems of care, and expanded surveillance and data systems.

The Eleven Goals of the 2015 Vermont Platform:

1. Promote awareness that suicide is a public health problem.
2. Build sustainable and integrated infrastructure in Vermont for mental health promotion, suicide prevention, intervention and postvention.
3. Develop and implement strategies to promote positive public attitudes toward being socially and emotionally healthy.
4. Develop, implement and monitor programs that promote social and emotional wellness.
5. Promote efforts to reduce access to lethal means among people at risk of suicide.
6. Provide training to community members and professionals on how to recognize suicide related behaviors and how to intervene.
7. Promote suicide prevention, screening, intervention, and treatment as core components of health care services with effective clinical and professional practices.
8. Improve coordination and accessibility of mental health and substance abuse treatment services.
9. Promote responsible reporting and accurate portrayals of suicidal behavior, mental health conditions and substance abuse in the media.
10. Improve and expand surveillance systems in order to: 1) monitor trends and profiles of at-risk populations, 2) assess the impact of existing policies and programs, and 3) inform the development of future efforts.
11. Provide care and support to individuals affected by suicide deaths and attempts.

What has not changed? This Platform maintains the ongoing commitment to the fundamental principle that *everyone* has a role in suicide prevention. As in the past edition, each Vermont goal is structured to include strategies in which people, at all levels of society, can play a part. We invite you to read on, and find *your* role.



JoEllen Tarallo-Falk, Ed.D., MCHES, FASHA
Director, Vermont Suicide Prevention Center
Executive Director, Center for Health and Learning

What We Know About Suicide

- Suicide is a public health issue that affects individuals and families of all ages, socio-economic groups, and cultural and ethnic backgrounds. Stigma, myths and social attitudes about suicide can make it difficult for people and families in pain to get the help they need, and leave others unsure of how to offer or receive support after an attempt or death.
- Most people who die by suicide – up to 90% – have experienced a mental health condition, often untreated. People die daily from emotionally painful conditions that might have responded to treatment.
- Youth who are Lesbian, Gay, Bisexual, Transgender, or Questioning are at four times greater risk of attempting suicide than their heterosexual peers. They are four times more likely to be threatened by a weapon at school and, though they represent 10% of the population, they represent 25% of the homeless population.
- It is critical to restrict access to lethal means by people at high risk of suicide.
- National suicide research identifies that a population acknowledged to be at high-risk – white, non-Hispanic middle-aged men – is experiencing a significant increase in death by suicide. In studies examining the ten-year period of 1999 through 2010, the rate of suicide increased by 28% for both men and women in the 35 – 64 age range (though men still die at a much higher rate than women). During the same time period the rate of death by suicide rose 7% for ages 10 through 34, and dropped by 5.9% for ages 65 and over. Suicide is now the fourth leading cause of death for middle-aged Americans, versus the eighth leading cause of death in 1999.
- Military veterans also constitute a high-risk group due to exposure to violence, potential traumatic brain injury, post-traumatic stress disorder, and a traditional military culture that often discourages help-seeking.

In Vermont...

- The number of suicide deaths is higher than from motor vehicle accidents, and much higher than homicides.
- 21% of high school students reported feeling depressed for more than two weeks – the definition of clinical depression.
- Vermont is approximately 95% white, but a disproportionately large percentage (9%) of young people who were referred for mental health concerns identified as non-white.
- In 2009, the last year for which the complete data are available, there were 400 visits to emergency departments for Vermonters who attempted suicide.
- Suicide rates increase across the age ranges, and are highest among those 65 and older. The rates of suicide death for Vermonters over 65 steadily increased from 12.6 per 100,000 in 2008 to 25.5 per 100,000 in 2011. Vermont elders struggle with many challenges, from chronic pain to grief and depression, and may be at higher risk for physical isolation in rural settings. As we age, many people struggle with feeling disconnected from their life purpose, and are frequently concerned that they have become a burden to others. This perceived burdensome-ness, in combination with isolation and lack of connection, presents a significantly high-risk profile.
- Between 2010 and 2013, Vermont veterans had a suicide rate of 28 deaths per 100,000 people, compared to 19 deaths per 100,000 non-veterans.
- The majority of Vermont suicide deaths (57%) are the result of firearms, higher than the national average of 50%.
- A notable sex discrepancy exists when considering lethal means. The most recent Vermont research tells us that men are four times more likely to die by suicide than women overall, and 64% of male deaths were firearm related. Here we see reflected the effects of high lethality of means of choice. While 43% of female suicide deaths were also firearm related, a higher number were due to poisoning, at 48%.

What We Know About Suicide

Fast Facts – National Data

Frequency interval in minutes of deaths by suicide across the lifespan:	12.8
Frequency interval in minutes of deaths by suicide of elders:	73
Frequency interval in minutes of deaths by suicide of a youth:	108
Ratio of deaths by suicide to suicide attempts:	1 : 25
Number of suicide attempts:	1,028,725
Frequency interval in seconds of suicide attempts across the lifespan:	24
Causes of death from most to least common among youth aged 15 – 24:	Accidents Suicide Homicide
Ratio at which males kill themselves as opposed to females killing themselves:	3.5 : 1
Ratio at which females attempt suicide as opposed to males attempting suicide:	3 : 1
Percent of all deaths that are the result of suicide:	1.6
Percent of deaths among 15 – 24 year-olds that are the result of suicide:	17.1
Ranking of suicide and homicide as causes of death:	10th & 16th
Estimated minimum number of people intimately and profoundly affected by each suicide:	6

Deaths by Suicide

	Yearly	Daily
Nationally	41,149	112.7
Males	32,055	87.8
Females	9,094	24.9
Whites	37,154	101.8
Nonwhites	3,995	10.9
Elders (65+ yrs.)	7,215	19.8
Youth (15 – 24 yrs.)	4,878	13.4

2013 National - Vermont Data Comparisons

	National	Vermont
Number of deaths by suicide	41,149	112
Rate of deaths by suicide per 100,000	13	17.9
Percent of High School students who have made a suicide plan in the last 12 months	12.8	11
Percent of High School students who have attempted suicide in the last 12 months	7.8	5

Resources for Data: American Association of Suicidology 2013; Youth Risk Behavior Survey 2013 Vermont Department of Health

National Strategy for Suicide Prevention

The Vermont Suicide Prevention Platform is aligned with the **National Strategy for Suicide Prevention (NSSP)** – a document issued by the Office of the U.S. Surgeon General and the National Action Alliance for Suicide Prevention that provides a guide for organized prevention efforts for the United States.

One of the central tenets of the NSSP, that Vermont embraces, is that everyone – businesses, educators, health care institutions, government, communities, and every single American – has a role in preventing suicide and creating a healthier nation. Prevention must be woven into all areas of our lives.

Due to the dramatic growth of activity in the field of suicide prevention since the first National Strategy was issued in 2001, the Surgeon General and the Action Alliance revised and updated the document in 2012. In that intervening decade, much progress was made in increased training of clinicians and community members in detection of suicide risk and appropriate response, and enhanced communication and collaboration between public and private sectors on suicide prevention.

The 2012 strategy revision reflects the major developments in suicide **prevention, research, and practice**, including:

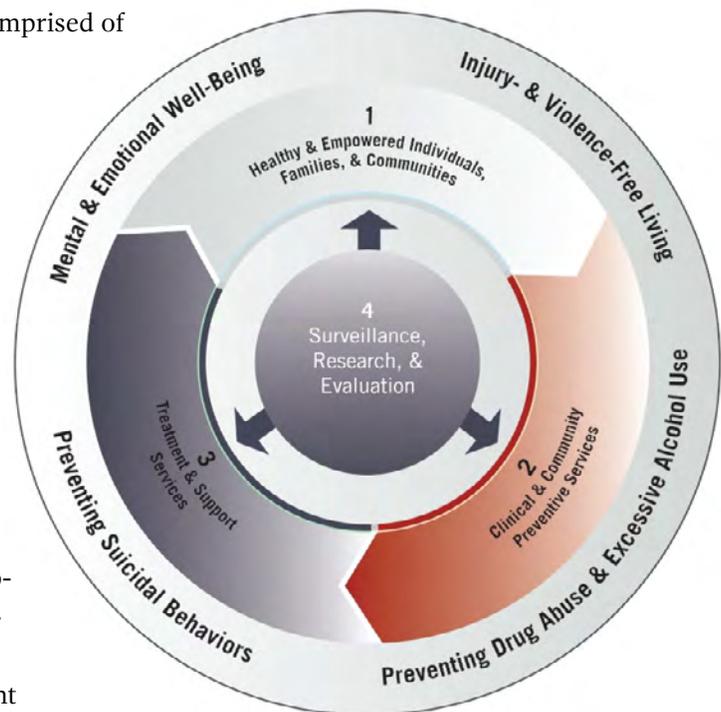
- An increased understanding of **the link between suicide and other health issues**. Ongoing research continues to confirm that health conditions such as mental illness and substance abuse, as well as traumatic or violent events, can influence a person's risk of suicide later in life. Research suggests that **connectedness** can help protect individuals from a wide range of health problems, including suicide risk.
- New knowledge on **groups at increased risk**. Research continues to suggest important differences among various demographics in regards to suicidal thoughts and behaviors.
- Evidence of the **effectiveness of suicide prevention interventions**. New evidence suggests that a number of interventions, such as behavior therapy, crisis lines and follow-up are particularly useful.
- Increased recognition of **the value of comprehensive and coordinated services**. Combining **new methods of treatment** for suicidal patients with **prompt patient follow-up** after discharge from the hospital is an effective suicide prevention method.

The 2012 NSSP outlines **four strategic directions** comprised of 13 goals and 60 objectives that are meant to work together:

1. Create supportive environments that promote healthy and empowered individuals, families, and communities;
2. Enhance clinical and community preventive services;
3. Promote the availability of timely treatment and support services; and
4. Improve suicide prevention surveillance collection, research, and evaluation.

The eleven goals of the Vermont Platform fall within these strategic directions, as the state commits to implementing policies and programs with the **strongest evidence**, built on the **most up-to-date knowledge base** and **solid, ongoing evaluation**.

The Vermont Platform strives to guide the state, via multiple interwoven strategies, to that most important destination: *Everyone has a role in preventing suicides.*



Zero Suicide

ZERO SUICIDE: A commitment to suicide prevention in health and behavioral health care systems.

Zero Suicide, a project of the Suicide Prevention Resource Center (SPRC), is a key concept of the 2012 National Strategy for Suicide Prevention and a priority of the National Action Alliance for Suicide Prevention.

The foundational belief of Zero Suicide is that **suicide deaths for individuals under care within health and behavioral health systems are preventable**. It presents both a bold goal and an aspirational challenge.

Vermont, in its efforts to remain at the forefront of evidence-based practice, is taking on this challenge. The Vermont Department of Mental Health has chosen Zero Suicide as the framework for current state efforts in health care systems.

As Vermont aligns its efforts with the National Strategy, the results and successes of this growing national initiative in communities around the country present an opportunity to have an immediate impact on the number of deaths by suicide.

7 Elements of Suicide Care for Health and Behavioral Health Care Systems to Adopt

After researching successful approaches to suicide reduction, the Action Alliance's Clinical Care and Intervention Task Force identified seven essential elements of suicide care for health and behavioral health care systems to adopt:

- **Lead** – Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care.
- **Train** – Develop a competent, confident, and caring workforce.
- **Identify** – Systematically identify and assess suicide risk among people receiving care.
- **Engage** – Ensure every individual has a pathway to care that is both timely and adequate to meet his or her needs. Include collaborative safety planning and restriction of lethal means.
- **Treat** – Use effective, evidence-based treatments that directly target suicidal thoughts and behaviors.
- **Transition** – Provide continuous contact and support post-discharge.
- **Improve** – Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

Throughout these elements Zero Suicide emphasizes the necessity of involving survivors of suicide attempts and suicide loss in leadership and planning.

As part of the state's coordinated efforts, Zero Suicide will play a vital role for individuals under care.

Context for Suicide Prevention in Vermont

Suicide has been recognized in Vermont as a significant public health issue since 2000, when the Vermont Department of Health included goals related to suicide deaths, suicide attempts, substance abuse, and mental health as named priorities in Healthy Vermonters 2010 as part of the national Healthy People initiative. The Healthy People initiative provides science-based, 10-year national objectives for improving the health of all Americans, and each state chooses objectives based on areas of highest need.

To formalize efforts, following the initial release of the 2001 National Strategy for Suicide Prevention, the Department of Health in 2004 worked with a suicide prevention planning team in conjunction with an advocacy group, Vermonters for Suicide Prevention, to develop a state prevention platform. Members of this group represented various state agencies, legislators, and interested individuals. In 2005, the Vermont Suicide Prevention Platform was the result of this effort.

In 2008 and 2011, the Center for Health and Learning, with the support of the Department of Mental Health and the Department of Health, received two consecutive three-year Garrett Lee Smith Memorial Youth Suicide Prevention grants through the federal Substance Abuse and Mental Health Services Administration, ushering in new opportunities for Vermont. The target audience for services under the grant is 10 – 24 year-olds. An interagency Suicide Prevention Data Work Group was formed to begin to strategically collect and report data on this issue.

This federal support has allowed for the strengthening of Vermont infrastructure, and led to the statewide accomplishments on the following page. During this time, the Vermont Department of Health again prioritized suicide prevention in Healthy Vermonters 2020. Vermont also continues to have a strong grass-roots suicide prevention effort and presence in the form of the state chapter of the American Foundation for Suicide Prevention.

In 2012, foreseeing the need to build sustainable and collaborative public-private partnerships for suicide prevention, the Center for Health and Learning created the Vermont Suicide Prevention Center, under the advisement of key partners in the Vermont Suicide Prevention Coalition. A small state allocation was secured to support VT-SPC in 2013 and 2014, and the coalition is seeking an expanded allocation to continue the work established under federal funding.

Garrett Lee Smith (GLS) Memorial Youth Suicide Prevention Grants

The GLS grants have played an integral role in the history of Vermont's suicide prevention efforts, and have offered unprecedented opportunities to lay the foundation for future work. The combination of program planning guidance and strong evaluation components of the nationwide grant program have been carried out in collaboration with the Vermont Child Health Improvement Program at the University of Vermont. This assists Vermont in implementing the most up-to-date findings from the field, and in adjusting direction when new strategies – such as Zero Suicide – show growing impact and promise.

