

# VERMONT OPIOID COORDINATION COUNCIL

AS CREATED BY GOVERNOR PHIL SCOTT  
EXECUTIVE ORDER 02-17

## INITIAL REPORT OF RECOMMENDED STRATEGIES

December 2017

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# EXECUTIVE SUMMARY OF THE RECOMMENDATIONS

Vermont's opioid crisis affects all Vermonters across all socio-economic and geographic boundaries. It has devastated families across generations – those who have become addicted, parents and family members, and children.<sup>1</sup> Nationally, drug fatalities now outnumber all Vietnam War deaths, and exceed AIDS-related deaths at the height of the HIV epidemic in 1995.<sup>2</sup> Deaths from opioid-related overdoses increased 159%<sup>3</sup> in Vermont between 2010 and 2016 and continue to climb. (See Appendix II.1) More than half (53%) of the 266 children ages 0 – 5 in Vermont custody are there due to opioid abuse issues. (See Appendix II.6) The costs to the state in terms of lost productivity and increased social services, treatment and law enforcement are immeasurable.

This crisis is rooted in the excessive prescribing of opioids beginning in the late 1990s. It resulted in an unprecedented surge in substance use disorders (SUDs) which overwhelmed Vermont's ability to treat those afflicted with this disease. While there is evidence that prescribing rates are leveling off and may be declining in some areas, the volume of opioids prescribed is still too high. With easy access to opioids on the street, and the increasing demands for prevention, treatment and recovery supports, Vermont has struggled to keep families safe and resilient.

Governor Scott has determined that these struggles need not be permanent features of the Vermont landscape. The Opioid Coordination Council (OCC) offers this report to provide a first set of strategies designed to focus the efforts of state government and to energize communities, providers, and families.

Under the directives of Governor Scott's Executive Order 02-17 (09-17), the OCC recommends establishing strategies *that identify and stop the current pathways to opioid addiction, break the generational cycle of addiction and the stigma associated with it, and ensure lifelong recovery*. This will require comprehensive prevention efforts and strong treatment and recovery support. Strategies that address each of these core areas, if implemented and sustained, will turn this tide and build resilience in our youth, workers, businesses, parents, and the economy.

Vermont has achieved successes that serve as foundation for next steps. The Vermont Prescription Monitoring System (VPMS), new prescriber rules, and prescriber and patient education are showing promise and must continue and be expanded appropriately. Healthcare providers recognize they are important partners in solving this epidemic. The Hub and Spoke system for treatment is recognized nationally and must be supported, assessed, and improved upon. The next steps, however, are critical. To create a firewall of resilience for our families, mothers with SUDs and their infants must have supports, and individuals in whose treatment we have invested must be supported in their recovery. The odds of sustaining recovery without relapse rise significantly between years one and three, and remain high after three years.<sup>4</sup> (See Appendix II.8)

The Drivers for Systemic Improvement – **prevention, treatment, recovery, and enforcement** – are a simplified framework. Each is essential to address this crisis, and they cannot be considered in isolation from each

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<sup>1</sup> The Vermont Department for Children and Families reported in November 2016 that 53% of the 266 children ages 0-5 in state custody were there due to opioid-related issues.

<sup>2</sup> "Statistical information about casualties of the Vietnam War." The National Archives. <https://www.archives.gov/research/military/vietnam-war/casualty-statistics.html>; "HIV Surveillance – United States, 1981-2008." CDC Morbidity and Mortality Weekly Report, June 2011.

<sup>3</sup> Vermont Department of Health Vital Statistics System. (See chart Appendix II, page 46.)

<sup>4</sup> National Institute on Drug Abuse (NIDA), presentation: Drug Abuse and Addiction: Bringing the Full Power of Science to Bear on Drug Abuse and Addiction. Based on Dennis et. al., Eval. Rev. 2007. [www.nida.nih.gov](http://www.nida.nih.gov).

other. The need for **education** crosses all drivers – prescribers, patients, parents, teachers, employers, service providers, law enforcement and first responders -- have much to learn about brain chemistry and opioids, co-occurring mental health conditions, and about stigma. And the need for **intervention** – taking advantage of every contact with an individual with an SUD to move toward treatment and recovery – is the gateway to restoring families and communities.

This initial report summarizes the OCC's findings based on its first six months of work. The Director of Drug Prevention Policy Jolinda LaClair, Community Engagement Liaison Rose Gowdey, and members of the OCC visited communities in Vermont to learn about best practices. The strategies reflect input from all sectors and from many diverse perspectives: State experts, business leaders, service agencies, community organizations, and individuals affected by SUDs either directly or as family members and friends.

### Next Steps

In the coming six months and year, the OCC is committed to supporting state government and other sector leaders in launching any strategy development supported by Governor Scott, and to more deeply assessing best practices and any barriers to preventing and overcoming Vermont's opioid-related challenges through prevention, treatment, support for recovery, and law enforcement efforts.

The OCC is grateful for this opportunity to serve and looks forward to taking these next steps.

## **Recommended Strategies**

### **1. OVERARCHING/SYSTEMIC**

- A. **DEVELOP A CONTINUUM OF CARE:** DEVELOP A CONTINUUM OF CARE FROM PRE-BIRTH TO AT LEAST THREE YEARS OF AGE THAT SUPPORTS A TWO-GENERATION APPROACH FOR PREGNANT WOMEN WITH SUD AND THEIR CHILDREN AND FAMILIES BY CONNECTING PROGRAMS WITHIN AND ACROSS THE AGENCY OF HUMAN SERVICES AND HEALTH CARE PROVIDERS.

**Action:** Convene a cross-agency working group which includes regional and statewide community resources, to develop a statewide system of program delivery which provides health and social supports for all women with SUDs and their children. Universal home visits for all women and children including an analysis of cost and return on investment will be considered.

- B. **GROW AND SUPPORT VERMONT'S WORKFORCE:** EMPLOY VERMONTERS IN RECOVERY; EXPAND THE SUD WORKFORCE

1. EXPAND THE NUMBER OF VERMONTERS IN RECOVERY WHO HAVE A JOB.

**Action:** A multi-sector working group will develop a blueprint to implement employment support services in Vermont's Recovery Centers and the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (ADAP), Preferred Provider treatment system of care by March 2018. State agencies and departments, the Vermont Recovery Network, employers, and treatment providers will work to develop this program.

2. EXPAND AND SUPPORT VERMONT'S SUD WORKFORCE.

**Action:** Form an OCC Committee that will engage higher education institutions, mental health and substance use disorder service organizations, and others to continue work on developing the substance use disorder workforce, with additional recommendations developed by June 2018.

- C. **IMPROVE DATA INTEROPERABILITY IN VERMONT:** IMPROVE VERMONT’S STATEWIDE DATA COLLECTION AND ANALYSIS CAPABILITY TO ASSESS AND IMPROVE OUTCOMES FOR INTERVENTION, TREATMENT AND RECOVERY SERVICES.

**Action:** The OCC will convene a multi-sector working group, to include the Agency of Digital Services (ADS), the Agency of Human Services (AHS), University of Vermont Medical Center (UVMCMC), Project Vision, and the Chittenden County Opioid Alliance (CCOA), to explore other models for data and information sharing.

## 2. PREVENTION, EDUCATION AND INTERVENTION STRATEGIES

- A. **IMPLEMENT STATEWIDE COMPREHENSIVE SCHOOL-BASED PREVENTION:** IMPLEMENT A STATEWIDE COMPREHENSIVE SYSTEM FOR DELIVERY OF SCHOOL-BASED PRIMARY PREVENTION PROGRAMS. The Agency of Education and the VT Department of Health (VDH), Alcohol and Drug Abuse Programs (ADAP), in collaboration with the Vermont Department of Mental Health (DMH) and prevention specialists, must lead our state in this effort. This system will include a professional trained in primary prevention and SUD intervention, and best practice programs available to all students in every school. School-based programs should be aligned and in partnership with community-based prevention programs.

**Actions:**

- Support the addition of an FTE in the Agency of Education to ensure access and availability of evidence-based models for prevention and intervention.
- The Vermont Agency of Education, and VDH/ADAP and DMH, will lead a working group to inventory school professional resources supporting primary prevention and SUD intervention.

- B. **EXPAND HEALTH CARE EDUCATION, MONITORING AND SCREENING FOR PROVIDERS AND PATIENTS:**

1. ENSURE FULL PARTICIPATION AMONG PROVIDERS IN THE VERMONT PRESCRIPTION MONITORING SYSTEM (VPMS).
2. ENSURE ALL PRESCRIBERS AND THOSE IN TRAINING TO PRESCRIBE, RECEIVE TRAINING ON ALTERNATIVES TO OPIOIDS PAIN MANAGEMENT, INCLUDING NON-PHARMACOLOGIC OPTIONS, AND ON PATIENT EDUCATION REGARDING OPTIONS AND RISKS IN PAIN MANAGEMENT.
3. EXPAND SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT (SBIRT) THROUGHOUT PRIMARY CARE, EMERGENCY DEPARTMENTS, IN CORRECTIONS AND SCHOOLS -- FOR ALL FROM PRE-KINDERGARTEN THROUGH ELDERLY. (HEALTH CARE REFORM).

**Actions:**

- The OCC requests that ADAP educate the OCC on prescriber and patient education programs and activities underway and planned at its February 2018 meeting. The OCC will then make recommendations for next steps.
- The OCC will review the results of the VPMS analysis of prescriber registration and participation and will consider additional recommendations.
- Support the Agency of Human Services in development of a plan to implement SBIRT services in Vermont’s emergency departments, primary care practices, and school health services. Support for resources may be needed.

- C. **BUILD COMMUNITY-BASED PREVENTION:** BUILD, REPLICATE, AND SUPPORT STRONG COMMUNITY-BASED MODELS THROUGH MULTI-SECTOR PARTNERSHIPS, INNOVATION, AND RESEARCH RESULTING IN OUTCOMES THAT EXCEED PREVIOUS, LESS COLLABORATIVE EFFORTS.

**Actions:**

- The Council will convene a working group to identify resources to support community-based initiatives to address the challenges which rise from drugs and substance use disorder at the local level.
- The OCC will also support work among agencies, departments, community partners, and others to develop a statewide comprehensive system for primary prevention programs addressing health and wellness in communities and schools.

**D. CREATE A COMPREHENSIVE DRUG PREVENTION MESSAGING CAMPAIGN:** CREATE A STATEWIDE PREVENTION MESSAGING CAMPAIGN DESIGNED TO RAISE PUBLIC AWARENESS, REDUCE STIGMA, PROVIDE HOPE FOR FAMILIES, AND STRENGTHEN RESILIENCE IN VERMONT'S COMMUNITIES.

**Action:** Convene a multi-sector working group that brings together the key public and private sectors, including ADAP, State Chief Marketing Officer, medical institutions, and private sector, by October 2018. Ensure 2-1-1 is incorporated into the messaging campaign.

**E. INTERVENTION: EXPAND SYRINGE EXCHANGE AVAILABILITY:** EXPAND VERMONT'S SYRINGE EXCHANGE PROGRAMS AND SERVICES TO INCREASE GEOGRAPHIC REACH AND HOURS OF OPERATION. SUPPORT ACCESS TO INCREASED CASE MANAGEMENT SERVICES FOR ALL PARTICIPANTS.

**Action:** Vermont Department of Health will lead a working group to develop an implementation plan by June 2018.

**F. INTERVENTION: SUPPLY NALOXONE AND PROVIDE TRAINING:** ALL VERMONT LAW ENFORCEMENT, VERMONT EMERGENCY MEDICAL SERVICES (EMS) AND PEOPLE LIKELY TO BE NEAR A PERSON WHO MAY OVERDOSE SHOULD HAVE NALOXONE AND EFFECTIVE TRAINING.

**Action:** The Vermont Department of Health will conduct continuous outreach and education in an effort to reach 100% utilization of naloxone for any emergency as needed.

**G. HARM REDUCTION: EXPAND DRUG DISPOSAL OPTIONS:** EXPAND CURRENT DRUG DISPOSAL OPTIONS AND EVENTS, AND INCREASE PUBLIC PARTICIPATION ACROSS THE STATE.

**Action:** Support and expand public opportunities for drug disposal and "take back" days.

**H. HARM REDUCTION: IMPROVE SHARPS COLLECTION AND DISPOSAL:** CREATE A STATEWIDE STRATEGY AND COMMUNITY TOOLKIT TO IMPROVE COLLECTION AND DISPOSAL OF SHARPS.

**Action:** Action is underway. Continue to support. Strategy development will begin with data collection and will include state, regional and community connections/partners; public education about proper disposal methods; siting of kiosks; addressing transportation issues and options for pick-up and disposal; solid waste management; and resource needs.

**3. TREATMENT STRATEGIES**

**A. SUPPORT, EVALUATE AND IMPROVE VERMONT'S HUB AND SPOKE SYSTEM:** CONTINUOUSLY SUPPORT, EVALUATE AND IMPROVE UPON VERMONT'S HUB AND SPOKE SYSTEM FOR OPIOID TREATMENT TO SUSTAIN, AND EXPAND WHERE NEEDED, HUB AND SPOKE TREATMENT SERVICES ACROSS THE STATE, INCLUDING MEDICATION-ASSISTED TREATMENT.

**Action:** The OCC will review evaluation of Vermont's Hub and Spoke system and support Vermont's Blueprint for Health, and the Health Department Division of Alcohol and Drug Abuse Programs, to implement recommendations for continuous improvement.

- B. **EXPAND MEDICATION-ASSISTED TREATMENT IN CORRECTIONAL FACILITIES:** EXPAND ACCESS TO MEDICATION-ASSISTED TREATMENT (MAT) IN ALL VERMONT CORRECTIONAL FACILITIES.

**Action:** The OCC will support the VT Department of Corrections (DOC) in their effort to secure resources needed to develop policy, program, and infrastructure necessary to expand MAT in all Vermont Correctional facilities.

- C. **MAXIMIZE NON-PHARMACOLOGICAL APPROACHES:** MAXIMIZE THE USE OF NON-PHARMACOLOGICAL APPROACHES - INTEGRATIVE HEALTH CARE PROFESSIONS -- FOR PREVENTION, TREATMENT AND RECOVERY.

**Action:** In the next year, the OCC will support a working group, including Blueprint, Health Care Reform, Vermont Department of Health, and integrative health care professionals to address research opportunities, coverage across all payers, and the availability of integrative health care options throughout Vermont.

- D. **EXPAND DRUG TREATMENT COURTS/FAMILY TREATMENT COURTS:** SUPPORT THE VERMONT JUDICIARY'S PLAN TO EXPLORE EXPANDED ACCESS TO TREATMENT DOCKET TECHNIQUES:

- Adult Treatment Dockets in the Criminal Division, and
- The Family Abuse and Neglect Docket in the Family Division

**Action:** The OCC will support the Vermont Judiciary's plan to explore expanded access to the above treatment docket techniques.

- E. **EXPAND MEDICARE AND MEDICAID COVERAGE:** SUPPORT THE NATIONAL GOVERNORS' ASSOCIATION RECOMMENDATION TO EXPAND MEDICARE AND MEDICAID COVERAGE FOR OPIOID TREATMENT.

**Action:** The Agency of Human Services and the Governor's Health Care Reform initiative are leading this effort. No additional action is recommended at this time.

#### 4. RECOVERY STRATEGIES

- A. **STRENGTHEN RECOVERY CENTERS, RECOVERY COACHES:** ENSURE VERMONT HAS A STRONG STATEWIDE NETWORK OF RECOVERY CENTERS, RECOVERY COACHES, AND SUPPORTS, AND THAT EACH REGIONAL RECOVERY CENTER HAS THE CAPACITY TO DELIVER PROGRAMS AND SERVICES TO INDIVIDUALS IN RECOVERY, THEIR FAMILIES, AND LOVED ONES.

**Action:** The OCC will work with the Vermont Department of Health/Alcohol and Drug Abuse Programs Division (ADAP) and other departments of the Agency of Human Services, the Vermont Recovery Network, the Vermont Association for Mental Health and Addiction Recovery (VAMHAR), and the 12 recovery centers to develop a results-based budget and program delivery system proposal for investment by March 2018.

- B. **EXPAND RECOVERY HOUSING:** EXPAND THE AVAILABILITY OF RECOVERY HOUSING AND THE DEPARTMENT FOR CHILDREN AND FAMILIES' FAMILY SUPPORTIVE HOUSING PROGRAM TO ENSURE INDIVIDUALS AND FAMILIES HAVE ACCESS TO A STABLE HOME ENVIRONMENT THROUGHOUT VERMONT.

