

**Governor's Opioid Coordination Council**

**State of Vermont**

**Monday, June 11, 2018**

**1:00 – 3:00 p.m.**

**Meeting Materials Packet**

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**Governor's Opioid Coordination Council**  
**State of Vermont**  
**Monday, June 11, 2018**  
**1:00 – 3:00 p.m.**  
**Waterbury State Office Complex, Cherry Conference Room**

**Advance Agenda**

**1:00 – 1:10 Welcome, Introductions, Minutes**

**1:10 – 1:25 Director's Report**

- Highlight: Department of Libraries

**1:25 – 2:20 Theme: Recovery Strategy Development**

This panel is designed to help synthesize the recovery strategies as developed since January 2018 by the OCC Recovery Strategies Committee, looking at recovery centers and network, recovery coaching, and at the role transportation, housing, employment and criminal records play in sustaining recovery. Perspectives include the individual, organizational and systems level.

**Moderator:** Sara Byers, OCC member

**Overview/Context:** Hugh Bradshaw, Department of Disabilities, Aging and Independent Living, Division of Vocational Rehabilitation

**Connecting Needs and Services to Support Recovery: Recovery Center Perspective**

- Tracie Hauck: Turning Point Center of Rutland – programs and supports; recovery coaching in correctional facilities; housing.
- Cindy Boyd: Kingdom Recovery Center, St. Johnsbury – personal experiences, wraparound supportive services, and the role and needs of recovery centers.

**The State's role in supporting recovery programs and services:** Cindy Thomas, Director, Alcohol and Drug Abuse Programs, Vermont Department of Health

**2:20 – 2:55 Discussion**

**2:55 – 3:00 Public Comment**

**3:00 Adjourn**



## Vermont Governor's Opioid Coordination Council

### Meeting Minutes 05/14/2018

**Location and Time:** 1:00 – 3:00 p.m. Waterbury State Office Complex, Sally Fox Conference Center, Cherry (2<sup>nd</sup> Floor)

**Present:** Chairs: A. Gobeille, J. Leddy. Members: L. Augustyniak, M. Bucossi, S. Byers, S. DiSanto, L. Genge, B. Grearson, M. Levine, P. Mallary, D. Ricker, S. Thompson. Clarence Davis (alternate designee). Staff: J. LaClair, R. Gowdey, E. Springer (VISTA), J. Zanin (Intern)

**Absent:** T. Anderson, B. Bick, J. Berry Bowen, A. Bunting, K. Black, T. Donovan, R. Marcoux, C. Nolan, K. Sigsbury

**Visitors:** Chris Bell (VDH), Diane Derby (Sen. Leahy), Kayla Donohue (CCOA), Devon Greene (VAHHS), Jane Helmstetter (AHS), Vin Livoti (Lib), Cass Mabbott (Lib), James Pepper (SAS), Judy Rex (DCF), Jill Sudhoff-Guerin (VTMD), Joy Worland (Lib)

Agenda Item	Discussion	Action/ Next Steps
Opening of Meeting	Secretary Al Gobeille. Opening Comments, introductions	Quorum not reached
Director's report (J. LaClair)	<ul style="list-style-type: none"> <li>• Recovery Committee progress on employment, transportation and housing. New partnership with VTrans, working with AHS, DVHA, ADAP) to support transportation to treatment and recovery centers and employment. Partnership with Dept. of Labor for an employment consultant at six recovery locations</li> <li>• Introduce Eleanor Springer, OCC VISTA through August, who will work on S.107 (Safe Consumption Sites report for Senate Judiciary Committee)</li> <li>• No meeting in July. Interim report on strategies due.</li> <li>• Prevention Committee: continuing focus on primary/secondary prevention, and on intervention and harm reduction. What is working and not working:               <ul style="list-style-type: none"> <li>○ Highly trained counselors in some schools across state</li> </ul> </li> </ul> Schools need resources – not just money, but personnel	
		Attained quorum
Approval of Minutes	No Changes. Motion to approve: Deb Ricker, Second: Peter Mallary.	Approved unanimously voice vote.
Legislative Summary (Sec A. Gobeille, Comm. Anderson, Comm. M. Levine)	A. Gobeille: <ul style="list-style-type: none"> <li>• On Sat. 5/12 senate approved operating budget bill, Governor intent to veto.</li> <li>• AHS has \$2.5 billion budget</li> <li>• Tobacco money should be coming, more information to be shared with Council as finalized</li> </ul> M. Levine: Harm reduction strategies: <ul style="list-style-type: none"> <li>• Naloxone: Good Samaritan Laws. Costs (special fund/pharma companies). No one needing has been turned away. Hope funding continues.</li> <li>• Syringe Exchange Programs: need funding – becoming standard practice. Historically not high priority for funding. Avenue for treatment and preventing viral diseases.</li> <li>• Safe Consumption Sites: not widely accepted as harm reduction; require more discussion. Vancouver, BC as role model.</li> <li>• Fentanyl Testing: Pilot in VT through VDH to provide kits to test for fentanyl by those who use street</li> </ul>	

	<p>opioids has shown on type to be successful. Knowing fentanyl is present changes behavior for the better. Requires funding.</p> <p>“Social Autopsy” initiative underway to learn more about any person that dies from overdose, to then inform conversation about continuum of care.</p>
<p>Strategy Development Topic: <b>Law Enforcement and Vermont’s Opioid Crisis: Supply Reduction and Effective Community Strategies to Address Substance Use Disorders and Mental Illness</b></p>	
<p><b>Moderator:</b> Jim Leddy</p>	<ul style="list-style-type: none"> <li>For every victim, there are many others (family members, etc.) who usually do not get help. Recognize Sara Byers for receiving the Mercy Connections Catherine McAuley award</li> </ul>
	<p><b>Drug trafficking and supply chain in Vermont</b></p>
<p>Presenters:</p> <ul style="list-style-type: none"> <li>Asst. U.S. Attorney Kevin Doyle</li> <li>VT State Police Lt. Teresa Randall</li> </ul>	<p>K. Doyle</p> <ul style="list-style-type: none"> <li>Refer to PowerPoint presentation</li> <li>States attorneys are limited in capacity, must rely on local and state policy and sheriff’s offices, multi-faceted approach</li> <li>Many drug dealing operations have financial incentive to buy property in the towns they ‘serve’</li> <li>The Five Tier supply chain (slide 4), with prosecution only for tiers 2-5. Tiers 2 and 3 are good candidates for drug court. Lower tier offenders are given incentive to testify against higher tiers.</li> <li>(Final slide) Rutland Drug Court, soon in Burlington, allows those convicted of drug crimes to go through regulated program of treatment and recovery to reduce sentence. Re-release into the community is not the best outcome for some addicts.</li> </ul> <p>T. Randall</p> <ul style="list-style-type: none"> <li>VT State Police Drug Task Force – grant funded. 4 quadrants for local/state work. Most of drugs are either primarily fentanyl, or at least laced.</li> <li>State police now working to collect information on Vermonters being picked up for drug-related crimes beyond state borders</li> </ul>
	<p><b>Impact of the Opioid Crisis on Regional and Local Law Enforcement</b></p>
<p>Presenter: Newport Police Chief Seth DiSanto</p>	<ul style="list-style-type: none"> <li>Drug trafficking organizations working through the woods of the NEK; marijuana, cocaine, and synthetic pills come from Canada in exchange for cash and guns</li> <li>In 2009, a bust with 100-200 bags was big. Today, 1,500 and more</li> <li>Police no longer field-test drugs -- high-risk for officers. Cases take longer to prosecute. Drug investigations are lengthy and expensive.</li> <li>75-80% of cases in Newport related to opioid crisis</li> </ul>

