February 16, 2025

"A new state hospital is desperately needed."
Officer Joe Corrow,
President Burlington Police Officers' Association

White Paper #1

Clarion Call for a Comprehensive Solution to the Homelessness Crisis

by

Jack T. Scully

Introduction

According to Vermont's Housing and Homelessness Alliance, our state had 3,458 unhoused people on one census night last year. See Vermont Homelessness Count 2024.

Of these, 855 had "serious mental illnesses;" another 400 had "substance abuse disorders." That's 1,255 people, caught in a vicious cycle of unending pain and delusion, stress and despair, exacerbated by potent street drugs and self-destructive behavior.

Comorbidity runs high. Mental illness and addiction often overlap. Nationally, nearly 9 million people have a co-occurring disorder, according to the Substance Abuse and Mental Health Services Administration. Yet, only 7 percent of these individuals get treatment for both conditions. And nearly 60 percent receive no treatment at all.

The Human Costs of Not Acting

Risk of premature death is high. The Alliance found that 244 (19%) of Vermont's homeless people had died of accidental drug overdoses in 2022 alone. Most troubling, the state has seen a 500% uptick in drug overdose deaths in the last ten years. Though difficult to quantify, hypothermia and related health conditions have taken their toll among addicts unwilling to trade getting high for a warm bed.



Homeless Woman with a Gifted Tent, City Hall Park, Burlington, VT

Photo by James Buck for *Seven Days* Newspaper, February 7, 2025

In October 2024, *Fox News* sent two reporters to Burlington to assess its escalating social and public safety problems. See related *NY Post* article here: Homelessness, Drug Addiction and Safety Concerns in Vermont's Largest City. After interviewing city and state officials, the journalists estimated at least 350 homeless people were living on Burlington streets—a record number. A growing percentage of these unhoused individuals were ravaged by addiction to deadly street drugs: fentanyl and xylazine, also known as *tranq*.

The Homelessness Alliance squarely places the blame on Montpelier for the crisis in these words:

Failure to provide adequate mental health and substance abuse services.

Its 2024 Report, further urges the state to stop using:

Vermont's criminal legal system to provide health care,
treat substance abuse disorder and mental illness.

Effects on Vermont's Largest City

On Sept 4, 2024, *Seven Days* Newspaper gave readers an opportunity to express their opinion on homelessness. See **Readers Weigh In on 'Bad News in Burlington'.** Besides graphically portraying the public safety issues, the compilation is a good barometer of what needs to be done. Of 100 comments, here is a representative sampling:

1. We need more beds statewide for mental health and substance abuse treatment. Some of those beds need to be lockdown beds as an alternative to letting these repeat offenders go.

2. Homelessness is an issue everywhere. However, in addition to building affordable housing, every state needs treatment, recovery centers, and long-term care. (Access to shelter does not equate to effective therapy…)

3. Shoplifting and property theft is out of control. The owner of *Homeport* was quoted as saying he lost $70,000 due to shoplifting last year.

4. This do-nothing, slap-on-the-wrist approach to crime and drug use is killing the city, closing small businesses and ruining the middle class.

5. The change [in Burlington] has grown steadily since 2020…. I have seen people shooting up on my porch, [my] trash and recycling cans have both stolen, bikes dumped on my property, my car broken into. I can't even begin to describe the amount of trash dumped on my lawn as well as *so many needles.*

6. Defunding law enforcement [and demoralizing police officers] have consequences. Now [we're] living with it.

7. If you want to largely mitigate the issues affecting Burlington, it's really simple. We need more police on the streets. End of story.

8. The Old North End is constantly bombarded by people screaming at each other, people stumbling around just barely hanging on, and I do not feel safe. Downtown is terrible.

9. [Here is] a list of complains I have received as a property manager of two downtown buildings:

- Tenants harassed getting into the buildings.
- Homeless people masturbating in their windows.
- Blatant open drug use weekly.
- Car break-ins weekly.
- Needles scattered around the property.
- Muggings and overdoses.
- Trash, clothes, shopping cars thrown on the property.
- Human feces in and around people's front door and bushes.

10. It seems like local leaders care more about 300 homeless individuals than the 45,000 people trying to live safe, happy lives in our beautiful city.

11. The solution, in my opinion, is to uphold the law and stop the normalization of drug use, theft, camping, and verbal/physical harassment. If someone is doing drugs in public, they should be arrested and thrown in jail (longer than a couple of hours). If someone steals or harasses people on Church Street, there must be consequences and common sense.

12. Burlington is such a beautiful city, yet its attractive old buildings are now covered with graffiti. The law-abiding citizens no longer seem to have a place in the city. We are so concerned with our safety that we stay away… I just get myself into and out of Burlington as quickly as I can.



Sample of Large Graffiti Tags Defacing Downtown Burlington, VT

13. I am fairly liberal but believe that defunding the police was a serious mistake. Every effort should be made to rebuild the police force to its former size (and quality!). I think that efforts to date have been half-hearted at best. This should be priority one.

14. The pandemic of drugs, violence, vandalism and petty crime in Burlington will not end until we deal with underlying causes.

15. I used to walk to my office in Burlington, but I stopped based on the numerous horrible experiences with these homeless drug-addicted criminals. From blow jobs to drug ODs, from witnessing death and muggings, and to a city government that has so obviously failed to control this insanity and in most cases promotes more of it.

Early in January 2025, I engaged in an exchange with Kara Alnasrawi of the Church Street Marketplace, Director of Business & Workforce Development, regarding the state of safety, security, theft, loitering, homelessness, mental health, graffiti, and policing in downtown Burlington, VT. My key points:

As a concerned Vermonter, who once lived in Burlington and whose son moved out of the city due to nightly harassment by homeless people while walking his dog on Maple Street and whose girlfriend had her car stolen on Pine Street, please allow me to add my voice to hundreds of citizens who *fear* our Queen City is spiraling into an unrecoverable descent.

Time and time again, the anti-social, criminal interests of several hundred vandals, shoplifters, drug addicts and their dealers, mentally ill people, loiterers, petty thieves, felons, and their fellow travelers have trumped the rights of 45,000 Burlingtonians and thousands of visitors and shoppers.

In response, Ms. Alnasrawi shared her "deep concerns for our downtown." She also reminded me that there is little city officials can do to address these issues. Key points:

1. Most of your suggestions can only be addressed at the **judicial and state level**. Much of the change you are looking for lies with the State's Attorney, the court system, and the State of Vermont.

2. [In the Marketplace] we see extreme rates of recidivism, particularly related to retail theft and have advocated at the state level to have these issues addressed.

3. Homeless services and mental health services lie squarely with the state. There are no municipalities in Vermont that have health departments. This means that all federal health-related funding goes straight to Montpelier. It is their decision how to spend it.

3. Graffiti is most definitely a problem in Burlington, but we have no control over tags on private property.

4. In terms of private security, I can confirm that we recently spent $60k for overtime police patrols during the holidays. This is not a sustainable expense for us to manage, nor can BPD officers continue to work substantial amounts of overtime.

Our full exchange is contained in Appendix 3.

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Tragic Fallacy of Treating All Homeless People the Same

To date, Vermont has spent hundreds of millions of dollars to house homeless people. The expenditures pay off for people who are down on their luck and need a helping hand. With assistance from the Chittenden County Homeless Alliance, Burlington has already helped more than 150 households transition from the temporary housing in motels/pods into permanent housing through the county's "coordinated entry" system.

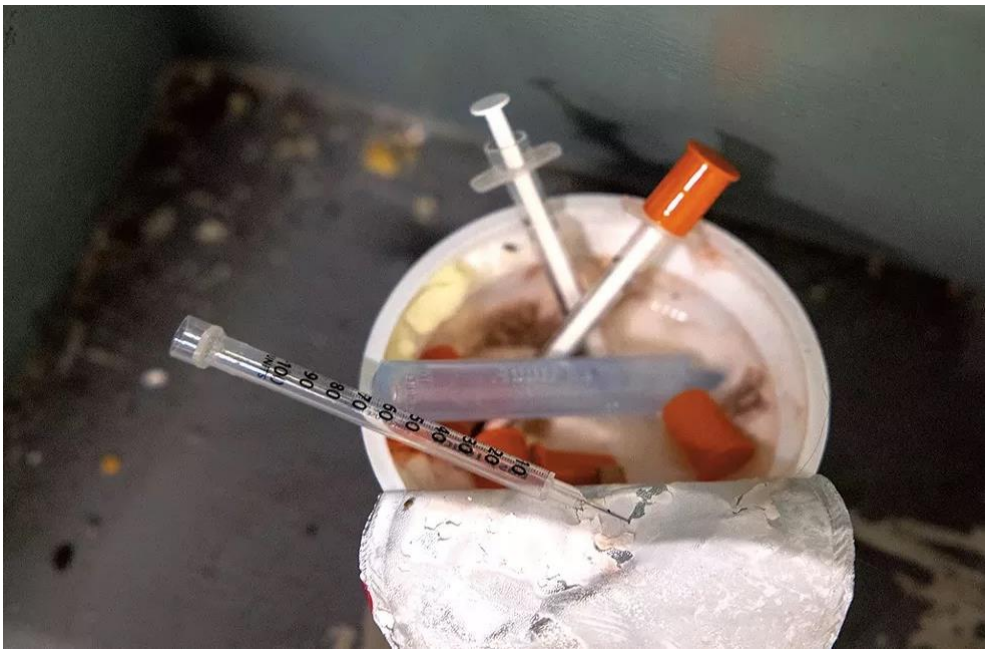
Such is not the case when dealing with mentally ill and addicted people. Health care professionals and social workers concur:

You simply cannot place a severely impaired person in a motel room or temporary shelter and expect a good outcome.

