The Vermont Department of Health, Division of Substance Use Programs

Substance Use System of Care Needs Assessment: *A Community Perspective*

Report of Findings

December 18, 2024

HEALTH RESOURCES IN ACTION

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Introduction and Purpose

Purpose and Goals of Assessment

The Vermont Department of Health, Division of Substance Use Programs (DSU) aims to help Vermonters prevent and eliminate the problems caused by alcohol and other drug use. DSU's role, in partnership with other public and private organizations, includes leadership, planning, coordination, oversight, evaluation, and support of prevention, as well as early intervention, treatment, and recovery support services for adult and adolescent consumers and their families. DSU also focuses on public education and anti-stigma initiatives while partnering with other state agencies to better serve those affected by substance use.

In Summer 2023, DSU contracted with Health Resources in Action (HRiA) to conduct a comprehensive, community-centered statewide needs assessment of Vermont's substance use system of care. The primary goal was to inform a strategic planning process that would launch in Fall 2024 by capturing the experiences and needs of Vermont residents, particularly those with direct experience with substance use and the state's system of care. This assessment was not designed to be an evaluation of DSU's internal operations or a comprehensive review of DSU's existing efforts, but rather an outward-looking exploration intended to understand the broader community experience and identity ways DSU could respond to the needs expressed by Vermont residents.

Over a six-month data collection period, the assessment specifically sought to identify needs, strengths, and gaps across the substance use care continuum, encompassing harm reduction, prevention, intervention, treatment, and recovery services. The emphasis was on gathering insights from people with lived experience in Vermont's substance use system of care, including those currently engaged in treatment and recovery.

This report provides a summary of findings from the assessment, distilling insights into actionable recommendations, organized by both sector and vulnerable populations. These findings highlight key opportunities for enhancing Vermont's substance use system of care, providing DSU with an understanding of community experiences to incorporate into future planning.

Methods

Stakeholder Engagement

To ensure the assessment process was informed by diverse perspectives across sectors and populations, the DSU Needs Assessment employed a participatory approach, when possible.

This approach helps guide the assessment methods and questions, so they are salient to the community and aids in building support and buy-in at the community level for both the assessment and subsequent planning processes. To this end, DSU identified and recruited thirteen individual stakeholders representing a range of sectors and experiences external to DSU, forming an Advisory Group (AG) for the project. The AG met five times between November 2023 and July 2024 and provided input on methodology, community and stakeholder engagement, suggestions and feedback on qualitative data questions, and helped make connections or warm handoffs during recruitment for interviews and focus groups. Additionally, community members and stakeholders who participated in interviews and focus groups were also used as a source to identify others to engage as part of the assessment data collection.

Qualitative Data Collection

To capture the perspectives and experiences of community members, people with lived experience, organizational leaders, and other stakeholders with connection and insight to the substance use system of care in Vermont, a total of 134 individuals were engaged through interviews or focus group discussions. These types of conversations not only collect critical information on the "why" and "how" behind the data, but also identify the current level of interest, readiness, or political will for future strategies for action. **Table 1** describes the sectors and groups represented in the qualitative data collected.

Table 1. Sectors and Groups Reached through Focus Groups and Interviews

Sector or Perspective Represented	Count of Individuals Engaged
Prevention	**14**
Regional Prevention Consultants	6
Representatives from Vermont Prevention Lead Organizations (VPLOs)	4
Representative from DSU Prevention Unit	3
Representatives from Prevention Coalitions	1
Treatment	**17**
Providers at Spoke Locations	6
Providers at HUB Locations	2
Providers of Treatment to Youth	4
Providers of Residential Treatment	3
Providers of Outpatient Treatment	1
Person using HUB services*	1
Harm Reduction	**7**
Staff of Harm Reduction Programs	3

Person using Harm Reduction Services*	1
Friends/family members of persons with SUD*	3
Recovery	**46**
Recovery Coaches (Hospital & Community)	9
Recovery Housing Staff/Leadership	4
People living in recovery housing*	4
People at recovery centers (Franklin, Windham, and Addison Counties) *	29
Other Sectors	**30**
Housing shelter staff/leadership	12
Staff of Department of Corrections Mental Health program	1
Staff of Domestic Violence program	1
Frontline staff of the Cultural Brokers Program	7
Representative of the State Perinatal Initiative for Substance Use	1
Representative from the Abenaki tribal organization	1
Representatives from veteran serving organizations	7

NOTE: Asterisk (*) denotes participants who were incentivized to participate with a gift card to Amazon or Walmart.

A semi-structured guide was used across all discussions to ensure consistency in the topics covered, with prompts tailored to the specific audience and/or sector engaged. Discussions generally touched upon: perceptions of substance use or trends in the community; factors contributing to substance use in the community; awareness, accessibility, and cultural responsiveness of services; referral to or transition between services, experience with services; perceived success and impact of services; facilitators and barriers to service delivery; perceptions of collaboration across the system of care; identification of emerging needs; and recommendations for service and/or system improvement.

Interviews generally lasted between 30 and 90 minutes, depending upon the number of participants, which ranged from one to three. Focus groups, which were conducted with between four and sixteen participants, generally lasted for 90 minutes. All were led by experienced HRiA facilitators based on a semi-structured guide tailored to the given sector or group being engaged and detailed notes were taken. Individuals who participated based on their own personal experience (i.e., not based on their professional role) were provided Amazon or Walmart gift cards for participation ($100 for an individual interview and $75 if part of a focus group).

All notes taken during qualitative data collection were reviewed for completeness and accuracy by both the facilitator and notetaker before being coded for thematic analysis by the qualitative data analyst. The analyst identified key themes that emerged across all groups and interviews, as well as unique issues pertinent to specific populations. Differences

between groups, such as variations in perspectives or experiences, were carefully examined to highlight any disparities or commonalities. Selected illustrative quotes—stripped of any personal identifying information—are presented throughout the narrative of this report to further clarify and emphasize key points within each topic area.

Review of Secondary Data

To establish the current context of substance use in Vermont and to complement and augment the qualitative data, HRiA reviewed a wide range of existing secondary data from both state and local sources. This data included self-reported responses from surveys, such as the Behavioral Risk Factor Surveillance System (BRFSS), the Youth Risk Behavior Survey (YRBS), and the National Survey on Drug Use and Health (NSDUH), as well as state vital statistics and other relevant health data, including the Vermont Prescription Monitoring System, the Vermont Vital Statistics System, and the Vermont Substance Use Dashboard. Additionally, an environmental scan was conducted to identify and incorporate data from existing reports, data briefs, published literature, and other resources that could further inform the synthesis and interpretation of findings. The sources reviewed included the Vermont Social Autopsy Report, the Health Care Workforce Census, and other pertinent resources.

Limitations of Assessment

As with all research efforts, several limitations related to the assessment's methods should be acknowledged. One of the primary limitations is the use of a convenience sample, which means that while we aimed to reach a broad range of populations, some groups were not fully represented despite being prioritized in the planning process and outreach efforts being made. Thus, some sectors of the system of care may be more extensively represented than others, leading to potential imbalances in the data collected. It is also important to note that the data were collected at a single point in time. Therefore, while the findings are directional and provide a snapshot of the current context, they should not be interpreted as definitive or reflective of long-term trends.

A particular limitation was that people with lived experience were primarily part of the recovery sector discussions. While these individuals provided valuable insights into their direct experiences across different sectors of the system of care, the assessment may not fully capture the perspectives of those who are currently and actively using substances. This gap could mean that the assessment underrepresents the experiences and needs of this critical population.

Qualitative research inherently carries its own set of limitations. Although the focus groups and interviews conducted for this study offer rich, detailed insights, the results are not statistically representative of the broader population due to non-random recruitment techniques and the small sample size. Recruitment was generally facilitated by community organizations, which means that participants were often those already engaged in community programming. As a result, the responses gathered might reflect a particular perspective, potentially overlooking other viewpoints within the community. And while efforts were made to engage a diverse cross-section of individuals, demographic data were not systematically collected from focus group and interview participants. Consequently, we cannot confirm whether the participants accurately reflect the demographic composition of the broader population, which may affect the generalizability of the findings.

Finally, the review of secondary data, though comprehensive, was not exhaustive. Emphasis was intentionally placed on qualitative data collection for this assessment to identify and capture new information that had previously gone unexamined by DSU, especially considering that DSU already has a comprehensive system for analyzing and disseminating secondary data findings. Instead, secondary data was used selectively—to fill gaps in the qualitative findings, provide important context, add to the interpretation of findings, or reinforce key themes that emerged. This approach allowed for the complementing of rich insights gathered from direct feedback without duplicating the state's robust ongoing data monitoring efforts.

Additionally, the secondary data itself presents some notable limitations. Some data sources were not fully current and may predate key recent events or policy changes within Vermont. Also, the COVID-19 pandemic created unique disruptions across many quantitative data sources, impacting both the timing and methodology of data collection, and which may result in trend data anomalies. However, pandemic-related interventions and shifting behaviors may have altered typical patterns and data comparisons pre- and post- COVID-19 may reflect real change in the metric being reported. Caution is therefore recommended when interpreting trends from this period.

Context of Vermont

General Overview of DSU

The Vermont Department of Health takes a public health approach to supporting health promotion, prevention, intervention, treatment, harm reduction, and recovery services to prevent, reduce and eliminate the health impacts of alcohol, cannabis, opioid and other drug use. Most of the Health Department's substance use-related work is led by the Division of Substance Use Programs (DSU), but Vermont's public health approach benefits from significant collaboration with other divisions of the health department such as the Divisions of Emergency Preparedness, Response, and Injury Prevention, Health Statistics and Informatics, Family and Child Health, and Health Promotion and Disease Prevention.

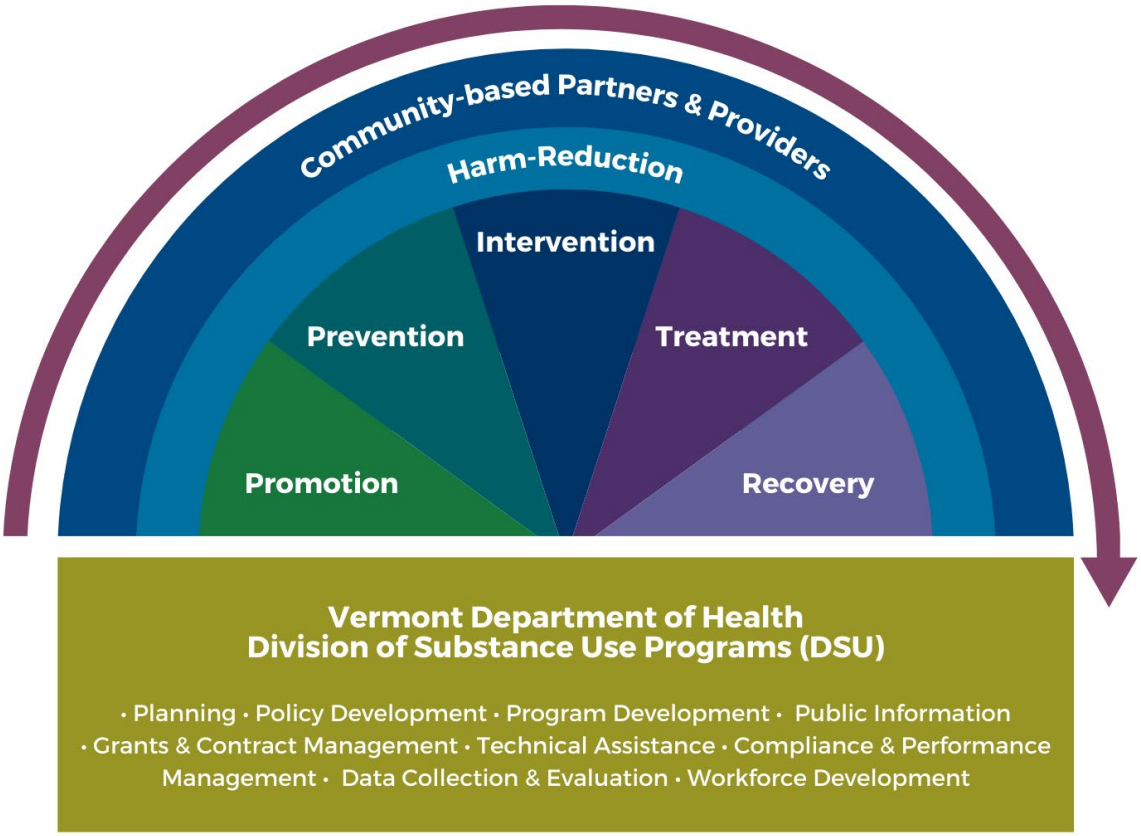
DSU also supports Vermont's integrated Hub and Spoke opioid treatment network. According to Vermont's Blueprint for Health, which leads the model of care, **"Hub and Spoke is Vermont's system of treatment for opioid use disorder (OUD). Nine Regional Hubs offer daily support for patients with complex addictions. At over 75 local Spokes, doctors, nurses, and counselors offer ongoing OUD treatment fully integrated with general healthcare and wellness services."** DSU leads the health department's contribution to the interdepartmental oversight for the program, helping communities monitor treatment needs, waitlist length, average time to treatment, and program performance.

DSU also partners with communities, local organizations, and partners at state and national levels to make programs and services available and accessible to Vermonters. The health department and DSU leverage local, state, and national data to plan and guide program improvements, and to support Vermont's statewide system of providers that provide substance use services.

DSU Programmatic Context

The Division of Substance Use Programs (DSU) works with providers and community partners to sustain and improve Vermont's substance use system of care (**Figure 1**). In addition to continuous quality improvement efforts, DSU leads large scale initiatives to enhance service delivery and tailor funding to meet the needs of the state including enhancing the opioid use disorder (OUD) treatment system and increasing access to services.

Figure 1. Vermont Substance Use Disorder System of Care



Concurrent with the data collection activities for this assessment of the system of care, several process improvement projects were underway in Vermont. As of March 2024, such efforts included:

- **Opioid Use Disorder Treatment Enhancements - *Hub Expansion Pilot:*** The Agency for Human Services received approval from the Vermont State Legislature in June 2023 for a two-year Hub and Spoke Expansion pilot (Act 78). The goal is to enhance the quality, depth and breadth of care for people with substance use disorder (SUD) and co-occurring conditions, emphasizing mental health, physical health and polysubstance use disorders. ***Medication Dosing Units (MDU):*** This expansion also includes the implementation of satellite locations to provide Medication Dosing Units (MDU), with the intention of increasing geographic equity in access to medications for opioid use disorder (MOUD) for Vermonters (Act 22).
- **Expanding SUD Services Access Under 1115 Waiver -** In 2022, Vermont received approval from the Centers for Medicare and Medicaid Services (CMS) to expand 1115 initiatives intended to enhance and expand access to critical SUD treatment and recovery

services across the state. ***Recovery Services:*** The Vermont Agency of Human Services (AHS) has received approval from CMS to develop a benefit for people on Medicaid that would reimburse for direct recovery services. ***Withdrawal Management:*** Vermont is working towards establishing clinically managed residential withdrawal management programming as a Medicaid reimbursable benefit to enhance access and quality of services for people with substance use disorder (SUD). Though this service is currently available in Vermont, the objectives of this enhancement are to increase the number and enhance accessibility of clinically managed residential withdrawal management programs (certified and funded by the Health Department) to be reimbursed through Medicaid, and provide long-term, sustainable funding for clinically managed residential withdrawal management programs through Medicaid reimbursement for Vermonters covered by Medicaid.

Legislative Context

The following list highlights several relevant and significant legislative actions that have occurred between 2023 and 2024, and which may have significant implications for Vermont's system of care. For detailed information on these actions, click the links below to access a PDF summary of the act.

- ***An act relating to a harm-reduction criminal justice response to drug use (H.72)***
- ***An act relating to reducing overdoses (H.222)***
- ***An act relating to miscellaneous cannabis amendments (H.612)***
- ***An act relating to peer support provider and recovery support specialist certification (H.847)***
- ***An act relating to the establishment of the Psychedelic Therapy Advisory Working Group (S.114)***
- ***An act relating to the systemic evaluation of recovery residences and recovery communities (S.186)***

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Key Themes

Findings from data collected through focus groups, interviews, the secondary data review, and the environmental scan were compiled, reviewed, and synthesized to identify a set of key themes and associated sub-themes, which serve as the unifying framework for the findings (**Table 2**). The key themes represent the overarching areas of need identified through the needs assessment process. The sub-themes associated with each key theme provide more detailed insights within these broad areas and help to pinpoint specific targets for future action. Importantly, each theme and sub-theme transcends any single sector of the system of care, population, or topic, offering a cohesive framework that supports strategic planning efforts and guides actionable steps across the entire system of care.

How to Use This Report

As readers proceed through the body of the report, they will find that it delves into sectors, populations, and topics separately, offering specific findings and tailored recommendations within each section. The key themes and sub-themes serve as a roadmap or lens to view these detailed sections, helping to unify and contextualize the information presented.

Table 2. Key Themes and Sub-Themes Identified

Key Theme / Core Area of Need Identified	Sub-Theme / Specific Target of Action
Access to Care	Systemic Challenges
	Transportation
	Language Accessibility
	Impact of Stigma
	Social Determinants of Health
Expansion of Services or Supports	Harm Reduction
	Prevention and Intervention
	Outpatient Treatment
	Residential Treatment
	Recovery and System of Support
Coordination and Collaboration	Community Based Organizations
	Mental Health
	Schools

	Healthcare
	Legislature
	System of Care
Training, Education, and Awareness	Education
	Provider Training
	Cultural Responsiveness
	Awareness
Resources and Capacity	Workforce
	System Fragmentation
	System Capacity
	Funding and Sustainability

Current State of Substance Use in Vermont

Prevalence of Substance Use

This section details the prevalence of substance use and substance use disorders in the state of Vermont. **Figure 2** highlights areas where Vermont ranks among the top 5 states for several indicators of substance use, with the state having the greatest prevalence of cannabis use in the country.

Figure 2. Top 5 States for Prevalence of Substances Used and Substance Use Disorder, 2021/2022

	In past month		In past year	
	Alcohol	**Cannabis**	**Cocaine**	**Substance Use Disorder**
1	New Hampshire 58.7%	**Vermont 24.2%**	Colorado 2.8%	Alaska 23.0%
2	Wisconsin 58.3%	Alaska 21.9%	**Vermont 2.8%**	New Mexico 22.8%

3	**Vermont 57.2%**	Oregon 21.8%	Rhode Island 2.5%	Colorado 22.0%
4	Connecticut 56.5%	New Mexico 21.3%	Massachusetts 2.4%	Oregon 21.9%
5	North Dakota 55.6%	Washington 21.1%	California 2.3%	**Vermont 21.8%**

DATA SOURCE: 2021/2022 National Survey on Drug Use and Health
NOTE: Data is among people aged 12 and older. Not included in ranking, the District of Columbia has an alcohol use rate of 62.7% and a cocaine use rate of 2.6%.

Community Concern

When asked what they liked about Vermont, interviewees and focus group members praised its rural beauty and close-knit, small communities. However, they also revealed some substantial community concerns, with substance misuse being a primary issue. Substance misuse, they noted, affects Vermonters across all income levels, areas, and age groups. It is also, participants reported, increasingly intergenerational. Among substances used, participants cited alcohol, cannabis, and an ever-growing list of high-risk substances including opioids and stimulants. A few people shared that substance misuse is more prevalent than current statistics might indicate because, as one community participant explained, ***"[people] are not self-identifying because of the stigma and are not seen because they have the resources to house and help manage the loved ones' needs."***

Echoing the input of participants in this DSU assessment, the recently completed ***Vermont State Health Assessment 2024*** determined that mental health and substance use were among the top concerns that arose across all communities and sub-populations that were engaged in the process. These populations included older adults, Indigenous peoples, people of color, the LGBTQ+ community, unhoused people, and people with disabilities.

Alcohol

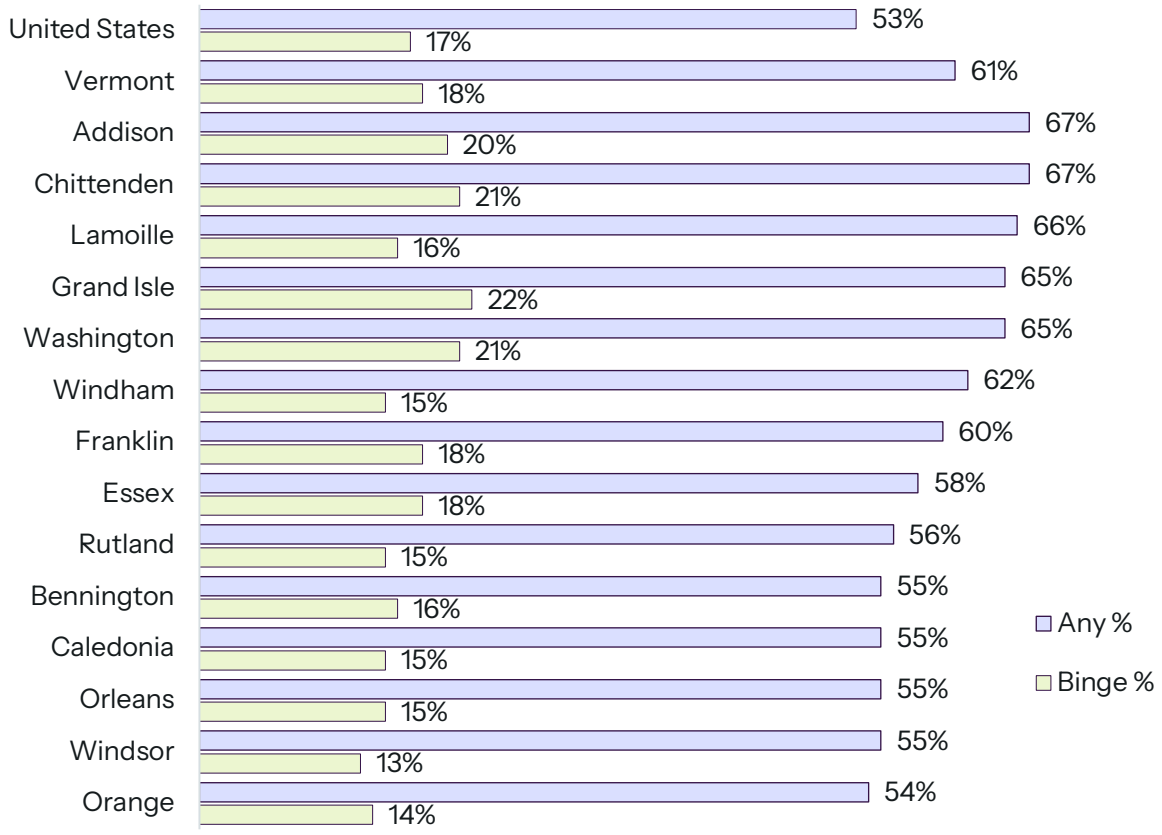
Although recent public focus has been on opioids, interviewees and focus group participants working across Vermont's system of care described alcohol misuse as most prevalent in the state. A treatment sector participant stated that alcohol, accounting for 40% of admissions, tops the list of substance-related issues. A recovery sector participant echoed this observation stating, ***"alcohol is by far our number one issue."*** Alcohol Use Disorder (AUD) is also frequently seen in hospital emergency departments (EDs) and primary care settings. Another treatment sector participant stated, ***"AUD is a huge issue in our EDs, and it's still***

the number one reason people seek services in the ED." Participants working with veterans, indigenous communities, newcomers, and older residents all stated that among the groups they work with, alcohol misuse is the most common substance-related problem they encounter.

> ***"Alcohol is number one, and it kills more folks per year than anything, and it's often not discussed because of the focus on opiates the last decade."*** – Treatment Sector

Figure 3 shows that the prevalence of current alcohol consumption is 8% higher among Vermonters than that of the United States overall. The greatest percentage of residents consuming any amount of alcohol in the past month are in Addison and Chittenden counties (67%), while the greatest proportion of residents who report binge drinking in the past month are in Grand Isle County (22%).

Figure 3. Alcohol Consumption (Any and Binge) in Past Month, By US, State, and County, 2022



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS) and 2022 Vermont Behavioral Risk Factor Surveillance System Report
NOTE: Binge drinking is defined for males as consuming five or more drinks and for females as consuming four or more drinks in one sitting.

When examining data across demographic groups in the state, residents with income greater than $75,000 have the greatest proportion of individuals who report any amount of drinking (74%), while young adults aged 18-24 have the highest proportion of individuals reporting binge drinking (31%) (**Table 3**). Additionally, state data from 2020 indicate that 11% of pregnant people consume alcohol (any amount) during pregnancy.[1]

Table 3. Alcohol Consumption (Any and Binge) in Past Month, By Demographic Characteristic, 2022

	Any %	Binge %
Male	63%	22%
Female	59%	14%
18-24	56%	31%
25-44	69%	26%
45-64	63%	17%
65+	54%	5%
Low <$25K	42%	17%
Middle $25K-<$50K	50%	15%
High $50K-<75K	65%	17%
Highest $75K+	74%	22%
White, non-Hispanic	62%	18%
BIPOC	55%	21%
Non-LGBTQ+	61%	17%
LGBTQ+	65%	25%
No Disability	66%	19%
Any Disability	48%	15%

DATA SOURCE: 2022 Vermont Behavioral Risk Factor Surveillance System Report
NOTE: Binge drinking is defined for males as consuming five or more drinks and for females as consuming four or more drinks in one sitting.

Data from the Youth Risk Behavior Survey also shows alcohol use among Vermont high schoolers, with nearly half (47%) of students having tried alcohol in their lifetimes and a

[1] Vermont Department of Health. (2020). *Pregnancy Risk Assessment Monitoring System (PRAMS) Vermont, 2020*. Vermont Department of Health. https://www.healthvermont.gov/stats/population-health-surveys-data/pregnancy-risk-assessment-monitoring-system-pram

quarter (25%) having consumed alcohol in the past month (**Table 4**). While students use alcohol at similar rates when compared by gender, race and ethnicity, and LGBTQ+ identity, the proportion of students using alcohol in 2021 increases as student grade level increases, with 26% more seniors (37%) currently using alcohol than freshmen (11%).

Table 4. Alcohol Use (Lifetime, Current, and Binge) Among High School Students, By Demographic Characteristic, 2021

	Lifetime %	Current %	Binge %
United States	N/A	**23%**	**11%**
Vermont	**47%**	**25%**	**12%**
Male	43%	23%	11%
Female	50%	27%	13%
Grade 9	29%	11%	4%
Grade 10	42%	20%	9%
Grade 11	54%	31%	15%
Grade 12	62%	37%	21%
White, non-Hispanic	48%	25%	13%
BIPOC	42%	22%	11%
Non-LGBTQ+	46%	25%	13%
LGBTQ+	50%	24%	11%

DATA SOURCE: High School Youth Risk Behavior Survey United States 2021 Results, and 2021 Youth Risk Behavior Survey, Vermont Department of Health

Opioids, Fentanyl, and Other Illicit Drugs

While statistics and anecdotal evidence point to a higher prevalence of alcohol misuse among Vermonters, participants across focus groups and interviews expressed greatest concern about growing rates of high-risk substance use. In just a decade, the landscape of substance misuse has shifted dramatically. Opioid use, participants report, is high, but of greater concern is the rise in use of the more dangerous synthetics fentanyl and xylazine. These substances, often cut into heroin, cocaine, and methamphetamines, are also increasingly used on their own, with devastating effects, including overdose deaths. One social sector participant observed, ***"I can't believe we're talking about heroin as the safe alternative nowadays."*** Interviewees working in recovery and Hubs also reported high rates of stimulant use among people to whom they provided care, especially crack cocaine and

methamphetamines. To a lesser extent they reported working with people abusing Adderall and other stimulants.

Ease of access to high-risk substances was mentioned by several participants. Some pointed to a growth of suppliers in the state, particularly Burlington and along the I-91 corridor, that has proliferated the supply in smaller Vermont communities. Substances, especially synthetics, are available on the dark web, as well as at Vermont's many concerts and festivals. Overall, several participants from the harm reduction sector explained, use patterns reflect what is available; one person shared, ***"people are at the mercy of what's out there; if their dealer was a meth dealer and now deals crack, that's what they will be using."*** A few people also shared that while, historically, high-risk substances were expensive, which put them out of reach for some individuals, newer synthetic drugs are cheaper.

Hallucinogens are the most misused high-risk substance among young adults in Vermont (17.4%), followed by prescription drugs (10.5%) and cocaine (7.4%). Prevalence of high-risk substance use is slightly higher amongst males in all categories (**Table 5**).

Table 5. Substance Use in Past Year Among Young Adults, by Sex, 2022

	Hallucinogens	Prescription Drug Misuse	Cocaine	Heroin
Vermont	**17.4%**	**10.5%**	**7.4%**	**1.8%**
Male	19.7%	12.5%	8.8%	3.0%
Female	15.4%	8.4%	5.9%	0.6%

DATA SOURCE: Vermont Young Adult Survey 2022

Cannabis

Cannabis is legal for medicinal and recreational uses in Vermont. Cannabis was legalized for medicinal use in 2004, decriminalized in 2013, and legalized for adults 21 and older in 2018. As of October 2022, cannabis has been sold in retail markets[2] and as of July 2024, there are 78 cannabis retailers in the state of Vermont.[3]

Several participants stated that cannabis use is increasing in the state, across all age groups, but particularly among youth. One adolescent treatment provider stated that two-thirds of treatments in their facility was related to cannabis use. Several participants attributed the growth in cannabis use to legalization, which has led to the perception that using is "not a big deal". Cannabis use among youth has risen, according to participants, as a form of self-

[2] Vermont Department of Health. (2024). Cannabis regulatory landscape: Changes in cannabis access and use. Vermont Department of Health. https://healthvermont.gov
[3] State of Vermont Cannabis Control Board. (2024). Licensed cannabis products, establishments, and employees. State of Vermont Cannabis Control Board. https://ccb.vermont.gov/licenses

medication and to cope with anxiety. Easy availability of vapes and the ability to hide use have also contributed to its popularity, according to treatment providers.