	<ul style="list-style-type: none"> <li>• Tier 4 and 5 offenders are immediately referred to task force and federal partners. Less than 5% of pursuits are Tier 1 offenders</li> </ul>	
	<p><b>Building Community Relationships via Intervention: Law Enforcement &amp; Street Social Workers/St. Albans</b></p>	
<p>Presenters:</p> <ul style="list-style-type: none"> <li>• VSP Lt. Maurice Lamothe</li> <li>• NW Medical Ctr: Nick Tebbetts, Melinda Lussier</li> </ul>	<ul style="list-style-type: none"> <li>• Increase in police calls for mental health service over past two decades, sparking conversation for embedded case worker to enhance ability to deal with people in mental health crisis</li> <li>• Street social worker embedded with State Police barracks 40 hours/week from Northwest Medical Center; mental health and SUD expertise</li> <li>• Includes follow-up</li> <li>• Benefits – troopers on the scene for less time per situation (worker helps to de-escalate). Increased referrals and access to help</li> <li>• Challenges – one FTE – could use more (night shift)</li> <li>• Act 49 seed funding</li> <li>• Development of Thrive empanelment: a number of services and centers that can share information about an individual to provide services as a suite (individual signs release)</li> </ul>	
	<p><b>Building Community Relationships through Intervention: Law Enforcement and Street Social Workers ... South Burlington and Surrounding Communities</b></p>	
<p>Presenters:</p> <p>City Manager Kevin Dorn and Police Chief Trevor Whipple, South Burlington</p>	<ul style="list-style-type: none"> <li>• Chittenden County Community Outreach – about partnership – local communities with Howard Center and AHS</li> <li>• Increase in calls for social services needs (mental health, drug abuse, etc.), which was starting to take a mental/emotional toll on service providers</li> <li>• Started program for 4 full time embedded social service workers. Now that the program exists, there is abundant need for the outreach workers</li> <li>• This is the start of a county-wide program <ul style="list-style-type: none"> <li>○ Training and resources</li> <li>○ Full access to databases (law enforcement and mental health)</li> <li>○ Utilized in a variety of ways</li> <li>○ Available to go out on calls, including calls where officers are not needed.</li> </ul> </li> </ul>	
<p><b>Discussion: Demand reduction, prevention, referral to treatment, and recovery</b></p>		
	<ul style="list-style-type: none"> <li>• What about statewide programs to embed outreach workers? What vehicle could bring together these partners to talk to and learn from each other.</li> </ul>	

	<p>Can the Council facilitate this?</p> <ul style="list-style-type: none"> <li>• Franklin County model is State Police – expansion would be at state level initiative, if deemed effective and funding/community partnership found (each community would be somewhat different). Training pilot needed</li> <li>• Refer to Acts 280 and 283.</li> <li>• Need to find a way to do this without dependence on payers</li> <li>• Re Fentanyl – Pilot testing program shows 10% pure fentanyl on streets, 70% pure heroin, 20% mix.</li> <li>• Street encounters with fentanyl and testing results may be different</li> <li>• Re Drug courts: <ul style="list-style-type: none"> <li>○ evolving quickly, as the drug trade evolves. Key to success lies in working with the right population. Needs to be the only possible measure left before jail is only option.</li> <li>○ Local variations: Numbers up in Barre, with full-time coordinator. Chittenden court thriving – more accountable. Almost 70 people. Rutland fell back, and now numbers up again.</li> <li>○ Proposal in Supreme Court for Chittenden family treatment court</li> <li>○ Potential benefit of a judicial master with enough authority to operate juvenile court principles in docket. Take a regional approach and go county to county to implement early treatment and monitoring.</li> <li>○ More judges being sent for drug court training</li> </ul> </li> <li>• How/why do extreme cases – with 35 convictions including felonies – end up in treatment court (not jail)?</li> <li>• Only 3 enforcement strategies in the Council’s recommendations. Need more emphasis, more legislative buy-in. How can OCC support convening a statewide forum to bring together the embedded model operators in state and local police?</li> </ul>	
Public Comment		No remarks
Closing remarks. Adjourn	Motion to Adjourn: Bob Bick at 3:27 p.m. Next meeting Monday, June 11, 2018	



## Collaborative Community Based Strategies for Libraries as Place, Space, and Community & Informational Hubs

### VTLIB Top 5 Actions:

1. Department of Libraries collection development, resources and bibliographies. The focus of these resources will cover topics and areas to include: Substance Abuse & Prevention, Tobacco, Alcohol, Opiates, Healing from Trauma, Resilience, Youth intervention, self-Help, and parenting guides. Collection development for public libraries will be provided through continuing education, everyday diversity strategies, book lists, and community discussions.
2. Creation of a circulating exhibit for libraries, like the VT Folklife Center exhibit using the Inter-Library Loan (ILL) courier system to move the exhibit throughout the state.
3. Training public libraries on Naloxone, Stigmatization, Recognition of Symptoms. Expanded and updated workshops on Human Services, Mental Health, and Federal / State / Local resources will be added to the continuing education opportunity for libraries; possible discussions will include exchanges and sharps collection & disposal.
4. Health Care literacy training, partnerships with VT Human Services, 211, public awareness campaign of consumer health & prevention information through library resources. Connections with the American Library Association (ALA), National Institute of Health (NIH), and the U.S. National Network of Libraries of Medicine (NNLM) to support the direct needs of health information consumers by providing materials that are multilingual, culturally appropriate and easy-to-read, and by developing methods and materials to teach consumers how to evaluate health information resources, especially those found on the Internet.
5. Circulation of Healing Kits that will assist libraries, library users, families, parents, and care providers in expanding discussions. *The Healing Library: Lending Healing Experiences* has been developed to start families on their unique journey of healing during periods of trauma. Kits have been developed to assist families with healing in a healthy way while teaching parents the skills of looking critically at the message being promoted through books and utilizing them to communicate with children.

## Collaborative Community Based Strategies for Libraries as Place, Space, and Community & Informational Hubs

**Prevention, Education and Intervention:** These strategies strive to ensure Vermont’s children receive effective programs that deter initiation into illicit drug use, Vermont’s communities are supported in collaborative prevention efforts, and Vermonters have access to interventions that will point them away from risk and toward help.

- A. Implement a statewide comprehensive system to deliver school-based primary prevention programs.  
Department of Libraries: Agency of Ed curriculum crosswalk; Agency of Ed liaison; Reach out to School librarians, VSLA about information and programs currently provided regarding substance abuse and treatment options.
- B. Expand health care education, monitoring and screening for providers and patients, including provider participation in the *Vermont Prescription Monitoring System (VPMS)*; *provider training, and patient education*, in alternatives to opioids for pain management including *non-pharmacological options*; and expansion of *Screening, Brief Intervention and Referral to Treatment (SBIRT)* in primary care, emergency departments, corrections and schools.  
Department of Libraries: Health Care literacy campaign & programming; Partner with Human Services; Highlight Gale resources; ALA resources.
- C. Build replicate and support strong community-based models through multi-sector partnerships, innovation, and research resulting in outcomes that exceed previous, less collaborative efforts.  
Department of Libraries: Discussion and Collaborations on a culminating writers project / voices & stories for youth and their families going through the opioid cross that can serve as a public awareness campaign; Offering the library as “place & space”.
- D. Create a comprehensive drug prevention messaging campaign designed to raise public awareness, reduce stigma, provide hope for families, and strengthen resilience in Vermont’s communities.  
Department of Libraries: Exhibits for libraries, using ILL courier to move around the state; having programs in libraries; CE for library staff across Vermont, Discussion and Collaboration with ASPENI Health providing workshops on: Adverse Childhood Experiences & Resilience; Positive Messaging to Eliminate Stigma; Naloxone; Fentanyl and the Fentanyl Analogs, Pharmaceutical Opioids – Heroin & Fentanyl.



The Vermont Department of Health’s Division of Alcohol and Drug Abuse Programs (ADAP) supports a comprehensive system of prevention, intervention, treatment and recovery through funding, oversight and technical assistance. Recovery services are an integral part of Vermont’s system to impact the problems caused by alcohol and drug misuse and dependence.

The following is a summary of funding supports provided by ADAP to Vermont’s system of recovery. These funds come from several funding sources such as the Mental Health and Substance Abuse Block Grant, the Opioid State Targeted Response Grant, and Global Commitment Investments. Along with financial support, ADAP provides technical assistance to support the sustainability of the prevention system.

### **Funding Supports**

Recovery Centers \$1,149,976

ADAP funds each Recovery Center a base amount to support the infrastructure of the Center. The funds are provided to the Center through a grant with ADAP. Each Center is required to offer and provide an array of support services to assist people in finding, maintaining and enhancing recovery through peer supports, sober recreation and education.

