VERMONT DEPARTMENT OF HEALTH

Vermont Prevention Inventory Report

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Contents

Introduction

This report was prepared in order to develop an inventory of programs in Vermont that provide substance misuse prevention services. The development of this inventory was requested by the Vermont Legislature through Act 82 with the goal of providing information that will be useful for guiding the state's efforts to better coordinate prevention programs across state and community agencies. Along with ADAP, the Substance Misuse Prevention Oversight and Advisory Council (SMPC), also created by Act 82, provided oversight for this work.

Vermont has made significant progress in developing a comprehensive regional prevention structure over the past decade, and rates of alcohol use and prescription drug misuse among youth have trended downward during that time. However, in recent years increases in youth marijuana use and use of electronic vapor products (EVP)[1], Vermont's high underage drinking rate relative to the nation[2], and continued concern about opioid and prescription drug misuse, all highlight the need for improved coordination and enhancements to the current system. It is our hope that this report will provide useful information that can help guide the state's efforts to better coordinate prevention programs across state and community agencies, with the goal of achieving a more effective and efficient statewide substance misuse prevention system.

Developing a statewide prevention substance misuse prevention inventory is a novel exercise for which there are no clearly established approaches or methods. A number of important issues have been encountered and much has been learned in the process. The insights gained through implementing this project process are reflected in the Summary and Recommendations section of this report.

[1] https://www.healthvermont.gov/sites/default/files/documents/pdf/HSVR_YRBS_2019_KeyFindings.pdf

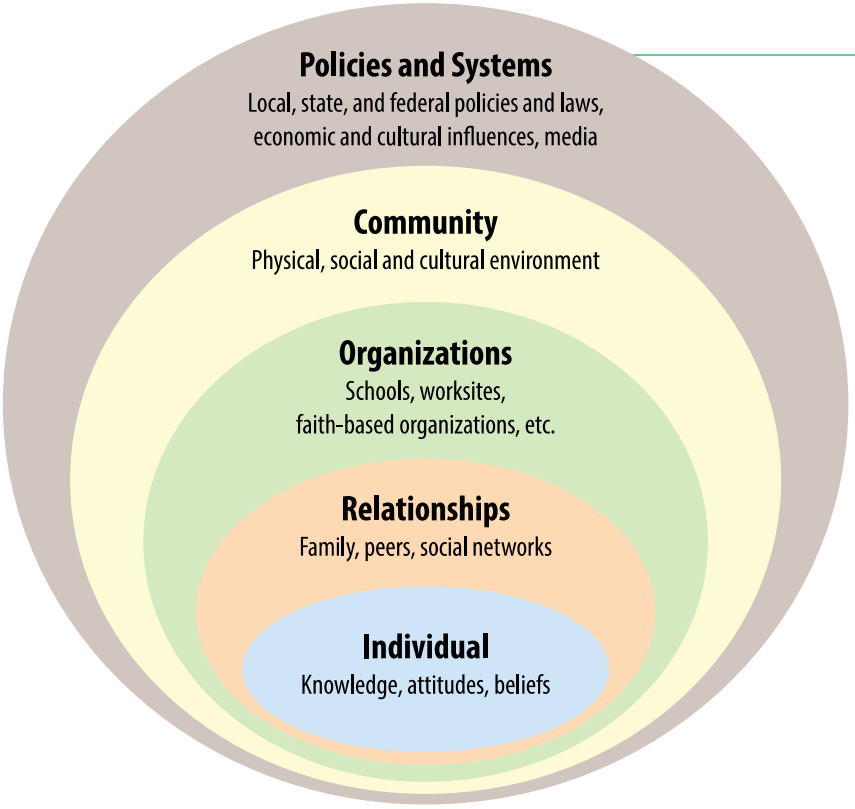
[2] SAMHSA, 2020. National Survey on Drug Use and Health: Comparison of 2016-2017 and 2017-2018 Population Percentages (50 States and the District of Columbia). Table 16. Downloaded on 10-20-20 from: https://www.samhsa.gov/data/sites/default/files/reports/rpt23236/NSDUHsaeShortTermCHG2018/NSDUHsaeShortTermCHG2018.pdf

Defining Substance Misuse Prevention Programs and Services

In the field of public health, prevention is typically categorized into three levels; primary, secondary, and tertiary. Primary prevention refers to interventions that take place before disease or health effects occur. Secondary prevention includes interventions in early stages of health effects, and tertiary prevention aim to slow or stop the progression of a disease once it has already occurred.[3]

The Institute of Medicine (IOM) has developed additional classifications of prevention interventions based on the population of focus[4]. The IOM categories include universal, selective and indicated, and are defined below.

- **Universal prevention** aims to prevent or delay the use or misuse of alcohol, tobacco, and other drugs. Universal prevention assumes all members of the population share the same general risk for substance misuse, although the risk may vary greatly among individuals. Universal prevention programs are delivered to large groups without any prior screening for substance abuse risk.
- **Selective prevention** focuses on subsets of the total population that are thought to be at higher risk for substance misuse. Selective prevention targets the entire subgroup regardless of the degree of risk of any individual within the group.
- **Indicated prevention** interventions focus on individuals who are showing signs of substance misuse with the aim of reduction in the length of time the signs continue, delay of onset of substance misuse, and/or reduction in the severity of substance misuse.



Vermont Prevention Model

In addition to the classifications of prevention described above, Vermont has adopted a socio-ecological model of prevention known as the Vermont Prevention Model. This model depicts five different levels of environmental and personal factors that can influence behavior and health outcomes including policies and systems, community, organizations, relationships, and individual. PIRE's evaluations of both the Strategic Prevention Framework State Incentive Grant (SPF SIG) and Partnerships for Success (PFS) II projects in Vermont have shown that a prevention approach that follows the Strategic Prevention

[3] https://www.cdc.gov/pictureofamerica/pdfs/picture_of_america_prevention.pdf

[4] http://dpbh.nv.gov/uploadedFiles/mhnvgov/content/Meetings/Bidders_Conference/Institute%20of%20Medicine%20Prevention%20Classifications-rev10.20.14.pdf

Framework[5], or SPF, which is a public health planning model developed by the Substance Abuse and Mental Health Services Administration (SAMHSA), and includes a comprehensive set of strategies from across the levels of the Vermont Prevention Model, leads to positive outcomes on measures of youth substance use.[6]

The three frameworks just described all view prevention from somewhat different perspectives, all of which are useful and complementary. For substance misuse prevention specifically, the IOM framework appears to be more applicable than the more general public health model. In particular, "selective" prevention programs are delivered to persons or groups with elevated risk of substance misuse but who are not known to already be misusing substances. Such programs are an important and distinct component of substance misuse prevention services, but within the public health model they would be considered a "primary" prevention approach and grouped together with "universal" prevention strategies. For this reason, we have characterized prevention programs as universal, selective, and indicated/tertiary. The third category includes programs targeted to individuals or groups who are (or have been) already misusing substances, and includes harm reduction, treatment, and recovery strategies. In this report programs have also been categorized according to their level within the socio-ecological model, as it provides a different and unique dimension used to capture the organizational contexts in which programs are implemented, all of which contribute to a comprehensive and effective prevention strategy.

[5] More information on the Strategic Prevention Framework can be found at https://www.samhsa.gov/sites/default/files/20190620-samhsa-strategic-prevention-framework-guide.pdf

[6] See: SPF-SIG Project Leads to Reductions in Underage Drinking and Marijuana Use (April, 2012) and Interim Outcome Evaluation Report for Vermont's Regional Prevention Partnerships (RPP) Initiative: Executive Summary (posted in 2019); both available on the ADAP website.

Data and Methodology Used

The report was compiled from several data sources.

(1) Stakeholder Interviews. In order to identify organizations to potentially include in the inventory, phone interviews were conducted in late June and July with 33 different stakeholders with knowledge of substance misuse prevention services in Vermont. These stakeholders represented members of the following agencies and organizations:

- Substance Misuse Prevention Oversight and Advisory Council (SMPC)
- Vermont Department of Health District Offices
- VDH Division of Alcohol and Drug Abuse Programs ADAP
- VDH Division of Health Promotion and Disease Prevention (HPDP)
- VDH Division of Maternal and Child Health
- Agency of Education
- Department of Liquor and Lottery
- Department of Mental Health
- Department of Public Safety
- Department of Children and Families
- State Office of Highway Safety
- Prevention Works
- Vermont Afterschool
- MENTOR Vermont
- Association of Student Assistance Professionals of Vermont.

A complete list of stakeholders interviewed and the interview guide can be found in Appendix A. A list of over 400 organizations and their contact information were identified for potential inclusion in the inventory.

(2) Vermont Prevention Inventory Survey. The initial list of organizations was reviewed and edited[7] in consultation with VDH and an invitation was sent via email to the contact person at 362 organizations inviting them to complete an online survey. The survey included questions aimed at understanding organizations' programs and activities that contribute to the prevention of substance misuse, including tobacco. Survey questions asked about organization and program type, program objectives, funding sources and duration, substances of focus, populations and geographic area served. The survey was open for the month of August and a total of 111 usable surveys were submitted. A copy of the survey instrument can be found in Appendix B.

(3) Consultation with VDH and Prevention Partners. Once all survey data were submitted, some follow up was needed with VDH staff and respondent organizations to clarify responses, particularly related to data collected about funding sources. PIRE staff contacted these individuals and used the additional information provided to further characterize details about the prevention services reported in the survey.

[7] Removed from the list of organizations were any schools (with the exception of afterschool programs implemented through a school or school district – see limitations section), and programs that did not appear to meet the initial criteria as described in the stakeholder interview guide.

Limitations of the Data Sources

There are several limitations to these data sources that are described below. All findings should be considered with these limitations in mind.

(1) Stakeholder Interview Limitations

As noted above, organizations invited to participate in the survey were identified through interviews with stakeholders from various state and community-based agencies with the intent to obtain a broad list of organizations and programs from all regions of the state that involve activities that could have an impact on the prevention of substance misuse among Vermonters. It is possible that some organizations that might be engaged in such activities were not identified through the interview process for inclusion in the survey or in the resulting inventory.

(2) Survey Data Limitations

Because of the timing of the survey in August and the fact that school districts were facing the challenge of planning the upcoming school year within the guidelines for in-person and remote learning established by the Agency of Education, the decision was made along with ADAP to exclude schools and school districts from the survey and from the inventory. Substance misuse prevention interventions and activities are indeed taking place within many Vermont schools, and further exploration of these activities would be a worthy endeavor at a future time.

Survey data were collected from a small number of programs (8) that are implemented by VDH primarily through the Offices of Local Health. A decision was made in collaboration with ADAP to exclude data from these programs in our analyses and instead focus this report on the services provided by VDH community-based partners. In many cases survey responses from these VDH entities included information on activities by community partners, which theoretically would be captured in the responses by those partners. Prevention efforts that are implemented by VDH and the Offices of Local Health will be described separately in a report that ADAP will be preparing for the Vermont Legislature.

Because so much of the prevention work that happens around the state is done through collaboration between multiple community partners, it is possible that there could be duplication of some of the programmatic information presented in our findings. We have identified and removed duplicate program data whenever it was apparent, but it is possible that some duplication was missed and that data from the same program may be reported more than once.

We also recognize that variability almost certainly existed across respondents in how they interpreted the survey items and response options. Despite efforts to provide clear definitions and examples, certain questions are by nature somewhat subjective and may have been viewed differently by those completing the survey. Additionally, not all questions were answered, and we cannot be certain that respondents in all cases had correct information in providing their responses. Due to the process used to identify respondents, however, and the self-selection involved in deciding to respond to the survey, we do have a high degree of confidence in the knowledge of the respondents and their interest in providing useful and accurate information.

Lastly, the survey data reported here are limited to information about only those organizations and programs that responded to the survey. Multiple reminders to complete the survey were sent by both VDH and PIRE, and the survey was voluntary. Additional efforts, including direct emails and phone calls, were made to reach those organizations that are known with certainty by VDH and other stakeholders to have a primary focus on substance misuse prevention, and as a result there are only four such organizations that did not participate in the survey. Other organizations may have decided based on the language in the survey invitation that they did not fit the criteria for what we were looking for and may have chosen to not complete the survey. Some limited information on the additional two hundred plus organizations that did not complete the survey, was gathered through the stakeholder interviews and will be provided to ADAP in a separate file that includes a list of all organizations that were invited to participate.

