VILLAGE OF ESSEX JUNCTION TRUSTEES
TOWN OF ESSEX SELECTBOARD
MEETING AGENDA

Online
Essex Junction, VT 05452
Tuesday, June 9, 2020
7:15 PM

E-mail: manager@essex.org | *www.essexjunction.org* | *www.essexvt.org* | *Phone: (802) 878-1341* | *(802) 878-6951*

Due to the Covid-19 pandemic, ***this meeting will be held remotely****. Available options to watch or join the meeting:*

- The meeting will be live-streamed on Town Meeting TV.
- Join Microsoft Teams Meeting. Depending on your browser, you may need to call in for audio (below).
- Join via conference call (*audio only*): (802) 377-3784 | Conference ID: 357 235 525#
- For the purpose of recording minutes, you will be asked to provide your first and last name.
- When listening to the meeting, please keep your phone or computer on "mute" as to prevent interruptions during the meeting. For agenda items when it is appropriate for the public to speak, please unmute your phone or computer and introduce yourself before requesting the floor from the Chair/President.

The Selectboard and Trustees meet together to discuss and act on joint business. Each board votes separately on action items.

1. **CALL TO ORDER** [7:15 PM]
2. **AGENDA ADDITIONS/CHANGES**
3. **APPROVE AGENDA**
4. **PUBLIC TO BE HEARD**
   a. Comments from Public on Items Not on Agenda
5. **BUSINESS ITEMS**
   a. Presentation on Chittenden Solid Waste District FY21 Budget—Executive Director, Sarah Reeves
   b. *Interviews for Essex Housing Commission
   c. Adopt resolution recommending use of face masks
   d. Discussion and potential action on future meeting schedule
6. **CONSENT ITEMS**
   a. Award Mansfield Ave/Brickyard Gravel Wetland construction bid
   b. Adopt Drug and Alcohol Testing Policy for Commercial Motor Vehicle Operators and Parks and Recreation Senior Van Drivers
   c. Adopt resolution supporting fair and direct federal emergency aid to reopen and rebuild local American economies
7. **READING FILE**
   a. Board Member Comments
   b. Release of VT Opioid Use Harm Reduction Evaluation - Informational
   c. Memo from Greg Duggan re: Open Meeting Law and whether to hold in-person meetings
   d. Green Up Day 2020 summary and Green Up Day 2020 flyer
   e. Upcoming meeting schedule
8. **EXECUTIVE SESSION**
   a. *An executive session may be necessary for appointment of public officials
9. **ADJOURN**

Members of the public are encouraged to speak during the Public to Be Heard agenda item, during a Public Hearing, or, when recognized by the Chair or President, during consideration of a specific agenda item. The public will not be permitted to participate when a motion is being discussed except when specifically requested by the Chair or President. This agenda is available in alternative formats upon request. Meetings, like all programs and activities of the Village of Essex Junction and the Town of Essex, are accessible to people with disabilities. For information on accessibility or this agenda, call the Unified Manager's office at 878-1341 TTY: 7-1-1 or (800) 253-0191.

Certification: 06/05/2020 

Chittenden Solid Waste District

ADMINISTRATIVE OFFICE
1021 Redmond Road
Williston, VT 05495

EMAIL info@cswd.net
TEL (802) 872-8100

www.cswd.net

June 1, 2020

Tammy Getchell
Town of Essex
Village of Essex Junction

Dear Tammy:

Attached please find a copy of the Chittenden Solid Waste District Proposed FY 21 Budget. **CSWD is scheduled to meet with the Town of Essex and the Village of Essex Junction at the joint meeting to be held on Tuesday, June 9, 2020 at 8:00 p.m. or later.** Please forward the attached copies to your select board/trustees for their review.

The Board of Commissioners approved sending the Proposed FY 21 Budget to Member towns for their approval on Wednesday, May 27, 2020. Below is Section 4. (b) of the Chittenden Solid Waste District Charter.

Within 45 days of the approval of the budget by the Board of Commissioners, the legislative body of each member municipality shall act to approve or disapprove the budget.

The budget shall be approved if approved by the legislative bodies of a majority of the member municipalities. (For such purposes, each member municipality shall be entitled to one vote.) A legislative body that disapproves the budget must file with the Board of Commissioners a written statement of objections to the budget identifying those specific items to be changed, and failure to file such statement of objections within the forty-five (45) day period shall constitute approval by such municipality. A legislative body that fails to act to approve or disapprove the budget within the forty-five (45) day period shall likewise be deemed to have approved the budget.

As stated above, each member municipality may choose to approve or disapprove the budget prior to July 11, 2020. Please feel free to contact me should you have any questions. Thank you.

Sincerely,

Amy Jewell
Director, Administration

Cc: Alan Nye – Town & Village Rep. , Max Levy – Town Alt., George Tyler -Village Alt.

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Why We Exist and How We're Funded

Why CSWD Exists

Municipalities in the State of Vermont are responsible for the management and regulation of the storage, collection, processing, and disposal of solid wastes within their jurisdiction. The Chittenden Solid Waste District is a municipality created by its member cities and towns in 1987 to fulfill this responsibility and to plan and implement solid waste management mandates legislated by the State of Vermont on their behalf.

These mandates include the requirement that municipalities execute a Solid Waste Implementation Plan (SWIP) every five years with the primary goal of reducing the amount and toxicity of their waste. The SWIP requires the following components to achieve this goal:

- Implement a variable rate pricing system that charges for the collection of municipal solid waste from residential customers for disposal based on the volume or weight of the waste collected.
- Maintain and provide hauling service information for community members.
- Provide ongoing on-site education and assistance to K-12 schools, businesses, institutions and the general public on waste prevention, waste reduction, landfill bans and diversion opportunities.
- Assist with waste reduction and waste diversion opportunities at public events.
- Maintain a website with information on haulers, food donation groups, state disposal bans, collection information, reuse, recycling and other diversion opportunities for various materials.
- Provide for the collection of hazardous waste from households and small businesses.
- Ensure year-'round collection opportunities for landfill-banned materials such as batteries, fluorescent lamps, used oil, tires, electronics, appliances, paint and propane tanks.
- Ensure year-'round collection opportunities for textiles, leaf and yard debris, clean wood, asphalt shingles, drywall.
- Collaborate with food recovery organizations to provide outreach and education to local businesses and institutions on food donation opportunities.
- Track and report disposal and landfill diversion information to the State.
- Develop a process and standards to determine whether proposed solid waste facilities should be included in the SWIP.

How is CSWD funded?

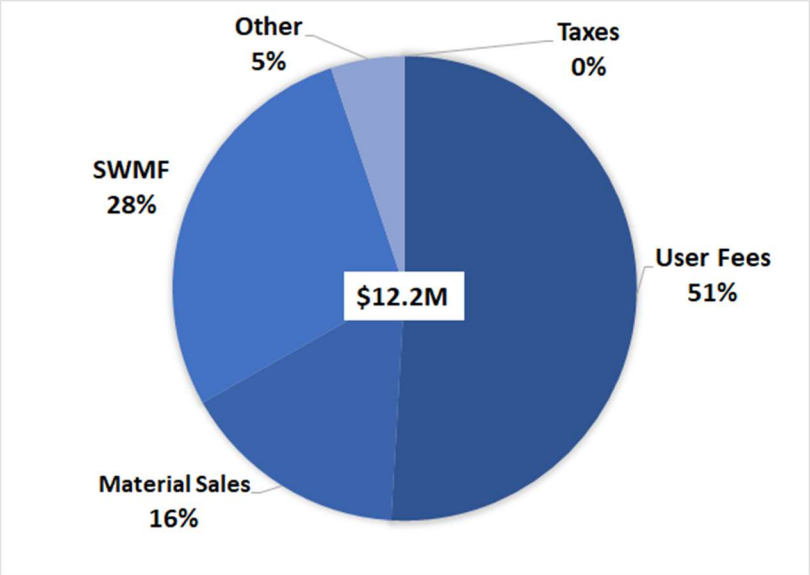
Our revenue comes from three primary sources:

User fees: 51%

Solid Waste Management Fee: 28%

Material Sales: 16%

- Blue-bin Recycling
- Compost products
- Local Color Paint
- Scrap metal and other Special Recycling
- Compost and recycling bins



State grant for hazardous waste management and **reimbursement for Product Stewardship** programs: 5%

We do not receive tax funding from the State or member municipalities. We do not charge any "per capita" or other fees to member municipalities.

CSWD charges two types of fees to cover expenses that exceed revenue from materials sales:

1. **User fees** cover the costs of providing the service or product.
   - *Tip Fees* are paid by hauling companies that bring large loads of recyclables to the Materials Recovery Facility (MRF) and food scraps to the CSWD compost facility.
   - *User Fees* are paid by Drop-Off Center and Environmental Depot customers.

2. **Solid Waste Management Fee:** $27/ton of trash disposed
   This is a tax paid by haulers on trash they've collected that's going to the landfill. It is intended to cover routine CSWD expenses as well as costs associated with mandates set by the State of Vermont Agency of Natural Resources, and/or priorities established by the CSWD Board of Commissioners that are not covered directly by user fees. These mandates and priorities include hazardous waste handling, the landfill post-closure reserve, future projects planning, special project research, and public education and communications.

The following graphic represents how Chittenden County is performing in terms of materials management: How much material we create that needs to be managed, and how much we are keeping out of as well as sending to the landfill.

HOW WE'RE DOING

These charts represent the materials that individuals and businesses in Chittenden County generated in calendar year 2018, and how they chose to manage those materials.

The color key represents the options available to Vermonters for managing those materials. Full details are available in the CSWD Diversion Report.

This chart represents ALL materials generated.

It shows the composition of the 61% that was kept out of the landfill by the methods shown in the key, and the 39% that was sent to a landfill.

"BLUE-BIN" RECYCLING

Paper, cardboard & clean containers

ORGANICS DIVERSION

Food scraps & yard debris

SPECIAL RECYCLING

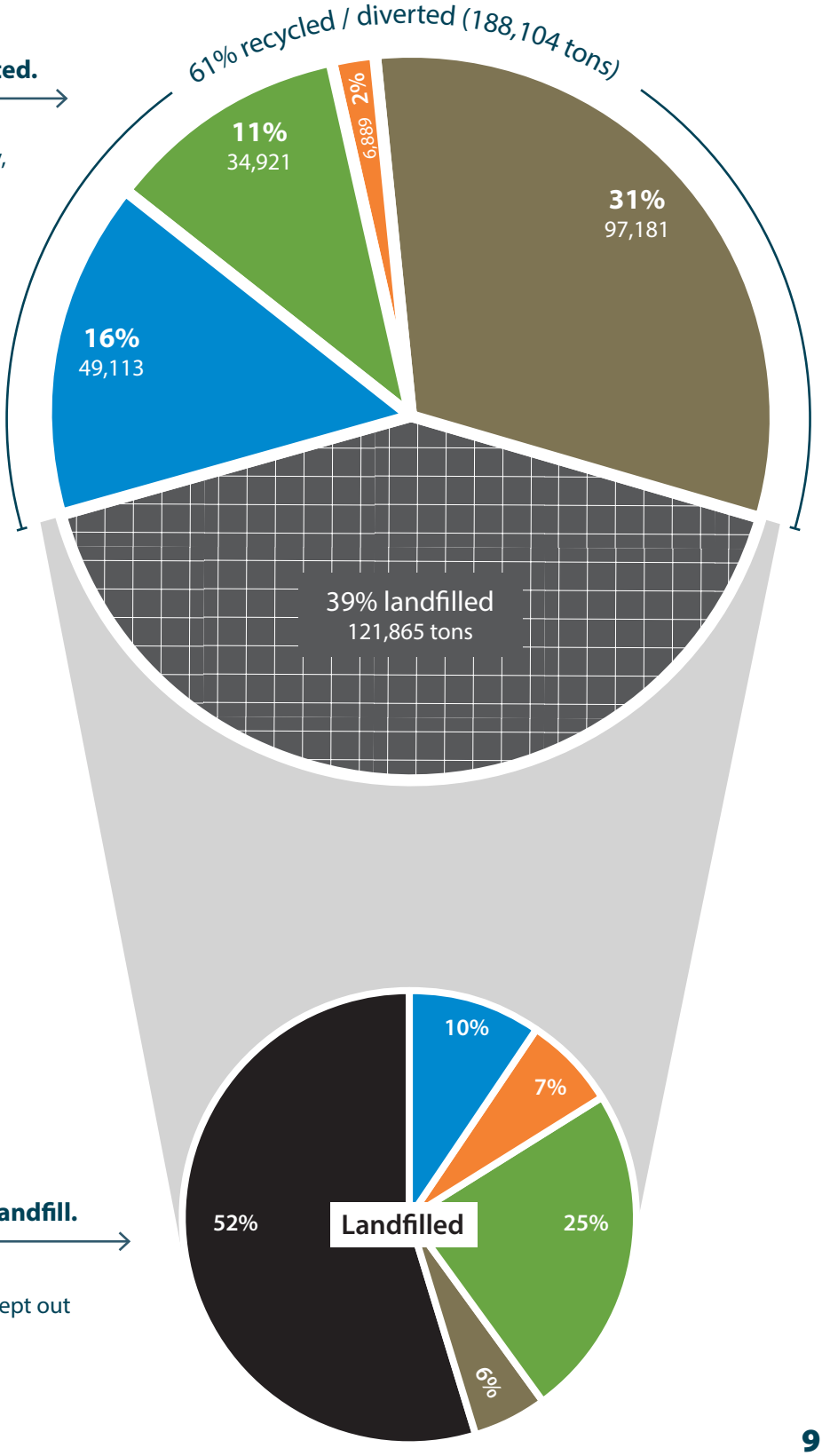
E-waste, textiles, scrap metal, etc.

C&D DIVERSION

Construction & demolition debris

TRASH

Items that can't be recycled or recovered using current programs & facilities



This chart represents materials sent to the landfill.

It shows missed opportunities--the portions that businesses, institutions, and residents could have kept out of the landfill via existing programs and facilities.

Chittenden Solid Waste District

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To: Board of Commissioners
From: Sarah Reeves, Executive Director
Date: May 22, 2020
RE: FY 2021 Budget Proposal

The FY 2021 budget as being proposed to the Board of Commissioners is somewhat different from what the Manager team and I thought it would be back in February. The budget as proposed must be viewed through the lens of a strong caveat. All budgets are a snapshot in time based on a best guess of the next twelve months. The caveat for FY 2021 is this: ***This is our best understanding of where the numbers are right now.*** **FY 2021 will require constant monitoring of, and potential adjustments to, the budget** as we learn more over the coming months.

No one can predict how, or how quickly, the economy will recover from the effects of the all-sector closures and shut-downs related to COVID-19 containment. Solid waste generation is highly responsive to economic conditions, as we've seen over the past five years of low unemployment/high waste generation in Chittenden County. Our assumptions in this budget are conservative and anticipate reduction in waste generation in every sector: residential, commercial, industrial, and institutional. Solid waste will continue to be generated, with each sector recovering at a different rate.

SOURCES OF REVENUE

CSWD's revenue has three main components: Solid Waste Management Fees (SWMF), User Fees (tip fees), and Material Sales. Each component comprises roughly 30% of the overall revenue. The remaining revenue comes from rental income, license fees, bin sales, grants, and Extended Producer Responsibility reimbursements. **CSWD receives no payments (assessments, per capita fees, tax payments, etc.) from our member communities**.

- Solid Waste Management Fees: $27/ton charged on each ton destined for disposal. Four material types make up the tons subject to the SWMF-municipal solid waste, construction & demolition debris (C&D), construction & demolition debris fines, and material eligible to be used as alternate daily landfill cover (ADC). C&D fines and ADC are charged 25% of the SWMF, or $6.75/ton.
- Tipping/User Fees: Fees charged for material disposal at Drop-Off Centers, the Materials Recovery Facility, the Organics Diversion Facility, and the Environmental Depot.
- Material Sales: Revenue generated from the sale of products we make—compost products, Local Color paint, baled recyclables—or products we purchase on behalf of the public and then resell, like compost bins.

The assumptions presented to the Finance Committee in February and early March have been adjusted in light of COVID-19 effects, and revenue and expense projections have been reduced accordingly.

REVENUE SNAPSHOT

	FY18 Actual	FY19 Actual (Unaudited)	FY20 Budget	CY19 Actual	FY21 Budget	Change from FY20 Budget	Change from FY19 Actual
Revenue (in thousands)							
Tip Fees	$4,950	$6,243	$7,034	$6,873	$7,706	+10.8%	+12.13%
Material Sales	$2,782	$1,946	$1,584	$1,777	$1,420	-8.4%	-20.11%
SWMF	$3,363	$3,421	$3,496	$3,495	$2,575	-26.92%	-26.34%
All Other	$464	$565	$514	$551	$531	+3.3%	-3.7%
TOTAL	$11,559	$12,175	$12,628	$12,696	**$12,232**	-3.26%	-3.66%
Cost of Goods Sold	$207	$135	$99	$131	$143	+31.8%	+8.4%
Gross Profit	$11,353	$12,040	$12,530	$12,565	**$12,089**	-3.6%	-3.8%

Assumptions in calculating the SWMF:

The SWMF is the source of revenue most impacted by a recession and where we have spent the most time refining projecting.

Starting with April 2020 Chittenden County tonnage reports, which we consider to be the county generation nadir, staff developed the FY 2021 estimates using additional information gleaned from (among other sources) statewide economic impact projections, Chittenden County specific economic impact estimates, estimates from the restaurant industry, CSWD commercial database information, and anecdotal information gathered from haulers and large commercial generators. The majority of the MSW reductions are commercial tons and include events that attract hundreds or thousands of people (we've assumed zero events through September). UVM, Champlain College, and St. Michael's College have announced they intend to reopen to students in the fall, however we've moderated the waste generation assumptions in the event this does not happen. The medical center is assumed to be resuming "normal" activity by August. Major construction projects, like Finney Crossing, resumed activity in May however we are assuming projects that were slated to begin in April or May will not. We've assumed that 40% of Chittenden County restaurants will not reopen to full capacity, with 10-15% not reopening at all.

We are assuming residential waste generation will slow, as it is expected that not all job losses are temporary. Basic level trash and recycling generation will continue, and we've held that generation rate steady to slightly depressed. Special waste and bulky waste generation is expected to slow considerably as people constrict spending on durable goods.

Tip Fees, User Fees, and Material Sales Assumptions:

Tip fees are up primarily due to the MRF tip fee increase to cover the cost of processing recyclables.

- MRF tip fees were raised in March 2020 to $80/ton and we are not proposing raising the tip fee in FY 2021. The average commodity revenue value for April and May 2020 is $50/ton, up from $30/ton average over the 2nd and 3rd quarters. Cardboard and mixed paper pricing increased due to increased demand and processing capacity at domestic paper mills. This increased demand is expected to continue through the 1st quarter of FY 2021.

- Organics Diversion Facility (ODF) tip fees are being held at $60/ton. We've reduced anticipated food scraps tons inbound to 5,300 tons, just above FY 2018 levels. This is a reduction of nearly 20% of pre-COVID tonnage expectations. As of the writing of this memo, the July 1, 2020 food scrap landfill disposal ban had not been delayed or removed from law. We are anticipating seeing increased tons of food scraps brought to the Drop-Off Centers (DOCs) and a significant reduction in food scraps from the commercial and education sectors. The DOC increases will not completely compensate for the losses from the commercial sector, however the reduced inbound allows for savings in excess material movement to out of state processors. We will be able to easily manage the reduced tonnage onsite.

  ODF product sales through May 2020 were astonishing, with Garden Mix selling 661% (not a typo) above FY 2019. Sales for FY 2020 will be more than 50% over budget. We are projecting a significant increase in sales budget-over-budget, based on current year demand in a suppressed economy. The increase to the Cost of Goods Sold is because for the first time in 10 years we need to purchase sand (part of our Garden Mix recipe), and we are also planning to purchase additional woodchips to ensure adequate odor control and material porosity.

- DOC user fees are being held when viewed as an average. Meaning, the flat-fee rates that were implemented due to COVID-19 may be kept in place for a short time into FY 2021. FY 2021 anticipates an increase in mattress fees due to a proposed increase for mattress disposal at the All-Cycle (Casella) transfer station. Several materials management contracts expire in FY 2021 and will be either rebid or will be taken in-house. The analysis is ongoing and is in part dependent on revenues through the 1st and 2nd quarters.

EXPENSES SNAPSHOT

	FY18 Actual	FY19 Actual (Unaudited)	FY20 Budget	CY19 Actual	FY21 Budget	Change from FY20 Budget	Change from FY19 Actual
Expenses (in thousands)							
Salary/Wages	$2,721	$2,767	$3,050	$2,652	$2,872	-6.45%	+8.30%
Benefits	$1,054	$1,153	$1,230	$1,070	$1,228	-.2%	+14.72%
Travel/Training	$48	$54	$124	$63	$61	-117.77%	-3.29%
Administrative	$101	$95	$129	$83	$142	+13.05%	+69.85%
Professional Services	$222	$189	$302	$211	$180	-64.62%	-14.89%
Equip/Fleet	$544	$460	$569	$435	$556	-2.75%	+27.8%
Gen. Supplies	$121	$85	$109	$79	$84	-29.98%	+6.26%
Mat'l Management	$4,499	$5,125	$5,261	$5,624	$6,128	+16.91%	+8.96%
Property Management	$418	$403	$504	$192	$498	-1.71%	+26.82%
Promotion & Education	$164	$169	$169	$127	$88	-48.19%	-31.26%
Maintenance				$104			
TOTAL*	$9,895	$10,501	$11,450	$10,844	**$11,837**	+3.68%	+9.16%

**Expenses shown are before capital contributions and contributions to overhead.*

Key Points:

- Compared to FY20 budgeted, most FY21 expenses have decreased with budget cuts as described below. One area where costs are expected to increase dramatically is materials management. Materials management is how we refer to hauling services we use to move materials we produce (compost, recyclables) to market, and move materials we collect (MSW from Drop-Off Centers, HHW we process, trash we generate, etc) to disposal. The largest single increase in materials management ($300k+) is the cost to transport glass and/or processed glass aggregate from the MRF to market.
- Salaries and wages increased modestly and the cost of benefits increased as expected. We switched the District's health insurance provider mid-year from Blue Cross/Blue Shield to MVP precisely because BCBS's proposed rate hike was extremely high.
- Administrative costs are higher because website licensing, maintenance, and development expenses were moved to the IT Systems budget from Outreach & Communications.

CUTS SNAPSHOT

The following programs implemented the following cuts to reduce expenses in FY 2021:

Program	Program Estimates (Jan/Feb)	Cuts	Percent Reduction	Significant Items (not all-inclusive)
Wages & Benefits	$4,414,716	$333,319	7.6%	Two vacancies not filled; One new position not filled; O&C seasonal staff cut; ½ year Depot seasonal staff cut
Outreach & Communication	$1,050,523	$168,622	15.2%	Advertising cut 50%; bin subsidy eliminated; grants reduced
Operations**	$6,143,134	$208,701	3.4%	Reduced transportation costs
Admin, Finance, Property Mgmt	$444,262	$47,100	10.6%	Travel & Training reduced by 75%; Achievement Award cut by 1/3; meetings meal budget cut 40%
Compliance	$24,030	$10,150	42.2%	Mileage cut by 50%; database development postponed
TOTAL	**$12,076,665**	**$767,892**	**6.4%**	

**Operations includes MRF, compost, DOCs, Depot, and Maintenance. The Biosolids program is a pass-through whose components are agreed upon by the participating member towns and is not included in this calculation.

Key Points:

- In addition to the above, cuts were made to travel and training budgets across all programs, legal services in individual programs were reduced or eliminated, we reduced signage for facilities, subscriptions and dues were curtailed or eliminated, transportation charges were cut, waste reduction grants reduced by 60%, advertising cut by 50%. Subsidies for bins and buckets were eliminated, Green Up Vermont contribution was cut by 50%, consultant fees and projects have been cut across the board, hauler container grants were eliminated, and printing costs were reduced by 1/3. Capital program cuts and project/purchase deferments are addressed in the capital budget memo.

- These cuts to services, operations, and wages and benefits are in line with cuts being proposed in some of CSWD's member cities and towns. CSWD does not rely on one source of revenue. The diversification of revenue sources allows the District to weather storms and continue to provide essential services. If this budget proves too rosy, rather than management's current view of the budget as conservative, there are additional measure that can be taken to reduce operational expenses. The plan for managing a catastrophic reduction in all sources of revenue is underway, however **the FY 2021 budget proposal is realistic, and conservative given what is known on the date of delivery to the Board of Commissioners**.

BOTTOM LINE

Each year, we need to "get to zero". Municipal budgets should net zero, and budgets being what they are, some years municipalities are over and some years they're under. For CSWD, this means any income in excess of revenue must be transferred to specific reserves or funds. Excess solid waste management fees are transferred to the SWMF rate stabilization fund, excess MRF income is transferred to the MRF capital reserve, etc. For the past three fiscal years CSWD has been transferring excess SWMF to the rate stabilization fund. The rate stabilization fund was created to maintain balance in the solid waste management fee across multiple fiscal years, to minimize the need for annual adjustments up or down to accommodate changeable economic conditions. Because we are anticipating a small shortfall in the FY 2021 budget due to the lowered expectations for SWMF revenue, and because management feels strongly that we should not add to the public's financial difficulties during this stressful time, I am proposing in this budget that we make up the shortfall out of the SWMF rate stabilization fund. The anticipated shortfall is $80,500 or .7% of the overall budget.

Also notable in the calculation of the bottom line is a contribution to overhead from the programs that do not use solid waste management fee monies—the MRF, the Biosolids program, and the Closed Landfill program. The MRF contributed 10% of its program budget to overhead, and Biosolids and Closed Landfill contributed 1% each. These percentages were arrived at by evaluating the general support needs of the programs from Administration and Outreach & Communications. The MRF is the only program this year contributing to capital.

Annual anticipated expenses for managing the closed landfill are reimbursed out of the landfill post-closure reserve (LFPC).

Revenue	$12,232,485	
Cost of Goods Sold	$143,310	
Gross Profit		**$12,089,175**
Expenses		*$11,836,939*
Income from Operations		**$252,236**
Capital Contribution	$416,296	
Contribution to Overhead	$371,800	
Income After Capital & Allocations		**($535,860)**
Overhead Offset	$371,800	
Transfer from LFPC Reserve	$83,561	
Transfer from SWMF Rate Stabilization Fund	$80,499	
Net		**$0**

CHITTENDEN SOLID WASTE DISTRICT
FY 21 DISTRICT SUMMARY BUDGET

	FY 18 ACTUAL	FY 19 ACTUAL (Unaudited)	FY 20 BUDGET	CY 19 ACTUAL	FY 21 BUDGET	CHANGE FROM FY 20 BUDGET $	CHANGE FROM FY 20 BUDGET %	CHANGE FROM CY 19 ACTUAL $	CHANGE FROM CY 19 ACTUAL %
Revenue									
Tipping Fees	$ 4,949,759	$ 6,242,860	$ 7,034,429	$ 6,872,768	$ 7,706,159	$ 671,730	10.76%	$ 833,391	12.13%
Material Sales	$ 2,782,243	$ 1,946,123	$ 1,583,836	$ 1,777,383	$ 1,419,960	$ (163,876)	-8.42%	$ (357,423)	-20.11%
Solid Waste Management Fees	$ 3,363,221	$ 3,421,566	$ 3,496,110	$ 3,495,803	$ 2,575,125	$ (920,985)	-26.92%	$ (920,678)	-26.34%
License, Fines, Fees	$ 15,991	$ 14,854	$ 14,430	$ 2,643	$ 21,055	$ 6,625	44.60%	$ 18,412	696.63%
Rent	$ 96,920	$ 96,820	$ 56,910	$ 92,006	$ 88,200	$ 31,290	32.32%	$ (3,806)	-4.14%
Other	$ 9,623	$ 15,061	$ 52,000	$ 62,796		$ (52,000)	-345.27%	$ (62,796)	-100.00%
Product Stewardship	$ 249,005	$ 260,670	$ 267,180	$ 288,109	$ 285,516	$ 18,336	7.03%	$ (2,593)	-0.90%
Interest and Divedends	$ 7,030	$ 71,335	$ 17,500	$ 51,848	$ 30,000	$ 12,500	17.52%	$ (21,848)	-42.14%
Grants	$ 85,271	$ 106,471	$ 106,470	$ 53,236	$ 106,470	$ -	0.00%	$ 53,234	100.00%
Revenue Total	**$ 11,559,064**	**$ 12,175,759**	**$ 12,628,865**	**$ 12,696,591**	**$ 12,232,485**	**$ (396,380)**	**-3.26%**	**$ (464,106)**	**-3.66%**
Cost of Goods Sold									
Cost of Goods Sold	$ 206,511	$ 135,179	$ 98,894	$ 130,889	$ 143,310	$ 44,416	32.86%	$ 12,421	9.49%
2 - Cost of Goods Sold Total	**$ 206,511**	**$ 135,179**	**$ 98,894**	**$ 130,889**	**$ 143,310**	**$ 44,416**	**32.86%**	**$ 12,421**	**9.49%**
GROSS PROFIT	**$ 11,352,552**	**$ 12,040,580**	**$ 12,529,971**	**$ 12,565,702**	**$ 12,089,175**	**$ (440,796)**	**-3.66%**	**$ (476,527)**	**-3.79%**
Expense									
Salaries and Wages	$ 2,721,199	$ 2,767,020	$ 3,050,676	$ 2,652,093	$ 2,872,220	$ (178,456)	-6.45%	$ 220,127	8.30%
Benefits	$ 1,054,865	$ 1,153,073	$ 1,230,442	$ 1,070,523	$ 1,228,156	$ (2,286)	-0.20%	$ 157,634	14.72%
Travel and Training	$ 47,859	$ 53,491	$ 124,216	$ 63,301	$ 61,221	$ (62,995)	-117.77%	$ (2,080)	-3.29%
Administrative Costs	$ 101,275	$ 94,891	$ 129,144	$ 83,324	$ 141,524	$ 12,380	13.05%	$ 58,200	69.85%
Professional Services	$ 222,599	$ 189,217	$ 302,500	$ 211,764	$ 180,235	$ (122,265)	-64.62%	$ (31,529)	-14.89%
Equipment and Fleet	$ 544,233	$ 460,702	$ 568,991	$ 435,286	$ 556,317	$ (12,674)	-2.75%	$ 121,031	27.80%
General Materials and Supplies	$ 120,889	$ 85,282	$ 109,741	79,220.05	$ 84,177	$ (25,564)	-29.98%	$ 4,957	6.26%
Materials Management	$ 4,498,900	$ 5,125,621	$ 5,261,240	$ 5,624,060	$ 6,127,887	$ 866,647	16.91%	$ 503,827	8.96%
Property Management	$ 418,855	$ 403,023	$ 504,438	$ 392,322	$ 497,531	$ (6,907)	-1.71%	$ 105,209	26.82%
Promotion and Education	$ 164,143	$ 169,053	$ 169,132	127,539.48	$ 87,670	$ (81,462)	-48.19%	$ (39,869)	-31.26%
Maintenance Charges	$ 0		$ 0	104,541.58	$ 0	$ 0	#DIV/0!	$ (104,541)	-100.00%
Expense Total	**$ 9,894,818**	**$ 10,501,374**	**$ 11,450,520**	**$ 10,843,973**	**$ 11,836,939**	**$ 386,419**	**3.68%**	**$ 992,965**	**9.16%**
INCOME FROM OPERATIONS	**$ 1,457,735**	**$ 1,539,206**	**$ 1,079,451**	**$ 1,721,728**	**$ 252,236**	**$ (827,215)**	**-53.74%**	**$ (1,469,492)**	**-85.35%**
Capital and Allocations									

Capital Contributions (from Self Funding Programs only in FY 21)	$ 1,079,194	$ 814,574	$ 665,468		$ 416,296	$ (249,172)	-30.59%
Support Program Allocations	$ -	$ (0)			$ 371,800	$ 371,800	
						$ -	
Capital and Allocations Total	**$ 1,079,194**	**$ 814,574**	**$ 665,468**	**$ -**	**$ 788,096**	**$ (26,478)**	**-3.25%**
						$ -	
INCOME AFTER CAPITAL & ALLOC	**$ 378,541**	**$ 724,632**	**$ 413,983**	**$ 1,721,728**	**$ (535,860)**	**$ (1,260,492)**	**-173.95%**
Other Transfers							
SWMF Subsidy					**$ -**		
Contribution to Administrative Costs (Self-Funded Programs)					$ 371,800		
Transfer from Reserve	$ 378,540	$ 63,118	$ 82,264		$ 83,561		
Transfer from / (TO) SWMF RA Stabilization		$ (787,750)			$ 80,499		
NET DISTRICT	**$ 1**	**$ (0)**	**$ 331,719**	**$ 1,721,728**	**$ 0**		

Chittenden Solid Waste District

ADMINISTRATIVE OFFICE
1021 Redmond Road
Williston, VT 05495

EMAIL info@cswd.net
TEL (802) 872-8100

www.cswd.net

MEMORANDUM

TO: Board of Commissioners
FROM: Josh Tyler, Director of Operations
DATE: May 21, 2020
RE: FY 2021 Capital Budget Detail

CSWD total Capital Budget for FY 2021 is $1,479,350 and is reflective of fiscal reductions for anticipated economic impacts of the COVID-19 global pandemic. The capital budget total cost equals the fiscal year's anticipated expenses ($1,735,850) minus program contributions ($256,500) (Attachment 1). Currently, the only District program providing a contribution to offset capital program costs is the Materials Recovery Facility (MRF), as the tip fee is set so that the facility's capital needs are met on an annual basis. The capital improvement needs for the Organics Diversion Facility will be partially offset by the grant CSWD received from the Vermont Agency of Natural Resources (VTANR). All other capital projects are funded through previous program contributions or though solid waste management fees.