Vermont Recovery Network (VRN) \$219,656

ADAP funds the Vermont Recovery Network to offer guidance and support to the Recovery Centers under the direction of the Vermont Recovery Network Executive Council. Funds are also used to support data collection, data analysis and training of Recovery Center staff. (\$148,400)

ADAP funds ten (10) Pathway Guides at .5 full-time equivalent (FTE). One of the Centers’ current priorities is improving the recovery capital of those receiving MAT for OUD by engaging peer recovery support guides, known as Pathway Guides, at the outset of treatment. Pathways Guides initially began at eleven sites through a SAMHSA Targeted Capacity Expansion grant. Additional funds through SAMHSA’s 2015 Medication Assisted Treatment – Prescription Drug and Opioid Addiction grant provided additional capacity in two of these sites. (\$74,200)

Vermont Association of Mental Health and Addiction Recovery \$114,000

ADAP funds ongoing training including 10 community trainings on Vermont Recovery Advocacy in all corners of the state. Funding also supports the Vermont Recovery Coach Academy.



Opioid State Targeted Response Grant (STR) \$1,558,447

- Telephone-based Peer Recovery Supports: Two-year funds are used to develop a telephone peer recovery support service for individuals transitioning out of residential SUD treatment. Funds are used to provide trainings, cover costs for two support staff, evaluation capacity, a software license for the program and supervision of the volunteers. (\$74,000)
  
- Recovery Services in Vermont Hospital Emergency Departments: Two-year funds to VRN are used to create recovery services in 5 hospital emergency departments across the state. VRN to administer the Recovery Coaches in each identified Center. Three pilots are beginning in Bennington County, Chittenden County and Washington County. Two additional locations will be added in 2018. (\$1,143,500)
  
- Recovery Coaches: One-year funds will support 6 Recovery Coaches/Pathway Guides. Pathway Guides work out of local Recovery Centers and Opioid Treatment Hubs to engage people who want to receive Medication Assisted Treatment (MAT) for opiate addiction. Pathway Guides also introduce participants to the existing Peer Recovery Support Services available in their community. (\$85,947)
  
- Supported Employment Program: One-year funds in three regions of the state: Northeast Kingdom, Washington County and Chittenden County. Employment staff will provide recovering individuals with the necessary skills-training and will work with employers in the community to establish relationships and develop agreements for employing individuals in the program. The program will also provide employers with support and training on employing individuals in recovery as well as employer incentives. (\$255,000)

# Opioid Coordination Committee – Transportation Working Group

## Summary of Findings

May 17, 2018

### Background

On March 22<sup>nd</sup>, Vermont Agency of Transportation (VTrans) was invited to the monthly meeting of the Recovery Strategies Committee of the Governor’s Opioid Coordination Council (OCC) to discuss transportation services for those struggling with addiction. While we provided an overview of the standard route and demand-response services, the discussion quickly moved to the type of critical needs not accessible through the current system. Trips to essential services such as group meetings, Recovery Centers, drug test sites, job training and access, were highlighted and we were asked to form a Recovery Transportation Working Group with several members of the OCC. This summary of findings is the result of the work Working Group has performed.

### The Process

This Working Group met in April and considered the services, data, and reporting needed to reasonably address both the demand and capacity for an expansion of transit services. Since then, we have collected surveys and/or information from Vermont Division of Vocational Rehabilitation (VR), the Recovery Centers, the transit providers and some housing programs. We also learned of a federal grant program in the St. Albans region and the Vermont Employment Transportation Initiative. Both programs are designed to assist individuals to access recovery and job access services not currently covered by the statewide transit programs. These efforts confirmed the service needs, as well as the potential usage of any expanded service.

### The Status of Transportation Services

VTrans invests roughly \$35 million dollars annually in public transit services throughout Vermont. While half of the operating portion of the budget provides 5 million transit trips, the other half is expended on 200,000 demand-response or “dial-a-ride” trips. In addition to these public transit trips, The Department of Vermont Health Access (DVHA) coordinates transportation with these same providers for Medicaid-eligible trips, investing \$12 million dollars annually. In all, over 560,000 trips are scheduled through this demand-response process. There are other smaller programs, grants and pilots to address job access and recovery services, and those projects have revealed a real need for expanded transportation service. Taken together, the Working Group has agreed on the following factors:

- Employment is key to restoring a productive life in recovery with abstinence.
- The success of treatment, employment, and recovery rely heavily on the availability of transportation.
- Lack of vehicle, and/or restrictions on driving and licenses, often create significant obstacles for people, especially in early recovery.
- Travel to obtain Medication-Assisted Treatment (MAT), counseling, other support services can consume several hours every day, and require the willingness of family members and friends, whose transportation situations may also be limited or unavailable.
- Combination of travel needs for treatment/recovery services and jobs can be complicated but is essential.
- Transportation limitations can also prevent individuals from seeing their children and other family members, a primary motivating factor for so many in recovery.

## Service Needs

Through discussions and the data received, the identified needs (priorities) not covered by current programs are as follows:

- Group Meetings and Therapy sessions
- Access to Recover Centers
- Access to Drug Test sites
- Medical Appointments
- Job Access (training, interviews, and initial commutes)

These needs represent the most frequent and important recurring requests at all our organizations. The nexus between trips to assist recovery and to gain employment is directly related and we must strive to help all vulnerable Vermonters struggling with transportation to access the above services. Providing these services for anyone in Vermont addresses important aspects of recovery, including prevention, providing resilience, and hope for those at the lower end of the economic spectrum.

Given these needs, we approached our partners and asked for estimates on the potential demand for these types of trips. The data can be found in addendum to this report, and the results by category suggest:

- Vocational Rehabilitation: roughly 440 trips per month, and the expected needs, by category, are as follows:
  - o Transportation to training/work experiences: 100 trainees X 20 round trip rides= 2,000
  - o Transportation to employment: 50 workers X 5 weeks (time to identify other transportation options) = 1,250
  - o Transportation to support services/groups: 100 individuals X 20 round trips= 2,000
- Recovery Centers: During FY 2017 and 2018, the Recovery centers located in VT have served 31,000 people seeking services. There were an estimated 2,000 calls or visitors that were looking for recovery support meetings, Inpatient, detox, childcare, mental health needs. Out of those, needs we have been able to help by providing transportation on some level, with the cost falling on the center. We estimate a need of at least 300-400 trips to essential recovery services every month.
- Housing programs – While there may be unmet needs in terms of recovery and job access, many of those in subsidized housing are already working with VR. As such, we are referring to the VR estimates with the knowledge that many residents will be included in the expanded services already captured in this report.
- Transit Agencies: collectively, the transit entities project they will provide 569,535 demand response trips in SFY 2018. They also suggest the system could provide an additional 2,500 -3,000 trips per month. This considers some anticipated trip coordination and scheduling efficiencies. This was a welcome outcome, as the actual need is lower than the capacity, so essentially, we can provide the service if we have the funds.

**In summary, the Working Group estimates the transit providers could provide at least 800-1000 trips per month for recovery services and/or job access opportunities.**

## Costs

Each transit provider has a “fully allocated trip cost” for the demand response service. Due to variations in population densities, service ratios, etc., these can range from \$17-\$36 per trip, and given the likely distances and scheduling efficiencies, we estimate the average per trip cost would be between \$20-\$25 per trip. The partners indicate roughly 1,000 trips would cost approximately \$20,000 to \$25,000 per month.

## **Service Delivery**

As stated above, the Vermont Public Transit entities already have the process in place to receive trip requests and schedule the service (via volunteer driver or small bus). These providers may be able to expand this process to address another set of trip purpose; possibly a “Support and Job Access” transportation program.

## **Recommendations from the Working Group**

1. Regional Coordination Meetings. Using the Northwestern Medical Center’s successful pilot project, we recommend meetings between the recovery centers, the local support organizations, transit providers, and other related services to ensure eligible trips are being scheduled and all regional entities are in communication regarding demand and services.
2. Seek funds for vehicles for the recovery centers and service providers. These vehicles may provide the flexibility for these organizations to manage their own trips to counseling sessions, treatment, etc.
3. Launch an expanded demand response program, specifically serving those in recovery and seeking job access. Trips can be coordinated through recovery centers, UA sites, VR, and other pre-approved partners. This recommendation is the most comprehensive of the three recommendations, but if funding is awarded, it does appear we have the right program, processes, and approach to quickly institute direct and valuable service to bridge the identified gaps to a successful recovery and/or to joining the workforce.
4. This group urges all agencies and organizations directly receiving funding to help those with opioid addiction and/or job entry and access to consider applying a percentage of these funds to partially pay for additional transportation services.