**Action:** The OCC will convene an initial collaborative meeting with state agencies, Vermont's non-profit housing provider network, and private sector housing providers and home builders, to consider and provide recommendations to grow Vermont's inventory of, and access to, safe and healthy home environments, by June 2018.

- C. **EXPAND EMPLOYMENT IN RECOVERY:**

(See "Expand the number of Vermonters in recovery who have a job," page 4, B.1.)



## 5. ENFORCEMENT STRATEGIES

- A. **PURSUE ROADSIDE DRUGGED DRIVING TESTING:** SUPPORT RESEARCH, DEVELOPMENT, AND COURT ADMISSIBILITY OF A SIMPLE, ACCURATE AND COST-EFFECTIVE ROADSIDE TESTING METHOD FOR DRUGGED DRIVING.<sup>5</sup>

**Action:** Support legislative and legal efforts to achieve this strategy.

- B. **INCREASE DRUG TRAFFICKING INVESTIGATIONS:** INCREASE VERMONT'S RESOURCES FOR DRUG TRAFFICKING INVESTIGATIONS.

**Action:** Support State of Vermont/VT Law Enforcement efforts to achieve this strategy.

- C. **PROVIDE DRUG RECOGNITION TRAINING:** PROVIDE DRUG RECOGNITION TRAINING FOR LAW ENFORCEMENT, FIRST RESPONDERS, AND INCREASE THE NUMBER OF DRUG RECOGNITION EXPERTS (DRES).

**Action:** Support State of Vermont Law Enforcement efforts to achieve this strategy.

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<sup>5</sup> The VT Marijuana Advisory Commission is also developing recommendations.

# INTRODUCTION

A Vietnam veteran once poignantly and prophetically observed that, “Heroin is the doorknob to hell.”<sup>6</sup> Since the late 1990s, the number of Americans and Vermonters who have turned this doorknob to heroin and other opioids — with all the resulting tragedy and heartbreak — has continued to rise. Many medical professionals say we have a “lost generation” of people, so many suffering with the chronic disease of opioid use disorder.

In his inaugural address Vermont’s Governor Phil Scott determined to change this trend. By executive order he created the Opioid Coordination Council (OCC), with a roster of Vermonters from all walks of life and professions. The Governor charged the OCC with — among other things — a thorough review of inter-agency and intra-agency efforts to combat this epidemic. The OCC was also mandated to identify best practices to address opioid use disorder and misuse in order to:

1. Significantly reduce the demand for opioids through prevention and education;
2. Provide treatment to those afflicted with opioid addiction; and
3. Significantly reduce the supply of illegal opioids.

Since its first meeting six months ago, the OCC has worked diligently to meet this critical challenge. This report builds upon the work of state agencies, a network of non-profit and private sector providers, law enforcement, community leaders, and citizens to address this issue and sets forth a blueprint to move Vermont toward addiction recovery. It is, however, a beginning, not an end.

## THE OPIOID CHALLENGE: UNITED STATES AND VERMONT

Locally and nationally, the use of illegal opioids and the abuse of prescription opioids has reached epidemic proportions and continues to rise. Drug overdoses now kill more people than gun homicides and car crashes combined.<sup>7</sup> In 2016, 64,070 Americans died from drug overdoses – 175 each day.<sup>8</sup> Annual drug fatalities now outnumber American fatalities during the entire Vietnam War. They also exceed AIDS-related deaths in the worst year of the HIV epidemic (50,628 deaths in 1995).<sup>9</sup> It is a national public health emergency.

Closer to home, virtually every Vermonter has been directly or indirectly touched by this crisis. The cost to the State in human suffering, lost opportunity, and increased social services, treatment, and law enforcement is incalculable. Vermont saw 106 deaths from opioid-related overdoses in 2016, a 159% increase between 2010 and 2016. Unfortunately, overdose deaths have continued to climb. Through September 2017, 72 Vermonters lost their lives to opioid-related overdose deaths. At this rate, Vermont will again exceed last year’s record number of opioid-related deaths.<sup>10</sup> (See Appendix II.1.)

Our children and family services have seen the impact as well. The Department for Children and Families reported that in 2016, Vermont had 1,302 children in custody. Of the 266 children ages 0 – 5, over half (53%)

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<sup>6</sup> Quotation from former Howard Mental Health Director and Opioid Coordination Council Co-Chair James Leddy.

<sup>7</sup> President’s Commission on Combating Drug Addiction and the Opioid Crisis, Interim Report, March 29, 2017.

<sup>8</sup> “Provisional Counts of Drug Overdose Deaths as of 8/6/2017.” Centers for Disease Control and Prevention. [https://www.cdc.gov/nchs/data/health\\_policy/monthly-drug-overdose-death-estimates.pdf](https://www.cdc.gov/nchs/data/health_policy/monthly-drug-overdose-death-estimates.pdf)

<sup>9</sup> “Statistical information about casualties of the Vietnam War.” The National Archives.

<https://www.archives.gov/research/military/vietnam-war/casualty-statistics.html>; “HIV Surveillance – United States, 1981-2008.” CDC Morbidity and Mortality Weekly Report, June 2011.

<sup>10</sup> Vermont Department of Health Vital Statistics System. (See chart Appendix II, page 46.)

were in custody due to opioid abuse issues.<sup>11</sup> (See Appendix II.6) Nineteen percent of persons who are homeless self-report chronic substance abuse.<sup>12</sup>

This crisis has its genesis in a health care system that has quadrupled the number of prescription opioids in the United States since the 1990s.<sup>13</sup> In 2016 prescribers wrote 66.5 opioid prescriptions for every 100 Americans; that means 66 out of every 100 Americans were issued a prescription for opioids last year.<sup>14</sup> “In fact, in 2015, the number of opioids prescribed in the U.S. was enough for every American to be medicated around the clock for three weeks.”<sup>15</sup>

Vermont mirrors the national increase. In 2015, over 600,000 opioid prescriptions were issued – nearly one half of the total prescriptions issued in the state.<sup>16</sup> This represents a staggering 20 percent increase since 2010, without any evidence of a corresponding increase in the amount of pain Vermonters may be suffering.<sup>17</sup> (See Appendix II.4)

## ADDICTION, MENTAL ILLNESS, AND STIGMA

### Addiction and “Use Disorders”

Definitions of and attitudes toward addiction have changed significantly in recent years, thanks in part to research in brain science, mental health, and substance use disorders. One sad but hopeful side effect of the Vermonters’ widespread experience of family members and friends with SUDs, is increased understanding of the disease.

According to the National Institutes of Health/National Institute on Drug Abuse website, addiction is defined as, “a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. It is considered a brain disease because drugs change the brain; they change its structure and how it works. These brain changes can be long lasting and can lead to many harmful, often self-destructive, behaviors.”<sup>18</sup> This interpretation has been reinforced to the OCC in presentations by Dr. Sanchit Maruti, M.D., psychiatrist and assistant professor at University of Vermont Medical Center (UVMCMC) who specializes in SUD.

The term “substance use disorders” (SUDs) now replaces “substance abuse” or “substance dependence” in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). SUDs are determined to be mild, moderate, or severe, by the number of diagnostic criteria met by an individual.

**Substance use disorders** occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major

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<sup>11</sup> Department for Children and Families.

<sup>12</sup> 2017 PIT Count (Point-in-Time, an annual, statewide, unduplicated count of persons experiencing homelessness in both unsheltered and sheltered (homeless program) places on a single night.)

<sup>13</sup> “Annual Surveillance Report of Drug-Related Risks and Outcomes.” Centers for Disease Control and Prevention, 2017. <https://www.cdc.gov/drugoverdose/pdf/pubs/2017-cdc-drug-surveillance-report.pdf>; President’s Commission on Combating Drug Addiction and the Opioid Crisis, Interim Report, March 29, 2017.

<sup>14</sup> *Id.*

<sup>15</sup> President’s Commission on Combating Drug Addiction and the Opioid Crisis, Interim Report, March 29, 2017.

<sup>16</sup> “Opioids in Vermont: Prevalence, Risk, and Impact.” Vermont Department of Health, October 27, 2016.

[http://www.healthvermont.gov/sites/default/files/documents/2016/12/ADAP\\_Opioids\\_Prevalence\\_Risk\\_Impact.pdf](http://www.healthvermont.gov/sites/default/files/documents/2016/12/ADAP_Opioids_Prevalence_Risk_Impact.pdf)

<sup>17</sup> *Id.*

<sup>18</sup> <https://www.drugabuse.gov/publications/media-guide/science-drug-abuse-addiction-basics>

responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.<sup>19</sup>

**Opioid use disorder** is a category within substance use disorders. Symptoms are similar to those of other substance use disorders, and according to SAMHSA include, “strong desire for opioids, inability to control or reduce use, continued use despite interference with major obligations or social functions, use of larger amounts over time, development of tolerance, spending a great deal of time to obtain and use opioids, and withdrawal symptoms that occur after stopping or reducing use.”<sup>20</sup>

#### Mental Health and Substance Use Disorders: Treating Co-Occurring Illnesses

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), people with mental health disorders are more likely than people without mental health disorders to experience alcohol and substance use disorders. Once referred to as “dual diagnoses,” SAMHSA reported approximately 7.9 million adults in the United States had co-occurring disorders in 2014. It is often difficult for services providers, including law enforcement, to identify the presence of both types of conditions when determining treatment approaches. An integrated approach is most effective, and may lower costs while creating better outcomes.<sup>21</sup> Vermont’s service providers work hard to address the challenges in this area, including diagnosing, treatment, addressing stigma, and addressing the costs of treatment.

#### Stigma and the Role of Jobs, Housing, and Social Supports

Stigma presents barriers to intervention, treatment, and to sustaining recovery. When an individual reveals a history involving addiction or SUD, job offers often disappear, housing doors slam shut, and social connection can be difficult to build. And yet, it is these things – housing, jobs, and social support and engagement – that are the foundation of both prevention and recovery.

Stigma can be described as a “complex of attitudes, beliefs, behaviors, and structures that interact at different levels of society . . . and manifest in prejudicial attitudes about and discriminatory practices against people with mental and substance use disorders.”<sup>22</sup>

Addressing stigma through education and public awareness efforts has the potential to rally employers, landlords, and communities to create more opportunities with recovery support in mind. Building supports for family members and loved ones of those with SUD will create additional understanding of the disease. These efforts will help to break multi-generational cycles of SUD, and build resilience in the face of trauma and adverse childhood experiences.

## OPIOIDS AND MARIJUANA

The opioid crisis must be viewed against the backdrop of the efforts to decriminalize and legalize marijuana in Vermont and across the country. The OCC would be remiss to simply ignore the impact marijuana legalization may have on the opioid crisis. These two issues cannot be neatly segregated. The opioid crisis

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<sup>19</sup> <https://www.samhsa.gov/disorders/substance-use>

<sup>20</sup> (ibid.)

<sup>21</sup> <https://www.samhsa.gov/disorders/co-occurring>

<sup>22</sup> (Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change. Committee on the Science of Changing Behavioral Health Social Norms; Board on Behavioral, Cognitive, and Sensory Sciences; Division of Behavioral and Social Sciences and Education; National Academies of Sciences, Engineering, and Medicine. Washington (DC): [National Academies Press \(US\)](https://www.ncbi.nlm.nih.gov/books/NBK384923/); 2016 Aug 3. <https://www.ncbi.nlm.nih.gov/books/NBK384923/>)

facing the country began in the healthcare system and was profoundly affected by the convergence of several factors. One primary factor was the lack of any reliable research or studies on dosage and potential for abuse of opioids before the prescribing of opioids exploded in the late 1990s and 2000s. This led to flawed and unproven claims that sustained opioid use would not lead to addiction or abuse. The OCC shares the concerns articulated by the President's Commission on Combating Drug Addiction and the Opioid Crisis:

"There is a lack of sophisticated outcome data on dose, potency, and abuse potential for marijuana. This mirrors the lack of data in the 1990's and early 2000's when opioid prescribing multiplied across health care settings and led to the current epidemic of abuse, misuse and addiction. The Commission urges that the same mistake is not made with the uninformed rush to put another drug legally on the market in the midst of an overdose epidemic."

The OCC therefore counsels a cautious approach to the legalization of marijuana based on the lack of data on the health risks of marijuana; recent compelling evidence that cannabis use may increase the risk of developing nonmedical prescription opioid use and opioid use disorder; Youth Risk Factor Behavior Survey data showing the decreasing and already low percentage of youth who believe regular use of marijuana is harmful; and the risk of sending a mixed message to Vermont's youth regarding drug use.

In short, whether and to what degree marijuana legalization may exacerbate the opioid crisis should be fully understood and considered as the Legislature debates legalizing another drug susceptible to abuse. Regardless of whether marijuana is legalized in Vermont, Vermont must commit to investing – proactively – in strong prevention messaging and prevention programming to deter the use and abuse of marijuana and other drugs, especially among youth.

## TURNING THE CORNER

Is there reason for hope? Yes. New acute pain prescribing rules in Vermont implemented in July of this year are already influencing public awareness and medical practices. Changing prescribing practices must continue to be an essential and critical component of any campaign to end this addiction epidemic.<sup>23</sup> As noted by the Centers for Disease Control in July 2017, "The number of opioids prescribed in the U.S. is still too high, with too many opioid prescriptions for too many days at too high a dosage."<sup>24</sup> But there is growing evidence that irresponsible prescribing is leveling off and may even be declining. Healthcare providers are on the frontline of this struggle and are our partners in controlling this epidemic.

The availability of treatment for those seeking it has improved dramatically since Vermont introduced the "Hub and Spoke" system of treatment in 2012. This system provides outpatient services designed to address specialized intensive treatment needs at a network of nine regional "Hub" centers across the state. The "spokes" serve those who require fewer intensive services, through primary care and other office-based practices. This system has gained national attention for the success it has achieved. Law enforcement has also stepped up efforts to identify, investigate and arrest those in-state and out-of-state individuals trafficking in opioids and other substances. Much is being done on these fronts. Much work remains.

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<sup>23</sup> "Annual Surveillance Report of Drug-Related Risks and Outcomes." Centers for Disease Control and Prevention, August 31, 2017. <https://www.cdc.gov/drugoverdose/pdf/pubs/2017-cdc-drug-surveillance-report.pdf>

<sup>24</sup> "Opioid prescribing is still high and varies widely throughout the U.S." Centers for Disease Control and Prevention, July 6, 2017. <https://www.cdc.gov/media/releases/2017/p0706-opioid.html>

### The Role of Education and Intervention

Two key elements within the “Prevention” strategies (see the “Drivers for Systemic Improvement” section below) make it possible to turn the corner on this crisis: education and intervention. For the purposes of this report, they have been placed within the “Prevention” category (See the “**Drivers for Systemic Improvement**” section below). They are the glue in a comprehensive strategy to reverse the opioid and substance use disorder trends. Both underlie many of the strategies recommended in this report.

The first, **education**, is a pillar of school and community-based prevention work. Although new prescribing rules are in place, ongoing prescriber education is the foundation for ensuring prescribers understand the dangers of overprescribing opioids, know what to communicate to their patients, how to recommend alternatives to opioids, and how to participate in the Vermont Prescription Monitoring System (VPMS). Education is critical for every student, parent, and patient – the more we know about addiction and the associated behaviors, and options for pain management – the greater the success Vermont can realize to reduce the number of Vermonters ever using an illicit substance. Education is also an essential component of helping those in treatment and recovery to sustain their success and prevent relapse, and it is key to supporting families and loved ones.

The second, **intervention**, is what communities, service providers, family members, and friends, must prepare themselves for when an individual appears ready to address the disease. Maximizing opportunities to support someone to transition from active substance misuse to treatment and recovery is the first step in: reducing the likelihood that person may engage in criminal behavior to support addiction; in improving one’s ability to remain engaged with family; and in breaking the generational cycle of adverse childhood experiences and addiction. Emergency rooms, syringe exchange programs, primary care and prenatal services, referral services, and the justice system are key intervention connections. Vermont must ensure people with this disease have access to a knowledgeable service provider, referral service, or family member when ready.

### MESSAGE OF HOPE

Substance use disorder is a health condition that is preventable and treatable. Addiction is not a moral failing or a character flaw; it is a disease.

If we allow success to be measured only by statistics, we will be defined more by our failures than our achievements. Our true measures of success are in the faces of people, in the communities that care for all who live there, and in our ability to extend a warm hand to people with addiction and the parents and families who struggle every day.