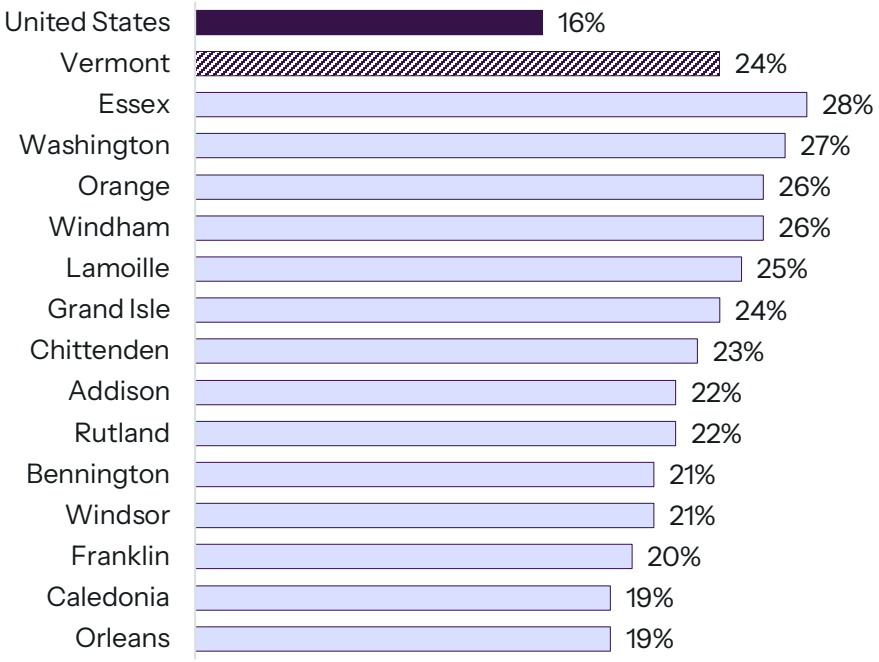
> ***"The ubiquity and the ease of access make [cannabis] easy and undetectable. You can smoke a cart[ridge], and it is undetectable; you're not smoking a joint in the dugout anymore."*** – Treatment Sector

Legalization of cannabis, participants shared, has normalized cannabis use and the subsequent growth in dispensaries has made this substance more accessible, contributing to rising rates of misuse. The small size and popularity of vapes has contributed to increased use of cannabis and nicotine, particularly among youth. Research examining the long-term effects of cannabis use is still new, participants shared, but one participant pointed to early evidence of the negative effects of THC on the brain development of young people. An adolescent treatment provider noted that use of cannabis can lead to increased anxiety and potentially psychosis in teens.

> ***"You can go to the store and buy [cannabis] like buying candy. And the nicotine and Juuls being advertised to middle schoolers."*** – Social Services Sector

Nearly one quarter (24%) of Vermonters currently used cannabis in 2022, compared to 16% of the United States overall (**Figure 4**).

Figure 4. Any Cannabis Use in Past Month, By US, State, and County, 2022



DATA SOURCE: 2021/2022 National Survey on Drug Use and Health, 2022 Vermont Behavioral Risk Factor Surveillance System Report. NOTE: Data is among people aged 12 and older.

Within demographic groups, over a third of young adults aged 18-24 (36%), adults aged 25-44 (34%), and LGBTQ+ communities (39%) used cannabis in the month prior to being surveyed (**Table 6**).

Table 6. Any Cannabis Use in Past Month, By Demographic Characteristic, 2022

	%
Male	28%
Female	19%
18-24	36%
25-44	34%
45-64	23%
65+	11%
Low <$25K	31%
Middle $25K-<$50K	25%
High $50K-<75K	25%
Highest $75K+	23%
White, non-Hispanic	23%
BIPOC	27%
Non-LGBTQ+	22%
LGBTQ+	39%
No Disability	22%
Any Disability	29%

DATA SOURCE: 2022 Vermont Behavioral Risk Factor Surveillance System Report

One-fifth of Vermont high schoolers reported current use of cannabis, compared to 16% of high school students in the country overall (**Table 7**). In Vermont, 16% of 9th graders reported ever trying cannabis, with that proportion jumping to nearly half of Grade 12 students (46%). These data further indicate that among high school students who currently use cannabis, 21% of them are using it at least once a day.

Table 7. Cannabis Use (Lifetime and Current) Among High School Students, By Demographic Characteristic, 2021

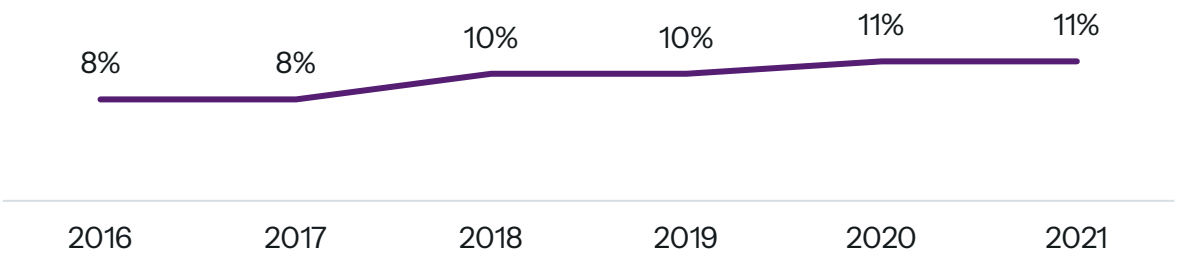
	Lifetime %	Current %
United States	**28%**	**16%**
Vermont	**31%**	**20%**
Male	29%	19%

Female	33%	21%
Grade 9	16%	9%
Grade 10	27%	17%
Grade 11	36%	24%
Grade 12	46%	30%
White, non-Hispanic	31%	20%
BIPOC	31%	21%
Non-LGBTQ+	29%	18%
LGBTQ+	37%	25%

DATA SOURCE: 2021 Youth Risk Behavior Survey, Vermont Department of Health

Between 2016 and 2021, the proportion of pregnant persons using cannabis has grown by 3%, with 11% reporting use during pregnancy in 2021 (**Figure 5**).

Figure 5. Trend in Cannabis Use Among Pregnant Persons in VT (2016-2021)



DATA SOURCE: Cannabis Adult Health Concerns, Vermont Department of Health, 2024

State data from 2021 and 2022 show that the most common methods for cannabis use were smoking, vaping, and consuming edibles.[4,5,6] Popularity of each method varied between age groups.[7] Smoking cannabis was the most reported method among youth (76%), young adults (86%), and adults (68%). Nearly half (43%) of young adults using

[4] Vermont Department of Health. (2021). Youth Risk Behavior Survey. Vermont Department of Health.
[5] Vermont Department of Health. (2022). Vermont Young Adult Survey. Vermont Department of Health.
[6] Vermont Department of Health. (2022). *Behavioral Risk Factor Surveillance System Report*. Vermont Department of Health.
[7] Note: Respondents to this question in the Young Adult Survey were able to make multiple selections, while respondents to the YRBS and the BRFSS were asked to select only their primary method of consumption. The YRBS and BRFSS cannot be directly compared to the Young Adult Survey.

cannabis reported use of edibles and a third (33%) reported vaping. Youth and adults reported using vapes at similar rates (10%), while adults were more likely to use edibles (19%) than youth (9%).

Tobacco and Electronic Vapor Products

Vapes, participants noted, have also made tobacco more accessible, which has contributed to a rise in nicotine use and addiction. According to participants, vaping has changed how nicotine is used. As one treatment sector participant explained, ***"...because you can use it so often and not the natural restrictions that came with cigarettes. And it's being used as a primary coping and emotional management tool more than in the past; It's like a pacifier now, a literal pacifier."*** Participants also noted that flavoring and marketing has made tobacco attractive to children and youth. These factors have contributed to a concerning rise in nicotine addiction among youth.

> ***"A lot of the kids know they are addicted to vaping and they don't like it, but they can't stop. I was talking to a kid who the whole time he is in school is going through withdrawal, and he is going through serious withdrawal."*** – Treatment Sector

State data from 2022 shows that 13% of Vermont adults currently smoke combustible cigarettes and 6% of Vermont adults currently use electronic vapor products (EVPs).[8] Age groups with the highest rates of use were 55 to 64 years for combustible cigarettes (18%) and 18 to 24 years for EVPs (22%). Among high school students, data from 2021 showed that 16% are currently using EVPs (**Table 8**). Nearly double that proportion (36%) of young adults reported current use of EVPs.

Table 8. Current Tobacco/Electronic Vapor Product Use Among Young Adults and High School Students, by Demographic Characteristic, 2021/2022

Young Adults (18-25), 2022	
Vermont (n=1,538)	**36%**
Male (n=477)	41%
Female (n=1,056)	30%
High School Students, 2021	
Vermont	**16%**
Male	15%

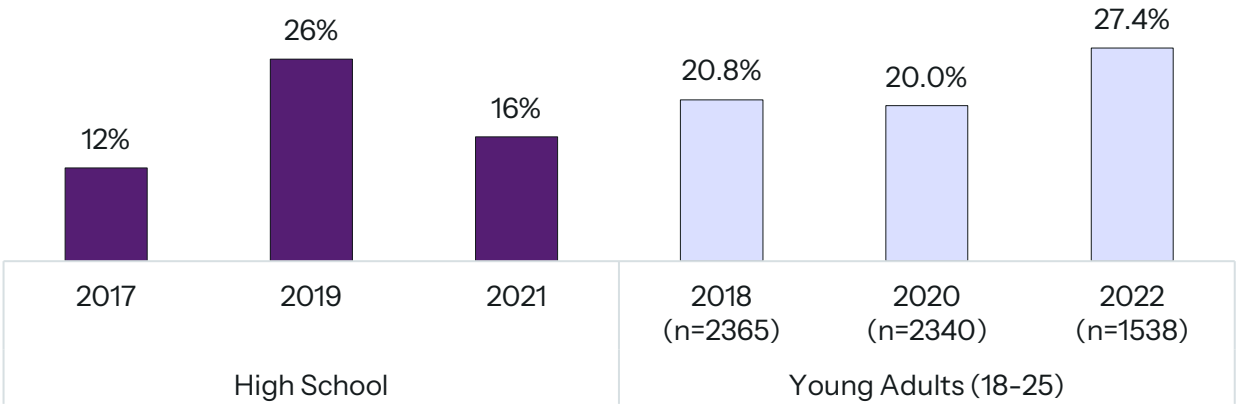
[8] Vermont Department of Health. (2022). *Behavioral Risk Factor Surveillance System Report*. Vermont Department of Health.

Female	18%
Grade 9	9%
Grade 10	14%
Grade 11	19%
Grade 12	23%
White, non-Hispanic	16%
BIPOC	18%
Non-LGBTQ+	15%
LGBTQ+	19%

DATA SOURCE: Vermont Young Adult Survey 2022; 2021 Youth Risk Behavior Survey, Vermont Department of Health; NOTE: Tobacco products include cigarettes, cigars, or smokeless tobacco products.

Use of electronic vapor products containing nicotine has fluctuated among young people throughout the years. Based on available data, use among high schoolers peaked in 2019 at 26% and decreased to 16% in 2021 (**Figure 6**). Use among young adults grew between 2018 and 2022, increasing by 6.6%.

Figure 6. Trend in Use of EVPs Containing Nicotine Among Young Adults and High School Students (2016-2021)

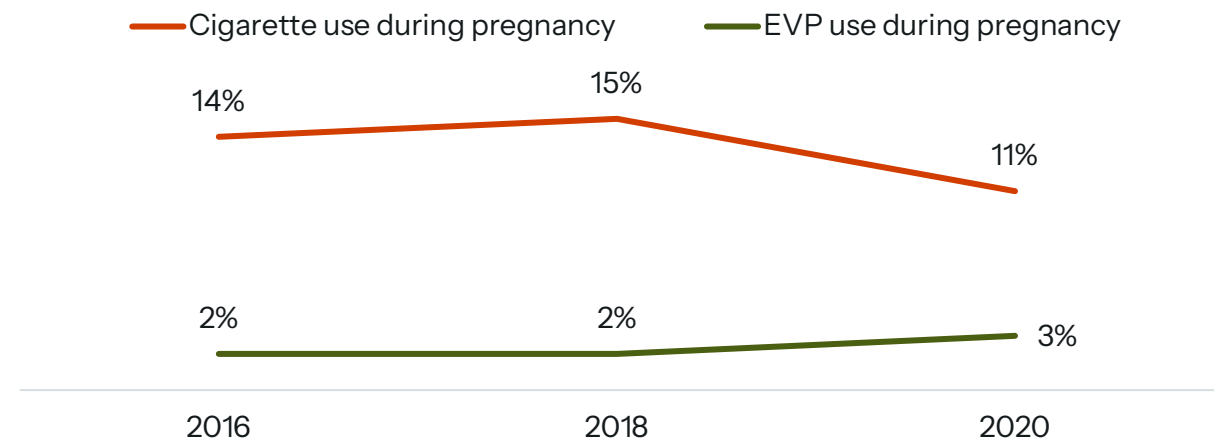


DATA SOURCE: Vermont Young Adult Survey 2022; 2019 and 2021 Youth Risk Behavior Survey, Vermont Department of Health; NOTE: Refers to electronic vapor products containing nicotine, not cannabis. Current use refers to use in the past 30 days. For the 2018 survey, this percentage includes only respondents who reported that the vaping product usually contained nicotine and therefore is probably a slight underestimate of any use of a vaping product containing nicotine.

State data from 2021 indicate that the most frequently identified reasons for using EVPs among high school students who currently use them were 'to get a high or buzz' (i.e., boredom) (32%) and 'was feeling anxious, stressed' (i.e., mental health) (30%). Additionally, data showed that among current users of EVPs, 30% were using them on at least a daily basis.[9]

Among pregnant persons, 11% used cigarettes during pregnancy in 2020 compared to 3% using EVPs (**Figure 7**).

Figure 7. Trend in Cigarette and EVP use Among Pregnant Persons in VT (2016-2020)



DATA SOURCE: Vermont Department of Health Vermont PRAMS Highlights, 2016, 2018, and 2020

Perceived Ease of Access

When young adults aged 18 to 24 were asked about ease of access to substances for underage persons, most survey respondents reported cannabis (74%) as easily accessible, followed by electronic vapor products (53%). When thinking about easy access to high-risk substances amongst young adults in general, stimulants without a prescription were most reported (34%) (**Table 9**).

Table 9. Perception that it is Very or Somewhat Easy to Access Substances Among Young Adults in Vermont (2022)

	All (n=1,538)	Age 18-20 (n=526)	Age 21-25 (n=1,012)
Easy for underage persons to access			
Alcohol in stores	31.0%	27.6%	33.6%
Alcohol in bars/restaurants	21.3%	16.6%	24.7%
Cannabis	74.2%	73.1%	75.1%

[9] Vermont Department of Health. (2021). Youth Risk Behavior Survey. Vermont Department of Health.

Cigarettes	39.1%	35.5%	41.7%
E-cigarettes or other electronic vapor products	52.6%	54.6%	51.2%
Easy for young adults to access			
Cocaine	18.8%	N/A	N/A
Rx pain relievers without prescription	17.9%	15.6%	19.6%
Stimulants without prescription	33.5%	30.0%	36.0%
Buprenorphine without prescription	10.3%	N/A	N/A

DATA SOURCE: Vermont Young Adult Survey 2022

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Drivers of Substance Use

There are many drivers and factors that contribute to an individuals' likelihood of substance use. Based on the literature, drivers include boredom, family history, genetic factors, peer relationships, co-occurring disorders, and social environment, among others.[10] Traumatic experiences such as violence, abuse, neglect, and family or social conflicts have also been identified as key drivers of substance use later in life.[11,12] When asked about root causes of substance use in Vermont, participants cited boredom, loss of stability and opportunity, trauma and related mental health issues.

Several participants suggested that, despite Vermont's beauty, activities in communities are limited, especially for younger people, which can contribute to boredom. One participant from the recovery sector described, ***"there's no opportunity to do anything other than go to a field and get drunk and it's the same still except even younger. We started in 9th; they' re starting in 5th or 6th."*** A prevention sector participant shared a similar perspective saying, ***"many people say 'there's nothing to do here' and 'the only place to go to meet [other young] people is the bars.'"***

Lack of opportunity and loss of financial stability, especially since COVID, also contributes to substance misuse according to participants from across sectors. Vermont's high cost of living has led to a feeling that people can't get ahead, several interviewees explained. One

[10] Alhammad, M., Aljedani, R., Alsaleh, M., Atyia, N., Alsmakh, M., Alfaraj, A., Alkhunaizi, A., Alwabari, J., & Alzaidi, M. (2022). Family, individual, and other risk factors contributing to risk of substance abuse in young adults: A narrative review. Cureus, 14(12), e32316. https://doi.org/10.7759/cureus.32316
[11] National Institute on Drug Abuse. (2024, February 6). Trauma and stress. Retrieved August 20, 2024, from https://nida.nih.gov/research-topics/trauma-and-stress
[12] Roche, D. J. O., & Foster, K. T. (2023). Trauma and substance misuse: Charting heterogeneity in comorbidity dynamics, vulnerable populations, and treatment adaptation. Journal of Dual Diagnosis, 19(4), 177–179. https://doi.org/10.1080/15504263.2023.2260325

recovery sector participant shared, ***"we live in a rural depressed area with a heyday of over 50 years ago and there isn't a lot of industry or employment. Folks are scared and not sure what to do and dying quickly in that process."*** Many participants spoke about the high cost of housing in Vermont and very limited affordable housing options. They observed that this creates additional barriers for individuals and families to achieve financial stability and has contributed to rising rates of homelessness across the state. These conditions can also contribute to substance misuse.[13]

Participants most frequently mentioned the connection between mental health concerns and substance misuse. Many stated that rising rates of anxiety, depression, stress, and more serious mental health concerns, have contributed to substance misuse in the state. For example, they shared that young people who are dealing with anxiety and depression might smoke or use cannabis. A senior resident experiencing isolation may have a few drinks. A veteran who has sustained injuries might turn to street drugs for long-term relief. As a treatment sector participant shared, ***"what I see going on in the communities is very much tied into this massive mental health crisis we are in and a subgroup of those struggling with those issues who have adopted use of substances as a primary coping ability."***

As an indicator of the prevalence of mental health conditions among substance use treatment clients, data from a Vermont-based evaluation of a subset of high-risk Hub and Spoke clients in 2019 can be considered.[14] In it, the authors reported that 34% of the 442 clients in the cohort had severe depressive symptoms at baseline, 65% had severe anxiety, and 39% met criteria for PTSD. These data confirm that people entering treatment for SUD frequently present with co-occurring mental health conditions.

Many participants reference the established link between substance misuse and trauma. Those working with new immigrants, indigenous residents, veterans, and domestic violence survivors all reported that substance misuse among some of their clients can be linked to trauma. For example, cultural brokers shared that many immigrants coming to this country have experienced extreme violence in their home countries. PTSD from these experiences, as well as everyday challenges of navigating a new language and new systems, can lead to substance misuse. A leader from the Abenaki community observed that substance misuse among residents from the Abenaki tribes can be linked to unaddressed historical and

[13] Austin, A. E., Shiue, K. Y., Naumann, R. B., Figgatt, M. C., Gest, C., & Shanahan, M. E. (2021). Associations of housing stress with later substance use outcomes: A systematic review. Addictive Behaviors, 123, 107076. https://doi.org/10.1016/j.addbeh.2021.107076

[14] Height, K., Paumgarten, A., Salvas, N., Gunnet-Shoval, K., Hunt, T., & Calcaterra, P. (2019). Treating high-risk participants with opioid use disorder in Vermont's Hub & Spoke System: Evaluation of a SAMHSA-funded initiative to expand treatment. Dartmouth Hitchcock Medical Center.

intergenerational trauma resulting from forced integration and the loss of identity and culture.

> ***"We are regularly and increasingly experiencing a combo of mental health and substance use interactions. Getting them to resources when they are ready and having available staff within the county is difficult."*** – Social Services Sector

The key drivers of substance use that were identified by community members participating in the State Health Assessment, completed in 2024, are shown in **Table 10**. Many of these factors also arose during the interviews and focus groups conducted as part of this DSU assessment and are detailed throughout this report.

Table 10. Substance Use: Summary of Key Drivers, State Health Assessment, 2024

Key Drivers as Identified by Community Members (not in order of importance)
Substance use in Vermont is an increasing, pervasive crisis.
Mental health and substance needs are closely related.
The substance use crisis is impacting everyone in the community.
There are multiple, major substance use workforce issues.
Treatment complications due to the nature of the drug supply.
Medication Assisted Treatment ambivalence leads to decreased use.
Timing of treatment is critical and it's difficult to match needs to services.
Inadequate treatment options in volume and type.
Insurance coverage and Medicaid barriers make it difficult to get services.
Lack of recovery housing is a gap in the service continuum.
Healthcare discrimination based on substance use is very common.
Multigenerational substance use is increasing.
Youth turn to readily accessible substances to treat stress and mental health concerns.

DATA SOURCE: Vermont State Health Assessment Community Engagement Data – Mental Health and Substance Use, 2024

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Outcomes and Consequences of Substance Use

Impact of the Changing Drug Supply

Participants pointed to several disturbing trends affecting substance misuse in Vermont, including ever more dangerous substances on the market, ease of accessibility, and lack of awareness among users about what they are taking or the consequences of use of these more dangerous substances. Recent research has shown a trend toward increasingly potent illicit drug supplies across North America.[15] And a recent Drug Enforcement Administration (DEA) National Drug Threat Assessment press release identified the shift from plant-based drugs such as heroin and cocaine to synthetic drugs such as fentanyl and methamphetamine has contributed a more dangerous and deadly drug crisis in the United States.[16] In 2022, fentanyl and other synthetic drugs were responsible for 70% of overdose deaths nationally (currently accounting for 95% of overdose deaths in VT). Fentanyl and fentanyl mixtures including other synthetic opioids and sedatives have contributed to an even more dangerous drug supply. Xylazine, a veterinary sedative not approved for human use in the US, has also been designated as an emerging threat in the United States due to its increasing prevalence in overdose deaths.[17] In 2022, Vermont was the state with the highest rate of xylazine-related deaths (10.5 per 100k), followed by Connecticut (9.8) and Pennsylvania (5.9).[18]

Participants stated that the drug supply in Vermont has shifted towards these ever more dangerous and addictive substances, specifically synthetics such as fentanyl and xylazine. As one recovery sector participant explained, ***"the drugs coming in today, it's not what we saw ten years ago. The stuff out there today is dangerous."*** The physical effects of these substances—infections, ulcers, and necrosis—are devastating. Participants in the treatment, recovery, and harm reduction sectors also shared that non-opioid synthetic drugs do not respond to NARCAN® and higher doses or multiple administrations of NARCAN® may be required due to the higher potency of fentanyl, making these combinations more deadly.

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[15] Meyer, M., Westenberg, J. N., Jang, K. L., Choi, F., Schreiter, S., Mathew, N., King, C., Lang, U. E., Vogel, M., & Krausz, R. M. (2023). Shifting drug markets in North America - a global crisis in the making? International Journal of Mental Health Systems, 17(1), 36. https://doi.org/10.1186/s13033-023-00601-x

[16] Drug Enforcement Administration. (2024). National drug threat assessment 2024. U.S. Department of Justice, Drug Enforcement Administration. https://dea.gov/2024-NDTA-updated-7.5.2024.pdf

[17] The White House. (2023). Biden-Harris administration designates fentanyl combined with xylazine as an emerging threat to the United States. Office of National Drug Control Policy. https://www.whitehouse.gov/ondcp/briefing-room/2023/04/12/biden-harris-administration-designates-fentanyl-combined-with-xylazine-as-an-emerging-threat-to-the-united-states/

[18] Cano, M., Daniulaityte, R., & Marsiglia, F. (2024). Xylazine in overdose deaths and forensic drug reports in US states, 2019-2022. JAMA Network Open, 7(1), e2350630. https://doi.org/10.1001/jamanetworkopen.2023.50630

Participants also reported that as the drug supply becomes increasingly tainted and unreliable, users are less aware of what they are actually taking. Fentanyl and xylazine are cut into other drugs, making them more addictive. Because newer, synthetic drugs are more powerful and cheaper, users also mix substances on their own. As one recovery sector participant explained, ***"people say 'well I just do coke.' Well, you're not just doing coke, there's mixing."*** A participant working in recovery observed a growing pattern of users overcoming opioid addiction, only to relapse into use of cocaine tainted with fentanyl, which compounds their addiction and makes them even sicker.

> ***"We are in 2024. You know we think back to the good old days of 'just heroin' use. If you said that seven years ago, that would have been wild.*** "– Treatment Sector

The constantly shifting landscape of ever more dangerous substances creates challenges for those working in Vermont's system of care. As one harm reduction sector participant stated***, "we just notice something is different and now it's the new normal."*** A growing number of Vermonters are using—and misusing—substances. One social service sector participant summarized, ***"the level of addiction and risk associated with what's available is so much higher."*** Participants also shared that recovery from some of these new substances takes longer and has more serious consequences.

Impact on Community

Substance misuse has had a substantial negative impact on residents and communities affecting not only the physical health effects described earlier, but also individual, family, and community dynamics. Participants reported observing a rise in familial conflict and domestic violence linked to substance use among the people they work with. Several further shared that misuse is increasingly intergenerational – they see more and more children and youth are experimenting with substances because they see their parents using them.

One treatment sector participant explained, ***"oftentimes it's something [people] grew up with, saw their mom and dad do it."*** Others expressed concern about the negative impacts on children and youth who have lost parents and family members to substance use, and who are being raised in the foster care system or by other relatives.[19] As one treatment sector provider remarked, ***"we haven't seen all that parentless/under parented will bring to our community. The devastating effects are still to come."***

[19] National Institutes of Health. (2023). More than 321,000 US children lost a parent to drug overdose from 2011 to 2021. National Institutes of Health. https://www.nih.gov/news-events/news-releases/more-321000-us-children-lost-parent-drug-overdose-2011-2021

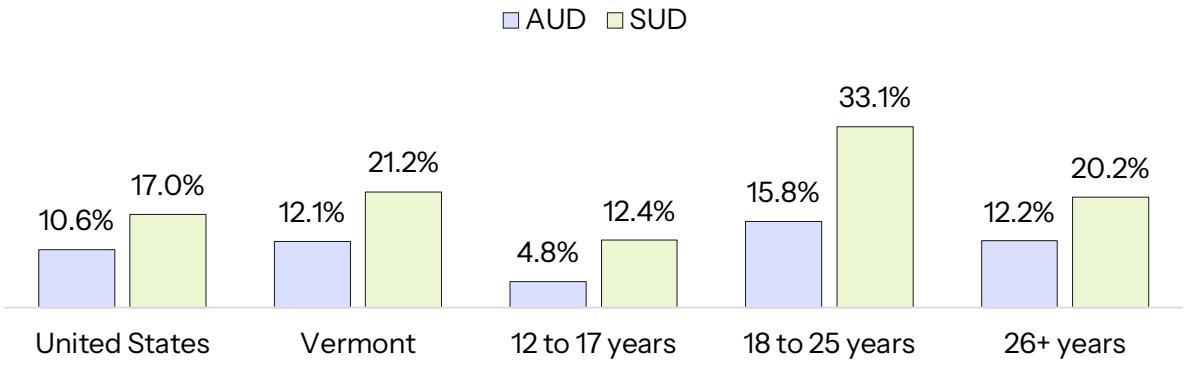
At a community level, participants noted that substance misuse has an impact on community safety. Some shared that communities have experienced an increase in panhandling, aggressive behavior, and homelessness. Other participants pointed to needles in parks and a rise in theft and other crime within communities. These changes, several participants mentioned, have contributed to stigma toward substance users as well as people with mental health issues. As one harm reduction sector participant stated, ***"[people with substance use disorders] are a group that a lot of people are allowed to hate."***

Rising rates of substance misuse have also affected care delivery as hospitals and health care workers address new and more serious health concerns among substance users, such as wound care in response to xylazine use. Additionally, participants in the recovery sector shared that substance users often delay seeking healthcare because they do not have insurance or have had past negative experiences with healthcare providers. This means they wait to get care until they have a health crisis, which requires more extensive treatment. Other participants observed that law enforcement and other first responders are increasingly overwhelmed by the high volume of overdose calls.

Substance Use Disorder Diagnoses

Prevalence of alcohol use disorder (AUD) and substance use disorder (SUD) are higher among Vermonters than the United States overall. Young adults aged 18 to 25 years saw the highest rates, with approximately a third (33.1%) of these adults classified with a substance use disorder (**Figure 8**).

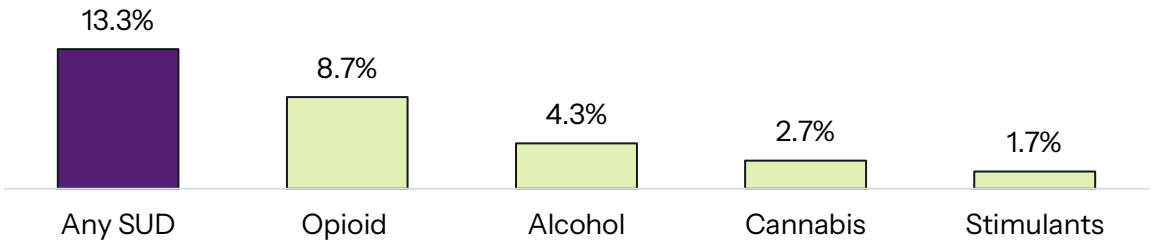
Figure 8. Prevalence of Alcohol Use Disorder & Substance Use Disorder Among Vermont Residents, by Age, 2021/2022



DATA SOURCE: National Survey on Drug Use and Health, 2021/2022
NOTE: Alcohol use disorder (AUD) is a medical condition that is characterized by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) as "a problematic pattern of alcohol use leading to clinically significant impairment or distress." Substance use disorder (SUD) is a medical condition that affects a person's brain and behavior, leading to their inability to control their use of substances like legal or illegal drugs, alcohol, or medications.

Among nonelderly Medicaid enrollees in Vermont, about 13% were determined to have a clinically identified substance use disorder in 2019, and about 9% had a clinically identified opioid use disorder (**Figure 9**). These numbers were the highest out of any state's Medicaid nonelderly enrollees. Vermont is followed by Ohio (12.4%), Delaware (11.7%), New Mexico (11.6%), and Connecticut (11.4%). Importantly, rates can vary across states not only because of prevalence, but also because of other factors, such as the extent of provider screenings and variation in Medicaid coverage of SUD services.

Figure 9. Clinically Identified Substance Use Disorders Among Nonelderly Medicaid Enrollees (Aged 12+) in Vermont (2019)

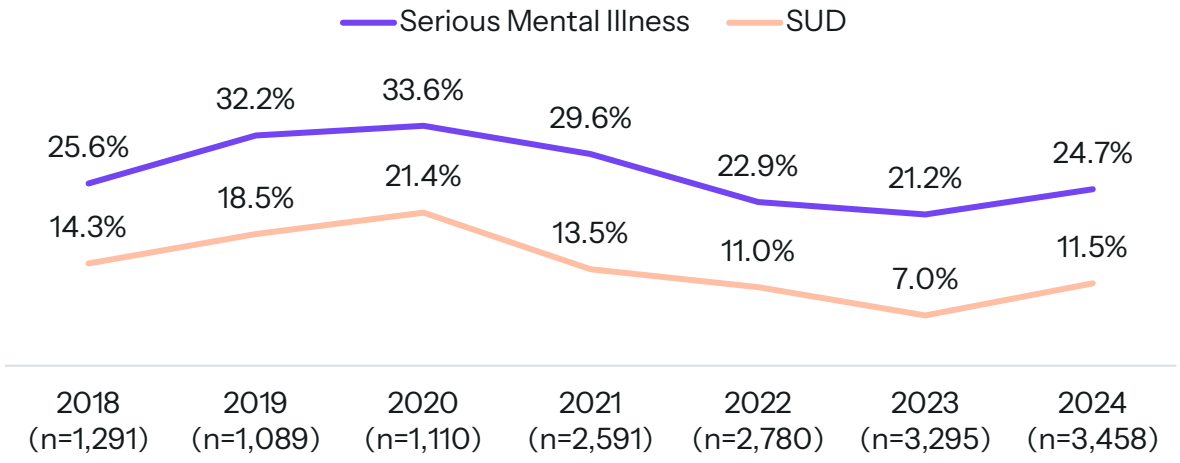


DATA SOURCE: KFF analysis of the T-MSIS Research Identifiable Files, 2019
NOTE: There were 46,967,389 enrollees in the 49 states and D.C. included in this analysis. Two states were excluded due to missing or inconsistent data. "Any Substance Use Disorder" includes enrollees with at least one opioid, alcohol, cannabis, stimulant, or other SUD. Enrollees were excluded if they were under the age of 12, over age 64, or had Medicare as their primary source of coverage.