(3) COVID-19 and Its Impact on This Project

We had originally planned to conduct stakeholder interviews in person but because of COVID-19 all interviews took place by phone. This may have resulted in a higher interview completion rate due to more flexible scheduling options since no travel was needed.

It is possible that some organizations did not complete the survey because of COVID-19 related staffing reductions, program suspensions, and/or limited capacity to complete this task. We had originally intended to contact organizations that did not respond by phone, but we found it challenging to reach our contacts by phone and ended up relying primarily on email correspondence to remind and encourage participation.

Findings

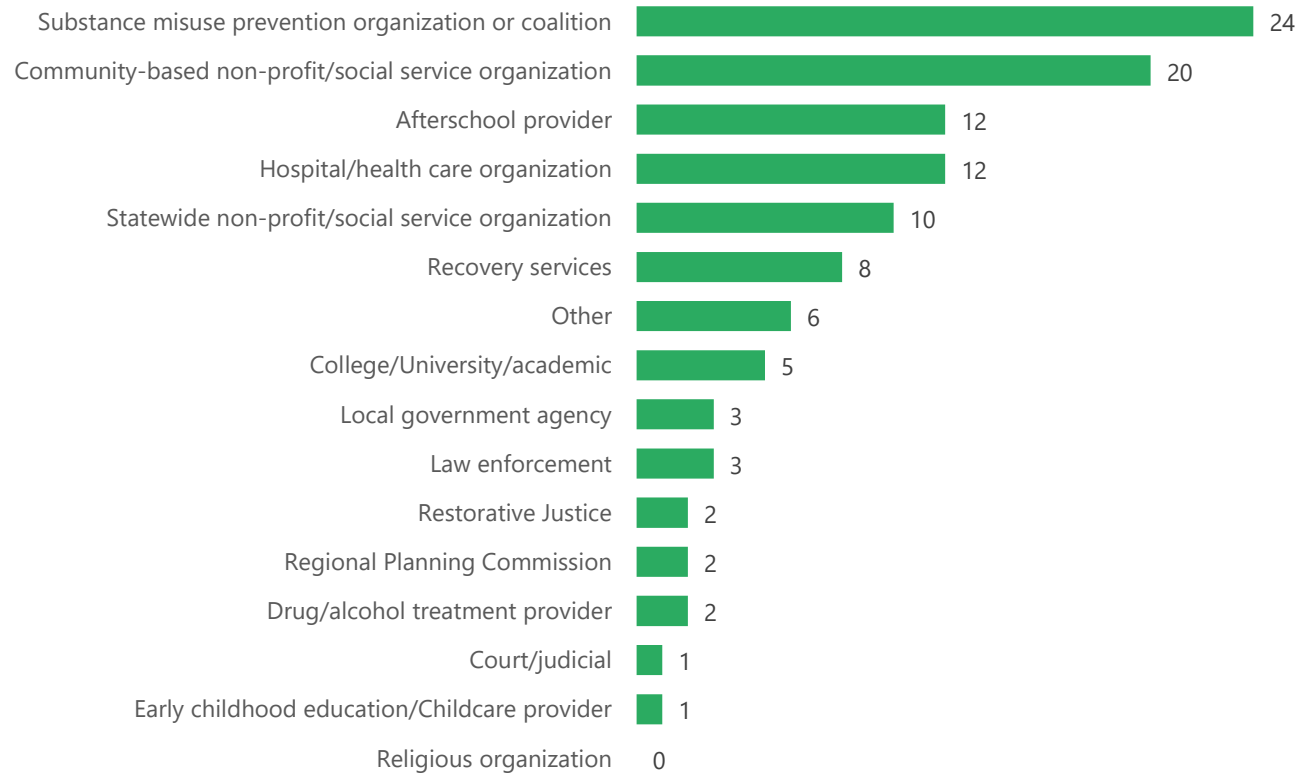
This section summarizes selected findings from the Vermont Prevention Inventory Survey. The survey had two sections; one included questions about the organization as a whole, and the other included questions about each of the organization's programs that are related to substance misuse prevention. A total of 111 organizations completed the survey, reporting a total of 358 programs being implemented (note that not all survey respondents reported program information). Results of the survey will be presented at the organizational level for some items and at the program level for others. A complete set of tables with results from all items in the survey can be found in Appendix C.

Organizational Level Findings

Organization Type

Of the organizations that completed the survey, the largest proportion were substance misuse prevention organizations/coalitions and community-based non-profit/social service agencies, followed by afterschool providers, hospitals/health care organizations and statewide non-profits (Figure 1). These are also the types of organizations most commonly identified by stakeholders during the interview process.

Figure 1. Number of each organization type (N=111)

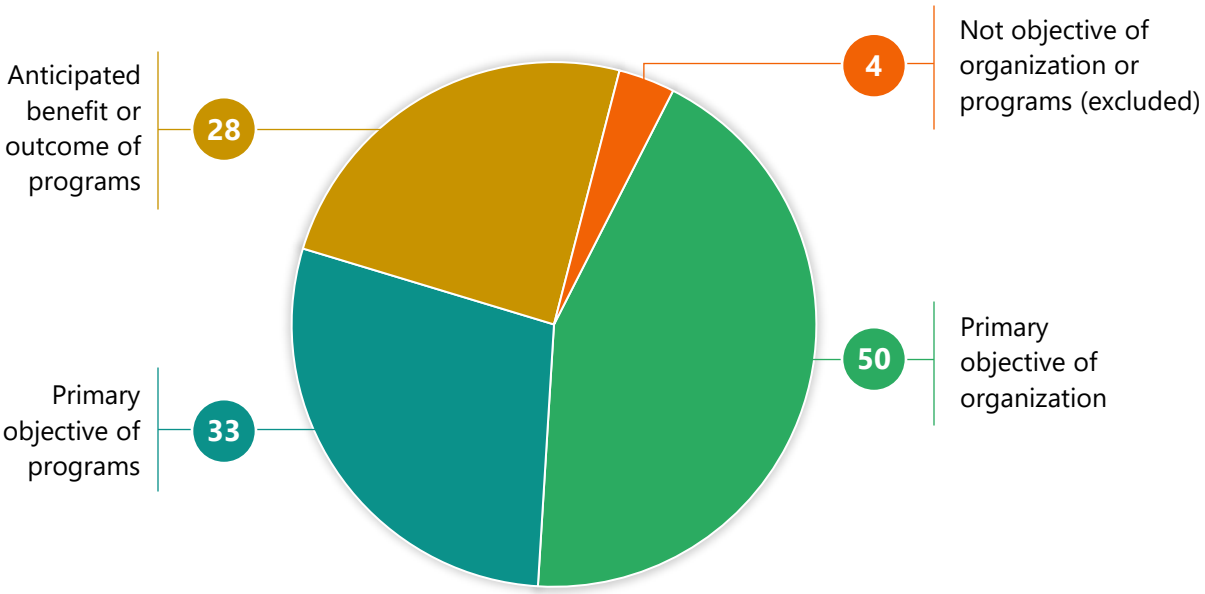


Focus on Substance Misuse Prevention

Respondents were asked a series of questions that were designed to understand the degree to which organization and/or its programs focuses on substance misuse prevention. Organizations may not have the prevention of substance misuse as one of the primary organizational or programmatic goals, but one or more of their programs or activities might be expected to have some impact on substance misuse as an additional benefit to whatever the primary goal of the program might be (e.g. impacting a risk or protective factor that is known to be associated with substance misuse).

Slightly less than half identified that the prevention of substance misuse was part of their organization's stated mission or primary objective. Almost all of the 65 remaining organizations reported that the prevention of substance misuse was either a primary objective or anticipated benefit of one or more of their programs. There were four organizations that answered "no" to all three of the questions in the series and were therefore excluded from all analyses because they did not identify having any organizational or programmatic focus or expected outcome related to substance misuse prevention.

Figure 2. Number of organizations with substance misuse prevention as primary mission, the primary objective of any of its programs, or anticipated benefit or outcome of any of its programs. (N=115)



Structured Planning Process

The survey included a measure of whether organizations implementing substance misuse prevention programs have used a structured planning process to identify appropriate strategies to meet the community's needs (Figure 3). If they indicated that they have used a structured planning process, then they were asked to describe that process. These descriptions were then categorized into eight different types (Figure 4). About half of the organizations indicated that they have followed a structured planning process, and of those, about half indicated that they used Substance Abuse Mental Health Services Administration's (SAMHSA) Strategic Prevention Framework (SPF). This is not particularly surprising given that many of the organizations that responded to the survey receiving funding from SAMHSA, either directly or through VDH, which emphasizes the use of the SPF.

Figure 3. Has your organization followed a structured planning process (e.g. the Strategic Prevention Framework, Plan-Do-Study-Act, etc.) to guide the selection, planning, and implementation of its programs and interventions? (N=111)

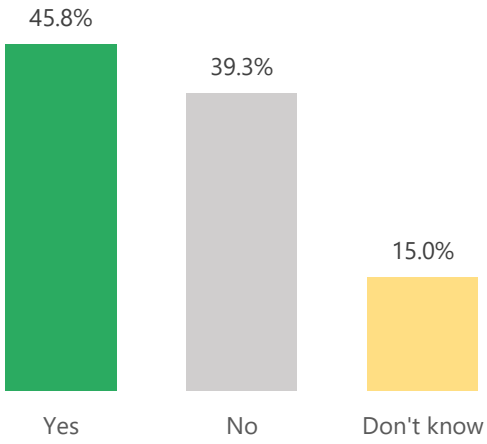
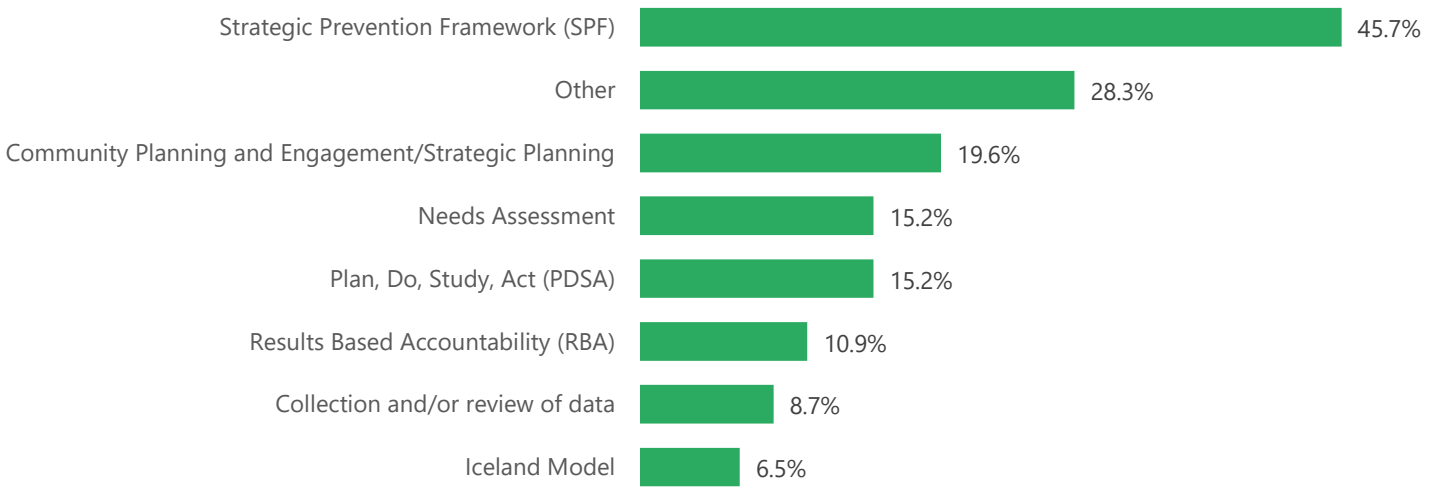


Figure 4. Type of structured planning process used[8] (N=46)