The case of Burlington's Decker Towers is a prime example. It is a low-income, high-rise apartment building that has been overrun by homeless people and drug addicts. See *Seven Days* report here: The Fight for Decker Towers.

Seven Days reporter Derek Brouwer, who spent several nights in the building last winter, described what he saw:

> Decker Towers is functioning as an unfunded warming shelter, an unmonitored injection site, and a hub for distribution of drugs and stolen goods… Every day, dozens of people enter the building to buy and use drugs, or simply to escape the cold. Its twin stairwells are littered with used needles, crack pipes and glassine bags. They're streaked with urine and feces, etched with vulgar graffiti, and strewn with blankets and other meager belongings of the people who sleep there each night.
>
> Intoxicated visitors routinely stumble around or pass out on the stairs, in the hallways and in the laundry rooms…
>
> Over the past few weeks, someone defecated in a hallway recycling bin, and the stench permeated nearby apartments. A vandal or thief ripped the door to a resident-run food shelf off its hinges. Someone tried to cut through a $600 steel cage installed to shield residents' packages from thieves. Laundry machines were ripped apart. In the parking lot, within view of surveillance cameras mounted on a mobile security trailer, a car windshield was smashed.



Discarded Drug Paraphernalia in Hallway at Decker Towers, Burlington, VT

James Buck Photo for *Seven Days* Newspaper, August 14, 2024

> Multiple shelters, among Vermont's 76 motels/hotels housing homeless people, have been rendered unlivable due to self-destructive behavior: urine, vomit, and feces on floors and walls. Rooms have been trashed, carpets ripped apart, walls splattered with graffiti, garbage dumped everywhere. Windows and toilets have been broken. Remnants of fire have been found alongside walls. At one site, human waste was dumped into a swimming pool.

On July 17, 2024, *Seven* Days' Alison Novak reported on abysmal living conditions at Rutland's Cortina Inn. According to Rutland Town Police Chief Ed Dumas, police calls to Cortina increased from around 150 in 2019 to more than 1,400 in 2023. (Until its temporary closure in 2024, the Cortina paid Rutland Town $23,000 a month for demands placed on its municipal services, including policing.)

A drug raid at the hotel in February 2023 led to the arrest of a woman selling cocaine. Chief Dumas says he has personally responded to multiple drug overdoses at the hotel and strongly believes the state should provide intensive social services, such as mental health support for people in its shelters. The state is "keeping [homeless people] from freezing to death, and that's about all they're doing," Dumas said.

John Paul Faignant, Rutland's health officer, said he's observed unsafe conditions at the Cortina, including backed up toilets and black mold on the walls. A sewer backup last year caused raw sewage to flood two rooms—one occupied by a disabled veteran; the other by a man with a cognitive disability.

The conditions are so bad, Faignant said, that the "**Cortina needs to be bulldozed."**

But there's little health officials can do. Because of a 2022 state policy change, local health officers can no longer enforce regulations at hotels. He blames the state for not providing adequate oversight.

And yet, the Cortina is better than some of the alternatives, said Brenda Siegel, the executive director of End Homelessness Vermont. A former Democratic candidate for governor, Siegel similarly faults the state for failing to ensure vulnerable people in Vermont are safely sheltered. In her view, the Agency of Human Services should have required hotels to enter into lease agreements with clients that include strict health and safety standards. To date, it has declined to do so.

The *Seven Days* article also quotes Rep. Eric Maguire (R-Rutland City) on the subject of Vermont's care for homeless people. (Maguire is also House Director of the **Rutland Dismas House**, which provides transitional housing for people released from prison.) He raised concerns about the state's sheltering program during an April 2024 floor speech at the Statehouse:

> Babies are growing up in hotel rooms; children are being exposed to drugs, human trafficking and violence. People are dying in these hotel rooms. There are no kitchens; there is no living space. We are concentrating our most vulnerable, impoverished and disabled people in buildings not designed for permanent habitation.

In March 2024, *Seven Days* further reported that the Scott Administration's goal is to "phase out the motel program and to build or acquire permanent homeless shelters and housing stock." Gov. Scott was quoted at that time as saying restoring existing homes and creating new ones "is the only way to truly end homelessness in Vermont."

While this approach is laudable, it ignores the most pressing need for a secure and safe treatment center for those who need more than shelter to survive.

Pleas for Help

The demands that homelessness places on Vermont's cities and towns cannot be underestimated. Last Fall, political leaders from five municipalities participated in a Montpelier press conference. Said Rutland Mayor Mike Doenges:

> We are calling on state government, all three branches, to take immediate charge of this situation and assume their legal responsibilities for this population in need.

See full coverage of the press conference here: Cities and Towns are pleading for state help in handling homelessness.

The Critical Need for Inpatient Treatment

Despite Montpelier's procrastination, there is a groundswell of professional and private opinion appealing for an inpatient facility or facilities for homeless people suffering from serious drug and mental disorders.

Until 2011, the state funded the Vermont State Hospital Complex in Waterbury. It closed after being severely damaged by Tropical Storm Irene. The antiquated hospital buildings were already in poor condition due to inadequate funding and had been the subject of repeated calls for closure. The hospital found itself decertified

after failing to address substandard conditions, care issues, and suicides. Advocates for renovations were also bucking a national trend toward "deinstitutionalization." It was gaining momentum among health care professionals and politicians believing that mental health patients could be successfully rehabilitated with a new generation of medications, administered on an outpatient basis in “community settings.”

According to Alice Feller, MD, a psychiatrist and writer based in Berkeley, CA., whose work has appeared in the *Journal of the American Psychoanalytic Association*, the *San Francisco Chronicle* and *New York Times*, American psychiatric hospitals began to close their door in the 1960s. The movement began in California, first with the large state hospitals and then the small community hospitals as well.

By 1994 nearly half a million former patients had been sent back to live with their families, who were often unable to care for them. A quarter million newly discharged patients ended up on the streets or behind bars after committing serious crimes, including rape and murder.

So many were incarcerated that jails and prisons have become our *de facto* mental hospitals. Today, the vast majority of inpatient psychiatric care in America is provided behind bars. For her full commentary, see After Deinstitutionalization, California Has Tragically Come Full Circle on Mental Illness.

Her assessment is summarized in Appendix 1.

The Waterbury Site Today



The Vermont State caption for this photo on its website reads:

Located on the Winooski River and originally built in 1890 as the Vermont State Asylum for the Insane, the institution once housed over 1,500 patients suffering from a variety of mental disabilities, epilepsy, addiction, and other issues.

As treatments advanced, the facility transitioned into state offices for the Agency of Human Services and the Agency of Natural Resources, also known as the Waterbury State Office Complex.

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Note: The state's caption fails to say that the Vermont's population has doubled since the 1890s and that advances in medications have been outstripped by new generations of illegal drugs, readily available to both drug addicts and mentally ill people. According to the Centers for Disease Control and Prevention, the popular street drug fentanyl is up to 100 times more powerful than other opioids such as morphine, heroin, or oxycodone.

Although Vermont could not find funding to revamp antiquated conditions at the Waterbury State Hospital complex, it did find $130 million in financing to clean up the property, transform multiple buildings, and build a 500-year sea wall to protect the site from future floods. Today, multiple state agencies are housed there in several buildings See: New $130 Million Flood-proof State Office Complex in Waterbury

The Need for an Inpatient Center for People with Severe Mental Health and Drug Addictions

Based on mountains of empirical data and updated medical opinion, it is clear that Vermont needs to make a long time, capital investment in opening and professionally staffing a State Psychiatric Hospital. State-owned land with existing infrastructure makes Waterbury a prime candidate though others sites should be examined.

The need becomes even more critical with the announcement that the inpatient psychiatry units at Central Vermont Medical Center has recently stopped admitting new patients to its 14-bed unit. The high cost of regional health coverage is cited as a driving factor. "People will die," as a result of the closure, said state Rep. Anne Donahue (R-Northfield) in a November 19, 2024 interview with *Seven Days.* Ms. Donahue is a long-time advocate of improving support for people with mental health conditions.