Nationally, 16.5% of unhoused people in 2023 reported chronic substance use,[20] and so the unhoused are a subpopulation that may have a particular high need for substance use services. In Vermont, data suggest that between 2018 to 2024, the number of unhoused people in Vermont increased by approximately 2,000 individuals (**Figure 10**). Within that time, the percent who were classified with a substance use disorder varied from a low of 7% in 2023 to a high of 21.4% in 2020. The data further show the percentage of unhoused that are classified with a serious mental illness, which ranged from a low of 21.2% in 2023 to a high of 33.6% in 2020.

[20] U.S. Department of Housing and Urban Development. (2023). Continuum of Care Homeless Assistance Programs, Homeless Populations and Subpopulations. U.S. Department of Housing and Urban Development.

Figure 10. Trend in Prevalence of Substance Use Disorder or Serious Mental Illness Among Vermont Residents who are Experiencing Homelessness, 2018-2024

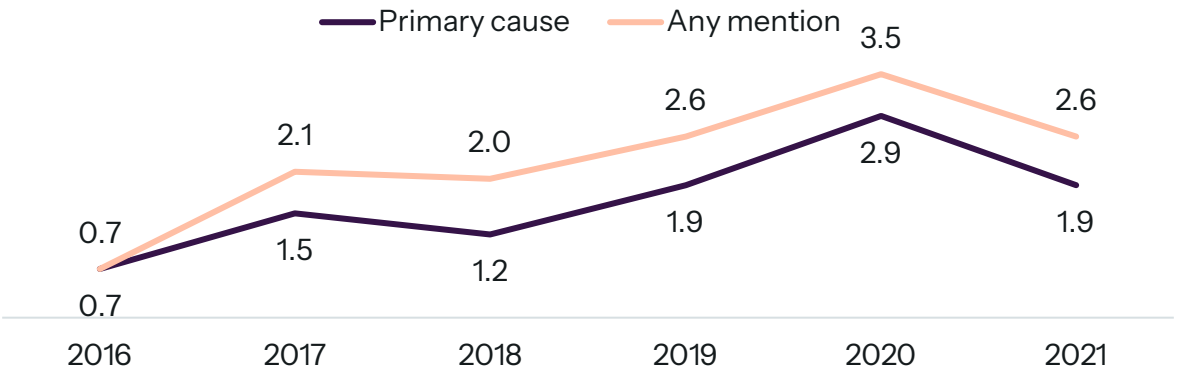


DATA SOURCE: Vermont Point-in-Time Count of Those Experiencing Homelessness 2024

Illness and Injury

Substance misuse can escalate into serious situations requiring medical assistance. Between 2016 and 2021, the rate of emergency department visits related to cannabis in Vermont has risen, with a peak in visits in 2020 (**Figure 11**).

Figure 11.Trend in Emergency Department Visit Related to Cannabis Among Vermont Residents, Rate per 10,000 (2016-2021)



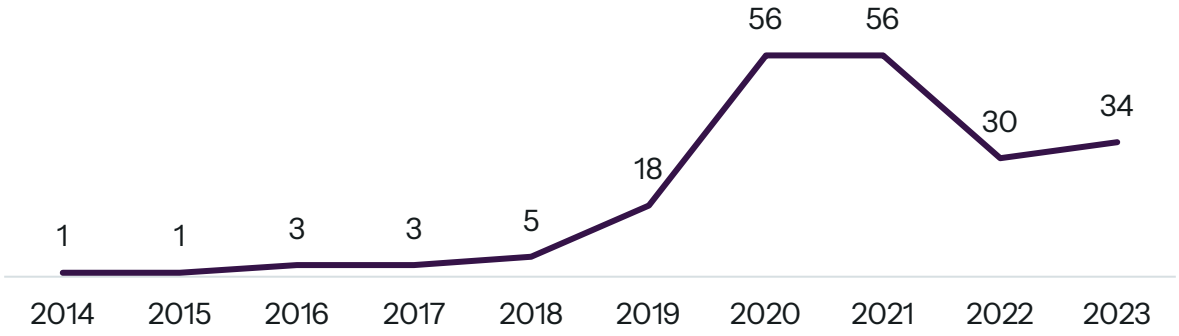
DATA SOURCE: Vermont Uniform Hospital Discharge Data System (VUHDDS) via Cannabis Adult Health Concerns, Vermont Department of Health, 2024

Nationally, unintentional ingestion of edible cannabis products in children under 5 accounted for 41.6% of all human poison exposures reported in 2020.[21] Regional data show that there

[21] Marit S. Tweet, Antonia Nemanich, Michael Wahl; Pediatric Edible Cannabis Exposures and Acute Toxicity: 2017–2021. *Pediatrics* February 2023; 151 (2): e2022057761. 10.1542/peds.2022-057761

were 34 calls to the New England Poison Center for such cases in 2023 (**Figure 12**). While not solely reflecting the occurrences among Vermont children, these data likely reflect the trend within the state.

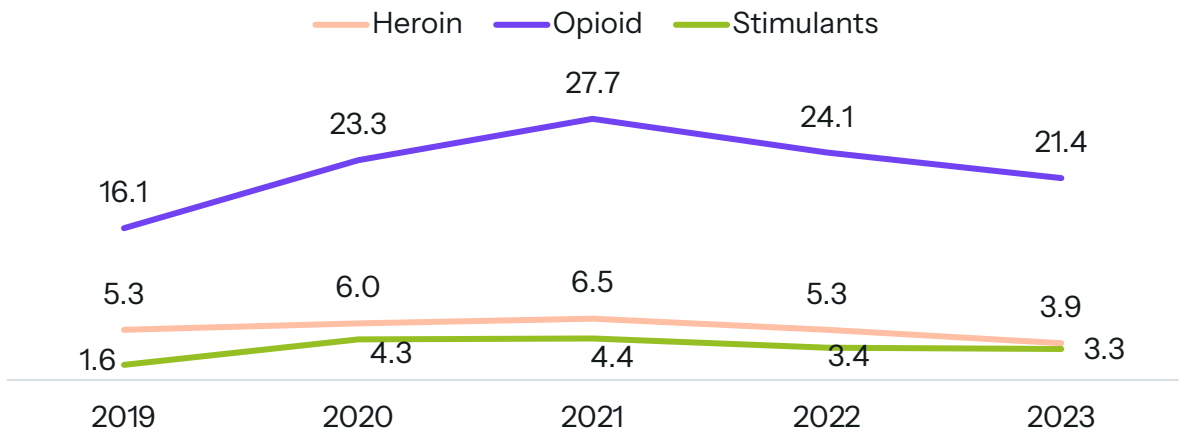
Figure 12. Trend in Calls to the New England Poison Center for Accidental Ingestion of Cannabis by Children, Count (2014-2023)



DATA SOURCE: Northern New England Poison Center via Cannabis Youth Health Concerns Data Brief by Vermont Department of Health, 2024; NOTE: The Northern New England Poison Center serves Maine, New Hampshire, and Vermont.

Between 2019 and 2023, overall rates of nonfatal overdoses due to any opioids (including heroin) increased from 16.1 per 10k ED visits in 2019 to 21.4 per 10k ED visits in 2023 (**Figure 13**). Non-fatal stimulant overdoses doubled in the same timeframe, increasing from 1.6 per 10k in 2019 to 3.3 in 2023. Conversely, non-fatal overdoses due to heroin alone decreased from 5.3 per 10k in 2019 to 3.9 in 2023.

Figure 13. Rate of Non-fatal Overdoses per 10,000 ED Visits, by Substance Type, 2019-2023

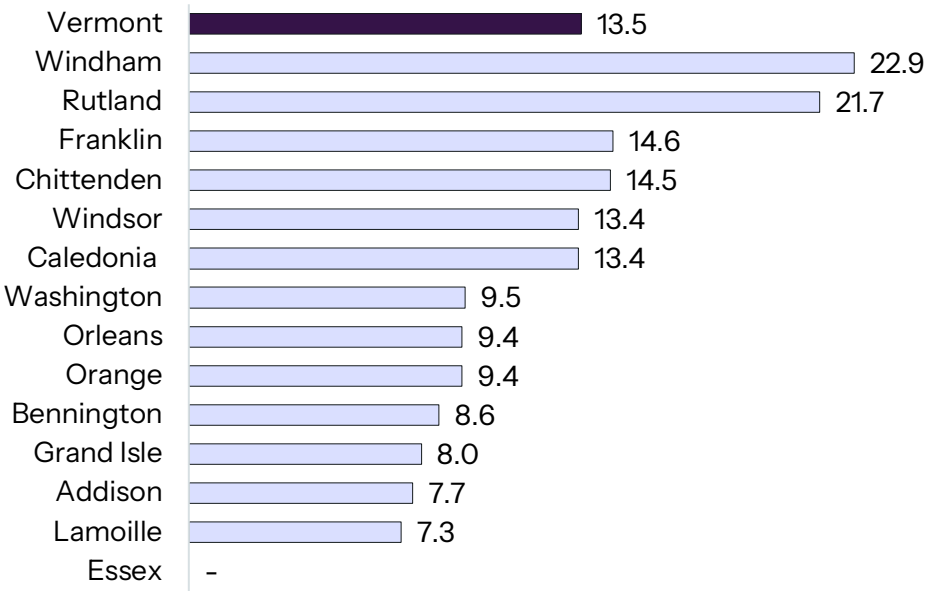


DATA SOURCE: Vermont Vital Statistics, The Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) via the VT Substance Use Dashboard
NOTE: Opioid data includes overdoses involving heroin.

As an indicator of non-fatal overdoses occurring within the community, data on NARCAN® administration can be examined. Evaluation data from the Community Naloxone Program suggests that more than 300 overdoses were reversed annually between 2019 and 2021. These are based on client self-reports, which may underestimate the true number of non-fatal overdoses occurring in the community.[22]

Based on EMS administration, overall there were 13.5 EMS calls per 10k residents involving drug overdoses requiring NARCAN® administration in 2023 (**Figure 14**). Windham and Rutland counties saw the highest rate of EMS involved overdoses, at 22.9 and 21.7 per 10k, respectively.

Figure 14. Rate of Emergency Medical Services Calls Involving NARCAN® Administration per 10,000 Residents, by County, 2023



DATA SOURCE: Vermont State Incident Reporting Network (SIREN), 2023 via Vermont Department of Health Emergency Medical Services Naloxone Distribution and Administration Q4 2023 Report
NOTE: Dash (-) denotes data suppressed due to insufficient data.

Exploring these data more deeply, the 2023 data on EMS-administered NARCAN® show that most people receiving NARCAN® fell between 30 and 59 years old (68%), with 42 years as the median age of recipients (**Table 11**). About two-thirds (67%) of recipients were male. Notable, these data mirror the demographics of people who experience fatal opioid-related overdoses which show that 72% of death are male and the median age is 44 years at the time of death.

[22] Vermont Department of Health. (2023). *Evaluation of the Health Department's Community Naloxone Program*. Vermont Department of Health.

Table 11. Demographic Characteristics of People Administered NARCAN® by EMS, 2023

	%
Male	67%
Female	33%
Under 18	1%
18-29 years old	12%
30-59 years old	68%
60+ years old	19%
Median Age	42

DATA SOURCE: Vermont State Incident Reporting Network (SIREN), 2023 via Vermont Department of Health Emergency Medical Services Naloxone Distribution and Administration Q4 2023 Report

Mortality

State data shows that alcohol-attributable deaths (AADs) among Vermont residents have increased in recent years, from 328 deaths in 2017 to 446 deaths in 2021.[23] Increases were observed among most age groups, and the increase was highest among 35- to 49-year-olds (59% increase). However, the rate of AADs among Vermonters aged 65 and older was significantly higher compared to other age groups, highlighting the severe impact of alcohol on this demographic. **Table 12** summarizes the number of AADs by age group and is further subdivided by chronic vs. acute causes. Older Vermonters are more likely to accumulate more years of impact of alcohol use than younger Vermonters, leading them to die due to chronic causes (i.e., alcoholic liver disease, alcohol abuse, and heart disease), rather than acute causes (i.e., poisoning, motor vehicle accidents, and suicides).

Table 12. Alcohol-Attributable Deaths due to Excessive Alcohol Use in Vermont, by Age Group, 2021

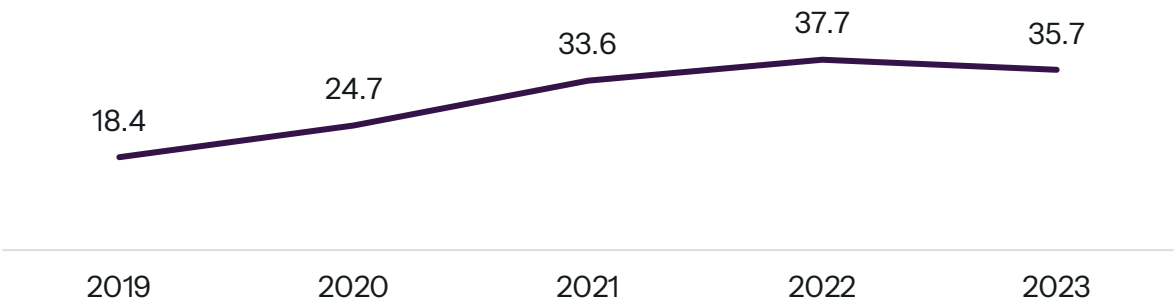
	Overall	0-19	20-34	35-49	50-64	65+
Total for All Causes	439	5	29	65	126	215
Chronic Causes	324	0	4	30	92	197
Acute Causes	115	4	25	34	34	18

DATA SOURCE: Centers for Disease Control and Prevention, Alcohol Related Disease Impact (ARDI) Application, 2024

Between 2019 and 2023, the rate for accidental opioid-related deaths in Vermont nearly doubled from 18.4 to 35.7 per 100,000 residents (**Figure 15**).

[23] Vermont Department of Health. (2023). *Alcohol-Attributable Deaths in Vermont*. Vermont Department of Health.https://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP_Data_Brief_AlcoholDeath.pdf

Figure 15. Trend in Accidental/Undetermined Opioid-Related Death Among Vermont Residents, Rate per 100,000, 2019-2023



DATA SOURCE: Vermont Vital Statistics, The Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE)

Opioid-related death rate data stratified by county shows that in 2023 the rate was highest in Essex (100.1 per 100,000), Windham (61.1 per 100,000), Rutland (54.7 per 100,000), and Bennington counties (53.5 per 100,000) (**Table 13**). And when examined over time, the greatest percentage increases between 2019 and 2023 occurred in Addison (244.4%), Essex (212.8%), and Chittenden counties (198.1%).

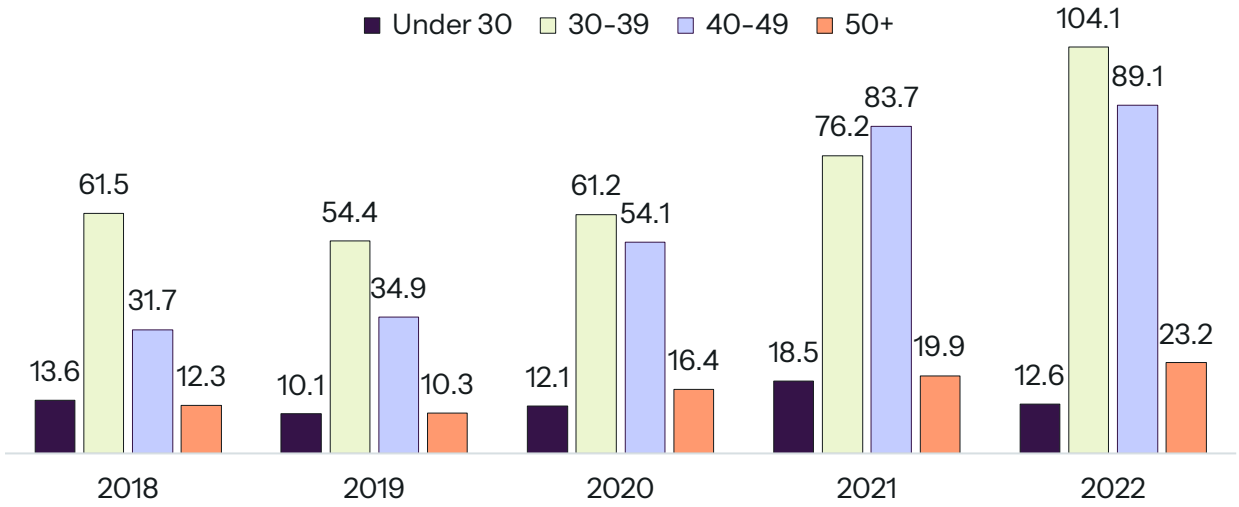
Table 13. Trend in Accidental/Undetermined Opioid-Related Death Among Vermont Residents, Rate per 100,000 by County (2019-2023)

	2019	2020	2021	2022	2023	% change since 2019
Vermont	**18.4**	**24.7**	**33.6**	**37.7**	**35.7**	**94.0%**
Addison	5.4	10.7	13.4	18.6	18.6	244.4%
Bennington	30.9	24.1	45.6	45.5	53.5	73.1%
Caledonia	33.0	39.8	32.9	39.2	26.2	-20.6%
Chittenden	10.3	15.4	24.3	28.4	30.7	198.1%
Essex	32.0	0.0	0.0	50.1	100.1	212.8%
Franklin	10.4	10.0	29.8	35.5	15.8	51.9%
Grand Isle	0.0	41.2	27.0	26.7	26.7	*
Lamoille	15.8	19.3	42.1	30.7	15.3	-3.2%
Orange	0.0	23.9	40.6	33.5	33.5	*
Orleans	18.6	21.9	32.7	47.0	39.8	114.0%
Rutland	22.3	33.1	46.2	56.3	54.7	145.3%
Washington	18.9	35.1	38.4	23.3	26.6	40.7%
Windham	39.8	26.2	45.6	61.1	61.1	53.5%
Windsor	23.5	50.3	36.1	51.6	44.7	90.2%

DATA SOURCE: Vermont Vital Statistics, The Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE); NOTE: Asterisk (*) indicates that percent change is unavailable due to 2019 rates of zero. Data is classified by County of residence.

Across years, opioid-related death rates are highest among those aged 30-39 and 40-49 years (**Figure 16**). Rates among these two age groups have increased the most dramatically between 2018 and 2022, while rates among the younger (under 30 years) and older (age 50+) have increased more modestly.

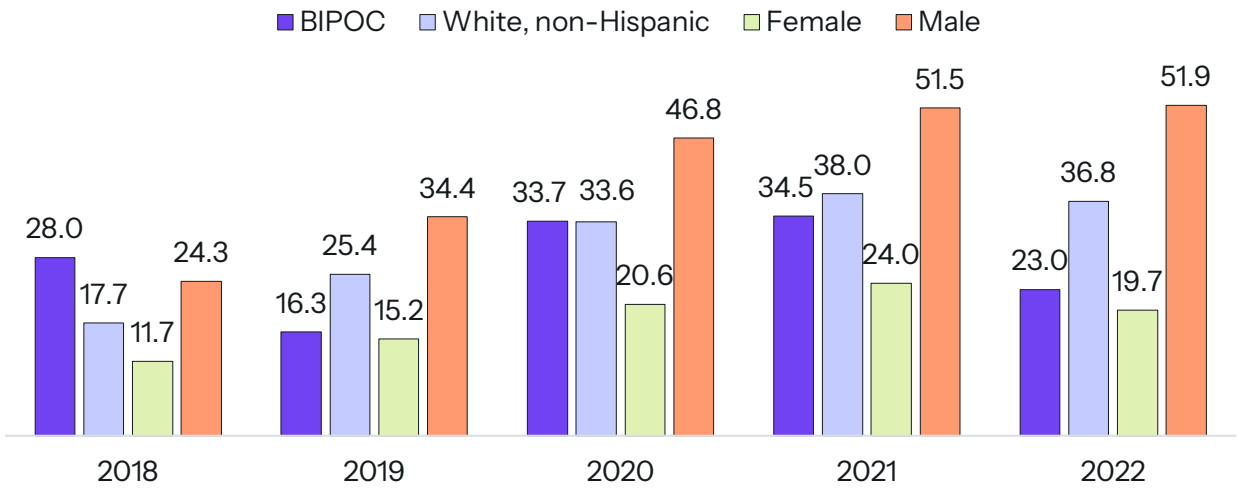
Figure 16. Trend in Accidental/Undetermined Opioid-Related Death Among Vermont Residents, Rate per 100,000 by Age Group, 2018-2022.



DATA SOURCE: Vermont Vital Statistics System via Vermont Department of Health, Division of Health Statistics and Informatics

The opioid-related death rate has also been consistently higher among male residents than among female residents, 51.9 per 100k for males and 19.7 for females in 2022 (**Figure 17**).

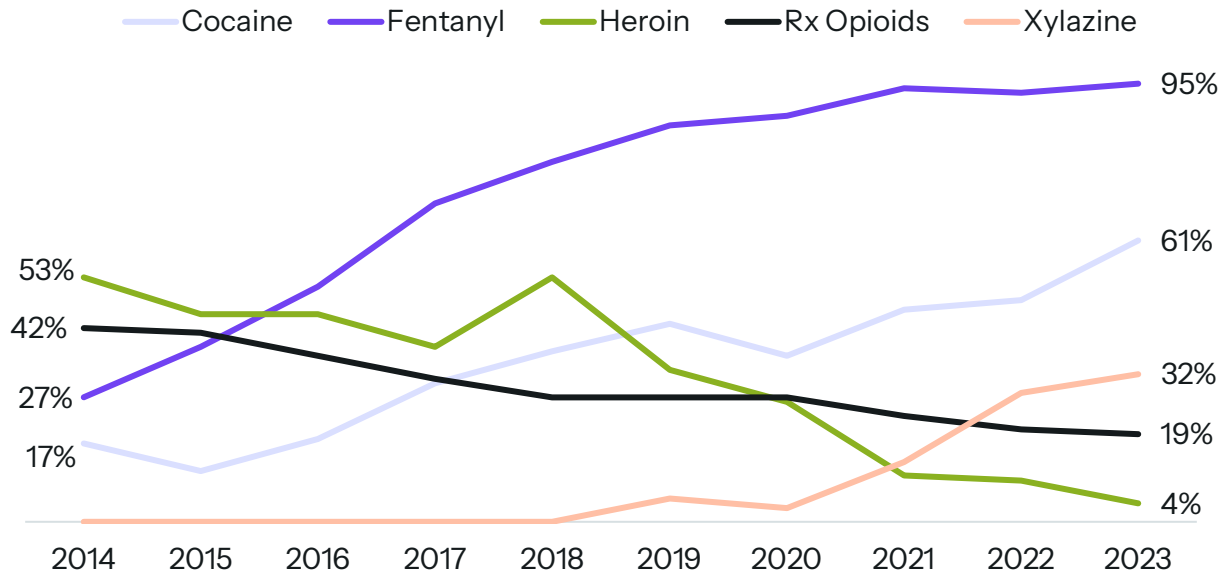
Figure 17. Trend in Accidental/Undetermined Opioid-Related Death Among Vermont Residents, Rate per 100,000 by Race/Ethnicity and Sex (2018-2022)



DATA SOURCE: Vermont Vital Statistics System via Vermont Department of Health, Division of Health Statistics and Informatics

Data on the substances involved in opioid-related deaths in Vermont highlights some concerning trends. Fentanyl has been the most common substance involved in opioid-related deaths since 2016, and in 2023 it was involved in close to all opioid-related deaths (95%) (**Figure 18**). On the rise as well has been the involvement of xylazine, moving from zero to nearly a third of deaths (32%) between 2018 and 2023. Notably in 2022, of all US states Vermont had the highest rate of xylazine involved overdose deaths with an estimated 10.5 deaths per 100,000 residents.[24]

Figure 18. Trend in Substances Involved in Opioid-Related Deaths Among Vermont Residents, Percent of Deaths (2014-2023)



DATA SOURCE: Vermont Vital Statistics System via Vermont Department of Health, Division of Health Statistics and Informatics; NOTE: Prescription (Rx) opioids data does not contain fentanyl involvement. Involvement of individual substances is not mutually exclusive.

Additionally, data showed that in 2023, 91% of opioid-related fatal overdoses involved two or more substances, with 29% involving four or more substances. The top three combinations in 2023 all involve fentanyl: fentanyl and cocaine, which accounted for over half (59%) of all opioid-related fatal overdoses, fentanyl and xylazine (32%), and fentanyl, cocaine, and xylazine (21%).

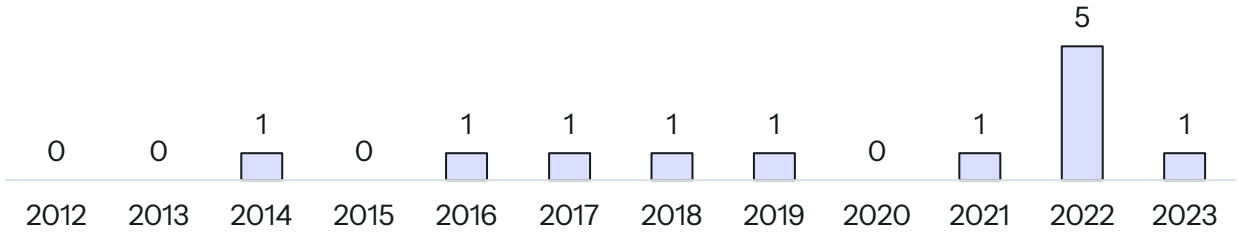
One in eight drug overdose deaths in Vermont do not involve opioids and the number of non-opioid drug overdose deaths has increased by 127% between 2013 and 2022. [25] The data on

[24] Cano, M., Daniulaityte, R., & Marsiglia, F. (2024). Xylazine in overdose deaths and forensic drug reports in US states, 2019-2022. *JAMA Network Open, 7*(1), e2350630. https://doi.org/10.1001/jamanetworkopen.2023.50630
[25] Vermont Vital Statistics System via Vermont Department of Health, Division of Health Statistics and Informatics

these non-opioid related drug overdose deaths show cocaine as the most common substance contributing to death (39%), followed by prescription medications (31%) and alcohol (24%).

Maternal deaths due to accidental overdose (of any source) are relatively low in Vermont, that a sharp peak was observed of 5 deaths in 2022 (**Figure 19**).

Figure 19. Trend in Number of Maternal Deaths due to Accidental Overdose in Vermont, 2012-2023



DATA SOURCE: Vermont Vital Statistics, 2012-2022; NOTE: Includes deaths during pregnancy, birth, and up to one year postpartum. 2022 and 2023 data are preliminary. Although only one death from 2023 was reviewed by the panel in 2023, additional deaths may be identified during 2024 review.

Findings from the ***Vermont Social Autopsy Report 2023,***[26] which is based upon opioid-related deaths occurring in 2021, provide extensive insight into how Vermonters who died of a drug overdose interacted with state systems prior to death to identify opportunities for intervention. Of the 231 Vermonters who died of an overdose in 2021, fentanyl was involved in 83% of deaths. Most (93%) had a diagnosed substance use disorder, most (77%) interacted with three or more agencies, and more than two-thirds were enrolled in Medicaid within 90 days of death. Data also showed that 43% of all who died had some type of mental health diagnosis, though prevalence was highest among the youngest and oldest age groups (51% of those aged 15-24 years and 62% of those aged 55 years or older). More than half of Vermonters that died of an overdose in 2021 were unhoused at some point in their lives (53%), while 21% were homeless within 6 months of their death.

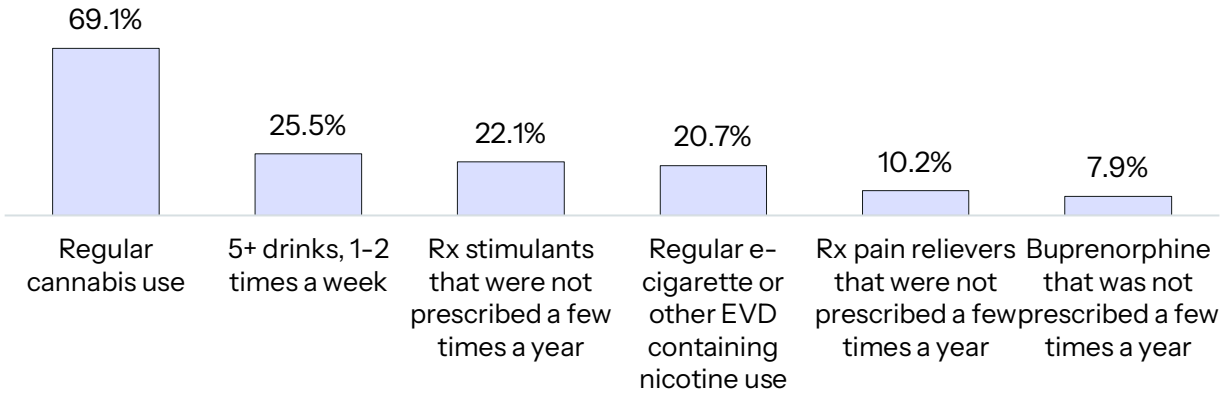
Perceptions of Risk or Harm

When asked about their perception of which substances are not or only slightly harmful, most young adults selected cannabis (69.1%) (**Figure 20**). A quarter of respondents (25.5%) selected that there was no or little harm in having more than 5 drinks once or twice a week,

[26] Vermont Department of Health. (2023). Vermont social autopsy report 2021 data analyses, August 2023 (Updated September 2023). Vermont Department of Health. https://www.healthvermont.gov/sites/default/files/ document /dsu-2021-Vermont-social-autopsy-report.pdf

closely followed by occasional use of prescription stimulants (22.1%) and regular cigarette or nicotine use (20.7%).