District staff has identified capital projects and purchases that need to go forward so as to not place any facility in risk of inadequate equipment, nor defer necessary facility maintenance, nor leave safety improvement projects unaddressed.

First Priority:

Project/Purchase	**Cost**
Compost facility site improvements, equipment	$1,041,500
DOC roll-off container replacement	$50,000
Essex DOC compactor replacement & site work	$42,000
Burlington DOC paving pothole	$7,500
South Burlington DOC paving pothole	$5,500
Admin Server	$35,000
Maint waste oil tank replacement	$12,000
Loader Refurbish	$35,000
MRF tip floor repair	$15,000
Environmental Depot roof replacement	$70,000
Contingency	$50,000
Total	**$1,363,500**

Staff recognizes that the COVID-19 global pandemic may require critical reassessment of capital expenses and understands that the following projects and equipment may not be feasible:

Second Priority:

Project/Purchase	Cost
MRF Loader Replacement	$235,000
MRF Steel Side Wall Refurbishment	$6,500
Maintenance Special Waste Trailer	$9,100
Maintenance Rack Truck Replacement	$55,000
Maintenance Overhead Door Replacement	$1,500
Maint Equipment Trailer	$10,250
Richmond DOC Pavement Project	$55,000
Total	**$372,350**

Please Note that the second priority projects/purchases have significant potential for increased maintenance costs of existing equipment and could require upwards of $100,000 if all items end up needing to be addressed in FY 2021. If we can't tackle second priority items in FY 2021, they will become first priorities in FY 2022.

The following capital items were deemed noncritical and moved out to upcoming fiscal years:

- FY 2022: $220,000 Closed Landfill PFAS Leachate Treatment System and will follow anticipated guidance from VTANR
- FY 2023: $50,000 Richmond DOC gate relocation and access road improvement
- FY 2023: $95,000 Rover Purchase

A three-year Capital Budget is included as Attachment 2 and reflects the above costs that have been moved out to other fiscal years.

CHITTENDEN SOLID WASTE DISTRICT
FY 21 SOLID WASTE MANAGEMENT FEE

SWMF Collected	$	2,575,125
SWMF Subsidy:		
Administrative Programs	$	1,824,529
Drop Off Centers	$	302,499
Environmental Depot	$	438,169
Organics Diversion Facility	$	27,643
Paint	$	15,784
Property Management		
Owed to LFPC Reserve	$	47,000
Total SWMF Subsidy and Pymt	$	2,655,624
Balance Needed from Reserves	$	(80,499)
FY 19 Reserve Balance (Unaudited)	$	2,937,699
Projected Balance	$	2,857,200

FY 21 CONTRIBUTIONS TO RESERVES FROM SELF FUNDED PROGRAMS

Materials Recycling Facility	$	359,663.00
Biosolids	$	34,500.00
Property Management	$	11,133.00
Total Transfer to Reserves	$	405,296.00

Memorandum

To: Village Trustees and Town Selectboard
From: Tammy Getchell, Assistant to the Manager
Re: Appointment of volunteers to the Joint Essex Housing Commission
Date: June 4, 2020

Issue
The issue is whether the Selectboard and Trustees will fill up to seven vacant seats on the Joint Essex Housing Commission.

Discussion
The Joint Essex Housing Commission Charter states, *"The Commission is composed of up to seven members jointly appointed by the Selectboard and Trustees. Each member shall serve a staggered three-year term with no term limit. In appointing Commission members, the Selectboard and Trustees should select members who represent a variety of relevant interests and backgrounds, including but not limited to: for-profit and non-profit housing developers; housing authorities and agencies; social services organizations; representatives of area businesses; and at-large members of the community. Four of the members shall be residents; for the remaining members, residency is preferred but not required."*

Eight Essex residents have stepped forward for consideration to join the Joint Essex Housing Commission. The volunteers are prepared to interview with the Trustees and the Selectboard and expect a notification of decision at a later date after all interviews have taken place. Interviews will take place over two meetings:

June 9	June 23
Mia Watson	Patrick Scheld
Will Towne	Don Miller
Mark Redmond	Joseph Engelken
Gabrielle Smith	Ned Daly

The appointment of public officials can be a protected discussion during the interview, provided that the Trustees and Selectboard make a final decision to appoint a public official in an open meeting and shall explain the reasons for its final decision during the open meeting.

Cost
None.

Recommendation
It is recommended that the Selectboard and Trustees interview Mia Watson, Will Towne, Mark Redmond, and Gabrielle Smith on June 9th for the Joint Essex Housing Commission. If the board members wish to enter executive session, the following motion is recommended:

"I move that the *Trustees/Selectboard* enter into executive session to discuss the proposed public official appointment(s) in accordance with 1 V.S.A. Section 313(a)(3) and to include the Unified Manager, the Assistant Manager and the candidate."

vhfa
Vermont Housing Finance Agency

Dear Members of the Selectboard and Board of Trustees,

I am writing to express my interest in applying for membership on the Joint Essex and Essex Junction Housing Commission. I believe I can bring a wealth of experience to the Commission, both with my personal knowledge of housing research and policy and my work at Vermont Housing Finance Agency (VHFA).

VHFA has considerable experience with housing issues at the local level, with staff having served on housing commissions in South Burlington and Winooski. We have also developed policy resources aimed at helping communities promote affordable housing and frequently provide information or guidance for local housing research projects. Although this would be my first experience serving on a local committee, I will have the benefit of our collective experience and connections to other area housing agencies and professionals.

As part of my work, I help operate the Vermont Housing Data website (www.housingdata.org). The website hosts a directory of Vermont's affordable rental housing, as well as community profiles that display housing-related data at the state, county, and municipal level. I am personally responsible for developing and maintaining the interactive data visualizations on the site. Should I be appointed, I can help the Commission leverage these resources to inform its work.

I am personally familiar with some of the housing challenges that Essex faces, having provided some assistance to Darren Schibler as he developed Essex's recent Housing Needs Assessment. Moreover, as an Essex resident, I am personally invested in the effort to make our town more vibrant, inclusive, and prepared for the future.

I'd like to thank the Selectboard and Board of Trustees again for their vision in effort in enacting a Joint Housing Commission and hope that I can be a part of its mission to promote housing opportunities in Essex.

Sincerely,

Mia Watson

P.O. Box 408, Burlington, VT 05402-0408 | Ph: 802.864.5743 800.339.5866 Fx: 802.864.8081 | www.vhfa.org

William Towne

12 March 2020

To whom it may concern,

I am excited to be considered for a spot on the Essex Housing Commission.

Over the last seven years, I have worked within the housing program at Spectrum Youth & Family Services, serving the homeless youth population. At first, I worked directly with the youth addressing day-to-day issues and helping establish stability in their lives. Now, as my responsibilities have shifted and I have joined boards and numerous committees, I have the privilege of working on systems change and taking a more broad approach to the housing issues that affect our communities. I routinely work with the State of Vermont, housing providers, landlords, financial entities, and housing authorities to address the needs of those in our county and state that are homeless or housing insecure. I believe the issues before us require a multi-faceted approach that requires all aspects of the housing community to work closely together, and I hope that is something we could accomplish with this commission.

Housing is a basic need that is not being made readily available to an alarming amount of people in our area, and it is encouraging to see towns taking the matter seriously and forming commissions like this. I would be honored to be a part of it, and believe that I would add a great deal to the work that needs to be done.

Thank you for taking the time to consider me.

Sincerely,

Will Towne

Supported Housing Program Manager

Mark Redmond

May 26, 2020

To the members of the Essex Village Selectboard and Trustees,

I am submitting my application to serve on the Joint Housing Commission. I am presently the executive director of Spectrum Youth and Family Services and have four decades of experience in the area of human services, including housing supports.

I have lived in Essex since 2003 and would appreciate the opportunity to lend my expertise and experience in this way.

Sincerely,

Mark Redmond

Dear Darren, Tammy:

I would like to serve on the Town of Essex Housing Commission. I have been a resident of the Town and the Junction since moving here in 2006. My husband and I were fortunate to have been able to purchase a home for our family, I am aware of the issue of housing in our community. I want to learn more and be a part of understanding options and supporting solutions that are just, equitable, safe, and affordable for many different incomes. I am interested in how our town could provide additional, varied options for occupancy and home ownership for new and existing residents.

I have been active in the civic life of our community. I am a founding board member of the Heart & Soul of Essex, a non-profit that serves the community in a variety of ways. Of note recently was the fundraiser we organized in April to raise emergency grants to residents of Essex and Westford affected by the COVID-19 pandemic, either through illness or loss of income in the household. Over 130 members of our community and the Town of Essex Selectboard donated over $45,000 that provided over 90 grants of $500 each. Most receipients reported using all or some of these funds for housing costs.

Thank you for considering my interest.

Gabrielle Smith

Dear Evan and Tammy

I would like to officially apply for a position on the recently created Essex Housing Commission. I am a resident of Essex Junction and recently appointed to the Village Planning Commission. I understand from recent conversations I've had with Maura Collins and Elaine Haney that the new Housing Commission is seeking representation from both the Village and Town Planning Commissions. I would like to represent the Village Planning Commission and expand my service to the community.

I work for the Vermont Department of Housing and Community Development which is a division within the Agency of Commerce and Community Development. My role as a Community Development Specialist is to perform consultative and administrative work assisting municipalities throughout Vermont with numerous community development initiatives. Specifically, I assist the municipalities in accessing federal HUD Community Development Block Grant (CDBG) funding for projects such as affordable housing, infrastructure (water/sewer), public facilities (childcare facility, community centers..), and economic development projects that result in job creation.

I hope you will consider me for one of the open seats on the recently formed Housing Commission. Please find my attached resume.

I look forward to your response.

Sincerely,
Patrick Scheld
Essex (Village) Resident

Good morning, I've been asked by Darren to supply you with an email expressing my interest in serving on the Housing Commission and to include a resume. It's been a number of years since I looked for work and prepared a resume so I ask your forgiveness for my somewhat creative version. Please let me know if there is anything else you need from me.

Don Miller

March 18, 2020

Essex Town Selectboard and
Village Board of Trustees
81 Main Street
Essex Junction, VT 05452-3209

Re: Joint Essex and Essex Junction Housing Commission

Dear Selectboard and Trustees,

As a real estate professional and resident of Essex Town, I was very encouraged to hear about the formation of the Joint Essex Housing Commission. The longstanding imbalance of supply and demand in Chittenden County is a problem that has yet to be solved. As such, quality housing that is also affordable continues to elude many Vermonters. Though I focus primarily on rental housing and commercial real estate, I communicate regularly with local residential brokers about the difficulties they have finding homes for their clients. In the 4 years that I've lived and worked here that reality has not changed. The formation of this commission is a signal that Essex Town and Essex Junction are committed to developing a thoughtful approach to rectifying the housing crunch within our town. Given my background, I believe I am well-equipped to help the Selectboard, Board of Trustees, and others within our community address this housing issue. As a private developer who has an excellent grasp of the financial feasibility of development, I would be more than happy to offer my expertise and point-of-view to this joint endeavor.

You can reach me directly by phone X or by e-mail at X. Please do not hesitate to call or e-mail. I look forward to connecting with you.

Best Regards,

Joe Engelken

Tammy:

I would like to formally express my interest in serving on the proposed Essex Housing Commission.

I have been a resident of Essex Junction for 8 years and have been a member of the Essex Planning Commission for the past 5 years. Before retirement, I was involved for 45 years in the construction industry, having contributed to the successful completion of over $4B of noteworthy buildings, ranging from garden apartments to 2 million sq. ft office buildings. My work as a contractor, designer, and owner's representative has given me a broad understanding of the development process and I feel this would be an asset to the housing Commission.

I continue to stay current with the latest trends in building and design and feel I would help bring a broader vision to the critical process here in the town and the village. I see the two entities as being at a key point in their future development and the needs for housing al all levels will be crucial if we are to enjoy positive growth in the future. It is one of my strong views that we can have creative new development that will last for years to come.

I am available at any time for questions or an interview.

Thank you for your consideration.

Ned Daly

Town of Essex
Village of Essex Junction

RESOLUTION ENCOURAGING THE USE OF FACE COVERINGS DURING COVID-19 STATE OF EMERGENCY

WHEREAS, the Centers for Disease Control and Prevention (CDC) recommend the use of simple cloth face coverings to slow the spread of the COVID-19 coronavirus and to help prevent people who may unknowingly have the virus from transmitting it to other; and

WHEREAS, the Vermont Department of Health "recommends that all Vermonters wear cloth face coverings when outside of the home to help slow the spread of COVID-19"; and

WHEREAS, Governor Phil Scott and the Vermont Agency of Commerce and Community Development have issued the following instructions in conjunction with the Governor's executive orders regarding COVID-19:

"Employees must wear face coverings over their nose and mouth when in the presence of others. In the case of retail cashiers, a translucent shield or 'sneeze guard' is acceptable in lieu of a mask. Businesses and non-profit and government entities may require customer or clients to wear masks" while on their premises and, "The legislative body of each municipality may enact more strict local requirements regarding mask use than those set forth herein"; and

WHEREAS, COVID-19 remains a health hazard to residents of the Town of Essex, inclusive of the Village of Essex Junction, and a significant threat to vulnerable populations and the people of the Town of Essex, inclusive of the Village of Essex Junction, and we believe in protecting our loved ones and our neighbors; and

WHEREAS, The Town of Essex Selectboard and Village of Essex Junction Board of Trustees recognize the potentially disastrous effects COVID-19 could have, and has had, on its citizens were business and citizens not to follow the responsible, common sense and creative measures to conduct business in a manner consistent with CDC and Vermont Department of Health social distancing guidelines and other health care recommendations; and

WHEREAS, wearing a face covering is an important act we can do in an effort to protect others from an infection that we may not even know we have; and

WHEREAS, as the State of Vermont begins to slowly resume opening businesses and public spaces, the Town of Essex Selectboard and Village of Essex Junction Board of Trustees recognize the need to ensure these measures, particularly the use of Personal Protective Equipment, are followed in order to avoid the needless illness and deaths of its citizens; and

WHEREAS, the Town of Essex Selectboard and Village of Essex Junction Board of Trustees do not condone "mask shaming" (when someone covering their face against COVID-19 shames someone for not wearing a mask) and appreciate each individual's understanding that not all individuals can wear a mask as it may be more harmful than healthy. Furthermore, the Town of Essex Selectboard and Village

of Essex Junction Board of Trustees appreciate and thank those who believe in the best intentions of humanity; and

WHEREAS, the Town of Essex Selectboard and Village of Essex Junction Board of Trustees by adopting a resolution and not an ordinance understand this resolution is not enforceable by the Town of Essex Police Department. Instead, this resolution is to be used as an educational tool and aid for businesses and the community to assist in ensuring the health of our community;

NOW, THEREFORE, be it resolved that beginning June 10, 2020 all establishments located in the Town of Essex, inclusive of the Village of Essex Junction, that invite the public into their premises for the purpose of transacting business, shall require both staff and customers (or visitors) to wear cloth face coverings or face shields over their nose and mouth while inside the establishment when appropriate social distancing is not feasible.

Cloth face coverings should not be placed on young children under age 5; anyone who has trouble breathing; or anyone who is unconscious, incapacitated or otherwise unable to remove the mask without assistance.

Each establishment is responsible to post signage at the entrance and at other appropriate locations stating that customers (or visitors) are required to wear face coverings by order of the Town of Essex Selectboard and Village of Essex Junction Board of Trustees.

This Order shall remain in effect until the Town of Essex Selectboard and Village of Essex Junction Board of Trustees amends, rescinds, or suspends this Order or until the Governor declares an end to the COVID-19 State of Emergency in Vermont, whichever occurs first.

Village of Essex Junction Trustees	**Town of Essex Selectboard**
Andrew Brown, President	Elaine Haney, Chair
George Tyler, Vice President	Patrick Murray, Vice Chair
Dan Kerin	Andy Watts
Raj Chawla	Vince Franco
Amber Thibeault	

Memorandum

To: Board of Trustees; Selectboard; Evan Teich, Unified Manager
Cc: Sarah Macy, Finance Director/Assistant Manager; Tammy Getchell, Assistant to the Manager
From: Greg Duggan, Deputy Manager GSD
Re: Future meeting schedule
Date: June 5, 2020

Issue

The issue is whether the Trustees and Selectboard want to adjust their upcoming meeting schedules.

Discussion

Some board members have indicated a desire to have individual board meetings on nights separate from joint meetings. The two Selectboard and Trustees may wish to discuss adjustments to the current meeting schedule.

Cost

N/a

Recommendation

This memo is for discussion.

MEMORANDUM

TO: Town of Essex Selectboard and Village of Essex Junction Trustees
FROM: James Jutras, Water Quality Superintendent
Chelsea Mandigo, Stormwater Coordinator/Wastewater Operator
Dennis Lutz, P.E. Public Works Director
cc: Evan Teich Unified Municipal Manager
Gregory Duggan, Deputy Manager
Sarah Macy, Finance Director, Assistant Manager
Ricky Jones, Public Works Superintendent
Annie Costandi, E.I. Stormwater Coordinator/Staff Engineer
DATE: May 26, 2020
SUBJECT: Mansfield Brickyard Stormwater Gravel Wetland Construction Bid Award

Issue: To award a bid contract for the construction of a stormwater gravel wetland located at the corner of Mansfield Ave and Brickyard Road.

Discussion: The Mansfield/Brickyard Gravel wetland was one of the top four projects in the Indian Brook Flow Restoration Plan developed as part of the Village's Municipal Separate Storm Sewer System (MS4 permit). The gravel wetland design has both flow restoration and phosphorus reduction benefits. The project drainage area is 17.67 acres (6.28 acres impervious and 11.39 acres pervious). The phosphorus load from the drainage basin is 10.19 lbs. and the wetland is designed to treat 60% with an estimated reduction of 6.11 lbs. in phosphorus annually. The design includes meeting the State of VT Total Maximum Daily Load (TMDL) high flow targets for Indian Brook Flow Restoration Plan by 23.7%.

Costs: The lowest construction bid was by SD Ireland at $196,316.50. The following funding summary is based on two grants and anticipated project expenses. NOTE: The values presented here are estimates based on the low bid received and project costs to date. These grant eligible amounts WILL VARY because we received more grants than project costs.

Total Project cost	$252,772.50	(Engineering $56,456 and low bid $196,316.50)
TAP 16(7) Grant	$178,069.93	(20% match $35,613.99 project based on original estimate)
Block Grant	$136,985.00	(50% match $68,493.50 based on Eng. Est for construction)

The community cost share is estimated at $104,150 +/- based on our understanding project costs and grant eligibility. This match that will be paid from the Town Stormwater Capitol Fund. There are sufficient funds in this account to cover the local share of the project costs, including increases if necessary.

Both the Town Selectboard and the Village Trustees are asked to approve the bid award since the project is a Village project but funded through the Town's Capital Plan.

Recommendation: Staff recommends that the Town Selectboard and Village Trustees award the bid to construct the Mansfield/Brickyard Stormwater Gravel Wetland to the lowest bidder, S.D. Ireland., at the submitted bid price of $196, 316.50.

Mr. James Jutras
Water Quality Superintendent
Via email: Jim@EssexJunction.org

May 26, 2020

SUBJECT: Bid Analysis and Recommendation for
Village of Essex Juction – TAP TA 16(7) Gravel Wetland

Dear Mr. Jutras,

Seven bids were received on May 20, 2020 for construction of the subject project. The bids were stamped as received, the time of receipt was written on the outer envelope, and at 1:00 pm (local time), were opened and read aloud by Chelsea Mandigo. Due to Covid-19, D&K personnel were not in attendance at the bid opening.

Chelsea scanned the bids into pdf format and emailed them to me in the afternoon of May 20, 2020. After reviewing the pdf for each respective bidder, I prepared a draft bid tabulation spreadsheet and forwarded to you and Chelsea. The bids were then reviewed for compliance with the bid documents. All bids received appear to be in compliance with the bid documents.

Therefore, it is our opinion that the bid received by SD Ireland Brothers Corporation of Williston, Vermont should be selected for the project. SD Ireland attended the mandatory pre-bid meeting and are on the Agency of Transportation's prequalified list. Additionally, their bid included submission of a bid security in the form of a bid bond, acknowledgement of Addenda, a bid bond, EEO certification, Debarment and Non-collusion affidavit, worker classification compliance requirement form, and a bid form with a Total Bid Price of $196,316.50. A copy of the final bid tabulation is attached. A copy of SD Ireland's bid is also attached.

Once you have reviewed this information, please let us know if there are any questions or if you would like to discuss further.

Very truly yours,
DuBOIS & KING, INC.

Michael Hildenbrand

Michael P. Hildenbrand, P.E.
Project Manager

Encl. Bid Tabulation
Bid from SD Ireland Brothers Corp.

Village of Essex Junction - Subsurface Gravel Wetland TAP TA 16(7)
D&K Project #123507
Bid Tabulation
Bid Opening May 20, 2020

				Engineer's Estimate		Dale E. Percy, Inc.		Blue Mountain T&E		Munson Earth Moving		Ormond Bushey & Sons		SD Ireland		GW Tatro		G+N Excavation	
ITEM NO.	**DESCRIPTION**	**Est. Qty**	**UNIT**	**Unit Price**	**AMOUNT**	**Unit Price**	**AMOUNT**	**Unit Price**	**AMOUNT**	**Unit Price**	**AMOUNT**	**Unit Price**	**AMOUNT**	**Unit Price**	**AMOUNT**	**Unit Price**	**AMOUNT**	**Unit Price**	**AMOUNT**
201.11	Clearing and Grubbing, Including Individual Trees and Stumps	0.65	ACRE	$25,000.00	$16,250.00	$10,000.00	$ 6,500.00	$26,620.00	$17,303.00	$26,500.00	$17,225.00	$17,476.00	$11,359.40	$15,000.00	$ 9,750.00	$16,153.85	$10,500.00	$20,000.00	$13,000.00
203.15	Common Excavation	2920	CY	$ 15.00	$43,800.00	$ 25.00	$73,000.00	$ 15.00	$43,800.00	$ 34.00	$99,280.00	$ 20.30	$59,276.00	$ 16.00	$46,720.00	$ 30.00	$87,600.00	$ 18.00	$52,560.00
203.30	Earth Borrow	28	CY	$ 12.00	$ 336.00	$ 100.00	$ 2,800.00	$ 40.00	$ 1,120.00	$ 45.00	$ 1,260.00	$ 12.30	$ 344.40	$ 23.00	$ 644.00	$ 30.00	$ 840.00	$ 13.00	$ 364.00
204.30	Granular Backfill for Structures	6	CY	$ 41.00	$ 246.00	$ 100.00	$ 600.00	$ 75.00	$ 450.00	$ 38.00	$ 228.00	$ 67.00	$ 402.00	$ 100.00	$ 600.00	$ 95.00	$ 570.00	$ 45.00	$ 270.00
301.25	Subbase of Crushed Gravel, Coarse Graded	3	CY	$ 37.00	$ 111.00	$ 100.00	$ 300.00	$ 100.00	$ 300.00	$ 36.00	$ 108.00	$ 98.00	$ 294.00	$ 100.00	$ 300.00	$ 99.00	$ 297.00	$ 42.00	$ 126.00
601.0905	12" CPEP	195	LF	$ 80.00	$15,600.00	$ 85.00	$16,575.00	$ 70.00	$13,650.00	$ 40.00	$ 7,800.00	$ 35.00	$ 6,825.00	$ 50.00	$ 9,750.00	$ 66.00	$12,870.00	$ 78.00	$15,210.00
601.0915	18" CPEP	10	LF	$ 90.00	$ 900.00	$ 100.00	$ 1,000.00	$ 160.00	$ 1,600.00	$ 68.00	$ 680.00	$ 36.00	$ 360.00	$ 100.00	$ 1,000.00	$ 120.00	$ 1,200.00	$ 87.00	$ 870.00
601.0920	24" CPEP	55	LF	$ 100.00	$ 5,500.00	$ 150.00	$ 8,250.00	$ 75.00	$ 4,125.00	$ 76.00	$ 4,180.00	$ 104.00	$ 5,720.00	$ 65.00	$ 3,575.00	$ 198.00	$10,890.00	$ 96.00	$ 5,280.00
604.11	Concrete Catch Basin w/ Cast Iron Grate (6' Diameter)	2	EA	$ 5,000.00	$10,000.00	$ 7,300.00	$14,600.00	$ 8,500.00	$17,000.00	$ 7,100.00	$14,200.00	$ 7,927.00	$15,854.00	$ 6,000.00	$12,000.00	$ 5,762.00	$11,524.00	$ 5,000.00	$10,000.00
605.11	8" Underdrain Pipe	4	LF			$ 200.00	$ 800.00	$ 200.00	$ 800.00	$ 32.00	$ 128.00	$ 148.00	$ 592.00	$ 100.00	$ 400.00	$ 76.00	$ 304.00	$ 30.00	$ 120.00
613.11	Stone Fill, Type II	35	CY	$ 45.00	$ 1,575.00	$ 100.00	$ 3,500.00	$ 60.00	$ 2,100.00	$ 50.00	$ 1,750.00	$ 54.80	$ 1,918.00	$ 75.00	$ 2,625.00	$ 49.00	$ 1,715.00	$ 48.00	$ 1,680.00
630.10	Uniformed Traffic Officers	20	HR	$ 52.00	$ 1,040.00	$ 100.00	$ 2,000.00	$ 110.00	$ 2,200.00	$ 59.00	$ 1,180.00	$ 68.00	$ 1,360.00	$ 100.00	$ 2,000.00	$ 77.00	$ 1,540.00	$ 66.00	$ 1,320.00
630.15	Flaggers	200	HR	$ 24.00	$ 4,800.00	$ 50.00	$10,000.00	$ 50.00	$10,000.00	$ 35.00	$ 7,000.00	$ 42.00	$ 8,400.00	$ 50.00	$10,000.00	$ 41.00	$ 8,200.00	$ 55.00	$11,000.00
635.11	Mobilization/Demobilization	1	LS	$20,000.00	$20,000.00	$25,000.00	$25,000.00	$51,000.00	$51,000.00	$51,000.00	$51,000.00	$29,955.00	$29,955.00	$20,000.00	$20,000.00	$20,850.00	$20,850.00	$40,000.00	$40,000.00
641.11	Traffic Control, All-Inclusive	1	LS	$ 5,000.00	$ 5,000.00	$10,000.00	$10,000.00	$65,000.00	$65,000.00	$ 6,500.00	$ 6,500.00	$ 5,580.00	$ 5,580.00	$ 3,000.00	$ 3,000.00	$ 5,600.00	$ 5,600.00	$16,920.00	$16,920.00
649.31	Geotextile Under Stone Fill	70	SY	$ 2.75	$ 192.50	$ 5.00	$ 350.00	$ 8.00	$ 560.00	$ 2.50	$ 175.00	$ 10.00	$ 700.00	$ 3.00	$ 210.00	$ 15.00	$ 1,050.00	$ 5.00	$ 350.00
651.15	Seed	30	LB	$ 10.00	$ 300.00	$ 15.00	$ 450.00	$ 25.00	$ 750.00	$ 5.00	$ 150.00	$ 8.50	$ 255.00	$ 10.00	$ 300.00	$ 3.00	$ 90.00	$ 10.00	$ 300.00
651.15	Wetland Plant Seed	6	LB	$ 125.00	$ 750.00	$ 100.00	$ 600.00	$ 150.00	$ 900.00	$ 125.00	$ 750.00	$ 115.00	$ 690.00	$ 200.00	$ 1,200.00	$ 74.00	$ 444.00	$ 225.00	$ 1,350.00
651.18	Fertilizer	300	LB	$ 3.00	$ 900.00	$ 5.00	$ 1,500.00	$ 5.00	$ 1,500.00	$ 1.00	$ 300.00	$ 0.60	$ 180.00	$ 3.00	$ 900.00	$ 4.00	$ 1,200.00	$ 5.00	$ 1,500.00
651.20	Agricultural Limestone	1.2	TON	$ 800.00	$ 960.00	$ 1,800.00	$ 2,160.00	$ 500.00	$ 600.00	$ 500.00	$ 600.00	$ 460.00	$ 552.00	$ 500.00	$ 600.00	$ 1,289.16	$ 1,546.99	$ 655.00	$ 786.00
651.35	Topsoil	275	CY	$ 40.00	$11,000.00	$ 65.00	$17,875.00	$ 62.00	$17,050.00	$ 63.00	$17,325.00	$ 54.00	$14,850.00	$ 50.00	$13,750.00	$ 60.00	$16,500.00	$ 43.00	$11,825.00
653.10	Hay Mulch	1.2	TON	$ 600.00	$ 720.00	$ 1,500.00	$ 1,800.00	$ 500.00	$ 600.00	$ 750.00	$ 900.00	$ 803.00	$ 963.60	$ 700.00	$ 840.00	$ 2,229.17	$ 2,675.00	$ 710.00	$ 852.00
653.20	Rolled Erosion Control Product, Type I	2465	SY	$ 3.00	$ 7,395.00	$ 2.00	$ 4,930.00	$ 4.00	$ 9,860.00	$ 1.00	$ 2,465.00	$ 1.60	$ 3,944.00	$ 2.50	$ 6,162.50	$ 3.00	$ 7,395.00	$ 3.00	$ 7,395.00
653.476	Silt Fence, Type II	40	LF	$ 12.00	$ 480.00	$ 5.00	$ 200.00	$ 10.00	$ 400.00	$ 3.00	$ 120.00	$ 3.80	$ 152.00	$ 3.00	$ 120.00	$ 11.00	$ 440.00	$ 7.00	$ 280.00
653.55	Project Demarcation Fence	880	LF	$ 1.75	$ 1,540.00	$ 2.00	$ 1,760.00	$ 5.00	$ 4,400.00	$ 0.80	$ 704.00	$ 0.68	$ 598.40	$ 1.50	$ 1,320.00	$ 2.00	$ 1,760.00	$ 2.00	$ 1,760.00
656.85	Tree Protection	1	LS	$ 1,500.00	$ 1,500.00	$ 2,000.00	$ 2,000.00	$ 1,000.00	$ 1,000.00	$ 1,800.00	$ 1,800.00	$ 92.00	$ 92.00	$ 1,000.00	$ 1,000.00	$ 826.00	$ 826.00	$ 4,825.00	$ 4,825.00
900.608	Special Provision (Pea Stone 3/8")	85	CY	$ 45.00	$ 3,825.00	$ 75.00	$ 6,375.00	$ 82.00	$ 6,970.00	$ 140.00	$11,900.00	$ 70.00	$ 5,950.00	$ 50.00	$ 4,250.00	$ 62.00	$ 5,270.00	$ 72.00	$ 6,120.00
900.608	Special Provision (Washed Stone 3/4")(FPO)	505	CY	$ 30.00	$15,150.00	$ 75.00	$37,875.00	$ 68.00	$34,340.00	$ 46.00	$23,230.00	$ 52.00	$26,260.00	$ 40.00	$20,200.00	$ 45.00	$22,725.00	$ 75.00	$37,875.00
900.608	Special Provision (Hydric Soil)	210	CY	$ 50.00	$10,500.00	$ 125.00	$26,250.00	$ 128.00	$26,880.00	$ 104.00	$21,840.00	$ 98.00	$20,580.00	$ 110.00	$23,100.00	$ 110.00	$23,100.00	$ 125.00	$26,250.00
			Total Base Bid		**$180,370.50**		**$279,050.00**		**$336,258.00**		**$294,778.00**		**$224,006.80**		**$196,316.50**		**$259,522.00**		**$270,188.00**
			Contingency		**$27,055.58**														
			Project Total		**$207,426.08**		**$279,050.00**		**$336,258.00**		**$294,778.00**		**$224,006.80**		**$196,316.50**		**$259,522.00**		**$270,188.00**

Notes: 1. The highlighted areas had a discrepancy between the words and numbers on the bid form line.