On January 28, 2025, *Vermont Public* quoted Montpelier's Lise Ewald, a former patient at the unit as saying:

The terribly irresponsible part of [closure] is they shut it
before they created an alternative.

See also WCAX coverage of this story: State to Close Central Vermont Psychiatry Unit.

According to *Vermont Business Magazine*, 112 Vermont psychiatrists, who are members of the Vermont Psychiatric Association and practice in all corners of the state, strongly oppose the 2025 closure of the inpatient psychiatric unit at Central Vermont Medical Center. See: Psychiatrists Oppose Closure of Central Vermont Medical Center Inpatient Psychiatric Unit

In a unanimous statement, they wrote:

> The anticipated impacts of cutting these services should be of grave concern to all Vermonters, particularly given the devastating impacts it will have on the most vulnerable members of our community — individuals experiencing mental health crises and their families.
>
> ***We have been advocating for years that Vermont has too few psychiatric beds to serve the needs of our patients.***
>
> Public health research indicates that an optimal level of mental health services require at least 35 in-patient psychiatric beds per 100,000 population. Vermont has 18 beds per 100,000, and some of these are restricted to certain kinds of admissions, falling woefully short of the recommended minimum.
>
> **To eliminate more beds is taking our State in exactly the wrong direction.**

Calls for Inpatient Care from Judiciary and Mental Health Advocates

In addition to the empirical evidence and recommendation of Vermont's Psychiatric Association, presented in this White Paper, the following Vermont stakeholders are on record urging Vermont to establish a state-wide facility for people suffering from severe drug and mental health disorders:

1. Honorable Christina Reiss, Chief Judge District of Vermont.
2. Honorable Kevin Doyle, Magistrate Judge District of Vermont.
3. Honorable Elizabeth Novotny, Vermont Superior Court Judge.
4. Honorable Kevin Griffin, Vermont Superior Court.
5. Eric Maguire, Vermont House Representative & Director of Dismas House, Rutland.
6. Michael Cusick, U.S. Probation Officer, District of Vermont.
7. Sara Puls, Federal Public Defender.
8. Michael Desautels, Federal Public Defender.
9. Dawn Tatro, Founder, Jenna's Promise.
10. Mark Redmond, Spectrum's Executive Director.
11. Dr. Mark Levine, Vermont Health Commissioner.
12. Dr. John Brooklyn, Associate Clinical Professor of Family Medicine and Psychiatry at the UVM Larner College of Medicine; Medical Director, the Howard Center Chittenden and the Baymark St. Albans Hub.
13. Dr. Stephen Leffler, Chief Medical Officer, University of Vermont Network.
14. Ginny Lyons, Vermont State Senator.
15. Theresa Wood, Vermont State Legislator.
16. Martin LaLonde, Vermont State Legislator.
17. Multiple unnamed treatment providers in Vermont, New Hampshire, and NY.

To quote Chief Judge District of Vermont, Christina Reiss:

From my perspective, the substance use scourge in Vermont has grown progressively worse. I do not believe we have been "successful" in addressing it regardless of how that term is defined. In my opinion, it is time to revisit what

we are doing and be prepared to admit we are on the wrong track.

In speaking to other stakeholders, we have coalesced around a **single critical missing piece in Vermont's recovery network—a lack of long-term residential options for intensive substance use treatment.**

Call to Action

The evidence is overwhelming. Despite cries of budgetary restrictions, the time for action is now.

First and foremost, we need to understand that homelessness is not a monolithic problem. It is a symptom of three problems. We must therefore empower health care professionals and social workers to divide the homeless population into three addressable groups:

1. Healthy people who are intact socially, mentally and physically,
2. Unhealthy people suffering from drug and alcohol abuse,
3. Unhealthy people suffering from mental illnesses.

As noted, existing municipal and state programs with federal support, though costing hundreds of millions of dollars, are making progress for the first group.

Fiscal and social costs run exceedingly high though when Groups 2 & 3 are pigeon-holed with little or no supervision into the top segment. Again, the problem is not that these people are homeless; the problem is that drug addictions and mental disorders interfere with their ability to find/keep a residence and act responsibly.

It also creates negative community impacts:

Property crimes: theft, shoplifting, burglary, littering, arson, graffiti, vandalism.

Violent crimes: assault, murder, rape, robbery, human trafficking.

Nuisance crimes: loitering, vagrancy, panhandling, disturbing the peace, unpermitted encampments & sleeping outdoors, open drug use, public urination/defecation, anti-social behavior.

The destructive impact of homelessness on society is only now being place in perspective:

- The San Diego County District Attorney's Office has reported that homeless individuals are 514 times more likely to be arrested and charged with a felony and often face multiple criminal charges.
- The data reveals higher rates of robbery, residential burglary, assault, arson, and vandalism.
- According to reports compiled by numerous police departments, homeless people account for a "disproportionate" percent of all crime.

The Tragic Cycle

On the street, homeless people often present with multiple overriding afflictions. Whether ill due to drugs/alcohol, mental health issues, or both, they are often battling multiple demons as well as coping with the harsh prospect of daily survival. Some get arrested and sent to jail; others stay briefly at a medical facility then, if lucky, land in a community halfway house. Soon after, they are pushed back into the

streets. (This is the so-called **"Wash-Rinse-Repeat Cycle**" that characterizes homeless lives. With no place to go and no money for basic human needs, the cycle starts over again.

Breaking the Cycle

For Groups 2 and 3, we must find a way to get sick people off the streets and into long-term (90 days minimum) residential drug, alcohol and mental illness treatment programs. Only there do they stand a chance of recovery.

The August 26, 2024 letter to Governor Scott, signed by multiple stakeholders, (see Appendix 1) outlines a "new approach to substance abuse and mental health disorders" that will offer Vermonters a new opportunity for "sustained recovery."

Key Provisions of Proposed Plan to Governor Scott;

1. Initial short-term inpatient stay at a residential, rehabilitation facility.

2. Transfer, without a break, to a residential stepdown facility, such as a re-opened Waterbury Hospital wing, that offers therapeutic services in a sober environment.

Note: Stepdown living is a critical missing step in Vermont's current approach to treating homelessness. Importantly, it separates the recovering homeless person from the triggers (persons, places, things) that often leads to recidivism.

3. The stepdown facility must provide a minimum of 60-90 days of therapeutic services in a stable, structured environment with goal of long-term recovery . It should not be developed or seen as a place to lock up and hide people away. Services

should include professional support for legal, social, psychological, job, housing, transportation and medical challenges. Supervised reintegration into society should the objective.

Note 1: While in session, Montpelier officials should launch a concerted campaign at the state and federal level to gain Medicaid insurance reimbursements for people receiving treatment for addiction and mental health disorders.

Note 2: Medicaid reimbursements are a critical missing step in Vermont's current approach to funding services for homeless people.

4. Only following a successful stepdown program, should healthcare providers consider reintegration into society. If transitioned to a halfway house, patients still require a high level of oversight and assistance. Failure to meet standards should result in transfer back to the stepdown rehabilitation facility.

Net Result of Structured Plan for Vermont

On the upside, a comprehensive plan would reduce not only the number of addicted people living on the streets, it would also reduce the number of mentally ill being warehoused in jails. This in turn has the potential of increasing the number of prison cells available to house convicted criminals.

Law Changes Needed in Vermont:

As Kara Alnasrawi, a Director at Burlington's Church Street's Marketplace and other vested parties have urged, some laws need to be updated and new laws need to be passed to save Vermont's cities and reduce homelessness.

In our opinion, legal changes should include:

1. Sleeping outside or in an encampment without a permit should be illegal. People in this predicament should be immediately arrested for a court adjudicated transfer to a residential or stepdown facility to deal with root causes.
2. Panhandling and trespassing should be re-categorized as criminal offenses.
3. All property crimes, regardless of the amount, should be upgraded to felonies.

Minimum sentences of 200 hours community service in Public Works Department projects to fix damage and remove tags should be imposed for vandalism and graffiti.

4. Loitering, urinating/defecating in public should be reclassified as societal crimes. Intervention by police should no longer be regarded as harassment.



Cherry Street Garage, Burlington, VT

James Buck Photo for *Seven Days* Newspaper, August 14, 2024

5. Obtaining, possession, manufacturing, distributing and selling illegal street drugs should upon conviction result in a minimum mandatory sentence of 20 years in prison.

6**.** Using a deadly weapon in a crime should carry a mandatory 20 year prison sentence.

7. Any crime committed that results in the death or serious injury to an innocent civilian, police officer, first responder, or emergency personnel should carry a mandatory life sentence. Under no circumstances should the rights of the offender trump the rights of the victim.

8. Recidivism should not be tolerated.

As former Chittenden County State's Attorney Frank Murray once said, "Setting repeat offenders free is an invitation to more crime and harm to innocent people… We need to reinstall *Three strikes and you're out*, which means a long sentence for career criminals convicted of three felonies."