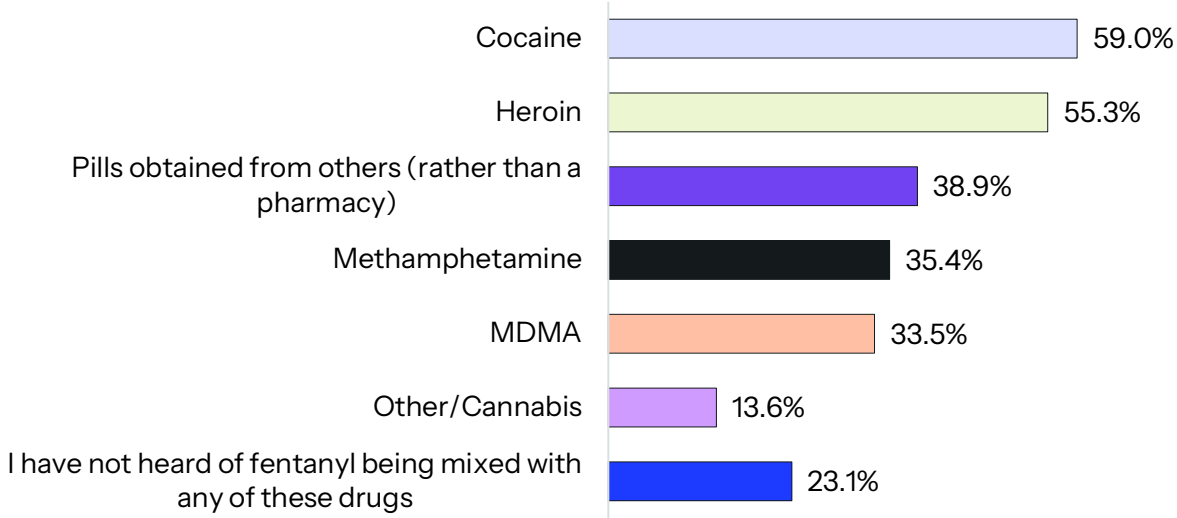
Figure 20. Perceived No or Slight Harm from Using Substances Among Young Adults (Age 18-25) in Vermont, 2022 (n=1,538)



DATA SOURCE: Vermont Young Adult Survey 2022; NOTE: Regular use was not defined by the survey and may differ in interpretation for survey respondents.

Young adults also reported their awareness of the danger of fentanyl being mixed with other substances, primarily reporting awareness of fentanyl in cocaine (59.0%) and heroin (55.3%) (**Figure 21**). About a quarter (23.1%) of respondents had no awareness of fentanyl being added to any other drugs.

Figure 21. Awareness of Dangers of Fentanyl Being Added to Substances Among Young Adults in Vermont, by Substance, 2022



DATA SOURCE: Vermont Young Adult Survey 2022; NOTE: 95% of "other" responses described hearing about fentanyl being mixed with cannabis.

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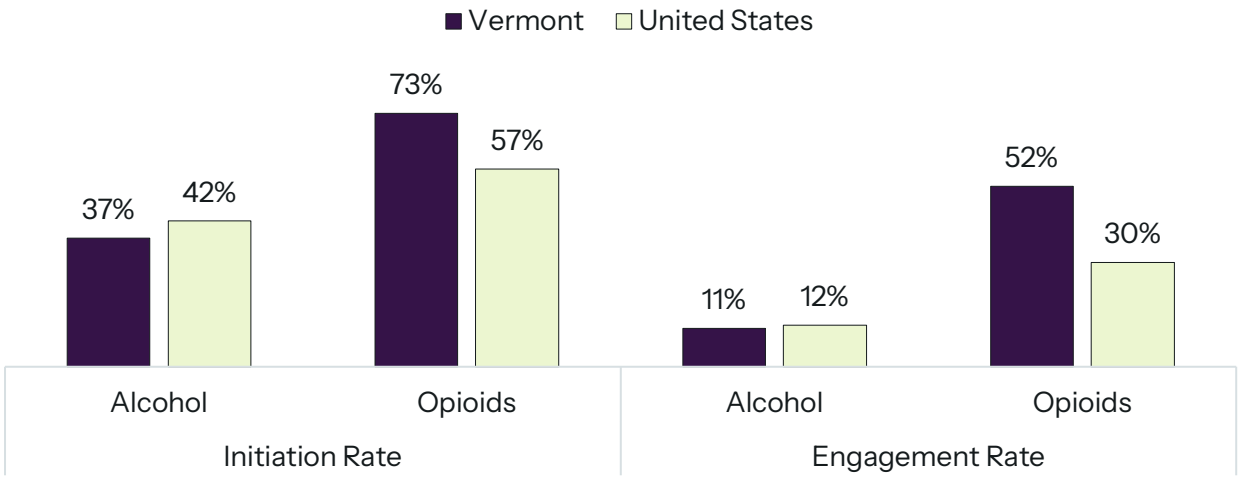
Utilization of Treatment Services

Treatment initiation, or the start of a treatment plan, and engagement, the continued participation in such a plan, are key data points that demonstrate the efficacy of substance use treatment services. As defined by the Centers for Medicare & Medicaid Services, initiation rates refer to the percentage of people diagnosed with a substance use disorder who receive treatment within two weeks of their diagnosis. as receiving treatment within 34 days following the initial treatment after diagnosis.[27]

Among Medicaid enrollees in Vermont, just over a third of people diagnosed with alcohol use disorder are receiving treatment within 2 weeks, and about 10% of these individuals are receiving treatment within 34 days (**Figure 22**). These percentages are slightly lower than national initiation (42%) and engagement (12%) rates in the U.S. However, Vermont surpasses the national average in opioid use disorder treatment initiation (73% vs. 57%) and engagement (52% vs. 30%). This likely reflects the ease of access to MOUD in Vermont, coupled with the high rate of Medicaid enrollment among residents.

Figure 22. Treatment Initiation and Engagement Among Medicaid Enrollees, by State and US, 2022



DATA SOURCE: Medicaid Claims and Medicaid and CHIP Scorecard via Vermont Department of Health, Substance Use Disorder Initiation and Engagement in Treatment 2024

Overall, the total number of people treated for SUDs in Vermont has declined by approximately 3,000 between 2019 and 2023 (**Table 14**). This likely reflects interruptions in

[27] Centers for Medicare & Medicaid Services. (2024). Medicaid & CHIP health care quality measures: Technical assistance resource. Centers for Medicare & Medicaid Services.

treatment availability/provision due to COVID-19.[28] In 2023, the largest number of people treated were between the ages of 35 and 44 years (n=3,080). Importantly, these data only reflect people receiving treatment within the DSU funded treatment system only.

Table 14. Number Treated for Substance Use Disorder through DSU Funded Programs, by Age, 2019-2023

	2019	2020	2021	2022	2023
Total	**11,223**	**10,385**	**9,213**	**9,024**	**8,665**
Under 18	299	258	150	181	191
18-24	1,097	891	681	576	514
25-34	4,046	3,577	2,979	2,757	2,432
35-44	3,034	3,033	2,955	3,057	3,080
45+	2,747	2,626	2,448	2,453	2,448

DATA SOURCE: Substance Abuse Treatment Information System (SATIS) via Vermont Department of Health, Substance Use Disorder Treatment Trends 2024; NOTE: Data are organized by fiscal year, and includes Vermonters treated for substance use disorder (SUD) at providers funded by the Vermont Department of Health Division of Substance Use Programs (DSU). These services include outpatient treatment, intensive outpatient treatment, medications for opioid use disorder (MOUD) in specialty opioid treatment programs known as "hubs", and non-hospital based residential withdrawal management and treatment. Reporting comes from the providers and at times there are gaps in reporting that impact trends. Providers who are not funded by DSU are not required to submit treatment data. This report does not include SUD treatment provided by private practitioner licensed counselors, hospitals, and medical practitioners who provide SUD treatment. Office based opioid treatment, which is known as a “spoke” service in Vermont, is also excluded from this report.

Between 2019 and 2023, heroin and opioid misuse were the most commonly treated substances, making up just over half (56%) of those seeking SUD treatment in 2023.[29] Among people under 18 years of age seeking treatment, the primary substance treated was cannabis. At least three quarters of youth receiving treatment were being treated for cannabis misuse in 2023. trends in substances treated were generally consistent between 2019 and 2023, however treatment for stimulants increased by 5% among the overall treatment population.

Medications for Opioid Use Disorder (MOUD), previously termed Medication Assisted Treatment (MAT), uses medication such as methadone and buprenorphine, as part of a comprehensive opioid use disorder treatment program. MOUD is not the only treatment for opioid addiction, but it has been shown to be the most effective form of treatment for most

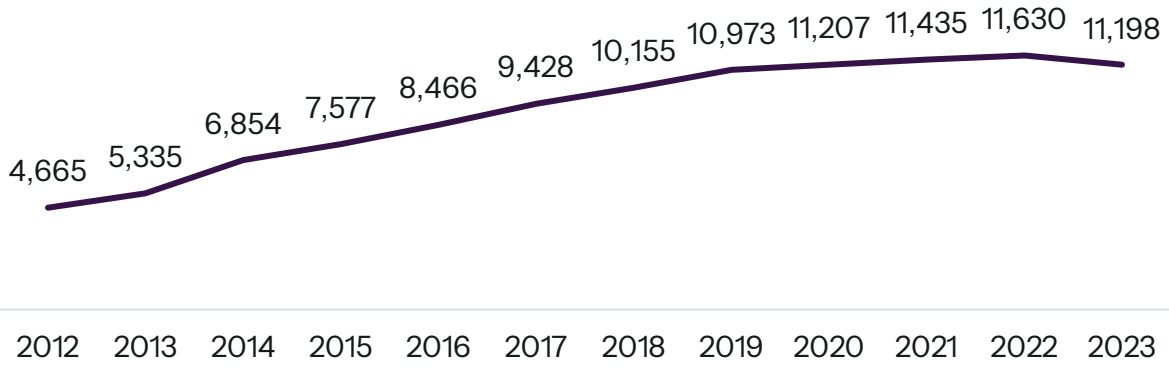
[28] Vermont Department of Health. (2021). Substance use during COVID-19: 2019-2020 report. Vermont Department of Health. https://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP-SubstanceUseDuringCOVID-2019-2020-Report.pdf

[29] Vermont Department of Health. (2024). *Substance Use Disorder Treatment Trends 2024.* Substance Abuse Treatment Information System (SATIS).

people and is endorsed by the American Medical Association, the American Academy of Addiction Psychiatry, and the American Society of Addiction Medicine.

Between 2012 and 2023, the number of people receiving MOUD overall in Vermont has more than doubled from about 5,000 to over 11,000 individuals (**Figure 23**). Additionally, data show that MOUD use among birthing persons has remained stable at about 4-5% use rates prior to, during, and after pregnancy between 2016 and 2020.[30]

Figure 23. Trend in Number of People (Age 18-64) Receiving MOUD, 2012-2023



DATA SOURCE: Vermont Prescription Monitoring System (VPMS), Substance Abuse Treatment Information System (SATIS), and Medicaid Claims via Vermont Department of Health, 2024
NOTE: 2022 and 2023 data are preliminary.

The Vermont Department of Corrections (DOC) has offered MOUD to inmates since 2013. As of July 2018, based on Vermont Act 176, MOUD is recognized as a medically necessary component of treatment for all Vermont citizens who are diagnosed with OUD, including inmates of the DOC. When people who have an OUD are incarcerated without access to treatment, they experience forced abstinence, which reduces their tolerance and greatly increases the risk of overdose death after release.

The period of incarceration provides an opportune time to engage people in treatment who may not have previously had access or readiness to attempt treatment.[31] Current quarterly data show that over half (57.1%) of people incarcerated in Vermont are receiving MOUD (**Table 15**). The percentage is higher among White individuals (63.0%), as well as those in the 25-34 years (67.5%) and 35-44 years (65.3%) age groups.

[30] Vermont Department of Health. (2020). *Pregnancy Risk Assessment Monitoring System (PRAMS) Vermont, 2020*. Vermont Department of Health. https://www.healthvermont.gov/stats/population-health-surveys-data/pregnancy-risk-assessment-monitoring-system-pram
[31] Opioid Use Disorder Treatment: How Vermont Integrated its Community Treatment Standards into its State Prisons; E. Mette and J. Manz, National Academy for State Health Policy (2021)

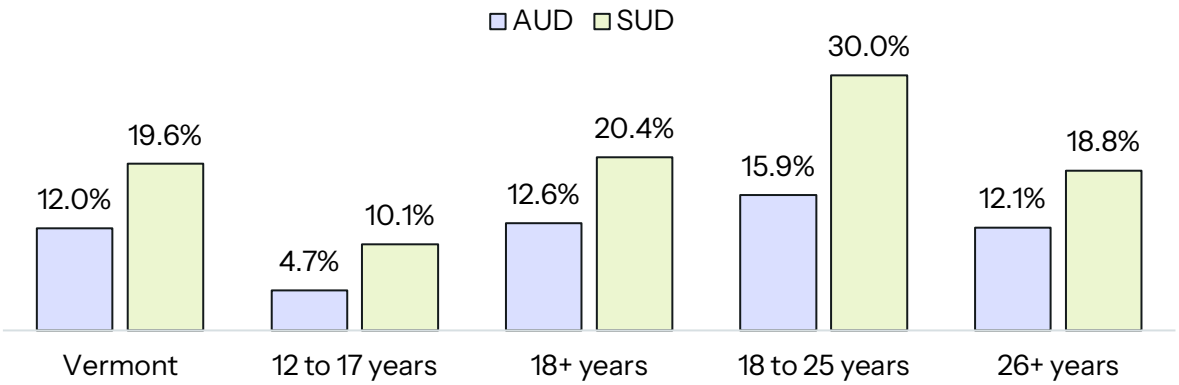
Table 15. Point-in-Time Estimate of MOUD Among Incarcerated People in Vermont (July 30, 2024)

	Total Count	% on MOUD
Total Incarcerated Population	**1,339**	**57.1%**
People of Color	251	31.5%
White	1,082	63.0%
Men	1206	57.1%
Women	133	56.4%
Under 25 years	93	47.3%
25-34 years	388	65.7%
35-44 years	496	65.3%
45-54 years	205	54.1%
Over 55 years	157	19.1%

DATA SOURCE: VT Department of Corrections: Medication Assisted Treatment (MAT) Report 6/30/2024; NOTE: Data do not include people on MOUD who are housed at TCCF.

Data from the National Survey on Drug Use and Health show that among Vermonters who needed treatment for a substance use disorder in 2021, 19.5% did not receive it (note, this is inclusive of alcohol use disorders) (**Figure 24**). Among young adults aged 18-25, rates were notably higher, with around 30% not receiving treatment for SUD and about 16% for alcohol use disorder.

Figure 24. Needing but Not Receiving Treatment for Substance Use Disorder in Past Year, 2021/2022



DATA SOURCE: National Survey on Drug Use and Health, 2021/2022; NOTE: Alcohol use disorder (AUD) is a medical condition that is characterized by the DSM-5 as "a problematic pattern of alcohol use leading to clinically significant impairment or distress." Substance use disorder (SUD) is a medical condition that affects a person's brain and behavior, leading to their inability to control their use of substances like legal or illegal drugs, alcohol, or medications. AUD is included in the overall category of SUD.

This measure serves to highlight gaps in access to treatment services within the state. Importantly, these data do not only reflect structural barriers to treatment access, as it has been shown that nearly 94.7% of adults who had a SUD but were not receiving treatment did not perceive that they needed treatment.[32]

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Prevention and Early Intervention in Vermont

Role of DSU

Vermont's Division of Substance Use Programs (DSU) operates a robust prevention system focused on reducing the harmful effects of tobacco, alcohol and other drugs and stopping addiction. Prevention efforts aim to address the root causes of substance use by promoting protective factors and reducing risk factors that lead to drug and alcohol misuse. One key aspect of Vermont's prevention approach is fostering collaboration through local coalitions, community organizations, and state health offices, which work together to implement strategies that support healthy behaviors and environments.

This work included the establishment of four Vermont Prevention Lead Organizations (VPLO) that serve as fiscal agents to community organizations, coordinate through a regional advisory structure, and work with district partners to allocate substance misuse prevention funding in their region. The work also includes Vermont's Regional Prevention Partnerships (RPP) which coordinate a statewide and regional approach to prevent and reduce alcohol and cannabis use by youth and young adults. These statewide efforts include coordination of training, technical assistance, prevention messaging and prevention capacity-building strategies. Regional Prevention Consultants (PCs) provide technical assistance on substance misuse prevention around the state through the Health Department's Office of Local Health. The PCs serve the agencies, organizations, and

[32] Substance Abuse and Mental Health Services Administration. (2023). Key substance use and mental health indicators in the United States: Results from the 2022 National Survey on Drug Use and Health (HHS Publication No. PEP23-07-01-006, NSDUH Series H-58). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2022-nsduh-annual-national-report

individuals within those District catchment areas with the goal of increasing local community capacity to carry out effective substance misuse prevention efforts to impact positive changes in behavior, attitudes, skill development, and environmental changes.

In addition, DSU prevention initiatives include a state-wide drug disposal system, higher education initiatives, extensive media messaging, and funding of Prevention Works! Which is a statewide organization that supports healthy coalitions and prevention professionals in Vermont. Vermont's prevention efforts are a cornerstone of the state's broader strategy to address substance use and related public health issues. ***Click here for more information on DSU's current prevention model***.

Perceptions of Prevention Efforts

Prevention sector participants stressed that much of the substance use prevention work is localized. They stated that they use the state's strategic prevention framework to help their communities assess the local data and choose interventions based on the locally relevant risks and protective factors. While some prevention messaging is universal, they explained that prevention messaging is more often tailored to specific substances, communities, or audiences—for example, working with a school district to address vaping among its students. Data from the ***Prevention Inventory report from 2020,***[33] confirms that a considerable amount of prevention is taking place at the local level with 23% of programs occurring at the town level, and 36% at the county level. Approximately 9% of prevention programming efforts at that time were occurring at the state level.

Prevention sector participants further shared that they approach prevention in a multi-faceted way, recognizing the impact of social determinants of health, mental health, and access to healthcare on substance misuse. They praised the work of the VLPOs in coordinating efforts and supporting and aligning prevention work across the state. Additionally, they valued the work of PreventionWorks!, which provides training, workshops and networking opportunities to prevention professionals. Participants reported that they also work towards policy change. One prevention sector participant stressed the importance of these efforts by saying, ***"if we don't do the long-term work like policy and environmental strategies, we are not going to affect the population-level change."***

[33] Vermont Department of Health. (2020). Vermont prevention inventory report. Vermont Department of Health. https://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP_Vermont-Prevention-Inventory-Report-2020.pdf

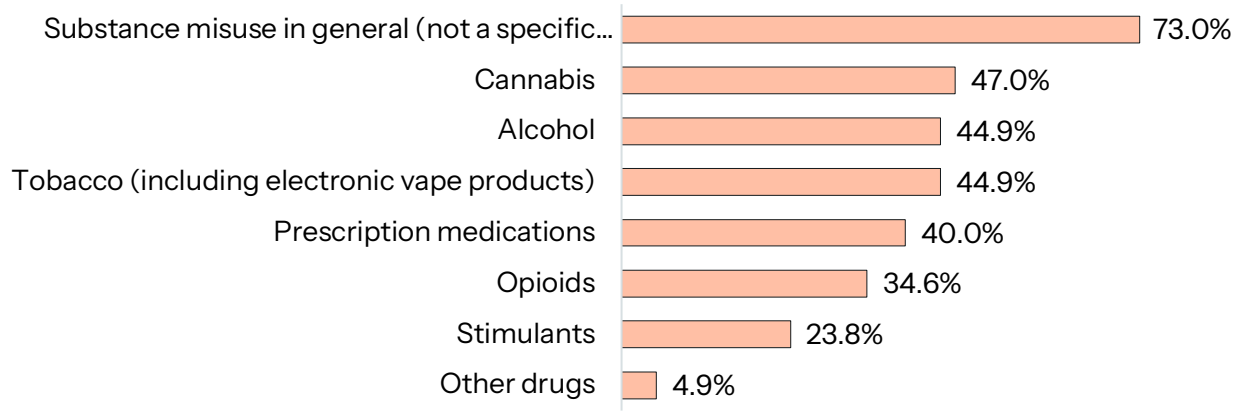
Prevention sector participants did emphasize that although alcohol is the most misused substance in the state, it receives less prevention messaging than other substances. This is largely because alcohol is legal and more culturally accepted. It is also generally perceived as a less serious addiction, as one participant shared, because ***"you can drink and maintain a job and have relationships and still be able to function."*** A similar public perspective has emerged about cannabis, participants reported, as a result of legalization and increased accessibility. These perspectives make prevention messaging challenging.

> ***"We don't focus on alcohol enough to match the level of misuse of alcohol in this state."*** – Prevention Sector

Currently, much prevention messaging focuses on youth use of cannabis and nicotine. Prevention sector participants shared that they deliver prevention education to students in schools and work with substance use teams in schools. They also work with these organizations to build their capacity to implement substance use prevention strategies and support students who are misusing substances. Work in schools is reported to be challenging due to lack of time and resources. As one prevention sector participant described, ***"there is so much fatigue in the schools with those doing the work and they have no capacity to do an ounce more."*** In addition to school settings, PC's also work with youth-serving community-based organizations. One participant shared an example of connecting recovery coaches to teen service providers in the county, which was noted as showing some success.

According to the ***Vermont Prevention Inventory Report in 2020***, most substance use prevention programs at that time focused on misuse in general, rather than specific substances (**Figure 25**). Just under half focused on cannabis (47.0%), followed closely by alcohol (44.9%) and tobacco and vape products (44.9%).

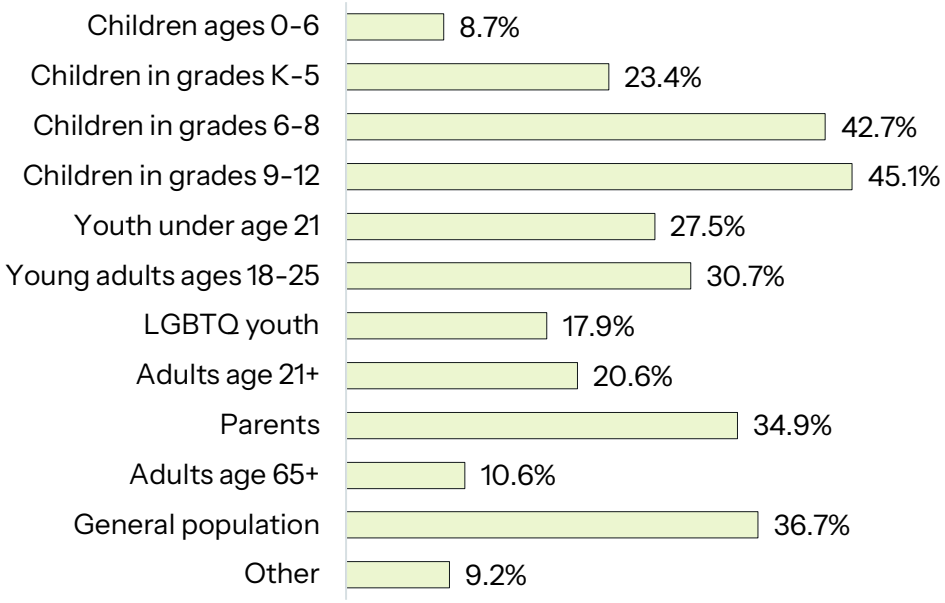
Figure 25. Substance Use Prevention Programs, by Substance of Focus (n=185), 2020



DATA SOURCE: Vermont Prevention Inventory Report, Vermont Department of Health, 2020
NOTE: Because multiple substances could be reported, percentages sum to more than 100.

The greatest proportion of prevention programs served high school students (45.1%) (**Figure 26**). One-fifth of programs reported serving adults over 21 (20.6%), and 10% reported serving older adults over the age of 65.

Figure 26. Substance Use Prevention Programs, by Population(s) Served (n=218), 2020



DATA SOURCE: Vermont Prevention Inventory Report, Vermont Department of Health, 2020
NOTE: Because multiple populations could be reported, percentages sum to more than 100.

Much of the opportunity for prevention and health education is taking place within schools under the director of Lead Health Educators (LHE). Data from the ***Vermont School Health Profiles Report 2020,***[34] provides insight into this work. Overall, 59% of LHEs had received professional development in the past 2 years on the topic of alcohol/drug use prevention, with 67% of LHEs indicating they would like additional professional development on this topic. Nearly all schools (95%) were addressing key alcohol and other drug-use prevention topics in a required health course. About half of schools conduct assessments for alcohol or other drug-use (49%) and/or have a cooperative or formal agreement with an outside agency to provide assessment and treatment (47%), and nearly three-quarters (71%) provide referrals to outside organizations for students needing treatment.

When asked whether they thought prevention messaging was reaching intended audiences, prevention sector participant responses were mixed. Some felt that effectiveness ebbs and flows depending on audience interest, readiness, and funding; this is why, one participant

[34] Vermont Department of Health. (2020). School health profiles report. Vermont Department of Health. https://www.healthvermont.gov/sites/default/files/documents/pdf/HSVR_SHP_School_Health_Profiles_Report_2020.pdf

explained, capacity building work is so important. There are also practical aspects, such as the difficulty reaching audiences in some of the most rural areas of the state. Some prevention sector participants reported that lack of sufficient funding also makes it difficult to engage in robust messaging campaigns. Participants also shared that measuring the impact of prevention efforts is a current challenge. As one prevention sector participant explained, ***"for harm reduction, you can see how you save a life right now, so that investment makes sense to people; it can be harder to show benefits of prevention since the results aren't immediate."***

> ***"We're not the best about selling what we are doing because it's not flashy and there's not that because you invested here, this is your outcome. It's hard to get people to see that because you invest now, you save later.*** "– Prevention Sector

Several prevention sector participants additionally shared that it has been difficult to partner with organizations outside their sector, including healthcare providers, law enforcement, employers, and mental health agencies. As one participant stated, ***"the funny thing is a lot of them care about overdose prevention but can't see the connection to primary prevention."*** Workforce challenges within and outside the prevention sector were identified by participants as a substantial constraint on collaboration.

Another challenge that arose during discussions was insufficient funding for prevention efforts. Prevention sector participants reported that prevention-focused organizations must rely on small grants and, at times, unrealistic expectations about outcomes given the difficulty collecting data about prevention efforts. There is also very little funding for advocacy and policy work. Additionally, they noted, changing funding priorities relative to target populations and substances makes it hard for prevention professionals to develop a strong messaging infrastructure. Funding challenges have directly affected the prevention workforce, which participants described as largely low wage, part-time employees with few career advancement options. As one prevention sector participant shared, ***"sometimes we can find the ONE person who's willing to do it for love of the work, but we can't then expand that program across the state because there aren't enough people who will do it without adequate pay."*** One participant did note, however, that new state funding is more flexible than in the past, allowing for prevention efforts to be more responsive to needs, interests, and opportunities.

A recurring theme across discussions with all sectors was the close connection between substance use and mental health and the many Vermonters who are struggling with both (co-occurring disorders). Participants recognized the importance of addressing mental health as a root cause of substance misuse. Prevention sector participants noted that current

substance use prevention efforts largely focus on education around the dangers of substances to discourage their use. One Prevention Consultant observed, ***"we do substance use prevention and our strategies are based on reducing substance use, but the reality is substance use is the result of all these underlying links and as a system we do not tread on that."*** One treatment sector participant working in schools shared a similar perspective saying, ***"the kids know it's a bad idea [to vape] and half don't want to be doing it even. One kid said, 'why are you talking to us about vaping like this is the biggest issue in our life?'"***

According to prevention sector participants, the broadness of social drivers of health and other risk factors for negative health outcomes, make it difficult to implement comprehensive substance use prevention strategies that focus more on upstream factors and that address both mental health and substance use. However, many participants did note that at a local level, community organizations are working to strengthen trauma-informed care and provide youth programming that focuses on the development of protective factors which naturally addresses some mental health concerns.

Recommendations for Prevention

Those working on substance misuse prevention in the state shared several suggestions to improve prevention efforts:

- ✓ **Continue and expand public education around substance use, addiction, and importance of prevention**. Prevention sector participants saw a need for continued educational efforts to raise awareness across the state about the root causes of substance use and addiction and what prevention is and why it's important. Participants shared suggestions for more targeted education efforts. Other participants recommended more messaging and education for seniors about the signs and dangers of substance misuse. A participant from the harm reduction sector suggested more grassroots outreach to users to inform them of the dangers of new substances.
- ✓ **Increase prevention messaging focused on cannabis to counter the perception of safety**. Given that legalization has normalized cannabis use and created the perception that it is safe, Prevention Consultants see a need for more messaging around the dangers of long-term cannabis use and its impact on the development of children and youth. A few suggested applying messaging lessons from alcohol and tobacco to campaigns focused on cannabis.
- ✓ **Support comprehensive prevention approaches and messaging that address mental health further upstream**. Participants in and outside the substance use prevention

sector described a need to work further upstream to address the causes of substance use, particularly among youth. One treatment provider stated, ***"primary prevention is so important and it's different than what we are looking at now."*** Participants provided a range of suggestions, including strengthening community-based youth services and programs that build trusting relationships with young people, expanding efforts that teach children and youth emotional management skills, and investing in youth and family-focused interventions like Prevent Child Abuse VT, parenting support programs, and home visiting programs that address trauma and adverse childhood experiences (ACEs) and support those who struggle with parenting.

- ✓ **Expand prevention programming through new partnerships with other sectors and organizations**. Participants saw an opportunity to expand prevention efforts through partnerships with others. One prevention sector participant described a recent effort to engage a small group of employers to develop a toolkit to support employers to prevent and address substance use. Others would like to see greater engagement with law enforcement to help them understand how prevention supports their work and to develop shared strategies. One participant also recommended expanding efforts to engage retailers in advertising. A treatment sector participant would like to see greater engagement of treatment and recovery providers in prevention work including the engagement of clinicians in regional prevention networks and better coordination between school-based Student Assistance Programs (SAPs) and local community clinical providers. This recommendation echoes earlier feedback received from the prevention sector in Vermont[35] which included the recommendation to "**build shared responsibility for prevention across state departments, and to identify areas for improved coordination among departments for greater impact and improved service delivery".**
- ✓ **Provide more sustained and predictable funding for prevention efforts**. Participants from the prevention sector saw a need for more consistent and sustained funding for prevention efforts across the state to continue and expand prevention work and to ensure stability in the workforce. Several participants observed that making the case for prevention to decision-makers and having data to share is essential. One participant recommended greater standardization of goals and measures for prevention across the

[35] Vermont Department of Health. (2022, July). *State Medical Practice Committee meeting materials*. https://www.healthvermont.gov/sites/default/files/documents/pdf/VDH-SMPC-July-2022-Meeting-Materials.pdf

state so the sector can more effectively collect and share information about prevention efforts and their impact.

> ***"If we don't put money on the table people are not going to be staying in this field and do the work. If we don't find a way to pay these people, we are going to lose people who have this great experience and love the work.*** "– Prevention Sector

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Awareness of Substance Use Services

Treatment Services

When asked whether they believed residents of Vermont are generally aware of available substance use treatment services, participants in every sector had varied responses. Some stated that people know about services, especially in smaller communities. One person in treatment reflected this view saying, ***"everybody knows everybody up here. If you've never heard about it, you have a friend who knows, might have even worked there, might have an aunt who works there."*** A treatment sector participant shared a similar perspective about awareness among Vermonters in more urban areas: ***"people [in Burlington] know where to go to get the drugs and the same clusters of people know where to go for treatment."***

Other participants, however, stated that people in Vermont do not know where to find treatment services, especially outpatient treatment services. and several stated that treatment providers have not been very effective at promoting their services. While treatment sector participants did report that they participate in local community events such as festivals and county fairs, they emphasized that they tend not to actively advertise their services. This is changing a bit, one participant shared, as private mental health and substance use service providers are more assertively marketing to those who have private insurance or self-pay. Currently, word of mouth, many reported, is the way many people learn about treatment services.