GLS Grant activities in Vermont have focused on these objectives over the past seven years:

- Train schools in suicide prevention, protocol development, and use of student curricula
- Train professionals in mental health, law enforcement, social and youth services, first response, primary care, and faith leadership about their role as suicide prevention Gatekeepers
- Provide technical assistance and training to eight high-risk communities in Vermont
- Create and disseminate the *Umatter* public information campaign about suicide prevention and mental health wellness
- Evaluate grant activities and measure the effectiveness of systems for early identification and referral of suicidal youth
- Work with Institutions of Higher Education on campus suicide prevention issues
- Foster the growth of the Vermont Youth Suicide Prevention Coalition

In that time, the following has been accomplished:

- Provided 24-hour phone service by trained responders for suicidal response across the state, through the United Ways of VT 2-1-1 system, which received 786 suicide-related calls.
- Trained 514 educators and school personnel in 115 schools in *Umatter* gatekeeper model including how to recognize signs of suicide, what to say and do, how to refer to help; school related protocols and how to implement the Lifelines curriculum.
- Trained eight high-needs communities with prevention training and technical support for a coordinated community response to suicide, reaching the professions described immediately below.
- Trained 308 professionals from Mental Health, Law Enforcement, First Response, Social Services, Primary Care, and Faith Leadership in the use of profession-specific protocols.
- Developed and published Vermont Suicide Prevention and Postvention Protocols for those six professions, and for Workplace Supervisors.
- Launched three websites:
 1. www.UmatterUCanHelp.com with information and resources for adults and professionals
 2. www.UmatterUCanGetHelp.com with information and resources for youth and young adults
 3. www.vtspc.org as the go-to source for suicide prevention resources in Vermont
- Launched and maintained the *Umatter* Public Information Campaign promoting awareness and help-seeking through newspapers, radio, Facebook, and Youtube.
- Coordinated the Campus Suicide Prevention Work Group and Symposium for Institutions of Higher Education, in which professionals from 13 colleges participate.
- Expanded the focus of the Vermont Youth Suicide Prevention Coalition to a lifespan focus, and supported and expanded the awareness of suicide as a public health issue across the lifespan.
- Identified and referred 345 youth who were depressed or suicidal (61% girls, 39% boys), via trained school personnel.
- Developed a Cadre of 30 gatekeeper trainers and 9 postvention trainers across the state.
- Launched *Umatter for Youth Community Action*, engaging 95 youth and 35 adult leaders in education about key concepts of mental health wellness, and in the development of local action projects promoting mental health wellness.



Umatter Suicide Prevention

You matter
because you may
need help.



You matter
because you may
be able to help.

Why “Umatter”?

Everyone has a place in the Big Picture. Everyone has a contribution to make, something important to do, and a purpose waiting to be fulfilled. We want to give people the message that feeling down or depressed is a common experience. Reaching out for help is a healthy response and, when trauma hits, help is especially important.

Asking for help does not mean that they are helpless or that they cannot do things on their own. It is an act of courage, not a sign of weakness. We want people to know that they can go to a trusted peer or adult for help and that person will be able to respond or connect them to professionals who can help. We want to offer hope by helping people connect to their family, their friends, their community, and helping professionals. We must learn to make these connections for each person individually by focusing more on their assets than on their liabilities, building on their strengths, and offering support.



About Umatter Suicide Prevention

Umatter was developed based upon a review of other suicide prevention programs to determine key concepts. Research from the American Association of Suicidology and the academic literature regarding suicide were applied. Once program goals and objectives were developed, experiential learning activities were designed to reach all learning preferences and styles of participants to ensure the maximum transfer of knowledge, skills, and attitudes.

Umatter Training Programs Include:

- *Umatter for Schools*
- *Umatter for Communities/Professionals*
- *Umatter for Youth and Young Adults*

Umatter Public Information

Umatter also includes a public information campaign. The central message of this campaign is that you matter because you may need help, and you matter because you may be in a position to help. The campaign promotes natural helping, and communication, coping and help-seeking skills.

For more information:

www.vtspc.org
www.umatterucangethelp.com
www.umatterucanhhelp.com



Underlying Principles of the Vermont Platform

The Vermont Suicide Prevention Platform is based upon a number of underlying principles derived from the National Strategy for Suicide Prevention 2012, the Vermont Suicide Prevention Platform from 2012, and the work of the Vermont Youth Suicide Prevention Coalition.

Those principles include:

- Suicide is generally preventable – suicidality is a diagnosable and treatable mental health condition.
- Suicide is a public health issue.
- Mental health and physical health are equal and inextricably linked as components of overall health.
- Suicide shares risk factors with substance abuse, bullying and harassment, traumatic events (including sexual abuse, violence, post-traumatic stress), as well as other mental health conditions.
- Consumers of mental health services, and survivors of suicide and suicide attempts, need to be actively involved in planning, implementing, and evaluating suicide prevention activities.



Eleven Goals of the Vermont Platform

The Vermont Suicide Prevention Platform 2015 is a planning document, aligned to the National Strategy for Suicide Prevention 2012. The Platform was developed with input from the Vermont Suicide Prevention Center, Vermont Suicide Prevention Coalition, and other key stakeholders including survivors of suicide and attempts.

The Platform contains guiding principles, goals and objectives, actions and resources based on the latest research and evidence of success in suicide prevention. Each goal has suggested strategies that can help people in all sectors of society think about what changes they could influence.

These goals have a place for everyone to participate in suicide prevention, because suicide is largely preventable, and everyone has a role to play.

The Eleven Goals of the 2015 Vermont Platform:

1. Promote awareness that suicide is a public health problem.
2. Build sustainable and integrated infrastructure in Vermont for mental health promotion, suicide prevention, intervention and postvention.
3. Develop and implement strategies to promote positive public attitudes toward being socially and emotionally healthy.
4. Develop, implement and monitor programs that promote social and emotional wellness.
5. Promote efforts to reduce access to lethal means among people at risk of suicide.
6. Provide training to community members and professionals on how to recognize suicide related behaviors and how to intervene.
7. Promote suicide prevention, screening, intervention, and treatment as core components of health care services with effective clinical and professional practices.
8. Improve coordination and accessibility of mental health and substance abuse treatment services.
9. Promote responsible reporting and accurate portrayals of suicidal behavior, mental health conditions and substance abuse in the media.
10. Improve and expand surveillance systems in order to: 1) monitor trends and profiles of at-risk populations, 2) assess the impact of existing policies and programs, and 3) inform the development of future efforts.
11. Provide care and support to individuals affected by suicide deaths and attempts.



Eleven Goals of the Vermont Platform

GOAL #1

Promote awareness that suicide is a public health problem.

Objective: Increase public knowledge about depression, mental health conditions, suicide risk and protective factors, and how to help.

WHAT VERMONT CAN DO

Individuals & Families:

- Talk about suicide openly in all your circles – the size of the problem, that it is largely preventable, and that everyone can help.
- Share the facts about suicide and suicide prevention through easy-to-access and visible ways – social media, print media, person-to-person. Take every opportunity to dispel the myths.
- Become involved in the community of suicide prevention work.

Organizations:

Non-profit, Community-Based, Faith-Based, and Businesses

- Maintain and support outreach to share information and training that will help people understand the public health danger suicide represents.
- Hold awareness events and trainings in mental health promotion and suicide prevention at your location and through Employee Assistance Programs – at staff meetings, faith services, and for the people you serve.
- Link to and support the *Umatter* websites for youth and adults, and the website of the Vermont Suicide Prevention Center, through your own website. Follow the Vermont Suicide Prevention Center's Facebook Page. These sites provide a research-based approach to suicide prevention.
- Share educational materials in highly visible locations – lobbies, vestries, waiting rooms.

Schools, Colleges, and Universities:

- Provide information about suicide and mental health in all health-related classes. Include suicide in public health studies.
- Hold suicide prevention training for staff, faculty and students.
- Disseminate age-appropriate prevention messages that work for the specific setting.
- Host events around national awareness days, such as Suicide Prevention Awareness Day, and Depression Awareness Month.

Healthcare:

- Approach suicide as a diagnosable mental health condition in all healthcare settings. Approach suicide prevention as you would tobacco prevention, heart disease prevention, and diabetes prevention.
- Promote the messages of suicide prevention as other public health issues are promoted in healthcare settings.

Policy and Systems:

- Maintain a central source of current and effective suicide prevention messaging and resources.
- Support a public education campaign about mental health conditions and the continuum of services across prevention, intervention, treatment and recovery.
- Collect and disseminate data about the incidence of suicide and suicide attempts to inform policies, programming and funding related to suicide prevention in Vermont.

GOAL #2

Build sustainable and integrated infrastructure in Vermont for mental health promotion, suicide prevention, intervention and postvention.

Objective: Increase collaboration across a broad spectrum of individuals, families, agencies, institutions, and groups to ensure that suicide prevention efforts are comprehensive.

WHAT VERMONT CAN DO

Individuals & Families:

- Help increase the number of youth and young adults advising the prevention activities of the Vermont Suicide Prevention Coalition.
- Help ensure the input of people with lived experience of mental health conditions, and suicide and attempt survivors, in advising suicide prevention initiatives and activities.

Organizations:

Non-profit, Community-Based, Faith-Based, and Businesses

- Increase partnerships between the Vermont Suicide Prevention Center and Vermont Suicide Prevention Coalition and other statewide coalitions, including peer recovery, survivors of suicide and suicide loss.
- Join the Vermont Suicide Prevention Coalition and integrate your organizational work into the state's mental health promotion and suicide prevention infrastructure.
- Support the development of the Vermont Suicide Prevention Center as sustainable infrastructure for suicide prevention, intervention and postvention, through collaboration across a broad spectrum of agencies, institutions, and groups.
- Encourage professional, voluntary and other organizations to integrate effective, sustainable and collaborative suicide prevention programming.
- Strengthen relationships between mental health services, schools, Institutions of Higher Education, and family-serving and community organizations.

- Ensure Vermont 2-1-1 and other crisis lines are accessible and include effective suicide response.
- Increase the number of Vermont communities that use the *Umatter* for Schools and *Umatter* for Communities programs, ASIST, or other best-practice suicide prevention programs.

Schools, Colleges, and Universities:

- Use JED Foundation comprehensive model to assess current, and identify priority, prevention strategies that are well integrated into systems and services.

Healthcare:

- Treat mental health conditions as you would treat physical health conditions – as treatable conditions that everyone deals with and that may require specialty care.
- Link general practitioners and community mental health services for integrated referral networks.

Policy and Systems:

- Sustain and strengthen leadership of collaborations across state agencies to advance suicide prevention.
- Integrate suicide prevention into all relevant health care reform efforts.
- Support the Vermont Suicide Prevention Center in coordinating suicide prevention efforts and helping local communities implement the recommendations of the Vermont Suicide Prevention Platform.

Eleven Goals of the Vermont Platform

GOAL #3

Develop and implement strategies to promote positive public attitudes toward being socially and emotionally healthy.

Objective: Increase help-seeking behavior by fighting the stigma and promoting the benefits of receiving support for mental health conditions and substance abuse issues.

WHAT VERMONT CAN DO

Individuals & Families:

- Promote understanding and acknowledgment that:
 - ▶ Emotional health and physical health are intertwined.
 - ▶ Loss and grief can contribute to emotional health struggles, and may require ongoing support.
 - ▶ Depression is a common human condition that many people need help to overcome.
 - ▶ People may need short and long term support following traumatic events and experiences.
- Promote help-seeking across all stages of life – talk openly about it, be a role model, remind people who may be struggling that no one should be expected to “go it alone.”
- Talk openly about how people who have suicidal thoughts can get help and can get better.

Organizations:

Non-profit, Community-Based, Faith-Based, and Businesses

- Work with health promotion coalitions across the state that address mental health issues and that connect mental and emotional health with physical health, including the link between substance abuse and suicide risk.
- Encourage and educate about peer helping strategies and the benefits of support from people with similar life experiences.
- Promote Employee Assistance Programs and other sources of support at worksites.

Schools, Colleges, and Universities:

- Peer involvement in activities that promote mental health wellness on campus.
- Campus mental health action planning.
- Promote social networks.

Healthcare:

- Educate the public and providers that mental, emotional, social and physical health are all components of overall health.
- Educate the public that mental health services are available, and people can recover.
- Work directly with patients and clients to emphasize that mental and emotional health conditions should be viewed like physical health conditions – and that everyone struggles with them.
- Increase linkages and collaboration to integrate primary care, mental health and substance abuse services, enhancing their efforts to detect early warning signs.

Policy and Systems:

- Broaden access to mental health services and remove barriers that may exist.
- Strengthen the interface between systems that address mental health and substance abuse, including state agencies, schools, county agencies, primary health care and other community service organizations.

GOAL #4

Develop, implement and monitor programs that promote social and emotional wellness.

Objective A: Life Skills Training Increase decision-making, problem-solving, goal-setting, conflict resolution, advocacy, coping, and mindfulness skills for all ages to reduce suicide risk factors.

WHAT VERMONT CAN DO

Individuals & Families:

- Beginning in early childhood, focus on the development of social and emotional skills, build knowledge about the effects of substance abuse, develop culturally competent relationships that respect differences, and teach skills for how to respond to bullying as a by-stander or victim.
- Talk about and teach how to identify youth who are at-risk of suicide, and emphasize seeking out supportive adults for help.
- Recognize that everyone needs support in building resiliency skills, and promoting resiliency across the lifespan – including middle-aged adults and elders.

Organizations:

Non-profit, Community-Based, Faith-Based, and Businesses

- Emphasize life skills development in settings that engage youth, young adults and adults, such as worksites, senior centers, and places of worship.
- Support the development of programs and practices that promote resiliency-building skills for families across the lifespan.
- Emphasize life skills training in multiple settings and use of prevention, intervention, treatment, and recovery services.

Schools, Colleges, and Universities:

- Provide skill-building opportunities in school to reduce risk factors, enhance protective factors, and involve families.
- Increase the number of Institutions of Higher Education that actively use best practice suicide prevention programs.
- Continue skill-building workshops in problem solving and coping skills into college and beyond.

Healthcare:

- Increase the knowledge and skills for suicide prevention of all providers.
- Directly refer struggling families to community programs that focus on conflict-resolution and coping skills, and promote the existence of such programs to all patients.
- Include suicide prevention in the pre-training of health and behavioral health care providers, senior network providers and social services professionals.

Policy and Systems:

- Connect school-based training with existing state statutes for teaching about health, bullying, harassment, and suicide prevention including the development of individualized learning plans and alternative pathways for learning.

Eleven Goals of the Vermont Platform

GOAL #4

Develop, implement and monitor programs that promote social and emotional wellness.

Objective B: Screening for Mental Health Conditions Research and adopt best practices for screening to identify individuals in need of support or further evaluation and intervention, related to a variety of risk factors, including loss of job, financial problems, substance use, addictions and suicidal ideation.

WHAT VERMONT CAN DO

Individuals & Families:

- Be open to and supportive of family members participating in screenings for depression, other mental health conditions, and suicide risk.
- Learn the risk factors and warning signs of suicide risk, and if you see them, encourage family and friends to access services where they could get screened – such as making an appointment with their primary care doctor.

Organizations:

Non-profit, Community-Based, Faith-Based, and Businesses

- Support identification of suicide risk and appropriate referral in a variety of settings.
- Learn the best practice recommendations for screening and referral for your profession or organization – workplaces, faith communities, and agencies.
- Assess current efforts and gaps in screening for suicide risk in workplace and community settings, including senior centers.

Schools, Colleges, and Universities:

- Assess current efforts and gaps for screening that identifies students at risk for suicide across the lifespan.
- Train staff, faculty and students in how and when to refer for screening.

Healthcare:

- Train professional healthcare staff in multiple settings across prevention, intervention, treatment, and recovery services to recognize the importance of identifying suicidality as a diagnosis independent of underlying conditions, and the importance of addressing recent stressors and life events in the prevention of suicide.
- Identify primary care screening tools for screening for mental health conditions for all age groups.
- Ensure that clinicians are available to assess and treat referred individuals.

Policy and Systems:

- Develop population-based strategies for screening and identifying people at risk for suicide.

GOAL #4

Develop, implement and monitor programs that promote social and emotional wellness.