## **Working Group Members:**

- Donna Baker, Executive Director, Green Mountain Community Network, [dbaker@greenmtncn.org](mailto:dbaker@greenmtncn.org), 447-0477
- Hugh Bradshaw, Employment Services Manager, Vocational Rehabilitation, [www.cwsvt.com](http://www.cwsvt.com), 241-0319
- Cynthia Boyd, Executive Director, Kingdom Recovery Center, [c.boyd@stjkrcc.org](mailto:c.boyd@stjkrcc.org), 751-8520
- Stefani Capizzi, Executive Director, North Central Vermont Recovery Center, [recovery@ncvrc.com](mailto:recovery@ncvrc.com), 851-8120
- Kayla Donohue, Data Analyst, Chittenden County Opioid Alliance & Burlington Police Department, United Way, [Kayla@unitedwaynwvt.org](mailto:Kayla@unitedwaynwvt.org)
- Melinda Lussier, MAT Care Coordinator, Northwestern Medical Center, [mlussier@nmcinc.org](mailto:mlussier@nmcinc.org), 752-1993
- Ross MacDonald, VTrans Public Transit Coordinator, [ross.macdonald@vermont.gov](mailto:ross.macdonald@vermont.gov), 828-5577
- David Pelletier, VTrans Planning Coordinator, [dave.pelletier@vermont.gov](mailto:dave.pelletier@vermont.gov), 595-9675
- David Riegel, Executive Director, Vermont Foundation of Recovery, [david@vermontfoundationofrecovery.org](mailto:david@vermontfoundationofrecovery.org), 578-5504



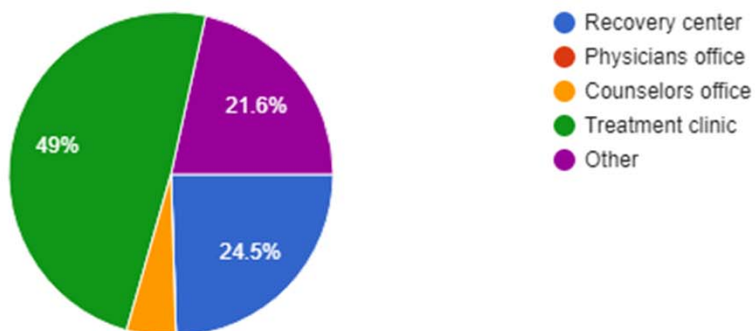


# Opioid Coordination Council Transportation Working Group

Transportation Survey for Vermonters in Recovery  
and/or Seeking Job Access  
Produced by The Turning Point Center of  
Chittenden County

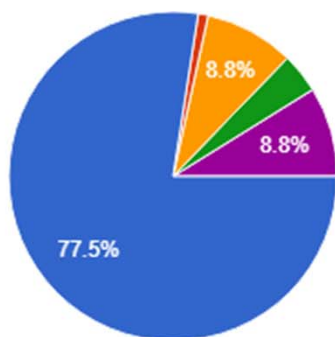
Where were you asked to complete this survey?

102 responses



## What is your relationship to recovery?

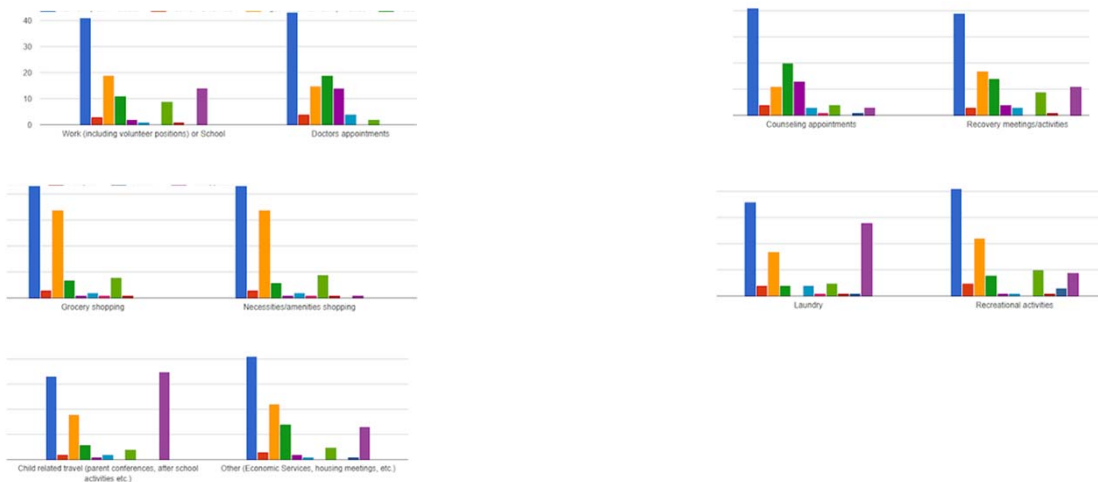
102 responses



- I am a person in recovery
- I am a person seeking recovery
- I have a family member or friend in recovery
- I volunteer to support recovery
- I have no connection to recovery

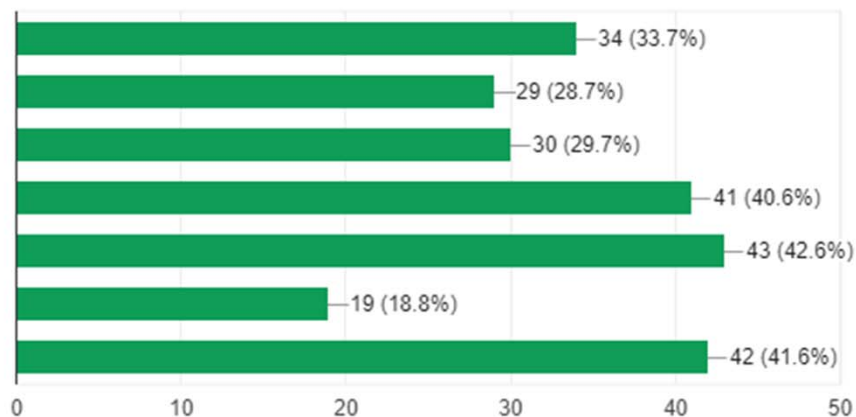
## What is your primary method of transportation for daily activities?

■ I drive my own vehicle 
 ■ I borrow a vehicle 
 ■ I get rides with family/friends 
 ■ I use public transportation 
 ■ I use rides paid for by my insurance 
 ■ I pay for taxis/uber/lyft 
 ■ I rent a vehicle 
 ■ I walk/bike 
 ■ I carpool 
 ■ Other... 
 ■ Not applicable



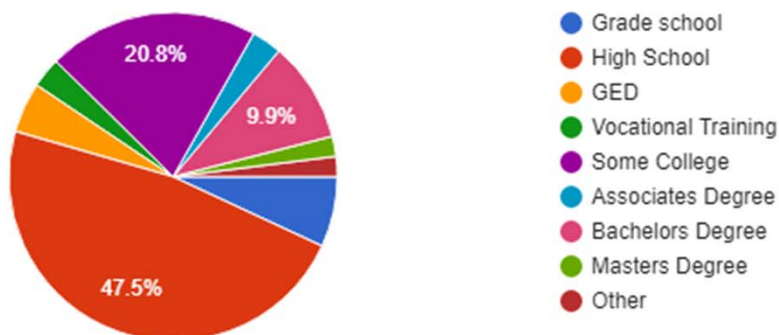
### Transportation barriers effect my ability to ...

101 responses



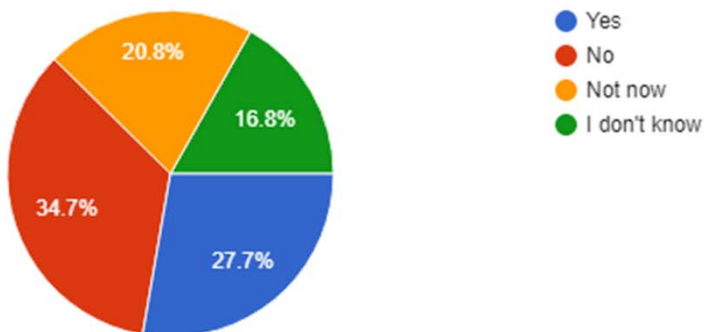
### What is the highest level of education you completed?