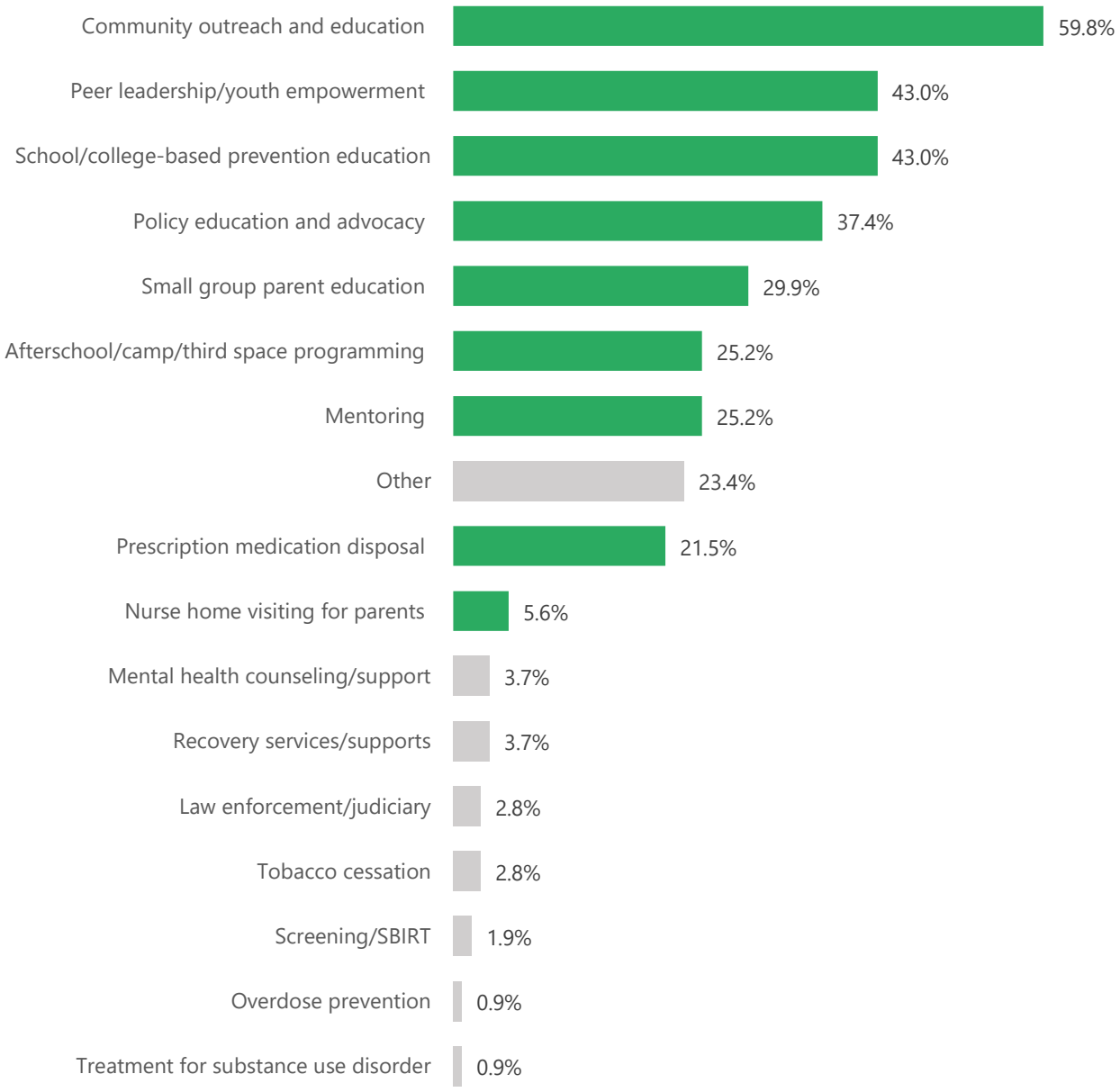


[8] Because multiple types of planning processes may have been reported, percentages may sum to more than 100.

Program Types

Survey respondents were asked to identify all of the different types of programs being implemented that are related to substance misuse. Nine program type options were provided, based on commonly implemented substance misuse prevention intervention types (reflected by the green bars in Figure 5). There was also an option to select and name up to three "other" program types. Each of these "other" program types was then reviewed and categorized either into one of the original nine categories, a new category, or "other". Figure 5 shows the percentage of organizations selecting each type of program, including several program types that were developed from the "other" descriptions (the 23.4% in the "other" category below includes program types that were not recategorized).

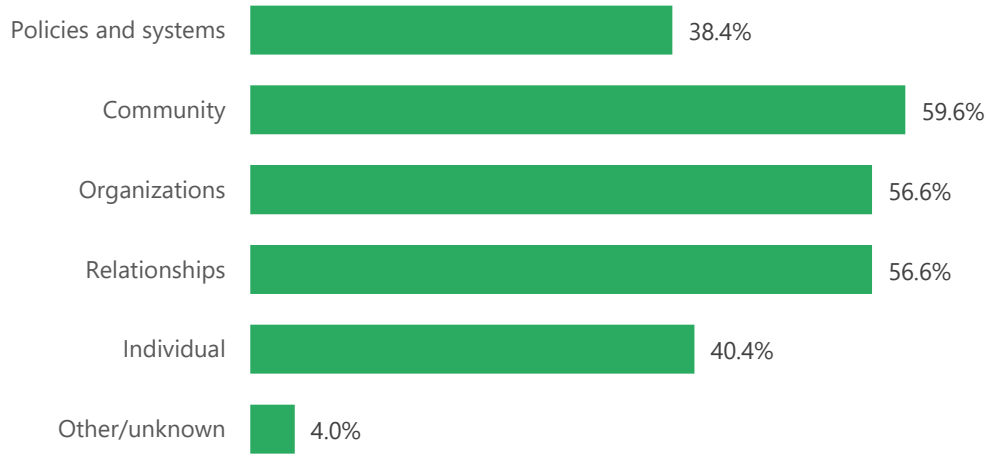
Figure 5. Percent of organizations implementing each program type[9] (N=107[10])



[9] Because multiple types of programs could be reported, percentages sum to more than 100.
[10] Four organizations entered information about their organization, but did not enter any data on any of their programs.

In addition to looking at the overall types of programs being implemented by all organizations, we also looked at a subset of organizations that reported implementing **at least one universal or selective prevention program** (N=99). We chose to focus on this subset of organizations, and on universal and selective prevention programs, for this and other analyses because they represent the scope of prevention services identified by VDH and the SMPC as the priority focus for this project. These organizations implemented a range of one to nine different program types, with three being the average number of program types implemented. Figure 6 shows the percent of these organizations that have at least one program at each level of the Vermont Prevention Model.

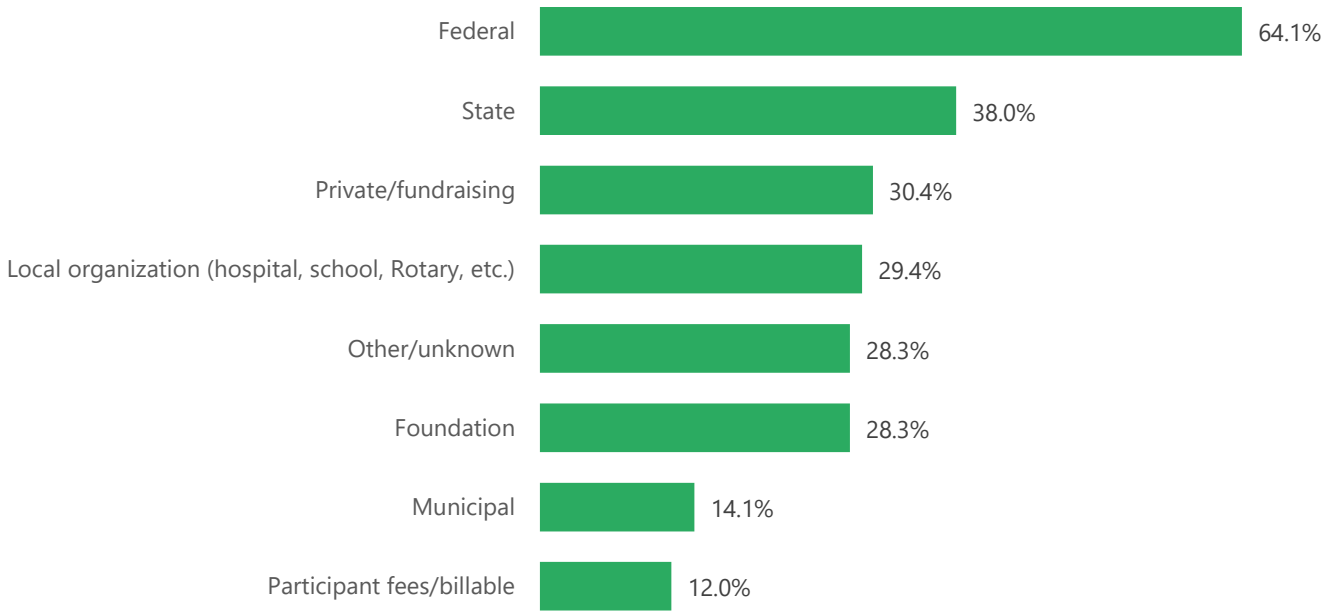
Figure 6. Percent of organizations implementing programs at each level of the Vermont Prevention Model (N=99)



Funding

For each program being implemented by an organization, a question was asked about the funding source(s). The specific funding sources identified were then categorized into the overall types listed in Figure 7, which shows the percent of organizations reporting each overall funding source for one or more of its programs. Note that almost two-thirds of organizations report federal sources for one or more programs, and a little over a third report state sources for one or more programs.

Figure 7. Percent of organizations reporting each funding source for one or more programs[11] (N=92)



[11] Because multiple funding sources could be reported, percentages sum to more than 100.

Impacts of COVID-19

There was an opportunity at the end of the survey for the respondent to share comments about the impacts of COVID-19 on their organization. Table 1 summarizes these comments. Not surprisingly, most of the comments included impacts that were negative, such as having to suspend programming, challenges providing services remotely, and increased stress among clients or participants served. There were, however, some positive impacts such as the removal of transportation barriers by shifting to remote services and the ability to adapt to providing services differently and/or meeting different needs as a result of COVID-19.

Table 1. Impacts of COVID-19 on the organization (N=90)

	Number	Percent[12]
Negative Impacts		
Programs have been slowed or put on hold	34	37.8
Direct service/in-person programming and relationship building has been limited	16	17.8
Challenges to providing services remotely (technology issues, harder to engage youth, safety concerns accessing from home, etc.)	13	14.4
Negative effect on community and clients served (stress, isolation, increased substance use, etc.)	11	12.2
Decrease in staff/volunteer capacity or decrease in stakeholder engagement	7	7.8
Decrease in service utilization; reaching fewer people	6	6.7
Negative effect on funding/budget (or expectation that there will be)	5	5.6
Harder to engage in prevention due to other pressing needs/concerns	4	4.4
Successful adaptations or positive Impacts		
Adapted to provide services remotely	37	41.1
Some or all in-person services have resumed or will resume soon	10	11.1
Focus of the work and programming has shifted to meet more immediate needs	8	8.9
Some beneficial consequences (removal of transportation barrier/better access for rural clients, creativity, etc.)	5	5.6
Neutral or N/A		
Increased need for services and supports	3	3.3
Organization's work is considered essential service	2	2.2
Work has not really been impacted by COVID	1	1.1

[12] Because multiple types of comments could be provided, percentages sum to more than 100.