When we ask, as we must, “And how are the children? And how are your children? And how are your grandchildren?” – we must be ready for any answer, with a willingness to celebrate, or to struggle – together.

More than anything, we must profess by example after example of real people in communities across Vermont that prevention works, treatment is available and effective, and recovery is possible. In this battle to combat the impact of opioids on Vermont’s children, families and communities, we must come to believe that there is no final victory. “One day at a time,” we stand together and demonstrate our resilience. There is always hope.

# VERMONT OPIOID COORDINATION COUNCIL

## MISSION AND MANDATE

The OCC's mission as stated in Executive Order 02-17 (amended in 09-17) is,

*... to lead and strengthen Vermont's response to the opioid crisis by ensuring full interagency and intra-agency coordination between state and local governments in the areas of prevention, treatment, recovery and law enforcement activities. Where practicable, the Council will apply the strategies and lessons learned from Project VISION to other communities throughout Vermont.*

- A. Identify best practices for communities to address opioid addiction and abuse in order to assist them in: (1) significantly reducing the demand for opioids through prevention and education; (2) providing treatment and recovery services to those afflicted with opioid addiction; and (3) significantly reducing the supply of illegal opioids;
- B. Develop and adopt data driven performance measures and outcomes which will allow State and local community programs to determine whether they are meeting their goals and objectives in reducing opioid addiction and abuse;
- C. Review existing State health, mental health, and drug and alcohol addiction laws, regulations, policies, and programs and propose changes to eliminate redundancy and break down barriers faced by communities in coordinating action with State government;
- D. Propose legislation to strengthen a Statewide approach to fight opioid addiction and abuse and facilitate adaptation to the changing nature and multiple facets of the opioid crisis;
- E. Consult and coordinate with federal agencies and officials as well as those in surrounding states;
- F. Work in coordination with the Alcohol and Drug Abuse Council created pursuant to 18 V.S.A. 4803;
- G. Report to the Governor on a quarterly basis and as otherwise required by the Governor regarding: (1) recommendations for resource, policy, and legislative or regulatory changes; and (2) progress made under State and local programs measured against established data driven performance measures; and
- H. In consultation with the Director of Drug Policy, do all things necessary to carry out the purpose of this Executive Order.

## DRIVERS FOR SYSTEMIC IMPROVEMENT: PREVENTION, TREATMENT, RECOVERY, ENFORCEMENT (AND INCLUDING EDUCATION AND INTERVENTION)

These four areas of focus form the foundation of Vermont's efforts to address the opioid crisis through private and public endeavors. The OCC's work is to assess current systems and strategies in each area, and determine what is working, how to replicate and scale best practices, where gaps and challenges lie, and to develop strategies to improve upon the State's successes in transforming the opioid crisis, and ensure sustainability of that success.

**PREVENTION** strengthens children, adults, families, and communities by helping to change personal, social, or environmental factors and thereby delay or prevent the onset of drug misuse and its progression. Community resources to support healthy choices and avoid the potential harm that drug use can cause are essential.

Education and Intervention are two additional factors critical to achieving systemic improvement. *Education* involves curricula and programming that touches all students; *intervention* includes maximizing opportunities to move individuals away from risk and toward services they need.

- Primary Prevention: Involves delivering services and education prior to the onset of SUD, and which are designed to prevent or reduce the risk of developing a behavioral health problem, such as underage alcohol use, prescription drug misuse and abuse, and illicit drug use.
- Secondary Prevention: Focuses on early detection and treatment of a substance use disorder, to shorten its duration and prevent further illness, impairment, or degradation of health.
- Demand Reduction: Reduces the demand for opioids that drives substance use disorders through prescribing practices and education, intervention, treatment and recovery support for those with SUD, and through community- and school-based programs.
- Harm Reduction: involves managing chronic illnesses to restore function and quality of life, and reducing negative impacts on those with chronic illness, and on families and communities. In substance use disorders, this may include drug and needle disposal, syringe exchange, drug diversion programs, and overdose intervention.

Successful prevention efforts combine effective programs, curricula and public awareness messaging with the engagement of communities and the partnership of public and private institutions, including healthcare providers, schools, state agencies, service organizations, and businesses. It also addresses multi-generational risk factors such as Adverse Childhood Experiences (ACEs) and opioid dependence among older adults.

The goal of prevention is to address the social factors that lead to the misuse of opioids, and the consequences. Current Vermont resources include student assistance professionals in one-third of our middle and high schools, sixty percent of the state is served by one of 23 community-based coalitions dedicated to substance use prevention, and other school and community-based models created to address opioids such as Rutland's Project Vision, the Chittenden County Opioid Alliance, and St. Johnsbury's DART - Drug Abuse Resistance Team.

**TREATMENT** begins when the individual asks for, or responds to, an opportunity for intervention. Treatment and recovery are inseparable partners in supporting the success of the individual with SUD. Treatment provides timely, affordable and effective services designed to treat the immediate and long-term needs of all individuals seeking to address their addiction to opioids, and substance use disorder. This includes but is not limited to in-patient and out-patient options, and may involve detoxification, medication-assisted treatment (MAT), counseling, non-pharmacological (integrative) health care options, and other methods. Vermont has the Hub and Spoke system, nationally recognized as a model for replication.

**RECOVERY** from SUDs requires sustained wraparound lifestyle supports that make it possible for the individual to transform a life often destroyed by the disease. Recovery supports begin simultaneously with the early stages of treatment. They include housing, social and vocational skill development, employment, and ongoing personal and community support and engagement. Recovery has an essential "tie-back" to prevention, particularly in addressing multi-generational risk factors such as trauma (ACEs- Adverse Childhood Experiences) and substance abuse in the family. Vermont has 12 recovery centers which comprise the Vermont Recovery Network, and a statewide education and advocacy organization.

**ENFORCEMENT** efforts span public safety and policing, the court system, prosecution practices, and efforts through the corrections system. Enforcement includes:



- Supply reduction: reducing the supply of opioids available for unauthorized use by creating deterrents to the sale and trafficking of illicit drugs, using tools such as aggressive investigation and prosecution.
- Alternatives to incarceration: Ensuring treatment and recovery services are available and maximized for those engaged with Vermont's courts and correctional systems, over incarceration where possible.
- Harm reduction: law enforcement plays a critical role in reducing the diversion and misuse of prescription drugs through drug disposal efforts.

Vermont has examples of effective community-based collaborations which successfully bring law enforcement together with prevention, treatment, and recovery service providers.

## PATHWAYS TO EFFECT CHANGE: POLICY, PROGRAM, INFRASTRUCTURE AND INVESTMENT

The recommended strategies follow four pathways for engaging effective change. They are:

- **POLICY**: Assess and review the current state of laws, legislation and policies, identify gaps and redundancies, and recommend changes that will simplify, clarify and focus resources toward effective changes in practice.
- **PROGRAM**: Support the implementation and integration of both innovative and best practice programs for individuals, families and communities, maximizing and leveraging multi-sector resources.
- **INFRASTRUCTURE**: Identify improvements in the relationships between programs, departments and agencies to increase efficiencies and outcomes.
- **INVESTMENT**: Identify and evaluate funding sources and utilization; and explore public, private, and non-profit partnerships to best leverage resources.

## ALIGNMENT, AND CONSIDERATION, OF STRATEGIES AND RECOMMENDATIONS BY OTHER STATE AND NATIONAL COMMISSIONS AND COUNCILS

Governor Scott's top three priorities:

- Grow the Economy
- Make Vermont More Affordable for Families and Businesses
- Protect the Vulnerable

Vermont's Challenges: 6-3-1

- There are six fewer Vermonters in the workforce every day;
- Three fewer children every day in the public school system; and
- One baby born every day to a mother with addiction.

President's Commission on Drug Abuse and the Opioid Crisis: In reviewing the President's Commission recommendations, the OCC found many points of alignment. These have been indicated in this report.

National Governor's Association (NGA) recommendations: Vermont responded to the NGA recommendations, finding much alignment, and taking the opportunity to provide additional suggestions based on the OCC's priorities. These have been indicated in this report.

Governor's (Agency of Human Services) Health Care Reform proposal: The OCC is already engaged with the Office of Health Care Reform, and will continue to collaborate toward expanding a multi-payer approach to prevention, early intervention, treatment, and recovery services.

Marijuana Advisory Commission: The OCC will consistently communicate with the Marijuana Advisory Commission (MAC) regarding the intersection of each organization's respective charge. Research, data and information-sharing will support the work of both entities. The MAC's Education and Prevention, and Roadway Safety committees in particular will address key OCC priorities, including youth prevention programs, availability of treatment services, broad-based prevention messaging, and an appropriate impairment testing mechanism.

DRAFT

## OCC VISION

Vermont is committed to reversing the upward trend of those addicted to opioids and breaking the generational cycle of addiction. Consistent and positive relationships must exist for every child, every family, and every person in recovery, and a seamless continuum of care that is person- and family -centered must be the norm. Our communities and their schools and workplaces must strive to provide a drug free environment in which stigma is eliminated. All Vermonters should have equitable access to resources and supports no matter who they are or where they live. Discrimination is not tolerated; services are designed and delivered based on need, diversity and equity.

## OCC GOALS

The OCC's primary goal is to sharply reduce the incidence of substance use disorders and attack the societal conditions that have created this crisis. By reforming prescribing practices, ensuring treatment, and through engagement of families and communities this goal is achievable. When an individual is afflicted with an SUD, the OCC's goal is to ensure that Vermont has services in place that will minimize harm to individuals, families and communities, maximize access to treatment, and will make long-term recovery the norm among those who suffer this disease.

The OCC challenges itself, and the departments, agencies and communities of Vermont, to reduce:

- The number of people with substance use disorders (SUDs)
- The number of opioid overdose deaths
- The number of babies born into addiction
- The number of children in state custody as a result of SUDs
- The number of opioid prescriptions written each year
- The number of youth using illegal substances
- The supply of illicit drugs in Vermont
- Prevent, reduce, eliminate opioid related crime

... and to increase:

- The number of people in treatment
- The number of people in recovery who have housing, jobs, and social supports
- Vermont communities that are strong, safe, and resilient.

Governor Scott's top three priorities:

- Grow the Economy
- Make Vermont More Affordable for Families and Businesses
- Protect the Vulnerable

# STRATEGIES

Every strategy is person-centered, family-centered, and community-centered . . .

## LEADERSHIP REQUIRED

Leadership must include authority and be accompanied by access to resources. This model and practice is critical to ensure development and implementation of any strategy which requires intra- and inter-agency cooperation and integration of programs and funds.

### 1. OVERARCHING/SYSTEMIC

#### A. DEVELOP A CONTINUUM OF CARE

**DEVELOP A CONTINUUM OF CARE FROM PRE-BIRTH TO AT LEAST THREE YEARS OF AGE THAT SUPPORTS A TWO-GENERATION APPROACH FOR PREGNANT WOMEN WITH SUD AND THEIR CHILDREN AND FAMILIES BY CONNECTING PROGRAMS WITHIN AND ACROSS THE AGENCY OF HUMAN SERVICES AND HEALTH CARE PROVIDERS.**

**Action:** Convene a cross-agency working group which includes regional and statewide community resources, to develop a statewide system of program delivery which provides health and social supports for all women with SUDs and their children. Universal home visits for all women and children including an analysis of cost and return on investment will be considered. Scope of work will address:

- A nurse home visit for every newborn and family, from pre-natal to 16 weeks.
- More intensive nurse home visits to families at risk.
- Assurance of services as family-centered and integrated.
- Increase in family focus for Hub and Spoke services, including targeted prevention approaches for the children of adults in treatment.
- A framework to demonstrate outcomes-based results, evaluation and quality Improvement.

**Related goals:**

- Reduce the number of babies born into addiction.
- Reduce the number of children in state custody as a result of SUDs.
- Governor's Priorities: Protect the Vulnerable.

**Narrative:** Nearly every day, a baby is born to a mother with addiction. When the mother is in treatment, these babies have good outcomes, underscoring the importance of developing a *continuum of care* that reaches women early in their pregnancies. In addition, supporting mothers and their babies through the early critical developmental years to age three is well-established. Programs providing nurse home visits from prenatal to age three for families demonstrate:

- Improved maternal health including identification of substance use and mental health conditions such as depression
- Healthy child development
- Greater community connections
- Safer homes
- Improved parenting and strong maternal-child attachment
- Improved familial participation in the work force and economic independence

Early intervention and support can help achieve positive outcomes and to avert a cycle of adverse childhood experiences.

The Agency of Human Services sponsors an array of programs aimed at early childhood, primarily organized through the Children's Integrated Services (CIS) Division of the Department for Children and Families. In particular, the "early home visiting" programs and Parent-Child Centers focus on young children and their families. The CIS system provides a strong foundation to build upon.

President's Commission #47 - The Commission recommends that HHS, the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Administration on Children, Youth and Families (ACYF) should disseminate best practices for states regarding interventions and strategies to keep families together, when it can be done safely (e.g., using a relative for kinship care). These practices should include utilizing comprehensive family centered approaches and should ensure families have access to drug screening, substance use treatment, and parental support. Further, federal agencies should research promising models for pregnant and post-partum women with SUDs and their newborns, including screenings, treatment interventions, supportive housing, non-pharmacologic interventions for children born with neonatal abstinence syndrome, medication-assisted treatment (MAT) and other recovery supports.

## **B. GROW AND SUPPORT VERMONT'S WORKFORCE: EMPLOY VERMONTERS IN RECOVERY; EXPAND THE SUD WORKFORCE**

### **1. EXPAND THE NUMBER OF VERMONTERS IN RECOVERY WHO HAVE A JOB.**

**Action:** A multi-sector working group will develop a blueprint to implement employment support services in Vermont's Recovery Centers and the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (ADAP), Preferred Provider treatment system of care by March 2018. State agencies and departments, the Vermont Recovery Network, employers, and treatment providers will work to develop this program.

**Related goals:**

- Increase the number of people in recovery who have housing, jobs, social supports.
- Governor's priorities:
  - o Grow the Economy
  - o Make Vermont More Affordable for Families and Businesses

**Narrative:** The Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (ADAP) in collaboration with Vermont's Director of Drug Prevention Policy, proposes to implement employment support services in Vermont's Recovery Centers and the ADAP Preferred Provider treatment system of care. Employment counseling is an effective way to support people with substance use disorders find and maintain employment. Employment offers a path toward independence, self-sufficiency and connection to community, and employment services should be an integral component of all substance use treatment programs. The model used will be guided by the SAMHSA/CSAT Treatment Improvement Protocols. The Vermont Division of Vocational Rehabilitation, Agency of Commerce and Community Development, and Department of Labor will participate in the program and resource development of this model.

NGA Recommendation from VT: Recovery: Support for Employment in Recovery. Employment in Recovery offers a path towards independence, self-sufficiency and connection to community. Employers who provide strong workplace supports for people in recovery help ensure that we

are maximizing our workforce potential and valuing every Vermonter's contribution to our labor needs. People in Recovery who have a job feel valued, are better able to support themselves and families, and are more likely to sustain recovery over time. Workforce Innovation and Opportunity Act (WIOA) funds can be used to help employers adopt effective hiring and retention practices, learn about financial incentives available for employing at-risk individuals, and match jobseekers with available jobs. WIOA programs also support employees in recovery as they work to overcome obstacles - including the stigma of drug-related criminal records and disclosing their recovery status.

President's Commission: #49. The Commission recommends that ONDCP, federal partners, including DOL, large employers, employee assistance programs, and recovery support organizations develop best practices on SUDs and the workplace. Employers need information for addressing employee alcohol and drug use, ensure that employees can seek help for SUDs through employee assistance programs or other means, supporting health and wellness, including SUD recovery, for employees, and hiring those in recovery. **#50.** The Commission recommends that ONDCP work with the DOJ, DOL, the National Alliance for Model State Drug Laws, the National Conference of State Legislatures, and other stakeholders to develop model state legislation/regulation for states to decouple felony convictions and eligibility for business/occupational licenses, where appropriate.

## 2. EXPAND AND SUPPORT VERMONT'S SUD WORKFORCE.

**Action:** Form an OCC Committee that will engage higher education institutions, mental health and substance use disorder service organizations, and others to continue work on developing the substance use disorder workforce, with additional recommendations developed by June 2018.