Michael Hildenbrand

Michael P. Hildenbrand, P.E.

Memorandum

To: Selectboard; Trustees; Evan Teich, Unified Manager
From: Travis Sabataso, HR Director TS
Re: Drug and Alcohol Testing Policy for Commercial Motor Vehicle Operators and Parks and Recreation Senior Van Drivers
Date: June 6, 2020

Issue

The issue is whether the Selectboard and Trustees will adopt the Town of Essex/Village of Essex Junction Drug and Alcohol Testing Policy for Commercial Motor Vehicle Operators and Parks and Recreation Senior Van Drivers.

Discussion

The draft policy was accepted by the Selectboard and Trustees at the May 26, 2020 meeting. Several changes have been made based on board comment, a revised final draft is enclosed.

Cost

There is no cost associated with this issue.

Recommendation

It is recommended that the Selectboard and Trustees adopt the policy.

Drug and Alcohol Testing Policy for Commercial Motor Vehicle Operators and Parks and Recreation Senior Van Drivers	
Revision Number: 1.0	**Town of Essex Selectboard** Adopted on:
Revision Date: ~~05/21/2020~~06-05-2020	**Village of Essex Junction Trustees**
Effective Date:	Adopted on:

Introduction

This policy applies to employees and prospective employees of The Town of Essex & Village of Essex Junction who operate commercial motor vehicles (CMVs) or who will operate CMVs if they are hired, transferred or promoted. This policy also applies to Parks and Recreation Senior Van Drivers, who are governed by Federal Transit Administration (FTA) Drug Testing Requirements. Employees and prospective employees are not subject to this policy by virtue of holding a Commercial Driver's License (CDL) unless their job duties may require them to operate a CMV.

The policy was developed based on the requirements articulated by the U.S. Department of Transportation (DOT) in Title 49, of the Code of Federal Regulations (CFR).

This policy does not constitute a contract of employment. Employment with the Town of Essex & Village of Essex Junction is ***at will*** and not for any definite period or successive periods of time. Absent language in a collective bargaining agreement, the Town/Village or the employee may terminate employment at any time, with or without notice. The Selectboard and the Trustees reserve the right to amend any of the provisions of this personnel policy for any reason and at any time, with or without notice.

Section 1: Applicability

This policy applies to all Town of Essex & Village of Essex Junction employees and prospective employees who operate commercial motor vehicles (CMVs) while engaged in any municipal business. This policy also applies to Parks and Recreation Senior Van Drivers. This policy supersedes any provisions in the Town and Village Personnel Guidelines, and any other Town/Village policies regarding the consequences of the possession or use of drugs and alcohol as they pertain to CMV operators and Senior Van Drivers.

For purposes of this policy,

Commercial motor vehicle or CMV means a motor vehicle or combination of motor vehicles as follows:

- Any single vehicle with a gross vehicle weight rating (GVWR) of 26,001 pounds or more.
- A combination vehicle with a gross combination weight rating (GCWR) of 26,001 or more pounds, provided the GVWR of the vehicle(s) being towed is in excess of 10,000 pounds.
- A vehicle designed to transport 16 or more passengers (including the driver).
- Any size vehicle which requires hazardous material placards or is carrying material listed as a select agent or toxin in 42 CFR part 73.

Individuals operating the above vehicles must have a valid commercial driver's license (CDL). Note that emergency vehicles (e.g. fire apparatus) are not CMVs.

Each employee who is subject to this policy is required to sign an acknowledgement that he or she has been provided a copy of this policy. This acknowledgement will be maintained in the Town's/Village's personnel files as part of the driver qualification file. An acknowledgement form is included as Appendix C.

Given the varied nature of municipal needs, employees who are employed to operate CMVs or the Senior Vans have the potential to serve in safety-sensitive functions during any part of their job. Therefore, employees are subject to this policy at all times while they are actively working and during periods when they may be called into work (e.g. to respond to weather-related incidents, respond to emergency situations, etc.). Safety-sensitive functions and other terms are defined in Appendix A: Definitions.

Section 2: Responsibility for Employee Information

The Town of Essex and Village of Essex Junction have assigned the Human Resources Director as the individual who can provide employees with information regarding this Drug & Alcohol Policy and answer related questions on the pertinent issues. Employees may also obtain information about applicable Federal regulations from 49 CFR. Sources of information are provided in Appendix B of this policy.

Section 3: Prohibited Conduct

Conduct listed in this section is prohibited.

- Having a verified positive, adulterated or substituted drug test result.
- Performing safety-sensitive functions after notification of a verified positive, substituted or adulterated drug test result or an Evidential Breath Testing Device (EBT) alcohol test result indicating a measured alcohol concentration of 0.02% or greater, regardless of when the drug or alcohol was ingested and regardless of whether or not the driver is under the influence of alcohol or using drugs, as defined in federal, state or local law.
- Reporting for duty or remaining on duty any time there is a quantifiable presence of a prohibited drug in the body above the minimum thresholds defined in 49 CFR PART 40, as amended.
- Consuming alcohol while performing safety-sensitive job functions or while on-call to perform safety-sensitive job functions. An on-call employee who has consumed alcohol must acknowledge the use of alcohol at the time that he/she is called to report for duty.
- Consuming alcohol within four (4) hours prior to the performance of safety-sensitive job functions.
- Misusing or being impaired by authorized or prescribed drugs or over-the counter medications which may affect work performance or pose a danger to the safety of the driver or to others. Drivers are required to inform the employer's designated representative of any therapeutic drug use that has the potential to impact the safe operation of equipment or motor vehicles.
- In cases where prescribed medication labeling suggests that machinery operation or driving may be compromised in any way, the driver shall obtain written authorization from the prescribing physician indicating that the driver is able to safely operate a CMV while using the substance. This must be provided to the municipality prior to operation of said CMV while using the prescribed substance(s).

- Reporting to work or remaining on duty requiring the performance of safety sensitive functions while having an alcohol concentration of 0.02% or greater regardless of when the alcohol was consumed.
- Consuming alcohol for eight (8) hours following involvement in an accident or before submitting to any required post-accident drug/alcohol testing, whichever occurs first.
- Engaging in the unlawful manufacture, distribution, dispensing, possession, or use of prohibited substances in the work place including municipal premises, vehicles, while in uniform or while on municipal business.
- Refusal to submit to alcohol or drug testing, as defined in Section 4, below.

Section 4: "Testing Refusal" Defined

Under federal law, a test refusal is considered as a positive test and has the same consequences. An employee or prospective employee is considered to have refused a test when s/he does any of the following:

- Fails to appear for any test within a reasonable time, as determined by the employer or testing pool administrator, after being directed to do so by the employer;
- Fails to remain at the testing site until the testing process is complete;
- Fails to provide a urine specimen for any drug test required by Part 40 or DOT agency regulations;
- In the case of an observed collection in a drug test, fails to permit the observation or monitoring of the collection of a specimen;
- Fails to provide a sufficient amount of urine when directed, and it has been determined, through a required medical evaluation, that there was no adequate medical explanation for the failure;
- Fails to provide an adequate amount of saliva or breath for any alcohol test required, and it has been determined, through a required medical evaluation, that there was no adequate medical explanation for the failure;
- Fails or declines to take a second test that the employer or collector has directed the employee to take;
- Fails to undergo a medical examination or evaluation, as directed by the Medical Review Officer (MRO) as part of the verification process, or as directed by the Designated Employer Representative (DER) as part of the "shy bladder" procedures;
- Fails to cooperate with any part of the testing process (e.g., refuses to empty pockets when so directed by the collector, behaves in a confrontational way that disrupts the collection process);
- If the MRO reports that there is verified adulterated or substituted test result.

Section 5: Testing

All testing and specimen collection prescribed under this policy will be done in accordance with federal requirements. Prescribed testing includes: pre-employment, random, reasonable suspicion, post-accident, return to duty, and follow-up, if applicable.

Testing shall be conducted in a manner to assure a high degree of accuracy and reliability and using techniques, equipment, and laboratory facilities which have been approved by the U.S. Department of Health and Human Service (DHHS). All testing will be conducted consistent with the procedures set forth in 49 CFR Part 40, as amended. The procedures will be performed in a private, confidential manner, and every effort will be made to protect the employee, the integrity of the drug testing procedure, and the validity of the test result.

Section 5a: The Drug Testing Process

The drug testing process will screen for drugs including marijuana, cocaine, opiates, opioids, amphetamines, and phencyclidine. The use of certain over-the-counter medications and other substances may result in a positive test.

After the identity of the donor is checked using picture identification, a urine specimen will be collected using the split specimen collection procedure. Each specimen will be accompanied by a DOT Chain of Custody and Control Form and identified using a unique identification number that attributes the specimen to the correct individual. The specimen analysis will be conducted at a DHHS certified laboratory.

An initial drug screen and validity test will be conducted on the primary urine specimen. For those specimens that are not negative, a confirmatory Gas Chromatography/Mass Spectrometry (GC/MS) test will be performed. The test will be considered positive if the amounts of the drug(s) and/or its metabolites identified by the GC/MS test are above the minimum thresholds established in 49 CFR Part 40, as amended.

If a drug test produces a result of negative-dilute, the donor will be required to submit to another specimen collection. The re-collection will not be done under direct observation. If the results of the second test are also negative-dilute, the Town of Essex and Village of Essex Junction will accept that result and cannot continue re-collections. The second test will be the test of record. Under federal law, an applicant/employee's refusal to submit to a re-collection for a negative-dilute result is a refusal to test.

The test results from the DHHS certified laboratory will be reported to an MRO. The MRO is a licensed physician with detailed knowledge of substance abuse disorders and drug testing. The MRO will review the test results to ensure the scientific validity of the test and to determine whether there is a legitimate medical explanation for a verified positive, substituted, or adulterated test result. The MRO will:

- Attempt to contact the employee to notify the employee of the non-negative laboratory result and provide the employee with an opportunity to explain the confirmed laboratory test result.
- Review any medical history and/or medical records that have been offered by the employee to determine whether there is a legitimate medical explanation for a non-negative laboratory result. If no legitimate medical explanation is found, the test will be confirmed as a verified positive or a refusal to test and reported to the Town of Essex and Village of Essex Junction DER. If a legitimate explanation is found, the MRO will report the test result as negative to the DER and no further action will be taken. If the test is invalid without a medical explanation, a retest will be conducted under direct observation.

Any covered employee who questions the results of a required drug test performed under this policy may request that the split specimen be tested. The employee's request for a split specimen test must be made to the MRO within 72 hours of notice of the original specimen verified test result. Requests after 72 hours will only be accepted at the discretion of the MRO if the delay was due to documentable facts beyond the control of the employee.

The original collected urine specimen is split into 2 specimens (primary specimen and split specimen) prior to testing, expressly for this purpose. The split specimen test must be conducted at a second DHHS-certified laboratory with no affiliation with the laboratory that analyzed the primary specimen. The test must be conducted on the split specimen that was provided by the employee at the same time as the primary specimen. The method of collecting, storing, and testing the split specimen will be consistent with the procedures set forth in 49 CFR Part 40, as amended.

Any covered employee who elects to have a split specimen tested agrees to fully reimburse the municipality for all costs associated with the testing. Reimbursement may be recouped via payroll deduction, or any other mutually agreeable method(s).

- If the analysis of the split specimen fails to confirm the presence of the drug(s) detected in the primary specimen, if the split specimen is not able to be analyzed, or if the results of the split specimen are not scientifically adequate, the MRO will declare the original test to be canceled and will direct a retest of the employee under direct observation. The retest must occur as quickly after notification as possible.

- The split specimen will be stored at the initial laboratory until the analysis of the primary specimen is completed. If the primary specimen tests negative, the split specimen will be discarded. If the primary specimen tests positive, the split specimen will be retained for testing if so requested by the employee through the MRO. If the primary specimen is positive, both the primary and split specimens will be retained in frozen storage for one year.

Section 5b: Observed Collections

Consistent with 49 CFR Part 40, collection under direct observation by a person of the same gender with no advance notice will occur in any of the following circumstances:

- The laboratory reports to the MRO that a specimen is invalid, and the MRO reports to the municipality that there was not an adequate medical explanation for the result;
- The MRO reports to the municipality that the original positive, adulterated, or substituted test result had to be cancelled because the test of the split specimen could not be performed;
- The test is a return-to-duty test or a follow-up test;
- The collector observes materials brought to the collection site or the employee's conduct clearly indicates an attempt to tamper with a specimen;
- The temperature of the original specimen was out of range; or
- The original specimen appeared to have been tampered with.

Section 5c: The Alcohol Testing Process

Tests for breath alcohol concentration will be conducted by a trained Breath Alcohol Technician (BAT) using a National Highway Traffic Safety Administration (NHTSA)-approved EBT.

If the initial test results indicate that alcohol is present, a confirmatory test will be conducted at least fifteen minutes after the completion of the initial test and will be performed by a trained BAT using a NHTSA-approved EBT. The EBT will identify each test with a unique sequential identification number. This number, time, and unit identifier will be provided on each EBT printout. The EBT

printout, along with an approved alcohol testing form, will be used to document the testing, all results, and to attribute the test to the correct employee.

The test will be performed in a private, confidential manner as required by 49 CFR Part 40, as amended. The procedure will be followed as prescribed to protect the employee, to maintain the integrity of the alcohol testing procedures and ensure the validity of the test result. An employee who has a confirmed alcohol concentration of 0.04% or higher will be considered to have a positive alcohol test and will be in violation of this policy. The consequences of a positive alcohol test are described below.

An employee undergoing alcohol testing who does not provide a sufficient amount of breath to permit a valid breath test will be directed to obtain an evaluation within 5 days, from a licensed physician who has expertise in the medical condition raised by the employee's failure to provide a sufficient specimen. The results of this evaluation will be reviewed by the MRO to determine the result of the test.

Even though an employee who has a confirmed alcohol concentration of 0.02% to 0.039% is <u>not</u> considered to have had a positive test, the employee shall still be removed from safety sensitive functions for twenty-four hours.

Subsequent to the required 24-hour removal, the employee will:

- Meet with the Relevant Supervisor and Department Head, Unified Manager, and HR Director to review the need to avoid alcohol use from any source during or proceeding work hours.
- If the employee has an alcohol test result of 0.02% to ≤ 0.039% two or more times within a six month period, the employee will again meet with a municipal representative from the list above to review the need to avoid alcohol use. The employee will be provided with contact and related information for the EAP program (currently Invest EAP). There is no requirement that the employee access those services.

An alcohol concentration of less than 0.02% will be considered a negative test.

The municipality affirms the need to protect individual dignity, privacy, and confidentiality throughout the testing process. If at any time the integrity of the testing procedures or the validity of the test results is compromised, the test will be cancelled. Minor inconsistencies or procedural flaws that do not affect the test result will not result in a cancelled test.

<u>Section 5d: Pre-employment Testing</u>

When an individual applies to work for the Town of Essex & Village of Essex Junction in a position that involves the operation of a CMV or a Senior Van, or when a municipal employee is under consideration for a position that involves the operation of a CMV or a Senior Van, that person will be required to undergo pre-employment urine drug testing. All offers of employment and offers for transfer for covered positions shall be <u>conditional</u> upon the applicant passing the drug test. Pre-employment testing must be completed prior to the individual working in the new position.

Pre-employment drug testing will be accomplished by providing advance notice of the test schedule and location to the position applicant. The length of the advance notice period will be kept as short as is reasonably feasible to coordinate and complete the test.

If an applicant fails a pre-employment drug test, the conditional offer of employment shall be rescinded. Prior to future consideration for employment performing safety sensitive functions, the municipality must receive evidence from a substance abuse professional that meets the requirements of 49 CFR part 40 as amended, regarding the absence of drug dependency. A negative pre-employment drug test will also be required.

Any applicant who fails a pre-employment drug test will be provided the results of the test along with the current Invest EAP brochure. This serves to provide the individual with information about substance abuse treatment opportunities.

If a drug test produces a result of negative-dilute the donor will be required to submit to another specimen collection. The re-collection will not be done under direct observation. If the results of the second test are also negative-dilute, the Town of Essex & Village of Essex Junction will accept that result and cannot continue re-collections. The second test will be the test of record. Under federal law, an applicant/employee's refusal to submit to a re-collection for a negative-dilute result is a refusal to test.

When an existing employee is being placed, transferred, or promoted into a position that is covered by this policy and that person submits a drug test with a verified positive result, the employee may be subject to disciplinary action as outlined in the municipal personnel policies. That employee will also be eliminated from consideration for the position which triggered the need for the pre-employment test.

If a pre-employment/pre-transfer test is cancelled for any reason, the applicant will be required to take and pass a pre-employment drug test before the individual is placed into a covered CDL or Senior Van driver position or performs safety sensitive functions.

FMCSA Clearinghouse

Effective January 6, 2020 in accordance with 49 CFR, all covered drivers shall be subjected to a query of the FMCSA Clearinghouse prior to employment as well as yearly throughout the driver's employment with the Town of Essex & Village of Essex Junction. This is an employer responsibility.

Drivers should also note that the following information will be reported to the Clearinghouse by the MRO, the VLCT PACIF-sponsored Drug & Alcohol Testing Consortium that is operated by the third-party administrator, DISA (formerly Drug Testing, LLC) (Consortium/TPA) and/or the employer. Drivers who fail to provide the necessary authorization to complete the initial or annual query will be subject to termination.

- A verified positive, adulterated, or substituted drug test result;
- An alcohol confirmation test with a concentration of 0.04 or higher;
- A refusal to submit to a drug or alcohol test;
- An employer's report of actual knowledge, as defined at 49 CFR § 382.107;
- On-duty alcohol use pursuant to 49 CFR § 382.205;
- Pre-duty alcohol use pursuant to 49 CFR § 382.207;
- Alcohol use following an accident pursuant to 49 CFR § 382.209;
- Drug use pursuant to 49 CFR § 382.213;
- SAP's report of the successful completion of the return-to-duty process;

- A negative return-to-duty test; and,
- An employer's report of completion of follow-up testing.

Section 5e: Random Testing

All municipal CDL drivers and Senior Van Drivers are placed in the Consortium/TPA operated by DISA. These employees are subject to random, unannounced testing. There is no discretion on the part of the employer or supervisor in the selection and notification of the individuals who are to be tested. The selection of employees is made by a scientifically valid method of randomly generated employee identifier numbers from the pool of covered employees. Under the selection process used, each covered employee shall have an equal chance of being tested each time selections are made.

The dates for administering unannounced testing are randomly selected each quarter and updated each calendar year, with a minimum percentage of the pool's drivers selected for drug testing, alcohol testing, or both as required by Federal regulations.

Random drug tests can be conducted at any time during an employee's shift when safety sensitive functions may be performed. Random alcohol tests can be performed just before, during, or just after the performance of a safety-sensitive duty. Employees are required to proceed immediately to the collection site or make themselves immediately available to collectors when they are notified that they have been selected for testing.

Section 5f: Reasonable Suspicion Testing

All covered employees will be subject to a reasonable suspicion drug and/or alcohol test when there is a reasonable suspicion to believe that drug or alcohol use is occurring, has recently occurred, or that the person is under the influence of drugs or alcohol. "Reasonable suspicion" shall mean that there is objective evidence, based upon specific, contemporaneous, articulable observations of the employee's appearance, behavior, speech or body odor that are consistent with possible drug use and/or alcohol misuse.

Reasonable suspicion drug test referrals will only be made by a supervisor or other designated individual with employee monitoring and assignment responsibilities who has received "reasonable suspicion training" in accordance with FMCSA regulations. The training ensures that supervisors or other designated employees with similar responsibilities have the skills and knowledge to objectively detect the signs and symptoms of drug and alcohol use in employees covered by this policy.

A reasonable suspicion alcohol test can only be conducted just before, during, or just after the performance of a safety-sensitive job function. A reasonable suspicion drug test can be performed any time the covered employee is on duty.

The Town of Essex & Village of Essex Junction shall be responsible for transporting the employee who will be tested to a suitable testing site identified by ODT. Transport shall include travel to and from the location and to the individual's residence, as they should not be permitted to work when they may be under the influence of a drug or alcohol.

Supervisors should avoid placing themselves and/or others into a situation which might endanger the physical safety of those present. An employee who refuses an instruction to submit to a reasonable suspicion drug/alcohol test shall not be permitted to finish his or her shift and will be subject to other

employment consequences. If an employee refuses transportation to a suitable testing site and/or to their residence and instead chooses to operate their personal vehicle, local law enforcement maybe notified immediately that the Town/Village has reasonable suspicion that said employee is operating a motor vehicle under the influence. Failure to submit to a reasonable suspicion test is prohibited conduct (test refusal), the consequences of which are outlined in Section 6: Consequences of a Positive Test.

A written record of the observations that led to a reasonable suspicion drug/alcohol test shall be prepared and signed by the supervisory individual making the observation. This record shall be prepared prior to the release of the test results. This written record shall be submitted to the Human Resources Director.

If an alcohol test required by this section is not administered within two hours following the reasonable suspicion determination, the employer shall prepare and maintain on file a record stating the reasons the alcohol test was not promptly administered. If an alcohol test required by this section is not administered within eight hours following the reasonable suspicion determination, the employer shall cease attempts to administer an alcohol test and shall state in the record the reasons for not administering the test.

~~If a drug test required by this section is not administered within 32 hours following the accident, the municipality will cease attempts to administer a controlled substances test and will document and maintain a record stating the reasons the test was not given within the required timeframe.~~

Section 5g: Post Accident Testing

All covered employees will be required to undergo post-accident urine and breath testing if they are involved in an accident with a CMV or Senior Van that meets the criteria outlined in the following chart:

If the accident involved any of the following:	Qualifying event: Was a citation issued to the CMV or Van driver?	Must test be performed by employer?
Human fatality	YES	**YES**
Human fatality	NO	**YES**
Bodily injury with immediate medical treatment away from the scene.	YES	**YES**
Bodily injury with immediate medical treatment away from the scene.	NO	NO
Disabling damage to any motor vehicle requiring tow away.	YES	**YES**
Disabling damage to any motor vehicle requiring tow away.	NO	NO

If an alcohol test required by this section is not administered within two hours following the accident, the municipality will document and maintain a record stating the reason(s) why the test was not promptly administered. If an alcohol test required by this section is not administered within eight hours following the accident, the municipality will cease attempts to administer an alcohol test and will document the conditions that led to the time delay and failure to test.

If a drug test required by this section is not administered within 32 hours following the accident, the municipality will cease attempts to administer a controlled substances test and will document and maintain a record stating the reasons the test was not given within the required timeframe.

Section 6: Consequences of a Positive Test

The MRO will report positive test results to the DER only after verifying the test results as outlined in 49 CFR, Part 40 as amended. When the DER is notified of this positive test result, the employee will be immediately suspended from operating CMVs, Senior Vans and other safety sensitive functions for the municipality and will be referred to a Substance Abuse Professional (SAP) for substance abuse assessment and/or treatment at the employee's expense.

On the day that the positive test results are received, the employee will be suspended from all duties with pay. Subsequent to that, the employee may be suspended without pay. The employee's length of suspension will run the period of time in which it takes the individual to satisfactorily complete the treatment (as confirmed by the treating SAP), and last for up to 3 months from the date the positive test result was received. After that period, if the employee has not successfully completed treatment, the employee may be terminated.

Any employee who has an initial positive test and has the split sample tested and obtains a negative result will immediately be permitted to return to their normal job duties.

An employee who provides written documentation from an SAP that substance abuse treatment has been satisfactorily completed within the 3-month suspension period must fulfill all return to duty testing requirements in Section 7: Return to Duty Testing prior to performing any safety sensitive functions. Follow-up testing will also be required as directed by the SAP.

An employee who has a second positive test after completing return to duty testing may be terminated.

Section 7: Return to Duty Testing

Covered employees having a positive test will not be permitted to return to duty until after a SAP has determined that the employee has successfully complied with prescribed education and/or treatment. The SAP will authorize the return to duty testing only when the employee is known to be drug and alcohol-free and there is no risk to public safety. The SAP will provide written documentation that the treatment has been completed and that the employee may undergo return to duty testing. The employee will then be allowed to take a return-to-duty test, as directed by the treating SAP.

The employee must have a negative drug test result and/or an alcohol test with an alcohol concentration of less than 0.02 before they may return to duty. For an initial positive drug test, a return to duty drug test is required and an alcohol test is allowed. For an initial positive alcohol test, a return to duty alcohol test is required and a drug test is allowed. Return to duty testing MUST be performed under direct observation.

Section 8: Follow-Up Testing

After satisfactory completion of return to duty testing, the driver is required to submit to at least 6 follow up tests during the first 12 months after resuming safety sensitive functions. Follow-up testing may be required for up to 60 months unless the SAP determines that testing is no longer warranted. The number and frequency of follow-up tests will follow the written guidance provided by the treating SAP. All follow-up tests are unannounced and may include testing for drugs and/or alcohol.

Follow-up alcohol testing will be conducted only when the driver is performing or just before performing safety sensitive functions, or just after the driver has ceased performing safety-sensitive functions. Follow-up testing MUST be performed under direct observation.

Follow-up testing is separate from and in addition to random, post-accident, reasonable suspicion, and return to duty testing.

Section 9: Employee Information

Employees are encouraged to seek information regarding the effects of alcohol and controlled substances and their health, employment, and personal life. Such information is available at:

http://www.samhsa.gov/;
http://www.fmcsa.dot.gov/rules-regulations/topics/drug/drug.htm
http://www.investeap.org/
http://www.dot.gov/odapc/employee-handbook-english

APPENDIX A: *Definitions*

Accident means an occurrence associated with the operation of a CMV or Senior Van, if as a result:

- An individual dies, or
- An individual suffers a bodily injury and immediately receives medical treatment away from the scene of the accident, or
- One or more vehicles incur disabling damage as the result of the occurrence and are transported away from the scene by a tow truck or other vehicle. For purposes of this definition, ***disabling damage*** means damage that precludes departure of any vehicle from the scene of the occurrence in its usual manner in daylight after simple repairs. Disabling damage includes damage to vehicles that could have been operated but would have been further damaged if so operated, but does not include:
    - damage which can be remedied temporarily at the scene of the occurrence without special tools or parts, or
    - tire disablement without other damage even if no spare tire is available, or
    - damage to headlights, taillights, turn signals, horn, mirrors or windshield wipers that makes them inoperative.

Adulterated specimen is a specimen that has been altered, as evidenced by test results showing either a substance that is not normally found in that type of specimen or showing an abnormal concentration of a substance that is normally found in that specimen.

Alcohol means the intoxicating agent in beverage alcohol, ethyl alcohol, or other low molecular weight alcohols contained in any beverage, mixture, mouthwash, candy, food, preparation or medication.

Alcohol Concentration is expressed in terms of grams of alcohol per 210 liters of breath as measured by an evidential breath-testing device (EBT).

Commercial motor vehicle means a motor vehicle or combination of motor vehicles used in commerce, to transport passengers, or property if the motor vehicle:

- Has a gross combination weight rating of 11,794 or more kilograms (26,001 or more pounds) inclusive of a towed unit with a gross vehicle weight rating of more than 4,536 kilograms (10,000 pounds); or
- Has a gross vehicle weight rating of 11,794 or more kilograms (26,001 or more pounds); or
- Is designed to transport 16 or more passengers, including the driver; or
- Is of any size and is used in the transportation of materials found to be hazardous for the purposes of the Hazardous Materials Transportation Act and which require the motor vehicle to be placarded under the Hazardous Materials Regulations (49 CFR part 172, subpart F).