Objective C: Comprehensive School-Based and Community-wide Programs Increase knowledge about and strategies to promote positive social and emotional health and wellness, to address the social and emotional issues that lead to depression and substance abuse that are associated with higher suicide risk.

WHAT VERMONT CAN DO

Individuals & Families:

- Participate in *Umatter for Youth and Young Adults* and other programs which increase knowledge and skills related to positive social and emotional health and wellness.
- Advocate for schools to implement effective depression education programs using the Lifelines curriculum.
- Increase the number of parents who have received training in the prevention of substance abuse, bullying and harassment, and training in suicide and depression awareness, and Gatekeeper skills.

Organizations:

Non-profit, Community-Based, Faith-Based, and Businesses

- Increase the number of organizations that have suicide prevention and postvention protocols in place and have trained Gatekeepers among their staff to intervene to reduce suicidal thoughts and behaviors.
- Implement comprehensive community-wide prevention strategies that engage first responders, social services, youth-serving professionals, primary care professionals, and faith leaders.

Schools, Colleges, and Universities:

- Increase the number of schools that have suicide prevention and postvention protocols in place and have trained Gatekeepers among their staff to intervene to reduce suicidal thoughts and behaviors.
- Provide technical assistance to schools and communicate about best practices for suicide prevention in their communities.
- Encourage cross-agency collaboration with other organizations such as the Vermont School Nurses' and Vermont School Counselors' Associations to effectively promote social and emotional health.
- Support school-based instructional content and professional training.
- Undertake campus mental health action planning.

Healthcare:

- Increase the number of mental health and primary care providers that have formalized working relationships with schools.

Policy and Systems:

- Promote and support models that are comprehensive and link educational, healthcare and mental health services together.

Eleven Goals of the Vermont Platform

GOAL #5

Promote efforts to reduce access to lethal means among people at risk of suicide.

Objective: *Promote the safe storage of medications, poisons, and firearms.*

WHAT VERMONT CAN DO

Individuals & Families:

- Take action to decrease access to lethal means among individuals at risk for suicide – lethal means can include weapons and medication, but can also mean cars, bridges, cleaning solutions and herbicides.
- Store guns safely – locked and unloaded – and secure any other dangerous means, such as medications.
- Recognize that this does not involve keeping the person away from dangers forever – it involves decreasing access to lethal means that are dangers *when that person is in a suicidal state*, which is usually a time-limited experience. The majority of suicidal individuals, if prevented from accessing their planned means, will not substitute one means of death for another.

Organizations:

Non-profit, Community-Based, Faith-Based, and Businesses

- Provide tools, resources, and information to your constituency that help them ask a suicidal individual about lethal means, and then reduce access.
- Encourage law enforcement and other providers that work with suicidal individuals to routinely assess and ask about the presence of lethal means (including firearms, drugs and poisons) in the home and educate clients and their families about associated risks and approaches that minimize risk.
- Train professionals and other adults that offer services to individuals at risk for suicide about the risk of firearms and suicide, and how to talk to and educate families about reducing access.

- Partner with firearm dealers, gun owners, and firing ranges to include suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.
- Provide education about the role substance abuse can play in increasing the use of guns and other lethal means.

Schools, Colleges, and Universities:

- Train faculty and staff in the importance of reducing lethal means in a suicidal crisis, and provide them the training and resources that will help them ask a suicidal individual about lethal means, and then reduce access.
- Provide education about the role substance abuse can play in increasing the use of guns and other lethal means.

Healthcare:

- Encourage primary healthcare, emergency room providers, mental health professionals and any other providers that work with suicidal individuals to routinely assess and ask about the presence of lethal means (including firearms, drugs and poisons) in the home.
- Train healthcare professionals in how to talk to patients, clients and their families about the risks of lethal means and possible approaches that minimize risk.
- Provide education about the role substance abuse can play in increasing the use of guns and other lethal means.

Policy and Systems:

- Explore and support policies that ensure suicidal individuals do not have access to lethal means.

GOAL #6

Provide training to community members and professionals on how to recognize suicide related behaviors and how to intervene.

Objective: All professional training in the state will incorporate suicide prevention and intervention curricula using best-practice or evidence-based programs as they evolve.

Individuals & Families:

- Access training and then participate as a community trainer in suicide prevention and postvention.
- Promote the concept in your circles that people should expect helping professionals to be knowledgeable about risk and protective factors and suicide prevention.

Organizations:

Non-profit, Community-Based, Faith-Based, and Businesses

- Develop a cadre of trainers in suicide prevention and postvention.
- Provide educational programs for family members of people at high risk.
- Provide training for clergy, correctional workers, attorneys, social service staff, employers, and others on how to identify and respond to persons at risk for suicide.

Schools, Colleges, and Universities:

- Provide training for teachers and other educational staff on how to identify and respond to persons at risk for suicide.

Healthcare:

- Improve suicide prevention training for nurses, physician assistants, physicians, emergency providers, social workers, psychologists and other counselors.
- Provide training to mental health and substance abuse treatment providers on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk.
- Develop and implement protocols and programs for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing suicide risk.

Policy and Systems:

- Support coordination at the state level, between departments of the Agency of Human Services and the Agency of Education.
- Develop licensure requirements for relevant professions that specifically include suicide training.
- Ensure that all suicide prevention training addresses issues related to cultural diversity, including but not limited to LGBTQ, military veterans, and youth in foster care or corrections.

Eleven Goals of the Vermont Platform

GOAL #7

Promote suicide prevention, screening, intervention, and treatment as core components of health care services with effective clinical and professional practices.

Objective: *Provide training and technical assistance to health care professionals on the National Strategy for Suicide Prevention, Zero Suicide, and best practices for suicide prevention, intervention, and postvention.*

WHAT VERMONT CAN DO

Individuals & Families:

- Encourage help seeking behavior for treatment services for mental health conditions, loss and grief, trauma, sexual assault, or physical abuse.
- Educate family members and significant others about their role in providing help and support to people with mental health conditions and who may be at risk for suicide.
- Continue contact and support, especially after a loved one has been in care.

Organizations:

Non-profit, Community-Based, Faith-Based, and Businesses

- Ensure every person has a pathway to care that is both timely and adequate to meet their needs.
- Systematically identify and assess suicide risk levels among people at risk.
- Ensure that individuals who typically provide services to suicide survivors have been trained to understand and respond appropriately to their unique needs.
- Promote positive mental health as being a result of community and environmental factors and not just related to the individual.
- Coordinate services among suicide prevention and intervention programs, health care systems, 211, and national suicide prevention hotline service.

Schools, Colleges, and Universities:

- Train student healthcare providers to provide ongoing depression screening, assessment, and treatment for student.

Healthcare:

- Promote the safe disclosure of suicidal thoughts and behaviors by all patients.
- Train primary care and mental health clinicians to

provide ongoing depression screening, assessment, and treatment for youth, adults, and elders.

- Use effective, evidence-based care, including collaborative safety planning, restriction of lethal means, and effective treatment of suicidality.
- Develop, disseminate, and implement guidelines/protocols for clinical practice and continuity of care for providers who assess and treat persons with suicide risk.
- Encourage health care delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts.
- Support hospital emergency departments, substance abuse treatment centers, specialty mental health treatment centers, and various institutional treatment settings to collaborate in the screening, treatment and follow-up of suicide risk among youth and adults with the intent of providing continuity of care.
- Create a leadership-driven, safety-oriented culture that commits to dramatically reducing suicide among people under care and includes suicide attempt and loss survivors in leadership and planning roles.
- Integrate mental health and substance abuse professionals in primary care offices to provide integrated physical, mental health, and substance abuse screening, assessment, and treatment.

Policy and Systems:

- Enhance and support the Vermont Designated Agency Mental Health Crisis System to serve youth and adults throughout the state.
- Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

GOAL #8

Improve coordination and accessibility of mental health and substance abuse treatment services.

Objective: People in need will have timely and appropriate access to mental health and substance abuse treatment services.

WHAT VERMONT CAN DO

Individuals & Families:

- Encourage people to seek help for mental health and substance abuse conditions.

Organizations:

Non-profit, Community-Based, Faith-Based, and Businesses

- Provide training so peers and family members know the available resources and how to access them.
- Provide materials alerting your constituency to the availability of mental health and substance abuse services.
- Talk openly about the struggles people face with mental health conditions and substances in your faith communities – as part of lessons and services, or in recognition of awareness days such as Depression Awareness Day.
- Integrate mental health, substance abuse and suicide prevention into health and social services outreach programs for both the general and at-risk populations.

Schools, Colleges, and Universities:

- Train students to support peers in seeking help for mental health and substance abuse conditions.
- Offer affordable, easily-accessible mental health services on campuses.
- Provide opportunities and encouragement for the formation of student support groups around mental health conditions and substance abuse.

Healthcare:

- Integrate mental health and substance abuse services into primary medical care through co-location and other convenient access to services.
- Locate mental health and substance abuse services in youth and young adult friendly spaces such as after-school clubs, teen drop-in centers, and sports activities.
- Provide integrated mental health and substance abuse and primary care services and support at home for seniors.

Policy and Systems:

- Continue to build capacity for mental health and substance abuse treatment statewide.
- Ensure health insurance benefit packages cover access to mental health and substance abuse care on par with access to physical health care.
- Design Vermont payment reform models that encourage timely provision of services to prevent suicide.
- Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.

Eleven Goals of the Vermont Platform

GOAL #9

Promote responsible reporting and accurate portrayals of suicidal behavior, mental health conditions and substance abuse in the media.

Objective: Reduce suicide contagion through communications media by providing editors with guidelines for reporting suicide and suicide prevention resource information.

WHAT VERMONT CAN DO

Individuals & Families:

- Teach youth to use social media and emerging technology to build positive social and interpersonal relationships.
- Talk to children and youth about social media – discuss the effects of cyber-bullying and other aspects of social media such as public gossiping that may exacerbate a pre-existing mental health condition.
- Write letters to media outlets when you see inaccurate, misleading or insensitive portrayals of suicide.

Organizations:

Non-profit, Community-Based, Faith-Based, and Businesses

- Publish articles on suicide prevention measures, how to get help, and how to support someone who is at risk.
- Train journalists about guidelines for safe reporting and the long-term, unintended consequences of reporting about suicide.
- Encourage and recognize news organizations that develop and implement policies and practices addressing the safe and responsible reporting of suicide and other related behaviors.

Schools, Colleges, and Universities:

- Encourage journalism programs to include the recommended guidelines in their curricula guidance on the portrayal and reporting of mental health, suicide, and suicidal behaviors.

Healthcare:

- Inquire of young patients about their relationship with social media and if it affects their mood and health, encouraging them to talk to their parents.

Policy and Systems:

- Encourage news reports on suicide to observe recommended guidelines in the depiction of suicide and mental health conditions.
- Review media recommendations regularly to incorporate the most up-to-date information.

GOAL #10

Improve and expand surveillance systems in order to:

- 1) Monitor trends and profiles of at-risk populations.
- 2) Assess the impact of existing policies and programs.
- 3) Inform the development of future efforts.

Objective: Conduct a broad-based multi-faceted assessment including both process and outcome measures, with a strong focus on strengthening and expanding surveillance and data systems.

Individuals & Families:

- Support survivors of suicide in being open about their experiences of loss, to help other families realize that reporting a death as a suicide is courageous and helps prevention efforts.
- Improve data collection on suicide attempts – via National Violent Death Reporting System (NVDRS).

Organizations:

Non-profit, Community-Based, Faith-Based, and Businesses

- Promote participation in data collection and bring awareness of the importance of data collection to guide suicide prevention activities.
- Implement policies and protocols based on data found in Vermont.
- Participate in ongoing efforts to develop and refine programs and trainings.

Schools, Colleges, and Universities:

- Participate in data collection and surveillance.
- Implement policies and protocols based on data found in Vermont.

Healthcare:

- Participate in data collection and surveillance.
- Implement policies and protocols based on data found in Vermont.
- Improve data collection on suicide attempts – via National Violent Death Reporting System (NVDRS).

Policy and Systems:

- Use data to guide and inform decisions and policy development relating to suicide prevention.
- Encourage law enforcement to develop and implement standardized protocols for death scene investigations.
- Increase the systematic use of data collection from crisis workers, mental health emergency professionals, schools and other sources.
- Produce reports on suicide and suicide attempts, and integrate data from multiple Vermont data management systems.
- Explore mandating reports on suicide attempts to Vermont Department of Health.
- Distribute data via website to appropriate parties and professionals.
- Develop and support a repository of research resources to help increase the amount and quality of research on suicide prevention and care in the aftermath of suicidal behaviors.

Eleven Goals of the Vermont Platform

GOAL #11

Provide care and support to individuals affected by suicide deaths and attempts.

Objective: *Promote healing, decrease stigma, and integrate those with lived experience into community prevention strategies.*

WHAT VERMONT CAN DO

Individuals & Families:

- Educate people about the importance of communicating about suicide and the impact of suicide on family and community members.
- Provide appropriate clinical care to individuals affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief.
- Adopt language to speak about suicide that decreases stigma around suicide.

Organizations:

Non-profit, Community-Based, Faith-Based, and Businesses

- Encourage the provision of peer and professional support for survivors of suicide attempts and loss.
- Work with affected employees, to ensure a supportive process for them to return to work.
- Assess, with affected employees, a supportive process for them in returning to work.
- Develop guidelines for effective comprehensive support programs for individuals bereaved by suicide, and promote their full implementation.
- Provide health care providers, first responders, and others with care and support when a patient under their care dies by suicide.
- Adopt, disseminate, implement, and evaluate guidelines for communities to respond effectively to suicide clusters and contagion within their cultural context, and support implementation with education, training, and consultation.
- Educate funeral homes about the role they play in preventing further suicides in their communities by disseminating information about risk and resources for support.

Schools, Colleges, and Universities:

- Encourage the provision of peer and professional support for mental health crisis.
- Ensure protocols exist for the reintegration into the educational community of individuals affected by suicide attempts.

Healthcare:

- Provide colleagues with care and support when a patient under their care dies by suicide.
- Assess patients affected by a suicide loss for suicidality and screen, and provide treatment and follow-up, when they are found to be at risk.
- Reach out to patients affected by a suicide loss and assess their grieving process.
- Provide continuing caring contact to all patients/clients who have attempted suicide.

Policy and Systems:

- Engage suicide attempt survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide-attempt-survivor support groups.

Language

An important objective of suicide prevention is to remove the stigma associated with suicide and mental health issues so that people will be more likely to seek the help they need. One of the ways we can do this is to be conscious of our use of language.

Sensitive Use of Language

Moving Beyond “Committed, Completed & Successful”

The term “committed suicide” implies a level of criminality while “completed suicide” implies earlier attempts when there may have been none. Both terms (committed and completed) perpetuate the stigma associated with suicide and are strongly discouraged. Using the word “successful” or “failed” to describe suicide is also discouraged. Terms such as “died by suicide” or “died of suicide” as well as “suicide death” and “fatal suicide behavior” are recommended. Sensitive use of suicide related language is appreciated.

Those who have lost a loved one to suicide are “suicide survivors”. Those who have lived through a suicide attempt are “suicide attempt survivors.” Even the phrase “suicide attempt” can raise controversy because it implies that the person failed in his or her intention to die.