> ***"Word of mouth is incredibly important – most providers are not out there advertising. We try to draw less attention to ourselves, show that we are discreet."*** – Treatment Sector

Treatment sector participants stated that many of their clients come to their services through referrals from other organizations and agencies. The corrections/justice system is a significant referral source – both prior to and after incarceration. People may be required to attend treatment or recovery programs as part of their pre-trial service or during adjudication or may be connected to these services upon release from prison as part of probation conditions. Schools play a role in identifying and referring students to substance misuse treatment services, while Vermont's Department of Children and Families (DCF) identifies parents in need of services. First responders – law enforcement and emergency medical services – also identify those in need of services. Community-based organizations, such as those who work with victims of domestic violence, new immigrants, indigenous residents, and veterans also direct clients to resources.

Participants broadly stated that the healthcare system plays an important role in identifying Vermonters who need substance use services. Primary care providers, for example, screen patients for substance use and make referrals. Within the Hub and Spoke system, providers refer to one another depending on the medication needs of patients.

Participants frequently mentioned the role of hospital emergency departments (EDs). EDs are often the first stop for individuals in crisis. In these settings, providers, discharge planners, and social workers all play a role in connecting patients with substance misuse issues to withdrawal management or other services. Several participants in recovery stated that for people in crisis, their experiences in the ER can play a significant role in their pathway to recovery: stigmatization and negative experiences with these first-line providers may discourage patients from seeking further treatment or recovery services; compassionate care may encourage them to seek further help. As one person in recovery summarized, ***"the ER is a vital place because people go there and it's the place that could make or break you. If you have a good welcoming experience, it could push you to want to [seek treatment] versus if you are treated like shit you are going to want to walk out that door."***

Perspectives on awareness and success of VT Helplink, designed to improve connection to substance use related services within the state, varied. Several participants reported that it is not well known among people needing substance use services. One recovery sector participant stated, ***"it's one of those things where people working in the field know about it, but your average Joe isn't going to know about it."*** Others, however, reported that the VT Helplink is well known among some residents. For example, the Substance Use and Aging Specialist working at DSU stated that ***"since we put [VT] Helplink in place there has been an increase in older adults to seek care and get into the system because of [VT] Helplink."***

Recovery Services

Similar to perspectives about awareness of treatment services above, participants in each sector had varying views about the extent to which Vermonters are aware of recovery services.

Providers in primary care and hospital EDs were identified as common sources of information about recovery programs. Vermont's ED-based recovery coaches connect patients who present at the ED with substance use issues with an immediate recovery coach to begin to make the case for substance use treatment services. One participant from the recovery sector stated about 60% of the people they see decide to engage with recovery services. Primary care providers also play a role in screening for substance misuse and talking to patients about SUD services. Participants reported that mental health workers, the court system, DCF, police and EMS also refer people to substance use recovery services.

However, some people in recovery said that they did not know where to go when they were seeking services. As one person in recovery shared, ***"if you need any kind of help you really have to go looking for it."***. Several reported that they had learned about services through events held by recovery providers. Few reported that they learned of recovery services from VT Helplink. As with treatment services, word of mouth is the way many people learn of recovery services.

Harm Reduction Services

As with both treatment and recovery services, participants reported that awareness of these services varies. The prevalence of harm reduction kits in community-based organizations has helped to raise awareness of harm reduction strategies. Word of mouth, participants reported, is how many learn about where to go for harm reduction services. However, several participants in the harm reduction sector shared that some people are reluctant to use services even if they know about them, either because they do not want to be identified as a user or because they have been badly treated by services in the past.

> ***"A lot of people look at it like we're replacing one drug with another. But if I was using the drugs I was using I wouldn't be able to maintain a normal life and that is what people look past: it's not getting us high, it's helping us. We don't want to have to do this. We don't want to go to the clinic every day and everything, but we do."*** – Person in Recovery

Recommendations for Improving Awareness

Participants shared several recommendations for how to enhance awareness of substance use treatment, recovery, and harm reduction services, including engaging community-based

partner organizations and healthcare providers to be aware of and promote services, increasing promotion of the VT Helplink, and engaging in a broader public campaign about available substance use services. Additional suggestions included:

- ✓ **Engage in more varied and directed outreach and education to improve awareness of available SUD services**. Participants suggested more advertising overall including through social media, advertising in town websites, on-line videos, and community events. They also stressed the need for persistent advertising to ensure those who need to hear them receive them. A couple of participants advocated for a wider education campaign about available substance use services. One social services sector participant even recommended saturating the public with information ***"to where this information is so well-known it's an annoyance"***
- ✓ **Increase coordination with community partners to promote connections and handoffs to SUD services**. Several participants suggested enhancing promotion of treatment services through partnerships with community-based organizations, including those working with veterans, domestic abuse survivors, new immigrants, and pregnant persons. Recommendations from these organizations can help destigmatize treatment-seeking. When paired with "warm hand-offs," this approach can significantly influence clients' likelihood of following through with services.
- ✓ **Increase active engagement of healthcare providers to ensure optimal screening and referrals**. Recognizing healthcare providers' role in screening patients for substance misuse, participants recommended increased outreach and information sharing about treatment services with these professionals and their staff. One participant also suggested placing information about services directly in doctors' office waiting rooms.
- ✓ **Better promote the VT Helplink to increase awareness and utilization**. Several participants recommended a central information resource for substance use services, highlighting the need for increased promotion of VT Helplink, which was designed for this purpose. They suggested more advertising about the service—both directly to the public and to healthcare providers and community-based organizations. Participants stressed the importance of keeping information updated.
- ✓ **Implement a crisis support line to help maintain recovery**. One person in recovery suggested a call-in line similar to those in place for mental health crises. As this person explained, ***"if you think you are going to use, and you can't talk to anyone else having that place to call and talk to would be a good thing."***

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Substance Use Treatment Services in Vermont

Role of DSU

Vermont's Division of Substance Use Programs (DSU) oversees a comprehensive treatment system aimed at addressing substance use disorders (SUDs). The system encompasses a wide range of services, outpatient treatment, which includes Medications for Opioid Use Disorder (MOUD) and Medications for Alcohol Use Disorder (MAUD), residential treatment programs, and recovery support services.

A significant focus is on opioid use disorder, with statewide access to MOUD through partnerships with local health providers. The state uses a Hub-and-Spoke model, with regional "hubs" providing intensive treatment for individuals with complex needs, and local "spokes" offering more routine care in primary care, and specialty care settings, including specialty SUD care and women's healthcare.

Through these coordinated efforts, DSU aims to ensure that treatment is accessible, community-focused, and responsive to the evolving needs of individuals struggling with substance use. ***Click here for more information on DSU's current efforts towards treatment is available*.**

Perceptions of Treatment Services

According to numerous participants, access to many types of treatment services has increased in Vermont in recent years. This includes expanded adult withdrawal management and outpatient services, facilitating quicker patient access to needed services. Participants specifically mentioned recent service expansions by Valley Vista and BAART. Medications for Opioid Use Disorder (MOUD) programs were also described as accessible, with providers working to be as low barrier as possible. They also stated that the Hub and Spoke model, which provides MOUD services to those recovering from opioid use, has improved in recent years. MOUD is seen as a vital part of a continuum of services. As one treatment sector participant explained, ***"many patients fail if they just try abstinence. That's the model behind [MOUD] services. It's a model that's evidence based."***

Local partnerships were also described as effective. Some participants from the treatment sector mentioned close collaboration with local police and fire departments who, in turn, are

strong advocates for treatment and recovery programs. A few participants shared local examples of close cooperation with local hospitals, easing the transition from crisis care to more sustained treatment services. Others pointed to the strong community connections within the Hub & Spoke system, which enables providers to effectively provide case management and address needs relative to the social determinants of health.

According to participants, another strength of Vermont's substance use treatment system is the quality of the staff. A couple of people in recovery shared specific examples of providers who sat with them during withdrawal management, who cared for them when they were sick during withdrawal, and who treated them without judgment. One treatment sector participant stated, ***"the staff/providers are dwindling at alarming pace, but those treatment providers that remain are really dedicated."***

Several participants observed that recent expansion in Vermont's substance use treatment sector—and across the continuum of care—can in part be attributed to greater awareness of substance use across communities. While stigma is still an issue, the pervasiveness of substance misuse means that more people, including those with decision-making power, have been affected by it. As one person in treatment stated, ***"everyone has someone who's done this, brother, or grandmother. It's a lot more accepted nowadays and with it being accepted there's a lot more treatment."***

While participants reported that substance use treatment services have expanded, with more treatment options now available, they also shared that existing services are still insufficient to meet the need. Additionally, there are differences in accessibility across the state and by type of service.

Residential Treatment

Many participants stated that access to residential treatment or withdrawal management services has improved in Vermont in recent years. One recovery sector participant described this change: ***"In Central VT we had [the experience of] Vally Vista getting people in really quickly and it's made a huge difference."*** However, many participants felt that two acute bed programs with three locations statewide operating at ASAM levels 3.5/3.7[36] (i.e., Valley Vista and Recovery House) are not enough. More specifically, they noted that there are few or no beds in Vermont available for women, women with children, and youth. One participant

[36] ASAM Level 3.5 refers to clinically managed residential programs which are of high intensity for adults; Level 3.7 refers to medically monitored inpatient programs which of intensive for adults; Level 3.1 refers to clinically managed low-intensity residential programs (American Society of Addiction Medicine. (2013). *The ASAM criteria: Treatment criteria for addictive, substance-related, and co-occurring conditions* (3rd ed.). American Society of Addiction Medicine.)

stated that Valley Vista, which had served youth in the past, now only serves adults, leaving the state with no residential treatment beds for those under 18. As a result, one youth treatment provider explained, Vermont youth end up in hospital EDs or seeking out Medicaid enrollment and single case agreements for out-of-state services, which can take several weeks.

Figure 27. Current Residential Treatment Facilities and Beds in Vermont (2024)

Several participants also described a lack of 'social detox' beds, which can help bridge the divide between the emergency department and residential substance use treatment programs, as a significant gap in Vermont's treatment system of care. Per SAMHSA[37], **"social detoxification programs are short -term, nonmedical treatment services for individuals with substance use disorders[...] offers room, board, and interpersonal support to intoxicated individuals and individuals in substance use withdrawal."**

Another gap in the withdrawal management or short-term stabilization landscape has recently emerged as a result of the closing of services at another provider due to staffing challenges – The Howard Center's ACT 1 public inebriate program and the BRIDGE program which offered short-term stabilization in non-medical setting. While immediate availability of more intensive residential treatment may mitigate the need for more social detox or less intensive stabilization programming, several participants believed these were still needed to enable patients to get a head start in the treatment journey or for those uncertain or untrusting of the more intensive residential treatment programs.

Waitlists

Consistently, participants stressed the importance of gaining immediate access to residential treatment when a client is ready and willing to begin. They perceived that any waitlist for a residential treatment bed meant that providers could lose that critical "window" at the time clients are most receptive to services. As one recovery sector participant shared, ***"most people I talk to are having a problem today or yesterday and most people with SUD are wired to want something today and as soon as possible and I am the bearer of bad news, who has to tell them the process and waitlists and you can feel the whole demeanor***

[37] Substance Abuse and Mental Health Services Administration. (2015). *TIP 45: Detoxification and substance abuse treatment*. U.S. Department of Health and Human Services. https://store.samhsa.gov/product/tip-45-detoxification-and-substance-abuse-treatment/sma15-4131

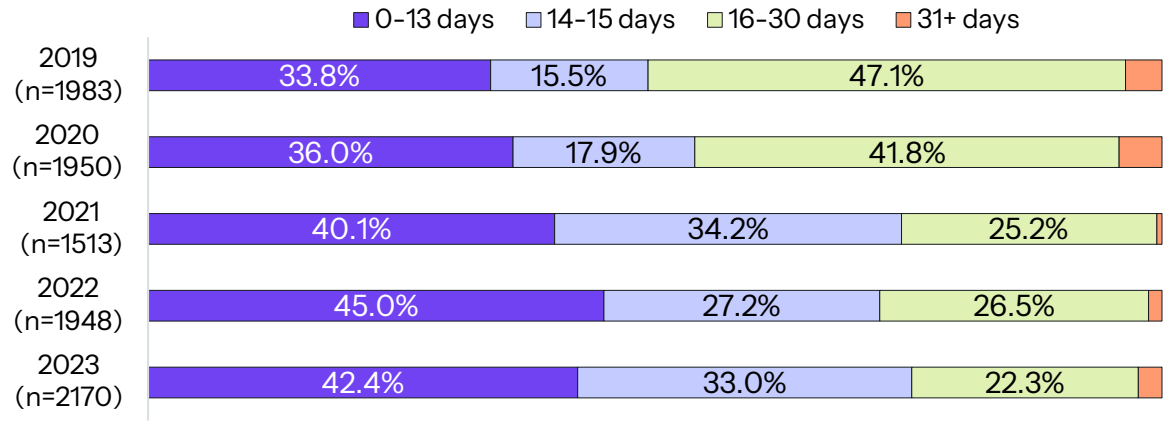
change and soul being crushed by my words." A treatment sector participant shared a similar view, saying, ***"if you wait too long to get youth into services, they are not going to be interested when off the waitlist."***

There were mixed perceptions as to whether waitlists for residential treatment beds were currently a concern in Vermont. Many participants' comments suggested that waitlists were believed to be the norm, while the treatment providers who were interviewed confirmed that the average daily census for beds over the past year has been below capacity, suggesting no shortage of residential treatment beds overall. Some of the misperception may stem from the experience of specific cases where bed limitations are acknowledged, such as beds for women, women with children, and youth. Additionally, treatment sector participants suggested that individual "no shows" at treatment have been complicating the perceptions of bed availability - "***I believe that this thought comes more from patients not showing or not answering phones and telling agencies '[Provider] cancelled the bed'. I hear this often and when I look it is not true."***

Length of Stay

Consistently, participants from across sectors stated the typical length of stay perceived to be available for residential treatment (i.e., 14-days or 2-weeks) was a considerable challenge to successful outcomes. Data available from DSU for years 2019 through 2023 confirm that, for most people, the length of stay in residential treatment was less than or equal to 15 days (**Table 16**). These data further show a shift occurred between 2020 and 2021 in which the average length of stay declined. Prior to 2021, over 40% of stays were longer than 15 days, whereas from 2021 onward, this percentage dropped to about 25%. Importantly, the percentage of stays designated as 'completed' has remained stable throughout the period (ranging between 60-65% each year) (data not shown).

Table 16. Trend in Residential Treatment Length of Stay, 2019-2023



DATA SOURCE: SATIS; NOTE: Data labels under 5.0% are not shown.

The factors driving the observed decrease in average length of stay are unclear. Treatment sector participants discussed a shift in the Medicaid payment model for residential treatment that occurred in 2019 (effective January 1, 2019) and the COVID-19 pandemic which emerged in Spring 2020, but how these factors may have contributed to a decreased average length of stay is unknown.

Almost universally across discussions with participants, 2-week residential treatment stays are perceived to be insufficient for optimal care and longer-term recovery planning. Furthermore, the lived experience of a 2-week stay has become so common that most participants believed that this is a treatment limit enforced by Medicaid.

> ***"We are triaging these people for 21 days. We're triaging the detox and we're triaging the treatment. Putting enough band aids on to get them to the next steps. Vermont Medicaid only covers 17-21 days and prior to [January 2024 rate increase] it was only 14 days."*** – Treatment Sector

> ***"That length of stay is such an issue, even 28 days realistically for the drugs being used is not enough to even scientifically make a difference and we are told all the time its Medicaid or Medicare that's the issue"*** – Recovery Sector

An additional point that was made by many participants was that the evolution of the drug supply (e.g., xylazine) along with increasing polysubstance use has led to more severe addictions with less predictable responses to withdrawal and more challenging side effects. Violence and psychosis were noted as more common, and the likelihood of stabilizing people within a 2-week period was reported by participants as increasingly difficult.

> ***"You aren't even done detoxing after two weeks and they kick you out. And you are detoxing through all of it, and a good share of it you are missing out on groups and stuff, so it's even shorter in reality."*** – Person in Recovery

> ***"The stay at rehab isn't long enough. For VT its 14 days and I know for myself I was a little bit clear minded but by the end I was barely testing negative for the stuff I was coming in on"*** – Person in Recovery

Payment Model

The residential treatment payment model (e.g. episodic payments replacing fee-for-service payments) which went into effect January 1, 2019, provides a single payment to residential treatment providers for all services needed by a patient assessed as ASAM Level 3.5/3.7 for the entire episode of care, from pre-admission through discharge with no limitation on length of stay (as summarized in **Table 17**). In this model, the cost of long stays is intended to

be offset by short stays, allowing providers to have more predictable revenue streams.[38] Some of the rates have increased over time due to Home and Community-Based Services (HCBS) funding. HCBS include medical and non-medical services that are provided in a home or community-based setting rather than an institutional setting and serve a variety of populations, including people with substance use treatment needs.

Table 17. Valley Vista and Recovery House Adult Episodic Rates for Treatment Episodes of three or more nights (ASAM Level 3.5/3.7)

Primary Substance and Co-Occurring Category	Rates 1/1/20	Rates 5/1/21	Rates 7/1/23 (Includes HCBS[1])	Rates 1/1/24 (Residential only)	Rates pending 4/1/25 (Excludes HCBS)
Other/Opioid Z - No co-occurring	**$2,976**	**$3,244**	**$3,684**	**$5,084**	**$4,931**
Other/Opioid A	$3,146	$3,429	$3,894	$5,374	$5,213
Other/Opioid B	$3,334	$3,634	$4,127	$5,695	$5,524
Other/Opioid C	$3,533	$3,851	$4,373	$6,035	$5,854
Alcohol/Benzo Z - No co-occurring	**$3,388**	**$3,693**	**$4,194**	**$5,787**	**$5,614**
Alcohol/Benzo A	$3,589	$3,912	$4,442	$6,130	$5,947
Alcohol/Benzo B	$3,805	$4,147	$4,709	$6,499	$6,304
Alcohol/Benzo C	$4,035	$4,398	$4,994	$6,892	$6,685
Short Stay (per diem)	**$220**	**$220**	**$249.83**	**$345**	**$334**

DATA SOURCE: Division of Substance Use Programs (DSU) Medicaid Rate Sheet, Effective 5/1/2024
Note: Rates have been rounded to the nearest dollar.
[1] Signed into law by President Biden on March 11, 2021, Section 9817 provides states with additional federal funding for Medicaid HCBS. States received a time-limited 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures. Vermont's plan for the HCBS FMAP funding is outlined in the Vermont HCBS Spending Plan Narrative Update, which is typically updated semi-annually. One example of activities in the Vermont HCBS Spending Plan Narrative includes provider rate increases.

Participants from the treatment sector reported that the new payment model, combined with more recent inflationary pressures and workforce challenges, have contributed to financial pressures and an inability to fully cover the cost of care, despite near-annual increases in episodic payment rates. One participant in the treatment sector specifically noted that prior to the recent rate increase in January 2024, the reimbursement rate was only covering 47% of their costs as more than 95% of their clients were Medicaid recipients. So, while the goal of the episodic payment model was to promote efficiency and innovation, and

[38] Substance Abuse and Mental Health Services Administration. (2023). Exploring value-based payment for substance use disorder services in the United States (HHS Publication No. PEP23-06-07-001). Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

to better ensure that people receive the appropriate types and levels of care, it appears that providers are unable to offset longer stays with shorter stays.

> ***"On average, we're getting reimbursed [by Medicaid] for 15 days of treatment. If we kept somebody for 30 days, we would get reimbursed about $200/day, which is not even close to covering costs. There's not another payer that does this. Cigna, BlueCross, those people are getting 35 days out of the gate. The relapse rate of those people is significantly less."*** – Treatment Sector

Continuum of Care Post Residential Treatment

Through the many discussions with participants, it became clear that the frustration and concern for the short length of stay in residential treatment was due to the lack of safe and stable recovery environments post discharge for many people. The availability of services for those leaving residential treatment, particularly recovery housing or sober living beds, were described as sparse throughout Vermont.

Figure 28. Current Recovery Sector Facilities and Beds in Vermont, 2024

These services were identified by participants as particularly important, if not essential, for many people. Discussions across the treatment and recovery sectors frequently surfaced the experience that most of the limited housing options in Vermont frequently have weekslong waiting lists that present huge barriers and prevent the continuation of a supportive living environment post residential treatment. In some instances, treatment sector participants noted that they had been able to successfully place people in programs out of state, including Maine, New Hampshire, Massachusetts, and even Delaware. In other instances, participants noted they had been forced to discharge some people as homeless.

> ***"I heard people say there is no difference between long term [residential] treatment and [outpatient] IOP services, and that may be true but if you live in a crack house, or unhoused or subsidized housing, and people are dealing in that environment, then you don't stand any chance of sustaining abstinence long term, so it turns into a rinse and repeat scenario."*** – Treatment Sector

A related finding also arose during the ***VT Helplink Equity Assessment***, which was conducted in 2022-2023. A key gap identified through that effort was "aftercare" for patients

released from residential treatment. Such care, which included supportive living environments as well as case management, was described as becoming less and less accessible. One participant of that assessment shared, **"Where do you go after you are released from [treatment]? Group homes are limited and then even if you find it, there needs to be effective leadership at these homes. Aftercare is really important for anyone who goes through any sort of treatment for anything. It's lacking."**

Adding to the availability challenge are the administrative hurdles residential treatment providers face as they are developing care plans prior to discharge from residential treatment. Some treatment sector participants noted that staff are on hold for 3, 4, or even 7 hours with economic services, transportation, or housing providers, trying to develop an aftercare plan. Some requirements of these services further impede the process, such as ***"having to be done on date of discharge"***, ***"only allowing screening on one day per week"***, or ***"getting denied because they require a 48-hour advance notice"***. This experience points to areas of opportunity for better communication and collaboration across the continuum of care regarding individual cases. As one treatment sector participant stated, ***"not enough communication. Providers are not on the same page and services are not on the same page for the same patient. Things are getting missed and are complicated".***

> ***"I would like to see clients receive assistance in receiving all levels of care in a seamless way. Need case management support, like see in mental health services. "*** – Treatment Sector

Outpatient and Intensive Outpatient Treatment Services

Participants stated that outpatient services have expanded in recent years. Through these services, Vermonters can receive assessments, develop treatment plans, and engage in group counseling or therapy. A treatment sector participant working with youth reported that the availability of outpatient programs for youth has also increased in recent years.

> ***"Folks can access outpatient services much better now than before – getting in and talking to someone and scheduling is much better than before."*** – Treatment Sector

However, people in recovery from the Northern and Central parts of Vermont shared that there are not enough intensive outpatient (IOP) programs in these regions, and they do not last long enough. Outpatient programs for children and youth are also lacking according to participants. One treatment sector participant shared that the Northeast Kingdom has a new clinician serving youth, which expands access in that region, but the CenterPoint Adolescent

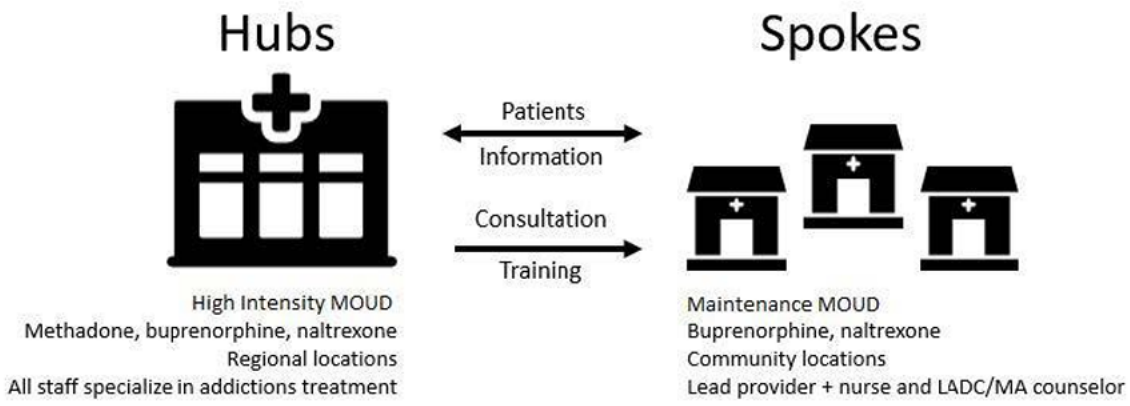
Treatment Services program in the Burlington region program is now closed. Several participants also stated that outpatient services for AUD services were difficult to obtain, in part because of the emphasis on treatment for higher risk drug use.

> ***"They don't have enough IOP programs in this area and if you don't have transportation to get to where the IOP are you are out of luck."*** – Person in Recovery

Hub and Spoke Services

Hub and Spoke is Vermont's system of Medication Assisted Treatment, supporting people in recovery from opioid use disorder (**Figure 29**). The Hubs are Opioid Treatment Programs, with expanded services and strong connections to area Spokes. There are currently 9 Hubs in Vermont. Each Hub is the source for its area's most intensive opioid use disorder treatment options, provided by highly experienced staff, while Spokes are Office Based Opioid Treatment settings, located in communities across Vermont. At many Spokes, addictions care is integrated into general medical care, like treatment for other chronic diseases.

Figure 29. Hub and Spoke System in Vermont



Participants stated that Vermont's Hub and Spoke services have improved in recent years. They pointed to the stability of Spoke organizations and the partnerships they have formed in the communities they serve, which have increased access and improved case management consistent with the goals outlined in Vermont's Blueprint for Health. In one community, for example, the MOUD team has collaborated with medical providers from outside the original umbrella to facilitate referrals, so patients do not have to wait for a primary care appointment.

> ***"Back in the day to get into these places they'd make sure you had to get into rehab before they accepted you. They also had 3-6 month long waiting lists. And so, you had to get into rehab, which also has a waiting list. In recent years, they're***

> ***getting people in so much quicker. People that need help they'll get in in like a week and I know people who've gotten in the next day."*** – Person in Treatment

However, many shared, there are gaps and challenges in the Hub and Spoke system. Participants referenced that the model was originally created and based upon people using heroin, and that more recent shifts in the drug supply are putting pressures on the services in ways contrary to the original design.

> ***When the model was created it was based on people using heroin [and] we're having to modify it. More people are going on methadone vs buprenorphine so the whole Hub/Spoke model is losing its original intention.*** – Treatment Sector

This was seen as leading to growing challenges with funding as the shift towards the utilization of Hub services, particularly for methadone. One participant in the treatment system additionally stated that people are also increasingly using non-Spoke, often for-profit, sites for medication assistance. These shifts and increasing competition have further strained resources and created staffing challenges and instability in the system as well as concerns about the quality of care. As one treatment sector participant stated, ***"we're only funded through Medicaid patients, and we're expected and asked to serve everyone regardless of payroll."*** And another, "***In our service area we've seen the # of Medicaid patients, that we get funded for, go from 98% of patients to less than 65%. We're seeing a huge transition."***

With a greater preference or need for methadone, several participants noted the geography of Hubs with few methadone clinics in some parts of the state, like Bennington. One treatment sector participant in Bennington did point out that the Spoke services in that area were robust and accessible, filling at least some of the need in that region but that "***we can't ask people to travel 2 hours round trip to get methadone***".

> ***"Vermont is really far ahead from others in the country in terms of treating SUD. People look to us as this great model, but I think we can do better than Hub and Spoke. I really do. I think we're ready for the next step, and more innovation." –*** Treatment Sector

Additionally, several participants shared that the system was designed so that people would move, or step down, from Hubs (and the use of methadone) to Spokes (and the use of buprenorphine) if their care allowed for such a transition. However, some participants reported that the motivations to move between Hubs and Spokes are shifting. They said that some patients are reluctant to move once they establish relationships with specific providers and the administrative process of moving back to a Hub (if needed in the future) is

unnecessarily duplicative, likely making providers or patients wary of a move to a Spoke provider. As one treatment sector participant described there is ***"an administrative burden from going from one agency to the other"*** and that ***"each agency has their own expectations and clients need to tell their story about three times in a row"***. This participant continued to say that the state does ***"not have too many places where you can go to different levels of care in the same entity"*** which can add to the administrative burden faced by patients seeking treatment.

Barriers and Challenges to Treatment

According to interviewees and focus group participants, there are various barriers that hinder access to treatment services in Vermont.

System Capacity Constraints

As described earlier, while participants noted that substance use treatment options have increased in Vermont in recent years, they still perceive that existing options are not sufficient to meet needs, leading to waitlists or delays in service provision. System capacity is significantly affected by staffing shortages and funding constraints. Participants named facilities that have closed or cut back services due to staffing and/or funding. Participants reported that they face challenges hiring staff, both finding qualified staff and being able to offer competitive wages.

Multiple treatment sector participants stated that the current Medicaid payment "bucket system", which provides a lump sum payment for residential and/or high intensity treatment services, substantially constrains system capacity. From the perspective of participants working in the residential treatment system, this payment model effectively limits the length of stay that providers can afford, typically, as one provider reported, between 17-21 days. As described above, this length of stay is deemed insufficient for treatment services without sufficient and supportive after-care services, such as recovery housing, which is needed for a solid pathway to recovery. As a result, providers reported that they seek out grant funding to be able to cover costs.

> ***We are triaging these people for 21 days. We're triaging the detox and we're triaging the treatment. Putting enough band aids on to get them to the next steps.*** –Treatment Sector

Participants with lived experience also spoke about the impact of low Medicaid reimbursement on their access to services. As one person in recovery stated, ***"there isn't even enough places to get people treatment and if you have Medicaid, you are at the***

bottom of that list." An additional pressure on system capacity, one treatment sector participant shared, has resulted from the way housing people with substance misuse was handled during COVID. At that time, resources were available to house people with substance misuse in hotels, without services. After funding ended, the state asked substance use centers to meet the service needs of these people. Now, this participant shared, ***"there are hotels with needles and addiction, and this created a cascading effect of demise."***

Geography and Transportation

Participants frequently mentioned transportation as a substantial challenge to accessing substance use services in Vermont. Public transit options are limited and serve only a small radius. Chittenden County, for example, has a bus system, but it is not accessible to those in outside towns like Milton.