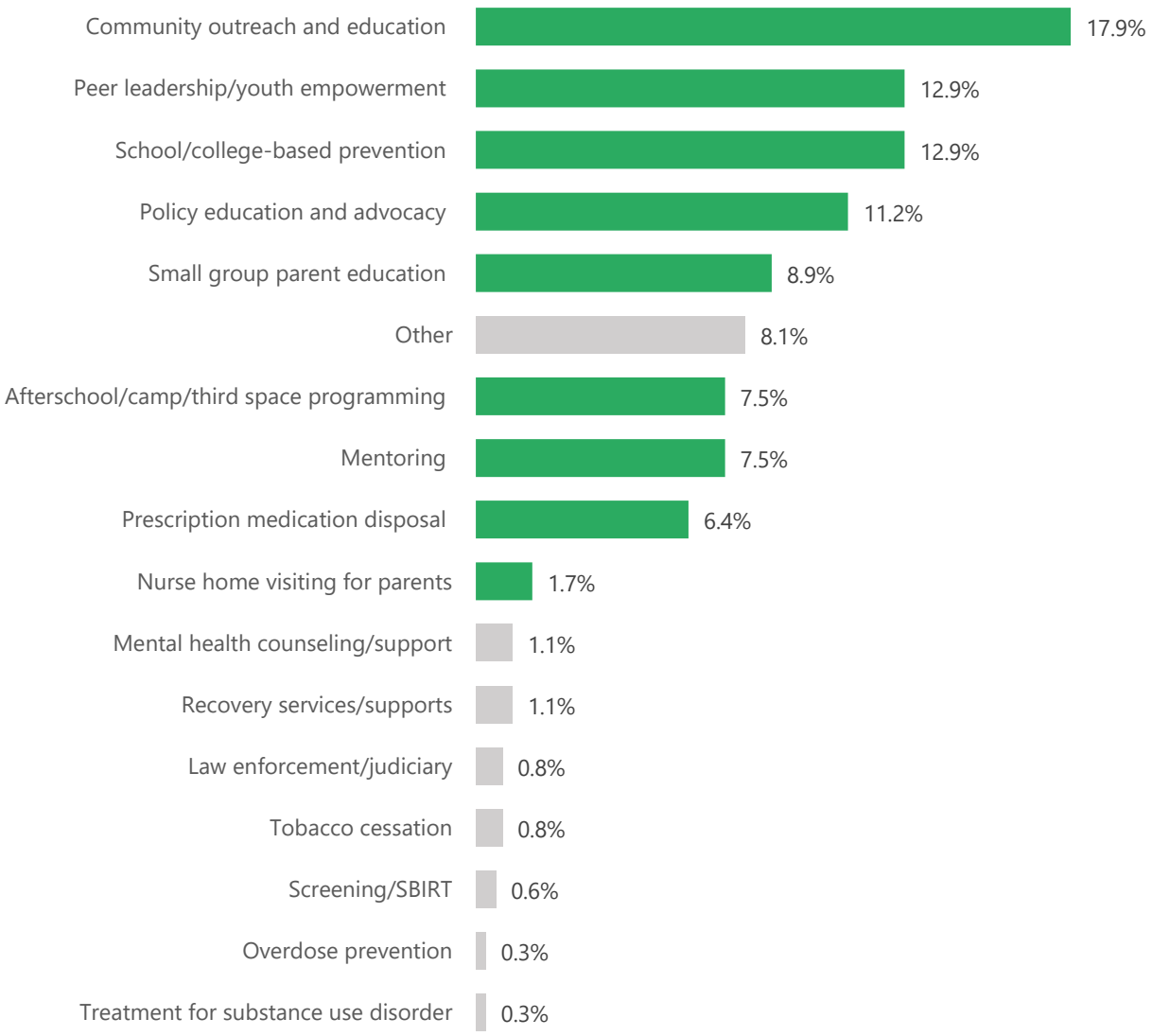
Program Level Findings

As noted previously, each organization was asked to provide information about the characteristics of each different program type they are implementing. This section will summarize the information reported on these programs. A total of 358 programs were reported, but not all questions were answered for every program so the N for individual items may be lower than 358.

Program Types

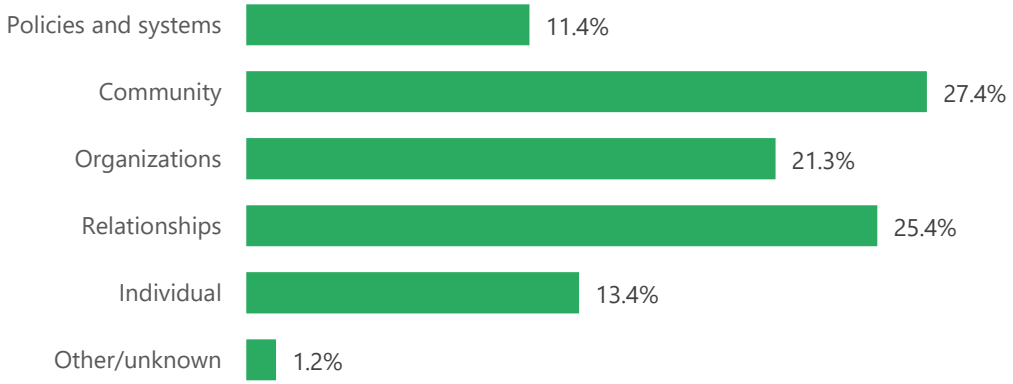
Figure 8 shows the frequency of each program type reported, which follows a similar pattern to the frequencies reported previously at the organizational level, the difference being that here the number of programs is the denominator as opposed to the number of organizations as reported above. The percentages in this table, therefore, sum to 100. As in the figure showing program types in the above section on organizational level findings, the nine program type options that were provided in the survey are represented by the green bars.

Figure 8. Among all programs reported, percent that are each program type (N=358)



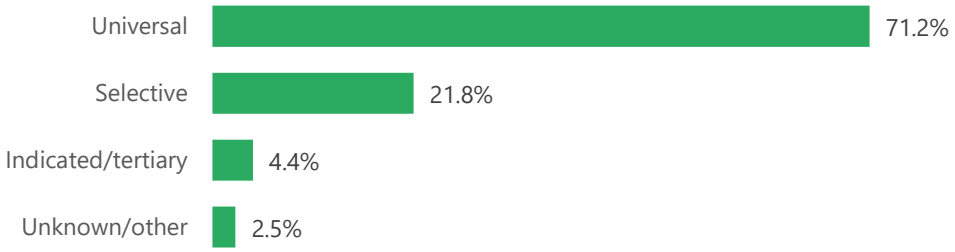
We also examined the frequency of programs at each level of the Vermont Prevention Model and by each of the Institute of Medicine levels of prevention. Around forty percent of programs reported are at the policies/systems and community levels, and sixty percent are at the organization, relationships and individual levels.

Figure 9. Percent of programs at each level of the Vermont Prevention Model (N=343)



The vast majority of the programs reported are considered to be universal prevention (see section "Defining Substance Misuse Prevention Programs and Services" on page 5 for definitions of each IOM category). Given the way in which potential organizations were identified, the self-selection of invited organizations to participate in the survey, and the wording of the survey questions, the categorization of the great majority of programs as being either universal or selective was consistent with the intent of the survey.

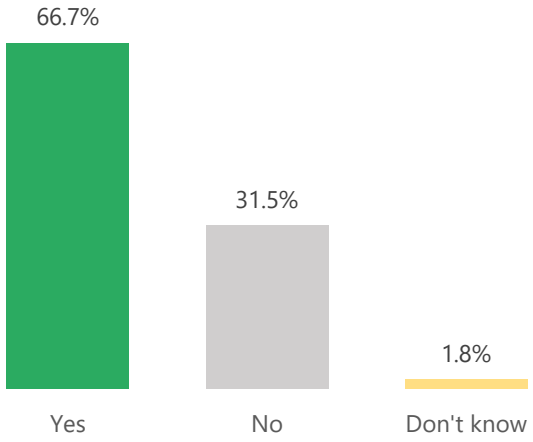
Figure 10. Percent of programs at each of the IOM prevention levels (N=316)



Substance(s) of focus, populations, and geographic areas served

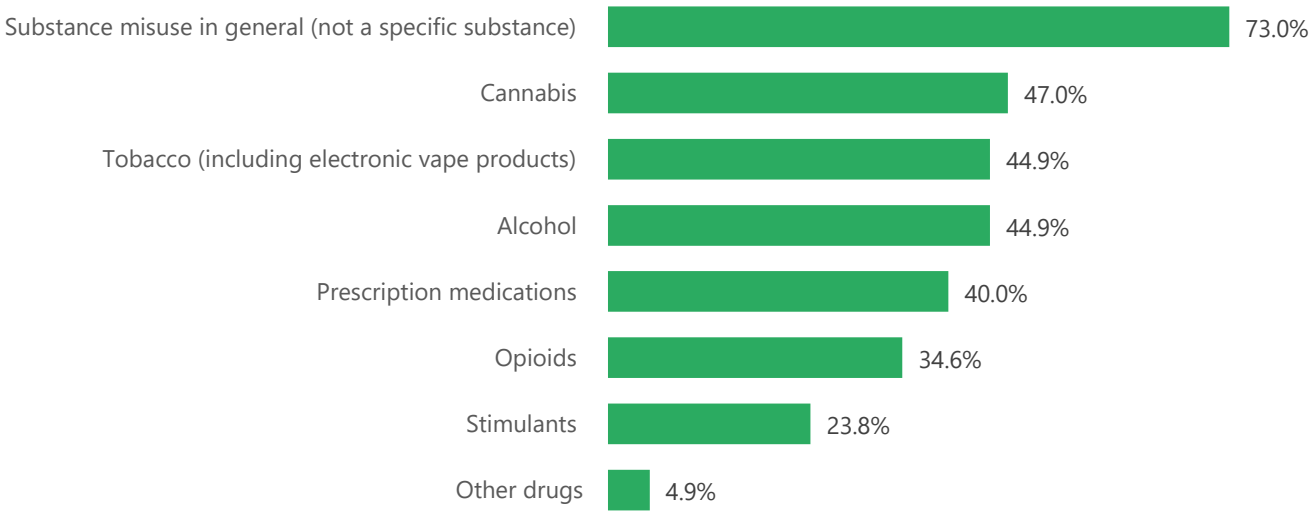
For each program type selected, respondents were asked whether the prevention of substance misuse is a specific focus of the program. Two-thirds of programs were identified as having a substance misuse focus (Figure 11).

Figure 11. Is the prevention of substance misuse an explicit component or focus of this program or intervention? (N=279)



When the response to this question was "yes", the respondent was then asked to identify the specific substance(s) on which the program focuses. Almost three-quarters of programs were identified as focusing on substance misuse in general. It should be noted that a distinction was not made in the response options between opioids and stimulants that are prescription and those that are not. Therefore some respondents may have selected these options even though their focus is on prescription opioids and/or prescription stimulants instead of or in addition to selecting prescription medications.

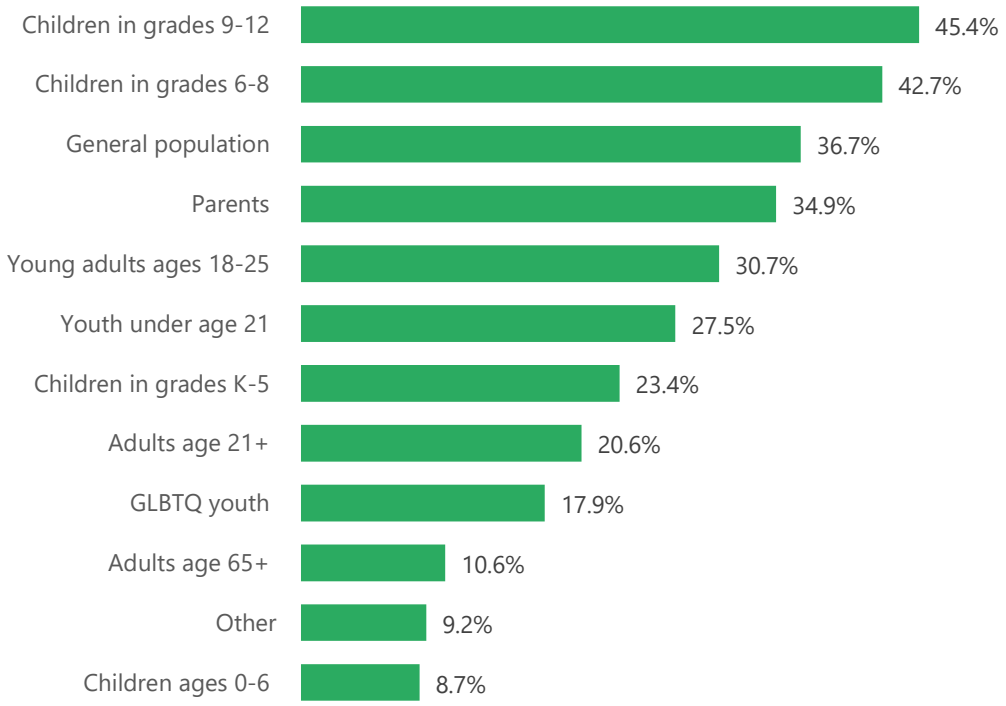
Figure 12. Percent of programs by substance(s) of focus[13] (N=185)



[13] Because multiple substances could be reported, percentages sum to more than 100.