101 responses

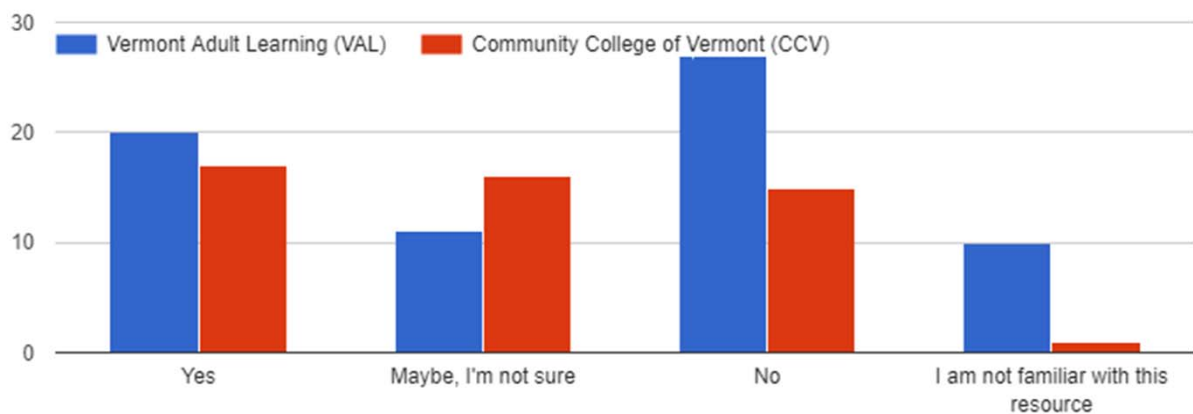


### Are you interested in completing or continuing your education?

101 responses

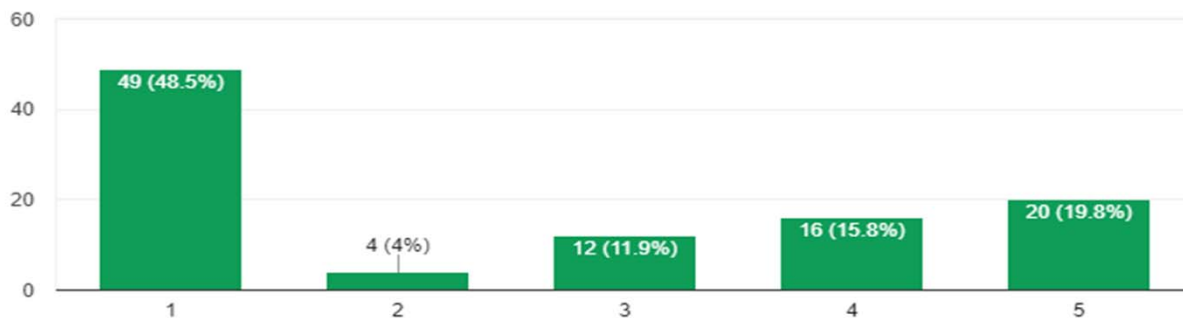


### If yes, would you consider Vermont Adult Learning or Community College of Vermont?



### To what extent do you feel transportation effects your educational decisions?

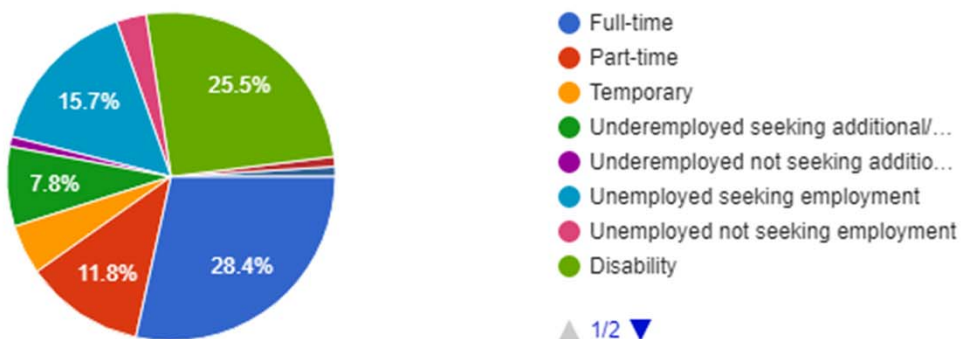
101 responses



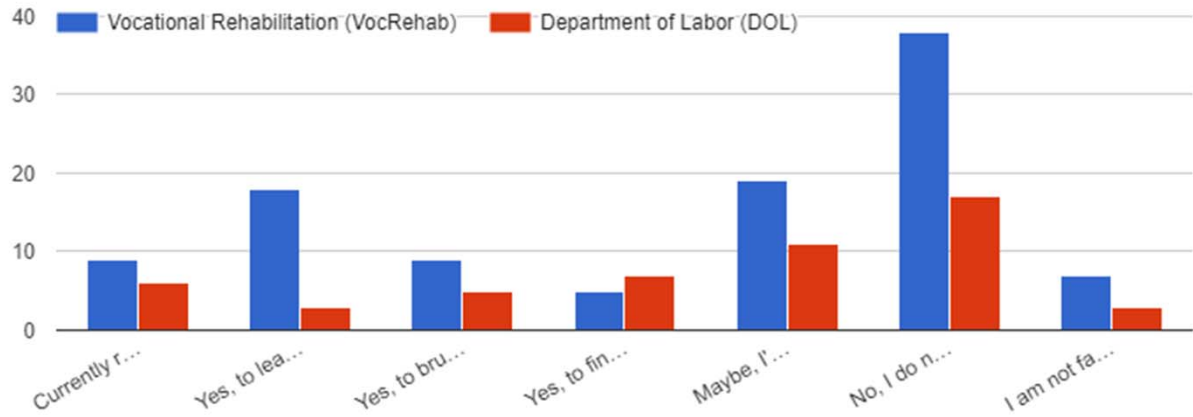
On a scale of 1-5 where "1" means *not at all* and "5" means *completely*

### What is your current employment status?

102 responses

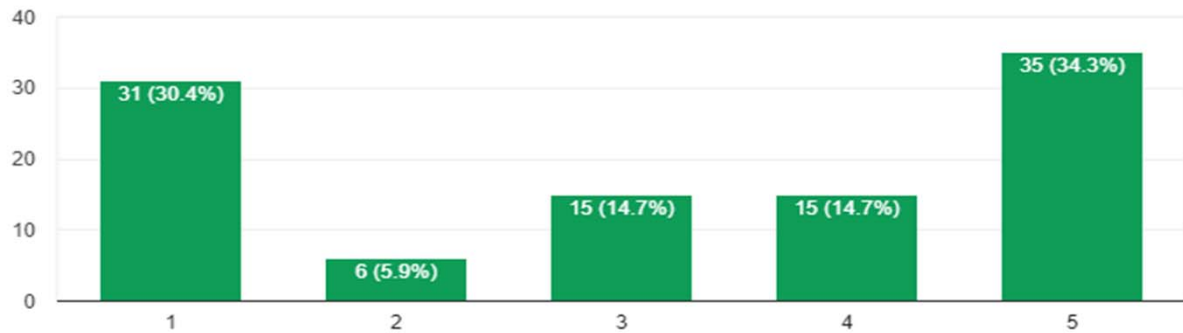


### Are you interested in working with Vocation Rehabilitation or Department of Labor?



### To what extent do you feel transportation effects your employment decisions?

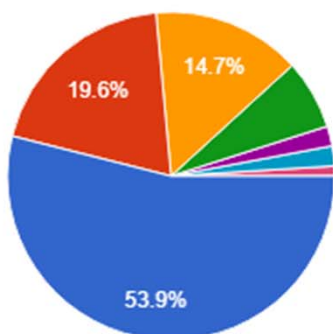
102 responses



On a scale of 1-5 where "1" means *not at all* and "5" means *completely*

## License status

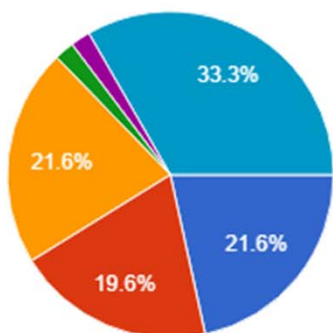
102 responses



- I have a valid license
- My driving privileges are suspended
- I am eligible for a license but cannot afford fees/fines to acquire it
- I have never had a license
- I would be eligible to get my license but don't have the time/ability to do...
- I have a medical condition that prevents me from getting a license
- I am not interested in having a license