-end-

About

Jack T. Scully is a graduate of St. Michael's College and the University of Vermont. Long active in local politics, he has been a selectman in Colchester, founder of the Malletts Bay Advisory Commission, and a former member of the Lake Champlain Advisory Committee. His interest in the homelessness question dates back to his childhood. An uncle, suffering from a serious

mental disorder and self-medicating with alcohol and street drugs, died homeless on the streets in Stamford, CT.

Appendix 1: Statement by Dr. Alice Feller, a California Psychiatrist, on the Tragic Result of Deinstitutionalization in America

Deinstitutionalization was accelerated through a little-known law, the Medicaid IMD exclusion, passed by Congress in 1965 along with the creation of Medicaid. The provision forbids the use of Medicaid dollars to pay for care in a mental hospital. Any psychiatric hospital with more than 16 beds is forbidden to take Medicaid.

Nevertheless, hospital treatment for severe mental illness can mean the difference between life and death. But because of this law, such treatment is specifically denied to the people who need it most. No other severe illness is subject to such discrimination.

We have come full circle from the early 19th century, when Dorothea Dix campaigned to rescue the mentally ill from the prisons where they languished, often under shockingly inhumane conditions. Due to her work, people with mental illness were rescued from prisons and cared for in hospitals.

But, as noted, today that life-saving trend has been reversed. Once again, Americans with serious mental illness are being warehoused, out of sight in our prisons. And many more are living unsheltered on our streets. A third of our homeless population today suffer from untreated severe mental illness, most commonly schizophrenia.

Schizophrenia is a brain disorder. It affects 1 out of every 100 human beings on Earth. Good parenting doesn't prevent it and bad parenting doesn't cause it. It begins in adolescence or early adulthood, and without treatment it will be permanently disabling. It leaves the afflicted person living in a psychotic world, unable to tell reality from delusion.

Lives are derailed. Suicide is common; violent crime occurs all too frequently..

Treatment requires early intervention by a specialized team of clinicians who collaborate on patient care. Unfortunately these dedicated programs are rare. Despite mountains of evidence showing their effectiveness, insurers refuse to cover early intervention programs.

While hospital care can provide stabilization and enable the patient to use outpatient treatment, insurance coverage for inpatient treatment is rare.

In my judgement, California, [as well as other states] can rectify this situation by obtaining a waiver of the IMD exclusion. Specifically,

We need to restore hospital care to stabilize our patients and enable them to use outpatient treatment. We need to mandate early intervention programs and require insurance coverage for this vital treatment.

These two interventions would do more than anything else to help our mentally ill homeless citizens. It is not a simple lack of housing that leaves so many homeless people vulnerable. Simply put, they are unable to use available housing due to their mental illnesses and debilitating addictions.

Dr. Feller's *expertise lies in diagnosis and treatment of mental illness, such as depression, anxiety disorders, substance abuse, and schizophrenia.*

Appendix 2: Letter to Gov. Phil Scott Signed by Vermont Authorities Urging Establishment of a State-wide Residential Treatment Center for People Suffering from Drug and Mental Health Disorders:

August 26, 2024

Governor Phil Scott
109 State Street, Pavilion
Montpelier, VT 05609

Re: Extended Treatment for Vermonters with Substance Use Disorder

Dear Governor Scott:

We hope to bring to your attention a new approach to substance use disorder that will afford Vermonters a much better opportunity to sustain recovery. As you know, Vermont's current model consists in part of short term stays (approximately fourteen to twenty-one days) at the highest level of care in one of Vermont's two primary residential rehabilitation providers: **Valley Vista** (eighty male beds, nineteen female beds) and **Serenity House** (twenty-four beds—collectively). Both offer rational recovery (RR) programs followed by treatment in the community.

After a short two to three week stay at an RR provider, Vermonters who are discharged to their communities usually participate in continuing substance use disorder and mental health services. This often forces them back to the very people, places, and things which fed their addictions. Because of the housing crisis and an inadequate patchwork of sober living options, relapses are frequent. After a relapse, Vermonters are often sent back for another two week stay with a Vermont RR provider, followed by a release back to the same community, outpatient treatment there, and another relapse, This creates a wash-rinse-repeat cycle that is not only extremely expensive, but wholly ineffective. As one treatment specialist put it, this approach is "a complete waste of money."

After talking to Vermont RR providers, Dr. Levine and his staff, addiction specialist John Brooklyn, M.D., Dr. Stephen Leffler, treatment providers in Vermont, New Hampshire, and New York, Senator Ginny Lyons, Representatives Theresa Wood and Martin LaLonde, and the founder of Jenna's Promise, Dawn Tatro, we believe we have identified a critical missing piece in Vermont's recovery network: residential stepdown facilities (a "stepdown").

A stepdown facility affords an individual the ability to continue to receive therapeutic services in a sober environment for sixty or ninety days or longer if necessary. This approach to recovery is available in both New Hampshire and New York. Stakeholders there claim it is both cost effective and necessary to achieve long term

sobriety. The scientific literature supports this conclusion as does common sense. The longer an individual is sober and has an opportunity to practice that sobriety, the more likely he or she will engage in a sustainable sober lifestyle,

We know Vermont cannot easily replicate stepdown facilities located elsewhere. We are realistic about the time and resources necessary to do so, We are thus asking you to either urge Vermont to aggressively pursue step-downs or support insurance and Medicaid changes that would allow Vermonters to access stepdown services in New York, New Hampshire, and elsewhere.

I. Our Collective Experience

We have collected testimonials from the following stakeholders for your consideration:

Dawn Tatro, Founder of Jenna's Promise

Mark Redmond, Spectrum's Executive Director

Bric Maguire, House Representative and Director of Dismas House Rutland

Hon. Christina Reiss, Chief Judge District of Vermont

Hon. Kevin Doyle, Magistrate Judge District of Vermont

Michael Cusick, Chief U.S. Probation Officer, District of Vermont

Michael Desautels and Sara Puls, Federal Public Defenders.

Hon. Elizabeth Novotny, Vermont Superior Court Judge

II. Extended Treatment Yields Better Outcomes

The current provision of twelve to seventeen days of treatment for Vermonters at RR providers is inadequate. Although we have heard longer stays are available, we have almost never seen them. We agree that many people do not need medically supported treatment for long periods of time. However, to effectively limit all residential treatment to two to three weeks is nonsensical. It does not contribute to successful treatment outcomes, and it is neither effective nor cost-efficient, especially if it results in repeated cycles, which it often does. Vermonters on Medicaid without the means to cover longer stays or to reasonably access care outside Vermont are especially disadvantaged,

Our experience tells us that most people with substance use disorders have significant trauma, with a high percentage of women being survivors of sexual or domestic violence and in some cases trafficking. Many people have co-occurring mental health conditions which often require medications that can take significant time to take effect and reach a therapeutic dose.

Although substance use disorders entail physical dependence on the substances themselves, people are often using substances to cope with their past and present experiences, psychological trauma, and mental illness. In a relatively short time, treatment or incarceration decreases tolerance, rendering individuals even more susceptible to overdoses and other adverse effects if they resume using controlled substances.

If the first week at the RR provider is an attempt to detox the individual and engage in after-care planning, this leaves little time, often only a week, for intensive therapeutic engagement and recovery, It is not possible to address years of trauma, substance use, mental health challenges, and the need for housing and employment in such a short amount of time.

Inpatient treatment alone is almost never enough for a person to achieve long-term, sustained recovery, It is not meant to be the solution unto itself, but rather the first of many steps in a person's recovery journey. If Vermont seeks to provide successful treatment, and more importantly better long-term outcomes, residential treatment options need to be more robust and include step-downs.

According to a study by the Recovery Research Institute, the average number of times a person goes to inpatient treatment before achieving five years of continuous sobriety is <u>eight times</u>. Some of the pressure presented by the sheer demand for RR providers in Vermont may be reduced by step-downs. It would also save money spent on healthcare costs and incarceration, while improving therapeutic

III. New Hampshire and New York Offer Longer Treatment

We have met with representatives from Granite Recovery Centers in New Hampshire which offers a regime of fourteen-day detox; fourteen-day rehab; thirty-day partial hospitalization program; and a thirty-day Intensive Outpatient Program. While this by no means guarantees a successful return to society for every person, it is a vast improvement over the treatment options available in Vermont. Granite Recovery Centers' thirty-day partial hospitalization phase equates to what we refer to as step-downs. Expensive medical services are not required at this stage because detox has been completed and the focus is on practicing life skills to sustain sobriety and recovery.

The average residential treatment stay in Northern New York is twenty-nine days. Some stays can be as short as fourteen days; however, there are also programs with longer residential treatment, such as St. Joseph's Addiction Treatment and Recovery Centers, which offer a ninety-day inpatient program. Aftercare planning begins early in the residential treatment process and, due to the length of stay, there is generally sufficient time to develop a comprehens1ve aftercare plan. An important part of that plan is housing. If the individual does not have a stable residence to return to, applications for sober housing are submitted as soon as possible. Once an individual completes residential treatment, they return home or to sober housing to participate in outpatient treatment.