It is expected that the issues and solutions of language usage will continue to evolve as the field of suicide prevention continues to grow.

Please Try to Avoid:

- Committed suicide
- A successful suicide
- A completed suicide
- Failed suicide attempt



Terms to Use Instead:

- Death by suicide
- Took her/his own life
- Died by suicide
- Killed him/herself
- Suicide death

For more Information:

Language Describing Suicidal Behavior:
www.maine.gov/suicide/about/language.htm

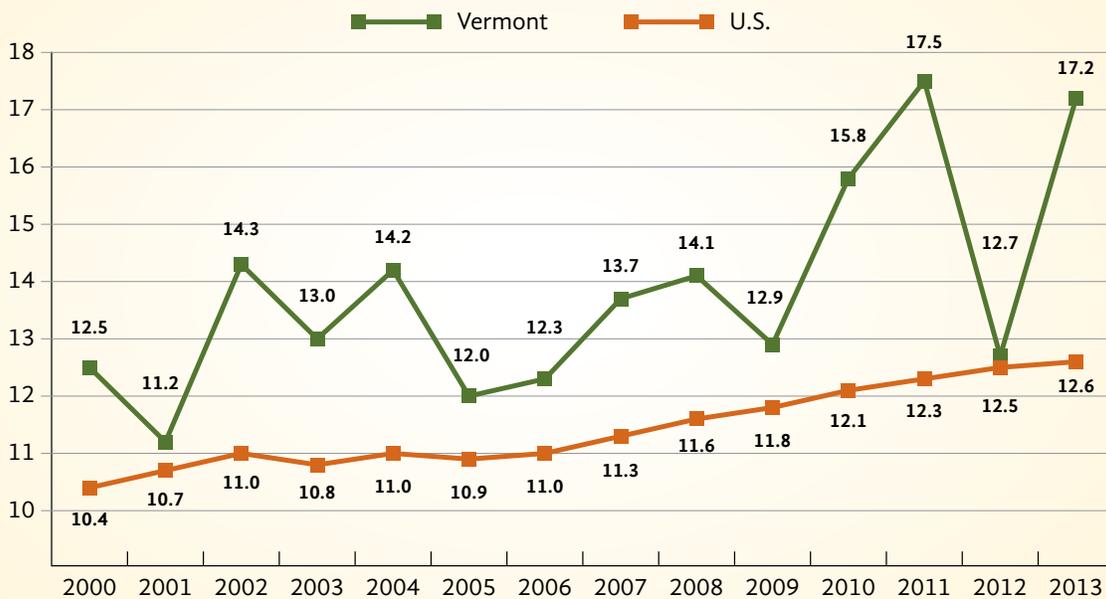
Appendix 1

Vermont Department of Health Data Across the Lifespan

Suicide death rates among Vermonters have been consistently higher than U.S. overall rates. 2010, 2011, and 2013 had the highest suicide death rates for Vermonters in recent history, and these were significantly higher than the U.S. rates. Since 2000, Vermont suicide death rates have ranged from a low of 11.2 per 100,000 in 2001 to 17.5 per 100,000 in 2011. The average number of suicide deaths per year in Vermont during this 14 year period is 91.

FIGURE 1.1

Suicide Death Rate per 100,000 Population Vermont and U.S., 2000 – 2013

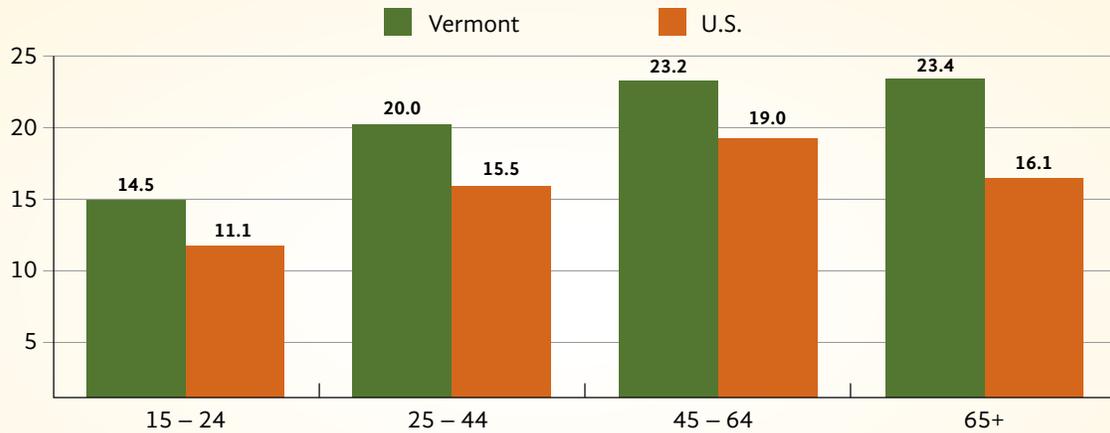


Data sources: U.S.: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. Vermont: Vermont Vital Statistics, 2000-2013.

When broken out by age, suicide rates in the U.S. and Vermont are typically lowest among ages 15-24. Generally, rates increase across age groups and are highest in ages 45-64 and ages 65+. In 2013, Vermont suicide death rates were higher than U. S. rates across all age groups.

FIGURE 1.2

Suicide Death Rates per 100,000, by Age Vermont and U.S., 2000 – 2013

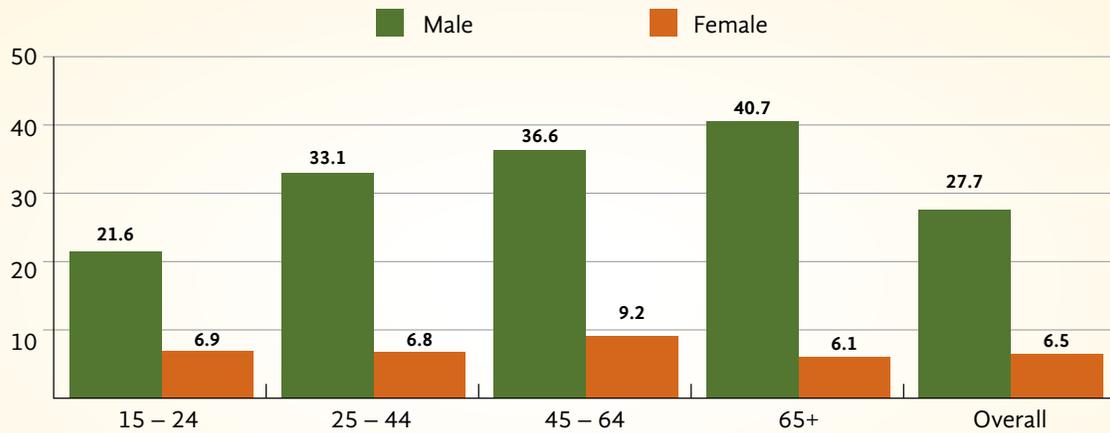


Data source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online].

In Vermont, males are overall more likely to die by suicide than are females: 27.7 per 100,000 versus 6.5 per 100,000. In recent years, male suicide deaths were most common among ages 65+ while female suicide deaths were most common in ages 45-64. Overall, male Vermonters are approximately four times more likely to die by suicide than are female Vermonters.

FIGURE 1.3

Suicide Death Rates per 100,000, by Gender and Age Vermont Residents, 2010 – 2013

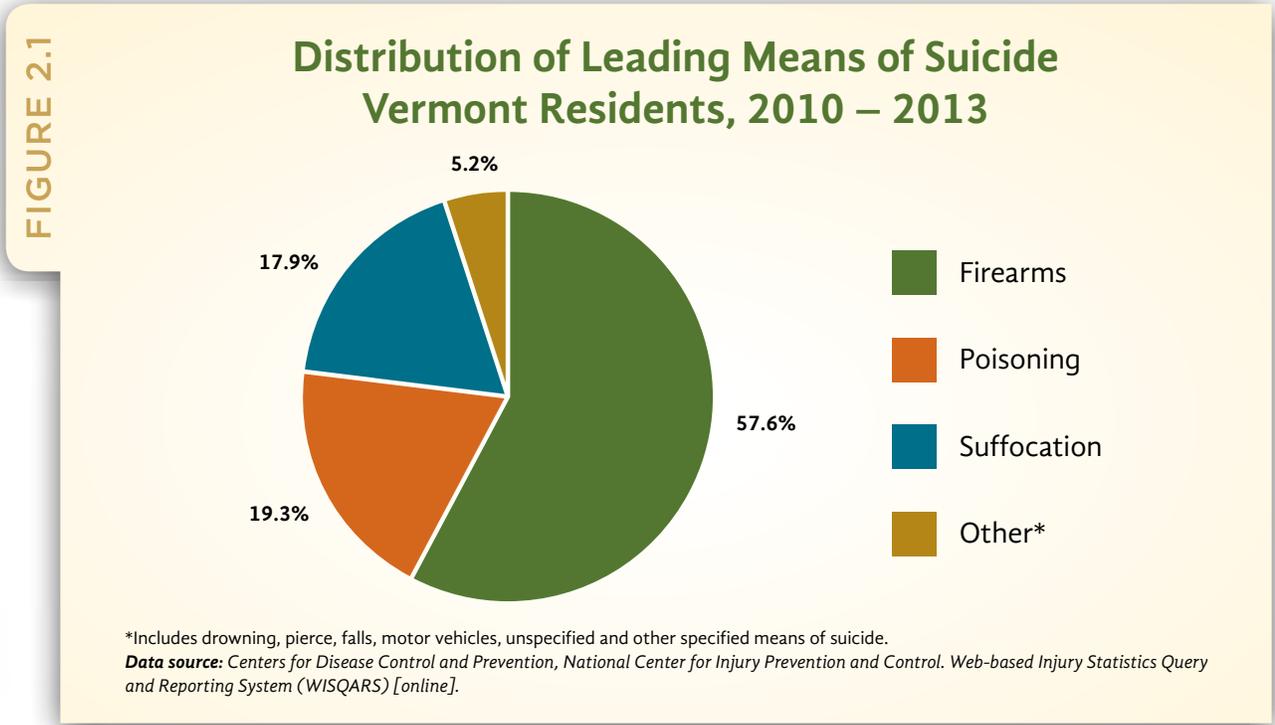


Data source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online].

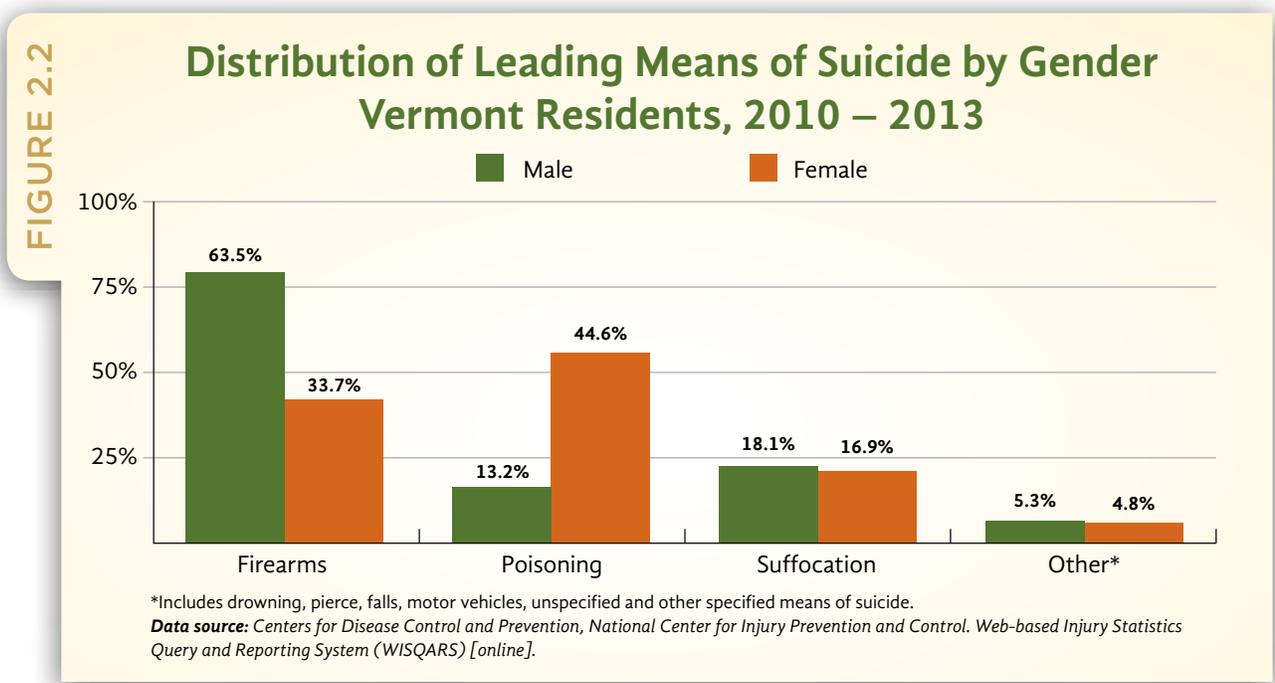
Appendix 2

Leading Means of Death in Vermont

In recent years, almost 6 out of 10 people who died by suicide used firearms. Other lethal means often used in Vermont suicide deaths are poisoning (including overdose) and suffocation.



Male and female Vermonters often use different means to take their lives. In recent years, almost two-thirds of male deaths by suicide used firearms, while approximately one-third of female deaths involved firearms. Almost half of recent female suicide deaths were by poisoning.