## Vehicle Status

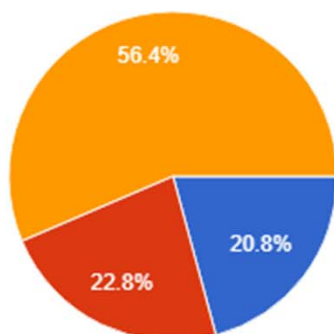
102 responses



- I can afford to keep my vehicle legal and in good running order
- I can afford to keep my vehicle legal and in good running order with hard...
- I cannot afford to keep my vehicle legal and in good running order, it is...
- I cannot afford to keep my vehicle in good running order, I still drive it
- I only drive a borrowed vehicle
- I do not own a vehicle

### Public transportation is ...

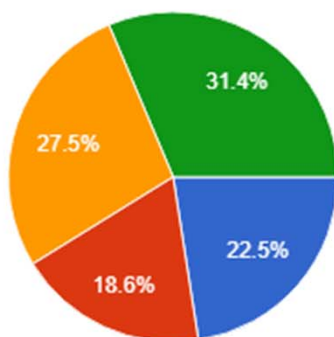
101 responses



- Close to my home and work (or other daily activities)
- Close to my home or my work (or other daily activities) but not to both
- Not close to either my home or work (or other daily activities)

### I use public transportation ...

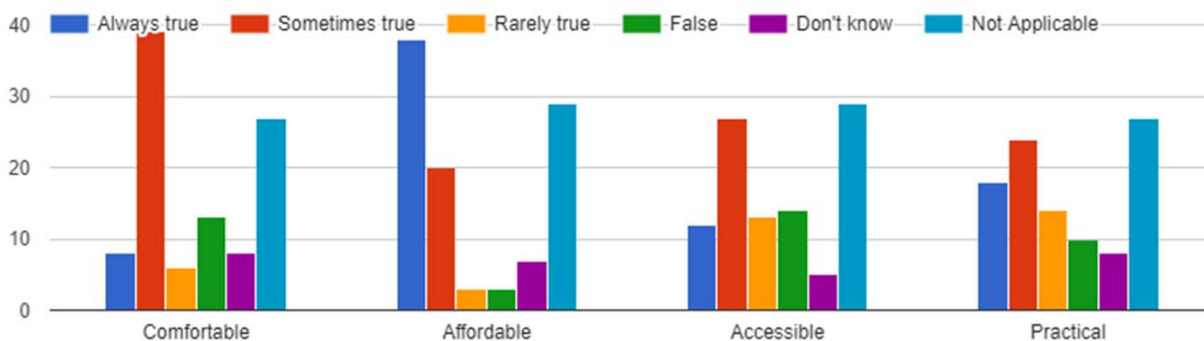
102 responses



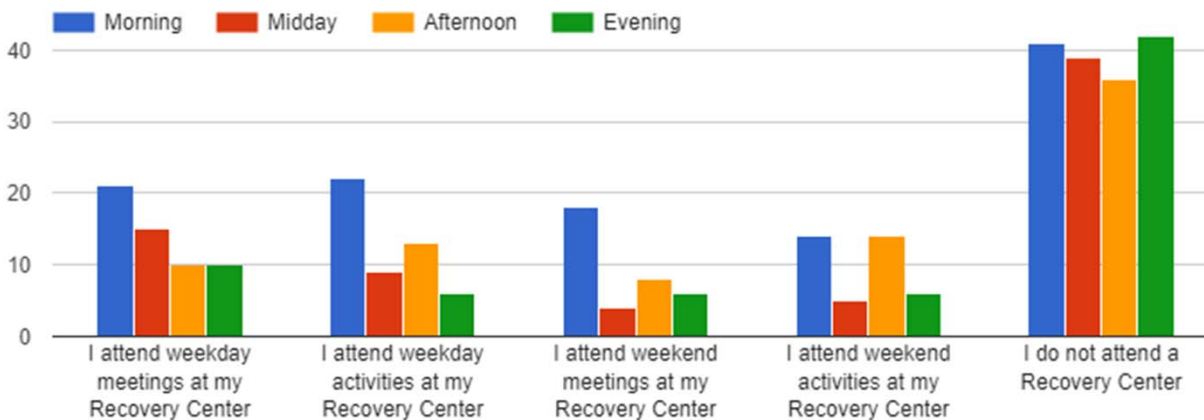
- Regularly
- Sometimes
- Rarely
- Never



### I find public transportation ...

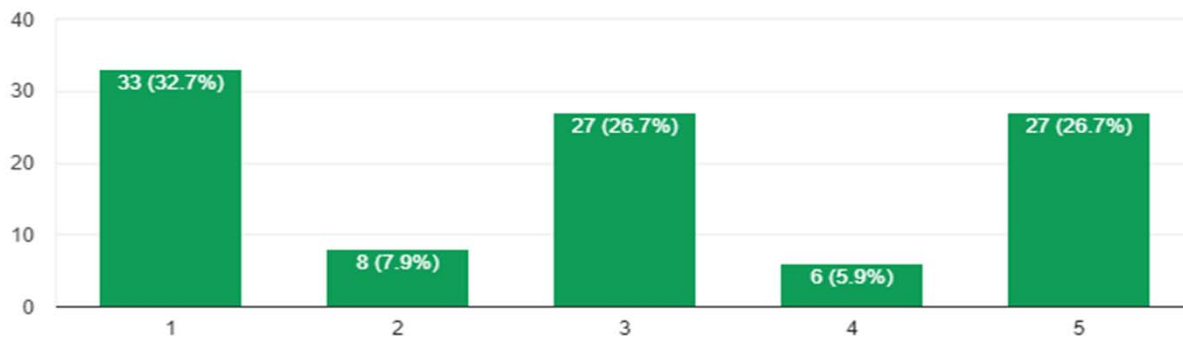


### When do you most frequently use your Recovery Center?



### I attend my Recovery Center ...

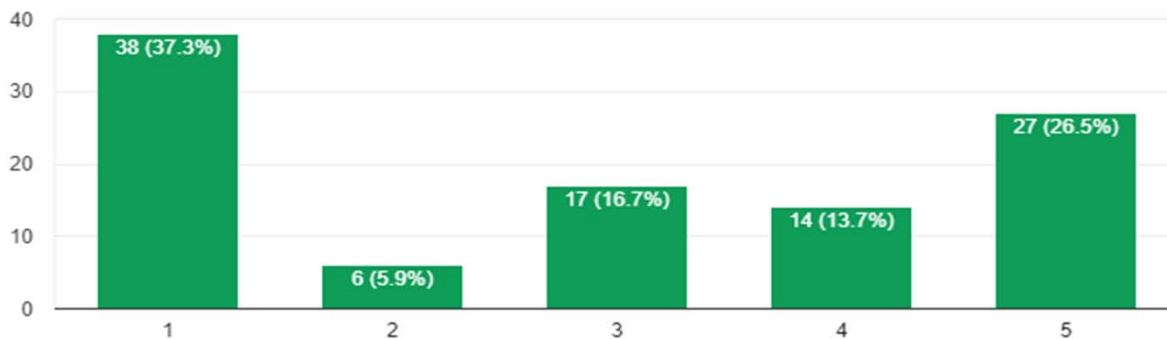
101 responses



On a scale of 1-5 where “1” means *much less than I want* and “5” means *as often as I want*

### To what extent do you feel transportation effects your Recovery Center participation?

102 responses



On a scale of 1-5 where “1” means *not at all* and “5” means *completely*

**Opioid Coordination Council**  
**Working Group Interim Report Template HOUSING**  
**June 2018**  
**DRAFT (under development)**

- 1. Background** People's *big picture realities* matter when identifying considerations to prevent addiction and improve treatment and outcomes for people in recovery. A social determinant of health like stable housing has deep impact on the day-to-day health and the interventions that are needed for individuals and families facing addiction. Early in 2017, when the OCC began to meet, Vermont was and is still facing an affordable housing shortage across the state. This is one more stressor for individuals trying to find recovery.
- 2. The Process** A small group of the OCC began to research and focus on the housing needs specifically of individuals hoping to initiate and to sustain long-term recovery from addiction. We executed a housing survey with the HUBs, Treatment Providers, the Recovery Network, and operators of Recovery Housing. We then created an inventory of Recovery Housing across the state.