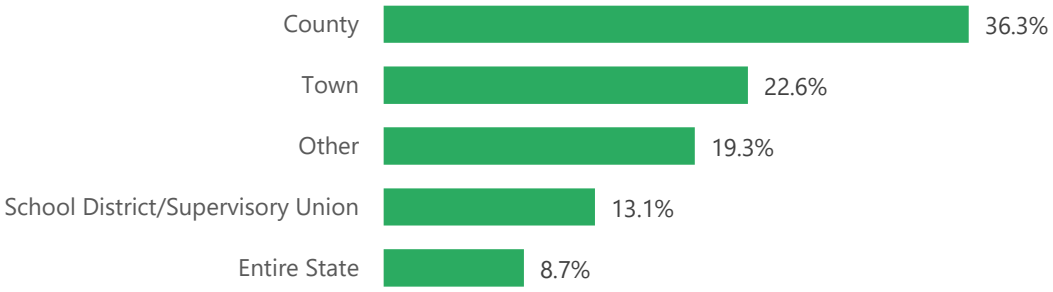
Respondents were asked to identify the primary population(s) and geographic areas served by each program. Note that we are missing some data on populations served for some programs due to an issue with the survey software. Figure 13 includes data from the 218 programs for which we were able to identify populations served. The largest proportion of programs serve youth in middle or high school. There are few programs serving older adults ages sixty-five and up and children six or younger.

Figure 13. Percent of programs by population(s) served[14] (N=218)



Also identified was the primary geographic area served by the program, as shown in Figure 14. The specific county(ies), town(s) or school district(s) were asked when these options were selected. Selected variables are summarized by county in another section of this report.

Figure 14. Percent of programs by geographic area served[15] (N=358)

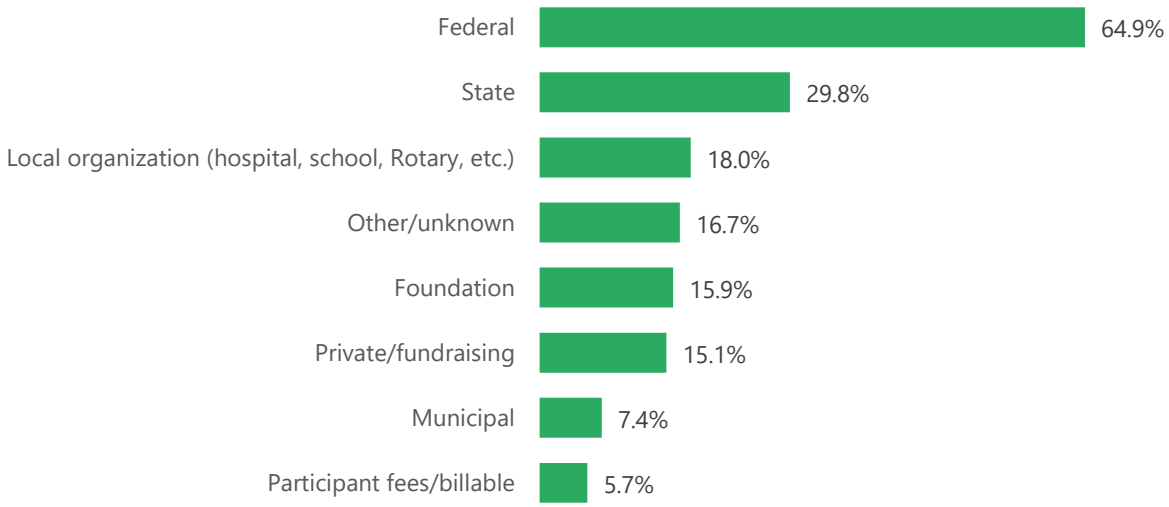


[14] Because multiple populations could be reported, percentages sum to more than 100.
[15] Some of the areas identified as "other" could possibly be recoded into one of the other geographic categories, but the number of these is small.

Funding

There were multiple items in the survey that asked about program funding, including the funding source (which was open-ended), funding start and end dates, and approximate annual cost to implement the program. As noted in the organization-level section, the responses to the question on funding source were categorized into general funding categories. Figure 15 identifies the percent of programs with each type of funding. Again, in this section the denominator is the number of programs as opposed to the number of organizations as reported above.

Figure 15. Percent of programs with each type of funding source[16] (N=245)



In addition to the source, respondents were also asked to identify the timeframe of the funding, including a start and end date. **Over ninety percent of programs indicated a funding end date of December 2021 or before**, meaning that most of the programs only had funding for another year-and-a-half or less from the time the survey was completed. We also calculated the duration of funding using the start and end dates and found that **almost seventy percent of programs had funding for a total of two years or less**.

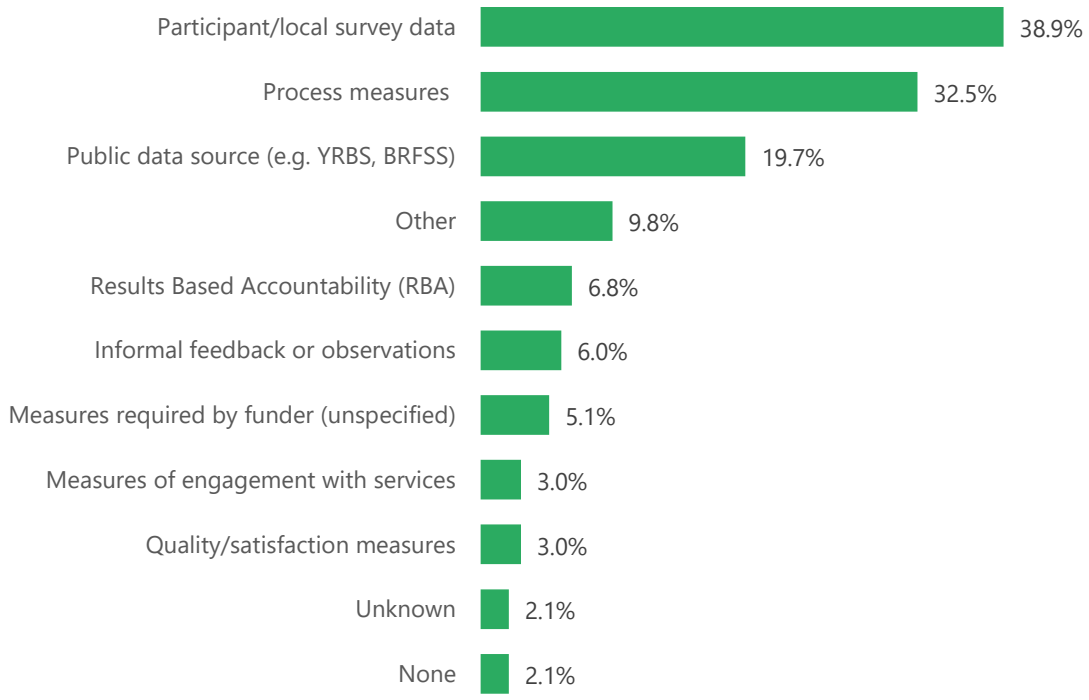
Responses to the question about annual cost of the program varied widely, even within program type, ranging from amounts of less than $100 to over $200,000, leading us to believe that the interpretation of what was being asked differed greatly among the respondents. There were several who indicated in the general comments field of the survey or in their response to this question that it was difficult to estimate the annual cost of specific programs. Some indicated that they had entered the total amount of funding that supports all of their programming. For these reasons, we do not feel that we can present accurate data on the cost of programs represented in this report. This would be an area for further investigation and may also warrant some technical assistance for organizations on tracking program-level costs.

[16] Because multiple funding sources could be reported, percentages sum to more than 100.

Program Effectiveness

Two questions were asked at the program level to understand the effectiveness of the programs being implemented and how outcomes are being measured. The first was whether the program was evidence-based with respect to substance misuse prevention. **Just over half of programs were identified as evidence-based**[17]. In addition, respondents were asked to describe how outcomes are measured for each program. These responses were categorized and the findings are shown in Figure 16, with the most common responses including some type of participant or community survey and process measures such as the number of participants served, number of meetings held, etc.

Figure 16. How program outcomes are measured[18] **(N=234)**



[17] Interpretation of "evidence-based" was left to the respondent. A formal definition or criterion for being an evidence-based program was not provided.

[18] Because multiple approaches may have been reported, percentages may sum to more than 100.

Gaps in Vermont's Prevention Services

An important component of this project as identified by VDH and the SMPC was to identify gaps in substance misuse prevention services provided in Vermont, including whether there are certain levels of the prevention model, populations served and substances addressed that are missing or underrepresented in certain parts of the state, and whether program funding is adequate and sustainable. This section will identify and highlight geographical gaps as well as additional observations of overall patterns (and possible gaps) related to funding across all survey respondents at a statewide level.

Gaps by geography

For the purposes of examining gaps in certain program characteristics by geographic regions, we chose to focus on counties. Programs were counted as serving a county if any of the geographic units they identified as the service area for the program were located within that county. Therefore, programs that are identified in the tables below to be serving a particular county may be serving the entire county, or they may be serving a smaller community within that county (e.g. a town or group of towns, a school district). Also note that organizations and programs may serve more than one county, so the totals reported in the bottom rows of these tables may include organizations or programs that have been counted more than once (i.e., once for each county they serve).

The first two tables in this section examine the distribution of certain types of organizations in each county. Table 2 shows the number of organizations reporting each level of substance misuse prevention focus, by county and Table 3 looks at specific organization types by county.

Table 2. Number of Organizations with Prevention Focus Types by County(ies) Served[19] (N=111)

County	SM prevention is primary focus of organization	SM prevention is primary focus of one or more of its programs[20]	SM is anticipated benefit but not primary focus of any of its programs	Any Type
Addison	5	5	4	14
Bennington	5	2	3	10
Caledonia	5	4	2	11
Chittenden	13	4	6	23
Essex	3	4	0	7
Franklin	7	5	1	13
Grand Isle	4	1	4	9
Lamoille	3	3	3	9
Orange	5	3	4	12
Orleans	4	4	3	11
Rutland	5	6	2	13
Washington	5	3	3	11
Windham	6	1	1	8
Windsor	8	6	6	20
Statewide[21]	7	7	4	18
Totals	85	58	46	189

The service areas of organizations in the first two categories, those whose organizational focus is substance misuse prevention and those that have programs or activities with a primary focus on substance misuse prevention, are fairly evenly distributed throughout the state.

[19] As determined by whether any programs implemented by an organization serve persons within the county (at any level, including county-wide, specific SUs, specific towns, or any other geographic units).
[20] Organizations in this group that serve more than one county don't necessarily implement programs with a primary focus on substance use in every county they serve.
[21] Organizations in this group indicated that one or more of their programs serve the entire state.

The first column of Table 3 below also indicates that all counties are served by at least one organization that identifies as a substance misuse prevention organization or coalition and most counties have more than one prevention organization providing services in at least part of the county. Gaps can be observed for other organization types, but it is important to note that this project is not intended to identify all organizations of these other types; only those that were identified by stakeholders as having a particular focus or programs that relate to the prevention of substance misuse. These data are also limited to only those organizations that responded to the survey.

Table 3. Number of organization Types by County(ies) Served (N=111)

County	Substance misuse prevention org or coalition	Community based non-profit	Statewide non-profit	Hospital or health care org	Law enforcement	Recovery services	College or University	Afterschool provider	Other	Any org type
Addison	1	4	3	1	0	0	1	3	1	14
Bennington	4	1	1	0	0	1	1	1	1	10
Caledonia	2	1	3	1	0	1	1	1	1	11
Chittenden	5	5	4	1	1	1	4	1	1	23
Essex	1	1	2	1	0	1	0	0	1	7
Franklin	2	1	3	3	1	1	1	0	1	13
Grand Isle	2	1	2	2	0	0	1	0	1	9
Lamoille	1	1	1	0	1	1	1	1	2	9
Orange	3	2	1	2	1	0	0	3	0	12
Orleans	2	3	2	0	0	1	1	1	1	11
Rutland	2	3	2	2	0	1	1	1	1	13
Washington	1	5	1	0	0	0	1	1	2	11
Windham	4	0	3	0	0	0	1	0	0	8
Windsor	6	3	2	5	0	0	1	0	3	20
Statewide	1	2	7	1	1	1	2	0	3	18
Totals	37	33	37	19	5	9	17	13	19	189

The next set of tables looks at different characteristics of the programs identified through the survey, by county.

Table 4 shows the distribution of programs by IOM level, showing a fairly even distribution of programs at the universal and selective levels throughout the state.