**Related goals:** Governor's priorities:

- Grow the Economy
- Make Vermont More Affordable for Families and Businesses

**Narrative:** The Governor's Summit on Vermont's Substance Use Disorder (SUD) workforce launched the work to support these recommendations:

- **Streamline the Licensed Alcohol and Drug Counselor (LADC) rules** through the implementation of emergency rulemaking.
- Creation of a **higher education consortium**.
- Strategies to promote the availability and quality of **clinical supervision toward licensure and professional development**, including tele-supervision.
- Expand Vermont's **recovery coach workforce**.

Recommended Strategies:

- a. **Streamline the LADC rules** through the implementation of emergency rulemaking: Action underway. In five months, the Office of Professional Regulation (OPR) and the Summit's Licensure and Higher Education Working Group completed a rewrite of the LADC rule maintaining high statutory standards of competence while eliminating unnecessary barriers to entry arising from idiosyncratic degree requirements and excessively prescriptive educational mandates. As the barriers of entry are eased, establishing an MOU process between OPR and higher education to ensure standardization of the educational programs and associated requirements will assure a simplified application process for prospective professionals.

b. Strategies for further development:

- **Create a higher education consortium**, which will work to align SUD degree programs within Vermont institutions of higher education, toward facilitating licensure and interstate reciprocity. This will involve outreach that promotes career pathways, education and/or training opportunities to students is needed. Consortium development underway.
- Strategies to promote the availability and quality of **clinical supervision toward licensure and professional development**, including tele-supervision.
- **Strategies for affordability:** Further explore loan repayment and loan forgiveness opportunities through changes in HRSA and AHEC policies and practices, and scholarship programs.
- **Expand Vermont's Recovery Coach Workforce:** Recovery coaching is the evidence based<sup>25</sup> practice of working with Vermonters to help sustain long-term recovery. Recovery coaches in Vermont are certified through the Vermont Association of Addiction Recovery and Mental Health (VAMHAR) after receiving an intensive 40-hour certificate. Approx. 100 well-trained certified recovery coaches are currently working and volunteering in Vermont -- in settings as diverse as the Lund Family Center, recovery centers, emergency rooms, and veterans' organizations. Recovery coaches are largely individuals who are in long-term recovery themselves, though family members and allies also receive certification. The combination of "lived experience" with an evidence-based training has created a strong model to support Vermonters in recovery. Given the number of Vermonters in treatment, we anticipate the need for certified recovery coaches working throughout the state to multiply.

President's Commission: #40 - The Commission recommends the Health Resources and Services Administration (HRSA) prioritize addiction treatment knowledge across all health disciplines. Adequate resources are needed to recruit and increase the number of addiction-trained psychiatrists and other physicians, nurses, psychologists, social workers, physician assistants, and community health workers and facilitate deployment in needed regions and facilities.

**Related: #42.** The Commission recommends further use of the National Health Service Corp to supply needed health care workers to states and localities with higher than average opioid use and abuse.

### C. IMPROVE DATA INTEROPERABILITY IN VERMONT

#### IMPROVE VERMONT'S STATEWIDE DATA COLLECTION AND ANALYSIS CAPABILITY TO ASSESS AND IMPROVE OUTCOMES FOR INTERVENTION, TREATMENT AND RECOVERY SERVICES.

**Action:** The OCC will convene a multi-sector working group, to include the Agency of Digital Services (ADS), the Agency of Human Services (AHS), University of Vermont Medical Center (UVMHC), Project Vision, and the Chittenden County Opioid Alliance (CCOA), to explore:

- Massachusetts' Center for Health Information and Analysis (CHIA), as a model for interoperability between local data systems, the State, payers, and providers.
- Data and information sharing environments to optimize program delivery.
- Interoperability between electronic health records (EHRs) and state prescription drug monitoring programs (PDMPs), and other data systems.

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\* <https://www.ncbi.nlm.nih.gov/pubmed/17895731>

\* VT Department of Health

\* <https://www.ncbi.nlm.nih.gov/pubmed/17895731>

- 42 CFR Part 2 and HIPAA in relation to data-sharing considerations.

**Related Goals:**

- Reduce the number of people with substance use disorders.
- Prevent, reduce, eliminate opioid related crime.
- Increase the number of people in treatment.
- Vermont communities will be strong, safe, and resilient.

VT responses to NGA recommendations:

- Require interoperability between electronic health records (EHRs) and state prescription drug monitoring programs (PDMPs). **YES.** Vermont supports interoperability between EHRs and PDMPs. Since this will be costly to implement, financial support to states may be needed. In addition, complications resulting from 42 CFR Part 2 must be considered.
- Align 42 CFR Part 2 with the Health Insurance Portability and Accountability Act (HIPAA). **YES.** Vermont is currently in conversations with SAMHSA to address the feasibility of getting our Opioid Treatment Program (OTP) data into our Prescription Drug Monitoring Program (PDMP). We agree that protecting patient records is essential. Aligning HIPAA standards to ease information sharing across State and Federal agencies for public safety, public health and quality assurance purposes would be very beneficial.
- Strengthen data and information sharing environments at the state level. This is both public health and public safety. **YES.** Difficulties with sharing information across stakeholders is a major barrier to the rollout of effective MAT programs. The development of special provisions to permit more open sharing of data (for public safety and quality assurance purposes) would be most helpful.

President's Commission: #16 – The Commission recommends that the Federal Government work with states to remove legal barriers and ensure PDMPs incorporate available overdose/naloxone deployment data, including the Department of Transportation's (DOT) Emergency Medical Technician (EMT) overdose database. It is necessary to have overdose data/naloxone deployment data in the PDMP to allow users of the PDMP to assist patients. **#20** The Commission recommends a federal effort to strengthen data collection activities enabling real-time surveillance of the opioid crisis at the national, state, local, and tribal levels.



## 2. PREVENTION, EDUCATION AND INTERVENTION STRATEGIES

### A. IMPLEMENT STATEWIDE COMPREHENSIVE SCHOOL-BASED PREVENTION

#### IMPLEMENT A STATEWIDE COMPREHENSIVE SYSTEM FOR DELIVERY OF SCHOOL-BASED PRIMARY PREVENTION PROGRAMS.

The Agency of Education and the VT Department of Health (VDH), Alcohol and Drug Abuse Programs (ADAP), in collaboration with the Vermont Department of Mental Health (DMH) and prevention specialists, must lead our state in this effort. This system will include a professional trained in primary prevention and SUD intervention, and best practice programs available to all students in every school. School-based programs should be aligned and in partnership with community-based prevention programs.

**Action:** Support the addition of an FTE in the Agency of Education to ensure access and availability of evidence-based models for prevention and intervention.

**Action:** The Vermont Agency of Education, and VDH/ADAP and DMH, will lead a working group to inventory school professional resources supporting primary prevention and SUD intervention.

This will include identifying best practices and resource gaps. The working group will propose a plan to implement an integrated model for prevention and intervention programs by September 2018. This effort will engage state education associations, including VT Superintendents Association, VT Principals Association, VT School Boards Association, VT-NEA, student assistance professionals and community coalitions.

#### **Related Goals:**

- Reduce the number of youth using illegal substances.
- Vermont communities will be strong, safe, and resilient.

**Narrative:** The OCC's exploration of prevention resources in schools across Vermont continues. The distribution of resources, including support for student professionals, curricula, and other programming throughout the state, is complex. Governor Scott has charged the Council with integrating resources across state government. In order to realize success in preventing new SUD involvement among Vermont's youth, two things are needed: 1) Leadership, with a designated position in the Agency of Education; and 2) a comprehensive assessment of current investment and its impact.

Vermont proposed the addition of a strategy to support school-based SUD professionals and curriculum, to the National Governor's Association for inclusion in its recommendations:

"The cumulative effects of Adverse Childhood Experiences (ACEs) due to substance use disorders in families, and the early introduction to drug misuse by our children, have left schools with steadily increasing numbers of students in need of direct support and referral for themselves and their families. Positive engagement with SUD professionals including powerful group experiences through evidence-based curricula and programming are demonstrating performance-based outcomes. Federal support is needed, especially in underserved rural areas, to ensure every child experiences effective prevention programming and every child in need is able to engage with a professional trained in substance use disorder intervention and referral."

President's Commission #4: The Commission recommends that Department of Education (DOE) collaborate with states on student assessment programs such as Screening, Brief Intervention and

Referral to Treatment (SBIRT). SBIRT is a program that uses a screening tool by trained staff to identify at-risk youth who may need treatment. This should be deployed for adolescents in middle school, high school, and college levels. This is a significant prevention tool.

## **B. EXPAND HEALTH CARE EDUCATION, MONITORING AND SCREENING FOR PROVIDERS AND PATIENTS**

1. ENSURE FULL PARTICIPATION AMONG PROVIDERS IN THE VERMONT PRESCRIPTION MONITORING SYSTEM (VPMS).
2. ENSURE ALL PRESCRIBERS AND THOSE IN TRAINING TO PRESCRIBE, RECEIVE TRAINING ON ALTERNATIVES TO OPIOIDS FOR PAIN MANAGEMENT, INCLUDING NON-PHARMACOLOGIC OPTIONS, AND ON PATIENT EDUCATION REGARDING OPTIONS AND RISKS IN PAIN MANAGEMENT.
3. EXPAND SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT (SBIRT) THROUGHOUT PRIMARY CARE, EMERGENCY DEPARTMENTS, IN CORRECTIONS AND SCHOOLS -- FOR ALL FROM PRE-KINDERGARTEN THROUGH ELDERLY. (HEALTH CARE REFORM).

### **Actions:**

- The OCC requests that ADAP educate the OCC on prescriber and patient education programs and activities underway and planned at its February 2018 meeting. The OCC will then make recommendations for next steps.
- The OCC will review the results of the VPMS analysis of prescriber registration and participation and will consider additional recommendations.
- Support the Agency of Human Services in development of a plan to implement SBIRT services in Vermont's emergency departments, primary care practices, and school health services. Support for resources may be needed.

### **Related goals:**

- Governor's Priority: Protect the Vulnerable
- Reduce the number of people with SUDs.
- Reduce the number of opioid prescriptions written each year.
- Reduce the number of opioid overdose deaths.
- Reduce the number of babies born into addiction.
- Reduce the number of youth using illegal substances.
- Increase the number of people in treatment

**Narrative:** Vermont's July 2017 prescribing rules for chronic pain have great potential to alter the future course of SUDs resulting from prescription opioids. Prescriber and patient education is essential, and should include education about non-pharmacological (complementary/ alternative/ integrative) approaches to pain management, insurance coverage for these options, screening for risk factors, and the ability to provide brief intervention and referral to treatment (SBIRT).

Prescriber education: In 2015, the Vermont Department of Health received a four-year grant from the Centers for Disease Control and Prevention (CDC) for opioid overdose prevention, focusing on medical provider education and quality improvement relating to opioid prescribing practices. Since then, VDH has worked with the University of Vermont Office of Primary Care to engage with prescribers on prescribing practices and alternatives to opioids for pain. Twelve Blueprint practice

facilitators are now trained on opioid prescribing quality improvement. Practice- and prescriber-level assistance is available through AHEC and VPMS programs.

Additional information is needed about efforts through the medical centers of Vermont, and in particular through UVMMC to incorporate new pain assessment and prescribing practices in the medical school curriculum.

Patient education: The ADAP website has information available for prescribers and patients on its website, with posters and flyers available for distribution, specialized to primary care, dental, and pediatric care offices.

The OCC will learn about VDH's outreach campaign to support prescribers' implementation of opioid prescribing best practices, which includes resources for informing patients about risks and benefits of pain management options, including a range of tools, addressing patients of all ages, with focus on young adults. The OCC will also seek information about additional collaborations and funding, with local medical providers, and national efforts through the Centers for Disease Control prescription awareness campaign, and other sources.

VPMS: The Health Department reports over 2,500 prescribers who are registered with VPMS, and will complete analysis by the end of 2017 to identify prescribers who have prescribed within the last year and were not registered with VPMS.

SBIRT: This evidence-based universal approach is designed to identify and address risky substance use in the general population and coordinate referrals to care for people who need substance abuse treatment. The program is based on screening for substance use in emergency departments and primary care practices. For people who endorse the use of substances (alcohol, tobacco, or drugs) either the attending physician or a licensed behavioral health clinician provides education about risk behaviors and engagement approaches to encourage follow-up. Brief interventions (up to three sessions) using education and motivational interviewing techniques follow. For most people, this type of brief intervention is sufficient to correct the risk behavior. For a subset of people who may be progressing from use towards addiction, a coordinated referral for specialized treatment is completed.

President's Commission: **#6** (informed patient consent); **#7** (national curriculum and standard of care for opioid prescribers); **#8** (collecting prescriber data); **#9** (model training program for medical education); **#10** (Congress/DEA – continuing medical education requirement for re-licensure for opioid prescribing); **#11** (pharmacy best practices) **#18-19** (supply reduction/enforcement and CMS/Pain assessment and payment)

VT response to NGA recommendation: Require prescribers to register with their state prescription drug monitoring program (PDMP) and complete evidence-based training on pain management and substance use disorder upon receiving or renewing their Drug Enforcement Administration (DEA) registration. **YES.** We support the above requirement as it aligns with Vermont's Prescription Monitoring (VPMS) System Rule. Vermont's rule requires dispensers including prescribers to report each dispensed prescription for a Schedule II, III, or IV controlled substance to the VPMS within either 24 hours or one business day of dispensing the prescription. This applies to all licensees, irrespective of location or number of prescriptions of a controlled substance dispensed. Vermont also requires education that includes alternatives to opioids for managing pain and risk assessments for abuse or addiction. Vermont currently has prescribing rules.

## C. BUILD COMMUNITY-BASED PREVENTION

**BUILD, REPLICATE, AND SUPPORT STRONG COMMUNITY-BASED MODELS THROUGH MULTI-SECTOR PARTNERSHIPS, INNOVATION, AND RESEARCH RESULTING IN OUTCOMES THAT EXCEED PREVIOUS, LESS COLLABORATIVE EFFORTS.**

### Action:

1. The Council will convene a working group to identify resources to support community-based initiatives to address the challenges which rise from drugs and substance use disorder at the local level.  
The working group will explore the development of a community tool kit and community mentoring program, to include:
  - Best practices supporting *cooperation and coordination between law enforcement and social service agencies*;
  - Mentoring on the Community STAT model, a data-driven approach to solving community problems with a specific focus on opioids, led by local Police Departments.
  - Guidance on fully utilizing and promoting VT 2-1-1 for resource referral.
  - Guidance on creating resources for families and loved ones of people with SUDs.
  - Research for replication of best community-based practices in Vermont and nationally.
2. The OCC will also support work among agencies, departments, community partners and others to develop a statewide comprehensive system for primary prevention programs addressing health and wellness in communities and schools.

### Related goals:

- Prevent, reduce, eliminate opioid related crime.
- Vermont communities will be strong, safe, and resilient.
- Reduce the number of people in Vermont with SUDs.

### Narrative:

1. Strong community-based collaborative models focus on public safety, community health, housing, neighborhoods, and other activities that strive to ensure a resilient next generation. Models in Vermont include Rutland's Project Vision, Chittenden County Opioid Alliance, St. Johnsbury's D.A.R.T., Springfield's Project Action, and Newport's R.I.S.C. They each employ similar, and distinctive approaches to integrating resources in their communities from across prevention, treatment, recovery and enforcement. Although every community is different, all can benefit from stronger collaboration among organizations and sectors. A tool kit and mentoring program will allow those communities with experience to share their successes and lessons learned, while also leveraging best practices from across the country.

Investment strategies to support these models, especially in high-need regions of VT, may include support from state or national foundations, USDA Rural Development, Agency of Commerce and Community Development, and other state and federal agencies that invest in community development.

Vermont 2-1-1 continues to develop its statewide database of health and human services resources. 2-1-1 currently handles over 35,000 calls per year, and operates 24/7, 365 days per year, with language translation, follow-up, and the ability to transfer callers in real time for crisis situations. There are over 1,000 agencies and more than 3,000 programs in the 2-1-1 data base,

including statewide SUD resources listed on the VT Health Department/Alcohol and Drug Abuse Programs webpage. At any given time, the database has a 93% update rate.

Enhanced resources for family members and loved ones is needed statewide. State agencies must collaborate with community partners to identify where they exist, and to begin the process of creating them where they do not.

2. A statewide comprehensive system for primary prevention programs addressing health and wellness, in communities and schools, is the systemic change needed to prevent introduction to drugs. The OCC will support work among agencies, departments, community partners and others to develop this system, including variations on local models such as RiseVT, 3-4-50,<sup>[1]</sup> and others. For now, the OCC's primary focus must be on community-based initiatives that maximize resource use in the effort to interrupt the drug and SUD trends in Vermont.