With adequate time for planning, sober housing is available with little to no waiting period.

IV. Housing/Aftercare Challenges

We acknowledge that, at some point, most Vermonters will return to Vermont after their extended treatment elsewhere, They may face many of the same temptations and challenges they currently face in the wash-rinse-repeat cycle, However, when they do so, they will have a significant period of sobriety under their belts. They will not be in the extremely fragile state of early recovery, In a more solid state of recovery, they are more likely to obtain and retain stable employment and housing,

The reality in Vermont is that existing sober housing does not meet the current need and waiting lists are long, Two weeks is often not enough time to secure a bed in a sober home, but in ninety days, this is achievable,

Additional time in residential treatment can have wide-reaching benefits in other areas:

- Time to reconnect with sober social supports that are frequently unavailable during active addiction,
- Obtaining a new ID driver's license,
- Applying for public benefits,
- Addressing pending criminal cases or other legal issues,
- Stabilizing on a new regimen of psychotropic 1nedication
- Obtaining employmen,t

These important components of long-term recovery should be available to Vermonters as they enter their recovery journey.

V. Cost savings

The expense of consistently treating Vermonters at the highest level of care in ER providers and using prison as the fallback is ultimately more expensive than if investments are made in stepdown and other longer term treatment options.

For example, when an individual must be incarcerated while awaiting a bed date at an ER provider, the cost to taxpayers is immense, In the federal system, because there are no Bureau of Prisons facilities in Vermont, many pre-trial federal inmates are held in Vermont's Department of Corrections ("DOC") facilities through a contract with the U.S. Marshals Service, or out of state and transported to and from that state for court appearances. The cost of incarceration in DOC is approximately $95,000 per year. By

contrast, the cost of supervising someone in the community is approximately $9,000, a difference of more than $86,000 per person, annually.[1]

The most recent advisory from the Administrative Office of the United States Courts, dated October 25, 2023, provides the following monthly cost data regarding federal costs:

	Bureau of Prisons Facilities	**Community Correction Centers**	**Supervision by Probation Office**
Daily	$136.00	$107.00	$12.00
Mo11tltly	$4,147.00	$3,266.00	$366.00
Annually	$49,770.00	$39,197.00	$4,387.00

We believe this reflects the current differential in the Vermont Department of Corrections as of 2022:

	Vermont Correctional Facilities	Out of State Facility	Field Supervision
Daily	$261.07	$109.98	$25.23
Monthly	$7.941.07	$3345.41	$767,67
Annually	$95,292.82	$40,145	$9,212

Treating individuals at the highest level of care for short periods of time again and again is a failing cycle that results in more incarcerated people. Vermont's current treatment regime requires more law enforcement and judicial resources as well.

We look forward to presenting our proposal to you in person. Your leadership could make the critical difference in vulnerable Vermonters obtaining the care they need and the outcomes they deserve.

---

[1] *Cost of Court Backlog: Department of Corrections,* Jan. 18, 2023, *available at* https://legislature.vermont.gov/Documents/2024/WorkG1·oups/Senate%20Judicia1y/Comt%20Backlog/W~Nicholas%20Deml~DOC%20Costs%20of%20Court%20Backlog~1-18-2023.pdf.

Very truly yours,

Isl Mark Redmond
/s/ Kevin Doyle

/s/ Eric Maguire
Isl Michael Cusick
Isl Sara Puls

Is/ Christina Reiss
Isl Michael Desautels

Mark Redmond, Spectrum's Executive Director
Eric Maguire, House Representative and Director of Dismas House: Rutland
Hon. Christina Reiss, Chief Judge District of Vermont
Hon. Kevin Doyle, Magistrate Judge District of Vermont
Michael Cusick U.S. Probation Officer, District of Vermont
Michael Desautels and Sara Puls, Federal Public Defenders

Addendum

Literature:

1. Addressing Length of Stay in Substance Use Treatment to Predict Successful Completion: Journal of Social Work Practice in the Addictions: Vol 23, No 3 (tandfonline.com).

2. Childhood Trauma and Substance Use Treatment Length of Stay and Completion: Alcoholism Treatment Qua1terly: Vol 41, No 3 (tandfonline.com).

3. Effectiveness of long-term residential substance abuse treatment for women: findings from three national studies - PubMed (nib.gov).

4. Stay in residential facilities and mental health earn as predictors of re-admission for patients with substance use disorders - PubMed (nib.gov)

5. American Addiction Centers' Outcomes Study.

6. The "Sweet Spot" For Adolescents that Attend Residential Treatment, 60 to 90 days may be ideal - Recovery Research Institute (recoveryanswers.org).

7. What is the Evidence for Residential Treatment? A review and update - Recovery Research Institute (recoveryanswers.org).

8. Testimonials (See below.).

UNITED STATES DISTRICT COURT
DISTRICT OF VERMONT
P.O. BOX 446
BURLINGTON, VERMONT 05402-0446
802-951-6622

Chambers of
CHRISTINA REISS
Chief Judge

August 13, 2024

To whom it may concern,

I am the Chief Judge of the United States District Court for the District of Vermont. I was appointed to the State of Vermont trial court in 2004 by Governor James Douglas. In that capacity, I was the presiding judge in Chittenden, Addison, Lamoille, and Orleans Counties. I have also sat in Washington County family court and Franklin County criminal court. In 2009, President Barack Obama appointed me to the federal court bench. I was Chief Judge from 2010 to 2017, and I have recently begun another Chief Judge seven-year term.

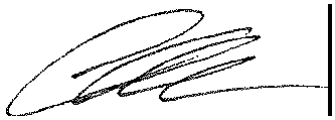
I have seen thousands of Vermonters in the throes of addiction who want and need treatment. From my perspective, the substance use scourge in Vermont has grown progressively worse. I do not believe we have been "successful" in addressing it regardless of how that term is defined. In my opinion, it is time to revisit what we are doing and be prepared to admit we are on the wrong track.

In speaking to other stakeholders, we have coalesced around a single critical missing piece in Vermont's recovery network---a lack of long-term residential options for intensive substance use treatment.

In 2009, Vermonters were able to access ninety day programs at the Phoenix House and Dublin House in New Hampshire. Now the typical stay at the very limited residential resources available in Vermont is two to three weeks. That is simply not enough time for an individual to detox and then change habits, thought patterns, perspectives, and practices that have often persisted for decades. Longer treatment yields better outcomes. It also prepares an individual to re-enter his or her community with a more solid recove1y underway which, in turn, increases the likelihood of stable employment and housing.

We ask you on behalf of some of the most vulnerable Vermonters to help us move Vermont in a different direction to produce much needed change.

Ve1y truly yours,



Christina Reiss, Chief Judge
United States District Court

Magistrate Judge Kevin Doyle's Testimony on Homelessness

As a magistrate judge, I have frequent interactions with individuals in the federal criminal justice system who suffer from substance use disorder. Upon arrest on a federal charge, an individual typically comes before the magistrate judge for an initial appearance.

It is frequently the case that individuals making their initial appearances in federal court have a significant history of substance use and test presumptively positive for one or more illegal controlled substances. Among the most prevalent controlled substances are cocaine, heroin, and fentanyl.

It is not uncommon at a detention healing for the judge to encounter an individual with a significant substance use history who is alleged to have possessed a firearm, provided a firearm to another in exchange for controlled substances, or engaged in drug distribution, In other words, the critical determination as to whether the person can be supervised in the community as the case progresses, or whether the person presents a risk to community safety that cannot be managed by release conditions, turns in significant part on an assessment of the risk presented by the1person's use of controlled substances,

It may not be possible initially to release a person who has a significant history of substance use disorder and is actively using substantial amounts of heroin or fentanyl, particularly where circumstances suggest the firearm offense or other crime charged may be related to the person's use of controlled substances and there is not yet a viable treatment plan in place. An individual detained at the initial appearance, however, frequently requests reconsideration of the initial detention decision, The centerpiece of these reconsideration requests is residential treatment with an appropriate aftercare plan consisting of continued treatment in the community and suitable housing. The court's task at this stage is to determine whether the treatment proposal is sufficient to soundly address the person's substance use challenges, thereby providing reasonable assurance that the drug use behavior contributing to- or perhaps largely responsible for the charged criminal conduct, can be mitigated, If it can, the judge will release the person to complete the proposed plan,

In my experience, those who are not successful after release often share certain characteristics, First, the standard 14-day residential treatment period is an inadequate amount of time for participants to both manage withdrawal symptoms at the inception of treatment and also engage in the program to the extent that they acquire the necessary skills to avoid relapse. Relapses upon completion of these relatively short treatment programs are not uncommon and often result in a violation hearing and reincarceration if the court determines that the person once again presents a danger to the community that cannot be addressed by release conditions. This often leads to a cycle of repeated residential treatment stays with a mixed rate of success.