Table 4. Number of Universal, Selective, and Indicated/Tertiary Programs by County(ies) Served (N=358)

County	Universal	Selective	Indicated/Tertiary	Other or Unknown	Any Level
Addison	19	7	1	1	28
Bennington	20	6	0	1	27
Caledonia	19	3	2	1	30
Chittenden	37	13	4	5	68
Essex	13	2	1	0	18
Franklin	26	7	2	2	46
Grand Isle	19	5	2	0	28
Lamoille	14	2	0	1	27
Orange	19	4	1	0	26
Orleans	14	7	1	1	23
Rutland	24	7	2	2	35
Washington	15	8	2	2	31
Windham	26	5	0	1	33
Windsor	38	12	5	3	62
Statewide	19	10	1	0	31
Totals	322	98	24	20	513

Table 5 includes only those programs that are at the universal or selective levels, and shows the distribution of these programs by the level of the Vermont Prevention Model they address. Each county has at least one program for each level of the Prevention Model with the exception of Lamoille, which does not show any program at the individual level. The pattern of distribution across the levels in individual counties is fairly similar, with more programs addressing the community, organization and relationships levels and fewer at the policies/systems and individual levels.

Table 5. Number of Universal or Selective Programs at Each Level of the Vermont Prevention Model by County(ies) Served (N=294)

County	Policies and systems	Community	Organizations	Relationships	Individual	Any Level
Addison	1	5	7	7	6	26
Bennington	2	8	5	7	4	26
Caledonia	2	8	5	4	3	22
Chittenden	4	16	10	14	6	50
Essex	2	7	3	2	1	15
Franklin	3	10	5	12	3	33
Grand Isle	3	5	3	10	3	24
Lamoille	1	4	6	5	0	16
Orange	2	7	4	7	3	23
Orleans	2	5	5	5	4	21
Rutland	3	10	6	7	5	31
Washington	2	5	4	6	6	23
Windham	4	9	6	8	4	31
Windsor	7	18	10	9	6	50
Statewide	6	5	7	9	2	29
Totals	44	122	86	112	56	420

Tables 6 through 8 show the distribution of populations served and substances of focus by county. These tables were limited to universal and selective programs. As noted in the program level findings section above, due to some missing data on populations served for some programs, tables 6 and 7 include data from the 218 programs for which we were able to identify populations served.

Table 6 includes programs that identified serving different categories of youth. Gaps can be seen in highlighted cells, and include five counties with no programs identified for the youngest age group, and one county with no program identified for GLBTQ youth, a population which experiences disparity in rates of substance misuse.

Table 6. Number of Universal or Selective Programs Serving Each Category of Youth, by County(ies) Served (N=218)

County	Ages 0-6	Grades K-5	Grades 6-8	Grades 9-12	Under age 21	GLBTQ youth
Addison	1	5	8	10	11	6
Bennington	0	3	11	9	5	2
Caledonia	2	6	10	7	4	2
Chittenden	4	7	14	16	10	8
Essex	5	9	10	9	7	6
Franklin	3	2	5	10	6	1
Grand Isle	2	3	5	8	4	1
Lamoille	0	2	4	4	4	2
Orange	2	7	11	10	4	4
Orleans	3	7	9	7	5	6
Rutland	0	4	12	11	9	3
Washington	0	4	4	5	2	0
Windham	0	5	11	11	3	3
Windsor	3	12	20	19	13	5
Statewide	1	4	9	10	5	3
Totals	26	80	143	146	92	52

For adult populations, there are gaps identified in one county for programs that serve all adults over the age of 21, and in three counties for programs that serve older adults.

Table 7. Number of Universal or Selective Programs Serving Each Category of Adults, by County(ies) Served (N=218)

County	General population	Ages 18-25	Adults 21+	Adults 65+	Parents
Addison	1	7	3	2	5
Bennington	6	3	0	0	3
Caledonia	7	7	5	4	5
Chittenden	11	14	8	6	15
Essex	7	10	9	7	9
Franklin	11	7	2	1	8
Grand Isle	8	6	1	0	7
Lamoille	1	3	3	1	3
Orange	5	4	4	2	6
Orleans	6	7	6	5	8
Rutland	9	9	5	3	8
Washington	4	4	5	4	3
Windham	6	7	1	0	5
Windsor	14	15	6	2	10
Statewide	10	6	5	1	6
Totals	106	109	63	38	101

Also, Table 8 shows the distribution of universal and selective programs that focus on specific substances (or substance misuse in general) in each county. The distribution is fairly even in all but Washington County, which shows programs only focusing on substance misuse in general. (Note that organizations in Washington County receive funding from VDH to focus on alcohol, tobacco, prescription medications and cannabis, but the respondents chose to categorize their programs as focusing on substance misuse in general; they also reported fewer programs as having an explicit focus on substance misuse prevention compared to organizations serving other counties).

Table 8. Number of Universal or Selective Prevention Programs Focused on Substance Types by County(ies) Served (N=167)

County	Substance misuse in general	Alcohol	Tobacco, (including vape)	Cannabis	Opioids	Stimulants	Prescription Meds	Other drugs
Addison	16	8	3	10	3	2	3	1
Bennington	9	5	4	5	4	1	4	2
Caledonia	9	8	6	10	7	6	8	1
Chittenden	25	17	14	16	9	5	16	2
Essex	8	9	9	10	9	6	6	2
Franklin	11	8	10	7	6	3	7	1
Grand Isle	7	3	7	3	2	1	3	1
Lamoille	9	6	5	6	2	2	4	1
Orange	13	9	9	9	9	8	9	0
Orleans	13	7	8	9	7	4	4	2
Rutland	17	11	10	10	9	8	13	1
Washington	8	0	0	0	0	0	0	0
Windham	9	11	11	10	8	6	10	2
Windsor	23	19	17	19	16	11	21	4
Statewide	11	0	0	0	1	0	0	0
Totals	188	121	113	124	92	63	108	20

Additional observations

Though not gaps per se, there are some findings related specifically to program funding statewide that are worth noting here as issues for the state and the SMPC to consider. As noted in the findings section, the largest proportion of funding for prevention programs identified through this project are from federal sources, which are typically distributed through discretionary grants directly to community-based organizations or are passed through state agencies to these organizations. The duration of funding sources identified is also relatively short, with almost 70% of programs reporting a two-year or less funding period. Finally, the reported challenges with the ability to identify costs at the program level, as identified by the widely varied responses received and comments made directly by respondents, is worth noting and represents a gap in the findings of this project.

In addition to highlighting zero-frequency cells for specific counties, gaps could also be defined or prioritized according to some predefined framework or standards. For example, the presence of any organization that does not use a structured planning process could be considered a gap. Or the implementation of any program that is not evidence-based or that does not in some way track outcomes. Even the manner in which prevention services are coordinated within a region across provider organizations could be considered in identifying insufficiencies, or gaps, in a regional prevention infrastructure. The tables provided in the report can be used to help identify some of these patterns, although we have not identified them specifically as gaps.

Summary and Recommendations

This report represents a view of the substance misuse prevention landscape in Vermont at a point in time. We know that due to funding cycles that are often unpredictable and other factors such as changing state laws related to the availability of substances (e.g. cannabis, electronic vaping products), the prevention landscape is constantly changing. The information presented in this report could be significantly different in at least some respects as soon as the next calendar year. While the data and information we were able to collect from stakeholders and from organizations surely does not include the entire scope of prevention services being provided around the state (e.g. services provided through schools have been excluded), we believe it provides a relatively comprehensive overview of these services and their characteristics at this particular time (i.e., summer 2020). Finally, it should be noted that although the COVID-19 pandemic is unlikely to have affected organizational characteristics and funding cycles, at least not yet, we know it has caused disruptions in delivery of certain programs, especially those that rely on services delivered in-person.

One of the challenges of developing an inventory of substance misuse prevention services is how to best define these services. If these services are defined too broadly, then we run the risk of losing focus on the specific issues related to substance misuse prevention and the specific solutions that are known to help reduce this problem. An argument can be made that most services or programs that support positive youth development and promote mental health and a healthy community environment could influence substance use and misuse behaviors. For the purpose of this inventory, however, and with the guidance of VDH and the SMPC, we designed a process including interviews and a survey to identify those organizations and programs that have at their core some component that relates directly to the prevention of substance misuse, either explicitly in their content or explicitly recognized as an anticipated outcome.

Our findings overall point to the fact that Vermont has an established network of organizations that together are providing relatively comprehensive prevention services in almost every region of the state. Strengths include the presence of multiple organizations that have a primary focus of substance misuse prevention in every county, and multiple universal and selective prevention programs being implemented in every county. By using county as the primary geographic unit for our analyses, we recognize that there are some limitations to identifying gaps that may exist within counties for any of the characteristics examined. Some of the services or programs identified as serving a particular county may in fact only be reaching a small community within that county. This is an area that warrants further exploration and analysis, and which could be studied with the survey data collected for this project.

Some gaps that were identified within this network of services include programs that serve the very youngest and oldest Vermonters. It is possible that some of the programs that serve families of very young children may not have identified themselves as providing substance misuse prevention services, and therefore may not have completed the survey. Another identified challenge is the short duration of most program funding and the reliance on federal sources of funding, which can often be short-term and fluctuate in their availability. Lastly, the lack of reliable data on the cost of implementing specific programs is noted as a limitation.

Recommendations

Based on these findings, we have the following recommendations:

- Consider supporting a similar process to inventory substance misuse prevention programs and services being implemented within schools. Our conversations with stakeholders indicated that there is a lot of prevention work happening in schools but that these services and programs are not necessarily being implemented consistently across the state. Schools are an important partner in implementing prevention programs and activities and it would be worthwhile to try to better understand and coordinate these efforts at the state level. Some relevant information is collected from schools through the School Health Profiles[22] survey, a CDC-coordinated effort conducted every two years, and would be a logical data source to explore using.

- Though it is not surprising that the majority of prevention services would be provided to school-age youth, young adults and parents, it is worth exploring additional options for services and programs that can be delivered to families with very young children and also to older adults, especially given the aging population of Vermont.

- Consider providing training or technical assistance to prevention service providers on budgeting and tracking their costs at the program level. The ability to do this could be very useful for obtaining funding, sustainability of programs, and also for better understanding and communication of return on investment.

- Through the current project we have established a list of organizations that make up the system of substance misuse prevention services in Vermont right now. One next step that would maximize the usefulness of this information would be to continue to collect information on these prevention programs in real time, or at least on a frequent basis, to keep this list up-to-date. Online access to the information in the inventory via searchable menus or maps would further enhance its usefulness. Making the prevention inventory a regularly updated or "live" resource could also help encourage all eligible organizations to participate.

- A project of this type is not designed to assess the quality of program implementation, other than through some very basic measures such as the use of a strategic planning process or whether programs provided are known (or perceived) to be evidence-based. This important dimension of prevention programming, therefore, could not be reflected in this inventory. High quality implementation should continue to be strongly promoted across the state's network of prevention service providers, because simply the existence of an organization or a specific program is only a starting point for assessing the overall adequacy (or excellence) of a state's prevention infrastructure.

- Sustain a regional structure for prevention across the state, as initiated by the PFS and RPP grant programs. We believe the focus of these grants on regional prevention capacity building likely contributed to the comprehensive scope of services across the state that is seen in the findings presented here.

- Advocate for "rainy day" funding for prevention services from the state during years in which federal funding is less available.

- Develop explicit standards or definitions for what constitutes a statewide prevention-focused system of care, and how to identify "gaps" in that system.