Covered Employee means an employee who performs a safety-sensitive function including an applicant or transferee who will be hired to perform a safety-sensitive function. Employees who operate CMVs are considered to be performing safety-sensitive functions as are employees operating Senior Vans.

Medical Review Officer (MRO) means a licensed physician (medical doctor or doctor of osteopathy) who is responsible for receiving laboratory results generated by the drug testing program who has knowledge of substance abuse disorders and has appropriate medical training to interpret and evaluate an individual's confirmed positive test result, together with his/her medical history and any other relevant bio-medical information.

Negative test result for a drug test means a verified presence of the identified drug or its metabolite below the minimum levels specified in 49 CFR Part 40, as amended. An alcohol concentration of less than 0.02% BAC is a negative test result.

Negative Dilute is a drug test specimen showing a creatinine level of greater than 5mg/dl and less than 20 mg/dl.

Non-negative test result is a test result found to be adulterated, substituted, invalid, or positive for a drug or drug metabolites. Non-negative results are considered a positive test or a refusal to test if the MRO cannot determine a legitimate medical explanation for the result or the refusal.

Observed Collection means the donor will provide his or her sample under the direct observation of either a collector or another individual of the same gender. The donor must raise his or her shirt, blouse, or dress/skirt, as appropriate, above the waist; and lower clothing and underpants to show the observer, by turning around, that he/she does not have a prosthetic device. After the observer has determined that the donor does not have a prosthetic device, the donor may return his/her clothing to its proper position for observed urination.

Positive test result for a drug test means a verified presence of the identified drug or its metabolite at or above the minimum levels specified in 49 CFR Part 40, Section 40.87 as amended. A positive alcohol test result means a confirmed alcohol concentration of 0.04% BAC or greater. Any positive test result reported to the DER by the MRO is verified by the MRO prior to reporting.

Primary specimen. In drug testing, the primary specimen is the urine specimen bottle that is opened and tested by a first laboratory to determine whether the employee has a drug or drug metabolite in his or her system; and for the purpose of validity testing. The primary specimen is distinguished from the split specimen, defined in this section.

Prohibited drug means marijuana, cocaine, opiates, opioids, amphetamines, phencyclidine, or MDMA (ecstasy) at levels above the minimum thresholds specified in 49 CFR Part 40, as amended.

Safety-sensitive function includes the timeframe that begins when a driver starts work or is required to be in readiness to work until the time he/she is relieved from work and all responsibility for performing work. Safety-sensitive functions shall include:

- All time at an employer or shipper plant, terminal, facility, or other property, or on any public property, waiting to be dispatched, unless the driver has been relieved from duty by the employer;
- All time inspecting, servicing, or conditioning any CMV or Senior Van at any time;
- All time spent at the driving controls of a CMV or Senior Van in operation;
- All time, other than driving time, in or upon any CMV or Senior Van except time spent resting in a sleeper berth;

- All time loading or unloading a vehicle, supervising, or assisting in the loading or unloading, attending a vehicle being loaded or unloaded, remaining in readiness to operate the vehicle, or in giving or receiving receipts for shipments loaded or unloaded; and
- All time repairing, obtaining assistance, or remaining in attendance upon a disabled vehicle.

Shy Bladder refers to any time a safety-sensitive employee is unable to provide a 45ml. sample of urine in a single void within a three hour time period.

Split specimen. In drug testing, a part of the urine specimen that is sent to a first laboratory and retained unopened, and which is transported to a second laboratory in the event that the employee requests that it be tested following a verified positive test of the primary specimen or a verified adulterated or substituted test result.

Substance Abuse Professional (SAP) means a licensed physician (medical doctor or doctor of osteopathy) or licensed or certified psychologist, social worker, employee assistance professional, or addiction counselor (certified by the National Association of Alcoholism and Drug Abuse Counselors Certification Commission or by the International Certification Reciprocity Consortium/Alcohol and other Drug Abuse) with knowledge of and clinical experience in the diagnosis and treatment of drug and alcohol related disorders.

Verified negative test means a drug test result reviewed by a MRO and determined to have no evidence of prohibited drug use above the minimum cutoff levels established in DOT Rule 49 CFR Part 40 Section 40.87 as revised.

V*alidity testing* is the evaluation of the specimen to determine if it is consistent with normal human urine. The purpose of validity testing is to determine whether certain adulterants or foreign substances were added to the urine, if the urine was diluted, or if the specimen was substituted.

APPENDIX B: *Contacts & Information*

DISA (formerly Occupational Drug Testing, LLC)
Manchester, NH
800-211-4469

VLCT/PACIF
Risk Management Services
89 Main St. Montpelier, Vermont 05602
802-229-9111

INVEST EAP
108 Cherry Street, Suite 203
Burlington, Vermont 05401
MAIN OFFICE: 888.392.0050
FAX: 802.863-7515
staff@investeap.org

Employee Access to Information

49 CFR part 40 and 49 CFR part 382 (and 49 CFR part 655 for Senior Van Drivers) must be available upon request to covered employees and representatives of employee organizations. 49 CFR part 40 is accessible on line at http://www.dot.gov/ost/dapc, by fax on demand at 1-800-225-3784 requesting document 151, by phone at 1-866-512-1800, or by writing to U.S. Department of Transportation, Office of Drug and Alcohol Policy and Compliance, 400 Seventh Street SW, Room 10403, Washington, D.C. 20590.

APPENDIX C: ***CMV and Senior Van Drug & Alcohol Testing Policy-Acknowledgement Form***

Town of Essex & Village of Essex Junction

I HEREBY ACKNOWLEDGE that I have received a copy of and read and understand my employer's **Drug and Alcohol Testing Policy for Commercial Motor Vehicle Operators and Parks and Recreation Senior Van Drivers.** I understand that I must abide by its terms as a condition of employment. I understand that during my employment I may be required to submit to a controlled substances and/or alcohol test based on U.S. Department of Transportation (DOT) and Federal Motor Carrier Safety Administration (FMCSA) regulations.

I also understand that refusal to submit to a controlled substances or alcohol test is a violation of DOT regulations and the above referenced policy and may result in disciplinary action, including suspension (with or without pay) or termination of employment for gross and willful misconduct. I further understand the consequences of controlled substances and/or alcohol use as outlined in this policy.

I acknowledge that the provisions of my employer's **Drug and Alcohol Testing Policy for Commercial Motor Vehicle Operators and Parks and Recreation Senior Van Drivers** are part of the terms and conditions of my employment, and that I agree to abide by them.

I acknowledge that I understand that Marijuana is still a banned substance under Federal law, in all forms including CBD and Medical Marijuana, and that the use of Marijuana may result in a positive drug test and my removal form duty.

By signing below, I also acknowledge that I understand the meaning of this form and agree that it will be used to document my understanding of the **Drug and Alcohol Testing Policy for Commercial Motor Vehicle Operators and Parks and Recreation Senior Van Drivers**.

Printed Name of Employee/Applicant: _____

Signature of Employee/Applicant: _____

_____
Employee/Applicant CDL ID # or DL ID #(For Van Drivers)

Date: _____

Witness Signature: _____

Date: _____

Original Acknowledgment of Receipt and Understanding will be kept in the Driver's Qualification File. Check here ☐ to confirm copy given to employee/applicant.

APPENDIX D: ***Drug Cutoff & Testing Limits as per DOT Rule 49 CFR Part 40 Section 40.87***

Initial test analyte	Initial test cutoff concentration	Confirmatory test analyte	Confirmatory test cutoff concentration
Marijuana metabolites	50 ng/mL	THCA[1]	15 ng/mL.
Cocaine metabolites	150 ng/mL	Benzoylecgonine	100 ng/mL.
Opiate metabolites			
Codeine/Morphine[2]	2000 ng/mL	Codeine	2000 ng/mL.
		Morphine	2000 ng/mL.
6–Acetylmorphine	10 ng/mL	6–Acetylmorphine	10 ng/mL.
Phencyclidine	25 ng/mL	Phencyclidine	25 ng/mL.
Amphetamines[3]			
AMP/MAMP[4]	500 ng/mL	Amphetamine	250 ng/mL.
		Methamphetamine[5]	250 ng/mL.
MDMA[6]	500 ng/mL	MDMA	250 ng/mL.
		MDA[7]	250 ng/mL.
		MDEA[8]	250 ng/mL

[1]Delta-9-tetrahydrocannabinol-9-carboxylic acid (THCA).

[2]Morphine is the target analyte for codeine/morphine testing.

[3]Either a single initial test kit or multiple initial test kits may be used provided the single test kit detects each target analyte independently at the specified cutoff.

[4]Methamphetamine is the target analyte for amphetamine/methamphetamine testing.

[5]To be reported positive for methamphetamine, a specimen must also contain amphetamine at a concentration equal to or greater than 100 ng/mL.

[6]Methylenedioxymethamphetamine (MDMA).

[7]Methylenedioxyamphetamine (MDA).

[8]Methylenedioxyethylamphetamine (MDEA).

Note: These cutoff limits may be subject to periodic revision by DOT.

[65 FR 79526, Dec. 19, 2000, as amended at 75 FR 49862, Aug. 16, 2010; 77 FR 26473, May 4, 2012; 82 FR 52244, Nov. 13, 2017]

Resolution: All cities, towns and villages in Vermont are essential, and Vermont local officials support fair and direct federal emergency aid to reopen and rebuild local American economies.

Whereas America's cities, towns and villages face unprecedented threats due to the ongoing COVID-19 pandemic emergency;

Whereas municipalities are essential to America's economic recovery and without funding support for local governments, municipalities may go from being a critical part of the economic solution, to becoming a major obstacle to long-term stabilization and recovery;

Whereas America's cities, towns and villages will experience budgetary shortfalls of up $134 billion in fiscal year 2020 alone, and the negative effects of the pandemic emergency on communities will continue long after this year;

Whereas three million critical municipal worker jobs are at risk, threatening cuts to basic community services, including 9-1-1 response, sanitation, economy recovery and maintenance;

Whereas communities have taken extraordinary measures to protect health, safety, and the continuation of essential services throughout the emergency;

Whereas Vermont's municipal leaders are united in helping their communities make a strong comeback after experiencing furloughs among municipal staff, loss of direct municipal revenue and tremendous demand from residents and Main Street and other local businesses for assistance; and

Whereas America's rural communities and small towns, especially here in Vermont, are struggling just as much as big cities and risk being left far behind; now, therefore, be it

Resolved, that

1. Vermont local officials call on Congress to allocate fair and direct federal support to all of America's communities, regardless of population size;

2. this funding be flexible and address not only the additional expenses incurred by communities to respond to the pandemic emergency, but also the dramatic budgetary shortfalls resulting from pauses in commerce, tourism, and other economic engines;

3. local governments will ensure federal funds are immediately used to rebuild and reopen the economy;

4. funding will keep workers employed and critical services operating; and

5. Vermont local officials have been part of the emergency response and now call on Congress to build a united national partnership for a safe, healthy, prosperous life.

Submitted by the Town of _____

By its duly elected officials and adopted on:

MEMORANDUM

TO: Evan Teich, Unified Manager; Essex Selectboard and Village Trustees

FROM: Rick P. Garey, Chief of Police

DATE: May 26, 2020

RE: Informational – Release of VT Opioid Use Harm Reduction Evaluation

ISSUE:

This final report was just released to law enforcement. We are offering it to the Selectboard and Trustees reading file for informational purposes, for those that might be interested.

DISCUSSION:

If at some later date the boards have questions or would like to discuss this report in further detail we can set up a time for more detailed discussion.

COSTS: $0 - No cost

RECOMMENDATION:

This is informational only, no action requested.

Vermont Opioid Use Harm Reduction Evaluation

FINAL REPORT

NOVEMBER 2019

Prepared by
Pacific Institute for Research and Evaluation

Acknowledgments

This report was prepared by the Pacific Institute for Research and Evaluation (PIRE) for the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (ADAP). Authors are Jessica Edwards and Vanessa Berman. Other team members reviewed the report and provided valuable suggestions, as well as contributed to the evaluation's overall development and implementation, including project consultant Abby Rudolph and PIRE colleagues Amy Livingston and Bob Flewelling.

We thank all of the participants for their time and insightful contributions. We also thank the organizations that provided space for interviews and shared information about the project during the data collection phase and the additional stakeholders who helped inform the design of the evaluation.

We appreciate the insights and guidance of Nicole Rau Mitiguy, the ADAP Program Manager for this project, and the valuable contributions of other VDH colleagues to the evaluation and this report.

We also acknowledge the funding source for PIRE's evaluation contract, which was the *Prescription Drug Overdose Prevention for States* grant awarded to the Vermont Department of Health by the U.S. Centers for Disease Control and Prevention (CDC).

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Executive Summary

The State of Vermont, Department of Health (VDH), Division of Alcohol and Drug Abuse Programs (ADAP) contracted the Pacific Institute for Research and Evaluation (PIRE) to conduct the Vermont Opioid Use Harm Reduction Evaluation, from June 1, 2018 to November 30, 2019. The evaluation was part of Vermont's *Prescription Drug Overdose Prevention for States* grant from the U.S. Centers for Disease Control and Prevention (CDC). This report summarizes the evaluation's findings and addresses the three project aims outlined below.

The primary objective of the evaluation was to conduct interviews with persons who misuse opioids and live in or access Syringe Services Program (SSP) services in three target counties (Franklin, Rutland, and Windham) in Vermont, to address the following project aims:

1: Assess current harm reduction services and strategies that are being used to lower the risk of opioid overdose and infectious disease transmission;

2: Assess gaps in knowledge and use of services and behavioral strategies that can lower the risk of opioid overdose and infectious disease transmission; and

3: Identify content and formats for effectively communicating health messages from the Department of Health and other agencies to populations at risk for opioid-related overdose and infectious disease transmission.

The distribution of the evaluation's 80 participants was generally equal across the target counties: Franklin (N=26), Rutland (N=27), and Windham (N=27). The sample included 69 individuals who reported using opioids in the past 30 days and 11 who reported using opioids previously but not in the past 30 days. The sample's composition reflected the evaluation's effort to elicit diverse perspectives on opioid-related risks, including recent experiences related to abstinence from opioid misuse and initial stages of being in recovery.

The report is organized into the following major sections: Introduction; Methods; Findings; and Recommendations.

Methods

Formative Interviews with Stakeholders

To prepare for the participant interviews, PIRE conducted 14 formative qualitative interviews with stakeholders (i.e., stakeholder interviews) between August and October 2018. The interviews were with individuals (e.g., state and community agency staff) whose work equips them with key knowledge and perspectives on opioid-related overdose and infectious disease transmission, harm reduction strategies, and

substance use disorder treatment. This stakeholder input was used to inform the development of the participant interview questions and participant recruitment strategies.

Community Outreach and Participant Recruitment

Additional community outreach was an important next step in the project's participant recruitment efforts. PIRE's interviewer was invited to attend community meetings in each of the three target counties to share information about the project and gather ideas for recruitment specific to each county. Using suggestions obtained from these community meetings and from stakeholder interviews, PIRE contacted locations in each county that could be potential sites for recruitment efforts for the participant interviews (e.g., libraries, substance use disorder treatment centers, community lunches, drop-in centers, homeless services providers, Community Action and recovery centers), in addition to Syringe Services Programs. Flyers and small handout cards were displayed, and contained general information about the project, including eligibility criteria and incentive information. Those interested were directed to call or text the interviewer at a local phone number to learn more about the project and to be screened for eligibility.

Participant eligibility criteria included being age 18 or older, living in or receiving SSP services in one of the three target counties, and having used illicit opioids (heroin or intentional use of fentanyl) or misused prescribed opioids (including buprenorphine and methadone) within the past 30 days. Use within the past 30 days, often a standard measure of current substance use, was used as an indicator of current or recent opioid use. In order to gain diverse perspectives on opioid-related risks, and recovery, the project sought to include up to 12 additional participants who had used opioids previously but not within 30 days prior to the interview.

Data Collection

Each participant's data collection session involved a questionnaire and an in-depth interview. The interview guide included a range of topics corresponding to the evaluation's aims. The questionnaire focused on collecting complementary quantitative data, including demographics, use of SSP and other services, and drug use and overdose experiences. On average, the data collection sessions took 1 to 1.5 hours to complete.

Data collection occurred in a private space at various locations, including SSPs, substance use disorder treatment centers, recovery centers, local libraries, or other settings of participants' choice. At the end of the session, participants received $30 cash for their time and participation and were offered naloxone and information about various community resources. These evaluation activities, as well as the formative interviews conducted with stakeholders, were reviewed by the Vermont Agency of Human

Services' Institutional Review Board (IRB) and determined not to meet the definition of human subjects research.

Data Analysis

Interviews were transcribed and subsequently analyzed using the qualitative software package Dedoose. Themes were identified within and across interviews by creating codes corresponding to specific substantive topics in the data. Coded data were reviewed to identify quotes that illustrate the themes. One evaluation team member had primary responsibility for coding the interviews. This team member and the interviewer reviewed the codes and themes together on an ongoing basis to ensure that they were reflective of the data and consistent with the information expressed during the interviews. Quantitative data were analyzed using SPSS. The quantitative results presented in this report focus on the questionnaire data for the 69 participants in the sample who reported using opioids in the past 30 days (i.e., these main quantitative analyses excluded participants identified as those who had formerly used opioids) since understanding current overdose risks and harm reduction practices was the main goal of the evaluation and many of the questions in the questionnaire applied to current opioid use. The qualitative findings draw on the full sample of 80 participants. Although some interview questions were applicable, or tailored, to participants based on their current opioid use status, all participants could provide insights on many of the issues addressed in the interview regardless of their current opioid use status. Therefore, we sought to maximize the insights, experiences, and perspectives available to inform the evaluation by including all participants' data.

Findings

Description of Sample

For the quantitative data presented in the report, the sample (N=69) consists mainly of individuals in the 25-54 age range, with 25-34-year-olds constituting 37.7%. An additional half of participants were in the 34-44 and 45-54 age groups, in equal proportions. Over half (56.5%) of participants identified as male and 42.0% as female. Most (91.3%) participants identified as White, followed by 10.1% of the sample identifying as Native American/American Indian. Forty-six percent of participants reported their highest level of education as being a high school graduate or having received their GED, with an additional 27.5% reporting at least some college education. Thirty-seven percent of participants reported that they were currently working full or part time, including self-employment, while 27.5% of participants were not employed and were looking for work. One-fifth of the sample reported currently receiving Social Security/Social Security Disability Insurance benefits and an additional 21.7% was applying or waiting on a decision on their application for these benefits. Notably, 38.2% of the sample reported that they were currently homeless, meaning they slept outside or

in a shelter, with an additional 22.1% responding that that were “staying at someone else’s place.”

Context of Opioid Use

Most commonly, participants explained that their opioid use initiation arose from an injury, disease, or medical procedure that led to an opioid being prescribed by a medical professional for pain. Examples included car crashes, work-related injuries, C-sections, cancer, wisdom teeth removal, and injuries sustained while serving in the military.

Past 30-Day Substance Use

Heroin was the most commonly used opioid among the sample. On the questionnaire, 69.6% of the participants reporting using it in the past 30 days. More than half of the sample (55.1%) reported using fentanyl (either intentional or unintentional) during this period. Following opioids, the most commonly used substances were marijuana (66.7%), crack (60.9%), and powder cocaine (49.3%).

Knowledge of and Engagement in Harm Reduction Behaviors

Overall, participants expressed a high level of knowledge and engagement in behaviors and services related to reducing the risk of opioid-related overdose and infectious disease transmission. This included a solid understanding of the importance of going slow to test a new batch of drugs, keeping naloxone on hand, and taking care not to use drugs alone as protective measures against fatal overdose. The majority of participants were also particularly insistent that they are always careful to use new injection supplies.

Infectious Disease Acquisition and Transmission Prevention Strategies

In response to the questionnaire, 77.4% of participants who had injected drugs in the past 90 days responded that, in that period, they had never used injection supplies that had already been used by someone else. Consistent with this, during the interviews, participants tended to be uniform and emphatic in describing the safety precautions they took with their injection practices. Among those participants who did use injection supplies after someone had already used them, they indicated the following reasons for doing so: not having access to clean supplies at the time; feeling that they knew the person they were sharing with and not being worried about disease transmission; or being too focused on getting high and, therefore, not prioritizing using new supplies.

Syringe Services Program Utilization

Use of harm reduction services was high as indicated by almost three-fourths of the sample reporting on the questionnaire that they have ever used an SSP, with nearly half of these individuals using an SSP at least once per month. However, awareness of the

SSP mobile van in Franklin County was essentially absent among participants, with only one individual indicating knowledge of the van.

Among the participants who reported on the questionnaire using the SSPs, they primarily did so for access to free safer injection supplies. In addition, two-thirds detailed picking up naloxone there, and more than half of participants reported going to SSPs for information and education and to get safer sex supplies. Many participants who used SSP services reported that they pick up supplies for their peers, either intentionally as part of a pre-existing plan, or they pass out the supplies they had picked up for themselves to their peers while they are using drugs together.

Participants discussed the barriers they face when trying to access SSPs. Limited hours and transportation challenges were the primary barriers mentioned by participants, in addition to embarrassment from being seen and general stigma associated with accessing harm reduction services associated with drug use.

Comments Regarding Safe Consumption Sites

Although safe consumption sites were not a topic included in the interview guide or mentioned by the interviewer, approximately 10 percent of participants brought them up as an important harm reduction strategy for both the individuals who are using, and also as a way to keep used injection supplies out of the community.

Experiences with Medication Assisted Treatment

On the questionnaire, nearly two-thirds of the participants reported currently receiving medication assisted treatment (MAT). During the interviews, most participants on MAT described it as having eliminated or significantly reduced their opioid use. Participants explained that being on MAT helps them both physically and mentally. This included addressing physical pain for some individuals and avoiding the sickness and worry that would arise from not having access to opioids.

Participants mentioned a few main challenges to engaging and staying in MAT. These included differing views among participants regarding what type of MAT policies are most beneficial (i.e., a harm reduction-oriented approach versus an approach with penalties for any illicit use or missed programming), daily attendance requirement for dosing, and transportation.

Participants frequently mentioned that they continued to use opioids while on MAT and noted a few reasons for doing so. Some believed their dose was not adequate to keep them from getting sick. Some described missing doses due to transportation or other barriers, which resulted in them using illicitly to keep from going into withdrawal.

Meeting individuals' MAT needs sometimes aligned with whether the program was a hub versus a spoke. Some participants who were in a hub felt like they needed strict

oversight and daily dosing, while others preferred to be in a spoke, particularly due to not having to attend as frequently. Participants mentioned lack of transportation and employment as the main reasons for preferring a spoke to a hub. Participants who received their MAT from a hub and were required to attend daily for dosing reported that accessing the clinic each day was a hardship, especially if they needed to rely on other people to drive them. These transportation challenges often resulted in illicit use, which would further delay their ability to receive take-home doses in the future. Transportation was also frequently mentioned as a challenge for accessing treatment services by individuals who live in rural areas and are not able to access the bus.

Housing Instability as a Barrier to Harm Reduction Services and Strategies

Participants conveyed how homelessness and unstable housing contribute to riskier behaviors and loss of hope for recovery. They described not being able to focus on themselves, what they enjoy, their family, or their recovery when they do not have safe spaces to live. They described needing the stability of a home and the hope for a better future before they are able to focus on stopping or reducing their drug use. Problems such as affordability, quality, and accessibility for individuals who are currently using drugs or had poor rental history due to previous drug use were mentioned as the main barriers to housing.

Experiences with Overdose and Accessing and Using Naloxone

Half of the participants reported on the questionnaire that they had overdosed one or more times in their lifetime. Among those who had ever overdosed, more than 40% had overdosed within the past 12 months. The vast majority (84.1%) of participants had ever witnessed an overdose. In addition, over half of the sample responded either “likely” or “very likely” to describe their perceived risk of dying from an overdose.

Participants described naloxone as being readily available and accessible. Almost three-fourths of participants reported keeping naloxone on hand at least sometimes, while less than one-third reported doing so always. Further, more than one-fourth of participants responded that they never keep naloxone on hand.

Many participants described reluctance around using naloxone, with it often being used as a last resort because it causes instant withdrawal and destroys a person’s high.

Attitudes Related to Calling 911 for an Overdose

Participants described a range of responses that can occur in the event of an overdose, sometimes with multiple actions being taken before resorting to calling 911 and involving authorities. Participants described attempting to wake the person who has overdosed by putting cold water on them, slapping or otherwise trying to rouse them, and/or administering naloxone. Participants were aware there is a desire among some to avoid a naloxone reversal if possible, and some participants also described that a peer administering naloxone is preferable to calling 911.

Awareness of and Views on Vermont's Good Samaritan Law

Prominent among the sample was a lack of awareness of Vermont's Good Samaritan Law and often a vague awareness of the law among those who had heard about it. Further, participants commonly expressed the belief that there is a general lack of awareness of the law's existence among their peers. Some felt that knowing about the law would increase one's willingness to call 911 in the event of an overdose, while others felt mistrust about the law and were still concerned about potential consequences if 911 were called.

Harm Reduction Messaging: Participants' Suggestions for Content of Messages and Methods of Communication

Participants provided suggestions for content for health messages for individuals at risk for opioid overdose and what they thought would be effective approaches for communicating those messages. Participants indicated the importance of disseminating information on the location and hours of SSPs, in addition to the types of services offered there and that all services are anonymous and free. Participants also felt it was important to share the rationale behind these programs (disease and overdose prevention and treatment connection) in order to build community support and reduce stigma. Other recommended content included overdose risk and prevention; the protections offered by the Good Samaritan Law; behavior changes that could reduce overdose risk; unintentional consequences of drug use, including trauma to family or friends who witness an overdose or lose a loved one to overdose; and general information on available resources accessible in the community.

Word of mouth among peers or by health and human service professionals was the most common suggestion for effectively communicating these messages. Participants suggested that these encounters take place at locations frequented by individuals at risk for overdose, such as SSPs, substance use disorder treatment centers, and locations where people receive economic and health services.

Recommendations

Based on participants' direct suggestions and other findings from the evaluation, the following recommendations are offered. We have intentionally not attempted to prioritize or rate these recommendations. Such considerations will need to be part of a broader discussion among policy makers, program staff, and stakeholders – one for which we expect these findings can make a useful contribution.

- Increase awareness and utilization of harm reduction programming, including:
    - Increase awareness of SSPs
    - Expand the hours of operation at SSPs
    - Address stigma in order to increase SSP utilization

    - Expand services at pharmacies (e.g., sell syringes, offer naloxone without a prescription)
    - Integrate harm reduction services such as syringe distribution into other programming (e.g., MAT providers and recovery centers)

- Increase MAT engagement and retention, including:
    - Expand dosing hours at hub programs
    - Increase spoke providers, or increase awareness of providers, especially in rural areas
    - Increase awareness of shortened wait times for MAT to correct misconceptions
    - Provide child care during dosing hours and meetings with clinicians
    - Integrate other harm reduction services, such as safer injection supplies and naloxone, into the existing MAT structure
    - Review polices surrounding marijuana use

- Improve access to residential programming, including detox programs, such as faster access to treatment and longer treatment stays, if needed

- Promote use of naloxone among individuals who are at risk and among the broader community

- Tend to the basic human needs of individuals, including housing, education, employment, and social connection

- Increase awareness of and trust in the Good Samaritan Law

- Consider the evaluation's implications and recommendations for messaging and services, including:

    - Address conflicting feelings about harm reduction strategies
    - Attend to stigma when raising awareness of harm reduction services
    - Leverage and build on individuals' commitment to act in an overdose situation
    - Address resistance to naloxone administration
    - Support being prepared and managing panic during overdoses
    - Address trauma of witnessing overdoses

1. Introduction

The State of Vermont, Department of Health (VDH), Division of Alcohol and Drug Abuse Programs (ADAP) contracted the Pacific Institute for Research and Evaluation (PIRE) to conduct the Vermont Opioid Use Harm Reduction Evaluation, from June 1, 2018 to November 30, 2019. The evaluation was part of Vermont's *Prescription Drug Overdose Prevention for States* grant from the U.S. Centers for Disease Control and Prevention (CDC). This report summarizes the evaluation's findings and addresses the three project aims outlined below.

The primary objective of the evaluation was to conduct interviews with persons who misuse opioids and live in or access Syringe Services Program (SSP) services in three target counties (Franklin, Rutland, and Windham) in Vermont, to address the following project aims:

1: Assess current harm reduction services and strategies that are being used to lower the risk of opioid overdose and infectious disease transmission;

2: Assess gaps in knowledge and use of services and behavioral strategies that can lower the risk of opioid overdose and infectious disease transmission; and

3: Identify content and formats for effectively communicating health messages from the Department of Health and other agencies to populations at risk for opioid-related overdose and infectious disease transmission.

The distribution of the evaluation's 80 participants was generally equal across the target counties: Franklin (N=26), Rutland (N=27), and Windham (N=27). The sample included 69 individuals who reported using opioids in the past 30 days and 11 who reported using opioids previously but not in the past 30 days. The sample's composition reflected the evaluation's effort to elicit diverse perspectives on opioid-related risks, including recent experiences related to abstinence from opioid misuse and initial stages of being in recovery.

The report is organized into the following major sections: Introduction; Methods; Findings; and Recommendations.

2. Methods

2a. Formative Interviews with Stakeholders

To prepare for the participant interviews, PIRE conducted 14 formative qualitative interviews with stakeholders (i.e., stakeholder interviews) between August and October

2018.[1] The interviews were with individuals (e.g., state and community agency staff) whose work equips them with key knowledge and perspectives on opioid-related overdose and infectious disease transmission, harm reduction strategies, and substance use disorder treatment. Some of the stakeholders interviewed were, by design, individuals who formerly misused opioids themselves. This stakeholder input was used to inform the development of the participant interview questions and participant recruitment strategies.

2b. Community Outreach and Participant Recruitment

Additional community outreach was an important next step in the project's participant recruitment efforts. Through collaborations with the local Substance Abuse Prevention Consultants in each of the three target counties, PIRE's interviewer was invited to attend community meetings, such as the Project VISION meeting and the Rutland Community Collaborative meeting in Rutland County; the Community Partnership meeting and MAT Neighborhood meeting in Franklin County; and the Consortium on Substance Use (COSU) meeting in Windham County. These meetings provided opportunities to share information about the project and gather ideas for recruitment specific to each county. Using suggestions obtained from these community meetings and from stakeholder interviews, PIRE contacted locations in each county that could be potential sites for recruitment efforts for the participant interviews (e.g., libraries, substance use disorder treatment centers, community lunches, drop-in centers, homeless services providers, Community Action and recovery centers), in addition to Syringe Services Programs. Flyers and small handout cards were displayed, and contained general information about the project, including eligibility criteria and incentive information. Those interested were directed to call or text the interviewer at a local phone number to learn more about the project and to be screened for eligibility.