A comprehensive, statewide approach is key to supporting communities across the state regardless of their resources. Taking a state-wide approach to resources and design will further Vermont's efforts to rise above competition among communities for finite resources by approaching the opioid and drug challenges as a "community-of-the-whole."

NGA Recommendation from VT: Prevention: Support for community-based initiatives. The Opioid Coordination Council, as created by Executive Order 02-17, seeks to support replication of successful community-based initiatives such as Rutland's Project Vision. These models bring law enforcement, intervention and treatment services, prevention programs, and recovery centers together, with outcomes that exceed previous, less collaborative efforts. Federal support for communities seeking to launch similar efforts will go a long way towards building a resilient next generation.

## **D. CREATE A COMPREHENSIVE DRUG PREVENTION MESSAGING CAMPAIGN**

**CREATE A STATEWIDE PREVENTION MESSAGING CAMPAIGN DESIGNED TO RAISE PUBLIC AWARENESS, REDUCE STIGMA, PROVIDE HOPE FOR FAMILIES, AND STRENGTHEN RESILIENCE IN VERMONT'S COMMUNITIES.**

**Action:** Convene a multi-sector working group that brings together the key public and private sectors, including ADAP, State Chief Marketing Officer, medical institutions, and private sector, by October 2018. Ensure 2-1-1 is incorporated into the messaging campaign.

**Related goals:**

- Reduce the number of people with SUD.
- Reduce the number of youth using illegal substances.

**Narrative:** Raise public awareness through a Statewide Messaging Campaign which educates community members about opioids and other drugs, resiliency and recovery, and inspires people to take action in their communities. The goals of this campaign would include (1) a universal drug prevention message; (2) youth directed messages on the dangers of drug use, including opioids, alcohol, and marijuana; (3) educational messages for patients and families about the science of the brain, opioid definitions, and statistics, safeguarding prescriptions, and proper disposal of unused prescriptions; and (4) the availability of treatment options and recovery supports. This campaign will be designed to enhance audience-specific campaigns addressing substance abuse and opioid use disorder already underway.

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<sup>[1]</sup> <http://www.healthvermont.gov/3-4-50>; <http://risevt.com/>

We can all reduce the stigma of addiction by acknowledging that it is a chronic disease.

NGA Recommendation from VT: Prevention: A national comprehensive messaging campaign to accompany the national declaration of emergency. In Vermont, and across the nation, families, communities and leaders need messages of hope and action. Vermont has been successful in reaching key age groups and populations with targeted message campaigns. These messages, however, often do not reach the public. We support a federal messaging initiative designed to accompany the national state of emergency which will increase public awareness, reduce stigma, and give hope for strong communities.

President's Commission: #5 The Commission recommends the Administration fund and collaborate with private sector and non-profit partners to design and implement a wide-reaching, national multi-platform media campaign addressing the hazards of substance use, the danger of opioids, and stigma. A similar mass media/educational campaign was launched during the AIDs public health crisis.

## **INTERVENTION: SAVING LIVES -- SYRINGE EXCHANGE PROGRAMS AND NALOXONE DISTRIBUTION**

### **E. EXPAND SYRINGE EXCHANGE AVAILABILITY**

**EXPAND VERMONT'S SYRINGE EXCHANGE PROGRAMS AND SERVICES TO INCREASE GEOGRAPHIC REACH AND HOURS OF OPERATION. SUPPORT ACCESS TO INCREASED CASE MANAGEMENT SERVICES FOR ALL PARTICIPANTS.**

**Action:** Vermont Department of Health will lead a working group to develop an implementation plan by June 2018.

**Related goals:**

- Reduce the number of opioid overdose deaths.
- Increase the number of people in treatment.

**Narrative:** When best practices are engaged, syringe services programs (SSPs) have proven to be effective for intervention and referral to treatment for people who inject drugs. Important among these programs are high accessibility in hours and locations, and the ability to engage regularly, without expectation, with program staff so that referral to treatment is possible when the individual is ready.

The Department of Health currently funds four organizations that operate syringe services programs in eight Vermont locations. Outside of Chittenden County, the highest hours of operation are eight per week, and lowest is less than two hours per week. The average is 3.4 hours per week (these hours do not include a mobile service which can be called to determine its availability). In Burlington, Safe Recovery is open 35 hours per week.

## F. SUPPLY NALOXONE AND PROVIDE TRAINING

### SUPPLY WITH NALOXONE, AND PROVIDE EFFECTIVE TRAINING TO ALL VERMONT LAW ENFORCEMENT, EMS, AND PEOPLE LIKELY TO BE NEAR A PERSON WHO MAY OVERDOSE.

**Action:** The Vermont Department of Health will conduct continuous outreach and education in an effort to reach 100% utilization of naloxone for any emergency as needed.

**Related Goal:** Reduce the number of opioid overdose deaths

**Narrative:** Every life saved has infinite impact: on family, on community, on Vermont. People suffering with SUD are our friends, neighbors, sisters, brothers, daughters, sons, mothers and fathers. They are worthy and valued, especially to those who love them. Last year, 106 Vermonters lost their lives to an overdose. If this trend continues, we will lose an equal or greater number of Vermonters next year. Naloxone has the power to save lives -- the life of the individual with SUD, and the lives in families and communities otherwise devastated by heart-breaking cycles of addiction. With Naloxone, treatment, and recovery can be possible.

In addition, law enforcement and first responder personnel face risks from fentanyl, its analogs such as carfentanil, and other opioids when called to emergency and overdose situations. While current data suggests that normal procedures are protective against these threats, we support the President's Commission Recommendations' call for supplying and training first responders, and for research on law enforcement and first responder exposure rates.<sup>[1]</sup> Naloxone supply and training in every appropriate organization across the state is an investment in the rescue and protection teams of our state.

Approximately 9,000 naloxone kits were distributed in 2016 to naloxone distribution sites, Vermont EMS, and law enforcement agencies. As of November 13, 2017, naloxone is available for public distribution at 30 sites across Vermont, carried by all Vermont EMS agencies, and 74 of 78 Vermont Law Enforcement agencies. Budget impact will be minimal, as coverage is high now and funds are currently available.

**President's Commission: #43** - The Commission recommends the National Highway Traffic Safety Administration (NHTSA) review its National Emergency Medical Services (EMS) Scope of Practice Model with respect to naloxone, and disseminate best practices for states that may need statutory or regulatory changes to allow Emergency Medical Technicians (EMT) to administer naloxone, including higher doses to account for the rising number of fentanyl overdoses.

**Related: #30:** The Commission recommends the White House develop a national outreach plan for the *Fentanyl Safety Recommendations for First Responders*. Federal departments and agencies should partner with Governors and state fusion centers to develop and standardize data collection, analytics, and information-sharing related to first responder opioid-intoxication incidents.

## HARM REDUCTION: DRUG AND SHARPS DISPOSAL

### G. EXPAND DRUG DISPOSAL OPTIONS

#### EXPAND CURRENT DRUG DISPOSAL OPTIONS AND EVENTS, AND INCREASE PUBLIC PARTICIPATION ACROSS THE STATE.

**Action:** Support and expand public opportunities for drug disposal and "take back" days, including:

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<sup>[1]</sup> President's Commission on Combating Drug Addiction and the Opioid Crisis Report, pp. 67-68.

- Expand Drug Take Back Days to four times per year.
- Implement/enhance a statewide public awareness campaign that reaches all Vermont communities – led by the Vermont Department of Health, with cross-department and cross-sector partnership.
- Increase the number and availability of year-round disposal facilities throughout the state, to include cooperative agreements with pharmacies.

**Related goal:** Vermont communities will be strong, safe, and resilient.

**Narrative:** Most people who misuse medications get them from friends or family – often straight out of the medicine cabinet. By ensuring the safe use, storage, and disposal of prescription drugs, we can help protect people, pets, wildlife, and water sources. The Vermont Department of Health coordinates a prescription drug disposal system to connect Vermonters with accessible, permanent disposal sites, such as pharmacies, hospitals and police stations, and also supports the biannual DEA National Prescription Drug Take Back Days.

To ensure all Vermonters have access to safe disposal options, expanding existing drug disposal activities and public awareness messaging are necessary. This can be done by expanding permanent drop off locations and increasing participation from law enforcement, hospitals, and pharmacies. A simultaneous, rigorous, messaging campaign will address the knowledge gap around proper disposal, increasing Vermonters’ awareness of how and where to safely dispose of medication.

**President’s Commission: #17** The Commission recommends community-based stakeholders utilize Take Back Day to inform the public about drug screening and treatment services. The Commission encourages more hospitals/clinics and retail pharmacies to become year-round authorized collectors.

## H. IMPROVE SHARPS COLLECTION AND DISPOSAL

### CREATE A STATEWIDE STRATEGY AND COMMUNITY TOOLKIT TO IMPROVE COLLECTION AND DISPOSAL OF SHARPS.

**Action:** Action is underway. Continue to support.

Strategy development will begin with data collection and will include state, regional and community connections/partners; public education about proper disposal methods; siting of kiosks; addressing transportation issues and options for pick-up and disposal; solid waste management; and resource needs.

**Related goal:** Vermont communities will be strong, safe and resilient.

**Narrative:** In the United States, the Food and Drug Administration estimates that approximately seven billion needles (often referred to as sharps) are used per year.<sup>[1]</sup> While many sharps are used at health care facilities and can be disposed of by the facility, some are used at home by individuals who are managing chronic medical conditions like diabetes, rheumatoid arthritis, multiple sclerosis, and HIV or even in public places<sup>[2]</sup> by individuals who inject drugs. If improperly disposed of at home

<sup>[1]</sup> US Food and Drug Administration, “Be Smart with Sharps” last modified February 12, 2014, accessed October 23, 2017, <https://www.fda.gov/downloads/medicaldevices/productsandmedicalprocedures/homehealthandconsumer/consumerproducts/sharps/ucm382005.pdf>.

<sup>[2]</sup> Gierzynski, Anthony, “Statewide Universal Needle Disposal,” last modified March 4, 2015, accessed October 23, 2017, <https://www.uvm.edu/~vlrs/Safety/needle%20disposal.pdf>.



or in a public area, a discarded needle or sharp can be dangerous to sanitation workers or to other community members. Accidental needle sticks pose a potential risk for the transmission of blood-borne pathogens like HIV/AIDS, Hepatitis B, and Hepatitis C. Although needle sticks mostly happen to nurses in health care settings, about 11% of reported needle sticks annually are disposal related according to the Centers for Disease Control.<sup>[3]</sup> It is important to note that the Vermont Department of Health does not currently have data about the number of improperly disposed of sharps or how many needle sticks happen in Vermont as a result of improperly disposed sharps (for either home-use or needles used for injecting drugs). In Vermont, there are resources to address the problem of improperly disposed of sharps and clear guidance provided by the Vermont Department of Health. Syringe Exchange Programs (SEPs), in particular, have served as integral partners in achieving proper sharps disposal (as a primary disease prevention strategy) since 1998, collecting over 1.6 million used sharps from 2010 to 2014 alone. During this same period the Vermont Department of Health distributed over 3.6 million syringes.

A coalition of stakeholders, the Statewide Sharps Disposal Taskforce, is now working to develop a statewide best practice for sharps disposal to include pick-up, collection and disposal of sharps. A statewide public education campaign will be developed by the VT Department of Health in collaboration with the Agency of Natural Resources, Vermont Cares, the Vermont League of Cities and Towns, the Vermont Association of Hospitals and Health Systems and others, to educate the public about safe collection and disposal of sharps.

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<sup>[3]</sup> Ibid.

### 3. TREATMENT STRATEGIES

#### A. SUPPORT, EVALUATE AND IMPROVE VERMONT'S HUB AND SPOKE SYSTEM

CONTINUOUSLY SUPPORT, EVALUATE AND IMPROVE UPON VERMONT'S HUB AND SPOKE SYSTEM FOR OPIOID TREATMENT TO SUSTAIN, AND EXPAND WHERE NEEDED, HUB AND SPOKE TREATMENT SERVICES ACROSS THE STATE, INCLUDING MEDICATION-ASSISTED TREATMENT.

**Narrative:** Vermont's death rate as a result of opioid overdose is on track in 2017 to match or exceed 2016's record of 106. This suggests that the demand for treatment has not crested. Other factors will continue to create a shifting environment, which may call for changes in capacity or delivery of services. Vermont's Blueprint for Health, and the Health Department Division of Alcohol and Drug Abuse Programs (ADAP), will implement continuous evaluation to refine the Hub and Spoke system of care.

**Action:** The OCC will review evaluation of Vermont's Hub and Spoke system and support Vermont's Blueprint for Health, and the Health Department Division of Alcohol and Drug Abuse Programs, to implement recommendations for continuous improvement.

#### B. EXPAND MEDICATION-ASSISTED TREATMENT IN CORRECTIONAL FACILITIES

EXPAND ACCESS TO MEDICATION-ASSISTED TREATMENT (MAT) IN ALL VERMONT CORRECTIONAL FACILITIES.

**Action:** The OCC will support the VT Department of Corrections (DOC) in their effort to secure resources needed to develop policy, program, and infrastructure necessary to expand MAT in all Vermont Correctional facilities.

**Related goals:**

- Prevent, reduce, eliminate opioid-related crime.
- Increase the number of people in treatment.

**Narrative:** Vermont currently has available term-limited MAT in correctional facilities. Access to MAT in Vermont's correctional facilities will include no less than 120 days, providing case-by-case review for extension dependent on length of incarceration and medical considerations. At time of incarceration, individuals may choose continuation, induction, or withdrawal. Prior to transition from incarceration, individuals receiving MAT will have a discharge plan for continuum of care, including MAT.

Within one year, the State of Vermont will implement a plan to provide unlimited access to MAT in Vermont correctional facilities. Budget and implementation challenges must be addressed by the Administration and the Legislature.

**President's Commission: #37.** The Commission recommends the National Institute on Corrections (NIC), the Bureau of Justice Assistance (BJA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and other national, state, local, and tribal stakeholders use medication-assisted treatment (MAT) with pre-trial detainees and continuing treatment upon release.

**VT response to NGA recommendation:** Permit Medicaid coverage of evidence-based substance use disorder services in jails that are particularly under-resourced. **Vermont: YES.**

## C. MAXIMIZE NON-PHARMACOLOGICAL APPROACHES

### MAXIMIZE THE USE OF NON-PHARMACOLOGICAL APPROACHES - INTEGRATIVE HEALTH CARE PROFESSIONS -- FOR PREVENTION, TREATMENT AND RECOVERY.

**Action:** In the next year the OCC will support a working group, including Blueprint, Health Care Reform, Vermont Department of Health, and integrative health care professionals to address research opportunities, coverage across all payers, and the availability of integrative health care options throughout Vermont.

**Related goals:**

- Reduce the number of people with SUD.
- Reduce the number of opioid prescriptions written each year.
- Reduce the number of youth using illegal substances.

**Narrative:** The OCC joined Health Commissioner Levine in a roundtable conversation about the potential of integrative health care professions and interventions to address pain management, treatment, and recovery. These may include acupuncture, chiropractic, yoga, physical therapy, massage therapy, meditation/mindfulness and other evidence-based methods.

Vermont integrative health professionals and the University of Vermont are working to advance strategies that can help to increase access to these methods.

VT response to NGA recommendation: Build the evidence base for non-opioid treatments for pain.

**YES.** Vermont supports the recommendation to continue to build the evidence base for alternatives to opioids in the treatment of pain. This includes support for complementary and integrative health care research institutions (including the NIH-NCCIH), the funding of independent research efforts, and studies that focus on key populations (e.g. minorities, veterans, rural). Vermont's Department of Corrections (DoC) offers non-pharmacological treatments for pain including NSAIDs, yoga, physical therapy, home exercise programs, meditation/mindfulness., and is exploring the use of acupuncture, cryotherapy, and any other evidence-based intervention. Numerous Vermont Treatment Providers and Recovery Centers offer non-pharmacological supports for pain management.

## D. EXPAND DRUG TREATMENT COURTS/FAMILY TREATMENT COURTS

### SUPPORT THE VERMONT JUDICIARY'S PLAN TO EXPLORE EXPANDED ACCESS TO TREATMENT DOCKET TECHNIQUES:

- Adult Treatment Dockets in the Criminal Division, and
- The Family Abuse and Neglect Docket in the Family Division

**Action:** The OCC will support the Vermont Judiciary's plan to explore expanded access to the above treatment docket techniques.