Appendix 3

10 Leading Causes of Death in Vermont 2013, All Races, Both Sexes

AGE GROUPS

Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	All Ages
1	Congenital Anomalies	Heart Disease	Unintentional Injury	Malignant Neoplasms	Unintentional Injury 31	Unintentional Injury 28	Unintentional Injury 31	Malignant Neoplasms 100	Malignant Neoplasms 238	Malignant Neoplasms 360	Malignant Neoplasms 348	Heart Disease 530	Malignant Neoplasms 1,318
2	Short Gestation	Homicide	Heart Disease	Suicide	Suicide 13	Suicide	Malignant Neoplasms 27	Heart Disease 52	Heart Disease 113	Heart Disease 215	Heart Disease 292	Malignant Neoplasms 237	Heart Disease 1,220
3	Maternal Pregnancy Comp.	Unintentional Injury	Malignant Neoplasms	Homicide	Malignant Neoplasms	Heart Disease	Suicide 23	Unintentional Injury 43	Chronic Low. Respiratory Disease 44	Chronic Low. Respiratory Disease 61	Chronic Low. Respiratory Disease 120	Alzheimer's Disease 189	Chronic Low. Respiratory Disease 353
4	Unintentional Injury				Congenital Anomalies	Chronic Low. Respiratory Disease	Heart Disease 11	Suicide 23	Unintentional Injury 31	Cerebrovascular 39	Alzheimer's Disease 69	Cerebrovascular 139	Unintentional Injury 352
5	Circulatory System Disease				Diabetes Mellitus	Complicated Pregnancy	Liver Disease	Liver Disease 13	Liver Disease 21	Diabetes Mellitus 34	Cerebrovascular 58	Chronic Low. Respiratory Disease 113	Alzheimer's Disease 269
6	Hematological Disorders				Heart Disease	Congenital Anomalies	Congenital Anomalies	Chronic Low. Respiratory Disease 12	Suicide 21	Unintentional Injury 32	Unintentional Injury 48	Unintentional Injury 102	Cerebrovascular 260
7	Hydrops Fetalis					Homicide	Benign Neoplasms	Cerebrovascular	Diabetes Mellitus 17	Liver Disease 18	Diabetes Mellitus 47	Hypertension 45	Diabetes Mellitus 139
8	Influenza & Pneumonia					Malignant Neoplasms	Aortic Aneurysm	Viral Hepatitis	Cerebrovascular 13	Suicide 17	Parkinson's Disease 29	Influenza & Pneumonia 42	Suicide 112
9	Slow Fetal Growth					Six Tied	Chronic Low. Respiratory Disease	Diabetes Mellitus	Viral Hepatitis	Influenza & Pneumonia 15	Hypertension 16	Diabetes Mellitus 35	Influenza & Pneumonia 77
10					Six Tied	Homicide	Benign Neoplasms	Two Tied	Septicemia 11	Liver Disease 16	Parkinson's Disease 31	Liver Disease 75	

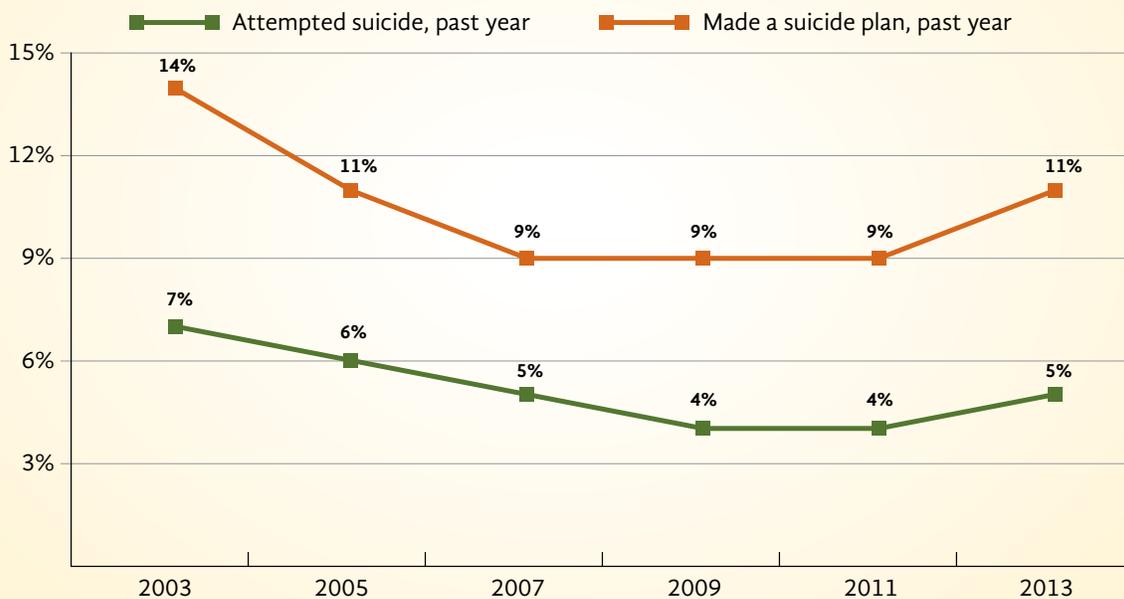
Appendix 4

Vermont Youth Risk Behavior Survey Data

The data collected here is from the 2001 – 2013 Youth Risk Behavior Survey, which is administered to Vermont high school students every two years. After showing a ten year trend of declining reports of having made a plan to kill him or herself by suicide and having made a suicide attempt, both of these measures appeared to show an increase in 2013 compared to 2011.

FIGURE 4.1

Percent of Vermont High School Students Reporting Suicide Measures, Youth Risk Behavior Survey, 2001 – 2013



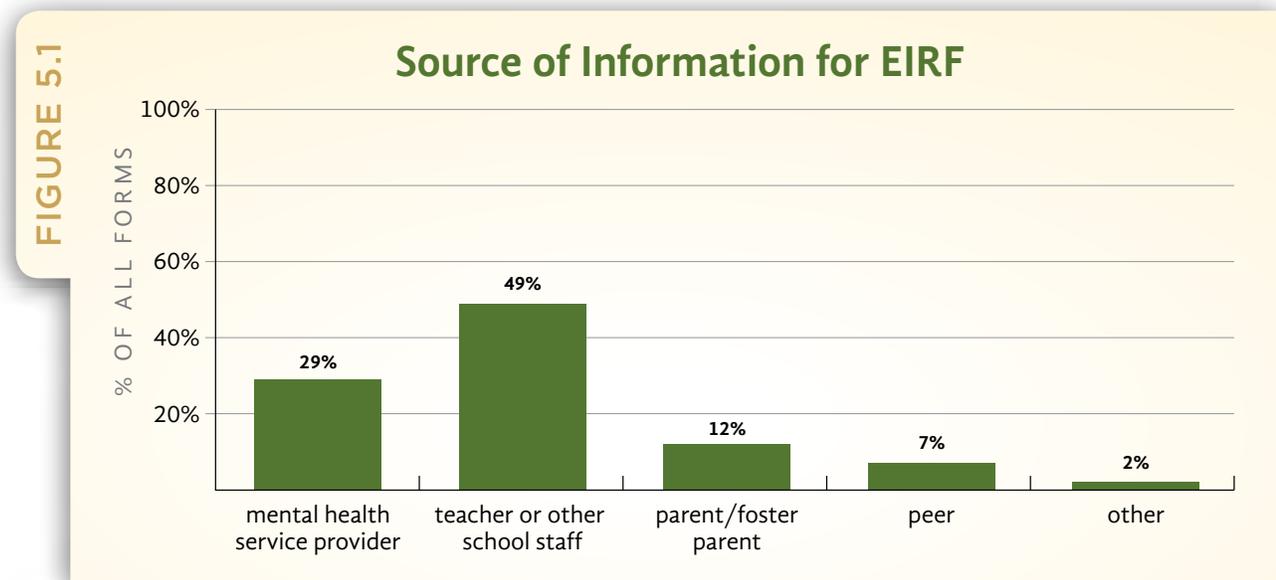
Appendix 5

Identifying Youth at Risk for Self-Harm and Referring for Care

As part of the evaluation of Vermont’s Garret Lee Smith Suicide Prevention SAMHSA grant, representatives from middle and high schools that participated in *Umatter for Schools* trainings are asked to submit anonymous data about young people at risk for self-injury. Schools submit data about how the young person was identified as being at-risk for harming themselves as well as about referrals that are made when a positive identification of risk occurs. These data are captured using a form called the Early Intervention, Referral and Follow-up (EIRF) form, which is submitted monthly during the school year.

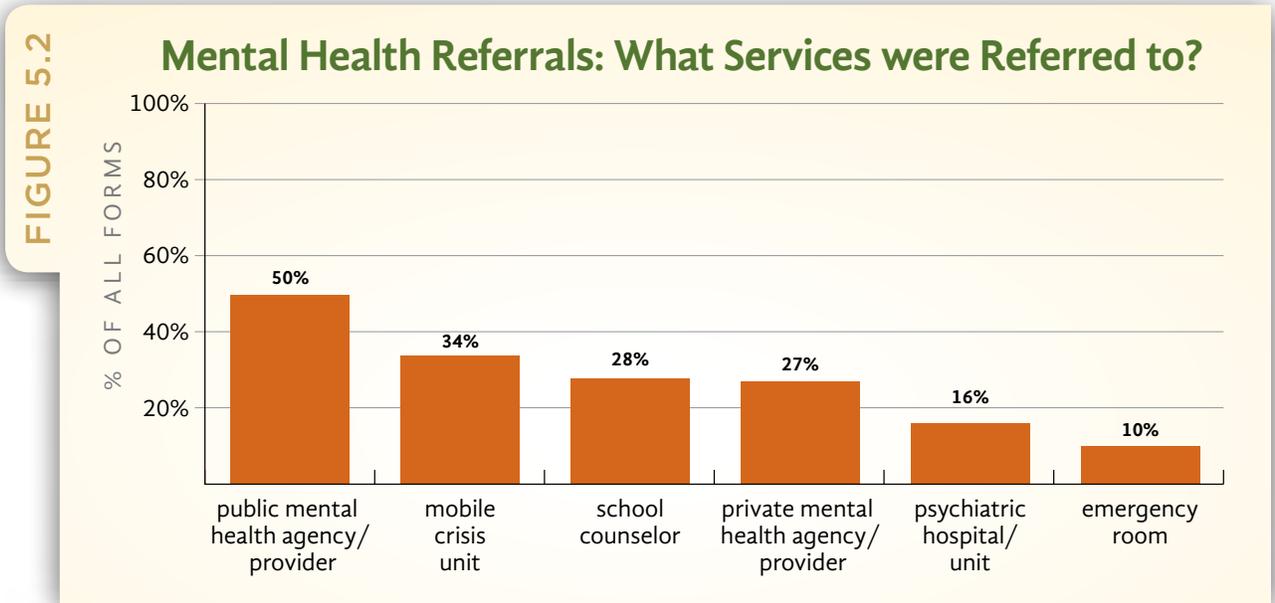
The following graphs describe EIRF data that were collected between 2012 and 2014, and are based on 149 EIRF forms. Almost all (86%) of these identifications occurred in a school setting. The average age of the youth represented in these graphs is 14.5 years, and 62% were female.

Figure 5.1 summarizes the primary source of information used in making the identification of the young person at risk. The most frequent sources were teachers or other school staff, mental health providers, parents/foster parents and peers.

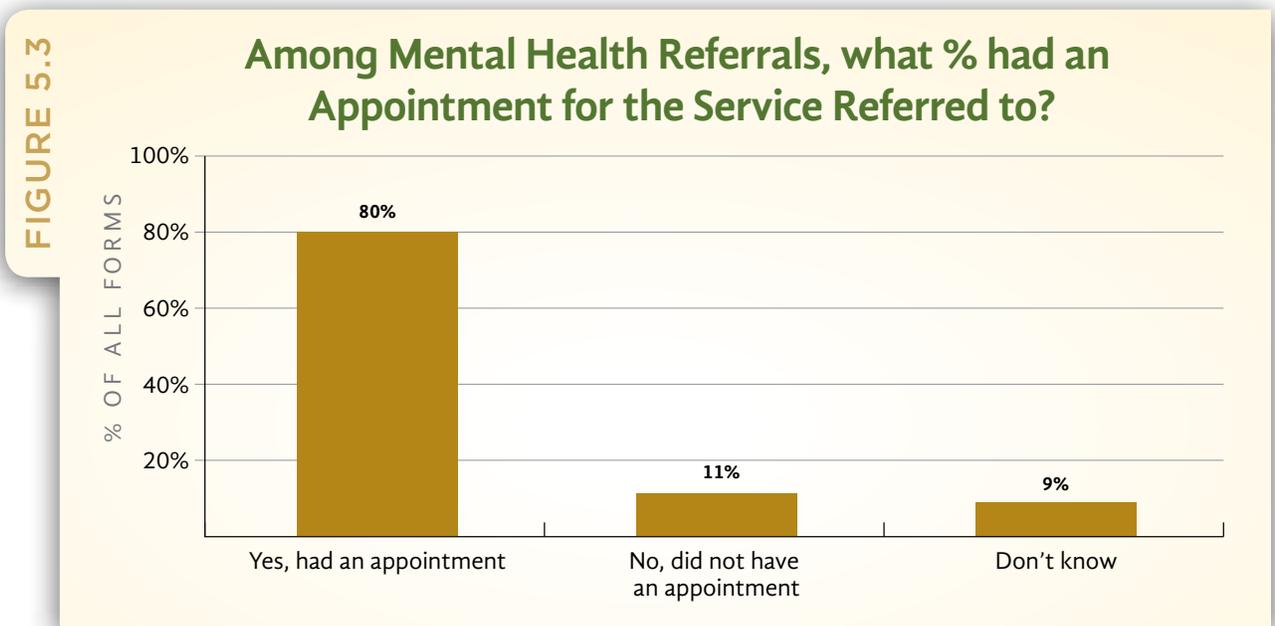


Appendix 5 (continued)

92% of young people identified by EIRF were referred for mental health services. Among the 8% who did not receive a mental health service referral, they were already receiving mental health services. Figure 5.2 shows that among young people referred for mental health services, the most common was to a public mental health agency followed by mobile crisis unit, school counselor, private mental health agency/provider, psychiatric unit and emergency room.



The follow-up data for mental health referrals presented in Figure 5.3 show that for 80% of EIRF forms there was evidence that a follow-up appointment occurred, while for the remaining 20% the follow-up either did not occur (11%) or the follow-up information was unavailable to the school (9%).

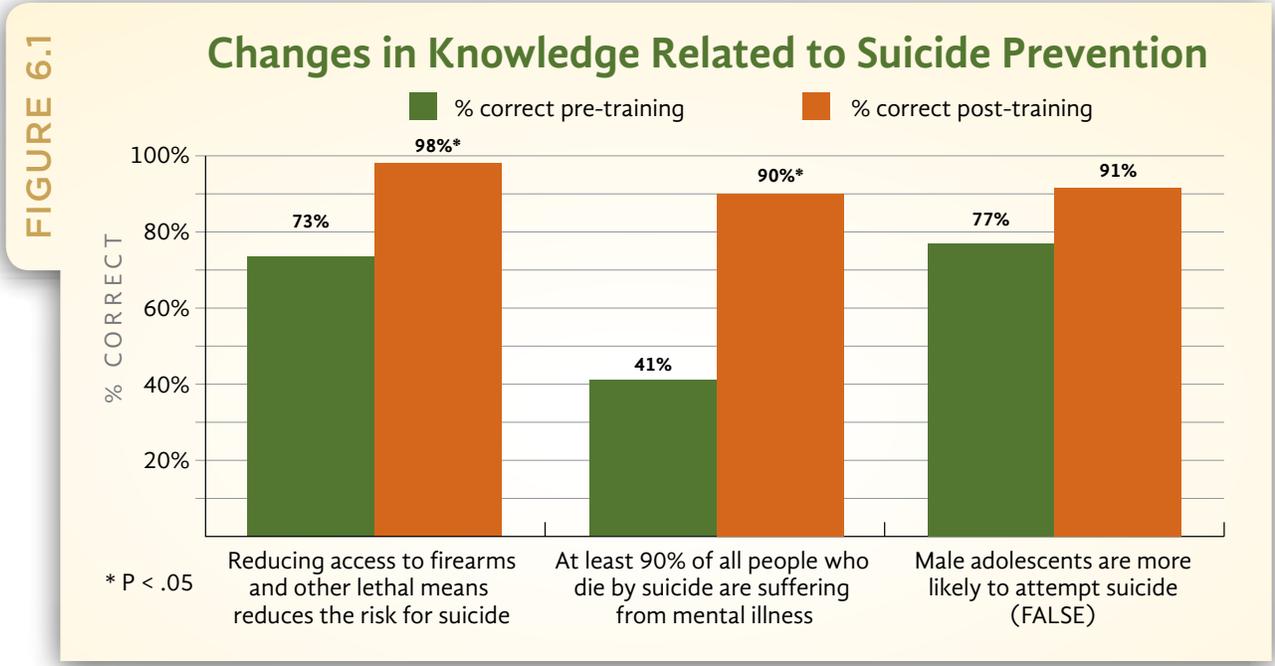


In conclusion, the EIRF data collected as part of Vermont's GLS Suicide Prevention Grant demonstrate that schools play a vital role in identifying young people who are at risk of harming themselves, and then connecting these young people to a variety of services and supports.