Participant eligibility criteria included being age 18 or older, living in or receiving SSP services in one of the three target counties, and having used illicit opioids (heroin or intentional use of fentanyl) or misused prescribed opioids (including buprenorphine and methadone) within the past 30 days. Use within the past 30 days, often a standard measure of current substance use, was used as an indicator of current or recent opioid use. In order to gain diverse perspectives on opioid-related risks, and recovery, the project sought to include up to 12 additional participants from the three target counties who had used opioids previously but not within 30 days prior to the interview. Interview appointments were scheduled for times and locations convenient for the participant. The interviewer was also available for drop-in (non-scheduled) interviews at the SSPs, recovery centers, drop-in centers, and substance use disorder treatment centers at times coordinated in advance with the interview locations.

[1] The stakeholder interviews were summarized in the following report available from the Vermont Department of Health Vermont: Opioid Use Harm Reduction Evaluation Stakeholder Interview Report, October 30, 2018.

2c. Data Collection

Each participant's data collection session involved a quantitative questionnaire and an in-depth interview. Figure 1 displays the interview topics. The questionnaire focused on collecting complementary quantitative data, including demographics, use of SSP and other services, and drug use and overdose experiences. On average, the data collection sessions took 1 to 1.5 hours to complete. Prior to beginning each interview, the interviewer provided an overview of the project and explained the purpose of the interview and why we were interested in participants' input. The interviewer explained that the interview was voluntary, that neither individuals' names nor other identifying information would be connected with their individual responses in reports of the data. Participants were also informed that, with their permission, the interview would be audio-recorded for project purposes only. The interviewer used an iPad to administer the questionnaire to participants verbally and collect their responses electronically. Following the brief questionnaire, the rest of the session focused on the interview. The semi-structured design of the interview allowed the interviewer to discuss topics raised by participants, in addition to asking the predetermined questions in the interview guide.

Figure 1.

Participant Interview Topics

- Drug use history and progression
- Services and supports needed by individuals who use opioids
- Experience with SSPs (including use of naloxone, fentanyl test strips), medication assisted treatment (MAT), and other services
- Hepatitis C and HIV knowledge and beliefs
- Behavioral harm reduction strategies
- Overdose experiences
- Access to naloxone
- Awareness of and views on Vermont's Good Samaritan Law
- Parenting
- Participants' suggestions for health messages

Data collection occurred in a private space at various locations, including SSPs, substance use disorder treatment centers, recovery centers, local libraries, or other settings of participants' choice. At the end of the session, participants received $30 cash for their time and participation and were offered naloxone and information about various community resources. These evaluation activities, as well as the formative interviews conducted with stakeholders, were reviewed by the Vermont Agency of Human Services' Institutional Review Board (IRB) and determined not to meet the definition of human subjects research.

2d. Data Analysis

Interviews were transcribed and subsequently analyzed using the qualitative software package Dedoose. Themes were identified within and across interviews by creating codes corresponding to specific substantive topics in the data. Coded data were reviewed to identify quotes that illustrate the themes. One evaluation team member had primary responsibility for coding the interviews. This team member and the interviewer reviewed the codes and themes together on an ongoing basis to ensure that they were reflective of the data and consistent with the information expressed during the interviews. Quantitative data were analyzed using SPSS. The quantitative results presented in this report focus on the questionnaire data for the 69 participants in the sample who reported using opioids in the past 30 days (i.e., these main quantitative analyses excluded participants identified as those who had formerly used opioids) since understanding current overdose risks and harm reduction practices was the main goal of the evaluation and many of the questions in the questionnaire applied to current opioid use. The qualitative findings draw on the full sample of 80 participants. Although some interview questions were applicable, or tailored, to participants based on their current opioid use status, all participants could provide insights on many of the issues addressed in the interview regardless of their current opioid use status. Therefore, we sought to maximize the insights, experiences, and perspectives available to inform the evaluation by including all participants' data.

3. Findings

3a. Description of Sample

For the quantitative data presented in the report,[2] the sample (N=69) consists mainly of individuals in the 25-54 age range, with 25-34-year-olds constituting 37.7%. An additional half of participants were in the 34-44 and 45-54 age groups, in equal

Figure 2. Age

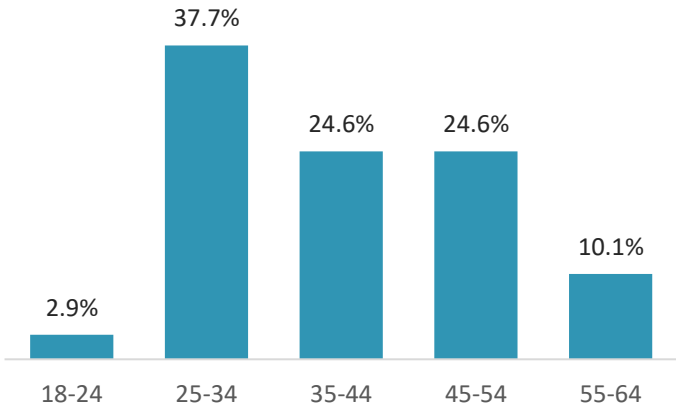
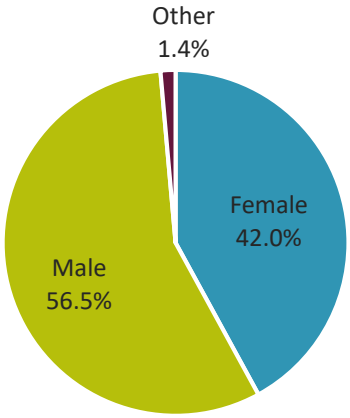


Figure 3. Gender



[2] Due to rounding, some totals presented in the report do not equal 100%.

proportions. Over half (56.5%) of participants identified as male and 42.0% as female. Most (91.3%) participants identified as White, followed by 10.1% of the sample identifying as Native American/American Indian. Forty-six percent of participants reported their highest level of education as being a high school graduate or having received their GED, with an additional 27.5% reporting at least some college education. Thirty-seven percent of participants reported that they were currently working full or part time, including self-employment, while 27.5% of participants were not employed and were looking for work. One-fifth of the sample reported currently receiving Social Security/Social Security Disability Insurance benefits and an additional 21.7% was applying or waiting on a decision on their application for these benefits. Notably, 39.1% of the sample reported that they were currently homeless, meaning they slept outside or in a shelter, with an additional 22.1% responding that that were "staying at someone else's place." Given the evaluation's interest in identifying effective communication methods, the questionnaire also asked about participants' cell phone and internet access. Seventy-one percent of participants reported having a reliable cell phone and 81.2% reported having reliable access to the internet.

Figure 4. Years of Education

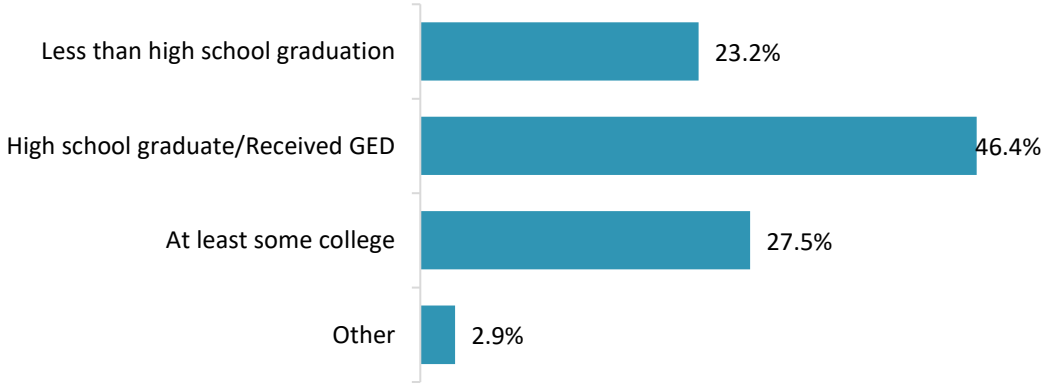
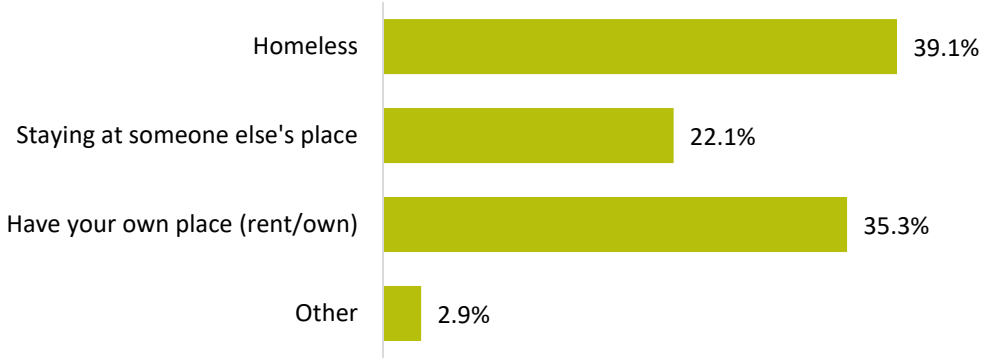


Figure 5. Housing Status



3b. Context of Opioid Use

For context, at the beginning of the interviews, participants were asked to describe how and when their opioid misuse started. Forty-three percent of the 80 participants who were interviewed explained that their initiation arose from an injury, disease, or medical procedure that led to an opioid being prescribed by a medical professional for pain. Examples included car crashes, work-related injuries, C-sections, cancer, wisdom teeth removal, and injuries sustained while serving in the military. Half of these individuals attributed their illicit opioid use to their medical provider terminating their opioid prescriptions.

- "It started with, I had some major operations and I was issued high doses of oxycodone and fentanyl for pain management for a long period of time. Then overnight they were just taken away from me. So, I spent four months getting clean. I did it myself. I couldn't get into a rehab program. I had to manage it myself and essentially do it cold turkey, which it took me a very long time to do and then once I was clean, I was clean for two and a half years and then I got back into seeing a pain management specialist at the same hospital that issued me the medications prior and after four months of seeing them they wanted to put me back on pain meds, which they did and they kept me on those pain meds for four months. Of course your tolerance goes right back up to where it was and once they saw that happening after four months of being issued narcotics, they said that they didn't want to do it anymore, they pulled my meds away from me and at that point in time I had gone to school, enrolled in college, and I was trying to better myself and so it was a very tough position for me … so I in turn started getting the same medications on the street and then what happened was is I couldn't afford the prescription medication on the street, it was cheaper going to the heroin and that's what I did."

- "It was rough. I've never been so sick in my life…I went to a detox facility for nine days trying to get off the fentanyl and I mean I was taking 100 micrograms, or whatever they are, every two days plus the percs, so when I detoxed off that with nothing it was awful and I can honestly say for about six months I didn't feel—I felt like I was a body with no head like I did not feel right for a long time…I had never experienced anything like coming off fentanyl, ever.…I can't even believe I'm alive today because you don't think of that you know? My doctor never said 'Oh, be careful because you know'…you know I put it on my skin for the longest time and you know you hear people say 'Oh, you know, and then one thing leads to another and before you know you're a full-fledged drug addict.'"

One-fifth of interviewees described using opioids to numb emotional trauma, either from their childhood and/or from an incident as an adult. Self-medicating mental health struggles and trauma was a theme that came up often during the interviews.

- “I had an accident where a friend of mine was killed and then so I kind of started using to like numb that type of thing and then it just kind of progressed from there where you know it started out with like Percocet and then it went to oxycontin and then when they took the oxycontin away really they boosted this epidemic themselves. Then I went to that [heroin] and it was just kind of a struggle ever since and now it’s more just to feel normal. So, yeah, I don’t get the high or the like—it’s not fun for me to do it, it’s just to be normal.”

- “I’m to this point and like I said heroin is the lesser of two evils for me. It’s like, ‘Do I stay in pain or do I use?’….I just had the whole world just fall on me and so I just I went back because it’s an easier way to go, you know backwards than it is forwards, just to go back to use again, because it’s like an old friend that’s always there and I can always reach back and grab it…. So, it’s like I just keep having these things, like, fortify my use, I keep getting reasons to look back and just say, you know, alright, it’s just easier to use and put a blanket over my eyes, a blindfold you could say.”

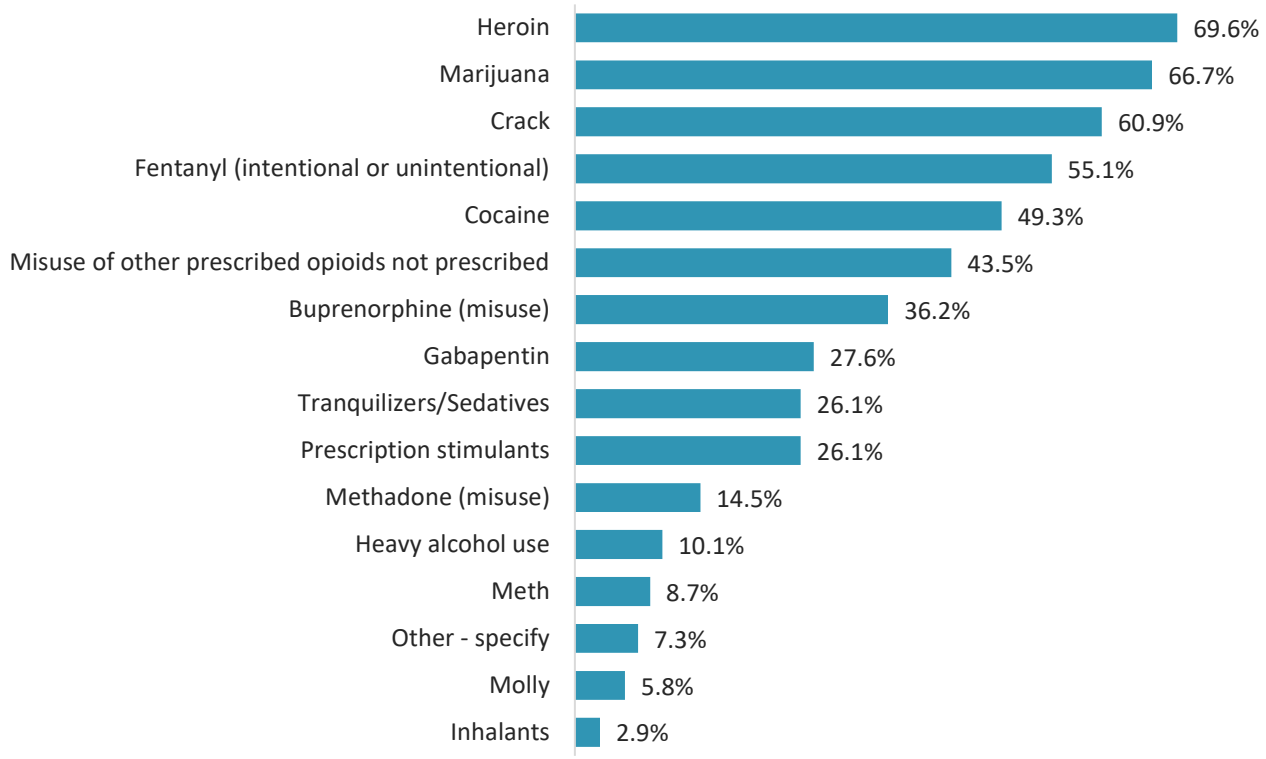
Participants also described the normalcy of drug use when they grew up with parents or around other adults using drugs. Among participants that didn’t identify a particular reason for initiation, as described above, they described the desire to feel good and to get a euphoric high.

Some participants mentioned that their opioid use began with heroin and/or injecting, although most participants started using opioids by taking pills (orally or snorting) and progressed to injecting heroin. The primary reason for this transition was cost (i.e., getting “more bang for your buck”), the ability to use less when injecting, and the difficulty in accessing pills.

3c. Past 30-Day Substance Use

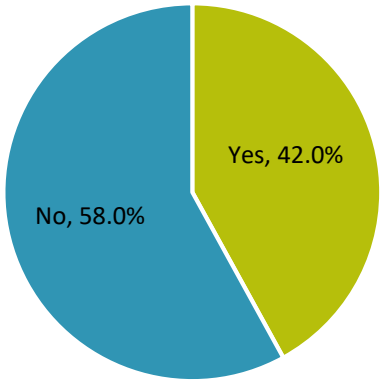
As discussed in the Methods sections, by the project’s design, all participants included in the report’s analyses had used opioids in the 30 days prior to the interview (i.e., current use). As shown in Figure 6, heroin was the most commonly used opioid among the sample, with 69.6% of the participants reporting its use in the past 30 days. More than half of the sample (55.1%) reported using fentanyl (either intentional or unintentional) during this period. Thirty-six percent of participants reported illicit use of buprenorphine, while 14.5% of the sample reported illicit methadone use in the past 30 days. Forty-four percent of participants had misused other prescription opioids. Following opioids, the most commonly used substances were marijuana (66.7%), crack (60.9%), and powder cocaine (49.3%). Figure 7 shows that 42.0% of the sample used all of these particular substances in the past 30 days – opioids, cocaine, and marijuana.

Figure 6. Past 30 Day Substance Use



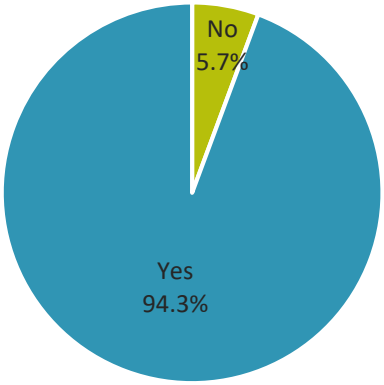
Note. Heavy alcohol use was defined in the questionnaire as 15 or more drinks per week for men and 8 or more drinks per week for women.

Figure 7. Used Opioids, Cocaine, and Marijuana in the Past 30 Days



Most participants (91.3%) reported having ever injected drugs, with 73.9% having done so in the past 30 days. Among those who had injected in the past 90 days, 94.3% reported having injected an opioid to get high (Figure 8).

Figure 8. Injected Any Illicit Opioid or Prescription Opioid Non-Medically or to Get High in the Past 90 Days



As noted, use of stimulants was high among participants. The quantitative data show that crack cocaine use was more prevalent than powder cocaine use in the past 30 days among participants. In the interviews, some participants described having a preference between the two types, while others reported that they would use whichever they could get:

- "They're both the same price. They're both easy to get, but it seems like over the…last couple of years now, it seems like now everybody has moved away from doing the coke snorting to now everybody and their brother now is smoking crack."

- "…it's kind of like whichever one I can get."

There was some awareness that crack and powder cocaine could be laced with fentanyl. One participant noted:

> "There has been more talk now that it's been advertised on TV and stuff where people are still getting to be a little bit more worried about getting the fentanyl overdoses.…all the fentanyl overdoses, well, now they're lacing it where it could be in your coke or it could be in your crack or now it could be in your marijuana.

Simultaneous use also differed among participants, with some preferring to do opioids and stimulants at the same time ("speedballing"), while others preferred to do them sequentially, or others not to combine them at all.

- "Usually I'll use crack and then the opioids to kind of calm everything down."

- “I kind of went back to like heroin. So you need heroin to function and then, like, when you smoke crack, it sucks the opiates right out of your body, coke or crack or whatever. So, by the time, say, you smoke a lot or whatever you’re fucking dope sick, you’re in withdrawals. It totally—it’s so dumb. And then and or you use the dope to come down off the crack or because your body is feeling it because the coke has sucked it all out of your body.”

- “I’m not going to say that I haven’t used both at the same time, but less frequently, you know what I mean, because of the fact I feel like if I’m upping myself so high and then all of a sudden, I go down like I’m looking at either a heart attack or you know what I mean? When you start mixing combinations of drugs, it’s as deadly as it is being heroin alone…you know what I mean? So that’s always stuck in my head, like, you know there could be fentanyl in this, but what’s in the cocaine? I don’t know. So, I started mixing things. I might make a concoction that’s going to make my heart go boom and that’s not something I wanted to do.”

Some participants felt that stimulant use was a way to prevent or reverse an overdose.

> The old way of dealing with a heroin overdose was a shot of cocaine because it just speeds back up the heart rate and breathing rate and I will tell you it does work. And another thing people do is they’ll blow crack smoke in someone’s mouth when they’re starting to go down to try to speed them back up again.”

Some participants reported an increase in their stimulant use once they started on a methadone program:

- “I was on a lot of methadone. They were like overdosing me with methadone when I first went there. I was passing out at the wheel. I couldn’t even drive home. It’s crazy. I was on 90 milligrams, so I was just so sedated. So, to keep yourself awake on methadone, a lot of people go back to using coke and that’s what I did, just smoking crack like crazy.”

- “I’ve noticed that being on methadone I use crack a lot more, though…. I think that methadone kind of makes you sleepy and sluggish. It [crack] also makes you want to eat everything…makes you more alert and…”

- “It [crack use] actually came into play when I started my methadone, which was weird. I stopped using heroin and I just really, really badly craved uppers. I don’t know why, but I did and then when I stopped doing methadone, the crack urge sort of went away.”

3d. Behavioral Harm Reduction Strategies

A key focus of the project was to learn about behavioral strategies individuals use to reduce their risk of opioid overdose. As the quotes below convey, several of the strategies are interrelated. In particular, participants routinely mentioned the importance of not using alone, keeping naloxone on hand, and testing the quality and intensity of the drug by starting out slow, as "you can always do more" from there but you cannot take away or go back from the amount of drug you have already consumed. A specific example of "starting slow" was by sniffing or snorting rather than injecting the drug.

Figure 9.

Behavioral Harm Reduction Strategies

- Don't use alone and have naloxone on hand
- Start slow
- Buy from the same person over time/know who you are buying from and test it
- Assess for fentanyl
- Use marijuana to deter opioid use

"…a lot of people nowadays are carrying Narcan. I mean I think a lot of us are really sick of losing friends. That's a huge one."

- "I guess I usually let people know when I'm going to go use if I'm going by myself or whatever, to check up on me in a little bit and my friends are usually really good about that and I do the same for them. I make sure I always have at least four Narcans on me."
- "Try not to use by yourself. Always have somebody around. Always have Narcan on hand and most people in this area are really good about that. There's usually somebody within the group that will have Narcan, so."
- "…you always let somebody go first and then you don't do that much. Those are just the rules…It could save your life, so it's important to do."
- "If I don't know what it is, and it's something new that I'm trying, I'll do very, very little and see how it kind of does and then because you can always kind of add, but you can't take away."
- "Yeah, sometimes I'll snort instead of inject because I don't know [about the quality of the drug]."

- “Usually if I get some, the first time I will either sniff it or I will just do half a ticket or less than half a ticket...”

Another strategy several participants mentioned was making it a point to know the person they get their drugs from or buying their drugs from the same person over time. With this familiarity, the person is more likely to be trusted to provide a quality product and might provide a caution against a particularly strong batch. Participants still described “starting slow” and testing the drugs obtained from these contacts:

- “…so the guy I get it through I can get a pretty good idea of what the quality is, so I know like how much to do. But then there is times he’ll be like this stuff is pretty good, so you know take it easy. You get the warning that’s when you’re like alright, so, you know, maybe have a [Naloxone] standing by and don’t go doing no half gram shots right off the bat, just take it easy because you can always do more, you can’t extract it back out as easy.”

- “…I try to deal with the same people all the time…Typically, if I’m getting it from a new person or if it’s a new product, I’ll start with just one bag and see how it affects me, that type of thing… see how hard it hits me, see if, you know, if it turns my stomach, things to that effect. But I typically try to stay with the same people because a lot of people also will cut things with some crazy stuff to increase their product and their money.”

Assessing for the presence of fentanyl was a specific type of testing that several participants described undertaking before they used their drugs. For some, this included using fentanyl test strips, but participants also explained that fentanyl could be detected by tasting the drug and discerning fentanyl’s sweet taste from heroin’s bitter one. In the questionnaire, 21.7% of participants reported having used fentanyl test strips previously (and would so again), with an additional 56.5% indicating that they had never used the test strips but would if they had access to them (Figure 10). Among participants who indicated that they would not use fentanyl test strips if they had access to them, their reasoning was due either to their perceived low risk of fentanyl exposure or their desire not to waste drugs. Participants who primarily used illicit suboxone felt that the risk of fentanyl contamination was low and therefore did not feel the test strips were necessary. Participants also expressed concern that using the fentanyl test strips required too much of their drugs for the test and they did not want to use their supply in this way.

Although less frequently than mentioning tasting, participants also noted that paying attention to the color of the drug was another way to determine whether they thought fentanyl was present in their drug.

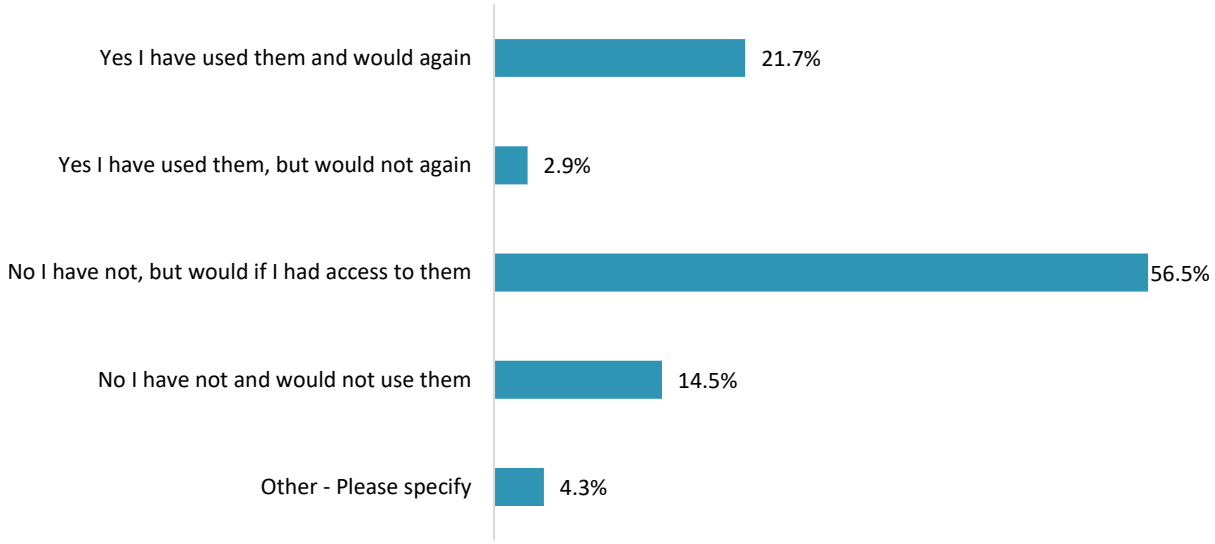
- “Well, you ask and if you don’t know, you’ve got to look at it yourself. You’ve got to know what you’re looking for because fentanyl really has kind of a sweet taste,

or no taste…you can…taste it, the color, you've just got to be cautious. Some people just don't care, so."

- "I mean I don't know really, but I feel like fentanyl is sweet, dope is bitter. If it's white colored normally it's got fentanyl in it, or something of the sort and you know the word around town about stamps… which ones are bad, which ones are strong, this and that."

- "Yeah, the sweetness of it..fentanyl is very sweet tasting. Heroin is very bitter….when I'm pushing air out of my syringe…I squirt some in my mouth so I can taste it."

Figure 10. Use of Fentanyl Test Strips



Participants described these strategies when asked specifically about steps they take to protect against overdose. In addition, during the interview discussions, some participants described marijuana use as a harm reduction strategy in that it helps deter or reduce their opioid use:

- "…the weed kind of helps deter me."

- "…people say it's a gateway drug. I think it's like a lock on the door drug because I'll think about using and get a lot of thoughts in my head, and I can sit down and smoke and relax and not think about it…

Further, several participants discussed using illicitly-obtained buprenorphine to manage their opioid use and withdrawal symptoms:

- "I've done bupe on the street before and it worked for me. I didn't think about getting high."

- “I mean, it took like two weeks, but I just started taking street bupe, until I got into the clinic…I think for most people it’s just you don’t want to be sick and you do whatever it takes to not be sick.”

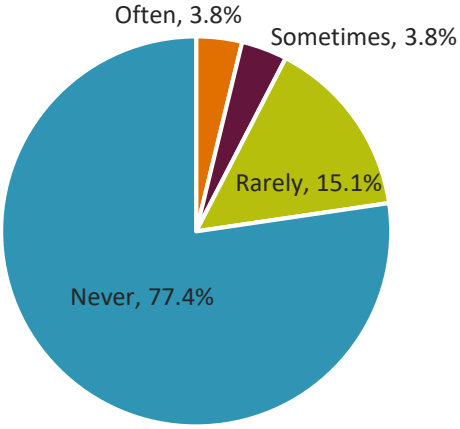
- “I’ve got to go buy it from the drug dealer, basically, back to some of my own ways, and I don’t like to do it, but I kind of have to until I can find a doctor who will sit down and listen to me and actually help me.”

3e. Infectious Disease Acquisition and Transmission Prevention Strategies

> “…most people try to use clean supplies. Like, there’s not a lot of people I know that just trade needles around like it’s not a big deal. I think that’s more of a stereotype that junkies get.”

In response to the questionnaire, 77.4% of participants who had injected drugs in the past 90 days responded that, in that period, they had never used injection supplies that had already been used by someone else (Figure 11). Consistent with this, during the interviews, participants tended to be uniform and emphatic in describing the safety precautions they took with their injection practices, as illustrated by the quotes below. Among those participants who did use injection supplies after someone had already used them, they indicated the following reasons for doing so: not having access to clean supplies at the time; feeling that they knew the person they were sharing with and not being worried about disease transmission; or being too focused on getting high and, therefore, not prioritizing using new supplies.

Figure 11. Used Injection Supplies That Had Already Been Used by Someone Else in the Past 90 Days



- “Well, I use a clean needle every time no matter what. I will never reuse a rig, never. I’ve always been really firm on that because I don’t want to get any of that shit and, you know, I always wash my cookers or spoons, whatever. Like I said, I’ll reuse the same tourniquet a bunch of times because you can still use shit from that. I won’t share cottons, I won’t share needles, I won’t do none of that, like none of it whatsoever. I just will not do it. I’d rather sniff a bag or not do it at all if I didn’t have a clean rig, but, yeah, I’m very good about that.”

- “I use a new syringe every time and have my own stuff. I don’t ever share or do anything with anybody.”

- “…if I can’t get something clean, I’d rather just snort or smoke it.”

Although participants generally felt comfortable with their hepatitis C and HIV transmission knowledge, a few participants expressed the belief that they could give themselves hep C by reusing their own injection supplies.

3f. Use of Syringe Services Programs

Another central objective of the evaluation was to assess use and barriers to use of Syringe Services Programs in the three target counties. There is one Syringe Services Program (SSP) in each of the target counties: VT CARES Mobile Van in Franklin county, which operates there once per week by appointment; VT CARES SSP in Rutland county, which operates every Wednesday 9:00am – 3:00pm; and the AIDS Project of Southern VT SSP in Windham county, which operates every Tuesday 10:00am – 2:00pm. Services offered at these harm reduction agencies include the availability of: safer injection supplies, safer sex supplies, fentanyl test strips (in Rutland and Franklin counties), HIV/HCV testing, and referrals to treatment and other services.