**Related goals:**

- Reduce the number of children in state custody as a result of SUDs.
- Reduce the number of youth using illegal substances.
- Prevent, reduce, eliminate opioid related crime.
- Increase the number of people in treatment.
- Increase the number of people in recovery who have housing, jobs and social supports.
- Vermont communities will be strong, safe, and resilient.

**Narrative (from Superior Court):** In addition, Judiciary plans to continue its ongoing work to bring existing treatment dockets into compliance with evidence-based best practices, including:

- Collaborate with prosecutors, defense attorneys, treatment providers, and policymakers to adopt statewide shared principles, based on evidence-based best practices, applicable to treatment dockets.
- Explore innovative and cost-effective ways to manage Adult Treatment Dockets, such as the possibility of judicial masters sitting in Adult Treatment Dockets.
- Support statutory, rule, and operational changes to ensure that individuals throughout the State who are clinically eligible for treatment dockets have access to existing dockets without limitation by county borders, including consideration of subsidized transportation for treatment docket participants, video communications and tele-services, and travel by treatment docket teams to other counties.
- Explore use of treatment docket techniques to promote rehabilitation by parents in the Abuse and Neglect Docket.

The Judiciary will convene and lead a commission on treatment dockets, chaired by Chief Justice Reiber, to make specific recommendations.

President's Commission: #38 - The Commission recommends DOJ broadly establish federal drug courts within the federal district court system in all 93 federal judicial districts. States, local units of government, and Indian tribal governments should apply for drug court grants established by 34 U.S.C. § 10611. Individuals with an SUD who violate probation terms with substance use should be diverted into drug court, rather than prison.

VT response to NGA recommendation: Prioritize federal support for state efforts that address justice-involved populations at risk from the opioid epidemic. **YES.** Vermont Department of Corrections currently provides interim maintenance; however, we lack the resources to initiate MAT prior to the patient's discharge. Vermont would welcome federal resources to develop and implement Outpatient Treatment Programs.

## **E. EXPAND MEDICARE AND MEDICAID COVERAGE**

### **SUPPORT THE NATIONAL GOVERNORS' ASSOCIATION RECOMMENDATION TO EXPAND MEDICARE AND MEDICAID COVERAGE FOR OPIOID TREATMENT.**

**Action:** The Agency of Human Services and the Governor's Health Care Reform initiative are leading this effort. No additional action is recommended at this time.

**Related goal:** Increase the number of people in treatment.

NGA Recommendation from VT: Expanding Medicare coverage for treatment costs. Treating opioid addiction as a chronic condition requires a broad range of interventions. Time limited funds can help launch innovative treatment options, but they do not cover the long-term costs of sustaining these programs. Many states, including Vermont, have used their Medicaid programs to establish treatment systems that provide medication-assisted treatment (MAT), which includes the medication, counseling, and other supports needed for successful treatment. While Medicare covers some outpatient services and some of the medications used in MAT, it does not cover all the medications, the critical supportive services, and services and medication in Vermont's Opiate

Treatment Programs. An important step towards full access to treatment will be the engagement of Medicare in opioid addiction treatment and system of care.

VT response to NGA recommendation: Eliminate the Institutions for Mental Diseases (IMD) exclusion to help states provide the full continuum of evidence-based care for Medicaid enrollees with substance use disorder. **YES.** Vermont needs adequate capacity to treat patients, and the IMD exclusion places what seems to be an arbitrary restriction on State's abilities to develop sufficient economies of scale to provide treatment. The priority should be to treat individuals in the setting most appropriate for the needed level of care. Given the high rate of comorbidity between mental health conditions and substance use disorders, these factors should be supported through inclusion.

President's Commission: #19 - The Commission recommends CMS review and modify rate-setting policies that discourage the use of non-opioid treatments for pain, such as certain bundled payments that make alternative treatment options cost prohibitive for hospitals and doctors, particularly those options for treating immediate post-surgical pain. See also #33, 34.

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## 4. RECOVERY STRATEGIES

### A. STRENGTHEN RECOVERY CENTERS, RECOVERY COACHES

**ENSURE VERMONT HAS A STRONG STATEWIDE NETWORK OF RECOVERY CENTERS, RECOVERY COACHES, AND SUPPORTS, AND THAT EACH REGIONAL RECOVERY CENTER HAS THE CAPACITY TO DELIVER PROGRAMS AND SERVICES TO INDIVIDUALS IN RECOVERY, THEIR FAMILIES, AND LOVED ONES.**

**Action:** The OCC will work with the Vermont Department of Health/Alcohol and Drug Abuse Programs Division (ADAP) and other departments of the Agency of Human Services, the Vermont Recovery Network, the Vermont Association for Mental Health and Addiction Recovery (VAMHAR), and the 12 recovery centers to develop a results-based budget and program delivery system proposal for investment by March 2018.

**Related goals:**

- Increase the number of people in recovery who have housing, jobs, and social supports
- Reduce the number of people with substance use disorders

**Narrative:** Recovery is the process of healing the physical, emotional, and spiritual harm caused by slipping into dependence on alcohol and drugs. The Vermont Recovery Network (VRN) and its 12 regional Recovery Centers helps people find, maintain, and enhance their recovery through peer supports, sober recreation, and educational opportunities. People with experience in recovery (Peer Recovery Support Service - PRSS) help visitors establish connections, often leading to employment, stable housing, and other needed services. As addiction takes its toll on families and loved ones of people with substance use disorder, Recovery Centers also provide family supports.

**Recovery Coaches:** Recovery coaching is the evidence based<sup>26</sup> practice of working with Vermonters to help sustain long-term recovery. Recovery coaches in Vermont are certified through VAMHAR after receiving an intensive 40-hour certificate. Approx. 100 well-trained certified recovery coaches are currently working and volunteering in Vermont – in settings as diverse as the Lund Family Center, Turning Point Centers, Emergency Rooms, and Veterans organizations. Recovery coaches are largely individuals who are in long-term recovery themselves, though family members and allies also receive certification. The combination of “lived experience” with an evidence based training has created a strong model to support Vermonters in recovery. Given the number of Vermonters in treatment, we anticipate the need for certified recovery coaches working throughout the state to multiply.

**President’s Commission: #39** The Commission recommends the Federal Government partner with appropriate hospital and recovery organizations to expand the use of recovery coaches, especially in hard-hit areas. Insurance companies, federal health systems, and state payers should expand programs for hospital and primary case-based SUD treatment and referral services. Recovery coach programs have been extraordinarily effective in states that have them to help direct patients in crisis to appropriate treatment. Addiction and recovery specialists can also work with patients through technology and telemedicine, to expand their reach to underserved areas.

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\* <https://www.ncbi.nlm.nih.gov/pubmed/17895731>

\* VT Department of Health

\* <https://www.ncbi.nlm.nih.gov/pubmed/17895731>

## B. EXPAND RECOVERY HOUSING

**EXPAND THE AVAILABILITY OF RECOVERY HOUSING AND THE DEPARTMENT FOR CHILDREN AND FAMILIES' FAMILY SUPPORTIVE HOUSING PROGRAM TO ENSURE INDIVIDUALS AND FAMILIES HAVE ACCESS TO A STABLE HOME ENVIRONMENT THROUGHOUT VERMONT.**

**Action:** The OCC will convene an initial collaborative meeting with state agencies, Vermont's non-profit housing provider network, and private sector housing providers and home builders, to consider and provide recommendations to grow Vermont's inventory of, and access to, safe and healthy home environments, by June 2018.

**Related goals:**

- Prevent, reduce, eliminate opioid related crime.
- Increase the number of people in recovery who have housing, jobs, and social supports.
- Vermont communities will be strong, safe, and resilient.

**Narrative:** Housing is critical for any individual or family to prevent the cycle of addiction. Vermont individuals and families impacted by opioid use disorder need access to safe, stable, affordable housing. This may be achieved by ensuring the availability of a continuum of housing options, including short-term emergency shelters, transitional housing, recovery residences, permanent supportive housing, rental assistance and new rental housing across the state. The OCC recognized the urgency of housing needs across Vermont. The housing bond investment will provide approximately 600 new units; expanding the capacity of support services and rental assistance is just as critical.

The strategies that follow reflect what is working well, including alignment of housing strategies supported by the Vermont Council on Homelessness. See the Vermont Plan to Prevent and End Homelessness report submitted July 2017.<sup>27</sup>

Flexibility in funding and programs is essential to meeting the housing needs of all Vermonters. The OCC supports coordination and collaboration between and among all State Agencies/Departments, non-profit housing programs (VHCB/Vermont Housing & Conservation Board, VCDP/VT Community Development Program, VHFA/VT Housing Finance Agency, VSHA/VT State Housing Authority, AHS) to provide housing options to people with SUDs who are in all stages of recovery.

Finally, Recovery Housing is a model of shared housing in an abstinence-focused and peer-supported community. This is a supportive housing option and should be available throughout Vermont to support successful long-term recovery.

Strategies:

1. **Expand the availability of family supportive housing statewide.**<sup>28</sup>
2. Conduct a **state-wide assessment of the continuum of housing needs** for individuals and families with SUD and in recovery.
3. Support the establishment of a **recovery housing certification program** through the Vermont Alliance for Recovery Residences (VTARR), a chapter of the National Alliance for Recovery Residences (NARR).
4. Explore **new federal housing opportunities** with subsidy and services for Vermont households with substance use disorder.

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<sup>27</sup> <http://humanservices.vermont.gov/boards-committees/vermont-council-on-homelessness/vch-2017-annual-report/view>

<sup>28</sup> A program of the VT Department of Children and Families.

5. Explore **incentives to encourage landlords to rent** to households with significant barriers to housing.
6. Engage in discussion with the Vermont Housing and Conservation Board to consider **strategic use of \$35 million housing bond** to support expanded *Recovery Housing options*.

President's Commission: **#46** - The Commission recommends that HHS implement guidelines and reimbursement policies for Recovery Support Services, including peer-to-peer programs, jobs and life skills training, supportive housing, and recovery housing. **#48** - The Commission recommends ONDCP, the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Department of Education (DOE) identify successful college recovery programs, including "sober housing" on college campuses, and provide support and technical assistance to increase the number and capacity of high-quality programs to help students in recovery. **#51** - The Commission recommends that ONDCP, federal agencies, the National Alliance for Recovery Residents (NARR), the National Association of State Alcohol and Drug Abuse Directors (NASADAD), and housing stakeholders should work collaboratively to develop quality standards and best practices for recovery residences, including model state and local policies. These partners should identify barriers (such as zoning restrictions and discrimination against MAT patients) and develop strategies to address these issues.

### C. EXPAND EMPLOYMENT IN RECOVERY

(See "Expand the number of Vermonters in recovery who have a job," pages 20-21, B.1.)



## 5. ENFORCEMENT STRATEGIES

### A. PURSUE ROADSIDE DRUGGED DRIVING TESTING

**SUPPORT RESEARCH, DEVELOPMENT, AND COURT ADMISSIBILITY OF A SIMPLE, ACCURATE AND COST-EFFECTIVE ROADSIDE TESTING METHOD FOR DRUGGED DRIVING.<sup>29</sup>**

**Action:** Support legislative and legal efforts to achieve this strategy.

**Related goals:**

- Reduce the number of youth using illegal substances.
- Reduce the supply of illicit drugs in Vermont.
- Prevent, reduce, eliminate opioid related crime.
- Vermont communities will be strong, safe, and resilient.

**Narrative:** States have struggled to develop and implement an effective roadside test for the presence of controlled substances. The rise in the number of people with substance use disorders in Vermont and surrounding states together with the decriminalization, medical use, and legalization of marijuana has caused a corresponding increase in the number of drivers under the influence of controlled substances and motor vehicle fatalities. Without an effective way to test for the presence of these drugs, the risk to the motoring public is substantial and growing. (NGA Letter)

NGA Recommendation from VT: Enforcement: Support research, development, and court admissibility of a simple, accurate and cost-effective roadside testing method for drugged driving.

### B. INCREASE DRUG TRAFFICKING INVESTIGATIONS

**INCREASE VERMONT'S RESOURCES FOR DRUG TRAFFICKING INVESTIGATIONS.**

**Action:** Support State of Vermont/VT Law Enforcement efforts to achieve this strategy.

- Increase investigation resources for local police and sheriffs throughout Vermont to address local drug traffickers affecting the community;
- Continue support for and consider expansion of Vermont Drug Task Forces;
- Explore the assignment of two state prosecutors exclusively to drug investigations and prosecutions, collaborating with local, state, regional and federal law enforcement.

**Related goals:**

- Reduce the number of youth using illegal substances.
- Reduce the supply of illicit drugs in Vermont.
- Prevent, reduce, eliminate opioid related crime.
- Vermont communities will be strong, safe, and resilient.

President's Commission: #24 - The Commission recommends that federal law enforcement agencies expressly target Drug Trafficking Organizations and other individuals who produce and sell counterfeit pills, including through the internet.

VT response to NGA recommendation: Strengthen Support for Regional Intensity Drug Trafficking Areas (HIDTAs) and state law enforcement efforts to address the supply of illicit opioids. **YES.** HIDTAs play a crucial role in state and local law enforcement's battle against opioids. The role of HIDTA should be expanded to allow for it to provide more robust assistance to state and local law enforcement led prevention efforts.

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<sup>29</sup> The VT Marijuana Advisory Commission is also developing recommendations.

## C. PROVIDE DRUG RECOGNITION TRAINING

PROVIDE DRUG RECOGNITION TRAINING FOR (ALL) LAW ENFORCEMENT, FIRST RESPONDERS, AND INCREASE THE NUMBER OF DRUG RECOGNITION EXPERTS (DRES).

**Action:** Support State of Vermont Law Enforcement efforts to achieve this strategy.

**Related goals:**

- Reduce the number of youth using illegal substances.
- Reduce the supply of illicit drugs in Vermont.
- Prevent, reduce, eliminate opioid related crime.
- Vermont communities will be strong, safe, and resilient.

President's Commission: #21 - The Commission recommends the Federal Government work with the states to develop and implement standardized rigorous drug testing procedures, forensic methods, and use of appropriate toxicology instrumentation in the investigation of drug-related deaths. We do not have sufficiently accurate and systematic data from medical examiners around the country to determine overdose deaths, both in their cause and the actual number of deaths.

# ACKNOWLEDGEMENTS

The OCC wishes first to thank Governor Scott for the honor and opportunity of serving on this Council. OCC members share a sense of urgency to offer our best work as quickly as possible. This first set of strategies is a call for action. We are motivated by the potential to have strong positive impact on the people and communities of Vermont. We pursue this work with gratitude.

The Governor's staff have ensured effective and timely communication not only with the Governor, but with constituents and organizations who are working in their own ways to combat opioids and their effects.

In addition, the following have been invaluable partners and resources in accomplishing the work of the OCC to date. We thank all who have been involved:

- The Agency of Human Services (AHS) Office of the Secretary, and the Commissioners and other leaders of Departments and Divisions:
  - Departments of Health (VDH), Corrections (DOC), Vermont Health Access (DVHA), Children and Families (DCF), Mental Health (DMH), and Disabilities, Aging and Independent Living (DAIL).
  - The VDH Alcohol and Drug Abuse Programs (ADAP) team, and Prevention Consultants; AHS Field Directors; and the Directors of Blueprint for Health and Health Care Reform.
- The Committees of the Council:
  - Treatment and Recovery Committee, chaired by Bob Bick and Peter Mallary.
  - Prevention and Enforcement Committee, chaired by Sheriff Roger Marcoux and Stephanie Thompson.
  - Licensure and Higher Education Working Group, chaired by Colin Benjamin and Annamarie Cioffari.
  - Affordability and Professional Development Working Group, chaired by Peter Espenshade and Ginger Cloud.
- The Agency of Education and the Department of Public Safety.
- The Vermont Judiciary.
- The Secretary of State's Office of Professional Regulation, for leadership toward expanding the substance use disorder workforce by creating emergency licensure rule changes.
- The Agency of Commerce and Community Development, and the Vermont Department of Labor, for partnership in exploring new avenues for employment in recovery.
- The many organizations who provided information, meeting space, and networking, including: Howard Center, the University of Vermont and Medical Center, the Vermont Association of Mental Health and Addiction Recovery (VAMHAR), PreventionWorks!, the Vermont Recovery Network and the 12 recovery centers.
- The towns and communities who hosted OCC staff and members for meetings and forums, including: Rutland, Chittenden County, Burlington, St. Johnsbury, Lamoille County, Bennington, Morrisville and Swanton.
- Other advisory groups with shared interests: the Vermont Alcohol and Drug Abuse Council (VADAC), the Children and Family Prevention Council, and the Marijuana Advisory Commission.
- The staff members of Vermont's Congressional Delegation, and the Vermont Legislators who have been working with us to integrate federal and state laws, funding, and opportunities.
- The many coalitions, non-profit organizations, businesses, and individual service providers who have contributed time, travel, and their experience and knowledge of the opioid crisis, substance use disorders, and the needs of individuals and families who are affected by and/or at risk.