[22] More information on the School Health Profiles can be found here: https://www.healthvermont.gov/health-statistics-vital-records/population-health-surveys-data/school-health-profiles

Appendix A

List of stakeholders interviewed and interview questions

Name	Organization and Role(s)
Lori Tatsapaugh Uerz	ADAP Director of Prevention and Recovery Services
Rhonda Williams	HPDP Public Health Chronic Disease Chief
Maryann Morris	Prevention Network Grant lead, SMPC member, Executive Director of The Collaborative
Melanie Sheehan	Prevention Network Grant lead, SMPC Co-Chair, Regional Prevention Program Manager, Mt. Ascutney Hospital
Hilary Fannin	ADAP Regional Prevention Partnership Program Manager
Matt Whalen Joan Marie Misek	ADAP Prevention Consultant District Director, Barre
Rachel Newton Megan Herrington	ADAP Prevention Consultant District Director, Bennington
Amanda Froeschle Heather Danis	ADAP Prevention Consultant District Director, Burlington
Robin Rieske Laura Overton	ADAP Prevention Consultant District Director, Brattleboro
Alan Saltis Moira Cook	ADAP Prevention Consultant District Director, Middlebury
Michelle Salvador Suzanne Masland	ADAP Prevention Consultant District Director, Morrisville
Julie Raboin Tin Barton-Caplin	ADAP Prevention Consultant District Director, Newport
Sarah A. Roy Renee Bousquet	ADAP Prevention Consultant District Director, Rutland
Heather Barbieri Becky Thomas	ADAP Prevention Consultant District Director, Springfield
Mary Pickener	ADAP Prevention Consultant District Director position vacant at the time of interview, St. Albans

Name	Organization and Role(s)
Kathrin Lawlor Heather Lindstrom	ADAP Prevention Consultant District Director, St. Johnsbury
Claudia Marieb Rudy Fedrizzi	ADAP Prevention Consultant District Director, White River Jct
Dan French	Secretary of the Agency of Education, SMPC member
Beth Keister	Agency of Education, Education Programs Coordinator
Sara Chesbrough Ilisa Stalberg	Maternal and Child Health
Chad Butt	Executive Director, MENTOR Vermont
Holly Morehouse	Executive Director, Vermont Afterschool
Marisa Bolognese	Prevention Works
Ross MacDonald	Agency of Transportation, Public Transit Program Manager
Chris Herrick	Deputy Commissioner of Public Safety, SMPC member
Skyler Genest	Director of Compliance & Enforcement, SMPC member Department of Liquor and Lottery
Amy Brewer	Health Educator, Northwestern Medical Center, SMPC member
Daisy Berbeco	Department of Mental Health, SMPC member
Debby Haskins	Association of Student Assistance Professionals of VT
Kreig Pinkham	Executive Director, Washington County Youth Services Bureau, Vermont Youth Development Program
Allison Laflamme	State Highway Safety Office
Erik Volk	Department of Liquor and Lottery Education Coordinator
Brenda Gooley	Department of Children and Families

Vermont Prevention Inventory

Stakeholder Interview Guide

Introduction

Pacific Institute for Research and Evaluation, or PIRE, is contracted with the Vermont Department of Health to develop an inventory of programs and services that have as an objective the prevention of substance misuse (including tobacco). As one of the first steps in developing this inventory, we are interviewing various stakeholders who are knowledgeable about prevention services around the state. The goal of these interviews is to develop a comprehensive list of organizations or programs that provide substance misuse prevention services. Once this list has been generated, we will be sending each of these organizations or programs a link to an online survey to gather more information about the services they provide such as populations and geographic area served, funding sources and timelines, and other characteristics of their services.

Our discussion will take about 30 minutes. I'll be asking you to identify organizations and/or programs that you are aware of that meet certain criteria which I'll describe. We will share with ADAP, and possibly with these programs, which stakeholder(s) identified them as a provider of substance misuse prevention services. I'd like to record our discussion so that I don't miss or forget anything that we talked about.

Types of programs to be included in inventory

The development of this inventory was requested by the legislature through Act 82. The Substance Misuse Prevention Oversight and Advisory Council (SMPC), also created by Act 82, is providing oversight for this work. The SMPC has developed some definitions for the type of programs that should be included in the inventory. Overall, this inventory will only include **organizations and programs whose mission or stated objective includes the prevention of substance misuse, and/or that are implementing primary[23] (universal) or secondary[24] (selective) prevention strategies.**

During this interview, we are interested in learning about programs or organizations that you are aware of that may be coordinating and/or implementing multiple discrete prevention interventions (e.g., community coalitions), as well as other organizations or programs that may be providing only one prevention service. These programs and strategies can include (but are not limited to):

[23] Primary prevention strategies "…address the entire population (national, local community, school, and neighborhood) with messages and programs aimed at preventing or delaying the abuse of alcohol, tobacco, and other drugs. For example, it would include the general population and subgroups such as pregnant women, children, adolescents, and the elderly. The mission of universal prevention is to prevent the problem. All members of the population share the same general risk for substance abuse, although the risk may vary greatly among individuals. Universal prevention programs are delivered to large groups without any prior screening for substance abuse risk. The entire population is assessed as at-risk for substance abuse and capable of benefiting from prevention programs" (Institute of Medicine).

[24] Secondary (selective) prevention strategies "…target subsets of the total population that are deemed to be at risk for substance abuse by virtue of their membership in a particular population segment… Risk groups may be identified on the basis of biological, psychological, social, or environmental risk factors known to be associated with substance abuse (IOM 1994), and targeted subgroups may be defined by age, gender, family history, place of residence such as high drug-use or low-income neighborhoods, and victimization by physical and/or sexual abuse. Selective prevention targets the entire subgroup regardless of the degree of risk of any individual within the group…The selective prevention program is presented to the entire subgroup because the subgroup as a whole is at higher risk for substance abuse than the general population." (Institute of Medicine).

a. Groups whose mission or objectives include the prevention of substance misuse (e.g., community coalitions)
b. Programs that focus on building community and family assets (e.g. health education campaigns, community mobilization and engagement, parent education)
c. Programs implementing healthy community design (e.g. education on policy approaches to reduce youth substance use, work with municipalities, regional planning commissions, retailers, and others to reduce youth access and exposure to substances)
d. Positive youth development programs (e.g. youth serving agencies, Above the Influence, Our Voices Xposed (OVX) and other peer leadership programs, mentoring)
e. Nurse home visiting programs (e.g. Nurse-Family Partnership)

Questions

1. Given the parameters I just described, please describe any organizations or prevention programs that you are aware of that fit these definitions. We are also interested in any entities that may coordinate prevention efforts at a broader geographic level, including state, regional, or county-wide.

2. For each of the organizations or programs you have mentioned, are you able to provide a contact name and email address?

3. Would you be comfortable with us identifying you as a source of information about the programs you've identified to these organizations or programs?

4. Can you think of anyone else (i.e. any other stakeholders) we should interview who has knowledge of either a specific category or a range of organizations or programs that meet the criteria we have discussed? [note: we are not looking to talk with individual organizations or programs, rather anyone who has information about a larger set of organizations or programs either of a specific type of covering a particular geographic region]

Thank you so much for your time and contributions.

Appendix B

Vermont Prevention Inventory

FINAL Program Survey

Introduction

Thank you for accessing our survey. This survey is being conducted by the Pacific Institute for Research and Evaluation (PIRE). PIRE is contracted with the Vermont Department of Health to develop an inventory of programs in Vermont that provide substance misuse prevention services. This inventory was requested by the legislature through Act 82. Along with the Department of Health, the Substance Misuse Prevention Oversight and Advisory Council (SMPC), also created by Act 82, is providing oversight for this work.

Important information:

- This survey should take between 15-30 minutes, depending on the number of programs related to substance misuse prevention being implemented by your organization.
- The survey will ask questions about the prevention activities in which your organization or program is engaged, including the estimated cost and funding source(s), populations and geographic area served, program effectiveness and other characteristics.
- Activities in which we are interested include programs that have **substance misuse prevention (including tobacco) as their primary objective and focus** as well as programs for which substance misuse prevention is **one of several anticipated benefits or outcomes** but not necessarily the primary objective.
- We understand that the COVID-19 emergency has likely impacted your activities. Please respond to the questions based on your activities before the COVID-19 emergency.

As you respond to the questions, **please only report on programs or interventions that are being directly implemented by [your organization]**. Do not include programs or interventions that are implemented by another entity or community partner, even if they are being funded by your organization. We have sent a survey link to many organizations around the state and your community partners have likely received it and will report on their own activities. You will have an opportunity at the end of the survey to tell us about any of your community partners so that we can make sure they have received the survey.

Please use the “Back” and “Next” buttons at the bottom of each page to navigate through the survey. Please do not use your browser’s forward and back buttons.

If you need to leave the survey before it has been completed, you may go back to it later by clicking on the link that was emailed to you. This will take you to back to the last completed page of your survey. A page is completed once you click on “Next” at the bottom of the page.

Your participation is completely voluntary and you may skip any questions you prefer not to answer. The information collected will help inform the Vermont Department of Health, the SMPC and the Vermont legislature on the status of prevention programs in the state including gaps in services and funding. Information that you provide may be included in a report to the Vermont Department of Health and/or the Vermont legislature, including information that identifies your specific organization or program.

At the end of the survey you will be invited to enter a drawing for a $500 cash prize for your organization or program.

If you have questions about the survey, you may contact Amy Livingston at PIRE at (802) 490-5071 or alivingston@pire.org. For more information about the inventory project or the SMPC, you may contact Nicole Rau Mituguy at the Vermont Department of Health at (802) 951-5803 or Nicole.Rau@vermont.gov.

Questions

***indicates response is required**

Please provide your name and contact information below.

1. Organization Name*
2. First Name*
3. Last Name*
4. Title or role
5. Street Address
6. City
7. State
8. Zip
9. Email Address*
10. Phone Number*
11. URL or web address

12. Which of the following **best** describes your organization? (please select one)
    a. Substance misuse prevention organization or coalition
    b. Community-based social service organization
    c. Statewide social service organization
    d. Hospital/health care organization
    e. Law enforcement
    f. Recovery services

g. College/University
h. Afterschool provider
i. Early childhood education/Childcare provider
j. Court/judicial
k. Drug/alcohol treatment provider
l. Regional Planning Commission
m. Religious organization
n. Restorative Justice
o. State agency (please describe)_____
p. Local government agency (please describe)_____
q. Other (please describe)_____

13. Is the prevention of substance misuse part of the stated mission or the primary objective of **your organization**? Yes/No [if yes, skip to question 16]
14. Is the prevention of substance misuse the primary objective of any of the **programs or other activities** being implemented by your organization? Yes/No [if yes, skip to question 16]
15. Is the prevention of substance misuse an anticipated benefit or outcome of any of the programs or other activities being implemented by your organization? Yes/No [if no, skip to question 31]
16. Has your organization followed a structured planning process (e.g. the Strategic Prevention Framework, Plan-Do-Study-Act, etc.) to guide the selection, planning, and implementation of its programs and interventions? Yes/No/Don't know
17. [if yes] Please describe the planning process used, including the steps involved, and when this was done or how often it occurs.
18. Which of the following types of programs are being implemented by your organization and are related to substance misuse prevention? (check all that apply) If you check any "other" program types, please choose those program types (up to three) that have the strongest and most direct connection to substance misuse prevention.*[soft require]
    a. Policy education and advocacy
    b. Community outreach and education (through traditional and social media and/or materials distribution)
    c. School-based prevention education or intervention
    d. Small group parent education
    e. Peer leadership/youth empowerment

f. Mentoring
g. Nurse home visiting for parents of infants/young children
h. Prescription medication disposal
i. Afterschool program
j. Other program type 1 (please describe)_____
k. Other program type 2 (please describe)_____
l. Other program type 3 (please describe)_____

[If any "other program type" is selected] Please make note of any "other" program types you have identified, as there will be some additional questions about that program type coming up that will only be identified as "Other program type 1", "Other program type 2", etc.

The next set of questions will ask you for more information about each of the program types you selected on the previous page.

[For each type of program selected above, questions 19-30 will be displayed:]

19. Please provide a brief description in a sentence or two of this program or intervention, including the program name if it has one.