Awareness of the program

Of the 26 participants in Franklin county, only one was aware of the SSP mobile van. Awareness of the SSPs in Rutland and Windham counties was generally high. As illustrated by the following quote, participants there tended to indicate that they and their peers knew about the programs, even if they did not use their services: “Everybody I know knows about it, but then there’s people that choose not to want to come down here.” Participants depicted a tension in balancing individuals’ concerns about anonymity when using an SSP and the importance of advertising the program to ensure people know it is there. Participants explained that some people’s apprehension to use an SSP may be reduced by letting them know that the services are anonymous and that the locations are discreet. However, participants also noted that in order for people to know about the SSPs, it is important to advertise them. The following quotes exemplify this challenge observed by participants:

- “I think the fact that they make them aware that it’s all anonymous, you know what I mean? It’s not like you’re named in there and that’s one thing I do like about them, not having anything on the doors. Because then people don’t have to think when you walk through a door, that’s what you’re going in there for. So that does work that way. But also, you know, you should have a little bit more advertisement to, like, to know that it’s there. So, it’s a Catch-22 kind of thing.”

- “I realize that these places are supposed to be anonymous or whatever…but can’t you publish where these places are like in the newspaper or places that people read…people don’t know it’s there.”

- “I knew they had one here somewhere…Yeah, they could do a little bit more advertising.”

- “It’s kind of hard to find.”

Participants’ use of SSPs

Seventy-four percent of participants reported having ever used an SSP, with one of these participants noting that they had done so only for the purpose of getting supplies for friends (Figure 12). Among those who have ever used an SSP, 35.3% reported that they visit an SSP at least once per month and an additional 11.8% indicated that they go at least once per week (Figure 13). One-fourth reported visiting an SSP at least once every six months. The “Other” responses for this question tended to explain that the participant just recently visited an SSP for the first time or had used an SSP previously but does not currently.

Figure 12. Ever Used a Syringe Service Program

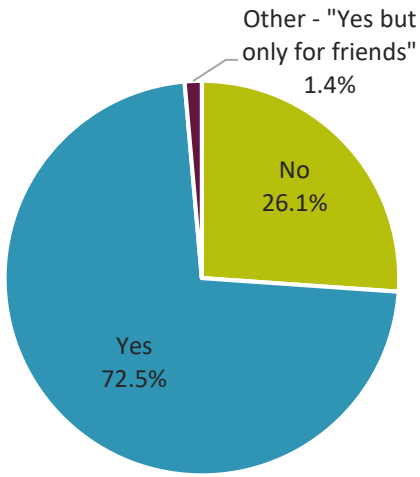
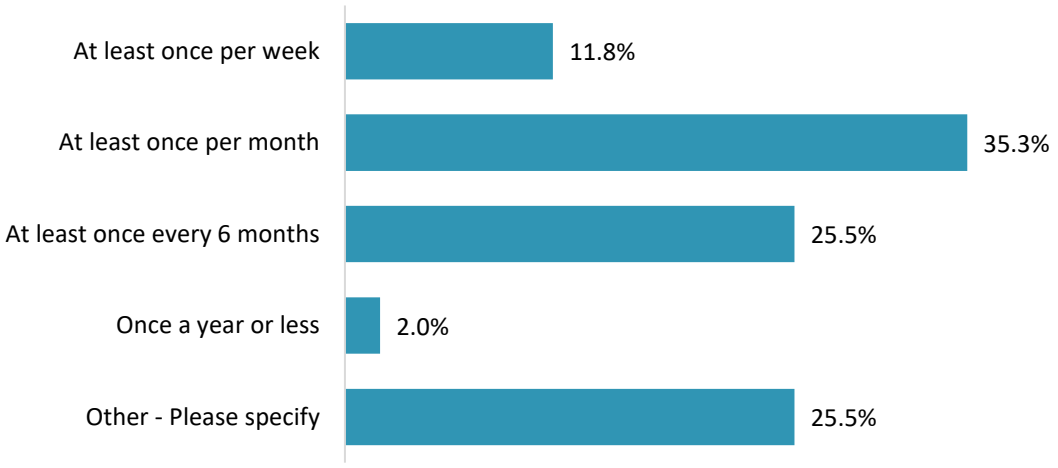


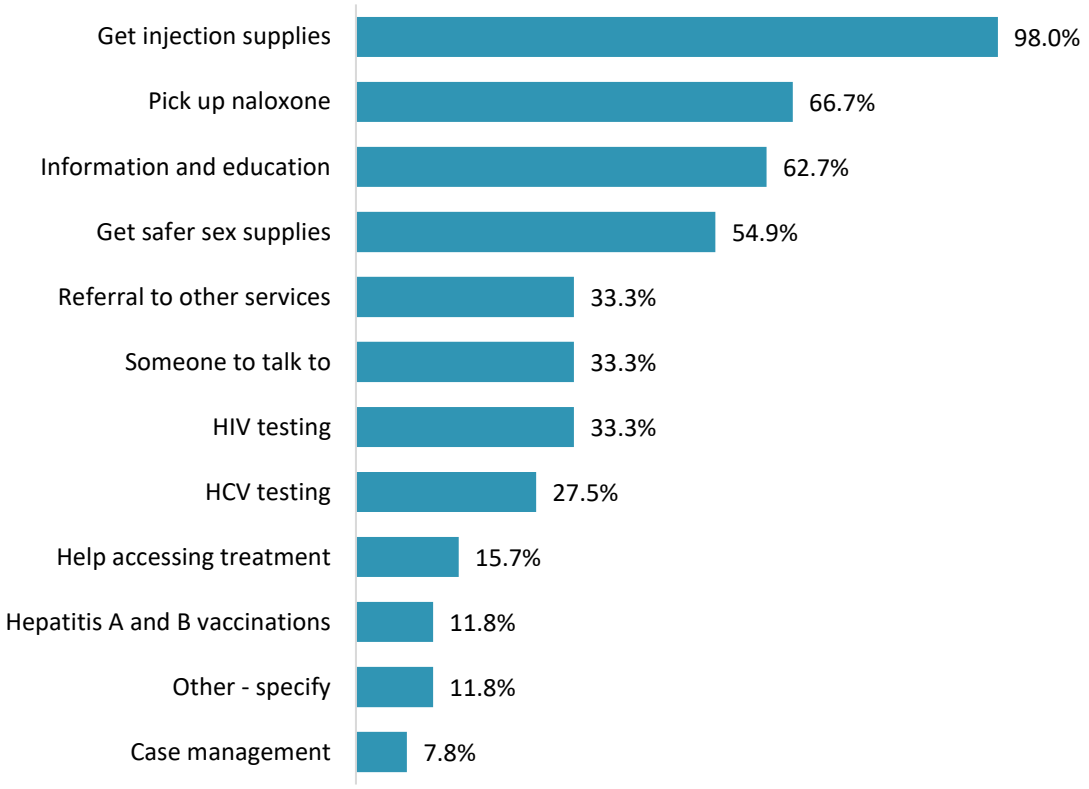
Figure 13. Frequency of Visiting a Syringe Service Program among Those Who Have Ever Used an SSP



Reasons for and benefits of using the program

Figure 14 displays the services participants reported having ever used at an SSP. In the questionnaire, the interviewer asked the participant to indicate whether or not they had ever received a series of different SSP services. Representing the most commonly reported service, almost all participants (98.0%) who had used an SSP reported getting injection supplies from the program. Picking up naloxone was the second most frequently reported service, with two-thirds of the participants who had ever used an SSP indicating this. Obtaining information and education and safer sex supplies were other relatively common services. In contrast, case management, hepatitis A and B vaccinations, and help accessing treatment were among the less commonly reported services. Examples of “Other” services participants mentioned included fentanyl test kits and wound care.

Figure 14. Services Used At SSP



> "I tell them [peers], you get clean rigs, you get the little container to put the old ones in so you can stop dropping them on the ground, and you bring them in and you get new ones. You get the cookers and, you know, it's free, so why say no [to using the SSP]?"

During the interviews, participants expressed appreciation for the SSPs in Windham and Rutland counties. Overall, they felt that they had the supplies they wanted and that the staff were courteous. Participants were aware they could access safer injection supplies, naloxone, and safer sex supplies at SSPs. However, not all Rutland participants were aware of the fentanyl test strips that were available at the Rutland SSP. In particular, participants valued SSPs as a way to help them stay safe from infectious disease. Some felt that they would not have any other option if SPPs were not available, while others explained that they already purchase syringes at pharmacies or would do so if SSPs were not an option.

Many of the participants who had used an SSP reported that they pick up supplies for their peers, either intentionally as part of a pre-existing plan or by passing out the supplies they had picked up for themselves to their peers while they are using drugs together. Fewer participants indicated that they were the recipients of secondary

exchange, though this was more prevalent in Franklin county where access to an SSP was more limited among participants.

- "Well, you know if they need them and I know they need them and they're using old needles, I just I bring them to them, you know? Tell them, 'Hey, I got some,' and I give them a bag, so, yeah."

- "I usually pick up the max, just because sometimes there's times when I'll go a few weeks before I come, or I'll come once or twice a month, so you know and I do have, I do know people that can't make it down, so I do grab an extra box or two for them."

- "I get tons of injecting supplies for my friends, condoms for my friends, condoms for my kids. I have teenage daughters and those things, like, you know, like the condoms, for sure, I would not be able to afford that on my own, for myself or anybody else. I find that people don't want to go out of their way to get either syringes or condoms or whatever and so they'll just kind of go without, but if they're presented with it and there's not a whole lot of work involved, they're more than happy to use those things."

Barriers to SSP use

Across the counties, during the interviews, the most commonly cited reasons preventing participants or their peers from using an SSP were lack of awareness of the SSP, days and hours of operation of the SSP, transportation, and stigma. In Franklin county, the greatest barrier was not knowing about the mobile van and lack of transportation for accessing the SSP in Burlington. For harm reduction services, they either used the SSP in Burlington, used secondary exchange with peers who traveled to Burlington, purchased syringes from pharmacies, or did not use new injection supplies when injecting.

> "I'm sure a lot of people don't want to be judged or feel like they're going to get in trouble or somebody's watching them and the fact that they have kind of funky hours and you don't really know how—like there's not really advertisement for it, I guess."

The most frequently mentioned barriers for Rutland and Windham county participants were the hours of operation. Participants described the challenges posed by the SSP being open for a limited number of hours per week:

- "The syringe program here, I know the only downfall to it is the once a week thing. I know that that prevents a lot of people from going because especially the hours and stuff. They work or if they don't—you know people that live like out

towards like Brandon or in Pittsford or in other parts of Rutland County that's not as accessible as someone like me who lives in town."

- "…I said to myself, 'Oh yeah, it's Wednesday, I should go to the clinic today'…then the next time I remembered…it was like four o'clock, and I was like 'Oh shoot, I guess I'll go next week.'"

- "I think a lot of people are like me, embarrassed of coming in here and they're scared and that's why I have a lot of people that come to me asking me for rigs and stuff because they don't want to come here. It's embarrassing to come here or either that or they just don't have the time, because actually the needle exchange isn't open a lot. They're open maybe, what, twice a week for, what, from ten to noon?… And people who work, I have friends who work maybe eight to five. They can't make it down here, so they can't get it. So another thing is if they can expand hours or maybe be open at night for an hour because a lot of people are working and they can't get here and at lunch break, they're not open enough. They're only open like you said one day a week, that's ridiculous. That's why people are dying every day they need to open a little bit more, have more volunteers here so that they could open because one day a week…how many people you think could be here one day a week between two hours?"

- "…they are out there for people, but they're not really out there."

- "I know a lot of people say they wish it was open on the weekends because they work all week, things like that. So, you know maybe even like a Wednesday and a Saturday thing or a Wednesday and a Friday thing…even just one more day can help so many more people get access to that program. I mean, it's like, I really can't stress like how much one day could really change that program a lot."

Across the counties, many of the participants described experiencing the stigma associated with substance use disorder and discussed ways in which stigma created barriers to accessing harm reduction and other services. One way this manifested was by individuals feeling embarrassed to reveal their drug use, or injection drug use specifically, both to people they encounter in the SSP and to others in the community who might see them at an SSP.

- "I didn't want to see people in here that I might know and then make them uncomfortable and make myself uncomfortable but, really, if they're in here, they're in here for the same reason I am, so really it doesn't matter."

- "…conscientious of people seeing me there, getting the things you know. Obviously, people know what that place is and when you come out of there

they're automatically going to assume the worst. That's the only barrier that originally kept me from going there."

- "I was always embarrassed because you know it's right in town and I know a lot of people. That's where I'm from, and I always hated going in there and seeing people I know. 'Oh, you use needles?', you know? But besides that, it was a good place. I'd always try to go in and out as fast as possible."

- "They think if you go into that [an SSP], you're automatically labeled that. So, say if you go in there and you see the guy that you see at the convenient store every day that doesn't know you from anything. He just knows that you buy a pack of Marlboro's. Now he thinks you're a needle user. And that's where I think a lot of people try to incorporate and they think, like, 'Oh no, you know, so I'd rather use a dirty needle'…I think that they're worried about these labels."

- "Well a lot of people, when you have, I have a counselor and I have people that don't know I do drugs, I mean and when they see you coming out of here, they automatically know you're doing something. What are you coming out of the needle exchange for? I certainly don't work here, they know me, they know my life. Some people don't know anything about my private life, and they see me coming out of here it just doesn't look good and they talk, and they whisper, and I don't like it."

- "Like say his girlfriend don't know and he pulls up and his girlfriend's girlfriend sees him over there, it's like oh my God, who do you think that's going to be calling him 10 minutes from now? His girlfriend, you know what I mean? That's the thing…it takes its toll. The thing is, the whole thing about it is, it's just a dirty, nasty secret."

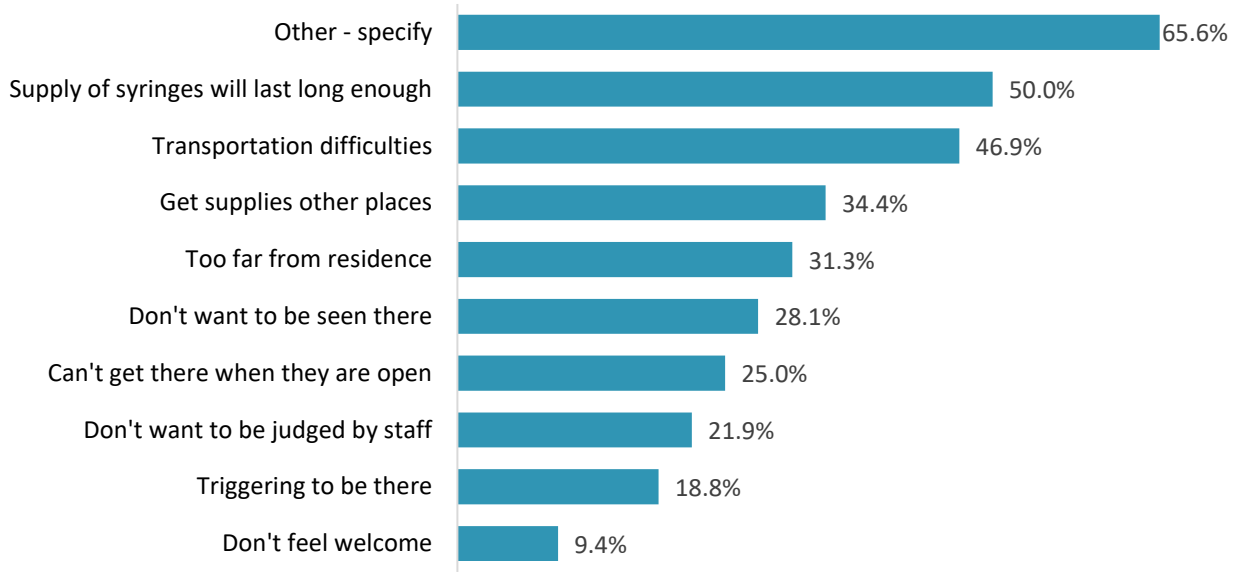
- Interviewer: And so, what are the reasons that you chose to never go there?

  Participant: More or less it's being seen coming out and the embarrassment of people knowing that I use needles and stuff like that, that's what kept me from going there so I would just get them from people that I knew that went there, so I didn't have to be seen going in or out. Not only that, but, like, family. Someone drives by, sees me coming out of a needle exchange, then, you know, it don't look good for your family when they see you coming out of a place like that.

Additional reasons, across the counties, that were described as reasons participants did not utilize SSPs more frequently than at least once within a six month period were: they obtained syringes at pharmacies, they obtained supplies from peers (e.g., secondary exchange), and they had the supplies they needed to last them.

Figure 15 displays participants' responses to the questionnaire's question regarding reasons for never using an SSP or for not using one more frequently. The responses generally are similar to the interview comments. The most common "Other" responses for not using SSP services were due to not injecting drugs and lack of awareness of the SSP and/or its location.

Figure 15. Reasons For Not Using An SSP or Not Using It More Frequently



3g. Comments Regarding Safe Consumption Sites

Although safe consumption sites were not a topic included in the interview guide or mentioned by the interviewer, approximately 10 percent of participants brought them up as an important harm reduction strategy for both the individuals who are using, and also as a way to keep used injection supplies out of the community.

- "I know a lot of people would really benefit from safe injection sites. I have people come to my house all the time just to have some place safe to get high…they're in really sketchy places, dirty places…and I know that a lot of people are really opposed to these you know injection sites, but it can save a lot of peoples' lives and it can also like prevent a whole generation of kids from being exposed to this stuff. I'm seeing people taking their kids places that they shouldn't or leaving their kids places they shouldn't so that they can have some place safe to inject and that's scary…It's going to change the whole game and every single person I've talked to about the safe injection sites is all for it. They're like fuck what everybody else thinks people are dying and we got to start doing something really drastically different here. And if the outside world doesn't want to look at the ugly epidemic that's happening that's their choice but it's not going to stop

happening just because you're putting your head in your hands… until more people can get clean and stay clean we just need to be as smart about it as we can."

- "It would help overdoses a lot. It would give people a sense of that there are people out there that care, that, okay, they're not letting me die. But, they know we're going to do it anyways, might as well do it clean and safe and don't die. And there's those same people that can help me stop if I choose and get me the things I need, like a job or a place to stay or whatever."

- "Probably a safe place to go to do it because they see them everywhere, and you see needles everywhere. I walk around the river and stuff like that and fish or whatever and there are just needles everywhere. There's no way in hell you can bring your kid down there and not worry about them getting a needle."

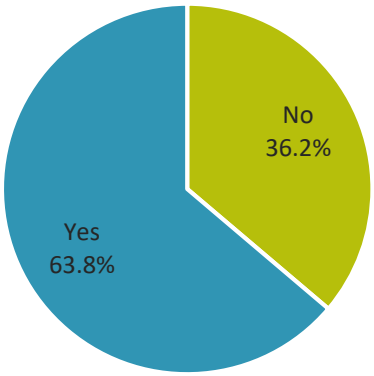
3h. Experiences with Medication Assisted Treatment

In the context of learning about individuals' opioid misuse and insights regarding harm reduction, the interview included asking participants about their experiences, if any, with Medication Assisted Treatment (MAT). MAT is offered throughout Vermont using the "Hub and Spoke" system, which consists of nine treatment Hubs to treat individuals with complex addiction needs, and over 75 Spokes for care integrated into general wellness services (https://blueprintforhealth.vermont.gov/about-blueprint/hub-and-spoke). Each of the evaluation's target counties has at least one Hub program in its largest town: BAART Behavioral Health Services in St. Albans (Franklin County), Westridge Center for Addiction Recovery in Rutland (Rutland County), and Habit OpCo and the Brattleboro Retreat in Brattleboro (Windham County). (https://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP_Treatment_Directory.pdf).

MAT as a harm reduction strategy

Nearly two-thirds (63.8%) of the participants were currently receiving MAT through a provider (Figure 16). During the interviews, most participants on MAT described it as having eliminated or significantly reduced their opioid use. One participant summarized their experience on suboxone with the following description, noting how it helped them achieve many positive life changes and avoid a series of hardships and risks, including a potential overdose:

Figure 16. Currently Receiving MAT Through a Provider



- "I know a lot of people that aren't former drug addicts think suboxone is a horrible thing and that it's basically another drug to cover up the drugs they were using before…It's [suboxone] basically turned my life around. I've been able to save money since then. We rent a house with land. I have bought my own car. I have a family now and I basically have a stable life and before, when I was using drugs, that never would have happened for me, so suboxone saved me from being on the streets having no money, having no life. I mean I could have overdosed. So many bad things could have happened."

Participants explained that being on MAT helps them both physically and mentally. This included addressing physical pain for some individuals and avoiding the sickness and worry that would arise from not having access to opioids:

- "I don't want to use. For others, they go to the clinic just, so they don't wake up sick. I go because I don't want to be in pain, physical actual like pain that prevents you from going about your life."

- "I have scoliosis in my spine. Years back I broke my leg, to where they had a titanium rod in there, but that broke, and when that broke, my leg healed. It was crooked and so I walked on that for three, four years like that and my gait was all wonky and stuff and so that put my spine and my hips and right down through my legs every joint was just aching and burning so I was using a lot and then when I came here and started the methadone, it was almost like a godsend that I could actually feel comfort, like lay down and feel at ease and just kind of sleep through the night."

- "I know I'm going to get dosed every day. I feel like I don't have to worry if I don't have the money to get high or whatever."

- “But just, knowing I’m not going to be sick tomorrow frees up my mind to think about positive things I can work on or just at work or school or being with the kids and doing stuff with the kids because I’m not sick. I’m not thinking about it.”

- “[Being on MAT]…I don’t have to search for something every day to keep unsick.”

- “…you will be fine for a day or whatever. You don’t have to like take more immediately a few hours later.”

A few participants reported that methadone lessened or blocked their ability to feel a high from opioids. This helped some not use because they felt there was no point, whereas others felt this put them at greater risk for overdose because they increased their use in order to feel high.

- “I want a better life and the other day when I used and that [overdose] happened, it really scared the shit out of me. Yesterday, I used one bag, didn’t even feel it, felt like a waste of money. I just feel like it’s a waste because of my methadone and the fact that it’s not working the right way. I’m not feeling any relief from it. I’m just putting it into my body. That’s it…”

- “If I do methadone there’s no point in doing heroin because I do not get anything out of it. To get anything out of it, I literally almost have to OD myself. Like, I have to do so much it’s pointless. I don’t feel a damn thing. I can sit there, snort three bags, not feel a fucking thing.”

- “Because what’s in methadone blocks the amount of good feeling that the heroin is supposed to implement in to your body….Yeah, more heroin when I do more opiate blocker. Less opiate blocker, less heroin. There’s a positive correlation and a negative correlation.”

- “…there is no rush anymore because the methadone completely kills that, but more than anything it’s just like a pain reliever for myself today.”

Continued opioid use on MAT

Participants frequently reported continued use of opioids while on MAT and noted a few reasons for doing so. Some believed their MAT dose was not adequate to keep them from getting sick. Consequently, some participants ultimately switched MAT programs or stopped altogether because the dosing or some other aspect of the medication did not work for them. Sometimes the challenges with determining appropriate dosing and treatment involved other health conditions that complicated individuals’ dosing.

- “Being on the methadone, not being sick, and not feeling that pain has really helped like a significant amount because the only time I even use now is when

I'm building up on the methadone. So, until I get to that right dosage I still get sick at some point throughout the day and it's kind of more a necessity at this point than it is a want."

- "It [buprenorphine/naloxone program] didn't really work for me. I mean I could take 16 milligrams of [buprenorphine/naloxone] a day, two 8 milligram strips, and still have cravings so I still felt like I needed to pop some pills or to get a ticket."

- "I think that they need to listen to patients more because, yeah, they might not want to dose past 16 but some of us need to start out there because unfortunately then you end up with what's happening now is I have to self-medicate to medicate and I shouldn't have to. I should be able to tell my doctor, 'Hey, this is what's going on'…"

- "…a lot of times they're not getting the right medication doses to take care of themselves so they don't feel sick, so they resort back to using."

As these quotes suggested, some participants expressed frustration in coordinating with their medical provider about their treatment, specifically explaining that they felt "nobody was listening":

- "I would say one of my reasons is I keep trying to tell my provider that my dose isn't, like it's wearing off and he doesn't really listen to me. Like, I haven't even took an extra sip of my stuff today and I'm already, like, I can't sit still because my legs hurt. I keep telling them that my dose isn't high enough and he won't up it, so I'm constantly sipping out of my three day take home until I'm guessing that it's good enough."

- "So, I mean in my eyes I don't think I was trying to become what I've become it was just that nobody was listening. Nobody was helping me get through that step that I needed to get through, so I had to do it on my own."

Other reasons participants mentioned for continuing to use opioids while on MAT included the desire to get high, using it to cope with stress, having a hard time avoiding it in the presence of peers who are using, and finding it hard to stop the routine associated with injecting or "the needle":

- "But now if I go a day without methadone…I'm so sick, it's worse than dope sickness, like ten times worse. So, what makes me do it? Just being in the presence of someone I guess who is doing it, I guess, and wanting the high."

- "I don't crave it as much. I mean I still crave it because, like I said, I really like, you know, the high, but I have, you know, the suboxone now, so I'm not always on edge wanting it."

- "When I get stressed out or upset, I'll sip it to go to sleep."

- "…if you walked in and said, 'I'm injecting my bupe, please help me,' it's going to be you're cut off from your prescription and that's not going to be helpful because then I'm going go out and buy it off the street or use something else. I just feel like there's no comfortable place to be able to talk about it and it would be awesome if there was because I feel like that's—I know a lot of people that do use their bupe like that. Most of them probably don't even use anything else, but they just cannot stop doing that one thing…I don't know what it is about that thing, but it's, like, so hard to stop."

MAT as an access point for other harm reduction strategies

Many participants who had access to naloxone had received it from the hub in their county. Some participants suggested distribution of other harm reduction supplies at MAT provider offices, such as safer injection supplies.

> "To be honest with you I don't see why this place shouldn't have free needles for people. I get it they're not here to advertise getting high, but maybe that's something that should happen. I mean, I don't know, see that's, it's kind of hard to have a clinic to try to get clean, but they're giving away needles… why not, say hey guys are you being safe at least right now? You need supplies or something right now? What can we do for you, you know?"

MAT challenges and barriers

Participants mentioned a few main challenges to engaging and staying in MAT. These included differing views among participants regarding what type of MAT policies are most beneficial (i.e., a harm reduction-oriented approach versus an approach with penalties for any illicit use or missed programming), daily attendance requirement for dosing, and transportation.

- "They don't condone it or anything, but you can still dose every day and smoke weed and I feel like I have to have something. Like, I feel like I can't just like go cold turkey off everything. I guess that helps."

- "If they were more stern with me I'd probably be clean. I'd be clean. I'm not saying it's their fault. It's my own fault, but it's like anybody who is trying to get away with something. They're going to push and they're going to manipulate and they're going to lie and they're going to do whatever they can to still do what they want to do and there's no repercussions for anything at that place."

- "I mean, the clinic it's good, but I thought it was a lot different than what it is. Like I said, it's like they give you permission to still use or it's okay now that you're a crackhead but you're not doing heroin anymore."

Meeting individuals' MAT needs sometimes aligned with whether the program was a hub versus a spoke. Some participants who were in a hub felt like they needed that stricter oversight and daily dosing, while others preferred to be in a spoke, particularly due to not having to attend as frequently. Participants mentioned lack of transportation and employment as the main reasons for preferring a spoke to a hub. Participants who received their MAT from a hub and were required to attend daily for dosing reported that accessing the clinic each day was a hardship, especially if they needed to rely on other people to drive them. These transportation challenges often resulted in illicit use, which would further delay their ability to receive take-home doses in the future. Some participants who missed doses due to transportation or other barriers described turning to illicit opioid use to keep from going into withdrawal.

Transportation was frequently mentioned as a challenge for accessing treatment services by individuals who live in rural areas and are not able to access the bus.

- "The only reason I did the dope yesterday and a week or two ago, I did some just because I couldn't get to the clinic in time. So, I missed it and, you know, you get that feeling. I'm running around trying to find a job, you know, and it's like I can't be sick, so I did it and it is what it is."

- "...what it means is you have to go every day and dose, even Christmas, holidays, nothing, and if you were to go visit a family member or had to travel, they will have to call that county and see where their closest place is, and you can go there while you're away…every morning I have to wake up and walk the 20 minutes in this weather each direction."

- "I had a really hard time with transportation. I was utilizing the Medicaid transportation ride. Almost always, nobody would show up on the weekend and there was nobody in the office to call and you miss three days, they cut your dose in half. It's real important to get there every single day. So that was most of my problem then."

- "I didn't have any transportation. That was basically it and I guess how people look at me, judge me, that's another reason why I didn't want to go."

Balancing MAT appointments and childcare was an additional challenge mentioned by some participants:

> "Fortunately, I had friends or I, you know, would trust my daughter enough to stay in the car and then have somebody that I know be able to just stand outside the car and watch, but if I didn't have those options at the time…I would be lying to say that I didn't say, alright [Name] I'm locking this door behind me, the heat is on, crack your window a tad bit, I will be back as soon as possible. And then you go into it thinking, 'Man, if there's a long line or something I'm just going to have

to not do this today'…I think back on that, the maybe two or three times, I had to choose to do that because I didn't have someone with me or somebody I trusted nearby. What if somebody did pull up and now DCF is involved in my life? What the hell? That would suck. All because I wanted to dose and not feel sick or relapse on something. I'm doing it to become a better parent and now someone is telling me I'm not being a good enough parent. Like that's kind of a shitty situation you know?"

One respondent described a program in Brattleboro that offers child care:

Participant: There's a program down there now where you can drop off your kids and then go dose and then pick them back up… a parent comes in with their kids, one, two, three, five, you bring them over, there's like a playground and a daycare center over there.

Interviewer: And is it just for dosing or can you… meet with your counselor?

Participant: Yes, you can if you have to meet with your counselor. It's pretty much anything to do with the hub program, so dosing, counselor, doctor. You can drop off your kids, they'll hang out, play, have lunch if that's the time period or whatever and then you pick them back up. I believe it actually might end at a certain time, like shortly after dosing, that's when that ends, but that is such a huge help.

A few participants reported being worried about getting off MAT once they started and not liking the idea of replacing one drug with another:

"So, I've been thinking about going back now [to MAT] because I've tried to quit on my own and I've weaned myself down tremendously but because it just kind of keeps you in the same mental state, you know, you've got to go get your fix every morning, going to the methadone clinic, and it's an opiate, you're just replacing it legally. I mean at least you know what you're getting. You don't know what you're getting out here on the streets when you buy a bag, but for me personally, you know, and it took a long time to get off of methadone, you know? They increase you way faster than they decrease you. I mean a base dose is 50 milligrams. They suggest a decrease of one milligram a week, it would take you a year to get off of it. That's crazy."