We thank the people in recovery, and the family members, friends and employers here in Vermont, who have shared their stories – lived experience, strength and hope – with the OCC. May we all keep our sights focused on accumulating everyday successes that will turn the curve on opioids and all drugs that lead to addiction and suffering.

# APPENDICES

- I. Members of the Opioid Coordination Council**
- II. Data, Graphs and Charts**
- III. Glossary**

DRAFT

## APPENDIX I: MEMBERS AND STAFF OF THE OPIOID COORDINATION COUNCIL

**Co-Chairs: Secretary of the Agency of Health and Human Services, Commissioner of Public Safety, and a community leader (appointed by & serve at the pleasure of the Governor):**

Al Gobeille, Secretary, Human Services

Tom Anderson, Commissioner, Public Safety

Jim Leddy, Community Leader (Chittenden)

**Commissioner of the Department of Health or designee:** Dr. Mark Levine, Commissioner

**Attorney General, or designee:** TJ Donovan, Vermont Attorney General

**United States Attorney, District of Vermont, or designee:** Acting US Attorney, Eugenia A.P. Cowles

**One representative of the Vermont Mayors Coalition:** David Allaire, Mayor (Rutland County)

**One representative of a local non-profit housing organization to be appointed by the Governor:**

Liz Genge, Director of Property and Asset Management, Downstreet Housing and Community Development (Washington County)

**One educator involved in substance abuse prevention to be appointed by the Governor:** Adam Bunting, Principal CVU (Chittenden County)

**One representative of State municipalities appointed by the Vermont League of Cities and Towns:**

Stephanie Thompson: Vice-Chair, Springfield Select Board; Londonderry Town Administrator; Springfield Prevention Coalition. (Windsor County)

**One substance abuse prevention and treatment professional to be appointed by the Governor:**

Lori Augustyniak, Executive Director, Prevention Works (Washington County)

**One representative of the Vermont Association of Mental Health, Addiction and Recovery (VAMHAR):**

Peter Mallary, VAMHAR Staff, former legislator (Orange County)

**One representative of a designated agency to be appointed by the Governor:** Bob Bick, Executive Director; Howard Services (Chittenden County)

**One representative of the Vermont Association of Hospitals and Health Systems:** Jill Berry Bowen, CEO, Northwestern Medical Center, St. Albans (Franklin County)

**One representative of the Vermont Sheriffs' Association:** Roger Marcoux (Lamoille County)

**One representative of the Vermont Association of Chiefs of Police:** Seth DiSanto, Chief of Police, Newport (Orleans County)

**One representative of the United States Drug Enforcement Administration:** John DeLena, Assistant Special Agent in Charge, Drug Enforcement Administration

**One first responder to be appointed by the Governor:** Michael Bucossi, Chief, Brattleboro Fire Department (Windham County)

**The Chief Justice, or designee:** Hon. Brian Grearson, Chief Superior Judge

**One representative of Vermont's business community to be appointed by the Governor:** Sara Byers, President, Leonardo's Pizza (Chittenden County)

**Two at-large members to be appointed by the Governor:**  
Debra Ricker, President, WorkSafe, (Washington County)  
Ken Sigsbury, Executive Director, Turning Point Center, Bennington (Bennington County)

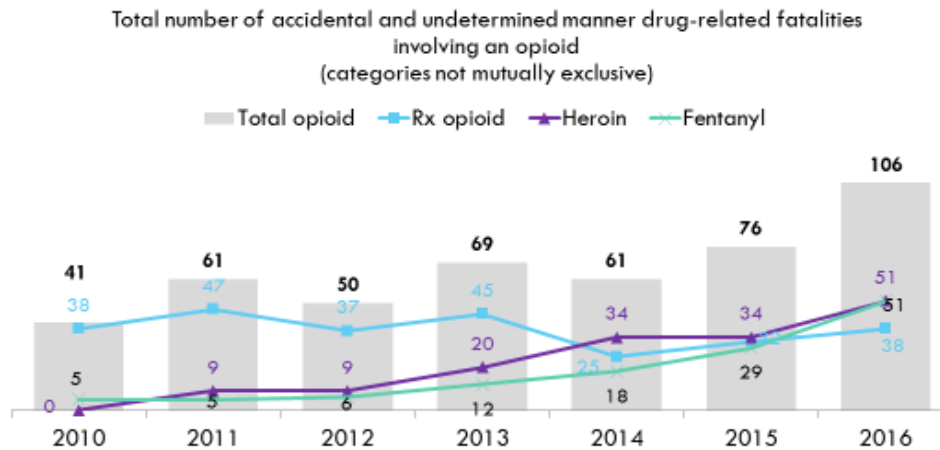
**Staff:**

Jolinda LaClair, Director of Drug Prevention Policy  
Rose Gowdey, Community Engagement Liaison

## APPENDIX II: DATA, GRAPHS & CHARTS

### 1. DRUG-RELATED FATALITIES INVOLVING OPIOIDS

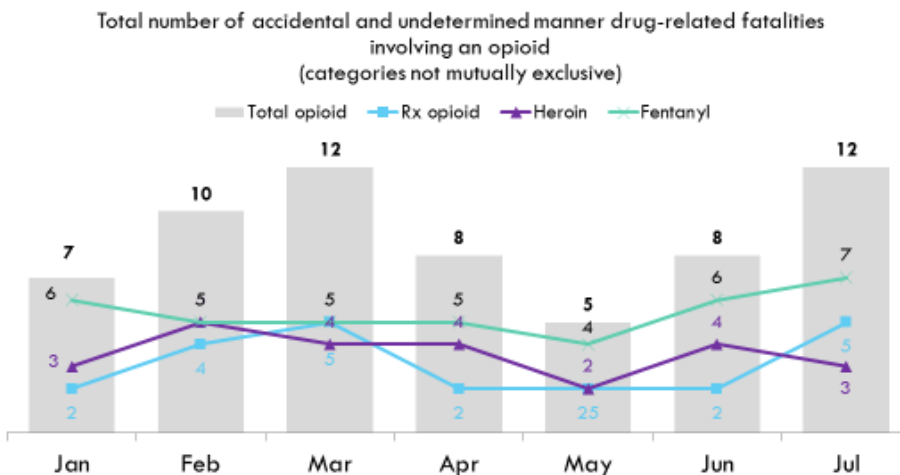
#### Drug-Related Fatalities Involving Opioids



Between 2010 and 2016 opioid overdoses increased by 159%. Rx drug fatalities were unchanged, heroin deaths increased from 0 to 51, and fentanyl increased by 920%

Source: Vermont Department of Health Vital Statistics System

#### Drug-Related Fatalities Involving Opioids – 2017 by Month

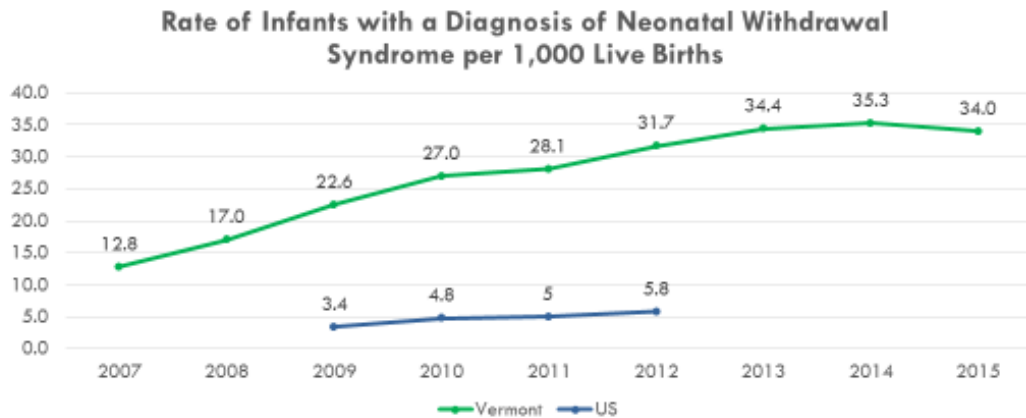


2017 estimated fatalities (106) are on pace to be similar to 2016 but given the significant month to month variation, it is possible the final number could be significantly different than the estimate.

Source: Vermont Department of Health Vital Statistics System

## 2. NEONATAL WITHDRAWAL SYNDROME

# Neonatal Withdrawal Syndrome



- Vermont has comprehensive prenatal programs for opioid dependent pregnant women resulting in high rates of identification.
- **Four out of five infants with neonatal withdrawal syndrome in Vermont were born to women in Medication Assisted Treatment.** Matched Medicaid claims and Vital Records, 2010, (ICD-9 codes 779.5 or 760.72)
- The average hospital stay for a diagnosed infant in VT is 7.4 days vs a U.S. average of 16.5 days.

Vermont Department of Health

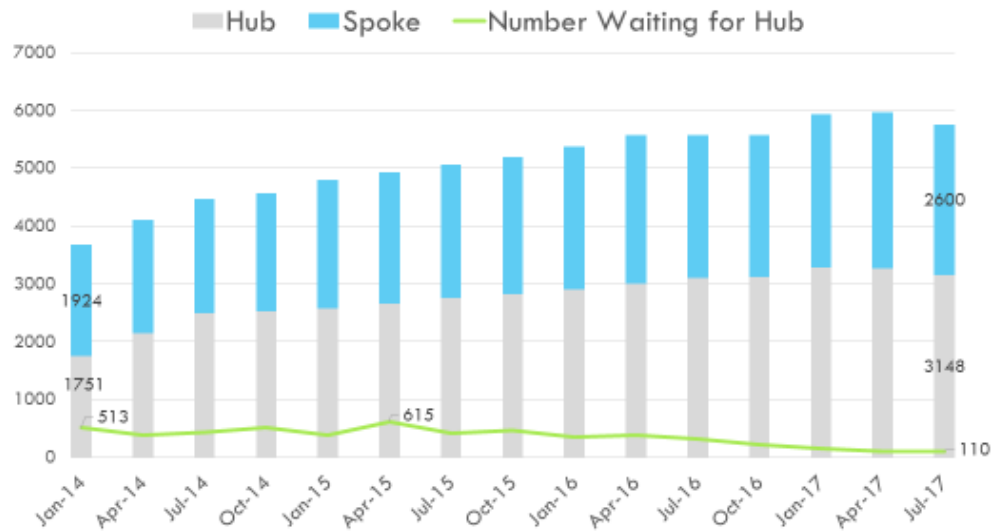
Codes Used: ICD-9 779.5, ICD-10 P96.1

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### 3. TREATMENT DATA

Number of people receiving MAT in hubs and spokes vs number waiting for services over time



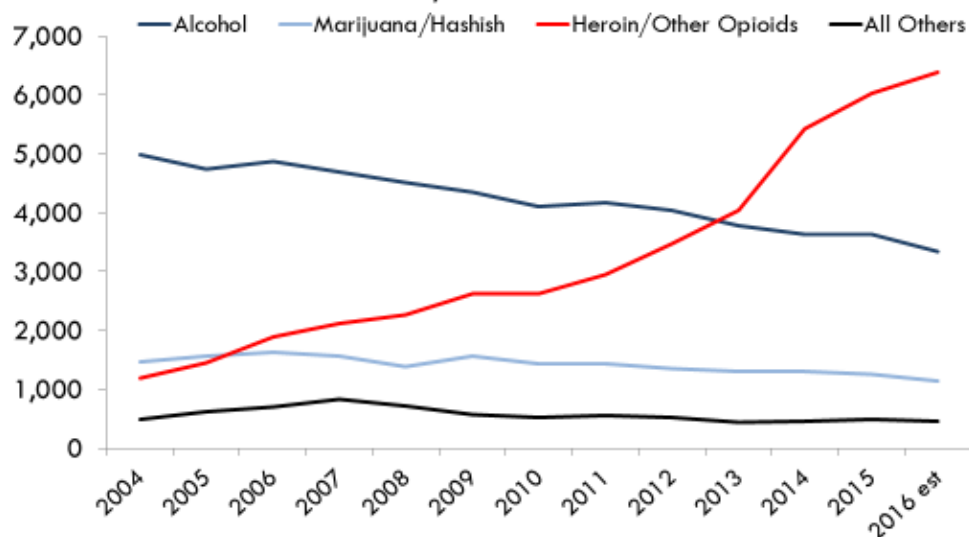
Source: Hub Census and Waitlist, Medicaid Claims for Spokes

Vermont Department of Health



The number of Vermonters treated for opioid addiction continues to increase

Number of people treated in ADAP Preferred Providers by substance



Vermont Department of Health

Source: Alcohol and Drug Abuse Treatment Programs 8

#### 4. PRESCRIPTIONS AND PRESCRIBING TRENDS (since new prescribing rule went into effect July 1, 2017)

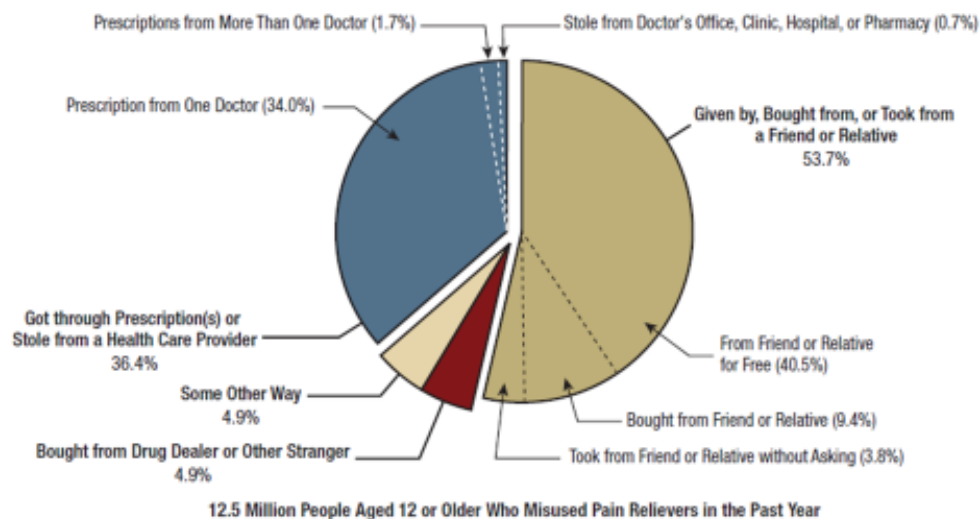
**Vermont Rate of Prescriptions per 100 Residents by Drug Class** (source: VPMS/VT Department of Health)

	<b>Opioid Analgesic</b> (for pain relief)	<b>Benzodiazepine</b> (sedative for anxiety, insomnia, etc.)	<b>Stimulants</b> (to increase alertness, attention, energy)
<b>2<sup>nd</sup> Quarter 2017</b>	14.5	9.8	7.6
<b>3<sup>rd</sup> Quarter 2017</b>	13.3	9.5	7.4

**Background:**

Nationally, over half of those who misused a prescription pain reliever got it from a friend or relative.

**Figure 24. Source Where Pain Relievers Were Obtained for Most Recent Misuse among People Aged 12 or Older Who Misused Prescription Pain Relievers in the Past Year: Percentages, 2015**



Note: The percentages do not add to 100 percent due to rounding.

Note: Respondents with unknown data for the Source for Most Recent Misuse or who reported Some Other Way but did not specify a valid way were excluded.