From February 2018 to the present time, we have met and discussed housing needs with the VT Coalition to End Homelessness, the VT Affordable Housing Coalition, VT Council on Homelessness, Valley Vista and heard perspectives from 6 Housing Program Administrators and 7 Housing Developers and Public Housing Authorities at the Recovery Committee April and May.

Community Development Corporations (CDCs) and Public Housing Authorities (PHAs) play a key role in helping to better align and focus **combined resources**. They mobilize the assets of community stakeholders through partnerships that provide wraparound services and build social support systems. In April, a statewide housing coalition was formed to specifically focus on this issue. This coalition will represent state-wide affordable housing agencies and act as a conduit for the OCC to the larger state, local and federal housing agencies as well as private landlords.

**A brief case statement/statement of need**

Recovery Housing, a sober living environment with peer to peer recovery support, is a central component of successful long-term recovery; people in recovery, family members and health care providers need access to recovery housing in their area with the understanding that it is a high-quality recovery housing environment.

Housing, rental assistance and support services: Homelessness persists and precarious housing is the norm for too many individuals and families; we need to ensure that in Vermont, all three legs of the stool are funded and available in order to prevent homelessness and promote the strength and resiliency of low income individuals and families seeking support for substance use disorders.

**3. The current status of these services**

Vermont offers programs with individualized support and services, rental assistance and high quality housing in many parts of the state. We can celebrate numerous housing programs and public-partnerships that are meeting the needs for people in recovery and also for those who are not in treatment or recovery and may be abusing substances. **This chart is only a sample of some of them.**

Housing Program or Partnership	How Meets Needs	Limitations
VT AHS (OEO) Family Supportive Housing Program	Intensive ongoing case management and service coordination promoting resiliency parents & children. Includes support of addiction recovery	Program not available in St. Albans, Middlebury, Morrisville, Springfield or Newport. Current programs have waitlist and seek to expand to 2 full time FSH case managers No rental assistance
AHS Department of Mental Health	Services and rental subsidy available	Specific population
AHS Department of Corrections	Sober and supportive living environments (transitional housing) case management & recovery supports	Specific population
Homeless Prevention Center and Landlord Liaison Project (funded in part by AHS HOP grant)	Landlord Liaison focus on getting into permanent housing & retention (prevent homeless episodes) Individualized Housing Support Specialists	In Rutland
Pathways Vermont	Housing First with rental subsidy with a local service team approach self-directed roads to wellness - statewide support line	Regional only, but has a statewide hotline
Champlain Housing Trust and UVM Medical Center	<a href="http://www.getahome.org/housing-is-healthcare">http://www.getahome.org/housing-is-healthcare</a>	In Chittenden County

**4. Any specific gaps revealed in the process**

- Vermont’s regions vary widely in housing and program availability. Strong local partnerships exist but they stand alone in a statewide context.
- There is a lack of recovery housing quality standards. There is no certification or coordinated consumer guidance for those looking for a high-quality recovery housing environment. There is no registry of certified recovery housing.
- There is a lack of quality affordable housing, rental assistance and support services available to meet needs throughout the state.

**5. Potential resources that have been identified through the work of the working group**

Housing funding grant possibilities Vermont Community Development Program (DHCA), Vermont Housing and Conservation Board, NeighborWorks America

**6. Recommendations for inter-department, inter-agency, and public-private collaboration and partnership to begin addressing unmet need.**

- Conduct a comprehensive assessment of need and market study for Recovery Housing throughout the state.

- Expand public awareness and understanding of Recovery Housing
- State level operation support of VTARR, the Vermont Alliance for Recovery Residences to implement quality standard certification processes and provide needed technical assistance activities.
- Family Supportive Housing recommendation (TBD)
- Seek to pilot and expand the Support and Services at Home (SASH) model and framework from serving Medicare eligible residents to include families.
- Include the VT Recovery Network in the VT Housing and Community Development's Consolidated Plan.
- Educate non-profit housing providers, (including naloxone training and distribution) public housing authorities, and private landlords on the challenges, opportunities and resources available for collaborations with local treatment/recovery service partners.
- Encourage housing providers to create a state-wide rapid response approach to addressing housing needs for people with SUD.
- Endorse the recommendation from Vermont Legal Aid supporting amendment to the expungement and sealing laws so that fewer Vermonters have barriers to housing due to criminal records.

**7. A list of working group members:**



**TO:** Jolinda LaClair & Rose Gowdey  
**FROM:** Mairead C. O'Reilly, Esq.  
**SUBJECT:** The Cost of Exclusion: The Case for Addressing Collateral Consequences as a Response to Vermont's Opioid Crisis  
**DATE:** June 7, 2018

## **Issue Statement**

For decades, state and federal drug laws have criminalized substance use and possession. This “War on Drugs” policy guarantees that many Americans who struggle with substance use disorder—especially those from low income and minority communities—have had criminal justice involvement during the course of their addiction. Of the 2.3 million people who were behind bars in 2006 in the United States, 84.8 percent (1.9 million) were “substance involved.”<sup>1</sup> Nearly two-thirds of the U.S. inmate population meet medical criteria of an alcohol or other substance use disorder.<sup>2</sup> Persons incarcerated in prison and jail are seven times more likely to have a substance use disorder than the general population.<sup>3</sup> And full one-third of the 2.3 million incarcerated have a diagnosed mental illness.<sup>4</sup> Vermont’s statistics are not significantly different from the national data; the majority of incarcerated persons in Vermont’s jails and prisons are substance involved, or have a substance use disorder.

Our national policy of arresting, charging, and convicting individuals for drug use and possession impacts justice-involved individuals long after the initial arrest, charge, or conviction. Each criminal justice contact, regardless of the outcome, creates “collateral consequences” for that person, their family and their community—consequences that are often multi-generational.<sup>5</sup> Some of the most common collateral consequences include denials from housing, employment, and educational opportunities. Today, between 80-90% of landlords and employers conduct criminal background checks, to screen their applicants.<sup>6</sup> Unfortunately, these decision-makers routinely reject applicants because of a criminal record, often without assessing the applicant’s rehabilitation—or other mitigating circumstances—that occurred since their criminal justice involvement. Fewer still carefully consider, in the first instance, the relevance of a criminal record to the work or tenancy

<sup>1</sup> THE NAT’L CENTER ON ADDICTION AND SUBSTANCE USE AT COLUMBIA UNIV., BEHIND BARS II: SUBSTANCE ABUSE AND AMERICA’S PRISON POPULATION (2010) (this is 1 in every 133 Americans).

<sup>2</sup> *Id.*

<sup>3</sup> *Id.*

<sup>4</sup> *Id.* A quarter of all prison and jail inmates have both a substance use disorder and a co-occurring mental illness

<sup>5</sup> <https://www.americanprogress.org/issues/poverty/reports/2015/12/10/126902/removing-barriers-to-opportunity-for-parents-with-criminal-records-and-their-children/>

<sup>6</sup> See, e.g., Jeffrey Selbin, et. al., *Unmarked? Criminal Record Clearing and Employment Outcomes*, 108 J. CRIM. L. & CRIMINOLOGY 1 (2018). (Citing study that 87% of large employers surveyed conduct criminal background checks on prospective applicants.)

responsibilities and whether there is any connection between ability to fulfill those responsibilities and the criminal issue. This is due, in large part, to federal and state laws that require background checks for certain employment positions<sup>7</sup> and housing programs, along with employers and landlords fears about incurring legal liability for negligent screening.

The result is that people with criminal records are broadly excluded from habitable housing, stable employment and educational opportunities, which creates an underclass of people who cannot change their material situation, no matter their efforts. The routine exclusion of people with criminal records—and the creation of this underclass—while founded on legitimate assumptions, is not particularly evidence-based.<sup>8</sup> Additionally, these exclusions often create the very risk to public safety that they were ostensibly created to avoid.<sup>9</sup> The routine exclusion is an expensive burden for state governments, as members of this group are often forced to rely on state-based assistance for survival, they are more likely to be repeat players in the criminal justice and emergency healthcare systems.<sup>10</sup>

This exclusion is particularly harmful to individuals who are in recovery and are striving to remake and reestablish themselves as productive and healthy community members. We know that formerly justice involved people who are unable to obtain stable housing or a decent job have a higher likelihood recidivism.<sup>11</sup> And individuals in recovery who cannot obtain stable housing or a decent job are at a higher risk for relapse.<sup>12</sup> This cycle of relapse and recidivism can, and often does, continue for

<sup>7</sup> See, e.g., Selbin et. al., *supra* note 6.