For others, who are facing barriers and are not receiving MAT, there is a belief and hope that being on MAT will result in positive changes:

"I've always thought if I could get on, if I could get on the bupe program… I wouldn't…be doing all this other stuff because right now what makes me keep doing it is because, like, let's say if I don't even have it like, say, for a couple

days, I get so sick…whereas if I were on the bupe program, like I said a couple of my other friends have been on it and they've been doing really good…they don't have that craving or that desire to go get something else because they're not sick anymore because they actually have something every day in their system."

3i. Housing Instability as an Additional Barrier to Harm Reduction Services and Strategies

In addition to the SSP, MAT, and other service barriers discussed in the previous sections, the interview guide included asking participants about housing and how it facilitates or hinders harm reduction practices and recovery. Participants described numerous stressors that homelessness and housing instability pose and, conversely, they expressed how fundamental a safe place to live is.

Barriers to accessing housing generally

Participants discussed hardships and barriers to finding appropriate housing. Problems such as affordability, quality and accessibility for individuals who are currently using drugs or had poor rental history due to previous drug use were mentioned.

- "I really wish they had, like, more rooms, rooming houses, you what I mean, where you can, like, share a kitchen and whatever. They need more of those… You have to have, like, a perfect credit score and be perfect and it's, like, they should at least have like rooming houses for people that aren't going to be able to get into that."

- "Evictions, even if you have like an eviction on your record, they should still have a place where you can still go, you know what I mean and get another chance."

- "I think the next spot to work on would be housing because we don't necessarily have a lack of housing, we have a lack of people who want to take people who have fucked up…so you can't sit there with an empty apartment because somebody is at the clinic and you're too scared so now we have all these empty apartments… so something again like a family advocate…now I need somebody to trumpet ahead of me and be like listen, her record looks shitty, you might think she's going to punch you, she's not, she's awesome I work with her all the time, like I personally can say I will come to her house. You know what I mean I need somebody to basically do that because they don't take my word and they're looking at my record you know what I mean and usually I can like have a one-on-one like I do now, I can be very professional and sell myself well. If you look at my record I'm fucked, and I don't get a call back."

One participant who had problems with their rental history described receiving a second chance, and support with harm reduction, from their landlord:

> "He gave me a second try. He didn't think about my track record. He was thinking about my reason for being up here. He's thinking about my reason for why I was homeless. I don't know if I would give myself a chance… Well, he gave me a second chance. He knew that I came up for alcohol and drugs and went to rehab and all that stuff, plus he has Narcan on there, plus it's a very—there are no appliances that are in danger of sparking or anything like that, so I feel like he does care about the residents."

Participants conveyed how homelessness and unstable housing contribute to riskier behaviors and loss of hope for recovery. They described not being able to focus on themselves, what they enjoy, their family, or their recovery when they don't have safe spaces to be. When asked what it is about housing instability that leads to drug use, one participant explained:

> "Lots of things. The first thing that comes to mind is obviously the stressors. You know it's stressful being impoverished and walking the streets all day every day and it's the boredom, that's where a lot of addicts are I think. We're bored, we get high to alleviate the boredom, plus there's so many addicts out here on the streets it's a group of us you know, you get like a flock or something you know?"

Other participants provided similar insights:

- "Oh, it's a terrible feeling like walking around the street at night knowing that no one gives a shit whether you live or die. It's a hard thing to accept and you know like that's honestly during my entire time of drug use that's been probably the biggest trigger for me is not having a place to go or having that feeling like nobody gives a shit you know?"

- "If when people are more stable, I think, you know, they do a lot better with not using, you know what I mean? If they had a safe place to sleep and stay warm and be able to get back and forth to a treatment center they could stay sober and go to groups."

- "It [housing] gives you a center to like, to want to do better, you know?

- "I just feel like I could get back on track and get my kids back and they would, I mean, like, they keep me motivated and busy. I wouldn't be probably talking to half the people I talk to that still do drugs and, but when you have nowhere to go, if you have money or stuff, they're willing to let you stay there."

A particular stressor some participants described as being related to their housing situation was risk related to solicitation for sex.

> Participant: Being a woman on these streets it's just horrible.

Interviewer: Where do you usually stay now?

Participant: I'm just staying on the couch, a friend's couch and like he's already solicited me…I'm trying to get out of here, get the hell out of here. It's hell, living on the streets. And I see why people use drugs…. housing would just flip-flop my whole life.

Interviewer: How would having stable housing affect your life and your drug use?

Participant: I don't believe I'd use. Or I'd use less because I'd be stable, have a home to go to. Like this guy's home I feel like he's staring at me and wants sex from me all the time… My whole life is just like a turmoil, just turmoil.

- "I left with like the clothes on my back and was homeless. I slept on park benches. I slept at peoples' houses that I knew, like, wanted to sleep with me and I had to like continually like bat them off because I—you know what I mean, the one thing that I haven't done for drugs is sexual favors and I don't judge anyone who does. I just, that's just not—I refuse to go that far. I will be sick if I have to, but I refuse to go that far. I've never needed it that bad."

Some participants mentioned the need for a Housing First model, where housing is accessible regardless of their current substance use. They described needing the stability of a home and the hope for a better future before they are able to focus on stopping or reducing their drug use.

Interviewer: How do you feel like your situation would be different if you had stable housing right now?

Participant: It would be huge.

Interviewer: In what ways?

Participant: Just being able to sleep. I'd be able to think about my sobriety, think of, you know, put more effort toward trying to—like right now it feels pointless, and maybe that's a bad way to look at it, but it just feels like I'm just getting by, I'm putting so much effort into doing anything that, it's, like, hard to want to change…I think that, it's, stable housing would give me a place to have something to look forward to, something to want to invest in. You know I think my time would be taken up more with, like, wanting to decorate it and wanting to, like, you know plan a house and eventually be able to maybe have my son come visit me, maybe have a place that I could entertain or have, like, a dinner, I don't know, it would be huge.

Some housing support services are accessible to anyone, regardless of their current drug use. This sometimes means that there is drug use occurring at drop-in centers or shelters where people do not have other options for a place to use.

> "That [access to housing] would work a lot better because they wouldn't have to come to like places like here and I'm not saying—this place is a godsend…but, like, if you're around 120 people that are using, it's still going to lead you right back to it. A lot of people don't have anywhere to go. This is a great place to sit, you know what I mean? But, you know, with that, obviously they can't, they obviously don't want people using, but they know it's going to happen, so I just think if they had more residential stuff, it would save people from having to, you know, be out on the streets where, like, they have to be around these people or go to a place where they have to be around these people. That would help, I think."

Once housed, people are able to see the difference in their behavior and their feelings about obligations and priorities.

> "It's been a lot easier to not do drugs since I have had stable housing. It's lifted a great deal of stress off of me. Also, I'm in a really nice neighborhood, which means I can go for walks and not run into people that I used to do drugs with or see drug deals going on, things like that. That's a first for me because every other neighborhood that I've ever lived in, everyone that I did drugs with lived nearby me or in the same, or even if they didn't live nearby me I would see drug deals going on or just see houses, just certain things that would trigger it. It's definitely made it, I mean, tremendously easier. Also, the fact that I have an obligation to pay rent every month. It's hard. Like I said, I do catch myself relapsing and being like, 'Well, this is stupid. You're going to be short on rent.' But it does at least put that thought in my head, you know, to at least recognize that that's bad and try to work on that, or other situations where I would get a craving or something and be like 'No, you've got rent to pay and that's that,' and won't even think about it anymore. So, yeah, if you have stable housing I think it can make not using, I mean, like I said, tremendously easier, you know?"

3j. Participants' Experiences with Overdose and Accessing and Using Naloxone

Experiences with overdose

Half of the participants (50.8%) reported that they had overdosed one or more times in their lifetime (Figure 17). Among those who had ever overdosed, more than 40% had overdosed within the past 12 months. The vast majority of participants (84.1%) had ever witnessed an overdose (Figure 18). Notably, 42% of the sample had witnessed 2 to 5 overdoses and almost one-third of the sample (30.4%) had witnessed 6 or more overdoses. In addition to asking participants about their experiences with overdose, the questionnaire included an item regarding their perceived risk of dying from an overdose. Over half (53.6%) of the sample responded either "likely" or "very likely."

Figure 17. Number of Times Overdosed

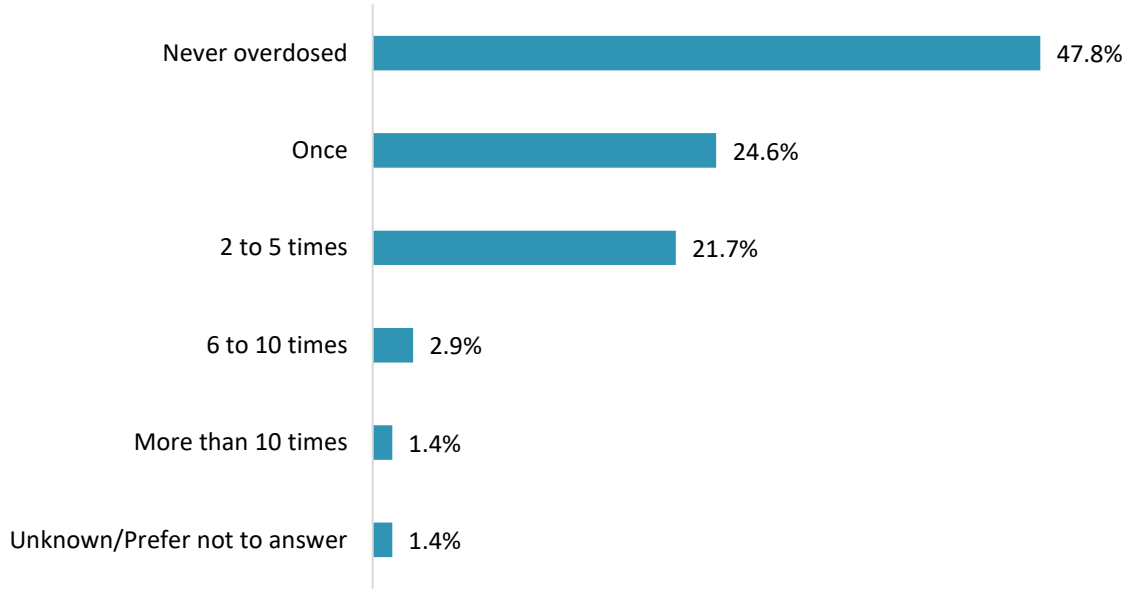
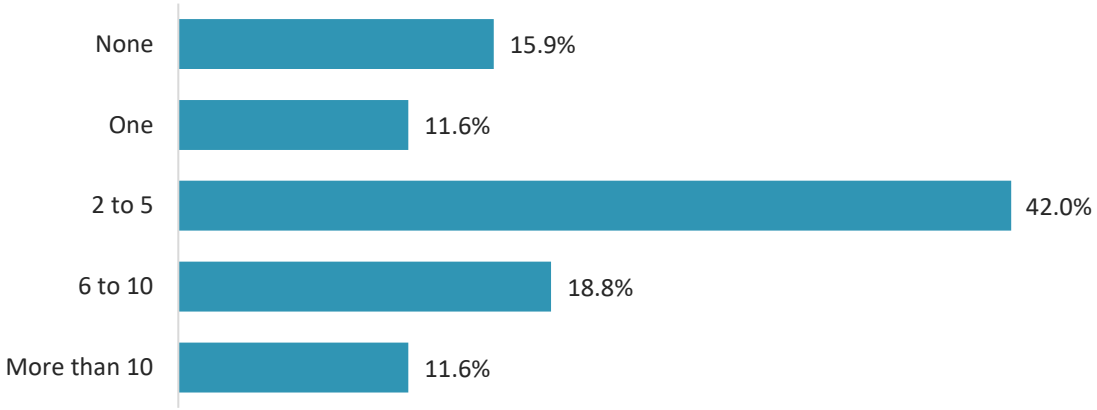


Figure 18. Number of Overdoses Witnessed



In discussing times when they had overdosed, some participants described how they have tried to be safer since then:

- "…that's when I said I would never do it alone again. And I've done it, I've done it since, but someone's always been around."

- "…I try to be diligent, whereas, times in the past I would go through someone else to get it and I didn't know what I was putting in my body. I don't even think I knew what fentanyl was the first time I overdosed. And so, yeah, I just tried to be safer about it, or as safe as I can be, I guess."

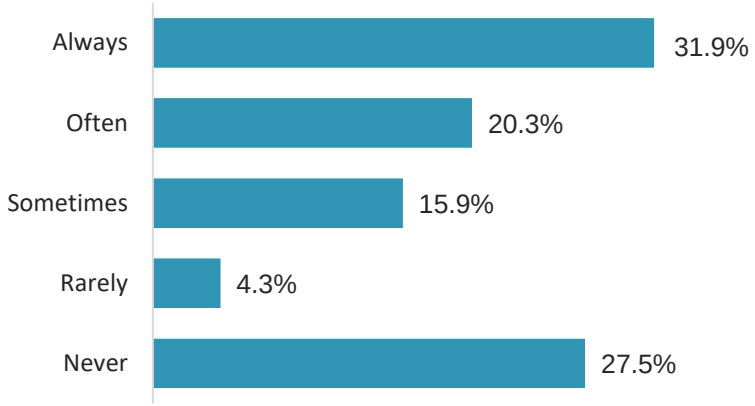
Accessibility and use of naloxone

As presented earlier in the report, two-thirds (66.7%) of the participants who had ever used services at an SSP reported that they had picked up naloxone at the program, as of one the services they reported receiving at the SSP. Receiving naloxone was the second most commonly reported service participants reported receiving at an SSP. During the interviews, participants described naloxone as being readily available and accessible. In addition to SSPs, other locations for obtaining naloxone included MAT hubs, recovery centers, and the Groundworks drop-in center in Brattleboro. A couple participants noted challenges to obtaining naloxone at hubs (e.g., they needed to know to ask for it), while others felt that obtaining it at these locations was easy and straightforward.

Keeping naloxone on hand

While 72% of participants reported keeping naloxone on hand at least some of the time, less than one-third (31.9%) of participants reported doing so always (Figure 19). Further, approximately 28% of participants responded that they never keep naloxone on hand. The questionnaire responses appear to show more variation than the interview comments on this issue. During the interview discussions, participants clearly cited the importance of having naloxone on hand. However, they also shared various circumstances where it is not kept on hand. For example, some individuals described that their only opioid misuse was illicit use of buprenorphine. Consequently, they perceived their overdose risk to be low and did not prioritize keeping naloxone available. In addition, despite the acknowledgment of the importance of having naloxone available and often actually doing so, or being with others who have naloxone, participants also described situations where they encountered barriers that resulted in them not carrying naloxone.

Figure 19. Participants' Reported Frequency of Keeping Naloxone on Hand



- "I try to have Narcan in my purse or whatever and most people know that. If I start to feel myself going down, I will tell somebody. It hasn't happened yet, but I don't usually do a lot at once and you can't protect yourself every time, but it hasn't happened."

- “My surroundings at home is with an elderly lady and my 18-year-old son. They obviously don’t know when I’m getting high, but they know that I’m a recovering addict that does use sometimes and they know that there’s Narcan in the house. So, they know if I’m like in the bathroom or the bedroom for too long and all of a sudden, they heard a thump on the floor my son would know to come in, he’d know what it is, and he knows where it is. So, I’ve set myself up that way. And it was hard because I had the Narcan in my house for four or five months and I didn’t tell him it was there, and I kept saying to a couple friends of mine it’s hard because they all think I’m still clean. They think I’m doing good and I don’t want the dynamics to change just because I want them to know there’s you know Narcan in the house. So, I told him, I said listen what is that stuff? I said it’s Narcan, and I told him what it was for and how to use it. Well why? And I said well I’m not an angel, I’m not an angel, I’m a recovering addict and there’s times that I slip up and there’s no sense in having this in the house if you guys don’t know about it.”

- “If I don’t feel like carrying around extra stuff in my backpack I usually don’t carry it, but sometimes I do, you know.”

- “…somebody that I know was arrested and manhandled by some cops because she was looking for a phone on the side of the road and she went—she comes to the clinic and they know she does…She had some [Naloxone] in the car, and they’re like well we need to search your car, just because she had [Naloxone] in her car…that’s another reason why we only carry one around at a time usually too is because it’s easy to get rid of.”

Resistance regarding administering naloxone

Many participants described reluctance around using naloxone, with it often being used as a last resort because it causes instant withdrawal and destroys a person’s high.

“…most addicts are scared to death of [Naloxone]. It puts you into instant withdrawals.”

- “…people are like if I fall out, try to do a sternum rub first. Like, try to do this other stuff first before you administer Narcan, for a lot of reasons. One, because it fucks up your buzz. Two, it makes you really, really sick and you go into instant withdrawal. Three, yeah, there’s a likelihood of going to the hospital. So, there will be a whole conversation about other types of interventions you can use to try to wake somebody up before giving it to them, which is a little bit crazy….”

- “Some people don’t like it [911] called. Some people don’t even want to get [Naloxone] unless it’s necessary, really…Just because they get sick, and they

don't want…I always try the cold water first unless it's already been a few minutes I guess. I'll usually make the call, I don't even usually administer the [Naloxone]. I only have once and that was just a couple weeks ago, or I might have drugs on me, so I might make sure everything is gone…But I always stick around long enough to make sure that what needs to be done is being done, whether there's [Naloxone] or 911 I will make the call if I have to but I'm not, I don't usually stick around."

- "I didn't come out of the bathroom. He came to check on me. You know, he said I was on the floor. My lips were blue. They threw—I was soaking wet when I got up—they threw ice cold water on me. Like, they didn't want to Narcan me, but they did."

- "Oh, they were pissed because they were high. It's like dude you weren't breathing! No, I was fine! No, I assure you, you weren't! Oh, they're always pissed, they're always pissed, yeah."

- "I don't know if it's the stuff they put in it that makes people really ugly, looking like they're not, you know, they're 'Why did you do that? I was fine! I didn't need that, you just ruined my life!' And it's like you try to explain it to them…"

- "…I guess you could say she was my girlfriend at the time, that literally, she fought with me because I let somebody give her Narcan. You let them Narcan me? Yeah! You were almost dead. Of course I did. It's crazy because now they're in their mind, they're, like, 'Oh my God I'm sick and I can't even use again right now.'"

3k. Attitudes Related to Calling 911 for an Overdose

> "…it [fear of questioning from police] still keeps people from calling or you know they're trying to do like everything they can before they have to call. Or they're taking the chance to just throw them in the car and drive them up to the hospital…"

Participants described a range of responses that can occur in the event of an overdose, sometimes with multiple actions being taken before resorting to calling 911 and involving authorities, if at all (e.g., attempting to wake the person who has overdosed by putting cold water on them, slapping or otherwise trying to rouse them, and/or by administering naloxone). Although, as discussed in the previous section, participants are aware there is a desire among some to avoid a naloxone reversal if possible, some participants also described that a peer administering naloxone is preferable to calling 911. The following quotes illustrate this view:

- “I think it’s more accepted to be able to save your friend’s life with Narcan or whatever else it takes, you know, pick them up, walk them around, put cold water on them, but obviously Narcan. If you save your friend’s life without calling 911, I’m thinking is the most acceptable way of doing it, you know, so you don’t have to have questions and such, you know what I’m saying? And on occasion I’ve been in houses where I haven’t been the person to Narcan and it’s been used, and I see what happens. You know everyone gets the F out real quick you know because no one wants to be there with a pocket full or drugs or whatever when questions are asked, you know?”

- “If you’re calling somebody else be prepared for the consequences for both and carry your own Narcan. That’s why all of us carry our own Narcan now. Rather help a friend out than call anybody.”

This participant’s recollection of the reactions that occurred during an overdose they witnessed was remarkable in that calling 911 appeared to be characterized as a misstep that could endanger someone’s life, rather than as a recommended life-saving action:

> “We didn’t have Narcan, but he just OD’ed. We threw him in the shower with cold, cold water and he was slapping him, and he got him to wake up and he just kept him in the shower, and he was walking him around the room and kept walking. Like, he’s good under pressure, he’s really good. Me, you’d probably die, because, one, I’d call 911, I’m hysterical. I don’t know CPR or any of that and I’d probably be taking your breath instead of giving it, you know?

Participants repeatedly conveyed their or others’ fear of getting in trouble by calling 911:

- “…that split second there, it was a good second, I was hesitant on calling or not because I was like oh my God I might get locked up for this and then I was like I don’t care she’s dead and I just called.”

- “I would [call 911] if I had to, you know? I’d get nervous that I’m going to get in trouble, but, you know, saving a life is more important.”

- “…a lot of people who are using have warrants and legal trouble and they have bad rapport with the cops so they think they will find a way to get them like to…arrest them, get them in trouble. They think that that’s the enemy, cops are the enemy and if they call 911, a cop is going to show up.”

- “I was told to call 911, so I did. In the meantime, while I’m on the phone, she wakes up and, of course, everybody is freaking out, screaming. It was just me and this couple, and they’re like, tell them never mind! Tell them never mind! Or whatever. So I got off the phone. Well, sure enough, surprise, surprise. They show up and that was really scary.”

As noted in an earlier section, some participants described how they or others might offer assistance in the case of an overdose, including by administering naloxone or calling 911 or both, but then not stick around and wait for emergency medical responders and law enforcement to arrive. By leaving, they seek to avoid questioning and potential consequences. The following quotes provide insights about these actions:

- "I've seen somebody call 911 and then leave the person because they still have drugs on them or they were high too and you know they didn't want any of the police contact, so…I had somebody get really upset with me once because they were on probation and I called 911 when they were overdosing. It's like, that's great, you're here to be mad at me, that's your life, so freaking what, I called 911? I Narcan'ed you three times and you didn't come out of it."

- "I would call 911, I don't care, I would call 911, whether I did and left, you know. If I wanted to leave, I would leave, because a lot of people don't want to get involved. Because then the cops, the cops are always asking the question, what kind of bag was it, what's the name of the bag, you know? Cops shouldn't ask that question when there's an OD involved. They shouldn't ask nothing. What kind of bag did you do? People don't want to talk to the cops because as soon as they see you talking to a cop you're going to be labeled a rat and everyone is going to give you shit."

The participant in the following interview exchange explained the detrimental repercussions of being questioned after calling 911:

Participant: I mean sometimes, most of the time, EMTs are just worried about getting the person in need of treatment, treated, then they're worried about saving their lives, and that's what the focus should be on.

Interviewer: And you feel like that's what the focus is on?

Participant: Yeah and the cops are always the opposite. They're always invasive, worried about where the hell the dope came from and this and that. They're not trying to help the situation they're trying to solve the problem, the bigger problem which isn't the current problem, and that's a problem.

Interviewer: How does that affect the current problem? How does that affect the situation kind of in the moment when the police are asking those questions?

Participant: Because it makes the people who did call 911 express anger and regret and it makes them anxious really and that can make the

EMTs not do their job properly, hearing all of it going on at the same time.

One participant explained the difference between calling 911 for someone who has overdosed and driving them to the hospital. The explanation indicated concerns about being questioned by emergency medical personnel and law enforcement, along with concerns about stigma and judgment during the encounter:

> "It's like this is a much more serious deal and they're much more likely to ask questions….It's just not a great feeling to have a whole group of people come flying into your house who have no concept of what it's like in your shoes and sort of you know pass judgment on what they're seeing."

Others described calling 911, but not specifying that the emergency was an overdose or they have deliberated whether this would be a better approach:

- "If you call 911 and say it's an overdose the cops will come and then they start drilling and wanting to get in your house and you know that's not—and so that makes it so people aren't going to call because they don't want to deal with it, so I don't really think that that's effective. If an overdose is called in, it should just be like anything else because I've called for an overdose and said the person fainted and no cops came, just the EMT and they dealt with it and left, and it was much easier…"

- "I was also so upset with my girlfriend there dying, if I would have just said, 'She stopped breathing. Will you please come?' But I was like, 'She's overdosed'…everybody's like 'You're an idiot. You shouldn't have said that'…you can call the ambulance and say, 'Oh, they're not breathing,' but don't say anything about drugs until they get there, then say she might have taken something…"

Other participants expressed less hesitation about calling 911 and indicating that an overdose had occurred, but one recalled being questioned by peers for doing so:

> "…I told them on the phone that it was a drug overdose. A couple of my friends afterwards when I told them that I said that, they're like, 'Why would you say that on the phone?' and I said, 'Because I want them to be prepared to come and to revive him if it's possible.' But they did say, 'Why would you say that?'"

The following interview exchange sought to gain insight about this issue, with this participant being clear about the ideal response:

> Interviewer: What about revealing that it's an overdose versus not when you're calling 911? Like do you, when you call 911, do you usually say it's an overdose?

Participant: You should.

Interviewer: You feel like you should say that?

Participant: Yeah, because it's just how you're dealing with the situation. You don't beat around the bush when somebody's dying.

This participant explained, "they're just anxious and their mind is crazy." Participants' descriptions' suggested that even for those who are willing to call 911, the panic and chaos of overdose situations can lead to erratic responses or a response where no one takes appropriate and timely actions.

Interviewer: "…what are your attitudes about calling 911?"

Participant: "Oh, it's important to do, but if there's time or whatever, you know what I mean? People don't know what to do in emergency situations. They get lost. I mean I had a house full of people. They did not know what to do, so all they did was watch me.

Interviewer: "So, nobody else called 911?...Do you think people thought about it and were scared to do it?"

Participant: "I think they were scared to do it probably. You shouldn't be scared, it's somebody's life. Call them, you know?"

Interviewer: "What do you think makes people scared about calling 911?"

Participant: "They're afraid they're going to get in trouble….Panic, people panic. They don't know what to do in emergency situations. They never had that education for whatever reason, so everybody acts different."

3l. Awareness of and Views on Vermont's Good Samaritan Law

In 2013, Vermont passed H.65, also known as the Good Samaritan Law, which provides protection for the victim of an overdose and any witnesses from drug related offenses if they call 911. Prominent among the sample was a lack of awareness of Vermont's Good Samaritan Law and often a vague awareness of the law among those who had heard about it. At least 35 individuals who were interviewed had never heard of the Good Samaritan Law or were not familiar with the meaning or details of the law. Further, participants commonly expressed the belief that there is a general lack of awareness of the law's existence among their peers, as this quote described:

> "I don't think that most people realize anymore that you cannot get in trouble if you're with somebody that overdoses, and you call 911. There need to be

posters up, things like that. People just don't realize, and people get left and that's, yeah, that's definitely a problem."

One participant discussed trying to convince peers that the law exists:

> "Yes, this law is true. You know you might have heard about it on the street and it is true because there's still some people that don't believe it's true and I've had people argue with me about it."

"I would probably say more people don't know about it than do know about it, I mean, that's just my opinion."

"I think a lot of people that don't…are the ones that are afraid they're going to get in trouble. That's basically the bottom line, that they're going to get in trouble if they call 911…That's the biggest downfall I think….I didn't know about this Samaritan Law.…"

"…the people that I've talked to they know about it and most of them say I don't buy it for one second."

Participants also conveyed a high degree of skepticism about the protections the Good Samaritan Law provides. Repeatedly, participants explained that people are afraid they will get in trouble if they call 911. Participants offered multiple reasons for this fear of calling 911 and the mistrust of the Good Samaritan Law. A fundamental reason is the lack of awareness of the law, including being unsure that it truly exists and unclear about what it entails. Another reason is concern about consequences due to involvement in illegal activity and, possibly, probation violations. These concerns about potential consequences can persist even for those who are aware of the Good Samaritan Law.

Two additional reasons for wariness about the Law pertained to concerns about interacting with law enforcement, or authority in general. This included general concerns or perceptions about coming into contact with law enforcement (e.g., not wanting to get in trouble), as well as concerns due to having heard about others' interactions with law enforcement officers that led them to be wary of the Good Samaritan Law. In addition, some participants' mistrust stemmed from prior negative experiences they had had with law enforcement.

Interviewer: "…Do you think people are aware of that law?"

Participant: I don't think so. I don't think people trust it either.

Interviewer: Okay, tell me more about that.

Participant: I don't think, for a lot of people, they're just, it's like poo-poo, yeah right, that's set up, you know what I mean? People get jaded around this stuff. They don't trust authority.

- "I guess I have kind of trouble trusting cops or believing them that they wouldn't get you in trouble or whatever for possession or whatever…"

- "Nobody will [call] even though they passed that Good Samaritan Law where you cannot be held responsible, searched, anything, but I've heard too many stories even just of late…"

- "I think people know, but I think a lot of people don't know still, but like I said, it's that, with the cops coming and then, it's, like, they turn it on you and they want to get in your house."

- "…they just kept questioning about how, who, when, what…and I just said I don't know. I am here for them, not for that…I didn't get any repercussions. I know some people do, but they're asking questions they shouldn't be…that service is there so you're a good Samaritan, not, you know, you're not going to interrogate me because I'm being a good Samaritan."

- "…I think that's [the Law] probably saved thousands of lives but this particular day when I called 911, the cops were so nasty to me and my mother…everything they asked me I was polite about it…they were searching her car and they had no rights to do that, you know. So that was just a bad situation. But…I would do it again, that wouldn't stop me from saving somebody's life."

- "I've seen people have tried to drag someone out and leave them somewhere, just really screwed up things. I mean the legal thing it's a huge issue. They don't, I mean, the truth is that even though there's that law that says if you call 911 you can't be penalized, first of all, there's not a lot of trust in law enforcement. Some law enforcement officials have earned trust in the drug community, but a lot of times they tell us things that aren't true, or they tell us stuff just to get what they want and then they like turn and go well, no I can lie to you if I need to get information and then, you know, slap cuffs on them. So, there's not a lot of trust."

The following comment summarized multiple barriers individuals faced when responding to an overdose, including fear of getting in trouble, fear of stigma and poor treatment by service providers and others, and concerns about the Good Samaritan Law:

> "I think there's a lot of fear around going to the hospital – what that's going to look like, am I going to get reported, are they going to treat me poorly because I'm an addict, you know? So, a lot of people will avoid going to the hospital for fear of how they'll be treated and how they'll be perceived. And am I going to go to jail? You know, whatever, and I think a lot of times when somebody is overdosing that's sort of the response that the bystanders have is that 'Oh my God am I going to get in trouble?' and they'll leave because they're scared to death that somebody is going to find out they're using or whatever and that has serious ramifications in their life. I think it needs to be much more clear that there won't be consequences, you know, like the Good Samaritan thing? And I think some people have seen even despite the Good Samaritan Law that they are getting in trouble for bringing people in and then that deters them in the future from saving someone's life because they don't want to deal with the ramifications in their own life."

A few participants commented on positive experiences and encounters they had had with emergency personnel and law enforcement during overdose situations:

> "Yeah, cause the cops could have came one night when I had to Narcan my friend and I could have gotten in some serious fucking trouble, but they're like you guys aren't in trouble. We're not going to search anything or you guys whatsoever."