Appendix 6

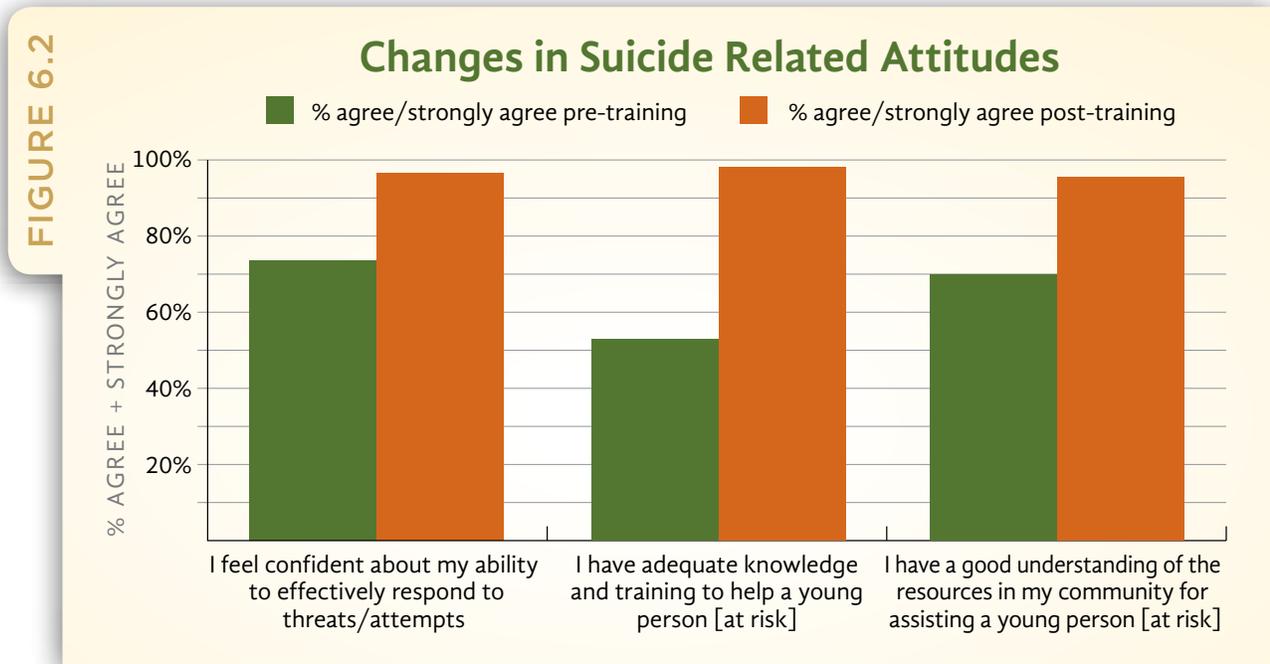
UMatter for Schools Training Data

This section presents data obtained at *Umatter for Schools* trainings that were conducted between March 2013 and October 2014. Figure 6.1 reflects that *Umatter* trainees showed statistically significant increases in their knowledge of the importance of lethal means safety for preventing suicide (73% vs. 98%) and in knowledge relating to very high proportion of people who died by suicide having experienced mental illness (41% vs. 90%). There was also a slight increase (77% vs. 91%) in trainees correctly answering “False” to the statement that male adolescents are more likely to attempt suicide.



Appendix 6 (continued)

Figure 6.2 shows considerable increases in *Umatter* trainees' agreement that they feel confident in their ability to respond to suicide threats and attempts, they have adequate knowledge and training to help a young person at risk and they have a good understanding of community resources for helping young people at risk.



Appendix 7

RESOURCES

ADULTS

Man Therapy

www.mantherapy.org

Therapy the way a MAN would do it. Dr. Rich Mahogany gives working-aged men a resource to help them with any problems that life sends their way, something to set them straight on the realities of suicide and mental health, and in the end, a tool to help put a stop to the suicide deaths of so many of our men.

Older Adults Suicide Prevention Resources

www.sprc.org/sites/sprc.org/files/OlderAdultSuicidePreventionResources.pdf

Information sheets and Overviews for professionals including training materials and guidelines provided by the Suicide Prevention Resource Center.

Working Minds

www.workingminds.org

COLLEGES AND UNIVERSITIES

Active Minds on Campus

www.activeminds.org

Working to utilize the student voice to change the conversation about mental health on college campuses, remove the stigma that surrounds mental health issues and create a comfortable environment for an open conversation about mental health issues on campuses throughout North America.

Jed Foundation

www.jedfoundation.org

Working nationally to reduce the rate of suicide and the prevalence of emotional distress among college and university students.

People Prevent Suicide

www.peoplepreventsuicide.org

Envisioning a world where all stakeholders of college campus life are prepared to prevent suicide and to support those affected by it.

Virginia Campus Handbook

www.campussuicidepreventionva.org

www.campussuicidepreventionva.org/facultyhandbook/

LESBIAN, GAY, BISEXUAL, TRANSGENDER & QUESTIONING (LGBTQ)

Pride Center of Vermont

www.ru12.org

Pride Center of Vermont celebrates, educates and advocates with and for lesbian, gay, bisexual, transgender and queer (LGBTQ) Vermonters.

GLSEN, Inc., the Gay, Lesbian & Straight Education Network

www.glsen.org

Leading national education organization focused on ensuring safe schools for all students.

Green Mountain Crossroads

www.greenmountaincrossroads.org

Green Mountain Crossroads offers education and events local to the southeast corner of Vermont.

Northeastern Vermont Area Agency on Aging

www.nekseniors.org/services-and-programs/lgbt-elder-resources/

LGBT Elder Resources.

Outright Vermont

www.outrightvt.org

Queer youth center and statewide advocacy organization for lesbian, gay, bisexual, transgender, queer and questioning (LGBTQQ) youth.

Vermont Diversity Health Project

www.vdhp.org

The mission of the Vermont Diversity Health Project (VDHP) is to improve the health and wellness of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Vermonters by building bridges between health care providers and LGBTQ people throughout the state.

MENTAL HEALTH

Depression and Bipolar Support Alliance (DBSA)

www.dbsalliance.org

The nation's largest patient-directed, illness-specific organization.

Families for Depression Awareness

www.familyaware.org

Helping families recognize and cope with depressive disorders to get people well and prevent suicides.

RESOURCES *continued*

It's All Right

www.itsallright.org

Mental health issues for and about young adults.

Mental Health America

www.mentalhealthamerica.net

Promoting mental health, preventing mental disorders and achieving victory over mental illness through advocacy, education, research and services.

National Alliance for Mental Illness

www.nami.org

In Vermont: www.namivt.org

In New Hampshire: www.naminh.org

Grassroots, volunteer organization committed to supporting families coping with mental illness, educating the public, advocating for adequate care and increasing funding for research. Dedicated to the eradication of mental illness and to the improvement of the quality of life of all whose lives are affected by it.

PROFESSIONALS

Suicide Prevention Resource Center

www.sprc.org

Emergency Room: Is Your Patient Suicidal?:

www.sprc.org/sites/sprc.org/files/library/ER_SuicideRiskPosterVert2.pdf

Role of the Media in Preventing Suicide

www.sprc.org/sites/sprc.org/files/library/media_guide.pdf

Suicide Prevention Toolkit for Rural Primary Care

www.sprc.org/pctoolkit/index.asp

Workshops and Toolkits

www.sprc.org/training-institute/workshops-and-toolkits

PURPOSE, MEANING AND ASSET-BUILDING

Circle of Courage

www.circleofcouragenz.org

A model for researching and teaching youngsters at high risk for negative life outcomes.

Developmental Assets

www.search-institute.org

www.search-institute.org/assets/

Grounded in extensive research in youth development, resiliency, and prevention, the Developmental Assets represent the relationships, opportunities, and personal qualities that young people need to avoid risks and to thrive.

Healthy Lifestyles

www.maine.gov

www.maine.gov/suicide/youth/healthylifestyles/

Some ideas for surviving and thriving.

Live Your Life Well

www.liveyourlifewell.org

Designed to help you cope better with stress and create more of the life you want.

SCREENING TOOLS, HOTLINES AND SERVICES

CRISIS Text Line

www.crisistextline.org

Text "LISTEN" to 741-741. Support for teens, 24/7.

GLBT National Health Center

www.glnh.org

GLBT National Hotline and National Youth Talkline

Online Peer-Support Chat: www.glnh.org/chat/
1.888.843.4564 1.800.246.PRIDE (7743)

Telephone volunteers in their teens and early twenties speak with teens and young adults up to age 25 about coming-out issues, relationship concerns, parent issues, school problems, HIV/AIDS anxiety and more.

National Hopeline Network

www.hopeline.com

800.442.HOPE (4673)

Screening for Mental Health

www.mentalhealthscreening.org

In-person and online screening programs for depression, bipolar disorder, anxiety disorder, PTSD, eating disorder, substance abuse and suicide prevention.

Suicide Prevention Lifeline

www.suicidepreventionlifeline.org

1.800.273.TALK (8255)

Trans Lifeline

www.translifeline.org
1.877.565.8860

The Trevor Project

www.thetrevorproject.org

Trevor Lifeline TrevorText

1.202.304.1200 1.866.488.7386

TrevorChat: Text the word “Trevor”. Providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender, and questioning youth.

Umatter U Can Get Help

www.UmatterUCanGetHelp.org

Award-winning program for youth who think they may need help or may be worried about someone else.

Veterans Crisis Line:

www.veteranscrisisline.net
1.800.273.TALK (8255) and PRESS 1

SUICIDE PREVENTION

American Association of Suicidology

www.suicidology.org

Serves as a national clearinghouse for information on suicide. Promotes research, public education and training for professionals and volunteers.

American Foundation for Suicide Prevention

www.afsp.org

Dedicated to advancing our knowledge of suicide and our ability to prevent it.

Means Matter

www.hsph.harvard.edu/means-matter/

Promoting activities that reduce a suicidal person’s access to lethal means of suicide.

National Suicide Prevention Resource Center

www.sprc.org

Provides a library, resources and prevention support specialists.

Stop a Suicide Today

www.stopasuicide.org

Screening for mental health.

Suicide Awareness Voices of Education (SAVE)

www.save.org

Believing that suicide should no longer be considered a hidden or taboo topic and that through raising awareness and educating the public, we can SAVE lives.

Umatter: You Can Help

www.UmatterUCanHelp.com

This website was created to increase your awareness and understanding of suicidal behavior in youth and enhance your ability to respond. This website is intended as a resource to help you learn the warning signs, to promote help seeking and effective response to suicidal behavior. You can learn effective tools that promote positive messages, and a three step process that encourage youth to seek help.

Zero Suicide

www.zerosuicide.sprc.org

Zero Suicide is a commitment to suicide prevention in health and behavioral health care systems, and encompasses a specific set of strategies and tools.

SUICIDE SURVIVORS

American Association of Suicidology Survivor Division

www.opentohope.com

Helping those who have suffered a loss to cope with their pain and find hope for the future.

American Foundation for Suicide Prevention: Vermont Chapter

www.afspvermont.org

Offering comfort to survivors through monthly support group meetings. Connecting with other survivors and talking openly about suicide with people who really understand can be a powerful experience and a crucial part of the healing process.

Fierce Goodbye: Living in the Shadow of Suicide

www.fiercegoodbye.com

A faith-based perspective on suicide.

Heartbeat: Grief Support Following Suicide

www.heartbeaturvivorsaftersuicide.org

Peer support offering empathy, encouragement and direction following the suicide of a loved one.

RESOURCES *continued*

Out of the Darkness Walks

www.outofthedarkness.org

AFSP provides opportunities for survivors of suicide loss to get involved through a wide variety of educational, outreach, awareness, advocacy and fundraising programs. Walk to honor loved ones and find an event near you.

Survivors of Suicide

www.survivorsofsuicide.com

Helping those who have lost a loved one to suicide resolve their grief and pain in their own personal way.

YOUTH AND SCHOOLS

Center for Mental Health in Schools

www.smhp.psych.ucla.edu

Pursuing theory, research, practice and training related to addressing mental health and psychosocial concerns through school-based interventions.

GLSEN, Inc., the Gay, Lesbian & Straight Education Network

www.glsen.org

Leading national education organization focused on ensuring safe schools for all students.

Preventing Suicide: A Toolkit for High Schools

www.sprc.org/content/high-school-toolkit

An extensive resource including getting started, protocols, after a suicide tools, staff education, parent/guardian education and outreach, student programs, and screening.

Maine Youth Suicide Prevention Program

www.maine.gov/suicide

Comprehensive youth suicide prevention resource.

The Jason Foundation

www.jasonfoundation.com

Dedicated to the prevention of the “Silent Epidemic” of youth suicide through educational & awareness programs to equip young people, educators/youth workers and parents with the tools and resources to help identify and assist at-risk youth.

MENTAL HEALTH SERVICES IN VERMONT

Clara Martin Center

www.claramartin.org

Randolph 802.728.4466
Bradford 802.222.4477
24-Hour Hotline 800.639.6360

Counseling Services of Addison County, Inc.

www.csac-vt.org

Middlebury 802.388.6751
24 Hour on-call Emergency Services. 802.388.7641

Health Care & Rehabilitation Services www.hcrs.org

Springfield 802.886.4500
Brattleboro 802.254.6028
Bellows Falls 802.463.3947
Windsor 802.674.2539
Hartford 802.295.3031
Toll-free 888.888.5144
Crisis/Emergency 24-Hour Hotline . 800.622.4235

First Stop for Children’s Services:

Springfield 855.220.9429
Hartford 855.220.9430
Brattleboro 855.220.9428

Howard Center - Chittenden County

www.howardcenter.org

24-Hour Crisis Hotlines:
First Call for Children & Families . . . 802.488.7777
Adult Mental Health. 802.488.6400

Lamoille County Mental Health Services www.lamoille.org

Morrisville 802.888.5026
Nights & Weekends 802.888.8888
Weekdays: 8-4:30 802.888.5026

Northeast Kingdom Human Services www.nkhs.org

Derby 802.334.6744 or 800.696.4979
St. Johnsbury 802.748.3181 or 800.649.0118

Northwestern Counseling & Support Services

www.ncssinc.org

St. Albans 802.524.6554
Toll-free 800.834.7793

Rutland Mental Health Services www.rmhsccn.org

Rutland 802.775.2381
24 Hour on-call Emergency 802.775.1000

United Counseling Service www.ucsvt.org

Family Emergency Services (FES) . . 802.442.1700
Bennington 802.442.5491
Manchester 802.362.3950

Washington County Mental Health www.wcmhs.org

Montpelier 802.229.0591

Appendix 8

Warning Signs of Suicide

When you are concerned there is an immediate crisis:

Get help. Stay with the person until professional help is available. Keep the person away from firearms, medications, alcohol and other substances which they might use to kill themselves, or which might lower their resistance to causing themselves harm.

Call your local mental health agency or 1-800-273-TALK (8255).

If someone needs immediate medical attention, call 9-1-1.