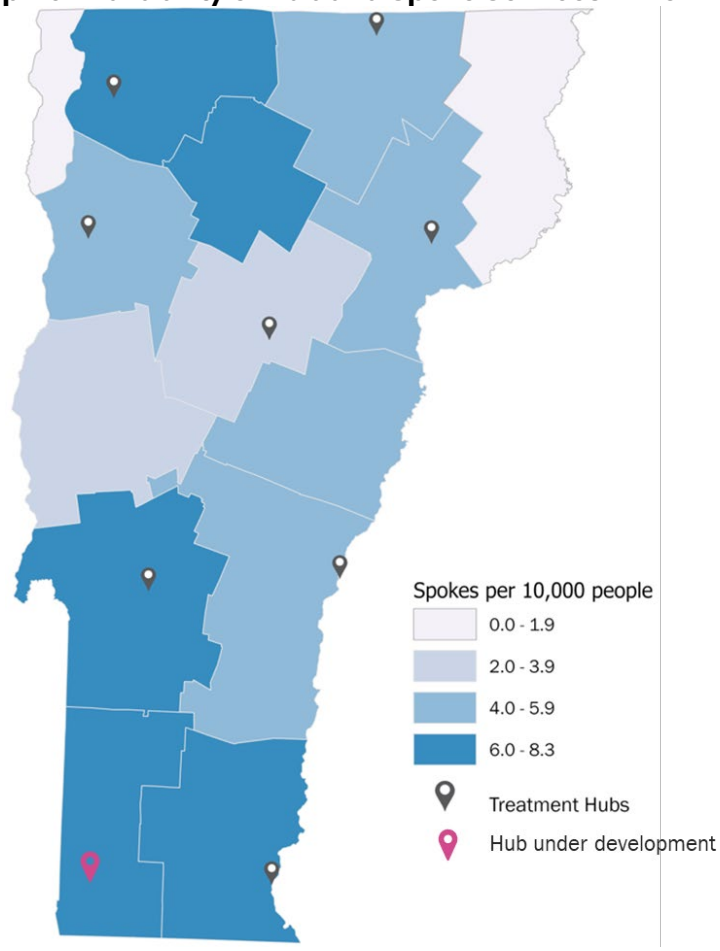
As one treatment sector participant shared, ***"we are a rural state; folks travel from outskirts in the county, and it will take 2 ½ hours to go 8 miles by public transportation."*** Most communities do not have any public transportation options. Those who have used public transit reported that they are unreliable, which has resulted in missed appointments. Taxis and Ubers are cost-prohibitive for many. Participants relayed that transportation can be particularly challenging for those using methadone which includes some rigidity around dosage times that available transportation options may not be able to meet.

> ***"Transportation is a huge issue. If someone really wants to get clean and get treatment but they got themselves in a rut, got their license taken away, how do they get into meetings, get treatment, and get services?"*** – Person in Recovery

Medicaid offers transportation, and several participants stated that they had good experiences with these services. However, coordinating this service can be a challenge for some, such as people leaving the ED. Some treatment providers also offer transportation. Central Vermont Medical Center, one participant reported, recently started providing hospital vans to transport patients to residential treatment. Turning Point was also identified by participants and providing transportation to treatment facilities.

Figure 30 shows the geographic spread of the state's Hub and Spoke locations as of 2022. The map shows higher rates (6.0-8.3) of Spokes per 10k residents in the southern and northwest regions of Vermont, and lower rates (0.0-3.9) in northeast and central regions. Areas with more availability of Spoke services may still struggle with transportation needs among residents. Additionally, the location of Hubs, while established to meet the needs of residents in each region of the state, illustrate the travel distances required for those living in more rural areas within those regions.

Figure 30. Geographic Availability of Hub and Spoke Services in Vermont, 2022



DATA SOURCE: Vermont Department of Health, Division of Substance Use, Availability of MOUD Services, 2022

Paperwork and Privacy

A few participants highlighted that paperwork and information that must be shared to receive substance use treatment services also create a barrier to accessing care. Several people in recovery specifically mentioned the length of time it takes to complete intake forms (much of which are required by Federal funding sources), the invasive questions, and the advanced reading levels of questions. As one person in treatment shared, ***"when you go in to take your first steps to get in there, you're not feeling good, your life is all messed up. The last thing you want is all the paperwork."*** Several participants stated that answering some questions—such as those about abuse and trauma—can be distressing. Others expressed concern about the privacy of information shared and worried about information being shared with employers and DCF. These concerns persist even though HIPPA and 42CFR Part 2 privacy laws apply to all care delivered in Vermont which protects the

confidentiality of SUD treatment records and ensures that individuals' privacy is maintained when seeking or receiving treatment.

Responsiveness

Several participants stated that language barriers and lack of cultural responsiveness within the substance use treatment service community can also create barriers to care. Cultural responsiveness, participants explained, includes understanding of cultures of other countries, as well as understanding of indigenous and military culture. While some providers are equipped to work with diverse groups, others are not, and this prevents some residents from seeking services.

Treatment Readiness

Lack of readiness can also be a barrier to treatment. According to the 2022 National Survey on Drug Use and Health (NSDUH), one of the top reasons individuals with substance use disorder (SUD) do not seek treatment is the belief that they should be able to handle their condition on their own. Specifically, 22.2% of those who did not seek treatment reported this reason.[39] Additionally, many people with SUD are experiencing multiple challenges in their lives, including meeting basic needs like housing and food access, and this can impede their ability to prioritize substance use services. As one social service sector participant stated, ***"if you have other things on your mind, like where you are going to sleep, that will be the priority."*** For this reason, participants stressed the need for services to be available when people are ready.

Co-occurring SUD, mental health, physical health, or developmental and age-related needs also may contribute to treatment readiness and present additional barriers to accessing needed SUD services. People with co-occurring disorders may not be focused on their SUD needs or recognize that they have a substance use issue. Additionally, some substances can exacerbate mental health conditions and individuals may use substances to try to address their mental health symptoms. Numerous participants stated that serious mental health needs need to be addressed first, or at least concurrently, before substance misuse can be effectively tackled. As one person in recovery stated, ***"you need to address the mental health first, that is so important."***

[39] Substance Abuse and Mental Health Services Administration. (2022). National Survey on Drug Use and Health (NSDUH) detailed tables. Substance Abuse and Mental Health Services Administration.

Treatment Sector Workforce

As described above, staffing substantially limits treatment system capacity. Participants reported staff vacancies for positions such as nurses, counselors, medical directors, and even security. Difficulty finding nurses was a theme in several conversations. Participants stated that nurses often work per diem and part time; since COVID, many in the workforce have become traveling nurses, which has increased costs and contributed to workforce instability. One treatment sector participant stated, ***"travel nursing has completely ruined nursing in Vermont. Costs have skyrocketed astronomically since COVID."***

Staffing challenges are directly linked to low compensation in the social services sector, including substance use treatment. Treatment sector participants who serve a large number of Medicaid patients talked about the challenges of paying a competitive wage when reimbursement rates are low. The high cost of living in Vermont makes it difficult to find staff willing to accept lower salaries. For context, the living wage for a single adult with no children in Vermont is estimated to be $23.02/hour or $47,892.[40]

One treatment sector participant stated, ***"our recovery technicians, being 95-97% Medicaid, aren't getting paid a lot. I've been able to find a lot of mission-driven individuals, but how do I keep them when their rents and expenses are going up?"*** A couple of participants identified additional challenges that affect staff hiring, including the lack of scheduling flexibility and demands of the job.

Participants reported that an aging workforce and workforce turnover also creates difficulties for the substance use treatment sector. More experienced members of the workforce are retiring, and fewer younger staff are stepping in. Turnover is also a challenge as staff move onto higher paying positions once they gain experience or licensure. This can affect the quality of care as one treatment sector participant explained: ***"the hardest for patients is counselors that come and go. Imagine spilling your guts, telling your deepest darkest issues to someone, and having to do it all over again [with someone new]."*** Noting that more experienced staff tend to move to for-profit providers and Medicaid clients tend to be higher need, another participant stated, ***"it's a system where the most experienced therapists are not where the most complex need is."***

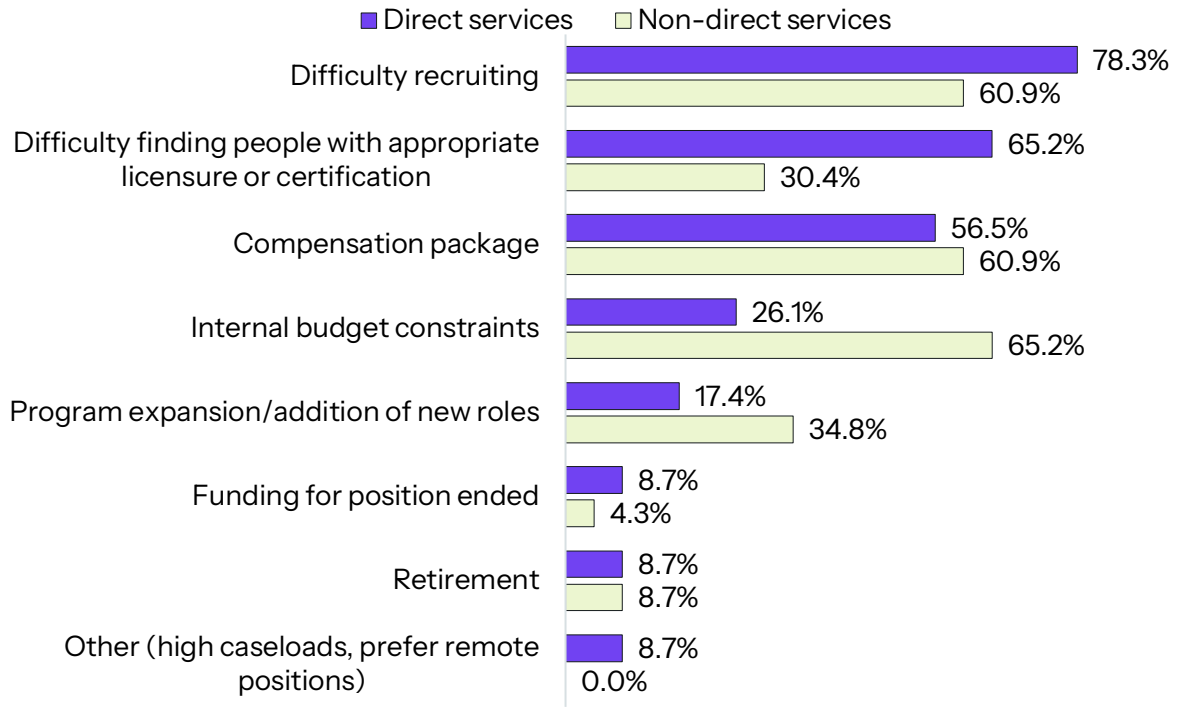
The DSU Workforce Survey of Provider Management (2024) was completed by organizations across the care continuum: prevention, treatment, recovery, and harm

[40] Living Wage Calculator. (2024). Massachusetts Institute of Technology; https://livingwage.mit.edu/states/50

reduction. Among 23 responding organizations, the overall vacancy rate for direct-service positions was 16%, and for non-direct, 6%. Furthermore, organizations report that within the next year, they anticipate an average loss of 14% of direct staff and 15% of non-direct staff.

When the survey asked about their perceptions on workforce vacancies, direct services organizations cited difficulties in recruitment (78.3%) as the primary reason for vacancies while non-direct service organizations cited internal budget constraints (65.2%). Over half (65.2%) of direct service organizations also reported difficulty finding candidates with appropriate licensures (**Figure 31**).

Figure 31. Perceived Reasons for Workforce Vacancies Among Organizational Leaders across the Care Continuum in Vermont, 2024



DATA SOURCE: DSU Workforce Survey of Provider Management 2024

Respondents of the DSU Workforce Survey, in open-ended questions, noted that staff recruitment and retention were major challenges, particularly for qualified and licensed clinical staff such as RNs, therapists, and LADCs. They also noted that it is difficult to find people with lived experience of SUD who are stable and have the education and job skills required for the position. Some noted in their responses that basic computer skills are essential in many direct service roles, but hard to find in candidates. There was also the sense that there was a lot of competition between employers in this sector for open roles, with a

limited applicant pool to draw from. Importantly, survey respondents indicated that the direct service vacancies have negatively impacted the quality of care delivered.

When asked what can be done to improve system and workforce capacity, many treatment sector participants cited funding, specifically increased reimbursement. This would enable providers to offer more competitive wages and meet staffing needs, and perhaps expand services as well. More broadly, a couple of participants pointed to the need for more housing, especially affordable housing, so that providers can afford to live in the communities they serve.

At the state level, Licensed Alcohol and Drug Abuse Counselors (LADC) FTEs have declined 16% between 2019 and 2023, from 264.3 FTEs to 222.4 FTEs. The data further show (**Table 18**) that there has been a decline in LADC FTE's in each county between 2019 and 2023, with the greatest declines in Essex County, which had 0 FTEs in 2023, and Bennington County, which went from 27.1 to 21.5 FTEs. Lamoille County has the highest number of FTEs among all counties, at 54.6, followed closely by Orange County with 51 FTEs.

Table 18. Trend in Licensed Alcohol and Drug Abuse Counselors, FTEs per 100,000 by County, 2019-2023

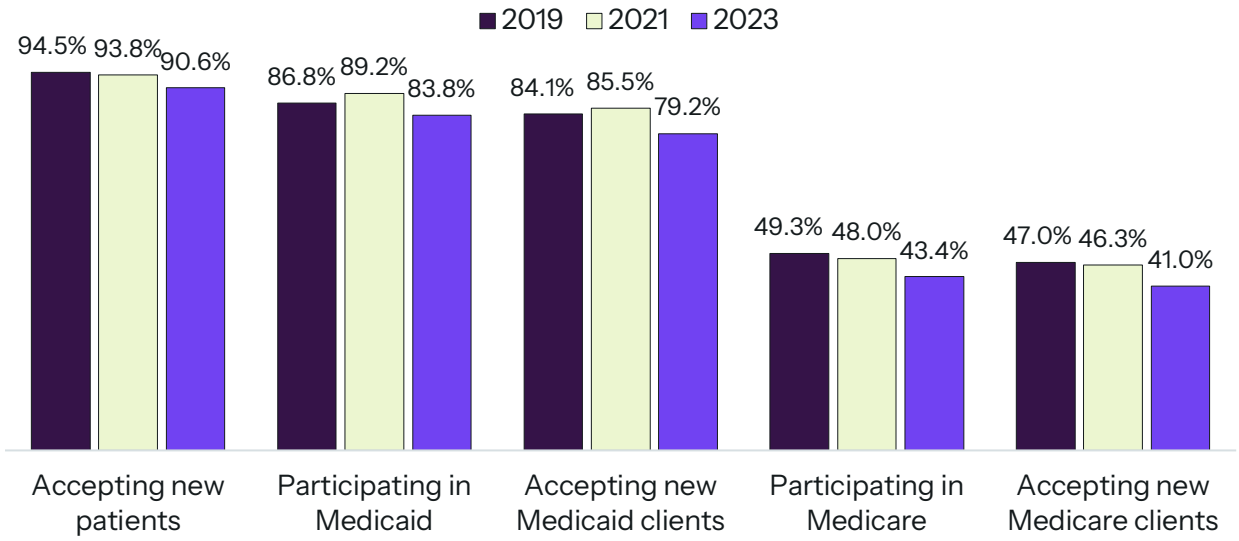
	2019	2021	2023	% Change since 2019
Addison	27.1	20.0	21.5	-20.7%
Bennington	20.9	12.5	11.7	-44.0%
Caledonia	55.7	30.4	44.6	-19.9%
Chittenden	51.0	40.3	42.6	-16.5%
Essex	5.6	6.8	0.0	-100.0%
Franklin	33.0	29.3	24.8	-24.8%
Grand Isle	13.2	6.4	15.0	13.6%
Lamoille	54.9	40.7	54.6	-0.5%
Orange	54.2	36.4	51.0	-5.9%
Orleans	42.4	26.1	30.4	-28.3%
Rutland	40.0	29.4	31.5	-21.3%
Washington	43.7	36.1	36.9	-15.6%
Windham	45.7	32.4	29.6	-35.2%
Windsor	36.6	21.8	28.4	-22.4%

DATA SOURCE: Vermont Department of Health, Health Care Workforce Census, Licensed Alcohol and Drug Abuse Counselors, July 2019 & March 2024; NOTE: LADCs use psychotherapy and other methods to assist people in understanding alcohol and drug abuse dependency problems, and defining goals, and planning actions reflecting the persons' interests, abilities, and needs.

In the context of these declines, there is evidence of impact on accessibility to LADCs. Although most counselors are still accepting new patients, the percentage has gradually

decreased between 2019 (94.5%) and 2023 (90.6%) (**Figure 32**). Less than half of counselors participated in (43.4%) or accepted new clients from (41.0%) Medicare in 2023, which may be due to Medicare not reimbursing LADCs directly.

Figure 32. Trend in Indicators of Access to Licensed Alcohol and Drug Abuse Counselors in Vermont, Percent (2019-2023)



DATA SOURCE: Vermont Department of Health, Health Care Workforce Census, Licensed Alcohol and Drug Abuse Counselors, March 2024; NOTE: Medicare does not reimburse Licensed Alcohol and Drug Abuse counselors directly so LADCs accepting Medicare must be able to bill using another provider type or provide services under supervision of a covered license type.

Further data details the demographic and practice characteristics of the LADCs currently practicing in the state.[41] As of 2023, the median age of LADCs was 54 years, with 37% being age 60 or older. Approximately one third of LADCs (35%) report working less than 20 hours per week at their main site while about half (52%) report working between 20 and 39 hours per week.

Data also provide insight into the populations served by Vermont's LADC workforce (**Table 19**). Most LADCs serve adults ages 18-64 (94.2%), while about half serve older adults (47.6%) and approximately a quarter counsel youth (27.5%).

[41] Vermont Department of Health. (2024, March). Health care workforce census: Licensed alcohol and drug abuse counselors.

Table 19. Populations Served by Licensed Alcohol and Drug Abuse Counselors in Vermont, Percent (2023)

	% of LADC's Serving Population in Vermont
Adults (18-64)	94.2%
Patients receiving MOUD	68.9%
Older Adults (65+)	47.6%
Youth (4-17)	27.5%
Military	27.5%

DATA SOURCE: Vermont Department of Health, Health Care Workforce Census, Licensed Alcohol and Drug Abuse Counselors, March 2024

Additional segments of the workforce which support people with SUD includes Licensed Clinical Social Workers (LICSWs) and Licensed Mental Health Counselors (LMHCs). Data from 2023 show that there were 1,072 LICSWs actively working in VT and of these, 81.6% reported mental health as their main specialty.[42] Data from 2024 show that there were 1,017 LMHCs actively working in VT and of these, 181 reported that they are also licensed as a substance abuse and/or addiction counselor.[43]

Recommendations for Treatment Services

Participants identified several areas that need attention to address gaps in Vermont's treatment services.

- ✓ **Increase the range of residential treatment options available to residents**. Many participants suggested more residential treatment beds are needed, especially in the northern part of the state and for women, women with children, and youth. Participants also recommended more social detox beds across the state, which would help fill the gap of time before a residential treatment bed becomes available and allow people to begin detoxing as soon as they are ready.
- ✓ **Increase the range of outpatient treatment services to better meet the diverse needs of Vermonters.** Many participants reported that they would like to see outpatient programs expanded geographically, especially in northern and central parts of the state, and also in terms of who is served, such as children and youth. Several participants also

[42] Vermont Department of Health. (2022). *Health care workforce census: Social workers, 2022*. https://www.healthvermont.gov/sites/default/files/document/HSI-stats-prov-sw22-report.pdf
[43] Vermont Department of Health. (2023). *Health care workforce census: Mental health counselors, 2023*. https://www.healthvermont.gov/sites/default/files/document/HSI-stats-prov-mhc23.pdf

noted that the focus on addressing the opioid epidemic has shifted attention away from alcohol and cannabis, two more commonly misused substances; they suggested more attention be given to addressing treatment of AUD and cannabis misuse through outpatient programming.

- ✓ **Increase reimbursable episodic payments for residential treatment and expand length of stay and/or availability of supportive aftercare (i.e., recovery housing)**. Numerous participants recommended that Medicaid increase the episodic reimbursement rate for residential and high intensity treatment stays to ensure providers are able to cover costs and provide more sustainable capacity. Additionally, many participants recommended that the length of residential treatment stays be extended so that patients are more successfully stabilized and have a clearer pathway to recovery. As one person in recovery stated, ***"definitely get insurance to pay for longer [residential treatment] because it takes time to see benefits of being sober and that starts being in a place where you cannot use while you get your head straight is essential."*** Participants also consistently pointed out the lack of supportive programing and stable housing available to people discharged from residential treatment in Vermont as a key need.
- ✓ **Expand Hub and Spoke services to underserved geographies and to meet the growing demand for methadone**. Several participants suggested expanding Hub and Spoke locations, so these are more accessible to residents, including a Hub in Bennington. To address challenges to accessing methadone, one participant recommended establishing methadone-like smaller HUBs. Several participants noted an increased need for methadone among clients, which they attributed to shifting drug supplies locally. As one treatment sector participant stated, ***"I think a lot of people have transitioned to methadone because of fentanyl."***
- ✓ **Address transportation barriers to improve access to SUD services**. Transportation is a barrier to accessing services for many residents; however, several participants noted that addressing this is difficult in a rural state. A few participants suggested that treatment providers find ways to provide more extensive and timely transportation options. As one person in recovery stated, ***"it would be so cool if you call rehab, and they have a bed available then they had some type of outreach that could come and pick you up because I could change my mind in an hour."*** A couple of other participants wondered if mobile outpatient services could be expanded. One harm reduction sector participant stated, ***"you've got to be very flexible with how people get their services"***

- ✓ **Increase cultural responsiveness of treatment providers through training and hiring practices**. Several social service sector participants who work with special populations—including new immigrants, indigenous residents, veterans, and seniors—suggested staff training to enhance the ability of treatment providers to meet the needs and work with these groups. Hiring staff from these communities was also suggested.
- ✓ **Expand strategies to identify those who need SUD services at an early stage or younger age**. Several treatment sector participants suggested more needs to be done to identify those who need treatment services earlier, before they are in crisis and intensive treatment is required. As one treatment sector participants stated, ***"sometimes the push to go to rehab happens too late."*** Suggestions included greater engagement with and education of primary care providers so they can identify and refer early; better street outreach including to encampments and shelters (i.e., expansion of work currently being done through Vermont's syringe service programs); and closer work with schools and organizations serving youth and their families.

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Recovery Services in Vermont

Role of DSU

Vermont's Division of Substance Use Programs (DSU) has worked with community partners to develop a strong infrastructure of support for individuals seeking recovery. DSU supports recovery through a variety of services and initiatives, including a system of 12 regional community-based recovery centers located throughout the state, robust Recovery Coaching and Peer Recovery Support Specialist programs that promote community connections and referrals, and access to a network of recovery residences to support housing stability during recovery. These services provide individuals with the tools to maintain recovery. ***Click here for more information on recovery services in Vermont***.

Perceptions of Recovery Services

Throughout conversations, participants working in the system of care and those who have received services underscored the importance of the recovery process and the need for a strong and effective recovery services infrastructure to ensure long-term well-being. Attaining sobriety, they stressed, is a process that requires not just reducing/stopping use,

but also rebuilding relationships and skills for self-sufficiency. Participants frequently identify the range of supports that are needed, including safe places to stay, connection to resources, accountability, and distance from environments and people who could contribute to relapse. As one person in recovery summarized, ***"we need every part of this to be successful, we really do. Recovery is not just about not using drugs."***

Participants consistently pointed to several strong features of Vermont's substance use recovery system. Many shared that Vermont's recovery centers have helped to connect people to needed coaching, group support, and MOUD services to successfully undertake their recovery journeys. People in recovery frequently used the same words to describe them: safe, welcoming, and compassionate. As one person in recovery stated, ***"there is no judgement. You walk through the door here and it feels welcoming, and you feel like people are there to help you."***

Recovery Centers/Recovery Coaching

Numerous participants stated that Vermont has a strong substance use recovery system, and named organizations such as Turning Point, Journey to Recovery, and North Central Vermont. People in recovery appreciated their welcoming and supportive approaches. As one person in recovery stated, ***"if you don't have any other safe space, the recovery center will be that place for you."*** A couple of participants were grateful for the confidentiality of these services; clients do not fear that their employers or community will learn that they are receiving recovery support.

> ***"Community has been a gamechanger this time around because I have never experienced anything like this. Having different meetings, different supports and activities based around recovery and a lot of that is like 12 step fellowships. I hear a lot of times recovery can be very lonely and that isn't the case down in this area for me."*** – Person in Recovery

While Burlington was described as having sufficient recovery services, there were more limited options in Rutland, Bennington, and more rural areas of the state. Participants stressed the importance of ensuring recovery services are available where and when people are ready and motivated. One recovery sector participant summarized, ***"availability of services makes a big difference in someone's recovery journey."***

Peer-Based Recovery Coaching

Key to the success of recovery services in Vermont, many participants believed, is peer-based recovery coaching. Peer recovery coaches—people who have been through and are in active recovery themselves —are a growing part of the SUD workforce. The model

emphasizes a peer-based, strengths-focused, and motivational interviewing approach to help clients engage with recovery or harm reduction pathways that align with their goals. Vermont certifies recovery coaches through rigorous, evidence-based training, which aligns with standards set by the International Certification & Reciprocity Consortium (IC&RC).

> ***"Peer-based recovery is where it's at, and that model is great. Having someone there that has been through it and believes in me is so important."*** – Person in Recovery

Recovery coaches embedded within Vermont's 14 emergency departments (EDs) were described as an asset. Numerous participants reported that these staff have, in the words of a person in recovery, ***"changed the tone in [recovery centers] a lot and for the better."*** ED-based recovery coaches play an important role in transitioning people in crisis to next level SUD services. Recovery sector participants working in the ED stated that they connect with patients who present in the ED with substance use issues to begin to make the case for substance use treatment services. One participant described their role as, ***"we bring a friendly face, a good vibe of recovery. We let people know we're a peer and a good connection to recovery, and that it's not one size fits all."***

These recovery sector participants further reported that in their work they have observed success in connecting many to recovery services, cutting down on the frequency of return visits to the ED, and having a positive impact on ED culture and provider attitudes toward those with addiction. Participants reported that they are working hard to ensure that recovery coaching is integrated into ED workflows and that coaches are informed as soon as someone in SUD crisis arrives at the ED.

Recovery/Transitional Housing

Recovery housing is a key component of the recovery system, providing those overcoming their addictions with safe housing, SUD recovery support programs, and connections to community resources. Recovery residences, participants reported, are critical services on the pathway to sustained recovery: they continue to support sobriety while at the same time preparing residents to live independently and substance-free. Recovery housing services provide opportunities for residents to develop and build their life skills, offering support for employment and education and teaching practical skills, such as money management and saving. Some provide transportation and support similar to case management to address the social determinants of health. One person in recovery stated, ***"If we could use drugs and live a successful life we would; like for me, I didn't want to stop using. It wasn't until I was here and living in sober living that I wanted to stay sober."***

> ***"[Recovery housing] helped me get my life back, I think it's really really important. It's hard when you get sober because you don't know how to live a normal life and it teaches you how to live a normal life. I didn't work for years and it's helped me figure how to sustain a life that's not using drugs." –*** Person in Recovery

Case Management/Support Services

Many treatment and recovery sector participants, including Spoke providers through Blueprint, adolescent treatment providers, recovery and transitional housing agencies, and nurses working with SUD patients, reported that they offer some form of case management or navigation to help clients navigate resources to help them become independent. Staff aim to connect clients to a variety of services offered through recovery centers or through partners including education and employment support, housing applications, parenting programs, vehicles and licenses, and resources to get clothing and food. Several people in treatment or recovery shared positive experiences with these supportive services. As one person in treatment shared, ***"we're at the very bottom we're trying to dig ourselves out – having somebody there to help with the process is huge."*** Additionally, many recovery sector participants stated local organizations offering education and employment services, food access, and transportation are other important partners who help recovery clients become independent.

Barriers and Challenges to Recovery

Focus group participants and interviewees cited similar barriers to accessing recovery services as for treatment services, including system capacity, geography, and cultural responsiveness.

System Capacity

Participants reported that recovery services have increased in Vermont in recent years but are insufficient to meet existing needs. As with treatment services, system capacity in the recovery sector is constrained by funding and staffing. Recovery services rely in part on grant funding, which is limited and ever-changing. Recovery sector participants reported that they do not have enough funding to hire the staff they need. One participant also mentioned lack of space as a constraint, explaining, ***"one of the biggest things, we need space. We need extra space so that way we can have more people come in as a recovery coach…The reality of that happening is not with our budget."***

Geography and Transportation

As was discussed within barriers and challenges to treatment, participants frequently mentioned transportation as a substantial challenge to accessing recovery services, including limited public transportation options and the high cost of rider services. Geography also creates barriers to providing recovery services through telehealth. Participants reported that some Vermont residents—those who are lower income or live in the most remote parts of the state—do not have computers, cellphones, or access to the internet. While a few participants described mobile services as one way to address geographic barriers, these services require funding and staff and are currently limited.

Cultural Responsiveness

Participants stated that language barriers and lack of cultural responsiveness within the recovery service community can also create barriers to care. While peer recovery models have enhanced the ability for clients to connect with people with shared lived experience, there are still few recovery providers who speak other languages or deeply understand other cultures, including indigenous and military culture.

Safe and Stable Housing

Consistently across conversations of every sector, participants stated that the lack of affordable housing, coupled with limited recovery housing in Vermont, is a substantial challenge, and a barrier to successful recovery from substance misuse. As one participant from the treatment sector stated, ***"The waitlist for housing is 6 months to a year. They're going to homeless shelters or out on the streets. Vermont's main problem is with housing and the other one is transportation."*** This sentiment was echoed by a participant in the housing shelter sector, ***"There isn't enough housing, we have a housing crisis. Jobs don't pay livable wages, and there are less houses that are more expensive. And as we have more homeless whose needs aren't being met, the more they self-medicate with drugs and substances."***

Some recovery housing beds have closed since COVID (i.e., Phoenix House sites), further constraining the supply. Several participants stated that there are limited beds for women and women with children statewide. Additionally, a recovery sector participant reported that finding housing for those with mental health issues or a criminal record is extremely difficult. Recovery sector participants attributed the short supply of recovery housing to lack of funding, the high cost of housing in Vermont generally, and resistance from local communities.

> ***"Our men's list can be from 20-30 on our waitlist for each house and our women's can be from 3-20 so it is definitely lower than men and our referrals for women are greater in the winter and in the summer they are a little lower and by far there are fewer women getting into the centers than men." –*** Recovery Sector

Additionally, the lack of sober housing or any independent housing after a recovery housing stay was a theme in many conversations with participants and was described as a substantial constraint on the whole SUD system. As a recovery sector participant explained, ***"people unable to transition to their own housing sets them back in recovery, keeps recovery housing full of people who really should be moving on."*** The high cost of housing in Vermont prevents many of those leaving recovery housing from seamlessly transitioning to independent housing. A recovery sector participant explained the challenge: ***"even if we have people ready to be housed, there isn't anywhere for them to go. Even if they have $5,000 in the bank, that's not enough for deposits."*** The stigma of being known in the community and by potential landlords as a person with SUD is another major barrier to housing. As one person in recovery described ***"It's all about housing, there are not enough beds for people and housing for people and we come from small communities so if someone is in a newspaper or known it's even harder to get housing, but the landlords will never say that."*** A couple of recovery sector participants also stated that the State's focus on funding housing pods and putting people in hotels is not a long-term solution to the state's housing crisis.