In my experience, the rate of relapse decreases significantly for individuals who participate in lengthier residential treatment programs. That is not to say that relapses do not occur, but I have observed a marked difference in success rates between the traditional 14-day programs and the programs that offer an extended stay with associated programming, For example, such extended stay programs include Jenna's Promise, Veterans Administration drug and mental health programs, and certain extended-stay programs in New Hampshire, These programs separate the individual for a longer period of time from he environment that gave rise to the substance use while

instilling more deeply in the person the critical skills to avoid relapse.

As to the second characteristic of those who are frequently not successful after release, such individuals often find themselves in living environments that are not conducive to remaining drug-free. It is often difficult for these individuals-recently having completed the 14-day residential program-to remain sober and committed to their successful return to the community if they do not have a safe and stable living environment that fosters a healthy lifestyle. For those who simply do not have healthy and stable living options, the need for suitable sober living environments is acute.

Longer-term residential treatment options coupled with appropriate post-treatment housing are essential to helping these vulnerable Vermonters achieve sustained sobriety, which in tum will promote healthier and safer communities.

Submitted,

Hon. Kevin Doyle, Magistrate Judge District of Vermont

JENNA'S PROMISE
A pathway to recovery

7/29/2024

To Whom It May Concern,

I am writing to you today as a parent who has lost a child to an overdose, our daughter, Jenna, struggled with addiction for six years, cycling through at least 20 drug rehabs across the country. Through this heartbreaking journey, I have learned what works and what doesn't, and I am speaking from deep personal experience,

After losing Jenna, my husband and I decided to build something that would truly make a difference. We founded Jenna's Promise based on a model that addresses the critical needs we Identified, The last program Jenna attended was at Granite Recovery, which brought together many effective elements. This program Is based on longer stays with gradual step-downs, allowing Individuals to stay for 90 days or more If needed.

Our experience has shown that people need more time to heal and to !let their brains functioning In recovery mode. Addiction often Involves significant trauma, making mental health support Just as crucial as addressing the substance use Itself, Our program stabilizes Individuals after at least 30 days, enabling them to begin working on their overall well-being. The potency of modern drugs means that detoxification now takes longer, necessitating extended treatment periods,

The brain does not heal In 16 to 30 days after years of substance abuse and trauma. This Is why the revolving door *of* treatment centers result in repeated admissions, costing the state millions and yielding few positive outcomes. Longer treatment stays have proved to be effective, especially when combined with safe housing and workforce development programs.

JENNA'S PROMISE
A pathway to recovery

7/29/2024

We have seen the success rates of our program at Jenna's Promise with a 65% success rate based on longer stays. This Is significantly higher compared to other facilities. The current standard of up to 14 days of treatment In Vermont Is Inadequate, primarily driven by Insurance limits and not by best practices or scientific research.

It Is crucial to advocate for longer treatment periods. Research supports that 90 days of Inpatient treatment marks a significant winning point in recovery, leading to Improved long term outcomes such as reduced relapse rates and recidivism. Inadequate treatment durations fall to address the complexities of addiction and co-occurring mental health conditions, leaving Individuals vulnerable and unprepared for recovery.

We must take steps to work with insurers, treatment centers, and other stakeholders to provide longer treatment periods. This will allow adequate time to connect Individuals to resources for long-term care and community support, ultimately saving lives and transforming our communities.

Thank you for your consideration.

Sincerely,

Dawn Tatro

Founder, Jenna's Promise



SPECTRUM
YOUTH & FAMILY SBRVJCBS

August 14, 2024

To Whom It May Concern,

I am the executive director of Spectrum Youth and Family Services, based In Burlington, Vermont but also working In St. Albans/Franklin County. I have been Exec Dr. at Spectrum since 2003 and worked In the field of caring for homeless and at-risk youth since 1981.

Our primary work at Spectrum Is with teenagers and young adults who are homeless or at-risk of such. The latter Includes youth who are In or exiting the Vermont foster care system; the children's mental health system; runaways; In the juvenile Justice system; suffering from mental health disorders and/or substance use disorders, We help them In a variety of ways, including 26 beds In Burlington for those who are homeless, with another 10 beds about to come on-line In St. Albans this Fall. We operate a social enterprise, a car detailing business In Williston, to provide them with Job training. We recruit and train mentors for scores of young people In Chittenden and Franklin Counties. We operate drop-In centers where young people can come In and receive a free hot meal, take a shower, receive free clothing and have access to the free health clinic In our building, Spectrum also operates RIverstone Counseling, which provides mental health and substance abuse counseling by licensed, masters-level professionals.

There are many holes In our various systems of care In Vermont, but one that Is particularly glaring Is that of substance abuse treatment. When we had **a** heroin epidemic In Vermont, at least there was the Chittenden Clinic run by the Howard Center to which we could refer young people requiring that level of care. But **now we have a fentanyl/xylazlne epidemic**. **We refer our youth to Valley Vista, whereupon they receive 17 days at the most, which Is barely enough time to detox**. They are then released, often ending up on our shelter doorstep. They have not received the treatment they need In order to recover from these deadly substances and almost always Immediately relapse. We watch this tragic cycle repeat Itself over and over.

We need not look very far to discover and learn from a state that Is taking this epidemic seriously and making Inroads In terms of proper treatment. In New Hampshire, they offer 15 days of detox, 15 days of rehab, 30 days of partial hospitalization and 30 days of Intensive outpatient. Does this guarantee sobriety? No It does not, but the evidence strongly predicts that longer stays of care mean better outcomes.

We desperately need In Vermont a form of care that resembles that of our next door neighbor state. I am urging you to take this Into careful consideration because as It stands right now, we are loslng the fight for a healthy Vermont.

Slncerely,

Mark Redmond
Executive Director

31Elmwood Avenue, Burlington, Vermont 05401 (802) 064-7423 tel: (0021 660-0576 fax www,spoctru1rivt,org

OFFICE OF THE FEDERAL PUBLIC DEFENDER
DISTRICT OF VERMONT

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ASSISTANT FEDERAL DEFENDERS
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SARAM, PULS

August 12, 2024

Vermont Needs Longer Residential Substance Use Treatment "Tale of Two Clients"

In the Federal Public Defender Office, we represent most of the people in Vermont charged with crimes in federal court. Many, many of our clients' cases and lives are riddled with substance use. Many clients try to "work on the problem" by themselves, And even try and try again. But ultimately most don't win the fight. Others, a precious few unfortunately, can get their substance use under· control and then start living like they have always wanted to, The difference between the two? Often it is a *comprehensive long-term residential treatment program* for the successful few. Two real life stories illustrate this.

Mr. "L"

Mr. "L" is in his mid-30's, He has struggled with drug use since he was a teenager. For the last several years his scourge has been methamphetami1e. Life dealt him some pretty tough cards in his early years, He eventually succumbed to the high that methamphetamine gave him, To keep his flow coming, he resorted to selling meth. After federal prison, he came out onto "supervised release"-- sort of a probation. L would get a job and do okay but would then fall back into methamphetamine use. He went to Valley Vista for 14 days treatment. He came out and lived with his girlfriend, and after a couple of weeks used methamphetamine again, He would get breaks from the U.S. Probation Office and he kept trying to get better, with some outpatient counseling. But then he would use methamphetamine again. And again.

He went to Granite Recove1y Centers in New Hampshire for *30 days* of inpatient treatment. Came out and lived with his girlfriend. He got a job in a fast-food restaurant, His supervisor there loved him - he was a hard worker. But the probation officer soon found that Mr. L was using methamphetamine, Again, Six weeks of Inpatient treatment at this point. Paid out by Medicaid. But no longer term structured residential programs *after Inpatient treatment,* Mr. L is now waiting to be sentenced for violating supervised releasee (by his drug use.) Extensive residential treatment in a supervised and controlled "recovery house" would have, I think., would have helped him along the way, But it has not been available for him. Contrast him with "Ms. G."

Ms. "G"

In her young 20s, she got so hooked on heroin and had completely lost her bearing.

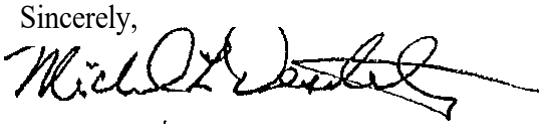
She was shooting multiple bags a day. She let her heroin dealers sell out of her house. She let them bring guns into her house, (And the guns went out to people involved in some bad crimes.) Ms. G did not want to be using heroin but could not see herself out of the mess, Her mother' was beside herself, watching her daughter spiral down, but could do nothing about it, The indictment changed thing. Conspiracy to Distribute Heroin and Distribution of Heroin were leveled against Ms. G. while her case was pending.

Ms. G stayed at Jenna's Promise for twelve months. Eventually, while living there and working on treatment, she was brought to a job at the coffee shop owned by Jenna's Promise. She was not ashamed of herself anymore. She acquired job skills. She kept at the therapy, the counseling, and the *living In* a strong, supervised, structed setting, Altogether, she was in the recovery program after *Valley Vista* for 12 months. Ms. G is still doing well. She is one of the few good success stories we see.