Warning signs of suicidal ideation:

- Threatening suicide or expressing a strong wish to die
- Making a plan to die with details for how, when, where
- Seeking access to lethal means such as guns, medications, poisons
- Talking, writing, drawing, or texting about death, dying or suicide
- Giving away prized possessions or putting their life in order
- Showing abrupt improvement after a period of sadness or withdrawal
- Feelings of being “beyond help”

Indications of Serious Depression that could lead to Suicide

The following are indications that someone is in severe psychological pain. They may not signal an immediate emergency, but the person does need help.

Related to mood or feelings	Related to functioning
Severe mood swings	Withdrawal from family or friends
Persistent feelings of failure	Persistent physical complaints
Unexpected anger or wish for revenge	Neglect of personal appearance
Unrelenting low mood	Increased alcohol or other drug use
Pessimism or hopelessness	Abandonment of activities once considered enjoyable
No sense of purpose in life	Impulsiveness or unnecessary risk-taking
Desperation or feeling trapped	Preoccupation with death or pain
Anxiety, agitation or psychic pain	Difficulty concentrating
Rejection of help or support	Trouble sleeping

Appendix 9

Recommendations for Reporting on Suicide[®]

Developed in collaboration with: American Association of Suicidology, American Foundation for Suicide Prevention, Annenberg Public Policy Center, Associated Press Managing Editors, Canterbury Suicide Project - University of Otago, Christchurch, New Zealand, Columbia University Department of Psychiatry, ConnectSafely.org, Emotion Technology, International Association for Suicide Prevention Task Force on Media and Suicide, Medical University of Vienna, National Alliance on Mental Illness, National Institute of Mental Health, National Press Photographers Association, New York State Psychiatric Institute, Substance Abuse and Mental Health Services Administration, Suicide Awareness Voices of Education, Suicide Prevention Resource Center, The Centers for Disease Control and Prevention (CDC) and UCLA School of Public Health, Community Health Sciences.

Important points for covering suicide

- More than 50 research studies worldwide have found that certain types of news coverage can increase the likelihood of suicide in vulnerable individuals. The magnitude of the increase is related to the amount, duration and prominence of coverage.
- Risk of additional suicides increases when the story explicitly describes the suicide method, uses dramatic/graphic headlines or images, and repeated/extensive coverage sensationalizes or glamorizes a death.
- Covering suicide carefully, even briefly, can change public misperceptions and correct myths, which can encourage those who are vulnerable or at risk to seek help.
- Suicide is a public health issue. Media and online coverage of suicide should be informed by using best practices. Some suicide deaths may be newsworthy. However, the way media cover suicide can influence behavior negatively by contributing to contagion or positively by encouraging help-seeking.
- Suicide Contagion or “Copycat Suicide” occurs when one or more suicides are reported in a way that contributes to another suicide.
- References and additional information can be found at: www.ReportingOnSuicide.org

Instead of This ❌	Do This ✅
Big or sensationalistic headlines, or prominent placement (e.g., “Kurt Cobain Used Shotgun to Commit Suicide”).	Inform the audience without sensationalizing the suicide and minimize prominence (e.g., “Kurt Cobain Dead at 27”).
Including photos/videos of the location or method of death, grieving family, friends, memorials or funerals.	Use school/work or family photo; include hotline logo or local crisis phone numbers.
Describing recent suicides as an “epidemic,” “skyrocketing,” or other strong terms.	Carefully investigate the most recent CDC data and use non-sensational words like “rise” or “higher.”
Describing a suicide as inexplicable or “without warning.”	Most, but not all, people who die by suicide exhibit warning signs. Include the “Warning Signs” and “What to Do” sidebar (p. 47) in your article if possible.
“John Doe left a suicide note saying...”.	“A note from the deceased was found and is being reviewed by the medical examiner.”
Investigating and reporting on suicide similar to reporting on crimes.	Report on suicide as a public health issue.
Quoting/interviewing police or first responders about the causes of suicide.	Seek advice from suicide prevention experts.
Referring to suicide as “successful,” “unsuccessful” or a “failed attempt.”	Describe as “died by suicide” or “killed him/herself.”

Avoid Misinformation and Offer Hope

- Suicide is complex. There are almost always multiple causes, including psychiatric illnesses, that may not have been recognized or treated. However, these illnesses are treatable.
- Refer to research findings that mental disorders and/or substance abuse have been found in 90% of people who have died by suicide.
- Avoid reporting that death by suicide was preceded by a single event, such as a recent job loss, divorce or bad grades. Reporting like this leaves the public with an overly simplistic and misleading understanding of suicide.
- Consider quoting a suicide prevention expert on causes and treatments. Avoid putting expert opinions in a sensationalistic context.
- Use your story to inform readers about the causes of suicide, its warning signs, trends in rates and recent treatment advances.
- Add statement(s) about the many treatment options available, stories of those who overcame a suicidal crisis and resources for help.
- Include up-to-date local/national resources where readers/viewers can find treatment, information and advice that promotes help-seeking.

Suggestions for Online Media, Message Boards, Bloggers & Citizen Journalists

- Bloggers, citizen journalists and public commentators can help reduce risk of contagion with posts or links to treatment services, warning signs and suicide hotlines.
- Include stories of hope and recovery, information on how to overcome suicidal thinking and increase coping skills.
- The potential for online reports, photos/videos and stories to go viral makes it vital that online coverage of suicide follow site or industry safety recommendations.
- Social networking sites often become memorials to the deceased and should be monitored for hurtful comments and for statements that others are considering suicide. Message board guidelines, policies and procedures could support removal of inappropriate and/or insensitive posts.

HELPFUL SIDEBAR FOR ARTICLES

Warning Signs of Suicide

- Talking about wanting to die
- Looking for a way to kill oneself
- Talking about feeling hopeless or having no purpose
- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious, agitated or recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

The more of these signs a person shows, the greater the risk. Warning signs are associated with suicide but may not be what causes a suicide.

What to Do

If someone you know exhibits warning signs of suicide:

- Do not leave the person alone
- Remove any firearms, alcohol, drugs or sharp objects that could be used in a suicide attempt
- Call the U.S. National Suicide Prevention Lifeline at 800-273-TALK (8255)
- Take the person to an emergency room or seek help from a medical or mental health professional

The National Suicide Prevention Lifeline

800-273-TALK (8255)

A free, 24/7 service that can provide suicidal persons or those around them with support, information and local resources.



Vermont Suicide Prevention Center is a program of
the Center for Health and Learning



With Funding from:



In Association with:



Environmental Factors and Plan

21. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please consider the following items as a guide when preparing the description of the state's system:

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

As TA needs are identified, ADAP will request TA.

Footnotes:

Environmental Factors and Plan

21. Support of State Partners

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.

Please note that key partnerships related to the integration of substance abuse intervention and treatment services into Vermont's health care system of payment reform and performance management have been described in Section 1: The Health Care System and Integration.

Key partnerships with criminal justice systems as it relates to the substance abuse intervention and treatment services are described in Section 13: Criminal and Juvenile Justice.

In addition, all departments of the Vermont Agency of Human Services are integral to the State's substance abuse strategy. Of high priority for 2016/17 is the Substance Abuse Treatment Coordination (SATC) Initiative. The purpose of the initiative is to identify Agency of Human Services (AHS) clients at risk for substance abuse in order to intervene early and coordinate services within AHS. AHS Policy 1.2 is newly established and requires the following:

- A systematized method of screening clients with an evidence-based tool
- Training of staff in evidenced-based substance abuse screening techniques
- Assurance that screening will in no way impact access to AHS services
- Establishment of Department-level protocols for implementation of the policy
 - Includes implementing a mechanism for referring clients who screen positive to appropriate assessment services

The SATC work group is led by the Secretary of Human Services and the VDH Deputy Commissioner of Alcohol and Drug Abuse Services. The AHS Departments of Health, Mental Health, Children and Families, Corrections, Aging and Independent Living and Vermont Health Access also participate on the SATC workgroup. A consistent training and menu of evidence-based screening tools have been developed. Each Department is developing systems to implement this policy with their own direct services staff and supervisors. The workgroup is determining the best method to ensure Departments are working together on cases that involve more than one department.

In addition, ADAP Strategic Plan Direction 2.1.2 supports increased alignment of community-based services across the continuum of care. State provider networks will be engaged in defining what that system of care should be, and how to meaningfully promote a more integrated approach to substance abuse at the community level. Key partners are:

- PreventionWorksVT, representing community coalitions and prevention advocates
- Vermont Association of Addiction Treatment Professionals, representing Vermont's publicly funded treatment providers organizations
- Vermont Association of Mental Health and Addiction Recovery (VAMHAR), representing peers in recovery, their family and friends
- Vermont Recovery Network, representing 12 community-based Recovery Centers

2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

See AHS Policy 1.2 (<http://humanservices.vermont.gov/policy-legislation/1-12-screening-for-substance-abuse.pdf/view>)

Please indicate areas of technical assistance needed related to this section.

We have no identified technical assistance needs at this time.



**State of Vermont
Agency of Human Services**

Office of the Secretary
208 Hurricane Lane, Suite 103
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www.humanservices.vermont.gov

Hal Cohen, Secretary

[phone] 802-871-3009
[fax] 802-871-3001

July 30, 2015

Mary M. McCann, LCSW, CAC III
State Project Officer
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-209
Rockville, MD 20857

Dear Ms. McCann,

The Vermont Agency of Human Services (AHS) and the Department of Health (VDH), Division of Alcohol and Drug Abuse Programs (ADAP) have a long and positive working relationship. The Department of Health is part of the Agency of Human Services. AHS recognizes the substantial burden that substance abuse has on individuals seeking AHS services, particularly those who need multiple services and therefore enter the AHS system through different doors. If we can intervene early and better service Vermonters dealing with substance abuse issues, then other outcomes will improve.

ADAP works closely with leadership of AHS to implement the Substance Abuse Treatment Coordination initiative. This requires that each AHS Department have protocols and systems for screening their clients with an evidence-based substance abuse screening tool, staff and supervisor training, and mechanisms for referring clients who screen positive to appropriate assessment services. Work is underway to ensure Departments are working together on how to handle cases that involve more than one AHS department. The Criminal Justice Capable Core Team, including ADAP, is working to identify and address treatment resource gaps.

AHS is also committed to prevention and recovery supports. ADAP is a partner on the Integrated Family Services initiative, the Suicide Prevention Policy Workgroup and the Child and Family Trauma Workgroup. The Integrated Family Services initiative is a partnership of state government and community organizations to ensure holistic and accountable service delivery for child youth and families. This includes prevention, early intervention and treatment services. AHS is engaged in developing a housing plan for high need clients and sober housing is a high priority within this plan.

This is a letter of support on behalf of ADAP and their application for the SAPT Block Grant for FY16-17. We at the Agency of Human Services value the partnership and working relationship we share, and look forward to advancing our common purposes to improve the health and well-being of Vermonters.

Sincerely,


Hal Cohen
Secretary
Vermont Agency of Human Services

cc: Barbara Cimaglio, Deputy Commissioner, Vermont Department of Health
Joyce Brabazon, ADAP, Vermont Department of Health



State of Vermont
Department of Health
Office of the Commissioner
108 Cherry Street - PO Box 70
Burlington, VT 05402-0070
healthvermont.gov

[phone] 802-863-7280
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[td] 800-464-4343

Agency of Human Services

July 27, 2015

Mary M. McCann, LCSW, CAC III
State Project Officer
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-209
Rockville, MD 20857

Dear Ms. McCann,

In Vermont, the Division of Alcohol & Drug Abuse Programs is part of the Department of Health (VDH), the Public Health Authority for the State of Vermont. Each of our divisions and programs work in close collaboration to pursue a common vision and mission, and achieve goals set out in the department's Strategic Plan. Substance Abuse is a priority as identified in our Healthy People 2020 objectives and Vermont's State Health Improvement Plan. Our state is deeply engaged in transforming our health care system, and ADAP's placement within VDH has been a strategic asset as we strive to integrate substance abuse and behavioral health into our reform strategy. Our state has also taken a comprehensive approach to the prevention and treatment of opioid addiction and overdose, and ADAP's role within VDH has been critical to defining and executing that strategy.

Our Division of Health Promotion and Disease Prevention partners with ADAP to promote an integrated community-based approach to chronic disease prevention. ADAP works closely with the Division of Maternal and Child Health in order to ensure priority services are available to opiate addicted pregnant and post-partum women, as well as opiate addicted prenatal and newborn offspring. Our Division of Emergency Preparedness, Response and Injury Prevention coordinates Vermont's Naloxone Opioid Overdose Prevention Pilot Program and works closely with ADAP as training and overdose prevention kit distribution is implemented. These are just a few examples of collaboration within the department.

This is a letter of support on behalf of ADAP and their application for the SAPT Block Grant for FY16-17. We at the Vermont Department of Health value the partnership and working relationship we share, and look forward to advancing our common purposes to improve the health and well-being of Vermonters.

Sincerely,



Harry Chen, MD
Commissioner





State of Vermont
Department of Mental Health
Commissioner's Office
Redstone Office Building
26 Terrace Street
Montpelier VT 05609-1101
<http://mentalhealth.vermont.gov/>

Agency of Human Services

[phone] 802-828-3867
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July 27, 2015

Mary M. McCann, LCSW, CAC III
State Project Officer
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-209
Rockville, MD 20857

Dear Ms. McCann,

The Vermont Department of Mental Health (DMH) and the Vermont Department of Health (VDH), Division of Alcohol and Drug Abuse Programs (ADAP) have a long and positive working relationship.

The Vermont Department of Health, Division of Alcohol & Drug Abuse Programs and the Department of Mental Health have been long time partners in advancing Health Care Reform. This includes both practice improvement and payment reform strategies, and workforce development related to co-occurring disorders. Our organizations are working cooperatively on a Certified Community Behavioral Health Center State Planning Grant Application.

ADAP and DMH maintain regular consultation pertaining to grant initiatives including the Youth Suicide Prevention Grant, the Partnership for Success and the Block Grant.

ADAP and DMH are involved together in Agency of Human Services (AHS) initiatives, including the Substance Abuse Treatment Coordination (SATC) initiative, the Suicide Prevention initiative, and Integrated Family Services (IFS). This latter program is working to identify and undertake changes in policy and internal operations (services, service design, grants payment structures, etc.) that are needed to improve outcomes and achieve integrated child-and-family-centered responses for children 0-22 years of age.

This is a letter of support on behalf of ADAP and their application for the SAPT Block Grant for FY16-17. We at the Vermont Department of Mental Health value the partnership and working relationship we share, and look forward to advancing our common purposes to improve the health and well-being of Vermonters.

Sincerely,

Frank Reed
Interim Commissioner

cc: Barbara Cimaglio, Deputy Commissioner, Vermont Department of Health
Joyce Brabazon, ADAP, Vermont Department of Health

State of Vermont
Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston VT 05495-2807
<http://dvha.vermont.gov>

[Phone] 802-879-5900
[Fax] 802-879-5651

Agency of Human Services

July 27, 2015

Mary M. McCann, LCSW, CAC III
State Project Officer
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-209
Rockville, MD 20857

Dear Ms. McCann:

The Department of Vermont Health Access (DVHA), the Blueprint for Health and the Vermont Department of Health (VDH), Division of Alcohol and Drug Abuse Programs (ADAP) have a long and positive working relationship.