This persistent concern for limited and insufficient recovery housing in Vermont was well detailed in the 2019 report ***Housing: A Critical Link to Recovery.***[44] This extensive assessment sought to enumerate the demand and need for recovery housing across the state. The findings determined that approximately 14% of people entering treatment for a SUD in 2017 (equaling 1,200 individuals), would have benefited from access to recovery housing. Specifically, to transition from a residential treatment facility and/or to support their continued recovery while in non-residential treatment. The factors contributing to the need for recovery housing among these individuals included homelessness, an inability to cover housing costs, and/or the high risk of relapse in unstable housing environments. The population with the greatest unmet need was women with dependent children. The report further documented that at least 300 additional recovery housing beds would be needed

[44] Ryan, J. (2019). Housing: A critical link to recovery – An assessment of the need for recovery residences in Vermont. Prepared for Downstreet Housing & Community Development with funding from Vermont Housing & Conservation Board.

statewide in order to serve this population sustainably. Importantly, this estimate was based on data prior to the closure of five larger capacity Phoenix House sites and may underestimate the true current need for new bed capacity.

Economic Stabilization and the Cliff Effect

An additional barrier to successful independence after substance use treatment, participants reported, is the structure of public benefits. The public benefit "cliff effect," in which people suddenly lose substantial benefits after reaching an income threshold, makes it challenging for people in recovery to work their way to independence in the recovery process. One person in recovery summarized this challenge, ***"you start to get better and get back on your feet but you're not quite there and your benefits get cut off, like Medicaid, because you make too much and can't continue the therapy or treatment. That is enough to make some people come into a nosedive."*** This often translates into cost prohibition for continued service. A recovery sector participant described this issue, ***"when they [patients] get to a certain level of success they no longer qualify for certain services, like Medicaid, so they have to start paying out of pocket payments and it becomes cost prohibitive..... Working a minimum wage job, getting just above that Medicaid line, will devastate them."***

Recovery Sector Workforce

As described above, there are substantial workforce challenges in the recovery sector. As with treatment services, staffing and funding are substantial constraints. As one recovery sector participant described, ***"compensation [in the recovery area], as in all substance use services, is a challenge. We haven't had great pay, but recently we have been able to increase wages a bit but with the cost of everything else going up it doesn't end up being a real increase."***

Recovery coaches with lived experience have been a welcome addition to the workforce, according to participants, and have improved the quality of care. One challenge, a participant reported, is the tension among those who advocate for an abstinence approach to recovery services and who do not view peer recovery coaching favorably. Another participant reflected on the challenge of the COVID epidemic on their peer coaching work, explaining that it has led some recovery coaches to take on some tasks that a case management typically would, which, this recovery sector participant explained, ***"stretches us quite thin at times."***

There were 134 recovery coaches IC/RC credentialed in Vermont as of June 2024 (**Table 20**). Of these, 88 had expired credentials, which may be related to the recent systemic challenges

maintaining their qualifications. Several participants stated that the recent and sudden closure of the Vermont Recovery Coach Academy has created pressure on the recovery workforce. While virtual training is available, participants reported that this closure has left sites scrambling to find other options for training, including having to go out of state.

Table 20. Number of Recovery Coaches IC/RC Credentialed in Vermont, by County, 2024

	n
Overall	134
Expired	88
Not Expired	46
Addison	7
Bennington	10
Caledonia	5
Chittenden	23
Franklin	10
Grand Isle	2
Lamoille	13
Orange	2
Orleans	7
Rutland	10
Washington	9
Windham	13
Windsor	14
Out of state	7
N/A	2

DATA SOURCE: Vermont Recovery Coach Registry, June 2024

Recommendations for Recovery Services

Participants shared several suggestions to enhance recovery services in Vermont:

- ✓ **Expand capacity of the recovery sector and its workforce**. Participants recommended continued investment in recovery centers and recovery coaching programs to address the need for services. One participant recommended co-locating supports and peer recovery into other types of community organizations and programs. Another participant suggested expanding the ED recovery coach model to places such as police departments. As with the treatment workforce, recovery sector participants reported that more funding could help to address staffing barriers in the sector. Finding people to serve in the workforce is also a major challenge. To address this, one participant wondered if community health workers, who are playing an increasing role in mental

health services, could be tapped for substance use recovery, specifically around treatment discharge planning and aftercare action plans.

One recovery sector participant stated that they would like to see greater professionalization of the recovery workforce and suggested a registration system with clear expectations and "boundaries" to help organizations better train their coaches and provide greater consistency in services. As this participant shared, ***"having some uniformity will go a long way in helping the profession become more homogenized, where our messaging is more uniform, our approach is similar."***

- ✓ **Invest in more recovery housing to match the need for stable, safe, and affordable housing that supports recovery.** The need for more investment in recovery housing was a theme in many conversations with participants in all sectors. As one treatment sector participant summarized, ***"we can do all these great things in terms of treatment, but if they don't have a place to sleep or any place to go, they will continue to be vulnerable to substance use. Their dealer will always be there."*** Participants advocated for a focus on expanding recovery housing options for women and women with children, and in currently underserved areas of the state. A couple of participants suggested tapping into opioid settlement resources to fund these services. Participants further advocated for more education of elected officials and local communities to increase understanding and support of recovery services.

  "The Columbia study from over 20 years ago proved if somebody has a supportive structure for at least a year, their chances of long-term recovery rise through the roof. It stumps me: we know what the answer is." - Recovery Sector

- ✓ **Expand case management and wraparound services beyond the treatment sector in order to facilitate transitions between the sectors of care and to better meet related social needs in recovery settings**. Funding to support the expansion of case management services was suggested. Participants would like to see case managers working and supporting people across the system of care, including in recovery services. As a participant from the treatment sector shared, "***I want to secure funding to have 10 case managers across the state so they can do screenings in community, bring them into treatment, get them to aftercare. I don't have funding to do that, but that is one of the goals."***

  Recover Sector participants suggested that the addition of case managers would improve outcomes. Case managers could and should take a comprehensive approach to meeting the needs of their clients because, in the words of one recovery sector participant, ***"if***

basic needs aren't being met [during recovery] then people can turn to substances." Participants recommended more support specifically to establish credit, buy a car and get a driver's license/license reinstatement, and access health care. One participant suggested classes that focus on building self-esteem and teaching life skills. A couple of participants recommended co-locating these services at recovery centers so they can be more easily accessed. As one person in recovery attested, ***"I've seen the wraparound services really work and [one location] makes it less complicated for people to get on their feet."***

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Harm Reduction Services in Vermont

Role of DSU

Multiple divisions across the Vermont Department of Health including the Division of Substance Use Programs (DSU) aim to minimize the negative impacts of substance use while promoting safer practices through its harm reduction efforts. These occur through collaborations with the Health Department's Division of Emergency Preparedness, Response and Injury Prevention, Division of Laboratory Sciences and Infectious Disease and a network of community-based organizations who deliver and support harm reduction at the community level. These community-based organizations are trusted sources of information and are key points of distribution for naloxone. Services also include overdose prevention and response education, connecting appropriate clients to HIV and HCV testing, xylazine and fentanyl test strips, and wound care support. Syringe Services Programs (SSP) provide case management services that support people in reducing their risk of overdose and other risks associated with substance use by connecting clients to services that increase protective factors such as substance use disorder treatment, infectious disease care and housing supports. Vermont's harm reduction initiatives are designed to meet people where they are, offering non-judgmental support while addressing the immediate risks associated with substance use. ***Click here for more information on DSU's current harm reduction efforts***.

Perceptions of Harm Reduction Services

Harm reduction efforts, including NARCAN® distribution, testing strip distribution, and syringe services, play an important role in saving lives. One treatment sector participant described the state's focus on harm reduction and keeping people alive as ***"really significant and a strength of Vermont."***

As heroin and fentanyl overdoses have risen, so has the use of nasal naloxone, also known as the brand name NARCAN®, to reverse opioid overdoses. NARCAN® use is no longer limited to SUD service providers and first responders; it is increasingly available in community-based organizations such as housing shelters and those working with victims of domestic violence. One treatment sector participant stated that Montpelier food pantries have recently made NARCAN® available and ***"it's flying off the shelves."***

Vermont's syringe services programs (SSPs) are four community-based programs that provide free and anonymous services to reduce the risk of infectious diseases and overdose by those who use substances. Through a combination of fixed site location and mobile services, the four organizations provide services in all of Vermont's 14 counties. Participants noted that despite this reach, some parts of the state are not served by these programs. Additionally, one person shared, these programs often have limited hours or must be scheduled in advance, which creates barriers to their use. As one person in recovery explained, ***"someone is not going to call and make an appointment. They are going to use [the needles] they have when they are ready, so they end up using dirty ones."***

NARCAN® is widely available at no cost to Vermonters. Vermont's community naloxone distribution programs began in 2014, first through Vermont's four Syringe Services Programs (SSPs), then through focused distribution by additional community-based organizations that also work with people at high-risk of opioid overdose. Distribution of Harm Reduction Packs (HRPs) that include a variety of overdose prevention resources, began in 2019, and Leave Behind Kits (similar to HRPs) started to be distributed to community members by first responders in 2020. In 2023, the Vermont Department of Health distributed 65,709 doses of naloxone to community partners (**Table 21**). The department also distributed 7,003 doses to emergency medical services, approximately half of which (3,118) were distributed by EMS via leave behind kits.

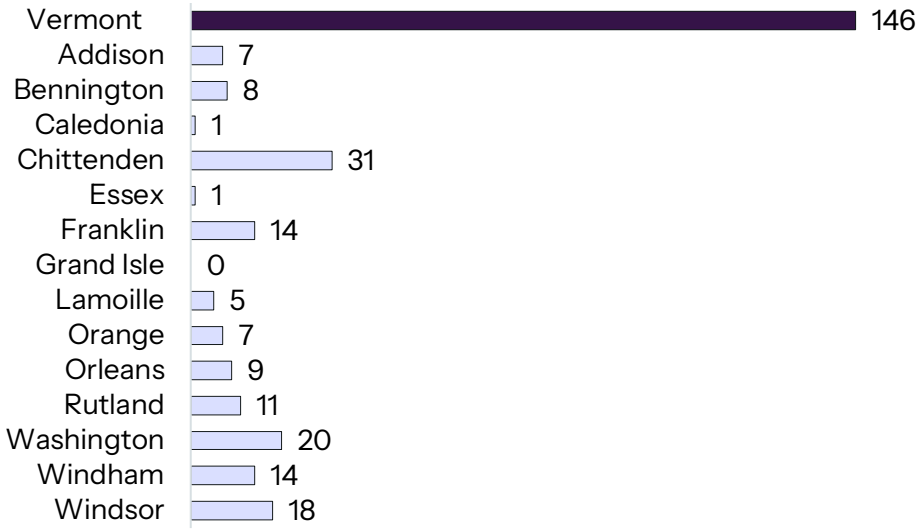
Table 21. State Naloxone Distribution, by Distributor, 2023

	NARCAN® kit program	Harm reduction packs	Leave behind kits	For EMS use	Total Doses
Community partners	35,167	30,542	N/A	N/A	65,709
Emergency medical services	N/A	N/A	3,118	3,885	7,003
Total distributed by Vermont Department of Health					**72,712**

DATA SOURCE: Vermont Department of Health Community Naloxone Distribution and Administration Q4 2023 Report & Vermont Department of Health Emergency Medical Services Naloxone Distribution and Administration Q4 2023 Report

The state of Vermont had 146 public community naloxone distribution sites in 2022 (**Figure 33**). By County, Chittenden had the most, with 31 sites, and Grand Isle County had the least, with no sites.

Figure 33. Public Community Naloxone Distribution Sites, by County, 2022



DATA SOURCE: Evaluation of the Health Department's Community Naloxone Program, 2023

DSU and SUD service providers continue to expand the reach of NARCAN® and reduce overdose deaths, including an initiative beginning in 2023 to install NARCAN® vending machines in rural areas of the state. Participants working in the harm reduction sector stressed that their goal is to "meet people where they are," without stigma or judgement. As one harm reduction sector participant explained, ***"whatever you want to do and wherever you want to go, we're going to meet you there and make sure you're as safe as possible."***

Barriers and Challenges to Harm Reduction

Participants acknowledged that for some in the SUD services community, and the public at large, harm reduction can be controversial and viewed as at odds with helping people to

achieve recovery. Numerous people stated that stigma is a substantial barrier to offering and expanding harm reduction services within the state.

Participants from the harm reduction sector reported a "not in my back yard" mindset that prevents harm reduction services and kits from being located in accessible places. For example, some communities and organizations have refused to allow the Vermont Cares van to come to their locations and others have resisted installation of NARCAN® vending machines. One social service sector participant stated that some Vermont towns will not add a budget line for needle collection, ***"due to not wanting to be associated with harm reduction."*** This resistance, participants explained, is rooted in assumptions about those with SUD and the perception that harm reduction strategies encourage substance use. One treatment sector participant stated, ***"the resistance to NARCAN® in my community is amazing. People are like if we hand it out, they'll come back alive and use again. It's a weird stigma."***

> ***"Everyone wants the needles off the street, but no one wants the site in their backyard."*** – Treatment Sector

Additionally, with the increasing prevalence of xylazine in the drug supply participants have noted an increased need for wound care and wound care supplies as a part of harm reduction programs, which are not currently being met to the extent they are needed. One social service sector participant working with unhoused people noted they are, ***"seeing a lot of people with wound care needs".*** The increase in wound care related needs outside the hospital setting was explained by harm reduction sector participants as being due to, ***"people have a strong aversion to healthcare and even with incentives people won't go to get treated"***

Recommendations for Harm Reduction Services

Participants provided several suggestions to address gaps in harm reduction services in Vermont:

- ✓ **Increase education to the broader community about the role and value of harm reduction**. Participants stressed the need for more education—of the public and elected officials—about the value of harm reduction and harm reduction services. One treatment sector participant stated, ***"we need to do a better job of educating the public of the benefit and how it's going to benefit the community and not just a place for people to do drugs, or act as an enabling service."***
- ✓ **Expand community-based distribution of NARCAN® and harm reduction packs**. Participants recommended a continued push to expand the availability of NARCAN® and

harm reduction packs in the community, including at public spaces like libraries and community-based organizations.

- ✓ **Increase availability of wound care kits to counter rise in infections from xylazine use**. Given the rising incidence of infection from the use of xylazine, several participants recommended increasing the availability of wound care kits that include medical supplies and instructions.
- ✓ **Extend Syringe Services Programs (SSP) to include more accessible times**. Noting that ***"nobody wants to meet at 9am for syringes,"*** one-participant working in the harm reduction section suggested SSPs extend and make the hours their services are available more flexible, including at night and on weekends.

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Perspectives of Sectors Serving Priority Populations

Housing Shelter Providers

Numerous assessment participants expressed concern about the growing number of Vermonters who are unhoused. They identified several causes of this: the high cost of housing; insufficient re-entry support for those leaving incarceration; and unaddressed mental health issues and substance misuse. Participants who work specifically in the shelter housing sector stated that many shelter residents have both substance use and mental health disorders; some, they noted, also have undiagnosed developmental delays. They reported significant challenges to meeting the needs of shelter residents with mental health and substance use disorders because, as one housing shelter provider explained***, "housing shelter staff are not trained to address mental health or substance use issues that are so prevalent among shelter residents."***

Housing shelter providers/staff reported there is high use of alcohol as well as heroin, fentanyl, and xylazine among people who are unhoused. Participants also reported that they are ***"NARCAN®ing on a regular basis"*** and frequently connecting people to the hospital for wound care. Use of methamphetamines is increasing and of growing concern, as one housing shelter provider explained, ***"since people are more unpredictable on meth and we don't have as much experience with it."***

Overall, housing shelter providers appreciated the partnerships they have developed with local law enforcement, community health centers, and hospital EDs, as well as with substance use providers. One participant expressed optimism about new DSU funding that will create the first hybrid recovery home/shelter for unhoused in Vermont.

Housing shelter providers identified several gaps in available substance use treatment and recovery services. Lack of longer-term residential substance use treatment was identified as a significant challenge for this population. As one participant explained***, "outpatient services don't mean a thing if we don't have residential treatment. A majority of our clients have been using hard drugs for decades every day and no outpatient is equipped to treat that."*** Participants further reported that the typical length of stay in residential treatment does not fully support the long-term success of unhoused individuals. In contrast, recovery services were reported to be generally easier to access, although there are long wait lists for recovery housing. Housing shelter providers also saw a need for safe use sites/overdose prevention centers (OPCs) for people who are in active use and may not be ready for treatment and recovery. These services, one participant explained, are a first step to connect users to services and can provide a pathway to open them to recovery.

> ***"We can't send anyone anywhere to get adequate treatment so they can maintain and achieve stable housing, so we are starting 20 steps behind even if we had adequate housing."*** –Housing Shelter Sector

Housing shelter providers expressed frustration with growing public and elected officials' animosity toward unhoused Vermonters, which contributes to lack of investment in the services and supports needed to help them. They pointed to bulldozing of encampments as well as lack of progress to build affordable housing. Stigma, they reported, is also a barrier for those who can be most helped by SUD programs and services.

Recommendations

Suggestions to better serve unhoused and housing unstable clients with substance use issues include:

- ✓ **Expand the availability of residential treatment and recovery housing to better meet the needs of unhoused individuals**. Numerous participants from the housing shelter sector stressed the need to expand residential options for those with substance use disorders and to extend the allowable length of stay for treatment. One housing shelter provider stated, ***"if we don't have a place to send people for [residential treatment] help then nothing is going to change. Until we have that we are treading water."***

Ideally, participants stated, these services would be paired with those that address the mental health needs of so many unhoused Vermonters.

- ✓ **Expand safe use sites and programs**. Recognizing that some people may continue to use substances, several housing shelter providers suggested expansion of safe use sites which would provide a major support and level of safety to unhoused individuals.
- ✓ **Provide education and training on SUD, mental health, and crisis response to housing shelter staff**. Housing shelter providers would like to see training for staff about substance use and working with those using substances so that they can better help the clients they see.

Incarcerated Populations

Substance misuse, particularly use of high-risk substances such as crack, heroin, xylazine, and fentanyl, is one of many challenges facing Vermonters who are incarcerated. Others include unaddressed mental health disorders, chronic illness, lower levels of education, and lack of stable housing. As the representative from Department of Corrections (DOC) observed, ***"these people have come to us after a failure of so many other systems before us."***

The DOC representative stated that DOC faces substantial challenges in connecting those who are released from prison to SUD services in the community. While Vermont's DOC funds transitional housing for recently released individuals, the state lacks re-entry or step-down facilities to connect people to SUD services available to them within their communities. In other states, these step-down and re-entry facilities play a pivotal role in connecting those newly released to community services. The representative explained, ***"we don't have re-entry facilities, we don't have detaining facilities, reception facilities, or step-down facilities for re-entry. We are too small for all these programs and don't have a lot of money for these."*** Probation officers were identified as the primary connection to the corrections system after release, but, as the DOC representative explained, ***"they are not treatment providers; they may not know the cast of characters providing services and they are community safety focused and have so much on their plate."***

The DOC representative and other assessment participants reported that once released and living back in the community, there is also some resistance among community-based providers to serve those who have been incarcerated. As one recovery sector participant shared, ***"we really struggle with patients that have violent or criminal backgrounds getting them into [residential] treatment; no one wants to talk to them. We can't find anything for them, not even New York, New Hampshire, Maine."***

An additional challenge, the DOC representative reported, is that a substantial portion of Vermont's detainees are very short-term. As a unified system state, about 35-40% of Vermont's incarcerated population is not yet sentenced or are incarcerated for a very short time (so-called detainers). Courts can release detainers at any time and with short notice. Additionally, DOC serves as a default service provider in some regions for VDH's public inebriate system: it houses people arrested for alcohol violations for 24 hours and then releases them. These different types of short-term stays, the DOC representative explained, results in a lost opportunity to address SUD in the community and creates the perception that the prison system is not doing its job addressing substance misuse among those incarcerated: ***"if you are a recovery coach or other provider you are on fire that the DOC isn't doing anything, but we do not know their legal status and can't do anything."***

Recommendations

Suggestions to better meet the need of those who have been incarcerated include:

- ✓ **Expand outreach and community support services to those recently released from incarceration**. There are systemic gaps that make it easy for those recently released from incarceration and short-term stays to "fall through the cracks" and closer connection to community supports was suggested. DOC, in partnership with Pathways Vermont, is currently piloting Forensic Assertive Community Treatment (FACT), an evidence-based approach that uses a team-based model to treat people with mental health and/or substance use challenges who are considered at risk for re-offending. This team will engage social service agencies and health care providers in the treatment approach and, if effective, could be expanded.
- ✓ **Educate and train probation officers and the court system about SUD and available SUD services in the community**. The DOC representative suggested more training and education for probation and parole officers and court system staff about SUD generally and SUD services available in the community.

Organizations Serving Immigrant Populations

Frontline staff working to support new immigrants as part of the Cultural Broker program shared that substance misuse among newcomers is often linked to mental health issues. Mental health concerns range from depression and stress to more serious issues such as trauma and PTSD. New immigrants also experience stress as they navigate US systems. This includes finding housing and employment, working with school systems, and accessing services. For adults, adapting to a new culture presents difficulties, including language and cultural challenges and familial conflict when dealing with children who are more quickly

Americanized. More serious mental health concerns, including PTSD, stem from living through conflict in their home countries and time spent in refugee camps.[45]

In 2024, the Cultural Broker program provided 616 total behavioral health screenings; of these, 71 (11.6%) were positive for substance use and 165 (26.8%) were positive for depression.[46] While 69 out of the 71 positive substance use screens received a brief intervention with their Cultural Broker, 20 (29%) declined referrals to any follow up care. Among the 165 who screened positive for depression, 157 received a brief intervention from their Cultural Broker, but 77 (49%) declined referrals to any follow up care. These data suggest that a good portion of those in need of more intensive services are reluctant to seek care more intensive care.

Staff of the Cultural Broker program identified alcohol misuse as most common among the populations they work with, although cannabis use is increasing in the younger cohort. They also stated that they are seeing more involvement with riskier drugs in the populations they serve, especially among younger immigrants. Brokers reported that a lack of mental health services, especially culturally appropriate ones, contributes to substance use as people self-medicate. The easy accessibility of substances in the US also plays a factor in use: alcohol and cannabis can be easily purchased, and youth obtain substances through people in school.

> ***"We have a problem with the youth. When they were in Africa, they never use drugs there and couldn't buy them; and here they can buy alcohol here and drugs because now they have a job and found that beers and alcohol is easier to buy." –*** Immigrant Services Sector

According to Cultural Brokers, newcomers face several challenges accessing substance misuse, mental health, and other direct social services. Long wait times for many of these types of services are one challenge. Another challenge is that many service providers in Vermont, including primary care, mental health, and substance use services, are not language accessible. Organizations are legally required to provide language access; however, Cultural Brokers shared that this is not always done, which creates a barrier for non-English speaking patients/clients.

Lack of cultural responsiveness among substance use providers is another barrier, Cultural Brokers reported. As one explained, ***"the community is not going to go to a provider who doesn't know the community."*** While Cultural Brokers shared that some providers are

[45] Vermont Department of Health. (2024). Vermont State Health Assessment community engagement data: Immigrants and refugees. Vermont Department of Health. https://healthvermont.gov
[46] Cultural Broker Program. Cultural Broker Program Referral Data SFY24, VT DSU

equipped to work with newcomers (Howard Center was mentioned), others are not. There are very few substance use treatment providers who are themselves immigrants. Additionally, one participant shared that some approaches to substance use treatment and recovery might not be culturally appropriate. For example, group therapy does not work with many newcomer populations. As one participant stated, ***"there needs to be some kind of culturally appropriate rehab centers because talking and other things don't work all the time. They want real action [..] and it is not happening here."***

Finally, stigma about substance misuse also creates barriers to seeking care in some immigrant communities. One Cultural Broker explained, ***"in our community it is not okay to be seen using drugs or alcohol at all; the community will cut you off."***

Recommendations

Cultural brokers provided several suggestions for how Vermont's system of care can better serve newcomer populations:

- ✓ **Ensure broader language access within SUD services**. Cultural Brokers urged substance use providers to meet their legal obligations and provide language access to services.
- ✓ **Require a portion of DSU funding to be allocated to services to underserved populations**. A couple of participants suggested that DSU require that a portion of grants made to organizations be allocated to serving underserved communities, which would make sure these groups are reached, and community equity is better addressed.
- ✓ **Strengthen cultural responsiveness among SUD service organizations and providers**. Cultural brokers recommended that substance use provider organizations enhance the cultural responsiveness of their staff. Suggestions include training for staff and doing more to hire people from newcomer communities as providers or cultural liaisons in substance use services organizations. One participant suggested, ***"we need to do more to make sure our people can be hired in these positions so people from our communities can provide care for the community."*** Another participant specifically suggested identifying ways to make it easier for those who were medical or other credentialled providers in their home countries to practice in the US.
- ✓ **Fund community-based organizations that provide assistance to newcomers**. Immigrant-serving organizations, like the Cultural Broker program, play a vital role in supporting newcomers as they adapt to life in Vermont. They provide case management, culturally relevant legal and social support, and connect clients to mental health and substance use services. These organizations can also be partners in identifying trends and needs in different communities and in crafting substance use prevention messaging

and outreach strategies. Cultural brokers suggested that sufficient and predictable funding would go a long way to ensuring that these organizations can continue to provide these vital services and expand their reach to new communities.

Indigenous Populations

Substance misuse is a challenge in Vermont's Abenaki community, which can be attributed to poverty, homelessness, unemployment, and historical and intergenerational trauma. An indigenous leader explained that longstanding attempts to eliminate Abenaki culture, institutions and language contribute to a sense of disconnection and lack of belonging over generations that has had an impact on both mental health and substance use. As the leader explained, ***"that lack of connection has real negative impact on folks, especially the youth. Not feeling like you can be proud of your identity is so harmful to youth."***

While alcohol misuse has been most common in the community, the indigenous leader interviewee reported that some are increasingly turning to other drugs now that they are more accessible and cheaper. Vaping among youth has also increased due to the attraction of flavors. The interviewee explained that historic mistrust and fear of the state and institutions means that many indigenous community members do not seek out healthcare or services until there is a crisis.

Research has reinforced how historical trauma and attempts to erase indigenous communities in Vermont has led to mistrust and lack of faith from Abenaki community toward state and local governments, healthcare providers, and community support agencies.[47] Additional barriers to accessing substance misuse services include lack of transportation and limited access to technology for learning about services or engaging in telehealth. Indigenous residents also face difficulty getting culturally relevant care, as there are few providers who are Abenaki or who understand the culture.[46] As a result, the leader explained, there is a sense that, ***"this works for everybody, so this has to work for you too."***, which is not effective for indigenous clients.

Recommendations

Suggestions to enhance system of care services for members of Vermont's indigenous communities include:

[47] Avila, M. M., Vining, C. B., Allison-Burbank, J., & Velez, C. (2022). Health Equity for Abenaki Indigenous People: Improving Access to Quality Mental Health and Substance Use Services. *Health equity*, *6*(1), 787–793. https://doi.org/10.1089/heq.2022.0091

- ✓ **Strengthen cultural responsiveness among SUD service organizations and providers**. Increase cultural responsiveness of SUD services to build trust of these institutions within the indigenous community. The indigenous leader interviewee shared that indigenous people ***"react positively when something is put in a cultural context."*** One suggestion is to identify ways to support Abenaki community members to become medical and substance use providers. Another recommendation is to encourage and fund substance use providers to hire cultural liaisons to connect with community.
- ✓ **Increase education and outreach to indigenous residents on SUD and available SUD services**. Abenaki people are not aware of substance use services and more outreach was suggested. One recommendation is to develop awareness campaigns about substance use prevention and services in the Abenaki language with culturally resonant messages. In-person outreach to people "on their front porch" and in their homes was also suggested.
- ✓ **Address transportation barriers to improve access to SUD services**. The indigenous leader recommended that substance use programs take steps to address transportation barriers, possibly by providing transportation services. As this person stated, ***"if you're setting up a program, are you ensuring people have access to not only the information but the program itself?"***
- ✓ **Partner with existing nonprofits led by Abenaki people.** Existing Abenaki-led organizations provide strong connections to the community and deep knowledge of Abenaki culture. The indigenous leader suggested that the system of care partner with these organizations to create or expand programs that reach indigenous residents. As this person stated, ***"so many of these services in Vermont are overwhelmed. If many of the challenges can be addressed within the community that would help on so many levels."*** Over the longer term, this participant would like to see a center for the Abenaki people that addresses substance use and mental health and provides case management and connection to other needed services.

Organizations Serving Older Adults

Assessment participants working with older adults shared that substance misuse among seniors is a growing challenge. They stated that alcohol is most often misused. The Substance Use and Aging Specialist working at DSU stated that ***"one quarter of older Vermonters drink at a risk level and that is a lot."*** Misuse of prescription medications, such as opioids and benzodiazepines, is also common. Of growing concern, an interviewee shared,

is the number of older Vermonters now using cannabis (11% as of 2022, which is an increase from 3% in 2017).

> ***"Since we have legalized [cannabis] there are many older adults showing up at the dispensaries and buying [cannabis]. I am concerned about the effect on older adults, who very likely will use [cannabis] because it is legal, and the fact that it is legal gives the impression that it is okay."*** – Substance Use and Aging Specialist

The specialist explained that social isolation is a major underlying cause for substance use among older adults. This issue was greatly exacerbated during the COVID epidemic. Recovery sector participants shared that isolation is increasingly victimizing older Vermonters in another way as well: they are becoming attractive targets for dealers and users who end up staying and dealing from their homes.

The health effects of substance misuse are more serious for older adults, for several reasons. The specialist explained that older adults are affected by alcohol or drugs differently than younger adults: for older adults two drinks are the equivalent of four drinks for someone 30-40 years old. Another health concern for older adults is the potential interaction effects between unprescribed substances and medications. For example, alcohol combined with some medications can increase the risk of overdose.

State BRFSS data from 2022 show that among older Vermonters who have been prescribed medications for pain, sleep or anxiety (primarily Opioids and Benzodiazepines, which are highly alcohol interactive), 25% are drinking alcohol at or above the risk level (3+ drinks on an occasion for men and 2+ for women). Similarly, research indicates that older adults are particularly sensitive to cannabis—it can be risky when taken by people using blood thinners and can worsen cognitive decline.[48]

The specialist reported that prevention services for older adults, including screening and education, have increased in recent years. Medical providers are increasingly using screening tools to identify older adults in need of substance use services although not to the degree these are used with younger adults. Older adult services such as Support and Services at Home (SASH) teams are also more actively identifying seniors with SUD and connecting them to services. However, the specialist reported, there are currently few treatment services in Vermont focused specifically on older adults. This is attributable in part to low

[48] Somes, J. (2023). Increased use of cannabis in our older adults–An emerging trend. Journal of Emergency Nursing, 49(4), 499–506.