3m. Harm Reduction Messaging: Participants' Suggestions for Content of Messages and Methods of Communication

As one of the main objectives of the evaluation, the interview included obtaining participants' insights and recommendations regarding health messages for individuals at risk for opioid overdose and what they thought would be effective approaches for communicating those messages.

Content of Messaging

Participants had many ideas on the type of information they would like to see shared with individuals at risk for overdose.

Syringe Services Programs

Participants indicated the importance of not only promoting the availability of SSPs, including the location and the hours, but also sharing information about the types of services that exist (e.g., HIV/HCV testing, safer sex supplies, syringe disposal supplies,

naloxone distribution) and that they are free and confidential. Participants also felt it was important to share the rationale behind these programs (disease and overdose prevention and treatment connection) in order to build community support and reduce stigma. In addition, participants noted that it is important to inform SSP members and others who might become members that SSP membership protects against paraphernalia charges.

Overdose risk and prevention

With the rise in fentanyl, participants felt that overdose prevention messaging should include information on the dangers of fentanyl, how to access fentanyl test kits, and also increase awareness that fentanyl has been found in other, non-opioid drugs such as cocaine and marijuana. They also believed it was important to increase awareness of the availability of free and anonymous naloxone.

Good Samaritan Law

Overwhelmingly, participants felt that increasing awareness of the Good Samaritan Law would save lives.

- "If they could put, just even if they could say on the radio about that law, that if you see, if you're with someone and you do the right thing and call 911 that nobody there will get charged. That message should get broadcast because that might save lives and that would be like one of the biggest things actually because I don't think a lot of people know that. I've seen people run, still, and why, you know? People that usually are sharing together are some kind of friends."

- Participant: Yeah, I didn't know, I didn't hear that. I didn't—that was right around one of the times that I was using, and I don't even remember when it came into law like anybody even talking about it. I've heard of the Good Samaritan, but I did not know that.

  Interviewer: Yeah do you feel like that would change peoples' behavior if they knew?

  Participant: Hell yeah, oh yeah. Yeah, because even if you're high, hey if I can't get in trouble, you're going to save your friend. I definitely think that would make a buttload of difference, absolutely. Yeah. No, and I've never heard that.

- "That's the biggest downfall I think. If people knew, you know, like you said, I didn't know about this Samaritan Law. That's good to know. I mean, I'll start spreading the word now. I mean, I will tell everybody about it, don't matter."

Behavior change

Participants believed it is important to educate individuals at risk for overdose and infectious disease transmission about protective drug use behavior changes, such as ensuring they are using the minimum needed to get the desired effect, going slow, using with someone, always having naloxone present, and using new injection supplies each time you inject. This included recommending specific messaging on how to inject safely.

Consequences

Some participants felt that people are not always aware of the dangers or potential complications when injecting or using opioids. Participants suggested that messaging campaigns include details of the unintentional consequences of drug use, such as the trauma for family or friends who witness an overdose or lose a loved one to overdose, and the general changes that opioid use causes in people.

Access to services/resources

Participants were not always aware of the resources available to them in their community. Some felt it would be helpful if there was a phone number or one centralized place (like a social media page) that had all of the local information on financial resources (e.g., fuel assistance, rent support, 3SquaresVT), MAT providers, recovery center calendar and other group schedules, housing and other community resources, and the overall message that places like SSPs and substance use disorder treatment centers are welcoming and non-judgmental.

Methods of Communication

Many participants recommended that word of mouth would be an effective communication method for reaching individuals at risk for opioid overdose. Word of mouth could be either peer to peer, or from a provider directly to an individual (such as from a counselor, health provider, or someone providing services at a human service agency). One participant expressed the opinion that "…Dopers are going to trust other dopers before they trust someone with a college diploma".

Participants also suggested there would be value in face-to-face outreach by harm reduction service providers at specific locations where those at high risk for opioid overdose might frequent. Participants believed it would be particularly helpful to have information on SSPs at substance use disorder treatment locations, for those who are not abstinent from using drugs. The range of suggested places included the following:

- Syringe Services Programs
- Substance use disorder treatment providers (hubs and spokes)
- Residential substance use disorder treatment centers
- Drop-in centers

- State office buildings (locations of Economic Services and Family Services)
- Recovery centers
- Medical providers
- Food shelves and other programs offering supports such as fuel assistance
- Probation and Parole offices
- Libraries
- Locations of group meetings, such as AA and NA
- Safe consumption sites (if they existed)

In addition to recommending promoting messages via outreach, participants felt that it is important to post and disseminate printed materials, especially considering that some individuals are not connected to services or might not feel comfortable sharing information about their drug use with others in a face-to-face encounter. Participants recommended that printed materials (containing health messages and information about services and events) be posted in the above-mentioned places, as well as the following places:

- Bus stations
- Grocery stores and convenient stores
- Courthouse
- Health centers
- Laundromats
- Places where people are known to use drugs in the community, such as certain parks or public restrooms

However, one participant felt that even looking at printed materials in their small town would result in too much unwanted attention:

> Participant: Like a poster, that would be cool. Like at the clinics or here at Turning Point. Maybe in the state building, you know places that—obviously not in a grocery store, you know, but at a doctor's office maybe.
>
> Interviewer: Tell me your ideas about not being at a grocery store.
>
> Participant: Because I feel like if we stand there looking at them, you know, that poster, that people are going to say, 'Oh, you know, she's using,' or, you know. That's what I'm worried about. Here, not so much in St. Albans.

Electronic methods also were recommended by participants, which included a mix of social media, online advertisements, e-mail, text messaging, phone calls, and advertisements on television and radio. Social media stood out as one of the most commonly recommended methods and included specific recommendations for:

- Facebook pages for specific counties or regions
- A Facebook page created by the Department of Health or local agency that had information on safe drug use, recent overdoses, and recovery supports. One participant felt that having all of the information on the same page would allow people who are currently using to see what is available for those in recovery as a way to increase hope and thoughts towards a healthier future.
- Twitter
- Snapchat

One participant offered this suggestion:

> "There's so much bad stuff going around and if there was maybe a Facebook page that somebody, like, that could go to and it would warn them that there's a bad batch of dope going around to be careful or something like that, it might help them to not do something stupid."

In addition, other ideas about communication methods included:

- Town meetings
- School educational programs
- Information booths at community events that are open to the public
- Seminars in the community
- Newspaper advertisements and articles
- VT-211 (ensure that they have accurate information first)
- County-specific resource guide that is distributed at the state office building, recovery centers, SSPs, drug treatment centers, and health provider offices
- An airplane with a banner to raise awareness
- A phone line to call in to anonymously, at any hour, with a pre-programmed message about recent overdoses, bad batches of drugs, and resources such as where to get fentanyl test trips and safer injection supplies

Last, a few participants had ideas about messaging methods that were specific to the content of the message. In particular, one participant thought that in order to increase trust in the Good Samaritan Law, it would be helpful to have the police share information on the Law via a public media campaign. That way, individuals at risk for overdose hear directly from law enforcement that they will not be charged with a drug-related crime if they call 911 in the event of an overdose.

4. Recommendations

Based on participants' direct suggestions and other findings from the evaluation, this section of the report identifies a number of ways for enhancing access to, and participation in, SSP services, as well as the quality and effectiveness of these services. Some recommendations will clearly be more challenging and/or costly to implement

than others, and their impact on the quality of the services and outcomes achieved will also vary. Furthermore, some recommendations are to give certain difficult issues further consideration, rather than provide specific plans for how these issues should be addressed. We have intentionally not attempted to prioritize these recommendations with respect to their potential importance or perceived effects, nor have we rated them in terms of feasibility. Such considerations will need to be part of a broader discussion among policy makers, program staff, and stakeholders – one for which we expect these findings can make a useful contribution.

The recommendations are organized into the following categories:

- Increase awareness and utilization of SSPs
- Increase MAT engagement and retention
- Improve access to residential programming, including detox programs
- Promote use of naloxone among individuals who are at risk and among the broader community
- Tend to the basic human needs of individuals, including housing, education, employment, and social connection
- Consider the evaluation's implication's for messaging and services

4a. Increase awareness and utilization of SSPs and expand availability of safer injection supplies

Increase awareness of programs – Some Franklin county residents mentioned that they travel to the Burlington SSP in Chittenden County to get supplies. The most common reason noted for doing this was the lack of awareness that an SSP mobile van existed in Franklin County. Participants felt that if people knew about the van, it would be used since it helps to overcome the transportation and stigma barriers that participants reported.

Participants recommended that the SSP advertise more in Franklin County to let individuals know of this option by posting flyers at the hub and spokes providing MAT to Franklin County residents and by posting information around town in places like the state office building, libraries, and convenience stores.

Participants also recommended that the outreach and advertisements about all of the SSPs include information about the services being anonymous and that other services are offered (e.g., HIV/HCV testing, naloxone distribution, safer sex supplies).

Expand hours of SSP operation – As mentioned above, participants indicated the limited hours of operation as a barrier to SSP use in Rutland and Windham counties. When life is chaotic, the ability to be at a certain place at a certain time is a challenge. Most participants felt that the SSPs would be used more if they expanded hours of operation, especially if there were some evening and/or weekend hours.

Address stigma in order to increase SSP – Many participants mentioned that people do not always feel comfortable entering the SSP due to fear of being seen and judged. In addition to a larger anti-stigma campaign, it is important for SSP providers to let the community know about other services they offer such as naloxone, HIV/HCV testing, case management, and educational and support programs, so that people may feel more comfortable entering a space that is not exclusively for exchanging safer injection supplies.

Integrate harm reduction services into existing programs – Some participants felt that including certain harm reduction services (i.e., safer injection supplies) in other existing programs (e.g., recovery centers, substance use disorder treatment providers, homeless shelters, community centers, doctor offices) would help increase access and general awareness of the programs.

Expand services at pharmacies – Some participants mentioned frustration that their local pharmacy did not sell syringes, which required them to travel out of town in order to access safe injection supplies. In addition, some participants thought it would be helpful for pharmacies to offer naloxone without a prescription. This would be particularly important in rural areas that are far from other community naloxone distribution sites.

4b. Increase MAT engagement and retention

Expand hours of operation for dosing at hub programs – Many participants felt that expanding the dosing hours at the three hubs (BAART Behavioral Health Services in Franklin, Westridge Center for Addiction Recovery in Rutland, and Habit OpCo and the Brattleboro Retreat in Windham) would improve MAT engagement and retention. Expanding dosing hours provide more options for people who work, have transportation barriers, or who have childcare scheduling needs (e.g., they need to get their child to school before they are able to dose, but do not have enough time to do that or cannot make that work with the bus schedules) to regularly receive MAT.

Increase spoke providers, or increase awareness of providers, especially in rural areas – People are traveling great distances to receive daily doses at hubs, when a closer spoke would be an easier and more sustainable option. If spoke providers do exist, individuals may be unaware of the services in their town.

Increase awareness of shortened wait times for MAT – due to MAT being unavailable or having a long wait previously, the perception in the community is often that MAT is not available. For those sites that have immediate, or close to immediate, access to MAT, it is important to share that information with potential referring providers and potential patients.

Provide child care during dosing hours and meetings with clinicians – Some participants felt that lack of child care was a barrier for accessing MAT, especially during the summer when school-age children were not in school.

Integrate other harm reduction services into the existing MAT structure – Many participants who had access to naloxone had received it from the hub in their county. This model works well in that many of the patients are still using opioids, at least initially, or are around other people who might be at risk for an opioid overdose. Some participants suggested distribution of other harm reduction supplies, such as safer injection supplies, at MAT provider sites.

Review policies surrounding marijuana use - Many participants reported great emotional and physical benefits of marijuana use, including supportive benefits towards their recovery from opioid use. Some participants reported frustration that their marijuana use interfered with their ability to get take-homes at the hub or access treatment at a spoke.

Discuss the use of MAT as a best practice and address concerns about "replacing one drug with another" – Participants reported being worried about getting off methadone or Suboxone once they started and not liking the idea of replacing one drug for another. It would be important to address these concerns when discussing treatment options with individuals with opioid use disorder.

4c. Improve access to residential programming, including detox programs

Strive for on-demand treatment – Participants felt that it is important to have access to residential and detox programs at the time the individual is ready. Waiting for treatment increases the risk of overdose and individuals choosing to not engage in treatment once the opening exists.

"When somebody is ready and they're like I need help, they need help immediately…they were clean for two days and they couldn't get into treatment, so they went right back to it and so now their tolerance was a little bit lower and they overdosed. It happens so many times, you know let me use one more time before I go, overdose. When you get that courage, or something goes that wrong in your life to give you that—like you're on the freeway and they're seeing the exit sign and you're ready to turn off you need to get off at that exit, you can't go past that exit. You know it might be 16 miles before the next exit and that 16 miles could be a long bumpy road and I think that would change things dramatically."

Increase the allowable duration of residential stays – Participants felt that 21-28 days was not always enough time to fully address the issues behind their drug use. Many felt that they need longer treatment stays where MAT is initiated and maintained.

4d. Promote use of naloxone among individuals who are at risk and among the broader community

Ensure that the community is aware of naloxone distribution sites – some participants indicated that they were not aware that they could receive naloxone from their local SSP, their MAT provider or the local recovery center. In these settings, it is important to promote the availability of naloxone for those who may not know to ask or seek it out. Promotion could be in the form of informational flyers and word of mouth advertisement by staff and peers. For those individuals who are not accessing these programs, it is recommended that naloxone distribution be expanded to other places such as hospitals, doctor's offices, community centers, Fire Departments, landlords, the office of Economic Services, and community events.

4e. Tend to the basic human needs of individuals, including housing, education, employment, and social connection

Make diverse housing opportunities available – As described above, housing is an important harm reduction tool in that the stability of having a roof over one's head often results in less drug use and/or less risky drug use behavior. Diverse opportunities (sober housing, transitional housing, supportive housing, etc.) allow for individuals to access the type of housing that works for whatever situation they are in to ensure they have the stability of a place to live.

Provide educational or employment opportunities to individuals with current or past opioid use – Participants mentioned the importance of being able to work to earn an income not only to contribute financially to their daily needs and expenses, but also to a sense of purpose and self-worth. Providing education and employment supports for individuals also serves as a prevention tool that could deter drug use in the first place or support recovery.

Expand community building and sober activities, particularly in rural communities – Many participants indicated that drug use initiation was a result of feeling bored or hopeless. We also heard that individuals who were trying to abstain from substances found it difficult to fill the hole that drugs left in their lives. Participants felt that more sober activities that bring people together, but don't necessary focus on the fact that they are sober or for people in recovery, would be helpful.

4f. Consider the evaluation's implications and recommendations for messaging and services

In addition to participants' direct suggestions for content of health messages, the interview data raise several areas for consideration for their implications for health messages and provision of services for individuals at risk for opioid overdose.

Address conflicting feelings about harm reduction strategies

During the interviews, some participants expressed critical or conflicted views regarding particular harm reduction strategies. Attention to the existence of such attitudes and associated concerns could help address potential barriers to use of harm reduction practices and services.

- "…it's enabling really…it was more or less a plus thing…[but] you're giving access to needles…so if you got dope, now you can definitely shoot it because you don't have to pay for the needles. So instead of there's no needle, so I'm sniffing it, I have access to a needle, so I can shoot it."

- **"**I feel like if I have the syringe handy that's giving me the opportunity to—if they're not around me I won't do the drug."

- "They give you an opiate to cover up an opiate…I have seen my son get sick from [buprenorphine/naloxone] withdrawal if he ran out of his strip and it's like watching somebody come down off of heroin or meth. So, I mean I don't see how that's even helping somebody."

Attend to stigma when raising awareness of harm reduction services

In discussing SSP programs, many participants acknowledged and recommended the importance of advertising the availability of SSPs and their services and suggested ways for doing so. However, often, participants would simultaneously question their recommendation and whether widely advertising SSP services would be acceptable, particularly to the general public. Addressing the stigma suggested by participants' hesitation and second guessing in recommending advertising of SSPs could help improve community norms and individuals' access and comfort regarding using these services.

- "I would say advertise but who wants to advertise that?"

- "…I feel like they could broadcast it a little better, but I also understand that that's a double-edged sword too…without making it sound to the rest of the world that they're just out there making the drug users think it's okay…Well no, that's not, it's just they're trying to not have people get diseases, they're trying not to have

people dropping dead and believe it or not, I mean, drug use will continue forever in this world. But I'm a realist, I get the realities of the world but a lot of people don't…"

Leverage and build on individuals' commitment to act in an overdose situation

Despite the hesitation, fear, and reluctance that many participants described in characterizing bystander reactions to overdose situations, several participants also remarked on their willingness to take appropriate actions despite the fears and other obstacles to using recommended measures, including administering naloxone and calling 911. Promoting and reinforcing the importance of the range of recommended responses in the event of an overdose, such as performing rescue breathing and staying with the person until emergency responders arrive, would be beneficial.

- "They're usually angry. I mean the people. Let's say there's a room full of people and I'm starting to administer Narcan and call 911, everybody is gone. Everybody is running now. No one wants to be there when the cops get there, F this. I've stayed with strangers more than I've stayed with people I know with reversing this kind of stuff and most of the time people are pissed when they come to. They all think, 'I would have been okay. I would have pulled through, this just happens.' 'No, you were turning blue and your freaking lips were—I know enough you were not okay. I had to put the needle in and it's—people get mad. I don't think I've really ever been thanked, and it wouldn't stop me."

- "I couldn't let somebody die. If I didn't call that's murder, if I didn't call and they died, I murdered them basically because I could have did something and didn't, so yeah. I don't know if I would sit there and wait for the cops, but I would definitely call 911 and probably take off, but I would make sure the cops had access to get to the person and where they were."

Address resistance to naloxone administration

To support the timely reversal of overdoses, a critical issue for attention is addressing concerns and reluctance to using naloxone due to individuals' fear of going into withdrawal and feeling sick. This would include increasing the norms and willingness both to administer naloxone and be reversed using naloxone. Related, helping professionals responsible for responding to overdose events, other service providers, and the broader community understand why individuals may immediately use again following an overdose is an opportunity for stigma reduction efforts. Understanding individuals' motivation to alleviate withdrawal symptoms may improve understanding and compassion, and reduce stigma, around the circumstances. In communicating the critical nature of responding with effective measures, including naloxone, attention should be given to addressing many individuals' inclination to at least first try slapping the person or using cold water as revival methods.

Interviewer: Did you call 911?

Participant: Yeah.

Interviewer: What happened when they eventually came?

Participant: They took her. She got out and went and used again. Yeah, that's what most people do because they took the Narcan out of you and I mean it takes the dope out of you and you're sick, so they go use.

Support being prepared and managing panic during overdoses

In describing the panic and chaos that can surround an overdose, an issue that some participants noted is the importance of ensuring that individuals are adequately educated and prepared to respond in these situations. This includes fundamental training in proper use of naloxone and, more generally, preparation for how to respond in the moment when an overdose crisis occurs.

- "And proper Narcan administration, because just sitting there and going over a paper is not enough. People don't do it right and you know you have to like really train people because if you just go over paper when it comes right down to when things are hectically crazy, they're spraying it everywhere. I've seen it, like, a million times. Like, they're not even getting it in the nose, you know. They're just so freaked out. So, I think better training around that would be really good."

- "…Narcan is self-explanatory. It's really not what you need to do with the Narcan, it's what you need to do with the situation."

Increase awareness of and trust in the Good Samaritan Law

Although Vermont's Good Samaritan Law has been in effect for over five years, many participants were not familiar with the law or its protections.

> "I didn't even know that about the Samaritan, that's horrible. That's something every addict should know because a lot of—I bet there wouldn't be as many overdoses. That's huge, I mean, that's fucking monumentous [sic]. I bet that would have saved more lives if people knew it…I had no idea because that's a huge fear, that you're going to jail or if they know that you sold this person this, and they're dying in your place, fuck, no one is going to call. I've heard people driving to the ER and just dropping them off and driving away, but no there's got to be information."

It is recommended that a public awareness campaign be launched with information on the protections of the Good Samaritan law, including personal stories from individuals who received protection when calling 911 in the event of an overdose. It is also

recommended, based on an idea from a project participant, that consideration be given to including law enforcement in the campaign in order for the community to see that they are on board with providing these protections in an effort to save lives. Attention should be given to building the trust to receive these messages and overcome some individuals' mistrust of authorities.

- "Maybe if more, I don't know, if police, I don't know, if they could come across with a message or something that you're not going to be in trouble…"

- "Some people don't even believe that that law even exists.…I think they should do a better job of getting it out there that, 'Listen, you're not going to get in trouble. We don't even have to take your name.' Maybe they should anonymously text 911, because I know you can text 911 now. Something that people can feel like—don't just leave. Don't just walk out of the apartment. Like do something. Call from that person's cell phone. Text from that person's cell phone. Do something.…I think the police need to, with their own voice, people need to hear it from their mouth, that 'We will not mess with you.'"

- "…if they could still somehow advertise more, stressing, you know, the confidentiality and, like, where they're not going to get in trouble. If it was known, let's say, you're doing drugs, you're not going to get the cops called on you or you're not going to get in trouble anyway. I think that's one of the biggest barriers too is where everybody thinks the cops are going to get called or they're going to get in trouble somehow."

Address trauma of witnessing overdoses

Given the chaos, stress, and trauma associated with overdose and the repeated overdose experiences many individuals have witnessed, an additional area for attention is attending to this trauma.

> "…if I went through that I would never want to do it again, you know what I mean? If they could only see what they went through or what you were going through, because it's hard. They can't tell because they're in it and they don't watch themselves, so they don't know, or they'd never do it again, they'd never pick up again because it's scary, you know what I mean. So, when they don't realize what's going on or what happened so it's like they didn't go through anything."

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Memorandum

To: Board of Trustees; Selectboard; Evan Teich, Unified Manager
Cc: Sarah Macy, Finance Director/Assistant Manager; Tammy Getchell, Assistant to the Manager
From: Greg Duggan, Deputy Manager
Re: Open Meeting Law and whether to hold in-person meetings
Date: June 5, 2020

Issue

The issue is for the Trustees and Selectboard to begin thinking about whether they want to resume in-person meetings.

Discussion

The Trustees and Selectboard have been meeting remotely during the COVID-19 pandemic. As restrictions are loosened around the number of people who can gather, the boards should begin to consider if and when to resume in-person meetings.

Staff believes a patient approach to resuming in-person meetings is warranted, for several reasons:

- COVID-19 is still a risk in the region, as demonstrated with a recent outbreak in Winooski.
- Board members should be comfortable with meeting in-person.
- In-person meetings will likely require attendees to wear face masks and/or maintain social distancing; the social distancing could create space challenges, depending on the meeting space.
- A joint meeting of the Trustees and Selectboard typically includes 15 or more people (10 board members, 3 administration members, 1 recording secretary, 1 camera person) before adding in any additional staff, residents, or other guests who may be present. A meeting that includes a hot issue or controversial topic would easily draw more than 25 people.
- Anecdotally, electronic meetings have seen growing attendance, and seem to draw more attendees than in-person meetings.

If and when the boards wish to resume in-person meetings, they could consider alternative locations that allow for more people; meeting in-person for individual board meetings but not joint meetings; in-person meetings for small gatherings with residents on specific issues.

Cost

N/a

Recommendation

This memo is for informational purposes. The boards may wish to have a broader discussion on the topic at a future meeting.

Green-Up Day 2020

This year's Green Up Day effort was significantly different than past years due to the continuing impact of the COVID-19 pandemic. The lengthy time frame when people were asked to remain at home, the closure of businesses, and the lack of visitors from out-of-state, created a situation where less roadside trash was evident. Also, a significantly smaller number of people participated in the clean-up. Most were individuals or families and not groups or organizations as in the past.

In spite of the difficult situation that was created by COVID-19, the total tonnage of trash picked up in both communities was .32 tons and approximately 30 tires. This compares to 4.78 tons picked up in 2019.

In an effort to create more interest, residents who brought their Green Up bags to either the Village drop-off or the Town Highway garage were signed up for a $10 restaurant gift certificate for participating. A total of sixteen residents took advantage of this offer. Four local restaurants were chosen at random, and the sixteen names were chosen also at random to match up with the four restaurants. The restaurants chosen were Martones, Vespa, Hoagies and Joyce's Noodle House. Thank you letters were sent with the gift cards to the sixteen who participated.

Some residents chose to leave their bags along the roadside and their effort is appreciated as well.

The accumulation of trash along the roadsides and in streams is an ongoing problem and everyone needs to do their part. It is especially important to keep waste material out of our waterways, including pet waste. Information on what you can do as an individual during the rest of the year can be found at www.rethinkrunoff.org, a web site dedicated to cleaning storm-water in Chittenden County. During the year, if a resident is aware of a particular non-residential site that needs clean-up, please contact either the Town Public Works Department at 878-1344 or the Village Public Works Department at 878-6944.

Town and Village Public Works,
Recreation Departments and Green-Up
Day Coordinators

GREEN UP DAY 2020
A DIFFERENT EXPERIENCE
SATURDAY, MAY 30, 2020
Green-Up Day Support Hours are 9 am – 1pm

With the COVID-19 Social Distancing and Personal Protection Guidelines still in effect, changes have been made to the Green-Up day procedures for this year. It is important that everyone participating in Green-Up Day protect both themselves and municipal workers supporting the effort by strictly adhering to the Governor's COVID-19 guidelines.

Please remember that:

All Green-Up litter must be put in specially marked bags. Bags may be picked up prior to Green-Up Day at 75 Maple Street (outside the Town and Village Parks and Recreation Building). Please take only the number of bags that you plan to use in support of this event.

The purpose of the day is cleaning roadsides, drainage swales and park/common areas and not personal yard or business site clean-up. In the past, a large number of tires have been deposited at some pick-up sites which appear to have originated from commercial businesses and not from roadway pick-up. Residents are encouraged to contact the Police Department if this type of drop-off is observed.

The Town of Essex and Village of Essex Junction will **only** accept Green-Up Day bags along the roadside. They may also be brought to one of two drop-off sites --the Highway garage in Essex off Sand Hill Road behind the Fire Station and at a truck located in the parking lot at Brownell Library. Any tires or metal objects must be brought to the Town Highway garage. Any materials other than Green-Up Day bags left by the side of the road will not be picked up.

Anyone bringing Green-Up Day bags or other material to the highway garage or the vehicle at Brownell Library must be wearing a mask when exiting their vehicle. Although no food will be served this year at the Town Highway Garage, residents who bring their Green Up Day bags to either the Town or Village drop-off sites, will be signed up to receive a $10 gift certificate to a local restaurant doing take-out. Only one gift certificate will be issued per party bringing trash to the sites (no multiple certificates).

DO not pick up needles or any hazardous waste! If you encounter any needles please contact the Essex Police Department (878-8331). If you have hazardous materials, contact the Chittenden Solid Waste District Facilities at 872-8100 for disposal information.

Tree and branch debris, leaves and weeds from private property will not be picked up or accepted – do not put this material at the curb. Contact the Chittenden Solid Waste District Facilities at 872-8100 for where it can be dropped off.

Please wear long pants, closed shoes and use appropriate bug spray. Be careful of vehicles when picking along roadsides. Wear masks when appropriate and Stay Safe.

Thank you for your help in keeping the community green!

MEETING SCHEDULES

06/03/2020

TOWN SELECTBOARD MEETINGS	VILLAGE TRUSTEES MEETINGS	JOINT MEETINGS
June 8, 2020—6:30 PM	Joint—online	
June 9, 2020—6:30 PM	VB, Joint, SB—online	
June 15, 2020—6:30 PM	SB Special—online	
June 23, 2020—~~7:00 PM~~ 6:30 PM	SB, Joint, VB—online *(time change 5/12)*	
~~**July 13, 2020—7:00 PM**~~	~~SB Regular~~ *(canceled 5/12)*	
July 14, 2020—6:30 PM	VB, Joint, SB—online *(changed to combined meetings 5/12)*	
~~**July 28, 2020—7:00 PM**~~	~~VB Regular~~ *(changed to combined meetings 5/12)*	
July 28, 2020—~~6:15 PM~~ 6:30 PM	SB, Joint, VB—online *(changed to combined meetings 5/12)*	
August 3, 2020—7:00 PM	SB Regular	
August 3, 2020—7:45 PM	JT Special—81 Main	
August 11, 2020—6:30 PM	VB Regular	
August 18, 2020—7:00 PM	SB Regular	
August 25, 2020—6:30 PM	VB Regular	
August 25, 2020—7:15 PM	JT Special—2 Lincoln	
September 8, 2020—6:30 PM	VB Regular	
September 14, 2020—7:00 PM	SB Regular	
September 29, 2020—6:30 PM	VB Regular	
September 29, 2020—7:15 PM	JT Special—2 Lincoln	
October 5, 2020—7:00 PM	SB Regular	
October 5, 2020—7:45 PM	JT Special—81 Main	
October 13, 2020—6:30 PM	VB Regular	
October 19, 2020—7:00 PM	SB Regular	
October 27, 2020—6:30 PM	VB Regular	
October 27, 2020—7:15 PM	JT Special—2 Lincoln	
November 2, 2020—7:00 PM	SB Regular	
November 2, 2020—7:45 PM	JT Special—81 main	
November 10, 2020—6:30 PM	VB Regular	
November 16, 2020—7:00 PM	SB Regular	
November 24, 2020—6:30 PM	VB Regular	

November 24, 2020—7:15 PM	JT Special—2 Lincoln
December 7, 2020—7:00 PM	SB Regular
December 7, 2020—7:45 PM	JT Special—81 Main
December 9, 2020—8:30 AM	VB All Day Budget Workshop
December 21, 2020—7:00 PM	SB Regular
December 29, 2020—6:30 PM	VB Regular
December 29, 2020—7:15 PM	JT Special—2 Lincoln
January 4, 2021—8:00 AM	SB—All Day Budget Workshop
January 11, 2021—7:00 PM	SB Regular
January 12, 2021—6:30 PM	VB Regular
January 18, 2021—7:00 PM	SB Regular
January 26, 2021—6:30 PM	VB Regular
January 26, 2021—7:15 PM	JT Special—2 Lincoln
February 1, 2021—7:00 PM	SB Regular
February 1, 2021—7:45 PM	JT Special—81 Main
February 9, 2021—6:30 PM	VB Regular
February 16, 2021—7:00 PM	SB Regular
February 23, 2021—6:30 PM	VB Regular
February 23, 2021—7:15 PM	JT Special—2 Lincoln
March 1, 2021—7:30 PM	Town Annual Meeting
March 9, 2021—6:30 PM	VB Regular
March 15, 2021—7:00 PM	SB Regular
March 23, 2021—6:30 PM	VB Regular
March 23, 2021—7:15 PM	JT Special—2 Lincoln
April 5, 2021—7:00 PM	SB Regular
April 5, 2021—7:45 PM	JT Special—81 Main
April 7, 2021—7:00 PM	Village Annual Meeting