What is the difference between Mr. L's and Ms. G's stories?

In my view, it is the longer-term residential supportive care and treatment.

Sincerely,



Michael L, Desautels

Federal Public Defender

U. S. Probation Office Testimonial, District of Vermont

What follows is an overview of the role the U.S. Probation Office plays in the criminal justice system in Vermont and a summary of my shared experience providing community supervision for individuals suffering with substance use disorder.

The U.S. Probation Office in the District of Vermont provides community supervision of individuals residing in Vermont who have been placed on federal pretrial conditions of release and post-conviction supervised release under probation by the U.S. District Court. A significant portion of individuals under supervision have a history of substance use disorder and co-occurring mental health disorders along with housing, employment, educational and other challenges. Individuals with these disorders routinely benefit from court-ordered conditions of supervision, including substance use and mental health counseling and treatment, and other conditions of supervision designed to assist individuals in the rehabilitative process.

Upon commencing federal community supervision in Vermont, individuals with substance use or mental health disorders participate in a clinical assessment and follow recommended treatment regimens based on the nature and extent of an individual's identified needs. For example, someone returning to the community following a significant period of incarceration would participate in a needs assessment. Treatment or counseling may be deferred or include lower level care, such as individual or group outpatient counseling and periodic drug testing to monitor sobriety.

In contrast, someone releasing from a brief period of pretrial or post-conviction detention, or suffering from an acute relapse while in the community, may require a more intense treatment regimen including withdrawal management, residential treatment, intensive outpatient treatment (!OP), and finally group or individual outpatient treatment, counseling and relapse prevention planning. This latter group generally represents the highest risk to themselves in terms of accidental overdose and death, and often a higher risk to public safely due to antisocial or criminal behavior exhibited by some individuals in acute relapse.

In some cases, addressing the needs of this latter group of individuals is where the current substance use and mental health treatment system has demonstrated deficiencies. In our experience, supervisees who relapse experience a period of stand-alone withdrawal management followed by residential treatment of up to 14 days, or a truncated withdrawal management period subsumed into residential treatment, reducing time engaged in meaningful residential programming.

Following these initial steps, our supervisees generally transition to intensive outpatient treatment (IOP) and often struggle to find appropriate housing, exposing them to the satellite stress-filled environments that may have contributed to relapse. It is this transition from residential treatment, which includes, by definition, a safe, sober and supportive living environment, back into the community and IOP, that represents the most vulnerable time for our supervisees.

What is missing from the current treatment regimen is an appropriate period of withdrawal management, followed by a longer-term period of intensive residential treatment (beyond the

typical 14 days), and an intermediate programming option that provides a safe and sober living environment in combination with access to appropriate treatment services. The current practice of returning supervisees to their previous living environment, or relying on the patchwork of sober living programs available in Vermont, is often ineffective at interrupting the cycle of substance use, sobriety and relapse we often see with our supervisee population.

Because the individuals we supervise are closely monitored, timely intervention strategies, including higher-level treatment interventions, increased dmg screening and more frequent office, home and community contacts by probation officers or, in extreme cases, arrest and temporary detention, have been effective at interrupting relapse behavior early in the process. Despite timely and appropriate interventions, however, we have experienced some of our· clients repeatedly relapsing after participating in multiple rounds of residential treatment because the length and availability of programming has simply not provided the tools and sufficient "distance" from substance use and risky environments to sustain long-term sobriety.

The State of Vermont has shown a great commitment to improving the lives of individuals struggling with substance use disorder including those involved in the criminal justice system and those who are not. The hub and spoke model has provided a large and efficient treatment template for a significant number of people. It does not, however, effectively serve the needs of a portion of our community, including those at the highest risk of acute relapse, and may not be the most effective model for the newer more potent drugs that are becoming commonplace, often with deadly consequences for the most vulnerable Vermonters. Due to the nature of our work, this is the population we most commonly interact with and effectively meeting their needs has become increasingly challenging. It is important to identify these high risk/high need individuals who would benefit from comprehensive residential treatment and housing support and provide access to longer more holistic programs that address the needs of this group in a way that keeps them safe, provides a path to rehabilitation, and reduces the negative collateral impacts on the community.

Submitted By:

Michael Cusick, U.S. Probation Officer, District of Vermont.

Rutland, VT
Dismas House

A PROGRAM OF DISMAS of VERMONT, INC,

August 22, 2024

Governor Scott:

Currently at this time, the state of Vermont infrastructure of continuum care for substance use treatment is inadequate in regards to relevant available longer treatment opportunities for the individual to address their substance use and remain engaged with treatment. The system of substance use care in Vermont has limits. Individuals on how long they can remain in inpatient treatment (Valley Vista and Serenity) and then places an unrealistic expectation engagement with community services for continued treatment will fail unless the individual is able to receive placement into a transitional housing provider.

As the Director of the Rutland Dismas House, which is a transitional housing program serving men and women returning to the community from incarceration, I have witnessed on numerous occasions individuals returning from their inpatient stay and immediately relapsing.

Research indicates that Individuals who stay in addiction treatment for three months or longer have higher rates of abstinence from substance use.

Longer treatment stays provide more time for individuals to address underlying issues contributing to addiction, learn new coping skills, and build a strong support network. The duration of a person's stay in drug and alcohol addiction treatment can significantly impact their· recovery journey. Longer treatment stays have been found to have higher rates of abstinence from substance use and offer more opportunities for addressing underlying issues, building coping skills and developing efficient aftercare plans with seamless transition to relevant services. Long-term therapeutic community program was linked to lower levels. of drug use compared to those receiving short-term residential treatment [2]. Shorter-length treatment programs, typically lasting 30 days or less, may not always be as effective as longer treatment stays, particularly for individuals with severe or long-standing addictions. For substance use disorder treatment, inpatient care lasting less than 90 days is usually less effective compared to longer stays, as it does not provide the necessary time for patients to achieve long-term sobriety and develop the skills needed for successful recovery.

The providers within the State of Vermont are doing their best they can. Every day we are giving our all to serve the individuals struggling with substance use. It is imperative that we invest into the proven, evidence based, best practice infrastructure of substance use treatment currently operating in the majority of the country,

Sincerely

Eric M. Maguire

Director Rutland Dismas House
VT State Rep. Rutland City-5

Addendum from Eric Maguire

In the realm of drug and alcohol addiction treatment, the length of stay plays a crucial role in the overall effectiveness of the treatment. Understanding the significance of addiction treatment length and comparing short-term treatment with long-term treatment is essential for individuals seeking recovery, The length of stay for addiction treatment can vary widely, ranging from as little as 30 days to 12 months or longer, Shorter-term treatment programs, typically lasting 30 days or less, may not always be as effective as longer treatment stays, especially for individuals

Research indicates that individuals who stay in addiction treatment for three months or longer have higher rates of abstinence from substance use. Longer treatment stays provide more time for individuals to address underlying issues contributing to addiction, learn new coping skills, and build a strong support network [l]. The duration of a person's stay in drug and alcohol addiction treatment can significantly impact their recovery journey, Longer treatment stays have been found to have higher rates of abstinence from substance use and offer more opportunities for addressing underlying issues, building coping skills and developing efficient aftercare plans with seamless transition to relevant services.

Studies conducted found that participation in a long-term therapeutic community program was linked to lower levels of drug use compared to those receiving shorter-term residential treatment [2]. Shorter-term treatment programs, typically lasting 30 days or less, may not always be as effective as longer treatment stays, particularly for individuals with severe or long-standing addictions. For substance use disorder treatment, inpatient care lasting less than 90 days is usually less effective compared to longer stays, as it does not provide the necessary time for patients to achieve long-term sobriety and develop the skills needed for successful recovery.

Research indicates that individuals who stay in addiction treatment for three months or· longer have higher rates of abstinence from substance use, In the United States, studies have shown that for residential treatment programs, the length of stay is positively related to successful treatment outcomes for patients with drug addiction, Longer stays, ranging from 90 days to 6 months, have been associated with better long-term outcomes [2],

Long-term residential treatment has shown promising results in promoting recovery from substance use disorders, According to data from the Substance Abuse and Mental Health Services Administration (SAMHSA), long-term residential treatment programs with lengths of stay ranging from 90 days to a year were more effective in promoting recovery compared to sho11er programs [3]. The duration of the treatment episode is another important factor in addiction treatment success, Patients who remain in treatment for longer periods are more likely to achieve maximum benefits, It is often observed that treatment episodes lasting three months or longer are predictors of successful outcomes,

Research suggests that almost 90 percent of those who remain abstinent for two years are also drug- and alcohol-free at ten years [4].