Medicare reimbursement rates[49], although recent changes to these rates are expected to lead to an expansion of SUD services for seniors.[50] Participants described recovery services oriented to older adults as more available in Vermont, in part because many recovery coaches are older persons themselves.

> ***"Of all the adults treated in the Vermont system, 2% of the people they serve are 65 or older, [but they] represent 20% of the adult population and they are just as likely to have a substance use problem as any other adult."*** - Substance Use and Aging Specialist

Recommendations

Participants provided several suggestions to enhance the ability of Vermont's system of care to address SUD among older Vermonters:

- ✓ **Increase SUD services tailored to older adults and their unique needs and risks**. Suggestions included dedicating DSU funding for treatment providers serving older Vermonters, similar to the approach used in the mental health sector which supports programming tailored to the older adult population. The Substance Use and Aging Specialist also saw a need to educate existing providers about how aging affects use of substances among older adults and its impact on them, and to develop geriatric-informed approaches. According to this participant, ***"treatment providers who have developed age, geriatric informed approaches do very well and the percent of older adults with successful treatment for SUD is very good."***
- ✓ **Enhance substance use screening of older adults for better risk identification and education**. Assessment participants also saw a need for more comprehensive approaches to identifying seniors at risk for substance misuse. They suggested educating medical providers about the importance of screening across all patients, including older adults, and to provide them with information that can help them refer older patients to services. The Substance Use and Aging Specialist suggested that this education needs to be paired with a more general approach to addressing ageism in healthcare.

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[49] Legal Action Center. (2021). Medicare coverage of substance use disorder services: A brief for advocates, providers, and policymakers. Legal Action Center. https://www.lac.org/assets/files/Medicare-sud-coverage-final-formatted-2.12.21-Final.pdf
[50] Centers for Medicare & Medicaid Services. (2023). Medicare program: Changes to Medicare payments for substance use disorder treatment services. Centers for Medicare & Medicaid Services. https://www.cms.gov/newsroom/fact-sheets/2023-medicare-program

- ✓ **Develop and launch more targeted prevention messaging focused on older adults**. The Substance Use and Aging Specialist stated that many older adults do not have long-standing substance misuse experiences, which can make prevention messaging particularly effective. Additionally, many seniors do not understand what substance misuse is and how it affects older adults. This participant recommended more extensive prevention messaging focused on seniors, in collaboration with local Prevention Consultants and networks.
- ✓ **Expand programming that addresses the risk of social isolation among older adults**. Disconnection from others is a root cause of substance misuse among older Vermonters. Participants suggested expanding programs that connect seniors to each other, including healthy living programs such as bone builder groups and tai chi, as well as social opportunities. The Substance Use and Aging Specialist explained, ***"there is an increased interest in healthy living among older adults and they are motivated. That motivation should be tapped on even more."*** This participant also advocated for expansion of intergenerational housing, particularly low-income housing, because many older adults have limited financial resources.

Organizations Serving Youth

Numerous prevention and treatment sector participants stated that substance misuse rates among children and youth are rising. As described earlier, the ubiquity of vaping has led to more youth becoming addicted to nicotine and using cannabis. Increasingly, youth are also experimenting with high-risk substances. Participants working with youth noted that drug use among younger youth is increasing. As one treatment sector participant stated, ***"the drugs kids are getting access to at a younger and younger age is very disturbing."*** The impact of use of these substances on developing brains, several noted, is only beginning to be understood. Of concern to providers is the lack of awareness of the impact of use.

> ***"Youth say, 'I don't drink that often and never alone' and when I ask about [cannabis] they say, 'I do it all the time'. There isn't an understanding that it is dangerous and there is no understanding that there are negative effects on the brain."*** – Recovery Sector

Schools, largely through substance abuse prevention counselors (SAPs), play an important role in identifying youth at risk or using substances and connecting them to resources. The strength of this infrastructure, participants explained, varies by school district. Parents are also critical partners in addressing youth SUD, although, as one treatment sector participant observed, ***"most of the time parents don't know what they need."***

Participants stated that there are several gaps in the youth SUD treatment landscape. Lack of services for youth, particularly in-patient or residential treatment services, was a theme in several conversations. Several treatment and recovery sector participants stated that there are no in-patient SUD beds for youth in Vermont, meaning that youth in crisis end up in the ED. And then, they explained, if they are on Medicaid, have to wait for prior authorization to get services out of state. The challenge with this is, as one treatment sector participant explained, ***"if you wait too long to get youth into services, they are not going to be interested when off the waitlist."***

Participants in the treatment sector noted that in Vermont outpatient services for youth are expanding and are more readily available, although it can be challenging to find developmentally appropriate IOP substance use services for those under 18, and both the Northeast Kingdom and Brattleboro have limited youth SUD services. Some participants shared examples of efforts currently underway to addressing youth substance misuse, including expanded school-based programs.

Recommendations

Participants provided several suggestions to enhance youth SUD services in Vermont:

- ✓ **Establish youth in-patient/residential treatment beds**. Several participants suggested that DSU and partners work to establish some youth residential services in the state to help youth in crisis and reduce reliance on EDs.
- ✓ **Expand Intensive Outpatient Program (IOP) services for youth**. Participants recommended expanding youth IOP services and other recovery support programs such as youth-based 12-step programs. They stressed that services need to be developmentally appropriate and destigmatizing. One treatment sector participant stated***, "the care needs to be fun and engaging and make social connections for [kids] because that is so important. We can't have kids sitting being bored for hours."*** Participants recommended programs include physical activity and a focus on health and wellness, as well as strengthen communication and coping skills. One participant mentioned that the Choices for Youth program in Rutland could serve as a model.
- ✓ **Strengthen connection and coordination between SUD providers and schools**. One participant suggested stronger collaboration between school SAP counselors and local SUD providers to strengthen school-based SUD services and better coordinate community-based care for youth.

Organizations Serving Pregnant Persons

Assessment participants working with pregnant people reported that substance misuse among soon-to-be and new parents is a concern in Vermont. While some of the perinatal population use opioids and stimulants, it is alcohol, tobacco, and cannabis that are of greater concern. Cannabis, one participant explained, is the substance most misused during pregnancy, in part because there is little, and inconsistent, information about its safety. As a Perinatal Nurse Program representative stated, ***"[providers] don't feel solid about the message we are giving people on cannabis. People are getting mixed messages about its safety."*** Additionally, alcohol continues to be a concern during pregnancy as well as after birth, as the representative stated ***"We know VT has a huge problem with alcohol. PRAMS shows disparity between screening and recommendations. We continue to see alcohol use in pregnancy."***

Participants praised Vermont's commitment to young families and saw this as a strength when addressing SUD among pregnant persons and new parents. They pointed to a solid early childhood support system, including Children and Recovering Mothers (CHARM) teams at the regional level, and a highly effective home visiting program. Additionally, the Perinatal Nurse Program representative described the state's continued effort to innovate to address the needs of those in the perinatal population that have SUD. New initiatives include a project to develop safe care plans for pregnant people with SUD who are also DCF-involved, and Vermont has recently become involved in an Alliance for Innovation on Maternal Health (AIM) initiative with DSU that focuses on evidence-informed best practices to enhance care for pregnant and post-partum people.

However, the Perinatal Nurse Program representative also noted gaps. Many ob-gyn offices do not have the funding or capacity to coordinate care to address SUD in patients. Some people are not well connected to primary care, which makes it more difficult to focus on substance use prior to or early on in a pregnancy and during the post-partum period where the risk of misuse is greater. The representative shared, ***"a lot of moms don't have primary care connections so after the 6-week follow up they are totally off the map and not getting any care until next baby."*** Lack of integration across systems serving parents and babies—perinatal, pediatric, substance use, mental health, community and clinical—is another challenge according to participants. As the Perinatal Nurse Program representative explained, ***"it is confusing for clients because they have all these providers. That's hard with a new baby, but impossible when you also have a substance use concern."*** This is starting to be addressed at a systems level, one participant reported, by Vermont's new Perinatal Quality Collaborative.

Recommendations

To better serve the needs of the perinatal population, participants suggested the following:

- ✓ **Expand training and education around SUD to ob-gyn providers and practices**. Assessment participants recommended training and outreach to engage more ob-gyn offices in identifying SUD and educating their patients about substance misuse. Stronger connections to perinatal substance use providers and those working in SUD recovery were suggested. The Perinatal Nurse Program representative stated, ***"I would like to see all downstream crisis management services way upstream to that first prenatal visit. I would like to see all the screening and connection to services happening at that first visit."***
- ✓ **More deeply integrate SUD services into pre/post-natal home visiting programs to improve access**. The Perinatal Nurse Program representative also recommended that substance use services could be expanded into Vermont's successful home visiting program to improve access for this population. Again, partnerships with the state's recovery programs were suggested.
- ✓ **Engage other sectors to play a role in SUD screening and education among the perinatal population**. Given that many are less engaged with their own healthcare providers after birth, participants suggested training pediatric providers to play a greater role in screening for SUD and mental health issues among new parents. Another untapped partner suggested by the Perinatal Nurse Program representative was childcare providers who ***"see and understand a lot about what is happening with family"*** and could provide information about substance misuse and available services to families.
- ✓ **Expand access to recovery programming to specifically support new parents**. Recovery sector participants suggested that SUD recovery programs expand their offerings to include groups for new parents or those with young children, which they saw as necessary to overcome the stigma often associated with substance use among parents.
- ✓ **Encourage SUD providers to test for pregnancy to support earlier connections to prenatal care**. The Perinatal Nurse Program representative suggested that SUD treatment providers more regularly screen for pregnancy or encourage patients to be tested so that pregnant persons can be connected to prenatal services early in their pregnancies.

Organizations Serving Survivors of Domestic Violence

Participants working with victims of domestic violence shared that substance use is a challenge among the populations they serve, as is mental health and trauma that comes from living in abusive situations.[51] Participants stated that organizations addressing domestic violence (DV) have been effective at educating survivors about SUD treatment and recovery services. As DV sector participant stated, ***"I feel like our community does a pretty good job of outreach and awareness when it comes to accessing resources."*** Additionally, one participant shared, community-based DV organizations work hard to ensure that there is a "warm hand-off" to other services, thereby increasing the likelihood that clients will participate in them.

Like other population groups, domestic violence survivors who are actively using or in recovery experience long wait times for many residential SUD services. DV sector participants reported that some peer support and recovery coach options are more readily available. Transportation and geographic isolation are substantial challenges for survivors trying to access SUD services, as many communities have limited or no public transportation options. Existing research has shown that social isolation and stigma associated with seeking care for DV and/or SUD can limit the awareness of existing services in Vermont.[52]

DV sector participants reported that their organizations have increasingly partnered with those providing substance use services to expand survivors' access. For example, one organization has partnered with Turning Point to conduct a support group for survivors in recovery. A challenge for DV organizations, one participant shared, is balancing a desire to support survivors who are actively using while at the same time trying to support people who are trying to stay sober. Lack of transitional housing makes it difficult to exit active users from a shelter because there are few safe options. Furthermore, one DV sector participant stated, doing so would make it less likely that people will be honest about their substance use. However, there are consequences to this, as one participant stated: ***"people have relapsed because they were staying with us and were exposed to something."***

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[51] Mehr, J. B., Bennett, E. R., Price, J. L., de Souza, N. L., Buckman, J. F., Wilde, E. A., Tate, D. F., Marshall, A. D., Dams-O'Connor, K., & Esopenko, C. (2023). Intimate partner violence, substance use, and health comorbidities among women: A narrative review. *Frontiers in psychology*, *13*, 1028375. https://doi.org/10.3389/fpsyg.2022.1028375

[52] Robert Wood Johnson Foundation. (2021). Rural Vermont residents experiencing intimate partner violence and opioid use face multiple barriers to recovery and safety. IRL Research Brief. https://irlwebsite.wpenginepowered.com

Recommendations

Participants from the DV sector shared several suggestions to better meet the needs of domestic violence survivors with substance use disorders:

- ✓ **Expand availability of recovery and transitional housing**. DV housing providers struggle to balance a safe, drug-free environment with supporting survivors who are actively using to become sober. They suggested that one way to address this is to expand transitional housing options across Vermont, including those that support women and survivors in recovery.
- ✓ **Provide education and training to DV organizations and providers to better support survivors with SUD**. One participant stated that DV organizations could benefit from training on SUD and different service options so they can better facilitate survivors to connect to them. DV sector participants would also like to see more SUD resources available in shelters, including those related to harm reduction.
- ✓ **Increase understanding of domestic violence among SUD providers**. One DV sector participant recommended training for SUD service providers so they better understand and recognize domestic violence and its connection to substance misuse and are better equipped to support survivors to overcome their addictions.

Organizations Serving Veterans

Participants working with veterans stated that substance misuse is a substantial challenge among military-affiliated people and families. It is often associated with self-medicating due to mental health concerns, including PTSD, and other stressors. Participants reported that alcohol misuse is high among veterans and those in the military; as one veteran services sector participant explained, ***"drinking to overcome your challenges, it's just the thing you do."*** They also observed that cannabis use has increased in recent years.

Military culture is a barrier to prevention messaging and help-seeking, veteran services sector participants explained. Drinking, for example, is seen as acceptable and part of the culture. Convincing someone that they have a substance use disorder is a challenge: ***"how do you motivate someone to make changes in their life if they don't see the problem or they don't want to?"*** Stigma associated with substance use is also high in the military, which one participant attributed to a ***"no defect culture."*** This further deters people from admitting they have a problem and seeking care, particularly those currently serving. One participant also explained that substance use is endemic within military families, making it ***"harder to say no or even avoid that exposure."***

Participants working in the veteran services sector stated that lack of access to substance use services, as well as healthcare and mental health services, is a substantial challenge for active military and veterans. They observed that veterans and current military are often not aware of substance use services in the community beyond Alcoholics Anonymous (AA). Many are also not connected to regular healthcare, which creates further barriers to connecting with mental health and SUD programs.

When asked specifically about ability to access SUD services, participants reported that few services exist and those that do have long wait times. While VA-associated services exclusively serve the military and their families, several people mentioned that existing facilities in Vermont are often full, and others expressed concern about the quality of care. As a result, Vermont veterans and military use out-of-state resources, including Starlight (specifically for military) and Stonington in Connecticut. Access to SUD services, veteran services sector participants also explained, is limited by TriCare, the military health insurance. As one participant explained, ***"[Tricare is] horrible insurance; a lot of places don't take it because they don't pay out well."***

Recommendations

Participants working in the veteran services sector provided several suggestions to increase substance misuse services for military personnel and veterans:

- ✓ **Improve information about SUD services available to Veterans**. Recognizing that many veterans and military are not aware of SUD services, participants suggested more direct outreach with information directly to miliary families and through others such as doctor's offices and community services. As one participant shared, ***"[information] has to be everywhere because that's the only way to reach the people that need to be reached."*** One participant also suggested developing a directory of services oriented to military-affiliated people or updating the Tricare online directory, which someone stated did not have accurate information.
- ✓ **Increase understanding of Veterans among SUD providers**. Veteran services sector participants stressed the importance of having providers who understand the military culture as a strategy to improve quality of care as well as to make people more comfortable seeking services.

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Impact of Stigma

Participants repeatedly pointed to the challenges of stigma, by providers, community members, and elected officials, that make it difficult for people to seek care and the system to make the changes necessary to provide needed SUD services.

> ***"[People] think it's a choice and they just say 'well just stop, don't pick it up, don't use it.' And the belief that that is the case is a big part of the problem."*** – Person in Recovery

Several people in treatment and recovery shared their experiences with providers who have not understood or been sympathetic to their situations. They shared examples of being accused of seeking substances while accessing healthcare, being questioned at a pharmacy when picking up suboxone, and being treated as if they are unable to make their own decisions. While peer recovery coaches and some other providers have had personal experience with addiction, many others have not, and this may increase barriers to effective treatment. As one person in recovery explained, ***"it takes a really compassionate person to understand addiction who hasn't lived it."*** Those who act on stereotypes, another person in recovery added, ***"discourage you from reaching out and asking for help because that attitude pushes you away."***

Recovery sector participants working in the ED noted they have begun to see a positive shift in how providers interact with patients who come into the ED over time. The growth was attributed to the time recovery coaches have put into relationship building and education of the providers. One recovery sector participant stated, ***"you definitely see the growth just on them [providers] and how things have transitioned, I've been doing it [ED Recovery Coaching] since 2020 and watching how they've looked at individuals, and they try to treat them with respect."***

Despite these shifts in provider interactions with patients, participants in the recovery sector noted continued challenges working with emergency department staff and providers. ED based recovery coach stated, ***"One of the toughest parts in the ED is the providers believing they need the patient's consent before they call us. That's just not the way the program is designed. These are professionals and I respect them immensely, but now I walk in, I tell everyone you don't need to check in before calling me. It doesn't matter if it's 2am. Would you get permission before calling case management? No."***

Another recovery sector participant spoke to how SUD is addressed in EDs, ***"there's inconsistency with providers in the ED and how they approach substance use withdrawal.***

5 out of 6 will try to keep someone as long as they can to help them manage withdrawal, the 6th one will give some treatment and send them home... It's hard to predict which provider will be good."

Stigma within communities is another challenge. Participants noted that inaccurate and negative perceptions about those who misuse substances makes it difficult for those in recovery to obtain housing and employment and effectively work with institutions like schools and DCF. Some people, for example those living in small towns or members of some cultural groups, avoid seeking SUD care for fear of being labeled or ostracized by their communities. For this reason, participants reported that confidentiality within the SUD system is critical. One person in recovery commented that stigma can also lead to denial: ***"in this community there is an exceptionalism that those issues don't happen here and if we deny it maybe it won't need to be addressed."***

> ***"All stigma is related – the community at large is picturing the same person when they picture drug use, homelessness, and crime and that can make it hard for someone in recovery to get to services."*** – Housing Shelter Sector

Community perceptions also affect the system of care. As described earlier, attitudes about substance misuse prevent expansion of harm reduction services. Stigma has also been reinforced, participants explained, by politicians. Statements linking substance misuse to increased crime, and visible actions such as bulldozing encampments, participants reported, reinforce negative stereotypes people already have, and prevents productive policies and investment needed to expand services.

Some participants reported that they believe attitudes are changing, as more people are affected by substance misuse among their own family and friends and as they interact with people who have been challenged by it. One treatment sector participant observed***, "there's been a shift around how we talk, think, act about substance use disorder. Some of the culture around that has really improved in our provider community."*** For example, one participant pointed out that physicians have become more accepting of MOUD therapies. Treatment sector participants also reported that they are actively working to shift attitudes. One, for example, holds public meet-and-greet events to introduce people to the idea of MOUD and to address misperceptions. As this participant explained, ***"[events enable] the community to look into the clinic. We're not dingy, we don't have blinking lights, and grease on the walls. We're a medical facility that serves a purpose for your community."***

Recommendations

Participants shared several recommendations to address stigma toward those using substances and those providing substance use services.

- ✓ **Increase public education efforts to humanize substance use and recovery**. While some suggested that ***"almost everyone knows someone who has struggled with substance use"*** numerous participants advocated for more public education. They suggested anti-stigma campaigns that highlight people who have been successful in treatment. They also recommended that providers continue to hold events that bring the public and elected officials through their doors.

  "We simply need a more knowledgeable community who are willing to support a recovery friendly community and thus support the growth of our very limited resources." – Friend/Family of Person with SUD

  "Talk about it more. If people are educated more and talk about it more and raise awareness people get more accepting, and it might catch on that way." -Person in Recovery

- ✓ **Lead anti-stigma training among healthcare providers to improve delivery of care to those with SUD**. While attitudes in the provider community are changing, participants suggested that there is more work to be done. One participant proposed that more work be done to educate ED providers about substance misuse as the ED is the first step toward treatment for many people. Others suggested training pharmacists and primary care providers. One participant recommended better provider training in how to ask screening questions and have conversations. ***"Cultural humility and a focus on listening to people with lived experience"*** should be core to any provider training one person in recovery recommended. Another echoed this, saying, ***"there's more to people than their substance use disorder. We've got to get there."*** Additional suggestions included using a patient-centered lens to make changes to signage, outreach information, and waiting rooms for SUD services so patients have a better experience. One participant pointed to the impact recovery coaches have had on shifting culture among ED providers and suggested that embedding these coaches in other healthcare and community-based services could be helpful.

  "I think efforts to integrate peers into the work environment and having peers on panels and discussions on the places that make decisions. We have seen that in the ED and the PD that breaks stigma. I don't think it's possible to break stigma

by reading about it, there needs to be intentionality in involving peers and interacting with peers." – Recovery Sector

- ✓ **Continue to educate and inform policymakers to improve their awareness of what is happening on the ground**. Policymakers play a key role in unleashing funds, creating laws and regulations that can facilitate or hinder effective care, and shifting public attitudes. Participants strongly suggested that efforts to educate policymakers should continue and expand. This might be particularly helpful for mitigating policies that can lead to increases in stigmatization of people with SUD. Recommendations include inviting elected officials to tour facilities, so they understand the work on the ground and what the needs are. One participant said, ***"spend a 6 to 8-hour shift in the ER, that would show what is actually happening in the community."*** echoing the suggestion of another participant that policymakers engage directly and regularly with on-the-ground providers.

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Cross-Sector Collaboration and Coordination

Vermont has created a multi-tiered system of care to address substance misuse including prevention, treatment, recovery, and harm reduction services. This multi-tiered system requires coordination and collaboration between many state partners across Vermont. The system calls for local organizations to collaborate to create a substance misuse continuum of care. The need for collaboration and maintaining local control over services has been perceived by assessment participants to lead to both strengths and challenges to the substance misuse system. Throughout conversations, participants were asked to describe Vermont's multi-tiered care system, what was working well, where there was room for improvement, examples of both successful and unsuccessful collaborations, and their thoughts broadly on the system.

Perceptions

Strengths

Vermont has a spirit of local control and participants pointed to numerous examples of local collaborations that are working well. They shared examples of partnerships between SUD service providers and schools, police, EMS, and fire departments. Some participants

described local collaboratives, such as the opiate use collaboration in Franklin County, that provide an opportunity for providers in the region to learn about trends and share ideas and concerns. After sharing a description of numerous partnerships in Burlington, one recovery sector participant summarized: ***"it is a scramble here, but we are all trying the best we can to come together and find some solutions."*** It is at the local level as well, one participant stated, where innovation in the system of care most happens.

Participants frequently mentioned partnerships with local healthcare providers, who screen and refer patients and are credible resources for substance misuse information. Some participants noted that embedding recovery coaches in ED was a great example of collaboration. Importantly, partnerships with healthcare providers have been successful, one treatment sector participant observed, because these are funded and ***"they can afford to put people into positions who will push and develop those collaborations."***

Challenges

Participants identified numerous collaboration challenges which they attributed to a bifurcated state structure, funding siloes, lack of communication, and lack of organizational "bandwidth" to engage in partnership. These challenges, they reported, create competition for resources and contribute to fragmented care for those seeking SUD services. As one veterans services sector participant summarized, ***"I don't think there is a continuum of care – there's an identification and then a lack of accessible resources."***

> ***"The duration of in-patient is too short, the handoff between levels of care is bumpy, and people fall through the cracks."*** – Treatment Sector

Many participants from across sectors, discussed the separation of mental health services and substance use services at the state level as a substantial structural barrier to collaboration and ability to address the needs of the many Vermonters with co-occurring disorders. Within each department as well, there are separate programs with their own funding sources that do not collaborate, participants reported. For example, one treatment sector participant explained, multiple separate funding streams in the Hub and Spoke system mean that, ***"those who need methadone or buprenorphine have to go to one place. [But] If I am a person who needs methadone, [and] needs a psychiatrist, and a DUI [program], I need to go to three separate agencies."***

Numerous participants described the overall system of care as "siloed", which creates challenges for clients to access services in a seamless way and transition across services as their needs change. One treatment sector participant explained that there are few agencies where different levels of SUD services are "under one roof" and thus, patients/clients must

navigate across organizations. This is even more complicated when multiple sectors are involved, as one treatment sector participant explained, ***"[patients] might have four different case managers at four different services."*** This fragmentation also contributes, some noted, to administrative burdens as ***"each agency has their own expectations, and a client needs to tell their story about three times in a row."***

Some participants stated that there are challenges to collaboration between the treatment and recovery agencies, as each is stretched thin. Residential treatment providers, for example, expressed frustration that calls to recovery services are not answered. One treatment sector provider stated that competition for resources also inhibits collaboration and leads to a perception of ***"'look at those folks failing over there so fund us and not them' [that] spurs narratives that are not helpful."***

> ***"I think people are generally trying the best they can, but I think the diffused nature of how the system of care is organized kind of keeps self-interest against the consumer experience. I don't think anyone set out to make a confusing system, but because we are all small organizations, and local control does make it hard to find these services."*** – Treatment Sector

Participants pointed to collaboration challenges with other systems that create challenges for their work and the ability to effectively serve clients and patients. Several treatment sector participants expressed frustration with lack of communication from the DOC about newly released detainees which prevents their ability to plan for discharge or ensure a smoother transition to community-based services. However, as discussed previously the experience of DOC is that there is a lack opportunity for connection to such services which prevents more effective transitions of detainees back to the community as the DOC representative stated, ***"there aren't enough community supports for them once they leave however... there isn't the workforce or community-based array to provide that kind of care. Once they get back to the community, they have no idea where to go"***

Data from the ***Vermont Social Autopsy Report 2021,***[53] provide some insight into the range and variety of systems Vermonters who died of a drug overdose interacted with prior to death. These interactions can be used to identify opportunities for agency and organization intervention as well as areas for greater collaboration and communication around the people within their care. **Figure 34** shows that the vast majority of individuals had a history of

[53] Vermont Department of Health. (2023). Vermont social autopsy report 2021 data analyses, August 2023 (Updated September 2023). Vermont Department of Health. https://www.healthvermont.gov/sites/default/files/document/dsu-2021-Vermont-social-autopsy-report.pdf

interaction with public safety, the Vermont Prescription Monitoring System, VT Medicaid, Emergency Medical Services, and/or the VT Department of Children and Families.

Figure 34. Interactions with Individual Agencies/Datasets Among Vermonters who Died of Overdose in 2021 – Vermont Social Autopsy Report

	Agency/Dataset	Description	Percent
	Public Safety	Interacted with Vermont State Police between 1988 and date of death.	84%
	VPMS	Had at least one prescription for a controlled substance in the 6 years prior to death.	78%
	Vermont Health Access	Were enrolled in Medicaid in year prior to death.	71%
	SIREN	Interacted with EMS between 2015 and date of death.	69%
	Children and Families	Interacted with DCF-FSD between 1982 and date of death.	59%
	IDRP	Had an impaired driving offense between 2000 and date of death.	24%
	ICA	Received homelessness services in year prior to death.	24%
	VDOL	Filed a claim for unemployment benefits in year prior to death.	19%
	Mental Health	Interacted with a Vermont Designated Agency or Specialized Service Agency in year prior to death.	13%
	Corrections	Were incarcerated within one year of their death.	9%

Data Source: Vermont Social Autopsy Report 2021 Data Analyses, August 2023 (Updated September 2023)

Recommendations

Participants stated that DSU can play a leadership role in fostering collaboration within the system of care. Suggestions included:

- ✓ **Improve collaboration between DSU and DMH to maximize resources and address system gaps**. Given the constraints of two different departments, participants focused on how collaboration could happen within the current separate departments. Among the many challenges that arose during conversations, this was most frequently mentioned as a key structural constraint, though few had suggestions beyond more communication between the two departments and the braiding of funding where possible, likely limited by the lack of understanding of how the two state agencies could better engage with one another in their delivery and oversight of programs or services.

- ✓ **Lead communication and coordination efforts across the continuum of care**. Numerous participants stated that DSU could play a greater role in leading and coordinating efforts across and between partners within the continuum of care. Suggestions included holding more regular meetings/convenings with providers across the system, including for-profit agencies, so that agencies can identify and address barriers to collaboration and address gaps in the system of care. As one treatment sector provider stated, ***"the residentials should be involved in any meetings with other recovery centers. We're not. We should all be meeting as a group with DSU about what we need and what to advocate for with legislation."*** One participant also suggested that DSU do more to identify and share best practices across the system of care. Another participant would like to see DSU fund more conferences and summits to bring people together from across the state, including those who are outside the formal system of care.
- ✓ **Improve coordination and communication with the legislature to ensure providers' perspectives are considered and policies are aligned**. Participants expressed a desire for DSU to enhance its role in facilitating communication with and education of the legislature. As one treatment sector participant emphasized, ***"providers need to have their voice heard with legislature."*** Recognizing the varying policy perspectives across the system of care, another participant suggested that DSU should actively seek to align policies across the continuum to advance efforts. Additionally, it was noted that despite the staffing challenges faced by many SUD service provider agencies, several participants emphasized the importance of including input from those on the ground in policy discussions. One participant suggested that those providing services be part of policy making groups such as the Opioid Settlement Advisory Committee. Another proposed that DSU have meetings with providers twice a year before going into legislative sessions to identify concerns that can be brought to policymakers. Key to understanding on-the-ground issues, a couple of participants pointed out, is getting to talk to SUD providers and those in the community who have been affected by substance use. Several see this as critical to better connecting decisions made at the state capital to the reality of local contexts and needs.
- ✓ **Expand and enhance collaborations with law enforcement and the justice sector**. Participants would like to see DSU work more closely with DOC and the court system to better understand policies and processes and make things work more smoothly. A few others suggested better coordination with DCF. Participants noted a desire for more education for probation officers and the court system around SUD and available SUD

services in their local communities. The DOC representative stated, ***"POs [parole officers] are not treatment providers they may not know the cast of characters providing services."***

- ✓ **Engage with community-based organizations and share knowledge and skills**. Social services sector participants working outside the substance use sector—providing shelter housing, addressing the needs of pregnant persons, and working with immigrants, indigenous groups, veterans, seniors, and survivors of domestic violence—shared a common desire to work more closely with providers in the system of care to better meet the SUD needs of the populations they serve. These organizations are deeply knowledgeable about and trusted by their communities and can and do play an important role in identifying and referring community members to SUD services. Numerous participants stated that they would like to be more knowledgeable about SUD and better connected to local SUD services providers. Suggestions included training in SUD for community organization staff and training SUD providers about the unique needs of these different communities.

"Why people chose recovery is individual and mysterious. There are these points where people pivot sometimes, like criminal justice involvement or being pregnant. There are places where differences can be made." – Treatment Sector

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Vision for the Future

When asked about their visions for the future, participants often pointed to specific changes in the parts of the system of care they are directly involved with or the constituencies they directly serve. Broadly, however, many aspired to see a state where there are fewer people struggling with substances. According to participants, this requires:

- An effective, expanded, and more equitably distributed system of substance use services, supported by a strong infrastructure at the state level, and seamless partnerships locally.
- Attention to the root causes of substance misuse, including mental health and trauma.
- Investments that enable families and communities to thrive, including affordable housing, youth programs, and support for parents.
- Greater community and elected leader understanding of substance use disorders, and willingness to support programs, policies, organizations, and individuals who are working or receiving services in the system of care.