<sup>8</sup> See, e.g., Kurlychek et. al., *Scarlet Letters and Recidivism: Does an Old Criminal Record Predict Future Offending?*, CRIMINOLOGY & PUBLIC POLICY (2006); FAITH E. LUTZE ET AL., *A Multisite Outcome Evaluation of Washington State's Reentry Housing Program For High Risk Offenders*, (2014)

<sup>9</sup> *Id.*

<sup>10</sup> See, e.g., Chaplin et. al., *A Cost-Benefit Analysis of Criminal Record Expungement in Santa Clara County*, Stanford University School of Public Policy, (2014). (Mapping out the government savings in increased tax revenue and decreased government benefits, for individuals who received record clearance assistance.)

<sup>11</sup> See, e.g., Tammy Meredith et al., APPLIED RESEARCH SERVS., INC., *Enhancing Parole Decision-Making through the Automation of Risk Assessment*, (2003) (finding that individuals who were on parole had 25% increase in their likelihood of re-arrest with every change of address during that time); American Correctional Assoc., 135th Congress of Correction, Presentation by Dr. Art Lurigio (Loyola University) Safer Foundation Recidivism Study (August 8, 2005). (According to a study in Illinois that followed 1,600 individuals recently released from state prison, only 8 percent of those who were employed for a year committed another crime, compared to the state's 54-percent average recidivism rate.)

<sup>12</sup> See, Linton, Sabriya L. et al., *The Longitudinal Association between Homelessness, Injection Drug Use, and Injection-Related Risk Behavior among Persons with a History of Injection Drug Use in Baltimore, MD*. DRUG AND ALCOHOL DEPENDENCE 132.3 (2013): 457–465; See also, PEW CHARITABLE TRUSTS, *Massachusetts Uses Job Training as a Path to Sobriety*, July 1, 2015 at <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/07/01/massachusetts-uses-job-training-as-a-path-to-sobriety>; Didenko et. al., *Substance Use: Pathways to Homelessness? Or a Way of Adapting to Street Life?* Accessed December 14, 2016.



years—often because of insufficient intervention rather than solely individual factors. This cycling has an exacting toll on individual, family, community and state resources.<sup>13</sup> And in the current overdose crisis where more relapses are fatal, it is even more imperative that Vermont policymakers and leaders commit to disrupting this cycle of criminal justice involvement and substance use, because doing so will save lives.

## **The Opportunity**

The Scott administration could take several steps to disrupt this cycle and to facilitate more permanent reintegration of this population, by marshaling existing resources and supporting common-sense policy proposals related to collateral consequences of criminal records. The following proposed actions would ultimately safeguard Vermont’s investment into the Hub and Spoke treatment system, by minimizing the risk of recidivism and relapse. And in the current drug overdose crisis, these interventions could literally save lives. The first 5 recommendations are housing-related, recommendations 6-9 are employment-related, and the final recommendation would reach both housing and employment.

(1) Support S. 173<sup>14</sup>, which would:

- a. Amend the expungement statute to automatically seal criminal charges that were dismissed and acquitted; change the “subsequent felony provision” to allow expungement of a qualifying crime after the commission of a felony, so long as 7 years has passed since the felony conviction.
- b. Create a study committee tasked with exploring the viability of automating expungement/sealing of certain convictions and expanding the list of “qualifying crimes” to include additional non-violent felony offenses. Of particular importance to this population are felony drug possession and felony property crime convictions.<sup>15</sup> Currently, only 4 felony offenses are expungement-eligible. That means that a Vermonter with a felony offense will likely have that record for life.<sup>16</sup>

<http://www.heretohelp.bc.ca/visions/housing-and-homelessness-vol4/substance-use-pathways-homelessness>

<sup>13</sup> *Economic Toll of Opioid Crisis in U.S. Exceeded \$1 Trillion Since 2001*,

<https://altarum.org/about/news-and-events/economic-toll-of-opioid-crisis-in-u-s-exceeded-1-trillion-since-2001>

<sup>14</sup> [S. 173](#) is sponsored by Sen. Dick Sears and has been passed by both houses. It is awaiting the Governor’s signature.

<sup>15</sup> Vermont must start considering making these remedies accessible to violent offenders who demonstrate rehabilitation—otherwise, their risk of recidivating remains high.

<sup>16</sup> That is, unless they committed the felony prior to turning 21. Then they could seal their record under 33 V.S.A. 5119(g).

1. *NOTE: The study committee will present their final report to the OCC, to solicit comments and support, before presenting the report to the Joint Justice Oversight Committee in November 2018.*
  2. The OCC has the opportunity to support these modest legislative changes: expanding the list of qualifying crimes to include, at least, several non-violent, drug and property-related felony offenses; automating the expungement process. The OCC could also recommend additional changes to the expungement statute—for example, shortening the eligibility timelines for certain non-violent misdemeanor offenses from 5 to 3 years. And increasing the age of the juvenile sealing statute from 21 to 25.
- (2) Encourage non-profit housing organizations that receive state funding to amend their criminal records admissions policies. The Scott administration could provide model “criminal record” policies to the state grantor agencies;
  - (3) Issue executive branch guidance for all housing organizations and private landlords about their obligations under the Fair Housing Act, as related to the non-discriminatory use of criminal records;
  - (4) Support the expansion of subsidized housing re-entry pilot programs (see, e.g., Burlington Housing Authority’s program with Vermont’s DOC);
  - (5) Support Fair Chance Ordinances at the local level;<sup>17</sup>
  - (6) Disseminate literature and develop training opportunities for employers about their obligations under Vermont’s “ban the box” law. Disseminate literature and develop training for employees about their rights under the “ban the box” law, as it relates to the application and interview process;<sup>18</sup>
  - (7) Issue state-level guidance for employers regarding the use of criminal records, to assist employers balance their legal obligation to comply with the Federal ADA, Civil Rights Act, and Vermont’s Ban the Box law, with their need to screen their employees sufficiently. (See, e.g., EEOC guidance; and include best-practice tips.);

<sup>17</sup> See, e.g., Seattle and San Francisco’s housing and employment Fair Chance ordinances: <http://murray.seattle.gov/wp-content/uploads/2017/06/OCR-Fair-Chance-Housing-ORD.pdf>; <http://www.seattle.gov/laborstandards/ordinances/fair-chance-employment>, <http://www.seattle.gov/Documents/Departments/LaborStandards/OLS-Guide-FCE.pdf>; <http://sfgov.org/olse/sites/default/files/FileCenter/Documents/12136-FCO%20FAQs%20Final.pdf>

<sup>18</sup> <http://ago.vermont.gov/divisions/civil-rights/ban-the-box-law.php> The AG’s website is an excellent start—dissemination and training for employers and employees is necessary.

- (8) Expand re-entry employment programming<sup>19</sup>, including collaborations with legal services providers to develop criminal record expungement services for Vermonters using DOL, VABIR and other state services;<sup>20</sup>
- (9) Offer incentives for employers who hire people in recovery, especially those who were formerly incarcerated;
- (10) Create or support the creation of a Reentry Coalition focused on incarcerated persons with substance use disorders:
  - a. To study best practices from around the country related to housing, employment, and educational opportunities for people in recovery and who have criminal records.
  - b. To pursue partnerships and funding opportunities (SAMSHA and Reentry Housing; DOL and criminal record clearance work).

<sup>19</sup> SEE, E.G., DOL WEBSITE:

<https://www.doleta.gov/Announcements/National-Health-Emergency-Dislocated-Worker-Demonstration-Grant-Program.cfm>

<sup>20</sup> Federal DOL reentry funding provides for a legal services component—in several states, this is being used to create legal clinics for DOL clients, to address records-related issues (among other legal issues). See, e.g., <https://www.doleta.gov/grants/docs/FOA-ETA-18-02.pdf>