[l]: https://www.addictioncenter,com/rehab-questions/how-long-does-treatment-take/
[2]: https://nida.nih,gov/sites/default/files/podat-3rdEd-508,pdf
[3]: https://www,samhsa,gov/newsroom/press-announcements/20230920/
[4]: https://www.ncbi.nlm.nih.gov/books/NBK64815/

Vision for Vermont's System of Care

by

Judge Kevin Griffin, Presiding Judge Chittenden Superior Court, Criminal Division and Adult Drug Treatment and Mental Health Court

and

Judge Elizabeth Novotny, Chittenden Superior Court, Family Division

Long-term residential treatment, preferably in VT, but could be out of state, to address substance use disorder and co-occurring mental health issues, including trauma.

- Minimum 30 days for substance use disorders that are successfully addressed using medically assisted treatment for substances such as opioids.
- Minimum 60-90 days for other substances not amenable to treatment, such as Methamphetamines.

More funding to expand extended stay sober living housing and programs. And, to address the need in the family court, particularly the juvenile docket, more Lund type programs accessible to everyone: men, women and non-gendered individuals and their children.

- Should include wrap around services.

Be available to the person in recovery for at least 1 year.

Note: Many sober living facilities require 30 days of sobriety before admission. Most (if not all) of our Vermont based residential centers only offer 2-3 week stay (i.e. Serenity House). Thus, individuals early into sobriety ate released from residential and unable to immediately enter stable sober living housing. The risk of relapse for people early into their sobriety following short residential stays is great; especially if the person leaves with no housing (houseless) or is placed in emergency housing hotels. Vermont hotels offering emergency housing se1ve an in1portant role in meeting Vermont's emnergency housing needs, However, these hotels also house people actively using illegal substances and are therefore a risky placement for individuals in early sobriety.

Adjustments to Medicaid to allow people leaving to attend out of state treatment to maintain their connection to VT based case management services (i.e. Howard Center). When the individual leaves the state for treatment, the Medicaid dollars follow them out of VT. The VT providers, such as Howard, close the case. This cuts off critical case manager services in VT that the person in early recovery needs before, during, and after discharge from residential.

Respectfully submitted by:

Judge Kevin Griffin Presiding Judge Chittenden Superior Court, Criminal Division and Adult Drug Treatment and Mental Health Court

Judge Elizabeth Novotny Chittenden Superior Court, Family Division

Please note: Effective September 3, 2024, Judge Griffin is the PresidingJudge for all Vermont Adult D1ug Treatment and Mental Health Cot1tts. Judge Novotny is the back-up judge to the Chittenden Adult Drug Treatment and Mental Health Court in addition to her assignment to the Franklin Superior Court Family Division.

Appendix 3: Email Exchange Between Jack T. Scully and Kara Alnasrawi, Director Church Street Marketplace Regarding Burlington's Downward Spiral Into Lawlessness

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Sent: Saturday, January 4, 2025 9:14 AM
To: Kara Alnasrawi <kalnasrawi@burlingtonvt.gov>
Cc: churchstmarketplace@gmail.com

Subject: Regaining Control of the Church Street Marketplace

Dear Kara and Marketplace Team,

As a concerned Vermonter, please allow me to add my voice to hundreds of citizens who *fear* that our Queen City is spiraling into an unrecoverable descent.

For the last five years, I have voiced my growing alarm to city government officials and participated in "Click-Fix" reports to department heads. Rarely have I received an acknowledgment, let alone seen progress in addressing critical issues.

Time and time again, the anti-social, criminal interests of several hundred vandals, shoplifters, drug addicts, mentally ill people, loiterers, petty thieves, felons, and their fellow travelers have trumped the rights of 45,000 Burlingtonians and thousands of visitors and shoppers.

For these reasons and more, please consider developing and promoting a comprehensive recommendation to city and state government, aimed at regaining public control and allaying the concerns of ordinary citizens about their personal safety in the Church Street Marketplace.

As an indicator of how bad conditions are in downtown Burlington, here are some incidents that have happened to just me, my family and acquaintances:

1. My son and his girlfriend moved out of their Maple Street apartment after being harassed nightly by homeless people loitering in a nearby garage and one of their cars was stolen.

2. An acquaintance's car was stolen while he and his wife were dining on Church Street;

3. A friend, descending the S. Winooski Avenue parking garage stairwell, was scared witless by a deranged man with a machete;

4. An acquaintance and her small daughter witnessed people shooting up in City Hall Park and tossing used syringes on the grass;

5. I have personally witnessed brazen shoplifters in stores;

6. A friend of my son, who worked in the Helly Hansen clothing store, attempted to stop a man leaving the store with an unpaid parka. When he approached the person, he was told: "back off XXX or I'll kill you." In a recent *You Tube* interview; I heard the owner of Homeport claim $70,000 of goods shoplifted last year alone.

7. My wife has twice been accosted by deranged people: A homeless woman persistently demanding her umbrella; a weird-acting beggar, who followed her, demanding money.

Based on these and other serious incidents, we, along with many of our friends are joining a growing chorus of people who say: "I'm not going downtown anymore--unless absolutely necessary."

City Officials, the State's Attorney, and the Court System must be convinced that they minimally need to do the following:

- Enforce the four proven approaches to crime control: deterrence, retribution, incarceration, and rehabilitation.

- Strengthen and adapt new anti-loitering laws to recognize that skulking about with no specific purpose typically precedes serious offenses and disorder, including panhandling, public intoxication, fencing stolen goods, drug dealing/use and robbery etc.

- Remove prominent graffiti tags and install surveillance cameras with motion detectors at high visibility sites to catch vandals in the act. Apprehended taggers should minimally be sentenced to 200 hours work cleaning up graffiti and their names entered into a registry. Repeat offenders should be sentenced to long term imprisonment.

- Hire additional private security teams to "walk the beat" in the marketplace, especially in peak shopping and dining hours.

- End degradation of felonies to misdemeanors; arrest and fast-track prosecution and incarceration of shoplifters and thieves.

- Stop tolerating and allowing people to camp out on streets/parks/doorways and in garages.

- Aggressively go after, arrest, prosecute, convict and incarcerate active drug dealers and users in public places.

- Promote reopening of the state psychiatric hospital in Waterbury or equivalent elsewhere with 21st century programs for humane, caring treatment of people overcome by deadly addictions and serious mental disorders. Involuntary civil commitment must be put into practice when voluntary measures fail.

This is a short list, to be sure, but we believe a necessary one to regain the confidence of law-abiding people and return public safety and civility to Vermont's largest city.

Sincerely,

Jack T. Scully

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E: jacktscully@gmail.com
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On Jan 5, 2025, at 2:52 PM, Kara Alnasrawi <kalnasrawi@burlingtonvt.gov> wrote:

Good afternoon Jack,

I appreciate your feedback and share your deep concerns for our downtown and the City has been extremely active in advocating for change.

Judicial/Court: **Most of your suggestions can only be addressed at the judicial and State level.** Much of the change you are looking for lies with the State's Attorney, the

court system, and the State of Vermont. I strongly suggest reaching out to those entities as well as your state legislators if the penal code is what you are looking to influence. We see extreme rates of recidivism particularly related to retail theft and have advocated at the State level to have these issues addressed. We do not have laws against gathering ("loitering") or sleeping in public. Public urination, defecation, and open containers (alcohol) are misdemeanors and do not result in a court hearing but rather a ticket of approximately $50.

Mental Health/Substance Use: **In addition, homeless services and mental health services lie squarely with the state**. There are no municipalities in the State of Vermont that have health departments. This means that all federal health-related funding goes straight to Montpelier and it is their decision how to spend it. The City of Burlington actively lobbies the State of Vermont to address the lack of mental health services and the extreme shortage of emergency shelter. We hire a professional lobbyist. We have also invited the Secretary of AHS and her Commissioners to come downtown and witness what we are experiencing.

Graffiti: Graffiti is most definitely a problem in Burlington. Please note that the City cannot remove graffiti from private property. We consistently urge private property owners to keep their property clean from graffiti. City Council has taken some steps recently towards enforcing proper care of properties (Burlington Council Proposes Steep Fees for Vacant Buildings | Seven Days Vermont). You can see the Mayor's most recent memo to Council on graffiti here: Mayor's Signing Statement: Graffiti Ordinance

Security/Law Enforcement: In terms of private security, I can confirm that we recently spent $60k for overtime police patrols during the holidays. This is not a sustainable expense for us to manage, nor can BPD officers continue to work substantial amounts of overtime. The BPD is actively recruiting and offering generous recruitment bonuses BPD Careers.

Community Safety Forums: Also please note that the Mayor regularly holds community safety forums that are open to the public. The next one is on January 9th. Please note that previous forums addressed concerns around bail and conditions of release. You do not need to be a resident to attend. Public Forums on Community Safety | Burlington, VT.

Please let me know if you have any further questions related to the municipality's role. Otherwise, I strongly encourage you to reach out to your State legislators as their session is about to begin. The City of Burlington will also be advocating again at the Statehouse.

Best,
Kara
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The Marketplace | Love Burlington | ELI