Vermont Department of Health

Source: National Survey on Drug Use and Health, 2015

## 5. SYRINGE EXCHANGE VISITS

Grant year, July 2016-June 2017- Number of member visits or encounters by SSP organization:

SAFE RECOVERY	9,116
H2RC (HIV/HCV RESOURCE CENTER)	507
VERMONT CARES	1,742
AIDS PROJECT OF SOUTHERN VERMONT	183

Vermont Department of Health



### Members Visiting Syringe Services Programs Over Time

Region	Jan-Mar 2013	Apr-Jun 2013	Jul-Sep 2013	Oct-Dec 2013	Jan-Mar 2014	Apr-Jun 2014	Jul-Sep 2014	Oct-Dec 2014	Jan-Mar 2015	Apr-Jun 2015	Jul-Sep 2015	Oct-Dec 2015	Jan-Mar 2016	Apr-Jun 2016	Jul-Sep 2016	Oct-Dec 2016	Jan-Mar 2017	Apr-Jun 2017
Burlington	593	668	702	698	712	838	799	802	815	898	854	779	844	843	868	821	722	675
White River Junction	40	51	47	44	54	57	66	49	55	65	69	56	74	60	58	52	71	62
Springfield																	4	26
St. Johnsbury	43	47	52	50	42	48	59	44	55	55	52	58	64	71	79	94	52	47
Rutland	N/A*	9	39	52	55	62	68	42	84	127	130	154	136	135	170	154	152	131
Barre																	25	33
Brattleboro																30	42	34
<b>Total</b>	<b>676</b>	<b>775</b>	<b>840</b>	<b>844</b>	<b>863</b>	<b>1,005</b>	<b>992</b>	<b>937</b>	<b>1,009</b>	<b>1,145</b>	<b>1,105</b>	<b>1,047</b>	<b>1,118</b>	<b>1,109</b>	<b>1,175</b>	<b>1,151</b>	<b>1,068</b>	<b>1,008</b>

\*Start Dates of New Sites: Rutland 4/2013, Brattleboro 10/16, Barre 1/17, Springfield 3/17

Vermont Department of Health

Source: VDH HIV/AIDS Program

## 6. CHILD CUSTODY, TRAUMA, ADVERSE CHILDHOOD EXPERIENCES (ACEs), AND OPIOIDS (data from DCF)

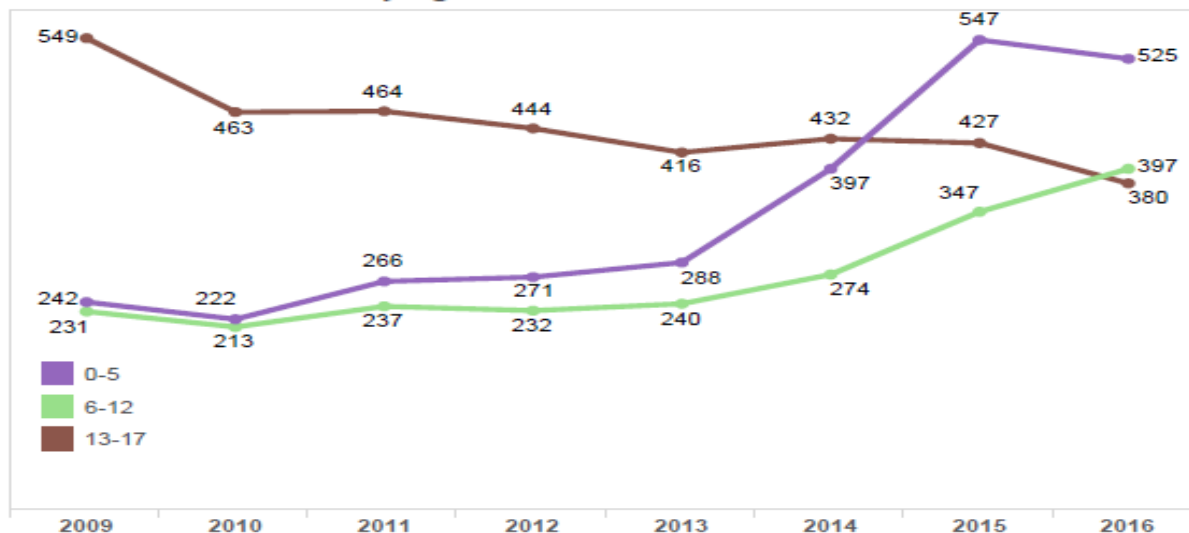
Since 2013, Family Services Division (FSD) of the Department for Children and Families (DCF) has experienced a 38% increase of children in DCF custody.

Children in DCF Custody	
Year	# of Children
2013	944
2014	1,103
2015	1,321
2016	1,302

Of the 266 children ages 0 – 5 in Vermont custody in 2016, 53% were there due to opioid abuse issues.

Child's Age	Nov. 2016: # of children	% of 0-5 children in custody
0	46	55%
1	44	44%
2	45	54%
3	53	56%
4	46	62%
5	32	50%
Total	266	53%

# of children in care by age at FFY end



## 7. HOMELESSNESS AND SUBSTANCE USE

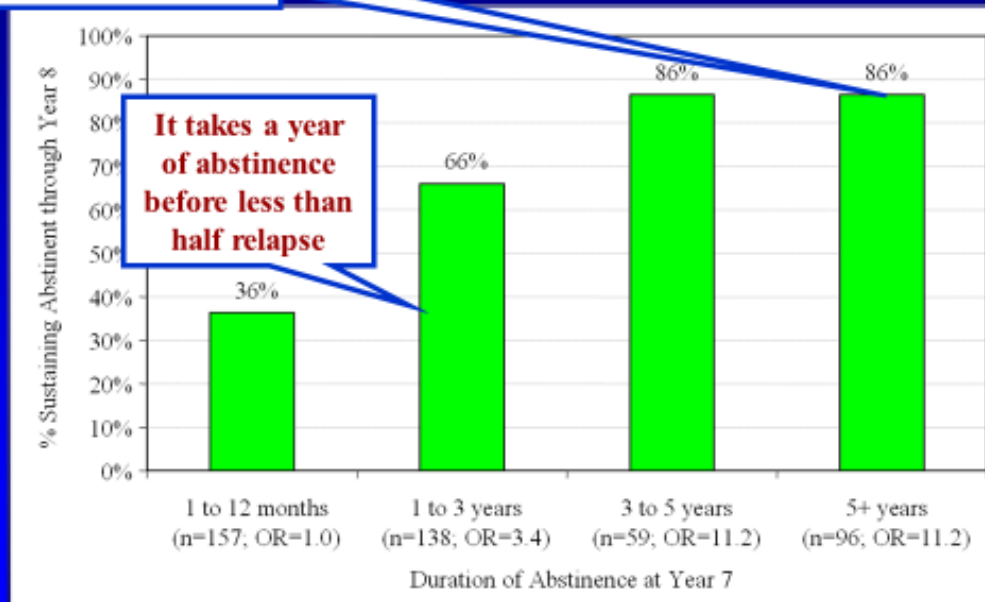
(from Family Services Division of the Vermont Department for Children and Families)

- ▶ 19% of persons who are homeless self-report chronic substance abuse (2017 PIT Count). (annual “Point in Time” assessment of homelessness in Vermont)
- ▶ In SFY 16, 12% (721) of all persons served by shelters, homelessness prevention and rapid re-housing programs self-reported chronic substance abuse as a disabling condition.
- ▶ Emergency Shelters estimate that between 30-40% of adults (approximately 3,000 annually) in shelter are in treatment and/or recovery with at least half of those for opioids.

## 8. SUSTAINING RECOVERY BEYOND ONE YEAR

### *Extended Abstinence is Predictive of Sustained Recovery*

After 5 years – if you are sober,  
you probably will stay that way.



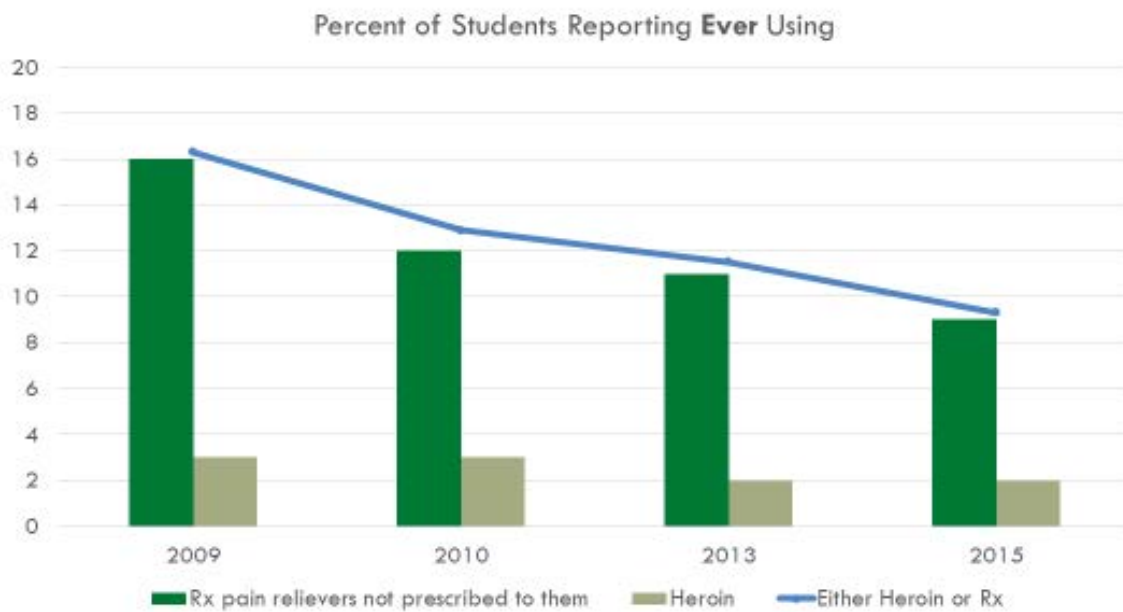
Dennis et al. Eval Rev. 2007

National Institutes of Health/National Institute on Drug Abuse (NIDA) presentation, “Bringing the Full Power of Science to Bear on Drug Abuse and Addiction.” Based on Dennis, et. al., Eval. Rev. 2007.

**Extended abstinence is predictive of sustained recovery.** The odds of remaining abstinent rise if patients have been abstinent for 1 to 3 years. After 3 years, the recovery odds remain high and stable. Therefore, as with other chronic diseases, addiction requires an ongoing and active disease management strategy.

## 9. A MESSAGE OF HOPE: HIGH SCHOOL STUDENTS REPORTING USE OF OPIOIDS

### Fewer High School Students Report Ever Using Heroin or Misusing Prescription Relievers



Vermont Department of Health

Source: Youth Risk Behavior Survey

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## APPENDIX III: GLOSSARY

**Addiction (SAMHSA):** The overpowering physical or emotional urge to continue alcohol or other drug (AOD) use in spite of adverse consequences. In the context of AOD, addiction is a cluster of chronic disorders that spring from multiple, interacting etiological influences and that vary considerably in their onset, course, and outcome.

**Co-occurring disorders (SAMHSA):** The co-existence of a substance use disorder and a mental health disorder at the same time (for example, alcohol dependence and depression). The combination of disorders can include any two or more of those identified in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). This condition is sometimes referred to as comorbidity.

**Demand Reduction:** Reducing the demand for opioids that drives substance use disorders through prescribing practices and education, intervention, treatment and recovery support for those with SUD, and through community- and school-based programs.

**Evidence-based practice (SAMHSA):** A practice that is based on rigorous research that has demonstrated effectiveness in achieving the outcomes that it is designed to achieve.

**Harm Reduction:** Managing chronic illnesses to restore function and quality of life, and reducing negative impacts on those with chronic illness, and on families and communities. In substance use disorders, this may include drug and needle disposal, syringe exchange, drug diversion programs, and overdose intervention.

**Intervention (SAMHSA):** A strategy or approach intended to prevent an undesirable outcome (preventive intervention), promote a desirable outcome (promotion intervention) or alter the course of an existing condition (treatment intervention).

**Integrative Health Care Professions** (see “Non-pharmacological approaches”) For purposes of this report, integrative health care refers to complementary and alternative (non-pharmacological) professions and approaches to pain management, and addiction treatment and recovery. “Integrative Services” or “Integrative Health Care” may also refer to the integration of conventional medical and support services in the treatment of addiction and other medical conditions. These terms are not used in this way in this report.

**Medication Assisted Treatment (MAT) (SAMHSA)-** Treatment for addiction that includes the use of medication along with counseling and other support.

**Non-pharmacological approaches** (see also “Integrative Health Care Professions”) For purposes of this report, the terms “integrative health care” and “non-pharmacologic approaches” or solutions refer to an array of health care and wellness professions, methods and practices that do not involve prescription and non-prescription medications. They may be used in conjunction with medications, or independently of medications, to reduce exposure to addictive substances in pain treatment; and to support treatment and recovery. Examples include acupuncture, cognitive behavioral therapy, massage therapy, meditation, yoga, various trauma treatment methods, naturopathy, chiropractic, and other professions. For additional information, see [National Institutes of Health/National Center for Complementary and Integrative Health](#).

**Peer Recovery Coaching (SAMHSA)** (see also “Recovery Coach”): A set of nonclinical activities, based on shared lived experience, that engage, educate, and support an individual to successfully recover from mental



and/or substance use disorders. Peer Recovery Coaches act as a recovery and empowerment catalyst, guiding the recovery process and supporting the individual's recovery choices, goals, and decisions.

**Peer Support** (SAMHSA)- The process of giving and receiving non-clinical assistance to achieve long-term recovery from severe psychiatric, traumatic or addiction challenges. This support is provided by peer supporters - people who have “lived experience” and have been trained to assist others in initiating and maintaining long-term recovery and enhancing the quality of life for individuals and their families. Peer support services are inherently designed, developed, delivered, evaluated and supervised by peers in long-term recovery. (Definition adapted from White, W. (2009). Peer-Based Addiction Recovery Support: History, Theory, Practice and Scientific Evaluation.)

**Prevention strategies** (SAMHSA - Source: [National Academies of Science](#))

Strategies that seek to prevent the onset of various physical and behavioral health disorders. The Institute of Medicine has defined three types of preventions strategies -- universal prevention strategies, selective prevention strategies, and indicated prevention strategies -- defined as follows:

- Universal prevention strategies address the entire population (such as national, local community, school, or neighborhood), with messages and programs to prevent or delay the development of behavioral health disorders.
- Indicated prevention strategies focus on preventing the onset or development of problems in individuals who may be showing early signs but are not yet meeting diagnostic levels of a particular disorder.
- Selective prevention strategies focus on specific groups viewed as being at higher risk for mental health disorders or substance use disorders because of highly correlated risk factors (for example, the children of parents with substance use problems).

**Recovery** (SAMHSA): A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Through the Recovery Support Strategic Initiative, SAMHSA has delineated four major dimensions that support a life in recovery: Health, Home, Purpose, and Community.

**Recovery Coach** ([CT Community for Addiction Recovery Coach Academy](#)) (see also “Peer Recovery Coaching”): Someone interested in promoting recovery by assisting recoverees to identify and overcome barriers to recovery, develop recovery capital and serve as a recovery guide and companion for those seeking or sustaining recovery.

**Recovery Housing (or Residences)** ([National Association of Recovery Residences](#)) A broad term describing a sober, safe, and healthy living environment that promotes recovery from alcohol and other drug use and associated problems. Many thousands exist in the United States that vary in size, organization, and target population. (The exact number of recovery residences is unknown since many RRs are not regulated by government or independent organizations.) At a minimum, RRs offer peer-to-peer recovery support with some providing professionally delivered clinical services all aimed at promoting abstinence based, long-term recovery.

**Relapse** (SAMHSA - Source: [NCI Dictionary of Cancer Terms](#)): The return of a disease or the signs and symptoms of a disease after a period of improvement. Relapse also refers to returning to the use of an addictive substance or behavior, such as cigarette smoking.

**Risk factor** (SAMHSA): Any factor, internal or external to an individual, which may contribute to negative health conditions and behavioral health outcomes for an individual or a population of individuals.



**Screening, Brief Intervention and Referral to Treatment (SBIRT)** (SAMHSA): A comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.

**Substance abuse** (Source: [SAMHSA](#)) The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), no longer uses the terms substance abuse and substance dependence, rather it refers to substance use disorders (see **substance use disorder** below).

**Substance use prevention** (SAMHSA): Substance use prevention refers to activities, practices, and strategies that promote healthy behavior, either by increasing protective factors or by limiting risk factors.

**Substance use treatment** (SAMHSA): Substance use treatment refers to the provision of assistance to individuals with existing substance use disorders.

**Substance misuse** (SAMHSA): The use of a legal substance, such as prescription or over-the-counter drugs, in a way that is either not legal or not intended, and for which the consequences can be hazardous to health and safety.

**Substance use** (Source: [SAMHSA](#)): The consumption of legal or illegal, or both, psychoactive substances.

**Substance use disorder** (Source: [SAMHSA](#)): Occurs when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.

**Wellness** (Source: [SAMHSA](#)): Concerns maintaining an overall quality of life and the pursuit of optimal emotional, mental, and physical health.