    If your organization implements more than one program or intervention of this type, please list and briefly describe each of these programs or interventions here. The first one listed should be the one that is most directly related to substance misuse prevention. Please then focus your answers for the remaining questions in this section on that one program or intervention that you listed first.
20. Is the prevention of substance misuse an explicit component or focus of this program or intervention? Yes/No/Don't know
21. [if yes to 20] Does this program/intervention focus on the prevention of a specific substance or substances, or on substance misuse in general? (please check all that apply)
    a. Substance misuse in general (not a specific substance)
    b. Alcohol
    c. Tobacco (including electronic vape products)
    d. Cannabis
    e. Opioids
    f. Stimulants
    g. Prescription medications
    h. Other drugs (please specify) _____
22. What is the primary objective of this program/intervention? _____

23. What are other objectives of this program/intervention (if any)? _____
24. Please list the funding source(s) for this program/intervention_____
25. What is the timeframe for the funding (i.e. when did it begin and when will it end)? Please enter in MM/DD/YYYY format. Start:_____ End: _____
26. What is the approximate annual cost for implementing this program? _____
27. Which population(s) is (are) the primary focus of this program/intervention? (please check all that apply)
    a. General population
    b. Children ages 0-6
    c. Children in grades K-5
    d. Children in grades 6-8
    e. Children in grades 9-12
    f. Youth under age 21
    g. Young adults ages 18-25
    h. Adults age 21+
    i. Adults age 65+
    j. Parents
    k. GLBTQ youth
    l. Other (please specify) _____
28. What is the primary geographic area served by this program/intervention?
    a. Entire state
    b. County(ies) (please specify)_____
    c. Town(s) (please specify) _____
    d. School district/Supervisory Union (please specify) _____
    e. Other (please specify)_____
29. Is this an evidence-based program/intervention with respect to substance misuse prevention? Yes/No/Don't know
30. How are you measuring outcomes for this program? _____

31. Does your organization provide funds, including pass-through funds, to any other organizations to implement any substance misuse prevention programs or interventions? Yes/No

32. [if yes] Please list any organizations to which you provide funding for substance misuse prevention activities, including the program name, contact person, and email address. We will check our list to make sure they also receive the survey.

    _____

33. Please share any comments or anything you have to add about the topics that were asked about in the survey, or about your experience taking the survey._____
34. Please briefly describe how the COVID-19 emergency has impacted the work of your organization.

Thank you very much for completing this survey. We appreciate your time.

As a reminder, **please do not share the survey link that was sent to you** as it is unique to your organization.

You are now able to enter a drawing for $500 prize for your organization.

To enter the drawing, please respond "yes" to the question on this page. You will then be directed to a separate site and be asked to provide your organization, name, e-mail address, and phone number. This drawing entry site is entirely separate from the survey site.

Would you like to enter the drawing? Yes/No

If yes, will be directed to drawing entry site. See page 2.

If no, will see the following message:

Thank you for taking our survey. Please contact Amy Livingston at 802-490-5071 or alivingston@pire.org with any questions.

Vermont Prevention Inventory 2020 Prize Drawing Entry Form

Please provide the following contact information to enter the drawing to win $500 for your organization. Note that duplicate entries will be discarded.

The winning organization will be randomly selected at the end of the survey period and will be notified in September.

[all items are required]

Organization name_____

First name_____ Last name_____

Email address_____

Phone number_____

If you decide not to enter this drawing, please delete any contact information entered above and then close your browser.

Once submitted, the following message will appear:

Thank you!

You have been entered into the prize drawing. The winner will be notified in September.

Contact Amy Livingston at 802-490-5071 or alivingston@pire.org with any questions.

Appendix C

Vermont Inventory Survey Tables of Results

Organization-level items	Number	Percent
Title/Role of respondent (N=111)		
Program Director/Coordinator	41	39.1
Executive Director/CEO	45	42.9
Regional Planner	2	1.9
Maternal Child Health Coordinator/Public Health Nurse	1	1.0
Law Enforcement Officer	3	2.9
Grant Manager	3	2.9
Prevention Specialist/Consultant	4	3.8
Other	6	5.7
Organization type (N=111)		
Substance misuse prevention organization or coalition	24	21.6
Community-based non-profit/social service organization	20	18.0
Statewide non-profit/social service organization	10	9.0
Hospital/health care organization	12	10.8
Law enforcement	3	2.7
Recovery services	8	7.2
College/University/academic	5	4.5
Afterschool provider	12	10.8
Early childhood education/Childcare provider	1	0.9
Court/judicial	1	0.9
Drug/alcohol treatment provider	2	1.8
Regional Planning Commission	2	1.8
Religious organization	0	0.0
Restorative Justice	2	1.8
Local government agency	3	2.7
Other	6	5.4
Prevention of substance misuse is primary objective of organization (N=111)		
Yes	50	45.1
No	61	55.0

Prevention of substance misuse is primary objective of programs or activities (N=61) (only answered if no to previous question)		
Yes	33	54.1
No	28	45.9
Prevention of substance misuse is anticipated benefit or outcome of programs or activities (N=28) (only answered if no to previous two questions)		
Yes	28	100.0
No	0	0.0
Organization has followed structured planning process (N=107)		
Yes	49	45.8
No	42	39.3
Don't know	16	15.0
If yes to previous question, type of planning process used (N=46) (Because multiple types of planning processes could be reported, percentages sum to more than 100)		
Strategic Prevention Framework (SPF)	21	45.7
Plan, Do, Study, Act (PDSA)	7	15.2
Collection and/or review of data	4	8.7
Iceland Model	3	6.5
Results Based Accountability (RBA)	5	10.9
Community Planning and Engagement/Strategic Planning	9	19.6
Needs Assessment	7	15.2
Other	13	28.3
Types of programs being implemented (N=107)[25] (because multiple types of programs could be reported, percentages sum to more than 100)		
Policy education and advocacy	40	37.4
Community outreach and education	64	59.8
School/college-based prevention education or intervention	46	43.0
Small group parent education	32	29.9
Peer leadership/youth empowerment	46	43.0
Mentoring	27	25.2
Nurse home visiting for parents of infants/young children	6	5.6
Prescription medication disposal	23	21.5
Afterschool/camp/third space programming	27	25.2
Recovery services/supports	4	3.7
Screening/SBIRT	2	1.9
Tobacco cessation	3	2.8

[25]Four organizations entered information about their organization, but did not enter any data on any of their programs.

Treatment for substance use disorder	1	0.9
Mental health counseling/support	4	3.7
Law enforcement/judiciary	3	2.8
Overdose prevention	1	0.9
Other	25	23.4
Funding sources (N=92) (because multiple funding sources could be reported, percentages sum to more than 100)		
Federal	59	64.1
State	35	38.0
Municipal	13	14.1
Foundation	26	28.3
Local organization (hospital, school, Rotary, etc.)	27	29.4
Private/fundraising	28	30.4
Participant fees/billable	11	12.0
Other/unknown	26	28.3
No funding	5	5.4
Organization provides funds to others to implement substance misuse prevention activities (N=110)		
Yes	18	20.0
No	72	80.0
General Comments (N=28) (because multiple types of comments could be reported, percentages sum to more than 100)		
Context for or clarification of responses	10	35.7
Additional information about the organization and/or programs	5	17.9
Had difficulty answering items on program cost	5	17.9
Other difficulty with survey or particular questions(s)	3	10.7
Survey took longer than expected	5	17.9
Suggestions for survey and/or prevention in general	3	10.7
Other	4	14.3
Impacts of COVID-19 (N=90) (because multiple types of impacts could be reported, percentages sum to more than 100)		
Direct service/in-person programming and relationship building has been limited	16	17.8
Negative effect on community and clients served (stress, isolation, increased substance use, etc.)	11	12.2
Programs have been slowed or put on hold	34	37.8
Adapted to provide services remotely	37	41.1
Some beneficial consequences (removal of transportation barrier/better access for rural clients, creativity, etc.)	5	5.6

Some or all in-person services have resumed or will resume soon	10	11.1
Challenges to providing services remotely (technology issues, harder to engage youth, safety concerns accessing from home, etc.)	13	14.4
Decrease in service utilization; reaching fewer people	6	6.7
Harder to engage in prevention due to other pressing needs/concerns	4	4.4
Focus of the work and programming has shifted to meet more immediate needs	8	8.9
Negative effect on funding/budget (or expectation that there will be)	5	5.6
Considered essential service	2	2.2
Decrease in staff/volunteer capacity or decrease in stakeholder engagement	7	7.8
Increased need for services and supports	3	3.3
Work has not really been impacted by COVID	1	1.1

Program-level Items	**Number**	**Percent**
Program Type (N=358)		
Policy education and advocacy	40	11.2
Community outreach and education	64	17.9
School/college-based prevention education or intervention	46	12.9
Small group parent education	32	8.9
Peer leadership/youth empowerment	46	12.9
Mentoring	27	7.5
Nurse home visiting for parents of infants/young children	6	1.7
Prescription medication disposal	23	6.4
Afterschool/camp/third space programming	27	7.5
Recovery services/supports	4	1.1
Screening/SBIRT	2	0.6
Tobacco cessation	3	0.8
Treatment for substance use disorder	1	0.3
Mental health counseling/support	4	1.1
Law enforcement/judiciary	3	0.8
Overdose prevention	1	0.3
Other	29	8.1
Prevention of substance misuse explicit component or focus? (N=279)		
Yes	186	66.7
No	88	31.5
Don’t know	5	1.8

If yes, substance(s) of focus (N=185) (because multiple substances could be reported, percentages sum to more than 100)		
Substance misuse in general (not a specific substance)	135	73.0
Alcohol	83	44.9
Tobacco (including electronic vape products)	83	44.9
Cannabis	87	47.0
Opioids	64	34.6
Stimulants	44	23.8
Prescription medications	74	40.0
Other drugs	9	4.9
Number of Programs at Each Level of Vermont's Prevention Model[26] (N=343)		
Policies and systems	39	11.4
Community	94	27.4
Organizations	73	21.3
Relationships	87	25.4
Individual	46	13.4
Other/Unknown	4	1.2
Number of Programs at each Institute of Medicine Level of Prevention[27] (N=316)		
Universal	225	71.2
Selected	69	21.8
Tertiary/Treatment, harm reduction, or recovery services	14	4.4
Unknown/Other	8	2.5
Funding source(s) (N=245) (because multiple funding sources could be reported, percentages sum to more than 100)		
Federal	159	64.9
State	73	29.8
Municipal	18	7.4
Foundation	39	15.9

[26] Levels of the Vermont Prevention Model were assigned using information provided by respondents in several program survey questions including program type and description, and is based on a socio-ecological model adopted by the Vermont Department of Health that depicts five different levels of environmental and personal factors that can influence behavior and health outcomes. More information on the Vermont Prevention Model can be found here: https://www.healthvermont.gov/alcohol-drug-abuse/programs-services/how-prevention-works.

[27] Institute of Medicine levels of prevention were assigned using information provided by respondents in several program survey questions including program type and description and is based on the Institute of Medicine classifications of prevention. More information on the Institute of Medicine classifications can be found here: http://dpbh.nv.gov/uploadedFiles/mhnvgov/content/Meetings/Bidders_Conference/Institute%20of%20Medicine%20Prevention%20Classifications-rev10.20.14.pdf

Local organization (hospital, school, Rotary, etc.)	44	18.0
Private/fundraising	37	15.1
Participant fees/billable	14	5.7
Other/unknown	41	16.7
No funding	6	2.5
Funding end date (N=174)		
12/31/20 or before	69	39.7
01/01/21 to 06/30/21	63	36.2
07/01/21 to 12/31/21	28	16.1
01/01/22 to 06/30/22	3	1.7
07/01/22 to 12/31/22	3	1.7
after 12/31/22	8	4.6
Overall funding duration in months (N=172)		
less than 12	15	8.7
12	72	41.9
13-24	28	16.3
25-36	7	4.1
37-60	25	14.5
more than 60	25	14.5
Populations served (N=218) (because multiple populations could be reported, percentages sum to more than 100)		
General population	80	36.7
Children ages 0-6	19	8.7
Children in grades K-5	51	23.4
Children in grades 6-8	93	42.7
Children in grades 9-12	99	45.4
Youth under age 21	60	27.5
Young adults ages 18-25	67	30.7
Adults age 21+	45	20.6
Adults age 65+	23	10.6
Parents	76	34.9
GLBTQ youth	39	17.9
Other	20	9.2
Geographic level served by program (N=358)		
State	31	8.7
County	130	36.3
Town	81	22.6

School District/Supervisory Union	47	13.1
Other	69	19.3
Evidence-based with respect to substance misuse prevention? (N=273)		
Yes	140	51.3
No	98	35.9
Don't know	35	12.8
How measuring outcomes? (N=234) (because multiple approaches could be reported, percentages sum to more than 100)		
Public data source (e.g. YRBS, BRFSS)	46	19.7
Participant/local survey data	91	38.9
Process measures (e.g. number of participants, meetings, etc.)	76	32.5
Quality/satisfaction measures	7	3.0
Informal feedback or observations	14	6.0
Measures required by funder (unspecified)	12	5.1
Measures of engagement with services	7	3.0
Results Based Accountability (RBA)	16	6.8
None	5	2.1
Other	23	9.8
Unknown	5	2.1