DHVA, the Blueprint for Health and ADAP continue to partner on efforts to implement comprehensive health care reform and fully integrate behavioral health services into the health care system. We collaborate on solutions to challenges such as Vermonters waiting for Medication-Assisted Therapy, lack of Medicare payment for services in specialty providers, the sensitivity of the population seeking services to out of pocket costs and lack of workforce with the necessary specialized training and skills. The Care Alliance for Opioid Treatment is a statewide treatment program implemented through a partnership of the Blueprint for Health, DVHA's Clinical Operations unit and ADAP. The Care Alliance expands access to methadone treatment, enhances methadone treatment programs with Health Home Services such as primary care and community supports, and embeds new clinical staff (a nurse and a Master's prepared, licensed clinician) in physician practices that prescribe buprenorphine, through the Blueprint Community Health Teams. DHVA and ADAP collaborate on utilization review processes for treatment of substance use disorders. In addition ADAP participates fully in the DVHA's Performance Improvement Project and other payment reform initiatives related to treatment of behavioral health disorders.

This is a letter of support on behalf of ADAP and their application for the SAPT Block Grant for FY16-17. We at the Department of Vermont Health Access value the partnership and working relationship we share, and look forward to advancing our common purposes to improve the health and well-being of Vermonters.

Sincerely,



Steven Costantino
Commissioner

cc: Barbara Cimaglio, Deputy Commissioner, Vermont Department of Health
Joyce Brabazon, ADAP, Vermont Department of Health



Department for Children and Families
Commissioner's Office
103 South Main Street – 5 North
Waterbury, VT 05671-2980
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Agency of Human Services

July 28, 2015

Mary M. McCann, LCSW, CAC III
State Project Officer
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-209
Rockville, MD 20857

Dear Ms. McCann,

The Vermont Department for Children and Families (DCF) and the Vermont Department of Health (VDH), Division of Alcohol and Drug Abuse Programs (ADAP) have a long and positive working relationship.

Addressing the impact of substance abuse on Vermont's families is a high priority for DCF. Opioid dependence and other substance use disorders have contributed to an increase in the numbers of children in state custody. Under the leadership of the Agency of Human Services, the Department of Children and Families partners with the Division of Alcohol and Drug Abuse Programs (ADAP) on systems change strategies intended to improve our outcomes. This includes the Substance Abuse Treatment Coordination initiative which involves joint planning, the implementation of screening and referral protocols, and workforce development. We also partner with ADAP on the Integrated Family Services initiative (IFS) that aims to bring all agency children, youth and family services together in an integrated and consistent continuum of services for families. The premise of IFS is that by giving families early support, education and interventions IFS will produce more favorable outcomes at a lower cost than waiting until circumstances are bad enough to access high-end funding streams.

Please accept this as a letter of support on behalf of ADAP and their application for the SAPT Block Grant for FY16-17. We at the Vermont Department of Children and Families value this shared partnership and working relationship, and look forward to advancing our common purposes to improve the health and well-being of Vermonters.

Sincerely,



Ken Schatz, Commissioner
Department for Children and Families
Agency of Human Services

cc: Barbara Cimaglio, Deputy Commissioner, Vermont Department of Health
Joyce Brabazon, ADAP, Vermont Department of Health



State of Vermont
Department of Liquor Control
13 Green Mountain Drive
Montpelier, VT 05620-4501
liquorcontrol.vermont.gov

[phone] 802-828-2339
[fax] 802-828-1031

James Giffin, Interim Commissioner

July 28, 2015

Mary M. McCann, LCSW, CAC III
State Project Officer
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-209
Rockville, MD 20857

Dear Ms. McCann,

The Department of Liquor Control (DLC) and the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (ADAP) have a long and positive working relationship.

DLC is responsible for retailer compliance testing for both alcohol and tobacco sales to minors. DLC and ADAP have a long history of collaboration on community and law enforcement education, retailer education, and data collection and analysis. DLC and ADAP also collaborate on program planning in the area of enhanced enforcement of the minimum legal drinking age. DLC is a participating member of the Vermont Alcohol and Drug Advisory Council and the Vermont Tobacco Review and Evaluation Board.

This is a letter of support on behalf of ADAP and their application for the SAPT Block Grant for FY16-17. We at DLC value the partnership and working relationship we share, and look forward to advancing our common purposes to improve the health and well-being of Vermonters.

Sincerely,



James C. Giffin
Interim Commissioner

cc: Barbara Cimaglio, Deputy Commissioner, Vermont Department of Health
Joyce Brabazon, ADAP, Vermont Department of Health



July 2015

Mary M. McCann, LCSW, CAC III, State Project Officer
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-209
Rockville, MD 20857

Dear Ms. McCann,

The Vermont Agency of Education (AOE) and the Vermont Department of Health (VDH), Division of Alcohol and Drug Abuse Programs (ADAP), have a long and positive working relationship.

The State Education Agency (SEA) collaborates with the Single State Authority (SSA) for alcohol and substance abuse – the Division of Alcohol and Drug Abuse Programs (ADAP) -- on youth development and substance abuse prevention priorities. AOE and VDH meet regularly on coordinated school health policy and program development issues, guided by the Whole School, Whole Community, Whole Child Model. AOE and ADAP collaborate on prevention grants development, data collection and communication of best practices and guidelines. AOE is an active participant on the Vermont Alcohol and Drug Abuse Advisory Council, and the Vermont Tobacco Evaluation and Review Board and the Agency of Human Services Child and Family Trauma Workgroup. Lastly, AOE supports educator in-service that includes mental health promotion and substance abuse prevention as a component of comprehensive school-based health.

This is a letter of support on behalf of ADAP and their application for the SAPT Block Grant for FY 16. We at the AOE value the partnership and working relationship we share, and look forward to advancing our common purposes to improve the health and well-being of Vermonters.

Sincerely,



Rebecca Holcombe
Secretary

cc: Barbara Cimaglio, Deputy Commissioner, Vermont Department of Health
Joyce Brabazon, ADAP, Vermont Department of Health



DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Commissioner's Office
103 South Main Street, Weeks 2
Waterbury VT 05671-1601
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July 28, 2015

Mary M. McCann, LCSW, CAC III
State Project Officer
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-209
Rockville, MD 20857

Dear Ms. McCann,

The Department of Disabilities, Aging and Independent Living (DAIL) and the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (ADAP) have a long and positive working relationship.

Under the leadership of the Agency of Human Services, the Department of Disabilities, Aging and Independent Living (DAIL) partners with the Division of Alcohol and Drug Abuse Programs (ADAP) on systems change strategies intended to improve our outcomes. This includes the Substance Abuse Treatment Coordination initiative which involves joint planning, the implementation of screening and referral protocols, and workforce development. Substance abuse is such a high priority for DAIL, that DAIL and ADAP co-fund an Elder Substance Abuse Policy and Operations Manager to increase the focus on the prevention needs of this growing Vermont population. This manager is working with a range of partners to increase provider, peer and community education. For example, DAIL, ADAP and the Vermont Association for Mental Health and Addiction Recovery will be co-sponsoring a conference on this topic in the coming year.

This is a letter of support on behalf of ADAP and their application for the SAPT Block Grant for FY16-17. We at DAIL value the partnership and working relationship we share, and look forward to advancing our common purposes to improve the health and well-being of Vermonters.

Sincerely,



Monica Caserta Hutt
Commissioner- Department of Disabilities, Aging and Independent Living
Agency of Human Services

cc: Barbara Cimaglio, Deputy Commissioner, Vermont Department of Health
Joyce Brabazon, ADAP, Vermont Department of Health

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Narrative Question:

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](#).⁹⁷

Additionally, [Title XIX, Subpart III, section 1941 of the PHS Act \(42 U.S.C. 300x-51\)](#) applicable to the SABG and the MHBG, requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

For MHBG and integrated BHPC: States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.

SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

*Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.*⁹⁸

⁹⁷<http://beta.samhsa.gov/grants/block-grants/resources>

⁹⁸There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Please use the box below to indicate areas of technical assistance needed related to this section:
As TA needs are identified, ADAP will request TA.

Footnotes:

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The substance abuse prevention, treatment and recovery system of care was a focus of the Vermont General Assembly in the 2015 legislative session. Pursuant to Act 58 Section E.313.1, 18 V.S.A. § 4803 was amended to re-structure the Vermont Alcohol and Drug Advisory Council. This includes revisions to the Council's charge and membership. The Council's charge has been enhanced to reflect Vermont's approach to health reform and best practices in the substance abuse field.

The Council is established within the Agency of Human Services (AHS) to promote the dual purposes of reducing problems arising from alcohol and drug abuse and improving prevention, intervention, treatment and recovery services by advising the Secretary of AHS on policy and program improvement. Duties include:

- (1) advise the Governor as to the nature and extent of alcohol and drug abuse problems and the programs necessary to understand, prevent and alleviate those problems;
- (2) make recommendations to the Governor and General Assembly for developing:
 - (a) a comprehensive and coordinated system for delivering effective programs, including any appropriate reassignment of responsibility for such programs; and
 - (b) a substance abuse system of care that integrates substance abuse services with health care reform initiatives, such as pay for performance methodologies;
- (3) provide for coordination and communication among the regional alcohol and drug abuse councils, State agencies and departments, providers, consumers, consumer advocates, and interested citizens;
- (4) jointly, with the State Board of Education, develop educational and preventive programs; and
- (5) assess substance abuse services and service delivery in the State, including the following:
 - (a) the effectiveness of existing substance abuse services in Vermont and opportunities for improved treatment; and
 - (b) strategies for enhancing the coordination and integration of substance abuse services across the system of care; and

(6) provide recommendations to the General Assembly regarding State policy and programs for individuals experiencing public inebriation.

Appointed members will include:

- Secretary of Human Services, or designee;
- Commissioner of Public Safety, or designee;
- Commissioner of Mental Health or designee;
- Deputy Commissioner of Health's Division of Alcohol and Drug Abuse Programs;
- Director of the Blueprint or designee;
- a representative of an approved provider or preferred provider, appointed by the Governor;
- a licensed alcohol and drug abuse counselor, appointed by the Governor;
- a representative of hospitals, appointed by the Vermont Association of Hospitals and Health Systems
- an educator involved in substance abuse prevention services, appointed by the Governor
- a youth substance abuse prevention specialist, appointed by the Governor
- a community prevention coalition member, appointed by the Governor
- a member of the peer community involved in recovery services, appointed by the Governor

Work to execute the charge outlined above and recruit members is underway. The former Vermont Alcohol and Drug Abuse Advisory Council, representing treatment, prevention, recovery, family-serving organizations, education, law enforcement, healthcare and the justice system have been active in review and feedback on Vermont's program plans.

In addition to this mechanism, stakeholder feedback on planning and services delivery has been provided through:

- Stakeholder surveys on school-based services
- Stakeholder surveys on workforce development needs
- Data collected from grantees
- Prevention, treatment and recovery provider feedback on system strengths and gaps gathered at ADAP Annual Provider Meeting, held on May 26, 2015

The Vermont Department of Health, Division of Alcohol and Drug Abuse Programs posts the SAPT Block Grant application, for a minimum of weeks, on our website at www.healthvermont.gov prior to submission for public comment.

The State of Vermont, Agency of Human Services publicizes the Annual Block Grant Hearing through their website at: <http://humanservices.vermont.gov/departments/office-of-the-secretary/state-plan>

The webpage includes the Block Grant plan and summary, as well as, public notices in the three largest newspapers in the State, a list of hearing attendees and a hearing transcript.

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year:

End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Barbara Cimaglio	State Employees	Alcohol and Drug Abuse Programs	108 Cherry Street, P.O. Box 70 Burlington, VT 05402-0070 PH: 802-951-1258 FAX: 802-651-1573	barbara.cimaglio@vermont.gov
Michael Hogan	State Employees	Department of Liquor Control	13 Green Mountain Drive Montpelier, VT 05620 PH: 802-828-2345 FAX: 802-828-2803	mike.hogan@vermont.gov
Chauncey Liese	State Employees	Department of Motor Vehicles	120 State Street Montpelier, VT 05603-0001 PH: 802-828-5766 FAX: 802-828-2170	chauncey.liese@vermont.gov
Patrick Martin	Others (Not State employees or providers)		57 Cramton Avenue Rutland, VT 05701 PH: 802-775-6608	collcartoy@aol.com
Mark Ames	Others (Not State employees or providers)		Vermont Recovery Center Network, P.O. Box 37 White River Junction, VT 05001 PH: 802-738-8998	vtrecoverynetwork@gmail.com
Mitch Barron	Providers	Centerpoint Adolescent Treatment Services	1025 Airport Drive South Burlington, VT 05403 PH: 802-488-7711 FAX: 802-488-7732	mitchb@centerpointservices.org
Willa Farrell	State Employees	Office of the Attorney General	109 State Street Montpelier, VT 05609 PH: 802-828-1360 FAX: 802-828-2154	wfarrell@atg.state.vt.us
Steve Waldo	State Employees	Department of Liquor Control	6 Baltimore Road Baltimore, VT 05143 PH: 802-263-5355	steve.waldo@vermont.gov
Mark Depman, M.D.	Others (Not State employees or providers)	Central Vermont Medical Center	P.O. Box 547 Barre, VT 05641 PH: 802-371-4522	mark.depman@cvmc.org
Lt. Matthew Birmingham	State Employees	Department of Public Safety		matthew.birmingham@vermont.gov
Mark Weikert	Others (Not State employees or providers)		PH: 802-824-6811	mweikert@brsu.org
Jennifer Wall-Howard	Others (Not State employees or providers)		PH: 802-225-8003	jen@mpsvt.org
Lori Augustyniak	Others (Not State employees or providers)	Prevention Works! VT		preventionworks@fairpoint.net
John Gramuglia	State Employees	Department of Corrections		john.gramuglia@vermont.gov

Marcus Hass	Others (Not State employees or providers)	Central Vermont New Directions		marcus.hass71@gmail.com
Peter Espenshade	Others (Not State employees or providers)	Vermont Association for Mental Health and Addiction Recovery		
Rebecca Holcomb	State Employees	Agency of Education	219 North Main Street, Ste. 402 Barre, VT 05641	
Todd Bauman	Providers	Northwest Counseling and Support Services	107 Fisher Pond Road St. Albans, VT 05478	tbauman@ncssinc.org
Erin Devost	State Employees	Vermont Department of Health	108 Cherry Street, P.O. Box 70 Burlington, VT 05402	erin.devost@vermont.gov
Rita Johnson	Others (Not State employees or providers)	Vermont Association for Mental Health and Addiction Recovery	100 State Street, Ste. 353 Montpelier, VT 05602	rita@friendsofrecoveryvt.org

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	20	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	0	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	0	
Parents of children with SED*	0	
Vacancies (Individuals and Family Members)	<input type="text" value="0"/>	
Others (Not State employees or providers)	9	
Total Individuals in Recovery, Family Members & Others	9	45%
State Employees	9	
Providers	2	
Federally Recognized Tribe Representatives	0	
Vacancies	<input type="text" value="0"/>	
Total State Employees & Providers	11	55%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="0"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="0"/>	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text" value="3"/>	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

They review the State's substance abuse policies and provide input to the Agency of Human Services about policy direction which includes programs and services funded by the SAPT Block Grant.

Footnotes: